Supplementary Material

Global research hotspots and trends on robotic surgery in obstetrics and gynecology: A bibliometric analysis based on VOSviewer

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**Supplementary Data S1.** Data of 1 430 papers related to robotic surgery in obstetrics and gynecology.

FN Clarivate Analytics Web of Science

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PT J

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AF Marty, Lindsay

Myrick, Olivia

TI Discrepancy in Gynecologic Case Volumes and Surgical Participation of

Obstetrics/Gynecology Residents

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article; Early Access

DE surgical education; surgical training; surgical residency; resident

education; obstetrics and gynecology education; obstetrics and

gynecology residency

AB Objective: Gynecology residents have self-reported deficits in preparation for surgical practice, particularly in robotic training. The primary source of surgical training is active participation in an operating room, which can be documented in a resident's case log. Educators and trainees may assume an institution's case volume reflects residents' participation, but there is no standard way to hold attending physicians accountable for surgical education, case-by-case. This study examined the percent of major gynecologic cases that allowed active trainee participation over 3 months at a major academic medical center.Materials and Methods: A baseline assessment of obstetrics/gynecology residents' participation in gynecologic surgical cases was conducted over 3 months at a large, urban academic medical center. All open and robotic gynecologic cases were recorded by the residency education team. Trainees were asked to document if a resident was present in a surgical case and that resident's level of participation in the procedure.Results: Of 324 open and robotic gynecologic surgeries, 74% were covered by residents. Of the 240 cases in which residents participated, 71% could be entered into clinical case logs, and 29% permitted minimal to no active participation. Thus, residents were only able to log active participation in 53% of all open and robotic gynecologic cases in the 3-month timeframe.Conclusions: Operative case volume at an academic medical center does not necessarily reflect resident participation and surgical training experience; there is a need to incorporate surgical-teaching skills into faculty-development programs and to emphasize the importance of active participation, case by case, in residency training further. (J GYNECOL SURG 20XX:000)

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PT J

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TI Pelvic floor and sexual function 3 years after hysterectomy - A

prospective cohort study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article; Early Access

DE abdominal hysterectomy; female sexual function; laparoscopic

hysterectomy; minimally invasive surgery; pelvic floor function; robotic

assisted laparoscopic hysterectomy; urinary incontinence

ID FUNCTION INDEX FSFI; LAPAROSCOPIC HYSTERECTOMIES; ORGAN PROLAPSE; WOMEN;

DISORDERS; PREVALENCE; VALIDATION; TRENDS

AB Introduction: Long term effects after hysterectomy, such as a worsening of pelvic floor and sexual function, have been studied with diverse results. Therefore, we investigated the long-term effects of hysterectomy for benign indication on pelvic floor and sexual function as well as differences in outcome depending on mode of hysterectomy.Material and methods: In a prospective clinical cohort study, we included 260 women scheduled for hysterectomy who answered validated questionnaires; pelvic floor impact questionnaire (PFIQ-7), pelvic floor distress inventory (PFDI-20) and female sexual function index (FSFI). Participants were followed up to 3 years after surgery. Nonparametric statistics and mixed effect models were used in analyses of the data.Results: After exclusions, 242 women remained in the study, with a response rate at the 3-year follow-up of 154/242 (63.6%) for all questionnaires. There was an improvement of pelvic floor function with a mean score of PFIQ-7 at baseline of 42.5 (SD 51.7) and at 3 years 22.7 (SD 49.4), (p < 0.001) and mean score of PFDI-20 at baseline was 69.6 (SD 51.1) and at 3 years 56.2 (SD 54.6), (p = 0.001). A deterioration of sexual function was seen among the sexually active women after 3 years with a mean score of FSFI at baseline 25.2 (SD 6.6) and after 3 years 21.6 (SD 10.1), (p < 0.001). However, this was not consistent with the unaltered sexual function for the whole cohort. No difference in pelvic floor or sexual function was detected when comparing robotic assisted laparoscopic hysterectomy, laparoscopic hysterectomy and abdominal hysterectomy.Conclusions: Three years after surgery robotic assisted laparoscopic hysterectomy, total laparoscopic hysterectomy and abdominal hysterectomy improve pelvic floor function to the same extent. Among the sexually active women, a decline of sexual function was seen after 3 years, not consistent with the entire cohort and independent of surgical methods. Whether this is a trend associated with aging or menopausal transition remains to be studied.

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TI The new surgical robot HugoTM RAS for total hysterectomy: a pilot study

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Robotic surgery; hysterectomy; surgical outcomes; malfunction; safety;

Hugo

ID TELELAP ALF-X; LAPAROSCOPIC HYSTERECTOMY; SYSTEM; FEASIBILITY;

MALFUNCTION; SURGERY

AB Background: With the rising popularity of robotic surgery, HugoTM RAS is one of the newest surgical robotic platforms. Investigating the reliability of this tool is the first step toward validating its use in clinical practice; and presently there arelimited data available regarding this. The literature is constantly enriched with initial experiences, however no study has demonstrated the safety of this platform yet. Objectives: This study aimed to investigate its reliability during total hysterectomy. Materials and Methods: A series of 20 consecutive patients scheduled for minimally invasive total hysterectomy with or without salpingo-oophorectomy for benign disease or prophylactic surgery were selected to undergo surgery with HugoTM RAS. Data regarding any malfunction or breakdown of the robotic system as well as intraand post-operative complications were prospectively recorded. Results: Fifteen of the twenty patients (75.0%) underwent surgery for benign uterine diseases, and five (25.0%) underwent prophylactic surgery. Among the entire series, an instrument fault occurred in one case (5.0%). The problem was solved in 4.8 minutes and without complications for the patient. The median total operative time was 127 min (range, 98-255 min). The median estimated blood loss was 50 mL (range:30-125 mL). No intraoperative complications were observed. One patient (5.0%) developed Clavien-Dindo grade 2 postoperative complication. Conclusions: In this pilot study, HugoTM RAS showed high reliability, similar to other robotic devices. What is new? Present findings suggest that HugoTM RAS is a viable option for major surgical procedures and deserves further investigation in clinical practice.

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PT J

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TI En-block butterfly excision of posterior compartment deep endometriosis:

The first experience with the new surgical robot

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Endometriosis; robotic surgery; docking; minimally invasive surgery.

ID INFILTRATING ENDOMETRIOSIS

AB Background: Minimally invasive surgery is the gold standard treatment for deep endometriosis when medical management fails. In selected cases, such as when bowel or urinary tract are involved, robotic assisted surgery can be useful due to its characteristics of high dexterity and manoeuvrability. This is the first case of robotic en-bloc excision of posterior compartment deep endometriosis performed with the new HugoTM RAS system. Objective: The purpose of this video article is to show for the first time the feasibility of bowel surgery for deep endometriosis with this new robotic device. Materials and methods: A 24-years-old woman affected by severe dysmenorrhea, chronic pelvic pain, dyschezia and dyspareunia underwent to deep endometriosis excision using the new robotic platform HugoTM RAS system at the Unit of Gynaecological Oncology, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy. Main outcome measures: Intraoperative data, docking set up, post-operative outcomes up to three months follow up were evaluated. Results: The surgical procedure was carried out without in tra-operative or post-operative complications, operative time (OT) was 200 minutes, while docking time was 8 minutes. No system errors or faults in the robotic arms were registered. Post-operative complete disease-related symptoms relief was reported. Conclusion: According to our results, the introduction of this new robotic platform in the surgical management of deep endometriosis seems to be feasible, especially in advanced cases. However, further studies are needed to demonstrate the benefits of this surgical system and the advantages of robotic surgery compared to laparoscopy in this subset of patients.

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ER

PT J

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TI Robotic Surgery in Gynaecology: A Retrospective Evaluation of an

Experience at a Single Centre

SO JOURNAL OF OBSTETRICS AND GYNECOLOGY OF INDIA

LA English

DT Article; Early Access

DE Hysterectomy; Laparoscopy; Robotic; Myomectomy; Cystectomy

ID ENDOMETRIOSIS; HYSTERECTOMY; MYOMECTOMY; DIAGNOSIS

AB ObjectiveThe aim of this research was to assess the role of robotics and its outcome in gynaecology both in benign and malignant cases in a single centre and provide a critical evaluation of possible advantages of robot assisted surgeries from surgeons' point of view.DesignA single centre, retrospective observational study.PopulationAll women who underwent robotic gynaecological surgeries between 2015 and 2022.MethodsThe Da Vinci Si (TM) robotic system was used for these surgeries performed by all surgeons at our quaternary care centre, and data were acquired retrospectively through electronic medical records. Descriptive statistical analysis of data was done. Main outcome measures included operative time, estimated blood loss, hospital stay, complications and conversion rates in all cases. Age was analysed as a demographic data.OutcomeA total of 211 robotic cases were performed including 172 hysterectomies, 20 myomectomies and 19 cases for other gynaecological indications. The mean operating time or hysterectomy and myomectomy was 113 and 129 min, respectively, and haemoglobin drop was 1.34 and 1.2 g/dl, respectively. No conversions to laparotomy were observed in either of the groups. The surgeries for 19 benign gynaecological conditions included ovarian cystectomy, cesarean scar repair and chronic cornual ectopic.ConclusionRobotic surgical system helps accomplish several procedures with exceptional laparoscopic skills. Robotic surgery is safe in all types of gynaecological procedures and is a promising alternative for comprehensive gynaecologic surgical care.

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TI First experience with the Hugo™ robot-assisted surgery system for

endometriosis: A descriptive study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article; Early Access

DE endometriosis; gynecological surgery; Hugo (TM) RAS; IDEAL framework;

robotic surgical procedures

ID PERIOPERATIVE OUTCOMES; CLASSIFICATION; COMPLICATIONS; COHORT

AB Introduction: The Medtronic Hugo (TM) Robot-assisted Surgery (RAS) system was recently approved for clinical use. We explored the safety and feasibility of this system for endometriosis surgery. The primary outcome was safe case completion without major surgical complications (Clavien-Dindo grade <= 2) and no conversion to open surgery or laparoscopy.Material and methods: Surgeries for endometriosis performed at the Department of Gynecology, Rigshospitalet, on the Medtronic Hugo (TM) RAS system were included. Two experienced robotic surgeons performed all surgeries with their usual robotic team. The variables included were patient demographics, peri- and postoperative data, complications and 30-day readmission rate. We used the IDEAL framework 1/2a for surgical innovation in this descriptive study.Results: The first 12 patients were included. All cases were completed without intraoperative complications or conversion. Four patients experienced Clavien-Dindo grade 1 postoperative complications. No patients were re-admitted within 30 days. Median docking time (17 minutes), console time (87.5 minutes), blood loss (40 mL) and length of hospital stay (1 day) were acceptable compared with previous literature.Conclusions: In this pilot study, we found the Medtronic Hugo (TM) RAS system safe and feasible for robot-assisted surgery for endometriosis. The advent of new robotic systems is welcomed to accelerate the development of technology that will advance surgical care for patients across the globe.

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PT J

AU Hebert, T

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TI Robotic assisted laparoscopy for deep infiltrating endometriosis

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Robotic surgery; Endometriosis; Laparoscopy; Fertility; Colorectal

surgery; Urinary tract; Diaphragmatic endometriosis; Pelvic nerves

ID NERVE-SPARING SURGERY; INDOCYANINE GREEN; DIAPHRAGMATIC ENDOMETRIOSIS;

COLORECTAL RESECTION; SURGICAL-MANAGEMENT; CLINICAL-USE; BLADDER;

VISUALIZATION; FEASIBILITY; PREVALENCE

AB Deep infiltrative endometriosis is a condition affecting up to 15 % of women of childbearing age, defined by extra uterine location of endometrial like tissues. The symptoms of endometriosis range from severe dysmenorrhea to infertility, chronic pelvic pain, bowel dysfunction and urinary tract involvement to name the most common. Endometriosis has an impact on the quality of life of patients, with personal and social consequences. Although medical treatment is indicated in the first instance, surgery may be necessary. Standard laparoscopy has become the gold standard for this surgery. However, surgery for deep infiltrative endometriosis is known to be highly complex, and the significant development of robotic assistance in recent years has had an impact on the evolution of surgical practice. This comprehensive review of the literature provides an overview of the contributions of robotic surgery in the field of endometriosis and gives an insight into the next steps in its development.

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PT J

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King, CR

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King, Cara R.

TI Surgical techniques for mini-laparotomy myomectomy

SO FERTILITY AND STERILITY

LA English

DT Article

DE Myomectomy; fertility sparing; leiomyoma; fibroid; minimally invasive

surgery

AB Context and background: The prevalence of uterine fibroids is estimated to be approximately 80%. Fibroids can be associated with abnormal uterine bleeding, pressure symptoms, and infertility. Given this high prevalence, approximately 30,000 myomectomies are performed in the United States per year. Minimally invasive approaches are preferred, if feasible. The minimally invasive techniques include laparoscopic, robot-assisted, hysteroscopic, and mini-laparotomy.Objective: To discuss the multiple techniques for optimizing the use of mini-laparotomy in minimally invasive myomectomy.Design: We use intraoperative surgical video to demonstrate techniques that optimize the use of the mini-laparotomy for myomectomy.Setting: Cleveland Clinic.Patient(s): Patient's undergoing fertility preserving, minimally invasive myomectomy at the Cleveland Clinic. The patient(s) included in this video gave consent for publication of the video and posting of the video online, including social media, the journal website, sci-entific literature websites (such as PubMed, ScienceDirect, and Scopus), and other applicable sites.Intervention(s): After the surgeon has selected to proceed with mini-laparotomy myomectomy, different techniques can be employed to optimize management. We demonstrate and discuss these techniques to ensure that surgeons have a set of tools to tackle a fibroid uterus. These techniques include direct palpation of the fibroids, use of a uterine manipulator to visualize the endometrial cavity, use of the uterine manipulator to aid in repair of the cavity if entered, suturing technique that avoids the endometrial cavity and therefore limits foreign body exposure and decreases intrauterine adhesion formation, utilization of barbed suture in a layered fashion, in-situ debulking to avoid injury to fallopian tubes and other critical uterine structures, easy identification of the optimal enucleation plane, use of single hysterotomy for multiple fibroids, visualization of the "Tortuga"sign, and evaluation of the abdominal cavity using the mini-laparotomy site as a port site. To limit postoperative adhesion formation, the investigators place cellulose-based adhesion barriers with peritoneum closure. Although the need for prolonged postoperative observation can be made on a case-by -case basis, we consider this as an outpatient surgery and anticipate same-day discharge for our patients.Main outcome measure(s): In this video, we perform a mini-laparotomy myomectomy optimally and describe the techniques employed.Result(s): Specific techniques employed in mini-laparotomy myomectomy make the case safe, effective, and can lead to same-day discharge.Conclusion(s): Mini-laparotomy myomectomy is a technique used to perform minimally invasive myomectomy. Following the discussed steps, surgeons can be more confident in performing this method of myomectomy. (Fertil Steril (R) 2023;120:1262-3. (c) 2023 by American Society for Reproductive Medicine.) Use your smartphone to scan this code

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TI Oncologic outcomes of robot-assisted laparoscopy versus conventional

laparoscopy for the treatment of apparent early-stage endometrioid

adenocarcinoma of the uterus

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Outcomes; Laparoscopy; Minimally invasive surgery;

Robotic surgery

ID HYSTERECTOMY; CANCER; SURGERY; SURVIVAL

AB <bold>Objective: </bold>To compare long-term oncologic outcomes in patients with clinically uterine-confined endometrioid endometrial cancer who underwent surgical staging with robot-assisted (RA) versus conventional laparoscopy.<bold>Methods: </bold>We performed a retrospective chart review of patients with newly diagnosed, uterine-confined endometrioid endometrial cancer who were treated and had primary surgery at our institution between 1/1/2009-1/1/2018. Clinicopathologic, surgical, and survival data were collected. Appropriate statistical methods were applied.<bold>Results: </bold>Of 1728 patients identified, 1389 (80.4%) underwent RA and 339 (19.6%) conventional laparoscopy. At diagnosis, median age was 60 years (range, 24-92) and median BMI was 30.2 kg/m(2) (range, 15.1-71.5). In the RA group, patients had longer operative time (170 vs 152 min, P < .001), lower conversion rate to laparotomy (0.6% vs 4.7%, P < .001), and a higher proportion had a BMI > 40 kg/m(2) (17.2% vs 11.5%, P = .01) and same-day discharge (19.2% vs 5.3%, P < .001). Overall, 93% (RA) and 90% (conventional) of patients underwent lymph node assessment (P = .1). Comparing the RA versus conventional groups, final surgical stage on pathology (P = .6), median follow-up (55.7 vs 52.9 months, P = .4), and rates of perioperative complications (9.9% vs 7.7%, P = .6), recurrence (9.5% vs 7.4%, P = .3), 5-year PFS (88.5% vs 91.0%, P = .3), and 5-year OS (92.5% vs 92.4%, P = .7) were not significantly different. No significant increase in risk of recurrence (HR = 1.2, 95% CI: 0.8-1.9, P = .3) or poorer OS outcomes (HR = 0.9, 95% CI: 0.6-1.4, P = .7) were observed in the RA group.<bold>Conclusion: </bold>In uterine-confined endometrioid endometrial cancers, surgical staging using RA laparoscopy was not associated with adverse survival outcomes compared to conventional laparoscopy.

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DA 2024-01-18

ER

PT J

AU Collins, A

Jacob, A

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AF Collins, Anna

Jacob, Annie

Moss, Esther

TI Robotic-assisted surgery in high-risk surgical patients with endometrial

cancer

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Robotic-assisted hysterectomy; Laparoscopic hysterectomy; Frailty;

Obesity; Prehabilitation

ID OBESE-PATIENTS; FRAILTY; MANAGEMENT; SURVIVAL; IMPACT; PREHABILITATION;

HYSTERECTOMY; LAPAROSCOPY; LAPAROTOMY; ANESTHESIA

AB Many patients diagnosed with an endometrial cancer are at high-risk for surgery due to factors such as advanced age, raised body mass index or frailty. Minimally-invasive surgery, in particular robotic-assisted, is increasingly used in the surgical management of endometrial cancer however, there are a lack of clinical trials investigating outcomes in high-risk patient populations. This article will review the current evidence and identify areas of uncertainty where future research is needed.

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FX No funding was obtained for this study. This research was carried out at

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Biomedical Research Centre (BRC) .

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J9 BEST PRACT RES CL OB

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OA hybrid

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ER

PT J

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Alrayyes, N

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Flynn, M

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Alrayyes, Nasser

Garcia, Katerina

Flynn, Michael

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Vallejo, Manuel

TI The effect of sugammadex on postoperative urinary retention

post-laparoscopic and robotic hysterectomy with and without concomitant

procedures

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Early Access

DE Postoperative urinary retention; Sugammadex; Glycopyrrolate;

Neostigmine; Hysterectomy

AB Introduction and hypothesis This study was aimed at determining the effect of sugammadex versus a combination of glycopyrrolate and neostigmine (GN) for neuromuscular reversal blockage on transient postoperative urinary retention (TPOUR) in patients undergoing a laparoscopic and robot-assisted laparoscopic hysterectomy.

Methods We conducted a retrospective cohort study in patients undergoing a laparoscopic or robotic hysterectomy between February 2017 and December 2021. Patients with and without concomitant procedures were included. Demographics and perioperative data were extracted from the patient's medical record. Before discharge, all patients were required to spontaneously void and have a post-void residual of less than 150 ml.

Results We identified 500 patients and 485 were included in the final analysis. We had 319 subjects who received sugammadex and 166 GN combination. Both groups had overall similar demographics and perioperative characteristics. Most patients had a conventional laparoscopy procedure (391 [82.5%]) compared with robotic (83 [17.5%]). Patients who received GN were significantly more likely to be discharged home with an indwelling catheter (odds ratio [OR], 1.82; 95% confidence interval [CI], 1.09-3.05). After adjusting for perioperative medications and sling implantation during the surgery a logistic regression model continued to demonstrate that patients who received GN had significantly higher odds of being discharged with a catheter (OR, 1.79; 95% CI, 1.03-3.12).

Conclusions Our findings suggest that sugammadex decreases the odds of TPOUR after laparoscopic hysterectomies with and without slings compared with the combination of GN. Additional prospective trials are required to confirm this finding.

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NR 21

TC 0

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U1 0

U2 0

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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SC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

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Farley, John

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TI Factors Associated with Inpatient Narcotic Medication Usage after

Robotic-assisted Laparoscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Narcotic medication; Gynecologic oncology

ID PAIN; HYSTERECTOMY

AB Study Objective: Describe factors that contribute to an increased narcotic medication use after robotic-assisted laparoscopic (RAL) surgery.Design: A retrospective cohort.Setting: A teaching hospital.Patients: All patients undergoing RAL surgery by gynecologist oncologists at St. Joseph's Hospital and Medical Center over a 3-year period.Interventions: RAL by gynecologist oncologists.Measurements and Main Results: Using retrospective chart review, patients who underwent RAL surgery from 2012 to 2015 in the division of gynecologic oncology were identified; 757 patients were eligible for inclusion in the study. Total narcotic use during the postoperative hospital stay was converted to oral morphine milligram equivalents (OME). Bivariate correlations of total OME narcotics to multiple variables were evaluated using Spearman's rho. The average age, body mass index, and length of stay were 53.76 years (17-92), 31.75 kg/m(2) (17-56), and 1.56 days (range, 0-19), respectively. Increased OME correlated positively with body mass index (Spearman's rho = .077, p = .036), any intraoperative complication (Spearman's rho = .05, p = .886), any postoperative complication (Spearman's rho = .16, p <.0001), length of stay in days (Spearman's rho = .282, p <.0001), procedure time (Spearman's rho .023, p = .52), and total anesthesia time (Spearman's rho, .032). Total OME narcotics were correlated negatively with age of 65 years or older (Spearman's rho, -.144, p <.0001) and use of patient-controlled analgesia (Spearman's rho, -.185, p <.0001).Conclusion: Age younger than 65 years seems to be a predictor for increased requirement of total morphine equivalent medication after RAL surgery, whereas patient-controlled analgesia use had a negative association. Journal of Minimally Invasive Gynecology (2023) 30, 926-930. (c) 2023 AAGL. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/)

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ER

PT J

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Baumfeld, Y

Shobeiri, SA

AF Snyder, Alexandra

Baumfeld, Yael

Shobeiri, S. Abbas

TI Robotic Surgery Trends and Efficiency in a High-Volume Gynecologic

Surgery Center

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article; Early Access

DE Robotic-assisted laparoscopic surgery; high volume medical center;

efficiency

ID HYSTERECTOMY; LAPAROSCOPY

AB Objective: This study evaluated trends and efficiency of robotic surgeons per surgical volume, procedure type, and subspecialty. As robotic surgery is more popular in gynecologic subspecialties, studies comparing surgical volume suggest that robotic gynecologic surgery is advantageous when performed by high-volume surgeons and used for complex surgeries.Materials and Methods: During 2017-2021, evaluations were made of 3914 robotic gynecologic surgery cases performed at the Inova Fairfax Women's Hospital, Fairfax, VA, USA. All patients having robotic gynecologic surgery during the study were included. Surgeons were divided into high-, medium-, and low-volume groups. Statistical analysis evaluated changes in procedure types, surgeon subspecialties, operating times, and surgeon volumes.Results: Over the 5 years, there was a significant increase in adnexal surgery, surgery for pelvic organ prolapse, and myomectomy. High-volume surgeons performed more-complex surgeries overall. Operating room (OR) and surgery times were significantly lower for high-volume surgeons than for other groups.Conclusions: There was an increased variety of procedure types performed on the Da Vinci (R) robot over the 5 years. The data showed that high-volume surgeons had shorter OR and surgery times while performing more-complicated surgeries. This supports that high-volume gynecologic surgeons perform robotic cases more efficiently. With the increased interest in robotic surgery among surgeons and patients, an ongoing analysis of robotic surgery trends is essential to optimize availability, usage, and outcomes of these surgeries. (J GYNECOL SURG 20XX:000)

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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ER

PT J

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TI Introducing a novice surgeon to an experienced robotic gynaecological

oncology team: An observational cohort study on the impact of a

structured curriculum on outcomes of cervical cancer surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Robot-assisted surgery; Learning curve; Cumulative sum

analysis

ID OPEN RADICAL HYSTERECTOMY; LEARNING-CURVE; PELVIC LYMPHADENECTOMY;

LAPAROSCOPIC SURGERY; STAGE; SINGLE; SIMULATION; CARCINOMA; SOCIETY; NO

AB Objective. To evaluate the effect on patient outcomes when introducing a novice robotic surgeon, trained in accordance with a structured learning curriculum, to an experienced robotic surgery team treating cervical cancer patients.Methods. Patients with early-stage cervical cancer who were treated with primary robot-assisted surgery be-tween 2007 and 2019 were retrospectively included. In addition to the 165 patients included in a former analysis, we included a further 61 consecutively treated patients and divided all 226 patients over three groups: early learning phase of 61 procedures without structured training (group 1), experienced phase of 104 procedures (group 2), and the 61 procedures during introduction of a novice with structured training (group 3). Risk-adjusted cumulative sum (RA-CUSUM) analysis was performed to assess the learning curve effect. Patient out-comes between the groups were compared.Results. Based on RA-CUSUM analysis, no learning curve effect was observed for group 3. Regarding surgical outcomes, mean operation time in group 3 was significantly shorter than group 1 (p < 0.001) and similar to group 2 (p = 0.96). Proportions of intraoperative and postoperative adverse events in group 3 were not significantly different from the experienced group (group 2). Regarding oncological outcomes, the 5-year disease-free survival, disease-specific survival, and overall survival in group 3 were not significantly different from the experienced group.Conclusions. Introducing a novice robotic surgeon, who was trained in accordance with a structured learning curriculum, resulted in similar patient outcomes as by experienced surgeons suggesting novices can progress through a learning phase without compromising outcomes of cervical cancer patients.(c) 2023 The Author(s). Published by Elsevier Inc. This is an open access article under the CC BY license (http:// creativecommons.org/licenses/by/4.0/).

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OA Green Submitted

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ER

PT J

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TI Procedures by Physician Associates in Obstetrics and Gynecology

SO WOMENS HEALTH REPORTS

LA English

DT Article; Proceedings Paper

CT Annual Conference of the American-Academy-Physician-Associates (AAPA)

CY MAY 20-24, 2023

CL Nashville, TN

SP Amer Acad Physician Assoc

DE physician associate; obstetrics; gynecology; workforce; procedures

ID PROVIDERS

AB Background and Objectives: The number of obstetricians and gynecologists in the United States is decreasing and providers backfilling this service have not been well described. The intent of the study was to identify the skills that physician associates (PAs) in obstetrics and gynecology (OBGyn) contribute to this aspect of medicine and surgery.Methods: A survey of PAs specializing in OBGyn was conducted in 2022. The intent was to list office-based procedures that were part of their skill set. A vetted questionnaire was sent to the 1,630 American Academy of Physician Associates members who identified themselves in OBGyn at some point in their career, and 729 responded (44.7% relative risk).Results: Most PAs (88.7%) in OBGyn first assist in surgery. This first-assist role ranged across the open, laparoscopic, and robotic-type operations. Categories of surgery included Cesarean section, hysterectomy, salpingo-oophorectomy, and subspecialty surgeries such as oncology and urogynecology. In the outpatient setting, PAs listed over 40 procedures ranging from biopsies of the endometrium, cervix, vagina, and vulva, as well as fetal assessment, ultrasonography, and long-acting contraceptive insertion and removals.Conclusions: The proceduralist role of PAs in OBGyn is broad. Furthermore, this role may need to be utilized more at a time of growing scarcity of clinicians. The OBGyn role for PAs adds to their specialization and increasing presence in American medicine.

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J9 WOMENS HEALTH REP

JI Womens Health Reports

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PG 8

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PT J

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TI Efficacy and prognosis of robotic surgery with sentinel node navigation

surgery in endometrial cancer

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial Cancer; Prognosis; Surgery; Sentinel Lymph Node; Lymph Nodes

ID PELVIC LYMPHADENECTOMY; MAPPING ALGORITHM; RISK-FACTORS; LYMPH-NODES;

MULTICENTER; BIOPSY; GUIDELINES; SURVIVAL; IMPACT; SAFETY

AB Objective: This study aimed to validate the surgical and oncologic outcomes of robotic surgery with sentinel node navigation surgery (SNNS) in endometrial cancer.Methods: This study included 130 patients with endometrial cancer, who underwent robotic surgery, including hysterectomy, bilateral salpingo-oophorectomy, and pelvic SNNS at the Department of Obstetrics and Gynecology of Kagoshima University Hospital. Pelvic sentinel lymph nodes (SLNs) were identified using the uterine cervix 99m Technetium-labeled phytate and indocyanine green injections. Surgery-related and survival outcomes were also evaluated. Results: The median operative and console times and volume of blood loss were 204 (range: 101-555) minutes, 152 (range: 70-453) minutes, and 20 (range: 2-620) mL, respectively. The bilateral and unilateral pelvic SLN detection rates were 90.0% (117/130) and 5.4% (7/130), respectively, and the identification rate (the rate at which at least one SLN could be identified on either side) was 95% (124/130). Lower extremity lymphedema occurred in only 1 patient (0.8%), and no pelvic lymphocele occurred. Recurrence occurred in 3 patients (2.3%), and the recurrence site was the abdominal cavity, with dissemination in 2 patients and vaginal stump in one. The 3-year recurrence-free survival and 3-year overall survival rates were 97.1% and 98.9%, respectively.Conclusion: Robotic surgery with SNNS for endometrial cancer showed a high SLN identification rate, low occurrence rates of lower extremity lymphedema and pelvic lymphocele, and excellent oncologic outcomes.

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NR 27

TC 2

Z9 2

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U2 0

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Walker, Z

Gargiulo, A

AF Walker, Zachary

Gargiulo, Antonio

TI Near-infrared and hysteroscopy-guided robotic excision of uterine

isthmocele with laser fiber: a novel high-precision technique

SO FERTILITY AND STERILITY

LA English

DT Article

DE Carbon dioxide laser; cesarean scar defect; near-infrared; robotic

surgery; uterine isthmocele

ID SCAR DEFECT; CLOSURE

AB Objective: To describe a novel high-precision technique for robotic excision of uterine isthmocele, employing a carbon dioxide laser fiber, under hysteroscopic guidance, and near-infrared guidance.Design: Video article.Patient(s): A 36-year-old multipara with 3 prior cesarean sections presented to our infertility clinic with secondary infertility. The patient had been trying to conceive for 6 months without success. The patient underwent a hystero-salpingo contrast sonography that identified a large cesarean scar defect with a 1.4-mm residual myometrial thickness (RMT). The patient was counseled on surgical management with robotic approach because of RMT <3 mm precluding her from hysteroscopic resection and the potential risk for a cesarean scar ectopic or abnormal placentation if she were to become pregnant in the future. She elected to undergo excision and repair and informed consent was obtained from the patient.Intervention(s): The robot was docked for traditional gynecologic robotic surgery. The uterus was injected with 5 units of vasopressin. We used a carbon dioxide laser fiber (Lumenis FIberLase) at a power of 5 watts as the sole energy source for dissection. The bladder was dissected off the uterus to identify the general area of the isthmocele. At that point, diagnostic hysteroscopy was performed using a 30 -degree 5-mm hysteroscope (Karl Storz) to identify and enter the isthmocele. Near-infrared vision (da Vinci Firefly, Intuitive USA) was activated to precisely outline the extent of the isthmocele, which was not visible with simple transillumination from the hysteroscope. We proceeded with laser excision in infrared/gray scale using the laser at a power of 20 watts removing the entire area that was highlighted by the Firefly. After full excision of the isthmocele, the hysteroscope was removed and was eventually replaced by a uterine manipulator (ConMed VCare DX). The hysterotomy was closed with a 2-layer closure: 4 mattress sutures of 2-0 Vicryl (Ethicon) followed by a running 2-0 PDS Stratafix (Ethicon). The peritoneal layer was closed over these 2 layers with 2-0 PDS Stratafix (Ethicon) in a running fashion. The uterine manipulator was removed and a 14 French Malecot catheter (Bard) was placed in the uterine cavity to allow the healing to proceed with minimal risk of cervical stenosis. The bladder was backfilled to ensure integrity of the bladder wall. Interceed adhesion barrier (Gynecare) was then placed over the area of the repair and the procedure was concluded. The patient included in this video gave consent for publication of the video and posting of the video online including social media, the journal website, scientific literature websites (such as PubMed, ScienceDirect, Scopus, etc.), and other applicable sites.Main outcome measure(s): Completion of excision and repair of cesarean scar defect without surgical complications.Result(s): Robotic excision and repair of a sizable uterine isthmocele with carbon dioxide laser fiber and da Vinci Firefly was completed successfully without any surgical complications. Diagnostic hysteroscopy was used to positively identify the isthmocele and provide transillumination. However, the thickness of the cervical myometrium only allows the hysteroscopic light to shine through the thinnest portion of myometrium at the apex of the isthmocele, whereas the near-infrared vision allowed by the da Vinci Firefly technology was used to precisely identify the borders of the defect.

The carbon dioxide laser was used to completely remove the defect while avoiding damage to delicate reproductive tissue and over-excision. No complications were identified during the postoperative visit. Magnetic resonance imaging 3 months after the surgery revealed an RMT of 10 mm at the location of excision compared with the initial RMT of 1.4 mm.Conclusion(s): Currently, there is no gold-standard technique for surgical management of isthmocele. This is the first description of the combined use of hysteroscopy, near-infrared vision, and laser fiber for the robotic excision of isthmocele. This specific setup proves to be a useful technical improvement. The use of near-infrared vision combined with precise hysteroscopic targeting allows much clearer definition of he isthmocele borders, and the flexible laser fiber allows millimetric xcision in the absence of appreciable lateral thermal spread. Further investigation is warranted to identify a gold-standard surgical technique for patients with cesarean scar defect. (c) 2023 by American Society for Reproductive Medicine.) El resumen esta disponible en Espanol al final del articulo.

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JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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PT J

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TI Laparoscopic administration of bupivacaine at the uterosacral ligaments

during benign laparoscopic and robotic hysterectomy: a randomized

controlled trial

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE bupivacaine; minimally invasive hysterectomy; opioids; postoperative

pain

ID MINIMALLY INVASIVE HYSTERECTOMY; POSTOPERATIVE PAIN; MANAGEMENT;

ANALGESIA; BLOCK

AB BACKGROUND: Postoperative pain continues to be an undermanaged part of the surgical experience. Multimodal analgesia has been adopted in response to the opioid epidemic, but opioid prescribing practices remain high after minimally invasive hysterectomy. Novel adjuvant opioid-sparing analgesia to optimize acute postoperative pain control is crucial in pre-venting chronic pain and minimizing opioid usage.OBJECTIVE: This study aimed to determine the effect of direct laparo-scopic uterosacral bupivacaine administration on opioid usage and post-operative pain in patients undergoing benign minimally invasive (laparoscopic and robotic) hysterectomy.STUDY DESIGN: This was a single-blinded, triple-arm, randomized controlled trial at an academic medical center between March 15, 2021, and April 8, 2022. The inclusion criteria were patients aged >18 years undergoing benign laparoscopic or robotic hysterectomy. The exclusion criteria were noneEnglish-speaking patients, patients with an allergy to bupivacaine or actively using opioid medications, patients undergoing transversus abdominis plane block, and patients under-going supracervical hysterectomy or combination cases with other surgical services. Patients were randomized in a 1:1:1 fashion to the following uterosacral administration before colpotomy: no adminis-tration, 20 mL of normal saline, or 20 mL of 0.25% bupivacaine. All patients received incisional infiltration with 10 mL of 0.25% bupiva-caine. The primary outcome was 24-hour oral morphine equivalent usage (postoperative day 0 and postoperative day 1). The secondary outcomes were total oral morphine equivalent usage in 7 days, last day of oral morphine equivalent usage, numeric pain scores from the universal pain assessment tool, and return of bowel function. Patients reported postoperative pain scores, total opioid consumption, and re-turn of bowel function via Qualtrics surveys. Patient and surgical characteristics and primary and secondary outcomes were compared using chi-square analysis and 1-way analysis of variance. Multiple linear regression was used to identify predictors of opioid use in the first 24 hours after surgery and total opioid use in the 7 days after surgery.RESULTS: Of 518 hysterectomies screened, 410 (79%) were eligible, 215 (52%) agreed to participate, and 180 were ultimately included in the final analysis after accounting for dropout. Most hysterectomies (70%) were performed laparoscopically, and the remainder were performed robotically. Most hysterectomies (94%) were outpatient. Patients ran-domized to bupivacaine had higher rates of former and current tobacco use, and patients randomized to the no-administration group had higher rates of previous surgery. There was no difference in first 24-hour oral morphine equivalent use among the groups (P1/4.10). Moreover, there was no difference in numeric pain scores (although a trend toward significance in discharge pain scores in the bupivacaine group), total 7-day oral morphine equivalent use, day of last opioid use, or return of bowel function among the groups (P>.05 for all). The predictors of increased 24-hour opioid usage among all patients included only increased postanesthesia care unit oral morphine equivalent usage. The predictors of 7-day opioid usage among all patients included concurrent tobacco use and mood disorder, history of previous laparoscopy, estimated blood loss of >200 mL, and increased oral morphine equivalent usage in the postanesthesia care unit.

CONCLUSION: Laparoscopic uterosacral administration of bupiva-caine at the time of minimally invasive hysterectomy did not result in decreased opioid usage or change in numeric pain scores.

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ER

PT J

AU Sastre, J

Mínguez, JA

Alcázar, JL

Chiva, L

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Minguez, Jose Angel

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Chiva, Luis

TI Microsurgical anastomosis of the fallopian tubes after tubal ligation: a

systematic review and meta-analysis

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Tubal reversal; Tubal anastomosis; Tubal reanastomosis; Reproductive

surgery; IVF

ID STERILIZATION REVERSAL; FEMALE STERILIZATION; REANASTOMOSIS; FERTILITY

AB Objective: Between 20% and 30% of women who have undergone tubal ligation regret their decision. The alternative to regain fertility for these women is either in vitro fertilization or tubal re-anastomosis. This article presents a systematic review with meta-analysis to assess the current evidence on the efficacy of tubal recanalization surgery in patients who have previously undergone tubal ligation. Study design: The search was conducted in the World of Science (WOS) database, The Cochrane Library and ClinicalTrials.gov record using the keywords "tubal reversal", "tubal reanastomosis" and "tubal anastomosis". The review was carried out by two of the authors. Data from 22 studies were evaluated, comprising over 14,113 patients who underwent the studied surgery, following strict inclusion criteria: articles published between January 2012 and June 2022, in English and with a sample size bigger than 10 patients were included. A random-effects meta-analysis was performed. Results: The overall pregnancy rate after anastomosis was found to be 65.3 % (95 % CI: 61.0-69.6). The percentage of women who had at least one live birth, known as the birth rate, was 42.6 % (95 % CI: 34.9-51.4). Adverse outcomes after surgery were also examined: the observed abortion rate among women who underwent surgery was 9.4 % (95 % CI: 7.0-11.7), and the overall ectopic pregnancy rate was 6.8 % (95 % CI: 4.6-9.0). No differences were found between the outcomes when differentiating surgical approaches: laparotomy, laparoscopy, or robotic-assisted surgery. The patient's age was identified as the most significant determining factor for fertility restoration. Finally, when comparing the results of tubal reversal with in vitro fertilization, reversal procedures appear more favorable for patients over 35 years old, while the results are similar for patients under 35 years old, but more data is needed to evaluate this finding. Conclusion: Therefore, the available literature review demonstrates that surgical anastomosis following tubal ligation is a reproducible technique with relevant success rates, performed by multiple expert groups worldwide.

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NR 33

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Z9 0

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U2 0

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PT J

AU Hayashi, S

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Sasaki, T

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Ono, M

Futagami, M

Nishi, H

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Yamamoto, Akiko

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Nishi, Hirotaka

TI Retrospective comparative study of robot-assisted surgery, laparoscopic

surgery, and laparotomy for endometrial cancer in patients with a low

risk of recurrence

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article; Early Access

DE endometrial cancer; laparoscopy; laparotomy; retrospective studies;

robotics

ID MINIMALLY INVASIVE HYSTERECTOMY; ABDOMINAL HYSTERECTOMY;

LYMPHADENECTOMY; COMPLICATIONS; METASTASIS; DISEASE; WOMEN

AB Aim Minimally invasive surgeries for endometrial cancer are increasing worldwide. In Japan, some articles have examined surgical outcomes, but only a few have addressed oncological outcomes. This study aims to compare robot surgery, laparoscopic surgery, and laparotomy in terms of surgical and oncological outcomes within a low-risk group for endometrial cancer recurrence.Methods This study included patients with endometrial cancer deemed to be at low risk of recurrence and who underwent surgery between January 2011 and December 2020. We studied 99 patients who underwent robot surgery, 85 patients who underwent laparotomy, and 77 patients who underwent laparoscopic surgery. Surgical and oncological outcomes were compared retrospectively for these groups of patients.Results The median follow-up period was 47, 61, and 60 months in the laparotomy, laparoscopy, and robotic groups, respectively. The three groups had similar perioperative and pathological data. No significant differences in overall survival and disease-free survival were observed among the groups. Univariate and multivariate analyses conducted on the overall study population for disease-free survival and overall survival showed that the surgical approach did not have any influence. Minimally invasive surgery groups had longer operating times compared to the laparotomy group, but they had significantly less blood loss. The number of resected pelvic lymph nodes was similar, and the complication rate was not significant.Conclusions Robot-assisted surgery and laparoscopic surgery were found to be less invasive and showed similar oncologic outcomes compared to laparotomy surgery for endometrial cancer in patients with a low risk of recurrence.

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JI J. Obstet. Gynaecol. Res.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Ballet, E

Rousseau, C

Barjat, TR

Chauleur, C

AF Ballet, Elodie

Rousseau, Clement

Barjat, Tiphaine Raia

Chauleur, Celine

TI Robotic retroperitoneal para-aortic lymphadenectomy via single-site port

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Extraperitoneal lymphadenectomy; Robotic; Single -site port

AB Para-aortic staging is sometimes a standard feature in the management of pelvic cancers. Minimal invasive approach is recommended. Several routes are possible: extra-peritoneal or intraperitoneal depending on the expertise of the surgeon. We performed several extraperitoneal para-aortic lymphadenectomy using the Da Vinci Xi robotic system through single-site incision. We have developed a step-by-step guide from patient installation, installation of the Gelpoint V monotrocar, docking of the robot arms, to surgery, with the aim of performing the most efficient and safest procedure.The surgery does not differ from standard laparoscopic extraperitoneal lymphadenectomy. The advantages of minimally invasive robotic surgery in this indication are comparable to those of the standard laparoscopy approach. But through single-site incision, the Da Vinci Xi robot improves video quality, plus its wristed tools facilitates movements compared to conventional laparoscopy.

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NR 9

TC 0

Z9 0

U1 0

U2 0

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ER

PT J

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Rousseau, Clement

Barjat, Tiphaine Raia

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TI Robotic retroperitoneal para-aortic lymphadenectomy via single-site port

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Extraperitoneal lymphadenectomy; Robotic; Single-site port

AB Para-aortic staging is sometimes a standard feature in the management of pelvic cancers. Minimal invasive approach is recommended. Several routes are possible: extra-peritoneal or intraperitoneal depending on the expertise of the surgeon. We performed several extraperitoneal para-aortic lymphadenectomy using the Da Vinci Xi robotic system through single-site incision. We have developed a step-by-step guide from patient installation, installation of the Gelpoint V monotrocar, docking of the robot arms, to surgery, with the aim of performing the most efficient and safest procedure.

The surgery does not differ from standard laparoscopic extraperitoneal lymphadenectomy. The advantages of minimally invasive robotic surgery in this indication are comparable to those of the standard laparoscopy approach. But through single-site incision, the Da Vinci Xi robot improves video quality, plus its wristed tools facilitates movements compared to conventional laparoscopy.

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PT J

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TI C-section technique vs minilaparotomy after minimally invasive uterine

surgery: a retrospective cohort study

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article; Early Access

DE C-section technique; Minilaparotomy; Myomectomy; Laparoscopy; Pain

management

ID LAPAROSCOPIC MYOMECTOMY; HYSTERECTOMY

AB Purpose Uterine leiomyomas are benign uterine tumors. The choice of surgical treatment is guided by patient's age, desire to preserve fertility or avoid "radical" surgical interventions such as hysterectomy. In laparotomy, the issue of extracting the fibroid from the cavity does not arise. However, in laparoscopy and robotic surgery, this becomes a challenge. The aim of the present study was to determine the optimal surgical approach for fibroid extraction following laparoscopic or robotic myomectomy in terms of postoperative pain, extraction time, overall surgical time, scar size, and patient satisfaction.Methods A total of 51 patients met the inclusion criteria and were considered in our analysis: 33 patients who had undergone the "ExCITE technique" (Group A), and 18 patients a minilaparotomy procedure (Group B), after either simple myomectomy, multiple myomectomy, supracervical hysterectomy, or total hysterectomy. The diagnosis of myoma was histologically confirmed in all cases.Results Regarding the postoperative pain evaluation, at 6 h, patients reported 4 [3-4] vs 6 [5.3-7] on the VAS in Group A and B, as well as at 12 h, 2 [0-2] vs 3.5 [2.3-4] in Group A and B, respectively: both differences were statistically significant (p < 0.001). No statistically significant difference at 24 h from surgery was found. All patients in Group A were satisfied with the ExCITE technique, while in Group B only 67% of them. The length of the hospital stay was significantly shorter in Group A as compared to Group B (p = 0.007). In terms of the operative time for the extraction of the surgical specimen, overall operative time, and the scar size after the surgery, there was a statistically significant difference for those in Group A.Conclusion The ExCITE technique does not require specific training and allows the surgeon to offer a minimally invasive surgical option for patients, with also an aesthetic result. It is a safe and standardized approach that ensures tissue extraction without the need for mechanical morcellation.

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Z9 0

U1 1

U2 1

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

AU Andjic, M

Sleiman, Z

Sparic, R

Tomasevic, D

Morciano, A

Tinelli, A

AF Andjic, Mladen

Sleiman, Zaki

Sparic, Radmila

Tomasevic, Dina

Morciano, Andrea

Tinelli, Andrea

TI The Transvaginal Natural Orifice Transluminal Endoscopic Surgery

(vNOTES) Procedures in Contemporary Gynecology: An Appraisal of the

Published Evidence and a Review

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE vNOTES; gynecology; endoscopic surgery; laparoscopy; minimally invasive

surgery

ID VAGINAL SURGERY; HYSTERECTOMY; OUTCOMES; SERIES

AB Objective: The transvaginal natural orifice transluminal endoscopic surgery (vNOTES) is a kind of natural orifice transluminal endo-scopic surgery in which the abdominal cavity is reached by using the natural orifices, such as the stomach, rectum, esophagus, and bladder. In comparison to traditional laparoscopic and robotic surgery, there are potential advantages of the vNOTES. This narrative review shows the use of vNOTES in contemporary gynecologic endoscopic surgery. Mechanism: MEDLINE, Scopus, and PubMed searches on these themes were conducted from 1990 to 2023 using a mix of keywords. Papers and articles were identified and included in this narrative review after the authors' revision and evaluation. Findings in Brief: The vNOTES procedures allow a short surgery time, as well as estimated blood loss and postoperative pain. These procedures are safe and feasible in contemporary endoscopic gynecology surgery. Conclusions: The vNOTES procedures are beneficial for the patients, and to be added to other minimally invasive procedures, such as conventional laparoscopy and robotic surgery. However, further studies about the long-term outcomes of vNOTES procedures are still needed.

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Z9 0

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U2 0

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA X8ST5

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ER

PT J

AU Minciuna, CE

Ivanov, M

Aioanei, S

Tudor, S

Lacatus, M

Vasilescu, C

AF Minciuna, Corina-Elena

Ivanov, Mihail

Aioanei, Sanziana

Tudor, Stefan

Lacatus, Monica

Vasilescu, Catalin

TI Short-term outcome of robotic and laparoscopic surgery for gynecological

malignancies: A single-center experience

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Gynecologic neoplasms; gynecologic surgical procedures; laparoscopy;

minimally invasive surgical procedures; neoplasms; postoperative

complications; robotic surgical procedures

ID MINIMALLY-INVASIVE SURGERY; RADICAL HYSTERECTOMY; CERVICAL-CANCER;

POSTOPERATIVE COMPLICATIONS; PREVENTION; SURVIVAL

AB Objectives: Minimally invasive surgery (MIS) has become the preferred option for many gynecologic pathologies since complication rate and postoperative recovery time have decreased considerably. Postoperative complications remain an important aspect when using the MIS approach, if they are not timely or accurately diagnosed and treated. The main aim of the study is to first assess their incidence, followed by identifying possible risk factors. Furthermore, the secondary aim is to identify if the type of MIS approach used, robotic or laparoscopic, may render some additional benefits.Materials and Methods: The database of the General Surgery Department was queried between 2008 and 2019 for patients with gynecologic pathology: 2907 cases were identified. An additional selection was performed using the following filters: MIS and neoplasia. All emergency surgeries were excluded. One hundred and ninety-eight cases were obtained.Results: The majority of complications were urological (11.6%) with only 7.07% requiring a specific urological procedure. The second most common was lymphorrhea 4.5%. Dindo-Clavien classification correlates positively with the postoperative hospital stay (PHS) (P = 0.000), the type of surgery (P = 0.046), the primary tumor location (P = 0.011), conversion rate (P = 0.049), the expertise of the lead surgeon (P = 0.012), and the operative time (P = 0.002). The urological complications correlate positively with the type of surgery (P = 0.002), the tumor location (P = 0.001), early reintervention (P = 0.000), operative time (P = 0.006), postoperative hemorrhage (P = 0.000), pelvic abscess (P = 0.000), venous thrombosis (P = 0.011), and postoperative cardiac complications (P = 0.002). Laparoscopic and robotic approaches were comparatively assessed. The PHS (P = 0.025), the type of surgery performed (P = 0.000), and primary tumor location (P = 0.011) were statistically significantly different.Conclusion: Postoperative complications reported after MIS for gynecological malignancies show similar incidence as in the current literature, also taking into consideration those for the open approach. The robotic approach seems to be able to perform more complex surgeries with no difference in the postoperative complication rates. The expertise of the lead surgeon in gynecology correlates with lower postoperative complications. Further prospective studies are needed to confirm these results.

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NR 20

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Z9 0

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PU WOLTERS KLUWER MEDKNOW PUBLICATIONS

PI MUMBAI

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J9 GYNECOL MINIM INVASI

JI Gynecol. Minim. Invasive Ther.-GMIT

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WC Obstetrics & Gynecology

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PT J

AU Nakai, C

Yamanoi, K

Horie, A

Yamaguchi, K

Hamanishi, J

Mandai, M

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Yamanoi, Koji

Horie, Akihito

Yamaguchi, Ken

Hamanishi, Junzo

Mandai, Masaki

TI Investigation of the effect of puncture order and position on the

difficulty of lower and middle abdominal port placement

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Laparoscopy; robotic-assisted surgery; trocar order; trocar place

ID SURGERY

AB Objectives: Port placements at the mid-abdomen (mainstay of robotic surgery [Rob]) appear to be difficult compared to that at lower abdomen (mainstay of conventional laparoscopy [Con-Lap]). We hypothesized that the reason for this may be the difference in port puncture places.Materials and Methods: We examined how the differences between the place and puncture order of ports affected Con-Lap cases with ports mainly placed in the lower abdomen and Rob cases with ports mainly placed in the middle abdomen. The trocar time was measured from the time when the puncture position and skin incision were determined and initiated, respectively, to the time when the port was punctured and fixed and used as the indicator of difficulty.Results: In the Con-Lap group analysis, the trocar time of the left lower port was longer (right lower: 77 s, middle lower: 117.5 s, and left lower: 138 s, P < 0.0001). In the Rob group analysis, the trocar time of the left most port was significantly longer (right-most: 89.0 s, right-middle: 92.5 s, left-middle: 121.0 s, and left-most: 197.0 s; P < 0.0001). In addition, the total trocar time was significantly longer in the first puncture at the right-middle port in the Rob group (right-most first: 8.4 min, right-middle first: 12.4 min, and left-middle first: 8.5 min, P = 0.0063).Conclusion: In the mid-abdomen port placement, mainstay of Rob cases, the puncture order, and port site have a significant impact on the difficulty of the procedure. It is preferable to avoid initially puncturing the right-middle port in case of the Rob.

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NR 14

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Z9 0

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PU WOLTERS KLUWER MEDKNOW PUBLICATIONS

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J9 GYNECOL MINIM INVASI

JI Gynecol. Minim. Invasive Ther.-GMIT

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VL 12

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ER

PT J

AU Yang, YY

Li, Z

Si, KY

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Dai, Qingqiang

Qiao, Yingying

Li, Dazhuang

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Wu, Fan

He, Jia

Wu, Guizhu

TI Effectiveness of Laparoscopic Pectopexy for Pelvic Organ Prolapse

Compared with Laparoscopic Sacrocolpopexy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Effectiveness; Laparoscopic pectopexy; Laparoscopic sacrocolpopexy;

Pelvic organ prolapse; Quality of life

ID QUALITY-OF-LIFE; COMPARATIVE CLINICAL-TRIAL; QUESTIONNAIRE;

INCONTINENCE; VALIDATION; PFDI-20; WOMEN

AB Study Objective: To evaluate the clinical benefits of laparoscopic pectopexy vs laparoscopic sacrocolpopexy in women with pelvic organ prolapse (POP).Design: Prospective cohort study.Setting: A tertiary hospital.Patients: We included 203 patients with POP.Interventions: Laparoscopic pectopexy or laparoscopic sacrocolpopexy.Measurements and Main Results: Anatomic effectiveness was measured using the POP Quantification system, both before and after operation. Functional recovery effectiveness was evaluated using complications and recurrence rates within 1 year. Quality of life was assessed by the Pelvic Floor Distress Inventory-20 and Incontinence Quality of Life questionnaires at enrollment and postoperative months 3, 6, and 12. Comparisons between groups were performed using t test, chi-square test, and mixed-effects model with repeated measures. The analysis included 203 eligible patients (sacrocolpopexy, 101; pectopexy, 102). The proportion of robotic-assisted surgeries was lower in the pectopexy group than in the sacrocolpopexy group (15.7% vs 41.6%, p <.001). The average operation time of pectopexy was shorter than that of sacrocolpopexy (174.2 vs 187.7 minutes) with a mean difference of 13.5 minutes (95% confidence interval, 3.9-23.0; p = .006). Differences of intraoperative blood loss, length of hospital stay, and postoperative 7-day complications between groups were not significant. Anatomic successes were obtained in both groups with similar improvement in POP Quantification scores. The rate of urinary symptoms recurrence was higher in the pectopexy group (13.7%) than in the sacrocolpopexy group (5.0%) at the 1-year follow-up (odds ratio, 3.1; 95% confidence interval, 1.1-8.8, p = .032). The Pelvic Floor Distress Inventory-20 and Incontinence Quality of Life scores were better improved at postoperative months 3, 6, and 12 for laparoscopic pectopexy than for sacrocolpopexy.Conclusion: Laparoscopic pectopexy revealed comparable anatomic success, shorter operation time, and better improve-ment in quality of life scores of prolapse, colorectal-anal, and urinary symptoms at 1-year follow-up, possibly being an alter-native when sacrocolpopexy is not practicable. However, clinicians should pay more attention to the recurrence of urinary symptoms after pectopexy. Journal of Minimally Invasive Gynecology (2023) 30, 833-840.

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Pudong Medical Combination; [SHDC2022CRS050]; [PFYLT2022-17]

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U2 1

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DA 2024-01-18

ER

PT J

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Rotem, R

O'Reilly, BA

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Rotem, Reut

O'Reilly, Barry A.

TI Robot-assisted laparoscopic pelvic floor surgery: Review

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Review

DE Robotic-assisted surgery; Sacrocolpopexy; Hysteropexy; Pelvic floor

repair

ID ORGAN PROLAPSE; VESICOVAGINAL FISTULA; RADICAL PROSTATECTOMY;

SACROCOLPOPEXY; HYSTERECTOMY; COMPLICATIONS; REPAIR; SACROHYSTEROPEXY;

PRESERVATION; OUTCOMES

AB Minimally invasive surgical techniques have become more common in pelvic floor reconstructive urogynaecological surgery, specifically, robotic-assisted pelvic floor surgery. Female pelvic floor anatomy is complex, and some repairs require highly experienced surgical skills that can be gained more easily using robotic-assisted surgery. A common application of the robotic platform in urogynaecological surgeries includes sacrocolpopexy, which has become the gold standard approach in the last decade for the correction of apical prolapse. Additional procedures include sacrohysteropexy, sacrocervicopexy, fistula repair, and complex procedures involving the bladder and other pelvic organs.

Despite its increasing use and clear benefit in our field, data in the literature and, in particular, randomised controlled trials are sparse. This review provides an update, incorporating recently published literature and our personal experience in that field. (c) 2023 Published by Elsevier Ltd.

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U2 5

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JI Best Pract. Res. Clin. Obstet. Gynaecol.

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PT J

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Masoud, AT

Abdelsattar, A

King, A

Brazil, G

Ulibarri, H

Parise, J

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Coriell, C

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Baruelo, G

Govindan, M

AF Marchand, Greg

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Abdelsattar, Ahmed

King, Alexa

Brazil, Giovanna

Ulibarri, Hollie

Parise, Julia

Arroyo, Amanda

Coriell, Catherine

Goetz, Sydnee

Moir, Carmen

Baruelo, Geneva

Govindan, Malini

TI Systematic Review and Meta-analysis of laparoscopic radical hysterectomy

vs. Robotic assisted radical hysterectomy for early stage cervical

cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Hysterectomy; Laparoscopic radical hysterectomy; Robotic radical

hysterectomy

ID CONVENTIONAL LAPAROSCOPY; PELVIC LYMPHADENECTOMY; SURGERY; OUTCOMES;

RISK

AB Objective: Following compelling evidence that open techniques may be related to better survival and disease free survival rates, many gynecologic oncologists in the US have turned away from performing laparoscopic radical hysterectomy (LRH) and robotic radical hysterectomy (RRH) for the treatment of early-stage cervical cancer. While this may be warranted as a safety concern, there is little high-quality data on the head-to-head comparison of LRH and RRH and therefore little evidence to answer the question of where this decrease in patient survival is originating from. In our systematic review, we aimed to compare the complications and outcomes of LRH against those of RRH.Data Sources: We searched PubMed, Cochrane CENTRAL, Medline, ClinicalTrials.Gov, SCOPUS, and Web of Science from database inception until February 1st, 2022.Methods of Study Selection: A total of 676 studies were identified and screened through a manual three-step process. Ultimately 33 studies were included in our final analysis. We included all studies that compared LRH and RRH and included at least one of our selected outcomes. We included retrospective cohorts, prospective cohorts, case-control, and randomized clinical trials.Tabulation, Integration, and Results: Data was independently extracted manually by multiple observers and the analysis was performed using Review Manager Software. PRISMA guidelines were followed. We analyzed homogenous data using a fixed-effects model, while a random-effects model was used for heterogeneous outcomes. We found that following RRH, women had a decreased hospital stay (MD = 0.80[0.38,1.21],(P < 0.002). We found no differences in estimated blood loss (MD = 35.24[-0.40,70.89],(P = 0.05), blood transfusion rate ((OR = 1.32[0.86,2.02],(P = 0.20), rate of post-operative complications (OR = 0.84[0.60,1.17],(P = 0.30), the operative time (MD = 6.01[-4.64,16.66],(P = 0.27), number of resected lymph node (MD =-1.22[-3.28,0.84],(P = 0.25) intraoperative complications (OR = 0.78[0.51,1.19],(P = 0.25), five-year overall survival (OR = 1.37 [0.51,3.69],(P = 0.53), lifetime disease free survival (OR = 0.89[0.59,1.32],(P = 0.55), intraoperative and postoperative mortality (within 30 days) (OR = 1.30[0.66,2.54],(P = 0.44), and recurrence (OR = 1.14 [0.79,1.64],(P = 0.50).Conclusions: RRH seems to result in the patient leaving the hospital sooner after surgery. We were unable to find any differences in our ten other outcomes related to complications or efficacy. These findings suggest that the decreased survival seen in minimally invasive RH in previous studies could be due to factors inherent to both LRH and RRH.Prospero Prospective Registration Number: CRD42022273727.

C1 [Marchand, Greg; Masoud, Ahmed Taher; King, Alexa; Brazil, Giovanna; Ulibarri, Hollie; Parise, Julia; Arroyo, Amanda; Coriell, Catherine; Goetz, Sydnee; Moir, Carmen; Govindan, Malini] Marchand Inst Minimally Invas Surg, Mesa, AZ 85209 USA.

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NR 65

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Ponce, J

Fernández, S

Barahona, M

Martínez, JM

Ortega, C

Martí, L

AF Ponce, Jordi

Fernandez, Sergi

Barahona, Marc

Martinez, Jose Manuel

Ortega, Carlos

Marti, Lola

TI Robotic-assisted para-aortic lymphadenectomy: Technique and indications

in gynecological oncology

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Robotic surgery; Lymphadenectomy; Minimally-invasive surgery; Oncology;

Gynecology

ID LYMPH-NODE DISSECTION; ENDOMETRIAL CANCER; CERVICAL-CANCER;

OVARIAN-CANCER; DOUBLE DOCKING; TRIAL; LAPAROSCOPY; CARCINOMA

AB The benefits of minimally-invasive surgeries have been documented, and they have been established as the preferred approach for gynecological surgeries. With the development of robotic surgery, many highly complex surgeries can benefit from these advantages. Due to the complexity of aortocaval lymphadenectomy, surgical technique protocols have been described to reduce risks by maximizing benefits.We describe the technique using five ports (4 robotic arms and an assistant) to work the upper abdominal field, and different instruments recommended in each of their positions to reduce errors and optimize surgical time. After the "step by step" description, we summarize indications of aortocaval lymphadenectomy for every gynecological cancer in different stages.& COPY; 2023 Elsevier Ltd. All rights reserved.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Success Rates of Sentinel Lymph Node Mapping for Endometrial Cancer in

Patients with Body Mass Index &lt; 45 Compared with Body Mass Index ≥ 45

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Lymphadenectomy; Minimally invasive; Obesity; Staging

ID MINIMALLY INVASIVE SURGERY; INDOCYANINE GREEN; OBESITY; MULTICENTER;

MORTALITY; BIOPSY; IMPACT

AB Study Objective: The objective is to evaluate the rate of sentinel lymph node (SLN) mapping in patients with body mass index (BMI [kg/m(2)]) BMI > 45 compared with < 45.Design: A retrospective chart review.Setting: Three urban referral-based settings-1 academic and 2 community based. Patients: Patients age > 18 years, with endometrial intraepithelial neoplasia or clinical stage 1 endometrial cancer who underwent robot-assisted total laparoscopic hysterectomy with attempted SLN mapping between January 2015 and December 2021.Interventions: Robot-assisted total laparoscopic hysterectomy with attempted SLN mapping.Measurements and Main Results: A total of 933 subjects were included: 795 (85.2%) with BMI < 45 and 138 (14.8%) with BMI > 45. Comparing the BMI < 45 with BMI > 45 group, bilateral mapping was successful in 541 (68.1%) vs 63 (45.7%), respectively. Unilateral mapping was successful in 162 (20.4%) vs 33 (23.9%), respectively. Failure to map occurred in 92 (11.6%) vs 42 (30.4%) (p <.001), respectively. Exploratory analysis also suggested an inverse relationship between success rate of bilateral SLN mapping and BMI, with patients with BMI < 20 having bilateral SLN mapping rates of 86.5% and patients with BMI > 61 having rates of 20.0%. The steepest decline in bilateral SLN mapping rates was from BMI group 46 to 50 compared to 51 to 55, at 55.4% to 37.5%, respectively. Adjusted odds ratio (compared with those with BMI < 30) for those in the BMI 30 to 44 group was 0.36 (95% confidence interval 0.21-0.60) and for those in the BMI > 45 group was 0.10 (95% confidence interval 0.06-0.19). Conclusion: There is a statistically significant lower rate of SLN mapping in patients with a BMI > 45 than BMI < 45. Understanding the success of SLN mapping in patients with morbid obesity is essential for preoperative counseling, surgical planning, and developing a risk-appropriate postoperative treatment plan. Journal of Minimally Invasive Gynecology (2023) 30, 735-741.(c) 2023 AAGL. All rights reserved.

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Nationwide trends in and regional factors associated with minimally

invasive hysterectomy for benign indications in Japan

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Laparoscopic hysterectomy; Minimally invasive surgery; Benign

gynecological disease; Regional disparities

ID DISPARITIES; SURGERY

AB Objective: To examine the prevalence trends of minimally invasive hysterectomy for benign indications in Japan and investigate regional disparities. Study Design: A retrospective cohort and ecological study using "The National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB) Open Data". Setting: Nationwide Japan. Patients: Individuals who underwent hysterectomy for benign indications from 2014 to 2020. Interventions: Trend analysis of minimally invasive surgery (MIS) rates through laparoscopic hysterectomies (LH) and robotic-assisted laparoscopic hysterectomies (RA-LH) at the national and prefecture levels. Examination of regional factors contributing to the disparity in MIS implementation rates by second medical service area (SMSA). Results: The number of LH has increased from 16,016 in 2014 to 27,755 in 2020. The nationwide MIS hysterectomy rate increased from 29% in 2014 to 55% in 2020 (p less than 0.001). More than 50% of hysterectomies have been performed as MIS since 2019. There was an increasing trend in MIS rates in all age groups. All prefectures except one showed a significant upward trend (p less than 0.05) in the MIS rates, but MIS rates varied widely (23-84%). In a multivariable model, the MIS was more likely to be performed in the SMSAs in western Japan (p = 0.011), in the SMSAs where the number of laparoscopy-qualified gynecologists is 5-10 (p = 0.013), and 11 or higher (p less than 0.001). Conclusions: This study reveals a shift towards minimally invasive surgery (MIS) in total hysterectomy procedures in Japan. However, significant disparities in the prevalence of MIS hysterectomy exist, potentially influenced by the number of laparoscopy-qualified gynecologists.

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

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Timmerman, S

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AF Tahapary, M.

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TI Implementation of robot-assisted myomectomy in a large university

hospital: a retrospective descriptive study

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Myoma; leiomyoma; fibroid; myomectomy; robot assisted surgery; robot

-assisted myomectomy.

ID UTERINE LEIOMYOMAS; MANAGEMENT; FIBROIDS; HYSTERECTOMY; BURDEN

AB Background: Myomectomy is often the preferred treatment for symptomatic patients with myomas who wish to preserve their fertility, with a shift from open surgery towards minimally invasive techniques.Objectives: Retrospective study assessing patient and surgery characteristics, follow-up, and outcomes of robot -assisted myomectomy (RAM) and abdominal myomectomy (AM) in women treated between January 1, 2018, and February 28, 2022, in a Belgian tertiary care hospital.Materials and Methods: A descriptive analysis was conducted on consecutive patients who underwent myomectomies. 2018 was considered the learning curve for RAM. Main Outcome Measures: We assessed rate of open surgery, operation time, postoperative hospital stay, and operative complications. Results: In total, 94 RAMs and 15 AMs were performed. The rate of AMs was 56.5% in 2018 versus 2.3% after the learning curve. The median operation time for RAM was 136.5 minutes and 131 minutes for AM. Conversion rate for RAM was 0%. The median postoperative hospital stay after RAM was 1 night and 4 nights for AM. Postoperative complication rate was low, with only 14.9% and 33.3% of patients requiring pharmacological treatment of complications after RAM or AM, respectively. No surgical re-intervention was needed in any group.Conclusions: Implementation of RAM at our centre resulted in a significant reduction of open surgery rate. RAM demonstrated shorter hospital stays and a lower incidence of complications compared to AM. What is new? Our study highlights the successful adoption of RAM, showcasing its potential to replace AM even in complex cases. The findings affirm the safety and feasibility of RAM, supporting its use as a valuable technique for minimally invasive myomectomy.

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JI Facts Views Vis. ObGyn

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Dennis, Thomas

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TI Robotic management of isolated endometriosis of sciatic nerve: a

reproducible approach that can guide through the labyrinth of pelvic

neuroanatomy

SO FERTILITY AND STERILITY

LA English

DT Article

DE Endometriosis; sciatic nerve; robotic surgery; pelvic neuroanatomy;

nerve-sparing

ID DEEP ENDOMETRIOSIS

AB Objective: To present the robotic, standardized, and reproducible surgical technique we routinely use in our center to manage isolated endometriosis of the sciatic nerve.Design: Surgical video article.Setting: Tertiary referral center.Patient: A 36-year-old woman suffering from left-sided sciatica pain was diagnosed with an isolated endometriotic nodule of the left sciatic nerve at preoperative assessment. The patient included in this video gave consent for publication of the video and posting of the video online, including on social media, the journal website, scientific literature websites (such as PubMed, ScienceDirect, and Scopus), and other applicable sites.Intervention(s): Complete removal of the isolated endometriotic nodule of the sciatic nerve may be performed through a stepwise robotic approach. The surgery starts laterally with the opening of the iliolumbar space between the external iliac vessels and the psoas muscle, as well as the identification of the genitofemoral and obturator nerves. The lumbosacral trunk and emergence of the sciatic nerve were then identified medially and caudally to the obturator nerve. The surgery moves medially with the anterograde dissection of both the internal iliac artery and vein, which allows a safe approach to the posterior and medial limits of the nodule. Ligation of branches of internal iliac vessels directed toward the nodule may be necessary during this step. Isolation and ligation of obturator ves-sels are frequently required to obtain a bloodless dissection of the lateral limit of the nodule from the lateral pelvic wall. The complete removal of the nodule was then achieved using an alternating approach to all limits of the nodule previously identified, with subsequent release of the sciatic nerve.Main outcome measure(s): Description of the relevant pelvic neuroanatomy and the evaluation of robotic routes in the field of pelvic neurosurgery.Result(s): The use of standardized techniques together with the advantages of a robotic route can make the radical excision of isolated endometriosis of the sciatic nerve reproducible, feasible, and safe. Conclusion(s): Because of the complexity of neuroanatomy and the risk of severe complications, this surgery remains challenging, and patients affected by deep infiltrating endometriosis involving retroperitoneal neural structures should be referred to multidisciplinary management in expert centers.(Fertil Steril & REG; 2023;120:703-5. & COPY;2023 by American Society for Reproductive Medicine.)

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JI Fertil. Steril.

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PT J

AU Ind, T

AF Ind, Thomas

TI Providing a standardised educational programme in robot-assisted

gynaecological surgery

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Education; Training; Assessment

ID CURRICULUM; VALIDATION; MORTALITY; SOCIETY; VOLUME

AB Standardisation of an educational programme in robotic gynae-cological surgery requires careful reflection to ensure that the correct surgeons are selected, that they are trained to the best of their ability, and that they have continued education into their careers. The generally agreed pathways included a proficiency-based progression model for procedures with validated assessment tools used for both formative and summative assessment. For new surgeons, a basic and advanced curriculum is required, involving tools on how to use the instruments as well as educational lectures and simulation. For advanced learning, there is a need for proctorship. To maintain their skills, a surgeon should demonstrate a reflective practice and continued good outcomes while adhering to a process of credentialing. Trainers should be validated on their ability to teach based on recognised training-the-trainers courses.Crown Copyright (c) 2023 Published by Elsevier Ltd. All rights reserved.

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PT J

AU Park, SY

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Jeong, K

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TI Robotic single-port hysterectomy versus robotic multisite hysterectomy

in benign gynecologic diseases: A retrospective comparison of clinical

and surgical outcomes

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE hysterectomy; multisite; robotic surgery; single-port; uterus

ID SITE; SURGERY; LAPAROSCOPY

AB Background: This study aimed to compare clinical and surgical outcomes of robotic single-port hysterectomy (RSPH) using the da Vinci((R)) SP surgical system and robotic multisite hysterectomy (RMSH) with the da Vinci Xi system in benign gynecologic disease.

Methods: The retrospective study included 134 patients who underwent RSPH or RMSH between November 2019 and December 2020. Total operation time, amount of blood loss, and the change in hemoglobin (Hb) after surgery and the weight of the removed uteri were also measured. Data on complications such as post-operative fever and length of hospitalization were also compared and analyzed.

Results: There was no significant difference in the total operation time between the two groups, although the operation time was slightly longer in the RSPH group. Results in the RSPH group were superior to the RMSH group in docking time and wound incision time (1.67 +/- 0.79 vs. 5.46 +/- 2.25 min, p-value <0.01; 6.48 +/- 4.29 vs. 9.10 +/- 4.64 min, p-value <0.01, respectively). On the other hand, wound suture time took longer in the RSPH group (18.12 +/- 5.66 vs. 10.69 +/- 3.18 min, p-value <0.01). The weights of the removed specimens were higher in the RMSH group (302.64 +/- 190.56 vs. 369.24 +/- 181.70 g, p-value <0.04). The amount of blood loss during surgery and the difference in hemoglobin (Hb) before and after surgery were less in the RSPH group (97.39 +/- 113.79 vs. 224.93 +/- 152.29 mL, p-value <0.01, 1.51 +/- 1.08 vs. 2.54 +/- 1.08 g/dL, p-value <0.01). When considering the weight difference as a correction between the two surgical groups (because there were many heavier samples in the RMSH group), the blood loss of the RSPH group was also less than that of the RMSH group by 115.95 +/- 23.78 mL (p-value <0.01).

Conclusions: On the basis of our data, the robotic hysterectomy using the da Vinci SP surgical system might be feasible and safe, even if the hysterectomy is complex, and comparable to robotic multisite surgery by the da Vinci Xi system.

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TI Long-term health-related quality of life and symptom severity following

hysterectomy, myomectomy, or uterine artery embolization for the

treatment of symptomatic uterine fibroids

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; myomectomy; quality of life; uterine artery embolization;

uterine fibroids

ID MANAGEMENT; EPIDEMIOLOGY; LEIOMYOMA; IMPACT; WOMEN; QUESTIONNAIRE;

MORBIDITY; BURDEN

AB BACKGROUND: Few studies have directly compared different surgical procedures for uterine fibroids with respect to long-term health-related quality of life outcomes and symptom improvement.OBJECTIVE: We examined differences in change from baseline to 1-, 2-, and 3-year follow-up in health-related quality of life and symptom severity among patients who underwent abdominal myomectomy, laparoscopic or robotic myomectomy, abdominal hysterectomy, laparoscopic or robotic hysterectomy, or uterine artery embolization.STUDY DESIGN: The COMPARE-UF registry is a multiinstitutional prospective observational cohort study of women undergoing treatment for uterine fibroids. A subset of 1384 women aged 31 to 45 years who underwent either abdominal myomectomy (n=237), laparoscopic myomectomy (n=272), abdominal hysterectomy (n=177), laparoscopic hysterectomy (n=522), or uterine artery embolization (n=176) were included in this analysis. We obtained demographics, fibroid history, and symptoms by questionnaires at enrollment and at 1, 2, and 3 years posttreatment. We used the UFS-QoL (Uterine Fibroid Symptom and Quality of Life) questionnaire to ascertain symptom severity and health-related quality of life scores among participants. To account for potential baseline differences across treatment groups, a propensity score model was used to derive overlap weights and compare total health-related quality of life and symptom severity scores after enrollment with a repeated measures model. For this health-related quality of life tool, a specific minimal clinically important difference has not been determined, but on the basis of previous research, a difference of 10 points was considered as a reasonable estimate. Use of this difference was agreed upon by the Steering Committee at the time when the analysis was planned.RESULTS: At baseline, women undergoing hysterectomy and uterine artery embolization reported the lowest health-related quality of life scores and highest symptom severity scores compared with those undergoing abdominal myomectomy or laparoscopic myomectomy (P<.001). Those undergoing hysterectomy and uterine artery embolization reported the longest duration of fibroid symptoms with a mean of 6.3 years (standard deviation, 6.7; P<.001). The most common fibroid symptoms were menorrhagia (75.3%), bulk symptoms (74.2%), and bloating (73.2%). More than half (54.9%) of participants reported anemia, and 9.4% women reported a history of blood transfusion. Across all modalities, total health-related quality of life and symptom severity score markedly improved from baseline to 1-year with the largest improvement in the laparoscopic hysterectomy group (Uterine Fibroids Symptom and Quality of Life: delta= [+] 49.2; symptom severity: delta= [-] 51.3). Those undergoing abdominal myomectomy, laparoscopic myomectomy, and uterine artery embolization also demonstrated significant improvement in health-related quality of life (delta= [+]43.9, [+]32.9, [+] 40.7, respectively) and symptom severity (delta= [-]41.4, [-] 31.5, [-] 38.5, respectively) at 1 year, and the improvement persisted from baseline for uterine-sparing procedures during second (Uterine Fibroids Symptom and Quality of Life: delta= [+]40.7, [+]37.4, [+]39.3 SS: delta= [-] 38.5, [-] 32.0, [-] 37.7 and third year (Uterine Fibroids Symptom and Quality of Life: delta= [+] 40.9, [+]39.9, [+]41.1 and SS: delta= [-] 33.9, [-]36.5, [-] 33.0, respectively), posttreatment intervals, however with a trend toward decline in degree of improvement from years 1 and 2.

Differences from baseline were greatest for hysterectomy; however, this may reflect the relative importance of bleeding in the Uterine Fibroids Symptom and Quality of Life, rather than clinically meaningful symptom recurrence among women undergoing uterus-sparing treatments.CONCLUSION: All treatment modalities were associated with significant improvements in health-related quality of life and symptom severity reduction 1-year posttreatment. However, abdominal myomectomy, laparoscopic myomectomy and uterine artery embolization indicated a gradual decline in symptom improvement and health-related quality of life by third year after the procedure.

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PT J

AU Van Trappen, P

AF Van Trappen, Philippe

TI Robotic para-aortic sentinel lymph node mapping in endometrial,

cervical, and ovarian cancer

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Cervical cancer; Endometrial cancer; Ovarian cancer; Para-aortic;

Sentinel; Staging

ID INDOCYANINE GREEN; BIOPSY; STANDARDIZATION; GUIDELINES; MANAGEMENT;

ALGORITHM; STEP

AB The concept of pelvic sentinel lymph node mapping has been well investigated in endometrial and cervical cancer. A variety of tracers have been used including blue dye, technetium-99-m (Tc-99 m), and fluorescent tracer indocyanine green. Pelvic sentinel lymph node mapping has shown its safety, efficacy, and diagnostic accuracy, with high sensitivity and negative predictive value of more than 90%, in retrospective cohort studies as well as in prospective trials for robotic surgery. The concept of pelvic sentinel lymph node biopsy has been incorporated in several international guidelines in early-stage endometrial cancer and a subgroup of early-stage cervical cancer, although survival data are still needed to confirm its standard use. The application of para-aortic sentinel lymph node mapping is still in a development phase, but its detection rate and diagnostic accuracy seem to be promising in initial studies. Here, an overview is given of the recent developments in the different methodologies used for identifying para-aortic sentinel lymph nodes in endometrial, cervical, and ovarian cancer.& COPY; 2023 Elsevier Ltd. All rights reserved.

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Zhang, SF

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Chen, Y

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TI Conservative surgical treatment of uterine fibroids in women of

childbearing age

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Uterine fibroids; Myomectomy; Uterine artery embolization;

High-Intensity focused ultrasound; Radiofrequency ablation; Pregnancy;

Fertility

ID OUTCOMES; SURGERY

AB Uterine fibroids are benign gynecologic tumors, and women aged between 30 to 50 years are known to have a high incidence of uterine fibroids. A growing number of pharmacotherapies and minimally invasive organ-preserving treatments have been designed and conducted over the past few years. However, there has not been any therapeutic drugs exhibiting an ideal therapeutic effect and low recurrence rate, such that the surgical treatment continues to be primarily employed in the actual clinical treatment. In general, surgical treatment has been performed as the organ-and fertility -preserving hysteroscopic or laparoscopic resections of the fibroids. Minimally invasive surgical equipment (e.g., hysteroscopy, traditional porous laparoscopy, trans-umbilical laparoscopy, transvaginal laparoscopy, as well as robot-assisted laparoscopy) has been extensively applied to clinical treatment. Compared with traditional laparotomy, minimally invasive surgical equipment is characterized by minimally invasive surgery, high efficiency and safety. As medical technology has been leaping forward, interventional therapy and radiofrequency ablation can also be employed for treating uterine fibroids. In accordance with the research progress worldwide, the current situation, limitations, and advantages of the treatment of uterine fibroids in patients with fertility requirements are reviewed in this study.

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PT J

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TI Robotic surgery in ovarian cancer

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Ovarian cancer; Robotic surgery; Minimally invasive surgery

ID EARLY-STAGE OVARIAN; SECONDARY CYTOREDUCTIVE SURGERY; INTERVAL DEBULKING

SURGERY; MINIMALLY INVASIVE SURGERY; FERTILITY-SPARING SURGERY;

NEOADJUVANT CHEMOTHERAPY; LAPAROSCOPIC CYTOREDUCTION; CONSERVATIVE

TREATMENT; MANAGEMENT; CARCINOMA

AB Ovarian cancer (OC) represents one of the most lethal cancers in women. The aim of surgical treatment is complete cytoreduction in advanced stages and a surgical staging in early stages. Although the guidelines still suggest laparotomy as the standard approach, in recent years minimally invasive surgery (MIS) has become increasingly popular in the treatment of OC, especially in early stages, because the 5-year relative survival exceeds 90% and the patients' quality of life cannot be overshadowed. However, MIS has been demonstrated to have a role even in advanced stages, in the prediction of optimal cytoreduction, identification patients who may benefit from neoadjuvant chemotherapy, and, more recently, in the interval debulking surgery, as in selected cases of secondary cytoreduction for recurrent ovarian cancer. The aim of this review is to describe the MIS (especially robotic surgery), with its advantages and pitfalls, in the treatment of OC.& COPY; 2023 Published by Elsevier Ltd.

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TI Comparison of quality of life after robotic-transvaginal natural orifice

transluminal endoscopic surgery and robot-assisted laparoscopic

hysterectomy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE complete QOL recovery; Hysterectomy; RALH; Robot-assisted; R-vNOTES

ID SURGICAL OUTCOMES; STATES

AB Objectives: We investigated quality of life (QOL) of patients who underwent total hysterectomy for benign uterine diseases using two surgical approaches: robotic-transvaginal natural orifice transluminal endoscopic surgery (RvNOTES) and robot-assisted laparoscopic hysterectomy (RALH). Study design: This single-center retrospective study was conducted in a tertiary academic setting and included 65 patients who underwent robotic-assisted hysterectomy for benign uterine diseases. Total hysterectomy was performed using R-vNOTES or RALH by the same gynecologist between December 2021 and June 2022. The primary outcome was a comparison of QOL over time and complete QOL recovery (postoperative QOL score/ preoperative QOL score & GE; 1) by postoperative day 28 (POD28) in the R-vNOTES and RALH groups. QOL was examined using EQ-5D-5L in this study. The secondary outcome was a comparison of the surgical outcomes in the R-vNOTES and RALH groups. Results: Complete QOL recovery was achieved by 62.7% in the R-vNOTES group and 7.3% in the RALH group at POD7 (p <.001) and by 100% in the R-vNOTES group and 56.1% in the RALH group at POD28 (p <.001). In a multivariable model, patients who underwent R-vNOTES achieved higher complete QOL recovery at POD 28 [adjusted hazard ratio: 4.03, 95% confidence interval: 2.03-8.04]. There was no significant difference between the R-vNOTES and RALH groups in terms of operating time (p =.07), intraoperative blood loss (p =.35), uterus weight (p =.76), or postoperative complications (p =.71). Conclusion: The R-vNOTES approach for total hysterectomy for benign uterine diseases provided better complete QOL recovery by POD28 compared to the RALH approach. The surgical outcomes for R-vNOTES were equivalent to those for RALH, suggesting that R-vNOTES may provide a safe approach for robot-assisted hysterectomy.

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TI An Extraordinary Location of Sentinel Lymph Nodes in a Patient with

Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Para-aortic sentinel lymph node; Indocyanine green

ID BIOPSY

AB Objective: To show dissection of sentinel lymph nodes.

Design: A step-by-step demonstration of the technique with narration.

Setting: Endometrial cancer (EC) is the most common gynecologic malignancy worldwide. Sentinel lymph node biopsy with indocyanine green (ICG) has become more widely used and has been featured in recently published guidelines for EC [1]. Minimally invasive approaches with the sentinel lymph node concept (conventional laparoscopy, laparoscopic-assisted vaginal surgeries or robotic) to EC staging have resulted in lower rates of peri- and postoperative complications than conventional staging procedures [2].

Interventions: No video article has been published in the literature about high pelvic, para-aortic sentinel lymph node dissection. An informed consent form was obtained from the patient. An institutional review board approval was not required. A 45 -year-old female with gravidity 0, parity 0, and body mass index of 23.4 kg/m(2) presented with complaints of abnormal uterine bleeding (spotting). Increased endometrial thickness was detected on transvaginal ultrasound (10 mm) in the post-menstrual period. Endometrioid-type endometrial adenocancer with focal squamous differentiation International Federation of Gynecology and Obstetrics grade I was detected on endometrial biopsy. The patient had hepatitis B virus positivity and no other chronic disease. A laparotomic myomectomy had been performed in 2016. Laparoscopic high pelvic, low para-aortic sentinel lymph node dissection with ICG and hysterectomy (without uterine manipulator) + bilateral salpingo-oophorectomy were performed (Supplemental Video 1). The operation time for the procedure was 110 minutes and the estimated blood loss was <20 mL. No major complications occurred during or after the surgery. The patient stayed in the hospital for 1 day. The final pathology result showed an International Federation of Gynecology and Obstetrics grade I, endometrioid-type endometrial adenocancer with focal squamous differentiation, as a 1.5 x 1 cm tumorous mass invading less than one-half of the myometrium. Neither lymphovascular invasion nor sentinel lymph node metastasis was detected. A multicenter, prospective study showed that sentinel lymph node dissection with ICG in clinical stage 1 EC is feasible and has a high degree of diagnostic accuracy in detecting EC metastases. In that study, isolated para-aortic sentinel lymph node was detected in 3 of 340 patients (<1%) [2]. Another study reported the detection rate of isolated para-aortic sentinel lymph node to be 1.1% in patients with intermediate- and high-risk EC [3].

Conclusion: There are in some cases 2 distinct channels emanating from one side, and it is important to follow each and to acknowledge there may be more than one sentinel, one of which is lower in a typical location and one higher as in this case. This video article is the first video demonstration of bilateral isolated high pelvic, para-aortic sentinel lymph node dissection in EC. Journal of Minimally Invasive Gynecology (2023) 30, 613-614. 2023 Published by Elsevier Inc. on behalf of AAGL.

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JI J. Minim. Invasive Gynecol.

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PG 2

WC Obstetrics & Gynecology

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ER

PT J

AU Arcieri, M

Romeo, P

Vizzielli, G

Restaino, S

Driul, L

Stabile, G

Granese, R

Cianci, S

Ercoli, A

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TI Robotic Single-Port da Vinci Surgical System (SP1098) in Gynecologic

Surgery: A Systematic Review of Literature

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE minimally invasive surgery; single -port surgery; robotic surgery

ID SITE; HYSTERECTOMY; COMPLICATIONS

AB Background: Recently, new surgical systems less invasive than standard laparoscopy have been developed. Among these, robotic single site surgery is playing a pivotal role. In this field, the da Vinci SP (Single-Port) Surgical System (SP1098) is one of the newest surgical technology that presents innovative characteristics that may lead to better surgical outcomes. Few groups have already published their experience and results with this system in gynecology. Methods: The aim of the present systematic review was to provide a comprehensive overview of the status and applications of da Vinci SP1098 in gynecologic surgery. A systematic review of the literature was performed. Studies were identified until September 2022. Results: Six studies were included, reporting a total of 211 patients. The indication for surgery was both benign and malignant disorders. In terms of operative outcomes, the mean/median docking time varied from 2.1 to 5 min while mean/median operating time from 86.5 to 245 min. There was no conversion to multi-port laparoscopy or laparotomy and no major complications related to SP surgery. Conclusions: In conclusion, the preliminary and limited data available regarding the da Vinci SP1098 Surgical System suggest the technical feasibility and safety for its use in gynecologic surgery, with minimal alteration of the surgical technique.

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JI Clin. Exp. Obstet. Gynecol.

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OA gold

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ER

PT J

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Truong, Mireille D.

Wright, Kelly N.

Siedhoff, Matthew T.

TI Surgical management of endometriosis to optimize fertility

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE assisted reproductive technology; deep infiltrating endometriosis;

endometrioma; endometriosis; infertility; laparoscopy; surgery

ID IN-VITRO FERTILIZATION; DEEP INFILTRATIVE ENDOMETRIOSIS; UNEXPLAINED

INFERTILITY; LAPAROSCOPIC TREATMENT; MILD ENDOMETRIOSIS; SURGERY; WOMEN;

IMPACT; INSEMINATION; OUTCOMES

AB Purpose of reviewSurgery is an integral element of treatment for infertility caused by endometriosis. This review summarizes the purported mechanisms of infertility in endometriosis, as well as the impacts of surgery for endometriosis on fertility, including pregnancy achieved spontaneously and with assisted reproductive technology (ART).Recent findingsEndometriosis' effect on fertility is multifactorial. The sequela of increased inflammation resulting from endometriosis causes alterations in ovarian, tubal, and uterine function. Removing or destroying these lesions reduces inflammation. Surgical treatment of both early-stage endometriosis and deeply infiltrating endometriosis improves spontaneous pregnancy rates and ART pregnancy rates. Conventional or robotic laparoscopy is the preferred surgical approach.Endometriosis has detrimental effects on fertility, including negative impacts on oocyte, tubal, and endometrial function. Laparoscopic surgery for endometriosis elevates both spontaneous and ART pregnancy rates above those achieved with expectant management alone. The resection or destruction of endometriosis implants reduces inflammation, which likely improves the multifactorial infertility related to endometriosis. This topic is complex and controversial; more research in the form of high-quality randomized control trials is needed.

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U2 6

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WC Obstetrics & Gynecology

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ER

PT J

AU Lin, E

Young, R

Shields, J

Smith, K

Chao, L

AF Lin, Emily

Young, Riley

Shields, Jessica

Smith, Katherine

Chao, Lisa

TI Growing pains: strategies for improving ergonomics in minimally invasive

gynecologic surgery

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE minimally invasive gynecologic surgery; strain; surgical ergonomics;

work-related musculoskeletal disorders

ID SURGICAL ERGONOMICS; PHYSICAL DISCOMFORT; SYMPTOMS; WORK

AB Purpose of reviewTo evaluate factors contributing to the development of work-related musculoskeletal disorders (WMSDs) and review strategies for mitigating ergonomic strain in minimally invasive gynecologic surgery.Recent findingsFactors associated with increased ergonomic strain and the development of WMSDs include increasing patient body mass index (BMI), smaller surgeon hand size, noninclusive design of instruments and energy devices and improper positioning of surgical equipment. Each type of minimally invasive surgery (laparoscopic, robotic, vaginal) confers its own ergonomic risk to the surgeon. Recommendations have been published regarding optimal ergonomic surgeon and equipment positioning. Intraoperative breaks and stretching are effective in reducing surgeon discomfort. Formal training in ergonomics has not yet been widely implemented, but educational interventions have been effective in reducing surgeon discomfort and can improve surgeon recognition of suboptimal ergonomics.Considering the serious downstream effects of WMSDs on surgeons, it is imperative to implement strategies for WMSD prevention. Optimal positioning of the surgeons and operative equipment should be routine. Intraoperative breaks and stretching should be incorporated during procedures and between every case. Formal education in ergonomics should be provided to surgeons and trainees. Additionally, more inclusive instrument design by industry partners should be prioritized.

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U2 1

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WC Obstetrics & Gynecology

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PT J

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Komatsu, H

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TI The learning curve of introduced robotic-assisted hysterectomy versus

skilled laparoscopic hysterectomy for benign gynecologic diseases

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE hysterectomy; laparoscopy; robotic surgical procedures

AB Aim This study aimed to compare introduced robotic-assisted hysterectomy (RAH) and skilled total laparoscopic hysterectomy (TLH) for the treatment of benign gynecological diseases.Methods Patients who underwent RAH or TLH by two surgeons at the Tottori University Hospital between January 2018 and May 2022 were included in this retrospective study. Inclusion criteria were patients with 100-300 g of uterine weight. The exclusion criteria were patients with stage IV endometriosis. Mean operative time and learning curve were compared among the first-half RAH, second-half RAH, and TLH groups.Results There were 40 eligible cases (first-half RAH: 20 cases, second-half RAH: 20 cases) in the RAH group and 44 cases in the TLH group. The total operative time (TOT) of the second half of RAH was significantly shorter than that of the first half of RAH (p = 0.021) and was comparable to that of the TLH group. The operative time (OT) of the second half of RAH was shorter than that of TLH (p = 0.023). The preparation time of TLH was shorter than that of the RAH group (p < 0.01). The learning curve of the TOT in RAH crossed that of TLH on the 31st case of RAH. In contrast, both curves of the OT crossed on the 11th case of RAH.Conclusion The TOT of the introduced RAH was equivalent to that of skilled TLH in approximately 30 cases since the first RAH. Furthermore, the OT of RAH was comparable to that of TLH in approximately 10 cases of surgery since the first RAH.

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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TI Contained specimen morcellation during robotics-assisted laparoscopic

supracervical hysterectomy for pelvic organ prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Early Access

DE Pelvic organ prolapse; Robotically assisted laparoscopic hysterectomy;

POP repair; Manual morcellation; Contained morcellation

ID PREVALENCE; WOMEN; SACROCOLPOPEXY

AB Introduction and hypothesisRobotics-assisted laparoscopic supracervical hysterectomy (RALSH) with concomitant apical robotics-assisted POP repair provides advantages of minimally invasive procedures; however specimen removal without intraperitoneal spillage of potential pathology remains challenging. The primary aim of our study is to determine the factors affecting contained manual morcellation (CMM) of specimens during RALSH for POP surgery. The secondary aim of the study is to report complications associated with CMM and on specimen pathology.MethodsA total of 67 sequential patients underwent RALSH with concomitant robotics-assisted sacrocolpopexy or uterosacral vaginal suspension. Factors analyzed to affect CMM were specimen weight, length of skin and fascia incisions, patient age, body mass index (BMI), and estimated blood loss (EBL).ResultsMedian CMM time was 11 min (1 to 46) and specimen weight 62 g (19 to 711). Median patient age was 56 years (36 to 83), and patient BMI was 28 (18 to 44). Median EBL was 50 ml (10 to 150). Median skin and fascial incision lengths were 3 cm (1.5 to 7), and 3.5 cm (1.5 to 8). CMM time was significantly dependent on specimen weight (p < 0.0001) and length of rectus fascia incision (p < 0.0126). There was no gross tissue spillage or bag ruptures. Uterine pathology revealed normal tissue (26%), leiomyoma (47%), adenomyosis (49%), and endometriosis (14%). 4.5% of specimens had evidence of microscopic neoplasm, and 5 years after surgery patients were cancer free.ConclusionContained manual extraction of the uterus and/or adnexae at the time of RALSH for POP surgery is a viable, safe, and efficient method of specimen removal.

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ER

PT J

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Youssef, Y

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Moawad, Gaby

TI Strategies and factors to maximize cost- effectiveness of robotic

surgery in benign gynecological disease

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Robotic gynecologic surgery; Cost; Minimally invasive surgery;

Hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; CLINICAL-OUTCOMES; VOLUME; SITE

AB Operating room procedures account for half of the gross hospital cost in the United States per annum. Hysterectomy is the eighth most common surgery nationally, with more than 300,000 cases every year. Since the introduction of robotic surgery in benign gynecology, concern has been raised regarding the increased cost without significant improvements in outcomes or practice. Sur-geon volume, complication rates, length of hospital stay, and selected intraoperative instrumentation are all factors that have a direct effect on cost in robotic surgery. Cost is indirectly influenced by the OR team workflow, postoperative processes to expedite discharge, and converting surgery to the ambulatory setting. More research is needed to develop evidence-based practices for cost containment in robotic surgery.& COPY; 2023 Published by Elsevier Ltd.

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Z9 1

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WC Obstetrics & Gynecology

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ER

PT J

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TI A cost-effective model for training in Robot-Assisted Sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Early Access

DE Robotic assisted surgery; Sacrocolpopexy; Hysteropexy; Pelvic floor

repair

ID SURGERY

AB BackgroundThe number of robotically assisted sacrocolpopexy procedures are increasing; therefore, experienced clinicians are needed. Simulation-based cadaver models are challenging in aspects of cost and availability. Therefore, we need to look at alternative and more cost-effective models.ObjectiveThe objective of this video was to design a new surgical model for the training of robotic-assisted sacrocolpopexy, which is affordable and accessible.MethodsWe used a whole chicken model to simulate the female pelvic floor. We used Medtronic's Hugo & TRADE; RAS system as the robotic console in that procedure. A vaginal cuff was prepared from the proventriculus (stomach), and a Y shaped mesh was secured to the ischium to simulate the sacrocolpopexy procedure.ConclusionThis model is easily constructed and in our view is cost-effective. We have demonstrated a new valuable education tool that can serve as a practical simulation model to teach the sacrocolpopexy procedure and to improve trainees' skills. A larger cohort study size is essential to demonstrate the learning curve among young trainees using this simulation model.

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PT J

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TI Effect of pre-operative warm-up on trainee intraoperative performance

during robot-assisted hysterectomy: a randomized controlled trial

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Early Access

DE Randomized controlled trial; Robotic hysterectomy; Simulation; Warm-up

ID LAPAROSCOPIC HYSTERECTOMY; SURGICAL PERFORMANCE; CONSTRUCT-VALIDATION;

MENTAL PRACTICE; SKILLS; SURGERY; SIMULATOR; METAANALYSIS; ACQUISITION;

ENVIRONMENT

AB Introduction and hypothesisThe objective was to study the effect of immediate pre-operative warm-up using virtual reality simulation on intraoperative robot-assisted laparoscopic hysterectomy (RALH) performance by gynecology trainees (residents and fellows).MethodsWe randomized the first, non-emergent RALH of the day that involved trainees warming up or not warming up. For cases assigned to warm-up, trainees performed a set of exercises on the da Vinci Skills Simulator immediately before the procedure. The supervising attending surgeon, who was not informed whether or not the trainee was assigned to warm-up, assessed the trainee's performance using the Objective Structured Assessment for Technical Skill (OSATS) and the Global Evaluative Assessment of Robotic Skills (GEARS) immediately after each surgery.ResultsWe randomized 66 cases and analyzed 58 cases (30 warm-up, 28 no warm-up), which involved 21 trainees. Attending surgeons rated trainees similarly irrespective of warm-up randomization with mean (SD) OSATS composite scores of 22.6 (4.3; warm-up) vs 21.8 (3.4; no warm-up) and mean GEARS composite scores of 19.2 (3.8; warm-up) vs 18.8 (3.1; no warm-up). The difference in composite scores between warm-up and no warm-up was 0.34 (95% CI: -1.44, 2.13), and 0.34 (95% CI: -1.22, 1.90) for OSATS and GEARS respectively. Also, we did not observe any significant differences in each of the component/subscale scores within OSATS and GEARS between cases assigned to warm-up and no warm-up.ConclusionPerforming a brief virtual reality-based warm-up before RALH did not significantly improve the intraoperative performance of the trainees.

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NR 35

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Z9 0

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PG 8

WC Obstetrics & Gynecology; Urology & Nephrology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Urology & Nephrology

GA M2GT0

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PM 37449987

DA 2024-01-18

ER

PT J

AU Bachi, A

Bille, A

Khazali, S

AF Bachi, Averyl

Bille, Andrea

Khazali, Shaheen

TI The Combined Robotic-assisted Laparoscopic and Thoracic Approach in the

Management of Diaphragmatic, Pleural, and Pericardial Endometriosis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometriosis; Diaphragmatic endometriosis; Pericardial endometriosis;

Robotic-assisted laparoscopy; Robotic-assisted thoracic surgery

AB Study Objective: To demonstrate the advantages of a combined robotic-assisted laparoscopic and thoracic approach in the management of extensive diaphragmatic, pleural, and pericardial endometriosis.Design: A video article demonstrating excision of endometriosis from pericardium, diaphragm, and pleura.Setting: Thoracic endometriosis is the most common site of extrapelvic endometriosis [1]. Surgical treatment aims to excise all visible disease to relief symptoms and prevent recurrence [2-4]. Interventions: A 41-year-old lady with cyclical shoulder tip and chest pain and known extensive diaphragmatic endometri-osis was referred to our center. The procedure was done jointly by a gynecologist and a thoracic surgeon experienced in robotic-assisted endometriosis excision (Supplemental Video 1). Robotic-assisted laparoscopy revealed extensive full-thick-ness diaphragmatic endometriosis and a full-thickness pericardial nodule. Pericardial endometriosis excision was performed and a 1 cm defect was left open in the pericardium. Multiple diaphragmatic endometriotic nodules were excised and pleural cavity was entered (Image 2). On robotic-assisted thoracic surgery, further deep endometriotic lesions were detected and excised from the posterior aspect of the diaphragm. These lesions were not identified abdominally despite complete division of falciform ligament, full mobilization of the liver, and the use of a 30-degree scope. Superficial endometriotic lesions on parietal pleura were also detected (Image 3) and excised. The defects on the diaphragm were closed (Image 4). Chest and abdominal drains were left in situ. The patient was discharged on day 4. Conclusion: The combined robotic-assisted laparoscopic and thoracic approach is indicated in selected cases and allows full exploration of the thoracic cavity and both sides of the diaphragm, thus preventing incomplete excision of the disease. Robotic surgery also allows smooth dual-surgeon teamwork. Journal of Minimally Invasive Gynecology (2023) 30, 533 -534. Crown Copyright & COPY; 2023. Published by Elsevier Inc. on behalf of AAGL. All rights reserved.

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NR 4

TC 2

Z9 2

U1 0

U2 0

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PG 2

WC Obstetrics & Gynecology

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ER

PT J

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TI Hysterectomy Trends and Risk of Vaginal Cuff Dehiscence: An Update by

Mode of Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Minimally invasive hysterectomy; Robotic hysterectomy; Laparoscopic

hysterectomy; Hysterectomy; Surgical complica-tions; Vaginal cuff

dehiscence

ID LAPAROSCOPIC HYSTERECTOMY; EVISCERATION

AB Study Objective: To analyze hysterectomy trends and vaginal cuff dehiscence (VCD) rates by mode of surgery at a tertiary care medical center and to describe characteristics of VCD cases. Design: Observational retrospective cohort study. Setting: Large academic hospital and affiliated community hospital. Patients: 4722 patients who underwent hysterectomy at Columbia University Irving Medical Center between January 2010 and August 2021. Interventions: Current Procedural Terminology and International Classification of Diseases codes identified hysterectomies and VCD cases. Hysterectomy trends and VCD rates were calculated by mode of surgery. Relative risks of VCD for each mode were compared with total abdominal hysterectomy (TAH). Clinical characteristics of VCDs were reviewed. Measurements and Main Results: There were 4059 total hysterectomies. Laparoscopic hysterectomies, including total laparoscopic hysterectomies (TLHs), laparoscopic-assisted vaginal hysterectomies, and robot-assisted TLHs (RA-TLHs), increased from 41.9% in 2010 to 65.9% in 2021 (p <.001). RA-TLH increased from 5.7% in 2010 to 40.2% in 2021. Supracervical hysterectomies followed similar trends and were excluded from VCD analysis. There were 15 VCDs (overall rate 0.37%). VCD was highest after RA-TLH (0.66%), followed by TLH (0.32%) and TAH (0.27%), with no VCDs after laparoscopic-assisted vaginal hysterectomy or total vaginal hysterectomy. Compared with TAH, the relative risk for VCD after RA-TLH was 2.44 (95% confidence interval 0.66-9.00) and after TLH was 1.18 (95% confidence interval 0.24-5.83), which were not statistically significant. The mean time to dehiscence was 39 days (range 8-145 days). The most common trigger event was coitus (41%). Conclusion: VCD rates were low (<1%) for all modes of hysterectomy, and rates after robotic and laparoscopic hysterectomy were much lower than previously reported. Although VCD rates trended higher after robotic and laparoscopic hysterectomy compared with abdominal hysterectomy, the difference was not significant. It is difficult to determine whether this finding represents true lack of difference vs a lack of power to detect a significant difference given the rarity of VCD. Journal of Minimally Invasive Gynecology (2023) 30, 562-568. & COPY; 2023 AAGL. All rights reserved.

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ER

PT J

AU Roth, K

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Jungmann, Peter

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TI Evolving trends in the surgical therapy of patients with endometrial

cancer in Germany: analysis of a nationwide registry with special

emphasis on perioperative outcomes

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Endometrial cancer; Robotic-assisted laparoscopic surgery; Laparoscopic

surgery

ID MINIMALLY INVASIVE SURGERY; LAPAROSCOPIC HYSTERECTOMY; ROBOTIC SURGERY;

CARCINOMA; MORBIDITY; SURVIVAL; COST

AB PurposeEndometrial cancer (EC) is the most common gynecological malignancy in women, with increasing incidence in the last decades. Surgical therapy is the mainstay of the initial management. The present study analyzed the evolving trends of surgical therapy in Germany in patients diagnosed with EC recorded in a nationwide registry.MethodsAll patients with the diagnosis of EC undergoing open surgery, laparoscopic surgery, and robotic-assisted laparoscopic surgery between 2007 and 2018 were identified by international classification of diseases (ICD) or specific operational codes (OPS) within the database of the German federal bureau of statistics.ResultsA total of 85,204 patients underwent surgical therapy for EC. Beginning with 2013, minimal-invasive surgical therapy was the leading approach for patients with EC. Open surgery was associated with a higher risk of in-hospital mortality (1.3% vs. 0.2%, p < 0.001), of prolonged mechanical ventilation (1.3% vs. 0.2%, p < 0.001), and of prolonged hospital stay (13.7 & PLUSMN; 10.2 days vs. 7.2 & PLUSMN; 5.3 days, p < 0.001) compared to laparoscopic surgery. A total of 1551 (0.04%) patients undergoing laparoscopic surgery were converted to laparotomy. Procedure costs were highest for laparotomy, followed by robotic-assisted laparoscopy and laparoscopy (8286 & PLUSMN; 7533euro vs. 7083 & PLUSMN; 3893euro vs. 6047 & PLUSMN; 3509euro, p < 0.001).ConclusionThe present study revealed that minimal-invasive surgery has increasingly become the standard surgical procedure for patients with EC in Germany. Furthermore, minimal-invasive surgery had superior in-hospital outcomes compared to laparotomy. Moreover, the use of robotic-assisted laparoscopic surgery is increasing, with a comparable in-hospital safety profile to conventional laparoscopy.

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JI Arch. Gynecol. Obstet.

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TI Weight-loss interventions and levonorgestrel intrauterine system

implantation for early-stage endometrial cancer and atypical endometrial

hyperplasia to reduce perioperative risk of severely obese patients

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Atypical endometrial hyperplasia; endometrial cancer; levonorgestrel

intrauterine system; preoperative management; weight-loss interventions

ID COMPLICATIONS; OUTCOMES; IMPACT

AB Endometrial cancer (EC) and atypical endometrial hyperplasia (AEH) are associated with obesity, which increases the perioperative morbidity and surgical difficulties in laparoscopic and robotic surgery. Weight-loss interventions (WLIs) are likely to reduce morbidity; however, delayed surgery may cause cancer progression. To minimize the tumor progression, levonorgestrel intrauterine system (LNG-IUS) with minimal side effects was used until the planned surgery. During 2016 and 2021, we conducted preoperative management of WLI using LNG-IUS for seven highly obese women with a body mass index (BMI) =35 kg/m(2) who had AEH and EC with Grade 1 and no myometrial invasion on magnetic resonance imaging. In three of the seven patients, the BMI decreased by more than 5. Two patients with AEH achieved remission after LNG-IUS placement and requested conservative management. Five patients with EC underwent laparoscopic hysterectomy, without perioperative complications.

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NR 11

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Z9 0

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U2 0

PU WOLTERS KLUWER MEDKNOW PUBLICATIONS

PI MUMBAI

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J9 GYNECOL MINIM INVASI

JI Gynecol. Minim. Invasive Ther.-GMIT

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ER

PT J

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TI Analysis of hysterectomy trends in the last 5 years at a tertiary center

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Laparoscopic hysterectomy; minimally invasive surgery; major

complications

ID VAGINAL CUFF DEHISCENCE

AB Objectives: This study aimed to assess trends by evaluating the types and complications of hysterectomies performed for benign gynecological reasons at our clinic, which is one of the largest hospitals in Turkey. Materials and Methods: Hysterectomies performed for benign reasons at our gynecology and obstetrics clinic between January 1, 2015 and December 31, 2020 were retrospectively reviewed and included in the analysis. Of the 4288 patients who had undergone hysterectomy, 888 patients were excluded some reasons. The data of the remaining 3400 patients were analyzed. Results: For the 3400 patients, the hysterectomy methods performed were as follows: Total Abdominal Hysterectomy (TAH (60%, n = 2055), Total Laparoscopic Hysterectomy (TLH), (27%, n = 948), Vaginal Hysterectomy (VH), (8.9%, n = 302), Conversion from laparoscopy to laparotomy (L / S > LT). (1.4%, n = 49), Robotic hysterectomy (RH), (1%, n = 33), and Subtotal hysterectomy (SH), (0.4%, n = 13). The length of hospital stay was statistically significantly lower in the TLH group than in the TAH group (P < 0.05). A statistically significant and moderate correlation was noted between the length of hospital stay and the duration of operation (r: 0.68 P = 0.00). Conclusion: The ratio of TLH group among hysterectomy modalities has increased over the years. There are many factors that affect the surgeon's decision in determining the hysterectomy method.TLH is the first option in patients who are not suitable for vaginal hysterectomy.

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NR 19

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Z9 0

U1 0

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PU WOLTERS KLUWER MEDKNOW PUBLICATIONS

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J9 GYNECOL MINIM INVASI

JI Gynecol. Minim. Invasive Ther.-GMIT

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ER

PT J

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TI Pain With Differing Insufflation Pressures During Robotic Sacrocolpopexy

A Randomized Controlled Trial

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ENHANCED RECOVERY; SURGERY; GUIDELINES

AB OBJECTIVE:To evaluate whether decreasing insufflation pressure reduces postoperative pain and opioid use in women undergoing robotic-assisted sacrocolpopexy.METHODS:In a single-blinded randomized trial, women with pelvic organ prolapse underwent robotic-assisted sacrocolpopexy at either 12 mm Hg (experimental) or 15 mm Hg (standard) insufflation pressure. The primary outcome was pain rating on a visual analog scale (VAS) on postoperative day 1 within 24 hours of surgery. Secondary outcomes included VAS pain rating at outpatient follow-up, inpatient and outpatient use of opioids, operative time, and estimated blood loss. A margin of 15 mm was considered clinically different on the VAS, and at 80% power, a sample size of at least 64 participants was needed to show significance.RESULTS:From April 27, 2021, to May 17, 2022, 80 women were enrolled, with 41 in the experimental group and 39 in the standard group. All participants underwent surgery as planned and attended a 2-week postoperative follow-up. Participants in the experimental group had less pain on postoperative day 1 with median VAS of 17.0 mm (interquartile range 26.0) compared with 29.0 mm (interquartile range 32.0, P=.007) in the standard group. No differences were noted in the secondary outcomes of operative time, estimated blood loss, or length of stay. Participants in the experimental group were noted to use fewer opioids while an inpatient (P=.04) and outpatient (P=.02). In multivariable analyses, lower insufflation pressure and increasing age were negatively associated with postoperative VAS scores.CONCLUSION:Lowering insufflation pressure (12 mm Hg) during robotic-assisted sacrocolpopexy safely reduced postoperative pain and opioid use compared with standard pressure (15 mm Hg).

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U1 0

U2 0

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JI Obstet. Gynecol.

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PG 9

WC Obstetrics & Gynecology

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ER

PT J

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TI Sacrocolpopexy after sub-total hysterectomy vs. sacral hysteropexy for

advanced urogenital prolapse: A propensity-matched study

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article; Early Access

DE Hysteropexy; mini-invasive surgery; pelvic organ prolapse; robotic

surgery; Sacropexy; urogynecology

ID SURGERY; COMPLICATIONS; VALIDATION

AB ObjectiveTo compare objective and subjective outcomes of laparoscopic sacral colpopexy with supracervical hysterectomy (L-SCP) and robotic sacral hysteropexy (R-SHP). MethodsThis is a multicenter retrospective propensity score matched study. In the period between January 2014 and December 2018, we enrolled 161 patients with apical prolapse stage 2 or above, alone or with multicompartment descensus. ResultsAfter propensity-match analysis, there were 44 women for each group. Patients of the two groups had similar preoperative characteristics. No difference was found in terms of estimated blood loss, hospital stay, operative time, and intraoperative or postoperative complications. Subjective success rate, 12 months after surgery, was statistically better in the L-SCP group (P = 0.034): 81.8% and 97.8% women had Patient Global Impression of Improvement scores less than 3, in R-SHP and L-SCP, respectively. The objective cure rate was high in both groups without any significant differences in recurrence rate (P = 0.266). ConclusionBoth procedures are safe and effective in pelvic organ prolapse treatment. Patients who no longer desire uterine preservation could be encouraged to consider L-SCP. R-SHP is an alternative in women who are strongly motivated to preserve their uterus in the absence of abnormal uterine findings.

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TC 1

Z9 1

U1 0

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Kim, Kenneth H.

TI Robotics in Gynecologic Oncology: Past, Present, and Future

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE gynecologic surgery; gynecologic cancer; minimally invasive surgery;

robotic surgery; robotic simulation

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; CANCER; LAPAROTOMY;

SURVIVAL; SURGERY; VALIDATION

AB In the 20 years since its inception, robotic surgery has evolved greatly in its design and clinical use. Most recently, the approach to training and gaining proficiency in robotic surgery techniques has also matured. This article reviews the development of robotic surgery systems, the trajectory of their use for patients with benign and malignant gynecologic conditions, and the advances in novel technologies that are driving the applications of robotic surgery forward. (J GYNECOL SURG 20XX:000)

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PG 9

WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

GA T7MD3

UT WOS:001018053400001

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ER

PT J

AU Lönnerfors, C

Persson, J

AF Lonnerfors, Celine

Persson, Jan

TI Can robotic-assisted surgery support enhanced recovery programs?

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE ERAS; Enhanced recovery; MIS; Robotic surgery; Sweden

ID SAME-DAY DISCHARGE; TOTAL LAPAROSCOPIC HYSTERECTOMY; POSTOPERATIVE

URINARY RETENTION; LENGTH-OF-STAY; GYNECOLOGIC ONCOLOGY;

RANDOMIZED-TRIAL; PERIOPERATIVE OUTCOMES; VAGINAL HYSTERECTOMY;

COLORECTAL SURGERY; BOWEL PREPARATION

AB Enhanced recovery after surgery (ERAS) protocols comprise a multimodal approach to optimize patient outcome and recovery. ERAS guidelines recommend minimally invasive surgery (MIS) when possible. Key components in MIS include preoperative patient education and optimization; multimodal and narcoticsparing analgesia; prophylactic measures regarding nausea, infection, and venous thrombosis; maintenance of euvolemia; and promotion of the early activity. ERAS protocols in MIS improve outcome mainly in terms of reduced length of stay and subsequently reduced cost. In addition, ERAS protocols in MIS reduce postoperative pain and nausea, increase patient satisfaction, and might reduce the rate of postoperative complications. Robotic surgery supports ERAS through facilitating MIS in complex procedures where laparotomy is an alternative approach.& COPY; 2023 Published by Elsevier Ltd.

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JI Best Pract. Res. Clin. Obstet. Gynaecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Saini, A

Gao, JY

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Wilkie, G

Matteson, K

Korets, S

AF Saini, Aashna

Gao, Jenny

Leung, Katherine

Wilkie, Gianna

Matteson, Kristen

Korets, Sharmilee

TI Intra-operative tumor spillage in minimally invasive surgery for

endometrial cancer and its impact on recurrence risk

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Intra-operative tumor spillage in endometrial cancer; Minimally invasive

surgery endometrial cancer Recurrence with intra-operative tumor

spillage Uterine manipulator and recurrence in endo- metrial cancer;

Uterine perforation and recurrence in endome- trial cancer;

Intra-operative tumor spillage and minimally invasive surgery

ID LAPAROSCOPIC HYSTERECTOMY; CELL SPILLAGE; SURVIVAL; RUPTURE; CAVITY

AB Objective. The prognostic impact of intra-operative tumor spillage (ITS) during minimally invasive surgery (MIS) for endometrial cancer (EC) is not well studied. The objective of this study was to determine if there is an association between ITS and EC recurrence.Methods. We performed a case-control study of patients with a laparoscopic or robot-assisted hysterectomy with EC on final pathology between 2017 and 2022 and compared those with (case) and without (control) a sub-sequent EC recurrence. Electronic medical records were reviewed for demographic, intra-operative and patho-logic details, and recurrence status. ITS was defined as uterine perforation with a manipulator, presence of extra-uterine tumor after colpotomy or specimen delivery, exposure of uncontained specimen into peritoneum, and/or pathology/operative reports noting specimen fragmentation. Conditional logistic regression was used to determine odds ratios for the association of cancer recurrence with ITS. We adjusted for >50% myoinvasion, tumor size, and adjuvant treatment.Results. 1057 patients underwent MIS for EC. Approximately 8% (n = 86) developed recurrent cancer and 172 patients were selected as controls. Twenty percent of recurrent cases (17/86) had ITS compared with 4% of non -recurrent controls (7/172). When adjusted for tumor size, deep myoinvasion, and adjuvant treatment, patients with ITS had a 5.6 times increased odds (aOR 5.63, 95% CI 1.52-20.86) of recurrence compared to patients without ITS.Conclusions. In patients with EC, we found an association between ITS and cancer recurrence. These findings warrant further investigation to determine if adjuvant therapy or surgical technique should be altered to improve outcomes.& COPY; 2023 Published by Elsevier Inc.

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ER

PT J

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TI Use of uterine manipulator and uterine perforation in minimally invasive

endometrial cancer surgery

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Endometrial cancer; Uterine manipulator; Uterine perforation

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; LYMPHOVASCULAR SPACE INVASION;

MANAGEMENT; CYTOLOGY; RISK

AB Objective: Safety of the uterine manipulator (UM) within endometrial cancer (EC) surgery is being ques-tioned. Its use might be one of the issues for potential tumor dissemination during the procedure, especially in the case of uterine perforation (UP). No prospective data on this surgical complication, nor on the oncolog-ical consequences exist. The aim of this study was to assess the rate of UP while using UM when performing surgery for EC and the impact of UP on the choice of adjuvant treatment. Methods: We conducted a prospective single-center cohort study from November 2018 to February 2022, considering all EC cases surgically treated by a minimally invasive approach with the help of a UM. Demo-graphic, preoperative, postoperative and adjuvant treatment corresponding to the included patients were collected and comparatively analyzed according to the absence or presence of a UP. Results: Of the 82 patients included in the study, 9 UPs (11%) occurred during surgery. There was no signifi-cant difference in demographics and disease characteristics at diagnosis that may have induced UP. The type of UM used or the approach (laparoscopic vs. robotic) did not influence the occurrence of UP (p = 0.44). No positive peritoneal cytology was found post hysterectomy. There was a statistically significantly higher rate of lymph-vascular space invasion within the perforation group, 67% vs. 25% in the no perforation group, p = 0.02. Two out of nine (22%) adjuvant therapies were changed because of UP. The median follow-up time for patients was 7.6 months (range 0.5-33.1 months). No recurrence was found in the UP group. Conclusion: Our study found a uterine perforation rate of 11%. This information needs to be further integrated to consider the usefulness of MU for EC surgery. & COPY; 2023 Elsevier Masson SAS. All rights reserved.

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ER

PT J

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Bifulco, Giuseppe

Giampaolino, Pierluigi

TI Three-dimensional imaging reconstruction and laparoscopic robotic

surgery: a winning combination for a complex case of multiple myomectomy

SO FERTILITY AND STERILITY

LA English

DT Article

DE Myomectomy; infertility; laparoscopic robotic surgery; 3D imaging

AB Objective: To demonstrate the intraoperative use of three-dimensional (3D) imaging reconstruction for a complex case of multiple myomectomy assigned to robot-assisted laparoscopic surgery.Design: Stepwise demonstration of the technique with narrated video footage.Setting: University tertiary care hospital.Patient(s): A 36-year-old nulliparous infertile woman with multiple uterine myomas (>20) presented with menorrhagia and pelvic discomfort for many months. Because of the huge number of fibroids present, the patient was considered eligible for laparoscopic robotic-assisted myomectomy.Intervention(s): A robotic-assisted laparoscopic myomectomy was performed with the use of intraoperative 3D imaging reconstruction. After opening the retroperitoneum through the adnexal triangle and identifying the ureters, to reduce intraoperative bleeding, bulldog clamps were used to temporarily reduce uterine vascularization. A multiple myomectomy was then performed with the use of tenaculum and Maryland bipolar forceps. During the intervention, the surgeon used the 3D uterine reconstruction to adapt its surgical strategy. Multilayer running closure was achieved using a bidirectional barbed suture ensuring introflexion of the serosa. Patients' consent was obtained for publication of the case; institutional review board approval was not required for this case report as per our institution's policy.Main Outcome Measure(s): Description of a robotic-assisted myomectomy with the intraoperative use of 3D imaging reconstruction.Result(s): The total operative time was 105 minutes. A total of 21 fibroids were removed with 150 mL of intraoperative blood loss. The patient was discharged the day after.Conclusion(s): The application of 3D imaging technology could overcome one of the limitations of robot-assisted minimally invasive surgery, the lack of haptic feedback, enabling the surgeon to rapidly locate myomas and guide the intraoperative plan to optimize the results. Additional studies evaluating the clinical impact of this technique and its improvement are required. (Fertil Sterile 2023;120:202-4.& COPY;2023 by American Society for Reproductive Medicine.) El resumen esta disponible en Espanol al final del articulo.

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J9 FERTIL STERIL

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

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Kilowski, KA

Recio, FO

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Recio, Fernando O.

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Kendrick, James E.

Holloway, Robert W.

TI Malignant peritoneal cytologic contamination with robotic hysterectomy

for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive surgery; Peritoneal cytology;

Robotic hysterectomy; Pelvic washings

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PROGNOSTIC-SIGNIFICANCE; CARCINOMA;

SURVIVAL; CERVIX

AB Background. Malignant peritoneal cytology in endometrial cancer (EC) is not considered an independent ad-verse prognostic factor for uterine-confined disease and is not a determinant factor in the International Federa-tion of Gynecology and Obstetrics (FIGO) staging system. NCCN Guidelines still recommend obtaining cytologies. The aim of this study was to determine the prevalence of peritoneal cytologic contamination following robotic hysterectomy for EC. Methods. Peritoneal cytology from the pelvis and diaphragm were obtained at the initiation of surgery, and from the pelvis only at the completion of robotic hysterectomy with sentinel lymph node mapping (SLNM). Cy-tology specimens were evaluated for the presence of malignant cells. Pre-and post-hysterectomy cytology re-sults were compared, and pelvic contamination was defined as conversion from negative to positive cytology following surgery. Results. 244 patients underwent robotic hysterectomy with SLNM for EC. Pelvic contamination was identified in 32 (13.1%) cases. In multivariate analysis, pelvic contamination was associated with >50% myometrial inva-sion, tumor size >2 cm, lymphovascular space invasion (LVSI), and lymph node metastasis. There was no asso-ciation with FIGO stage or histology subtypes. Conclusions. Malignant peritoneal contamination occurred during robotic surgery for EC. Large lesions (>2 cm), deep invasion (>50%), LVSI, and lymph node metastasis were each independently associated with peri-toneal contamination. Whether or not peritoneal contamination increases risk for disease recurrence should be studied in larger series, including an evaluation of patterns of recurrence and the potential impact of adjuvant therapies. Until the clinical impact of peritoneal contamination during hysterectomy for EC is better understood, methods to reduce peritoneal contamination are warranted. & COPY; 2023 Elsevier Inc. All rights reserved.

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PT J

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TI Evaluation of Peri-Operative Management in Women with Deep Endometriosis

Who are Candidates for Bowel Surgery: A Survey from the Italian Society

of Gynecologic Endoscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometriosis; ERAS; Perioperative management

ID LAPAROSCOPIC COLORECTAL SURGERY; PATIENT-CONTROLLED ANALGESIA;

RANDOMIZED CLINICAL-TRIAL; ENHANCED RECOVERY; CARE; GUIDELINES;

RECOMMENDATIONS

AB Study Objective: There is great consensus that the implementation of the enhanced recovery after surgery (ERAS) approach is beneficial for surgical patients, but there is a paucity of data concerning its application in women with deep endometriosis (DE) who are candidates for bowel surgery. The survey described herein was aimed at gathering detailed information on perioperative management of DE patients who were undergoing sigmoid/rectal (discoid or segmental) resec-tion within the Italian Society of Gynecologic Endoscopy (SEGI) group.Design: Baseline survey.Setting: National survey conducted within the main Italian cooperative group in minimally invasive gynecologic surgery (SEGI).Patients: The study did not involve patients.Interventions: A 63-item questionnaire covering ERAS items for gynecologic/elective colorectal surgery was sent to SEGI centers. Only questionnaires from centers that reported performing & GE;10 sigmoid/rectal resections per year were considered for this analysis.Measurements and Main Results: Thirty-three of 38 (86.8%) of the questionnaires were analyzed. The rates of concor-dance with the ERAS guidelines were 40.4%, 64.4%, and 62.6% for preoperative, intraoperative, and postoperative items, respectively. The proportion of overall agreement was 56.6%. Preoperative diet, fasting and bowel preparation, correction of anemia, avoidance of peritoneal drains, postoperative feeding, and early mobilization were the most controversial items. Comparative analysis revealed that the referred rates of complete disease removal and conversion to open surgery were sig-nificantly different depending on case volume (p = .044 and p = .003, respectively) and gynecologist's/surgeon's experience (p = .042 and p = .022, respectively), with higher chances of obtaining a complete laparoscopic/robotic excision of endome-triosis in centers that reported & GE;30 DE surgeries performed per year and/or & GE;90% of bowel resections performed by a gyne-cologist/general surgeon specifically dedicated to DE management. In contrast, the rates of concordance with the ERAS guidelines were not significantly different according to case volume (p = .081) or gynecologist's/surgeon's experience (p = .294).Conclusion: This is the first study on DE conducted on a national scale. The current survey results revealed suboptimal compliance with the ERAS recommendations and underline the need to improve the quality of perioperative care in DE patients undergoing sigmoid/rectal resection. This study is a first step toward building a consistent, structured reporting platform for the SEGI units and facilitating wide implementation and standardization of the ERAS protocol for DE patients in Italy. Journal of Minimally Invasive Gynecology (2023) 30, 462-472. & COPY; 2023 AAGL. All rights reserved.

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J9 J MINIM INVAS GYN

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ER

PT J

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TI Outcomes for patients with high-risk endometrial cancer undergoing

sentinel lymph node assessment versus full lymphadenectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE High-risk endometrial cancer; Sentinel lymph node biopsy

ID SURVIVAL; IMPACT; MULTICENTER; CARCINOMA; BIOPSY

AB Objective. The objective of this study was to determine the progression free survival (PFS) and overall survival (OS) among patients with high-risk endometrial cancer (EC) who underwent sentinel lymph node (SLN) map-ping and dissection compared to patients who underwent pelvic +/- para-aortic lymphadenectomy (LND).Methods. Patients with newly diagnosed high-risk EC were identified. Inclusion criteria included patients who underwent primary surgical management from January 1, 2014 to September 1, 2020 at our institution. Patients were categorized into either the SLN or LND group based on their method of planned lymph node assessment. Patients in the SLN group had dye injected followed by successful bilateral lymph node mapping, retrieval, and processing per our institutional protocol. Clinicopathological and follow-up data were extracted from patient's medical records. The t-test or Mann-Whitney test was used to compare continuous variables and Chi-squared or Fisher's exact test were used for categorical variables. Progression-free survival (PFS) was calculated from the date of initial surgery to the date of progression, death, or last follow-up. Overall survival (OS) was calculated from the date of surgical staging to the date of death or last follow-up. Three-year PFS and OS were calculated using the Kaplan-Meier method, and the log-rank test was used to compare cohorts. Multivariable Cox regression models were used to assess the relationship between nodal assessment cohort and OS/PFS while adjusting for age, adjuvant therapy, and surgical approach. A result was considered statistically significant at the p < 0.05 level of significance and all statistical analysis was done using SAS version 9.4 (SAS Institute, Cary, NC).Results. Out of 674 patients diagnosed with EC during the study period, 189 were diagnosed with high-risk EC based on our criteria. Forty-six (23.7%) patients underwent SLN assessment and 143 (73.7%) underwent LND. No difference was observed between the two groups in regards to age, histology, stage, body mass index, tumors myometrial invasion, lymphovascular space invasion, or peritoneal washing positivity. Patients in the SLN group underwent robotic-assisted procedures more frequently than those in the LND group (p < 0.0001). The three-year PFS rate was 71.1% (95% CI 51.3-84.0%) in the SLN group and 71.3% (95% CI 62.0-78.6%) in the LND group (p = 0.91). The unadjusted hazard ratio (HR) for recurrence in the SLN versus LND group was 1.11 (95% CI 0.56-2.18; p = 0.77), and after adjusting for age, adjuvant therapy, and surgical approach, the HR for recurrence was 1.04 (95% CI 0.47-2.30, p = 0.91). The three-year OS rate was 81.1% (95% CI 51.1-93.7%) in the SLN group and 95.1% (95% CI 89.4-97.8%) in the LND group (p = 0.009). Although the unadjusted HR for death was 3.74 in the SLN vs LND group (95% CI 1.39-10.09; p = 0.009), when adjusted for age, adjuvant therapy, and surgical approach, it was no longer significant with a HR of 2.90 (95% CI 0.94-8.95, p = 0.06).Conclusions. There was no difference in three-year PFS in patients diagnosed with high-risk EC who under-went SLN evaluation compared to those who underwent full LND in our cohort. The SLN group did experience shorter unadjusted OS; however, when adjusting for age, adjuvant therapy and surgical approach, there was no difference OS in patients who underwent SLN compared to LND.& COPY; 2023 Elsevier Inc. All rights reserved.

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AU Eissa, A

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Elsodany, I

Habib, G

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TI Robotic Pelvic Lymphadenectomy in Gynecological and Urological

Malignancies

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE pelvic lymph node dissection; robotic surgery; bladder cancer; cervical

cancer; endometrial cancer; prostate cancer

ID LYMPH-NODE DISSECTION; OPEN RADICAL CYSTECTOMY; STAGE CERVICAL-CANCER;

ENDOMETRIAL CANCER; PROSTATE-CANCER; BLADDER-CANCER; SENTINEL NODE;

ONCOLOGICAL OUTCOMES; SURGICAL OUTCOMES; INDOCYANINE GREEN

AB Objectives: Pelvic lymphadenectomy is a crucial step in the management of different pelvic cancers for both prognostic and/or therapeutic goals. Robotic surgeries offered numerous benefits over open and/or laparoscopic surgeries such as better visualization, shorter hospital stay, less pain and better cosmoses. The aim of this narrative review is to evaluate the value and outcomes of robotic pelvic lymph node dissection (PLND).Mechanism: The PubMed database was searched using the following keywords "Robotic" AND "pelvic lymph node dissection" to identify all the relevant articles concerned with the role and outcomes of robotic PLND. We included only English articles published between 2010 and 2022. Data from the retrieved articles were then used to formulate this review that highlight the introduction, the outcomes of robotic pelvic lymph node dissection (PLND), and the mapping of sentinel lymph node (SLN) in cervical, endometrial, prostate, and bladder cancers.Findings in Brief: PLND is an integral part of gynecological and urological oncology for its role in tumor staging and planning of further treatment plan. Furthermore, it may play an important therapeutic role in bladder cancer. Robotic approach to PLND is safe and efficient and can be potentially used for cervical, endometrial, prostate, and bladder cancers.Conclusions: Robotic PLND could be an alternative to open and laparoscopic approaches as it may decrease the associated morbidities without compromising the quality of Lymph node dissection (LND).

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PT J

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TI Laparoscopy with or without robotic assistance does not negatively

impact long-term oncologic outcomes in patients with uterine serous

carcinoma

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparotomy; Minimally invasive surgery; Uterine serous carcinoma

ID ENDOMETRIAL CANCER; ABDOMINAL HYSTERECTOMY; RISK; SURVIVAL; SURGERY;

WOMEN

AB Objectives. We sought to compare outcomes between minimally invasive surgery (MIS) and laparotomy in patients with clinical stage I uterine serous carcinoma (USC).

Methods. Patients who underwent surgery for newly diagnosed USC between 11/1/1993 and 12/31/2017 were retrospectively identified and assigned to either the MIS cohort or the laparotomy cohort. Patients with conversion to laparotomy were analyzed with the MIS cohort. Chi-square and Mann-Whitney tests were used to compare categorical and continuous variables, respectively. Kaplan-Meier curves were used to estimate survival and compared using the log-rank test.

Results. In total, 391 patients met inclusion criteria; 242 underwent MIS (35% non-robotic and 65% robotic-assisted laparoscopies) and 149 underwent laparotomy. Age, BMI, stage, and washings status did not differ between cohorts. Patients who underwent MIS were less likely to have lymphovascular space invasion (LVSI; 35.1% vs 48.3%), had fewer nodes removed (median, 9 vs 15), and lower rates of paraaortic nodal dissection (44.6% vs 65.1%). Rates of adjuvant therapy did not differ between cohorts. Median follow-up timeswere 63.0 months (MIS cohort) vs 71.0 months (laparotomy cohort; P=.04). Five-year PFS rates were 58.7% (MIS) vs 59.8% (laparotomy; P =.1). Five-year OS rates were 65.2% (MIS) compared to 63.5% (laparotomy; P =.2). On multivariable analysis, higher stage, deep myometrial invasion, and positive washings were associated with decreased PFS. Age >= 65 years, higher stage, LVSI, and positive washings were associated with shorter OS.

Conclusions. MIS does not compromise outcomes in patients with newly diagnosed USC and should be offered to these patients to minimize surgical morbidity. (c) 2023 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Robot-assisted tubo-tubal reanastomosis after sterilization in 10 steps

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Robot -assisted laparoscopy; Tubo-tubal reanastomosis; Sterilization

ID ANASTOMOSIS; REVERSAL

AB Five to 20% of women regret having a tubal ligation. These women are generally otherwise fertile and have a better chance of pregnancy than other patients experiencing infertility, whether by in vitro fertilization or after tubal surgery. Historically, tubal anastomosis surgery has long been performed by microsurgery through laparotomy, which provided very high precision but was associated with some degree of morbidity. The parallel development of in vitro fertilization and laparoscopy have contributed to reducing the indica-tions for tubal surgery. The laparoscopic approach is challenging because of the number and precision of the sutures needed. The robot-assisted laparoscopic approach may reduce the surgical difficulty and improve the accessibility of this technique. We have described the technique of tubo-tubal reanastomosis after steriliza-tion with robot-assisted laparoscopy in 10 steps. Robot-assisted laparoscopy provides favourable conditions for performing tubo-tubal reanastomosis after sterilization due to the camera stability, precision of move-ment, and amplitude of articulations.& COPY; 2023 Elsevier Masson SAS. All rights reserved.

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TI Robot-assisted vesicovaginal fistula repair: comparison of the

extravesical and transvesical techniques

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robot-assisted surgery; Fistula; Vesicovaginal; Multicenter study

ID SURGICAL REPAIR

AB Introduction and objectivesAlmost two decades after the description of robotic vesicovaginal fistula repair (R-VVF), the literature remains limited. The aims of this study are to report the outcomes of R-VVF and to compare the transvesical versus extravesical techniques.MethodsWe performed an observational, retrospective, multicenter study, including all patients who underwent R-VVF from March 2017 to September 2021 at four academic institutions. All abdominal VVF repair over the study period were performed using a robotic approach. The success of R-VVF was defined as the absence of clinical recurrence. The outcomes of the extravesical versus transvesical techniques were compared.ResultsTwenty-two patients were included. The median age was 43 years old (IQR 38-50). Fistulas were supratrigonal and trigonal in 18 and 4 cases respectively. Five patients had undergone previous attempts of fistula repair (22.7%). The fistulous tract was systematically excised, and an interposition flap was used in all but two cases (90.9%). The transvesical and extravesical techniques were used in 13 and 9 cases respectively. There were four postoperative complications, three minor and one major. None of the patients had vesicovaginal fistula recurrence after a median follow-up of 15 months.ConclusionsThe present series, one of the largest R-VVF reported to date, is consistent with the few series already published with a 100% cure rate. Systematic excision of the fistulous tract and the high rate of flap interposition may explain the high success rate. The transvesical and extravesical approaches yielded similar outcomes.

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PT J

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TI COVID-19 as a Catalyst for Same Day Discharge After Minimally Invasive

Hysterectomy

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE gynecology; gynecologic surgery; outpatient surgery; coronavirus; health

care utilization; enhanced recovery

ID SURGERY

AB Objective: This study quantified the COVID-19 pandemic's impact on same-day discharges for minimally invasive hysterectomy and evaluated the effect on postoperative morbidity and health care use.Materials and Methods: This retrospective cohort study, from March 2018 to October 2021 at a single institution, included women older than age 18 who had laparoscopic, vaginal, or robotic-assisted hysterectomy by any gynecologic surgeon. Primary outcome was rate of same-day hospital discharge. Secondary measures were length of stay and rates of 30-day postoperative morbidity and health care use. Univariate and multivariable logistic regression analyses were conducted to evaluate associations between patients' characteristics and likelihood of same-day discharge.Results: There were 1608 women included, 896 in a prepandemic cohort and 712 in a postpandemic cohort. Surgeon subspecialty rates were similar between groups, but surgical approaches differed, with more laparoscopic procedures in the postpandemic cohort (p = 0.007). Case order and lengths, and concurrent procedures were not different between groups. Postpandemic patients were more likely to be discharged on the same day even after controlling for confounders in a multivariable regression (32% versus 54%, respectively; odds ratio: 2.78; p < 0.001). Rates of 30-day postoperative complications, transfusions, emergency department visits, readmissions, reoperations, and mortality were not significantly different.Conclusions: The COVID-19 pandemic was associated with increased same-day discharges without increases in 30-day postoperative complications. The data confirmed that same-day discharge following minimally invasive hysterectomy was safe for managing hospital constraints caused by the COVID-19 pandemic. (J GYNECOL SURG 20XX:000)

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PT J

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TI The Feasibility and Safety of vNOTES Hysterectomy and Uterosacral

Ligament Suspension: A Case Series

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Feasibility; Hysterectomy; Safety; Uterosacral; vNOTES

ID TRANSLUMINAL ENDOSCOPIC SURGERY; SALPINGO-OOPHORECTOMY; LIFETIME RISK;

ADNEXECTOMY

AB The transvaginal natural orifice transluminal endoscopic surgery (vNOTES) is a recently introduced surgical approach that is even less invasive than conventional laparoscopy or robotic surgery. We conducted this study to report our experience in vNOTES hysterectomy and uterosacral ligament suspension and determine the feasibility and safety of this approach. Surgeries on 23 women were performed by a single surgeon in 1 tertiary medical center. Patient demographics, perioperative data, and follow-up details of 23 women were collected prospectively. Average age was 56.7 + 8.9 years. Median parity was 3. Nine patients were smokers, and 4 patients had diabetes. Median stage of prolapse was 3. One patient had extensive adhesions, and after vNOTES hysterectomy was completed, decision was made to perform uterosacral suspension by conventional vaginal access. Another patient had intraoperative identification by cystoscopy of unilateral kinking of the ureter that was resolved after the most distal uterosacral stitch was released. Mean uterine weight was 271.9 + 131.9 g. Average estimated blood loss was 85.22 + 55.6 mL. Median length of stay in the hospital was 1 day. Only 1 patient had intermittent voiding postoperatively and required an indwelling catheter for 3 days. Hysterectomy and uterosacral ligament suspension when performed via vNOTES is a safe and feasible procedure. Large prospective trials are on the way to continue shedding light on this new surgical modality. Journal of Minimally Invasive Gynecology (2023) 30, 414-417. & COPY; 2023 AAGL. All rights reserved.

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PT J

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Zhang, JH

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TI Survival outcomes of robotic-assisted laparoscopy versus conventional

laparoscopy and laparotomy for endometrial cancer: A systematic review

and meta-analysis

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Endometrial cancer; Robotic-assisted laparoscopy; Long-term survival;

Conventional laparoscopy; Laparotomy

ID OPEN SURGERY; HYSTERECTOMY; WOMEN; CARCINOMA; OBESE; MANAGEMENT; COST

AB Objective. Robotic-assisted laparoscopy (RALS) has gained widespread acceptance in the field of gynecologi-cal oncology. However, whether the prognosis of endometrial cancer after RALS is superior to conventional lap-aroscopy (CLS) and laparotomy (LT) remains inconclusive. Therefore, the aim of this meta-analysis was to compare the long-term survival outcomes of RALS with CLS and LT for endometrial cancer.Methods. A systematic literature search was conducted on electronic databases (PubMed, Cochrane, EMBASE and Web of Science) until May 24, 2022, followed by a manual search. Based on inclusion and exclusion criteria, publications investigating long-term survival outcomes after RALS vs CLS or LT in endometrial cancer patients were collected. The primary outcomes included overall survival (OS), disease-specific survival (DSS), recurrence-free survival (RFS) and disease-free survival (DFS). Fixed effects models or random effects models were employed to calculate the pooled hazard ratios (HRs) and 95% confidence intervals (CIs) as appropriate. Heterogeneity and publication bias were also assessed.Results. RALS and CLS had no difference in OS (HR = 0.962, 95% CI: 0.922-1.004), RFS (HR = 1.096, 95% CI: 0.947-1.296), and DSS (HR = 1.489, 95% CI: 0.713-3.107) for endometrial cancer; however, RALS was signifi-cantly associated with favorable OS (HR = 0.682, 95% CI: 0.576-0.807), RFS (HR = 0.793, 95% CI: 0.653-0.964), and DSS (HR = 0.441, 95% CI: 0.298-0.652) when compared with LT. In the subgroup analysis of effect measures and follow-up length, RALS showed comparable or superior RFS/OS to CLS and LT. In early-stage endometrial cancer patients, RALS had similar OS but worse RFS than CLS.Conclusions. RALS is safe in the management of endometrial cancer, with long-term oncological outcomes equivalent to CLS and superior to LT.(c) 2023 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http:// creativecommons.org/licenses/by-nc-nd/4.0/).

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Helpman, L

Pond, G

Nelson, G

Kwon, J

Altman, A

Feigenberg, T

Elit, L

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Sabourin, J

Samouelian, V

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TI Surgical margin status in relation to surgical approach in the

management of early-stage cervical Cancer: A Canadian cervical Cancer

collaborative (4C) study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Early cervical cancer; MIS; Surgical margin; Survival

ID RADICAL SURGERY; HYSTERECTOMY

AB Objective. Surgical margin status in women undergoing surgery for early-stage cervical cancer is an important prognostic factor. We sought to determine whether close (<3 mm) and positive surgical margins are associated with surgical approach and survival. Methods. This is a national retrospective cohort study of cervical cancer patients treated with radical hysterectomy. Patients with stage IA1/LVSI-Ib2(FIGO 2018) with lesions up to 4 cm at 11 Canadian institutions from 2007 to 2019 were included. Surgical approach included robotic/laparoscopic (LRH), abdominal (ARH) or combined laparoscopic-assisted vaginal/vaginal (LVRH) radical hysterectomy. Recurrence free survival(RFS) and overall survival (OS) were estimated using Kaplan-Meier analysis. Chi-square and log-rank tests were used to compare groups.Results. 956 patients met inclusion criteria. Surgical margins were as follows: negative (87.0%), positive (0.4%) or close <3 mm (6.8%), missing (5.8%). Most patients had squamous histology (46.9%); 34.6% had adenocarcinomas and 11.3% adenosquamous. Most were stage IB (75.1%) and 24.9% were IA. Mode of surgery included: LRH Predictive factors for close/positive margins included stage, tumour diameter, vaginal involvement and parametrial extension. Surgical approach was not associated with margin status (p = 0.27). Close/positivemargins were associated with a higher risk of death on univariate analysis (HR = non calculable for positive and HR = 1.83 for close margins, p = 0.017), but not significant for OS when adjusted for stage, histology, surgical approach and adjuvant treatment. There were 7 recurrences in patients with close margins (10.3%, p = 0.25). 71.5% with positive/close margins received adjuvant treatment. In addition, MIS was associated with a higher risk of death (OR = 2.39, p = 0.029).Conclusion. Surgical approach was not associated to close or positive margins. Close surgical margins were associated with a higher risk of death. MIS was associated with worse survival, suggesting that margin status may not be the driver of worse survival in these cases. (c) 2023 Elsevier Inc. All rights reserved.

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PT J

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TI Robotic surgery implementation in an isolated overseas territory-The

case of Reunion Island

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Robotic surgery; Reunion Island; Learning curve; Gynecology;

Hysterectomy

ID LEARNING-CURVE

AB Introduction: In February 2020, robotic surgery was introduced in University Hospital of St Pierre in Reunion Island. The aim of this study was to evaluate the implementation of robotic assisted surgery in the hospital and its impact on operating times and patient outcomes.Methods: Data was prospectively collected on patients undergoing laparoscopic robotic assisted surgery between February 2020 and February 2022. Information included patient demographics, type of surgery, operating times and length of stay.Results: Over the two-year study period, 137 patients underwent laparoscopic robotic assisted surgery per-formed by 6 different surgeons. 89 of the surgeries were in gynecology, including 58 hysterectomies, 37 were in digestive surgery, and 11 in urology. The installation and docking times decreased across all special-ties and were found to be significantly reduced when comparing the first and last 15 hysterectomies: mean installation time decreased from 18.7 to 14.5 minutes (p=0.048), mean docking time decreased from 11.3 to 7.1 minutes (p = 0.009).Conclusions: The implementation of robotic assisted surgery in an isolated territory such as Reunion Island was slow due to a lack of trained surgeons, supply difficulties and Covid crisis. Despite these challenges, the use of robotic surgery allowed for technically more challenging surgeries and demonstrated similar learning curves to other centers.(c) 2023 Elsevier Masson SAS. All rights reserved.

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Thigpen, B

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Sunkara, Sowmya

Thigpen, Brooke

TI Indocyanine Green-Assisted Retrograde Ureterolysis in Robotic

Transvaginal NOTES for the Management of Stage IV Endometriosis with

Obliterated Cul-de-sac

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Indocyanine green; Robotic; Stage IV endometriosis; Reverted

ureterolysis; Obliterated cul-de-sac

AB Study Objective: To explore the use of indocyanine green (ICG) in highlighting ureteral anatomical landmarks for the suc-cessful and safe execution of robotic-assisted transvaginal NOTES hysterectomy with resection of deeply infiltrated endometriosis. Design: Stepwise demonstration with narrated video footage. Setting: An academic tertiary care hospital. Our patient is a 38-year-old G4P1031 with a symptomatic enlarged uterus sec-ondary to adenomyosis and uterine myomas, dense adhesions between the posterior uterus, and left uterosacral ligament. Interventions: Stage IV endometriosis with obliterated cul-de-sac is a challenging procedure in the surgical management of endometriosis. Ureterolysis is the key step to performing this surgery successfully and safely; however, the routine dissec-tion of ureters from the sacral promontory level to the uterine artery is challenging in obliterated cul-de-sacs with pelvic side wall adhesions with the proximal ureter at greatest risk [1-4]. Using the ICG firefly technique allowed us to rapidly identify and safely dissect the ureter through robotic transabdominal endometriosis surgery [5,6]. The angle of approach in transvaginal NOTES surgery for hysterectomy with obliterated cul-de-sac endometriosis leads to far more difficulty in iden-tifying the ureter at the beginning of surgery [3]. Therefore, an obliterated cul-de-sac was associated with a potentially increased risk of ureteral injury and bowel injury. We used ICG to help identify the ureter at the beginning of the case lead-ing to reducing the risk of surgical complication, in which the concept of ureterolysis from the level of the uterine artery to the bifurcation of common iliac vessels in vNOTES surgery will be referred to as "vNOTES retrograde ureterolysis." With the cystoscope in place, a ureteral catheter was inserted into the right ureter and 5 cc of ICG was injected, and the same procedure was done on the left [1,5]. Bovie electrosurgical device was used to incise circumferentially around the cervix. The bladder was dissected off the pubovesical cervical fascia anteriorly and posteriorly with a combination of the Bovie as well as blunt and sharp dissection. Bilateral uterosacral and cardinal ligaments, as well as uterine arteries, were then clamped, transected with Mayo scissors, and secured. Entry into the anterior cul-de-sac was completed, and a stitch using 0 vicryl was used to tag the anterior peritoneum to the anterior vaginal cuff. Posterior entry was attempted unsuccessfully. The Gelpoint mini device was then placed, and the Da Vinci XI robot was docked. Bilateral ureters were identified and dis-sected out of bilateral pelvic sidewalls using the firefly mode at the level of the uterine artery. The ureters were easily dis-sected away from the uterus. The left broad ligament was then cauterized and transected using the vessel sealer. The plane between the uterus and the rectum was identified laterally, and the rectum was taken down from the uterus from the right to the left side. Bilateral broad ligaments were then cauterized and transected using the vessel sealer, followed by cauterization and transection of the round ligaments, utero-ovarian ligaments, and mesosalpinx bilaterally. The vaginal cuff angles were secured with a figure-of-eight stitch of 0 vicryl, and the vaginal cuff was then closed in a running fashion with 0 V-Loc. The patient was discharged in one day with reports of minimal pain (Videos 1-3).

Conclusion: Robotic-assisted NOTES hysterectomy with deeply infiltrated endometriosis resection is feasible and safe with ICG-assisted ureteral labeling in a case of obliterated cul-de-sac. The unique green color labeling of ureters offers a prominent landmark in assisting the ureteral dissection while avoiding ureteral and bowel injury, resulting in the possibility of using vNOTES surgery in challenging cases. Journal of Minimally Invasive Gynecology (2023) 30, 266-267. (c) 2023 AAGL. All rights reserved.

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TI Same-day Discharge after Robotic Hysterectomy for Benign Conditions:

Feasibility and Safety

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Outcome; Predictors; Robotic; Same-day discharge

ID LAPAROSCOPIC HYSTERECTOMY

AB Study Objective: To investigate the feasibility and predictive factors for same-day discharge (SDD) after robotic hysterec-tomy (RH) for benign indications to optimize patient selection by incorporating preoperative, intraoperative, and postopera-tive variables. Design: A single-center retrospective cohort study. Setting: Tertiary academic hospital. Patients: Patients undergoing RH for benign indications. Interventions: Patients were designated for SDD by implementing enhanced recovery after surgery protocol. Measurements and Main Results: The study included 890 patients who underwent RH for benign indications between the years 2016 and 2021. Of these, 618 (69.4%) were discharged the same day and 272 (30.5%) were admitted for overnight stay. Both groups had similar age (46.4 vs 46.2 years), body mass index (28.3 vs 28.9), and indications for surgery. In multi -variable logistic regression, factors that were significant for overnight stay were American Society of Anesthesiologists score 3, Charlson comorbidity index, previous laparotomy, and operative time. Other factors such as surgery start time and preoperative hemoglobin levels were not statistically significant. Postoperative outcomes were comparable for both groups with similar readmission and reoperation rates. Conclusion: The likelihood of SDD after RH in this cohort after implementing enhanced recovery after surgery protocol was almost 70%, and most of the predictive factors for overnight stay were nonmodifiable. Importantly, both groups had similar outcomes after surgery. Journal of Minimally Invasive Gynecology (2023) 30, 277-283. (c) 2022 AAGL. All rights reserved.

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PT J

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TI Robotic-assisted Gynecological Surgery in Older Patients - a Comparative

Cohort Study of Perioperative Outcomes

SO GEBURTSHILFE UND FRAUENHEILKUNDE

LA German

DT Article

DE benign and oncological indications; comorbidity; Clavien-Dindo

classification; old age; robotic-assisted gynecological surgery

ID ENDOMETRIAL CANCER; UTERINE-CANCER; CO-MORBIDITY; HYSTERECTOMY; AGE;

CLASSIFICATION; COMORBIDITY; PREVALENCE; LAPAROTOMY; PROLAPSE

AB Study design Because of current demographic developments, a hypothesis was proposed whereby older female patients aged > 65 years can be safely operated using minimally invasive, robotic-assisted surgery, despite having more preoperative comorbidities. A comparative cohort study was designed to compare the age group = 65 years (older age group, OAG) with the age group < 65 years (younger age group, YAG) after robotic-assisted gynecological surgery (RAS) in two German centers. Patients and methods Consecutive RAS procedures performed between 2016 and 2021 at the Women's University Hospital of Jena and the Robotic Center Eisenach to treat benign or oncological indications were included in the study. The age groups were compared according to their preoperative comorbidities (ASA, Charlson comorbidity index [CCI], cumulative illness rating scale - geriatric version [CIRS-G]) and perioperative parameters such as Clavien-Dindo (CD) classification of surgical complications. Analysis was performed using Welch's t-test, chi2 test, and Fisher's exact test. Results A total of 242 datasets were identified, of which 63 (73 +/- 5 years) were OAG and 179 were YAG (48 +/- 10 years). Patient characteristics and the percentage of benign or oncological indications did not differ between the two age groups. Comorbidity scores and the percentage of obese patients were higher in the OAG group: CCI (2.7 +/- 2.0 vs. 1.5 +/- 1.3; p < 0.001), CIRS-G (9.7 +/- 3.9 vs. 5.4 +/- 2.9; p < 0.001), ASA class II/ III (91.8% vs. 74.1 %; p = 0.004), obesity (54.1% vs. 38.2 %; p = 0.030). There was no difference between age groups, even grouped for benign or oncological indications, with regard to perioperative parameters such as duration of surgery (p = 0.088; p = 0.368), length of hospital stay (p = 0.786; p = 0.814), decrease in Hb levels (p = 0.811; p = 0.058), conversion rate (p = 1.000; p = 1.000) and CD complications (p = 0.433; p = 0.745). Conclusion Although preoperative comorbidity was higher in the group of older female patients, no differences were found between age groups with regard to perioperative outcomes following robotic-assisted gynecological surgery. Patient age is not a contraindication for robotic gynecological surgery.

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Plante, Marie

TI Robotic-assisted surgery for endometrial cancer is safe in morbidly and

extremely morbidly obese patients

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Morbid obesity; Robotic-assisted surgery

ID BODY-MASS INDEX; LAPAROSCOPIC HYSTERECTOMY; SURGICAL-TREATMENT;

LAPAROTOMY; OUTCOMES; IMPACT; COMPLICATIONS; HYPERPLASIA; EXPERIENCE;

CARCINOMA

AB Objective. Obesity has risen to affect >25% of the Canadian population. Perioperative challenges with in-creased morbidity are encountered. We evaluated the outcome of robotic-assisted surgery for endometrial can-cer (EC) in obese patients.Methods. We retrospectively reviewed all robotic surgeries performed for EC in women with BMI >= 40 kg/m2, from 2012 to 2020 in our center. Patients were divided into 2 groups (class III: 40-49 kg/m2, class IV: >= 50 kg/m2). Complications and outcome were compared.Results. 185 patients were included: 139 class III and 46 class IV. The main histology was endometrioid ade-nocarcinoma (70,5% of class III and 58,1% of class IV (p = 0,138)). The mean blood loss, overall sentinel node de-tection and median length of stay were similar in both groups. Six class III (4,3%) and 3 class IV (6,5%) patients required conversion to laparotomy due to poor surgical field exposure (p = 0,692). The rate of intraoperative complications was similar between the 2 groups (1.4% in class III vs none in class IV, p = 1). There were 10 class III (7,2%) and 10 class IV (21,7%) post-operative complications (p = 0.011), but most were grade 2 (3,6% in class III vs 13% in class IV, p = 0.029)). Grade 3 and 4 postoperative complications were low (2.7%) and not statistically different between the 2 groups. Readmission rate was low in both groups (4 in each group, p = 1.07). Recurrence occurred in 5,8% of class III and 4,3% of class IV patients (p = 1).Conclusion. Robotic-assisted surgery for EC in class III and class IV obese patients is a safe and feasible proce-dure, with low complication rate, similar oncologic outcome, conversion rate, blood loss, readmission rate and length of hospital stay.(c) 2023 Elsevier Inc. All rights reserved.

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ER

PT J

AU Fallon, M

Nolan, W

Jeyalingam, P

AF Fallon, Matthew

Nolan, William

Jeyalingam, Praba

TI Report Robotic-assisted Laparoscopic Supracervical Repair of a Chronic

Puerperal Uterine Inversion

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE DaVinci; Hysterotomy; Pregnancy

AB Surgical correction of a chronic puerperal uterine inversion traditionally requires an anterior or posterior cervical incision to relieve the constricting band. This case is only the second reported case of robotic-assisted correction of a chronic puerperal uterine inversion and the first to avoid a cervical incision. The patient was 5 months postpartum and desired future preg-nancy. After a laparoscopic Huntington technique was unsuccessful, a vertical hysterotomy was created in the anterior lower uterine segment and extended toward the fundus until the inversion could be relieved. The incision was repaired in 3 layers and a round ligament plication was performed to provide additional support within the pelvis. The patient's symptoms grad-ually improved during her postoperative course, and ultrasound 2 weeks after the procedure revealed the uterus in anatomic position in the pelvis. With a paucity of reported cases of laparoscopic correction of chronic puerperal uterine inversion, the present case offers a novel surgical approach that maintains cervical integrity and thereby minimizes long-term effects of the procedure on future pregnancies. Journal of Minimally Invasive Gynecology (2023) 30, 245-248. (c) 2022 AAGL. All rights reserved.

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PT J

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Tsuchiya, Hiroko

Matsuyama, Reiko

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TI Robotic-Assisted Laparoscopic Hysterectomy versus Conventional

Laparoscopic Hysterectomy for Endometrial Cancer at a Regional

Institution: A Retrospective Study

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE laparoscopic hysterectomy; local facility; minimally invasive surgery;

pelvic lymphadenectomy; robotic surgery; rural hospital; uterine corpus

cancer

ID SURGERY; SURVIVAL; RECURRENCE

AB Background: Minimally invasive surgeries, such as laparoscopic and robotic surgeries, have been the main treatment methods for stage I endometrial cancer instead of laparotomy. However, minimally invasive surgeries for malignant tumors have not yet been established in many rural hospitals or hospitals with few gynecologists. This study aimed to investigate whether laparoscopic or robotic surgery for stage I endometrial cancer is more sustainable and useful at a rural hospital where a single non-laparoscopic-specialized surgeon performs oncologic surgery and provides outpatient care. Methods: This retrospective case-control study was conducted at our hospital. The study enrolled 65 patients with endometrial cancer who underwent robotic-assisted laparoscopic hysterectomy (RALH) or total laparoscopic hysterectomy (TLH). We compared surgical outcomes such as patient background, operation time, blood loss, and other indices. Results: Exactly 34 patients underwent robotic surgery, and 31 underwent laparoscopic surgery. No severe adverse events required reoperation, conversion to laparotomy, or ureteral injury during either operation. The operation time decreased in patients who underwent robotic surgery compared with those who underwent laparoscopic surgery (193 (140-227) vs. 253 (219-287) min, p < 0.001). In addition, the blood loss volume decreased by half in patients who underwent robotic surgery compared to those who underwent laparoscopic surgery. Significantly more operations were completed by two operators rather than three operators at robotic surgery compared to laparoscopic surgery (59% vs. 26%, p = 0.007). The hospitalization days were 1.5 days shorter in the robotic surgery group than in the laparoscopic surgery group (p < 0.001). Exactly 18 patients underwent robotic surgery with pelvic lymphadenectomy, and 26 underwent laparoscopic surgery with pelvic lymphadenectomy. Patients who underwent robotic surgery required less operation time than those who underwent laparoscopic surgery (226 (199-246) vs. 261 (236-287) min, p = 0.001). Conclusions: In the surgical treatment of stage I endometrial cancer, robotic surgery was associated with a significantly shorter operation time, shorter hospital stay, and no obvious complications. This study proposes that robotic surgery is a promising solution for the sustainable introduction of minimally invasive surgery for stage I endometrial cancer in rural hospitals or hospitals with few gynecologists.

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AU Panico, G

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AF Panico, G.

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TI HUGOTM RAS System in urogynaecology: the first nerve sparing Sacral

Colpopexy for Pelvic Organ Prolapse

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Laparoscopy; pelvic organ prolapse; colposacropexy; anatomy; dissection

ID PERCUTANEOUS SURGICAL SYSTEM; SALPINGO-OOPHORECTOMY; HYSTERECTOMY;

METAANALYSIS

AB Background: Minimally invasive sacral colpopexy is considered the gold standard for surgical treatment of Pelvic Organ Prolapse (POP), combining high success rates with low recurrence risk in comparison to other techniques. This is the first case of robotic sacral colpopexy (RSCP) performed with the innovative HugoTM RAS robotic system. Objectives: The aim of this article is to show the surgical steps of a nerve sparing RSCP performed with the new HugoTM RAS robotic system (Medtronic), by also evaluating the feasibility of this technique using this novel Robotic System.Materials and methods: A 50-year-old Caucasian woman with symptomatic pelvic organ prolapse (POP-Q): Aa: +2, Ba: +3, C: +4, D: +4, Bp:-2, Ap:-2 , TVL:10 GH: 3,5 BP:3 underwent RSCP as well as a subtotal hysterectomy with bilateral salpingo-oophorectomy, using the new surgical robot HugoTM RAS in the Division of Urogynaecology and Pelvic Reconstructive Surgery, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy. Main outcome measures: Intraoperative data, docking specifics, objective and subjective outcomes at three months follow up.Results: Surgical procedure was carried out without intra-operative complications, operative time (OT) was 150 minutes, docking time was 9 minutes. No system errors or faults in the robotic arms were registered. Urogynaecological examination at three months follow up showed a complete resolution of the prolapse.Conclusion: RSCP using the HugoTM RAS system seems to be a feasible and effective approach according to results in terms of operative time, cosmetic results, postoperative pain and length of hospitalisation. Large number of case reports as well as longer follow up are mandatory to better define its benefits, advantages, and costs.

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AU Swartz, AZ

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Hassoun, JS

Crispens, MA

Prescott, LS

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Novoa, Victoria Novoa Y. Arruga

Hassoun, Jenine S.

Crispens, Marta A.

Prescott, Lauren S.

TI Robotic-assisted gynecologic surgery associated tympanic membrane

perforation: A report of two cases and review of the literature

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Review

DE Tympanic membrane perforation; Otorrhagia; Gynecologic surgery;

Trendelenburg; Robotic surgery; Endometrial cancer

ID BILATERAL OTORRHAGIA

AB Robotic gynecologic surgery is associated with the use of steep Trendelenburg positioning. Steep Trendelenburg is necessary to provide optimal exposure to the pelvis but is associated with an increased risk of non-surgical complications such as suboptimal ventilation, facial and laryngeal edema, increased intraocular and intracranial pressure as well as neurologic injury. Several case reports have described otorrhagia after robotic assisted surgery; however, there are limited reports on the risk of tympanic membrane perforation. To our knowledge, there are no published reports on tympanic membrane perforation in gynecologic nor gynecologic oncology surgery. We report two cases of perioperative tympanic membrane rupture and bloody otorrhagia associated with robot-assisted gynecologic surgery. In both cases otolaryngology/Ear Nose and Throat (ENT) was consulted, and the perforations resolved with conservative management.

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PT J

AU Lange, S

Chatziioannidou, K

Daellenbach, P

AF Lange, Soeren

Chatziioannidou, Kyriaki

Daellenbach, Patrick

TI Robotically assisted laparoscopic lateral suspension: a step-by-step

approach aiming to standardize a novel procedure

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Robotic surgery; Laparoscopic lateral suspension;

Uterine prolapse

ID PROLAPSE

AB Introduction and hypothesis The aim of this video is to show a step-by-step approach to robotically assisted laparoscopic lateral suspension for pelvic organ prolapse aiming to standardize this procedure.

Methods This video shows a robotically assisted laparoscopic approach to a POP-Q stage 3 prolapse with a combined anterior and apical defect. First, the trocars are positioned, with one 8-mm trocar, two lateral trocars 5 cm above the anterior-superior iliac spine, and a 10-mm assistant trocar either paraumbilically or suprapubically. Second, the uterovesical pouch is dissected up to 2 cm above the level of the bladder neck. The mesh is then fixed to the vesicovaginal fascia and to the isthmus uteri. Next, a laparoscopic forceps is inserted retroperitoneally through the lateral trocars and the lateral arms of the mesh are pulled retroperitoneally. The peritoneum of the uterovesical fold is sutured, including round ligament plication. Finally, the lateral arms of the peritoneum are fixed to the peritoneum of the abdominal wall.

Conclusions Robotically assisted laparoscopic lateral suspension is a safe alternative to laparoscopic and robotically assisted laparoscopic sacropexy and very well suited for uterine-preserving POP surgery. This video contributes to the standardization of this procedure, and we believe our video to be useful in helping urogynecologists to perform this innovative procedure.

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PT J

AU Montera, R

Ficarola, F

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Luvero, Daniela

TI The use of sealing hemostat patch (HEMOPATCH<SUP>®</SUP>) in laparotomic

myomectomy: a prospective case-control study

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE HEMOPATCH((R)); Sealing hemostat patch; Hemostatic agents; Laparotomic

myomectomy; Hemostasis time

ID LAPAROSCOPIC MYOMECTOMY; SEALANT; MATRIX; WOMEN; HYSTERECTOMY;

ADHESIONS; FLOSEAL; AGENT

AB Purpose Uterine myomas are the most common gynecological disease. In these cases, a myomectomy is performed traditionally laparotomically. However, alternatives have been widely used, including laparoscopic, endoscopic, and robotic surgery. During these techniques, diffuse parenchymatous bleeding remains one of the main intraoperative and postoperative complications and sometimes requires unplanned hysterectomies. Recently, hemostatic agents and sealants have been used to prevent excessive blood loss during surgical repair.

Methods We propose a prospective case-control study on the use of a sealing hemostat patch (HEMOPATCH((R))) on uterine sutures in laparotomic myomectomy. In the period between July 2016 and April 2017, 46 patients with symptomatic uterine fibromatosis underwent surgery. They were divided into two groups of 23 patients, with different treatments in the hemostatic phase of oozing bleeding. HEMOPATCH((R)) is applied in group A, and spray electrocoagulation is applied in group B.

Results In group A, we achieve faster hemostasis (p < 0.05), than in group B. We report a significantly lower C-reactive protein value on the second and third days after surgery for group A compared to group B.

Conclusions HEMOPATCH((R)), during laparotomic myomectomy, is a valid alternative solution for obtaining rapid hemostasis and consequently intraoperative and postoperative bleeding. Furthermore, we suggest that a lower inflammatory peritoneal state is probably correlated with the barrier effect of the patch on the suture.

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JI Arch. Gynecol. Obstet.

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TI Retrospective analysis of apical prolapse correction by unilateral

pectineal suspension: perioperative and short-term results

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Unilateral pectineal suspension; Robotic surgery

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC LATERAL SUSPENSION; CONTINUOUS

SERIES; OUTCOME REPORT; SACROCOLPOPEXY; EPIDEMIOLOGY; SYMPTOMS; INDEX;

WOMEN; MESH

AB Introduction and hypothesisWe have previously published the novel method of unilateral pectineal suspension (UPS) for apical prolapse correction. UPS provides mesh-free midline uterus suspension using a single non-absorbable suture to attach the anterior cervix to the lateral part of the iliopectineal ligament. The purpose of this retrospective cohort study was to analyze the short-term efficacy, perioperative complication rate, and overall patient acceptance of the new UPS surgical concept.MethodsForty-seven patients with POP-Q stage 2-4 who underwent robotic UPS between January 1, 2020 and December 31, 2021 were included in the study. Patient data were taken retrospectively from the patient files. Treatment success was the primary endpoint, measured both objectively using a defined composite endpoint and subjectively according to patients' acceptance 3-6 months after surgery during a follow-up examination. Secondary outcome measures included complications and conversions, and effect of additional procedures on operative time.ResultsTreatment success as measured by the defined composite endpoint was 93.6% for the entire cohort. No complications or conversions occurred. Mean operation time for isolated UPS was 46.5 min (n = 33 patients). UPS can be easily combined with additional surgical procedures for repair of remaining pelvic floor defects, incontinence surgery or other indications. Additional procedures performed had a significant influence on operation time (p < 0.0005, n = 14).ConclusionsUPS shows highly favorable results when looking at an unselected cohort of patients in need of primary POP surgery with respect to established quality parameters of POP repair.

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Laus, K

DeAndrade, S

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TI The impact of diabetes mellitus on pelvic organ prolapse recurrence

after robotic sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Sacrocolpopexy; Diabetes; Prolapse recurrence

ID RISK-FACTORS

AB Introduction and hypothesisData examining the effect of diabetes mellitus (DM) on prolapse recurrence after sacrocolpopexy (SCP) is limited. The primary objective of this study was to determine if DM affects prolapse recurrence after robotic SCP.MethodsThis was a retrospective cohort study of women who underwent robotic SCP between 2012 and 2019 at Kaiser Permanente Southern California. The cohort was divided into women with and without DM at the time of SCP. The primary outcome was composite failure. Secondary outcomes included recurrent compartment-specific prolapse, reoperation rates, and surgical complications.ResultsOf 547 patients included, 100 had DM. Women with DM were older, had higher BMI, higher parity, and were more likely to be nonwhite. Women with DM had more advanced prolapse at baseline but were not more likely to undergo concomitant procedures at the time of SCP. Over a median follow-up of 2.1 years (IQR 1.3, 3.4), women with DM had significantly increased risk of anterior vaginal prolapse (AVP) recurrence (13% vs 3%, p<0.01), but not composite failure (21% vs 14%, p=0.14). On multivariate regression, women with DM were almost 4 times as likely to experience AVP recurrence over time (AVP hazard ratio (HR) 3.93, 95% CI 1.29-12.03, p=0.02).ConclusionIn our cohort, DM was a risk factor for AVP recurrence but not composite failure after robotic SCP.

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TI Evaluation of robotic-assisted sacrocolpopexy videos on YouTube

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic; Sacrocolpopexy; YouTube

ID HEALTH INFORMATION; PATIENT; CARE

AB ObjectiveTo evaluate the quality and reliability of videos on YouTube about robotic-assisted sacrocolpopexy.MethodsYouTube's search function was used to find videos associated with robotic-assisted sacrocolpopexy. On June 1, 2022, systematic research was performed using the term "robotic-assisted sacrocolpopexy". The first 50 videos were included in the study. The quality of the videos was evaluated using the Global Quality Scale (GQS) [a 5-point scale: high quality (4 or 5), acceptable quality (3), low quality (1 or 2)]. The modified DISCERN scale was used to evaluate the reliability of the videos [a 5-point scale: high reliability (5), moderate reliability (3 and 4), low reliability (1 or 2)].ResultsA total of 50 videos associated with robotic-assisted sacrocolpopexy were analyzed. The most frequently discussed topics in the videos were the duration of the surgery (72%), the anatomical success rates (70%), the advantages and disadvantages of the procedure compared to the classical methods (68%), and the postoperative complications (60%). The mean GQS of the videos was 3.04 +/- 0.75. The mean DISCERN score of the videos was 2.21 +/- 1. No appropriate references were cited in any of the videos. There was no video that received a full score (5 points) from DISCERN.ConclusionOur study shows that the level of quality in YouTube videos associated with robotic-assisted sacrocolpopexy is at an acceptable and high level, but its reliability is low. Therefore, short and concise videos that contain accurate information and refer to scientific facts should be prepared by urogynecology associations.

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TI Excision of Deep Rectovaginal Endometriosis Nodules with Large

Infiltration of Both Rectum and Vagina: What Is a Reasonable Rate of

Preventive Stoma? A Comparative Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Deep endometriosis; Rectum; Disc excision; Rectovaginal fistula; Stoma

ID LOW ANTERIOR RESECTION; SYMPTOMATIC ANASTOMOTIC LEAKAGE; COLORECTAL

RESECTION; DEFUNCTIONING STOMA; DIVERTING STOMA; CANCER; VALIDATION

AB Study Objective: To compare postoperative complications and rectovaginal fistula rate in women undergoing excision of large rectovaginal endometriosis requiring concomitant excision of rectum and vagina during 2 time periods with differing policies for preventive stoma confection.Design: Retrospective before-and-after comparative cohort study on data prospectively recorded in a database. Patients managed from September 2018 to March 2020 (first period) were compared with those managed from April 2020 to June 2022 (second period). Patients: One hundred sixty-eight patients presenting with deep endometriosis infiltrating the rectum and vagina, with lesions more than 3 cm in diameter during 2 consecutive time periods with differing policies regarding use of preventive stoma.Interventions: Rectal disc excision or colorectal resection, concomitantly with large vaginal excision.Measurements and Main Results: A total of 87 and 81 women received surgery during the first and the second period, respectively, during which the rate of preventive stoma was, respectively, 32.2% and 8.6%. Deep rectovaginal nodule characteristics were comparable. The mean height (SD) of rectal sutures after disc excision and colorectal resection were, respectively, 6.5 cm (2.3 cm) and 7.2 cm (3.8 cm). Rectovaginal fistula was recorded in 17 patients, corresponding to an overall rate of 10.1%. The rates of rectovaginal fistula in the group of patients with and without preventive stoma, regardless of the period in which surgery was performed, were 11.4% and 9.8%, respectively (p = .76). The rates of fistula recorded during the first and the second period were, respectively, 9.2% and 11.1% (p = .80), and that of overall early main complications were 31% and 29.6% (p = .84). Regression logistic model identified an independent relationship between smoking and rectovaginal fistula (adjusted odds ratio [OR] 3.9, 95% confidence interval [CI] 1.1-14) after adjustment for the period (adjusted OR 1.4, 95% CI 0.4-4.9 related to the second period), stoma confection (adjusted OR 1.8, 95% CI 0.5-7.1 related to stoma confection), robotic surgery (adjusted OR 1.7, 95% CI 0.3-10.1 related to robotic assistance), and type of rectal surgery (adjusted OR 0.4, 95% CI 0.1-1.4 related to disc excision when compared with colorectal resection).Conclusion: No statistically significant differences were found concerning risk of rectovaginal fistula in women with rectovaginal endometriosis requiring large rectal and vaginal excision after a decision to no longer routinely perform preventive stoma. Journal of Minimally Invasive Gynecology (2023) 30, 147-155. (c) 2022 AAGL. All rights reserved.

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TI The long-term outcomes of vaginoplasty using acellular porcine small

intestinal submucosa grafts in patients with

Mayer-Rokitansky-Kuster-Hauser syndrome: A case series

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Mayer-Rokitansky-Kuster-Hauser syndrome; psychological outcomes; sexual

function restoration; small intestinal submucosa grafts; vaginoplasty

ID FEMALE SEXUAL FUNCTION; INDEX

AB Objective: To investigate the long -term outcomes for Mayer- Rokitansky- Kuster- Hauser syndrome (MRKH) patients undergoing vaginoplasty using acellular porcine small intestinal submucosa grafts (SIS).Design: A case series.Population: Seventy -eight MRKH syndrome patients and a post- SIS patient who delivered a baby following the world's first robot-assisted uterus transplantation.Methods: Mayer- Rokitansky- Kuster- Hauser syndrome patients were grouped based on the postoperative time and the diagnosis- surgery interval. Outcomes of sexual function and psychological status were assessed using the female sexual function index (FSFI), self-rating scale of body image (SSBI) and self-acceptance questionnaire (SAQ). Anatomical outcomes were measured by clinicians.Main Outcome Measures: The primary outcome was restoration of sexual function, defined by an FSFI score in the "good' range. Anatomical and psychological outcomes were also analysed.Results: Sexual function was restored in 42.3% (33/78) of patients and the total FSFI score was 23.44 +/- 4.43. Three factors (body defect, recognition of physical appearance and willingness to change physical appearance scores) in the SSBI and two in the SAQ decreased as the postoperative time increased. Based on the interval between diagnosis and surgery, the total SSBI score was lower in the short-interval group than in the long-interval group (7.25 +/- 5.55 versus 12.04 +/- 10.21, p = 0.038).Conclusions: Nearly half of MRKH patients in our study had good long -term sexual function after SIS vaginoplasty. Sexual function and psychological status improved as postoperative time increased. In addition, reducing the diagnosis to surgery interval was associated with improved psychological function.

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PT J

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TI Robotic Burch colposuspension: anatomical and technical considerations

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robot-assisted colposuspension; Surgical education; Stress urinary

incontinence

ID STRESS URINARY-INCONTINENCE; COOPERS LIGAMENT

AB Introduction and hypothesisUp to 13.6% of women will undergo surgical treatment for stress urinary incontinence during their lifetime. Midurethral slings are the mainstay of stress incontinence treatment; however, diversity of surgical options is needed to serve the large number of patients desiring treatment. The Burch colposuspension remains a viable treatment option for appropriately selected patients. Currently, information on procedural standardization and tools for surgical training on robot-assisted colposuspension is limited.MethodsWe describe a stepwise robotic approach aimed at enhancing procedural reproducibility, while decreasing risks of intraoperative injury and postoperative complications. We analyze perioperative outcomes of our technique in a retrospective cohort of patients who underwent robot-assisted colposuspension at our institution.ResultsSeven key procedural steps are defined to optimize safe dissection in the retropubic space and to reduce the potential for surgical complications. These include methods of avoiding bladder, urethral, and neurovascular injury, as well as enhancing adequate suture fixation that prevents urethral obstruction and adverse postoperative urinary and pain-related symptoms. Surgical outcomes for 20 patients are reported and reveal low rates of perioperative complications.ConclusionRobot-assisted colposuspension requires thorough knowledge of the retropubic space and the application of standardized techniques may reduce the risk of injury and optimize procedure efficiency and reproducibility.

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PT J

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TI Financial analysis of minimally invasive sacrocolpopexy compared with

native tissue vaginal repair with concomitant hysterectomy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Cost; ERAS; Sacrocolpopexy; Minimally invasive; Uterosacral;

Sacrospinous; Native tissue repair; Robotic

ID PELVIC ORGAN PROLAPSE; COST-ANALYSIS; LAPAROSCOPIC SACROCOLPOPEXY;

LIFETIME RISK

AB IntroductionMinimally invasive sacrocolpopexy (MISCP) is increasingly used for uterovaginal prolapse, but comparative cost data of MISCP versus native tissue vaginal repair (NTR) are lacking. The objective was to determine the cost difference, from a hospital perspective, between MISCP and NTR performed with hysterectomy for uterovaginal prolapse.MethodsThis was a retrospective cohort study at a tertiary care center of women who underwent NTR or MISCP with concomitant hysterectomy in 2021. Hospital charges, direct and indirect costs, and operating margin (revenue minus costs) were obtained from Strata Jazz and compared using SPSS.ResultsA total of 82 women were included, 33 MISCP (25 robotic, 8 laparoscopic) versus 49 NTR. Demographic and surgical data were similar, except that MISCP had younger age (50.5 vs 61.1 years, p<0.01). Same-day discharge and estimated blood loss were similar, but operative time was longer for MISCP (204 vs 161 min, p<0.01). MISCP total costs were higher (US$17,422 vs US$13,001, p<0.01). MISCP had higher direct costs (US$12,354 vs US$9,305, p<0.01) and indirect costs (US$5,068 vs US$3,696, p<0.01). Consumable supply costs were higher with MISCP (US$4,429 vs US$2,089, p<0.01), but the cost of operating room time and staff was similar (US$7,926 vs US$7,216, p=0.07). Controlling for same-day discharge, anti-incontinence procedures and smoking, total costs were higher for MISCP (adjusted beta = US$4,262, p<0.01). Mean charges (US$102,060 vs US$97,185, p=0.379), revenue (US$22,214 vs US$22,491, p=0.929), and operating margin (US$8,719 vs US$3,966, p=0.134) were not statistically different.ConclusionMinimally invasive sacrocolpopexy had higher costs than NTR; however, charges, reimbursement, and operating margins were not statistically significantly different between the groups.

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TI Factors Associated With Increased Estimated Blood Loss and Factors

Associated With Utilization of Type and Screen in Benign Gynecology: A

Retrospective Chart Review

SO UROGYNECOLOGY

LA English

DT Review

ID ENHANCED RECOVERY

AB Importance There is minimal literature discussing factors associated with increased estimated blood loss (EBL) or transfusion in gynecologic surgery in tertiary academic centers.Objective The aim of the study was to determine factors associated with transfusion and increased blood loss during gynecologic surgery.Study Design This retrospective cohort investigated patients undergoing benign gynecologic procedures at a tertiary medical center. We excluded women undergoing surgery for known or suspected malignancy, emergent surgery, obstetrical procedures, or cases with another surgical specialty. Patient age, body mass index, American Society of Anesthesiologists class, medical history, EBL, arterial line placement, preoperative laboratory studies, and transfusion receipt for up to 6 weeks postoperatively were extracted. The primary outcome was transfusion within 6 weeks of surgery; risk factors for high blood loss (EBL > 500 mL) and transfusion were explored.Results Nine hundred seventy-five surgical procedures were included (59% vaginal, 36% laparoscopic, 4% robotic). Median EBL was 50 mL (interquartile range, 10-100 mL). Estimated blood loss increased with duration of surgery (P < 0.01). Transfusions were more likely to occur during open procedures (13%) compared with vaginal (2%), laparoscopic (2%), or robotic (3%). Arterial line placement (relative risk [RR], 11.8; 95% confidence interval [CI], 5.3-26.1) and additional intravenous placement (RR, 6.0; 95% CI, 2.6 to 13.7) were associated with transfusion. Vaginal surgery (RR, 0.13; 95% CI, 0.05 to 0.32) and urogynecologic procedures (RR, 0.1; CI, 0.01-0.7) were associated with reduced risk of needing transfusion.Conclusions Most benign gynecologic surgical procedures have minimal blood loss. Patients undergoing surgery through minimally invasive routes or urogynecologic procedures are at further decreased risk of transfusion.

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TI Level 1 Evidence for Robotic Surgery for Urological and Gynecological

Pelvic Cancers: Where do We Currently Stand?

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE robotic surgery; randomized controlled trial; pelvic cancer; prostate

cancer; bladder cancer; endometrial cancer; cervical cancer

ID ASSISTED RADICAL CYSTECTOMY; ENDOMETRIAL

AB Robotic surgery is used for the surgical removal of female pelvic malignancies and encompasses procedures as radical cystectomy and radical hysterectomy. The aim of this paper is to provide an update of level 1 literature evidence about the outcomes of robotic surgery compared to other surgical approaches for the treatment of bladder, endometrial and cervical cancer. A non-systematic search of the PubMed and Scopus databases was conducted to identify peer-reviewed randomized controlled trials (RCTs) comparing surgical approaches for radical cystectomy and hysterectomy. To the purpose of capturing the lastest updates, 2020-2022 literature was reviewed. In the field of radical cystectomy, two RCTs supported the implementation of robotics as a more beneficial approach than open surgery -in terms of faster recovery, less thromboembolic events, less infectious events. In gynecology, despite robotics is accepted for the treatment of early endometrial tumors, the role of minimally invasive surgery (MIS) for the treatment of cervical cancer is still debated, with two recent systematic reviews and meta-analyses reporting conflicting results. Two-decades after the introduction of robotic surgery, there is still a number of current studies evaluating its role for the treatment of urological pelvic malignancies, especially for bladder cancer. The role of robotic surgery alone for the treatment of gynecological malignancies has been scarcely addressed with robotics being mostly evaluated as a part of MIS; updates about MIS for the treatment of cervical cancer continue to be ongoing.

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PT J

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TI Frailty and Acute Postoperative Urinary Retention in Older Women

Undergoing Pelvic Organ Prolapse Surgery

SO UROGYNECOLOGY

LA English

DT Article

ID MALNUTRITION; DISABILITY

AB Importance Acute postoperative urinary retention (POUR) is common after pelvic reconstructive surgery, occurring in 15-45% of women. There is a paucity of data on the relationship between frailty and POUR after prolapse surgery.Objective This study aimed to examine the association between frailty and POUR in older women who underwent pelvic organ prolapse surgery.Study Design This secondary analysis of a prospective study of postoperative delirium enrolled women 60 years and older undergoing prolapse surgery. The Fried Frailty Index was used to assess frailty before surgery. Acute POUR was defined as failure to pass a retrograde voiding trial at hospital discharge with postvoid residual volume of greater than 100 mL.Results Analyses included 165 women, with a mean & PLUSMN; SD age of 72.5 +/- 6.1 years and a body mass index of 28.0 +/- 4.4 kg/m(2). There were 49 laparoscopic/robotic apical suspension procedures (29.7%), 60 vaginal obliterative procedures (36.4%), 47 vaginal apical suspension procedures (28.5%), and 9 isolated anterior and/or posterior colporrhaphies (5.5%), of which 9 had a concomitant incontinence procedure. Seventy-eight women (47.3%) experienced acute POUR. Thirty-one (18.8%) met the criteria for "not frail, " 115 (88.5%) were "prefrail, " and 19 (11.5%) were "frail. " Neither frailty status nor score was associated with POUR. In an analysis of individual Fried Frailty Index components, self-reported unintentional weight loss was significantly associated with POUR (odds ratio, 4.6; 95% confidence interval, 1.23-17.15). This remained significant on multivariable logistic regression (adjusted odds ratio, 4.06; 95% confidence interval, 1.01-16.39).Conclusions Frailty was not associated with POUR in older women undergoing prolapse surgery. The observed association between POUR and unintended weight loss before surgery warrants further investigation.

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J9 UROGYNECOLOGY

JI Urogynecol.

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PT J

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TI Comparison of cesarean delivery outcome after robotic and laparoscopic

myomectomy

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Robotic surgical procedures; Uterine fibroids; Uterine

myomectomy

ID PREGNANCY OUTCOMES; ADHESION FORMATION; FERTILITY; MYOMAS

AB Objective: The aim of this study was to determine whether robotic myomectomy (RM) resulted in any measurable clinical improvement over laparoscopic myomectomy (LM) in subsequent cesarean delivery.Materials and methods: The medical records of 273 patients who had undergone LM or RM followed by subsequent cesarean delivery for the period of September 2015 to December 2020 were retrospectively reviewed. The patients were divided into LM (n = 222) and RM (n = 51) groups. The cesarean delivery outcomes between the two groups were compared. Results: RM had significantly more myomas removed (6.0 +/- 4.8 vs. 3.6 +/- 3.5, p < 0.001) and a larger size of largest myoma (7.7 +/- 2.4 vs. 6.1 +/- 2.4, p = 0.002) at myomectomy compared with LM. However, there were no significant differences in the groups' surgical characteristics at cesarean section, in their pregnancy complications, or in adhesion formation.Conclusions: Although more and larger myomas were removed in the RM group, RM showed similar cesarean delivery outcomes and adhesion formation to LM.(c) 2023 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

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JI Taiwan. J. Obstet. Gynecol.

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PT J

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TI Hysterectomy over the course of time. Retrospective analysis of surgical

techniques at the University Gynecology Hospital Essen over the last 20

years

SO GYNAKOLOGIE

LA German

DT Article; Early Access

DE Laparoscopy; Laparotomy; Intraoperative complications; Postoperative

complications; Robotic surgical procedures

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; SURGERY

AB Introduction: Minimally invasive surgery has for a long time been the standard for performing hysterectomy for benign indications. In this context robotic-assisted operations are generally considered comparable to conventional laparoscopy. Furthermore, robot-assisted surgery has the potential to also enable complex minimally invasive interventions and to make laparotomy unnecessary in the majority of patients.Material and methods: A total of 1939 patients who underwent hysterectomy for benign indications at the University Gynecology Hospital Essen between 2002 and 2020 were identified. Perioperative and postoperative data and patient characteristics were retrospectively collated.Results: Robotic surgery has been carried out in this hospital since 2010 and was the most frequent surgical approach (n = 771; 39.8%) and 60.2% (1168/1938) of hysterectomies were carried out using minimally invasive surgery. Over the years there was a clear shift with respect to the access route. In 2002, 51.4% of all hysterectomies were carried out using an open procedure but in 2020 this was reduced to 1.4%. Correspondingly, the proportion of minimally invasive procedures rose from 18.9% in 2002 to 98.6% in 2020. The introduction of robotic surgery in 2010 led to a significant shift to minimally invasive procedures, which led to shorter times in bed and less postoperative complications compared to laparotomy. Furthermore, this cohort includes the largest uterine myoma ever reported in the scientific literature with a weight of 54.8 kg.Conclusion: These data support the hypothesis that the introduction of robotic surgery expands the possibilities for minimally invasive surgery, whereby laparotomy can be avoided in nearly all cases. The known advantages of minimally invasive surgery could be confirmed.

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J9 GYNAKOLOGIE

JI Gynakologie

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PT J

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TI Health-related quality of life after robotic surgery for endometrial

cancer: a prospective longitudinal one-year follow-up study

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Quality of life; Mental health; Depression; Anxiety; Endometrial cancer;

Robotic surgical procedures

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; EUROPEAN-ORGANIZATION;

CLINICAL-TRIALS; GUIDELINES; QLQ-C30

AB PurposeThis study aimed to explore how patients treated for endometrial cancer (EC) with robotic surgery are affected in symptoms of anxiety and depression and HRQoL in the long term.MethodsWomen scheduled for primary robotic surgery for EC were included (n = 64), in this single-center study. Socioeconomic variables were obtained at baseline. The European Organization for Research and Treatment of Cancers Quality of Life Questionnaire Core 30 (QLQ-C30), its module for EC (EN24), the Generalized Anxiety Disorder Scale (GAD-7), and the Patient Health Questionnaire Depression Scale (PHQ-9) were followed prospectively from baseline to 2 weeks, 3 months and 1 year postoperatively.ResultsThe number of patients scoring above the clinical threshold for anxiety decreased from 17 (27.0%) at baseline to 4 (7.0%) at 2 weeks (p = 0.012). Depressive symptoms were reported in 20% of patients at baseline and did not change significantly during the one-year follow-up (p = 0.58). A significant decrease in Global health status was seen at 2 weeks (from 69.8 to 62.7; p = 0.048), with return to baseline levels after 3 months (68.5; p = 0.32) and stable at 1 year. Unemployment, low income, and adjuvant therapy correlated with lower Global health status at 3 months.ConclusionThe significant proportion of patients with anxiety symptoms preoperatively reduced prompt after surgery, while the proportion with depression remained constant, indicating that the primary treatment has no long-term negative effect on patients' mental health. At 3 months, there is no obvious remaining negative impact on patients' HRQoL, and these results are consistent after 1 year.

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PT J

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TI Is total laparoscopic hysterectomy with longer operative time associated

with a decreased benefit compared with total abdominal hysterectomy?

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; operative time; morbidity

ID AMERICAN-COLLEGE; SURGICAL VOLUME; MORBIDITY; OUTCOMES; MORTALITY;

COMPLICATIONS; METAANALYSIS; SURGERY; INDEX

AB BACKGROUND: It is well known that, in general, total laparoscopic hysterectomy is associated with less perioperative morbidity compared with total abdominal hysterectomy. However, total laparoscopic hysterectomy is also associated with longer operating times, which itself is an independent predictor of morbidity. Currently, it is unknown whether there is an operative time threshold beyond which total laparoscopic hysterectomy provides a diminishing return and higher risk of morbidity than a shorter abdominal hysterectomy.OBJECTIVE: This study aimed to determine whether there is an operative time limit beyond which the benefits of total laparoscopic hysterectomy diminished compared with shorter total abdominal hysterectomy.STUDY DESIGN: Targeted hysterectomy-specific data from the National Surgical Quality Improvement Project was used to identify patients undergoing total laparoscopic hysterectomy and total abdominal hysterectomy for benign indications between the years 2014 and 2018. The primary outcomes of interest were any major morbidity, and the length of stay after surgery was analyzed using generalized linear models. The models controlled for demographic data, comorbidities, and hysterectomy-specific information, such as uterine weight, presence of endometriosis, and pelvic inflammatory disease at the time of surgery. Missing data were addressed using multiple imputation analysis. Sensitivity analyses using propensity score matching and generalized additive models were per-formed to assess the effect of selection bias and nonlinear interactions between covariates and the outcomes, respectively. Common Procedural Terminology codes were used to identify women who underwent total abdominal hysterectomy (n=58,152) or total laparoscopic hysterectomy (n=58,570-58,573). Conventional laparoscopy could not be differenti-ated from robotic surgery as there is no mechanism for doing so within the National Surgical Quality Improvement Project. Therefore, total laparo-scopic hysterectomy also includes robotic-assisted surgery. Additional exclusion criteria included any surgery lasting > 360 minutes, as these represent significant outliers in the data and clinical practice; pelvic reconstructive procedure; anti-incontinence surgery; lymphadenectomy; radical hysterectomy; cytoreductive surgery; a pre-or postoperative diagnostic code for gynecologic malignancy; preoperative sepsis or renal failure; emergency surgery; or any concurrent nongynecologic surgery. Patients who underwent ureteral stenting during the procedure with no additional urologic procedures were included, as this may be performed at the time of hysterectomy or to address ureteral injury.RESULTS: The mean operating time was similar for both routes, 129 +/- 60 minutes for total laparoscopic hysterectomy and 129 +/- 64 minutes for total abdominal hysterectomy (P=.45). The complication rate was higher for total abdominal hysterectomy than total laparoscopic hysterectomy (16.6% vs 7.7%; P <.001); and the median length of stay was longer for total abdominal hysterectomy (2 [interquartile range, 2-3] days vs 1 [interquartile range, 0-1] days; P <.001).

After adjusting for confounders, an increase of 1 hour in operative time for hysterectomy was associated with a 45% (95% confidence interval, 41%-49%) increase in the risk of major morbidity; furthermore, total abdominal hysterectomy was associated with an additional time detriment, such that there was an additional 61% (95% confidence interval, 53%-68%) increase in the risk of a major morbidity for each additional hour of a total abdominal hysterectomy. There was no time point at which total abdominal hysterectomy was associated with less morbidity or a shorter length of stay than total laparoscopic hysterectomy, even if total laparoscopic hysterectomy was significantly longer than total abdominal hysterectomy. The same conclusions remained true with the propensity-matched analysis and generalized additive model analyses.CONCLUSION: Our findings showed that there is no reasonable operative time at which total laparoscopic hysterectomy is associated with a higher rate of complications or longer length of stay than total abdominal hysterectomy.

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ER

PT J

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Occhino, John A. A.

TI Robotic-Assisted Surgery for Pelvic Organ Prolapse: Sacrocolpopexy and

Beyond

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE Da Vinci device; vagina; vaginal; pelvic organ prolapse; surgery;

sacrocolpopexy

ID SURGICAL-MANAGEMENT; HYSTERECTOMY

AB Pelvic organ prolapse is a highly prevalent condition that can have a large impact on a patient's quality of life. Multiple approaches to surgical repair exist, each with a unique set of risks and benefits. For patients with apical prolapse, repair of the apex is the cornerstone of any surgical procedure. Since adaptation of robotic techniques to sacrocolpopexy were introduced in the early 2000s, the minimally invasive approach to sacrocolpopexy has surpassed open case volumes. Compared to native-tissue transvaginal procedures, minimally invasive sacrocolpopexy offers potential advantages in durability. This article reviews surgical techniques, troubleshooting, outcomes, and ongoing areas of development regarding the use of a robotic approach to prolapse surgery. (J GYNECOLOGIC SURG 2023:000)

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

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ER

PT J

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TI Abdominal and robotic sacrocolpopexy costs following implementation of

enhanced recovery after surgery

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE cost; enhanced recovery after surgery; liposomal bupivacaine; robotic;

sacrocolpopexy

ID LAPAROSCOPIC SACROCOLPOPEXY; OUTCOMES

AB ObjectiveTo compare perioperative costs and morbidity between open and robotic sacrocolpopexy after implementation of enhanced recovery after surgery (ERAS) pathway. MethodsThe present retrospective cohort study of patients undergoing open or robotic sacrocolpopexy (January 1, 2014, through November 30, 2017) used an ERAS protocol with liposomal bupivacaine infiltration of laparotomy incisions. Primary outcomes were costs associated with index surgery and hospitalization, determined with Medicare cost-to-charge ratios and reimbursement rates and adjusted for variables expected to impact costs. Secondary outcomes included narcotic use, length of stay (LOS), and complications from index hospitalization to postoperative day 30. ResultsFor the total of 231 patients (open cohort, 90; robotic cohort, 141), the adjusted mean cost of robotic surgery was $3239 higher compared with open sacrocolpopexy (95% confidence interval [CI] $1331-$5147; P < 0.001). Rates were not significantly different for intraoperative complications (robotic, 4.3% [6/141]; open, 5.6% [5/90]; P = 0.754), 30-day postoperative complications (robotic, 11.4% [16/141]; open, 16.7% [15/90]; P = 0.322), or readmissions (robotic, 5.7% [8/141]; open, 3.3% [3/90]; P = 0.535). The percentage of patients dismissed on postoperative day 1 was greater in the robotic group (89.4% [126/141] vs. 48.9% [44/90], P < 0.001). ConclusionsDecreased LOS associated with ERAS provided significant cost savings with open sacrocolpopexy versus robotic sacrocolpopexy without adverse impacts on perioperative complications or readmissions.

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ER

PT J

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TI Excision of triple compartment deep infiltrating endometriosis with

visceral involvement

SO JOURNAL OF ENDOMETRIOSIS AND PELVIC PAIN DISORDERS

LA English

DT Article

DE Deep infiltrating endometriosis; triple compartment; visceral

involvement; laparoscopy; rectal surgery; bladder surgery; hysterectomy

ID ULTRASOUND; DIAGNOSIS; ACCURACY

AB Background: Excision of multi-compartment deep infiltrating endometriosis with visceral involvement is challenging. We illustrate an interdisciplinary approach to complete minimally invasive excision in a single surgery. Case: We present a case of deep infiltrating endometriosis with visceral involvement in the anterior, middle, and posterior compartments. A collaborative surgical approach was taken with gynecologic, colorectal, and urologic surgeons to perform a robot-assisted total laparoscopic hysterectomy, bilateral salpingectomy, ovarian cystectomy, and unilateral oophorectomy with concurrent segmental resection of rectosigmoid and excision of transmural bladder and vaginal nodules. Conclusion: Thorough preoperative evaluation and an interdisciplinary approach to surgical planning involving radiology, gynecology, colorectal surgery, and urology allowed for complete simultaneous resection of bladder, rectosigmoid, and pelvic deep infiltrating endometriosis without complications via a minimally invasive route.

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ER

PT J

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TI The Effect of Patient Positioning on Ureteral Efflux During

Intraoperative Cystoscopy: A Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Intraoperative cystoscopy; Laparoscopy; Patient positioning; Ureteral

injury; Ureteral patency

ID BENIGN GYNECOLOGIC SURGERY; URINARY-TRACT INJURY; HYSTERECTOMY; PATENCY

AB Study Objective: To identify the relationship between patient position during surgery and time to confirmation of ureteral patency on cystoscopy.Design: Randomized controlled trial.Setting: Academic tertiary care medical center.Patients or Participants: A total of 91 adult women undergoing laparoscopic (either conventional or robotic) hysterectomy between February 2021 and February 2022 were randomized to intervention (n = 45) or control (n = 46). Exclusion criteria included known kidney disease or urinary tract anomaly, current ureteral stent, pregnancy, malignancy, and recognized intraoperative urinary tract injury. Interventions: Subjects in the control group were placed in a 0 degrees supine position during cystoscopy. Subjects in the interven-tion group were placed in a 20 degrees angle in reverse Trendelenburg (RT) position during cystoscopy.Measurements and Main Results: The primary outcome, time to confirmation of bilateral ureteral patency, was measured at the time the second ureteral jet was viewed during intraoperative cystoscopy. There was no significant difference in mean time to confirmation (66.5 seconds in supine vs 67 seconds in RT, p = .2) nor in total cystoscopy time (111 seconds in supine vs 104.5 seconds in RT, p = .39). There were no significant differences in need for alternative modalities to aid in ureteral efflux visualization, delayed diagnosis of ureteric injury, and operative time. RT position seemed to have reduced the time to confirmation for the small group of patients with longer confirmation time (>120 seconds).Conclusion: RT position does not change time to confirmation of bilateral ureteral patency compared with supine position. However, there may be a benefit in position change if time to confirmation is >120 seconds. Journal of Minimally Invasive Gynecology (2023) 30, 13-18.(c) 2022 AAGL. All rights reserved.

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TI Robotic-assisted laparoscopic and thoracoscopic approach: a challenging

multidisciplinary minimally invasive surgery of intravascular

leiomyomatosis with intracardiac extension

SO FERTILITY AND STERILITY

LA English

DT Article

DE Intravascular leiomyomatosis; robotic-assisted surgery; thoracoscopic

surgery

ID INTRAVENOUS LEIOMYOMATOSIS

AB Objective: To show a case of severe intravascular leiomyomatosis with intracardiac extension treated by a multidisciplinary minimally invasive surgery.Design: Stepwise demonstration of the technique with a video. Setting: General Hospital.Patient(s): A 40-year-old woman with palpitation and dyspnea. Intervention(s): The patient was diagnosed with intravascular leiomyomatosis by computed tomography scan. She underwent a suc-cessful single-stage minimally invasive surgery with complete excision.Main Outcome Measure(s): The feasibility and safety of using this technique for intravascular leiomyomatosis with intracardiac extension.Result(s): A combined thoracoabdominal surgery was successfully performed. During the procedure, cardiopulmonary bypass was maintained for 72 minutes. The patient soon recovered and was discharged.Conclusion(s): Minimally invasive surgery is a possible choice for intravascular leiomyomatosis with intracardiac extension. (Fertil Steriln 2023;119:155-57.(c) 2022 by American Society for Reproductive Medicine.)

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PT J

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TI Simple radiologic assessment of visceral obesity and prediction of

surgical morbidity in endometrial cancer patients undergoing

laparoscopic aortic lymphadenectomy: A reliability and accuracy study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE complications; endometrial carcinoma; intra-abdominal fat;

lymphadenectomy; minimally invasive surgical procedures

ID SAGITTAL ABDOMINAL DIAMETER; TOTAL MESORECTAL EXCISION; BODY-MASS INDEX;

COMPLICATIONS; SURGERY; RISK; OUTCOMES; IMPACT; EXTRAPERITONEAL;

TRANSPERITONEAL

AB AimTo evaluate the reliability of sagittal abdominal diameter (SAD)-a surrogate of visceral obesity-in magnetic resonance imaging, and its accuracy to predict the surgical morbidity of aortic lymphadenectomy.MethodsWe conducted a multicenter reliability (phase 1) and accuracy (phase 2) cohort study in three Spanish referral hospitals. We retrospectively analyzed data from the STELLA-2 randomized controlled trial that included high-risk endometrial cancer patients undergoing minimally invasive surgical staging. Patients were classified into subgroups: conventional versus robotic-assisted laparoscopy, and transperitoneal versus extraperitoneal technique. In the first phase, we measured the agreement of three SAD measurements (at the umbilicus, renal vein, and inferior mesenteric artery) and selected the most reliable one. In phase 2, we evaluated the diagnostic accuracy of SAD to predict surgical morbidity. Surgical morbidity was the main outcome measure, it was defined by a core outcome set including variables related to blood loss, operative time, surgical complications, and para-aortic lymphadenectomy difficulty.ResultsIn phase 1, all measurements showed good inter-rater and intra-rater agreement. Umbilical SAD (u-SAD) was the most reliable one. In phase 2, we included 136 patients. u-SAD had a good diagnostic accuracy to predict surgical morbidity in patients undergoing transperitoneal laparoscopic lymphadenectomy (0.73 in ROC curve). It performed better than body mass index and other anthropometric measurements. We calculated a cut-off point of 246 mm (sensitivity: 0.56, specificity: 0.80).Conclusionsu-SAD is a simple, reliable, and potentially useful measurement to predict surgical morbidity in endometrial cancer patients undergoing minimally invasive surgical staging, especially when facing transperitoneal aortic lymphadenectomy.

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TI Robotic Surgery and Deep Infiltrating Endometriosis Treatment: The State

of Art

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE robotic surgery; deep endometriosis; laparoscopy

ID PELVIC PAIN; LAPAROSCOPIC EXCISION; ASSISTED LAPAROSCOPY; LIFE

INSTRUMENT; CLASSIFICATION; HYSTERECTOMY; MANAGEMENT; HEALTH;

COMPLICATIONS; CYSTECTOMY

AB Objective: Surgical treatment of endometriosis, when indicated, has demonstrated to be effective in reducing painful symptoms and improve quality of life of patients affected with endometriosis. The minimally invasive approach via laparoscopy is the preferred method when compared with laparotomy but in the last two decades another minimally invasive approach has become available, the robotically assisted laparoscopic surgery. Robotic technology is widely used in different surgical branches, such as general surgery and urology. Moreover, the use of robotic surgery is already accepted for different gynecological procedures either for benign and for oncological diseases. The advantages of robotic surgery such as improve dexterity of movements, avoided tremor, increased magnification of 3 -dimensional vision seem strategic in the context of a complex surgery as is deep endometriosis eradication. However, to date there is no unanimous consensus on whether robotically assisted procedures are a valid and safe alternative to laparoscopy in the treatment of endometriosis. Mechanism: In this narrative review we analyze the available literature assessesing the robotic treatment of all types of endometriosis and specifically deep infiltrating endometriosis, compared to the outcomes of conventional laparoscopy. Findings in Brief: Indeed, the evidence of safety and effectiveness of robotically assisted laparoscopy in endometriosis treatment is strong and almost unanimous. There is no clear superiority of one approach to the other but robotic-related advantages and future prospective are promising to be able to improve operative outcomes, reduce surgeon's fatigue and provide a technology easy to implement with a fast learning curve. Conclusions: Robotic technology applied to laparoscopy in the treatment of endometriosis could be seen as an effective and safe alternative to the conventional laparoscopic treatment.

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SC Obstetrics & Gynecology

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ER

PT J

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TI Minimally Invasive Compared With Open Surgery in High-Risk Endometrial

Cancer <i>A Systematic Review and Meta-analysis</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Review

ID CLEAR-CELL CARCINOMA; ROBOTIC SURGERY; PERIOPERATIVE OUTCOMES;

UTERINE-CANCER; EARLY-STAGE; LAPAROSCOPY; LAPAROTOMY; WOMEN; PAPILLARY;

SURVIVAL

AB OBJECTIVE: To compare outcomes between minimally invasive surgery and open surgery in patients with high-risk endometrial cancer. DATA SOURCES: A cohort study of all patients who underwent surgery for high-risk endometrial cancer between 1999 and 2016 at Mayo Clinic (Rochester, Minnesota) and a literature search of MEDLINE, EMBASE, , Cochrane Central Register of Controlled Trials, and Scopus of all published studies until December 2020. METHODS OF STUDY SELECTION: The systematic review identified 2,332 patients (14 studies, all retrospective except a subanalysis of a randomized comparison) and the cohort study identified 542 additional patients. Articles were included if reporting original data on overall survival and disease-free survival among patients with high-risk endometrial cancer, defined as International Federation of Gynecology and Obstetrics grade 3 endometrioid, serous, clear cell, mixed histology, or uterine carcinosarcoma. Studies that did not report at least one of the main outcomes, those in which one surgical technique (robotic or laparoscopic surgery) was missing in the comparison analysis with open surgery, and case reports were excluded. Additional data were extracted from a retrospective cohort of patients from Mayo. A random-effect model was used for meta-analysis. TABULATION, INTEGRATION, AND RESULTS: This systematic review and meta-analysis was registered in PROSPERO. Literature search and data extraction were performed independently by two reviewers, as well as quality assessment using GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology, and the Newcastle-Ottawa Scale. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines were followed. Meta-analysis showed that disease-free survival and overall survival in patients with high-risk endometrial cancer who underwent minimally invasive surgery were not statistically different from those of patients who underwent open abdominal surgery (relative risk [RR] 0.93, 95% CI 0.82-1.05, I-2 20%, P=.23; and RR 0.92, 95% CI 0.77-1.11, I-2 31%, P=.12, respectively). Subgroup analysis by stage (early vs advanced) did not identify a difference between surgical approaches. CONCLUSION: Minimally invasive surgery and open surgery had similar disease-free survival and overall survival in patients with high-risk endometrial cancer.

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J9 OBSTET GYNECOL

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ER

PT J

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TI ?Less is More, is R-LESS More??-The Use of Robotic Laparoendoscopic

Single-Site Surgery in Gynaecology: A Scoping Review

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE single-site surgery; robotic surgery; review

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; ASSISTED

SACROCOLPOPEXY; PORT; FEASIBILITY; MYOMECTOMY; 1ST; METAANALYSIS;

GUIDANCE

AB Background: Since the Da Vinci system was introduced in the gynaecological profession, for benign and most malignant procedures, it appeared that using 5 incisions for trocar insertion could jeopardize the system's mini-invasiveness. To protect this important characteristic, robotic laparoendoscopic single-site surgery was developed and authorized for gynaecological use in 2013. Using a single small incision for the entire treatment appears to be a promising attempt to improve cosmetic results while lowering wound infections, postoperative pain, and recovery time. After nearly ten years of use, several limitations of this technique became apparent, such as a limited set of non-articulating instruments and electrical possibilities compared to multiport surgery, smoke evacuation and visual impairment. By examining the most relevant research, the goal of this review was to emphasize the indications, risks, and benefits of R-LESS in gynaecological surgery. Methods: A scoping review was conducted on Pubmed, Scopus, Web of Science, and Embase. Publications in English or Italian in the previous 10 years on the use of single-site robotic surgery in gynaecology for benign disorders were included. Results: This review includes 37 of the 297 papers that were retrieved. Myomectomy, hysterectomy, pelvic floor surgery, and endometriosis were the most common indications for single-site surgery. Several studies have reported R-LESS usage in cancer patients. According to the data analysis, the R-LESS approach is comparable to robotic multi-port surgery as regards feasibility and safety, with faster operative and postoperative durations, reduced pain, and a superior cosmetic outcome. Conclusions: The single-port robotic technique is gaining popularity. Our findings provide preliminary evidence of the global experience of surgical teams. Standardizing operative durations and conducting comparative research on the R-LESS learning curve represent one of the most significant future difficulties, as do surgical outcomes, costs, and patient satisfaction in the long run.

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Z9 0

U1 0

U2 0

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA gold

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ER

PT J

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Valha, P

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TI Sentinel lymph node mapping in endometrial cancer-robotic vs.

laparoscopic detection system

SO CESKA GYNEKOLOGIE-CZECH GYNAECOLOGY

LA English

DT Article

DE endometrial cancer; sentinel lymph node; indocyanine green; Da Vinci

Firefly; Novadaq Pinpoint

ID CARCINOMA; INJECTION

AB Objective: Comparison of systems to detect sentinel lymph node in endometrial carcinoma using indocyanine green. Robotic Firefl y Da Vinci fluorescence imaging system (Intuitive Surgical Inc., Sunnyvale, CA, USA) vs. laparoscopic Novadaq Pinpoint near-infrared imaging system (Novadaq, Ontario, Canada). Material and method: Fifteen patients with stage I endometrial cancer underwent sentinel lymph node bio psy after intracervical application of indocyanine green. For all of them, the detection was performed sequentially using both evaluated devices. The detection rate, identification match and extent of imaging of the lymphatic system were evaluated. Results: The detection rate of both systems verified on a set of patients was identical, the detected sentinel nodes were identical, and the lymphatic system was shown to the same extent. The quality of the display and overall user-friendliness is different due to the applied technologies. Conclusion: Both systems used in minimally invasive surgery provide excelent perioperative imaging of the lymphatic system.

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TC 0

Z9 0

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J9 CES GYNEKOL

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ER

PT J

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TI Cost drivers for benign hysterectomy within a health care system:

Influence of patient, perioperative, and hospital factors

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE healthcare costs; hysterectomy; length of stay; quality improvement;

robotic surgery

ID FINANCIAL ANALYSIS; ENHANCED RECOVERY; SURGERY; PROTOCOL; OUTCOMES

AB Objective: To identify patient, perioperative, and hospital factors that drive total hospital charges for benign hysterectomy.

Methods: The authors conducted a retrospective cohort study between July 2014 and February 2019 at five academic and community hospitals within an integrated healthcare system in the state of Maryland with a Global Budget Revenue methodology for hospital charges. Predictor variables included patient, perioperative and hospital characteristics. One-way analysis of variance was used to compare charges among approaches. A multiple linear regression model was built to account for the interaction between covariates.

Results: A total of 2592 patients underwent hysterectomy via laparoscopic (61%), abdominal (16%), robotic (14%), or vaginal (9%) approaches. Before adjusting for covariates, laparoscopic and vaginal approaches had similar charges ($11637 and $12229, respectively), while robotic and open approaches had higher charges ($17535 and $19099, respectively). After adjusting, charges for open, laparoscopic, and robotic approaches were higher than the vaginal approach ($692, $712, and $1279, respectively). Each operating room minute resulted in an increased cost of $46. Length of stay >23h was associated with an increase of $865. Year, uterine size, body mass index, additional procedures, and transfusion influenced charges.

Conclusion: Perioperative and hospital characteristics significantly influence hospital charges for benign hysterectomy, more so than nonmodifiable patient characteristics. This provides opportunities to reduce healthcare expenditures, such as improving operating room efficiency and reducing length of stay.

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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ER

PT J

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TI Variations in Peritoneal Lines of Attachment of the Sigmoid Colon in

Adult Females

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE colon; sigmoid; peritoneum; lymph-node excision; minimally invasive

surgical procedures

ID AORTIC LYMPHADENECTOMY; ENDOMETRIAL CANCER; HYSTERECTOMY

AB Objective: Left adnexectomy and/or pelvic lymphadenectomy often require mobilization of the sigmoid colon to gain adequate exposure, which involves division of peritoneal attachments of the sigmoid colon. Variations in native sigmoid attachments and techniques needed to achieve adequate mobilization have not been well-described.Materials and Methods: This was a prospective cohort study of patients undergoing laparotomy, laparoscopy, or robotic surgery by a gynecologic oncologist. Exclusions were patients who had pelvic surgery (other than tubal ligation), pelvic radiation therapy, concurrent pelvic inflammatory processes, or extensive pelvic peritoneal disease (e.g., ovarian cancer, severe endometriosis). Detailed patient and clinical data were collected, along with anatomical findings in the sigmoid colon, such as diverticula; length; and sigmoid colon attachments relative to the infundibulopelvic ligament (IPL), broad ligament, and posterior cul-de-sac.Results: Of the 92 patients in the study, 75 had peritoneal attachments of the sigmoid colon or its mesentery. The most-common attachment location was lateral to the IPL only (n = 27; 36%), followed by lateral to the IPL and to the IPL (n = 15; 20%). The most-common type of attachment was congenital (n = 60; 45.5%), followed by adhesive (n = 58; 45%). Congenital attachment lateral to the IPL was the most-common at 24% of all documented attachments.Conclusions: Peritoneal attachments of the sigmoid colon are a common finding of natural anatomy and may be complex and/or multifocal, even in patients without risk factors. Knowledge of the peritoneal lines of attachment is important for having adequate exposure when performing left adnexectomy and/or pelvic lymphadenectomy. (J GYNECOL SURG 20XX:000)

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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WC Obstetrics & Gynecology; Surgery

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SC Obstetrics & Gynecology; Surgery

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ER

PT J

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TI Association of Myomectomy With Anti-Mullerian Hormone Levels and Ovarian

Reserve

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID UTERINE ARTERY EMBOLIZATION; PREGNANCY OUTCOMES; LAPAROSCOPIC

MYOMECTOMY; INTRAMURAL FIBROIDS; HYSTERECTOMY; MORBIDITY; MANAGEMENT;

FERTILITY; OCCLUSION; IMPACT

AB OBJECTIVE:To assess whether open and minimally invasive myomectomy are associated with changes in postoperative ovarian reserve as measured by serum anti-mullerian hormone (AMH) level.METHODS:This prospective cohort study included patients who were undergoing open abdominal myomectomy that used a tourniquet or minimally invasive (robot-assisted or laparoscopic) myomectomy that used vasopressin. Serum AMH levels were collected before the procedure and at 2 weeks, 3 months, and 6 months after surgery. The mean change in AMH level at each postsurgery timepoint was compared with baseline. The effect of surgical route on the change in AMH level at each timepoint was assessed by using multivariable linear regression. A subanalysis evaluated postoperative changes in AMH levels among the open myomectomy and minimally invasive myomectomy groups individually.RESULTS:The study included 111 patients (mean age 37.9 +/- 4.7 years), of whom 65 underwent open myomectomy and 46 underwent minimally invasive myomectomy. Eighty-seven patients contributed follow-up data. Serum AMH levels declined significantly at 2 weeks postsurgery (mean change -0.30 ng/mL, 95% CI -0.48 to -0.120 ng/mL, P=.002). No difference was observed at 3 months or 6 months postsurgery. On multiple linear regression, open myomectomy was significantly associated with a decline in AMH level at 2 weeks postsurgery (open myomectomy vs minimally invasive myomectomy: beta=-0.63 +/- 0.22 ng/mL, P=.007) but not at 3 months or 6 months. Subanalysis revealed a significant decline in mean serum AMH levels in the open myomectomy group at 2 weeks (mean change -0.46 ng/mL, 95% CI -0.69 to -0.25 ng/mL, P<.001) postsurgery but not at three or 6 months. In the minimally invasive myomectomy group, no significant differences in mean AMH levels were detected between baseline and any postoperative timepoint.CONCLUSION:Myomectomy is associated with a transient decline in AMH levels in the immediate postoperative period, particularly after open surgery in which a tourniquet is used. Anti-mullerian hormone levels returned to baseline by 3 months after surgery, indicating that myomectomy is not associated with a long-term effect on ovarian reserve, even with the use of a tourniquet to decrease blood loss.FUNDING SOURCE:This study was funded in part by a Roche Diagnostics Investigator-Initiated Study Grant.

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funder was not involved in the studydesign, analysis, or writing of the

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Z9 3

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U2 0

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WC Obstetrics & Gynecology

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ER

PT J

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TI Save our surgeons (SOS) - an explorative comparison of surgeons'

muscular and cardiovascular demands, posture, perceived workload and

discomfort during robotic vs. laparoscopic surgery

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic-assisted surgery; Ergonomics; Surface electromyography; Static

muscle demands; Musculoskeletal discomfort; Work-related musculoskeletal

disorders

ID ROTATABLE HANDLE PIECE; MUSCULOSKELETAL DISORDERS; PREVALENCE;

ERGONOMICS; INSTRUMENT

AB Purpose Conventional laparoscopic surgery (CLS) imposes an increased risk of work-related musculoskeletal disorders. Technical innovations, such as robotic-assisted laparoscopic surgery (RALS), may provide ergonomic benefits. We compare the surgeon`s work-related demands of CLS vs RALS for benign hysterectomies. Methods Five specialists (3 females, 2 males) each performed four RALS and four CLS as part of their daily clinical routine. During the surgical procedures, muscular demands were assessed by bipolar surface electromyograms of the descendent trapezius, extensor digitorum and flexor carpi radialis muscles as well as cardio-vascular demands by electrocardiography, and neck, arm and torso posture by gravimetrical position sensors. Additionally, the subjects rated their level of perceived workload (NASA TLX questionnaire with 6 dimension) and musculoskeletal discomfort (11-point Likert-scale, 0-10). Results Muscular demands of the trapezius and flexor carpi radialis muscles were lower with RALS but extensor digitorum demands increased. Cardiovascular demands were about 9 heart beats per minute (bpm) lower for RALS compared to CLS with a rather low median level for both surgical techniques (RALS = 84 bpm; CLS 90 bpm). The posture changed in RALS with an increase in neck and torso flexion, and a reduction in abduction and anteversion position of the right arm. The perceived workload was lower in the physical demands dimension but higher in the mental demands dimension during RALS. Subjective musculoskeletal discomfort was rare during both surgical techniques. Conclusions This explorative study identified several potential ergonomic benefits related to RALS which now can be verified by studies using hypothesis testing designs. However, potential effects on muscular demands in the lower arm extensor muscles also have to be addressed in such studies.

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NR 36

TC 1

Z9 1

U1 3

U2 6

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 14

WC Obstetrics & Gynecology

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ER

PT J

AU Kobayashi, E

Kakuda, M

Ueda, Y

Kimura, T

AF Kobayashi, Eiji

Kakuda, Mamoru

Ueda, Yutaka

Kimura, Tadashi

TI Overview of laparoscopic surgery for cervical cancer in Japan: Updates

after the laparoscopic approach to cervical cancer trial

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE cervical cancer; laparoscopic surgery; minimally invasive surgery;

robotic surgery

ID ABDOMINAL RADICAL HYSTERECTOMY; TUMOR SIZE; ONCOLOGICAL OUTCOMES;

SURVIVAL; RECURRENCE; MULTICENTER; PATTERNS; COHORT; RATES

AB Laparoscopic radical hysterectomy (LRH) for cervical cancer has been reported to be similar oncologic outcome compared to abdominal radical hysterectomy (ARH) in many retrospective studies. In Japan, LRH has been covered by insurance since April 2018. In 2018, the same year that LRH became covered by insurance, Ramirez et al. at MD Anderson Cancer Center reported the results of a large phase III laparoscopic approach to cervical cancer trial (LACC trial) on the prognosis of open versus laparoscopic/robot-assisted minimally invasive radical hysterectomy. The results showed that minimally invasive approaches were associated with a higher rate of recurrence and death. At this point, it is not clear what is wrong with LRH and why it has a poorer prognosis compared to ARH. In this report, after the LACC report, we would like to review the current status of minimally invasive surgery for cervical cancer and future directions.

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NR 57

TC 0

Z9 0

U1 2

U2 3

PU WILEY

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EI 1447-0756

J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

PD JAN

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PG 13

WC Obstetrics & Gynecology

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GA 8R5JP

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DA 2024-01-18

ER

PT J

AU Buderath, P

Kimmig, R

Dominowski, L

Mach, P

AF Buderath, Paul

Kimmig, Rainer

Dominowski, Lisa

Mach, Pawel

TI Hysterectomy in benign conditions: a 20-year single-center retrospective

on the development of surgical techniques

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Hysterectomy; Robotic surgery; Benign conditions; Uterine fibroids;

Surgical gynecology

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; SURGERY

AB Introduction Minimally invasive (MI) surgery has long been established as a standard for hysterectomy in benign conditions. Robotic surgery is generally seen as equivalent to conventional laparoscopy in terms of patient outcome. However, robotics might facilitate an MI approach even in complex patients, rendering laparotomy unnecessary for almost all patients. Materials and methods We identified 1939 patients who underwent hysterectomy for benign conditions between 2002 and 2020 at the University Hospital of Essen. Peri- and postoperative data as well as patient characteristics were collected retrospectively. Results Robotic surgery, implemented at our institution in 2010, was the most common approach (n = 771; 39.8%). 60.2% of all hysterectomies (1168/1938) were performed using MI techniques. However, there was a significant shift in the methods used for hysterectomy over time. While in 2002 51.4% of all hysterectomies were performed via an open abdominal approach, this percentage dropped to 1.4% in the year 2020. Accordingly, the use of MI approaches increased from 18.9% in 2002 to 98.6% in 2020. The introduction of robotic surgery in 2010 marked a significant shift towards more MI procedures. MI surgery resulted in shorter hospital stay and less postoperative complications compared to laparotomy. On a special note, our cohort includes the largest uterus myomatous uterus in the scientific literature with a specimen weight of 54.8 kg. Conclusion Our data support the hypothesis that the implementation of robotic surgery leads to an improved capability to perform MI surgery and avoid laparotomy in almost all patients. The known benefits of MI surgery could be confirmed.

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Duisburg-Essen, covering the costs of a student assistant (Lisa

Dominowski) for 6 months.

NR 17

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Z9 2

U1 1

U2 1

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

AU Komatsu, H

Nakagawa, S

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Kawana, Kei

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Hamatani, Toshio

Aoki, Daisuke

TI Impact of the COVID-19 pandemic on surgery for benign diseases in

gynecology: A nationwide survey by the Japan Society of Obstetrics and

Gynecology

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE benign neoplasm; COVID-19; gynecologic surgery; gynecology; survey

AB Aim This study aimed to clarify the impact of coronavirus disease 2019 on gynecology practice in Japan, in particular, on surgeries for benign gynecological diseases. Methods An online questionnaire was distributed to 966 facilities in Japan, including core facilities, facilities participating in perinatal and gynecologic oncology registries, and facilities certified for training by the Japanese Society of Obstetrics and Gynecology Endoscopy. The number of surgeries performed was compared between 2019 and 2020, when the novel coronavirus disease was prevalent. Results Five hundred and eighty (58.2%) facilities responded. The total number of surgeries decreased from 129 648 in 2019 to 118 565 in 2020, by 8.5%, for all surgical procedures. However, there was a clear increase in the number of robotic surgeries performed in 2020 compared to that in 2019 for all populations. The number of total hysterectomies decreased markedly from 15 385 in 2019 to 12 531 in 2020, a fall of 10.1%. Conclusions The number of surgeries for benign gynecological diseases decreased by 8.5% in 2020 compared to that in 2019. This value is among the lowest in the world.

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FU Ministry of Health, Labour and Welfare (MHLW) Special Research Program

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U1 1

U2 1

PU WILEY

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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PT J

AU Clark, SG

Shepherd, JP

Sassani, JC

Bonidie, M

AF Clark, Stephanie Glass

Shepherd, Jonathan P.

Sassani, Jessica C.

Bonidie, Michael

TI Surgical cost of robotic-assisted sacrocolpopexy: a comparison of two

robotic platforms

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Sacrocolpopexy; Robotic surgery; Surgical costs; Pelvic organ prolapse

ID LAPAROSCOPIC SACROCOLPOPEXY; ERGONOMICS

AB Importance Robotic assistance in pelvic organ prolapse surgery can improve surgeon ergonomics and instrument dexterity compared with traditional laparoscopy but at increased costs. Objective To compare total costs for robotic-assisted sacrocolpopexy (RSC) between two robotic platforms at an academic medical center. Methods Retrospective cohort of Senhance (Ascensus) RSC between 1/1/2019 and 6/30/21 who were matched 2:1 with DaVinci (Intuitive) RSC. Primary outcome was total costs to hospital system; secondarily we evaluated cost sub-categories. Purchase costs of the robotic systems were not included. T-test, chi-square, and Fisher's exact tests were used. A multivariable linear regression was performed to model total costs adjusting for potential confounders. Results The matched cohort included 75 subjects. The 25 Senhance and 50 DaVinci cases were similar overall, with mean age 60.5 +/- 9.7, BMI 27.9 +/- 4.7, and parity 2.5 +/- 1.0. Majority were white (97.3%) and postmenopausal (86.5%) with predominantly stage III prolapse (64.9%). Senhance cases had longer OR times (Delta = 32.1 min, p = 0.01). There were no differences in concomitant procedures, intraoperative complications, or short-term postoperative complications between platforms (all p > 0.05). On univariable analysis, costs were similar (Senhance $5368.31 +/- 1486.89, DaVinci $5741.76 +/- 1197.20, p = 0.29). Cost subcategories (medications, supplies, etc.) were also similar (all p > 0.05). On multivariable linear regression, total cost was $908.33 lower for Senhance (p = 0.01) when adjusting for operative time, estimated blood loss, concomitant mid-urethral sling, and use of the GelPoint mini port system. Conclusions Despite longer operating times, total cost of robotic-assisted sacrocolpopexy was significantly lower when using the Senhance compared to the DaVinci system.

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NR 16

TC 1

Z9 1

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA 8B8HH

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PM 36282303

DA 2024-01-18

ER

PT J

AU Shigemi, D

Okada, A

Yasunaga, H

AF Shigemi, Daisuke

Okada, Akira

Yasunaga, Hideo

TI Postoperative adverse events and re-treatment among patients who have

undergone laparoscopic and robotic sacrocolpopexy for pelvic organ

prolapse in Japan

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Asia; laparoscopic surgical procedure; pelvic organ prolapse;

postoperative complications; recurrence; robotic surgical procedures

ID STRESS URINARY-INCONTINENCE; SURGERY; RISK

AB Objective To describe and compare the postoperative adverse events and re-treatment for recurrence after laparoscopic and robotic-assisted sacrocolpopexy in Japanese patients with pelvic organ prolapse (POP). Methods This was a retrospective cohort study using the DeSC database, which contains claims and medical check-up data provided by DeSC Healthcare Inc., Tokyo, Japan. We identified all patients who had undergone either laparoscopic or robotic-assisted sacrocolpopexy from April 2014 to May 2021. Patient backgrounds and postoperative outcomes were compared between the laparoscopic and robotic-assisted sacrocolpopexy groups. Moreover, the composite adverse event comprising vaginal erosion, postoperative urinary incontinence, postoperative dysuria, urinary tract injury, and abdominal incisional hernia was evaluated. Re-treatment for POP recurrence included pessary use and surgery for POP was also evaluated. Results Among 28 748 patients diagnosed with POP, 409 (1.4%) had undergone laparoscopic sacrocolpopexy and 52 (0.2%) had undergone robotic-assisted sacrocolpopexy. The prevalence of postoperative adverse events was 20.8% and 13.5% in the laparoscopic and robotic-assisted sacrocolpopexy groups, respectively (P = 0.270). One patient (1.9%) underwent surgery after robotic-assisted sacrocolpopexy, and none of the patients was administered pessaries postoperatively in both groups. Conclusion In Japan, postoperative outcomes after laparoscopic and robotic-assisted sacrocolpopexy are similar and comparable to those reported in western countries.

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Education, Culture, Sports, Science and Technology, Japan [20H03907,

21H03159]

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and Welfare, Japan (21AA2007), and the Ministry of Education, Culture,

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NR 21

TC 2

Z9 2

U1 1

U2 1

PU WILEY

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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BP 114

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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Dong, J

Wei, L

Zhou, FX

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Wei, Li

Zhou, Fuxing

Chen, Biliang

TI Procedures and technical considerations of robotic-assisted human uterus

transplantation

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Infertility; Pregnancy; Robotic-assisted surgery; Uterus transplantation

ID VENOUS DRAINAGE; DONOR; SURGERY; VEINS; LIVE

AB Background Uterus transplantation is the only treatment for absolute uterine factor infertility. Complex vascular anatomy, long operation time, and intraoperative injuries are the main factors that limit progress in uterus transplantation. Moreover, robot-assisted uterus transplantation is not popular at present due to technical difficulties, with only a few countries reporting success. Methods In this paper, we present the key technical points of robot-assisted uterine transplantation by analyzing and summarizing our surgical experience and other successful cases of robot-assisted uterine transplantation. This study provides an evidence-based reference for clinicians planning robot-assisted uterine transplantation procedures. Conclusion Minimally invasive technologies can shorten the operation time, reduce injuries, and contribute to analyzing the anatomy of complex blood vessels. Therefore, robot-assisted uterine transplantation is an important direction for the future of uterine transplantation, and the findings and procedures reported herein contribute to the standardization and promotion of robot-assisted uterine transplantation operations.

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FU General project of national Natural Science Foundation of China

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NR 31

TC 0

Z9 0

U1 1

U2 4

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 9

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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Petraglia, F

Minervini, A

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Capezzuoli, Tommaso

Fambrini, Massimiliano

Petraglia, Felice

Minervini, Andrea

TI Urinary Tract Endometriosis: How to Predict and Prevent Recurrence after

Primary Surgical Excision

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Deep infiltrating endometriosis; Hormonal therapy; Predictors;

Recurrence; Urinary endometriosis

ID SURGERY; THERAPY; RISK

AB Study Objective: To investigate the clinical and surgical predictors of urinary tract endometriosis (UTE) relapse.

Design: Retrospective single institutional study.

Setting: Italian multidisciplinary referral center for endometriosis.

Patients: Consecutive patients affected by UTE and surgically treated between January 2016 and March 2020.

Intervention: Surgical excision for UTE. Uni- and multivariate logistic regression analyses were fitted to evaluate clinical and surgical predictors of recurrence.

Measurements and Main Results: A total of 105 female age-reproductive patients were enrolled. Median age was 32 years (interquartile range, 24-37). Ureteral involvement was recorded in 53 patients (50.5%), being unilateral and bilateral in 46 patients (43.8%) and 7 patients (6.7%), respectively. Bladder involvement occurred in 52 patients (49.5%). Open surgical approach was performed in 24 cases (22.9%), whereas 30 patients (28.5%) and 51 patients (48.6%) were treated with laparo-scopic and robot-assisted approach, respectively. Overall, 53 patients (50.5%) received adjuvant hormonal therapy. At a median follow-up of 39 months (interquartile range, 22-51), 30 patients (28.6%) experienced disease relapse, with 14 recurrences (13.3%) recorded at the level of the urinary tract. At multivariable analysis, age at first surgery <25 years (odds ratio [OR], 1.23; 95% confidence interval [CI], 1.10-1.84; p = .02) and the presence of a concomitant autoimmune disease (OR, 1.45; 95% CI, 1.24-2.17; p = .02) were found as predictors of deep infiltrating endometriosis recurrence, whereas adjuvant postsurgical therapy showed a protective role (OR, 0.83; 95% CI, 0.53-0.98; p = .01).

Conclusions: Young age (<25 years) and the presence of autoimmune diseases were significant predictors for the develop-ment of disease recurrence, whereas adjuvant hormonal therapy showed a protective role. (C) 2022 AAGL. All rights reserved.

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NR 32

TC 1

Z9 1

U1 0

U2 0

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

AU Mateshaytis, J

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AF Mateshaytis, Jennifer

Brawner, Marina

Steed, Helen

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TI Improving the Rate of Same-day Discharge in Gynecologic Oncology

Patients with Endometrial Cancer undergoing Minimally Invasive Robotic

Surgery: A Quality Improvement Initiative

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Day surgery; Outpatient surgery; Ambulatory surgery; Uterine cancer;

Uterine malignancy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; SAFETY

AB Study Objective/Setting/Patients: Same-day discharge (SDD) in patients with endometrial cancer undergoing minimally invasive surgery (MIS) is safe and feasible, with multiple patient and healthcare system benefits. Despite this, our local rate of SDD was only 29.4%. Several studies have suggested methods to improve rates of SDD but few have evaluated the appli-cation of such methods. The objectives of our quality improvement (QI) initiative were 2-fold: (1) to increase the rate of SDD in eligible patients with endometrial cancer undergoing MIS to 70% and (2) to evaluate the implementation of methods to improve rates of SDD.Design/Interventions/Measurements: At our center, QI diagnostics were conducted, and root causes were identified. Four interventions were introduced: (1) setting SDD as the default discharge plan, (2) ensuring that a physician order for dis-charge was on the chart, (3) removing the Foley catheter in the operating room, and (4) introducing pre-and postoperative patient education documents. A time-series design was used; rate of SDD was tracked using baseline data and continuous post-intervention monitoring. Process measures (for each intervention) and balancing measures were defined and tracked.Main Results: At the conclusion of our QI initiative, the average rate of SDD was 78.3%-exceeding our aim of 70%. This was achieved without compromising patient satisfaction (98.2%) or significantly impacting rates of readmission or presenta-tions to the emergency department.Conclusions: Our initiative demonstrated the application of simple interventions that resulted in a substantial increase in our rate of SDD in the population of interest, without causing negative impacts on the defined balancing measures. These interventions were nonspecific to gynecologic oncology and could easily be applied across other surgical disciplines. Jour-nal of Minimally Invasive Gynecology (2022) 29, 1184-1193.(c) 2022 AAGL. All rights reserved.

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J9 J MINIM INVAS GYN

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TI Comparing Minimally Invasive Sacrocolpopexy With Vaginal Uterosacral

Ligament Suspension: A Multicenter Retrospective Cohort Study Through

the Fellows' Pelvic Research Network

SO UROGYNECOLOGY

LA English

DT Article

DE pelvic organ prolapse; apical support; uterosacral ligament suspension;

laparoscopic and robotic sacrocolpopexy; surgical outcomes;

complications

ID ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; SACRAL

COLPOPEXY; OUTCOMES; SURGERY; REPAIR; MESH

AB Importance Comparing one-year surgical outcomes of two widely used surgical procedures for apical suspension. Objectives The objective of this study is to compare anatomic outcomes after minimally invasive sacrocolpopexy (MISC) and vaginal uterosacral ligament suspension (vUSLS). Study Design This was a multicenter, retrospective cohort study through the Fellows' Pelvic Research Network. Patients with >= stage II pelvic organ prolapse (POP) who underwent MISC or vUSLS from January 2013 to January 2016, identified through the Current Procedural Terminology codes, with 1 year or longer postoperative data were included. Patients with prior POP surgery or history of connective tissue disorders were excluded. Anatomic success was defined as Pelvic Organ Prolapse Quantification System measurements: Ba/Bp <= 0 or C <= -TVL/2. Data were compared using chi(2) or Fisher exact tests. Continuous data were compared using Wilcoxon rank sum test. Results Three hundred thirty-seven patients underwent MISC (171 laparoscopic, 166 robotic) and 165 underwent vUSLS. The MISC group had longer operative time (205.9 minutes vs 187.5 minutes, P = 0.006) and lower blood loss (77.8 mL vs 187.4 mL; P < 0.001). Two patients (0.6%) in the MISC group had mesh exposure requiring surgical excision. Permanent suture exposure was higher after vUSLS (6.1%). At 1 year, anatomic success was comparable in the apical (322 [97%] MISC vs 160 [97%] vUSLS, P = 0.99) and posterior compartments (326 [97.6%] MISC vs 164 [99.4%] vUSLS; P = 0.28). Anterior compartment success was higher in the MISC group (328 [97.9%] vs 156 [94.9%], P = 0.04) along with longer total vaginal length (9.2 +/- 1.8 vs 8.4 +/- 1.5, P < 0.001). Conclusion At 1 year, patients who underwent MISC or vUSLS had similar apical support. Low rates of mesh and suture exposures, less anterior recurrence, and longer TVL were noted after MISC.

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JI Urogynecol.

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TI Revision sacrocolpopexy: tips and tricks for optimal outcomes

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Revision sacrocolpopexy; Recurrent pelvic organ prolapse

ID LAPAROSCOPIC SACROCOLPOPEXY

AB Introduction and hypothesis The aim of this video is to highlight important considerations and techniques for revision sacrocolpopexy in women with symptomatic recurrence of pelvic organ prolapse after sacrocolpopexy. Methods In this video, we show five patients who presented with recurrent symptomatic pelvic organ prolapse after prior sacrocolpopexy. We demonstrate techniques for robotic-assisted laparoscopic sacrocolpopexy revision including surgical dissection, revision of existing mesh, and/or addition of new mesh. Conclusions Overall, revision sacrocolpopexy requires an individualized approach. These surgeries are often challenging because of adhesions and altered anatomy from the prior sacrocolpopexy. The reviewed considerations and techniques can be useful for ensuring a safe and effective outcome.

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ER

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TI Robotic repair of a branching vesicouterine and vesicovaginal fistula

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vesicovaginal fistula; Robotic surgery; Urogynecology; Bladder fistula

AB Introduction and hypothesis We present technical considerations and tips for repairing a complex branching vesicouterine and vesicovaginal fistula via a robotic approach. Methods A 31-year-old female presented with constant urinary leakage following a vaginal birth after prior cesarean section. Evaluation with cystoscopy and cross-sectional imaging demonstrated a branching vesicouterine and vesicovaginal fistula. Repair with robotic-assisted approach was carried out. An intentional cystotomy was made with a tear-drop incision around the fistula tracts. The vesicouterine and vesicovaginal planes were dissected and mobilized. The vaginotomy and cystotomy were closed in a running two-layer fashion with absorbable suture and the uterine defect closed with interrupted absorbable suture. Retrograde bladder filling confirmed a watertight repair. A broad peritoneal flap was created, positioned, and secured with care to ensure it covered past the apex of the fistula closure. Results Following overnight observation she had an uneventful recovery, including catheter removal at 3 weeks after cystogram confirmed resolution of the fistula. At 6 weeks the fistula and her leakage remained resolved, with no de novo voiding or incontinence symptoms. Conclusions A robotic approach to complex branching vesicouterine and vesicovaginal fistula is technically feasible. Careful attention to surgical technique and the use of tissue interposition may improve fistula resolution rates.

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ER

PT J

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TI Robot-assisted laparoscopic anterior urethral diverticulectomy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Urethral diverticulum; Robotic surgery; Laparoscopic surgery

ID FEMALE

AB Introduction and hypothesis A 31-year-old patient with a history of fetal sacrococcygeal teratoma requiring tumor resection and pelvic reconstruction in infancy presented with a 3-year history of recurrent vulvar abscesses and voiding dysfunction. Magnetic resonance imaging demonstrated a fluid collection posterior to the pubic bone and inferior to the bladder. The objective was to demonstrate the key steps in the resection and repair of an anterior urethral diverticulum via robot-assisted laparoscopic approach. Methods Cystoscopy followed by robot-assisted laparoscopic retropubic dissection was used for resection of an anterior urethral diverticulum followed by urethral reconstruction. Results Cystoscopy revealed a large anterior cavity at the midpoint of the urethra consistent with an anterior urethral diverticulum. This likely tracked inferiorly toward her vulva during repeated episodes of infection expressing through her recurrent abscesses. Retropubic space exploration revealed dense fibrotic tissue adherent to the underside of the pubic tubercule contiguous with the anterior urethral diverticulum, which was successfully resected. Conclusions Female anterior urethral diverticulum is a rare entity. A robot-assisted laparoscopic approach can be safely utilized to identify and resect an anterior urethral diverticulum. Key points include optimization of port placement, use of a council-tip catheter to facilitate bladder drainage in the setting of distorted pelvic anatomy, and multi-layered tension-free urethral closure with flap placement.

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WC Obstetrics & Gynecology; Urology & Nephrology

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ER

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TI Minimally invasive management for multifocal pelvic retroperitoneal

malignant paraganglioma: a neuropelveological approach

SO BMC WOMENS HEALTH

LA English

DT Article

DE Paraganglioma; Neuropelveology; Robotic surgery; Minimally invasive

gynecological surgery; Surgery; Oncology; Cancer; Gynecology

ID PHEOCHROMOCYTOMA; DIAGNOSIS; GUIDELINE; RESECTION; GENETICS; TUMORS

AB Background Pheochromocytoma and Paraganglioma (PGL) are rare neuroendocrine tumors, with an estimated incidence of about 0.6 cases per 100.000 person/year. Overall, 3-8% of them are malignant. These tumors are characterized by a classic triad of symptoms (headaches, palpitations, profuse sweating) due to hypersecretion of catecholamines. Despite several advantages of minimally invasive surgery (MIS) for PGL debulking, the surgical approach is not standardized yet. In this scenario, we aimed to report a case of a multiple recurrent PGL with metastatic retroperitoneal localization involving the pelvic sidewall, excised with MIS. Case presentation We performed complete laparoscopic-assisted neuronavigation (LANN technique) with isolation of the sacral routes and the sciatic nerve to obtain complete exposure of the main anatomic landmarks. Robotic surgery was used to perform neurolysis of sacral plexus, and partial resection of left splanchnic nerves was needed. After the resection of the first mass, extensive neurolysis of all sacral routes, obturator nerve, pudendal nerve till the entrance of the pudendal (Alcock) canal, and sciatic nerve was performed. Finally, the mass was identified after trans gluteal incision and dissection of the maximum gluteal muscle, and a partial resection of the superior gluteal nerve and slicing of the sciatic nerve were needed to obtain a radical excision of the mass. Then neurorrhaphy of the sectioned nerve fibers of the superior gluteal nerve was performed, and nerve protection was obtained using a collagen nerve wrap. After 18 months of follow-up, the patient is free of disease at the MRI imaging and 123I-metaiodobenzylguanidine scintigraphy. Conclusions Minimally invasive gynecological surgery with neuropelveological approach could be considered as a feasible option in case of multifocal pelvic retroperitoneal malignant paraganglioma of the pelvic side wall.

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J9 BMC WOMENS HEALTH

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TI Impact of obesity on robotic-assisted surgery in patients with stage IA

endometrial cancer and a low risk of recurrence: An institutional study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE cancer of the endometrium; obesity; surgery

ID UTERINE-CANCER; SINGLE-CENTER; HYSTERECTOMY; LAPAROSCOPY; SURVIVAL;

OUTCOMES; COMPLICATIONS

AB Aim Westernization of lifestyle has increased the numbers of patients with endometrial cancer and obesity. This study aimed to compare the clinical outcomes of robotic-assisted surgery according to whether patients are obese, morbidly obese, or nonobese. Methods Sixty-three patients with endometrial cancer who underwent robotic-assisted surgery between March 2014 and June 2022 were categorized according to whether they had a body mass index (BMI) <30 (group A, nonobese, n = 40), >= 30 and <35 (group B, obese, n = 13), or >= 35 (group C, morbidly obese, n = 10). Operation time, blood loss, perioperative complications, and recurrence rate were investigated. Results Conversion to laparotomy was required in one case in group A and one in group C. There was no difference in total operation time, time for setting (including trocar installation and docking of the da Vinci robot), console time, or time for wound closure between the groups; however, there was a significant between-group difference in the total time for setting and wound closure. There was no significant difference in blood loss or complications between the groups. Three patients in group A and two in group B received adjuvant treatment; none have shown evidence of recurrent disease during a mean observation time of 21 months (range, 2-29). Two cases in group A and one in group B had recurrence during a mean observation time of 38 months (range, 19-46). Conclusion Patients with endometrial cancer who are obese can be treated safely by robotic-assisted surgery with a low risk of complications and few relapses.

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TI The MEMORY Study: MulticentEr study of Minimally invasive surgery versus

Open Radical hYsterectomy in the management of early-stage cervical

cancer: Survival outcomes

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Laparoscopic Approach to Cervical Cancer trial&nbsp;

LACC; Minimally invasive radical hysterectomy; Radical hysterectomy

ID ABDOMINAL HYSTERECTOMY; VAGINAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY;

RECURRENCE; LAPAROTOMY; COHORT; WOMEN

AB Objective. The Laparoscopic Approach to Cervical Cancer (LACC) trial found that minimally invasive radical hysterectomy compared to open radical hysterectomy compromised oncologic outcomes and was associated with worse progression-free survival (PFS) and overall survival (OS) in early-stage cervical carcinoma. We sought to assess oncologic outcomes at multiple centers between minimally invasive (MIS) radical hysterectomy and OPEN radical hysterectomy.Methods. This is a multi-institutional, retrospective cohort study of patients with 2009 FIGO stage IA1 (with lymphovascular space invasion) to IB1 cervical carcinoma from 1/2007-12/2016. Patients who underwent preoperative therapy were excluded. Squamous cell carcinoma, adenocarcinoma, and adenosquamous carcinomas were included. Appropriate statistical tests were used.Results. We identified 1093 cases for analysis-715 MIS (558 robotic [78%]) and 378. OPEN procedures. The OPEN cohort had more patients with tumors >2 cm, residual disease in the hysterectomy specimen, and more likely to have had adjuvant therapy. Median follow-up for the MIS and OPEN cohorts were 38.5 months (range, 0.03-149.51) and 54.98 months (range, 0.03-145.20), respectively. Three-year PFS rates were 87.9% (95% CI: 84.9-90.4%) and 89% (95% CI: 84.9-92%), respectively (P = 0.6). On multivariate analysis, the adjusted HR for recurrence/death was 0.70 (95% CI: 0.47-1.03; P = 0.07). Three-year OS rates were 95.8% (95% CI: 93.6-97.2%) and 96.6% (95% CI: 93.8-98.2%), respectively (P = 0.8). On multivariate analysis, the adjusted HR for death was 0.81 (95% CI: 0.43-1.52; P = 0.5).Conclusion. This multi-institutional analysis showed that an MIS compared to OPEN radical hysterectomy for cervical cancer did not appear to compromise oncologic outcomes, with similar PFS and OS. (c) 2022 Elsevier Inc. All rights reserved.

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Betcher, Raymond

Fontenot, Anna Claire

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TI Laparoscopic guided liposomal bupivacaine injection compared to

transversus abdominus plane block for postoperative pain after robotic

gynecologic oncology surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Minimally invasive surgery; Robotic surgery; Pain control; Postoperative

pain

ID EFFICACY; SAFETY

AB Objective. The purpose of this study was to determine if laparoscopically guided transversus abdominis plane block (Lap-Tap) with liposomal bupivacaine provides superior postoperative pain control when compared to ultrasound-guided block (US-Tap) with liposomal bupivacaine at the time of robotic surgery for gynecology on-cology patients.Methods. This was a prospective randomized controlled trial assigning patients to one of two cohorts: Cohort 1 consisted of US-Tap administered before the procedure using liposomal bupivacaine, Cohort 2 consisted of Lap -Tap administration with laparoscopic visualization using the medication above. Primary outcomes were pain scores and total opioid use in Oral Morphine Equivalents (OME) during the first 72 h after surgery. Secondary outcomes were postoperative pain satisfaction and oral narcotic requirements.Results. There was a significant increase in oral narcotic use in the first 24 h in the US-Tap cohort compared to the Lap-Tap cohort: Lap-Tap mean = 6.73 +/- 8.22 OME versus US-Tap mean = 12.69 +/- 12.94 p = 0.018 OME. The increase was equivalent to one additional Hydrocodone-Acetaminophen 7.5 mg/325 mg in the first 24 h after sur-gery. However, total oral narcotic use over the first 72 h was not significantly different between the two cohorts: Lap-Tap mean = 21.73 +/- 19.83 OME, US-Tap mean = 32.50 +/- 29.47, p = 0.062 OME. In addition, there was no significant difference in satisfaction or pain scores between the US-Tap and Lap-Tap groups at 24, 48, or 72-hours.Conclusions. Lap-Taps are comparable to US-Tap for postoperative analgesia during the first 72-h after surgery when performing robotic-assisted gynecologic oncology surgery.(c) 2022 Elsevier Inc. All rights reserved.

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TI A prospective randomized trial of standard versus

multimedia-supplemented counseling in patients undergoing endometrial

cancer staging surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Multimedia education; Endometrial cancer; Preoperative counseling;

Informed consent

ID INFORMED-CONSENT; SURGICAL-PROCEDURES; CARE; COMPREHENSION;

SATISFACTION; MULTICENTER; EDUCATION

AB Objectives. A patient's understanding of surgery is often limited, especially in the setting of complex oncologic procedures. The use of supplemental materials can improve patients' knowledge of their procedure and satisfac-tion with decision making. We sought to determine if a multimedia-supplemented approach in patients under-going robotic endometrial cancer staging improves satisfaction with preoperative counseling. Secondary objectives were patient comprehension, physician satisfaction, and visit length.Methods. From 2018 to 2019, patients were randomized to standard physician education (SPE) or multimedia-based education (MBE), which included watching two novel videos followed by focused physician counseling. Basic demographic information was collected. Patient satisfaction was assessed using the Client Sat-isfaction Questionnaire-8 (CSQ-8, a validated satisfaction survey, scored 8-32) and a global satisfaction score (GGS, 10-point scale). Physician satisfaction was assessed using a GGS. Comprehension was assessed with a study-specific 9-question survey at three time points. t-tests and linear mixed models were used to compare groups.Results. Of the 75 patients included in the analysis, the majority were white (70%), 50-70 years old (72%), and had at least some college education (74%). The MBE group reported higher satisfaction on the CSQ-8 (31.69 vs 30.69, p < 0.01) and global satisfaction score (9.95 vs 9.74, p = 0.04). There was no difference in comprehension scores over time (p = 0.84) or between groups (p = 0.23). Visit lengths were significantly longer in the MBE group (90.36 vs 80.46 min, p = 0.04).Conclusions. Patients had high satisfaction and comprehension with both SPE and MBE. Multimedia education may be implemented in preoperative counseling based on provider preference and consideration should be made for further study of satisfaction, both patient and physician, and visit length after the initial implementation period.(c) 2022 Elsevier Inc. All rights reserved.

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TI Operative Time for Minimally Invasive Sacrocolpopexy: Comparison of

Conventional Laparoscopy versus Robotic Platform

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Minimally invasive; Prolapse; Robotic surgery;

Sacrocolpopexy

ID PROLAPSE

AB Study Objective: To evaluate the operative time for minimally invasive sacrocolpopexy using conventional laparoscopy vs robotic assistance. In addition, we sought to compare intraoperative complications, mesh complications, anatomic prolapse recurrence, and retreatment.

Design: Retrospective cohort study.

Setting: Academic hospital.

Patients: All 142 women who underwent minimally invasive sacrocolpopexy between January 1, 2019, and December 31, 2019.

Intervention: We compared operative time between laparoscopic and robotic-assisted sacrocolpopexies.

Measurements and Main Results: A total of 142 women were included. Mean age was 61.8 +/- 9.6 years and mean body mass index 27.1 +/- 4.4 kg/m(2). A total of 86 (60.6%) sacrocolpopexies were performed laparoscopically and 56 (39.4%) with robotic assistance. There were no significant differences in baseline demographic variables. A higher proportion of concomitant hysterectomies were performed with robotic assistance as compared with laparoscopic cases (n = 42, 73.7% robotic vs n = 43, 50.6% laparoscopic; p <.01). Mean operative times were significantly different between robotic and laparoscopic groups (176.3 +/- 45.5 minutes and 195.0 +/- 45.4 minutes, p =.02). On linear regression, the variables predicting significant change in operative time were robotic assistance, concomitant hysterectomy, age, body mass index, and no resident involvement. There were no differences in intraoperative bladder or bowel injury, anatomic recurrence beyond the hymen, retreatment, or mesh complications (all p >. 05).

Conclusions: Contrary to previous research, the use of robotic assistance does not appear to increase operative time for patients undergoing minimally invasive sacrocolpopexy in a large academic practice. (C) 2022 AAGL. All rights reserved.

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TI Natural Orifice Specimen Extraction Colorectal Resection for Deep

Endometriosis: A 50 Case Series

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Colectomy; Deep endometriosis; Natural orifice; Rectovaginal

endometriosis; Robotic surgery

ID LAPAROSCOPIC RESECTION; SURGERY; CLASSIFICATION; COMPLICATIONS;

ANASTOMOSIS; COLECTOMY; EXCISION; NOSE

AB Study Objective: To describe our experience with the use of natural orifice specimen extraction (NOSE) technique for segmental bowel resection in patients with colorectal endometriosis.

Design: A retrospective, observational study.

Setting: A single tertiary referral center.

Patients: A total of 50 consecutive patients undergoing NOSE colectomy for colorectal endometriosis in our center, between March 2021 and November 2021.

Interventions: NOSE colectomy for colorectal endometriosis with removal of the excised colorectal specimen through the vagina or the anus.

Measurement and Main Results: A total of 45 procedures were performed laparoscopically and 5 procedures were performed robotically. All interventions were performed by 3 endometriosis surgeons in a multidisciplinary fashion, with involvement of a colorectal surgeon. There were no cases of conversion to laparotomy. Concomitant surgical procedures were performed in all cases. Eleven patients had concomitant interventions on the digestive tract. Five patients had concomitant interventions on the sacral plexus or sciatic nerve. All anastomoses were lateroterminal. The mean height of colorectal anastomosis was 12 cm (standard deviation [SD] +/- 4), and the mean length of the excised colorectal specimen was 9 cm (SD +/- 4). In 29 cases, the specimen was extracted through the vagina and in 21 cases through the anus. A total of 5 patients required a reoperation in the early postoperative period: We identified 1 case of anastomotic leak, 1 case of postoperative bowel obstruction, 1 case of hemorrhage and 2 cases of pelvic collection (no macroscopic evidence of pus). No patient received blood transfusion. The mean operative time was 158 minutes (SD +/- 70) and mean hospital stay was 4 days (SD +/- 1).

Conclusion: NOSE colectomy is a reproducible surgical technique for the management of colorectal endometriosis. The complication rate appears comparable with the conventional (minilaparotomy) surgical approach. In experienced hands, this technique has a short learning curve, both in laparoscopy and in robotic surgery. (C) 2022 AAGL. All rights reserved.

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TI Objective and Subjective Assessment of Bladder Function after

Robot-assisted Laparoscopic Radical Hysterectomy for Early-stage

Cervical Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Bladder hypotonia; Functional outcomes; Quality of life; Urodynamics

ID QUALITY-OF-LIFE; FUNCTION RECOVERY; URINARY; CLASSIFICATION;

QUESTIONNAIRE; COMPLICATIONS; SURGERY; IMPACT; TRIAL; WOMEN

AB Study Objective: To examine whether objective bladder function after robot-assisted radical hysterectomy (RRH) for early-stage cervical cancer is correlated with subjective patient-reported outcomes and quality of life during the first year after RRH.

Design: Prospective observational study.

Setting: Karolinska University Hospital, Sweden.

Patients: Women with early-stage cervical cancer (International Federation of Gynecology and Obstetrics stage IA2-IB1) between July 2017 and May 2019 were assessed for eligibility.

Interventions: RRH.

Measurements and Main Results: Subjective bladder function was evaluated with the Female Lower Urinary Tract Symptoms and Urinary Incontinence Quality of Life modules of the International Consultation on Incontinence Questionnaire. Objective urinary function was characterized with urodynamic tests, and the nerves ablated at RRH were quantified by using immunohistochemical staining of biopsies from the resected paracervix, vesicouterine, and sacrouterine ligaments. Twentyseven women were included for analysis at baseline, 2 weeks, 3 months, and 12 months after surgery. RRH caused hypotonia of the urinary bladder (p <. 05). Patient-reported outcomes of voiding and filling dysfunction were most significant 2 weeks after surgery (p <. 05) but for most of the women, bladder function recovered within 3 months. No correlations were found with either subjective or objective urinary function and the number of ablated nerves.

Conclusion: For most women, objective and subjective urinary bladder dysfunction recovered within 3 months after RRH. The absence of correlation between functional outcomes and ablated autonomous nerves suggests that other underlying causes play a significant role. Early detection of bladder overextension after RRH is paramount, and the role of postoperative bladder catheterization needs further investigation. (C) 2022 AAGL.

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Ouldamer, Lobna

Collinet, Pierre

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TI Trachelectomy: How is it actually done? A review from FRANCOGYN group

Titre: Trachelectomie: comment faire en pratique? Revue de la

litterature par le groupe FRANCOGYN

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Review

DE Cervical cancer; Trachelectomy; Fertility; Cerclage

ID STAGE CERVICAL-CANCER; VAGINAL RADICAL TRACHELECTOMY; FERTILITY-SPARING

SURGERY; NEOADJUVANT CHEMOTHERAPY; PREGNANCY OUTCOMES; HYSTERECTOMY;

CARCINOMA; WOMEN; MANAGEMENT

AB Because of the peak incidence of cervical cancer between the ages of 35 and 44 and the increasing age of first pregnancy, the issue of fertility preservation in cases of early-stage cervical cancer in women in this reproductive age category arises. Early-stage cervical cancer patients have a good prognosis and are surgically treated in cases of mildly aggressive human papillomavirus-related histological type (squamous cell carcinoma, adenocarcinoma), FIGO stage IA to IB1 (i.e., <2 cm), with shallow stromal invasion (<10 mm) and without the presence of lymph-vascular space invasion or lymph node or regional involvement. Under these conditions, conservative treatment by trachelectomy, which has recurrence-free and overall survival rates equivalent to that of hysterectomy, may be considered. After a complete pre-therapeutic assessment, including pelvic lymphadenectomy, to eliminate all contraindications to conservative treatment, a simple or enlarged trachelectomy can be chosen. According to some authors, the route of entry (vaginal, simple or robot-assisted laparoscopy, laparotomy) has no significant effect on survival or fertility, although the literature on the subject is limited. Trachelectomy offers good results in terms of fertility, with an estimated pregnancy rate of between 23% and 55% and a live birth rate of 70%. The significant reduction of the cervix associated with the procedure increases the risk of prematurity. However, this can be prevented by the use of a permanent cerclage. Close follow-up of these patients is essential for a minimum period of 5 years in order to detect any recurrence or postoperative complications. (C) 2022 Elsevier Masson SAS. All rights reserved.

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WC Obstetrics & Gynecology

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PT J

AU Song, JW

Lee, GP

Kim, WY

Paik, ES

AF Song, Ji Won

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TI Long-Term Outcomes of Reduced-Port Robotic Surgery (RPRS) for Uterine

Myomectomy with the da Vinci Surgical System

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE robotic myomectomy; RPRS; uterine myomas; long-term outcomes; surgical

outcomes

ID LAPAROSCOPY; MANAGEMENT

AB Background: Reduced-Port Robotic Surgery (RPRS) for myomectomy is feasible alternate method to overcome disadvantages of multiport and single-site platforms of robotic surgery with better cosmetic results. We demonstrated operative outcomes and long-term outcomes after RPRS. Methods: This is analysis of a prospective, non-randomized study of 115 patients who underwent RPRS from April 2016 through July 2021. Results: Overall 115 patients were included for analysis. Patients' median age was 42 years (range, 28-52). The largest myoma was mostly located on the anterior uterine wall in 59 patients. The median myoma size and weight were 7.5 cm (range, 3-12) and 163 g (range, 42-753), respectively. The median myoma enucleation time and suture time were 10 minutes (range, 4-82) and 14 minutes (range, 5-63). Trend of shorter docking time and console time was shown with experience. The procedure was successfully performed via RPRS in 104 patients (91.5%); 10 patients required placement additional ports, conversion to open surgery was conducted in one case. There were 6 patients (5.2%) with postoperative complication with surgical wound infection (1.7%), bleeding (0.9%), peritonitis (1.7%), and pneumonia (0.9%). For long-term outcomes, 12 recurrences (10.4%) were observed in median follow-up of 25 months (range, 6-62 months). Total of 4 patients became pregnant after RPRS, and three patients had delivered with Caesarean section without complications. Conclusions: Our long-term results demonstrate the safety and feasibility of RPRS for uterine myomectomy as a valid treatment modality.

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NR 15

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Z9 0

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U2 0

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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ER

PT J

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Wallace, SL

Ferrando, CA

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Wallace, Shannon L.

Ferrando, Cecile A.

TI Postoperative void trial failure and same-day discharge following apical

pelvic organ prolapse surgery: a retrospective matched case-control

study

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Void trial; Prolapse; Urinary retention

ID URINARY RETENTION; INCONTINENCE; PREDICTORS

AB Introduction and hypothesis Robust data comparing the timing of voiding trials following prolapse surgery are lacking. Filling in these knowledge gaps would be helpful in counseling patients preoperatively about the concerns regarding same-day discharge. We aimed to compare the rate of a failed void trial after apical pelvic organ prolapse (POP) repair between patients who were discharged on the day of surgery versus those discharged on postoperative day 1. Methods This was a retrospective matched case-control study of women who underwent either a laparoscopic/robotic or transvaginal apical POP surgery with or without concurrent hysterectomy. Patients who were discharged on postoperative day 0 (POD0) were identified as cases and matched to control patients discharged on postoperative day 1 (POD1). Patients were matched 1:1 based on age and surgical approach. Results A total of 59 patients in each group met the inclusion criteria. Of the entire cohort, 34 (28.8%) patients failed their void trial, with no statistically significant difference between those who were discharged on POD0 versus POD1 (33.9% vs 23.7%, p=0.47). Patients who were discharged on POD0 were more likely to be diagnosed with a urinary tract infection (22.0% vs 8.4%, p=0.041) during the postoperative period. Conclusions In patients undergoing surgery for apical prolapse, there was no difference in the rate of void trial failure in those who had a catheter removal on the day of surgery compared with those who experienced removal the following day.

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ER

PT J

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TI Effects of hysterectomy on pelvic floor function and sexual function-A

prospective cohort study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE abdominal hysterectomy; female sexual function; laparoscopic

hysterectomy; minimally invasive surgery; pelvic floor function; robotic

assisted laparoscopic hysterectomy

ID POSTOPERATIVE VAGINAL LENGTH; FUNCTION INDEX FSFI; QUALITY-OF-LIFE;

URINARY-INCONTINENCE; WOMEN; PREVALENCE; VALIDATION; DISORDERS; SURGERY;

TRENDS

AB Introduction Hysterectomy is one of the most common major surgical procedures in women. The effects of hysterectomy on pelvic floor and sexual function are uncertain. Our objective was to investigate the effects of hysterectomy for benign indications on pelvic floor and sexual function and to compare different modes of surgery. Material and methods We performed a prospective clinical cohort study. In all, 260 women scheduled for hysterectomy answered validated questionnaires (Pelvic Floor Impact Questionnaire, Pelvic Floor Distress Inventory and Female Sexual Function Index). Participants were followed 6 months and 1 year after surgery. Data were analyzed using nonparametric statistics and mixed effect models. Results Women with subtotal hysterectomy, vaginal hysterectomy, laparoscopic assisted vaginal hysterectomy, and previous prolapse/incontinence surgery were excluded from further analysis, leaving the remaining cohort to 242 patients. The response rate at 6 months and 1 year follow-up was 180/242 (74.3%) and 169/242 (69.8%), respectively. There was an improvement of pelvic floor function at both follow-ups; mean score of Pelvic Floor Impact Questionnaire at baseline was 42.5 (51.7), at 6 months 19.9 (42.2) and at 1 year 23.7 (50.3) (p < 0.001). The mean score of Pelvic Floor Distress Inventory at baseline was 69.6 (51.1), at 6 months 49 (43.2) and at 1 year 49 (43.2) (p < 0.001). There was an improvement of sexual function after 6 months (mean score of Female Sexual Function Index at baseline 17.9 [SD 11.7] and at 6 months 21.0 [SD 11.7]) (p < 0.001). There was no difference in pelvic floor or sexual function when comparing surgical techniques. Conclusions Robotic assisted laparoscopic hysterectomy, laparoscopic hysterectomy and abdominal hysterectomy improve pelvic floor function to the same extent at 6 months and 1 year after surgery. There was an overall improvement of sexual function 6 months after hysterectomy, but this did not persist after 1 year.

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U2 2

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AU Mach, P

Kaufold, C

Rusch, P

Kimmig, R

Buderath, P

AF Mach, Pawel

Kaufold, Cara

Rusch, Peter

Kimmig, Rainer

Buderath, Paul

TI Single-center study for robotic-assisted laparoscopic sacropexies: a

one-fits-all strategy for pelvic organ prolapse?

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Sacrocolpopexy; Cervicosacropexy; Robotic-assisted surgery; POP

ID SACROCOLPOPEXY; OUTCOMES

AB Purpose Sarcopenia has been established as the "gold standard" for the treatment of pelvic organ prolapse (POP). Minimal invasive laparoscopy can help to reduce the risks of open access surgery. We compare the surgical results and outcomes of robotic-assisted sacropexies. Methods In this monocentric retrospective study we enrolled 49 patients operated on symptomatic POP. Patients were divided into two groups according to the type of robotic-assisted sacropexy: patients with a history of hysterectomy received robotic-assisted sacrocolpopexy (RSCP; n = 19), while patients with subtotal hysterectomy received robotic-assisted cervicosacropexy (RCSP; n = 30). Failure was defined as recurrence of the disease with a need for reoperation. Validated questionnaires (the Pelvic Floor Distress Inventory-20 (PFDI-20) and Pelvic Floor Impact Questionnaire-7 (PFIQ-7)), were used for evaluation of patients quality of life postoperatively. Results The comparison between RCSP versus RSCP showed that the latter is related to slightly but not significantly increased recurrence rates and a higher impact of POP symptoms on quality of life in long-term follow-up (p = 0.04). Perioperative data showed similar complication rates in both RSP types but shorter postoperative time of bladder catheterization in the case of RCSP (p = 0.008). Conclusions The monocentric long-term data confirm that RSP is a safe and effective method of surgical POP treatment, regardless of the site of the anatomical compartment. In comparison to RSCP, RCSP is associated with a lower impact of POP symptoms on patients' quality of life with a tendency to slightly lower rates of POP recurrence.

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JI Arch. Gynecol. Obstet.

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ER

PT J

AU Lim, PC

AF Lim, Peter C.

TI A review of robotic surgery in the management of recurrent ovarian

carcinoma: indication and techniques

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Recurrent ovarian cancer; Secondary cytoreductive surgery;

Robotic-assisted secondary cytoreductive surgery; RASCS

ID SECONDARY CYTOREDUCTIVE SURGERY; EPITHELIAL OVARIAN; SELECTION CRITERIA;

RESIDUAL DISEASE; PREDICTIVE SCORE; OPEN-LABEL; STAGE-III; CANCER;

SURVIVAL; MULTICENTER

AB Background: Treatment of recurrent ovarian cancer may consist of salvage chemotherapy or secondary cytoreductive surgery. Retrospective studies suggest that radical secondary cytoreduction resulting in no macroscopic disease (R0) after completion of surgery benefits patients and prolongs survival. The role of robotic-assisted secondary cytoreductive surgery (RASCS) is in its infancy. The aim of this manuscript is to review the literature regarding the role, the indication, and the techniques of RASCS and to summarize the published perioperative, postoperative, and oncologic outcomes of RASCS. Methods: A comprehensive systemic review was conducted in the PubMed, MEDLINE, EMBASE, and Google Scholar databases from 1 January 1980 through 31 December 2021. Keywords searched were "ovarian cancer", "recurrence", "robotic-assisted secondary debulking/cytoreductive surgery", "morbidity and mortality of secondary cytoreductive surgery", "indications for secondary cytoreductive", and combinations of these terms. Studies selected and analyzed included randomized controlled trials (RCTs) as well as prospective and retrospective anlayses and case series. RASCS procedures and techniques are described. Results: Several retrospectives, meta-analyses and prospective randomized trials suggest that optimal secondary cytoreductive surgery is associated with extended progression-free and overall survival. Preoperative selection criteria, such as Memorial Sloan Kettering (MSK) criteria and AGO (Arbeitsgemeinschaft Gynaekologische Onkologie) scores demonstrate that clinical-pathological factors can predict optimal secondary cytoreductive surgery and correlate with improved progression-free survival and overall survival. The surgical procedures that are required in secondary cytoreductive surgery can be complex. Limited retrospective studies have demonstrated that secondary cytoreductive surgery utilizing a robotic surgical platform can achieve the same rate of optimal cytoreductive surgery as open laparotomy with decreased morbidity. The effect of RASCS on progressionfree and overall survival has not been established. Conclusions: Early literature reports indicate that RASCS, in selected patients, can be applied for surgical treatment of recurrent ovarian cancer without compromising morbidity; long-term studies are warranted to determine the effect on progression-free and overall survival.

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NR 42

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Z9 0

U1 3

U2 4

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JI Eur. J. Gynaecol. Oncol.

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PT J

AU Bogani, G

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TI Assessing the role of minimally invasive radical hysterectomy for

early-stage cervical cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Cervical cancer; Laparoscopy; Robotic; Radical hysterectomy

ID ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; SURGERY; OUTCOMES;

MORBIDITY; SURVIVAL; MULTICENTER; RECURRENCE; LAPAROTOMY; CARCINOMA

AB Surgery is the mainstay of treatment in the management of early-stage cervical cancer. Until the publication of the Laparoscopic Approach to Cervical Cancer (LACC) trial, minimally invasive radical hysterectomy was the recommended approach to treat patients with early-stage disease. The results of the LACC trial questioned the adoption of minimally invasive surgery in cervical cancer. In comparison with the open approach, minimally invasive surgery correlated with worse disease-free and cancer-specific survival. Similarly, other retrospective studies highlighted this correlation, thus corroborating the results of the LACC trials. In the present review, we evaluated current evidence and further prospective of the adoption of minimally invasive radical hysterectomy in cervical cancer. Moreover, we sought to assess some unsolved issues regarding the role of minimally invasive surgery in early-stage cervical cancer patients.

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TC 7

Z9 7

U1 0

U2 13

PU ELSEVIER

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PT J

AU Dieter, AA

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Carey, ET

AF Dieter, Alexis A.

Moore, Kristin J.

Willis-Gray, Marcella G.

Gutman, Robert E.

Iglesia, Cheryl B.

Carey, Erin T.

TI Length of Stay and 30-Day Postoperative Complications Following

Minimally Invasive Apical Prolapse Repair

SO UROGYNECOLOGY

LA English

DT Article

DE apical prolapse repair; length of stay; ACS NSQIP; postoperative

complications; urogenital surgical procedures

ID SAME-DAY DISCHARGE; READMISSION; RISK

AB Importance Data on the correlation between length of stay and postoperative complications following urogynecologic surgery are limited. Objectives The objective of this study was to use a nationwide database to examine the correlation between length of stay and 30-day postoperative complications following minimally invasive apical prolapse repair. Study Design This retrospective cohort study included women in the American College of Surgeons National Surgical Quality Improvement Program database from 2008 to 2018 who underwent laparoscopic/robotic sacrocolpopexy or uterosacral/sacrospinous repair and were discharged on postoperative day 0 (POD0) or 1 (POD1). The primary outcome was 30-day postoperative complication rate. Results Of the 28,269 women discharged home on POD0/1, 12,663 (45%) underwent laparoscopic/robotic sacrocolpopexy, and 15,606 (55%) underwent uterosacral/sacrospinous repair. Women discharged on POD0 were less likely to be White, less likely to have diabetes or hypertension, had lower mean body mass index, and were less likely to have undergone a hysterectomy (P < 0.05 for all). Within 30 days of surgery, 7% had a postoperative complication, and 3% had a major complication. Women discharged on POD0 had a lower risk of any complication or any major complication. The most common complication, urinary tract infection, was lower in women discharged on POD0 (3% vs 4%, P < 0.01). Women discharged home on the same day had a higher risk of superficial surgical site infection after undergoing laparoscopic/robotic sacrocolpopexy (1.3% vs 0.5%, P < 0.01) and a higher risk of myocardial infarction/cardiac arrest after uterosacral/sacrospinous repair (0.2% vs 0%, P < 0.04). Conclusions In women undergoing minimally invasive reconstructive apical repair, discharge on POD0 is correlated with similar or better (lower) 30-day postoperative complication rates compared with women discharged on POD1.

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ER

PT J

AU Garg, N

Milad, MP

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TI Female sterilization reversal in the era of in-vitro fertilization

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE in-vitro fertilization; sterilization reversal; tubal ligation; tubal

surgery

ID LAPAROSCOPIC TUBAL ANASTOMOSIS; MICROSURGICAL REVERSAL; RE-ANASTOMOSIS;

COST; OUTCOMES; RATES; WOMEN

AB Purpose of review Regret after female sterilization is not uncommon in the United States. Prior to the development of assisted reproductive technology (ART), surgical reversal of sterilization was the only option for patients interested in fertility. First performed in 1972, this procedure has since been refined over the years by gynaecologic surgeons. With in-vitro fertilization (IVF) gaining popularity, interest in sterilization reversal has waned. However, sterilization reversal should remain an important option in patients seeking pregnancy after tubal ligation. Recent findings A direct comparison between IVF and sterilization reversal is challenging due to inherent differences in reporting fertility outcomes. However, sterilization reversal may optimize fertility in younger women, whereas IVF may be more effective in older women. The surgical approach to sterilization reversal can be laparotomic, laparoscopic or robotic. Clinical decision making should include consideration of the risk of ectopic pregnancy, interval from sterilization to reversal, type of sterilization procedure, planned anastomotic site and projected remaining tubal length. In the era of IVF, sterilization reversal still has a place in the management in restoring fertility. Creating awareness of the role of sterilization reversal is the first step in improving access to adequate training in this procedure for the next generation of reproductive surgeons.

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PT J

AU Padoa, A

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Tsviban, A

Serati, M

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Levy, Eyal

Fligelman, Tal

Tomashev-Dinkovich, Roni

Tsviban, Anna

Serati, Maurizio

TI Predictors of persistent overactive bladder following surgery for

advanced pelvic organ prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Body mass index; Detrusor overactivity; Overactive bladder; Pelvic organ

prolapse; Pelvic organ prolapse surgery; Urinary urgency

ID URINARY-INCONTINENCE; OUTLET OBSTRUCTION; RISK-FACTORS; SYMPTOMS;

PREVALENCE; TERMINOLOGY; SEVERITY; OBESITY; WEIGHT; REPAIR

AB Introduction and hypothesis Reliable risk factors for persistent urgency following pelvic organ prolapse (POP) surgery are still unclear. We aimed to identify preoperative parameters related to persistent postoperative urgency in a cohort of women following surgery for POP stage 3-4 with concomitant overactive bladder (OAB). Methods In this retrospective analysis, women with POP stage 3-4 and OAB who underwent POP repair during November 2012-December 2020 were included. Preoperative evaluation included history, Pelvic Organ Prolapse Quantification (POP-Q), multi-channel urodynamic studies and Pelvic Floor Distress Inventory (PFDI-20). Surgical procedures included: anterior and posterior colporrhaphy, sacrospinous ligament suspension, anterior vaginal wall mesh repair and robotic-assisted laparoscopic sacrocolpopexy. At the 12-month follow-up, urogynecological history, POP-Q evaluation, cough stress test and the PFDI-20 questionnaire were repeated. Results One hundred seventy-three patients were included in the analysis. Resolution of urgency was observed in 56% of women. Variables associated with persistent postoperative urgency included body mass index (BMI) (27 kg/m(2) vs 25.7 kg/m(2), p = 0.04), preoperative increased daytime frequency (46.39% vs 61.84%, p = 0.05), urgency urinary incontinence (UUI) (51.46% vs 80.26%, p = 0.0001), detrusor overactivity (DO) (40.2% vs 61.84%, p = 0.009) and lower maximum flow rate on UDS (13.9 ml/s vs 15 ml/s, p = 0.04). Multivariate analysis confirmed preoperative DO (OR: 12.2 [95% CI: 1.4-16.6]; p = 0.01), preoperative UUI (OR 3.8 [95% CI: 1.3-11.0]; p = 0.008) and BMI > 25 kg/m(2) (OR 1.8 [95% CI: 1.1-7.2]; p = 0.04) as predictive factor for persistent urgency. Conclusions In women with advanced POP and OAB, being overweight, preoperative UUI and DO are related to persistent postoperative urgency. These findings will guide our future preoperative counseling and reinforce the role of UDS in POP management.

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AU Gopinath, D

Yong, C

Harding-Forrester, S

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McKenzie, D

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Yong, Chin

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McKenzie, Dean

Carey, Marcus

TI Laparoscopic and robot-assisted suture versus mesh hysteropexy: a

retrospective comparison

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Uterine prolapse; Uterine preservation; Uterine suspension; Uterosacral

plication

ID PELVIC ORGAN PROLAPSE; VAGINAL HYSTERECTOMY; ANATOMY

AB Introduction and hypothesis Our study was aimed at comparing the outcomes of laparoscopic and robot-assisted laparoscopic suture-based hysteropexy (SutureH) versus sacral hysteropexy using mesh (MeshH) for bothersome uterine prolapse. Our hypothesis is that MeshH is more successful and provides better uterine support than SutureH. Methods A retrospective cohort study of 228 consecutive women who underwent re-suspension of the uterus using uterosacral ligaments (SutureH n=97) or a "U-shaped" mesh from the sacral promontory (MeshH, n=132). Surgery was performed by laparoscopy or robot-assisted laparoscopy. Subjects were assessed at baseline, 1 year, and beyond 1 year. The null hypothesis, that SutureH and MeshH have similar success, was based on a composite outcome ("composite success"), and that they provide the same level of uterine support, was based on POP-Q point C at 1 year. "Composite success" was defined as: POP-Q point C above the hymen; absence of a vaginal bulge; no repeat uterine prolapse surgery or pessary placement. Other outcomes included improvement in symptomology using Patient Global Impression of Improvement, POP-Q point C change and complications. Results Follow-up data were available for 191 out of 228 women. "Composite success" was not significantly different between MeshH and SutureH groups (81.7% vs 84.5%, p=0.616). MeshH provided better elevation of the uterus than SutureH (point C change: -7.38cm vs -6.99cm; p<0.001). Similar symptom improvement and low complications occurred in both groups. Conclusions Laparoscopic and robot-assisted laparoscopic suture hysteropexy and mesh sacral hysteropexy provide women with minimally invasive, durable surgical options for uterine preservation. "Composite success" was similar in the two groups, but MeshH provided better uterine support than SutureH. However, SutureH gives women an effective mesh-free option.

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AF Kim, Nae Ry

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Kim, Tae Jin

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TI Minimally invasive surgery versus open surgery in high-risk histologic

endometrial cancer patients: A meta-analysis

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive surgery; Prognosis; Meta

-analysis

ID CLEAR-CELL CARCINOMA; ROBOTIC SURGERY; UTERINE-CANCER; SURVIVAL;

PAPILLARY; STAGE; LAPAROTOMY; WOMEN; LAPAROSCOPY; OUTCOMES

AB Objective. To compare the effects of minimally invasive surgery (MIS) and open surgery (OPS) on the risk of recurrence and mortality in patients with endometrial cancer (EC) of high-risk histology (grade 3 endometrioid adenocarcinoma, papillary serous carcinoma [PS], clear cell carcinoma [CC], and carcinosarcoma) using meta -analysis. Material and methods. We systematically reviewed published studies comparing MIS and OPS in EC patients with high-risk histology until January 2022. The endpoints were recurrence and mortality rate. Study design fea-tures that may have affected participant selection, recurrence/death detection, and manuscript publication were assessed. For pooled estimates of the effect of MIS on recurrence/mortality, the random-or fixed-effects meta -analytical models were used after assessing the cross-study heterogeneity. Result. Nine observational studies (eight retrospective and one prospective) fulfilled our search criteria (MIS, 8877 patients; OPS, 5751 patients). The fixed-effects model-based meta-analysis indicated that MIS did not sig-nificantly increase the risk of recurrence (hazard ratio [HR], 0.86; 95% confidence interval [CI], 0.71-1.05; p = 0.13) and mortality (HR, 0.86; 95% CI, 0.79-0.93; p < 0.001) when compared with OPS. This pattern was also ob-served in the subgroup analyses based on the stage (early stage vs. all stage), histology (PS and CC), and MIS type (laparoscopy vs. robotic). There was no evidence of publication bias.Conclusion. This meta-analysis of observational studies revealed that MIS did not compromise the prognosis of EC patients with high-risk histology. Well-designed randomized controlled trials could verify the results of this uncommon but deadly tumor.(c) 2022 Elsevier Inc. All rights reserved.

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CA 4C Canadian Cervical Canc Collabor

TI Comparison of outcomes between abdominal, minimally invasive and

combined vaginal-laparoscopic hysterectomy in patients with stage

IAI/IA2 cervical cancer: 4C (Canadian Cervical Cancer Collaborative)

study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Minimally invasive surgery

ID RADICAL HYSTERECTOMY; GYNECOLOGIC-ONCOLOGY; ENHANCED RECOVERY; SURGERY

ERAS; CARCINOMA

AB Objective. Although minimally invasive hysterectomy (MIS-H) has been associated with worse survival com-pared to abdominal hysterectomy (AH) for cervical cancer, only 8% of patients in the LACC trial had microinvasive disease (Stage IA1/IA2). We sought to determine differences in outcome among patients undergoing MIS-H, AH or combined vaginal-laparoscopic hysterectomy (CVLH) for microinvasive cervical cancer. Methods. A retrospective cohort study of all patients undergoing hysterectomy (radical and non radical) for FIGO 2018, microinvasive cervical cancer across 10 Canadian centers between 2007 and 2019 was performed. Re-currence free survival (RFS) was estimated using Kaplan Meier Survival analysis. Chi-square and log-rank tests were used to compare outcomes. Results. 423 patients with microinvasive cervical cancer were included; 259 (61.2%) Stage IA1 (22/8.5% with LVSI) and 164(38.8%) IA2. The median age was 44 years (range 24-81). The most frequent histology was squa-mous (59.4%). Surgical approach was: 50.1% MIS-H (robotic or laparoscopic), 35.0% AH and 14.9% CVLH. Overall, 70.9% underwent radical hysterectomy and 76.5% had pelvic lymph node assessment. There were 16 recurrences (MIS-H:4, AH:9, CVLH: 3). No significant difference in 5-year RFS was found (96.7% MIS-H, 93.7% AH, 90.0% CVLH, p = 0.34). In a sub-analysis of patients with IA1 LVSI+/IA2(n = 186), survival results were similar. Further, there was no significant difference in peri-operative complications (p = 0.19). Patients undergoing MIS-H had a shorter me-dian length of stay(0 days vs 3 (AH) vs. 1.5 (CVLH), p < 0.001), but had more ER visits (16.0% vs 3.6% (AH), 3.5% (CVLH), p = 0.036). Conclusion. In this cohort, including only patients with microinvasive cervical cancer, no difference in recur-rence was found by surgical approach. This may be due to the low rate of recurrence making differences hard to detect or due to a true lack of difference. Hence, this patient population may benefit from MIS without compromising oncologic outcomes. (c) 2022 Elsevier Inc. All rights reserved.

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TI Early evaluation of a next-generation surgical system in robot-assisted

total laparoscopic hysterectomy: A prospective clinical cohort study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE clinical trial; gynecology; minimal access surgery; robot-assisted

surgery; robotic surgical system; surgical robot

ID SURGERY; LAPAROTOMY; BARRIERS; OUTCOMES; CANCER; COST

AB Introduction This study aimed to demonstrate the safe and effective use of the Versius surgical system (CMR Surgical, Cambridge, UK) in robot-assisted total laparoscopic hysterectomy. This surgical robot was developed iteratively with input from surgeons to improve surgical outcomes and end-user experience. We report data from the gynecology cohort of an early clinical trial designed in broad alignment with IDEAL-D (Idea, Development, Exploration, Assessment, Long-term follow-up - Devices) stage 2b (Exploration). Material and methods The study is registered in the Indian clinical trials register (CTRI/2019/02/017872). Adult women requiring total hysterectomy who provided informed consent and met the eligibility criteria underwent procedures at one of three hospitals in India. Five surgeons performed robot-assisted total laparoscopic hysterectomies using the device from March 2019 to September 2020. The primary endpoint was rate of unplanned conversion to conventional laparoscopic or open surgery. Adverse events were adjudicated by an independent clinical events committee using endoscope video recordings and clinical notes. Results In total, 144 women underwent surgery (median age: 44 years [range: 28-78]; median body mass index 25.8 kg/m(2) [range: 14.3-47.8]). The rate of unplanned conversion to conventional laparoscopy was 2/144 (1.4%); neither conversion was device related. No surgery was converted to open. In total, 13 adverse events occurred among seven (4.9%) patients, comprising seven serious adverse events and six adverse events. One serious adverse event was deemed device-related. Two patients were readmitted to hospital within 30 days; both made a full recovery. No patients died within 90 days of surgery. Conclusions The device provides a safe and effective option for total laparoscopic hysterectomy; these findings support its continued implementation in larger patient cohorts and expansion in other major minimal access indications.

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TI Robotic surgery in gynaecology Scientific Impact Paper No. 71 (July

2022)

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED LAPAROSCOPY; PERIOPERATIVE OUTCOMES;

PHYSICAL DISCOMFORT; POSTURAL ERGONOMICS; COST-EFFECTIVENESS;

CERVICAL-CANCER; SACROCOLPOPEXY; COMPLICATIONS; MANAGEMENT

AB Plain language summary The use of robotic-assisted keyhole surgery in gynaecology has expanded in recent years owing to technical advances. These include 3D viewing leading to improved depth perception, limitation of tremor, potential for greater precision and discrimination of tissues, a shorter learning curve and improved comfort for surgeons compared with conventional keyhole and open abdominal surgery. Robotic-assisted keyhole surgery, compared with conventional keyhole surgery, improves surgical performance without increasing operating time, minimises blood loss and intra- or postoperative complications, while reducing the need to revert to abdominal surgery. Moreover, surgeons using a robot experience fewer skeletomuscular problems of their own in the short and long term than those operating without a robot as an additional tool. This Scientific Impact Paper looks at the use of a robot in different fields of gynaecological surgery. A robot could be considered safe and a more effective surgical tool than conventional keyhole surgery for women who have to undergo complex gynaecology surgery or have associated medical issues such as body-mass index (BMI) at 30 kg/m(2) or above or lung problems. The introduction of the use of robots in keyhole surgery has resulted in a decrease in the number of traditional open surgeries and the risk of conversion to open surgery after traditional keyhole surgery; both of which should be considered when examining the cost-benefit of using a robot. Limitations of robotic-assisted surgery remain the associated higher costs. In womb cancer surgery there is good evidence that introducing robotics into the service improves outcomes for women and may reduce costs.

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U2 3

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ER

PT J

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Vaucel, Edouard

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TI Robot-assisted laparoscopy repair of uterine isthmocele: A two-center

observational study

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE cesarean scar; laparoscopic niche resection; surgical management;

uterine niches; uterine scar defect

ID CESAREAN SCAR DEFECT; PREVALENCE; MANAGEMENT; SYMPTOMS; SERIES; NICHES

AB Objective To analyze outcomes and postoperative complications in patients undergoing robot-assisted isthmocele repair. Method This retrospective cohort study included 33 patients who had robot-assisted laparoscopic surgical management of an isthmocele between September 2013 and August 2020 in two French university hospitals. All charts were reviewed to identify patient characteristics, preoperative and postoperative anatomical findings, complications, and postoperative fertility and symptoms. Patients who had undergone this procedure were asked to complete a telephone questionnaire about their treatment satisfaction and symptoms. Results The isthmocele was discovered most often as a result of subfertility (57.6%), but also ectopic pregnancy (18.2%), pelvic pain (15.2%), and postmenstrual bleeding (9.1%). Robot-assisted repair of the isthmocele significantly improved myometrial thickness (from 1.55 mm before surgery to 4.26 mm after surgery [mean difference 2.71; 95% confidence interval, 1.91-3.51], P = 0.0005). Among 20 patients who still desired a child after surgery, 15 became pregnant and 14 had full-term live births. Among the nine patients who had surgery for disabling symptoms, five had no persistent symptoms, three reported global improvement, and one had the same gynecologic discomfort. Seventeen patients agreed to complete the questionnaires (51.5%), and all stated that they would choose to have this surgery again. Conclusion Robot-assisted repair of an isthmocele is a viable minimally invasive procedure.

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TC 5

Z9 5

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TI Is Same-Day Discharge Following Minimally Invasive Sacrocolpopexy Safe

and Feasible? A National Contemporary Database Analysis

SO UROGYNECOLOGY

LA English

DT Article

DE length of stay; pelvic floor disorders; pelvic organ prolapse; robotic

surgical procedures; surgical mesh

ID READMISSION

AB Objective The aim of this study was to investigate trends and outcomes of ambulatory minimally invasive sacrocolpopexy (MISC) using data from a contemporary multicenter nationwide cohort. Methods We used the American College of Surgeons National Surgical Quality Improvement Program database to identify women who underwent nonemergent MISC (laparoscopic and robotic) from 2012 to 2018. Exclusion criteria were age <18 or >= 90 years, rectal prolapse, postoperative discharge day >= 3, and concomitant hysterectomy, transvaginal mesh repair, colpocleisis, and/or colorectal surgery. Baseline demographics and 30-day outcomes were compared between patients who underwent same-day discharge (SDD; discharge on postoperative day [POD] 0) and those discharged on POD 1-2 using Kruskal-Wallis, Fisher exact, and Pearson chi(2) tests. A 2-sided Cochran-Armitage trend test assessed SDD over time, and person-years methodology was used to assess readmission rates. Multivariable logistic regression and Cox proportional hazards modeling evaluated associations between SDD and postoperative outcomes. We hypothesized that SDD increased over the study time frame and is not associated with adverse outcomes. Results Of 2,928 women, 362 (12.4%) were SDD, and 2,566 (87.6%) were discharged POD 1-2. The proportion of SDD nearly quadrupled over time (5.6% [2012], 20.6% [2018]; P < 0.001). The SDD group was younger (mean age, 61.9 vs 63.6; P = 0.04), with lower proportion of American Society of Anesthesiologists class III or higher (21.8% vs 27.5%; P = 0.02) and hypertension (37.3% vs.46.5%; P < 0.001), shorter total operation time (median, 142 vs 172 minutes; P < 0.001), and fewer concomitant slings (21.5% vs 33.0%; P < 0.001). Outcomes were similar for SDD: 30-day overall complications (3.0% vs 4.4%; P = 0.23), readmissions (1.1% vs 2.0%; P = 0.28), and reoperations (1.1% vs 0.9%; P = 0.55) and persisted with multivariable analysis. Conclusion Ambulatory MISC significantly increased during the study period and appears safe and feasible in select patients.

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J9 UROGYNECOLOGY

JI Urogynecol.

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TI Variations in Procedures for Ureterolysis with Sharp Dissection in

Minimally Invasive Hysterectomy

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE differences. Dissection; hysterectomy; minimally invasive surgical

procedure

ID URETERAL INJURY

AB To safely perform minimally invasive hysterectomy (MIH), including laparoscopic hysterectomy and robot-assisted hysterectomy, partial ureterolysis, or visualizing only the ureter without dissection is often inadequate. Moreover, careless blunt dissection could injure the blood vessels. We present our surgical method for ureterolysis using sharp dissection during MIH. First, the outer portion of the ureter is dissected. Dissecting between the pelvic sidewall and the posterior leaf of the broad ligament creates a pararectal space outside the ureter, enabling the easy identification of the ureter running on the posterior leaf. Second, the inner portion of the ureter is dissected. After determining the location of the ureter, a better partial dissection of the ureter can be performed from the posterior leaf, instead of dissecting along the entire circumference. If fine surgery has to be performed, the ureter can be dissected by enclosing it within its sheath. We primarily perform dissections using a monopolar device, which allows a sharp dissection. Furthermore, in our method, we often include the dissection of the ureteral tunnel. It is important to understand the anatomy and membrane structure of the ureter in each patient and adjust the extent of ureterolysis based on individual differences.

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TI Pass or Fail? Postoperative Active Voiding Trials in an Enhanced

Recovery Program

SO UROGYNECOLOGY

LA English

DT Article

DE postoperative voiding dysfunction; enhanced recovery

ID URINARY RETENTION; RISK-FACTORS; INCONTINENCE

AB Importance Pelvic reconstructive surgery is often associated with transient postoperative voiding dysfunction. Objective This study aimed to compare postoperative active voiding trial (AVT) outcomes before and after implementation of an enhanced recovery program (ERP) for women undergoing pelvic reconstructive surgery. In addition, risk factors for postoperative urinary retention were identified. Study Design We retrospectively identified patients undergoing inpatient vaginal or robotic pelvic reconstructive surgery before and after implementation of an ERP at our institution. Demographics, operative and postoperative details, and AVT outcomes were collected. Primary outcome was AVT failure. Variables associated with increased risk of AVT failure were identified using multivariate analysis. Results Three hundred seventeen patients were included-75 pre-ERP and 242 ERP. There was no difference in AVT failures between pre-ERP and ERP groups (21.3% vs 21.9%, P = 0.92). The AVT failures were highest among those with abnormal preoperative postvoid residual volume (PVR >= 100 mL, 25.9% vs 12.2%, P = 0.01) and those who underwent an incontinence procedure (midurethral sling or Kelly plication, 30.4% vs 16.9%, P = 0.01). Compared with a reference procedure (total vaginal hysterectomy [TVH]), the following procedures were associated with statistically significant higher odds ratios (ORs) of AVT failure: TVH with incontinence procedure (OR, 15.0; confidence interval [CI], 4.58-48.9; P < 0.001), TVH with anterior repair (OR, 4.98; CI, 1.93-12.9; P = 0.001), and robotic sacrocolpopexy (OR, 3.6; CI, 1.18-11.2; P = 0.02). Conclusions Postoperative AVT failure incidence did not differ pre- and post-ERP intervention. Abnormal preoperative PVR was associated with failed postoperative voiding trial. Concomitant incontinence procedures and/or anterior colporrhaphy were associated with increased incidence of voiding trial failure regardless of ERP cohort.

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JI Urogynecol.

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PT J

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Oh, HR

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Lim, MC

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Ha, Hyeong In

Lim, Myong Cheol

TI Learning curve analysis of multiport robot-assisted hysterectomy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE CUSUM graph; Learning curve; Multiport robot-assisted hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; SURGERY

AB Purpose The purpose of this study was to evaluate the surgical outcomes and learning curve of multiport robot-assisted hysterectomy. Methods Eighty-eight patients were identified who underwent multiport robot-assisted surgery for hysterectomy. A retrospective analysis was performed. The cumulative summation technique (CUSUM) was used to investigate the learning curve in surgical proficiency by analyzing total operative, docking, and console times. Results The patients' median age was 51 years. In addition, the median operative time was 120.5 min (range 56-344 min). The most common indication for surgery was myoma (33.0%). The median estimated blood loss was 30 mL (range 5-200 mL). There was no conversion to laparoscopic or open surgery. No transfusion was required, and only one complication including umbilical incisional hernia was reported. A tendency of decline in total operative time following the first 23 cases was found. The CUSUM graph for total operative time indicated the generation of three distinct performance phases: learning (n = 23), competence (n = 36), and mastery (n = 29). The median docking time was 3 min (range 1-10 min) and median console time was 70 min (range 24-298 min). Conclusion The multiport robot-assisted surgery is an easy and safe procedure with minimal postoperative complications and can be quickly learned. The learning curve was 23 cases to significantly decrease the operative time.

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TI Robotic sacrohysteropexy: an instructional video for uterovaginal

prolapse repair in patients with desired uterine preservation

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Hysteropexy; Mesh; Prolapse; Surgery

ID HYSTERECTOMY; WOMEN

AB Introduction Minimally invasive sacrohysteropexy is a feasible and safe option for the treatment of uterovaginal prolapse in patients with prior sacrorectopexy. This video demonstrates an approach to robotic sacrohysteropexy while also adapting for a patient's prior sacrorectopexy. Sacrohysteropexy has been shown to be a viable option in women undergoing pelvic reconstructive surgery for the repair of uterovaginal prolapse. Methods This video demonstrates key steps in performing a robotic sacrohysteropexy without compromising the integrity of the patient's prior sacrorectopexy. First, incision and dissection of the anterior and posterior peritoneum overlying the cervical stroma is carried out. Tunnels are made through the avascular plane of the broad ligament lateral to the uterine vessels, so as not to compromise uterine blood supply. The anterior and posterior arms of the mesh are attached with interrupted sutures to the cervical stroma. The presacral space is entered and dissected such that the anterior longitudinal ligament is exposed. Care is taken not to disrupt the sutures from the prior sacrorectopexy as the sacral arm of the mesh is secured with two interrupted stitches. Conclusion At completion of the procedure the patient had a well-supported apical compartment.

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WC Obstetrics & Gynecology; Urology & Nephrology

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PT J

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TI Outcomes of robotic and laparoscopic surgery for benign gynaecological

disease: a systematic review

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Review

DE Laparoscopy; robotic surgery; systematic review; surgical outcomes;

benign gynaecological diseases

ID LAPAROENDOSCOPIC SINGLE-SITE; COMPARING OPERATIVE TIMES; ASSISTED

HYSTERECTOMY; CONVENTIONAL LAPAROSCOPY; FUNCTIONAL OUTCOMES;

SACROCOLPOPEXY; MYOMECTOMY; STANDARD; COST; COMPLICATIONS

AB Benign gynaecological diseases are usually treated with minimally invasive approaches. Robotic surgery seems an alternative to laparoscopic surgery. No definitive conclusions have yet been made regarding comparison of robotic versus laparoscopic surgery for benign diseases. In this scenario, we performed a systematic review in order to assess the advantages and disadvantages of laparoscopy versus robotic surgery and conclude whether laparoscopy should be replaced by robotic surgery for the treatment of benign gynaecological conditions, following the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) Statement. We included 64 studies: no significant difference was observed regarding overall complication rate; no significant benefit of robotic approach was demonstrated regarding length of hospital stay and conversion to laparotomy; furthermore, robotic surgery is more easily used by non-experienced surgeons, while it is more expensive and characterised by longer operative time. In conclusion, current evidence indicates neither statistically significant nor clinically meaningful differences in surgical outcomes between robotic and laparoscopic surgeries for benign gynaecological diseases. Impact statement What is already known on this subject? Benign gynaecological diseases are usually treated with minimally invasive approaches. Nevertheless, no definitive conclusions have yet been made regarding comparison of robotic versus laparoscopic surgery for benign diseases. What do the results of this study add? No significant difference was observed regarding overall complication rate; no significant benefit of robotic approach was demonstrated regarding length of hospital stay and conversion to laparotomy; furthermore, robotic surgery is more easily used by non-experienced surgeon, while it is more expensive and characterised by longer operative time. What are the implications of these findings for clinical practice and/or further research? Robotic surgery should not replace laparoscopy for the treatment of benign gynaecological conditions; in addition, gynaecologic surgeon should offer robotic surgery for benign diseases only after a proper counselling and a balanced decision-making process involving the patient.

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JI J. Obstet. Gynaecol.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

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ER

PT J

AU Ross, JH

Park, AJ

AF Ross, James H.

Park, Amy J.

TI Female Pelvic Medicine and Reconstructive Surgery: Routes of Surgery and

Related Differences Among Training Programs

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE urogynecology; FPMRS; vaginal surgery; training; medical education

ID HYSTERECTOMY; OBSTETRICS; RESIDENTS; KNOWLEDGE

AB Female pelvic medicine and reconstructive surgery (FPMRS) relies on a range of surgical approaches to treat pelvic-floor disorders. Concomitant hysterectomy is involved in many of these approaches. In general, due to advances in nonsurgical treatment of benign conditions, the hysterectomy rate has decreased in the United States. Moreover, when hysterectomy is performed, the trend now favors minimally invasive laparoscopy and robotic-assisted techniques, while abdominal and vaginal approaches are less common. Mirroring national trends, studies examining trainee case logs have reported decreased volumes of vaginal hysterectomies. Surveys of trainees and program directors show wide variability in preparedness and case numbers, highlighting the lack of uniformity in training and expectations. To augment vaginal hysterectomy training, many efforts have been developed to enhance trainee education and simulation for vaginal surgery. Fidelity, cost, and validation vary in these simulation models. By simulating different steps of a vaginal hysterectomy, many models have been validated by trainees and expert surgeons to be accurate and helpful, but limited data exist on applications to FPMRS training. For FPMRS, limited studies cover training variability in vaginal, laparoscopic, and robotic approaches to prolapse repair. A 2020 Accreditation Council for Graduate Medical Education update on case minimums for FPMRS detailed the requirements for each procedure even more. As FPMRS adapts to growth of the field, surgeons must continue to educate the next generation of trainees on various routes, such as conventional laparoscopic, robotic-assisted laparoscopic, and vaginal surgery. (J GYNECOL SURG 20XX:000)

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PG 3

WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

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ER

PT J

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TI Surgical Science-Simbionix Robotic Hysterectomy Simulator: Validating a

New Tool

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Simulation; Surgical education; Robotic hysterectomy;

Global Evaluative Assessment of Robotic Skills

ID GLOBAL EVALUATIVE ASSESSMENT; SURGERY; VALIDITY; CONSTRUCT; SKILLS

AB Study Objective: To gather validity evidence for and determine acceptability of Surgical Science-Simbionix Hysterectomy Modules for the DaVinci Xi console simulation system (software; 3D Systems by Simbionix [now Surgical Science -Simbionix], Littleton, CO, and hardware; Intuitive Surgical, Inc., Sunnyvale, CA) and evaluate performance benchmarks between novice and experienced or expert surgeons.

Design: Prospective education study (Messick validity framework).

Setting: Multicenter, academic medical institutions.

Participants: Residents, fellows, and faculty in obstetrics and gynecology were invited to participate at 3 institutions. Participants were categorized by experience level: fewer than 10 hysterectomies (novice), 10 to 50 hysterectomies (experienced), and more than 50 hysterectomies (expert). A total of 10 novice, 10 experienced, and 14 expert surgeons were included.

Interventions: Participants completed 4 simulator modules (ureter identification, bladder flap development, colpotomy, complete hysterectomy) and a qualitative survey. Simulator recordings were reviewed in duplicate by educators in minimally invasive gynecologic surgery using the Modified Global Evaluative Assessment of Robotic Skills (GEARS) rating scale.

Measurements and Main Results: Most participants felt that the simulator realistically simulated robotic hysterectomy (64.7%) and that feedback provided by the simulator was as or more helpful than feedback from previous simulators (88.2%) but less helpful than feedback provided in the operating room (73.5%). Participants felt that this simulator would be helpful for teaching junior residents. Simulator-generated metrics correlated with GEARS performance for the bladder flap and ureter identification modules in multiple domains including total movements and total time for completion. GEARS performance for the bladder flap module correlated with experience level (novice vs experienced/expert) in the domains of interest and total score but did not consistently correlate for the other procedural modules. Performance benchmarks were evaluated for the bladder flap module for each GEARS domain and total score.

Conclusion: The modules were well received by participants of all experience levels. Individual simulation modules appear to better discriminate between novice and experienced/expert users than overall simulator performance. Based on these data and participant feedback, the use of individual modules in early residency education may be helpful for providing feedback and may ultimately serve as 1 component of determining readiness to perform robotic hysterectomy. (C) 2022 AAGL. All rights reserved.

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FU Intuitive Surgical

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WC Obstetrics & Gynecology

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ER

PT J

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Kamdar, N

Morgan, DM

As-Sanie, S

Till, SR

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Till, Sara R.

TI Effects of Pharmacologic Venous Thromboembolism Prophylaxis in Benign

Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 49th Annual Global Congress of the

American-Association-of-Gynecologic-Laparoscopists (AAGL) on Minimally

Invasive Gynecologic Surgery (MIGS)

CY NOV 06-14, 2020

CL ELECTR NETWORK

SP Amer Assoc Gynecol Laparoscopists

DE Anticoagulation; Perioperative care; Laparoscopic surgery

ID BLEEDING COMPLICATIONS; PREVENTION; THROMBOSIS; COHORT; RISK

AB Study Objective: To evaluate whether the addition of pharmacologic prophylaxis to mechanical prophylaxis for venous thromboembolism (VTE) is associated with changes in perioperative outcomes in hysterectomy for benign indications.

Design: Retrospective cohort study.

Setting: Michigan Surgical Quality Collaborative database.

Patients: Patients who underwent hysterectomy between July 2012 and June 2015 when VTE prophylaxis data were collected.

Interventions: Patients who received mechanical prophylaxis alone were compared with those receiving dual prophylaxis (mechanical and pharmacologic). Minimally invasive surgeries (MIS) included laparoscopic, vaginal, robotic-assisted, and laparoscopic-assisted vaginal hysterectomies and were analyzed separately from abdominal (ABD) hysterectomy.

Measurements and Main Results: Propensity score matching was used to minimize confounding because of the differences in demographic and perioperative characteristics. The primary outcome was estimated blood loss (EBL). The secondary outcomes were operative time, postoperative blood transfusion, VTE, surgical site infection, reoperation, readmission, and death. There were 1803 matched pairs in the MIS analysis. In the ABD hysterectomy analysis, 2:1 matching was used with a total of 1168 patients receiving mechanical prophylaxis alone matched to 616 patients receiving dual prophylaxis. EBL was higher by 54.5 mL (95% confidence interval [CI], 16.9- 92.1) in those receiving dual prophylaxis in the ABD hysterectomy analysis but did not differ between groups in the MIS analysis. Operative time was significantly longer with dual prophylaxis in both MIS (18.3 minutes; 95% CI, 13.8- 22.8) and ABD (15.3 minutes; 95% CI, 9.0- 21.6) surgical approaches. There was no difference in other secondary outcomes.

Conclusion: The addition of pharmacologic prophylaxis to mechanical prophylaxis in benign hysterectomy was associated with longer operative time, regardless of surgical approach and increased EBL in ABD hysterectomy. Given very low rates of VTE, no difference in other perioperative outcomes, and possible harm, it seems reasonable to encourage individualized rather than routine use of pharmacologic prophylaxis in patients undergoing benign hysterectomy receiving mechanical prophylaxis. (C) 2022 AAGL. All rights reserved.

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U1 0

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TI Minimally invasive myomectomy: practice trends and differences between

Black and non-Black women within a large integrated healthcare system

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE fibroids; minimally invasive myomectomy; open myomectomy; racial

differences; surgeon volume; uterine leiomyomas

ID UTERINE LEIOMYOMATA; RACIAL-DIFFERENCES; LEARNING-CURVE; HYSTERECTOMY;

ROUTE

AB BACKGROUND: Although multiple professional organizations encourage minimally invasive surgical approaches whenever feasible, nationally, fewer than half of myomectomies are performed via minimally invasive routes. Black women are less likely than their non-Black counterparts to have minimally invasive surgery.

OBJECTIVE: This study aimed to assess the trends in surgical approach among women who underwent minimally invasive myomectomies for uterine leiomyomas within a large integrated healthcare system as initiatives were implemented to encourage minimally invasive surgery, particularly evaluating differences in the proportion of minimally invasive surgery performed in Black vs non-Black women.

STUDY DESIGN: We conducted a retrospective cohort study of women, aged >= 18 years, who underwent a myomectomy for a uterine leiomyoma within Kaiser Permanente Northern California between 2009 and 2019. Generalized estimating equations and Cochran-Armitage testing were used to assess myomectomy incidence and linear trend in the proportions of myomectomy by surgical route-abdominal myomectomy and minimally invasive myomectomy. Multivariable logistic regression analyses were used to assess the associations between surgical route and (1) race and ethnicity and (2) complications, controlling for patient demographic, clinical, and surgical characteristics.

RESULTS: A total of 4033 adult women underwent a myomectomy during the study period. Myomectomy incidence doubled from 0.12 (95% confidence interval, 0.12-0.13) per 1000 women in 2009 to 0.25 (95% confidence interval, 0.24-0.25) per 1000 women in 2019 (P<.001). During the 11-year study period, the proportion of minimally invasive myomectomy increased from 6.0% to 89.5% (a 15-fold increase). The proportion of minimally invasive myomectomy in Black women remained lower than in non-Black women (54.5% vs 64.7%; P<.001). Black women undergoing myomectomy were younger (36.4 +/- 5.6 vs 37.4 +/- 5.8 years; P<.001), had a higher mean fibroid weight (436.0 +/- 505.0 vs 324.7 +/- 346.1 g; P<.001), and had a higher mean body mass index (30.8 +/- 7.3 vs 26.6 +/- 5.9 kg/m(2); P<.001) than their non-Black counterparts. In addition to patient race, surgery performed between 2016 and 2019 compared with surgery performed between 2009 and 2012 and higher surgeon volume compared with low surgeon volume were associated with an increased proportion of minimally invasive myomectomy (adjusted relative risks, 12.58 [95% confidence interval, 9.96-15.90] and 6.63 [95% confidence interval, 5.35-8.21], respectively). Black race and fibroid weight of >500 g each independently conferred lower rates of minimally invasive myomectomy. In addition, there was an interaction between race and fibroid weight such that Black women with a fibroid weight of <= 500 g or >500 g were both less likely to have minimally invasive myomectomy than non-Black women with a fibroid weight of <= 500 g (adjusted relative risks, 0.74 [95% confidence interval, 0.58-0.95] and 0.26 [95% confidence interval, 0.18-0.36], respectively). Operative, perioperative, and medical complications were low during the 11-year study period. In regression analyses, after controlling for race, age, fibroid weight, parity, low-income residence, body mass index, surgeon volume, and year of myomectomy, the risk of complications was not markedly different comparing abdominal myomectomy with minimally invasive myomectomy. Similar results were found comparing laparoscopic minimally invasive myomectomy with robotic-assisted minimally invasive myomectomy except for women who underwent laparoscopic minimally invasive myomectomy had a lower risk of experiencing any medical complications than those who underwent roboticassisted minimally invasive myomectomy (adjusted relative risk, 0.27; 95% confidence interval, 0.09-0.83; P=.02).

CONCLUSION: Within an integrated healthcare delivery system, although initiatives to encourage minimally invasive surgery were associated with a marked increase in the proportion of minimally invasive myomectomy, Black women continued to be less likely to undergo minimally invasive myomectomy than their non-Black counterparts. Race and fibroid weight alone did not explain the disparities in minimally invasive myomectomy.

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PT J

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Gadomski, T

Leung, TM

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TI Incorporation of a Sentinel Lymph-Node Mapping Algorithm in Patients

with Clinical Stage-I Endometrial Cancer

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE gynecology; surgery; tumor; endometrial cancer; sentinel lymph nodes;

minimally invasive GYN surgery

ID LYMPHADENECTOMY

AB Objective: Sentinel lymph-node biopsy (SLNB) is now as alternative to pelvic and para-aortic lymph-node dissection (PPALND) for managing endometrial cancers. These data have been largely published from high-volume specialized institutions, but complete PPALND is still performed by many surgeons at smaller nonspecialized centers. The aim of this research was to demonstrate that SLNB is feasible, reproducible, and sensitive without affecting cancer-specific outcomes when implemented at nonspecialized centers.Materials and Methods: Cases of patients with clinical stage-I endometrial cancer were retrospectively reviewed from September 2016 through February 2020. Endometrioid, uterine papillary serous (UPSC), malignant mixed-mesodermal tumor (MMMT), and clear-cell (CC) histologies were included. All patients had undergone either robot-assisted or laparoscopic hysterectomies with SLNB. Indocyanine green was injected into the cervix bilaterally. Per the algorithm, patients with suboptimal lymph-node mapping or nodes suspicious for metastasis underwent a side-specific pelvic lymph-node dissection (LND). Para-aortic LND was performed at the discretion of the surgeon. In addition to SLNB, PPALND was performed for patients with MMMT, UPSC, or CC. Sentinel lymph nodes (SLNs) were evaluated using ultrastaging protocols with serial sectioning and cytokeratin staining. The medical records were queried for clinical or radiographic evidence of recurrences.Results: A total of 92 cases were included: 69 stage IA; 12 stage IB; 3 stage II; and 8 stage III (2 IIIA, 2 IIIC1, 4 IIIC2). The majority of cancers were endometrioid (73%), followed by UPSC (15.0%), MMMT (5.0%), and CC (4%). At least 1 SLN was detected in 95.4% of cases. The rate of bilateral SLN detection was 74.3% and improved over time from 2017 to 2019: 70% (2017); 74.4% (2018); and 80% (2019). Twenty patients underwent PPALND. Non-SLNs were positive in 3 patients, all with high-risk histologies. No other patients had false-negative SLNs. No recurrences occurred in this cohort with a median follow-up of 22 months.Conclusions: SLNB is a sensitive and specific method for assessing lymph-node involvement in patients with clinical stage-I endometrial cancers. These results are comparable to the rates reported in the literature and shows that, in nonspecialized centers, this approach is safe and reproducible without affecting cancer-specific outcomes. (J GYNECOL SURG 20XX:000)

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WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

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DA 2024-01-18

ER

PT J

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TI Unilateral pectineal suspension - A new surgical approach for apical

correction of pelvic organ prolapse

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Apical prolapse; lateral fixation; mesh-free; robotic surgery; uterus

preservation

AB Background and objectives: There are numerous vaginal and abdominal surgical approaches for the treatment of pelvic organ prolapse (POP). Even the standard techniques show great variability due to modifications depending on anatomy, available instruments and materials. Recently, the role of hysterectomy in prolapse surgery as well as the use of synthetic meshes have been questioned. Here, we present a standardised mesh-free minimally invasive pelvic floor reconstruction technique with uterus preservation.

Materials and Methods: Unilateral pectineal suspension (UPS) is carried out in five defined steps with the use of the da Vinci Xi (R) surgical system. The desired anatomical result is simulated by intraoperative uterus manipulation. The cranial part of the pectineal ligament is used for lateral fixation. A non-absorbable suture is placed between the pectineal ligament and the anterior cervix to suspend the uterus in its natural anatomical position.

Main outcome measures: For outcome measurement, degree of prolapse was assessed pre- and postoperatively according to the POP-Q system.

Results: Unilateral pectineal suspension offers several advantages. Medial tension-free positioning of the uterus is achieved. The use of the cervix as fixation structure allows for excellent pelvic floor support and stable results. Normal pelvic floor mobility and natural axis of the vagina are restored.

Conclusions: Unilateral pectineal suspension is an efficient minimal-invasive mesh-free procedure which allows uterus preservation and offers reliable level I support respecting the physiological pelvic anatomy. In addition, there is no need for ureteral dissection or bowel manipulation. The technique offers clinical standardization and can easily be integrated into the spectrum of modern surgical POP repair.

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JI Facts Views Vis. ObGyn

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OA Bronze

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ER

PT J

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TI Assessing the Content and Readability of Robotic and Laparoscopic

Sacrocolpopexy Information Online

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; apical prolapse; sacrocolpopexy; robotic surgery;

laparoscopic surgery; internet; online health information; patient

education; readability

ID PELVIC ORGAN PROLAPSE; HEALTH INFORMATION

AB Importance Apical pelvic organ prolapse is a common condition that affects women. Currently, sacrocolpopexy is considered the criterion standard surgical treatment, with an increasing preference for minimally invasive techniques. Objective In this study, the content and readability of select internet pages describing robotic and laparoscopic sacrocolpopexy were evaluated. Study Design Using an online key word planner, the phrases "robotic sacrocolpopexy" and "laparoscopic sacrocolpopexy" were determined to be the most popular search terms. These terms were systematically browsed in incognito mode in 3 of the most popular web search engines: Google, Yahoo, and Bing. Links that were nontext primary, duplicate, irrelevant, and non-English were excluded. The Flesch-Kincaid Grade Level and Flesch-Kincaid Reading Ease indices were used to assess readability. Results The average readability of all sites was 12.9, requiring at least a 12th-grade reading level, which is significantly higher than the recommended American Medical Association/National Institutes of Health (AMA/NIH) level of sixth-grade or below. One hundred percent of all analyzed sites were above this recommended sixth-grade reading level. There was no significant difference between mean grade level or reading ease score from the type of web source (P = 0.32 and 0.34, respectively), approach of surgery (P = 0.91, 0.70), or specialty (P = 0.48, 0.36). Conclusions Almost all websites require at least a high school education to properly comprehend, regardless of source or specialty. It is important that health care providers be aware of available information, so they may direct patients to specific resources that are personally validated or provide in-office materials at an appropriate reading level.

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NR 19

TC 0

Z9 0

U1 0

U2 0

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SN 2151-8378

EI 2154-4212

J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

PD JUN

PY 2022

VL 28

IS 6

BP E201

EP E204

DI 10.1097/SPV.0000000000001184

PG 4

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 2E6PI

UT WOS:000812348600007

PM 35421013

DA 2024-01-18

ER

PT J

AU Benoit, L

Delangle, R

Van, NT

Villefranque, V

Koskas, M

Belghiti, J

Uzan, C

Canlorbe, G

AF Benoit, L.

Delangle, R.

Van, N. T.

Villefranque, V.

Koskas, M.

Belghiti, J.

Uzan, C.

Canlorbe, G.

TI Feasibility and security of laparoscopic (± robotic) total hysterectomy

in outpatient surgery: A French multicenter retrospective study

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Article

DE Ambulatory; Hysterectomy; Laparoscopy; Robotic surgery

ID SAME-DAY DISCHARGE; INVASIVE HYSTERECTOMY; RADICAL HYSTERECTOMY;

GYNECOLOGIC ONCOLOGY; ENDOMETRIAL; SAFETY; SATISFACTION; READMISSION

AB Objective. - To assess the feasibility and safety of total hysterectomy by laparoscopic approach (+/- robot assisted) in ambulatory.

Materials and methods. - French three-center retrospective study including 165 patients who had laparoscopic (+/- robot assisted) total hysterectomy scheduled as outpatients from January 2016 to December 2020. Clinical and perioperative data were collected. Factors associated with outpatient failure and rehospitalization were evaluated.

Results. - The outpatient success rate was 92.7%. Factors associated with outpatient failure were incision time > 13:00, large volume of blood loss, intraoperative complications with Oslo score >= 2, uterine weight >= 250 g, indication for benign pathology, and robot-assisted approach. Among patients managed as outpatients, 7.2% were rehospitalized at a mean of 10 days from surgery. The factors associated with rehospitalization were the use of an effective antiaggregant or anticoagulant treatment and the use of intraoperative adhesiolysis. Four patients (2.6%) underwent revision surgery.

Conclusion. - Minimally invasive hysterectomy can be performed as an outpatient procedure even in cases of malignant pathology. Age and body mass index are not associated with an increased risk of failure or rehospitalization within one month. (C) C 2022 Elsevier Masson SAS. All rights reserved.

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NR 42

TC 1

Z9 1

U1 0

U2 1

PU ELSEVIER FRANCE-EDITIONS SCIENTIFIQUES MEDICALES ELSEVIER

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SN 2468-7197

EI 2468-7189

J9 GYNECOL OBST FERT SE

JI Gynecol. Obstet. Fertil. Senol.

PD MAY

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PG 8

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 1X6FM

UT WOS:000807548100002

PM 34979303

DA 2024-01-18

ER

PT J

AU Mitsuhashi, A

Ishikawa, H

Habu, Y

Usui, H

AF Mitsuhashi, Akira

Ishikawa, Hiroshi

Habu, Yuji

Usui, Hirokazu

TI The effect of steep head-down tilt on respiratory status in endometrial

cancer patients with obesity during robot-assisted hysterectomy

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

DE Endometrial cancer; Robot-assisted hysterectomy; Head-down tilt; Obesity

ID VOLUME-CONTROLLED VENTILATION; TRENDELENBURG POSITION; PRESSURE;

PNEUMOPERITONEUM; METAANALYSIS; SURGERY

AB Objective: To evaluate the effect of head-down tilt on airway pressure in gynecologic patients with obesity during robot-assisted hysterectomy.

Methods: We retrospectively reviewed the records of 27 patients with body mass index (BMI) >= 25 kg/m(2) who underwent robot-assisted hysterectomy for endometrial cancer and endometrial atypical hyperplasia using the da Vinci Xi system. Mechanical ventilation was performed using pressure-controlled ventilation (PCV). Surgery was performed at 20 degrees (group A, n = 17) or 25 degrees head-down tilt (group B, n = 10). Respiratory parameters, including positive end-expiratory pressure (PEEP), tidal volume (TV), mean airway pressure (P mean), and peak airway pressure (P peak), were measured before (T1) and after the head-down tilt at 1 h (T2) and 2 h (T3) during anesthesia.

Results: The median BMI was 37.5 (range 28-51) kg/m(2), with no between-group variation. Oxygenation was maintained intraoperatively for all patients. The expiratory carbon dioxide partial pressure was 43.6 (95% confidence interval (CI) 42.2-45.0) mmHg. The P mean peak at T2 in group B was significantly higher than in group A (P < 0.011); however, other parameters at T2 and T3 did not differ significantly between the groups. Patients with BMI >= 40 kg/m(2) had significantly higher respiratory parameters than those with BMI < 40 kg/m(2). In patients with BMI >= 40 kg/m(2), the mean P means and P peaks at T3 were 17.3 cmH(2)O (95% CI 16.3-18.3) and 29.4 cmH(2)O (95% CI 27.1-31.7), respectively.

Discussion: With careful anesthetic management during PCV, robot-assisted surgery with a head-down tilt of 25 degrees or below may be safe, even in patients with class III obesity.

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NR 16

TC 4

Z9 4

U1 1

U2 1

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J9 GYNECOL ONCOL REP

JI Gynecol. Oncol. Rep.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Maldonado, DV

Yi, JHY

Madsen, AM

AF Vargas Maldonado, Darlene

Yi, Johnny

Madsen, Annetta M.

TI Laparoscopic Approach to Surgical Treatment of Pelvic Organ Prolapse

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE laparoscopic surgery; pelvic organ prolapse; sacrocolpopexy;

laparoscopic uterosacral ligament suspension

ID UTEROSACRAL LIGAMENT SUSPENSION; VAGINAL VAULT PROLAPSE; PERIOPERATIVE

COMPLICATIONS; ABDOMINAL SACROCOLPOPEXY; TERM OUTCOMES; COLPOPEXY;

FIXATION

AB Correction of apical descent is an essential component of a durable prolapse surgery and can be achieved by multiple different techniques and surgical approaches. Laparoscopic prolapse surgery produces excellent outcomes and lower costs, compared to robotic surgery, without compromising success and remains a valuable surgical approach to prolapse repair. This review summarizes the evidence for conventional laparoscopic apical prolapse repair, compared to alternative surgical approaches, and provides recommended techniques with tips and tricks to optimize this approach.

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NR 26

TC 0

Z9 0

U1 0

U2 4

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

PD FEB 1

PY 2023

VL 39

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BP 19

EP 24

DI 10.1089/gyn.2022.0037

EA MAY 2022

PG 6

WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

GA 8W5BE

UT WOS:000806144400001

DA 2024-01-18

ER

PT J

AU Truong, MD

Tholemeier, LN

AF Truong, Mireille D.

Tholemeier, Lauren N.

TI Role of Robotic Surgery in Benign Gynecology

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Robotic surgery; Benign gynecology; Minimally invasive surgery; Surgical

simulation; Surgical innovation

ID ASSISTED LAPAROSCOPIC TREATMENT; ABDOMINAL MYOMECTOMY; HYSTERECTOMY;

ENDOMETRIOSIS; BLADDER; METAANALYSIS; ERGONOMICS; PREGNANCY; RESECTION;

WOMEN

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NR 76

TC 3

Z9 4

U1 1

U2 4

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J9 OBSTET GYN CLIN N AM

JI Obstet. Gynecol. Clin. N. Am.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 1X6NH

UT WOS:000807568600006

PM 35636808

DA 2024-01-18

ER

PT J

AU St Laurent, JD

Silberman, JN

Worley, MJ

AF St Laurent, Jessica D.

Silberman, Jason N.

Worley, Michael J., Jr.

TI Robotic resection of isolated ovarian cancer recurrence in the lesser

sac

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

DE Recurrent ovarian cancer; Recurrence; Secondary cytoreduction;

Laparoscopy; Porta hepatis

ID CYTOREDUCTION

AB In recurrent ovarian cancer patients the addition of surgical cytoreduction is associated with prolonged overall survival compared to chemotherapy treatment alone when complete cytoreduction is achieved (Harter et al., 2021; Shi et al., 2021; Coleman et al., 2019). In the appropriate surgical candidates, a minimally invasive approach may be used to achieve complete cytoreduction of isolated lesions with proper exposure and surgical planning. This video demonstrates safe robotic entry into the lesser sac and resection of recurrent high-grade serous ovarian carcinoma near the pancreatic neck. The patient is a 78-year-old BRCA negative female with a history of a stage IIIC high-grade serous carcinoma. She previously underwent cytoreductive surgery and adjuvant chemotherapy in 2018 and presented 24 months later with a normal CA 125 and CT findings of an isolated lesion near the porta hepatis. An MRI was obtained preoperatively to further characterize the location of the lesion demonstrating a 2.2 x 1.6 cm hypoechoic mass adjacent to the pancreatic neck. Given the patient's prolonged disease-free interval, fitness for surgery and single site of disease, she met strict inclusion criteria for recent studies demonstrating clinical benefit with secondary cytoreduction (Harter et al., 2021; Shi et al., 2021). She was taken for a robotic secondary cytoreduction. At subsequent follow up 7 months later, our patient was still disease free and continues surveillance. In this video, we demonstrate the careful dissection of this isolated lesion from the omental bursa. We review important pre-procedural and anatomic considerations for robotic surgery in the lesser sac.

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NR 3

TC 0

Z9 0

U1 0

U2 0

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JI Gynecol. Oncol. Rep.

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PG 2

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 2E5FX

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PM 35638095

OA Green Published, gold

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ER

PT J

AU Marquini, GV

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Martins, SB

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Sartori, MGF

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de Oliveira, Leticia Maria

Martins, Sergio Brasileiro

Takano, Claudia Cristina

Katalin de Jarmy Di-Bella, Zsuzsanna Ilona

Ferreira Sartori, Marair Gracio

TI Historical perspective of vaginal hysterectomy: the resilience of art

and evidence-based medicine in the age of technology

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Hysterectomy; Laparoscopic hysterectomy; Robotic hysterectomy; Vaginal

hysterectomy

ID ROUTE

AB Objective The aim of this study was to describe, from a historical perspective, the relevance, resilience and outcomes of vaginal hysterectomy (VH) in gynecology in the age of technological scenario. Methods The authors searched records from January 2011 to January 2021 on the following databases: Medline, EMBASE, and CENTRAL (The Cochrane Library) for combinations of the terms "vaginal hysterectomy," "outcomes" AND "history"; and before that period, if the search had historical relevance. Inclusion criteria: randomized clinical trials; hysterectomy performed for benign gynecological conditions; and VH outcomes compared with Abdominal Hysterectomy (AH), Laparoscopic Hysterectomy (LH) or Robotic Hysterectomy (RH). Results The VH combines sequences of reproducible techniques which have been developed over the years to safely and effectively overcome the limitations of difficult cases of vaginal extirpation from the uterus. Conclusion The authors support endoscopic surgical approaches in complex surgery for benign indications, urogynecology, and gynecologic oncology when appropriate. However, what makes the gynecological surgeon different from the general surgeon is the vaginal access. It is essential to continue to train residents in vaginal surgical skills and provide safe and cost-effective patient care. The art of technology is the resilience of keeping only the patient at the center of innovation.

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NR 23

TC 0

Z9 0

U1 0

U2 0

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EI 1432-0711

J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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IS 5

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA G5KF9

UT WOS:000797746400001

PM 35589991

DA 2024-01-18

ER

PT J

AU Karkia, R

Tailor, A

Ellis, P

Madhuri, T

Scala, A

Read, J

Perry, M

Patil, K

Blackburn, A

Butler-Manuel, S

Chatterjee, J

AF Karkia, Rebecca

Tailor, Anil

Ellis, Patricia

Madhuri, Thumuluru

Scala, Andrea

Read, James

Perry, Matthew

Patil, Krishna

Blackburn, Adam

Butler-Manuel, Simon

Chatterjee, Jayanta

TI Minimally invasive pelvic exenteration for gynaecological malignancy: A

single-centre case series and review of the literature

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Pelvic exenteration; Robotic surgery; Recurrent gynaecological

malignancy; Minimal access surgery

ID EXPERIENCE; SURGERY

AB For those with certain recurrent gynaecological cancers where primary management such as chemo-radiotherapy has failed, or in cases of recurrence following primary surgery, pelvic exenteration (PE) is considered the only curative option. Whilst initially considered a morbid procedure, improved surgical techniques, advancing technology, and nuanced reconstructive options have facilitated more radical resections and improved morbidity and mortality. Open PE remains the gold standard approach, however, minimally invasive techniques for PE may lessen morbidity whilst achieving the same oncological outcomes. The objective of this study was to assess the feasibility and safety of minimally invasive PE with a laparoscopic or robot-assisted approach. We also performed a review of the literature on robot-assisted PE which has not been widely reported for cases of recurrent gynaecological malignancy.

Between 2015 and 2021 six minimally invasive PE were performed. All patients underwent extensive multi-disciplinary assessment and counselling pre-operatively. Patient characteristics, treatment indication, perioperative data, short-term complications, and histological outcomes were recorded. There were two anterior exenterations, three posterior exenterations and one total exenteration performed. The primary cancer stage varied from stage 1a-3b. Five out of six patients had pre-operative chemo-radiotherapy. The average operative time (including surgical docking) was 600 min. Mean blood loss was 400 mL and the average length of stay was eight days. Enhanced recovery practices were used where possible. There were no intraoperative complications and one major post-operative complication which was breakdown of an inferior gluteal artery perforator flap perineal reconstruction. All patients had negative margins at post-operative histopathology. All patients are alive and recurrence free at follow-up, but long-term outcome data is needed.

This initial case series suggest that minimally invasive pelvic exenteration can feasibly be performed in place of open pelvic exenteration. Furthermore, our findings suggest this may be a safe alternative as we report similar findings to the existing literature, however no firm conclusions can be drawn at such an early stage. Long term follow-up data and a larger cohort study will be needed to establish non-inferiority to open PE.

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NR 30

TC 2

Z9 2

U1 0

U2 2

PU ELSEVIER

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EI 1872-7654

J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

PD JUL

PY 2022

VL 274

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DI 10.1016/j.ejogrb.2022.05.003

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WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA 5C2UX

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ER

PT J

AU Argenta, PA

Mattson, J

Rivard, CL

Luther, E

Schefter, A

Vogel, RI

AF Argenta, Peter A.

Mattson, Jordan

Rivard, Colleen L.

Luther, Elizabeth

Schefter, Alexandra

Vogel, Rachel, I

TI Robot-assisted versus laparoscopic minimally invasive surgery for the

treatment of stage I endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Uterine cancer; Laparoscopy; Robotic; Minimally

invasive

ID HYSTERECTOMY; SURVIVAL; WOMEN; RECURRENCE; LAPAROTOMY

AB Objective. Recent reports in both cervical and endometrial cancer suggest that minimally invasive surgery (MIS) had an unanticipated negative impact on long-term clinical outcomes, including recurrence and death. Given increasing use of robotic surgery since the LAP2 trial, we sought to compare the intermediate and long-term outcomes between those who underwent robotic surgery or laparoscopy for Stage I endometrial cancer.

Methods. We performed a retrospective review of patients from a single, large, academic, urban practice who underwent either laparoscopic or robot-assisted MIS (RA-MIS) for the treatment of endometrial carcinoma between 2006 and 2016, ensuring at least 5 years of potential follow-up. To adjust for differences in confounding variables between groups, propensity score-based inverse probability of treatment weighting (IPTW) was performed. Overall and recurrence-free survival were compared using Cox proportional hazards regression models adjusting for confounding weights.

Results. 1027 patients were included; 461 received laparoscopy and 566 received RA-MIS. RA-MIS use increased steadily during the study window, which resulted in longermean surveillance in laparoscopy group (median 8.7 years versus 6.3 years, p < 0.001). RA-MIS was associated poorer recurrence-free (HR: 1.41, 95% CI: 1.12, 1.77) and overall survival (HR: 1.39, 95% CI: 1.06, 1.83). Disease-specific survival was also poorer in the RA-MIS group (HR: 3.51, 95% CI: 2.19, 5.63). Among those who recurred, median time to first recurrence was shorter in the RA-MIS group than the laparoscopy group (16.3 vs. 28.7 months, p = 0.07).

Conclusion. RA-MIS was associatedwith poorer long-term patient outcomes. Our data in this lower-risk population indicate relevant clinical endpoints may be occurring during intermediate and long-term follow-up windows. These findings support a prospective evaluation of the long-term outcomes of RA-MIS. (c) 2022 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http:// creativecommons.org/licenses/by-nc-nd/4.0/).

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NR 20

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U2 1

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Andiman, SE

Bui, AH

Ascher-Walsh, C

Wright, JD

Xu, X

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Bui, Anthony H.

Ascher-Walsh, Charles

Wright, Jason D.

Xu, Xiao

TI Surgical Complications and Hospital Costs in Robot-Assisted Versus

Conventional Laparoscopic Hysterectomy With Concurrent Sacrocolpopexy:

Analysis of the Nationwide Readmissions Database

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE Nationwide Readmissions Database; hospital costs; laparoscopy; pelvic

organ prolapse; perioperative complications; robotic surgery;

uterovaginal prolapse

ID OUTCOMES; RISK; SURGERY; TRENDS

AB Objectives Despite increasing use of robotic technology for minimally invasive hysterectomy with sacrocolpopexy, evidence supporting the benefits of these costly procedures remains inconclusive. This study aimed to compare differences in perioperative complications, 30-day readmissions, and costs between robot-assisted and conventional laparoscopic hysterectomy with concurrent sacrocolpopexy using a large national database. Methods Using the 2009-2015 Nationwide Readmissions Database and procedure codes, we identified patients who underwent a robot-assisted or conventional laparoscopic hysterectomy with sacrocolpopexy. We measured in-hospital perioperative complications using diagnosis and procedure codes and measured 30-day readmissions based on patient linkages across hospitalizations. Hospital costs were estimated using charges and cost-to-charge ratios. These outcomes were compared between robot-assisted and conventional laparoscopic procedures using bivariate and multivariable regression analysis. Results Our weighted sample included a total of 7,675 patients. Major perioperative complications occurred in 6.7% of robot-assisted and 11.2% of conventional laparoscopic procedures (unadjusted P < 0.001; adjusted odds ratio, 0.69; 95% confidence interval, 0.51-0.93; P = 0.02). Hospital costs were higher in robot-assisted than in conventional laparoscopic procedures (respective median costs, $16,367 vs $13,898; P < 0.001), with an adjusted cost ratio of 1.24 (95% confidence interval, 1.17-1.31; P < 0.001). The risk of 30-day readmission was similar between robot-assisted and conventional laparoscopic procedures. Conclusions Nationally representative data suggest that, in laparoscopic hysterectomy with sacrocolpopexy, the robot-assisted approach is associated with a lower risk of perioperative complications, despite higher costs, compared with the conventional one. The risk of 30-day readmission was similar between the robot-assisted and conventional laparoscopic approaches.

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NR 28

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Z9 3

U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

AU Culligan, PJ

Saiz, CM

Rosenblatt, PL

AF Culligan, Patrick J.

Saiz, Cristina M.

Rosenblatt, Peter L.

TI Contemporary Use and Techniques of Laparoscopic Sacrocolpopexy With or

Without Robotic Assistance for Pelvic Organ Prolapse

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID FLOOR DISORDERS; OUTCOMES; WOMEN; INCONTINENCE; HYSTERECTOMY;

PREVALENCE; SYMPTOMS; FIXATION; REPAIR; SUTURE

AB The past 4 years have been consequential in the world of surgery to correct pelvic organ prolapse. In 2018, results of a large, multicenter randomized trial demonstrated very disappointing cure rates of traditional native tissue repairs at 5 years or more. In 2019, a vaginal mesh hysteropexy kit was removed from the market by the U.S. Food and Drug Administration only to subsequently demonstrate it provided better cure rates and similar risk profile to vaginal hysterectomy plus native tissue repair in its own 5-year study published in 2021. Meanwhile, the use and techniques of laparoscopic sacrocolpopexy with or without robotic assistance have evolved such that it is commonly adapted to treat all support defects for patients with uterovaginal or posthysterectomy prolapse. This article is intended to provide an overview of the contemporary use and techniques of laparoscopic sacrocolpopexy based on the evidence and our clinical experience.

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NR 41

TC 2

Z9 2

U1 1

U2 1

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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PT J

AU Kim, JH

Lee, EJ

AF Kim, Ji-Hye

Lee, Eun-Ju

TI Single-Site Robotic Myomectomy without Accessory Instrument Compared

with Two-Port Laparoscopic Myomectomy: A Propensity Score Matching

Analysis

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Single-site robotic surgery; Uterine myomectomy; Perioperative outcome

ID INITIAL REPORT

AB Objectives: Despite the advantages of robotic technology, single-site robotic myomectomy (SSRM) without an accessory instrument is limited by a restricted range of motion, weaker suturing of a thick myometrium, and non-articulating instruments. We present our novel gradual turning out method (GTOM) of SSRM and our assessment of its feasibility and safety by comparing its perioperative outcomes with those of two-port laparoscopic myomectomy (LM). Design: A retrospective cohort case-control study was carried out. Methods: This study included consecutive 46 patients who underwent SSRM for intramural myomas larger than 7 cm, from 2016 to 2019. Subsequently, 46 patients who underwent LM were selected by 1:1 propensity score matching by controlling for age, body mass index, myoma number, myoma diameter, and the presence of sexual intercourse. The perioperative outcomes of the two groups were compared using a Mann-Whitney U test and Fisher's exact test. The effect of covariates on operation time was analyzed using univariable and multivariable linear regression. Results: SSRM was performed successfully with GTOM for myomas of up to 14 cm in the longest diameter, without conversion to laparotomy and intraoperative injuries. No differences between the groups were found in length of hospital stay, estimated blood loss, hemoglobin level decrease, transfusion rate, and postoperative pain, but operative time was significantly longer in the SSRM group than in the LM group (p < 0.001). Larger myomas, location of the lower segment, and the operation method of SSRM were significantly associated with a longer operation time. Whereas operation time for myomas located at the anterior wall, singleton myomas, and myomas <10 cm was significantly longer in the SSRM group than in the LM group, that for myomas at the posterior or lateral side of the uterus, multiple myomas, and myomas >= 10 cm did not differ significantly between the groups, indicating the advantage of SSRM for difficult myomectomy. Limitations: Retrospective nature of the study and limitation to a single-center study are the limitations of the study. Conclusions: Despite the lack of an accessory instrument, SSRM using the GOTM was feasible and safe as it yielded similar perioperative outcomes to those of LM.

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FU Basic Science Research Program through the National Research Foundation

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NR 14

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Z9 1

U1 1

U2 2

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J9 GYNECOL OBSTET INVES

JI Gynecol.Obstet.Invest.

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ER

PT J

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Guvenc, G

Dede, M

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Yenen, Mufit Cemal

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TI Comparison of health-related quality of life of women undergoing robotic

surgery, laparoscopic surgery or laparotomy for gynecologic conditions:

A cross-sectional study

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE clinical characteristics; postoperative nursing care; quality of life;

robotic gynecologic surgery

ID ABDOMINAL HYSTERECTOMY; RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER;

EXPERIENCE; OUTCOMES; DISEASE

AB Objective To assess and compare the health-related quality of life of women undergoing robotic gynecologic surgery, laparoscopic gynecologic surgery or laparotomy for benign and cancerous conditions. Methods Cross-sectional study design was used. The present study was carried out with 240 women, who underwent gynecologic surgery (robotic 48, laparoscopic 96, and laparotomy 96) in a tertiary care hospital. Instruments included a participant description questionnaire and Medical Outcomes Study Short Form-36. The data were collected 4 weeks after surgery, at the first postoperative visit of women to the clinic. Pearson chi(2) test, one-way analysis of variance, and regression analysis were used to assess the data. Results Over half of the women in each group had surgery because of gynecologic cancer. All the subscale scores of Medical Outcomes Study Short Form-36 were significantly higher in the robotic group than the other surgical groups (P < 0.05). Women in the robotic group had better quality of life in terms of both the physical component and the mental component after surgery. Conclusions Knowledge of health-related quality of life in the recovery period after surgery is important for healthcare providers to provide adequate preventive measures, information, and follow up.

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NR 24

TC 1

Z9 1

U1 1

U2 5

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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ER

PT J

AU Guo, XM

Tian, S

Wang, H

Zhang, JN

Cheng, YF

Yao, YQ

AF Guo, Xinmeng

Tian, Shuang

Wang, Hui

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Cheng, Yanfei

Yao, Yuanqing

TI Outcomes associated with different surgical approaches to radical

hysterectomy: A systematic review and network meta-analysis

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Review

DE radical hysterectomy; surgical approaches; systematic review; vaginal

surgery

ID STAGE CERVICAL-CANCER; VAGINAL HYSTERECTOMY; ABDOMINAL HYSTERECTOMY;

SURVIVAL; MANAGEMENT; MULTICENTER; EXPERIENCE; WOMEN

AB Objective To evaluate the efficacy and safety of five different approaches to cervical cancer surgery. Methods We conducted a systematic search for comparative studies on different radical hysterectomy types for cervical cancer in PubMed, Embase, the Cochrane Library, and Web of Science databases. All included observational studies used survival analyses to compare clinical outcomes of patients undergoing different radical hysterectomy types. All studies were assessed by the Newcastle-Ottawa Scale with scores of at least seven points. We extracted the relevant data and conducted a network meta-analysis to compare clinical outcomes among five surgical approaches. Results Thirty studies (n = 11 353) were included. Robotic surgery had the lowest blood loss volume and hospitalization duration; open surgery had the shortest operative time. Vaginal assisted laparoscopic surgery was associated with the highest number of resected lymph nodes and lowest rate of perioperative complications. Survival outcomes and tumor recurrence outcomes were similar among the approaches. Conclusion The current approaches to cervical cancer surgery have comparable efficacies.

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NR 59

TC 3

Z9 3

U1 2

U2 9

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JI Int. J. Gynecol. Obstet.

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SC Obstetrics & Gynecology

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ER

PT J

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Soares, Thiers

Pereira, Thiago Dantas

de Souza, Ricardo Jose

TI Surgical Treatment of Adenomyosis

SO CURRENT OBSTETRICS AND GYNECOLOGY REPORTS

LA English

DT Article

DE Adenomyosis; Fertility; Minimally invasive surgery; Robotic surgery;

Conservative surgery; Laparoscopy

ID SPONTANEOUS UTERINE RUPTURE; LAPAROSCOPIC ADENOMYOMECTOMY; CONSERVATIVE

SURGERY; DIFFUSE ADENOMYOSIS; PREGNANCY; RECURRENCE; LAPAROTOMY; UTERUS

AB Purpose of review This paper aims to discuss the state of the art of the conservative surgical treatment of adenomyosis. Recent findings Medical treatment for adenomyosis is usually the first step, but some patients do not respond. Hysterectomy using minimally invasive techniques is the gold-standard treatment for those patients that do not desire pregnancies. Although there is no definitive evidence to support conservative surgical treatment for adenomyosis, many authors described good results in women who wish to preserve fertility. Although hysterectomy is the main form of treatment, conservative options should be offered to women who wish to maintain their fertility. Several excisional and non-excisional techniques can be indicated for selected patients with promising results, always keeping in mind the risks of uterine rupture and recurrence with these techniques.

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NR 29

TC 1

Z9 1

U1 0

U2 2

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J9 CURR OBSTET GYNECOL

JI CURR. OBSTET. GYNECOL. REP.

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WC Obstetrics & Gynecology

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ER

PT J

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Moawad, G

Catherine, U

Geoffroy, C

AF Thomas, Dabreteau

Romain, Delangle

Henri, Azais

Phe, Veronique

Moawad, Gaby

Catherine, Uzan

Geoffroy, Canlorbe

TI Robot-assisted sacrocolpopexy for recurrent pelvic organ prolapse:

Insights for a challenging surgical setting

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Sacrocolpopexy; Pelvic organ prolapse; Robot-assisted laparoscopy;

Recurrence; Minimally invasive surgery; POP

ID METAANALYSIS; REOPERATION; SURGERY; RISK

AB Background: No consensus exists regarding the management of recurrent pelvic organ prolapse (POP). The aim of this study was to evaluate robot-assisted laparoscopic sacrocolpopexy for recurrent pelvic organ prolapse (POP), and to investigate postoperative outcomes.Methods: We conducted a single-center retrospective study including 10 consecutive patients who underwent a robot-assisted sacrocolpopexy for symptomatic POP recurrence from February 2017 to December 2019. Recurrence rates and patient satisfaction, measured by the Pelvic Floor Impact Questionnaire (PFIQ-7) were recorded.Results: Median age was 57 years (IQR: 54-67). No intraoperative complications were reported. The median hospital stay after surgery was 2 nights (IQR: 1-4). Two patients (20%) experienced early recurrence: at 1 month for one and at 4.5 months for the other. The median follow-up for the remaining eight patients was 18 months (IQR: 12-23). Among the recurrence-free patients, the median PFIQ-7 score was 11.4 at 12 months.Conclusions: Robot-assisted sacrocolpopexy is feasible and safe for the management of POP recurrence, with a high patient satisfaction.(c) 2022 Elsevier Masson SAS. All rights reserved.

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TC 2

Z9 2

U1 0

U2 1

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

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ER

PT J

AU Maldonado, DV

Linder, BJ

Occhino, JA

AF Maldonado, Darlene Vargas

Linder, Brian J.

Occhino, John A.

TI A "cooler" simulation model for robotic cuff closure and sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Simulation model; Educational; Vaginal cuff closure; Mesh attachment;

Robotic surgery

ID HYSTERECTOMY; DEHISCENCE

AB Introduction and hypothesis The objective of this video was to demonstrate the build and use of a single robotic simulation model for a double-layer vaginal cuff closure and sacrocolpopexy vaginal mesh attachment. Simulation models are frequently used to improve surgical skills and augment operating room experience for surgical trainees. Methods To create our robotic simulation model, we utilized the Advincula arch manipulator handle with a sacrocolpopexy tip attached to the ALLY Uterine Positioning System. To simulate the vagina, we used a pink, slim can cooler/coozie attached to the sacrocolpopexy tip. The edges of the coozie represented the vaginal cuff following a hysterectomy. Mesh attachment was demonstrated using a precut Y-shaped polypropylene mesh. Conclusions Simulation has become a critical part of education in surgical training programs as it enhances learner knowledge and improves surgical confidence and preparedness in the operative setting.

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NR 6

TC 1

Z9 1

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U2 0

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J9 INT UROGYNECOL J

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PG 4

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA 4O6FT

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DA 2024-01-18

ER

PT J

AU Berges, AJ

Vedula, SS

Malpani, A

Chen, CCG

AF Berges, Alexandra J.

Vedula, S. Swaroop

Malpani, Anand

Chen, Chi Chiung Grace

TI Virtual Reality Simulation Has Weak Correlation with Overall Trainee

Robot-Assisted Laparoscopic Hysterectomy Performance

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Assessment; Robotic surgery; Simulation training; Technical skill;

Virtual reality

ID DA VINCI SKILLS; CONSTRUCT-VALIDATION; SURGERY; SCORE

AB Study Objective: Both simulator practice and intraoperative performance serve to inform surgical trainee training, but the skill transfer from simulation to the intraoperative setting remains unclear. This study evaluates the correlation between trainee performance on virtual reality simulation and (1) overall intraoperative performance during robotic-assisted laparoscopic hysterectomy (RALH) procedures and (2) suturing performance during vaginal cuff closure portion of the case. Design: Retrospective subgroup analysis of randomized controlled trial. Setting: Academic hospital. Patients: Patients with RALH (N = 29). Interventions: Gynecological trainees (N = 21) performed simulation tasks using the da Vinci skills simulator on the day of surgery before performing RALH. Attending surgeons assessed participants' intraoperative performance using Global Evaluative Assessment of Robotic Skills (GEARS). Performance of the vaginal cuff closure step was subsequently assessed using GEARS scoring of anonymized videos. Spearman's correlation was used to quantify the relationship between simulation and intraoperative performances. Measurements and Main Results: Trainees achieved a median intraoperative GEARS score of 18.5/30 (interquartile range: 17-22) and a median total simulator score of 84.4/100 (interquartile range: 78.1-87.5). More advanced residents exhibited worse overall simulator performance (median score 86.6/100 compared with 78.8/100, p = .03) and similar intraoperative GEARS scores during overall RALH and vaginal cuff closure compared with less experienced trainees. Total simulation performance score was negatively correlated with GEARS Bimanual Dexterity (rho =-0.46, p = .02) and Force Sensitivity subscores (rho=-0.39, p = .05). There was no correlation between total GEARS intraoperative vaginal cuff closure scores and overall simulation performances; however, total Tubes simulation score was correlated with higher GEARS Force Sensitivity subscore (rho= 0.73, p = .05). Conclusions: In this study, there was limited correlation between simulation score metrics and trainees' overall intraoperative performance. Furthermore, we identified that GEARS scores could not distinguish between similar trainee skill levels. These findings underscore the need to develop intraoperative assessment tools that can better discriminate different but similar skill levels. (c) 2021 AAGL. All rights reserved.

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U1 0

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ER

PT J

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Sammour, Bashar

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TI Is robot-assisted laparoscopic myomectomy superior to laparoscopic

myomectomy?

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Minimally invasive surgery; Laparoscopic myomectomy; Robot-assisted

myomectomy; Intra-operative; Post-operative; Outcomes

ID ABDOMINAL MYOMECTOMY

AB Background: To determine whether RLM (Robot-assisted Laparoscopic Myomectomy) or LM (Laparoscopic Myomectomy) provides better surgical and post-operative outcomes for patients willing to have minimally invasive myomectomy. Methods: In this retrospective cohort (Class II-2) analysis, all patients who underwent RLM and LM by a single expertise surgical team from January 1st, 2018 to March 31st, 2020 were identified. The patients' characteristics, operative data, and post-operative outcomes were collected and statistically analyzed. Results: A total of 118 patients with an indication of myomectomy were included, 39 of whom underwent RLM, while 79 underwent LM. There were no significant differences among the groups in demographic characteristics (p > 0.05). RLM was associated with lower estimated blood loss (55.00 +/- 39.11 mL vs. 110.80 +/- 74.72 mL, respectively, p < 0.001) and larger myoma size (6.92 +/- 1.88 cm vs. 6.00 +/- 2.07 cm, p< 0.001) compared with LM. No significant differences were noted between the groups for other parameters (p> 0.05). Conclusions: Although RLM was associated with significantly less blood loss, this difference did not entail clinical implications. In general, both methods demonstrated similar clinical outcomes. For cost effectiveness, LM appears to outperform RLM, particularly in experienced hands.

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PG 8

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ER

PT J

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TI Neoadjuvant chemotherapy with quick cisplatin-VP 16 followed by robotic

radical trachelectomy in FIGO 2018 stage 1B2 cervical cancer

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Cervical cancer IB2; Fertility sparing treatment; Neoadjuvant

chemotherapy with quick cisplatin-VP 16; Robotic radical trachelectomy

ID SURGERY

AB Background: The typical treatment of the International Federation of Gynecology and Obstetrics 2018 stage IB2 cervical cancer is radical hysterectomy. With the trend of delayed childbearing, the importance of fertility sparing in the treatment of women with cervical cancer has drawn attention. Case: We report a case of stage IB2 cervical cancer treated by neoadjuvant chemotherapy with quick cisplatin-VP 16 followed by robotic radical trachelectomy. Conclusions: Neoadjuvant chemotherapy (NACT) using platinum-based therapy with cisplatin and trachelectomy performed through the vagina or abdominal approach was used in most previous cases. We successfully performed NACT with quick cisplatin-VP 16, followed by robotic radical trachelectomy in stage 1B2 cervical cancer. Further studies are needed to accumulate cases and outcomes of fertility-preserving treatment techniques.

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U1 0

U2 1

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JI Clin. Exp. Obstet. Gynecol.

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PT J

AU Nordskar, NJ

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TI "Long-term outcome in endometrial cancer patients after robot-assisted

laparoscopic surgery with sentinel lymph node mapping"

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrial cancer; Sentinel lymph node mapping; Lymph node metastases;

Survival

ID GOG 244-THE LYMPHEDEMA; SELECTIVE LYMPHADENECTOMY; PELVIC

LYMPHADENECTOMY; RISK-FACTORS; CARCINOMA; MULTICENTER; ALGORITHM;

SURVIVAL; IMPACT; METASTASIS

AB Objective: Sentinel Lymph Node (SLN) mapping is increasingly used as an alternative to lymphadenectomy in endometrial cancer. There is, however, limited data regarding the clinical outcome and survival after SLN mapping. The aim of the study was to determine long-term outcome data in endometrial cancer patients undergoing robot-assisted laparoscopic surgery and SLN mapping. Study design: Retrospective cohort study of 108 patients with primary endometrial cancer who underwent robot-assisted laparoscopic surgery and sentinel lymph node mapping using the Memorial Sloan Kettering Cancer Center (MSKCC) algorithm with near-infrared fluorescence detection of indocyanine green for endometrial cancer, from November 20th 2012 to January 1st 2016 at St. Olav's Hospital in Norway. The primary endpoint was recurrence-free survival. Secondary endpoints were overall survival and treatment complications. Results: Among 108 patients operated in accordance with the SLN algorithm, 17 (16%) had lymph node metastases. Adjuvant chemotherapy was administered on indication endometrial cancer to 36 (33%) of the patients. After a median follow up of 75 months (range 61-98), five (4.6%) patients had recurrence, and three patients had died from the disease. Four of the patients who had recurrence had lymph node metastasis at diagnosis. The 5year recurrence-free survival was 95.4% (95% CI, 91.5 - 99.3). The 5-year disease-specific survival was 97.2% (95% CI, 94.1 - 100.3). The 5-year overall survival was 92.6% (95% CI, 87.7 - 97.5). Peripheral neuropathy after chemotherapy was the most common complication (9.3%), followed by lower limb lymphedema (2%) and postoperative hernia (2%). Conclusion: The present study demonstrated excellent oncologic outcome and low long-term treatment complication rate in patients treated according to the SLN algorithm more than five years after diagnosis.

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U2 1

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PT J

AU Ota, Y

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TI Robotic-assisted total hysterectomy with low pneumoperitoneal pressure

(6 mmHg) and use of surgical plume evacuator system to minimize

potential airborne particles according to the joint statement on

minimally invasive gynecologic surgery during the COVID-19 pandemic: A

case report from Japan

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Coronavirus disease 2019; evacuation; filtration system;

robotic-assisted hysterectomy; surgical plume

AB We presented a case of uncontrolled genital bleeding caused by subserosal fibroid and treated by robotic-assisted hysterectomy during the coronavirus disease 2019 (COVID-19) pandemic. A 49-year-old woman had severe anemia with hypermenorrhea due to submucosal fibroid. Hysterectomy was deemed necessary to control genital bleeding. However, at that time, the number of confirmed COVID-19 cases has been increasing in Japan. Serious concerns have been raised about the risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) dissemination during minimally invasive surgery due to pneumoperitoneum-associated aerosolization of particles. We tried to prevent the spread of surgical plume by performing surgery under low pneumoperitoneal pressure at 6 mmHg and by using an evacuation/filtration system. As a result, we successfully performed robotic-assisted hysterectomy with minimized risk of spreading surgical plume-containing aerosol particles into the operating room. It is essential to follow the guidelines issued by the relevant societies and act accordingly to reduce the risk of SARS-CoV-2 infection in medical settings while performing surgery. We hope that our experience will help prevent secondary cases of future SARS-CoV-2 infections.

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PT J

AU Scarpelli, E

Armano, G

Monfardini, L

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Rotondella, I

Scebba, D

Butera, D

AF Scarpelli, Elisa

Armano, Giulia

Monfardini, Luciano

Valenti, Alissa

Barresi, Giuseppe

De Finis, Alessandra

Rotondella, Isabella

Scebba, Davide

Butera, Diana

TI Minimally invasive surgery in gynecological cancers: update and

systematic review

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE Minimally invasive surgery; Endometrial cancer; Ovarian cancer; Cervical

cancer

ID ABDOMINAL RADICAL HYSTERECTOMY; ROBOTIC-ASSISTED HYSTERECTOMY; RECURRENT

OVARIAN-CANCER; PORT-SITE METASTASIS; ENDOMETRIAL CANCER; LAPAROSCOPIC

HYSTERECTOMY; STAGE OVARIAN; CERVICAL-CANCER; LEARNING-CURVE; SENTINEL

NODE

AB Introduction: In the last decades, the introduction of laparoscopy and, more recently, of robotic surgery, offered new options for surgical treatment also in gynecological malignancies, as an alternative to open surgery. When considering the best surgical treatment option for gynecological malignancies, evidence about safety, feasibility, and oncological outcomes must be taken into account, to offer the best treatment to the patient. The present review aims to provide an updated scenario over the available evidence in the use of minimally invasive surgery (MIS) in gynecological malignancies. Material and methods: An electronic search was performed using the following keywords: 'minimally invasive surgery' and 'gynecology', 'minimally invasive surgery' and 'endometrial cancer', 'minimally invasive surgery' and 'ovarian cancer', 'minimally invasive surgery' and 'cervical cancer'. The agreement about potential relevance was reached by consensus of the researchers and according to PRISMA statement guidelines. Systematic reviews, meta-analyses, clinical trials, and original articles were included in the present review. Results: Fifty-eight studies were considered eligible for the study, 23 studies regarding MIS in endometrial cancer (EC), 19 studies on MIS in ovarian cancer (OC), and 16 studies regarding MIS in cervical cancer (CC). The total of patients enrolled was 180,057, 131,430 in the EC group, 23,774 in the OC groups, and 24,853 in the CC group. Conclusions: According to the available evidence and current clinical practice, MIS is undoubtedly the gold standard for early-stage EC treatment and may represent an acceptable option even in high-risk EC patients. Concerning OC, MIS is a safe and useful tool for staging purposes in advanced-stage disease, and a treatment option only in high volume centres with expert oncologic surgeons. On the contrary, MIS should be abandoned in the context of CC, exception made for well-selected patients, who received adequate counselling about current evidence.

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U2 8

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JI Clin. Exp. Obstet. Gynecol.

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PG 15

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GA 1C1UA

UT WOS:000792911600022

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ER

PT J

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Havrilesky, LJ

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Wright, JD

AF Albright, Benjamin B.

Chen, Ling

Havrilesky, Laura J.

Moss, Haley A.

Wright, Jason D.

TI Out-of-network bills among privately insured patients undergoing

hysterectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE financial toxicity; health policy; hysterectomy; out-of-network billing;

out-of-pocket costs; private health insurance

AB BACKGROUND: In recent years, the issue of out-of-network billing for privately insured patients has been highlighted as a source of unexpected out-of-pocket charges for patients, even in the setting of an in-network primary surgeon. The Congress recently passed the No Surprises Act to curtail these practices. However, the new law contains exceptions, and its regulatory system has yet to be established. As one of the most frequently performed major surgical procedures, hysterectomy represents a significant exposure to out-of-network bills among nonelderly females in the United States.

OBJECTIVE: To describe the extent and nature of out-of-network bills at the time of hysterectomy among privately insured patients in the context of the recently passed No Surprises Act.

STUDY DESIGN: We performed a retrospective cohort study of women aged 18 to 64 years who underwent simple hysterectomy from 2008 to 2018 with an in-network primary surgeon in the IBM Watson Marketscan claims database, which includes data from over 350 different payers. We identified out-of-network claims for facility or professional services and analyzed the frequency, size, and source of the payments. We used multivariable logistic regression to assess for patient, procedure, and facility characteristics associated with the risk of out-of-network claims.

RESULTS: We identified 585,223 hysterectomy cases meeting all the inclusion criteria, and they were evenly split between inpatient (49.6%) and outpatient (50.4%) procedures. Overall, 8.8% of cases included at least 1 out-of-network claim, with median out-of-network expenditures of $553 for inpatient procedures and $438 for outpatient procedures. Compared with professional out-of-network claims, facility out-of-network claims were less common (2.3% vs 7.4%) but far greater in the amount billed (median $8,307 vs $400 inpatient, $3,281 vs $407 outpatient). Among the professional claims, those from midlevel surgical assistants were most frequently out-of-network when present (13.8% inpatient; 20.0% outpatient), whereas out-of-network claims from anesthesia were most common overall and largest (median $890 inpatient, $1,021 outpatient) when present. In a multivariable model, older age, increasing comorbidity, and complications during the stay were associated with higher odds of any out-of-network claim. In contrast, the risk of facility out-of-network claims was more strongly associated with the facility region and the surgical approach, with the highest odds for cases in the North Central region and those using robotic approach.

CONCLUSION: Out-of-network bills for privately insured patients at the time of hysterectomy occurred in 8.8% of cases. Approximately one-quarter of these included out-of-network facility claims tended to have higher payments than out-of-network professional claims and may not be prevented by the No Surprises Act. Gynecologic surgeons should be aware of the potential out-of-network charges for ancillary services at the time of surgery, particularly the network status of the facility, to provide maximal transparency and financial protection to our patients.

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WC Obstetrics & Gynecology

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ER

PT J

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Silberman, J

Gargiulo, AR

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Silberman, Jason

Gargiulo, Antonio R.

TI Current Trends in the Evaluation and Management of Uterine Fibroids

SO CURRENT OBSTETRICS AND GYNECOLOGY REPORTS

LA English

DT Article

DE Fibroids; Leiomyomas; Myomectomy; Infertility

ID HYSTEROSONOGRAPHIC EXAMINATION; TRANSVAGINAL SONOGRAPHY; INTRAMURAL

FIBROIDS; ULIPRISTAL ACETATE; FOCUSED ULTRASOUND; OPEN MYOMECTOMY;

DOUBLE-BLIND; OUTCOMES; LEIOMYOMAS; PLACEBO

AB Purpose of Review Evaluation and management of uterine fibroids is an ever evolving area of medicine, impacting a large percentage of the female population. We present contemporary trends in evidence-based practice and research.

Recent Findings Point of care intraoperative ultrasound may improve surgical ability to detect and remove small myomas, improving surgical success and decreasing the likelihood of fibroid recurrence. Imaging modalities including elastography, augmented reality, and 3D printing are not currently optimized for clinical practice but offer promise as potential avenues through which to better gauge tumor burden. Pregnancies have been reported after uterine artery embolization and radiofrequency ablation for fibroid management, but the rate of pregnancy loss is substantial, and additional information regarding fertility and pregnancy outcomes after non-surgical intervention for treatment of fibroids is needed before these technologies can find safe applicability in women who have not completed childbearing. Robotic myomectomy may have advantages over laparoscopic myomectomy in the hands of skilled operators. Non-cavity distorting intramural fibroids are clearly associated with reduced odds of live birth in an infertile patient population, but additional research is needed to indicate whether removal of these tumors improves fertility and pregnancy outcomes.

Summary The high prevalence of fibroids in the general population results in a high incidence of fibroid-associated morbidity and high frequency of gynecology visits for discussion of fibroid management. MRI remains the gold standard imaging modality for pre-operative evaluation of fibroids. There is data to support the use of both GnRH-agonists and GnRH-antagonists as short-term treatment strategies. These medications can be used to optimize patients prior to surgery. Selective progesterone receptor modulators (SPRMs) are not currently approved in the USA, but nonetheless they remain a promising option for the medical treatment of uterine fibroids in the future. There is a growing body of literature on the role of non-surgical intervention (UAE, radiofrequency ablation, MR-guided ultrasound) for the treatment of fibroids, but there is insufficient data on fertility and pregnancy outcomes to recommend these strategies as first-line treatment to women desiring future fertility. Ultimately, surgery is the most definitive fibroid management option. Minimally invasive myomectomy is associated with improved outcomes when compared to open myomectomy, but choice of surgical management should be guided by fibroid burden as well as patient preference and-ultimately-surgeon experience.

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NR 68

TC 0

Z9 0

U1 0

U2 6

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J9 CURR OBSTET GYNECOL

JI CURR. OBSTET. GYNECOL. REP.

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WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

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Bonidie, M

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Clark, Stephanie Glass

McGough, Christine E.

Shepherd, Jonathan P.

Bonidie, Michael

TI Sacrocolpopexy experience with a novel robotic surgical platform

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT 41st Annual Scientific Meeting of the American-Urogynecologic-Society

(AUGS) / Pelvic Floor Disorders (PFD) Week

CY OCT 06-10, 2020

CL ELECTR NETWORK

SP Amer Urogynecol Soc

DE Robotic surgery; Sacrocolpopexy; New technology

ID PELVIC ORGAN PROLAPSE; HYSTERECTOMY

AB Introduction and hypothesis The objective was to describe early experience performing sacrocolpopexy using a novel robotic surgical platform. Methods This is a case series of all women who underwent robotic-assisted sacrocolpopexy using a new robotics platform (TransEnterix Senhance) between January 2019 and July 2021. All sacrocolpopexies were performed by a single Female Pelvic Medicine and Reconstructive surgeon at a large academic institution. Perioperative information including complications was abstracted from the medical record. Anatomical recurrence was defined as any anatomical point at or past the hymen (>= 0). Data are descriptive, with Mann-Whitney U test used for comparison of operative time between the first and second half of the patients. Results A total of 25 sacrocolpopexies were performed using the new robotics platform. Mean age was 62.3 years (+/- 9.2) and mean BMI was 26.5 (+/- 3.8). Ten (40.0%) patients had a prior hysterectomy. Most (n = 21, 84.0%) had stage III or IV prolapse preoperatively. Mean operative time was 210.2 min (+/- 48.6) and median estimated blood loss was 35 ml (IQR 25-50). Mean operative time decreased between the first and second half of the patients (231.7 min vs 190.3 min, p = 0.047). There were no major intraoperative complications. Median follow-up time was 16 weeks (IQR 4-34) and there were no subjective recurrences or retreatments during this period. Two patients (8.0%) had anatomical recurrence without subjective bother. There were two postoperative readmissions (8.0%) within 30 days for small bowel obstruction, one treated surgically and the other with nonsurgical management. Conclusions Our case series demonstrates feasibility and successful early adoption of a new robotics platform for robotic sacrocolpopexy.

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NR 28

TC 3

Z9 3

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SC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

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TI Peri- and postoperative outcomes in patients with endometriosis

undergoing hysterectomy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometriosis; Hysterectomy; Complication; Robotic; Conversion

ID QUALITY-OF-LIFE; IMPACT; COMPLICATIONS; LAPAROSCOPY

AB Objectives: To assess whether hysterectomy in patients with endometriosis is associated with higher proportion of complications compared with patients without, and whether route of hysterectomy affects this outcome.Study design: This is a population-based retrospective cohort study. Data were prospectively obtained from three National Swedish Registers. Patients undergoing a benign hysterectomy between 2015 and 2017 in Sweden were included in the study and were grouped according to a histology-proven diagnosis of endometriosis. Different hysterectomy modes were compared in patients with endometriosis. Perioperative data and postoperative complications up to 1 year after surgery were collected and measured.Results: In all, 8,747 patients underwent a benign hysterectomy, and 1,166 patients with endometriosis was compared with 7,581 patients without. Patients with endometriosis had higher proportion of complications (adjusted Odds ratio aOR 1.2, 95% CI 1.0-1.4), were more often converted to abdominal hysterectomy (aOR 1.7, 95% CI 1.1-2.6), had higher estimated blood loss (EBL) (200-500 ml; aOR 1.8, 95% CI 1.4-2.3, >500 ml; aOR 3.1, 95% CI 2.2-4.4) and a longer operative time (1-2 h; aOR 2.1, 95% CI 1.4-3.2, >2 h; aOR 4.3, 95% CI 2.7-6.6) than endometriosis-free patients. The conversion rate was 13.8 times higher in total laparoscopic hysterectomy (TLH) compared with robotic-assisted laparoscopic hysterectomy (RATLH) (aOR 13.8, 95% CI 3.6-52.4).Conclusion: Higher conversion rate, higher EBL and higher frequency of complications were seen in patients with endometriosis. RATLH was associated with lower conversion rate compared to TLH.

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TC 2

Z9 2

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U2 2

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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GA 1C2IQ

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OA hybrid

DA 2024-01-18

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TI Robotic-assisted vesicovaginal fistula repair using a vaginal cuff flap

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic; Vesicovaginal; Fistula; Genitourinary; Vaginal cuff flap

AB Introduction and hypothesis Vesicovaginal fistula (VVF) is an abnormal communication between the bladder and the vagina. Complex fistulae include those after failed repair attempts, radiotherapy, measuring >= 2 cm, located in the trigone, or with concomitant ureteric strictures or fistulae. We aimed to describe a technique for the robotic repair of a complex VVF using a vaginal cuff flap. Methods A 56-year-old woman with a history of ovarian debulking surgery and radiotherapy underwent repair for VVF and rectovaginal fistula. In lithotomy, cystoscopy was performed for fistulous tract cannulation. Port placement, extensive adhesiolysis, and robot docking followed. The vaginal apex was dissected, the VVF excised, and the bladder closed. The rectum was separated from the posterior vaginal wall, the rectovaginal fistula excised, and the rectum closed. A vaginal cuff flap was harvested and interposed between the bladder and the vagina. Results Operative time was 9 h, estimated blood loss was 300 cc, and no intraoperative complications occurred. The patient was discharged on postoperative day 8. Further management included 37 sessions in a hyperbaric chamber and a transvesical endoluminal bladder closure 10 months after the initial surgery. Follow-up at 30 months shows no fistula recurrence. Conclusions Vaginal cuff flaps represent a feasible interposition tissue in patients with hysterectomy for managing complex VVF in the case of omentum unavailability.

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NR 9

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Z9 0

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WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

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TI A robotic approach to management of failed sacrocolpopexy and

sacrocolpopexy complications: a case series

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Complications; Mesh; Prolapse; Robotics; Reoperation; Sacrocolpopexy

ID PELVIC ORGAN PROLAPSE

AB Introduction and hypothesis Approximately 5% of patients pursue reoperation after sacrocolpopexy (SCP). Reasons for re-operation include recurrence of prolapse, mesh erosion, bowel and bladder dysfunction, and pain. We aim to describe patient presentation, intraoperative findings, and subsequent robotic approach to management of SCP failures and complications. Methods This is a case series of patients who underwent abdominal re-exploration after SCP over 7 years at a single institution. Demographic data, previous prolapse surgery, presenting complaint, prolapse stage, operative notes, and outcomes were reviewed. Nineteen patients were identified by CPT codes; ten met inclusion criteria. Results Seven of the ten patients presented with vaginal bulge, urinary frequency and urgency; four also had stress urinary incontinence. Two patients presented with vaginal bleeding and another with vaginal pain. Operative findings on reoperation for patients who had vaginal bulge included detachment from the vagina or cervix (n = 4, 57%) and the anterior longitudinal ligament (n = 3, 43%). Of these, two had their SCP mesh reattached, and five had SCP mesh removal and replacement. The patients with vaginal bleeding and pain underwent mesh excisions. All ten patients had uncomplicated postoperative courses with resolution of symptoms in most cases. Conclusions Prolapse recurrence and complications after SCP have a significant impact on patient quality of life. Recurrent prolapse after SCP theoretically occurs because of mesh detachment from the cervix/vagina, the anterior longitudinal ligament, or disruption/stretching of the mesh. Our case series demonstrates that abdominal re-exploration is feasible and valuable in these rare cases.

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Z9 0

U1 0

U2 0

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JI Int. Urogynecol. J.

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ER

PT J

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TI Advanced Cystocele is a Risk Factor for Surgical Failure after

Robotic-assisted Laparoscopic Sacrocolpopexy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 12th Annual Scientific Meeting of the

European-Urogynaecological-Association (EUGA)

CY OCT 16-19, 2019

CL Tel Aviv, ISRAEL

SP European Urogynaecol Assoc

DE Success; Complications; Pelvic organ prolapse; Quality of life; Robotic

surgery

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; MESH; OUTCOMES;

MANAGEMENT; RECURRENCE

AB Study Objective: To assess the outcome of robotic-assisted laparoscopic sacrocolpopexy (RALSCP) and to identify risk factors for surgical failure and long-term complications in patients at high risk for surgical failure.

Design: Retrospective cohort study.

Setting: A university hospital.

Patients: Sixty-seven women with pelvic organ prolapse (POP) at high risk for surgical failure.

Interventions: RALSCP from November 2012 to July 2020.

Measurements and Main Results: Information was collected from the electronic medical records. Preoperative and postoperative assessment included urogynecologic history, prolapse staging, cough stress test, and validated quality of life questionnaires. Anatomic success was defined as POP stage < 2 at the last follow-up. Mean follow-up was 24.6 +/- 17.9 months. Sixteen women (23.9%) reported bulge symptoms at the latest follow-up; upon POP Quantification staging, surgical failure or recurrence was observed in 35 patients (52.2%). On multiple logistic regression analysis, a preoperative POP Quantification point Ba measurement >= 3 cm beyond the hymen was independently related to surgical failure. Late postoperative complications included 3 cases (4.5%) of postoperative ventral hernia and 5 cases (7.5%) of mesh erosion, all in patients operated using Ethibond sutures.

Conclusions: Anatomic success of RALSCP in POP patients at high risk for surgical failure is worse than previously reported. Advanced preoperative anterior vaginal wall prolapse is a risk factor for surgical failure. Delayed absorbable sutures for vaginal mesh fixation seem to be safer than multifilament, permanent sutures, in terms of the risk of mesh erosion. (C) 2021 AAGL. All rights reserved.

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NR 33

TC 8

Z9 8

U1 1

U2 2

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Robotic Donor Hysterectomy Results in Technical Success and Live Births

After Uterus Transplantation: Subanalysis Within the Dallas Uterus

Transplant Study (DUETS) Clinical Trial

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE living donor; minimally invasive surgery; robotic hysterectomy; uterus

transplantation

ID VENOUS DRAINAGE; SURGERY; VEINS

AB Minimally invasive procurement of uterine grafts for transplantation can decrease living donor recovery time. We examined recipient outcomes for grafts procured by robotic-assisted donor hysterectomies with transvaginal extraction in the Dallas UtErus Transplant Study (DUETS). All 5 grafts were successfully transplanted. Recipients had a median 4.5-hour surgical time, 0.25 L estimated blood loss, and 4-day hospital stay. Four recipients had grade III surgical complications and three had acute cellular rejection. At 18 months, graft viability was 100%, with an 80% live birth rate. This report demonstrates the feasibility and reproducible success of using uterus grafts from living donors who underwent robotic-assisted donor hysterectomy.

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TC 4

Z9 4

U1 0

U2 5

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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PG 9

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SC Obstetrics & Gynecology

GA YI9MF

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PT J

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TI Technological Advancements in Uterus Transplantation

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE uterus transplant; diagnostics; bioengineering; robotic surgery

ID VENOUS DRAINAGE; SURGERY; VEINS

AB Uterus transplantation is barely a decade old and in a young, evolving field it is hard to identify "technological advances" since it is, in of itself, a technological advance. Nonetheless, one can still identify advances in diagnostic imaging that have improved donor screening to avoid graft losses, highlight the adoption of robotic surgery to make the living donor uterus procurement more minimally invasive, and look to a future of biotechnology like perfusion pumps and bioengineering such as synthetic uterus to increase donor supply. Additional technologies are on the horizon and promise to shape the field further.

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U2 2

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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PT J

AU Monterossi, G

Anchora, LP

Alletti, SG

Fagotti, A

Fanfani, F

Scambia, G

AF Monterossi, G.

Anchora, L. Pedone

Alletti, S. Gueli

Fagotti, A.

Fanfani, F.

Scambia, G.

TI The first European gynaecological procedure with the new surgical robot

Hugo™ RAS. A total hysterectomy and salpingo-oophorectomy in a woman

affected by BRCA-1 mutation

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE HUGO RAS; total hysterectomy; robotic surgery

ID TELELAP ALF-X; LAPAROSCOPIC HYSTERECTOMY; BENIGN DISEASE

AB Background: The benefits of minimally invasive surgery are well known in gynaecology. Robotic-assisted surgery has gained widespread acceptance within the surgical community and seems to be the most rapidly developing sector of minimally invasive surgery.

Objectives: This video shows the salient steps of total hysterectomy with new robotic technology, Hugo (TM) RAS. The objectives were to introduce and demonstrate the feasibility, efficacy, and safety of this new advanced device.

Material and Methods: A sixty-two years-old woman affected by BRCA-1 mutation underwent the first European gynaecological surgical procedure using the new surgical robot Hugo (TM) RAS in the Division of Gynecologic Oncology, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy.

Main Outcomes measures: Docking and operative times.

Results: The docking time was 6 minutes and the total operative time was 58 minutes. There were no system errors and faults in the robotic arms. The surgeon found no friction or rasping in the arms. The estimated blood loss was 30 mL. No intraoperative complications were recorded.

Conclusion: Gynaecological surgery with Huge (TM) RAS seems feasible, safe and effective as shown by initial experiences in urological surgery. A larger case series would confirm the current experience and determine whether this technology could offer any additional benefit.

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JI Facts Views Vis. ObGyn

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PT J

AU Rustia, GM

Baracy, MG

Drouillard, FJ

Hagglund, KH

Aslam, MF

AF Rustia, Gabriella Marguerite

Baracy, Michael G., Jr.

Drouillard, Felicia J.

Hagglund, Karen H.

Aslam, Muhammad Faisal

TI Failure Rate of Retropubic Midurethral Sling With and Without

Concomitant Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE midurethral sling; sacrocolpopexy; stress urinary incontinence

ID FREE VAGINAL TAPE; STRESS URINARY-INCONTINENCE; OUTCOMES; PROLAPSE;

SURGERY; BURCH

AB Importance The retropubic midurethral sling (rMUS) and sacrocolpopexy are treatments for stress urinary incontinence (SUI) and pelvic organ prolapse, respectively, which are often performed concomitantly. Objective The purpose of this study was to identify whether a difference exists in the failure rates of rMUS when placed alone or at the time of robotic sacrocolpopexy (RSC). Study Design We conducted a single-center retrospective cohort study of patients who underwent rMUS placement between December 2015 and March 2020. The primary outcome was rMUS failure defined as additional treatment for SUI at any point. Results There were 160 patients who underwent isolated rMUS and 175 patients who underwent rMUS and RSC. Patients who underwent isolated rMUS were more likely to be obese (P < 0.01). Patients who underwent RSC were older (63.3 +/- 9.9 vs 57.7 +/- 13.7 years, P < 0.0001) and more likely to be White (P = 0.02). Follow-up ranged from 0 to 46 months (median, 3 months; interquartile range, 3 months). Failure was observed in 2.3% of rMUS placed alone and 8.6% of rMUS with RSC. Patients who underwent rMUS and RSC had an odds ratio of 3.63 for rMUS failure (P = 0.03; 95% confidence interval, 1.16-11.38). Hypertension was associated with 4 times higher rMUS failure (odds ratio, 4.18; P = 0.02; 95% confidence interval, 1.29-13.58). Conclusions We observed a significantly increased rate of rMUS failure from those placed alone to those placed at the time of RSC. Retropubic midurethral sling at the time of RSC was 4 times more likely to result in additional SUI treatment.

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Z9 2

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U2 0

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JI Female Pelvic Med. Reconstr. Surg.

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PT J

AU Deblaere, S

Hauspy, J

Hansen, K

AF Deblaere, Stephanie

Hauspy, Jan

Hansen, Karen

TI Mesh exposure following minimally invasive sacrocolpopexy: a narrative

review

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Mesh exposure; Mesh extrusion; Prolapse repair; Laparoscopic

sacrocolpopexy; Robotic sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; QUALITY-OF-LIFE; LAPAROSCOPIC SACROCOLPOPEXY;

SACRAL COLPOPEXY; ABDOMINAL SACROCOLPOPEXY; VAGINAL HYSTERECTOMY;

UTERINE PRESERVATION; ABSORBABLE SUTURE; TERM OUTCOMES; COMPLICATIONS

AB Introduction and hypothesis Sacrocolpopexy is considered mainstay treatment for apical or vaginal vault prolapse and is currently most often performed via a minimally invasive approach. Although mesh-related complications after this procedure are uncommon, mesh exposure can have an important impact on the patient's quality of life. Our objective is to perform a literature review on this complication post laparoscopic or robotic sacrocolpopexy. Methods Web of Science and MEDLINE databases were searched for relevant articles published between 2005 and 2021. We retrieved 272 articles of which 83 ultimately were withheld. Results Minimally invasive sacrocolpopexy (MISC) implies a low risk of mesh exposure, which is currently estimated at 3.5%. Literature however is marked by substantial methodological heterogeneity. Controversy remains in the debate over prevention of mesh exposure after MISC. Performing a concomitant total hysterectomy is associated with an increased risk compared to subtotal hysterectomy or hysteropexy. Treatment of mesh exposure is challenging as guidelines are lacking. Although supported by few prospective data, patients with asymptomatic mesh exposure are managed conservatively. Surgical intervention, preferentially performed by an experienced pelvic surgeon, is indicated in symptomatic patients. Conclusions Mesh exposure is often undiagnosed and remains untreated. There is a gap in evidence exploring risk factors for mesh-related complications and efficient measures for reducing them. Choosing the best treatment option is still difficult. Management should be individualized and optimized at the time of diagnosis. Lack of acknowledgement and experience can result in increased morbidity.

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PT J

AU Altin, D

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Ortaç, F

Tokgözoglu, N

Vatansever, D

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Kahramanoglu, Ilker

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Celik, Cetin

Demirkiran, Fuat

Kose, Faruk

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Ayhan, Ali

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TI Diagnostic accuracy of sentinel node biopsy in non-endometrioid,

high-grade and/or deep myoinvasive endometrial cancer: A Turkish

gynecologic oncology group study (TRSGO-SLN-006)

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial neoplasms; High-risk; Sentinel lymph node; Diagnostic

accuracy

ID PARAAORTIC LYMPHADENECTOMY; MAPPING ALGORITHM; PERFORMANCE; MULTICENTER;

OUTCOMES; TRIAL

AB Introduction. This study aimed to evaluate the diagnostic accuracy of the sentinel lymph node (SLN) mapping algorithm in high-risk endometrial cancer patients.

Methods. Two hundred forty-four patients with non-endometrioid histology, grade 3 endometrioid tumors and/or tumors with deep myometrial invasion were enrolled in this retrospective, multicentric study. After removal of SLNs, all patients underwent pelvic +/- paraaortic lymphadenectomy. Operations were performed via laparotomy, laparoscopy or robotic surgery. Indocyanine green (ICG) and methylene blue (MB) were used as tracers. SLN detection rate, sensitivity, negative predictive value (NPV) and false-negative rate (FNR) were calculated.

Results. Surgeries were performed via laparotomy in 132 (54.1%) patients and 152 (62.3%) underwent both bilateral pelvic and paraaortic lymphadenectomy. At least 1 SLN was detected in 222 (91%) patients. Fifty-five (225%) patients had lymphatic metastasis and 45 patients had at least 1 metastatic SLN. Lymphatic metastases were detected by side-specific lymphadenectomy in 8 patients and 2 patients had isolated paraaortic metastasis. Overall sensitivity, NPV and FNR of SLN biopsy were 81.8%, 95% and 182%, respectively. By applying SLN algorithm steps, sensitivity and NPV improved to 96.4% and 98.9%, respectively. For grade 3 tumors, sensitivity, NPV and FNR of the SLN algorithm were 97.1%, 98.9% and 2.9%.

Conclusion. SLN algorithm had high diagnostic accuracy in high-risk endometrial cancer. All pelvic metastases were detected by the SLN algorithm and the isolated paraaortic metastasis rate was ignorable. But long-term survival studies are necessary before this approach becomes standard of care. (C) 2022 Elsevier Inc. All rights reserved.

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PT J

AU Ekdahl, L

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Thumuluru, Kavitha Madhuri

Butler-Manuel, Simon A.

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Boggess, John F.

Persson, Jan

Falconer, Henrik

TI Long term oncologic and reproductive outcomes after robot-assisted

radical trachelectomy for early-stage cervical cancer. An international

multicenter study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Robotic radical trachelectomy; Long-term follow-up;

Recurrence; Reproductive outcome

ID FERTILITY-SPARING SURGERY; CARCINOMA; HYSTERECTOMY; RISK

AB Objectives. Long term outcomes following fertility sparing robot-assisted radical trachelectomy (RRT).

Methods. A retrospective study of consecutive women selected for RRT between 2007 and 2019 at five referral centres. Generally used selection criteria for fertility-sparing surgery were applied. Oncologic, reproductive and long-term clinical data were analysed.

Results. Of the 166 included women, 149 completed a RRT. Median tumor size was 9 mm (range 3-20 mm), 111 women (75%) had FIGO 2009 stage IB1 cancer and 4.8% were node positive. At a median follow up of 58 months, 12 of all women (72%) and 9 of 149 women (6%) who underwent completed RRT with fertility preservation had recurred and two had died. 70 of 88 women (80%) who attempted to conceive succeeded, resulting in 81 pregnancies that progressed beyond the first trimester and 76live births of which 54 (70%) were delivered at term and 65 (86%) delivered after gestational week 32. A short postoperative cervical length was associated with impaired fertility. A late secondary hysterectomy was necessary in four women due to persistent bleeding (n - 2), hematometra due to a cervical stenosis (n = 1) and recurrent dysplasia (n = 1).

Conclusion. In this long-term follow-up of RRT the recurrence rate is comparable to larger individual studies of minimally invasive or vaginal radical trachelectomy with similar risk profile and follow up. The high pregnancy rate and low rate of premature delivery before 32 weeks GA may promote the use of robot-assisted approach. (C) 2022 The Authors. Published by Elsevier Inc.

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FU Skane County Council's Research and development Foundation [REGSKANE

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[95230]

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PT J

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Fowler, Jeffrey M.

Backes, Floor J.

TI Who will be readmitted? Evaluation of the laparoscopic hysterectomy

readmission score in a gynecologic oncology population undergoing

robotic-assisted hysterectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparoscopic hysterectomy; Laparoscopic hysterectomy readmission score;

Minimally invasive hysterectomy; Robotic hysterectomy; Readmission; Same

day discharge

ID SAME-DAY DISCHARGE; RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER;

FEASIBILITY; SAFETY

AB Objectives. The laparoscopic hysterectomy readmission score (LHRS) was created to identify patients for whom same day discharge (SDD) after minimally invasive hysterectomy (MIH) may not be advisable and includes diabetes, chronic obstructive pulmonary disease, disseminated cancer, chronic steroid use, bleeding disorder, length of surgery, and any postoperative complication prior to discharge. We evaluated the performance of the score at predicting readmission in a gynecologic oncology population, and additionally sought to determine if any factors known prior to surgery could replace those that are not known until the time of surgery (operative time and postoperative complication).

Methods. This was a single-institution retrospective cohort study of women undergoing robotic hysterectomy by a gynecologic oncologist in 2018. Associations between pre-operative, operative and post-operative factors and 30-day readmission, SDD and postoperative complications were assessed using logistic regression.

Results. The 30-day readmission rate among the 423 women in the cohort was 45% and 1.9% in those undergoing SDD. Readmission rates by LHRS were: score 1 (4.9%), score 2 (7.8%), score 3 (13.6%), score 4 (16.7%). Patients with a LHRS of >= 3 had higher odds of readmission compared to those with a lower score (OR 4.20, p = 0.02). Infectious morbidity accounted for the majority of postoperative complications, emergency room visits and readmissions. We did not identify preoperative factors to replace the intra- and post-operative factors used in the score.

Conclusions. The readmission rate following MIH is low, and a LHRS of >= 3 is associated with increased risk of readmission. Our findings support the applicability of the LHRS to a gynecologic oncology population; addressing risk factors for postoperative infection or doser follow up for patients with a LHRS >= 3 could reduce postoperative readmissions. (C) 2021 Elsevier Inc. All rights reserved.

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PT J

AU Shoraka, M

Wang, S

Carbajal-Mamani, SL

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TI Oncologic outcomes in older women with endometrial carcinoma (≥70 years)

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Older women; endometrial cancer; surgery; survival; robotic surgery

ID ELDERLY-PATIENTS; ROBOTIC SURGERY; UTERINE-CANCER; ADVANCED-STAGE;

SURVIVAL; MANAGEMENT; IMPACT; LAPAROSCOPY; AGE; LAPAROTOMY

AB Data are limited in the management of elderly women with endometrial cancer as they are under-represented in clinical trials. The aim of this study was to evaluate the outcomes of women >= 70 years who underwent hysterectomy. One hundred and twenty-one patients met the inclusion criteria. The median age among the cohort was 75 years (range: 70-91), and 52% underwent robotic surgery. The five-year overall survival (OS) rate was 67%. The five-year cumulative incidence of recurrence was 19%. Based on univariate analysis, white race, lower ASA score, higher pre-operative and post-operative haematocrit, lower estimated blood loss, stage I and robotic surgery were associated with improved OS. On multivariable analysis, ASA score, preoperative haematocrit, estimated blood loss and stage were associated with survival. Survival rates among older women were low and disease recurrence was high. Robotic surgery was safe and appeared to improve perioperative outcomes in older women with endometrial cancer.Impact Statement What is already known on this subject? Endometrial cancer is the most common gynaecologic cancer with an overall survival above 90%. Surgery is the cornerstone of treatment. With an ageing population, an increased incidence of endometrial cancer is also expected. Increased frailty and comorbid conditions may prevent this population from undergoing surgery; consequently, these patients are often undertreated for a potentially curable disease. What do the results of this study add? Older women with endometrial cancer have low survival rates and high disease recurrence rates. Elderly women can tolerate robotic surgery to reduce the risk of adverse events. What are the implications of these findings for clinical practice and/or further research? It is important to develop best practices to optimise patients for minimally invasive surgery. The benefits of robotic surgery may encourage patients and surgeons to partake in this approach. A multidisciplinary approach with geriatric evaluation may improve post-operative care and survival. Future clinical trials should include elderly women.

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TC 2

Z9 2

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ER

PT J

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TI Determinants of Surgical Approach and Survival Among Women with

Endometrial Carcinoma

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Laparoscopic surgery; Endometrial carcinoma; Effect

modification

ID ROBOTIC-ASSISTED HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY; CANCER;

SURGERY; OUTCOMES; LAPAROTOMY; RECURRENCE; PROGRAM; SAFETY; CARE

AB Study Objective: To investigate determinants of surgical approach among women with endometrial carcinoma (EC) and associations between surgical approach and overall survival (OS).

Design: Retrospective cohort.

Setting: The National Cancer Database, 2010 to 2015.

Patients: A total of 140 470 patients with histologically confirmed EC who underwent hysterectomy.

Interventions: Patients were grouped according to surgical approach.

Measurements and Main Results: A total of 140 470 patients with EC were included. Robotic-assisted laparoscopy (RAL) was the most common surgical approach (48.8%), followed by laparotomy (33.6%) and traditional laparoscopy (17.6%). Use of RAL increased over the study period, and the percentages of cases managed by laparotomy decreased. Older women, those with insurance, residing in ZIP codes with lower proportions of individuals who did not graduate from high school, and those treated at noncommunity cancer programs were less likely to undergo laparotomy than RAL, and non-white women, those diagnosed with high-grade histology, and those with advanced-stage EC were more likely to undergo laparotomy than RAL. Compared with RAL, all other surgical approaches were associated with worse OS (laparotomy: hazard ratio 1.21; 95% confidence interval, 1.18- 1.25; traditional laparoscopy: hazard ratio 1.06; 95% confidence interval, 1.02 - 1.09). Significant effect modification of the surgical approach and OS relationship according to age, race, histology, stage, and adjuvant treatment was observed.

Conclusion: RAL increased in frequency over the study period and was associated with improved OS, supporting the continued use of RAL for EC management. (C) 2021 AAGL. All rights reserved.

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PT J

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TI Malfunction Events in the US FDA MAUDE Database: How Does Robotic

Gynecologic Surgery Compare with Other Specialties?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE MAUDE; Robotic surgery; Gynecologic surgery

ID SURGICAL SYSTEM; COMPLICATIONS; EXPERIENCE; IMPACT

AB Study Objective: To review malfunction events (MEs) related to the use of the da Vinci robot reported to the United States Food and Drug Administration Manufacturer and User Facility Device Experience in the last 10 years and compare gynecologic surgery with other surgical specialties.

Design: A retrospective review.

Setting: Manufacturer and User Facility Device Experience database.

Patients: Reports from 2010 to 2020 with keywords "Davinci" and "Intuitive".

Interventions: Report review.

Measurements and Main Results: There were 679 reports included in the final analysis. Most MEs occurred intraoperatively (81.7%) and were related to robotic instrument malfunction (84.5%), and 30% required an instrument switch to complete the procedure. Conversion to open and laparoscopic surgery was required in 3.1% and 1.3% of MEs, respectively. Injury to the patient occurred in 15.6% of MEs. Of the reported injuries to patients, 6.6% were related to robotic malfunction, 49.2% to instrument malfunction, and 18% to surgeon or staff misuse of the robotic system, and 15.6% were complications inherent to the procedure, not related to the robotic system. Of all the reported MEs, 4.4% were related to robot malfunction, 1.5% to console malfunction, 73.3% to Intuitive accessory malfunction, 11.2% to other accessory malfunction, 4% to surgeon or staff misuse of robotic system, and 3% to complications inherent to the procedure. Comparison between gynecologic surgery and other surgical specialties showed that 14.4% of issues were solved intraoperatively in gynecologic surgery vs 13.7% in other specialties (p =.185). The procedure was completed robotically in 85.2% in gynecologic surgery vs 84% in other specialties, laparoscopically 4.6% vs 3.7%, and open in 10.2% vs 12.4%, respectively (p =.883). In gynecologic surgery, reported MEs were made by patients in 14.8% vs 4.8% in other specialties, manufacturer in 78.4% vs 74.2%, and operating room staff in 2.3% vs 16.1%, respectively (p =.007). Injury to patient was similar in gynecologic surgery compared with other specialties (35.1% vs 23.4%, p =.122). Gynecologic and other specialty MEs did not state the need for procedure rescheduling (0% vs 0%).

Conclusion: Most reported robotic MEs occurred intraoperatively, were related to robotic instrument malfunctions, and required an instrument switch. Most surgeries are completed robotically, but conversion to either an open or laparoscopic approach was reported in 4.4%. Of the 114 reported injuries, 47.4% were Clavien-Dindo grade III+. There were no differences noted in patient injury between gynecologic surgery and other specialties. (C) 2021 AAGL. All rights reserved.

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Z9 3

U1 1

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ER

PT J

AU Saget, E

Peschot, C

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TI Robot-assisted laparoscopy for deep infiltrating endometriosis: a

retrospective French multicentric study (2008-2019) using the Society of

European Robotic Gynecological Surgery endometriosis database

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Deep infiltrating endometriosis; Robot-assisted laparoscopy; Da Vinci

system (R)

ID SURGICAL-MANAGEMENT; DUAL-CONSOLE; COSTS; WOMEN

AB Objective This study aimed at assessing perioperative results of robot-assisted laparoscopy (RAL) in the context of deep infiltrating endometriosis (DIE).

Methods This retrospective French multicentric study included all patients with DIE who underwent surgical treatment managed by RAL (Da Vinci (R) System). From November 2008 to June 2019, patients were included in a single European database, in Robotic Assisted Laparoscopic Gynecologic Surgery, with Society of European Robotic Gynecological Surgery collaboration. Patients had different DIE sites as follows: gynecological, urological, or digestive, or combinations of these. Surgical procedures and perioperative complications were evaluated. To assess complications, patients were divided into the following four groups according to surgical procedure and DIE site: gynecological only; gynecological and urological; gynecological and digestive; and gynecological, urological, and digestive.

Results A total of 460 patients treated at one of eight health-care facilities from November 2008 to June 2019 were included. Median operative time was 245 min (IQR 186-320), surgeon console time was 138 +/- 75 min and estimated blood loss was 70.0 mL +/- 107 mL. Among this patient sample, 42.1% had a multidisciplinary surgical approach with a digestive or urology surgeon in addition to gynecology surgeon (25.5% and 16.6% of cases, respectively). Among those with intraoperative complications (n = 25, 5.4%) were primarily conversion to laparotomy (n = 6, 2.0%), transfusion (n = 2, 0.6%), and organ wounds (n = 8, 1.7%). Overall, 5.6% had severe postoperative complications (Clavien-Dindo classification >= Grade 3).

Conclusion This is among the largest published series addressing RAL for DIE. Interest in this procedure appears promising, with no observed increases in blood loss or in peri- or post-operative complications. DIE laparoscopic surgery can require complex surgical procedures performed by multidisciplinary surgical teams. Thus, it may be one of the best candidates for RAL within gynecology surgery.

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NR 32

TC 2

Z9 3

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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ER

PT J

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Cianci, Antonio

TI Robotic-assisted laparoscopic cervicouterine anastomosis in a patient

with agenesis of the uterine isthmus

SO FERTILITY AND STERILITY

LA English

DT Article

DE Mullerian anomalies; uterine malformations; isthmus agenesis; robotic

surgery; minimally invasive surgery

ID CLASSIFICATION

AB Objective: To demonstrate the surgical management of agenesis of the uterine isthmus.

Design: Stepwise description of robotic-assisted laparoscopic cervicouterine anastomosis.

Setting: Academic medical center.

Patient(s): A 27-year-old nulligravida with primary amenorrhea and cyclic pelvic pain.

Intervention(s): The patient underwent a robot-assisted cervicouterine anastomosis using the following surgical steps: adhesiolysis of the right ovary from the rudimentary uterine horn; vesicouterine peritoneal fold dissection and mobilization of the cervical canal; the opening of the cervical canal and dilatation with Hegar dilators; longitudinal incision of the lower third of the anterior uterine wall up to the endometrial cavity; insertion of a 14 Ch Foley catheter, not inflated, fixed to the cervix with a suture and removed after 7 days; and closure of the cervicouterine breach with a double-layer Vicryl suture. Informed consent was obtained from the patient for the use of video and images.

Main outcome measure(s): After 3 months, the patency of the anastomosis site was assessed via hysteroscopy. Subsequent follow-up was performed by referring physicians.

Result(s): Postoperatively, anatomic continuity was restored and the patient was menstruating with regular monthly cycles; furthermore, cyclic pelvic pain was relieved. Few cases of this condition have been reported in the literature and, currently, surgical treatment of agenesis of the uterine isthmus is controversial, with some treatments including laparoscopic-assisted uterocervical anastomosis using a stent to prevent restenosis, primary cervicouterine anastomosis by laparotomy performed with a Foley catheter in the cervical canal, and anastomosis of the uterine isthmus agenesis. However, to our knowledge, we are the first to use a robotic approach. Preservation of reproductive function and symptom relief represent the goals of the surgery. Therefore, hysterectomy cannot be considered as a treatment option. However, after a cervicouterine anastomosis procedure, the normal uterine morphology cannot be achieved; cyclic abdominal pain may remain after surgical treatment. In this case, an alternative surgical approach, such as hysterectomy, can be considered.

Conclusion(s): Robotic-assisted treatment of this uncommon mu euro llerian anomaly is feasible and may be an alternative to hysterectomy in individuals who wish to preserve fertility. Follow-up is needed to evaluate fertility and reproductive function. (Fertil Sterile 2022;117:463-5. (c) 2021 by American Society for Reproductive Medicine.)

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Z9 1

U1 0

U2 3

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JI Fertil. Steril.

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ER

PT J

AU Dioun, S

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TI Uptake and outcomes of sentinel lymph node mapping in women undergoing

minimally invasive surgery for endometrial cancer

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE lymph node dissection; nationwide trends; sentinel lymph node mapping;

surgical outcomes; uterine cancer

ID LOWER-LIMB LYMPHEDEMA; RISK-FACTORS; PELVIC LYMPHADENECTOMY; TREATMENT

FAILURE; ACCURACY; THERAPY; TRIAL

AB Objective To examine the patterns and outcomes of sentinel lymph node (SLN) assessment in women with endometrial cancer. Design Retrospective cohort study. Setting United States inpatient and outpatient hospital services. Population Women with endometrial cancer who underwent a laparoscopic or robotic-assisted hysterectomy. Methods The Perspective Database from 2012 to 2018 was used. Performance of lymph node dissection was classified as SLN mapping, lymph node dissection or no nodal evaluation. Adjusted regression models were developed to examine the association between SLN mapping and morbidity and cost. Main Outcome Measures Utilisation rates, morbidity and cost of both lymph node dissection and SLN mapping. Results Among 45 381 patients, SLN mapping was performed for 7768 patients (17.1%), lymph node dissection was performed for 23 214 patients (51.2%) and no lymphatic evaluation was performed for 14 399 patients (31.7%). SLN mapping increased from 1.8% in 2012 to 35.3% in 2018, whereas the rate of lymph node dissection decreased from 63.5% to 39.1% (p < 0.001). Among women who underwent nodal evaluation, residence in the west, White race and use of robotic-assisted hysterectomy were associated with SLN mapping (p < 0.05 for all). The complication rate was 5.9% for SLN mapping, compared with 7.3% in those that underwent lymph node dissection (aRR 0.85, 95% CI 0.77-0.95). The median hospital costs for women who underwent SLN mapping ($10 479) and lymph node dissection ($10 747) were higher than for those who did not undergo nodal assessment ($9149) (p < 0.001). Conclusions The performance of SLN mapping is increasing for endometrial cancer. Compared with lymph node dissection, SLN mapping is associated with lower morbidity. SLN mapping significantly increases the costs compared with hysterectomy alone.

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NR 32

TC 10

Z9 10

U1 0

U2 2

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J9 BJOG-INT J OBSTET GY

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ER

PT J

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Cai, J

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TI A meta-analysis of survival after minimally invasive radical

hysterectomy versus abdominal radical hysterectomy in cervical cancer:

center-associated factors matter

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Cervical cancer; Minimally invasive surgery; Laparoscopic radical

hysterectomy; Robotic-assisted radical hysterectomy; Abdominal radical

hysterectomy; Oncological outcome; Overall survival; Disease-free

survival; Recurrence

ID ONCOLOGIC OUTCOMES; SURGERY; WOMEN; EXPERIENCE; LYMPHADENECTOMY;

MULTICENTER; RECURRENCE; COHORT; VOLUME

AB Purpose To explore the possible factors that contributed to the poor performance of minimally invasive surgery (MIS) versus abdominal surgery regarding progression-free survival (PFS) and overall survival (OS) in cervical cancer. Methods MEDLINE, EMBASE, Cochrane Library and Web of Science were searched (January 2000 to April 2021). Study selection was performed by two researchers to include studies reported oncological safety. Summary hazard ratios (HRs) and 95% confidence intervals (CIs) were combined using random-effect model. Subgroup analyses were stratified by characteristics of disease, publication, study design and treatment center. Results Sixty-one studies with 63,369 patients (MIS 26956 and ARH 36,049) were included. The overall-analysis revealed a higher risk of recurrence (HR 1.209; 95% CI 1.102-1.327) and death (HR 1.124; 95% CI 1.013-1.248) after MIS versus ARH expect in FIGO IB1 (FIGO 2009 staging) patients with tumor size less than 2 cm. However, subgroup analyses showed comparable PFS/DFS and OS in studies published before the Laparoscopic Approach to Cervical Cancer (LACC) trial, published in European journals, conducted in a single center, performed in centers in Europe and in centers with high sample volume or high MIS sample volume. Conclusion Our findings highlight possible factors that associated with inferior survival after MIS in cervical cancer including publication characteristics, center-geography and sample volume. Center associated factors were needed to be taken into consideration when evaluating complex surgical procedures like radical hysterectomy.

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JI Arch. Gynecol. Obstet.

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TI Technical features, perioperative and anatomical outcomes of a

standardized suturing pattern for robotic sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Sacrocolpopexy; Mesh suture; Robotic surgery; Pelvic organ prolapse;

Reconstructive surgery

ID ASSISTED SACROCOLPOPEXY; PROLAPSE

AB Introduction and hypothesis Several technical alternatives to repair mesh using laparoscopic sacrocolpopexy exist. We aim to describe the outcomes and surgical technique of robotic-assisted colpo-/cervicosacropexy using a standardized suturing scheme to repair the mesh. Methods We retrospectively reported data of 60 consecutive cases of robotic-assisted colpo-/cervicosacropexy for advanced multicompartmental prolapse using a standardized suturing design. We placed three non-absorbable stitches on the cervix or three absorbable stitches on the apex of the vaginal vault, six long-term absorbable stitches on the anterior vaginal wall deep to the basis of the vesical trigone, six similar posterior stitches with the deeper row of sutures down to the levator ani plane and three non-absorbable stitches on the sacral promontory as the cranial support for Y-shaped polypropylene mesh. Results Median operative time was 188 +/- 43 min. All the procedures were successfully performed using a Da Vinci Si platform in a three-arm configuration, and no conversion to open or traditional laparoscopic surgery was needed. The length of hospital stay was 1.2 +/- 1.7 days, and no readmission within 30 postoperative days was reported. At a follow-up of 12 and 24 months, no case of extrusion or exposure of the mesh occurred, and the retreatment rate was 6.7%. Conclusions Our suturing technique is safe and effective, with negligible risk of complications and good medium-term results. It is plausible that robotic systems may facilitate precise, accurate and reproducible placement of the stitches, thereby favoring wider diffusion of minimally invasive treatment of advanced prolapse.

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PT J

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TI Robotic-Assisted Laparoscopic Approach to Removal of Mullerian Remnants

SO JOURNAL OF PEDIATRIC AND ADOLESCENT GYNECOLOGY

LA English

DT Article

DE Robotic; Surgery; Mullerian remnant

AB Background: Robotic-assisted laparoscopy (RAL) is an alternative to traditional laparoscopic surgery that might increase a surgeon's ability to offer minimally invasive removal of Mullerian remnants (MR) to patients with complex anatomy. We report on 2 cases of RAL resection Cases: RAL allowed for adequate resection of MR without complications in 2 cases. Case 1 was a 13 year-old female adolescent with VACTERL and uterine remnant close to the ureter of her ipsilateral single kidney. Case 2 was a 16 year-old female adolescent with cloacal exstrophy and omphalocele with remnant hindgut and cervical remnant deep in the pelvis close to the ileal conduit. Summary and Conclusion: In 2 adolescents with complex anatomy and surgical history, RAL allowed for successful removal of MR.

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TI Five-Year Experience in the Surgical Treatment of Endometrial Cancer:

Comparing Laparotomy with Robotic and Minimally Invasive Hysterectomy

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY CANADA

LA English

DT Article

DE robotic surgical procedures; laparoscopy; hysterectomy; endometrial

neoplasms; postoperative complications

ID SURGERY; MORBIDITY; SURVIVAL; OUTCOMES; LAPAROSCOPY; RECURRENCE; CANADA;

WOMEN

AB Objectives: To compare surgical and oncological outcomes in the treatment of endometrial cancer between laparotomy and minimally invasive surgery. The secondary objective was to determine which MIS approach was the most beneficial.

Methods: This was a single-centre retrospective review of all endometrial cancer surgeries performed between November 1, 2012 and October 31, 2017 in a gynaecologic oncology unit of a university hospital. Descriptive statistics were used to compare histopathologic results and oncological outcomes, and Kaplan Meier estimates were used to compare survival.

Results: A total of 735 cases were reviewed. The majority of patients (77%) underwent either laparotomy (35%) or robotic-assisted hysterectomy (42%); the remaining patients underwent total laparoscopic hysterectomy (12%) or a laparoscopic-assisted vaginal hysterectomy (8.7%). There was a statistically significant overall survival benefit (P = 0.02), a shorter hospital stay (P < 0.0001), and fewer early surgical complications (<30 d; P = 0.0002), as well as a survival benefit in elderly patients (>70 y) in the robotic-assisted hysterectomy group (P = 0.043) than the laparotomy group. Operating time was shorter in the laparotomy group (P < 0.0001). Recurrence rates in stage 1 low-risk disease were similar between groups.

Conclusion: Minimally invasive surgical approaches, particularly robotic surgery, do not compromise oncologic outcomes, especially for early-stage low-risk disease. In addition, these approaches are associated with fewer early surgical complications and shorter hospital stay, with significantly more same-day discharges. Overall survival and survival in a subgroup of elderly patients were significantly better in the robotic-assisted hysterectomy group.

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PT J

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TI Factors Associated with Same Day Discharge after Laparoscopic Surgery in

Gynecologic Oncology

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Enhanced recovery after surgery; Laparoscopic surgery; Same day

discharge

ID MINIMALLY INVASIVE HYSTERECTOMY; ENHANCED RECOVERY; FEASIBILITY;

READMISSION; PROTOCOL; BENIGN; SAFETY

AB Study Objective: To identify factors associated with same day discharge (SDD) after laparoscopic surgery in gynecologic oncology.

Design: Retrospective cohort.

Setting: Teaching hospital.

Patients: Total of 800 patients having minimally invasive surgery in the division of gynecologic oncology during a 20month period.

Intervention: Minimally invasive surgery cases were reviewed for determinants of SDD to identify factors that could improve the SDD rate.

Measurements and Main Results: During the study period, 800 minimally invasive procedures were performed with a 43.0% SDD rate. Patients who had SDD were younger (52.3 years vs 58.0 years; p <.001), had a lower body mass index (31.1 kg/m 2 vs 33.7 kg/m(2); p <.001), were less likely to have a malignancy (28.2% vs 55.5%; p <.001), had a lower estimated blood loss (36 vs 72 mL; p <.001), and were more likely to have received an enhanced recovery after surgery protocol (49.8% vs 39.3%; p <.003). Total surgical time was shorter in women with SDD (156 minutes vs 208 minutes) as was total narcotic use in morphine equivalents (MEq) (milligram intravenous MEq, 23.1 mg MEq vs 28.8 mg MEq). SDD was also associated with earlier start time (p <.001). Laparoscopic cases were most likely to have SDD (51.4%) as compared with robotic assisted surgery (16.1%) or minilaparotomy (10.5%). There was a wide range of SDD among surgeons ranging from 19.8% to 56.2% (p <.001). In a multivariate analysis, the factors predicting SDD in order of predictive factors were surgical time (p <.001), recovery time (p <.001), start time (p <.001), surgeon (p <.001), age (p <.001), estimated blood loss (p <.001), and type of surgery (p = .005).

Conclusion: Multiple factors affect SDD. Modifiable factors for SDD include the start time, surgeon preference, and patient expectations for SDD. Given these data, centers should prioritize surgical order by which patients are more likely to go home, and surgeons should analyze their own data with respect to achieving higher SDD rates. (C) 2021 AAGL. All rights reserved.

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ER

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TI Superior Hypogastric Plexus Nerve Block in Minimally Invasive

Gynecology: A Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hypogastric nerve; Gynecology; Opioid

ID POSTOPERATIVE PAIN; DOUBLE-BLIND; HYSTERECTOMY; LAPAROSCOPY

AB Study Objective: To assess the efficacy of a superior hypogastric plexus nerve block in reducing opioid requirements in the first 24 hours after minimally invasive gynecologic surgery.

Design: Patient-blinded randomized controlled trial.

Setting: Single-center academic institution (Sydney Women's Endosurgery Centre). Two surgeons administering the blocks in their own surgeries.

Patients: Patients undergoing either laparoscopic or robot-assisted laparoscopic hysterectomy or myomectomy for benign indications.

Interventions: Ropivacaine 10 mL (0.75%) infiltrated into the retroperitoneal space overlying the superior hypogastric plexus vs control of no block given at the completion of surgery.

Measurements and Main Results: The primary outcome was the total opioid use in the first 24 hours after surgery, measured in morphine milligram equivalents (MME). Standardized fentanyl patient-controlled analgesia was given to all patients in the trial. The secondary outcome was pain measured on a visual analog scale (1 to 10) at 1, 2, 6, 12, and 24 hours after surgery. Fifty patients out of 56 approached for the study participated in, and completed, the study (89.2%). The patients were randomized over a 5-month period, March 2020 to July 2020. A total of 27 patients were randomized to receive a nerve block, and 23 were randomized to the control. There was a difference of -21.8 MME in the block group compared with the no-block group (95% confidence interval [CI], -38.2 to -5.5; p = .008). This correlated to a 38% reduction in opioid use in the block group. The mean opioid use in the patients in the block group was 33.1 MME (95% CI, 24.2 -41.9) and in those in the no-block group 54.9 MME (95% CI, 40.7-69.1). For the block group, opioid use ranged from 1.0 to 76.5 MME, with an interquartile range of 37 (14-51). For the control group, the range was 7.5 to 113.5 MME, with a higher interquartile range of 60 (28-88). Pairwise comparisons of the mean pain scores over the 24 hours showed a lower pain score with a nerve block of 1.8 (95% CI, 1.5-2.1) compared with a no-block score of 2.6 (95% CI, 2.3-2.9) No adverse effects of local anesthetic toxicity, nerve injury, or bowel/vascular injury were noted in any patient.

Conclusion: A superior hypogastric plexus nerve block is a simple technique for reducing postoperative opioid requirements and pain in the first 24 hours after minimally invasive gynecologic surgery. Copyright (C) 2021. Published by Elsevier Inc. on behalf of AAGL. All rights reserved.

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ER

PT J

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TI Fertility and Pregnancy Outcomes After Robotic-assisted Laparoscopic

Myomectomy in a Canadian Cohort

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic-assisted laparoscopic myomectomy; Myomectomy; Fertility;

Pregnancy; Myoma; Leiomyoma

ID ABDOMINAL MYOMECTOMY; WOMEN

AB Study Objective: Myomectomy is the gold standard treatment for patients with symptomatic fibroids who desire fertility preservation. Given the relatively recent application of robotic surgery in the field of gynecology, there is only a small amount of data describing fertility outcomes after robotic-assisted laparoscopic myomectomy (RALM). The objective of this study was to determine the pregnancy rate in patients trying to conceive after RALM.

Design: A single-center, retrospective case series.

Setting: Department of Obstetrics and Gynecology, St. Michael's Hospital, Toronto, Ontario, Canada.

Patients: All patients who underwent RALM between October 2008 and September 2015 and who consented to a telephone interview were included.

Intervention: None. The primary outcome was pregnancy rate after RALM. Secondary outcomes included whether patients underwent fertility treatment, rate of live births after RALM, rate of spontaneous abortion mode of delivery in pregnancies following RALM, obstetric complications, and symptoms experienced postoperatively.

Measurements and Main Results: A total of 123 patients underwent RALM between 2008 and 2015. Of them, 101 consented to be interviewed. Average age +/- standard deviation was 34.4 +/- 4.4 years. Average myoma size was 8.9 +/- 2.2 cm. Of all myomas, 64 (63.4%) were intramural, 35 (34.7%) were subserosal, and 2 (2%) were submucosal according to preoperative imaging. The pregnancy rate after RALM was 42/60 (70.0%). Three additional patients became pregnant who were not trying to conceive. Of the 45 patients who became pregnant, 38 (84.4%) successfully delivered or were pregnant at the time of data collection.

Conclusion: The pregnancy rate after RALM was 70.0%, which is similar to that reported in previous studies. Future research should aim to conduct larger, prospective studies investigating fertility outcomes after RALM and should aim to identify variables that predict pregnancy. (C) 2021. Published by Elsevier Inc. on behalf of AAGL. All rights reserved.

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TI Rethinking Disparities in Minimally Invasive Myomectomy: Identifying

Drivers of Disparate Surgical Approach to Myomectomy Between African

American and White Women

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Myoma burden; Healthcare disparities; Laparoscopic surgery; Myomectomy;

Robotic-assisted laparoscopic myomectomy

ID UTERINE FIBROID TUMORS; HYSTERECTOMY; LEIOMYOMA; AGE

AB Study Objective: To identify drivers of disparities among patients undergoing surgical management of myomas when stratified by self-identified patient race.

Design: This is a retrospective institutional review board-approved chart review of all patients who underwent a myomectomy at a large academic center. Surgical approach to myomectomy was classified as abdominal, laparoscopic, or robotic-assisted laparoscopic. Myoma burden was quantified preoperatively using uterine volume, intraoperatively by number of myomas listed on operative report, and postoperatively by myoma weight from pathology reports.

Setting: A large tertiary care hospital containing a comprehensive myoma treatment center.

Patients: A total of 265 white patients and 121 African American patients who underwent a myomectomy between January 2012 and October 2018 were included in the study population.

Interventions: Abdominal, laparoscopic, and robotic-assisted myomectomy. Laparoscopic and robotic-assisted myomectomy were classified as minimally invasive myomectomy. Multivariable logistic regression models and a propensity score matching algorithm were used to match African American (AA) women and white women for myoma burden.

Measurements and Main Results: A total of 386 women were included in the study. AA women (31%; n = 121) had higher myoma burden than white women by preoperative imaging (AA: 36% with 3 or more myomas; white: 19% with 3 or more myomas; p <.01) and operative report (>8 AA: 31% vs white 13%; p <.01). Despite this, AA women underwent minimally invasive myomectomy at similar rates as compared with white women when adjusted for myoma burden, body mass index, preoperative hematocrit, hypertension, and surgical indication (adjusted odds ratio 1.3; 95% confidence interval, 0.8-2.2 myomas; p <.01). Sensitivity analysis using propensity score matching found similar results.

Conclusion: In this population, AA women had a higher myoma burden than white women. When matched for myoma burden, however, there was no statistically significant difference between rates of minimally invasive myomectomy and abdominal myomectomy. This finding was consistent when controlling for myoma burden measured by preoperative, intraoperative, or postoperative methods of measurement. Further studies are needed to better characterize this disparity at other hospitals and to investigate ways to increase access and equity among patients undergoing minimally invasive myomectomy. (C) 2021 Published by Elsevier Inc. on behalf of AAGL.

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JI J. Minim. Invasive Gynecol.

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PT J

AU Salvo, G

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TI Open vs minimally invasive radical trachelectomy in early-stage cervical

cancer: International Radical Trachelectomy Assessment Study

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE disease-free survival; fertility; hysterectomy; laparoscopy; minimally

invasive surgical procedures; recurrence; retrospective studies; robotic

surgical procedures; trachelectomy; uterine cervical neoplasms

AB BACKGROUND: Minimally invasive radical trachelectomy has emerged as an alternative to open radical hysterectomy for patients with early-stage cervical cancer desiring future fertility. Recent data suggest worse oncologic outcomes after minimally invasive radical hysterectomy than after open radical hysterectomy in stage I cervical cancer.

OBJECTIVE: We aimed to compare 4.5-year disease-free survival after open vs minimally invasive radical trachelectomy.

STUDY DESIGN: This was a collaborative, international retrospective study (International Radical Trachelectomy Assessment Study) of patients treated during 2005-2017 at 18 centers in 12 countries. Eligible patients had squamous carcinoma, adenocarcinoma, or adenosquamous carcinoma; had a preoperative tumor size of <= 2 cm; and underwent open or minimally invasive (robotic or laparoscopic) radical trachelectomy with nodal assessment (pelvic lymphadenectomy and/or sentinel lymph node biopsy). The exclusion criteria included neoadjuvant chemotherapy or preoperative pelvic radiotherapy, previous lymphadenectomy or pelvic retroperitoneal surgery, pregnancy, stage IA1 disease with lymphovascular space invasion, aborted trachelectomy (conversion to radical hysterectomy), or vaginal approach. Surgical approach, indication, and adjuvant therapy regimen were at the discretion of the treating institution. A total of 715 patients were entered into the study database. However, 69 patients were excluded, leaving 646 in the analysis. Endpoints were the 4.5-year disease-free survival rate (primary), 4.5-year overall survival rate (secondary), and recurrence rate (secondary). Kaplan-Meier methods were used to estimate disease-free survival and overall survival. A post hoc weighted analysis was performed, comparing the recurrence rates between surgical approaches, with open surgery being considered as standard and minimally invasive surgery as experimental.

RESULTS: Of 646 patients, 358 underwent open surgery, and 288 underwent minimally invasive surgery. The median (range) patient age was 32 (20-42) years for open surgery vs 31 (18-45) years for minimally invasive surgery (P=.11). Median (range) pathologic tumor size was 15 (0-31) mm for open surgery and 12 (0.8-40) mm for minimally invasive surgery (P=.33). The rates of pelvic nodal involvement were 5.3% (19 of 358 patients) for open surgery and 4.9% (14 of 288 patients) for minimally invasive surgery (P=.81). Median (range) follow-up time was 5.5 (0.20-16.70) years for open surgery and 3.1 years (0.02-11.10) years for minimally invasive surgery (P<.001). At 4.5 years, 17 of 358 patients (4.7%) with open surgery and 18 of 288 patients (6.2%) with minimally invasive surgery had recurrence (P=.40). The 4.5-year disease-free survival rates were 94.3% (95% confidence interval, 91.6-97.0) for open surgery and 91.5% (95% confidence interval, 87.6-95.6) for minimally invasive surgery (log-rank P=.37). Post hoc propensity score analysis of recurrence risk showed no difference between surgical approaches (P=.42). At 4.5 years, there were 6 disease-related deaths (open surgery, 3; minimally invasive surgery, 3) (log-rank P=.49). The 4.5-year overall survival rates were 99.2% (95% confidence interval, 97.6-99.7) for open surgery and 99.0% (95% confidence interval, 79.0-99.8) for minimally invasive surgery.

CONCLUSION: The 4.5-year disease-free survival rates did not differ between open radical trachelectomy and minimally invasive radical trachelectomy. However, recurrence rates in each group were low. Ongoing prospective studies of conservative management of early-stage cervical cancer may help guide future management.

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AU Fan, EM

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AF Fan, Ethan M.

Zimmern, Philippe E.

TI Challenges of Managing Lower Urinary Tract Symptoms in Women with

Tamoxifen Use

SO WOMENS HEALTH REPORTS

LA English

DT Article

DE tamoxifen; urinary tract infection; urinary incontinence; pelvic organ

prolapse; women

ID ESTROGEN-RECEPTOR MODULATORS; PELVIC ORGAN PROLAPSE; POSTMENOPAUSAL

WOMEN; VAGINAL ESTROGEN; INCONTINENCE; EPITHELIUM; TRIAL; RISK

AB Objective: Tamoxifen complicates management of conditions such as urinary tract infections (UTIs), urinary incontinence (UI), and/or pelvic organ prolapse (POP) that traditionally benefit from hormonal intake; thus, we reviewed our experience in managing these hormonally deprived women.

Materials and Methods: After IRB approval, electronic medical records from women with current use or history of tamoxifen use and referred to a tertiary care center with female pelvic medicine and reconstructive surgery expertise for UTI, UI, and/or POP were reviewed.

Results: From 2015 to 2020, 32 women treated with tamoxifen 10-40 mg for a median of 4 years were referred for UTIs (9), UI (10), symptomatic POP (8), or for a combination of these (5). Participants with UTI treated with antibiotics, prophylactic supplements, and/or electrofulguration had satisfactory response at median followup of 1 year (interquartile range [IQR]: 0.5-1). Ten of 15 women with UI chose intervention, with no self-reported UI recurrence at median follow-up of 2.5 years (IQR: 1-3). All but one participant with POP underwent vaginal or open/robotic mesh repairs, with satisfactory outcomes at median follow-up of 3 years (IQR: 2-7).

Conclusions: The management of UTIs, UI, and POP in women on tamoxifen or unable to benefit from hormonal intake is challenging, but traditional interventions can be considered with satisfactory results.

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NR 45

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Z9 1

U1 1

U2 3

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J9 WOMENS HEALTH REP

JI Womens Health Reports

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TI Surgical approach to uterine myomatosis in patients with infertility:

open, laparoscopic, and robotic surgery; results according to the

quantity of fibroids

SO JORNAL BRASILEIRO DE REPRODUCAO ASSISTIDA

LA English

DT Article

DE laparoscopic surgery; robotic surgery; myomectomy; infertility; fibroids

ID ABDOMINAL MYOMECTOMY; FERTILITY; OUTCOMES; RUPTURE

AB Objective: To compare approaches to myomectomy (laparotomic, laparoscopic, and robotic). To show the relationship between the number of fibroids and the reproduction diagnosis.

Methods: Observational, analytical, retrospective, and cross-sectional study; where the surgical approach used, was evaluated in terms of surgical bleeding, time, number and weight of fibroids and reproductive results.

Results: 69 patients were treated through different approaches and divided into 3 groups. The differences found among groups were in favor of laparotomic myomectomy in terms of the number (p=0.000) and weight of fibroids (p=0.004). Robotic surgery was also longer (p=0.000). In the analysis of the influence of the number of fibroids to achieve pregnancy, the result was in favor of the minimally invasive routes, after surgery, both in the group of < 6 fibroids (p=0.017), and that of > 6 fibroids (p=0.001), without differences in the time from surgery to pregnancy (p=0.979).

Conclusions: The surgical approach decision should consider the number and size of resected fibroids, surgical time, and reproductive diagnosis. The minimally invasive route should be offered whenever possible due to its better outcome on achieving pregnancy, without forgetting the benefits of laparotomy, while also accrediting the recently introduced robotic-assisted approach.

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NR 27

TC 3

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U1 0

U2 2

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J9 J BRAS REPROD ASSIST

JI J. Bras. Reprod. Assist.

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TI A novel technique for myometrial defect closure after robot-assisted

laparoscopic adenomyomectomy: A retrospective cohort study

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Adenomyomectomy; Adenomyosis; Robot-assisted laparoscopy

ID UTERINE ADENOMYOSIS; SURGERY; MYOMECTOMY; UTERUS

AB Objective: To introduce our novel technique for myometrial defect closure after adenomyomectomy.

Materials and methods: A retrospective cohort study. A total of 40 patients with adenomyosis who visited our clinic between October 2012 and January 2018 were recruited. Of those 34 patients were eligible for analysis.

Results: The mean thickness of the affected uterine wall before surgery was 4.02 cm +/- 1.11, dropping to 2.37 cm +/- 0.84 postoperatively. This led to a mean drop of 41% in the thickness of the affected wall, which was found to be significant using a paired t-test (p < 0.0001). The mean preoperative pain score was 8.68 +/- 1.12, while the postoperative mean was 0.06 +/- 0.34. The mean preoperative CA 125 was 121.73 +/- 117.29, dropping to 6.95 +/- 2.60 postoperatively. This was found to be significantly lower using both the Wilcoxon Signed Rank and Sign tests (p = 0.0156).

Conclusion: Myometrial defect closure in a layer-by-layer fashion after robot-assisted laparoscopic adenomyomectomy is a reproducible technique. This uterine conserving method was effective in reducing our patients' pain. It may be the solution to maintaining adequate myometrial wall thickness, uterine layer alignment, and endometrial integrity. (C) 2022 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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NR 23

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Z9 6

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U2 1

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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ER

PT J

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TI Validation of a Simulation Model for Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT 40th Joint Annual Scientific Meeting of the

American-Urogynecologic-Society (AUGS) and the

International-Urogynecological-Association (IUGA)

CY SEP 24-28, 2019

CL Nashville, TN

SP Amer Urogynecol Soc, Int Urogynecol Assoc

DE robotic training; presacral dissection; sacrocolpopexy

ID GLOBAL EVALUATIVE ASSESSMENT; LAPAROSCOPIC SACROCOLPOPEXY; ASSISTED

SACROCOLPOPEXY; LEARNING-CURVE; SKILLS; PERFORMANCE; METAANALYSIS

AB Objective We sought to validate a simulation model for robotic sacrocolpopexy (RSCP) that includes multiple steps: presacral dissection/mesh attachment, vaginal mesh attachment, and peritoneal closure. Methods An RSCP training model was developed. Female pelvic medicine and reconstructive surgery (FPMRS) experts and current FPMRS fellows were videotaped using the model; sessions were timed and scored using the Global Evaluative Assessment of Robotic Skills (GEARS) by 3 surgeon reviewers masked to participants' identities. Construct validity was measured by comparing performance on the model between experts and trainees. Interrater reliability was determined by calculating intraclass correlation coefficients for total GEARS scores. Face validity was assessed by a postprocedure questionnaire. Results Experts included 9 board-certified FPMRS physicians experienced in RSCP; trainees were 17 fellows. Experts practiced at 7 different institutions in the United States, and the majority (5/7) taught fellows. Trainees were from 7 institutions and in various years of training: postgraduate year (PGY) 5 (n = 6), PGY 6 (n = 5), and PGY 7 (n = 6). Experts' performances were rated significantly higher for total GEARS scores and for relevant domains of the GEARS scale. Intraclass correlation coefficient for the 3 reviewer pairs (0.96-0.99) indicated high interrater reliability. All participants "agreed/strongly agreed" that the model closely approximated live RSCP surgery and was useful for teaching and learning the procedure, indicating high face validity. Conclusions This novel, multistep simulation model demonstrated construct validity and high interrater reliability. Face validity was also established. Consequently, this RSCP model could be used for surgical training and assessment of these discrete surgical skill steps.

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NR 21

TC 4

Z9 4

U1 0

U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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TI Long-term satisfaction of patients after laparoscopic and

robotic-assisted hysterectomy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Da Vinci Xi; Laparoscopic hysterectomy; Questionnaire; Robotic surgery;

Patient satisfaction

ID POSTOPERATIVE VAGINAL LENGTH; FUNCTION INDEX FSFI; SEXUAL FUNCTION;

SURGERY; OUTCOMES; CANCER; PAIN

AB Introduction Da-Vinci-Xi is the most recent device used in gynecologic robotic surgery. The aim of the present study was to compare the long-term satisfaction of patients who had undergone conventional laparoscopic hysterectomy or robotic assisted laparoscopic hysterectomy using the Da-Vinci-Xi surgical system. Methods All hysterectomies performed at the University Hospital of Luebeck from 2018 to 2019 were reviewed. Postoperative outcomes were compared between women who had undergone total hysterectomy with da Vinci Xi (n = 42) or conventional laparoscopy (n = 97). Postoperative outcomes included pain, elimination of complaints after surgery, bladder function, sexual function, satisfaction with the cosmetic outcome, positive experiences after robotic surgery, and satisfaction with the surgeon's preoperative explanation. Obese patients were evaluated separately in a subgroup analysis. Results Both groups had similar baseline characteristics and complication rates. Preoperative complaints subsided after surgery in a little more than 90% of patients. No significant differences were noted between groups in this regard (p = 0.262), or with reference to postoperative pain after one week (p = 0.866) and one month (p = 0.580), stress incontinence (p = 0.343), sexual function (p = 0.766) and the cosmetic outcome of the abdominal incisions (p = 0.273). The majority of patients who had undergone robotic surgery (96.8%) would be willing to undergo the procedure again if necessary. The subgroup analysis of obese patients revealed no significant differences. Conclusion The Da-Vinci-Xi device did not improve the long-term surgical satisfaction of normal-weight or obese patients who underwent hysterectomy compared with patients who underwent conventional laparoscopy performed by experienced laparoscopic surgeons.

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TI Ovarian transplantation with robotic surgery and a neovascularizing

human extracellular matrix scaffold a case series in comparison to

meta-analytic data

SO FERTILITY AND STERILITY

LA English

DT Article

DE Fertility preservation; cryopreservation; ovarian tissue

transplantation; robotic surgery; extracellular matrix

ID STRAND BREAK REPAIR; FERTILITY-PRESERVATION; TISSUE CRYOPRESERVATION;

CORTEX TRANSPLANTATION; CORTICAL STRIPS; LIVE BIRTH;

AUTOTRANSPLANTATION; PREGNANCY; FROZEN; CHEMOTHERAPY

AB Objective: To report our experience with robot-assisted (RA) autologous cryopreserved ovarian tissue transplantation (ACOTT) with the use of a neovascularizing extracellular matrix scaffold.

Design: Case series with meta-analytic update.

Setting: Academic.

Patient(s): Seven recipients of RA-ACOTT.

Intervention(s): Before or shortly after initiating chemotherapy, ovarian tissue was cryopreserved from 7 women, who then underwent RA-ACOTT 9.9 +/- 1.8 years (range, 7-12 years) later. Perioperatively, they received transdermal estrogen and low-dose aspirin to enhance graft vascularization. Ovarian cortical pieces were thawed and sutured on an extracellular matrix scaffold, which was then robotically anastomosed to the bivalved remaining ovary in 6 cases and retroperitoneally (heterotopic) to the lower abdomen in 1 case.

Main Outcome Measure(s): Ovarian function return, the number of oocytes/embryos, aneuploidy %, live births, and neonatal outcomes were recorded. Graft longevity was compared with the mean from the meta-analytic data.

Result(s): Ovarian function returned 13.9 +/- 2.7 weeks (11-16.2 weeks) after ACOTT, and oocytes were retrieved in all cases with 12.3 +/- 6.9 embryos generated. In contrast to orthotopic, the heterotopic ACOTT demonstrated low embryo quality and an 80% aneuploidy rate. A recipient did not attempt to conceive and 2 needed a surrogate, whereas 4 of 4 delivered 6 healthy children, compared with 115 of 460 (25% pregnancy rate) from the meta-analytic data (n = 79). The mean graft longevity (43.2 +/- 23.6/47.4 +/- 22.8 months with/without sensitivity analysis) trended longer than the meta-analytic mean (29.4 +/- 22.7), even after matching age at cryopreservation.

Conclusion(s): In this series, RA-ACOTT resulted in extended graft longevity, with ovarian functions restored in all cases, even when the tissues were cryopreserved after chemotherapy exposure. (C) 2021 by American Society for Reproductive Medicine.

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PT J

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TI Robot-assisted Extraperitoneal Para-aortic Lymphadenectomy Is Associated

with Fewer Surgical Complications: A Post Hoc Analysis of the STELLA-2

Randomized Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Staging; Robotic; Minimally invasive; Morbidity

ID ENDOMETRIAL CANCER; LAPAROSCOPY; OUTCOMES; SURGERY; FEASIBILITY

AB Study Objective: To evaluate if extraperitoneal para-aortic lymphadenectomy (PALND) using a robot-assisted approach was associated with fewer complications than all other approaches (conventional laparoscopic transperitoneal or extraperitoneal and robot-assisted transperitoneal) without compromising lymph node yield, operative time, or length of stay.

Design: Post hoc analysis of the prospective randomized open-label multicenter trial (STELLA-2).

Setting: Three academic referral hospitals.

Patients: Two hundred and three eligible patients from the STELLA-2 trial were included.

Interventions: The patients were randomized to extraperitoneal or transperitoneal PALND using a minimally invasive approach (either laparoscopic or robot-assisted) for surgical staging of endometrial or ovarian cancer. The minimally invasive approaches were not subjected to randomization.

Measurements and Main Results: The primary end point was evaluated through a composite variable that included at least 1 of the following events: blood loss >= 500 mL during PALND, any intraoperative complication related to PALND, severe postoperative complication (Clavien-Dindo >= grade IIIA), impossibility of completing the procedure, or conversion to laparotomy.

Of the 203 patients analyzed, 68 were assigned to the extraperitoneal laparoscopic group (X-L), 62 to the transperitoneal laparoscopic group (T-L), 35 to the extraperitoneal robotic group (X-R), and 38 to the transperitoneal robotic group (T-R).

A reduced trend in complications was observed in the extraperitoneal robot-assisted arm when considering the primary end point (X-L: 25.0%, T-L: 24.2%, X-R: 5.7%, T-R: 28.9%; p = .073). In a multivariable analysis, age (odds ratio [OR] 1.05; 95% confidence interval [CI], 1.00-1.09), body mass index (OR 1.09; 95% CI, 1.03-1.16), and waist-to-hip ratio (OR 1.66; 95% CI, 1.12-2.47) were found to independently increase the risk of PALND complications, whereas the extraperitoneal robotic approach (OR 0.13; 95% CI, 0.02-0.64) was an independent protective factor for complication occurrence.

Conclusion: Robot-assisted extraperitoneal PALND is associated with fewer surgical complications, without compromising lymph node retrieval, operative time, or length of stay. Robot-enhanced 3D visualization, surgeon ergonomics, or hemostatic precision could explain our results. (C) 2021 AAGL. All rights reserved.

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d'Hebron (approval number: PR[AMI] 168/2015; year of approval, 2015).

This study was registered on ClinicalTrials.gov on October 14, 2015

(registration number: NCT02676726;

https://clinicaltrials.gov/ct2/show/NCT02676726).Data related to this

study are available at

https://data.mendeley.com/datasets/td9zh6jkx2/1.Vicente Bebia and

Antonio Gil-Moreno contributed equally to this work.

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PT J

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TI Predictors of Persistent Postsurgical Pain After Hysterectomy-A

Prospective Cohort Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Hysterectomy; Pain sensitivity; Pain catastrophizing;

Persistent postsurgical pain

ID RISK-FACTORS; ASSOCIATION; SURGERY

AB Study Objective: To determine sociodemographic, surgical, and psychologic risk factors, including pain sensitivity, for persistent postsurgical pain (PPSP) after hysterectomy.

Design: A prospective cohort study.

Setting: Canadian academic medical center.

Patients: Patients (N = 200) who underwent hysterectomy (vaginal, laparoscopic, robotic, or open) between 2013 and 2014.

Interventions: Participants completed preoperative questionnaires assessing baseline pain scores and psychologic factors, including the Pain Sensitivity Questionnaire, Brief Pain Inventory Interference Items, the Beck Depression Inventory, the Numeric Rating Scale (NRS), and the Pain Catastrophizing Scale. Pain was recorded 1 and 24 hours postoperatively using the NRS. Patients were reassessed at 6 weeks postoperatively and completed the Brief Pain Inventory Interference Items, Patient Global Impression of Change, and the NRS. Patients who reported pain at 6 weeks were reassessed at 12 weeks using the above-mentioned questionnaires.

Measurements and Main Results: Of 200 study participants, 58 (32%) met the definition for PPSP (NRS >= 1 at 12 weeks), and 11 (6.1%) met the definition for moderate to severe postsurgical pain (NRS >= 4 at 12 weeks). Risk factors for PPSP included baseline pain scores, depression, pain catastrophizing, uterine mass, open surgical approach, acute postoperative pain, history of chronic pain, and having a hysterectomy due to pain. Multivariate regression analysis revealed that depression, pain catastrophizing, open surgical approach, and acute postoperative pain at 1 hour represent independent predictors of PPSP. Pain sensitivity was not associated with PPSP but was associated with acute and severe acute (NRS >= 4) pain at 24 hours.

Conclusion: Patients at risk for PPSP after hysterectomy can be identified preoperatively using validated questionnaires. This information can be used to guide targeted perioperative interventions to mitigate their risk. (C) 2021 AAGL.

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TI Surgical Outcomes of Hysterectomy via Robot-assisted versus Traditional

Transvaginal Natural Orifice Transluminal Endoscopic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic; Robotic; Transvaginal single-site surgery; Transvaginal

hysterectomy

ID ROUTE

AB Study Objective: To evaluate the safety and feasibility of robot-assisted transvaginal natural orifice transluminal endoscopic surgery (R-vNOTES) hysterectomy when compared with traditional vNOTES (T-vNOTES) hysterectomy. Design: Retrospective chart review.

Design: Retrospective chart review.

Setting: Academic tertiary setting.

Patients: Total of 114 patients with benign gynecologic indication for hysterectomy.

Interventions: T-vNOTES or R-vNOTES hysterectomy performed by a single minimally invasive gynecologic surgeon in the study period.

Measurements and Main Results: The primary outcome of this study was surgical equivalence, measured principally by total operative time between T-vNOTES and R-vNOTES hysterectomy. Secondary operative outcomes that were measured included estimated blood loss, length of hospital stay, reported postoperative pain levels, and number of conversions. A total of 79 women underwent T-vNOTES hysterectomy, and 35 women underwent R-vNOTES hysterectomy without differences in operative time (p = .37), estimated blood loss (p = .27), length of hospital stay (p = .06), or reported postoperative pain levels at weeks 1, 2, and 3 after surgery (p = .78, p = .36, p = .38, respectively). A total of 6 patients underwent conversion in the T-vNOTES hysterectomy group compared with 0 in the R-vNOTES hysterectomy group; however, this was not statistically significantly different, and there were no conversions to laparotomy.

Conclusion: R-vNOTES hysterectomy is a feasible approach to surgery when compared with T-vNOTES hysterectomy and warrants further consideration as a skill set in a gynecologic surgeon's toolbox. Wristed instruments may allow surgeons who are inexperienced in single-site laparoscopy to adopt vNOTES more quickly as a new technique when performing hysterectomy through a comparable minimally invasive approach. (C) 2021 AAGL. All rights reserved.

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U2 3

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TI Optimizing Robotic Hysterectomy for the Patient Who Is Morbidly Obese

with a Surgical Safety Pathway

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Obesity; Perioperative complications; Robotic hysterectomy; Surgical

outcomes

ID INVASIVE GYNECOLOGIC SURGERY; BODY-MASS INDEX; ENHANCED RECOVERY;

PROTOCOL; PROGRAM; IMPLEMENTATION; OUTCOMES; QUALITY; WEIGHT; TRIAL

AB Study Objective: Obesity is a growing worldwide epidemic, and patients classified as obese undergoing gynecologic robotic surgery are at increased risk for surgical complications. This study aimed to evaluate the feasibility and outcomes of a surgical safety protocol known as the High BMI [Body Mass Index] Pathway (HBP) for patients with BMI >= 40 kg/m(2) undergoing planned robotic hysterectomy. Our primary outcome was the rate of all-cause perioperative complications in patients undergoing surgery with the use of the HBP.

Design: A retrospective cohort study.

Setting: An academic teaching hospital.

Patients: A total of 138 patients classified as morbidly obese (BMI >= 40 kg/m(2)) undergoing robotic hysterectomy.

Interventions: The HBP was developed by a multidisciplinary team and was instituted on January 1, 2016, as a quality improvement project. Patients classified as morbidly obese undergoing robotic hysterectomy after this date were compared with consecutive historical controls.

Measurements and Main Results: Seventy-two patients underwent robotic hysterectomies on the HBP and were compared with 66 controls. There were no differences in age, BMI, blood loss, number of comorbidities, or cancer diagnosis. Since the implementation of the HBP, there has been a decrease in anesthesia time (-57.0 minutes; p = .001) and total operating room time (-47.0 min; p = .020), as well as lower estimated blood loss (median 150 mL [interquartile range 100-200] vs 200 mL [interquartile range 100-300]; p = .002) and reduction in overnight hospital admissions (33.3% vs 63.6%; p <.001). In the HBP group, there were fewer all-cause complications (19.4% vs 37.9%; p = .023) and infectious complications (8.3% vs 33.3%; p = .001), and there was no increase in the readmission rates (p = .400). In multivariable analysis, the HBP reduced all-cause complications (odds ratio 0.353; p = .010) after controlling for the covariate (total time in the operating room).

Conclusion: The HBP is a feasible method of optimizing the outcome for patients classified as morbidly obese undergoing major gynecologic surgery. Initiation of the HBP can lead to decreased anesthesia and operating times, all-cause complications, and overnight hospital admissions without increasing readmission rates. (C) 2021 AAGL. All rights reserved.

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Z9 0

U1 0

U2 5

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PM 34139329

DA 2024-01-18

ER

PT J

AU Zhang, YM

Delgado, S

Liu, J

Guan, ZK

Guan, XM

AF Zhang, Yiming

Delgado, Stephanie

Liu, Juan

Guan, Zhenkun

Guan, Xiaoming

TI Robot-assisted Transvaginal Natural Orifice Transluminal Endoscopic

Surgery for Management of Endometriosis: A Pilot Study of 33 Cases

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic; Transvaginal natural orifice transluminal endoscopic surgery;

Endometriosis; Chronic pelvic pain; Vaginal surgery

ID DEEP INFILTRATING ENDOMETRIOSIS; HYSTERECTOMY; SACROCOLPOPEXY; OUTCOMES

AB Study Objective: To describe the surgical techniques and short-term outcomes for 33 cases of robot-assisted transvaginal natural orifice transluminal endoscopic surgery (RvNOTES) to treat endometriosis.

Design: Retrospective case series study.

Setting: Academic tertiary care university hospital in Houston, TX.

Patients: Patients who underwent RvNOTES resection of endometriosis between March 2020 and March 2021.

Interventions: RvNOTES.

Measurements and Main Results: A total of 33 cases of patients, with pathology-confirmed endometriosis, who underwent RvNOTES total hysterectomy with resection of endometriosis were included in the study. Thirty-two cases were completed successfully by RvNOTES, and 1 case was converted to robotic transumbilical single-incision laparoscopic surgery plus 1 additional port owing to an obliterated posterior cul-de-sac and upper abdominal wall endometriosis. The average operative time was 141.93 +/- 40.22 (85-264) minutes, and the mean estimated blood loss was 52.25 +/- 33.82 (25-150) mL. The mean preoperative pain score using the visual analog scale (VAS) score was 8.08 +/- 2.39 (2-10). The mean VAS pain score 1 week after surgery was 6.73 +/- 2.62 (0-10), which was significantly lower than the preoperative scores (p = .059). The mean VAS pain score in the second and third week after surgery was 4.81 +/- 2.42 (0-9) and 2.63 +/- 2.36 (0-7) respectively, which were both significantly lower than those before surgery (p = .001). There were 4 postoperative complications: urinary tract infection, pneumonia, headache requiring admission, and conversion disorder.

Conclusion: RvNOTES is a safe and feasible approach for the treatment of endometriosis, with promising short-term improvements in pain. (C) 2021 AAGL. All rights reserved.

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ER

PT J

AU Ekdahl, L

Crusensvärd, M

Reynisson, P

Lönnerfors, C

Persson, J

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Crusensvard, Malin

Reynisson, Petur

Lonnerfors, Celine

Persson, Jan

TI Quality of life and long-term clinical outcome following robot-assisted

radical trachelectomy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Quality of Life; Sexual function; Lymphedema; Robot-assisted radical

trachelectomy

ID STAGE CERVICAL-CANCER; FERTILITY-SPARING SURGERY; LYMPH-NODE DETECTION;

VAGINAL TRACHELECTOMY; EUROPEAN-ORGANIZATION; BACTERIAL VAGINOSIS;

PRETERM DELIVERY; CARCINOMA; RISK; METRONIDAZOLE

AB Quality of Life and long-term clinical outcome following robot-assisted radical trachelectomy. Objectives: To evaluate quality of life (QoL) and long-term clinical outcome following robot-assisted radical trachelectomy (RRT).

Study Design: Prospectively retrieved clinical data were rereviewed on all women planned for a fertility sparing RRT for early stage cervical cancer at Skane University Hospital, Sweden between 2007 and 2020. QoL was assessed using the validated questionnaires EORTC QLQ-C30, QLQ-CX24 and the Swedish LYMQOL.

Results: Data was analyzed from 49 women, 42 with a finalised RRT and seven with an aborted RRT due to nodal metastases (n = 3) or insufficient margins (n = 4). At a median follow-up time of 54 months one recurrence (2%) occurred (aborted RRT). According to QLQ-C30 the median global health status score was 75. The disease specific QLQ-C24 showed an impact on symptoms related to sexual function where sexual/vaginal functioning had a median score of 25 and 48% of patients reported worry that sex would cause physical pain. Despite this the functional items sexual activity and sexual enjoyment both had a median score of 66.7. Lymphoedema was reported in 45%, where 9% reported severe symptom with an impact on their QoL. No intraoperative complications and no postoperative complications >= Clavien Dindo grade III were observed. Twenty-two of 28 (79%) women who attempted to conceive were successful. A metronidazole/no intercourse regimen was applied between GW 15 + 0-21 + 6 in 26 of 28 pregnancies beyond first trimester resulting in a 92% term (>= GW 36 + 0) delivery rate.

Conclusions: Although robot-assisted radical trachelectomy in this cohort was associated with a low recurrence rate, a high fertility rate and an exceptionally high term delivery rate, women's quality of life was affected postoperatively, particularly with regards to their sexual well-being and lymphatic sideeffects. (C) 2021 Elsevier B.V. All rights reserved.

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NR 51

TC 1

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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GA 0B0KP

UT WOS:000774333200020

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ER

PT J

AU Evans, S

McCarter, M

Abimbola, O

Myers, EM

AF Evans, Sarah

McCarter, Maggie

Abimbola, Obafunbi

Myers, Erinn M.

TI Enhanced Recovery and Same-Day Discharge After Minimally Invasive

Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE same-day discharge; enhanced recovery; minimally invasive sacrocolpopexy

ID LAPAROSCOPIC SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; TERM OUTCOMES; RISK

AB Objective The objective of this study was to evaluate whether an enhanced recovery after surgery (ERAS) protocol was associated with a higher rate of same-day discharge after robot-assisted or laparoscopic sacrocolpopexy and to describe the safety and feasibility of same-day discharge after these procedures. Methods A historical control, retrospective cohort study of women undergoing minimally invasive sacrocolpopexy comparing rates of same-day discharge before and after implementation of an ERAS protocol was conducted. Secondary outcomes were obtained by comparing women discharged the same day with those discharged postoperative day >= 1, including postoperative complications and unplanned postoperative patient encounters within 30 days of surgery. Logistic regression was performed to control for potential confounders. Results Of the 166 women identified (83 before ERAS implementation; 83 after ERAS implementation), 43 underwent same-day discharge versus 123 admitted overnight. The rate of same-day discharge increased 28 percentage points after ERAS implementation (12% vs 40%, P < 0.01). Compared with women admitted overnight, same-day discharge women had shorter procedures (154 vs 173 minutes, P = 0.01), spent longer time in the postanesthesia care unit (130 vs 106 minutes, P = 0.01), and were more likely to be discharged with a Foley catheter (58% vs 28%, P < 0.01). After multivariable logistic regression analysis, ERAS was associated with increased odds of same-day discharge (odds ratio, 4.91; 95% confidence interval, 2.17-11.09). There were no differences in unplanned postoperative patient contacts or postoperative complications within 30 days between same-day discharge and overnight admission groups. Conclusions Implementation of an ERAS protocol for minimally invasive sacrocolpopexy was associated with a 3-fold increase in same-day discharge.

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TC 5

Z9 6

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U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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DA 2024-01-18

ER

PT J

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Güngör, M

AF Ozbasli, Esra

Gungor, Mete

TI Comparison of perioperative outcomes among robot-assisted, conventional

laparoscopic, and abdominal/open myomectomies

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Article

DE Robot-assisted surgery; laparoscopic surgery; open surgery; myomectomy

ID ETIOLOGY

AB Objective: To compare the perioperative results of myomectomy performed by robotic surgery (RM), laparoscopic surgery (LM), and open/abdominal surgery (OM).

Material and Methods: We included 227 patients who underwent either robotic (n=66), laparoscopic (n=88), or abdominal (n=73) myomectomy at our hospital between 2016 and 2020. Retrospective medical records, including fibroid characteristics, demographic findings, and surgical outcomes, were compared.

Results: The RM group had a significantly lower body mass index and significantly larger uterine size, myoma diameter, and myoma weight than the other groups. However, the OM group had the highest number of myoma. Moreover, the RM group had higher operative time and blood loss but significantly lower maximum visual analog scale values than the OM and LM groups. Hospitalization duration was significantly different among the groups. The rate of 1-day hospitalization was 56.2%, 64.8%, and 37.9% in the OM, LM, and RM groups, respectively. Furthermore, blood transfusion requirement was significantly higher in the OM group (12.3%) than in the LM and RM groups (0.0% and 4.5%, respectively).

Conclusion: Minimally invasive myomectomy may be preferable, particularly for women of reproductive age. In women with large uterine size and myoma, robot-assisted LM is recommended.

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TC 6

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J9 J TURK-GER GYNECOL A

JI J. Turk.-Ger. Gynecol. Assoc.

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WC Obstetrics & Gynecology

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ER

PT J

AU AlAshqar, A

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Yazdy, G

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Borahay, MA

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Wildey, Brian

Yazdy, Golsa

Goktepe, Metin E.

Kilic, Gokhan S.

Borahay, Mostafa A.

TI Predictors of same-day discharge after minimally invasive hysterectomy

for benign indications

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE minimally invasive hysterectomy; operative time; same-day discharge;

surgeon experience

ID LENGTH-OF-STAY; FINANCIAL ANALYSIS; COMPLICATIONS; OUTCOMES; SURGERY;

EFFICIENCY; RATES

AB Objective To identify predictors of same-day discharge after benign minimally invasive hysterectomy. Methods In this retrospective cohort study, we identified women (n = 1084) undergoing benign minimally invasive hysterectomy from 2009 to 2016. Multivariate logistic regression was used to examine demographic, operative, and surgeon factors associated with discharge on postoperative day 0. Results In our study population, 238 women (22%) were discharged on the same day. Robotic hysterectomy (risk ratio [RR] 2.24; 95% confidence interval [CI] 1.13-4.44), shorter operative time (lowest quartile; RR 5.28; 95% CI 2.66-10.46), and minimal blood loss (lowest quartile; RR 3.01; 95% CI 1.68-6.23) were associated with higher same-day discharge likelihood whereas later procedure start time (2-5 pm; RR 0.38; 95% CI 0.17-0.85) and postoperative complications (RR 0.19; 95% CI 0.06-0.55) significantly decreased its likelihood. The strongest predictor was surgeon's number of years in practice, with recently graduated surgeons more likely to discharge their patients on the same day (RR 3.15; 95% CI 2.09-4.77). Conclusion Same-day discharge after minimally invasive hysterectomy is determined by several patient, operative, and surgeon factors that can be incorporated into an implementation plan to promote earlier discharge. Most especially, scheduling patients based on perceived case complexity and targeted surgeon education can qualify a larger cohort for same-day discharge.

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FU (National Institute of Child Health and Human Development Bethesda)

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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ER

PT J

AU Polan, RM

Barber, EL

AF Polan, Rosa Miller

Barber, Emma L.

TI Association between cystoscopy at the time of hysterectomy performed by

a gynecologic oncologist and delayed urinary tract injury

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE hysterectomy; urinary bladder fistula; urinary fistula

ID UNIVERSAL CYSTOSCOPY; BENIGN HYSTERECTOMY; URETERAL INJURIES; SURGERY;

COMPLICATIONS; NATIONWIDE; UTILITY

AB Objective Guidance regarding the use of cystoscopy at the time of hysterectomy is lacking in gynecologic oncology. We compare the rate of delayed urinary tract injury in women who underwent cystoscopy at the time of hysterectomy performed by a gynecologic oncologist for benign or malignant indication with those who did not. Methods This was a retrospective cohort study of patients who had a hysterectomy performed by a gynecologic oncologist recorded in the National Surgical Quality Improvement Program between January 2014 and December 2017. The primary outcome was delayed urinary tract injury in the 30-day post-operative period. Secondary outcomes were operative time and urinary tract infection rate. The exposure of interest was cystoscopy at the time of hysterectomy and bivariable tests were used to examine associations. Results We identified 33 355 women who underwent hysterectomy for benign (41%; n=13 621) or malignant (59%; n=19 734) indications performed by a gynecologic oncologist. Surgical approach was open (39%; n=12 974), laparoscopic or robotic-assisted laparoscopic (55%; n=18 272), and vaginal or vaginally-assisted (6%; n=2109). Overall, 12% of women (n=3873) underwent cystoscopy at the time of surgery; cystoscopy was more commonly performed in laparoscopic (15%; n=2829) and vaginal (12%; n=243) approaches than with open hysterectomy (6%; n=801) (p<0.001). There was no difference in the rate of delayed urinary tract injury in patients who underwent cystoscopy at the time of surgery compared with those who did not (0.4% vs 0.3%, p=0.32). However, patients who underwent cystoscopy were more likely to be diagnosed with a urinary tract infection (3% vs 2%, RR 1.3, 95% CI 1.1 to 1.6). In cases where cystoscopy was performed, median operative time was increased by 9 min (137 vs 128 min, p<0.001). Conclusion Cystoscopy at the time of hysterectomy performed by a gynecologic oncologist does not result in a lower rate of delayed urinary tract injury compared with no cystoscopy.

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FU NICHD [K12 HD050121--12]; NIA [P30AG059988--01A1]; GOG Foundation

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JI Int. J. Gynecol. Cancer

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PT J

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AF Eltabbakh, Gamal H.

TI Robotic laparoscopic Hysterectomy for Large Cervical Fibroid <i>A Case

Report</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE fibroids; uterine; gynecologic surgery; hysterectomy; leiomyoma; robotic

surgical procedures; robotics; salpingo-oophorectomy

AB BACKGROUND: Robotic surgery is rapidly being adopted for different gynecologic procedures. Surgery for cervical fibroids is technically difficult, and there are theoretical advantages to robotic surgery for this indication. There is scarcity of reported cases of robotic hysterectomy for large cervical fibroids.

CASE: A 51-year-old woman with postmenopausal bleeding and pelvic pain was found to have a 7 cm cervical fibroid. She underwent successful robotic hysterectomy and bilateral salpingo-oophorectomy and had no operative or postoperative complications.

CONCLUSION: Robotic hysterectomy is feasible for women with large cervical fibroids.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA YJ6TT

UT WOS:000744665200023

DA 2024-01-18

ER

PT J

AU Mabuchi, S

Waki, K

AF Mabuchi, Seiji

Waki, Keita

TI The first case of recurrent small cell neuroendocrine carcinoma of the

uterine cervix successfully treated with robotic-assisted super radical

hysterectomy

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

DE Persistent cervical cancer; Recurrent cervical cancer; Robotic surgery;

Super radical hysterectomy; Complete resection

ID SURGICAL-TREATMENT; CANCER; SURVIVAL

AB Recurrent cervical cancer occurring in a previously irradiated field is one of the most complicated challenges for gynecological oncologists. Super-radical hysterectomy is a standard procedure for laterally extended cervical tumors, particularly recurrent cervical cancer in a previously irradiated field. This potentially curative procedure is challenging to perform due to the technical complexities and lack of reproducibility. Thus, it is performed only by skilled surgeons, either via open or laparoscopic approaches wherein the entire paracervix at the pelvic wall and the hypogastric vessels are transected.

In this report, we described the first case of recurrent small cell neuroendocrine carcinoma of the uterine cervix that was successfully treated with robot-assisted super-radical hysterectomy.

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ER

PT J

AU Obermair, A

Nicklin, J

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TI A phase III randomized clinical trial comparing sentinel node biopsy

with no retroperitoneal node dissection in apparent early-stage

endometrial cancer - ENDO-3: ANZGOG trial 1911/2020

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID LYMPHADENECTOMY; SURGERY

AB Background Sentinel node biopsy is a surgical technique to explore lymph nodes for surgical staging of endometrial cancer, which has replaced full retroperitoneal lymph node dissection. However, the effectiveness of sentinel node biopsy, its value to patients, and potential harms compared with no-node dissection have never been shown in a randomized trial.

Primary Objectives Stage 1 will test recovery from surgery. Stage 2 will compare disease-free survival at 4.5 years between patients randomized to sentinel node biopsy versus no retroperitoneal node dissection.

Study Hypothesis The primary hypothesis for stage 1 is that treatment with sentinel node biopsy will not cause detriment to patient outcomes (lymphedema, morbidity, loss of quality of life) and will not increase treatment-related morbidity or health services costs compared with patients treated without a retroperitoneal node dissection at 12 months after surgery. The primary hypothesis for stage 2 is that disease-free survival at 4.5 years after surgery in patients without retroperitoneal node dissection is not inferior to those receiving sentinel node biopsy.

Trial Design This phase Ill, open-label, two-arm, multistage, randomized non-inferiority trial (ENDO-3) will determine the value of sentinel node biopsy for surgical management of endometrial cancer. Patients with endometrial cancer are randomized to receive: (1) laparoscopic/robotic hysterectomy, bilateral salpingo-oophorectomy with sentinel node biopsy or (2) laparoscopic/robotic hysterectomy, bilateral salpingo-oophorectomy without retroperitoneal node dissection. In stage 1, 444 patients will be enrolled to demonstrate feasibility and quality of life. If this is demonstrated, we will enroll another 316 patients in stage 2.

Major Inclusion and Exclusion Criteria Inclusion criteria include women aged 18 years or older with histologically confirmed endometrial cancer; clinical stage 1, who meet the criteria for laparoscopic or robotic total hysterectomy and bilateral salpingo-oophorectomy. Patients with uterine mesenchymal tumors are excluded.

Primary Endpoints The endpoint for stage 1 is surgical recovery, with the proportion of patients returning to usual daily activities at 3 months post-surgery as measured with the EQ-5D. Stage 2 is disease-free survival at 4.5 years.

Sample Size 760 participants (both stages).

Estimated Dates for Completing Accrual and Presenting Results Stage 1 commenced in January 2021 and is planned to be completed in December 2024 when 444 participants have completed 12 months' follow-up. Stage 2 will enroll a further 316 participants for a total of 760 patients.

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ER

PT J

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TI Incidence of Sacral Osteomyelitis and Discitis After Minimally Invasive

Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacrocolpopexy; osteomyelitis; discitis; minimally invasive

ID LUMBOSACRAL SPONDYLODISCITIS; VERTEBRAL OSTEOMYELITIS; COLPOPEXY;

PROLAPSE; ABSCESS

AB Objective The incidence and associated risk factors for sacral osteomyelitis and sacral discitis after sacrocolpopexy remain unknown. The aim of this study was to determine the incidence of sacral osteomyelitis and discitis after minimally invasive sacrocolpopexy and their association with the method of sacral mesh fixation. Methods This is a retrospective cohort study of consecutive minimally invasive sacrocolpopexies performed by 11 female pelvic medicine and reconstructive surgery board-certified surgeons from January 2009 to August 2019 within a single health system. Sociodemographic, procedure, and clinical variables were abstracted from the electronic health record (EHR). We then performed a confirmatory EHR interrogation, cross-referencing procedural codes for laparoscopic and robot-assisted sacrocolpopexy and diagnostic codes for sacral osteomyelitis and sacral discitis. Results The EHR chart review identified 1,189 women who underwent laparoscopic (55.2%) and robot-assisted (44.8%) minimally invasive sacrocolpopexy, all with polypropylene mesh. Median follow-up was 7.7 months (interquartile range, 0-49.8). Titanium helical tacks were used in 52.7% patients, sutures in 41.6%, and both in 5.6%. No cases (0%) of sacral osteomyelitis or discitis were identified by chart review. The system-wide EHR interrogation of procedural and diagnostic codes identified 421 additional procedures for a total of 1,610 minimally invasive sacrocolpopexies. Among these, there were no cases (0%) of osteomyelitis or discitis. Conclusions Sacral osteomyelitis and discitis are rare early outcomes after minimally invasive sacrocolpopexy with an incidence of less than 1/1,000 cases. Given an absence of cases, we were unable to assess for an association between method of sacral attachment and sacral osteomyelitis and sacral discitis.

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NR 30

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

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Advincula, Arnold P.

TI Robotic Surgery Advancements and Inflection Points in the Field of

Gynecology

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Robotic surgery; Ergonomics; Surgeon console; Haptic feedback;

Stereoscopic imaging; Hospital privileging

ID LAPAROSCOPIC HYSTERECTOMY; GUIDELINES; OUTCOMES; NEED

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TC 1

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ER

PT J

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Rupa, Bana

TI Robotic Myomectomy: Five Modifications in Our Practice

SO JOURNAL OF OBSTETRICS AND GYNECOLOGY OF INDIA

LA English

DT Article

DE Robotic; Myomectomy; Cost; Laparoscopy; Fibroid; Technique; Instruments;

Modifications; Reduce

ID COSTS

AB We discuss five technical modifications made over 8 years in the technique of robotic myomectomy at our institution. Universal preoperative MRI was the first modification. Precise hysterotomy incisions were planned by accurate myoma mapping. The second modification was to reduce the number of ports. We performed surgery with one 12-mm-port for the camera and one 8-mm-port on either side of the patient for scissors and fenestrated bipolar forceps. Third modification was to reduce the number of robotic instruments by using laparoscopic myoma screw instead of robotic tenaculum during enucleation and discard the use of a second needle driver and prograsp forceps. So instead of six instruments in classical technique, we now use only three instruments thus reducing the cost of instruments by 40-50%. The fourth modification was to use a single 30 or 45 cm barbed suture. A single long suture efficiently managed by wristed needle driver of robot was sufficient in most cases for hysterotomy closure. This reduces the time needed for multiple needle pass and cost due to reduced number of sutures used. The fifth modification was to not use the electro mechanical morcellator and commercially available bags. We do cold knife morcellation in indigenous plastic bags. Over a period of eight years, we have made robotic myomectomy efficient and reduced the cost of instruments by 40-50% as compared to the classical technique. This has enabled wider adoption of robotic myomectomy at our institution thus reducing open myomectomy in all types of myomas.

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TC 0

Z9 0

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U2 1

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J9 J OBSTET GYN INDIA

JI J. Obstet. Gynecol. India

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AU Ding, Y

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Zhang, Ying

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Ding, Jingxin

Hua, Keqin

TI Cervicovaginal reconstruction with small intestinal submucosa graft in

congenital cervicovaginal atresia: A report of 38 cases

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Uterovaginal anastomosis; Cervicovaginal atresia; Acellular porcine

small intestinal; submucosa grafts; Quality of life

ID UTERINE CERVIX ATRESIA; ASSISTED UTEROVAGINAL ANASTOMOSIS; FOLLOW-UP

AB Objective: To evaluate the quality of life and surgical outcomes in patients with congenital cervicovaginal malformation after cervicovaginal reconstruction. Study design: Thirty-eight patients diagnosed with congenital cervicovaginal aplasia and underwent cervicovaginal reconstruction using acellular porcine small intestinal submucosa (SIS) grafts were included in the study from January 2012 to December 2019. Of these, twenty-one patients underwent conventional laparoscopy, nine underwent robotic surgery, and eight underwent laparoendoscopic single-site (LESS) surgery. Clinical characteristics, perioperative data, condition of the neovagina and neocevix, post-operation complications, body image, resumption of menstruation, sexual function, and quality of life were assessed. Results: The average age of the patients was 16.4 +/- 5.78 years. The operative procedure lasted 182.29 +/- 70.85 min, with a hemoglobin decrease of 12.53 +/- 7.55 g/dl. All surgery was completed successfully without complications. The total cost was highest in the robotic surgery group (P < 0.001). The cosmetic scores were significantly higher in the LESS group (P < 0.001). At a median follow-up of 49.79 +/- 31.02 months, all patients resumed menstruation, except one patient who underwent hysterectomy due to vaginal obstruction. The average length of neovagina was 8.11 +/- 0.75 cm, and the length of the cervix was 1.7 3 +/- 1.00 cm. There were one patient with vaginal stenosis, two patients with cervical occlusion, two patients with cervical stenosis, and six patients with intrauterine device loss. Fourteen patients experienced sexual activity, with the total female sexual function index scores of 26.83 +/- 3.49. Six patients had a desire of pregnancy, and one patient had pregnant via assisted-reproduction techniques. No differences in the mean physical component score (PCS) and mental component score (MCS) were identified among three different groups at baseline and all post-surgery time points (P > 0.05), but with the extension of follow-up, both PCS and MCS increased significantly in all groups (P < 0.001). Conclusion: Cervicovaginal reconstruction using an SIS graft is safe and efficient to the management of congenital cervicovaginal atresia whatever by the conventional laparoscopy, robotic surgery or LESS, with good surgical outcomes and high of quality of life. (c) 2021 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

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U1 2

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Lee, JH

Yoo, HK

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AF Lee, Jung Hun

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Park, So Yun

Moon, Hye-Sung

TI Robotic single-port myomectomy using the da Vinci SP surgical system: A

pilot study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE gynecology; laparoscopy; myomectomy; robotic surgery; single-port

surgery

ID SITE

AB Aim To report our initial experience with robotic single-port myomectomy (RSPM) using the da Vinci SP surgical system and to evaluate the feasibility of the procedure. Material and Methods This prospective observational study was performed at a university teaching hospital from January 2019 to December 2019. Sixty-one women with symptomatic fibroids received RSPM. Results Based on seven resected fibroids and a maximal diameter of resected fibroids <10 cm, the women were arbitrarily divided into two groups. The mean number and maximal diameter of the removed fibroids were 3.7 +/- 3.8 (2.3 +/- 1.8 in Group 1 vs. 7.2 +/- 5.3 in Group 2) and 7.6 +/- 2.9 cm (6.8 +/- 1.6 in Group 1 vs. 9.5 +/- 4.3 in Group 2), respectively. The mean operation time, hemoglobin change, and hospital stay were 149.9 +/- 72.9 min (123.8 +/- 43.8 in Group 1 vs. 217.6 +/- 89.4 in Group 2), 2.3 +/- 1.0 g/dL (2.1 +/- 0.9 in Group 1 vs. 2.7 +/- 1.2 in Group 2), and 4.5 +/- 0.8 days (4.4 +/- 0.8 in Group 1 vs. 4.7 +/- 0.9 in Group 2). There was no conversion to multi-port laparoscopy or laparotomy nor were there any major complications. Conclusions RSPM using the da Vinci SP surgical system is feasible surgical modality for women with symptomatic fibroid and is expected to increase indications of single-port myomectomy by solving many of the ergonomics problems inevitably accompanying single-port laparoscopic myomectomy.

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NR 13

TC 5

Z9 5

U1 1

U2 4

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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SC Obstetrics & Gynecology

GA XY5XI

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ER

PT J

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TI Single-site robotic-assisted hysterectomy and sentinel lymph node

mapping for low-risk endometrial cancer: surgical technique and

preliminary outcomes

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Single-site hysterectomy; Laparoendoscopic

single-site surgery; Robotic single-site surgery; Sentinel node mapping

ID TRANSUMBILICAL TOTAL HYSTERECTOMY; LYMPHADENECTOMY; BIOPSY; SURGERY;

MULTICENTER; ALGORITHM; CARCINOMA; ACCURACY; TRIAL

AB The staging of endometrial cancer has changed from clinical to surgical over the years. Lymph node disease is recognised as an important prognostic factor as well as an aid to tailoring adjuvant therapy. The development of sentinel lymph node mapping algorithms shows promise in diagnostic accuracy and reducing the morbidity associated with comprehensive lymphadenectomy. In select patients, it is feasible to perform sentinel lymph node mapping using minimally invasive surgical techniques. We present a series of single-site robotic-assisted laparoscopic hysterectomy and sentinel lymph node mapping for low-risk endometrial cancer focusing on the surgical technique required and perioperative outcomes.

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Z9 0

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JI Eur. J. Gynaecol. Oncol.

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SC Oncology; Obstetrics & Gynecology

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PT J

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TI History and pioneers of laparoscopy

SO GYNAKOLOGE

LA German

DT Article

DE History of medicine; Robotic surgical procedures; Artificial

intelligence; Augmented reality; Deep learning

ID ENDOSCOPY; FUTURE

AB The introduction of laparoscopy into the clinical practice is an outstanding success story in the history of medicine. The first laparoscopy in a human being was performed almost exactly 100 years ago. Subsequently, a number of decisive advancements were made in laparoscopy from the 1960s to the 1980s, accompanied by a transition from diagnostic to surgical laparoscopy. These developments are inseparably linked with the names Palmer, Frangenheim and Semm. The speed of development had a major impact on gynecology. Laparoscopy, a discovery that faced bitter criticism in the surgical community has become the medical treatment of choice for several benign and malignant diseases in a variety of medical specialties. The new generation of the 2000s takes laparoscopy for granted. Conventional laparoscopy has been extended to include robotic-assisted surgery. We are now on the verge of introducing artificial intelligence and augmented reality in laparoscopy. The present review of the development of laparoscopy highlights past achievements and describes current challenges and opportunities.

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NR 30

TC 2

Z9 2

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U2 5

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J9 GYNAKOLOGE

JI Gynakologe

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IS 12

SI SI

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DI 10.1007/s00129-021-04871-9

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WC Obstetrics & Gynecology

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TI Impact of Legislation on Opioid Prescribing following Hysterectomy and

Hysteroscopy in Arizona and Florida

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Hysterectomy; Hysteroscopy; Legislation; Opioid prescribing; Oral

morphine equivalents

ID POSTOPERATIVE PAIN; DOUBLE-BLIND; PATIENT USE; PRESCRIPTION; PATTERNS;

COHORT; STATES; SITES; RISK

AB Objectives: This study aimed to determine the oral morphine equivalents (OMEs) prescribed and refill rates following hysterectomy and hysteroscopy in the setting of opioid prescribing practice changes in 2 states. Design: This is a retrospective cohort analysis consisting of 2,916 patients undergoing hysterectomy or hysteroscopy between July 2016 and September 2019 at 2 affiliated academic hospitals in states that underwent legislative changes in opioid prescribing in 2018. Methods: Participants were identified using the Current Procedural Terminology procedure codes in Arizona and Florida. Hysterectomy was chosen as the most invasive gynecologic procedure, while hysteroscopy was chosen as the least invasive. Medical records were abstracted to find opioid prescriptions from 90 days before surgery to 30 days after discharge. Patients with opioid use between 90 and 7 days before surgery were excluded. Prescriptions were converted to OMEs and were calculated per quarter year. Statistical analysis included Wilcoxon rank sum t tests for OMEs and chi(2) t tests for refill rates. Interrupted time-series analysis was used to determine significant change in OMEs before and after legislative change. Statistical analysis was performed using SAS version 9.4 (SAS Institute, Cary, NC, USA). Results: In Arizona, 1,067 hysterectomies were performed; 459 (43%) vaginal, 561 (52.6%) laparoscopic/robotic, and 47 (4.4%) abdominal. There were 530 hysteroscopies. Overall median OMEs decreased from 225 prior to July 2018 to 75 after July 2018 (p < 0.0001). The opioid refill rate remained unchanged at 7.4% (p = 0.966). In Florida, there were 769 hysterectomies; 241 (31.3%) vaginal, 476 (61.9%) laparoscopic/robotic, and 52 (6.8%) abdominal. There were 549 hysteroscopies. Overall median OMEs decreased from 150 prior to July 2018 to 0 after July 2018 (p < 0.0001). The opioid refill rate was similar (7.8% before July 2018 and 7.3% after July 2018; p = 0.739). Limitations: Limitations include involvement of a single hospital institution with a total of 10 fellowship-trained surgeons and biases inherent to retrospective study design. Conclusions: Legislative and provider-led changes coincided with decreases in opioid prescribing after 2018 in both states without increasing rates of refills and showed actual data reflected in the medical record. Gynecologists must actively participate in safe prescribing practices to decrease opioid dependence and misuse.

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NR 27

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Z9 2

U1 1

U2 6

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J9 GYNECOL OBSTET INVES

JI Gynecol.Obstet.Invest.

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PT J

AU Kampers, J

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TI Perioperative morbidity of different operative approaches in early

cervical carcinoma: a systematic review and meta-analysis comparing

minimally invasive versus open radical hysterectomy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Early cervical cancer; Radical hysterectomy; Minimally-invasive;

Laparoscopy; Robot-assisted; Postoperative morbidity

ID PELVIC LYMPHADENECTOMY; SURVIVAL OUTCOMES; LEARNING-CURVE; CANCER;

RECURRENCE; LAPAROTOMY; SURGERY; IB

AB Purpose Radical hysterectomy and pelvic lymphadenectomy is the standard treatment for early cervical cancer. Studies have shown superior oncological outcome for open versus minimal invasive surgery, but peri- and postoperative complication rates were shown vice versa. This meta-analysis evaluates the peri- and postoperative morbidities and complications of robotic and laparoscopic radical hysterectomy compared to open surgery. Methods Embase and Ovid-Medline databases were systematically searched in June 2020 for studies comparing robotic, laparoscopic and open radical hysterectomy. There was no limitation in publication year. Inclusion criteria were set analogue to the LACC trial. Subgroup analyses were performed regarding the operative technique, the study design and the date of publication for the endpoints intra- and postoperative morbidity, estimated blood loss, hospital stay and operation time. Results 27 studies fulfilled the inclusion criteria. Five prospective, randomized-control trials were included. Meta-analysis showed no significant difference between robotic radical hysterectomy (RH) and laparoscopic hysterectomy (LH) concerning intra- and perioperative complications. Operation time was longer in both RH (mean difference 44.79 min [95% CI 38.16; 51.42]), and LH (mean difference 20.96 min; [95% CI - 1.30; 43.22]) than in open hysterectomy (AH) but did not lead to a rise of intra- and postoperative complications. Intraoperative morbidity was lower in LH than in AH (RR 0.90 [0.80; 1.02]) as well as in RH compared to AH (0.54 [0.33; 0.88]). Intraoperative morbidity showed no difference between LH and RH (RR 1.29 [0.23; 7.29]). Postoperative morbidity was not different in any approach. Estimated blood loss was lower in both LH (mean difference - 114.34 [- 122.97; - 105.71]) and RH (mean difference - 287.14 [- 392.99; - 181.28]) compared to AH, respectively. Duration of hospital stay was shorter for LH (mean difference - 3.06 [- 3.28; - 2.83]) and RH (mean difference - 3.77 [- 5.10; - 2.44]) compared to AH. Conclusion Minimally invasive radical hysterectomy appears to be associated with reduced intraoperative morbidity and blood loss and improved reconvalescence after surgery. Besides oncological and surgical factors these results should be considered when counseling patients for radical hysterectomy and underscore the need for new randomized trials.

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U1 0

U2 1

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PT J

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TI A Clinically Applicable Prediction Model for the Risk of Transfusion in

Women Undergoing Myomectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Myomectomy; Blood transfusion; Gynecologic surgery; Minimally invasive

surgery

ID COMPLICATIONS; MORBIDITY

AB Study Objective: We sought to identify the variables independently associated with intra/postoperative blood transfusion at the time of myomectomy. We further hoped to develop an accurate prediction model using preoperative variables to categorize an individual's risk of blood transfusion during myomectomy.

Design: Case-control study.

Setting: Not applicable to this study, which used the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database.

Patients: Women who underwent an open/abdominal or laparoscopic (robotic or conventional) myomectomy between 2014 and 2017 at participating ACS-NSQIP sites.

Intervention: The primary dependent variable was occurrence of intra/postoperative bleeding requiring blood transfusion. Patient demographics, clinical characteristics, preoperative comorbidities, intraoperative variables, and additional 30-day postoperative outcomes were compared at the bivariable level. For the prediction-model development, only variables that can be reasonably known before surgery were included. Variables associated with intra/postoperative bleeding were entered into 2 separate multivariable logistic regression models. Validation of our prediction model was performed internally using 250 bootstrapped iterations of 50% subsamples drawn from the overall population of myomectomy cases from the ACS-NSQIP database.

Measurements and Main Results: We identified 6387 myomectomies performed during the defined study period. The most common race in our population was black/African American (45.7%), and most of the patients (57.5%) received an open/abdominal route of myomectomy. A total of 623 patients who underwent myomectomy (9.8%) experienced intraoperative/postoperative bleeding with a need for blood transfusion. At the bivariable level, we identified several variables independently associated with the need for blood transfusion at the time of myomectomy. In using only those variables that can be reasonably known before surgery to develop our prediction model, additional multivariable logistic regression elucidated black race, need for preoperative blood transfusion, planned abdominal/open route of surgery, and preoperative hematocrit value as independently associated with blood transfusion.

Conclusion: We identified a number of perioperative variables associated with intraoperative or postoperative bleeding requiring blood transfusion at the time of myomectomy. We subsequently created a model that accurately predicts individual bleeding risk from myomectomy, using variables that are reasonably apparent preoperatively. Making this prediction model clinically available to gynecologic surgeons will serve to improve the care of women undergoing myomectomy. (C) 2021 AAGL. All rights reserved.

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NR 14

TC 1

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PT J

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TI Epithelial ovarian cancers and minimally invasive cytoreductive surgery

after neoadjuvant chemotherapy: A systematic review

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA English

DT Review

DE Advanced ovarian cancer; Neoadjuvant chemotherapy; Minimally invasive

surgery; Laparoscopy; Robotic surgery

ID PRIMARY DEBULKING SURGERY; GYNECOLOGIC-ONCOLOGY; EVALUATION CRITERIA;

FALLOPIAN-TUBE; LAPAROSCOPY; INTERVAL; LAPAROTOMY; MANAGEMENT;

CONVERSION; CLASSIFICATION

AB Introduction. - Advanced epithelial ovarian cancer (EOC) is associated with high mortality and often managed first with neoadjuvant chemotherapy (NACT) followed by debulking surgery. Laparoscopic surgery with or without robotic assistance (Minimally Invasive Surgery (MIS)) may represent a beneficial option for these patients. The objective of this literature review is to clarify the place of MIS in the management of advanced EOC for selected patients. Method. - Pubmed, Cochrane and Clinicaltrials.gov online databases were used for this review, to select English or French published articles. Results. - We selected 11 original articles published between 2015 and 2020, 6 of which compared MIS and laparotomy. Among these 11 studies, 8 were retrospective cohorts, 2 were phase II trials, and one was a case-control study. In total, there were 3721 patients, of which 854 (23%) were treated with MIS. The robotic assistance was used with 224 patients (26%) of those MIS patients. Looking specifically at MIS patients, the laparoconversion rate was 9.5%, the rate of complete resection (CC-0) was 83.4%. Finally, the MIS complication rate was 1% intraoperatively and 12% postoperatively. The rate of complete resection, postoperative complication, as well as overall survival (OS) were comparable between patients treated with MIS or laparotomy. One study found an improved disease-free survival (DFS) in MIS versus laparotomy (18 months versus 12 months; P = 0.027). Conclusion. - MIS seems feasible, effective, and reliable in comparison to laparotomy for the completion of cytoreductive surgery after NACT without compromising oncological safety. Prospective randomized controlled trials are needed to confirm the role of MIS in advanced EOC. (c) 2021 Elsevier Masson SAS. All rights reserved.

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U1 2

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J9 GYNECOL OBST FERT SE

JI Gynecol. Obstet. Fertil. Senol.

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ER

PT J

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Gauthier, T

AF Margueritte, Francois

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Fauconnier, Arnaud

Gauthier, Tristan

TI Time to conceive after myomectomy: CrossMark should we advise a minimum

time interval? A systematic review

SO REPRODUCTIVE BIOMEDICINE ONLINE

LA English

DT Review

DE Myomectomy; Pregnancy; Time to conception; Uterine rupture

ID SPONTANEOUS UTERINE RUPTURE; ASSISTED LAPAROSCOPIC MYOMECTOMY; PREGNANCY

OUTCOMES; ABDOMINAL MYOMECTOMY; VAGINAL MYOMECTOMY; INTRAMURAL MYOMAS;

FERTILITY; WOMEN; SUBSEQUENT; GESTATION

AB The optimal time interval between myomectomy and pregnancy is unclear and no specific guidelines exist. The aim of this review was to study the time interval from myomectomy to pregnancy and the occurrence of uterine rupture after myomectomy. Randomized controlled trials, cohort studies and retrospective studies were used to assess the primary objective, and case reports, cases series or letters to the editor for the secondary objective. Only articles reporting myomectomy performed via the vaginal route, laparotomy, laparoscopy or robot-assisted surgery were selected for inclusion. Among 3852 women who wanted to become pregnant after the surgery, 2889 became pregnant, accounting for 3000 pregnancies (77.9%) and 2097 live births (54.4%). Mean time between myomectomy and pregnancy was estimated at 176 months (SD 9.2) for 2451 pregnant women. Among 1016 women, a third were advised to delay attempting to conceive for between 3 and 6 months and another third for between 6 and 12 months. A total of 70 spontaneous uterine ruptures with a mean gestational age of 31 weeks at occurrence were identified. No linear relationship was found between gestational age at the event and time interval from myomectomy to conception (P = 0.706). There are insufficient data to advise a minimal time interval between myomectomy and conception.

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NR 108

TC 6

Z9 6

U1 1

U2 4

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JI Reprod. Biomed. Online

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ER

PT J

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TI Evaluating Rates of Preoperative Medical Optimization to Correct Anemia

in Patients Undergoing Myomectomy

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE anemia; fibroids; transfusion; myomectomy; knowledge translation

ID BLOOD MANAGEMENT; MORBIDITY

AB Objective: The aims of this retrospective cohort study were to determine the proportion of women on medical therapy to correct anemia, defined as hemoglobin <12.0g/dL prior to myomectomy and to determine the association between preoperative optimization and transfusion rates, accounting for preoperative anemia.

Materials and Methods: Patients undergoing myomectomy (open, laparoscopic, or robot-assisted) between February 2015 and June 2018 at a single high-volume academic hospital were included.

Results: There were 224 patients who underwent open (70.5%), laparoscopic (10.7%), or robotic (18.8%) myomectomy, with 30.4% (n = 68) anemic immediately prior to surgery. Of those patients, 76.5% (n = 52) received medical preoperative optimization before surgery: 23 (33.8%) had iron therapy alone; 16 (23.5%) had hormonal therapy alone; 12 (17.7%) had iron and hormonal therapy; and 9 (13%) had tranexamic acid. Perioperative blood transfusion-a transfusion given intraoperatively or within 2 days postoperatively was given to 32 (14.3%) patients; 84.4% (n = 27) were open cases. Half (n = 16) of the transfused patients were anemic before surgery and 25% were not receiving preoperative medical optimization. Preoperative anemia significantly increased the odds of perioperative blood transfusion (odds ratio [OR] = 2.69, 95% confidence interval [CI] :1.26-5.77; p = 0.011). Taking medications prior to surgery did not affect the odds of receiving transfusion across all patients, including those with preoperative anemia (adjusted OR = 0.87; 95% CI: 0.38-1.98; p = 0.732).

Conclusions: One quarter of transfused patients were not on medications preoperatively despite being anemic. An attempt should be made to optimize and correct anemia actively prior to myomectomy, particularly for a planned open procedure.

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NR 24

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Z9 0

U1 0

U2 0

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

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DA 2024-01-18

ER

PT J

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Cao, YJ

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TI Effectiveness of robotic surgery for endometrial cancer: a systematic

review and meta-analysis

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Endometrial cancer; Robotic; Laparoscopic; Laparotomy; Meta-analysis

ID LAPAROSCOPIC HYSTERECTOMY; PERIOPERATIVE OUTCOMES; STANDARD LAPAROSCOPY;

LAPAROTOMY; LYMPHADENECTOMY; MANAGEMENT; RECURRENCE; SURVIVAL; COST

AB Background Our current study was performed aimed at determining the efficacy and safety profile of robotic surgery (RS) compared to laparoscopic surgery (LPS) and laparotomy (LT) in the treatment of endometrial cancer on the basis of relevant studies. Patients and methods A systematic literature search was conducted based on appropriate keywords, using the Embase, Cochrane library, as well as PubMed. Our studiers also reviewed the key pertinent sources among the publications and included associated literatures published by June 2021. Odds ratios (ORs), mean difference (MD), as well as 95% confidence interval (95% CI) for each study were measured for further assessment and synthesis of outcomes. Results Thirty studies involving a total of 12,025 patients were eventually included in the current meta-analysis. Compared with LPS, RS could significantly decrease the estimated blood loss, the incidence of intraoperative complications, the length of hospital stay, and the rate of conversion, and increased the rate of readmission. Compared with LT, RS significantly decreased the estimated blood loss, blood transfusion volume, the length of hospital stay, the rate of total, intraoperative and postoperative complications, and the rate of readmission and re-operation, and increased the operative time. Conclusion Considering the effects and safety profile of RS in terms of treating endometrial cancer, our study suggest that RS exerts superior outcomes than that of LPS and LT.

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NR 37

TC 3

Z9 3

U1 0

U2 5

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JI Arch. Gynecol. Obstet.

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ER

PT J

AU Matsuo, K

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Chang, EJ

Zhang, RH

Matsuzaki, S

Klar, M

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Mandelbaum, Rachel S.

Nusbaum, David J.

Chang, Erica J.

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TI Risk of Upper-body Adverse Events in Robot-assisted Total Laparoscopic

Hysterectomy for Benign Gynecologic Disease

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Trendelenburg position; Surgical morbidity; Upper body

complication

ID STEEP TRENDELENBURG POSITION; ENDOMETRIAL CANCER; RADICAL HYSTERECTOMY;

HEMODYNAMIC-CHANGES; CERVICAL-CANCER; UNITED-STATES; SURGERY;

COMPLICATIONS; PNEUMOPERITONEUM; METAANALYSIS

AB Study Objective: Recent studies suggest that prolonged Trendelenburg positioning during robot-assisted total laparoscopic hysterectomy (RA-TLH) may lead to fluid shifts and pulmonary, airway, head and neck, and cranial complications in the upper body. This study examined the upper-body complications during RA-TLH for benign gynecologic disease.

Design: Population-based retrospective study.

Setting: The National Inpatient Sample.

Patients: A total of 771 412 women who had total hysterectomy for benign gynecologic disease from October 2008 to September 2015, including 661 284 women who had total abdominal hysterectomy (TAH), 51 544 women who had traditional TLH, and 58 584 women who had RA-TLH.

Interventions: A multiple-group generalized boosted model to balance the measured baseline covariates across the 3 hysterectomy groups and a generalized estimating equation model to assess the effect size of complication risk (overall and upper-body complications).

Measurements and Main Results: Women in the RA-TLH group were more likely to be older, white, and have a higher comorbidity index (all, p<.001). The overall rate of upper-body complications was 4.6% across the 3 groups. RA-TLH was not associated with increased risk of upper-body complications compared with traditional TLH (odds ratio [OR] 1.06; 95% confidence interval [CI], 0.90-1.26) or TAH (OR 0.98; 95% CI, 0.87-1.11). In contrast, RA-TLH was associated with decreased risk of overall perioperative complications compared with TAH (12.0% vs 18.6%; OR 0.64; 95% CI, 0.59-0.70; p<.001). RA-TLH and traditional TLH had similar risk of overall perioperative complications (12.0% vs 13.1%; OR 0.91; 95% CI, 0.8-1.02; p = .099). Women who developed upper-body complications had a higher perioperative mortality rate (0.4% vs <0.01%; OR 79.1; 95% CI, 36.0-174). The highest rates of complications (62.5%) were observed in morbidly obese women aged 70-79 with a comorbidity index of >= 4.

Conclusion: In hysterectomy for benign gynecologic disease, RA-TLH was not associated with an increased risk of upper body complications compared with TAH or traditional TLH. However, older age and higher comorbidity are key risk factors that increase the risk of upper-body complications which carry a disproportionally high mortality rate. (C) 2021 AAGL. All rights reserved.

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U2 1

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PT J

AU Wang, HF

Chen, HH

Ting, WH

Lu, HF

Lin, HH

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AF Wang, Hsiao-Fen

Chen, Hui-Hua

Ting, Wan-Hua

Lu, Hsin-Fen

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TI Robotic or laparoscopic treatment of cesarean scar defects or cesarean

scar pregnancies with a uterine sound guidance

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Cervix; Cesarean section; Laparoscopy; Ectopic; Robotics

ID SECTION; REPAIR; MANAGEMENT; DEHISCENCE; MYOMECTOMY; OUTCOMES; WOMEN

AB Objective: To evaluate the feasibility and effectiveness of robotic/laparoscopic repair of cesarean scar defects or cesarean scar pregnancies with a uterine sound. Materials and methods: All consecutive women with cesarean scar defects or cesarean scar pregnancies who underwent robotic/laparoscopic repair with a bent uterine sound guidance were reviewed. Subjective changes in symptoms and objective changes in the depth and width of cesarean scar defects after surgery were reviewed. Results: A total of 20 women underwent robotic (n = 3) or conventional laparoscopic (n = 17) repair of cesarean scar defects, which included postmenstrual vaginal bleeding associated with cesarean scar defects (n = 15), cesarean scar pregnancies (n = 3), accumulated pus in the cesarean scar defect (n = 1) and an incomplete abortion incarcerated in the cesarean scar defect (n = 1). Bladder perforation occurred in one woman during robotic adhesiolysis. All women with cesarean scar defects (n = 15) reported an improvement in postmenstrual vaginal bleeding after surgery. Follow-up sonography showed a decrease in the depth and width of the cesarean scar defect and an increase in the residual myometrial thickness. Conclusion: Robotic or laparoscopic repair with a uterine sound guidance seems to be a feasible and effective method in the treatment of cesarean scar defect or cesarean scar pregnancy. (c) 2021 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

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U2 9

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JI Taiwan. J. Obstet. Gynecol.

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TI Decline in surgeon volume after successful implementation of advanced

laparoscopic surgery in gynecology: An undesired side effect?

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE gynecological surgeon volume; hospital volume; hysterectomy; minimally

invasive surgery; robotic surgery

ID SURGICAL VOLUME; HYSTERECTOMY; MANAGEMENT; ROUTE; EXPERIENCE;

OBSTETRICS; LAPAROTOMY; RESIDENTS; OUTCOMES; IMPACT

AB Introduction: The implementation of advanced minimally invasive surgical (MIS) techniques has broadened. An extensive body of literature shows that high hospital and surgeon volumes lead to better patient outcomes. However, no information is available regarding volume trends in the post-implementation phase of MIS. This study investigated these trends and poses suggestions to adjust these developments. This knowledge can provide guidance to optimize patient safe performance of new surgical techniques.

Material and methods: A national retrospective cohort study in the Netherlands. The number of advanced laparoscopic (level 3 and 4) and robotic procedures and the number of gynecologists performing them were collected through a web-based questionnaire to determine hospital and gynecological surgeon volume. These volumes were compared with our previously collected data from 2012.

Results: The response rate was 85%. Hospitals produced larger volumes for advanced laparoscopic and robotic procedures. However, still 63% of the hospitals perform low-volume level 4 laparoscopic procedures. Additionally, gynecological surgeon volumes appeared to decrease for level 3 procedures, as the group of gynecologists performing fewer than 20 procedures expanded (64% vs. 44% in 2012), with 15% of the gynecologists performing fewer than ten procedures. Despite an increase in surgeon volumes for level 4 laparoscopy and robotic surgery, volumes continued to be low, as still 49% of gynecologists performed fewer than 10 level 4 procedures per year and 41% performed fewer than 20 robotic procedures per year.

Conclusions: The broad implementation of advanced MIS procedures resulted in an increasing number of these procedures with increasing hospital volumes. However, as a side-effect, a disproportionate rise in number of gynecologists performing these procedures was observed. Therefore, surgeon volumes remain low and even decreased for some procedures. Centralization of complex procedures and training of specialized MIS gynecologists could improve surgeon volumes and therefore consequently enhance patient safety.

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Z9 4

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JI Acta Obstet. Gynecol. Scand.

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PT J

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TI Does ventral mesh rectopexy at the time of sacrocolpopexy prevent

subsequent posterior wall prolapse?

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Article

DE Pelvic organ prolapse; sacrocolpopexy; rectopexy; minimally invasive

surgery; multicompartmental prolapse

ID PELVIC ORGAN PROLAPSE; URINARY-INCONTINENCE; LIFETIME RISK; OUTCOMES;

SURGERY; EFFICACY; SUPPORT

AB Objective: To determine whether ventral mesh rectopexy at the time of sacrocolpopexy reduces the rate of future posterior wall prolapse.

Material and Methods: This was a retrospective cohort study of women with pelvic organ prolapse (POP) who underwent sacrocolpopexy or without concomitant rectopexy at a single community hospital from December 1, 2015 to June 30, 2019. Preoperative pelvic organ prolapse quantification (POP-Q) and urodynamic testing was used in evaluation of POP. Patients were followed for 12-weeks postoperatively and a 12-week postoperative POP-Q assessment was completed. The incidence of new or recurrent posterior prolapse was compared between cohorts.

Results: Women with POP (n=150) were recruited, of whom 41 (27.3%) underwent sacrocolpopexy while the remainder (n=109, 72.7%) did not receive rectopexy. Patient demographics did not statistically differ between cohorts. Post-surgical posterior wall prolapse was reduced in the robotic assisted sacrocolpopexy (RASC) + rectopexy group compared to RASC alone, however this did not reach statistical significance. There were no patients who underwent concomitant rectopexy and RASC that needed recurrent posterior wall prolapse surgery, compared to eightpercent of patients that underwent isolated RASC procedures.

Conclusion: Our findings suggest a reduction in the need for subsequent posterior wall surgery when rectopexy is performed at the time of sacrocolpopexy. In our study, no future surgery for POP was found in the concomitant sacrocolpopexy and rectopexy group, while a small proportion of the RASC only group required future POP surgery. Our study, however, was underpowered to elucidate a statistically significant difference between groups. Future larger studies are needed to confirm a reduced risk of posterior wall prolapse in patients who undergo concomitant RASC and rectopexy.

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JI J. Turk.-Ger. Gynecol. Assoc.

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PT J

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CA GO SOAR Team

TI Determining post-operative morbidity and mortality following

gynecological oncology surgery: protocol for a multicenter,

international, prospective cohort study (Global Gynaecological Oncology

Surgical Outcomes Collaborative-GO SOAR)

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE surgical oncology; gynecologic surgical procedures; postoperative

complications

ID SAFETY CHECKLIST; COMPLICATIONS; HEALTH

AB Background The Global Gynaecological Oncology Surgical Outcomes Collaborative (GO SOAR) aims to develop a network of gynecological oncology surgeons, surgical departments, and other interested parties that will have the long-term ability to collaborate on outcome studies. The protocol for the first collaborative study is presented here.

Primary Objective To evaluate international variation in 30-day post-operative morbidity and mortality following gynecological oncology surgery between very high/high and medium/low human development index country settings.

Hypothesis There is no variation in post-operative morbidity and mortality following gynecological oncology surgery between very high/high and medium/low human development index country settings.

Study Design International, multicenter, prospective cohort study. Patient data will be collected over a consecutive 30-day period through gynecological oncology multidisciplinary teams/tumor boards and clinics across different human development index country groups. All data are collected on a customized, secure, password protected, central REDCap database.

Major Inclusion/Exclusion Criteria Inclusion criteria include women aged >= 18 years undergoing elective/emergency, curative/palliative surgery for primary/recurrent tubo-ovarian/peritoneal, endometrial, cervical, vulval, vaginal, gestational trophoblastic malignancies. Surgical modality may be open, minimal access (laparoscopic/robotic), or vaginal.

Primary Endpoint 30-day post-operative morbidity and mortality defined as per Clavien-Dindo classification system.

Sample Size 1100 (550/arm).

Estimated Dates for Completing Accrual and Presenting Results It is estimated recruitment will be completed by 2022 and results published by 2023.

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CA Trial Monitoring Comm SOLUTION Tri

TI Solution to prevent tumor spillage in minimally invasive radical

hysterectomy using the endoscopic stapler for treating early-stage

cervical cancer: Surgical technique with video

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Cervical cancer; Spillage; Endoscopic stapler; Minimally invasive

surgery

AB Gynecologic oncologists had originally preferred minimally invasive surgery (MIS) over laparotomic surgery for patients with early-stage cervical cancer until the Laparoscopic Approach to Cervical Cancer (LACC) trial reported a worse prognosis and more loco-regional recurrence in patients treated with MIS. Although some controversy remains, experts suggested that tumor cell spillage and aggravation may have been caused by intra-corporeal colpotomy, usage of uterine elevators, maintenance of Trendelenburg position, and tumor irritation by capnoperitoneum during surgery. Thus, we introduce a surgical procedure with some steps added to the conventional MIS radical hysterectomy for preventing tumor spillage during the surgery, which is currently being evaluated in terms of safety and efficacy through a prospective, multicenter, single-arm, phase II study, entitled "Safety of laparoscopic or robotic radical surgery using endoscopic stapler for inhibiting tumor spillage of cervical neoplasms (SOLUTION trial: NCT04370496)". (C) 2021 Elsevier Masson SAS. All rights reserved.

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JI J. Gynecol. Obstet. Hum. Reprod.

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ER

PT J

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Young, O. J.

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TI Minimally invasive management of juvenile cystic adenomyoma: report of

three cases

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Juvenile cystic adenomyosis; chronic pelvic pain; minimally invasive

surgical management

ID LAPAROSCOPIC MANAGEMENT; UTERINE MALFORMATION; MIMICKING; UTERUS;

DIAGNOSIS

AB Background: Juvenile cystic adenomyosis (JCA) represents a rare form of focal adenomyosis in young women.

Objectives: To determine safety and effectiveness of minimally invasive surgery (MIS for JCA).

Materials and Methods: Three patients aged 16-30 years old presented with chronic pelvic pain [2016 2019]. Hormonal treatment failed in two cases. Cystic lesions in the myometrium (n=2), and the broad ligament (n=1) was detected on transvaginal 2D ultrasound (TV 2D US) and/or magnetic resonance imaging (MRI). The cyst was separate from the endometrium in all the cases, within the myometrium in two patients and in the right broad ligament in one case. The cystic lesions were confirmed on laparoscopy; and laparoscopic excision of the cysts with adequate repair of the myometrial beds were performed in all cases with fertility preservation. Robotic assistance was chosen in one case in an attempt to avoid injury of the fallopian tube based on the cyst location during a previous laparoscopy. The endometrial cavity was entered in one case.

Main outcome measures: Absence of intraoperative complications and relief of presenting symptoms postoperatively.

Results: Pathology report confirmed the diagnosis of JCA is all cases. There were no intraoperative complications. All three patients reported relief of their symptoms 6 to 8 months after surgery. No recurrence of the JCA was reported using TV 2D US in all cases.

Conclusions: MIS could be the treatment of choice for patients with JCA. The technique described in our study is safe, effective, and easy to master in experienced hands. What is new? Value of MIS in treatment of patients with JCA.

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WC Obstetrics & Gynecology

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PT J

AU Wagar, MK

Sobecki, JN

Chandereng, T

Hartenbach, EM

Wallace, SK

AF Wagar, Matthew K.

Sobecki, Janelle N.

Chandereng, Thevaa

Hartenbach, Ellen M.

Wallace, Sumer K.

TI Postoperative venous thromboembolism in gynecologic oncology patients

undergoing minimally invasive surgery: Does modality matter?

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID LAPAROSCOPIC SURGERY; ENDOMETRIAL; PROPHYLAXIS; CANCER; RISK;

THROMBOPROPHYLAXIS; SOCIETY

AB Objectives: Minimally invasive surgery (MIS) is increasingly utilized for gynecologic cancers. While incidence of venous thromboembolism (VTE) after MIS is low, some guidelines recommend extended chemoprophylaxis for these patients undergoing MIS. Our objectives were to determine incidence of postoperative VTE in patients undergoing MIS, evaluate differences in the incidence by MIS modality and assess the need for extended chemoprophylaxis.

Methods: We conducted a retrospective cohort study including all patients undergoing MIS (robot-assisted, multi-port laparoscopy, single-port laparoscopy) for gynecologic cancers between January 2014 and December 2018 at our institution. Demographic and perioperative variables were collected. Patients <18 years, with benign pathology, or on preoperative anticoagulation were excluded. Chi-square, Fisher's exact test, and one-way ANOVA were performed to determine risk factors related to VTE occurrence.

Results: We identified 806 patients who underwent MIS with median age 61. Most had Stage I disease (81.5%) and uterine cancer (81.5%). Five VTE events occurred within 90 days following surgery (0.6%). Incidence of 90 day VTE did not differ between MIS modalities (p = 0.6). Patients with longer OR times (p = 0.004) were more likely to experience VTE. Age, smoking status, BMI, type of cancer and stage were not significant risk factors for VTE.

Conclusions: The incidence of postoperative VTE in patients with gynecologic cancers undergoing MIS is low and does not appear to differ by MIS modality. Given the very low incidence of postoperative VTE, extended chemoprophylaxis is unlikely to benefit patients with gynecologic malignancies undergoing MIS procedures. (C) 2021 Elsevier Inc. All rights reserved.

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ER

PT J

AU Chuang, FC

Chou, YM

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Chen, WH

Huang, KH

AF Chuang, Fei Chi

Chou, Yu Min

Wu, Ling Ying

Yang, Tsai Hwa

Chen, Wen Hsin

Huang, Kuan Hui

TI Laparoscopic pectopexy: the learning curve and comparison with

laparoscopic sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Laparoscopy; Learning curve; Pectopexy; Pelvic organ prolapse;

Sacrocolpopexy

ID COMPARATIVE CLINICAL-TRIAL; PECTINEAL LIGAMENT; SPONDYLODISCITIS;

SURGERY

AB Introduction and hypothesis In addition to laparoscopic sacrocolpopexy (LS), laparoscopic pectopexy (LP) is a novel surgical method for correcting apical prolapse. The descended cervix or vaginal vault is suspended with a synthetic mesh by fixing the bilateral mesh ends to the pectineal ligaments. This study was aimed at developing a learning curve for LP and to compare it with results with LS. Methods We started laparoscopic/robotic pectopexy in our department in August 2019. This retrospective study included the initial 18 consecutive women with apical prolapse receiving LP and another group undergoing LS (21 cases) performed by the same surgeon. The medical and video records were reviewed. Results The age was older in the LP group than in the LS group (65.2 vs 53.1 years). The operation time of LP group was significantly shorter than that of the LS group (182.9 +/- 27.2 vs 256.2 +/- 45.5 min, p < 0.001). The turning point of the LP learning curve was observed at the 12th case. No major complications such as bladder, ureteral, bowel injury or uncontrolled bleeding occurred in either group. Postoperative low back pain and defecation symptoms occurred exclusively in the LS group. During the follow-up period (mean 7.2 months in LP, 16.2 months in LS), none of the cases had recurrent apical prolapse. Conclusions Laparoscopic pectopexy is a feasible surgical method for apical prolapse, with a shorter operation time and less postoperative discomfort than LS. LP may overcome the steep learning curve of LS because the surgical field of LP is limited to the anterior pelvis and avoids encountering the critical organs.

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WC Obstetrics & Gynecology; Urology & Nephrology

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AU Marchand, G

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TI Systematic review and meta-analysis of all randomized controlled trials

comparing gynecologic laparoscopic procedures with and without robotic

assistance

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Laparoscopic surgery; Meta-analysis; Robot-assisted laparoscopic

hysterectomy; Robotic assisted laparoscopic surgery; Robotic assisted

surgery; Robotic laparoscopic surgery; Robotic surgery

ID HYSTERECTOMY; SURGERY; COMPLICATIONS; LAPAROTOMY; ONCOLOGY; COST

AB Objective: Following the publication of several high quality randomized controlled trials regarding the comparison of similar laparoscopic gynecologic procedures being performed with or without robotic assistance, we aimed to perform a systematic review to identify any differences in patient safety and expected incidence of complications in these procedures. Data Sources: Articles on ClinicalTrials.Gov, Embase, MEDLINE, PubMed, Scopus, and Web of Science data-bases were retrieved and screened for eligibility up to April 1st 2021. Methods of Study Selection: In addition to meeting our screening algorithm, we included studies that met all the following: randomized control trials (RCT), enrolling patients for indicated laparoscopic gyne-cologic procedures, and comparing Robotic Surgery (RS) with Laparoscopic Surgery (LS) in terms of safety or complications. Tabulation, Integration, and Results: Data was pooled as mean difference (MD) or risk ratio (RR) with a 95% confidence interval (CI). Ultimately, six studies were included in this meta-analysis. Pooled data revealed that RS and LS have similar risk for intraoperative complications (RR = 0.87; 95% CI [0.23, 3.36], P = 0.84), postoperative complications (RR = 1.07; 95% CI [0.57, 2.01], P = 0.83), significant intraoperative hemor-rhage (RR = 1.40; 95% CI [0.59, 3.34], P = 0.44), postoperative hemorrhage (RR = 0.43; 95% CI [0.15, 1.22], P = 0.11), vaginal cuff dehiscence (RR = 1.13; 95% CI [0.24, 5.41], P = 0.88), postoperative wound infection, urinary tract infection, and urinary bladder or ureteral injury. RS had "surgeon declared" lower estimated blood loss (MD = 85.27; 95% CI [46.45, 124.09], P < 0.00001) and shorter postoperative hospital stay (MD = 1.20; 95% CI [0.38, 2.01], P = 0.004). Conclusion: There was a statistically significant decrease in hospital stay and "surgeon declared" blood loss seen in the RS group. There was no statistically significant increase in risk of developing other post -operative complications between the LS and R groups. (c) 2021 Elsevier B.V. All rights reserved.

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PT J

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TI Fertility-sparing treatment in cervical cancer: Abdominal trachelectomy

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Abdominal trachelectomy; Cervical cancer; Fertility-sparing surgery

ID VAGINAL RADICAL TRACHELECTOMY; PRESERVING SURGERY; OBSTETRIC OUTCOMES;

HYSTERECTOMY; PRESERVATION; CARCINOMA; PREGNANCY; WOMEN; MANAGEMENT;

SERIES

AB In the last two decades, great strides have been made to treat cancer while sparing fertility for young women. This is at least partly in response to changing demographics, including delayed childbearing and fewer historically traditional couples. The trachelectomy has become emblematic in this endeavor. With comparable outcomes to hysterectomy and successful conceptions, trachelectomy utilization has increased over time. It is now a standard of care for many situations. While there are several approaches, (vaginal, laparoscopic, and robotic), the abdominal trachelectomy allows surgeons to overcome several limitations, such as patient anatomy, surgical experience, and resources (i.e. no robot) to provide women everywhere this revolutionary operation. In this chapter, we outline surgical techniques, outcomes, and other aspects of the abdominal trachelectomy. (c) 2021 Published by Elsevier Ltd.

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ER

PT J

AU Ind, T

AF Ind, Thomas

TI Radical vaginal trachelectomy

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Cervical cancer; Trachelectomy; Complications; Cervical cerclage;

Premature labour

ID STAGE CERVICAL-CANCER; FERTILITY-SPARING SURGERY; PELVIC

LYMPHADENECTOMY; OBSTETRIC MANAGEMENT; PREGNANCY OUTCOMES; PRESERVING

OPTION; SERIES; HYSTERECTOMY; PRESERVATION; CARCINOMA

AB Radical vaginal trachelectomy (RVT) is the oldest fertility-sparing procedure for stage 1b cervical cancer. For that reason, there are more published data for RVT than for all the other radical trachelectomy approaches. However, there are no randomised controlled studies between RVT and radical hysterectomy proving the comparability of survival and no randomised controlled studies comparing a vaginal approach with open, standard laparoscopy and robotic approaches. This article intends to describe the case selection, the procedure and outcomes for RVT. (c) 2021 Published by Elsevier Ltd.

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AU Salvo, G

Pareja, R

Ramirez, PT

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Pareja, Rene

Ramirez, Pedro T.

TI Minimally invasive radical trachelectomy: Considerations on surgical

approach

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Cervical cancer; Radical trachelectomy; Fertility-sparing; Minimally

invasive approach

ID STAGE CERVICAL-CANCER; FERTILITY-SPARING SURGERY; CONSERVATIVE

MANAGEMENT; HYSTERECTOMY; OUTCOMES

AB Current evidence supports that radical trachelectomy is a safe and feasible alternative to patients with early-stage cervical cancer who wish to preserve fertility. In addition, published retrospective literature supports that oncologic outcomes are equivalent to those of radical hysterectomy. First published as a vaginal approach, a number of other approaches have been reported including laparotomic, laparoscopic, and robotic. In 2018, the first ever prospective randomized trial (LACC) comparing open vs. minimally invasive radical hysterectomy showed worse disease-free and overall survival for the minimally invasive (both laparoscopic and robotic) approach than the open approach. This landmark publication raised concerns regarding the oncologic safety of minimally invasive radical trachelectomy. In the United States, minimally invasive became the dominant approach by 2011 for radical trachelectomy. Given that radical trachelectomy is an infrequent performed procedure, only small retrospective studies, systematic reviews, and large database studies have been published. These studies are limited by their retrospective nature, small sample size, patient selection bias, unbalanced groups, and sequential surgical approach comparisons. However, the available evidence thus far shows that oncologic outcomes for both open and minimally invasive radical trachelectomy are equivalent. Given the rarity of the procedure and the low recurrence and death rates of patients with early-stage cervical cancer undergoing radical trachelectomy, a prospective randomized trial seems unlikely. A multi-institutional international registry study (International Radical Trachelectomy Assessment IRTA study) has been recently completed evaluating open vs. minimally invasive radical trachelectomy. There are three ongoing prospective studies evaluating the possibility of less radical surgery in a low-risk early stage cervical cancer population, ConCerv, SHAPE, and GOG 278. We look forward to the final results of these studies that will hopefully shed light on the optimal treatment option for patients with early-stage cervical cancer wishing to preserve fertility. This article will review the most impacting publications comparing open vs. minimally invasive radical trachelectomy and analyze the limitations of the current available literature. (c) 2021 Published by Elsevier Ltd.

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TI Post robotic investment: Cost consequences and impact on length of stay

for obese women with endometrial cancer

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE costs of care; endometrial cancer; length of stay; long follow-up; obese

women; resource consumption; robotic-assisted laparoscopic hysterectomy

ID SURGERY; HEALTH; REGISTERS; BMI

AB Introduction The aim of the study was to investigate whether robotic-assisted surgery is associated with lower incremental resource use among obese patients relative to non-obese patients after a Danish nationwide adoption of robotic-assisted surgery in women with early-stage endometrial cancer. This is a population-based cohort study based on registers and clinical data. Material and methods All women who underwent surgery (robotic, laparoscopic and laparotomy) from 2008 to 2015 were included and divided according to body mass index (<30 and >= 30). Robotic-assisted surgery was gradually introduced in Denmark (2008-2013). We compared resource use post-surgery in obese vs non-obese women who underwent surgery before and after a nationwide adoption of robotic-assisted surgery. The key exposure variable was exposure to robotic-assisted surgery. Clinical and sociodemographic data were linked with national register data to determine costs and bed days 12 months before and after surgery applying difference-in-difference analyses. Results In total, 3934 women were included. The adoption of robotic-assisted surgery did not demonstrate statistically significant implications for total costs among obese women (euro3,417; 95% confidence interval [CI] -euro854 to euro7,688, p = 0.117). Further, for obese women, a statistically significant reduction in bed days related to the index hospitalization was demonstrated (-1.9 bed days; 95% CI -3.6 to -0.2, p = 0.025). However, for non-obese women, the adoption of robotic-assisted surgery was associated with statistically significant total costs increments of euro9,333 (95% CI euro3,729-euro1,4936, p = 0.001) and no reduction in bed days related to the index hospitalization was observed (+0.9 bed days; 95% CI -0.6 to 2.3, p = 0.242). Conclusions The national investment in robotic-assisted surgery for endometrial cancer seems to have more modest cost implications post-surgery for obese women. This may be partly driven by a significant reduction in bed days related to the index hospitalization among obese women, as well as reductions in subsequent hospitalizations.

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JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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PT J

AU Baker, MV

Kisby, CK

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TI Vesicouterine Fistula: A Robotic Approach

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vesicouterine fistula; Uterine conservation; Robotic surgery

ID REPAIR

AB Introduction and hypothesis This video demonstrates surgical repair of a vesicouterine fistula via a robotic, uterine-sparing approach. Methods In this video, we present a vesicouterine fistula, which occurred after cesarean delivery. The patient presented with cyclical hematuria 4 years following delivery. She underwent uterine-conserving robotic repair via excision of the fistula tract through an intentional cystotomy. The uterus and bladder were closed in multiple layers. Results The patient tolerated the procedure well, and CT cystogram 6 weeks following surgery demonstrated no concern for defect or recurrent fistulization. The patient was asymptomatic 9 months following her procedure. Conclusion Repair of a vesicouterine fistula may be safely completed via a minimally invasive approach without need for routine hysterectomy.

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NR 10

TC 3

Z9 3

U1 0

U2 1

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PG 3

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA 2F0XW

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DA 2024-01-18

ER

PT J

AU Tait, DL

Lehman, A

Brown, J

Crane, EK

Kemp, EV

Taylor, VD

Naumann, RW

AF Tait, David L.

Lehman, Alanna

Brown, Jubilee

Crane, Erin K.

Kemp, Erin V.

Taylor, Valerie D.

Naumann, R. Wendel

TI Comparison of Perioperative Outcomes between Minimally Invasive Sentinel

Node Biopsy and Full Lymphadenectomy for Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Lymph nodes; Surgical staging; ERAS

ID LYMPH-NODE; ASTEC TRIAL; SOCIETY; WOMEN

AB Study Objective: To review the perioperative differences between patients undergoing a minimally invasive sentinel lymph node dissection and those undergoing a full lymphadenectomy.

Design: Retrospective review.

Setting: Teaching hospital.

Patients: All patients undergoing a minimally invasive procedure for endometrial cancer that included nodal evaluation.

Interventions: Patients who underwent a sentinel lymph node biopsy were compared with those who underwent a full lymphadenectomy at the time of minimally invasive surgery by either laparoscopic or robot-assisted surgery.

Measurements and Main Results: A total of 241 minimally invasive surgery procedures for endometrial cancer were performed during the 20-month study period. Nodal dissection was indicated and performed in 156 (65%) of these patients, with 93 undergoing a sentinel lymph node biopsy and 63 a full lymphadenectomy. There was no difference between the sentinel group and the lymphadenectomy group with respect to age, estimated blood loss (p = .23), use of a preoperative enhanced recovery after surgery program (p = .82), or body mass index (34.0 kg/m(2) vs 33.7 kg/m(2); p = .87). The use of full lymphadenectomy was very dependent on the surgeon (p < .001). There was no difference in narcotic use in milligram intravenous equivalents of morphine in surgery (20.9 vs 22.2; p = .37), recovery (4.6 vs 4.9; p = .73), or total dose (25.4 vs 27.0; p = .33). The surgical procedure was longer with lymphadenectomy (185.2 minutes vs 214.2 minutes; p < .001) and the relative risk of discharge from recovery was lower (0.71; 95% confidence interval, 0.51-0.97; p = .03). The hospital stay was longer with lymphadenectomy (16.3 hours vs 25.5 hours; p < .001) and same-day discharge less frequent (48.5% vs 13.8%; p < .001). A multivariate analysis confirmed that sentinel node biopsy was associated with an increased relative risk of discharge of 1.68 (95% confidence interval 1.11-2.53; p = .01)

Conclusion: Total narcotic requirements are similar between sentinel node biopsy and lymphadenectomy. However, sentinel node biopsy is associated with a shorter surgical time, recovery time, and hospital stay. (C) 2021 Published by Elsevier Inc. on behalf of AAGL.

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U2 0

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

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Vacca, L

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Lombisani, A

Scambia, G

Ercoli, A

AF Campagna, Giuseppe

Vacca, Lorenzo

Panico, Giovanni

Caramazza, Daniela

Lombisani, Andrea

Scambia, Giovanni

Ercoli, Alfredo

TI Laparoscopic lateral suspension for pelvic organ prolapse: A systematic

literature review

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Pelvic organ prolapse; Lateral suspension; Laparoscopy; Robotic surgery;

Mesh; Systematic review

ID ANTERIOR VAGINAL WALL; GENITAL PROLAPSE; SACROCOLPOPEXY; MESH;

EPIDEMIOLOGY; REPAIR; SERIES; POP

AB Background: Abdominal lateral suspension with mesh represents an alternative treatment to suspend the vaginal apex.

Objectives: The aim of this study was to summarize literature data regarding the anatomical and functional outcomes, and intra- and postoperative complications of this technique with minimally invasive approach (laparoscopic/robotic).

Search strategy: Systematic literature search using MEDLINE/PubMed, SCOPUS, Web of Science.

Data collection and analysis: Two authors extracted data on baseline characteristics (age, BMI, prior pelvic reconstructive surgery, preoperative POP stage), perioperative outcomes (operative time, estimated blood loss, intraoperative and postoperative complications, admission time), objective and subjective success rate, surgical failure, time of follow-up. Data were presented descriptively.

Main Results: Thirteen studies were included in the review. The overall number of patients for our analysis was 1066. Patients referred for laparoscopic/robotic lateral suspension were most frequently postmenopausal, aged 50 to 65 years, BMI >= 25 kg/m(2); 22.2% were already hysterectomized, while 17% had already a previous POP surgery. Operative time ranged from 78.4 +/- 29.7 to 254 +/- 45 min. The overall anatomic success was more than 90% in the apical compartment and more than 88% in the anterior compartment. Subjective cure rate varies from 78.4% to 100% in medium-term follow-up. Post-operative complication grade >= 3 according to Claiven-Dindo Scale was 1.03%. Mesh erosion rate varied between 0% and 13%.

Conclusions: Results coming from our systematic review suggest safety, efficacy and feasibility of minimally invasive lateral suspension with optimal anatomical and functional outcomes. Well-designed, randomized, controlled trials are required to confirm this data. (C) 2021 Elsevier B.V. All rights reserved.

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NR 33

TC 10

Z9 11

U1 1

U2 7

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Nasioudis, D

Byrne, M

Ko, EM

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TI Minimally invasive hysterectomy for stage IA cervical carcinoma: a

survival analysis of the National Cancer Database

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE cervical cancer; laparoscopes; laparotomy; hysterectomy

ID RADICAL HYSTERECTOMY; IMPACT

AB Objective To evaluate the outcomes of minimally invasive surgery for patients with stage IA cervical carcinoma undergoing hysterectomy. Methods Patients with pathological stage IA (IA1, IA2, IA not otherwise specified) squamous, adenocarcinoma, adenosquamous carcinoma of the cervix, no history of another tumor, who underwent radical or simple hysterectomy with known mode of surgery, diagnosed between 2010 and 2015 with at least 1 month of follow-up, were drawn from the National Cancer Database. Comparisons of demographic and clinicopathologic characteristics were made with the chi(2) test. The impact of minimally invasive surgery (robotic-assisted or traditional laparoscopic) on overall survival was assessed with the log-rank test following generation of Kaplan-Meier curves. A Cox model was constructed to control for confounders. Results A total of 1930 patients were identified; the majority (73.3%, 1414 patients) had stage IA1 disease, while 458 (23.7%) patients had stage IA2, and 58 (3%) patients had stage IA not otherwise specified. In the present cohort, 685 patients (35.5%) had open, 438 patients (22.7%) had laparoscopic, and 807 patients (41.8%) had robotic-assisted laparoscopic hysterectomy. Patients who had an open approach were more likely to undergo lymphadenectomy (58.1% vs 52.7%, p=0.021) and have radical hysterectomy (42% vs 32.4%, p<0.001). Patients who had minimally invasive surgery had a shorter hospital stay (median 1 vs 3 days, p<0.001). There was no difference in overall survival between patients who had open and minimally invasive hysterectomy (p=0.87); 4-year overall survival rates were 97.7% and 98.6%, respectively. There was no difference in overall survival between the open and minimally invasive surgery groups for patients who had simple (p=0.61; 4-year overall survival rates 97.6% and 98.7%, respectively) or radical hysterectomy (p=0.70; 4-year overall survival rates 97.8% and 98.4%, respectively). After controlling for patient age, tumor histology, and presence of lymphovascular invasion, minimally invasive hysterectomy was not associated with worse survival (HR 0.94, 95% CI 0.49 to 1.81). In a sensitivity analysis, based on 3048 patients with clinical stage IA after controlling for confounders, minimally invasive surgery was not associated with worse survival than laparotomy (HR 1.06, 95% CI 0.65 to 1.72). Conclusions In a large cohort of patients with stage IA cervical carcinoma, performance of minimally invasive hysterectomy was not associated with a detrimental effect on overall survival.

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NR 16

TC 6

Z9 7

U1 0

U2 3

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PG 5

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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PM 33962993

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DA 2024-01-18

ER

PT J

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Girardo, M

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TI Surgical Decision Regret in Women Pursuing Surgery for Endometriosis or

Chronic Pelvic Pain

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Excision of endometriosis; Patient satisfaction; Postoperative regret

ID VALIDATION; MANAGEMENT

AB Study Objective: To identify incidence of decision regret associated with surgery for endometriosis or chronic pelvic pain (CPP).

Design: Survey study.

Setting: Academic medical center.

Patients: All patients undergoing excisional surgery for endometriosis or CPP between January 2016 and June 2019.

Interventions: The women were contacted to complete 2 validated questionnaires: the Decision Regret and Patient Global Impression of Improvement scales.

Measurements and Main Results: A total of 253 patients were contacted, and 154 patients responded (60.8% response rate) to the survey. A total of 137 women (90%) agreed or strongly agreed that having excisional surgery was the right decision; 134 women (87%) indicated that they would choose to have surgery again.

The survey responders did not differ from nonresponders in age (years, 33.9 vs 35; p = .25), robotic route of surgery (83.1% vs 78.8%; p = .66), or performance of hysterectomy (27.3% vs 26.3%; p = .85). The responders were more likely to have stage III/IV endometriosis (50.6% vs 29.3%; p < .01), more previous surgeries for endometriosis (median surgeries, 1 vs 0; p = .01), higher complication rate (8.4% vs 2.0%; p = .03), and pathology test results more frequently positive for endometriosis (87.7% vs 77.8%; p = .03).

Overall, 25 patients (16.3%) reported some level of regret after excisional surgery for endometriosis or CPP. Regret was not associated with a lower Patient Global Impression of Improvement score (odds ratio [OR] 4.37; 95% confidence interval [CI], 0.81-23.7), age (OR 0.98; 95% CI, 0.93-1.04), time since surgery (OR 1; 95% CI, 0.97-1.04), number of previous surgeries (OR 1.08; 95% CI, 0.9-1.31), negative pathology test results (OR 2.82; 95% CI, 0.95-8.32), hysterectomy (OR 1.23; 95% CI, 0.45-3.32), or complications (OR 1.07; 95% CI, 0.22-5.16).

Conclusion: Most women who pursue excisional surgery for endometriosis or CPP are satisfied with their decision. Regret was not associated with patient-reported lack of improvement, negative pathology test results, hysterectomy, or complications. Gynecologic surgeons should engage in shared decision-making with patients and feel comfortable offering surgical evaluation and management to patients with endometriosis or CPP when clinically indicated. (C) 2020 AAGL. All rights reserved.

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NR 20

TC 1

Z9 2

U1 0

U2 0

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PG 8

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA TF4DD

UT WOS:000670664700018

PM 32979533

DA 2024-01-18

ER

PT J

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AF Montes de Oca, Mary Katherine

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TI Adnexal Masses in Pregnancy

SO OBSTETRICAL & GYNECOLOGICAL SURVEY

LA English

DT Article

ID GRADE SEROUS CARCINOMA; HYPERREACTIO LUTEINALIS; OVARIAN-CANCER;

LAPAROSCOPIC MANAGEMENT; CONSERVATIVE MANAGEMENT; SURGICAL-MANAGEMENT;

CESAREAN-SECTION; NATURAL-HISTORY; WOMEN; DIAGNOSIS

AB Importance Adnexal masses are identified in approximately 0.05% to 2.4% of pregnancies, and more recent data note a higher incidence due to widespread use of antenatal ultrasound. Whereas most adnexal masses are benign, approximately 1% to 6% are malignant. Proper diagnosis and management of adnexal masses in pregnancy are an important skill for obstetricians. Objective The aim of this study was to review imaging modalities for evaluating adnexal masses in pregnancy and imaging characteristics that differentiate benign and malignant masses, examine various types of adnexal masses, and understand complications of and explore management options for adnexal masses in pregnancy. Evidence Acquisition This was a literature review using primarily PubMed and Google Scholar. Results Ultrasound can distinguish between simple-appearing benign ovarian cysts and masses with more complex features that can be associated with malignancy. Radiologic information can help guide physicians toward recommending conservative management with observation or surgical removal during pregnancy to facilitate diagnosis and treatment. The risks of expectant management of an adnexal mass during pregnancy include rupture, torsion, need for emergent surgery, labor obstruction, and progression of malignancy. Historically, surgical removal was performed more routinely to avoid such complications in pregnancy; however, increasing knowledge has directed management toward conservative measures for benign masses. Surgical removal of adnexal masses is increasingly performed via minimally invasive techniques including laparoscopy and robotic surgery due to a decreased risk of surgical complications compared with laparotomy. Conclusions and Relevance Adnexal masses are increasingly identified in pregnancy because of the use of antenatal ultrasound. Clear and specific guidelines exist to help differentiate between benign and malignant masses. This is important for management as benign masses can usually be conservatively managed, whereas malignant masses require excision for diagnosis and treatment. A multidisciplinary approach, including referral to gynecologic oncology, should be used for masses with complex features associated with malignancy. Proper diagnosis and management of adnexal masses in pregnancy are an important skill for obstetricians. Target Audience Obstetricians and gynecologists, family physicians Learning Objectives After completing this activity, learners should be better able to compare different types of adnexal masses found in pregnancy, including incidence, clinical features, and imaging characteristics; evaluate an adnexal mass with imaging and laboratory tests; describe complications related to an adnexal mass in pregnancy; and determine management and/or surgical approaches for removal.

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NR 110

TC 7

Z9 7

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U2 0

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J9 OBSTET GYNECOL SURV

JI Obstet. Gynecol. Surv.

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ER

PT J

AU Peng, HH

Huang, YT

Cheng, ZX

Lee, CL

Lin, CT

AF Peng, Hsiu-Huei

Huang, Yi-Ting

Cheng, Zhuo-Xin

Lee, Chyi-Long

Lin, Cheng-Tao

TI Immunomodulating Therapy by Picibanil-based Imiquimod and Virotherapy

for Advanced Uterine Cancer after Laparoscopic Surgery

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Advanced uterine cancer; immunotherapy; virotherapy

AB This is a case report of a uterine cancer with the International Federation of Gynecology and Obstetrics staging 3c2 with the initial clinical presentation of postmenopausal vaginal bleeding in August 2015. Endometrium biopsy showed invasive nests of poorly differentiated grade 3 endometrioid adenocarcinoma. The patient received robotic surgery including total hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic lymph node dissection, para-aortic lymph node dissection, and washing cytology. The final pathology showed an endometrioid carcinoma with myometrium invasion up to 85% and para-aortic and pelvic lymph nodes invasion. The patient received six courses of adjuvant chemotherapy (paclitaxel and carboplatin) with concurrent chemoradiotherapy after the surgery. Later, immunotherapy with Picibanil (OK-432) and interleukin-2 (IL-2) was given, and cancer did not recur for 34 months until tumor recurrence at the liver dome and bilateral lung was noted by positron-emission tomography scan in July 2018. The patient received laparoscopic surgery for intra-abdominal tumor excision in December 2018, and the tumor found extended to the right diaphragm, liver surface, omentum, bilateral flank to pelvic peritoneum, Douglas pouch, and upper rectum. We continued the immunotherapy with OK-432, IL-2, Aldara cream (imiquimod), and later on, virotherapy (human papillomavirus vaccine). The immune risk profiles showed T-cells' proliferation and alteration of the Th1/Th2 activation after immunotherapy and virotherapy. Proctectomy with colon-anal anastomosis and cytoreduction surgery with hyperthermic intraperitoneal chemotherapy (HIPEC) (doxorubicin and paclitaxel) was performed in January 2019. After the surgery, the patient received chemotherapy (topotecan, paclitaxel, lipodox, and carboplatin) and continued the immunotherapy. The immune risk profiles showed CD4, CD4/CD8 increase after HIPEC and immunotherapy. The patient continued the therapy until May 2020.

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NR 11

TC 2

Z9 2

U1 0

U2 2

PU WOLTERS KLUWER MEDKNOW PUBLICATIONS

PI MUMBAI

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J9 GYNECOL MINIM INVASI

JI Gynecol. Minim. Invasive Ther.-GMIT

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PG 4

WC Obstetrics & Gynecology

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PT J

AU Sinha, R

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Mohanty, GS

AF Sinha, Rooma

Bana, Rupa

Mohanty, Girija Shankar

TI Acute presentation of port site hernia following robot-assisted

hysterectomy: A case report and review of the literature

SO JOURNAL OF MID-LIFE HEALTH

LA English

DT Review

DE 8-mm trocar; complication; gynecology; hysterectomy; port site hernia;

robotic surgery

ID PROSTATECTOMY

AB Port site hernia (PSH) has been reported following both laparoscopic and robotic surgery. Subsequent surgical intervention increases postoperative morbidity. We report the case of a PSH through the 8-mm trocar following robot-assisted hysterectomy in a 49-year-old female patient, along with a review of the literature. The case was performed with the standard protocol; however, increased intraoperative bleeding was encountered from right uterine artery and vein. Discharged at 48 h, she presented in emergency on the fourth postoperative day with acute intestinal obstruction. Computed tomography scan showed herniation of the jejunal loop through the 8-mm left-sided port. She underwent resection and anastomosis of the necrosed jejunal loop. We review the literature for PSH following robotic gynecological surgeries. Although rare, PSH requires surgical intervention, increasing the postoperative morbidity. Need for fascial closure of 8 mm ports should be considered. High index of suspicion and early recognition can avoid resection of the bowel loop.

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NR 13

TC 2

Z9 2

U1 0

U2 0

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PG 3

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

AU Turner, TB

Kim, KH

AF Turner, Taylor B.

Kim, Kenneth H.

TI Mapping the robotic hysterectomy learning curve and re-establishing

surgical training metrics

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic Surgical Procedures; Hysterectomy; Residency; Education

ID VALIDATION; RESIDENTS; SKILLS

AB Objective: Common robotic training curricula in the US entail completion of an online module followed by lab training with standardized exercises, such as manipulating needles with robotic needle drivers. Assessments are generally limited to elapsed time and subjective proficiency. We sought to test the feasibility of a simulation-based robotic hysterectomy curriculum to collect objective measurements of trainee progress, map the trainee learning curve and provide a system for trainee-specific evaluation.

Methods: An observational cohort study of a single institutions' residency members participating in a procedural hysterectomy simulation performed every 4 months. Each simulation episode had one-on-one teaching. The robotic platform was used to measure all movements within cartesian coordinates, the number of clutches, instrument collisions, time to complete the simulated hysterectomy, and unintended injuries during the procedure.

Results: Voluntary participation was high. Objective metrics were successfully recorded at each session and improved nearly universally. More senior residents demonstrated superior capabilities compared to junior residents as expected. The majority of residents (29/31) were able to complete an entire simulated hysterectomy in the allotted 30-minute training session period by the end of the year.

Conclusions: This program establishes learning curves based on objective data points using a risk-free simulation platform. The curves can then be used to evaluate trainee skill level and tailor teaching to specific objective competencies. The pilot curriculum can be tailored to the unique needs of each surgical discipline's residency training.

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NR 16

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Z9 6

U1 1

U2 3

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

PI SEOUL

PA 102-HO, 55-5, NONHYEON-DONG, GANGNAM-GU, SEOUL, 135-010, SOUTH KOREA

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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AU Moawad, GN

Klebanoff, JS

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Tyan, P

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Klebanoff, Jordan S.

Muldoon, Olga

North, Alexandra

Amdur, Richard

Tyan, Paul

TI Patterns of narcotic utilization in women undergoing hysterectomy for

benign indications

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Hysterectomy; Narcotics; Opioid crisis; Opioid prescriptions;

Post-anesthesia care unit

ID POSTOPERATIVE PAIN; UNITED-STATES; MANAGEMENT; GUIDELINE; OPIOIDS

AB Objective: To determine whether perioperative narcotic utilization at the time of hysterectomy has decreased since 2012.

Study Design: Retrospective cohort study.

Setting: Academic university hospital.

Patients: Patients who underwent a laparoscopic hysterectomy for benign indications between January 2012 and December 2018.

Interventions: Perioperative narcotics administration.

Measurements and Main Results: We identified 651 patients who underwent a hysterectomy for benign indications from 2012 to 2018. Of these, 377 surgeries were performed using robotic-assistance (58%) and the remainder (42%) were performed by conventional laparoscopy. Narcotic utilization declined significantly by year for both intra-operative and post-operative periods (both p<.001). The largest decline for intraoperative morphine milligram equivalents (MME) was between 2016 and 2017, while for post-operative MME, it was between 2012 and 2013. The pattern remained significant after adjusting for covariates. Intraoperative MME administration was correlated with postoperative MME use (Spearman r = 0.23, p<.001). Of the demographic variables only Body Mass Index was significantly associated with perioperative narcotic administration.

Conclusion: Administration of opioids for intraoperative and postoperative pain after minimally invasive hysterectomy substantially decreased from 2012 to 2018. Intraoperative narcotic utilization was correlated with immediate postoperative narcotic consumption. Heightened awareness of opioid administration practices during and immediately following surgery is critically important to decreasing risk of chronic opioid dependence and providing the best possible care for the patients we serve. (C) 2021 Elsevier Masson SAS. All rights reserved.

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Z9 2

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U2 1

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ER

PT J

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Lenters, E

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Koops, SES

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Lenters, Egbert

Broeders, Ivo A. M. J.

Schraffordt Koops, Steven E.

TI Robot-assisted sacrocolpopexy: not only for vaginal vault suspension? An

observational cohort study

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Female pelvic organ prolapse; Recurrence; Robot-assisted surgery;

Sacrocolpopexy; Sacrocervicopexy

ID PELVIC ORGAN PROLAPSE; VALIDATION; OUTCOMES; SURGERY

AB Introduction and hypothesis Surgery for pelvic organ prolapse (POP) has high recurrence rates. Long-term anatomical and patient-reported outcomes after pelvic floor repair are therefore required. Methods This prospective observational cohort study was conducted in a teaching hospital with tertiary referral function for patients with POP. Patients with symptomatic vaginal vault or uterine prolapse (simplified POP Quantification [sPOPQ] stage >= 2), who underwent robot-assisted sacrocolpopexy (RASC) or supracervical hysterectomy with sacrocervicopexy (RSHS), were included. Follow-up visits with sPOPQ evaluations were planned 4 years after surgery. Patients received pre- and postoperative questionnaires reporting symptoms of vaginal bulge, Urogenital Distress Inventory (UDI-6), and Pelvic Floor Impact Questionnaire (PFIQ-7). Primary outcome was patient self-reported symptoms. Secondary outcome was anatomical cure (sPOPQ stage 1) for all vaginal compartments. Results Seventy-seven patients were included. Sixty-one patients (79%) were evaluated after 50 months (physical examination n = 51). Symptoms of bulge (95% vs 15% p < 0.0005), median UDI-6 scores (26.7 vs 22.2, p = 0.048), median PFIQ-7 scores (60.0 vs 0, p = 0.008), and median sPOPQ stages in all landmarks improved significantly from the pre- to the postoperative visit. Thirty patients (59%) were completely recurrence free and 96% of patients had no apical recurrence. Most recurrences were asymptomatic cystoceles (20%). There was one surgical re-intervention for recurrent prolapse (1.6%). Conclusions Robot-assisted sacrocolpopexy and RSHS show sustainable results in the treatment of prolapse. Symptoms of bulge, urinary symptoms, and quality of life improved substantially 50 months postoperatively. Patients should be counseled about the risk of anterior wall recurrence and the small chance of recurrent symptoms that need treatment.

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Z9 1

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WC Obstetrics & Gynecology; Urology & Nephrology

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TI Combined use of ICG and technetium does not improve sentinel lymph node

detection in endometrial cancer: Results of the COMBITEC study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID BIOPSY; IMPACT; TRIAL; GREEN; RISK; BLUE

AB Objective. There is scarce evidence available about the benefit of combining technetium (Tc-99(m)) and indocyanine green (ICG) for sentinel lymph node (SLN) biopsy in endometrial cancer. The aim of this study was to compare the overall and bilateral pelvic detection rates of SLNs in two retrospective cohorts: ICG exdusive vs. combined ICG+ Tc-99(m).

Methods. The COMBITEC study (COMBined ICG and Technetium for SLN detection in Endometrial Cancer) consisted of a multicentre retrospective study (February 2015 June 2020) including patients diagnosed with endometrial atypical hyperplasia or early-stage endometrial carcinoma who underwent SLN biopsy by cervical injection of ICG with or without Tc-99(m) in four different referral centers in Spain.

Results. A total of 180 patients were included, 51% (n = 92) in ICG group and 49% (n 88) in ICG+Tc-99(m) group. Eighty-seven percent of the patients presented endometrioid histology, and over 99% of the procedures were performed by a minimally invasive approach. Both groups were comparable regarding their basal characteristics, except for a higher body mass index in ICG+Tc-99(m) group and a bigger proportion of robotic-assisted procedures in ICG group.

Overall detection rate was 92.8% without significant differences between groups (ICG: 94.6% vs ICG+Tc-99(m): 90.9%, p = .34). No significant differences were observed neither in bilateral pelvic nor aortic mapping rate. When Tc-99(m) was used, surgical procedures were significantly longer. In 7.3% of mapped patients, at least one positive SLN was found (ICG: 10.3% vs ICG+Tc-99(m): 3.9%, p = .109). Empty node packet rates and number of SLNs retrieved per patient were also similar between cohorts.

Conclusion. Combining preoperative Tc-99(m) to intraoperative ICG did not improve SLN detection in endometrial cancer, but resulted in longer procedures. (C) 2021 Elsevier Inc. All rights reserved.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

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TI Laparotomic versus robotic surgery in elderly patients with endometrial

cancer: A systematic review and meta-analysis

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Review

DE cancer; endometrium; laparotomy; robotics; surgery; tumor

ID HYSTERECTOMY; LAPAROSCOPY; GUIDELINES; MANAGEMENT; OUTCOMES; IMPACT;

COSTS

AB Background Although robotics has been shown to improve outcomes in some high-difficulty surgical category patients, it is unclear if such an approach may improve outcomes in elderly patients with endometrial carcinoma (EC).

Objective To compare robotic and laparotomic surgery in the treatment and staging of elderly EC patients.

Materials and methods A systematic review and meta-analysis was performed assessing the risk of overall, intra-operative, and peri-operative complications associated with the surgical approach (laparotomic vs robotic) for elderly patients with EC by relative risk (RR). Pooled means +/- standard deviation of length of stay were compared with the unpaired t test. Subgroup analyses for overall complications were performed based on different age cut-offs (>70, >65, and >75 years) and severity of complications (minor and major). A value of P less than 0.05 was considered significant.

Results Five studies with 7629 EC patients were included. Pooled RR for robotic compared with laparotomic surgery was 0.40 (P < 0.001) for overall, 0.46 (P = 0.18) for intra-operative, and 0.43 (P < 0.001) for peri-operative complications. Pooled difference between means +/- standard deviation of length of stay for robotic versus laparotomic surgery was -3.34 (P < 0.001). At subgroup analyses, pooled RR of overall complications for robotic surgery versus laparotomic surgery was 0.34 (P < 0.001) in the >70 years, 0.51 (P < 0.01) in the >65 years, 0.20 (P = 0.12) in the >75 years groups. Pooled RR was 0.50 (P = 0.1) in the minor complications subgroup, and 0.42 (P = 0.002) in the major complications subgroup.

Conclusion Robotics might be a viable alternative to the laparotomic approach for EC in elderly patients because it significantly decreases the risk of overall and peri-operative complications (mainly major complications), and the length of stay when compared with laparotomy. The decrease in risk of overall complications is greater with increasing patient age.

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PT J

AU Kanno, K

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Yanai, Shiori

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TI Clinical use of indocyanine green during nerve-sparing surgery for deep

endometriosis

SO FERTILITY AND STERILITY

LA English

DT Article

DE Deep endometriosis; indocyanine green; near-infrared fluorescence;

nerve-sparing; robotic surgery

ID RESECTION

AB Objective: To describe the anatomic and technical highlights of a novel nerve-sparing surgery in deep endometriosis (DE) using near infrared (NIR) fluorescence technology and indocyanine green (ICG).

Design: Stepwise demonstration of this method with narrated video footage.

Setting: An urban general hospital.

Patient(s): A 48-year-old woman was referred for severe chronic pelvic pain, dysmenorrhea, and pain on defecation, all of which were resistant to medication therapy. Magnetic resonance imaging revealed uterine adenomyosis and left ovarian endometrioma with DE involving the uterosacral ligament, posterior cervix, and surface of the rectum, with complete cul-de-sac obliteration.

Intervention(s): An intravenous injection of 0.25 mg/kg body weight of ICG for intraoperative NIR fluorescence imaging. Ethics approval was obtained from the institutional review board at our hospital (IRB No.: 985).

Main Outcome Measure(s): Evaluation of blood perfusion of DE nodule and achieving better visualization of anatomic relationship to the pelvic autonomic nerves.

Result(s): The procedure was performed using the following eight steps with the da Vinci Xi surgical platform: Step 0, observing peritoneal endometriotic lesions; Step 1, adhesiolysis and adnexal surgery; Step 2, separation of the nerve plane; Step 3, dissection of the ureter; Step 4, reopening of the pouch of Douglas; Step 5, complete removal of DE lesions while avoiding injury to the nerve plane; Step 6, hysterectomy (if the patient desires nonfertility-sparing surgery); Step 7, checking for rectal injury using air leakage test and tissue perfusion; and Step 8, barrier agents for adhesion prevention. During surgery, we could easily identify ischemic nodules, which included DE and fibrosis under NIR fluorescence imaging, beyond the limits of macroscopic disease. Endometriosis or fibrosis was confirmed pathologically from all resected tissues, and resection margins of these tissues were negative for the disease. These results suggest that this technique might be feasible for objectively identifying the border between DE lesions and healthy tissue. Furthermore, the hypogastric nerve and inferior hypogastric plexus were strongly highlighted by ICG and objectively preserved with the assessment of perfusion. The patient developed no perioperative complications, including postoperative bladder or rectal dysfunction after surgery.

Conclusion(s): To our knowledge, this is the first reported use of ICG during nerve-sparing surgery for gynecologic disease. Application of ICG with NIR fluorescence appears potentially useful, not only to remove DE, but also to improve nerve-sparing. ((C) 2021 by American Society for Reproductive Medicine.)

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PT J

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Virijevic, I

Kullinger, M

AF Giannakopoulos, Nikolaos

Virijevic, Ivana

Kullinger, Merit

TI Isolated vulvar metastasis after robot-assisted laparoscopic

hysterectomy for low grade, early stage endometrial cancer: a case

report and review of the literature

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Endometrial cancer; Vulvar metastasis; Minimally invasive surgery;

Hysterectomy; Robo-assisted

ID CELL CARCINOMA; GENITAL-TRACT; ADENOCARCINOMA; SECONDARY; TUMORS

AB Objectives: Our objective is to report a case of isolated vulvar metastasis after robot-assisted laparoscopic hysterectomy for early-stage endometrial adenocarcinoma and to conduct a systematic review of the related literature to determine the frequency of this rare metastasis. Methods: We present a case-report of a rare vulvar metastasis and conduct a systematic review of the English literature. Results: A 74-year-old woman with suspected uterine malignancy underwent a total laparoscopic hysterectomy with specimen removal through the vagina. Pathology revealed endometrioid carcinoma (WHO-World Health Organization-categorization of endometrial cancer histology) stage IA, grade 1 (FIGO-International Federation of Gynecology and Obstetrics-categorization). Upon a 12-month clinical examination after surgery, an isolated metastasis of the initial endometrial carcinoma was observed in the vulva and required surgical excision. Two and a half years later, the patient remains disease-free. Eleven articles consisting of 22 cases of metastatic endometrial carcinomato the vulva have been reported in the English literature. To our knowledge, this is only the second case of developing isolated vulvar metastasis after minimal invasive surgery for low risk gynecological cancer described in literature. Conclusion: The hereby presented case report aims to raise awareness, among surgeons, regarding lesions that can be developed in the vulva after minimally invasive surgery of even low-risk, well differentiated EAC, which may represent recurrence of the primary cancer.

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PT J

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TI An innovative tissue model for robot-assisted radical hysterectomy and

pelvic lymphadenectomy

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Robotic training; Tissue model; Radical hysterectomy; Pelvic

lymphadenectomy; Colpotomy; Uterine cervical cancer

ID SURGERY; FEASIBILITY

AB Objective: The purpose of this study was to evaluate a new tissue model and to conduct a questionnaire survey to assess its feasibility for robot-assisted radical hysterectomy, colpotomy, and pelvic lymph node dissection training. Methods: Sixteen gynecologists (1 2 males, 4 females; mean age: 47.1 years; all attending doctors with an average experience of 9.3 robot-assisted surgeries) were trained in robot-assisted radical hysterectomy, colpotomy, and pelvic lymphadenectomy using a new uterine and pelvic lymph node model (mainly composed of PVA) from Fasotec Inc. The participants were trained by the author using a dual console. They performed all surgical procedures following the author's instructions. The time required for completion of the surgeries was measured. The surgical skills of the participants were evaluated by the author using the operative performance rating scale recommended by the American College of Surgeons. After training, the participants answered a questionnaire for the assessment of the model and the training using a 5-point Likert scale. Results: We found that the mean time taken for radical hysterectomy, colpotomy, and pelvic lymphadenectomy was 57.3 minutes (range: 45-75 minutes), 12.2 minutes (range: 8-17 minutes), and 60.7 minutes (range: 45-70 minutes), respectively; the total time taken was 136.5 minutes (range: 98-162 minutes). The questionnaire survey revealed that this model followed pelvic anatomy and was practically trainable. Conclusion: This is the first report of a tissue model relevant to the uterus and the pelvic lymph nodes, and robot-assisted training using this model was considered effective.

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NR 15

TC 0

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U2 1

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J9 EUR J GYNAECOL ONCOL

JI Eur. J. Gynaecol. Oncol.

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PG 6

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA TE9FH

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ER

PT J

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TI Comparison of perioperative outcomes between standard laparoscopic and

robot-assisted approach in patients with rectosigmoid endometriosis

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE endometriosis; laparoscopy; surgical techniques; robot-assisted

laparoscopic surgery; rectosigmoid endometriosis

ID DEEP INFILTRATING ENDOMETRIOSIS; SEXUAL FUNCTION; WOMEN; EXCISION;

SURGERY

AB Introduction Robot-assisted laparoscopic surgery (RALS) has gained widespread application in several surgical specialties. Previous studies on the feasibility and safety of RALS versus standard laparoscopy (S-LPS) for rectosigmoid endometriosis are limited and reported conflicting data. This study aims to compare S-LPS and RALS in patients with rectosigmoid endometriosis in terms of perioperative surgical and clinical data.

Material and methods This is a multicentric, observational, prospective cohort study including 44 patients affected by rectosigmoid endometriosis referred to two tertiary referral centers for endometriosis from September 2018 to September 2019. Patients were divided into two groups: 22 patients underwent S-LPS, and 22 underwent RALS. Our primary outcome was to compare operative time (from skin incision to suture) between the two groups. Secondary outcomes included: operative room time (patient entry into operative room and patient out), estimated blood loss, laparotomic conversion rate, length of hospital stay, perioperative complications, and evaluation of endometriosis-related symptoms at 12-month follow up.

Results The two groups were comparable regarding preoperative and surgical data, except for higher rates of hysterectomies and bilateral uterosacral ligament removal procedures in the RALS group. Also after adjusting for these discrepancies, operative time was similar between S-LPS and RALS. Operative room time was statistically longer in the RALS group compared with that of S-LPS. No statistically significant difference was found concerning other study outcomes. Pain and bowel symptoms improved in both groups at 12-month follow up.

Conclusions If performed by expert teams, RALS provides similar perioperative outcomes compared with S-LPS in rectosigmoid endometriosis surgical treatment, except for longer operative room time.

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TC 5

Z9 5

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U2 1

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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ER

PT J

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Paraghamian, SE

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AF Zhang, Yingao

Grant, Megan S.

Zhang, Xinyi

Paraghamian, Sarah E.

Tan, Xianming

Clark, Leslie H.

TI Comparing Laparotomy with Robot-assisted Interval Debulking Surgery for

Patients with Advanced Epithelial Ovarian Cancer Receiving Neoadjuvant

Chemotherapy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cycles; Minimally invasive; Multivariate; Retrospective; NACT

ID MINIMALLY INVASIVE SURGERY; GYNECOLOGIC ONCOLOGY; CYTOREDUCTION

AB Study Objective: Compare survival of patients with advanced epithelial ovarian cancer (EOC) undergoing interval debulking surgery (IDS) with either robot-assisted (R-IDS) or open (O-IDS) approach. Second, we assessed the impact of adjuvant and neoadjuvant chemotherapy (NACT) cycles as independent variables associated with survival in this patient population.

Design: Retrospective cohort study.

Setting: Single tertiary care center.

Patients: Total of 93 patients diagnosed with advanced EOC who underwent NACT before primary debulking surgery after consultation with a gynecologic oncologist.

Interventions: All patients underwent IDS after completion of NACT with either R-IDS or O-IDS between 2011 and 2018 at a single tertiary care center. Exclusion criteria included receiving fewer than 3 or more than 6 cycles of NACT or having concurrent diagnoses of other malignancies during the treatment period.

Measurements and Main Results: A total of 93 patients were identified (n = 43 R-IDS; n = 50 O-IDS). Median age (63.0 vs 66.2 years) did not differ between the 2 groups (p = .1). Of the total patients, 91% were optimally cytoreduced (57% R0 and 34% R1), and R0 rate was not influenced by surgical modality (52% O-IDS vs 63% R-IDS, p = .4). Progression-free survival (PFS) and overall survival (OS) did not differ between patients undergoing O-IDS and those undergoing R-IDS (PFS 15.4 vs 16.7 months, p = .7; OS 38.2 vs 35.6 months, p = .7). Cytoreduction to R0 improved both PFS and OS independent of surgical approach. Subgroup analysis showed that, specifically in patients undergoing R-IDS, receiving >6 total cycles of chemotherapy was independently associated with both decreased PFS (hazard ratio 3.85; 95% confidence interval, 1.52 & minus;9.73) and OS (hazard ratio 3.97; 95% confidence interval, 1.08 & minus;14.59). When analyzed separately, neither NACT nor adjuvant cycle numbers had any effect on survival.

Conclusion: In this retrospective study of patients with advanced EOC undergoing IDS after NACT, the use of robot assisted surgery did not affect debulking success or oncologic survival indices. Receiving >6 total cycles of chemotherapy before IDS was associated with a decrease in both PFS and OS in patients undergoing R-IDS in this cohort and warrants further investigation. (C) 2020 AAGL. All rights reserved.

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NR 24

TC 5

Z9 6

U1 0

U2 3

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

AU Gillingham, A

Kenton, K

Geynisman-Tan, J

Brown, O

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Lewicky-Gaupp, C

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AF Gillingham, Akira

Kenton, Kimberly

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Brown, Oluwateniola

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Mueller, Margaret G.

TI Does a Hysterectomy Hurt? Comparing Narcotic Requirements and Pain

Scores in Patients Undergoing Apical Prolapse Repair With or Without

Hysterectomy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE apical prolapse repair; hysterectomy; postoperative pain scores;

narcotic use

ID ENHANCED RECOVERY

AB Objective

The aim of the study was to compare narcotic requirements with early postoperative pain scores in women undergoing apical prolapse surgery with or without hysterectomy. Methods

All cases of apical prolapse repair at our institution in 2016 were identified. The following was abstracted from the health record: demographics, comorbidities, procedure details, baseline and postoperative care unit (PACU) pain scores, and operating room (OR) and PACU narcotic doses. Doses were converted to morphine milligram equivalents (MME) for analysis. Correlations are reported using Pearson rho. Results

One hundred fifty-six cases were identified. Seventy-eight percent of participants were white and the mean +/- SD age was 59 +/- 11 years. One hundred seventeen patients (75%) underwent laparoscopic/robotic sacrocolpopexy, 35 (22%) native tissue vaginal repairs, and 4 (3%) open sacrocolpopexy. One hundred twenty-two patients (78%) underwent concomitant hysterectomy: 93 (76%) were laparoscopic, 25 (20%) vaginal, and 4 (4%) abdominal.

The groups were similar, with the exception of younger age and longer OR time in the hysterectomy group. Hysterectomy by any route was not associated with increased OR MMEs (29 vs 22, P = 0.22), PACU MMEs (13 vs 13, P = 0.54), 4-hour PACU pain scores (2.5 vs 2.0, P = 0.22), or 6-hour PACU pain scores (2.6 vs 2.3, P = 0.54). After controlling for age and OR time, there remained no differences in these variables. Likewise, when analyzing laparoscopic or vaginal groups separately on multivariate regression, there were no differences in MMEs or postoperative pain scores in patients with and without concomitant hysterectomy. Conclusions

Concomitant hysterectomy at the time of prolapse repair does not increase pain medication requirements or patient-reported postoperative pain scores.

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NR 8

TC 2

Z9 2

U1 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PY 2021

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA SM5AG

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ER

PT J

AU Hue, HJ

Choi, HJ

Park, JY

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AF Hue, Hye Jeong

Choi, Hyun Ji

Park, Jee Yoon

Suh, Dong Hoon

Lee, Jung Ryeol

Jee, Byung Chul

Kim, Seul Ki

TI Successful pregnancy following transmyometrial embryo transfer after

robot-assisted radical trachelectomy

SO CLINICAL AND EXPERIMENTAL REPRODUCTIVE MEDICINE-CERM

LA English

DT Article

DE Embryo transfer; Fertility preservation; Oocyte retrieval;

Trachelectomy; Uterine cervical neoplasms

ID CERVICAL-CANCER

AB Radical trachelectomy is a fertility-preserving alternative to radical hysterectomy in carefully selected young women with early-stage cervical cancer. However, in cases with subsequent severe cervical stenosis, assisted reproductive techniques can be difficult. This is a case report of a 34-year-old patient who underwent robot-assisted radical trachelectomy and cerclage for early-stage (IB2) adenosquamous carcinoma. Three months after surgery, the patient underwent ovarian stimulation using a gonadotropin-releasing hormone antagonist protocol. As it was impossible to perform transcervical embryo transfer due to the almost complete absence of the cervical opening, transmyometrial embryo transfer under ultrasound guidance was performed. This resulted in a successful singleton pregnancy. This is the first case of successful pregnancy conceived by in vitro fertilization with transmyometrial embryo transfer in a patient who had previously undergone robot-assisted radical trachelectomy.

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NR 9

TC 2

Z9 2

U1 0

U2 1

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J9 CLIN EXP REPROD MED

JI Clin. Exp. Reprod. Med.-CERM

PD JUN

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BP 184

EP 187

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PG 4

WC Obstetrics & Gynecology; Reproductive Biology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

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Geoffrion, R

AF Larouche, Maryse

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TI Surgical Management of Symptomatic Apical Pelvic Organ Prolapse <i>A

Systematic Review and Meta</i>-<i>analysis</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Review

ID UTEROSACRAL LIGAMENT SUSPENSION; RANDOMIZED CONTROLLED-TRIAL; ABDOMINAL

SACRAL COLPOPEXY; VAGINAL VAULT PROLAPSE; PERIOPERATIVE

BEHAVIORAL-THERAPY; LAPAROSCOPIC SACROCOLPOPEXY; UTEROVAGINAL PROLAPSE;

SEXUAL FUNCTION; ROBOTIC SACROCOLPOPEXY; SACROSPINOUS COLPOPEXY

AB OBJECTIVE: To systematically review objective and subjective success and complications of apical suspensions for symptomatic uterine or vaginal vault pelvic organ prolapse (POP).

DATA SOURCES: MEDLINE, CENTRAL, , and EMBASE (2002-2019) were searched using multiple terms for apical POP surgeries, including comparative studies in French and English.

METHODS OF STUDY SELECTION: From 2,665 records, we included randomized controlled trials and comparative studies of interventions with or without hysterectomy, including abdominal apical reconstruction through open, laparoscopic, or robotic approaches and vaginal apical reconstructions. Repairs using transvaginal mesh, off-the-market products, procedures without apical suspension, and follow-up less than 6 months were excluded.

TABULATION, INTEGRATION, AND RESULTS: Relative risk (RR) was used to estimate the effect of surgical procedure on each outcome. For each outcome and comparison, a meta-analysis was conducted to pool the RRs when possible. Meta-regression and bias tests were performed when appropriate. The GRADE (Grades for Recommendation, Assessment, Development and Evaluation) system for quality rating and PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) reporting were used. Sixty-two articles were included in the review (N=22,792) and 50 studies in the meta-analyses. There was heterogeneity in study quality, techniques used, and outcomes reported. Median follow-up was 1-5 years. Vaginal suspensions showed higher risk of overall and apical anatomic recurrence compared with sacrocolpopexy (RR 1.82, 95% CI 1.22-2.74 and RR 2.70, 95% CI 1.33-5.50) (moderate), whereas minimally invasive sacrocolpopexy showed less overall and posterior anatomic recurrence compared with open sacrocolpopexy (RR 0.59, 95% CI 0.47-0.75 and RR 0.59, 95% CI 0.44-0.80, respectively) (low). Different vaginal approaches, and hysterectomy and suspension compared with hysteropexy had similar anatomic success. Subjective POP recurrence, reintervention for POP recurrence and complications were similar between most procedures.

CONCLUSION: Despite variations in anatomic outcomes, subjective outcomes and complications were similar for apical POP procedures at 1-5 years. Standardization of outcome reporting and comparative studies with longer follow-up are urgently needed.

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TC 19

Z9 20

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U2 3

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PG 13

WC Obstetrics & Gynecology

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ER

PT J

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TI Paracervical Block or Uterosacral Ligament Infiltration for Benign

Minimally Invasive Hysterectomy: A Systematic Review and Meta-analysis

SO OBSTETRICAL & GYNECOLOGICAL SURVEY

LA English

DT Review

ID VISUAL ANALOG SCALE; PREEMPTIVE LOCAL ANALGESIA; POSTOPERATIVE PAIN;

RELIABILITY; MANAGEMENT; VALIDITY; SURGERY; TRIAL

AB Objective The aim of this study was to estimate the efficacy of preemptive paracervical block or uterosacral ligament infiltration in reducing postoperative pain and opioid consumption after benign minimally invasive hysterectomy.

Data Sources We searched MEDLINE, Cochrane Library, Embase, , and Google Scholar from inception until February 2020.

Methods of Study Selection We identified randomized placebo-controlled trials assessing the primary outcome of pain and opioid consumption after paracervical block or uterosacral infiltration in benign laparoscopic, vaginal, or robotic hysterectomy. Two investigators evaluated studies for risk of bias and quality of evidence.

Tabulation, Integration, and Results We reviewed 219 abstracts; 6 studies met the inclusion criteria: 3 using paracervical block (2 vaginal and 1 laparoscopic) and 3 using uterosacral ligament infiltration (all vaginal). Two studies were included in the meta-analysis (both vaginal hysterectomy). Because of lack of numerical data, or comparison, the other 4 studies are reported in narrative form.

Three controlled trials reported a moderate benefit from paracervical block up to 8 hours after vaginal and 4 hours after laparoscopic surgery. Meta-analysis could not be performed because of the lack of numerical data for pooling results or the lack of a laparoscopic hysterectomy comparison group. Three trials reported that uterosacral infiltration decreases pain up to 6 hours after vaginal hysterectomy, and meta-analysis pooling the results of 2 of these studies demonstrated improvement in pain up to 4 hours on a 0- to 100-mm visual analog scale for pain (-19.97 mm; 95% confidence interval, -29.02 to -10.91; P < 0.000).

Five trials reported a moderate reduction in cumulative opioid use within 24 hours after vaginal surgery for both paracervical block and uterosacral infiltration. Meta-analysis was not performed for paracervical block because only 1 trial provided suitable data for pooling. Meta-analysis pooling the results of 2 trials of uterosacral infiltration demonstrated opioid consumption of 20.73 morphine milligram equivalents less compared with controls (95% confidence interval, -23.54 to -17.91; P < 0.000).

Conclusions There were a total of 6 randomized placebo-controlled studies evaluated in this study. Although a meta-analysis was unable to be performed for all studies because of lack of comparison groups or numerical data, there is evidence that preemptive uterosacral ligament infiltration may reduce postoperative pain and opioid consumption after vaginal hysterectomy. Our study does not allow us to make any substantive conclusions on the use of paracervical block in vaginal hysterectomy or the use of either type of injection in laparoscopic or robotic hysterectomy.

Target Audience Obstetricians and gynecologists, family physicians

Learning Objectives After completing this activity, the learner should be better able to describe the afferent neuroanatomy pathway of the uterus and cervix; assess the literature on the use of preemptive paracervical block and uterosacral ligament infiltration in benign minimally invasive hysterectomy; analyze the role of preemptive paracervical block and uterosacral ligament infiltration in the management of postoperative pain after benign minimally invasive hysterectomy; and identify the effect of preemptive paracervical block and uterosacral ligament infiltration on opioid consumption after benign minimally invasive hysterectomy.

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NR 40

TC 3

Z9 3

U1 0

U2 1

PU LIPPINCOTT WILLIAMS & WILKINS

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SN 0029-7828

EI 1533-9866

J9 OBSTET GYNECOL SURV

JI Obstet. Gynecol. Surv.

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PG 14

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Brunes, M

Forsgren, C

Warnqvist, A

Ek, M

Johannesson, U

AF Brunes, Malin

Forsgren, Catharina

Warnqvist, Anna

Ek, Marion

Johannesson, Ulrika

TI Assessment of surgeon and hospital volume for robot-assisted and

laparoscopic benign hysterectomy in Sweden

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE complications; conversion rate; hospital volume; robot&#8208; assisted

laparoscopic hysterectomy; surgeon volume; total laparoscopic

hysterectomy

ID OUTCOMES; COMPLICATIONS; IMPACT

AB Introduction The study aims to analyze differences between robot-assisted total laparoscopic hysterectomy (RATLH) and total laparoscopic hysterectomy (TLH) in benign indications, emphasizing surgeon and hospital volume.

Material and methods All women in Sweden undergoing a total hysterectomy for benign indications with or without a bilateral salpingo-oophorectomy from January 1, 2015 to December 31, 2017 (n = 12 386) were identified from three national Swedish registers. Operative time, blood loss, conversion rate, complications, readmission, reoperation, length of hospital stays, and time to daily life activity were evaluated by univariable and multivariable regression models in RATLH and TLH. Surgeon and hospital volume were obtained from the Swedish National Quality Register of Gynecological Surgery and divided into subclasses.

Results TLH was associated with a higher rate of intraoperative complications (adjusted odds ratios [aOR] 2.8, 95% CI 1.3-5.8) and postoperative bleeding complications (aOR 1.8, 95% CI 1.2-2.9) compared with RATLH. Intraoperative data showed a higher conversion rate (aOR 13.5, 95% CI 7.2-25.4), a higher blood loss (200-500 mL aOR 3.5, 95% CI 2.7-4.7; > 500 mL aOR 7.6, 95% CI 4.0-14.6) and a longer operative time (1-2 h aOR 16.7 95% CI 10.2-27.5; >2 h aOR 47.6, 95% CI 27.9-81.1) in TLH compared with RATLH. The TLH group had a lower caseload per year than the RATLH group. Higher surgical volume was associated with lower median blood loss, shorter operative time, a lower conversion rate, and a lower perioperative complication rate. Differences in conversion rate or operative time in RATLH were not affected by surgeon volume when compared with TLH. One year after surgery, patient satisfaction was higher in RATLH than in TLH (aOR 0.6, 95% CI 0.4-0.9).

Conclusions RATLH led to better perioperative outcome and higher patient satisfaction 1 year after surgery. These outcome differences were slightly more pronounced in very low-volume surgeons but persisted across all surgeon volume groups.

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U1 0

U2 0

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Kampers, J

Gerhardt, E

Sibbertsen, P

Flock, T

Klapdor, R

Hertel, H

Jentschke, M

Hillemanns, P

AF Kampers, Johanna

Gerhardt, E.

Sibbertsen, P.

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Klapdor, R.

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Jentschke, M.

Hillemanns, P.

TI Protective operative techniques in radical hysterectomy in early

cervical carcinoma and their influence on disease-free and overall

survival: a systematic review and meta-analysis of risk groups

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Early cervical cancer; Hysterectomy; Minimally invasive; Operating

techniques; Oncologic outcome; Uterine manipulator

ID CANCER; LAPAROSCOPY; LAPAROTOMY; OUTCOMES

AB Purpose Radical hysterectomy with pelvic lymphadenectomy presents the standard treatment for early cervical cancer. Recently, studies have shown a superior oncological outcome for open versus minimal invasive surgery, however, the reasons remain to be speculated. This meta-analysis evaluates the outcomes of robotic and laparoscopic hysterectomy compared to open hysterectomy. Risk groups including the use of uterine manipulators or colpotomy were created. Methods Ovid-Medline and Embase databases were systematically searched in June 2020. No limitation in date of publication or country was made. Subgroup analyses were performed regarding the surgical approach and the endpoints OS and DFS. Results 30 studies fulfilled the inclusion criteria. Five prospective, randomized-control trials were included. Patients were analyzed concerning the surgical approach [open surgery (AH), laparoscopic surgery (LH), robotic surgery (RH)]. Additionally, three subgroups were created from the LH group: the LH high-risk group (manipulator), intermediate-risk group (no manipulator, intracorporal colpotomy) and LH low-risk group (no manipulator, vaginal colpotomy). Regarding OS, the meta-analysis showed inferiority of LH in total over AH (0.97 [0.96; 0.98]). The OS was significantly higher in LH low risk (0.96 [0.94; 0.98) compared to LH intermediate risk (0.93 [0.91; 0.94]). OS rates were comparable in AH and LH Low-risk group. DFS was higher in the AH group compared to the LH group in general (0.92 [95%-CI 0.88; 0.95] vs. 0.87 [0.82; 0.91]), whereas the application of protective measures (no uterine manipulator in combination with vaginal colpotomy) was associated with increased DFS in laparoscopy (0.91 [0.91; 0.95]). Conclusion DFS and OS in laparoscopy appear to be depending on surgical technique. Protective operating techniques in laparoscopy result in improved minimal invasive survival.

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NR 46

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Z9 15

U1 0

U2 2

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 11

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Yang, KL

Cheng, SD

Cai, YK

Qiao, JK

Xu, YY

Li, XF

Xiong, SW

Lu, Y

Mei, AB

Li, XS

Zhou, LQ

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Cheng, Sida

Cai, Yukun

Qiao, Jiankun

Xu, Yangyang

Li, Xinfei

Xiong, Shengwei

Lu, Ye

Mei, Aobing

Li, Xuesong

Zhou, Liqun

TI Clinical characteristics and surgical treatment of ureteral

endometriosis: our experience with 40 cases

SO BMC WOMENS HEALTH

LA English

DT Article

DE Ureteralendometriosis; Ureteroureterostomy; Ureteroneocystostomy;

Nephroureterectomy; Case report

ID DEEP INFILTRATING ENDOMETRIOSIS; URINARY-TRACT ENDOMETRIOSIS;

LAPAROSCOPIC MANAGEMENT; PROPOSAL

AB BackgroundTo present the experience with the surgical management of ureteral endometriosis (UE) in our single center.MethodsTo present the experience with the surgical management of ureteral endometriosis (UE) in our single center. A retrospective analysis of 40 patients with UE who presented with intraoperative surgical findings of endometriosis involving the ureter and pathology-proven UE was performed.ResultsForty patients (median age, 42.5 years) with histological evidence of UE were included. Six (15%) patients had a history of endometriosis. Twenty-one (52%) patients had urological symptoms, and 19 (48%) patients were asymptomatic. All patients had hydronephrosis. The mean glomerular filtration rate (GFR) of the ipsilateral kidney was significantly worse than that of the contralateral kidney (23.4 vs 54.9 ml/min; P<0.001). Twelve (30%) patients were treated with ureteroureterostomy (11 open approaches and 1 robotic approach). Twenty-two (55%) patients underwent ureteroneocystostomy (17 open approaches, 4 laparoscopic approaches and 1 robotic approach). Five patients underwent nephroureterectomy. One patient refused aggressive surgery and received ureteroscopic biopsy and ureteral stent placement. Thirteen (33%) patients required gynecological operations. Three (8%) patients in the open group suffered from major surgical complications. Nine (24%) patients received postoperative endocrine therapy. Twenty-eight (70%) patients were followed up (median follow-up time, 71 months). Twenty-four patients received kidney-sparing surgeries. The success rate for these 24 patients was 21/24 (87.5%). The success rates of ureteroneocystostomy and ureteroureterostomy were 15/16 (93.8%) and 5/7 (71.4%), respectively.Conclusions Although UE is rare, we should remain vigilant for the disease among female patients with silent hydronephrosis. Typically, a multidisciplinary surgical team is necessary. For patients with severe UE, segmental ureteral resection with ureteroureterostomy (UU) or ureteroneocystostomy may be a preferred choice.

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FX Guiyang science and technology plan fund: zhukehe [2018] No. 1-11.

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NR 35

TC 1

Z9 1

U1 0

U2 3

PU BMC

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EI 1472-6874

J9 BMC WOMENS HEALTH

JI BMC Womens Health

PD MAY 17

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WC Public, Environmental & Occupational Health; Obstetrics & Gynecology

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ER

PT J

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Veldhuis, Wouter B.

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Gerestein, Cornelis G.

Zweemer, Ronald P.

TI Robot-assisted laparoscopic debulking surgery for recurrent adult

granulosa cell tumors

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

DE Granulosa cell tumor; Robot-assisted laparoscopy; Debulking;

Cytoreductive surgery; Recurrence

ID OVARIAN-CANCER; CYTOREDUCTION; LAPAROTOMY; MANAGEMENT

AB Despite an often early diagnosis and effective initial surgical management, one third of adult granulosa cell tumors (aGCTs) eventually, and often repeatedly, recurs. Debulking surgery remains the preferred treatment modality for recurrent aGCT, although the risk of intraoperative complications increases with repeated laparotomy. Minimally invasive surgery may limit the risk of complications. We aim to share our initial experience with robotic debulking surgery for recurrent aGCT. Clinical and surgical data of patients with recurrent aGCT who underwent robotic cytoreductive surgery over a three-year period at a tertiary referral center were retrospectively collected and analyzed. Between 2017 and 2020, three patients underwent robotic debulking surgery for recurrent aGCT at our institution. Complete cytoreduction was achieved in all patients. No intraoperative or postoperative complications were reported. This small pilot series at a single academic institution suggests that robot-assisted laparoscopy may be feasible and safe in selected patients with recurrent aGCT. A minimally invasive approach could reduce the complexity of successive surgeries for aGCT relapse.

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NR 26

TC 2

Z9 3

U1 0

U2 2

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PG 4

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

GA UU0RE

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OA Green Published, gold

DA 2024-01-18

ER

PT J

AU McLeod, LJ

Nensi, A

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TI Robotic-Assisted Laparoscopic Hysterectomy for Endometrial Hyperplasia

or Grade 1 Endometrial Adenocarcinoma: A 10-year, Single-Centre

Experience

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY CANADA

LA English

DT Article

DE robotics; hysterectomy; endometrial carcinoma; obesity; intraoperative

complications

ID BODY-MASS INDEX; OBESE-PATIENTS; CANCER; SURGERY; COMPLICATIONS;

CLASSIFICATION; OUTCOMES; RISK

AB Objective: To describe the outcomes of patients undergoing roboticassisted laparoscopic hysterectomy for grade-1 endometroid endometrial cancer or endometrial hyperplasia at our centre.

Methods: Retrospective chart review was completed for 160 patients who underwent robotic-assisted laparoscopic hysterectomy by 5 general gynaecologists in a tertiary care setting between September 2008 and September 2018. Outcomes collected included operative time, estimated blood loss, length of stay, perioperative complications, readmissions, and recurrences. Subgroup analysis was completed after stratifying by body mass index (BMI; 3 groups: A, <40 kg/m(2); B, 40-50 kg/m(2); and C, >50 kg/m(2)). Subgroups were compared with ANOVA or Fisher exact test.

Results: The intraoperative complication rate was 3%. The rate of conversion to laparotomy was 2%, and the rate of bowel injury, 1%. The postoperative complication rate was 8%. The rate of major postoperative complications was 4%, and 3% of patients required readmission postoperatively. The mean BMI was 43 (range 21-71) kg/m(2). There were no differences in perioperative complication, readmission, or recurrence rates between subgroups. Groups B and C were more likely to have had an ASA of 3-4, suggesting a higher burden of comorbidity. Operating room time, procedure time, and estimated blood loss were higher in group C.

Conclusion: Despite this cohort's mean BMI falling within the category of class III obesity, complication and conversion rates were similar to those reported in the literature and did not increase with BMI, despite an increased comorbidity burden. These results suggest that robotic surgery is a safe and effective method for providing minimally invasive surgery to a technically challenging population.

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NR 29

TC 0

Z9 0

U1 0

U2 0

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JI J. Obstet. Gynaecol. Can.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA SE1ZE

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DA 2024-01-18

ER

PT J

AU Park, KM

Kang, S

Kim, C

Sung, Y

Chung, YJ

Song, J

Kim, S

Kim, MR

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Kim, Chaewon

Sung, Yeji

Chung, Youn-Jee

Song, JaeYen

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TI Variables that prolong total operative time for robotic-assisted

laparoscopic myomectomy: A 10-year tertiary hospital study in Korea

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Operative time; Robotic surgical procedures; Uterine myomectomy

ID ABDOMINAL MYOMECTOMY

AB Study objective: To identify factors that prolong total operative time (TOT) in robotic-assisted laparoscopic myomectomy (RALM).

Design: Retrospective cohort study.

Setting: Tertiary university hospital.

Patients: Women who underwent RALM between April 2009 and May 2019 conducted by a single high volume gynecologic surgeon.

Interventions: Patients' demographic data and intraoperative records were obtained. The association between the perioperative characteristics and TOT was analyzed.

Measurements and main results: A total of 584 cases met the inclusion criteria, with a mean TOT of 231.6 +/- 86.7 min. The mean patient age was 36.3 +/- 5.5 years, and the patients had a mean of 4.2 +/- 4.0 myomas. The dominant myoma had a mean diameter of 7.6 +/- 2.6 cm. The mean total weight of the extracted myomas removed was 202.2 +/- 152.6 g.

From multiple regression analysis, the following perioperative factors were intimately associated with the TOT: (1) body mass index, (2) the number of myomas, (3) weight of total myomas, (4) location of dominant myoma, (5) type of da Vinci robot system, (6) endometrial cavity opening during the operation, (7) intraoperative blood loss, and (8) patient hospitalization period. The number of myoma was most closely related to the TOT, with an R-2 value of 0.330. All of the above factors with the exception of the type of robot system and location of dominant myoma were related to the console time. Age, parity, history of previous abdominal surgery, surgical indication, diameter, and FIGO classification were not associated with the TOT.

Conclusion: With an accurate identification of the perioperative parameters above, we can improve the quality of RALM by counselling, selecting an appropriate patient selection, and preoperative planning. (C) 2021 Elsevier B.V. All rights reserved.

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NR 21

TC 1

Z9 1

U1 0

U2 2

PU ELSEVIER

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

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Brunes, M

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Persson, Jan

TI Cesarean scar pregnancy: Reproductive outcome after robotic laparoscopic

removal with simultaneous repair of the uterine defect

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Cesarean scar pregnancy; Robotic surgery; Fertility outcome

ID SERIES

AB Objective: To describe perioperative adverse events, fertility and obstetric outcome, following a robot assisted laparoscopic approach for treating Cesarean scar pregnancies (CSP). Study Design: A retrospective case series of 14 consecutive women with a CSP and a wish for and attempts towards subsequent pregnancies, having undergone minimal invasive surgical treatment at two tertiary referral Swedish centers (Dep's of Obstetrics and Gynecology Skane University Hospital, Lund, and Sodersjukhuset, Stockholm) between 2008 and 2019. The surgery was performed by temporary intraoperative occlusion of the uterine blood supply, removal of the CSP and repair of the niche, by the use of robot assisted laparoscopy (Da Vinci surgical robot, Intuitive Surgical, Sunnyvale, CA). Results: All surgeries were uneventful with a median bleeding of 75 mL. One woman had a postoperative Clavien-Dindo complication grade IIIa (hysteroscopic resection of an isthmic synechiae). During follow up nine women (64 %) conceived naturally; eight of these had an uneventful pregnancy and a full-term Cesarean delivery and one had recurrent CSP and Cesarean with simultaneous hysterectomy in gestational week 33. Conclusion: A robotic removal of a CSP with simultaneous repair of the defect is a feasible option with acceptable reproductive outcome and should be considered when counseling women with a wish for future childbirth in cases of a live CSP and a thin, or absent, myometrium in the niche. A temporary intraoperative occlusion of the uterine blood supply may be useful in cases of live pregnancies and/or high serum beta-hCG levels. (c) 2021 Elsevier B.V. All rights reserved.

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PT J

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TI Robotic Vaginal Natural Orifice Transluminal Endoscopic Hysterectomy for

Benign Indications

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Vaginal surgery; Robotic vaginal natural orifice

transluminal endoscopic surgery (RvNOTES); Robotic-assisted surgery;

Vaginal natural orifice transluminal endoscopic surgery (vNOTES)

ID LAPAROSCOPIC HYSTERECTOMY; SURGERY VNOTES; FEASIBILITY

AB Study Objective: The Hominis surgical system is a novel robot-assisted system, designed specifically for robotic vaginal natural orifice transluminal endoscopic surgery (RvNOTES). We presented our experience of the first 30 RvNOTES hysterectomies assessing the feasibility and safety of this technology.

Design: A two-center prospective study.

Setting: Academic tertiary referral centers. The ethics committees approved the study in both centers.

Patients: Thirty women with benign indication for hysterectomy.

Intervention: RvNOTES hysterectomy performed by the Hominis surgical system.

Measurements and Main Results: The primary outcome of the study was the rate of conversion to open or conventional laparoscopic approaches. Secondary outcomes included intra-and postoperative adverse events, operative time, estimated blood loss, length of hospital stay, and 6-week follow-up assessment. A total of 15 women were enrolled at each site. The median age was 59 years (range: 37-79) and the median body mass index was 25.4 kg/m(2) (range: 17.6-40.0). Twenty-four women (80%) had comorbidities. All the procedures were completed successfully without conversion to open abdominal, traditional vaginal, or conventional laparoscopic surgery. No intraoperative complications were observed. Median blood loss and procedure duration were 50 mL (range: 20-400) and 57 minutes (range: 24-88), respectively. Postoperative pain was minimal, with a median visual analog scale of 3 (range: 1-5) for the first 24 hours following surgery. The median hospital stay was 3 days (range: 2-8). According to the treating physicians' evaluations, the vaginal cuff was fully healed in all patients at the 6-week postoperative follow-up visit.

Conclusions: This is the first publication of robot-assisted vaginal hysterectomy using the Hominis surgical system. The positive results of this study show this new technology to be a safe and effective tool for vaginal natural orifice transluminal endoscopic surgery, enabling surgeons to operate vaginally with the known advantages of robotic modality. (C) 2020 Published by Elsevier Inc. on behalf of AAGL.

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TI Postoperative Opioid Prescribing and Consumption after Hysterectomy: A

Prospective Cohort Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic surgery; Opioid epidemic; Opioid use; Postoperative pain;

Public health

ID PAIN; INTERVENTION; PRESCRIPTION; PATTERNS

AB Study Objective: To examine opioid prescribing and consumption patterns after hysterectomy and identify factors associated with postoperative opioid consumption.

Design: Prospective cohort study.

Setting: Single university medical center.

Patients: Women undergoing hysterectomy for benign, nonobstetric indications.

Interventions: Participant preoperative and surgical characteristics were obtained through chart review and patient report of baseline pain score. During the third postoperative week, participants completed a telephone interview, including a direct count of remaining opioid pills and assessment of satisfaction with pain management. We assessed factors associated with opioid consumption in oral morphine equivalents (OME) using a linear regression model.

Measurements and Main Results: Of the 129 participants, 113 (88%) completed the postoperative survey after hysterectomy: 16 vaginal, 43 robotic-assisted, 42 conventional laparoscopic, and 12 abdominal hysterectomies. The median amount of opioid prescribed was 150 OME (interquartile range [IQR] 113-200), while the median amount consumed was 75 (IQR 10-135), reflecting an average consumption of about 50% of the prescription. Opioid prescription size was associated with consumption; for every additional oral morphine equivalent prescribed, on average, an additional 0.5 was consumed (p<.001). If the indication for hysterectomy was related to pain, participants consumed 25.3 additional OME (p=.04). The amount of opioid prescribed was inversely correlated with pain management satisfaction; every additional point on a 1 through 5 Likert scale of increasing satisfaction was associated with 44 fewer OME prescribed (standard error 9 OME, p<.001). For the 1464 total unused pills among the 104 participants with leftover opioids, only 20% reported an Food and Drug Administration-compliant opioid disposal plan.

Conclusion: Gynecologic surgeons can respond to the opioid epidemic by reducing excess opioid pills after hysterectomy by providing both the smallest effective prescription size and concrete resources for safe opioid disposal. These actions may contribute to a reduction in opioid use disorder cases or overdose deaths. (C) 2020 AAGL. All rights reserved.

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TI Robotic LESS and Reduced-Port Hysterectomy Using the da Vinci SP

Surgical System: A Single-Institution Case Series

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Single-incision surgery; R-LESS; Single site

ID SITE

AB Study Objective: To present a series of robotic laparoendoscopic single-site surgery (LESS) and reduced-port hysterectomy cases and discuss the surgical technique required for successful use on this new platform.

Design: Retrospective case series.

Setting: Academic medical center.

Patients: All patients undergoing robotic LESS or reduced-port hysterectomy with the SP1098 da Vinci SP Surgical System (Intuitive Surgical, Sunnyvale, CA) from December 2019 to March 2020.

Interventions: Robotic LESS or reduced-port hysterectomy.

Measurements and Main Results: A total of 8 cases of hysterectomy were performed successfully. Four cases included concomitant resection of endometriosis. Five cases required placement of an additional port. The average uterine weight was 136.1 g +/- 61.5 g (range 87-246). The average estimated blood loss was 37.5 mL +/- 27 mL (range 20-100). The average operative time was 86.5 minutes +/- 27.1 minutes (range 60-132). The time required for vaginal cuff closure was available for patients 5 to 8, and ranged from 10 minutes to 13 minutes. All patients had same-day discharge. There were no conversions to alternative surgical modality, complications, or readmissions.

Conclusion: Our preliminary experience with the SP1098 da Vinci SP Surgical System demonstrated the technical feasibility and safety of this surgical modality for gynecologic surgery. Additional studies examining postoperative outcomes and prospective studies comparing this modality with traditional robotic surgery are indicated. (C) 2020 AAGL. All reserved.

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TI Postoperative Opioid Utilization in Older Women Undergoing Pelvic Organ

Prolapse Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE older adults; opioid use; postoperative opioid use; postoperative

narcotic use; prolapse surgery

ID NAIVE PATIENTS; PRESCRIPTIONS; ANALGESICS; OVERDOSE

AB Objectives

The objective of this study was to determine total postoperative opioid consumption by women 60 years and older during the first week after pelvic organ prolapse surgery. We secondarily aimed to describe opioid prescribing patterns in this cohort. Methods

This is a secondary analysis of a prospective cohort study assessing changes in cognition in women 60 years and older undergoing prolapse surgery. Postoperative opioid use at home during the first week was collected through daily self-reported diary entries. Total postoperative opioid consumption was calculated by adding opioid administration in the postoperative anesthesia recovery unit, inpatient setting, and home opioid use (as documented in diary). Regression models were used to identify demographic and clinical factors associated with total postoperative opioid consumption in the top quartile of this cohort and home opioid use. Results

Data from 80 women were analyzed. Mean +/- SD age was 71.78 +/- 6.14 years (range, 60-88 years). Fifty women (62.5%) underwent vaginal surgery, and 30 (7.5%) underwent laparoscopic/robotic surgery, with concomitant hysterectomy in 47 (58.8%). The median (interquartile range) total morphine milligram equivalents used during the first week after surgery was 30 (7.5-65.75). The median (interquartile range) total morphine milligram equivalents prescribed was 225 (150-225). Conclusions

Opioid consumption after prolapse surgery in older women is very modest and equates to a median (interquartile range) of 4 (1-9) oxycodone (5 mg) tablets. Opioid prescribing patterns should be adjusted accordingly.

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JI Female Pelvic Med. Reconstr. Surg.

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TI The shift from inpatient to outpatient hysterectomy for endometrial

cancer in the United States: trends, enabling factors, cost, and safety

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE endometrial neoplasms; hysterectomy; surgical oncology; postoperative

complications; gynecologic Surgical Procedures

ID MINIMALLY INVASIVE SURGERY; TOTAL LAPAROSCOPIC HYSTERECTOMY; SAME-DAY

DISCHARGE; GYNECOLOGIC-ONCOLOGY; FEASIBILITY; WOMEN; OOPHORECTOMY;

SURVIVAL; OUTCOMES; RATES

AB Objective

To evaluate trends in outpatient versus inpatient hysterectomy for endometrial cancer and assess enabling factors, cost and safety.

Methods

In this retrospective cohort study, patients aged 18 years or older who underwent hysterectomy for endometrial cancer between January 2008 and September 2015 were identified in the Premier Healthcare Database. The surgical approach for hysterectomy was classified as open/abdominal, vaginal, laparoscopic or robotic assisted. We described trends in surgical setting, perioperative costs and safety. The impact of patient, provider and hospital characteristics on outpatient migration was assessed using multivariate logistic regression.

Results

We identified 41 246 patients who met inclusion criteria. During the time period studied, we observed a 41.3% shift from inpatient to outpatient hysterectomy (p<0.0001), an increase in robotic hysterectomy, and a decrease in abdominal hysterectomy. The robotic hysterectomy approach, more recent procedure (year), and mid-sized hospital were factors that enabled outpatient hysterectomies; while abdominal hysterectomy, older age, Medicare insurance, black ethnicity, higher number of comorbidities, and concomitant procedures were associated with an inpatient setting. The shift towards outpatient hysterectomy led to a $2500 savings per case during the study period, in parallel to the increased robotic hysterectomy rates (p<0.001). The post-discharge 30-day readmission and complications rate after outpatient hysterectomy remained stable at around 2%.

Conclusions

A significant shift from inpatient to outpatient setting was observed for hysterectomies performed for endometrial cancer over time. Minimally invasive surgery, particularly the robotic approach, facilitated this migration, preserving clinical outcomes and leading to reduction in costs.

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TI Multicystic Benign Mesothelioma Resected Robotically in a Postpartum

Female <i>A Case Report</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE abdominal neoplasms; cystic mesothelioma; cytoreduction surgical

procedure; mesothelioma; peritoneal neoplasms; pregnancy; progesterone

receptors; robotic surgical procedures

ID CYSTIC MESOTHELIOMA; PERITONEUM

AB BACKGROUND: Multicystic benign mesothelioma is a rare intraabdominal tumor that arises from the peritoneal mesothelium, usually in reproductive age females. Management consists of surgical resection with the goal of complete gross resection of disease.

CASE: A 29-year-old woman presented postpartum with progressive abdominal pain and bloating. Computerized tomography (CT) revealed extensive abdominal and pelvic complex multiseptated masses concerning for malignancy. Complete cytoreduction was successfully achieved with a minimally invasive robotic approach. The patient had a prompt recovery and a good outcome with no residual disease noted on CT imaging 7 months after surgery.

CONCLUSION: Aggressive surgical management is often required for the treatment of multicystic benign mesothelioma. We report a minimally invasive robotic approach with achievement of complete gross resection of visible disease.

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TI Laparoscopic vs. robotic-assisted laparoscopy in endometrial cancer

staging: large retrospective single-institution study

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial Cancer; Laparoscopy; Robotic Surgical Procedures;

Gynecologic Neoplasms

ID MINIMALLY INVASIVE SURGERY; STANDARD LAPAROSCOPY; RECURRENCE; SURVIVAL;

LAPAROTOMY; OUTCOMES; MANAGEMENT; WOMEN

AB Objective: The aim of this study is to analyze and draw the potential differences between the robotic-assisted surgery (RS) and the laparoscopy (LPS) in endometrial cancer staging.

Methods: In this single-institution retrospective study we enrolled 1,221 consecutive clinical stage I-III endometrial cancer patients undergone minimally invasive surgical staging. We compared patients treated by LPS and by RS, on the basis of perioperative and oncological outcomes (disease-free survival [DFS] and overall survival [OS]). A sub-analysis of the high-risk endometrial cancer population was performed in the 2 cohorts.

Results: The 2 cohorts (766 treated by LPS and 455 by RS) were homogeneous in terms of perioperative and pathological data. We recorded differences in number of relapse/progression (11.7% in LPS vs. 7% in RS, p=0.008) and in number of deaths (9.8% in LPS vs. 4.8% in RS, p=0.002). Whereas, univariate and multivariate analyses according to DFS and OS confirmed that the surgical approach did not influence the DFS or the OS. In the multivariable analysis the association of the age and grading was significant for DFS and OS. In the sub-analysis of the 426 high risk EC patients (280 in LPS and 146 in RS) the univariate and the multivariate confirmed the influence of the age in DFS and OS, independently of the minimally invasive approach.

Conclusions: In our large retrospective analysis, we confirmed that the RS and LPS have similar efficacy and safety for endometrial cancer staging also for the high-risk endometrial cancer patients.

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TC 18

Z9 18

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J9 J GYNECOL ONCOL

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PG 14

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ER

PT J

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Minassian, Vatche Arakel

TI Pelvic organ prolapse after 3 modes of hysterectomy: long-term follow-up

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE abdominal hysterectomy; laparoscopic hysterectomy; pelvic organ

prolapse; robotic hysterectomy; vaginal hysterectomy

ID URINARY-INCONTINENCE; FLOOR DISORDERS; RISK; EPIDEMIOLOGY; SURGERY;

REPAIR; TRENDS; TRIAL; WOMEN; TIME

AB BACKGROUND: There are various indications and approaches for hysterectomy; yet, the difference in long-term risk of subsequent prolapse after surgery is not well studied.

OBJECTIVE: To assess the risk of prolapse after abdominal, vaginal, and laparoscopic or robotic hysterectomy for up to 17 years from surgery.

STUDY DESIGN: A retrospective chart review study of women undergoing hysterectomy across all indications (benign and malignant) between 2001 and 2008 was conducted. An equivalent random sample of hysterectomy patients was selected each year. We compared demographic and other surgical characteristics data including age, race, parity, body mass index, indication and year of hysterectomy, blood loss, cervix removal, cuff suspension, and complications using chi-square, Kruskal-Wallis test, and Fisher's exact across the 3 groups. Presence and treatment of subsequent prolapse (based on patient symptoms, pelvic exam, International Classification of Diseases, Ninth Revision diagnosis, and current procedural terminology pessary or surgical codes) were compared with Kaplan-Meier survival analysis and Cox proportional hazards regression.

RESULTS: Of the 2158 patients, 1459, 375, and 324 underwent open, vaginal, and laparoscopic or robotic hysterectomy, respectively. The vaginal group (56) was older than the abdominal (52) or laparoscopic or robotic (49) groups, with a P value of <.05. Most patients were White with a mean body mass index of 30 kg/m2. The main indication was cancer for abdominal (33%) and laparoscopic or robotic hysterectomy (25%) and prolapse for vaginal hysterectomy (60%). Time to prolapse was shortest after vaginal surgery (27 months) and longest after laparoscopic or robotic surgery (71 months). After controlling for confounders, including surgery indication, the hazard ratio for subsequent prolapse was no different among vaginal (hazard ratio=1.36 [0.77-2.45]), laparoscopic or robotic (hazard ratio=1.47 [0.80-2.69]), or open (reference) hysterectomy. Prolapse grade was similar across the 3 groups. About 50% of women with recurrent prolapse received physical therapy, pessary, or surgical treatment.

CONCLUSION: At the 17-year follow-up, the route of hysterectomy is not associated with a difference in recurrence, grade, or subsequent treatment of prolapse when the indication for hysterectomy is considered. Prolapse, as an indication for hysterectomy, increases risk for recurrence. Women planning a hysterectomy should be counseled appropriately about the risk of subsequent prolapse.

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TC 7

Z9 8

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ER

PT J

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TI Understanding Patient Interest and Preferences for Same-Day Discharge

After Minimally Invasive Hysterectomy

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE minimally invasive surgery; gynecology; patient preference; hysterectomy

AB Objective: This study was conducted to assess patient interest in same-day discharge and to understand factors associated with these patient preferences.

Materials and Methods: This was a prospective observational study of women undergoing minimally invasive hysterectomy for benign or oncologic indications. Participants completed a survey assessing interest in same-day discharge preoperatively, 4-6 hours postoperatively, and on postoperative day 1. Demographics and perioperative parameters were abstracted from the electronic medical records. Univariable exact logistic regression models were used to estimate the odds of desiring same-day discharge.

Results: Ninety-two patients were enrolled. The mean age was 47.9 years (standard deviation = 10). Most patients underwent laparoscopic or robotic hysterectomy (n = 77/92, 84%). Preoperatively, 65% (n = 60/92) of patients expressed interest in same-day discharge. Patients meeting discharge milestones were 4.24 (95% confidence interval [CI]: 1.10-24.43; exact p = 0.03) times more likely to desire same-day discharge. Conversely, patients expecting to stay at least 1 night were 0.12 (95% CI: 0.01-0.72; exact p = 0.02) times as likely to desire same-day discharge. Age, surgical route, indication, surgery duration, start time, and time of postoperative evaluation were not associated with interest in same-day discharge (all exact p > 0.05). The most-common reason for desiring overnight admission was pain control (n = 33/64, 52%).

Conclusions: Preoperatively, most patients expressed interest in same-day discharge. Postoperatively, patients meeting discharge criteria and expecting discharge on the day of surgery were more likely to be interested in same-day discharge. Optimizing preoperative hysterectomy counseling would likely promote patient desire for same-day discharge.

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TC 0

Z9 0

U1 0

U2 1

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ER

PT J

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TI Docking for robotic extraperitoneal para-aortic lymphadenectomy with Da

Vinci Xi surgical system

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Gynecological surgery; Robotic surgery; Cervical cancer; Ovarian cancer;

Endometrial cancer; Extraperitoneal Para-aortic Lymphadenectomy

AB Regarding extraperitoneal para-aortic lymphadenectomy, installation is key when performed with the assistance of the Da Vinci Xi robotic system. We developed a step-by-step guide, from patient installation to placement of the trocars to patient cart docking, to perform in the efficient and safest installation possible this procedure. The operation does not differ from standard laparoscopic extraperitoneal lymphadenectomy. The benefits of robotic surgery in this indication are comparable to those of the standard laparoscopic approach. Those benefits imply a precise knowledge of the management and installation of the da Vinci Xi robotic system. (C) 2021 Elsevier Masson SAS. All rights reserved.

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NR 5

TC 4

Z9 4

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ER

PT J

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Barnes, WA

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TI Patterns of voiding following laparoscopic hysterectomy

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Outpatient hysterectomy; Voiding patterns; Minimally invasive

hysterectomy

ID URINARY RETENTION; SURGERY; DISCHARGE; RISK

AB Objective: Clarify the normal patterns of voiding after minimally invasive hysterectomy. We also aim to identify perioperative factors associated with delayed time to void immediately following hysterectomy.

Design: Retrospective cohort study

Selection: Women undergoing laparoscopic hysterectomy between September 2012 to October 2018 at a single academic university hospital.

Results: 450 minimally invasive hysterectomies were included in the final analysis, 274 (60.9%) robotically-assisted, and 176 (39.1%) conventional laparoscopy. The overall median postoperative time-to-void following a retrograde bladder filling of 150 mL normal saline was 179 min. Based on the 50th percentile of the distribution of the time-to-void, two groups were created. Demographic characteristics between the groups were similar, except those who were above the 50th percentile were more likely to be older, have a reported history of previous myomectomy, and had a longer postoperative PACU stay compared to those below or equal to the 50th percentile. The mean time-to-void following conventional laparoscopic hysterectomy was less than that of robotic surgery (187.3 vs 200.5 min) however the difference was not statistically significant (p=.22). The use of hydromorphone intraoperatively and the combination of oxycodone-acetaminophen postoperatively were more likely to be associated with the group of patients above the 50th percentile but there was no significant difference in perioperative utilization of median morphine milliequivalents (MME) between the two groups.

Conclusions: Following laparoscopic hysterectomy (either conventional or with robotic-assistance) with a retrograde bladder fill of 150 mL normal saline most patients will void within 4 h after surgery. This is consistent with historic data on normal voiding patterns facilitating safe same day discharge without prolonged time in the PACU. (C) 2021 Elsevier Masson SAS. All rights reserved.

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TI Ergonomic Robotic Console Configuration in Gynecologic Surgery: An

Interventional Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Hysterectomy; Ergonomics; Surgeon pain

AB Study Objective: The objectives of this study were to (1) pilot a robotic console configuration methodology to optimize ergonomic posture, and (2) determine the effect of this intervention on surgeon posture and musculoskeletal discomfort.

Design: This was an institutional review board- approved prospective cohort study conducted from February 2017 to October 2017.

Setting: A single tertiary care midwestern academic medical center.

Participants: Six fellowship-trained gynecologic surgeons, proficient in robotic hysterectomy, were recruited: 3 men and 3 women.

Interventions: Each surgeon performed 3 robotic hysterectomies using their self-selected robotic console settings (preintervention). Then, a robotic console ergonomic intervention protocol was implemented by trained ergonomists to improve posture and decrease time in poor ergonomic positions. Each surgeon then performed 3 robotic hysterectomies using the ergonomic intervention settings (postintervention). All surgeries used the da Vinci Xi surgical system (Intuitive Surgical, Inc., Sunnyvale, CA) and were the first case of the day. The surgeons wore inertial measurement unit (IMU) sensors on their head, chest, and bilateral upper arms during surgery. The IMU sensors are equipped with accelerometers, gyroscopes, and magnetometers to give objective measurements of body posture. IMU data were then analyzed to determine the percentage of time spent in ergonomically risky postures as categorized using a modified rapid upper limb assessment. Before and after each hysterectomy, the surgeons completed identical questionnaires for an assessment of musculoskeletal pain/discomfort. The outcome measurements were compared pre- versus postintervention on the basis of fitting generalized linear mixed models that handled the individual surgeon as a random effect and "setting" as a fixed effect.

Measurements and Main Results: With regard to the IMU posture results, there was a significant decrease in time spent in the moderate- to high-risk neck position and a decrease in average neck angle after the ergonomic intervention. The average percentage of time spent in moderate- to high-risk categories was significantly lower for the neck (mean, 54.3% vs 21.0%; p =.008) and right upper arm (mean, 15.5% vs 0.9%; p =.02) when using the intervention settings compared with the surgeons' settings. Pain score results: There were fewer reported increases in neck (4 [22%] vs 1 [6%]) and right shoulder (4 [22%] vs 2 [11%]) pain or discomfort after completion of robotic hysterectomy postintervention versus preintervention; however, these differences did not attain statistical significance (p =.12 and p =.37, respectively).

Conclusion: An ergonomic robotic console intervention demonstrated effectiveness and improved objective surgeon posture at the console when compared with the surgeons' self-selected settings. (C) 2020 AAGL. All rights reserved.

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ER

PT J

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TI Pre-emptive Non-narcotic Pain Medication before Minimally Invasive

Surgery in Gynecologic Oncology

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE ERAS; Hospital stay; Laparoscopic surgery; Perioperative narcotics;

Recovery time

ID ERAS(R) SOCIETY RECOMMENDATIONS; ENHANCED RECOVERY PATHWAYS; VAGINAL

HYSTERECTOMY; PERIOPERATIVE CARE; GUIDELINES; PREGABALIN; METAANALYSIS;

MANAGEMENT; OUTCOMES; PROGRAM

AB Study Objective: To review the impact of enhanced recovery after surgery (ERAS) after minimally invasive surgery (MIS) with respect to perioperative narcotics, time in the recovery room, and total time in hospital.

Design: Retrospective cohort.

Setting: Teaching hospital.

Patients: All patients having MIS in the division of gynecologic oncology during a 20-month period.

Intervention: MIS cases were compared before and after the implementation of an ERAS protocol that incorporated orally administered acetaminophen, gabapentin, and celecoxib.

Measurement and Main Results: A total of 800 MIS cases were performed during the period (77% laparoscopy, 18% robotic, 5% mini-lap). Of these, 449 cases were treated without and 351 with the ERAS protocol. There were no significant differences between the groups with respect to age, BMI, surgery type, smoking, surgical indication, blood loss, or diagnosis. Total narcotic use in milligram intravenous equivalents of morphine (mg IV Eq) was significantly less in the ERAS patients (28.5-mg IV Eq vs 23.6-mg IV Eq; p <.001). There was a trend toward less narcotics in recovery (4.8-mg IV Eq vs 4.1-mg IV Eq; p = .08). Postoperative recovery room time was not different between the groups (129 minutes vs 131 minutes; p = .66). ERAS was associated with a higher rate of same day discharge (38.5% vs 49.0%; p = .003) and a shorter length of hospital stay (22.9 hours vs 18.5 hours; p = .008), with a hazard ratio for discharge of 0.82 (0.71 & minus;0.94). However, the same day discharge rate varied widely between treating physicians (20% to 56%).

Conclusions: Implementation of an ERAS protocol for MIS appears to reduce total perioperative narcotic use but does not reduce recovery room time. There was a reduction in total hospital time, but this may be dependent on practice patterns of individual physicians. (C) 2020 AAGL. All rights reserved.

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TI Outcomes of Minimally Invasive versus Open Radical Hysterectomy for

Early Stage Cervical Cancer Incorporating 2018 FIGO Staging

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Surgery; Laparotomy; Cervical carcinoma; Outcomes

AB Study Objective: To compare outcomes after minimally invasive surgery (MIS) vs open radical hysterectomy for early stage cervical cancer incorporating 2018 Federation of Gynecology and Obstetrics (FIGO) staging.

Design: A retrospective analysis.

Setting: A single teaching hospital.

Patients: Patients after radical hysterectomy for stage IA1 with lymphovascular invasion, IA2, or IB1 squamous, adenosquamous, or adenocarcinoma of the cervix between 2007 and 2018, mirroring the Laparoscopic Approach to Cervical Cancer trial criteria.

Interventions: The use of MIS surgery for performing radical hysterectomy.

Measurements and Main Results: The outcomes were compared between patients undergoing MIS vs open approaches. A total of 126 patients met the inclusion criteria. The approach was open in 44 patients (35%) and MIS in 82 patients (65%); 49% were laparoscopic and 51% were robotic. Distribution based on the 2009 FIGO staging showed 1 stage IA1 with lymphovascular invasion, 15 stage IA2, and 110 stage IB1 patients. Although not statistically significant, the 3-year disease-free survival (DFS) was higher in the open compared to the MIS group (95% vs 87%; p = .17), and the overall survival was higher in the open compared to the MIS group (97% vs 92%; p = .25).

Fourteen patients whose disease recurred were Stage IB1 by FIGO 2009 staging; 11/14 were reclassified to a higher stage by 2018 FIGO staging (5/5 open, 6/9 MIS). Adjuvant therapy was recommended for all these patients based on the Sedlis criteria (10/14) or other risk factors (4/14). Despite this, only 1/9 of MIS patients whose disease recurred received adjuvant therapy compared with 3/5 patients whose disease recurred in the open group (p = .05).

Conclusion: In a cohort of patients similar to that of the Laparoscopic Approach to Cervical Cancer trial, 2018 FIGO staging may be useful to refine indications for MIS radical hysterectomy in early stage cervical cancer. However, disparate outcomes between MIS and open approaches may be explained by differences in compliance with National Comprehensive Cancer Network guidelines for adjuvant therapy. (C) 2020 AAGL. All rights reserved.

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WC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Ulrich, D

Preyer, O

Bjelic-Radisic, V

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Reinstadler, Evi

Tamussino, Karl

Mazanek, Andrea

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TI The Austrian Sacrocolpopexy Registry: Surgical Techniques, Perioperative

Safety, and Complications

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; Abdominal prolapse surgery; Abdominal mesh;

Urogynecology

AB Study Objective: Sacrocolpopexy (SCP) has become the standard procedure to correct uterovaginal prolapse in women, but techniques and approaches are not standardized. We report the results of the Austrian Sacrocolpopexy Registry, which aimed to collect data on surgical techniques and perioperative outcomes.

Design: The Austrian Urogynecology Working Group initiated a registry to assess surgical variability and perioperative safety of SCP. The study was performed at 14 centers (13 in Austria,1 in Switzerland). Institutional review board approvals were obtained.

Patients: Consecutive patients with symptomatic pelvic organ prolapse (POP).

Interventions: SCP in the course of routine POP treatment.

Measurements and Main results: Preoperative assessment included demographic data, clinical data on bladder, and bowel functions and POP-Q status. Surgical data included surgical approach (open, laparoscopic, robotic), type of mesh, depth of dissection, nerve sparing techniques, suture materials, uterus or cervix-sparing techniques, peritoneal closure, and concomi-tant surgeries. A total of 401 patients were recruited into the study. The mean age was 57 years (range: 26-84) and mean body mass index was 34. A total of 137 (34%) patients had undergone previous surgery for prolapse and in 264 cases SCP was the primary procedure. A total of 170 (42%) patients had undergone previous hysterectomy; For patients with uterus, SCP was performed with subtotal (n = 148) or total (n = 3) hysterectomy. A total of 285 (71%) SCPs were done laparoscopi-cally, 102 (25%) robotically and 10 (3%) per laparotomy. The conversion rate from laparoscopy to abdominal surgery was 4.5%. Various meshes and suture materials were used and fixation techniques also varied widely. Four patients underwent reoperation within 30 days (2 trocar herniations, and 1 bowel obstruction, 1 compartment syndrome). One patient died of aortic dissection 7 days after SCP.

Conclusions: Most SCPs in this registry were performed laparoscopically, but there was considerable variation in surgical techniques. Perioperative morbidity appears modest. (C) 2020 AAGL. All rights reserved.

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PT J

AU Bogani, G

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Chiappa, V

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AF Bogani, Giorgio

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Chiappa, Valentina

Lopez, Salvatore

Monti, Marco

Muzii, Ludovico

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TI Minimally invasive surgery in cervical cancer

SO MINERVA OBSTETRICS AND GYNECOLOGY

LA English

DT Review

DE Uterus; Laparoscopy; Robotics; Hysterectomy

ID ABDOMINAL RADICAL HYSTERECTOMY; NEOADJUVANT CHEMOTHERAPY; LAPAROSCOPY;

RECURRENCE; SURVIVAL; OUTCOMES; PREDICTORS; CARCINOMA; COHORT

AB In recent years, minimally invasive surgery has replaced open surgery for almost all surgical indications in gynecological practice. Recently, the results of the laparoscopic approach to cervical cancer (LACC) trial questioned the role of minimally invasive surgery for patients affected by early-stage cervical cancer. In the present paper, we discussed the current evidence regarding the adoption of minimally invasive surgery for patients with cervical cancer. We evaluated the current evidence focusing on four interesting features: 1) the impact of tumor volume; 2) reasons explaining worse outcomes of patients undergoing minimally invasive surgery; 3) methods to reduce the risk of recurrence during minimally invasive surgery; and 4) the effect of minimally invasive surgery in patients with locally advanced cervical cancer. At the moment, in the light of current evidence, minimally invasive radical hysterectomy should be offered only in the context of clinical trials. Extensive counseling and appropriate patients' selection are needed. Further prospective evidence is warranted to identify the better approach for cervical cancer patients.

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JI Minerva Obstet. Gynecol.

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ER

PT J

AU Chen, AH

Robertson, MW

AF Chen, Anita H.

Robertson, Matthew W.

TI Route of Hysterectomy: Robotic

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE gynecology; hysterectomy; robotic; surgery

AB The annual percentage of hysterectomies performed with robotic-assisted laparoscopy has steadily increased since the U.S. Food and Drug Administration (FDA) approved the platform for gynecologic surgery in 2005. The rapid adoption and continued expansion of this technique are due to many factors, including 3-dimensional cameras with better visualization, instrumentation enabling precise movements with tremor control, and better ergonomics for surgeons. Residency training, with decreased numbers of minimally invasive techniques using vaginal and laparoscopic approaches, likely contributes to this trend as well. Despite these ever-increasing numbers, gynecologic societies have yet to determine and outline a standardized credentialing process. The robotic-assisted laparoscopic platform enables challenging cases, which previously would have been relegated to laparotomy, to be addressed in a minimally invasive platform. Obese patients and those with enlarged uteri or with significant adhesive disease have benefited from this unique technology. Hysterectomies performed with the robotic platform have consistently had lower surgical blood loss and shorter lengths of hospital stays. Complication rates between robotic-assisted laparoscopy and standard laparoscopy for hysterectomies appear to be similar; however, the robotic platform has longer operative times. This could be balanced by the demonstrated overall shorter hospital stay, compared to standard laparoscopic hysterectomy, and by a lower conversion rate to laparotomy. Advantages of the robotic platform appear to be magnified when surgeons have greater experience. Costs associated with purchase and use of robotic platforms continue to cause concern. It is hoped that competition with alternative robotic systems will decrease these costs. However, they must be viewed within the context of improved surgical and perioperative outcomes.

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GA RG7TR

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ER

PT J

AU Kalogera, E

Nelson, G

Dowdy, SC

AF Kalogera, Eleftheria

Nelson, Gregg

Dowdy, Sean C.

TI Enhanced Recovery in Gynecologic Surgery

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE enhanced recovery; perioperative care; gynecologic surgery; abdominal

hysterectomy; vaginal hysterectomy; laparoscopic hysterectomy

ID GUIDELINES

AB Enhanced Recovery After Surgery (ERAS) is a perioperative quality-improvement program that uses evidence-based interventions within the preoperative, intraoperative, and postoperative phases of surgical care. ERAS interventions aim to decrease the stress response to surgery, and when implemented together in a structured fashion, result in reductions in hospital length of stay, complications, and cost of care as well as improving patients' satisfaction. ERAS is now firmly entrenched in multiple surgical specialties, including gynecology, where recent randomized studies have shown benefit. This review describes ERAS elements relevant to gynecologic surgery (for both benign and malignant indications), including avoiding preoperative fasting and mechanical bowel preparation; giving preemptive analgesia; using a standardized anesthesia protocol; maintaining normothermia and euvolemia; preventing postoperative nausea and vomiting; avoiding use of drains/tubes; and implementing opioid-sparing pain control, early postoperative feeding, early removal of urinary catheter, and active mobilization. A separate section on minimally invasive surgery (vaginal, laparoscopic, and robotic procedures) is included to discuss ERAS considerations specific to these approaches. This is especially important, as the discipline of gynecologic surgery increasingly leans toward same-day discharge.

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U2 6

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ER

PT J

AU Roberts, K

Slopnick, E

Chapman, G

Mangel, J

Sheyn, D

AF Roberts, Kasey

Slopnick, Emily

Chapman, Graham

Mangel, Jeffrey

Sheyn, David

TI Adverse Cardiovascular Events Associated With Female Pelvic

Reconstructive Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE major adverse cardiovascular; and cerebrovascular events; urogynecology

AB Objective

To evaluate national trends in major adverse cardiovascular and cerebrovascular events (MACCE) in female pelvic reconstructive surgery (FPRS). Methods

Data from the National Inpatient Sample was used to identify women undergoing FPRS between 2012 and 2016. Demographic, procedural, and comorbidity data were collected. Patients were stratified into those with and without MACCE (defined as all-cause mortality, cardiac arrest, myocardial infarction (MI) and acute ischemic stroke). Descriptive statistics are expressed as medians and interquartile ranges. Pairwise analysis was performed using Wilcoxon rank-sum or Fisher exact test as appropriate. Multivariable logistic regression was used to identify independent risk factors for MACCE. Results

During the study period, 53,540 patients underwent FPRS. The rate of MACCE was 4.8 per 1000 surgeries; MI, 3.7; acute ischemic stroke, 0.6; cardiac arrest, 0.4; and all-cause mortality, 0.3. Patients experiencing MACCE were more likely to have major preexisting cardiovascular comorbidities, coagulopathy, neurologic disease (ND), and diabetes and were more likely to undergo robotic colpopexy (20.7% vs 9.6%, P < 0.001), vaginal colpopexy (32.0% vs 28.5%, P = 0.04), and to receive a blood transfusion (8.2% vs 2.5%, P < 0.001).

On logistic regression, preexisting coagulopathy was the strongest predictor of MACCE (adjusted odds ratio [aOR], 5.53; 95% confidence interval [CI], 2.39-12.78), followed by blood transfusion (aOR, 4.84; 95% CI, 1.89-12.45), congestive heart failure (aOR, 3.61; 95% CI, 1.56-8.37), ND (aOR, 3.14; 95% CI, 1.23-8.06), and electrolyte abnormalities (aOR, 1.99; 95% CI, 1.05-3.99). Conclusion

Major adverse cardiovascular and cerebrovascular events after FPRS is a rare event, with MI being the most common manifestation. Preexisting ND, congestive heart failure, coagulopathy, electrolyte disturbances, and perioperative transfusions are strongly associated with MACCE.

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JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

AU Chang, CL

Chen, CH

Chang, SJ

AF Chang, Chia-Lun

Chen, Chun-Hua

Chang, Shang-Jen

TI Comparing the outcomes and effectiveness of robotic-assisted

sacrocolpopexy and laparoscopic sacrocolpopexy in the treatment of

pelvic organ prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic surgery; Laparoscopy; Sacrocolpopexy; Pelvic organ prolapse

AB Introduction and hypothesis Abdominal sacrocolpopexy is regarded as the gold standard for management of pelvic organ prolapse (POP). Nowadays, minimally invasive surgeries are preferred, and sacrocolpopexy can be performed using either a laparoscopic or robotic-assisted approach. The aim of the current study was to compare the efficacy and safety of robotic-assisted sacrocolpopexy (RASC) and laparoscopic sacrocolpopexy (LSC) through an updated systematic review and meta-analysis. Methods We performed a systematic literature review of different databases and related references from their inception until July 2020 without language restrictions. All randomized control trials and comparative studies that compared RASC and LSC for the management of POP were included. Results A total of 13 studies including 2115 participants were included for the pooled analysis. The pooled results revealed that RASC was associated with a significantly longer operative time (weighted mean difference, 29.53 min; 95% confidence interval [CI], 12.88 to 46.18 min, P = 0.0005), significantly less estimated blood loss (weighted mean difference, -86.52 ml; 95% CI -130.26 to -42.79 ml, P = 0.0001), significantly fewer overall intraoperative complications (odds ratio [OR] 0.6; 95% CI 0.40 to 0.91; P = 0.01) and significantly lower conversion rate (OR 0.39; 95% CI 0.19 to 0.82; P = 0.01) compared with LSC. There were no significant differences between the length of hospital stays, overall postoperative complications, postoperative stress incontinence, mesh erosion and effectiveness between the two groups. Conclusion The current study showed comparable efficacy between RASC and LSC. Though RASC was associated with less blood loss and a lower conversion rate, the differences were not clinically significant. The choice of surgical procedure with either RASC or LSC is according to surgeon discretion and patient preferences.

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PT J

AU Geoffrion, R

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TI Guideline No. 413: Surgical Management of Apical Pelvic Organ Prolapse

in Women

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY CANADA

LA English

DT Article

DE surgical mesh; suspensions; uterine prolapse; pelvic pain; urinary

bladder; decision making; shared

ID SACROSPINOUS LIGAMENT FIXATION; ABDOMINAL SACRAL COLPOPEXY; RANDOMIZED

CONTROLLED-TRIAL; VAGINAL VAULT PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY;

UTEROVAGINAL PROLAPSE; ROBOTIC SACROCOLPOPEXY; UTERUS PRESERVATION;

SEXUAL FUNCTION; TERM OUTCOMES

AB Objective: To compare success and complication rates of apical suspension procedures for the surgical management of symptomatic uterine or vaginal vault prolapse.

Target population: Women with symptomatic uterine or vaginal vault prolapse seeking surgical correction.

Options: Interventions included abdominal apical reconstructive repairs (sacrocolpopexy, sacrohysteropexy, or uterosacral hysteropexy) via open, laparoscopic, or robotic approaches; vaginal apical reconstructive repairs (vault suspensions or hysteropexy, sacrospinous, uterosacral, iliococcygeus, McCall's, or Manchester types); and vaginal obliterative procedures (with or without uterus in situ). Individual procedures or broad categories of procedures were compared: (1) vaginal versus abdominal routes for reconstruction, (2) abdominal procedures for reconstruction, (3) vaginal procedures for reconstruction, (4) hysterectomy and suspension versus hysteropexy for reconstruction, and (5) reconstructive versus obliterative options.

Outcomes: The Urogynaecology Committee selected outcomes of interest: objective failure (obtained via validated pelvic organ prolapse [POP] quantification systems and defined as overall objective failure as well as failure rate by compartment); subjective failure (recurrence of bulge symptoms determined subjectively, with or without use of a validated questionnaire); reoperation for POP recurrence; complications of postoperative lower urinary tract symptoms (de novo or postoperative stress urinary incontinence; reoperation for persistent, recurrent, or de novo stress urinary incontinence; urge urinary incontinence; and voiding dysfunction); perioperatively recognized urinary tract injury (bladder or ureter); other complications (mesh exposure, defined as mesh being visible and exposed in the vagina, and non-sexual pelvic pain); and sexual function (de novo dyspareunia and sexual function score according to a validated questionnaire).

Benefits, harms, and costs: This guideline will benefit patients seeking surgical correction of apical POP by improving counselling on surgical treatment options and possible outcomes. It will also benefit surgical providers by improving their knowledge of various surgical approaches. Data presented could be used to develop frameworks and tools for shared decision-making.

Evidence: We searched Medline, the Cochrane Central Register of Controlled Trials (CENTRAL), and Embase from 2002 to 2019. The search included multiple terms for apical POP surgical procedures, approaches, and complications. We excluded POP repairs using transvaginal mesh and studies that compared procedures without apical suspension. We included randomized controlled trials and prospective or retrospective comparative studies. We limited language of publication to English and French and accessibility to full text. A systematic review and meta-analysis was performed.

Validation methods: The authors rated the quality of evidence and strength of recommendations using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. See online Appendix A (Tables A1 for definitions and A2 for interpretations of strong and weak recommendations).

Intended users: Gynaecologists, urologists, urogynaecologists, and other health care providers who assess, counsel, and care for women with POP.

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PG 14

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

GA RC1XZ

UT WOS:000632599800015

PM 33548503

DA 2024-01-18

ER

PT J

AU Matsuo, K

Matsuzaki, S

Mandelbaum, RS

Kanao, H

Chang, EJ

Klar, M

Roman, LD

Wright, JD

AF Matsuo, Koji

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Mandelbaum, Rachel S.

Kanao, Hiroyuki

Chang, Erica J.

Klar, Maximilian

Roman, Lynda D.

Wright, Jason D.

TI Utilization and perioperative outcome of minimally invasive pelvic

exenteration in gynecologic malignancies: A national study in the United

States

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Pelvic exenteration; Minimally invasive surgery; Laparoscopic; Robotic

assisted; Complication; Systematic review

ID EXPERIENCE; SURVIVAL; CANCER; MORBIDITY; ONCOLOGY

AB Objective. To examine characteristics and short-term perioperative outcomes related to minimally invasive pelvic exenteration for gynecologic malignancy. Methods. This comparative effectiveness study is a retrospective population-based analysis of the National Inpatient Sample from 10/2008?9/2015. Women with cervical, uterine, vaginal, and vulvar malignancies who underwent pelvic exenteration were evaluated based on the use of laparoscopic or robotic-assisted surgery. Patient demographics and intraoperative/postoperative complications related to a minimally invasive surgical approach were assessed. Results. Among 1376 women who underwent pelvic exenteration, 49 (3.6%) had the procedure performed via a minimally invasive approach. The majority of minimally invasive cases were robotic-assisted (51.0%). Women in the minimally invasive group were more likely to be old, white, have cervical/uterine cancers, and receive urinary diversion, but less frequently received vaginal reconstruction or colostomy when compared to those in the open surgery group (P < 0.05). Overall perioperative complication rates were similar between the minimally invasive and open surgery groups (79.6% versus 77.7%, P = 0.862), but the minimally invasive group had a decreased risk of high-risk complications compared to the open surgery group (adjusted-odds ratio 0.19, 95% confidence interval 0.07?0.51). Specifically, a minimally invasive approach was associated with decreased incidence of sepsis and thromboembolism compared to an open approach (P < 0.05). The minimally invasive group had a shorter length of stay (median, 9 versus 14 days) and lower total charge (median, $127,875 versus $208,591) compared to the open surgery group (P < 0.05). Conclusion. Laparotomy remains the main surgical approach for pelvic exenteration for gynecologic malignancy and minimally invasive surgery was infrequently utilized during the study period in the United States. Before widely adopting this surgical approach, the utility and role of minimally invasive pelvic exenteration requires further investigation.

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FU Ensign Endowment for Gynecologic Cancer Research

FX Ensign Endowment for Gynecologic Cancer Research (K.M.)

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U2 3

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

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PY 2021

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BP 39

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EA MAR 2021

PG 7

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA RC3OP

UT WOS:000632713900006

PM 33402282

DA 2024-01-18

ER

PT J

AU Azadi, S

Green, IC

Arnold, A

Truong, M

Potts, J

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AF Azadi, Shirin

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Martino, Martin A.

TI Robotic Surgery: The Impact of Simulation and Other Innovative Platforms

on Performance and Training

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotics; Simulation; Innovation; Simulator; Technology

AB Objective: To review the current status of robotic training and the impact of various training platforms on the performance of robotic surgical trainees.

Data Sources: Literature review of Google Scholar and PubMed. The search terms included a combination of the following: "robotic training," "simulation," "robotic curriculum," "obgyn residency robotic training," "virtual reality robotic training," "DaVinci training," "surgical simulation," "gyn surgical training." The sources considered for inclusion included peerreviewed articles, literature reviews, textbook chapters, and statements from various institutions involved in resident training.

Methods of Study Selection: A literature search of Google Scholar and PubMed using terms related to robotic surgery and robotics training, as mentioned in the "Data Sources" section.

Results: Multiple novel platforms that use machine learning and real-time video feedback to teach and evaluate robotic surgical skills have been developed over recent years. Various training curricula, virtual reality simulators, and other robotic training tools have been shown to enhance robotic surgical education and improve surgical skills. The integration of didactic learning, simulation, and intraoperative teaching into more comprehensive training curricula shows positive effects on robotic skills proficiency. Few robotic surgery training curricula have been validated through peer-reviewed study, and there is more work to be completed in this area. In addition, there is a lack of information about how the skills obtained through robotics curricula and simulation translate into operating room performance and patient outcomes.

Conclusion: Data collected to date show promising advances in the training of robotic surgeons. A diverse array of curricula for training robotic surgeons continue to emerge, and existing teaching modalities are evolving to keep up with the rapidly growing demand for proficient robotic surgeons. Futures areas of growth include establishing competency benchmarks for existing training tools, validating existing curricula, and determining how to translate the acquired skills in simulation into performance in the operating room and patient outcomes. Many surgical training platforms are beginning to expand beyond discrete robotic skills training to procedure-specific and team training. There is still a wealth of research to be done to understand how to create an effective training experience for gynecologic surgical trainees and robotics teams. (C) 2020 Published by Elsevier Inc. on behalf of AAGL.

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NR 48

TC 30

Z9 32

U1 2

U2 5

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA RC2NU

UT WOS:000632642200018

PM 33310145

OA Bronze

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ER

PT J

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Hou, JY

Khoury-Collado, F

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Wright, JD

Melamed, A

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Gamble, Charlotte R.

St Clair, Caryn M.

Hou, June Y.

Khoury-Collado, Fady

Gockley, Allison A.

Wright, Jason D.

Melamed, Alexander

TI The Role of Minimally Invasive Surgery in the Care of Women with Ovarian

Cancer: A Systematic Review and Meta-analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopic staging; Laparoscopic cytoreduction; Laparoscopic

evaluation of resectability

ID CYTOREDUCTIVE SURGERY; LAPAROSCOPY; LAPAROTOMY; HYSTERECTOMY; LANDSCAPE;

SURVIVAL; OUTCOMES; SOCIETY

AB Objective: To synthesize evidence from studies investigating survival outcomes for patients with ovarian cancer undergoing minimally invasive surgery (traditional or robotic laparoscopy) compared with those for patients with ovarian cancer undergoing laparotomy.

Data Sources: We searched Ovid MEDLINE and Embase (from inception to December 2019).

Methods of Study Selection: Observational cohort studies and randomized controlled trials that compared risk of recurrence or death between women undergoing minimally invasive and open procedures for staging (10), interval cytoreduction (4), secondary cytoreduction (2), and evaluation of resectability (1) were included.

Tabulation, Integration, and Results: Data on the number of participants, number of deaths and recurrences, and results of analyses of overall or progression-free survival were abstracted for all studies. A random-effects meta-analysis was used to pool the results of studies comparing minimally invasive staging and open staging. The surgical approach (minimally invasive versus open) was not significantly associated with hazard of death or recurrence (pooled hazard ratio 0.92; 95% confidence interval, 0.61-1.38) or all-cause mortality (pooled hazard ratio 0.96; 95% confidence interval, 0.49-1.89). One randomized trial demonstrated that diagnostic laparoscopy could triage patients to neoadjuvant chemotherapy and avoid suboptimal primary surgery, without affecting recurrence-free or overall survival. Most studies included in this review were observational and at high risk for bias, and few studies accounted for potential confounding.

Conclusion: Although existing studies do not demonstrate deleterious survival effects associated with minimally invasive surgery for ovarian cancer, these data must be viewed with caution given the significant methodologic shortcomings in the existing literature. (C) 2020 Published by Elsevier Inc. on behalf of AAGL.

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FU National Center for Advancing Translational Sciences, National

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FX This study was supported by the National Center for Advancing

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OA Bronze, Green Accepted

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PT J

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Kho, Rosanne

TI Non-hysteroscopic Myomectomy and Fertility Outcomes: A Systematic Review

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Pregnancy; Leiomyoma; Laparoscopy; Robot-assisted laparoscopic

myomectomy

ID ABDOMINAL MYOMECTOMY; UTERINE LEIOMYOMA; FIBROIDS; DETERMINANTS;

LAPAROSCOPY; WOMEN

AB Objective: To perform a systematic review of the literature to identify best practices for nonhysteroscopic myomectomy for women with myomas who desire future fertility. The focus areas included factors associated with conception and pregnancy outcomes after myomectomy, impact of surgical route (laparotomic, laparoscopic, and the incorporation of robot assistance), and preoperative findings and surgical techniques that have an impact on reproduction.

Data Sources: Librarian-led electronic searches of the Ovid MEDLINE, Ovid Embase, and Cochrane CENTRAL databases were performed from inception to February 2020. A targeted reference review was performed to update the original searches.

Methods of Study Selection: The participants were women of reproductive age with myomas who underwent myoma removal surgery through laparotomic or laparoscopic approaches. The fertility outcomes included markers for ovarian reserve, clinical pregnancy rates, and pregnancy outcomes. We performed quality assessment using National Institutes of Health Study Quality Assessment Tools and developed clinical recommendations graded according to the strength of the evidence.

Tabulation, Integration, and Results: The initial search identified 2163 studies, of which 51 met the inclusion criteria. These consisted of 11 studies that focused on the factors associated with conception or pregnancy outcomes after myomectomy, 10 studies that examined the route of nonhysteroscopic myomectomy, and 30 that were related to intraoperative techniques and findings. Overall, younger age, lower myoma number, and distortion of the endometrial cavity were associated with improved reproductive outcomes after myomectomy. The route of nonhysteroscopic myomectomy and intraoperative uterine artery occlusion did not significantly affect pregnancy rates or outcomes. Adhesion barriers present a possible target for further research.

Conclusion: This study provides insights into patient selection and intraoperative techniques for nonhysteroscopic myomectomy. Further research with well-designed clinical trials is needed to highlight the relationships between myoma characteristics (International Federation of Gynecology and Obstetrics type, location, and size) and reproductive outcomes. (C) 2020 AAGL. All rights reserved.

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NR 63

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Z9 8

U1 0

U2 4

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JI J. Minim. Invasive Gynecol.

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GA RC2NU

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OA Bronze

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ER

PT J

AU Dion, L

Thierry, LJ

Tardieu, A

Carbonnel, M

Ayoubi, JM

Gauthier, T

Lavoue, V

AF Dion, L.

Thierry, L. Jacquot

Tardieu, A.

Carbonnel, M.

Ayoubi, J-M

Gauthier, T.

Lavoue, V

TI Uterus transplantation, current prospect and future indications. State

of art with review of literature

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Review

DE Uterus transplantation; Deceased donor; Living donor; Absolute uterus

infertility

AB Objectives. - The aim of this review is to summarize the development of UT on worldwide and to develop the new questions posed by this technique in 2020.

Methods. - According to the PRISMA model, via Pubmed, we searched for publications containing the keywords: uterus transplantation; UT and cryopreservation from 2000 to 2020.

Results. - At least 76 UTx have been carried out around the world and 19 healthy babies were born. The main indication remains the uterine agenesis (MRKH Syndrome > 85% cases) then the history of hysterectomy (hemorrhage of the delivery or cervical cancer) and the non-functional uterus (Asherman's syndrome, diffuse adenomyosis). The 2 types of donors (living and deceased) are developed representing respectively 75% and 25% of the TU; the success rate in terms of return of rules is better in the living donor group and is 79% vs 68% in the deceased donor group. The choice of donor type must take into account the constraints of both procedures. Surgical complications (grade III) for the donor are estimated to be 14% mainly represented by ureter wounds. Technical simplifications concerning the venous return of the graft but also the carrying out of robot-assisted surgery would reduce the operating time for the donor and facilitate the collection process.

Conclusion. - TU is a complementary alternative to GPA and adoption allowing patients to be surrogates, legal and biological of the baby. An extension of the indications to patients with non absolute uterine infertility is in the process of democratization. (C) 2020 Elsevier Masson SAS. All rights reserved.

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U2 5

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JI Gynecol. Obstet. Fertil. Senol.

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PG 11

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA RB0YP

UT WOS:000631843800008

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OA hybrid

DA 2024-01-18

ER

PT J

AU Greene, KA

Wyman, AM

Tamhane, N

Tanner, JP

Bassaly, RM

Salemi, JL

AF Greene, Kristie A.

Wyman, Allison M.

Tamhane, Nupur

Tanner, Jean Paul

Bassaly, Renee M.

Salemi, Jason L.

TI Adnexal surgery at the time of hysterectomy in women 65 years and older

undergoing hysterectomy for prolapse: do practice trends differ by route

of surgery?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vaginal hysterectomy; Adnexal surgery; Pelvic organ prolapse

AB Introduction and hypothesis The objective was to determine whether the rate of adnexal surgery varies by route of hysterectomy in women over the age of 65 undergoing hysterectomy for prolapse. We hypothesized that women undergoing vaginal hysterectomy would be less likely to undergo bilateral salpingo-oophorectomy (BSO) at the time of their hysterectomy for prolapse. Methods This was a cross-sectional analysis using the National Inpatient Sample (NIS) database. Our primary outcome was concomitant adnexal surgery performed at the time of hysterectomy, classified into five groups: BSO, unilateral salpingo-oophorectomy (USO), bilateral salpingectomy (BS), other adnexal surgery, and no adnexal surgery. The study sample included women aged 65 years and older who underwent hysterectomy between 1 January 2009 and 31 December 2014 and with a diagnosis of genital prolapse. Results Of the 91,292 patients over the age of 65 who underwent a hysterectomy for prolapse, the majority of hysterectomies were vaginal (69%), followed by abdominal (13%), laparoscopic (11%), and robotic (7%). The number of women having a hysterectomy and undergoing a BSO was much lower for vaginal than for other hysterectomy types; 20.3% of women undergoing vaginal hysterectomies had a BSO, compared with 79.2% in abdominal, 81.8% in laparoscopic, and 73.8% in robotic-assisted procedures. Women who received vaginal hysterectomies were five times as likely (RR: 5.02, 95% CI: 4.70-5.35) to have no concomitant adnexal procedure compared with other routes of hysterectomy. Conclusions Women over the age of 65 undergoing hysterectomy for prolapse are significantly less likely to have adnexal surgery if undergoing hysterectomy via vaginal route compared with the other routes.

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NR 15

TC 3

Z9 3

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

PD AUG

PY 2021

VL 32

IS 8

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DI 10.1007/s00192-020-04663-0

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PG 9

WC Obstetrics & Gynecology; Urology & Nephrology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Urology & Nephrology

GA TW6VT

UT WOS:000625013000005

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ER

PT J

AU Bizzarri, N

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Alletti, SG

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AF Bizzarri, N.

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Gioe, A.

La Fera, E.

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TI Sentinel lymph node detection in endometrial cancer with indocyanine

green: laparoscopic versus robotic approach

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Endometrial cancer; Sentinel lymph node; Robotic surgery; Laparoscopy;

Indocyanine green; minimally invasive surgery

ID BIOPSY; CARCINOMA; SURGERY; IMPACT

AB Background: The aims of the present study were to assess bilateral sentinel lymph node (SLN) mapping with laparoscopic versus robotic approach, to assess variables affecting bilateral detection rates and to assess survival difference in patients with no/unilateral, compared to bilateral SLN detection.

Methods: This is a retrospective, single-centre, observational cohort study, including patients with endometrial cancer FIGO stage IA-IVB, treated with minimally invasive primary surgery and undergoing indocyanine green (ICG) injection to detect SLN, between January 2015 and December 2019.

Results: Of the 549 included patients, 286 (52.1%) and 263 (47.9%) underwent the laparoscopic and robotic approach respectively. 387 (70.5%) patients had bilateral SLN mapping, 102 ( 18.6%) and 60 (10.9%) had unilateral and no mapping, respectively. Patients who underwent the robotic approach were older (median 61 versus 64 years, p=0.046) and had a higher BMI (median 26.0 versus 34.8 kg/m(2), p<0.001). No difference in any SLN mapping or in SLN bilateral detection was evident between the laparoscopic or robotic approach (p=0.892 and p=0.507 respectively). Patients with bilateral SLN detection in the entire cohort were younger (p<0.001) and had a better 3-year disease- free survival (DFS) compared to patients with no/unilateral SLN mapping (77.0% versus 66.3%, respectively, p=0.036). No 3-year overall survival (OS) difference was reported (p=0.491).

Conclusion: SLN mapping and bilateral SLN detection with ICG in endometrial cancer was not different in the laparoscopic and robotic approach, even though patients undergoing the robotic approach were older and more obese. Bilateral SLN detection was associated with improved 3-year DFS, but not with 3-year OS, compared to no and unilateral SLN detection.

C1 [Bizzarri, N.; Restaino, S.; Alletti, S. Gueli; Monterossi, G.; Gioe, A.; La Fera, E.; Gallotta, V; Fagotti, A.; Scambia, G.; Fanfani, F.] Fdn Policlin Univ A Gemelli, IRCCS, UOC Ginecol Oncol, Dipartimento Salute Donna & Bambino & Salute Publ, Largo Agostino Gemelli 8, I-00168 Rome, Italy.

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J9 FACTS VIEWS VIS OBGY

JI Facts Views Vis. ObGyn

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PG 11

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

AU Boitano, TKL

Smith, HJ

Cohen, JG

Rossi, EC

Kim, KH

AF Boitano, Teresa K. L.

Smith, Haller J.

Cohen, Joshua G.

Rossi, Emma C.

Kim, Kenneth H.

TI Implementation and evaluation of a novel subspecialty society fellows

robotic surgical course: the SGO minimally invasive academy surgical

curriculum

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Surgical Training; Surgical Education; Gynecologic Oncology

ID VALIDATION; SKILLS; SURGERY; SIMULATORS

AB Objective: To evaluate the utility of a society-based robotic surgery training program for fellows in gynecologic oncology.

Methods: All participants underwent a 2-day robotic surgery training course between 2015-2017. The course included interactive didactic sessions with video, dry labs, and robotic cadaver labs. The labs encompassed a wide range of subject matter including troubleshooting, instrument variation, radical hysterectomies, and lymph node dissections. Participants completed a pre- and post-course survey using a 5-point Likert scale ranging from "not confident" to "extremely confident" on various measures. Statistical analysis was performed using SPSS Statistics v. 24.

Results: The response rate was high with 86% of the 70 participants completing the survey. Sixteen (26.7%) of these individuals were attending physicians and 44 (73.3%) were fellows. In general, there was a significant increase in confidence in more complex procedures and concepts such as radical hysterectomy (p=0.01), lymph node dissection (p=0.01), troubleshooting (p=0.001), and managing complications (p=0.004). Faculty comfort and practice patterns were cited as the primary reason (58.9%) for limitations during robotic procedures followed secondarily by surgical resources (34.0%).

Conclusion: In both gynecologic oncology fellows and attendings, this educational theory-based curriculum significantly improved confidence in the majority of procedures and concepts taught, emphasizing the value of hands-on skill labs.

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FU Intuitive Surgical

FX Dr. Kim reports grants from Intuitive Surgical and personal fees from

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Oncology and an educational grant from Intuitive Surgical.

NR 19

TC 6

Z9 6

U1 0

U2 2

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EI 2005-0399

J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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PG 7

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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PT J

AU Ferrero, S

Stabilini, C

Barra, F

Clarizia, R

Roviglione, G

Ceccaroni, M

AF Ferrero, Simone

Stabilini, Cesare

Barra, Fabio

Clarizia, Roberto

Roviglione, Giovanni

Ceccaroni, Marcello

TI Bowel resection for intestinal endometriosis

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Bowel endometriosis; Colorectal resection; Complications; Rectosigmoid

endometriosis; Recurrence; Surgery

AB Over the last twenty years, segmental resection (SR) has been the technique most frequently used to treat bowel endometriosis. Nowadays, it is most commonly performed by laparoscopy; however, there is evidence that it can be safely performed by robotic-assisted laparoscopic surgery. Rectovaginal fistula and anastomotic leakage are the two major complications of SR; other complications include pelvic abscess, postoperative bleeding, ureteral damage, and anastomotic stricture. Several studies showed that SR causes improvement in pain and intestinal symptoms; nerve-sparing SR may improve the functional outcomes. The rates of postoperative recurrence of bowel endometriosis vary across the studies, possibly because of the different definitions of recurrence. (C) 2021 Elsevier Ltd. All rights reserved.

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NR 79

TC 9

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U1 1

U2 3

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Gültekin, IB

Karabük, E

Köse, MF

AF Gultekin, Ismail Burak

Karabuk, Emine

Kose, Mehmet Faruk

TI Hey Siri! Perform a type 3 hysterectomy. Please watch out for the

ureter!" What is autonomous surgery and what are the latest

developments?

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Review

DE Autonomous surgery; robotic surgery; machine learning; skill learning;

skill analysis

ID INSTRUMENTS; EVOLUTION; ROBOTICS; TRACKING; SYSTEMS

AB As a result of major advances in deep learning algorithms and computer processing power, there have been important developments in the fields of medicine and robotics. Although fully autonomous surgery systems where human impact will be minimized are still a long way off, systems with partial autonomy have gradually entered clinical use. In this review, articles on autonomous surgery classified and summarized, with the aim of informing the reader about questions such as " What is autonomic surgery?" and in which areas studies are progressing.

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NR 31

TC 2

Z9 3

U1 1

U2 13

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JI J. Turk.-Ger. Gynecol. Assoc.

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WC Obstetrics & Gynecology

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PT J

AU Hijazi, A

Chung, YJ

Kang, HJ

Song, JY

Cho, HH

Kim, MR

AF Hijazi, Ayah

Chung, Youn-Jee

Kang, Hee Jin

Song, Jae Yen

Cho, Hyun Hee

Kim, Mee-Ran

TI Robot-assisted laparoscopic myomectomy for FIGO type II sub-mucosal

leiomyoma without endometrial injury for a patient with history of

miscarriage

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Article

DE Endometrium; surgical procedures; robotic; fibroid uterus

AB To introduce a technique for robot-assisted laparoscopic myomectomy for FIGO type II sub-mucosal leiomyoma with > 50% myometrial extension, without endometrial injury. A narrated video demonstration of our technique has been provided. Our patient was a 35- year-old, gravida 1, para 0 woman with secondary infertility. She had been married for three years. She complained of heavy menstrual bleeding and severe dysmenorrhea with a pain score of 10 on visual analogue scale (VAS). Surgery was done after thorough counseling and an informed consent was obtained. Institutional Review Board number: KC17OESI0375, approval date: 21.09.2018. Several steps can be taken to help prevent endometrial injury, and these include: ( 1) proper preoperative imaging to plan surgery; (2) use of intraoperative ultrasound to determine best location of incision; (3) use of a "cold cut" technique with monopolar curved scissors without energy to avoid obscuring the border between the leiomyoma and the endometrium; (4) careful millimeter by millimeter dissection; (5) use of diluted indigo carmine to aid delineation of the endometrial cavity during dissection. The patient had a normal post-operative course. On follow-up her VAS pain score was 0. Transvaginal ultrasound repeated four months postoperatively showed normalization of uterine anatomy and endometrial contour. Robot-assisted laparoscopic myomectomy may be an option to preserve fertility and minimize endometrial injury. This surgical method allows complete removal of large sub-mucosal leiomyomas in one session with exact suturing.

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FU Basic Science Research Program through the National Research Foundation

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Z9 2

U1 0

U2 1

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JI J. Turk.-Ger. Gynecol. Assoc.

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PG 3

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ER

PT J

AU Hur, C

Falcone, T

AF Hur, Christine

Falcone, Tommaso

TI Robotic treatment of bowel endometriosis

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Bowel endometriosis; Robotic-assisted laparoscopic surgery; Segmental

bowel resection; Colorectal endometriosis

AB Endometriosis describes a condition with the presence of ectopic endometrial glands and stroma outside the endometrial cavity that affects up to 15% of reproductive-aged women. Of women affected with endometriosis, 3.8-37% will have endometriosis involving the bowel, primarily the rectosigmoid colon. While medical management is often recommended as a first-line therapy, it is not curative, and surgery is often required as an adjunct for the management of symptoms. Minimally invasive surgery has become the standard of care for managing these patients. The use of robotic-assisted laparoscopy offers benefits that may allow surgeons to perform these challenging surgical cases using a minimally invasive technique. For lesions that affect the colon, there are three primary techniques used for removal which include: 1) rectal shaving, 2) discoid excision and 3) segmental resection. The decision to pursue one approach over another is largely dependent on the number of lesions present, a lesion's size and depth of invasion as well as the involved circumference of the bowel. The available evidence of using robotic-assisted laparoscopy in cases of bowel endometriosis is limited in the literature. In this review, we will summarize the role of robotic-assisted laparoscopy in the management of bowel endometriosis.

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NR 38

TC 5

Z9 5

U1 1

U2 2

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ER

PT J

AU Marchand, GJ

Azadi, A

Anderson, S

Ruther, S

Hopewell, S

Brazil, G

Sainz, K

Wolf, H

King, A

Vallejo, J

Ware, K

Cieminski, K

Galitsky, A

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Ruther, Stacy

Hopewell, Sophia

Brazil, Giovanna

Sainz, Katelyn

Wolf, Hannah

King, Alexa

Vallejo, Jannelle

Ware, Kelly

Cieminski, Kaitlynne

Galitsky, Anthony

TI LESS hysterectomy through a bluntly created 11 mm incision

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Article

DE Hysterectomy; single port; LESS; laparoendoscopic single site surgery;

robotic hysterectomy; laparoscopic hysterectomy; laparoscopy

AB In the field of minimally invasive surgery, there is a constant drive to devise and execute the most minimally invasive surgeries possible. By the very nature of laparoscopy and robotic surgery, what one can accomplish with several ports of a given size will invariably be studied and attempted with fewer ports and with ports of smaller sizes. After researching the literature, we were not able to find any single port hysterectomies performed through a port size of smaller than 15 mm. We were able to perform, described here, a technique for performing laparoscopic hysterectomy through a single port of only 11 mm in diameter. We illustrate the technique in the accompanying video and believe the technique to be safe and reproducible.

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NR 6

TC 0

Z9 0

U1 0

U2 0

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ER

PT J

AU Ribeiro, MD

Freire, T

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William, WK

AF Ribeiro, M. D.

Freire, T.

Leite, F.

Werebe, E.

Cabrera Carranco, R.

Kondo William, W.

TI The importance of early diagnosis and treatment of incidental tension

pneumothorax during robotic assisted laparoscopy for diaphragmatic

endometriosis: a report of two cases

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE diaphragmatic endometriosis; pneumothorax

AB We describe two cases of diaphragmatic endometriosis treated using the robotic assisted laparoscopic approach, in which an incidental tension pneumothorax occurred during the initial inspection and assessment of diaphragmatic lesions. We demonstrate the importance of early diagnosis of this complication and report successful resolution using the thoracic drainage technique. In case one, after the pneumoperitoneum was installed, during the cavity assessment and inspection, small endometriotic lesions were observed in the tendon portion of the diaphragmatic surface. We observed a sudden increase in maximum airway pressures and a reduction in tidal volume, associated with arterial hypotension and hemodynamic instability and bulging of the diaphragm, which led to the diagnosis of a tension pneumothorax. In case two, diaphragmatic endometriotic lesions were also observed after hepatic mobilisation and following visualisation of the endometriotic lesions, an abrupt decrease in the capnography values was observed, consistent with hypertensive pneumothorax. In both cases, even after deflation of the abdominal cavity, hemodynamic instability persisted. We treated both cases with thoracic drainage, which immediately normalised respiratory parameters and resulted in hemodynamic stabilisation, and the surgical procedures were continued. During laparoscopic procedures for the treatment of diaphragmatic endometriosis, the endometriotic lesions can behave as communication hole in the tendon portion of the diaphragmatic surface and the changes in ventilatory patterns and haemodynamic instability should alert the medical team to the development of an incidental tension pneumothorax. The early identification of this complication in both cases allowed rapid intervention for chest drainage and allowed the surgical procedure to continue.

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Z9 0

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JI Facts Views Vis. ObGyn

PD MAR

PY 2021

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PG 4

WC Obstetrics & Gynecology

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ER

PT J

AU Giugale, LE

Hansbarger, MM

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Visco, AG

Shepherd, JP

Bradley, MS

AF Giugale, Lauren E.

Hansbarger, Molly M.

Askew, Amy L.

Visco, Anthony G.

Shepherd, Jonathan P.

Bradley, Megan S.

TI Assessing pelvic organ prolapse recurrence after minimally invasive

sacrocolpopexy: does mesh weight matter?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Anatomical pelvic organ prolapse recurrence; Laparoscopic sacral

colpopexy; Lightweight mesh; Pelvic organ prolapse; Robotic sacral

colpopexy; Time to prolapse recurrence; Ultra-lightweight mesh

AB Introduction and hypothesis There has been a trend toward the use of ultra-lightweight mesh types for minimally invasive sacrocolpopexy. We hypothesized that ultra-lightweight mesh would have a greater proportion of composite anatomical pelvic organ prolapse recurrence than lightweight mesh. Methods Retrospective cohort study of minimally invasive sacrocolpopexies at two academic institutions from 2009 to 2016. Our primary outcome was composite anatomical prolapse recurrence, defined as prolapse beyond the hymen or retreatment with pessary or surgery, compared between ultra-lightweight (<= 21 g/m(2) [range 19-21]) and lightweight (>21 g/m(2) [range 35-50]) mesh types. We assessed time to prolapse recurrence using Kaplan-Meier and Cox regression. Results The cohort consisted of 1,272 laparoscopic (n = 530, 41.7%) and robotic-assisted sacrocolpopexies (n = 742, 58.4%). Lightweight mesh was used in 745 procedures (58.6%) and ultra-lightweight mesh in 527 (41.4%). The lightweight mesh had longer median follow-up than the ultra-lightweight group (344 [IQR 50-670] vs 143 days [IQR 44-379], p < 0.01). There was no difference in composite anatomical prolapse recurrence between lightweight and ultra-lightweight mesh (54 [7.2%] vs 35 [6.6%], p = 0.68). Ultra-lightweight mesh demonstrated a shorter time to prolapse recurrence (p < 0.01), which remained significant on multivariate Cox regression (HR 2.38 [95% CI 1.47-3.87]). The lightweight mesh had significantly more mesh complications (43 [5.8%] vs 7 [1.3%], p < 0.01). Conclusions Ultra-lightweight mesh for minimally invasive sacrocolpopexy was not associated with a higher proportion of composite anatomical prolapse recurrence; however, it was associated with a shorter time to recurrence. Longer follow-up is needed to assess the clinical importance of this finding, particularly given the trade-off of more complications with lightweight mesh.

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NR 14

TC 6

Z9 7

U1 0

U2 0

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ER

PT J

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Pucheril, D

De, EJB

AF Mozafarpour, Sarah

Nwaoha, Ngozi

Pucheril, Daniel

De, Elise J. B.

TI Robotic assisted proximal dorsal urethral diverticulectomy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Urethral diverticulum; Robotic surgery; Dorsal

ID DIAGNOSIS; FEMALE

AB Introduction and hypothesis Urethral diverticula are rare but clinically significant entities among female patients. Ventrally located, mid-to distal, simple or horseshoe diverticula are most commonly observed and are usually repaired via a transvaginal approach with varying levels of difficulty but high success rates. Dorsally (anteriorly) located urethral diverticula are more challenging to repair secondary to the need to access the side of the urethra opposite the vaginal lumen, abutting the external urethral sphincter. Unique proximal anatomy in the case presented led to careful consideration of the surgical options. Methods We present a review of techniques reported in the literature and a video demonstrating our technique for transabdominal robot-assisted laparoscopic excision of a large, dorsal, very proximally located, crescenteric urethral diverticulum in a patient who initially presented with urosepsis. Results Robotic-assisted excision of the urethral diverticulum was accomplished in 3:27 h with an estimated blood loss of 50 cc. Vaginal counter-incision was not necessary. The patient's postoperative course was uneventful. Postoperative voiding cystourethrogram prior to suprapubic catheter removal revealed a well-healed repair without extravasation. At 6-month follow-up, she denied any de novo lower urinary tract symptoms such as urinary incontinence, post-void dribbling, urinary tract infection or urinary hesitancy. Conclusions Dorsal urethral diverticulum in women, particularly when very proximal, can present a diagnostic and surgical challenge for reconstructive pelvic surgeons. The robotic approach to urethral diverticulectomy is feasible for a proximal dorsal urethral diverticulum which lies cephalad to the pubic symphysis. This or other laparoscopic applications may also be considered as an adjunct to the standard vaginal approach for complex urethral diverticuli with a proximal dorsal component.

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NR 9

TC 4

Z9 4

U1 0

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ER

PT J

AU Miyamoto, Y

Tanikawa, M

Sone, K

Mori-Uchino, M

Tsuruga, T

Osuga, Y

AF Miyamoto, Yuichiro

Tanikawa, Michihiro

Sone, Kenbun

Mori-Uchino, Mayuyo

Tsuruga, Tetsushi

Osuga, Yutaka

TI Introduction of minimally invasive surgery for the treatment of

endometrial cancer in Japan: a review

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Minimally invasive surgery; Laparoscopic surgery; Robotic-assisted

surgery; Endometrial cancer; Learning curve; Japanese health insurance

system

ID ROBOTIC SURGERY; LAPAROSCOPIC HYSTERECTOMY; LEARNING-CURVE; LAPAROTOMY;

SURVIVAL; LYMPHADENECTOMY; MANAGEMENT

AB Minimally invasive surgery is now becoming the standard surgical method for early stage endometrial cancer. In this review, we describe the path minimally invasive surgery has travelled from being an exceptional treatment to be the current standard in Japan. At the beginning of the 21th century, laparoscopic surgery has been employed for the treatment of gynecologic malignancies including cervical cancer and endometrial cancer. Robotic-assisted surgical system, which appeared a little later than laparoscope, has begun to be actively applied to surgical treatments for gynecologic malignancies that require particularly elaborate technologies. Both laparoscopic and robotic surgery have attracted the attention of surgeons because they enable safe, precise and less invasive surgery. Since the safety of minimally invasive surgery depends largely on the skill and experience of the surgeon, there is an urgent need to establish an educational system for implementing minimally invasive surgery. Here we describe various issues regarding minimally invasive surgery that Japan is currently facing, such as the medical economy, regulations by the Japanese health insurance system, a shortage of surgeons, the roles of academic organizations to educate surgeons and guide the appropriate implementation of minimally invasive surgery.

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NR 43

TC 1

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WC Oncology; Obstetrics & Gynecology

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GA QC1SN

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DA 2024-01-18

ER

PT J

AU Noh, JJ

Kim, TJ

AF Noh, Joseph J.

Kim, Tae-Joong

TI The current evidence for the use of minimally-invasive surgery in

endometrial cancer

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Endometrial cancer; Minimally-invasive surgery; Laparoscopy; Laparotomy;

Gynecology

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; TOTAL ABDOMINAL HYSTERECTOMY;

SENTINEL-NODE BIOPSY; EARLY-STAGE; ROBOTIC HYSTERECTOMY; RADICAL

HYSTERECTOMY; SURGICAL APPROACH; SEROUS CARCINOMA; UTERINE-CANCER;

OBESE-PATIENTS

AB The aim of the present study is to review the current available data regarding the use of minimally-invasive surgery in endometrial cancer patients and investigate the feasibility and safety of it for cancer control. We also reviewed the current understanding of sentinel lymph node mapping and the use of robotic surgery in endometrial cancer. Studies have consistently demonstrated better short-term outcomes of minimally-invasive surgery in endometrial cancer compared to laparotomy such as less blood loss, shorter hospital stay, and fewer wound complications. Large randomized clinical trials and meta-analyses also suggest the feasibility and safety of minimally-invasive surgery in terms of oncologic outcomes especially in patients with early stage disease. Although evidence for advanced stage disease and patients with high risk for recurrence are still lacking, the current available data seem to support the use of minimally-invasive surgery for those patient groups as well. A large body of literature supports the role of sentinel lymph node mapping in endometrial cancer with a high sensitivity and a low false negative rate, as well as a favorable negative predictive value. Studies also show that robotic surgery is a safe and effective alternative to conventional laparoscopicsurgery for endometrial cancer staging but further long-term data are required. Further prospective studies with long-term follow-up are warranted to evaluate the feasibility and safety of minimally-invasive surgery especially in patients with advanced stage disease and high risk for recurrence. However, the current available data support the use of minimally-invasive surgery in all patient groups of endometrial cancer.

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Z9 0

U1 0

U2 4

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

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TI Is robotic-assisted sacrocolpo(hystero)pexy safe and effective in women

over 65 years of age?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Geriatric; Prolapse; Robotic; Sacrocolpopexy; Surgery

AB Introduction and hypothesis The objective was to evaluate the safety and efficacy of robotic-assisted sacrocolpo(hystero)pexy in elderly patients with symptomatic apical pelvic organ prolapse and to compare the outcomes of open abdominal and robotic-assisted sacrocolpo(hystero)pexy in geriatric patients. Methods Elderly patients (>= 65 years of age) who underwent open abdominal or robotic-assisted sacrocolpo(hystero)pexy for treatment of symptomatic grade 3 and 4 apical pelvic organ prolapse between November 2015 and May 2019 were evaluated retrospectively. The success rates of the procedures, the surgical outcomes, and the perioperative adverse events of both groups were compared. Perioperative adverse events were categorized according to the Clavien-Dindo classification. Results Forty-four patients underwent open abdominal sacrocolpo(hystero)pexy and 30 patients underwent robotic-assisted sacrocolpo(hystero)pexy. The mean age in the open abdominal sacrocolpo(hystero)pexy group was 68.4 +/- 3.4 years and in the robotic-assisted sacrocolpo(hystero)pexy group it was 69.7 +/- 4.1 years. The success rates in the open abdominal sacrocolpo(hystero)pexy and robotic-assisted sacrocolpo(hystero)pexy groups were 59% and 57% at median follow-up time of 28 months and 24 months respectively. Although the mean dosage of the analgesic (10.1 mg/24 h) and the mean length of hospital stay (2.1 days) were significantly lower and shorter for the robotic-assisted sacrocolpopexy group, the mean duration of operation was considerably longer (141.2 min). The rate of grade 2 or higher complications for open abdominal sacrocolpopexy was 16% (7 out of 44) and for robotic-assisted sacrocolpopexy it was 17% (5 out of 30). Conclusions Anatomical outcomes and adverse events are similar in elderly patients undergoing open sacrocolpo(hystero)pexy and robotic-assisted sacrocolpo(hystero)pexy.

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U1 0

U2 7

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PT J

AU Tanaka, T

Ueda, S

Miyamoto, S

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TI Short-term outcomes for patients with endometrial cancer who received

robot-assisted modified radical hysterectomy: A retrospective

observational study

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robot assisted hysterectomy; Laparoscopic

hysterectomy; Minimally invasive surgery

ID LAPAROSCOPIC HYSTERECTOMY; SURGERY; LYMPHADENECTOMY; LAPAROTOMY

AB Objective: Minimally invasive surgery is a standard treatment for endometrial cancer patients with uterine-confined disease. Robot-assisted surgery has been covered under public insurance since 2018 in Japan. The aim of the current study was to compare the short-term outcomes between robot-assisted modified radical hysterectomy (RAMRH) andtotal laparoscopic modified radical hysterectomy (TLMRH). Methods: A total of 190 patients with endometrial cancer who had undergone RAMRH or TLMRH were retrospectively reviewed. Short-term outcomes, including surgical time, estimated blood loss, complications, and hospital stay, were compared between the groups. Results: Among 190 patients, including 67 with RAMRH and 123 with TLMRH, the median (interquartile range [IQR]) surgical time was 247 (IQR: 221-313) min in RAMRH and 271 (IQR: 236-280) min in TLMRH. The estimated blood loss was less than 10 mL in most cases. There was 1 major vessel injury and 1 vescio-vaginal fistula in the RAMRH group. In contrast, there were 2 bladder injuries, 1 bowel injury, 2 obturator nerve injuries, 1 major vessel injury, and 2 pelvic abscesses in the TLMRH group. The median hospital stay was 10 (IQR:10-10) days in RAMRH and 9 (IQR: 9-10) days in TLMRH. Conclusion: Robot-assisted procedures were not associated with poorer short-term outcomes than laparoscopy in patients with endometrial cancer.

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U1 0

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JI Eur. J. Gynaecol. Oncol.

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GA QC1SN

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ER

PT J

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TI Robotic hysterectomy with pelvic lymphadenectomy for early endometrial

cancer in a patient with situs inversus totalis using 3D-CT analysis: a

case report

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Situs inversus totalis; Robotic hysterectomy; Pelvic lymphadenectomy;

Early endometrial cancer

AB Background: Pelvic lymphadenectomy should be considered the standard of care for endometrial cancer patients with intermediate-risk. In such cases, lymph node assessment may be performed via a minimally invasive approach. Situs inversus totalis is a congenital condition wherein the major visceral organs are reversed or mirrored from their normal anatomical positions. Reports state that performing surgery on patients with this condition is difficult due to the anatomical abnormality. However, few clinical studies have been conducted to evaluate the efficacy of robotic surgery for endometrial cancer patients with situs inversus totalis because it is technically challenging. Case presentation: A 69-year-old woman with situs inversus totalis (gravida 2 para 2) was brought to our hospital due to a uterine tumor. Endometrial biopsy showed grade 1 endometrioid carcinoma. Using 3 dimensional -computed tomography reconstruction, her common iliac arteries and veins were found to be reversed or mirrored from their normal positions. She underwent hysterectomy with pelvic lymphadenectomy using the multi-articulated arms or 3 dimensional high-definite vision of the da Vinci (R) surgical system, and 19 lymph nodes were harvested. She was followed up for 24 months without signs of recurrence. Conclusion: The multi-articulated arms or 3 dimensional high-definite vision of the da Vinci (R) surgical system may be a feasible and safe approach for performing a pelvic lymphadenectomy on patients with situs inversus totalis using 3 dimensional computed tomography analysis.

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Z9 0

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U2 2

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WC Oncology; Obstetrics & Gynecology

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GA QC1SN

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PT J

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Oral, E

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Usta, Taner

Baghaki, Hayriye Sema

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TI Relation between educational reliability and viewer interest in YouTube®

videos depicting endometrioma cystectomy surgical techniques

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Cystectomy; Educational activities; Endometrioma; Instructional films

and videos; Laparoscopy

ID PATIENT INFORMATION; QUALITY; SURGERY

AB Objective: To assess the reliability of YouTube (R) endometrioma cystectomy videos based on technical video analysis and considering the surgical steps.

Material and method: The present study yielded 756 videos after a search on YouTube (R) with the keywords "endometriosis cystectomy, endometrioma cystectomy, chocolate cyst cystectomy, and endometrioma surgery'' during the period from January 7, 2007 to January 7, 2019. The viewer interest parameters such as total number of subscribers, views, likes, dislikes, comments, source of the videos, and the date of upload were assessed. Besides, the surgical steps were also evaluated considering committee suggestions.

Results: There were 140 (78.7 %) videos in Group 1 (not useful and slightly useful) and 38 (21.3 %) videos in Group 2 (useful and very useful). The mean numbers of subscribers, views, and likes were 5737.843 +/- 15741.302, 10614.257 +/- 32702.339, and 17.7 +/- 43.57, respectively, in Group 1, and 851.052 +/- 1613.599, 8192.55 +/- 15989.955, and 11.92 +/- 27.52, respectively, in Group 2. The type of surgery was significantly different between the study groups. The videos of cases with robotic surgeries presented more useful descriptive information (p = 0.003). There was a significant difference between the study groups regarding the type of hemostasis. The presence of didactic steps was higher in Group 2 (47.4 %) compared to Group 1 (28.6 %) (p = 0.02)

Conclusions: Overall, only around 21 % of YouTube videos presenting endometrioma surgery were defined as useful or very useful. The interest rates of the viewers may not compatible with the usefulness rate of the videos. (c) 2020 Elsevier Masson SAS. All rights reserved.

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TC 9

Z9 9

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ER

PT J

AU Alshiek, J

Marroquin, J

Shobeiri, SA

AF Alshiek, Jonia

Marroquin, Joanna

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TI The Fresh Frozen Cadaveric Study of Direct Pouch of Douglas Laparoscopic

and Robotic Trocar Insertion for Vaginal Natural Orifice Transluminal

Endoscopic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Pouch of Douglas; Robotic trocar; Trocar; vNOTES

ID HYSTERECTOMY

AB Study Objective: To determine the distances and angles that assure a safe entry into the pouch of Douglas (POD) during blind laparoscopic and robotic trocar entry.

Design: Trocars were inserted into the POD of 4 intact fresh frozen female pelves. Cadaveric dissection was performed, and the distance from the POD to the sacrum at rest and with maximal pressure to POD with the trocar was measured. In addition, the optimal angle for trocar insertion and entry was evaluated.

Setting: Inova Advanced Simulation and Technology Evaluation Center.

Patients: Fresh frozen cadavers with intact reproductive organs.

Interventions: Vaginal POD trocar insertion.

Measurements and Main Results: Measurements were recorded from the sacrum to the POD at rest and from the sacrum to the hymen with trocar pressure. The dissection demonstrated correct trocar placement in the POD of human cadaveric specimens. The mean distances from the sacrum to the hymen, the sacrum to the POD, and the sacrum to the POD with pressure were 18.75 cm, 9.75 cm, and 7.25 cm, respectively. After the deployment of the trocar, the tip was observed to be 2 cm below the cervix in the POD. The mean trocar angle to clear the sacral promontory and the neurovascular structures without injury to the uterus was 25 degrees to 40 degrees from the horizontal plane and 15 degrees to 30 degrees from the coronal plane.

Conclusion: A direct trocar entry into the POD has been found to be feasible in fresh frozen cadaveric specimens. This study provided valuable information for the angle of entry into the POD to facilitate vaginal and robotic trocar entry for minimally invasive gynecologic procedures. (C) 2020 AAGL. All rights reserved.

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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TI A Case Series of Robot-assisted Rectus Abdominis Flap Harvest for Pelvic

Reconstruction: A Single Institution Experience

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Pelvic reconstruction; Rectus flap; Recurrent prolapse

AB Study Objective: To analyze outcomes and postoperative complications in patients undergoing robot-assisted rectus abdominis flap harvest for pelvic floor reconstruction.

Design: Case series.

Setting: Academic setting.

Patients: Pelvic reconstruction surgery patients.

Interventions: The rectus abdominis muscle flap can be used as a flap for pelvic reconstruction, providing a large volume of soft tissue that can be used in the treatment of many comorbid conditions, including genital fistulas, postradiation pelvic exenteration, and abdominoperineal resection defects. Intraperitoneal harvest of the rectus muscle using a robotic approach allows avoidance of laparotomy and subsequent disruption of the anterior rectus sheath, thus preserving the integrity of the abdominal wall.

Measurements and Main Results: A retrospective analysis of patient demographic and clinical characteristics was performed for all patients who underwent robot-assisted rectus abdominis flap harvest for pelvic floor reconstruction at our institution from October 1, 2016, to October 31, 2018. The postoperative complications analyzed included bowel obstructions, surgical site infections, emergency room visits, and need for readmission. Six patients (4 women and 2 men), with a mean age of 69.2 years (range = 57-79 years) and median follow-up time of 9.2 months (range = 5-12 months), were included. Muscle flap harvest was performed on the right side in 4 patients and on the left in 2 patients. The indications for reconstructive surgery included vesicovaginal fistula, complex pelvic organ prolapse, anterior and posterior exenteration, partial and total vaginectomy, partial vulvectomy, and abdominoperineal resection. Two patients received neoadjuvant chemoradiation. One of the 6 cases was converted to laparotomy; however, this was not owing to the rectus harvest. Three patients experienced no complications after reconstruction; 1 patient reported occasional abdominal pain; 1 patient had intermittent bowel obstruction; and 1 patient developed a pelvic abscess, requiring readmission. All 6 patients achieved satisfactory healing of the pelvic wound after robot-assisted rectus abdominis flap inset.

Conclusion: Robot-assisted rectus abdominis flap harvest for pelvic floor reconstruction is a reliable means of defect closure, despite the presence of substantial comorbidities and risk factors in this patient cohort. Patient selection and counseling are crucial to optimize surgical outcomes in this complex population. (C) 2020 AAGL. All rights reserved.

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FX Mayo Clinic Arizona provided funding for the purchase of disposal bags.

NR 12

TC 4

Z9 4

U1 0

U2 1

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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EA FEB 2021

PG 4

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA RC2MY

UT WOS:000632640000018

PM 32389736

DA 2024-01-18

ER

PT J

AU Huh, WK

Johnson, JL

Elliott, E

Boone, JD

Leath, CA

Kovar, JL

Kim, KH

AF Huh, Warner K.

Johnson, John L.

Elliott, Emily

Boone, Jonathan D.

Leath, Charles A.

Kovar, Joy L.

Kim, Kenneth H.

TI Fluorescence Imaging of the Ureter in Minimally Invasive Pelvic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Contrast agent; Laparoscopic; Near infrared; Nerindocianine; Ureteral

delineation

AB Study Objective: Determine near-optimal dose, safety, and efficacy of nerindocianine in pelvic ureter detection with near-infrared fluorescence imaging in women undergoing minimally invasive pelvic surgery with 3 Food and Drug Administration-cleared imaging systems.

Design: Open label, phase 1/2a study.

Setting: University of Alabama at Birmingham.

Patients: Forty-one female subjects undergoing minimally invasive gynecologic surgery.

Interventions: Subjects received a single dose of nerindocianine sodium, starting at 0.06-mg/kg body weight and increased/decreased until the near-optimal dose was determined (part A). Examine the degree of concordance between endoscopic and robotic devices (part B).

Measurements and Main Results: In part A, composite scores were collected every 10 minutes for 30 minutes and then every 15 minutes through 90 minutes using a scale measuring the anatomy/laterality of ureter visualization. In part B (paired imaging system efficacy), 2 cohorts of 8 subjects each received the near-optimal dose. Composite scores for visualization of the ureter were collected at 10 and 30 minutes postinfusion with the Firefly Imaging System and either the PINPOINT or 1588 AIM endoscope. Composite scores were compared to examine the degree of concordance between devices. Part A comprised 25 total subjects enrolled in dosing groups 1, 2, and 3 (0.06-, 0.12-, and 0.045-mg/kg, respectively). Median time to first ureter visualization was 10 minutes (all groups). The nerindocianine 0.06-mg/kg and 0.12-mg/kg groups had longer length of time of visualization than the 0.045-mg/kg group, resulting in the selection of 0.06 mg/kg as the near-optimal dose. Part B enrolled 16 total subjects in 2 groups dosed at 0.06 mg/kg. Efficacy analysis showed no statistically significant difference in composite scores with Firefly versus PINPOINT or 1588 AIM.

Conclusion: Nerindocianine was well tolerated with visualization of the ureter demonstrated in 88.9% of the subjects through 90 minutes postdosing. No meaningful visualization differences were observed among the Food and Drug Administration-cleared surgical imaging systems used. (C) 2020 AAGL. All rights reserved.

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FX The financial support has been provided by LI-COR, Inc.

NR 12

TC 5

Z9 5

U1 0

U2 0

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JI J. Minim. Invasive Gynecol.

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PG 24

WC Obstetrics & Gynecology

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UT WOS:000632640000029

PM 32615331

OA Bronze

DA 2024-01-18

ER

PT J

AU How, JA

Siedel, JH

Shafer, A

AF How, Jeffrey A.

Siedel, Jean Hansen

Shafer, Aaron

TI Post-operative gastroparesis following carbohydrate loading in a

diabetic patient

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

DE Diabetes mellitus; Enhanced Recovery after Surgery; Gastroparesis;

Robotic surgery

ID ENHANCED RECOVERY

AB Gastroparesis is a syndrome of delayed gastric emptying associated with nausea, vomiting, and postprandial fullness. Despite multiple etiologies, diabetes is one of the principal causes of gastroparesis. This case report examines a 57 year-old woman with poorly controlled diabetes type II (HbA1c 8.3%) complicated by diabetic nephropathy who was readmitted for gastroparesis after two days following uncomplicated robotic surgical staging for endometrial cancer. Prior to the procedure, the patient had received carbohydrate loading in accordance with our center's enhanced recovery pathway; this resulted in severe acute hyperglycemia, a recognized cause of gastroparesis in women with diabetes. During her readmission, she improved with bowel rest and optimization of glycemic control. This case suggests that routine pre-operative carbohydrate loading should be used with caution in poorly controlled diabetic patients.

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FU NIH T32 training grant [T32 CA101642]; Dr. Henry R. Shibata Fellowship

Award/Cedars Cancer Foundation

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Cancer Foundation (JAH).

NR 9

TC 1

Z9 2

U1 0

U2 1

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J9 GYNECOL ONCOL REP

JI Gynecol. Oncol. Rep.

PD MAY

PY 2021

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AR 100714

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PG 3

WC Obstetrics & Gynecology

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ER

PT J

AU Kerbage, Y

Rouillès, J

Estrade, JP

Collinet, P

Huchon, C

Villefranque, V

Rubod, C

AF Kerbage, Yohan

Rouilles, Julie

Estrade, Jean Philippe

Collinet, Pierre

Huchon, Cyrille

Villefranque, Vincent

Rubod, Chrystele

TI Surgical training through simulation dedicated to French Ob-gyn

residents. Evaluation and satisfaction

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Simulation; Ob-gyn; Residents; Surgery

AB Objective: In order to be able to develop surgical training of residents through simulation, we carried out a descriptive study, evaluating the satisfaction of participating residents and the benefit of the workshops offered during the 4th Junior Master Class, free annual training organized in 2017 in Lille University Hospital. It is dedicated to ob-gyn residents in France, overseas departments and territories.

Material and Methods: During two days, plenary sessions and practical workshops on animal models or simulators were organized in laparoscopy, diagnostic and operative hysteroscopy, vaginal surgery and robotic surgery. A questionnaire was given anonymously to each student, collecting on the one hand their surgical curriculum, on the other hand, the evaluations of the theoretical contribution and the quality of the interventions and materials offered during the plenary sessions. The last part was subdivided into a questionnaire specific to each workshop.

Results: The 48 residents who voluntarily followed this training were overwhelmingly satisfied with the quality of the training offered. The practical benefits outweighed the theoretical benefits. These workshops improved their practical skills from 63 % to 84 % depending on the workshops offered. In addition, 100 % of students would recommend this training to other residents and consider it useful for their future practice.

Conclusion: These very satisfactory results encourage us to organize new surgical training. Simulation is the key point for an appropriate surgical learning. (C) 2021 Elsevier Masson SAS. All rights reserved.

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FX Societe de chirurgie gynecologique et pelvienne (SCGP), for financial

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NR 10

TC 0

Z9 0

U1 0

U2 0

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

PD SEP

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PG 4

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA UJ4SO

UT WOS:000691277100025

PM 33515852

OA hybrid

DA 2024-01-18

ER

PT J

AU Wang, R

Hacker, MR

Richardson, M

AF Wang, Rui

Hacker, Michele R.

Richardson, Monica

TI Cost-effectiveness of Surgical Treatment Pathways for Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE cost-effectiveness analysis; pelvic organ prolapse; minimally invasive

surgery; vaginal apical suspension; laparoscopic sacrocolpopexy; robotic

sacrocolpopexy; prolapse recurrence; surgical complications

AB Objective

To evaluate the cost-effectiveness of surgical treatment pathways for apical prolapse. Study Design

We constructed a stochastic Markov model to assess the cost-effectiveness of vaginal apical suspension, laparoscopic sacrocolpopexy, and robotic sacrocolpopexy. We modeled over 5 and 10 years, with 9 pathways accounting for up to 2 separate surgical repairs, recurrence of symptomatic apical prolapse, reoperation, and complications, including mesh excision. We calculated costs from the health care system's perspective. Results

Over 5 years, compared with expectant management, all surgical treatment pathways cost less than the willingness-to-pay threshold of US $50,000 per quality adjusted life-years. However, among surgical treatments, all but 2 pathways were dominated. Of the remaining 2, laparoscopic sacrocolpopexy followed by vaginal repair for apical recurrence was not cost-effective compared with the vaginal-only approach (incremental cost-effectiveness ratio [ICER], >$500,000). Over 10 years, all but the same 2 pathways were dominated. However, starting with the laparoscopic approach in this case was more cost-effective with an ICER of US $6,176. If the laparoscopic approach was not available, starting with the robotic approach similarly became more cost-effective at 10 years (ICER, US $35,479). Conclusions

All minimally invasive surgical approaches for apical prolapse repair are cost-effective when compared with expectant management. Among surgical treatments, the vaginal-only approach is the only cost-effective option over 5 years. However, over a longer period, starting with a laparoscopic (or robotic) approach becomes cost-effective. These results help inform discussions regarding the surgical approach for prolapse.

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FU Harvard Catalyst | The Harvard Clinical and Translational Science Center

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NR 28

TC 6

Z9 6

U1 0

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

PD FEB

PY 2021

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BP e408

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DI 10.1097/SPV.0000000000000948

PG 6

WC Obstetrics & Gynecology

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GA QH5PU

UT WOS:000618328300040

PM 32941315

OA Green Accepted

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ER

PT J

AU Masghati, S

McDaniel, A

Swainston, D

Howard, DL

AF Masghati, Salome

McDaniel, Alexandra

Swainston, Darin

Howard, David L.

TI Residents' Participation in Robotic Surgery and Operative Time: Does

Attending Surgeons' Volume Influence This Relationship?

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE surgery; robotic surgery; resident participation; surgical volume; total

operative time

AB Objective: This research assessed if attending surgical volume impacted the relationship between resident participation and operative time in robotic surgery for benign gynecologic conditions.

Materials and Methods: This retrospective cohort study included 1 academic and 1 community hospital, where a total of 329 patients underwent robotic surgery for benign gynecologic conditions from January 2018 to March 2019. The primary outcome was total operative time. The primary exposure was resident participation versus nonparticipation in robotic cases. The patients were operated on by 3 surgeons from the same group. The lifetime robotic hysterectomy volumes were 1250 (over 11 years), 146 (over 8 years), and 107 (over 8 years), respectively for the 3 surgeons.

Results: The unadjusted mean total operative time was longer for cases involving residents (130.3 minutes [95% confidence interval (CI): 122.8-137.7 minutes] versus 109.6 minutes [95% CI: 104.0-115.3 minutes]; p < 0.001). Among hysterectomy cases, the adjusted mean total operative time was 22.3 minutes longer for cases with resident participation versus no participation (95% CI: 11.9-32.7 minutes longer; p < 0.001). Among hysterectomy cases, the mean total operative time for the high-volume surgeon increased by 14.9 minutes with resident participation, compared to an increase of 45.3 minutes for his 2 low-volume partners.

Conclusions: This retrospective chart review's results suggest that attending surgeon robotic volume and surgery type appear to mediate the relationship between resident participation in robotic surgery and total operative time. More research is needed to confirm these findings.

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NR 9

TC 1

Z9 1

U1 0

U2 0

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

PD AUG 1

PY 2021

VL 37

IS 4

BP 303

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DI 10.1089/gyn.2020.0152

EA JAN 2021

PG 5

WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

GA TV9IA

UT WOS:000614576200001

DA 2024-01-18

ER

PT J

AU Margulies, SL

Yeh, J

Alvarez, MA

Bercik, R

AF Margulies, Samantha L.

Yeh, Judy

Acevedo Alvarez, Marian

Bercik, Richard

TI Incidental Finding of Asymptomatic Vaginal Cuff Dehiscence with

Evisceration of Abdominal Content During Prolapse Repair

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE gynecology; vagina; vaginal; transvaginal; pelvic organ prolapse;

vaginal cuff dehiscence; vaginal cuff evisceration

ID HYSTERECTOMY

AB Background: Vaginal cuff dehiscence with abdominal content evisceration is typically a surgical emergency.

Case: A 45-year-old woman with a history of vaginal hysterectomy, anterior/posterior repair, and needle bladder-neck suspension 2 years prior presented with new-onset seepage of fluid from the suprapubic incision and recurrent pelvic organ prolapse (POP). A staged approach was planned: included surgical exploration of the suprapubic incision, and then repair of the recurrent POP. An intact vaginal cuff had been confirmed during the initial surgery and postoperative examination. However, vaginal cuff dehiscence with evisceration of colonic epiploica was discovered incidentally during the planned prolapse repair.

Results: This patient underwent repair of the dehiscence with planned robotic-assisted laparoscopic sacrocolpopexy and recovered without known complications.

Conclusions: This is a rare instance of nonemergent, asymptomatic chronic vaginal cuff dehiscence with evisceration of abdominal contents.

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NR 10

TC 0

Z9 0

U1 0

U2 0

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JI J. Gynecol. Surg.

PD JUN 1

PY 2021

VL 37

IS 3

BP 257

EP 260

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PG 4

WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

GA SM2PT

UT WOS:000613495000004

DA 2024-01-18

ER

PT J

AU Nakayama, JM

Sheyn, D

Mahran, A

El-Nashar, SA

AF Nakayama, John M.

Sheyn, David

Mahran, Amr

El-Nashar, Sherif A.

TI Gynecologic Surgery Proportion and Utilization Trends in the NSQIP

Database from 2010 through 2015 with Correlation to Technology and

Policy

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE CPT; surgical trends; surgical volume; minimally invasive surgery;

gynecologic surgery; NSQIP

ID UNITED-STATES; VAGINAL HYSTERECTOMY; REIMBURSEMENT; QUALITY; CANCER;

TIME

AB Objective: To assess the volume and temporal trends in utilization of gynecologic surgery codes between 2010 and 2015.

Study design: The American College of Surgeons National Surgical Quality Improvement Program (NSQIP) was queried to determine the frequency of individual gynecologic surgical procedures from 2010 to 2015. The National Inpatient Sample was used to further define the frequency of minimally invasive hysterectomies from 2012 to 2016. Data were analyzed using linear regression and chi-squared tests.

Results: Gynecologic procedures represented 6.8% (95% confidence interval 6.8-6.9) of all surgical procedures included in the NSQIP database from 2010 through 2015 and this percentage was stable during the study period. The top 10% of procedures make up similar to 70% (66.5%-71.2%) of all procedures performed. The top 40% of procedures make up similar to 97% (96.8%-97.5%) of all procedures. Although hysterectomy codes were consistently among the top 10 most utilized codes, significant trends were observed in utilization related to the route of hysterectomy with rise of total laparoscopic hysterectomy (TLH). This was correlated with increasing adoption of robotic-assisted laparoscopy and decline of total vaginal hysterectomy (TVH) and abdominal hysterectomy (p < 0.001). There was also a large increase in concomitant adnexal surgery at the time of TLH, which potentially mirrors the recent rise in opportunistic salpingectomy.

Conclusion: In this analysis, we highlight changes in the utilization of different gynecologic procedures to inform policy makers of challenges to appropriate reimbursement for laparoscopic procedures and a potential skills loss in open and vaginal procedures.

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Hospital; University Hospitals of Cleveland; Case Western Reserve

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Western Reserve University; Case Western Reserve University Hospital;

Egyptian Knowledge Bank (EKB); Assiut University; University Hospitals

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NR 19

TC 1

Z9 1

U1 1

U2 2

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J9 J GYNECOL SURG

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WC Obstetrics & Gynecology; Surgery

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SC Obstetrics & Gynecology; Surgery

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ER

PT J

AU AlAshqar, A

Goktepe, ME

Kilic, GS

Borahay, MA

AF AlAshqar, Abdelrahman

Goktepe, Metin E.

Kilic, Gokhan S.

Borahay, Mostafa A.

TI Predictors of the cost of hysterectomy for benign indications

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Hysterectomy; Laparoscopy; Length of stay; Minimally invasive surgery;

Robotic-assisted surgery

ID LAPAROSCOPIC HYSTERECTOMY; FINANCIAL ANALYSIS; OPERATING-ROOM; OUTCOMES;

SURGERY; TRENDS

AB Introduction: Hysterectomy is a commonly performed procedure with widely variable costs. As gynecologists divert from invasive to minimally invasive approaches, many factors come into play in determining hysterectomy cost and efforts should be sought to minimize it. Our objective was to identify the predictors of hysterectomy cost.

Materials and Methods: This was a retrospective cohort study where women who underwent hysterectomy for benign conditions at the University of Texas Medical Branch from 2009 to 2016 were identified. We obtained and analyzed demographic, operative, and financial data from electronic medical records and the hospital finance department.

Results: We identified 1,847 women. Open hysterectomy was the most frequently practiced (35.8 %), followed by vaginal (23.7 %), laparoscopic (23.6 %), and robotic (16.9 %) approaches. Multivariate regression demonstrated that hysterectomy charges can be significantly predicted from surgical approach, patient's age, operating room (OR) time, length of stay (LOS), estimated blood loss, insurance type, fiscal year, and concomitant procedures. Charges increased by $3,723.57 for each day increase in LOS (P <0.001), by $76.02 for each minute increase in OR time (P <0.001), and by $48.21 for each one-year increase in age (P 0.037). Adjusting for LOS and OR time remarkably decreased the cost of open and robotic hysterectomy, respectively when compared with the vaginal approach.

Conclusion: Multiple demographic and operative factors can predict the cost of hysterectomy. Healthcare providers, including gynecologists, are required to pursue additional roles in proper resource management and be acquainted with the cost drivers of therapeutic interventions. Future efforts and policies should target modifiable factors to minimize cost and promote value-based practices. (C) 2020 Elsevier Masson SAS. All rights reserved.

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U2 3

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

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PT J

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Uzan, C

Canlorbe, G

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Azais, Henri

Belghiti, Jeremie

Uzan, Catherine

Canlorbe, Geoffroy

TI Minimally invasive surgery for early-stage cervical cancer:

Rediscovering the Schautheim robot-assisted procedure

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Early-stage cervical cancer; LACC trial; Minimally invasive surgery;

Schautheim procedure

ID RADICAL HYSTERECTOMY

AB Introduction: The Laparoscopic Approach to Cervical Cancer (LACC) trial recently showed a significant inferiority of the minimally invasive surgery when we considered them both equivalent in the treatment of cervical cancer. The objective of this article is to describe and discuss the interest of the Schautheim procedure.

Surgical technique: The Schautheim is the association of a radical hysterectomy by laparoscopy/robot assisted or not as described by Wertheim after a primary vaginal closure, like the first step of Schauta's hysterectomy. This technique is described in ten steps, with a video material.

Discussion: The return to open surgery could lead to a loss of benefits associated with the laparoscopic approach in terms of per and post-operative morbidity. One way to achieve similar results would be to prohibit the use of uterine manipulators and create a vaginal cuff.

Conclusion: Several authors suggest that early-stage cervical cancer patients could still be operated by laparoscopy without reducing overall survival or increasing risk of recurrence if certain measures are followed. (C) 2020 Elsevier Masson SAS. All rights reserved.

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TC 2

Z9 2

U1 0

U2 1

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GA PU2UK

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DA 2024-01-18

ER

PT J

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Coronado Martin, P. J.

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TI Gynaecological surgery in the obese patient

SO CLINICA E INVESTIGACION EN GINECOLOGIA Y OBSTETRICIA

LA Spanish

DT Review

DE Obesity; Minimally invasive surgery; Surgical complications; Robotic

surgery

ID ENDOMETRIAL CANCER; PERIOPERATIVE OUTCOMES; ROBOTIC SURGERY; IMPACT;

LAPAROSCOPY; WOMEN; COMPLICATIONS; COST

AB Surgery in the obese patient is a challenge for the surgeon and anaesthetist as it is associated with an increase in intra- and post-operative complications. Adverse effects, such as surgical site infection, thromboembolic disease, or surgical wound complications are more frequent in these patients. Minimally invasive surgery has led to an advance in the surgical treatment of these patients, reducing some complications associated with the laparotomy approach, especially in the management of gynaecological cancer. The development of robotic surgery has led to an improvement in the limitations of laparoscopic surgery, due to greater accuracy or 3D vision. Specifically, in the obese patient, robotic surgery provides advantages, such as reduction of intra- and post-operative complications, greater number of lymph nodes, a reduction in hospital stay, as well as less surgical bleeding compared to other approaches. (C) 2020 Elsevier Espana, S. L. U . All rights reserved.

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Z9 0

U1 0

U2 1

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J9 CLIN INVESTIG GINECO

JI Clin. Investig. Ginecol. Obstet.

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ER

PT J

AU Smith, W

Dutta, R

Matthews, C

AF Smith, Whitney

Dutta, Rahul

Matthews, Catherine

TI Robotic-assisted ureteral reimplantation and psoas hitch after ureteral

injury during cesarean section

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Ureteral injury; Ureteral reimplantation; Robotic surgery; Cesarean

section; Psoas hitch; Ureteroneocystostomy

AB Introduction and hypothesis Ureteral injury during gynecological surgery can be managed in a variety of ways, from endoscopic stent placement to ureteroneocystotomy with accompanying psoas hitch and/or Boari flap. The majority of these occur during hysterectomy; therefore, gynecologic surgeons may not be as familiar with repair in women with intact uteri. Herein we present our technique for delayed robotic-assisted ureteral reimplant and psoas hitch in a woman with a ureteral injury sustained during cesarean section, which initially presented as a uretero-cervical fistula. Methods In this video, we describe the evaluation and surgical management of a patient with delayed recognition of a left distal ureteral injury sustained during cesarean section. We present necessary modifications to robotic-assisted laparoscopic ureteroneocystostomy and psoas hitch to accommodate an intact uterus including the need for uterine manipulation, division of the round ligament, bladder mobilization from the lower uterine segment and development of the retropubic space, reimplantation steps, and psoas hitch. Conclusions Simple modifications to a traditional technique of robotic-assisted ureteroneocystotomy effectively compensate for the presence of a uterus. Obstetricians should maintain a high index of suspicion for ureteral injury in women with new-onset severe urinary leakage post-cesarean section.

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TC 0

Z9 0

U1 1

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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GA US8TW

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ER

PT J

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Lockrow, E

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Lockrow, Ernest

TI Continuous Hydrogen Sulfide Gas Monitoring using the PortaSens II

Portable Gas Leak Detector Model C16 during Laparoscopic or Robotic

Surgery Cannot Be Used Intraoperatively to Detect Bowel Injury

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotics; Surgical complications; Minimally invasive; Unrecognized

AB Study Objective: To determine the feasibility of measuring hydrogen sulfide (H2S) gas in the insufflated abdomen during laparoscopic surgery after transmural bowel injury as a marker of unrecognized bowel injuries. Design: This is a feasibility study performed on swine models during a robotic training course. We aimed to determine baseline H2S levels and subsequent elevations in H2S levels after enterotomy of the large and small intestines.

Setting: University-based robotic training lab.

Participants: Three swine participants.

Interventions: During initial insufflation of the swine abdominal cavity, baseline H2S levels were recorded over 15-second intervals for 10 minutes using the PortaSens II Portable Gas Leak Detector Model C16 (Analytical Technology, Inc., Collegeville, PA). The same values were recorded in separate studies after transmural transection of the small intestine and the large intestine using laparoscopic shears with and without monopolar electrosurgery.

Measurements and Main Results: Baseline H2S level over the initial 10 minutes of insufflation was 0 parts per million (ppm). The device is calibrated to detect levels of H2S of 0 ppm to 200 ppm. H2S levels after small and large bowel enterotomies without monopolar electrosurgery initially showed a rise to 1 ppm to 2 ppm. However, repeat confirmatory testing failed to show any elevation in H2S levels. H2S levels after small and large bowel enterotomies with monopolar electrosurgery both showed increases to 108 ppm and 74 ppm with a duration of elevation measuring 4 minutes and 4 minutes 15 seconds, respectively. Although our study did show elevations in H2S after transection with monopolar electrosurgery, this was later determined to be the result of cross contamination with carbon monoxide, which was a confounding factor.

Conclusion: Our study demonstrated that using the methodology and detection methods described, H2S cannot be used to detect unrecognized bowel injury during laparoscopic surgery. Our results were due to cross contamination with other gases created with the use of electrosurgery, and we were unable to reproduce initial testing results, which did show slight rises in H2S levels after enterotomies without monopolar electrosurgery. Further testing of other gases produced by the gastrointestinal tract or the use of alternative detection methods may provide more clinically relevant results. (C) 2020 Published by Elsevier Inc. on behalf of AAGL.

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JI J. Minim. Invasive Gynecol.

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ER

PT J

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Sticco, Peter

Blevins, Miranda

Boyd, Sarah

Gutmann, Daniel

Holcombe, Jenny

Mohling, Shanti

TI Efficacy and Safety of a Surgeon-Performed Laparoscopic-Guided, 4-point

Transversus Abdominis Plane Block: A retrospective review

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Postoperative pain control; Laparoscopic gynecologic surgery; Regional

TAP block; 4-point TAP block; Same-day discharge

ID ROBOTIC-ASSISTED HYSTERECTOMY; UNANTICIPATED ADMISSION; LIPOSOMAL

BUPIVACAINE; AMBULATORY SURGERY; PAIN; INFILTRATION

AB We performed a retrospective chart review from October 2017 to March 2019 to demonstrate the safety and efficacy of a surgeon-performed, laparoscopically guided, transversus abdominis plane (TAP) blocks for robot-assisted gynecologic procedures. A total of 116 patients who underwent robot-assisted gynecologic surgery, at 1 academic hospital, with administration of a 4-point TAP block were included. A 4-point TAP block was performed under laparoscopic visualization, by the same surgeon, after induction of anesthesia and immediately after placement of the laparoscope. Liposomal bupivacaine (20 mL) and 0.5% bupivacaine (20 mL) mixed with saline were used as the injectant. All information from the surgical admission and the postoperative follow-up were reviewed. Data were presented in our descriptive study. A total of 116 patients were included with a mean age of 40.6 years (19-80 years) and a mean body mass index of 30.6 kg/m(2) (17.2-53.3 kg/m(2)). Of the patients, 70.7% were discharged to home on the day of surgery. Of the 29.3% of patients who were admitted, 20.6% were admitted because of pain control. Those who were admitted for pain control comprised 6.0% of the total of all study participants. There were no adverse events in our cohort and no readmissions because of pain control. A surgeon-performed TAP block, under laparoscopic visualization, is a safe and efficacious intervention to reduce postoperative pain and may add to a multimodal approach for enhanced recovery protocols. (C) 2020 AAGL. All rights reserved.

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U2 1

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PT J

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Rusch, P

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TI Cancer field surgery in endometrial cancer: peritoneal mesometrial

resection and targeted compartmental lymphadenectomy for locoregional

control

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Cancer field surgery; Peritoneal mesometrial

resection; Sentinel lymph node; Targeted compartmental lymphadenectomy

ID RADICAL HYSTERECTOMY; CLASSIFICATION; EXPERIENCE; TRIAL; PMMR

AB Objective: Peritoneal mesometrial resection (PMMR) plus targeted compartmental lymphadenectomy (TCL) aims at removal of the locoregional cancer field in endometrial cancer (EC). Optimal locoregional control without adjuvant radiotherapy and acceptable surgical morbidity should be achieved concomitantly sparing systematic lymphadenectomy (LNE) for most of the patients.

Methods: We evaluated data from 132 patients treated for EC. Out of these, between January 2017 and June 2020 we performed robotic PMMR and TCL on 51 women. We present the first data of feasibility and safety of the procedure as well as preliminary oncological results.

Results: The 51 patients treated with robotic PMMR and TCL showed comparable morbidity to classic laparoscopic hysterectomy or PMMR without LNE. One intraoperative complication occurred. Postoperative complications grade 3 and higher occurred in 2 cases (3.9%). One of these (85 years old) experienced grade 5 following pulmonary embolism with lysis therapy. Fifteen patients (29.4%) could be spared complete LNE. The rate of adjuvant radiotherapy was 3.9% in our collective (n=2), compared to 39.2% of patients (n=20) eligible for irradiation according to international guidelines. In a mean follow-up time of 15 months (0-41), no locoregional recurrences were observed, although three patients showed distant relapse.

Conclusions: Our data suggest that robotic PMMR and pelvic TCL can be performed regardless of BMI and comorbidities without a relevant increase in surgical morbidity. Moreover, despite a relevant reduction of adjuvant radiotherapy, first follow-up data hint at a favorable locoregional recurrence rate in the reported cohort.

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NR 35

TC 4

Z9 4

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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PT J

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Pastor, Z

Novackova, M

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TI Robot-assisted donor hysterectomy in uterus transplantation - a modality

to increase reproducibility

SO GINEKOLOGIA POLSKA

LA English

DT Review

DE robot-assisted surgery; hysterectomy; uterus; transplantation; living

donor

ID SURGERY

AB Uterus transplantation is a non-lifesaving vascularized composite allotransplantation procedure requiring immunosuppression until removal of the graft.The focus of uterus transplantation is changing regarding refining individual treatment procedures included in this complex treatment of absolute uterine factor infertility, such as robot-assisted donor hysterectomy. The inferior hypogastric nerve plexus should be preserved during robotic dissection of the ureter and uterine vessels to prevent postoperative complications such as urine and fecal evacuation disturbances and sexual disorders. As most uterus transplantations have been performed in living donor concepts, robot-assisted donor hysterectomy should contribute to increased availability of uterus transplantation, particularly because it uses the precise blood-less technique of surgical dissection in the deep pelvis and has cosmetic benefits among living donors.

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J9 GINEKOL POL

JI Ginekol. Pol.

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SC Obstetrics & Gynecology

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PT J

AU Crisp, CC

Herfel, CV

Kleeman, SD

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AF Crisp, Catrina C.

Herfel, Charles V.

Kleeman, Steven D.

Pauls, Rachel N.

TI Critical Anatomy for Robotic Sacrocolpopexy: A Long-term Follow-up Study

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE anatomy; presacral; robotic sacrocolpopexy; sacral suture; vasculature

AB Objective

This study aimed to assess anatomy relative to sacral sutures 20 to 24 months after robotic sacrocolpopexy. Methods

This was an institutional review board-approved prospective anatomy study of women undergoing robotic sacrocolpopexy. After placement of suture into the anterior longitudinal ligament, a small vascular clip was secured on the base of the suture. Subjects were imaged at 6 weeks and between 20 and 24 months after surgery. Measurements were calculated by the primary investigator and radiologist coinvestigator. Results

Of the 11 subjects enrolled in the initial 6-week postoperative study, 5 (45%) completed the long-term follow-up. Regarding the vascular anatomy, no significant changes were documented. Similarly, the major urologic structure, the right ureter, was stable at 16 mm from the clip. A significant change was noted, however, in the distance from the apex of the vagina to the sacral suture. At 6 weeks postoperatively, the mean (SD) distance from the vaginal apex to the clip was 69.3 (14) mm; this increased to 85.2 (11.3) mm at the long-term follow-up (P = 0.004). Conclusions

Reassuringly, the position of the clip remained stable, which is reflected in the constancy of the measurements to the vascular landmarks. Nevertheless, alteration in the distance to the vaginal apex suggests elongation of the mesh or vaginal tissue with time. Although the increase in length was greater than 1.5 cm, it may bear clinical relevance in certain patients. This information may help guide surgeons regarding appropriate mesh tensioning during this critical step of the procedure.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

AU Díaz-Feijoo, B

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TI Surgical complications comparing extraperitoneal vs transperitoneal

laparoscopic aortic staging in early stage ovarian and endometrial

cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Early stage endometrial cancer; Early stage ovarian cancer; laparoscopic

extraperitoneal paraaortic staging; Transperitoneal paraaortic staging;

Complications; Robotic surgery; Survival; Disease-free survival

ID SENTINEL LYMPH-NODE; PARAAORTIC LYMPHADENECTOMY; GYNECOLOGICAL

MALIGNANCIES; CERVICAL-CANCER; CARCINOMA; ALGORITHM; BIOPSY; VULVA;

TRIAL

AB Objective. To determine whether the extraperitoneal approach for paraaortic staging lymphadenectomy results in a lower rate of surgical complications compared to the transperitoneal approach, without compromising oncological outcomes.

Methods. Prospective randomized multicenter study of patients with early endometrial or ovarian cancer undergoing paraaortic lymphadenectomy in 2010-2019. Patients were randomized to minimally invasive surgery (laparoscopy or robotic-assisted) using an extraperitoneal or a transperitoneal approach. The primary end point measure was a composite outcome that included developing one or more of the following surgical complications: bleeding during paraaortic lymphadenectomy >= 500 mL, any intraoperative complication related to paraaortic lymphadenectomy, severe postoperative complication (Dindo >= IIIA), impossibility to complete the procedure, or conversion to laparotomy.

Results. There were 103 patients in the extraperitoneal group and 100 in the transperitoneal group. Differences in the composite outcome (transperitoneal 26.0% vs, extraperitoneal 18.4%; P = 0.195) were not found. Differences in the operative time, conversion to laparotomy, intraoperative bleeding, or survival were not observed. A higher number of lymph nodes were retrieved through the extraperitoneal approached (median, interquartile range [IQR] 12 [7-17] vs, 14 [10-19]: P = 0.026). Older age and greater body mass index (BMI) or waist-to-hip ratio (WHR) increased the risk for surgical complications independently of the laparoscopic approach.

Conclusions. The extraperitoneal approach did not show differences regarding surgical and oncological parameters compared with the transperitoneal approach, although the number of aortic nodes retrieved was higher. The decision to use one or another laparoscopic route is a matter of the surgeon preference. Published by Elsevier Inc.

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FU Instituto de Salud Carlos III [PI14/01817]; (European Regional

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PT J

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TI Short-Term Outcomes of Vaginal Hysterectomy at the Time of Robotic

Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE vaginal hysterectomy; robotic sacrocolpopexy; complications

AB Objective

With the introduction of robotic sacrocolpopexy (RSC) at our institution in 2008, we noted a reduction in residents' vaginal hysterectomy (VH) experience. In 2012, we made a transition to perform VH on all robotic sacrocolpopexies. Our objective was to report our short-term outcomes and adverse events. Methods

In this case series, we evaluated women who underwent VH with concomitant RSC for stages II to IV pelvic organ prolapse between 2012 and 2017. In these cases, the vesicovaginal and rectovaginal spaces were developed transvaginally. Descriptive analysis including demographics, short-term outcomes, and adverse events are reported. Results

In this group of 209 women, median (interquartile interval) duration of follow-up was 49 (26-60) weeks. The majority of the women were white (84.7%) and postmenopausal (80.9%), with a mean (SD) age of 59 (9) years. At a median follow-up time of 49 weeks, pelvic organ prolapse quantification revealed 20 patients (12.4%) with Ba or Bp greater or equal to 0 and 1.4% of patients required repeat prolapse surgery. Among 9 women (4.3%) with postoperative fever, 4 (1.9%) were treated for pelvic collection/abscess. Of 5 women (2.4%) who had venous thromboembolism, 3 (1.4%) were diagnosed with pulmonary embolism. There were 18 patients (8.6%) treated for urinary tract infection within 6 postoperative weeks. Mesh exposure was noted in 16 (7.7%) of the patients, and 11 (6.2%) required reoperation. Conclusions

Vaginal hysterectomy at the time of RSC may increase the risk of infection and mesh exposure compared with procedures without concomitant hysterectomy.

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FU National Center for Advancing Translational Sciences, National

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WC Obstetrics & Gynecology

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PT J

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Chae, Hee Dong

Moon, Hye-Sung

TI First report comparing the two types of single-incision robotic

sacrocolpopexy: Single site using the da Vinci Xi or Si system and

single port using the da Vinci SP system

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; Postmenopausal women; Robotic surgery;

Sacrocolpopexy; Single incision

ID PELVIC ORGAN PROLAPSE; LIFETIME RISK; ASSISTED SACROCOLPOPEXY; SURGERY;

OUTCOMES; EPIDEMIOLOGY; LAPAROSCOPY

AB Objective: The gold standard procedure for treating patients with apical pelvic organ prolapse (POP) is sacrocolpopexy. However, no report comparing the two types of single-incision robotic sacrocolpopexy, namely, single-site robotic sacrocolpopexy (SS-RSC) and single-port robotic sacrocolpopexy (SP-RSC) exists. Therefore, we compared the safety and effectiveness of SS-RSC and SP-RSC.

Materials and methods: In this study, 48 patients who underwent single-incision RSC, 40 nonconsecutive patients who underwent SS-RSC, and 8 consecutive patients who underwent SP-RSC for symptomatic POP quantification stage III-IV and were eligible for the 1-year follow-up (FU) were included. We compared the surgical time and operative outcomes of SS-RSC and SP-RSC. We also compared the data of the initial 8 cases in each group. Results: The mean patient age was 59.2 +/- 11.0 years and 66.1 +/- 8.0 years in the SS-RSC (n = 40) and SPRSC (n = 8) groups, respectively. The mean operative time (OT) and console time were comparable between the SS-RSC and SP-RSC groups (135.3 +/- 31.6 min vs 141.8 +/- 23.5 min; 94.6 +/- 32.2 min vs 89 +/- 9.5 min, respectively). The docking time and cervix suturing time were short in the SP-RSC group (P < 0.05). However, in the analysis of the initial 8 cases in each group, all surgical times except the cervix suturing time were shorter in the SP-RSC group (P < 0.05). Three cases had intraoperative bladder injury (two [5.0%] in the SS-RSC and one [12.5%] in the SP-RSC group). Two cases (5.0%) had umbilical incisional hernia in the SS-RSC group. Two cases had vaginal mesh erosion on the posterior vaginal wall, with 1 case in each group. One case (2.5%) experienced a recurrence of POP; an anterior compartment POP-Q stage 2 following SS-RSC at the 4-week FU.

Conclusion: Single-incision RSC, both SS-RSC and SP-RSC, is a feasible and effective surgical option for treating symptomatic apical POP with an aesthetic finish.

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WC Obstetrics & Gynecology

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PT J

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Dulskas, Audrius

Samalavicius, Narimantas Evaldas

TI Robotic gynaecological surgery using Senhance® robotic platform: Single

centre experience with 100 cases

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Gynaecology; Minimally invasive surgery; Robotic surgery; Senhance

robotic system

ID TELELAP ALF-X; HYSTERECTOMY; FEASIBILITY; LAPAROSCOPY

AB Objective: In this article, we present the first 100 gynaecological robotic surgeries in Klaipeda University Hospital, Klaipeda, Lithuania.

Study Design: A prospective analysis was performed of 100 women age range 22-82, on average 52 years. Patients underwent various robotic gynaecological operations, 61 (61 %) procedures were robotic total hysterectomy with bilateral salpingo-oophorectomy.

Results: Duration of the surgery varied from 30 min to 185 min, on average 99 +/- 33 min. Of all 25 (25 %) patients had operations in the past. Most operations (72 %) were performed for benign diseases and 28 % of the patients were operated for various types of gynaecological malignancies. All cancer surgeries were radical (RO). In-hospital stay was on average 4 +/- 2.3 days, range 1-14 days. There were six (6%) conversions: one to laparoscopy and five to open. Three (3%) complications occurred during 30 days after surgery, one demanded surgery (Clavien-Dindo II-IIIb). There was no mortality in this patient population.

Conclusion: Our early experience with different types of robotic gynaecological surgeries allows us to state that Senhance (R) robotic system is feasible and safe in gynaecology. (C) 2020 Elsevier Masson SAS. All rights reserved.

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

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ER

PT J

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TI Robotic surgical staging of lymphadenectomy during pregnancy - case

report

SO CESKA GYNEKOLOGIE-CZECH GYNAECOLOGY

LA Czech

DT Article

DE pelvic lymphadenectomy; carcinoma cervicis uteri; pregnancy; robotic

surgery

ID GYNECOLOGIC CANCERS; GUIDELINES

AB Objective: We aim to present a case of a 43-year-old patient diagnosed with cervical adenocarcinoma in the 15th week of pregnancy, who underwent robotically-assisted staging in a laparoscopic pelvic lymphadenectomy. Further therapeutic approach was based on the results of subsequent lymph node histopathologic assessment. Conclusion: In pregnant women with cervical cancer, robot-assisted laparoscopic lymphadenectomy is a method of choice for surgical staging.

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J9 CES GYNEKOL

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Panwar, Vikas Kumar

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Ranjan, Rohit

Ranjan, Satish Kumar

TI Robot-assisted laparoscopic approach in a patient of zinner syndrome

with hematuria: A rare presentation

SO JOURNAL OF MID-LIFE HEALTH

LA English

DT Article

DE Excision; hematuria; robotics; syndrome; Zinner

ID SEMINAL-VESICLE CYST

AB Congenital malformations of the seminal vesicles (SVs) are rare and are often associated with abnormalities of the ipsilateral upper tracts as embryologically both the ureteral buds and SVs arise from the mesonephric ducts. The triad of SV cysts, ipsilateral renal agenesis, and ejaculatory duct obstruction is known as the Zinner syndrome. We herein present the case of Zinner syndrome with hematuria as the mode of presentation. A 52-year-old gentleman presented with complaints of gross and painless hematuria for 3 months. An initial ultrasound revealed absent right kidney with a cystic structure abutting the urinary bladder. Cystoscopic examination revealed a high bladder neck. Magnetic resonance imaging of the abdomen revealed an absent right kidney and a large tubular structure in the region of the right ureter extending up to right SV with blood content and stones within. It was distally seen communicating with one of the cysts of the right SV. The cystic structure was removed with a robot-assisted laparoscopic approach. The console time was 110 min with minimal blood loss. Postoperative course was uneventful. Histopathology of the cyst wall revealed chronic inflammation. The patient is doing well on 6 months follow-up. This case was unique in terms of it presenting with a large intra-abdominal cyst with sharp stones within, probably first of its kind to be ever reported. Surgery is mandated for such symptomatic cysts and the daVinci robot with its minimally invasive approach offers the perfect platform for treating such challenging cases.

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JI J. Mid-Life Health

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PT J

AU Yanai, S

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TI Robot-assisted extraperitoneal para-aortic lymphadenectomy (RAePAL)

performed with the bipolar cutting method

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic Surgical Procedures; Lymph Node Excision; Retroperitoneal Space

AB Objective: In comparison with laparoscopic transperitoneal para-aortic lymphadenectomy, the advantages of laparoscopic extraperitoneal para-aortic lymphadenectomy (ePAL) are that the operative field is not obstructed by bowel and the Trendelenburg position is not required [1]. The ePAL technique has been adopted to the robotic surgery with the da Vinci Xi. There are only a few reports demonstrating the technical feasibility of robot-assisted ePAL (RAePAL) [2,3]. This report describes the new surgical technique of RAePAL with the bipolar cutting method.

Methods: The patient was a 53-year-old woman diagnosed as ovarian clear cell carcinoma (CCC) after left salpingo-oophorectomy. As the re-staging surgery, robot-assisted right salpingo-oophorectomy, hysterectomy, omentectomy, and pelvic lymphadenectomy were planned following ePAL. The patient was placed in the supine position and tilted S degrees to the right. Three da Vinci arms were docked at the patient's left side (Fig. 1). The bipolar cutting method was performed by with the surgeon's right hand. An AirSeal (R) port (ConMed, Utica, NY, USA) was placed on the side near the assistant. After the para-aortic space was expanded, lymphadenectomy was performed up to the renal veins with the bipolar cutting method.

Results: The PAL operative time was 155 minutes, estimated blood loss was 25 mL. The patient developed no perioperative complications, and the postoperative diagnosis was stage IC1 ovarian CCC with no pelvic (n=0/42) and para-aortic lymph nodes (n=0/59) metastasis.

Conclusion: RAePAL with the bipolar cutting method was technically feasible. Performing lymphadenectomy between the aorta and the vena cava was facilitated by the articulated robotic arm.

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NR 3

TC 2

Z9 2

U1 0

U2 2

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

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J9 J GYNECOL ONCOL

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PT J

AU Zhang, CY

Sun, ZJ

Yang, J

Xu, T

Zhu, L

Lang, JH

AF Zhang, C-Y

Sun, Z-J

Yang, J.

Xu, T.

Zhu, L.

Lang, J-H

TI Sacrocolpopexy compared with transvaginal mesh surgery: a systematic

review and meta-analysis

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Review

DE Mesh; pelvic organ prolapse; sacrocolpopexy; transabdominal;

transvaginal

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACRAL COLPOPEXY; TOTAL VAGINAL

MESH; ABDOMINAL SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; COST-ANALYSIS;

QUALITY; REPAIR; COMPLICATIONS; OUTCOMES

AB Background The use of mesh is controversial in the treatment of female pelvic organ prolapse.

Objectives To systematically review the outcomes of sacrocolpopexy compared with transvaginal mesh surgery and to provide evidence-based suggestions.

Search strategy The MEDLINE, EMBASE, Cochrane Library and clinicaltrials.gov databases were searched on 21 November 2018.

Selection criteria Randomised controlled trials and prospective and retrospective cohort studies were included.

Data collection and analysis Data were extracted by one reviewer and examined by a second reviewer for accuracy. Odds ratios and 95% CI were calculated using random-effects models.

Main results Twenty comparative studies were included. The meta-analysis was performed with subgroups. The summary odds ratios of the randomised controlled group were 1.84 (95% CI 0.79-4.29, I-2 = 75%) for anatomical success, 1.41 (95% CI 0.47-4.24, I-2 = 38%) for subjective success, 0.42 (95% CI 0.18-0.98, I-2 = 0%) for mesh complications, 0.61 (95% CI 0.20-1.91, I-2 = 0%) for prolapse reoperation and 0.44 (95% CI 0.23-0.88, I-2 = 0%) for de novo dyspareunia. The mean differences were 0.77 (95% CI 0.31-1.23, I-2 = 66%) for total vaginal length and -1.28 (95% CI -2.00 to -0.55, I-2 = 66%) for point C after surgery.

Conclusions Very-low-quality evidence indicated that the anatomical and subjective success rates of sacrocolpopexy were similar to those of transvaginal mesh surgery; sacrocolpopexy might be more beneficial than transvaginal mesh surgery in terms of mesh-related complication rates, prolapse recurrence and de novo dyspareunia. However, additional high-quality randomised trials with long-term follow-up durations are needed.

Tweetable abstract Sacrocolpopexy is beneficial after surgical anatomical changes and has decreased rates of mesh-related complications and dyspareunia.

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FU Beijing Natural Science Foundation [Z190021] Funding Source: Medline;

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ER

PT J

AU Choi, JI

Sang, JH

Chung, SH

AF Choi, Jeong In

Sang, Jae Hong

Chung, Soo-Ho

TI Is laparotomy better than laparoscopic surgery in early cervical cancer?

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Uterine cervical neoplasms; Laparotomy; Laparoscopy

ID MINIMALLY INVASIVE SURGERY; RADICAL HYSTERECTOMY

AB Introduction: Cervical cancer is the fourth most common cancer among women worldwide. Conventional open cervical cancer surgery was often performed in the past, but laparoscopic/robot-assisted surgery is now more common, in accordance with the recent trend toward increased use of minimally invasive surgery. Materials and methods: A total of 266 patients with early cervical cancer, who underwent type II, III radical hysterectomy with or without pelvic lymphadenectomy during the 10-year period between March 2008 and February 2018 at a tertiary hospital (performed by three surgeons), were divided into laparotomy (group 1, n = 132) and laparoscopic/robot-assisted surgery (group 2, n = 134) groups. The variables of interest in this retrospective chart review study were age, body mass index (BMI), cancer stage, surgery type (laparotomy or laparoscopic/robot-assisted), pathology, complications after surgery, additional therapy after surgery, recurrence, and mortality. Results: The surgery type differed significantly according to cancer stage: patients in early and later stages were more likely to undergo laparotomy and laparoscopic/robot-assisted surgery, respectively (p = 0.016). Patients with a higher BMI were more likely to undergo laparoscopic/robot-assisted surgery (p = 0.032). Most patients (n = 170) received adjuvant therapy following surgery. The cervical cancer recurrence rate was 8.3% (11/132) group 1 and 8.2% (11/134) group 2 (p = 0.573). The proportion of postsurgical complications was similar, 8% in group 1 and 5% in group 2, p = 0.469. Conclusions: In this heterogeneous group of patients, most of whom received adjuvant therapy, with found no difference by univariate analysis in the mortality or recurrence rate or the rate of postoperative complications.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Badiglian, L

Faloppa, CC

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Baiocchi, Glauco

TI Vaginally assisted NOTES hysterectomy with adnexectomy (vNOTES) compared

with conventional laparoscopy. A retrospective observational cohort

study

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Hysterectomy; natural; NOTES; oophorectomy; orifices;

salpingoophorectomy; surgery; vaginal

ID TRANSLUMINAL ENDOSCOPIC SURGERY; CHOLECYSTECTOMY; SERIES

AB Objective To compare vaginally-assisted natural orifices endoscopic transluminal endoscopic surgery (vNOTES) hysterectomy with salpingectomy/salpingo-oophorectomy with standard laparoscopic access.

Methods Medical records for patients undergoing hysterectomy with adnexectomy for benign disease indication between February 1, 2019 and February 1, 2020 were retrospectively examined. Exclusion criteria were endometriosis, previous pelvic radiotherapy, inflammatory pelvic disease history, any other concurrent surgery, laparotomy, robotic surgery, and/or traditional vaginal hysterectomy.

Results Among 86 patients, 21 (24.4%) were allocated to a vNOTES group and 65 (75.6%) were allocated to a conventional laparoscopy (LAP) group. Mean ages for the groups were 47.19 +/- 11.11 years and 46.69 +/- 9.11 years, respectively (P = 0.928). There were no statistically significant differences in age, body mass index, arterial hypertension/diabetes, smoking, menopausal status, obstetric history, number of abdominal surgeries, or preoperative hemoglobin level between the two groups. The mean (range) operative times were 111.90 min (80-180 min) in the vNOTES group and 113.98 min (64-350 min) in the LAP group (P = 0.904). There were no statistically significant differences in terms of surgery indication, specific and unspecific complications, conversions, blood transfusion, reoperation, significant ileus/emesis, and hospital stay.

Conclusions Based on the parameters assessed, we found vNOTES to be comparable to laparoscopy among our cohort.

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NR 18

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Z9 7

U1 1

U2 2

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WC Obstetrics & Gynecology

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ER

PT J

AU Declas, E

Collinet, P

Bouchez, MC

Sanson, C

Phalippou, J

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AF Declas, Estelle

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Motton, Stephanie

TI ROBOT-ASSISTED ABDOMINAL LAPAROSCOPIC RADICAL TRACHELECTOMY FOR EARLY

STAGE CERVICAL CANCER :Case report with surgical intervention

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Robot; Trachelectomy; Surgical; Intervention

AB Background: Vaginal radical trachelectomy to preserve fertility in women with early stage cervical cancer was first described by Dargent in 1994. Nowadays, robot-assisted abdominal laparoscopic radical is a new alternative. We want to share our first experience of robot-assisted radical trachelectomy.

Technique: We report the case of a 28 years-old women with an early stage cervical cancer (1B1) and has a wish for preserved fertility (no anterior pregnancy). She undergoes a robot-assisted laparoscopic radical trachelectomy. We divide the technique into 10 surgical steps.

Experience: The duration of the surgery was : 4H30 with a bleeding < 100cc. The post operative period was simple without complications. Since the intervention, we perform 3 more robot-assisted radical trachelectomy. None of them have a complication during the surgery and the post operative period was simple.

Conclusion: Robot-assisted laparoscopic radical trachelectomy is a safe and acurate technique. We want to share our recent experience by sharing this video. The surgeon in our hospipal are used to pratic robot-assisted laparoscopic. However, it was our first robot-assisted laparoscopic radical trachelectomy. Thus we would like to demonstrate the feasibility and the reproducibility of this technique. (C) 2020 Elsevier Masson SAS. All rights reserved.

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NR 6

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Z9 0

U1 0

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JI J. Gynecol. Obstet. Hum. Reprod.

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WC Obstetrics & Gynecology

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PT J

AU Le Gac, M

Ferrier, C

Touboul, C

Owen, C

Arfi, A

Boudy, AS

Jayot, A

Bendifallah, S

Daraï, E

AF Le Gac, Marjolaine

Ferrier, Clement

Touboul, Cyril

Owen, Clementine

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Boudy, Anne-Sophie

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Darai, Emile

TI Comparison of robotic versus conventional laparoscopy for the treatment

of colorectal endometriosis: Pilot study of an expert center

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Endometriosis; Colorectal endometriosis; Laparoscopy; Robotic surgical

procedures

ID INFILTRATING ENDOMETRIOSIS; SEGMENTAL RESECTION; SURGERY; MANAGEMENT;

MORBIDITY; DIAGNOSIS; BLADDER; IMPACT; BOWEL; SCORE

AB Introduction: Surgical management of deep endometriosis with colorectal involvement remains an option after failure of medical treatments. Conventional laparoscopy is currently considered the standard approach for surgical treatment. Recently, assisted-robotic laparoscopy emerged as an alternative to conventional laparoscopy but with low evidence.

Methods: From March 2019 to September 2019, we conducted a prospective cohort study of 48 patients undergoing a surgical treatment for colorectal endometriosis (rectal shaving, discoid excision or segmental resection). The interventions were either performed by robotic or conventional laparoscopy. Patients' characteristics, operative and post-operative data were compared between the robotic and the conventional laparoscopic group.

Results: 48 patients were included, 25 in the conventional laparoscopy group and 23 in the robotic group. Patients' characteristics and operative findings were similar between the two groups, except for a trend in a higher incidence of associated surgical urinary or digestive procedures in the robotic group (p = 0.06). The mean total surgical room occupancy time and operating time were longer in the in the robotic group (281 +/- 97 min vs 208 +/- 85 min; p = 0.008) and (221 +/- 94 min vs 163 +/- 83 min (p = 0.03), respectively. The mean intra operative blood loss, the incidence of intra operative, post-operative complication (according to Clavien-Dindo classification) rates and voiding dysfunction were similar in the two groups. The rate of grade III complication was higher in the robotic group (13 % vs 0%) without reaching a significance (p = 0.17). The mean hospital stay was 8 +/- 4.4 days in the robotic group and 6.5 +/- 2.6 days in the conventional laparoscopy group (p = 0.18).

Conclusion: Despite our initial experience in robotic surgery, our results support that robotic surgery is an adequate alternative to conventional laparoscopy for endometriosis colorectal resection. (C) 2020 Elsevier Masson SAS. All rights reserved.

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U1 0

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PT J

AU Mach, P

Kimmig, R

Buderath, P

AF Mach, Pawel

Kimmig, Rainer

Buderath, Paul

TI The role of sentinel-node biopsy in ovarian cancer

SO MINERVA GINECOLOGICA

LA English

DT Review

DE Carcinoma; ovarian epithelial; Sentinel lymph node; Neoplasms

ID ENDOMETRIAL CANCER; LYMPHATIC DRAINAGE; STAGES I; METASTASIS;

LYMPHADENECTOMY; INVOLVEMENT; CARCINOMA; SITES

AB Lymph node involvement is an important prognostic factor in early and advanced epithelial ovarian cancer (EOC). However, to date there is no reliable method of detecting lymph node involvement, apart from surgical staging. Thus, pelvic and paraaortic lymphadenectomy (LNE) are still part of standard surgery of early ovarian cancer. There is conflicting evidence about the therapeutic value of systematic LNE in early EOC. Thus, the developmemt of a method to predict nodal status accurately, without extensive LNE, is the subject of ongoing research. Sentinel lymphadenectomy (SLN) has become a standard procedure in oncological surgery. However, SI,N is not yet an established and widely accepted procedure for EOC. This review aimed at summarizing available evidence on its feasibility and reliability in EOC. Overall, evidence of SLN in early EOC is still scarce. So far, only small series of patients with a variety of tracers and injection sites were published. From the available literature, the most promising technique seems to be injection into the infundibulopelvic, as well as the proper ovarian ligament. Indocyanine green seems to be an excellent tracer for successful SLN of ovarian tumors, which can be used during laparoscopic or robotic surgery. The detection rates and true positive rates of studies support further investigation of the technique. Results from prospective studies, e.g. the ongoing SELLY trial, are necesssary to implement SLN into the standard treatment of early EOC.

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NR 28

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Z9 2

U1 0

U2 6

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J9 MINERVA GINECOL

JI Minerva Ginecol.

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WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

AU Nica, A

Kim, SR

Gien, LT

Covens, A

Bernardini, MQ

Bouchard-Fortier, G

Kupets, R

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Vicus, D

Laframboise, S

Hogen, L

Cusimano, MC

Ferguson, SE

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Kim, Soyoun Rachel

Gien, Lilian T.

Covens, Allan

Bernardini, Marcus Q.

Bouchard-Fortier, Genevieve

Kupets, Rachel

May, Taymaa

Vicus, Danielle

Laframboise, Stephane

Hogen, Liat

Cusimano, Maria C.

Ferguson, Sarah Elizabeth

TI Survival after minimally invasive surgery in early cervical cancer: is

the intra-uterine manipulator to blame?

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE cervical cancer; laparoscopes; surgical procedures; operative

ID RADICAL HYSTERECTOMY; UTERINE MANIPULATOR; ENDOMETRIAL CANCER;

RECURRENCE RATES

AB Objectives

Minimally invasive radical hysterectomy is associated with decreased survival in patients with early cervical cancer. The objective of this study was to determine whether the use of an intra-uterine manipulator at the time of laparoscopic or robotic radical hysterectomy is associated with inferior oncologic outcomes.

Methods

A retrospective cohort study was carried out of all patients with cervical cancer (squamous cell carcinoma, adenocarcinoma or adenosquamous carcinoma) International Federation of Gynecology and Obstetrics 2009 stages IA1 (with positive lymphovascular space invasion) to IIA who underwent minimally invasive radical hysterectomy at two academic centers between January 2007 and December 2017. Treatment, tumor characteristics, and survival data were retrieved from hospital records.

Results

A total of 224 patients were identified at the two centers; 115 had surgery with the use of an intra-uterine manipulator while 109 did not; 53 were robotic and 171 were laparoscopic. Median age was 44 years (range 38-54) and median body mass index was 25.8 kg/m(2) (range 16.6-51.5). Patients in whom an intra-uterine manipulator was not used at the time of minimally invasive radical hysterectomy were more likely to have residual disease at hysterectomy (p<0.001), positive lymphovascular space invasion (p=0.02), positive margins (p=0.008), and positive lymph node metastasis (p=0.003). Recurrence-free survival at 5 years was 80% in the no intra-uterine manipulator group and 94% in the intra-uterine manipulator group. After controlling for the presence of residual cancer at hysterectomy, tumor size and high-risk pathologic criteria (positive margins, parametria or lymph nodes), the use of an intra-uterine manipulator was no longer significantly associated with worse recurrence-free survival (HR 0.4, 95% CI 0.2 to 1.0, p=0.05). The only factor which was consistently associated with recurrence-free survival was tumor size (HR 2.1, 95% CI 1.5 to 3.0, for every 10 mm increase, p<0.001).

Conclusion

After controlling for adverse pathological factors, the use of an intra-uterine manipulator in patients with early cervical cancer who underwent minimally invasive radical hysterectomy was not an independent factor associated with rate of recurrence.

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PG 7

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WE Science Citation Index Expanded (SCI-EXPANDED)

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PM 33037109

OA Bronze

DA 2024-01-18

ER

PT J

AU Takmaz, Ö

Güngör, M

AF Takmaz, Ozguc

Gungor, Mete

TI Robotic versus laparoscopic hysterectomy; comparison of early surgical

outcomes

SO JOURNAL OF THE TURKISH-GERMAN GYNECOLOGICAL ASSOCIATION

LA English

DT Article

DE Robotic hysterectomy; laparoscopic hysterectomy

ID ASSISTED HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; SURGERY

AB Objective: To compare early surgical outcomes of robotic assisted laparoscopic hysterectomy with laparoscopic hysterectomy for benign diseases, in terms of operation time, estimated blood loss (EBL), perioperative complications, hospital stay and first gas discharge.

Material and Methods: Medical records of 146 patients who either underwent laparoscopic (n=84) or robotic assisted laparoscopic hysterectomy (n=62) for benign diseases were extracted from records. Demographic characteristics and operation time, EBL, length of hospital stay and first gas discharge were compared between the groups.

Results: Mean age and mean body mass index of both groups were comparable. The difference in the mean EBL was not statistically significant between laparoscopic (91 +/- 65 mL) and robotic group (80 +/- 37 mL, p=0.43). The difference in the mean first gas discharge time was not statistically different between laparoscopic (15 +/- 5 hours) and robotic group (17 +/- 6 hours, p=0.33). The length of hospital stay was comparable between groups (1.4 +/- 0.5 vs 1.5 +/- 0.7 days, p=0.64). The mean operation time was longer for the robotic group (150 +/- 180 minimum) when compared with laparoscopic group (105 +/- 18 minimum, p<0.01). The mean uterine weight of the robotic group was significantly heavier compared with laparoscopic group (234 +/- 157 grams vs 153 +/- 1I9 grams, respectively, p<0.01).

Conclusion: Early surgical outcomes of robotic assisted laparoscopic and laparoscopic hysterectomy were comparable in terms of EBL, first gas discharge and hospital stay. Operation time was longer for robotic hysterectomy.

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NR 32

TC 2

Z9 2

U1 1

U2 2

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J9 J TURK-GER GYNECOL A

JI J. Turk.-Ger. Gynecol. Assoc.

PD DEC

PY 2020

VL 21

IS 4

BP 260

EP 264

AR PMID 32517432

DI 10.4274/jtgga.galenos.2020.2019.0187

PG 5

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

GA PB8NI

UT WOS:000596570800007

PM 32517432

OA Green Published, gold

DA 2024-01-18

ER

PT J

AU Wang, R

Haviland, MJ

Hacker, MR

Lefevre, R

AF Wang, Rui

Haviland, Miriam J.

Hacker, Michele R.

Lefevre, Roger

TI Effect of Visual Aids During Surgical Consents on Patient Understanding

and Satisfaction

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE surgical consent; visual aids; patient knowledge; patient satisfaction

AB Objective

This study aimed to assess whether the use of visual aids to augment the consent process for pelvic floor surgeries affects patient understanding and satisfaction. Methods

We conducted a single-blind, randomized controlled trial. Adults planning robotic sacrocolpopexy or suburethral sling surgeries were eligible. All participants received standard preoperative consent counseling. Participants randomized to the intervention also viewed slides with visual aids that paralleled standard counseling; participants randomized to the control group received only standard counseling. All participants completed surveys after their preoperative visit, the day of surgery, and at their postoperative visit. Each survey contained 12 true-false questions about risks, benefits, and alternatives of surgery, and expectations during recovery. The primary outcome was the percentage of correct true-false questions. We conducted an intention-to-treat analysis. Results

We randomized 32 participants undergoing robotic sacrocolpopexy and 32 undergoing suburethral sling surgeries, yielding 16 in the intervention group and 16 in the control group for each procedure. The intervention and control groups for both surgeries were similar in age, body mass index, race, education, and previous surgery for similar symptoms.

Among participants undergoing robotic sacrocolpopexies, median knowledge scores at the preoperative visit were similar between the intervention (92% [interquartile range {IQR}, 86%-100%]) and control (86% [IQR, 75%-94%]) groups (P = 0.21). Similar results were seen for participants undergoing suburethral sling procedures in the intervention (83.3% [IQR, 71%-92%]) and control (83% [IQR, 75%-88%]) groups (P = 0.64). Conclusions

We found that using visual aids during the consent process for patients undergoing robotic sacrocolpopexy or suburethral sling surgeries did not improve knowledge.

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FU Harvard Catalyst/The Harvard Clinical and Translational Science Center

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FX This work was conducted with support from Harvard Catalyst/The Harvard

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the report; or the decision to submit the manuscript for publication.

NR 16

TC 3

Z9 3

U1 1

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

PD DEC

PY 2020

VL 26

IS 12

BP 746

EP 750

DI 10.1097/SPV.0000000000000703

PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA PA2IS

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PM 31135580

OA Green Accepted

DA 2024-01-18

ER

PT J

AU Zhang, GM

Chen, HY

Liu, YY

Niu, LY

Jin, LM

Li, D

Song, LH

Shang, LF

Lin, XY

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Zhang, XY

Zhang, XY

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Zhang, YP

Na, R

Su, RGG

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Liu, Yanying

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Jin, Liming

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Zhang, Xinyu

Zhang, Xiaoyu

Gao, Yan

Qiu, Dongyu

Zhang, Yunpu

Na, Ren

Su, Riguge

TI Is lymph node dissection mandatory among early stage endometrial cancer

patients? A retrospective study

SO BMC WOMENS HEALTH

LA English

DT Article

DE Endometrial cancer; Lymph node dissection; Low risk; PET-MRI; Metastasis

ID CORPUS CANCER; LYMPHADENECTOMY; PET/CT; PET/MRI; FUSION; MRI

AB Background Whether routine lymph node dissection for early endometrial cancer is beneficial to survival is still controversial. However, surgeons usually perform lymph node dissection on all patients with early endometrial cancer. This study aimed to prove that the risk of lymph node metastasis, as defined by our standard, is very low in such patients and may change the current surgical practice. Methods 36 consecutive patients who had staged surgery for endometrial cancer were collected. All eligible patients meet the following very low risk criteria for lymph node metastasis, including: (1) preoperative diagnosis of endometrial cancer (preoperative pathological diagnosis), (2) tumors confined to the uterine cavity and not beyond the uterine body, (3) PET-MRI lymph node metastasis test is negative. PET-MRI and pathological examination were used to assess the extent and size of the tumor, the degree of muscular invasion, and lymph node metastasis. Results The median age at diagnosis was 52 years (range 35-72 years). The median tumor size on PET-MRI was 2.82 cm (range 0.66-6.37 cm). Six patients underwent robotic surgery, 20 underwent laparoscopic surgery, 8 underwent Laparoscopic-assisted vaginal hysterectomy, and 2 underwent vaginal hysterectomy. 23% (63.9%) patients had high-grade (i.e. 2 and 3) tumors. Among the 36 patients who underwent lymph node sampling, the median number of lymph nodes retrieved was 32 (range 9-57 nodules). No patient (0%) was diagnosed with lymph node metastasis. According to the policy of each institution, 8 patients (22.2%) received adjuvant therapy, and half of them also received chemotherapy (4 patients; 50%). Conclusions None of the patients who met the criteria had a pathological assessment of lymph node metastasis. Omitting lymph node dissection may be reasonable for patients who meet our criteria.

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NR 17

TC 4

Z9 4

U1 1

U2 5

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EI 1472-6874

J9 BMC WOMENS HEALTH

JI BMC Womens Health

PD NOV 19

PY 2020

VL 20

IS 1

AR 258

DI 10.1186/s12905-020-01128-w

PG 5

WC Public, Environmental & Occupational Health; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Social Science Citation Index (SSCI)

SC Public, Environmental & Occupational Health; Obstetrics & Gynecology

GA OZ7NZ

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ER

PT J

AU Zimmermann, JSM

Radosa, JC

Radosa, MP

Sklavounos, P

Schweitzer, PA

Solomayer, EF

AF Zimmermann, J. S. M.

Radosa, J. C.

Radosa, M. P.

Sklavounos, P.

Schweitzer, P. A.

Solomayer, E. F.

TI Survey of current practices and opinions of German Society of

Gynecologic Endoscopy members regarding the treatment of ovarian

neoplasia by robotic surgery

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Minimally invasive surgery; Robotic surgery; Ovarian cancer; Borderline

ovarian tumor; AGE

ID PORT-SITE METASTASES; MINIMALLY INVASIVE SURGERY; EARLY-STAGE OVARIAN;

INTRAOPERATIVE RUPTURE; ASSISTED LAPAROSCOPY; SURGICAL OUTCOMES; CANCER;

LAPAROTOMY; MANAGEMENT; ONCOLOGY

AB Purpose As data on this topic are sparse and contradictory, we aimed to ascertain the opinions of the members of the German Society of Gynecologic Endoscopy (AGE) regarding the use of robotic surgery in the treatment of ovarian malignancies. Methods In 2015, an anonymous questionnaire was sent to AGE members to assess their views on the treatment of ovarian malignancies by robotic surgery according to T stage and the current treatment practices in their facilities. Results Of the 228 respondents, 132 (58%) were fellows or attending physicians and 156 (68%) worked at university hospitals or tertiary referral centers. Most [n = 218 (96%)] respondents reported treating < 10% of their patients using robotic surgery. Respondents felt that T1 and borderline ovarian tumors, but not T2 (51%) or T3/4 (76%) tumors, should and could be treated by robot surgery. 162 (71%) respondents considered the currently available data on this subject to be insufficient, and 42% indicated their willingness to participate in clinical studies on the applicability of robotic surgery to the treatment of T1/2 ovarian tumors. Conclusion The majority of AGE members surveyed considered robotic surgery to be an option for the treatment of T1 ovarian malignancies and borderline ovarian tumors. However, prospective randomized studies are needed to determine the relevance of robotic surgery in this context.

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FU German Society for Gynecologic Endoscopy (AGE) [01/15]

FX The study has been sponsored by the German Society for Gynecologic

Endoscopy (AGE) (Grant no. 01/15).

NR 46

TC 3

Z9 5

U1 0

U2 1

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EI 1432-0711

J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

PD MAY

PY 2021

VL 303

IS 5

BP 1305

EP 1313

DI 10.1007/s00404-020-05876-w

EA NOV 2020

PG 9

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA RO2IH

UT WOS:000590209200002

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OA Green Published, hybrid

DA 2024-01-18

ER

PT J

AU Klapczynski, C

Sallée, C

Tardieu, A

Peschot, C

Boutot, M

Mohand, N

Lacorre, A

Margueritte, F

Gauthier, T

AF Klapczynski, Clemence

Sallee, Camille

Tardieu, Antoine

Peschot, Clemence

Boutot, Manon

Mohand, Nadia

Lacorre, Aymeline

Margueritte, Francois

Gauthier, Tristan

TI Training for next generation surgeons: a pilot study of robot-assisted

hysterectomy managed by resident using dual console

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic surgery; Hysterectomy; Surgical education; Dual-console;

Resident

AB Purpose To assess feasibility of a standardized robot-assisted hysterectomy managed by resident and supervised by senior surgeon using dual-console on a 21-step grid (max score = 42) assessing resident autonomy. Methods A total of seven patients managed between September 2019 and March 2020 by six residents in gynecology and obstetrics were included. Standardized robot-assisted hysterectomy for endometrial cancer or adenomyosis was performed. Results No conversion to laparotomy, no intra- or post-operative incidents were reported. Mean score on the evaluation scale was 29.8 out of 42 (SD = 7.3). Mean operative time was 104 min (SD = 23). Mean average suturing time was, respectively, 335 s (SD = 57 s) and 270 s (SD = 53 s) for the first and the fourth knot. There was a 65 s improvement between the first and the fourth intracorporeal knot (p = 0.043). The perceived workload evaluated with the NASA TLX score showed a low level of stress (Temporal demand = 1.6 /10), and a low level of frustration (Frustration level = 3.6/10). Experience gained during the surgery was felt to be important (Commitment = 8.6/10). Conclusion Standardized robot-assisted hysterectomy managed by a resident supervised by a senior surgeon using the dual-console seems feasible. This tool could be useful to assess residents' surgical skills.

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NR 19

TC 2

Z9 2

U1 1

U2 3

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EI 1432-0711

J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

PD APR

PY 2021

VL 303

IS 4

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DI 10.1007/s00404-020-05870-2

EA NOV 2020

PG 6

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA RA6GV

UT WOS:000588863100001

PM 33180173

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ER

PT J

AU Brännström, M

Kvarnström, N

Groth, K

Akouri, R

Wiman, L

Enskog, A

Dahm-Kähler, P

AF Brannstrom, Mats

Kvarnstrom, Niclas

Groth, Klaus

Akouri, Randa

Wiman, Lennart

Enskog, Anders

Dahm-Kahler, Pernilla

TI Evolution of surgical steps in robotics-assisted donor surgery for

uterus transplantation: results of the eight cases in the Swedish trial

SO FERTILITY AND STERILITY

LA English

DT Article

DE Human; infertility; robotic; transplantation; uterus

ID QUALITY-OF-LIFE; VENOUS DRAINAGE; FOLLOW-UP; COMPLICATIONS; MORTALITY;

DONATION; VEINS

AB Objective: To perform a stepwise development of the surgical method for robotics-assisted laparoscopy in donor hysterectomy for uterus transplantation (UTx), a unique treatment for absolute uterine-factor infertility.

Design: Prospective observational study.

Setting: University hospital.

Patient(s): Eight donors, aged 38-62 years, underwent surgery for retrieval of the uterus and vasculature.

Intervention(s): Robotics-assisted laparoscopy was performed in donors for 6-7 h with video recording. Conversion to laparotomy was performed for last parts of retrieval surgery.

Main Outcome Measure(s): Description, evaluation, and timing of 12 specific surgical steps, as well as surgical outcomes and complications.

Result(s): There was a progression during the course of eight surgeries. In the initial two cases, seven and six items were completed with robotics compared with all 12 items in the last three procedures. The passive surgical time decreased from similar to 20% in the first four cases to similar to 8% in the last three procedures. The estimated median (range) blood loss, total surgical time, and length of hospital stay were, respectively, 125 mL (100- 600), 11.25 h (10-13), and 5.5 days (5-6). Two reversible complications occurred: One patient acquired pressure alopecia, and one developed pyelonephritis.

Conclusion(s): The study demonstrates a clear evolution of a strategy toward fully robotic donor surgery in UTx. This is likely to become the main approach in donor surgery of live UTx donors. ((C) 2020 by American Society for Reproductive Medicine.)

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FU Jane and Dan Olsson Foundation for Science; Swedish Research Council;

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FX Supported by the Jane and Dan Olsson Foundation for Science, the Swedish

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NR 25

TC 24

Z9 24

U1 0

U2 0

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J9 FERTIL STERIL

JI Fertil. Steril.

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PY 2020

VL 114

IS 5

BP 1097

EP 1107

DI 10.1016/j.fertnstert.2020.05.027

PG 11

WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA OP7QY

UT WOS:000588282900039

PM 32828495

OA hybrid

DA 2024-01-18

ER

PT J

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TI Complementary surgery for cervical cancer patients inadequately treated

with extrafacial hysterectomy

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Cervical cancer; Complication; Lymphadenectomy; Parametrectomy; Survival

ID ROBOTIC RADICAL PARAMETRECTOMY; PELVIC LYMPHADENECTOMY; SALVAGE

RADIOTHERAPY; SURGICAL-TREATMENT; RADIATION-THERAPY; CARCINOMA;

INADVERTENT; MANAGEMENT; TIME

AB Objective: To evaluate surgical outcomes and survival outcomes of cervical cancer patients who underwent complementary surgery after an extrafacial hysterectomy

Methods: Patients with cervical cancer, who underwent extrafacial hysterectomy initially and thereafter underwent complementary surgery were reviewed retrospectively. Complementary surgery consisted of radical parametrectomy, proximal vaginectomy and pelvic lymphadenectomy.

Results: Twenty patients were evaluated. Histopathologic subtype was squamous cell carcinoma in twelve patients, adenocarcinoma in six patients and adenosquamous carcinoma in two patients. Route of surgery was laparotomy in 19 patients and laparoscopy in one patient. Two patients were staged as stage 1A2, nine were staged as stage 1B1, four were staged as stage 1B2, one was staged as stage 2A1, one was staged as stage 2B and three were staged as stage 3C1. The median tumor size was 16.5 (Range, 4-40) mm. Grade >= 3 complications related to surgery occured in 8 (40%) patients. Four of them were managed intraoperatively and recovered problem free. Remaining four (20%) needed reoperation. Pathology reports revealed involvement of parametrium in one (5%) patient, involvement of the proximal vagina in one (5%) patient, matastasis to pelvic lymph nodes in 3 (15%) patients. Five (25%) patients received adjuvant radiotherapy. Consequently, 5-year and 10-year cumulative survival was calculated as 94%.

Conclusion: Complementary surgery and radiotherapy show similar oncologic outcomes in patients with early-stage cervical cancer who had undergone simple hysterectomy initially. Complementary surgery is associated with slightly higher rate of morbidity compared with radiotherapy, however significant proportion of complications can be noticed and repaired intraoperatively. (C) 2020 Elsevier Masson SAS. All rights reserved.

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NR 38

TC 0

Z9 0

U1 0

U2 1

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

PD NOV

PY 2020

VL 49

IS 9

AR 101800

DI 10.1016/j.jogoh.2020.101800

PG 8

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA OJ3EB

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PM 32416274

DA 2024-01-18

ER

PT J

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Hendrick, R

Dillon, N

Blum, E

Branscombe, L

Webster, S

Webster, RJ

Anderson, T

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Hendrick, Richard

Dillon, Neal

Blum, Evan

Branscombe, Lauren

Webster, Scott

Webster, Robert J.

Anderson, Ted

TI A Novel Robotic Endoscopic Device Used for Operative Hysteroscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 48th Global Congress of the

American-Association-of-Gynecologic-Laparoscopists (AAGL) on Minimally

Invasive Gynecology

CY NOV 09-13, 2019

CL Vancouver, CANADA

SP Amer Assoc Gynecol Laparoscopists

DE Robotics; Hysteroscopy; New instruments; Endoscopy

AB To trial the use of a novel endoscopic robot that functions using concentric tube robots, enabling 2-handed surgery in small spaces, in a bioengineering laboratory. This was a feasibility study of the endoscopic robot for hysteroscopic applications, including removal of a simulated endometrial polyp. The endoscopic robot was successfully used to resect a simulated endometrial polyp from a porcine uterine tissue model in a fluid environment. The potential advantages of this platform to the surgeon may include improved exposure, finer dissection capability, and use of a 2-handed surgical technique. Further study regarding the safe, efficient, and cost-effective use of the endoscopic robot in gynecology is needed. (c) 2020 AAGL. All rights reserved.

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NR 4

TC 6

Z9 6

U1 3

U2 17

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J9 J MINIM INVAS GYN

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA PZ3XW

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ER

PT J

AU Huang, YH

Ding, X

Chen, BL

Zhang, G

Li, AL

Hua, W

Zhou, DM

Wang, XL

Liu, DD

Yan, GQ

Zhang, CC

Zhang, JR

AF Huang, Yanhong

Ding, Xu

Chen, Biliang

Zhang, Geng

Li, Aili

Hua, Wei

Zhou, Dongmei

Wang, Xilin

Liu, Duoduo

Yan, Guoqing

Zhang, Cuicui

Zhang, Junru

TI Report of the first live birth after uterus transplantation in People's

Republic of China

SO FERTILITY AND STERILITY

LA English

DT Article

DE Uterine factor infertility; embryo transfer; clinical pregnancy;

immunosuppression; live birth

ID IN-VITRO FERTILIZATION; PREGNANCY; AGONIST; WOMEN

AB Objective: To present the first live birth after uterine transplantation (UTx) in the People's Republic of China.

Design: Case study.

Setting: University hospital.

Patient(s): A 22-year-old woman with Mayer-Rokitansky-Kuster-Hauser syndrome and previous surgery for vaginal reconstruction and UTx.

Intervention(s): Endometrial preparation, frozen embryo transfer, pregnancy follow-up, and cesarean section.

Main Outcome Measure(s): Results of in vitro fertilization, frozen embryo transfer, ultrasound measurements during pregnancy, rejection diagnosis and treatment, delivery, live birth, and histology of uterus.

Results(s): Frozen embryo (cleavage stage) transfer started 1.5 years after UTx. The first embryo transfer (n = 2) resulted in a biochemical pregnancy. The second, third, and fourth embryo transfer (n = 2, 2, 3) did not result in pregnancy. The fifth embryo transfer (n = 3) resulted in pregnancy with two gestational sacs, but with spontaneous disappearance of one in early pregnancy. During early pregnancy three episodes of vaginal bleedings occurred (gestational weeks 6 thorn 2, 13 thorn 1, and 16 thorn 3), with a spontaneously resorbing subchorionic hematoma diagnosed at the last bleeding episode. Bleeding episodes were treated with corticosteroids and tacrolimus. During pregnancy, blood flow velocity waveforms and fetal growth parameters were normal. A subacute cesarean section was performed at gestational week 33 thorn 6 due to uterine contraction pattern suggesting imminent labor. A healthy boy (2,000 g) with Apgar scores of 10, 10, 10 was delivered. The uterus was kept for a possible second pregnancy.

Conclusion(s): The first live birth after UTx in the People's Republic of China is reported and this occurred after a robotic-assisted laparoscopic uterus retrieval from the mother. ((C) 2020 by American Society for Reproductive Medicine.)

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FU Shannxi province Key RD Program [2020ZDLSF03-01]

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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AU Kim, JH

Shim, SH

Nam, SH

Lee, SW

Park, JY

Kim, DY

Suh, DS

Kim, JH

Kim, YM

Kim, YT

AF Kim, Ju-Hyun

Shim, Seung-hyuk

Nam, So-Hyun

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Park, Jeong-Yeol

Kim, Dae-Yeon

Suh, Dae-Shik

Kim, Jong-Hyeok

Kim, Yong-Man

Kim, Young-Tak

TI Prognostic Factors and Impact of Minimally Invasive Surgery in

Early-stage Neuroendocrine Carcinoma of the Cervix

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Uterine Cervical Neoplasm; Laparoscopy; Prognosis; Robotic Surgical

Procedures

AB Study Objective: To investigate the prognostic factors and impact of minimally invasive surgery (MIS) in surgically treated early-stage high-grade (HG) neuroendocrine cervical carcinoma (NECC).

Design: Retrospective cohort study.

Setting: Asan Medical Center, Seoul, Korea.

Patients: Patients with International Federation of Obstetrics and Gynecology (2009) stages IB1 to IIA HG NECC.

Interventions: All patients underwent radical hysterectomy (RH) with a laparotomy or an MIS approach.

Measurements and Main Results: Between 1993 and 2017, 47 patients with International Federation of Obstetrics and Gynecology stages IB1 to IIA1 HG NECC were initially treated with RH. Clinicopathologic variables of patients were retrospectively reviewed from electronic medical records. The median follow-up period was 28.2 months (interquartile range, 17.1-42). Stage IB1 disease was the most common (70.2%). Twenty-nine patients (61.7%) underwent RH by MIS. The overall survival (OS) and disease-free survival (DFS) rates were 63.8% and 38.3%, respectively. Lymph node metastasis and resection margin involvement were significant risk factors for DFS (hazard ratio [HR], 2.227; 95% confidence interval [CI], 1.018-4.871; p =.045 and HR, 6.494; 95% CI, 1.415-29.809; p =.016, respectively) and OS (HR, 3.236; 95% CI, 1.188-8.815; p =.022 and HR, 12.710; 95% CI, 1.128-143.152; p =.040, respectively). The Kaplan-Meier survival curves revealed no significant differences in OS and DFS between the laparotomy and MIS groups (50% vs 72.4% log-rank p =.196, 38.9% vs 37.9% p =.975).

Conclusion: Lymph node metastasis and resection margin involvement were poor prognostic factors of survival outcomes in initially surgically treated early-stage HG NECC. No difference was observed in the survival outcomes between the MIS and laparotomy approaches. (c) 2020 Published by Elsevier Inc. on behalf of AAGL.

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NR 30

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Z9 6

U1 0

U2 1

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PT J

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Carlsson, P

Wodlin, NB

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Kjölhede, P

AF Lundin, Evelyn Serreyn

Carlsson, Per

Wodlin, Ninnie Borendal

Nilsson, Lena

Kjolhede, Preben

TI Cost-effectiveness of robotic hysterectomy versus abdominal hysterectomy

in early endometrial cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE surgical oncology; uterine cancer; surgical procedures; operative;

laparoscopes; laparotomy

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; ERAS(R) SOCIETY RECOMMENDATIONS;

SURGERY ENHANCED RECOVERY; QUALITY-OF-LIFE; CARE; WOMEN; GUIDELINES;

LAPAROTOMY

AB Objectives

To compare total costs for hospital stay and post-operative recovery between robotic and abdominal hysterectomy in the treatment of early-stage endometrial cancer provided in an enhanced recovery after surgery (ERAS) setting. Costs were evaluated in relation to health impact, taking a societal perspective.

Methods

Cost analysis was based on data from an open randomized controlled trial in an ERAS setting at a Swedish tertiary referral university hospital: 50 women with low-risk endometrial cancer scheduled for surgery between February 2012 and May 2016 were included; 25 women were allocated to robotic and 25 to abdominal hysterectomy. We compared the total time in the operating theater, procedure costs, post-operative care, length of hospital stay, readmissions, informal care, and sick leave as well as the health-related quality of life until 6 weeks after surgery. The comparison was made by using the EuroQoL group form with five dimensions and three levels (EQ-5D). The primary outcome measure was total cost; secondary outcomes were quality-adjusted life-years (QALYs) and cost per QALY. The costs were calculated in Swedish Krona (SEK).

Results

Age (median (IQR) 68 (63-72) vs 67 (59-75) years), duration of hospital stay (ie, time to discharge criteria were met) (median (IQR) 36 (36-36) vs 36 (36-54) hours), and sick leave (median (IQR) 25 (17-30) vs 31 (36-54) days) did not differ between the robotic and abdominal group. Time of surgery was significantly longer in the robotic group than in the abdominal group (median (IQR) 70 (60-90) vs 56 (49-84) min; p<0.05). The robotic group recovered significantly faster as measured by the EQ-5D health index and gained 0.018 QALYs until 6 weeks after surgery. Total costs were 20% higher for the robotic procedure (SEK71 634 vs SEK59 319). The total cost per QALY gained for women in the robotic group was slightly under SEK700 000.

Conclusions

Robotic hysterectomy used in an ERAS setting in the treatment of early endometrial cancer improved health within 6 weeks after the operation at a high cost for the health gained compared with abdominal hysterectomy. The productivity loss and informal care were lower for robotic hysterectomy, while healthcare had a higher procedure cost that could not be offset by the higher cost due to complications in the abdominal group.

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RI Janson, Patrick/AAC-7581-2022

FU Medical Research Council of South East Sweden; Linkoping University;

Region Ostergotland

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AU Yang, J

Mead-Harvey, C

Polen-De, C

Magtibay, P

Butler, K

Cliby, W

Langstraat, C

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Magrina, J

AF Yang, Jie

Mead-Harvey, Carolyn

Polen-De, Clarissa

Magtibay, Paul

Butler, Kristina

Cliby, William

Langstraat, Carrie

Tri Dinh

Chen, Longwen

Magrina, Javier

TI Survival outcomes in patients with cervical cancer treated with open

versus robotic radical hysterectomy: Our surgical pathology

interrogation

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID CLASSIFICATION

AB Objective. To compare the survival outcomes and surgical radicality between women who underwent open versus robotic radical hysterectomy (RH) for early cervical cancer.

Methods. In this institutional retrospective study, patients with clinical stage IA2-IIA (FIGO 2009) squamous cell, adenocarcinoma and adenosquamous carcinoma of the cervixwho underwent either open or robotic RH between 2000 and 2017 were identified. Parametrial width and vaginal length were re-measured from pathology slides. An inverse propensity score weighting model was used to adjust selection bias.

Results. A total of 333 patients were included (181 open, 152 robotic). The median follow-up time was 130 months for the open group and 53 months for the robotic group. There were 31 (17.1%) recurrences in the open and 21 (13.8%) in the robotic group. The 5-year progression-free survival (PFS) for the robotic and open group were 79.0% and 90.5%, respectively (HR 2.37, 95% CI 1.40-4.02). Five-year overall survival (OS) were 85.8% and 95.3%, respectively (HR 3.17, 95% CI 1.76-5.70). The mean parametrial width was similar between the open and robotic groups (2.5 vs 2.4 cm, p = 0.99). Unique recurrences (38.1%, 8/21) were noted in the robotic group: 2 port-site, 4 peritoneal, and 2 carcinomatosis. The time to vaginal recurrence was shorter in the robotic group than the open group (p = 0.001).

Conclusion. Patients who underwent robotic RH had inferior PFS and OS compared to open surgery. Surgical radicality according to pathology measurements was similar between the two approaches. Published by Elsevier Inc.

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JI Gynecol. Oncol.

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SC Oncology; Obstetrics & Gynecology

GA OE5RE

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ER

PT J

AU Capmas, P

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AF Capmas, Perrine

Suarthana, Eva

Larouche, Maryse

TI Conversion rate of laparoscopic or robotic to open sacrocolpopexy: are

there associated factors and complications?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Sacrocolpopexy; Conversion rate; Laparoscopic surgery; Robotic surgery

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; LEARNING-CURVE;

OUTCOMES; HYSTERECTOMY; IMPACT; OBESE

AB Objectives To evaluate the conversion rate of laparoscopic or robotic to open sacrocolpopexy and to identify associated factors in a large population-based database. Methods We used Health Care Cost and Utilization Project-National Inpatient Sample (HCUP-NIS) databases 2005-2014. We extracted data on apical suspension and synthetic mesh with laparoscopy or robot in adult women using International Classification of Diseases, ninth edition, Clinical Modification (ICD-9-CM) codes. We evaluated the rate of conversion and used logistic regression to study the association with risk factors. Results We identified 3295 women with laparoscopic or robotic sacrocolpopexies. There were 2777 robotic procedures with 37 conversion (1.33%) and 518 laparoscopic procedures with 37 conversions (7.14%), with an overall conversion rate of 2.2%. Median age was 62 years [interquartile range (IQR) = 55-69]. Concomitant hysterectomy was significantly more frequent in the robotic than laparascopic group (41.7% versus 13.9%, p < 0.01) and was not associated with conversion. Factors associated with lower conversion included a robotic approach (adjusted odd ratio (aOR) 0.32 [95% CI 0.19-0.54]) and private insurance (aOR 0.53 [95% CI 0.32-0.86]). Factors associated with higher conversion were obesity (aOR 3.27 [95% CI 1.72-6.19]) and lysis of adhesions (aOR 3.32 [95% CI 1.89-5.85]). Accidental organ puncture was significantly associated with conversion (14.9% versus 3.8%; p < 0.01). Conclusion In this American database, the rate of conversion of laparoscopic or robotic to open sacrocolpopexy was low. The majority (84%) of minimally invasive sacrocolpopexies used a robotic approach, which was associated with a lower risk of conversion. Obesity and lysis of adhesions were associated with a higher risk of conversion.

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NR 25

TC 2

Z9 3

U1 0

U2 0

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JI Int. Urogynecol. J.

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PT J

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Petruzzi, VA

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Saad, AF

Kilic, GS

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TI Safety and efficacy of robotic-assisted Burch for pure stress urinary

incontinence: a large case series

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Burch; robotic-assisted; urethropexy

ID OPEN COLPOSUSPENSION; TRENDS

AB Burch urethropexy is one of the earliest and most effective surgeries for stress urinary incontinence. Minimally invasive robotic surgery is becoming more popular in the field of urogynecology. Herein, we present the safety and efficacy of a large case series of robotic-assisted Burch urethropexy. A retrospective chart review was performed on robotic-assisted Burch urethropexy cases performed between 2013 and 2019. Patient characteristics, perioperative data and follow-up outcomes were collected at a single teaching institution. A total of 76 women underwent robotic-assisted Burch urethropexy for pure stress urinary incontinence. Fifty of them had concomitant robotic procedures at the time of the Burch. We performed the robotic-assisted Burch urethropexy alone on 26 patients. The mean age was 55 years old. The overall treatment success rate was 85% with a mean follow-up time of 134 (+/- 157.8) days. Complications included cystotomy (3%), urinary tract infection (16%) and postoperative voiding dysfunction (10%). Our study reveals that robotic-assisted Burch urethropexy is a feasible option in the treatment of stress urinary incontinence in terms of operative outcomes and short-term efficacy.Impact statement What is already known on this subject?Minimally invasive robotic surgery is becoming more popular in the field of urogynecology. Surgical repairs for stress urinary incontinence will likely increase in the coming years secondary to an aging population. Burch urethropexy is one of the earliest and most effective surgeries for stress urinary incontinence and can be performed abdominally, laparoscopically and now, using robotic assistance. What do the results of this study add?This study reveals that robotic-assisted Burch urethropexy is a feasible option in the treatment of stress urinary incontinence in terms of intraoperative outcomes with good short-term efficacy. What are the implications of these findings for clinical practice and/or further research?Lately, interest in colposuspension procedures has been rekindled as physicians seek alternative stress urinary incontinence treatment options. Robotic-assisted Burch urethropexy will continue to gain popularity with its efficacy and safety.

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JI J. Obstet. Gynaecol.

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AU Na, ED

Choi, SH

Park, H

AF Na, E. D.

Choi, S. H.

Park, H.

TI Robotic laparoendoscopic single-site surgery for concurrent hysterectomy

and cholecystectomy

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Cholecystectomy; Hysterectomy; Robotic laparoendoscopic single site

surgery

ID COMBINED SURGICAL-PROCEDURES

AB With the quality ergonomics and rapid learning curve of the robotic surgery system taken into consideration, robotic laparoendoscopic single-site surgery (R-LESS) appears to be the best integration for maximizing the benefits of single-site surgery. However, there are drawbacks of robot-assisted procedures which include longer operative time and higher cost, because of this, we hypothesized that the burden of robotic surgery would be reduced if two surgeries could be completed within one session in R-LESS. Three cases of R-LESS were performed for combined hysterectomy and cholecystectomy in patients with concomitant benign uterine disease and cholecystopathy. The combined surgeries were successfully conducted without additional port insertion or conversion and included the benefits of decreased hospital stay, anesthesia risk, and cost compared with the sum of two separate surgeries. Therefore, in cases in which concomitant pathologies are detected in the abdominopelvic cavity, R-LESS can be an option for selected patients with the benefit of minimally invasive surgery.

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Kilic, GS

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Demirkiran, C

Dursun, F

Unlu, BS

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Lee, Toy

Lewis, Kelsey

Demirkiran, Cem

Dursun, Furkan

Unlu, Bekir Serdar

TI Perioperative, postoperative and anatomical outcomes of robotic

sacrocolpopexy

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; robotic-assisted sacrocolpopexy; robotic surgery

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACRAL COLPOPEXY; ASSISTED

SACROCOLPOPEXY; MANAGEMENT

AB The study aimed to analyse the anatomical, perioperative and postoperative outcomes of the robotic-assisted sacrocolpopexy (RSCP). After obtaining Institutional Review Board (IRB #19-0167) approval, our retrospective case series included 144 consecutive patients that underwent an RSCP for symptomatic stage II pelvic organ prolapse (POP) or symptomatic/asymptomatic stage III/IV POP. Patient information included operative parameters, perioperative and postoperative complications, readmissions and reoperation. Demographics and baseline characteristics were summarised by frequencies and percentages for categorical variables, and by mean/median, standard deviation, and ranges for continuous variables. In our study, concomitant surgeries with sacrocolpopexy consisted of hysterectomy, Burch colposuspension and midurethral sling. The anatomical success rate was 87.5% and the reoperation rate was 10.4%. The mean follow-up time was 12.5 (+/- 8.7) months. Intraoperative complications 13 (9%) were bowel serosal abrasion, bladder wall injuries, trochar site bleeds, subcutaneous emphysema and a retroperitoneal haematoma. Our results suggest that RSCP is a feasible and safe approach for the treatment of POP with a low complication rate and favourable medium-term outcomes regarding anatomical and symptomatic results.Impact statement What is already known on this subject?Pelvic organ prolapse affects more than 25% of women in the United States. Apical and anterior compartment defects are challenging cases and sacrocolpopexy is considered the gold standard treatment option for apical and anterior compartment defects. As technology has advanced, minimally invasive approaches have been popular with their pros. Whatthe results of this study add?We present the highest volume case series in the literature from our tertiary care centre for robotic-assisted sacrocolpopexy (RSCP). Our results suggest that RSCP is a feasible and safe approach for the treatment of POP with a low complication rate and favourable 1-year outcomes regarding anatomical and subjective results. Whatthe implicationsareof these findings for clinical practice and/or further research?Robotic-assisted sacrocolpopexy has the potential to gain more popularity in the near future based on accumulating data on its feasibility and safety results.

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NR 21

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Z9 3

U1 0

U2 1

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J9 J OBSTET GYNAECOL

JI J. Obstet. Gynaecol.

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ER

PT J

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Salamon, Charbel

TI Indwelling Versus Immediate Removal of Transurethral Catheter After

Robotic Sacrocolpopexy: A Randomized Clinical Trial

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT 38th Annual Scientific Meeting of the American-Urogynecological-Society

(AUGS) / PFD Week

CY OCT 02-07, 2017

CL Providence, RI

SP Amer Urogynecol Soc

DE Foley; incomplete bladder emptying; pelvic organ prolapse; robotic

sacrocolpopexy; UTI

ID URINARY-TRACT-INFECTION; RISK-FACTORS; SURGERY; INCONTINENCE;

PREVENTION; BLADDER

AB Introduction and Hypothesis This study evaluates the necessity and effect of an indwelling transurethral catheter in the early postoperative period following a robotic-assisted laparoscopic sacrocolpopexy. Methods This was a randomized clinical trial of patients who underwent a robotic sacrocolpopexy for pelvic organ prolapse. Patients were randomized to have their transurethral catheter removed 6 hours postoperative (intervention group) or the morning following surgery (control group). Our primary outcome was to compare the number of patients diagnosed with postoperative incomplete bladder empyting in each group. A sample size of 36 patients per group was needed to detect a 25% difference between the 2 groups. Anticipating a 20% patient withdrawal rate, we estimated that we would need a total of 88 participants. Outcome variable was analyzed using chi(2)test, Fisher exact test, Mann-WhitneyUtest, 2-proportions test, and 2-samplettest. Results From December 2015 through May 2017, 88 women were randomized and analyzed: 44 in the intervention group and 44 in the control group. Women in the intervention group were more likely to be diagnosed with incomplete bladder emptying, 14 (31%) of 44, compared with the control group, 2 (4.5%) of 44,P<0.001. Rate of urinary tract infections within the 30-day postoperative period was also increased in the intervention group, 4 (9%) of 44, compared with 0 in the control group. Postoperative complications were similar between groups. Conclusions In women undergoing a robotic sacrocolpopexy, early transurethral catheter removal (6 hours postoperative) is associated with an increased rate of incomplete bladder emptying, recatheterization, and urinary tract infections.

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NR 32

TC 6

Z9 7

U1 0

U2 6

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PY 2020

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BP 617

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Optimizing the robotic surgery team: an operations management

perspective

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic surgery; Sacrocolpopexy; Optimization; Teamwork; Efficiency;

Pelvic organ prolapse

ID LEARNING-CURVE; EFFICIENCY; IMPACT; PERFORMANCE

AB Introduction and hypothesis To assess the critical threshold to optimize operating room (OR) time for each surgical team member in robotically assisted sacrocolpopexy (RASCP) and to evaluate the most efficient team compositions. Methods All women who underwent RASCP for pelvic organ prolapse (POP) were prospectively entered in a database. Patients having unrelated concomitant surgery were excluded. Our primary outcome measure was total OR time. We utilized factor analysis, regression analysis, and analysis of variance, OR time mapping, and stochastic optimization to identify 'optimal' surgical team configuration. Results The database included 359 consecutive RASCPs, all performed for stage III-IV POP: 156 (43%) were with total and 44 (12%) supracervical hysterectomies and 159 (44%) post-hysterectomy. Mean age was 58.6 +/- 9.3 years. Mean parity was 2.8 +/- 1.4, and mean body mass index was 28 +/- 4.7 kg/m(2). A total of 4 surgeons, 34 first assistants, 20 circulating nurses, 15 surgical technologists, and 59 anesthesiologist/nurse anesthetists were involved. Optimal experience levels for each team member were achieved at the following number of robotic procedures: surgeon 44; first assistant 13; surgical technologist 66; circulating nurse 56; anesthesia provider 46. Our analysis revealed that the surgical technologist and first assistant played the most significant roles within the team. The surgeon was ranked third followed by the circulating nurse and anesthesia provider, respectively. Conclusion Operating time in robotic surgery is multifactorial. Experience of each member of a robotic surgery team is critical. An optimal team can be composed of a variety of combinations of experience levels among the robotic team members.

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TC 3

Z9 5

U1 2

U2 5

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GA SS2LL

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ER

PT J

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Tunn, Ralf

TI Vaginal repair of nonradiogenic urogenital fistulas

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Urethrovaginal fistulas; Vaginal surgical approach; Vesicovaginal

fistulas

ID VESICOVAGINAL FISTULA; MANAGEMENT; EXPERIENCE

AB Introduction and hypothesis In developed countries urogenital fistulas are rare and usually a complication of surgery or radiation therapy. Surgical repair can be accomplished transvaginally or by laparotomy, laparoscopy, robotic-assisted laparoscopy, or transurethral endoscopy. Closure can be achieved with or without tissue interposition. The vaginal approach is the least invasive and a variety of techniques with or without tissue interpositions and flaps have been described. This study reviews surgical approaches and techniques for the repair of nonradiogenic urogenital fistulas. Methods We identified and reviewed records from all patients treated for urogenital fistulas at our unit between 2008 and 2018. We analyzed fistula location, etiology, type and duration of corrective surgery, length of hospitalization, as well as complication and success rates. Results Fifty patients (mean age 52 years) were identified. 49 fistulas were related to previous gynecological surgery, 3 were related to obstetric trauma. Thirty-four patients had vesicovaginal, 11 urethrovaginal, 3 ureterovaginal, and 2 neobladder-vaginal fistulas. Forty-eight patients (96%) were operated on using a vaginal approach; a modified Sims-Simon repair was used in 47 cases (94%). No flaps or tissue interpositions were used. In 48 patients (96%) successful closure was achieved with one operation; the modified Sims-Simon technique was successful in all 47 cases. The median operation time was 40 min (range, 20-100 min); the complication rate was 14%. Conclusions This series demonstrates the feasibility and advantages of vaginal repair of benign gynecological fistulas. The success rate was high and extensive procedures were avoided.

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NR 18

TC 3

Z9 4

U1 0

U2 1

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JI Int. Urogynecol. J.

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ER

PT J

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TI Indocyanine green in the surgical management of endometriosis: A

systematic review

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Review

DE bowel endometriosis; deep infiltrating endometriosis; indocyanine green;

near-infrared; ureterolysis

ID DEEP INFILTRATING ENDOMETRIOSIS; PERITONEAL ENDOMETRIOSIS; BLOOD-FLOW;

RESECTION; SURGERY; WOMEN

AB Introduction Endometriosis is a very common disease that affects up to 10% of the female population. The use of indocyanine green (ICG) dye has been proposed to allow the proper localization of endometriotic lesions during surgery. Our purpose is to offer an overview of near-infrared (NIR)-ICG in the surgical treatment of superficial peritoneal endometriosis and deep infiltrating endometriosis. Material and methods Electronic databases were searched, including MEDLINE, Embase, Web of Science, Scopus, ClinicalTrial.gov, OVID and Cochrane Library. The studies were identified with the use of a mesh combination of the following keywords: "indocyanine green", "endometriosis", "deep endometriosis", "robotic surgery", "laparoscopy", "ureter", "rectosigmoid" from 2000 to May 2020. All articles describing the use of ICG applied to endometriosis surgery were considered for review. Only original papers that reported specific experience data on the topic were included. Moreover, video-articles were included in the analysis. Quality and risk of bias were evaluated by two authors, respectively. Results Fifty-three studies were reviewed and reviews or comment articles not reporting original data and original articles lacking specific data on the application of ICG in patients affected by endometriosis were excluded. The quality of the 17 studies included was assessed. Eight studies suggested the usefulness of NIR-ICG as a tool in the detection of endometriosis during surgery, and one randomized controlled trial and one prospective study did not confirm the advantage of its use. Eight studies found that NIR-ICG was useful for the evaluation of vascularization in intestinal anastomoses and ureterolysis after surgery for deep infiltrating endometriosis. Conclusions NIR-ICG appears useful in the evaluation of vascularization in intestinal anastomoses after segmental resection, confirming its role even after ureterolysis for parametrial deep infiltrating endometriosis. However, its usefulness as a tool in the detection of endometriosis during surgery is inconsistent.

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NR 40

TC 19

Z9 21

U1 0

U2 6

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JI Acta Obstet. Gynecol. Scand.

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PG 11

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Trends and survival outcomes of robotic, laparoscopic, and open surgery

for stage II uterine cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE uterine cancer

ID ENDOMETRIAL CANCER; UNITED-STATES; CARDIOVASCULAR-DISEASE; HYSTERECTOMY;

ADENOCARCINOMA; MORTALITY

AB Introduction A recent randomized clinical trial showed that minimally invasive surgery led to poorer survival compared with open surgery in early stage cervical cancer. We determined the trends in adoption of minimally invasive surgery and 5-year overall survival outcomes after open, laparoscopic-assisted, and robotic-assisted hysterectomy for stage II uterine cancer with cervical stromal involvement. Methods Data for patients with stage II uterine cancer were acquired from the National Cancer Database from 2010 to 2015. chi(2)testing, Kaplan-Meier methods, and Cox models were used for statistical analyses. Results Of 2949 patients, 44.3% underwent open hysterectomy, 13.9% underwent laparoscopic hysterectomy, and 41.8% underwent robotic hysterectomy. The proportion of robotic cases increased from 26.8% in 2010 to 48.3% in 2015 (annual percent change 10.1%), with a decrease in open hysterectomy from 63.3% to 34.3% (annual percent change -12.5%). The overall 5-year survival was 77.6% in robotic, 76.8% in laparoscopic, and 72.5% in open hysterectomy (p=0.045); however, after adjusting for known prognostic factors, robotic (HR 1.00, 95% CI 0.82 to 1.21; p=0.97) and laparoscopic hysterectomy (HR 1.09, 95% CI 0.83 to 1.44; p=0.54) did not portend for improved survival compared with open hysterectomy. Black women (HR 1.59, 95% CI 1.25 to 2.02; p<0.001) and individuals with co-morbidities (HR 1.45, 95% CI 1.21 to 1.75, p<0.001) had worse adjusted survival and the highest rates of open hysterectomy. Conclusion The use of minimally invasive surgery for stage II uterine cancer has increased over time, with comparable adjusted 5-year survival after robotic or laparoscopic hysterectomy compared with open hysterectomy. Black women and those with co-morbidities had lowest rates of minimally invasive surgery and the poorest adjusted survival.

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U2 6

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SC Oncology; Obstetrics & Gynecology

GA NS5XJ

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OA Bronze

DA 2024-01-18

ER

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TI Does Mesh Weight Affect Time to Failure After Robotic-Assisted

Laparoscopic Sacrocolpopexy?

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE mesh weight; robotic surgery; pelvic organ prolapse

ID BIOMECHANICAL PROPERTIES; ABDOMINAL SACROCOLPOPEXY; IMPLANTATION;

OUTCOMES

AB Objective The objective of this study was to compare time to anatomic failure after robotic sacrocolpopexy with use of ultralightweight versus heavier weight mesh types. Methods We performed a retrospective cohort study of women who underwent robotic sacrocolpopexy, from January 2012 to September 2016. We compared (1) sacrocolpopexy with ultralightweight mesh (<= 20 g/m(2)) versus (2) sacrocolpopexy with heavier weight mesh (<= 35 g/m(2)). Our primary outcome was time to anatomic failure, defined as recurrent prolapse beyond the hymen, or retreatment for prolapse with surgery or pessary. Secondary outcomes were compartment of failure and mesh exposure. Cox proportional hazards modeling was used to estimate the hazard of failure based on mesh type. Results Of 461 patients, 248 (53.8%) underwent sacrocolpopexy with ultralightweight mesh and 213 (46.2%) with heavier weight mesh. Failures occurred in 37 women, with 21 in the ultralightweight mesh group and 16 in the heavier weight mesh group. Time to failure was statistically significant between groups (P= 0.03). Ultralightweight mesh had twice the hazard of failure within 3 years compared with heavier weight mesh (hazard ratio, 2.15; 95% confidence interval, 1.10-4.21;P= 0.03). Among failures, use of ultralightweight mesh was associated with almost 5 times the hazard of anterior compartment failure (hazard ratio, 4.46; 95% confidence interval, 1.39-14.27;P= 0.01). There was no difference in time to posterior failure. Of 17 mesh exposures, there were fewer in the ultralightweight mesh group, although this group was followed for less time (1.6% ultralightweight vs 6.0% heavier weight,P= 0.01). Conclusions Women receiving ultralightweight mesh are more likely to experience earlier anatomic failure in the anterior compartment.

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NR 22

TC 12

Z9 13

U1 0

U2 1

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JI Female Pelvic Med. Reconstr. Surg.

PD SEP

PY 2020

VL 26

IS 9

BP 536

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PG 5

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SC Obstetrics & Gynecology

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ER

PT J

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Sundfeldt, Karin

Dahm-Kahler, Pernilla

TI Long-term survival in obese patients after robotic or open surgery for

endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Obesity; Robotic surgery; Long-term survival;

Disease-free survival; Prognostic factors

ID SURGICAL COMPLICATIONS; UTERINE-CANCER; OUTCOMES; CARCINOMA;

HYSTERECTOMY; IMPACT

AB Objective. To evaluate surgical outcomes and survival after primary robotic or open surgery in obese women with endometrial cancer (EC).

Methods. The study included obese women (BMI >= 30 kg/m(2)) with EC who underwent primary surgery before and after the introduction of robotics between 2006 and 2014. Data on complications, survival, and recurrence was obtained through the National Cancer Registry and medical files. Survival curves were calculated for overall (OS), relative (RS) and disease-free survival (DFS). Cox proportional hazards regression models to assess OS and DFS.

Results. In total, 217 patients were identified, 131 robotic and 86 open surgical procedures. Significantly lower estimated blood loss, surgical time and hospital stay were found in the robotic group and the relative risk ratio of complications grades II-V, using the Clavien Dindo classification, was 0.54 (95% CI 0.31-0.93) for the robotic compared to the open group. A significant difference in OS (p = 0.029) and RS (p = 0.024) in favor of robotics was shown in the univariable survival curves, using log rank tests. No difference was seen for DFS. The 5-year RS was 96.2% (95% CI 89.7-103.3) for the robotic and 81.6% (95% CI 72.1-92.3) for the open group. Multivariable analysis showed high risk histology to be an independent risk factor, for both OS (HR 2.90; 95% CI 1.42-5.93; p < 0.05) and DFS (HR 2.74; 95% CI 1.45-5.17; p < 0.05). Robotic surgery was not found a significant independent factor for survival. Conclusions. Robotic surgery in obese women with EC had equivalent long-term and disease-free survival compared to open with significantly less complications, lower estimated blood loss, shorter surgical time and hospital stay. (c) 2020 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

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Medical Society; Swedish Cancer Society [CAN 2017/594, KS-CAN 2018/384];

[KS 70950]

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DA 2024-01-18

ER

PT J

AU Magrina, JF

Magtibay, PM

AF Magrina, Javier F.

Magtibay, Paul M.

TI Robotic Resection of Diaphragm Metastases in Ovarian Cancer: Technical

Aspects

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic malignancy; Metastatic disease; Minimally invasive surgery;

Robotic surgery

ID CYTOREDUCTION; SURGERY

AB Diaphragm metastases in ovarian cancer can be safely resected robotically in selected patients. The technique is similar to laparotomy, whether it is a peritoneal or full-thickness excision. Trocar placement is very important for successful resection and is dependent on the location of the disease. Metastases involving the left diaphragm and the ventral aspect of the right diaphragm are accessed with trocars placed slightly cranial to the umbilicus. Metastases in the dorsal aspect of the right diaphragm are removed with trocars in the upper quadrants. Metastases located in the lateral portion of the right diaphragm are excised using an infrahepatic approach, and those in the medial aspect are removed using a suprahepatic approach. In peritoneal resection, monopolar instruments must be kept at 10 W to 15 W to prevent contraction of the diaphragm and pleural perforation. Intraoperative pleural decompression is performed via an aspirating catheter. A video of the technique described in this report is available online (Suppementary Video 1). (C) 2020 Published by Elsevier Inc. on behalf of AAGL.

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NR 9

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Z9 3

U1 0

U2 1

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SN 1553-4650

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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ER

PT J

AU Opoku-Anane, J

Vargas, MV

Marfori, CQ

Moawad, G

Maasen, MS

Robinson, JK

AF Opoku-Anane, Jessica

Vargas, Maria V.

Marfori, Cherie Q.

Moawad, Gaby

Maasen, Marloes S.

Robinson, James K.

TI Intraoperative tranexamic acid to decrease blood loss during myomectomy:

a randomized, double-blind, placebo-controlled trial

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE antifibrinolytics; blood loss; fibroids; hemorrhage; myomas; myomectomy;

laparoscopy; robotics; tranexamic acid; transfusion

ID LAPAROSCOPIC MYOMECTOMY; COMPLICATIONS; MYOMAS; WOMEN

AB BACKGROUND: Myomectomy is associated with a significant risk of hemorrhage. Tranexamic acid is a synthetic lysine derivative with antifibrinolytic activity used in other surgical disciplines to reduce blood loss during surgery. However, its utility in gynecologic surgery is not well understood.

OBJECTIVE: This study aimed to determine the effect of early administration of intravenous tranexamic acid on perioperative bleeding and blood transfusion requirements in women undergoing myomectomy.

STUDY DESIGN: This study was a double-blinded, randomized, placebo-controlled trial conducted in an academic teaching hospital. Women with symptomatic fibroids thought to be at risk for large intraoperative blood loss who met the following criteria were included in the study: (1) at least 1 fibroid >10 cm, (2) any intramural or broad ligament fibroid >6 cm, and/or (3) at least 5 total fibroids based on preoperative imaging. Patients were randomized to receive a single intravenous bolus injection of tranexamic acid 15 mg/kg (intervention group) versus an intravenous bolus injection of saline of equivalent volume (placebo group) 20 minutes before the initial surgical incision. Perioperative bleeding was defined by measuring intraoperative estimated blood loss, change between preand postoperative hemoglobin, and frequency of blood transfusions. Estimated blood loss was calculated by combining the blood volume collected within the suction canister and the weight of used sponges. The 2 groups were compared for age; body mass index; perioperative hemoglobin and hematocrit; perioperative blood loss; duration of surgery; blood transfusion requirements; and the number, total weight, and volume of myomas removed.

RESULTS: A total of 60 patients (30 per arm) were enrolled into the study between March 1, 2015, and January 29, 2018. Age, body mass index, baseline hemoglobin and/or hematocrit, number and total weight of myomas removed, and size of myomas did not differ between arms. Of 60 patients, 32 (53%) had laparoscopic myomectomy, 24 (40%) had robotic myomectomy, and 4 (7%) had laparotomy. Median estimated blood loss was 200 mL for the tranexamic acid group and 240 mL for the placebo group (P=.88). There was no difference in median duration of surgery (165 vs 164 minutes; P=.64) or change in perioperative hemoglobin (1.00 vs 1.1 g/dL; P=.64). Patients in the tranexamic acid group did not require blood transfusions; however, 4 patients (13.3%) in the placebo group (P=.11) required blood transfusions.

CONCLUSION: Intravenous administration of tranexamic acid in patients undergoing laparoscopic or robotic myomectomies was not associated with decreased blood loss.

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(CTSI-CN) Clinical Studies Resource Voucher Award Program

FX This study received financial support from the Clinical and

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U2 3

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JI Am. J. Obstet. Gynecol.

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ER

PT J

AU Panico, G

Campagna, G

Vacca, L

Caramazza, D

Pizzacalla, S

Rumolo, V

Scambia, G

Ercoli, A

AF Panico, G.

Campagna, G.

Vacca, L.

Caramazza, D.

Pizzacalla, S.

Rumolo, V

Scambia, G.

Ercoli, A.

TI The Senhance® assisted laparoscopy in urogynaecology: case report of

sacral colpopexy with subtotal hysterectomy with bilateral

salpingo-oophorectomy for pelvic organ prolapse

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Laparoscopy; Pelvic organ prolapse; Robotic surgery; Sacrocolpopexy

ID ROBOTIC SURGERY; SACROCOLPOPEXY; METAANALYSIS

AB The aim of this case report was to evaluate the feasibility, efficacy, and safety of nerve-sparing laparoscopic sacrocolpopexy (SCP) performed with a minimally invasive approach by using 2.9-mm Senhance (R) surgical robotic system (Senhance (R), TRANSENTERIX Inc., USA). A 60- year-old Caucasian woman with symptomatic pelvic organ prolapse-Q (POP-Q) Aa: 2, Ba: 3, C: +4, Bp:2, Ap: 2, TVL:10 underwent subtotal hysterectomy with bilateral salpingo-oophorectomy, with nerve-sparing SCP performed using the Senhance surgical robotic system.. The urogynaecological assessment on the day of discharge and at the 3 month follow-up showed surgical anatomic success (<2 POP-Q stage). The patient was fully satisfied with the cosmetic result. This is the first case of SCP performed with this innovative system. SCP using "Senhance (R)" is a feasible and effective approach with good results in terms of operative time, cosmesis, postoperative pain and length of hospitalisation.

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ER

PT J

AU Piver, P

Sallée, C

Durand, LM

Aubard, Y

Tardieu, A

Gauthier, T

AF Piver, P.

Sallee, C.

Durand, L. M.

Aubard, Y.

Tardieu, A.

Gauthier, T.

TI Robot-assisted laparoscopic auto-graft of patchwork ovarian cortex in

two steps

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Ischemia; Ovarian tissue autograft; Robotic; Birth; Cancer; Infertility

ID TRANSPLANTATION; TISSUE

AB The main difficulty of ovarian tissue autograft (OTA) is to preserve as many follicles as possible because the ovarian tissue undergoes warm ischemia during grafting until revascularisation, resulting in significant follicular loss. We describe a two-stage grafting technique to stimulate new vascularisation in order to enhance the revascularization process to reduce the ischemic injuries. Furthermore we performed ovarian patchwork in the laboratory and then grafting with robotic laparoscopy to facilitate surgery and increase precision. This technique is used in the DATOR study with promising results, such as a 40% delivery rate. (C) 2020 Elsevier Masson SAS. All rights reserved.

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JI J. Gynecol. Obstet. Hum. Reprod.

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PT J

AU Settnes, A

Topsoee, MF

Moeller, C

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Kopp, TI

Norrbom, C

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Joergensen, Annemette

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TI Reduced Complications Following Implementation of Laparoscopic

Hysterectomy: A Danish Population-based Cohort Study of Minimally

Invasive Benign Gynecologic Surgery between 2004 and 2018

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Hysterectomy; Laparoscopic; Minimally invasive;

Surveillance

ID SURGICAL COMPLICATIONS; TRENDS; CLASSIFICATION; MORBIDITY; RATES

AB Study Objective: To monitor and report nationwide changes in the rates of and complications after different methods for benign hysterectomy, operative hysteroscopy, myomectomy, and embolization in Denmark. To report the national mortality after benign hysterectomy

Design: National prospective, observational cohort study.

Setting: The Danish Hysterectomy and Hysteroscopy Database.

Patients: Women undergoing surgery for benign gynecologic diseases: 64 818 hysterectomies, 84 175 hysteroscopies, 4016 myomectomies, and 1209 embolizations in Denmark between 2004 and 2018.

Interventions: National meetings with representatives from all departments, annual working reports of institutional complication rates, workshops, and national guideline initiative to improve minimally invasive surgical methods.

Measurements and Main Results: Rates of the different methods and complications after each method with follow-up to 5 years as recorded by the database directly in the National Patient Registry. Nationwide, a decline in the use of hysterectomy, myomectomy, embolizations, and endometrial ablation. The total short-term complications were 9.8%, 7.5%, 8.9%, and 2.7% respectively, however, with a persistent risk of approximately 20% for recurrent operations within 5 years after endometrial ablation. Initially, we urged for increased use of vaginal hysterectomy, but only reached 36%. From 2010, we urged for reducing abdominal hysterectomies by implementing laparoscopic hysterectomy and reached 72% laparoscopic and robotic procedures. Since 2015, we used coring or contained morcellation for removal of large uterus at laparoscopic hysterectomy. The major and minor complication rates (modified Clavien-Dindo classification) were reduced significantly from 8.1% to 4.1% and 9.9% to 5.7% respectively. Mortality after benign hysterectomy was 0.27%0. The odds ratio for major complications after abdominal hysterectomy was 1.66 (1.52-1.81) compared to minimally invasive hysterectomy independent of the length of stay, high-volume departments, indications, comorbidity, age, and calendar year.

Conclusion: Fifteen years with a national database has resulted in a marked quality improvement. Denmark has 85% minimally invasive hysterectomies and has reduced the number of major complications by 50%. (C) 2019 AAGL. All rights reserved.

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ER

PT J

AU Truong, MD

Gala, RB

AF Truong, Mireille D.

Gala, Rajiv B.

CA ACOG Comm Gynecologic Practice

Soc Gynecologic Surg

TI Robot-Assisted Surgery for Noncancerous Gynecologic Conditions

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID VAGINAL CUFF DEHISCENCE; DEEP INFILTRATING ENDOMETRIOSIS; TOTAL

LAPAROSCOPIC HYSTERECTOMY; OBJECTIVE STRUCTURED ASSESSMENT; SURGICAL

OUTCOMES; ABDOMINAL MYOMECTOMY; LEARNING-CURVE; SACROCOLPOPEXY;

STANDARD; SIMULATION

AB For noncancerous conditions, such as hysterectomy, a minimally invasive approach to gynecologic surgery has well-documented advantages-including faster return to normal activities, decreased length of stay, and better quality of life-compared with an abdominal approach. Although the quality of data for robot-assisted surgery is still low to moderate, the use of robot-assisted surgery has rapidly increased since its approval, which highlights the need to develop effective and thoughtful strategies for its implementation. Reporting of adverse events currently is voluntary and nonstandardized; therefore, the true rate of complications is not known. Adoption of new surgical techniques should be driven by what is best for the patient and by evidence-based medicine, rather than external pressures. Although training in robot-assisted surgery increasingly is incorporated into obstetric and gynecologic residency programs, exposure to and training with robotic devices varies nationally. Obstetrician-gynecologists not previously trained in robot-assisted surgery can acquire the necessary skills through independent robot-assisted training programs and through courses offered and accredited by organizations such as the American College of Obstetricians and Gynecologists, the Society of Gynecologic Surgeons, the American Association of Gynecologic Laparoscopists, the Society of Gynecologic Oncology, and the American Urogynecologic Society. Ongoing quality assurance is essential to ensure appropriate use of the technology and, most importantly, patient safety. Well-designed studies are needed to determine which patients are most likely to benefit from robot-assisted surgery over other minimally invasive approaches.

NR 75

TC 9

Z9 9

U1 2

U2 4

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

AU Tyan, P

Klebanoff, JS

Smith, S

Amdur, R

North, A

Maassen, MS

Moawad, GN

AF Tyan, Paul

Klebanoff, Jordan S.

Smith, Savannah

Amdur, Richard

North, Alexandra

Maassen, Marloes S.

Moawad, Gaby N.

TI Perioperative Narcotic Trends in Women Undergoing Minimally Invasive

Myomectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Myomectomy; Opioid; Prescribing patterns

ID POSTOPERATIVE PAIN; RISK-FACTORS; OPIOID USE; MANAGEMENT; SURGERY;

ANALGESIA; HYSTERECTOMY; PREVENTION; MORPHINE; BURDEN

AB Study Objective: Evaluate the perioperative narcotic utilization patterns at the time of myomectomy, specifically as they relate to the opioid epidemic. We also aim to evaluate the differences between conventional laparoscopy and robotic surgery in terms of narcotic utilization.

Design: Retrospective cohort study.

Setting: Single academic university hospital.

Patients: Women undergoing minimally invasive myomectomy.

Interventions: Laparoscopic or robot-assisted myomectomy.

Measurements and Main Results: We identified 312 minimally invasive myomectomies to be included in the final analysis. For the entire cohort, the mean age (+/- standard deviation) was 35.7 +/- 5.1 years, and the mean body mass index was 28.3 +/- 6.3. Of the 312 myomectomies included, 239 (76.6%) were performed using robotic assistance, and the remainder (23.4%) were performed by conventional laparoscopy. A statistically significant inverse relationship was found between year of myomectomy and perioperative narcotic administration (p <.001). Yearly morphine milligram equivalent (MME) administration decreased significantly for both intraoperative and postoperative administration (p <.001). The largest decline for intraoperative MME use was between 2016 and 2017, and for postoperative MME use, it was between 2012 and 2013. There was no statistically significant difference in perioperative narcotic administration between conventional laparoscopy and robot-assisted myomectomy. The time effect for intraoperative (p <.001) and postoperative (p <.001) narcotic administration remained significant after adjusting for covariates, including mode of surgery, race, insurance, age, and body mass index. None of the background variables assessed were associated with perioperative narcotic administration.

Conclusion: Perioperative narcotic administration for minimally invasive myomectomy has decreased following widespread awareness of the national opioid crisis.(C) 2019 AAGL. All rights reserved.

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ER

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TI Pain after permanent versus delayed absorbable monofilament suture for

vaginal graft attachment during minimally invasive total hysterectomy

and sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Hysterectomy; Minimally invasive surgery; Pain; Pelvic organ prolapse;

Postoperative complications

ID ROBOTIC SACROCOLPOPEXY; PROLAPSE; FIXATION; OUTCOMES

AB Objectives The objective was to evaluate pain and dyspareunia in women undergoing minimally invasive total hysterectomy and sacrocolpopexy (TLH + SCP) with a light-weight polypropylene mesh 1 year after surgery. Methods This is a planned secondary analysis of a randomized trial comparing permanent (Gore-Tex) versus absorbable suture (PDS) for vaginal attachment of a y-mesh (Upsylon (TM)) during TLH + SCP in women with stage >= II prolapse. Patient data were collected at baseline and 1 year after surgery. Our primary outcome was patient-reported pain or dyspareunia at 1 year. Results Two hundred subjects (Gore-Texn = 99, PDSn = 101) were randomized and underwent surgery. Overall, the mean age +/- SD was 60 +/- 10 years, and BMI was 27 +/- 5 kg/m(2). The majority were white (89%), menopausal (77%), and had stage III/IV (63%) prolapse. 93% completed a 1-year follow-up and are included in this analysis (Gor-Texn = 95, PDSn = 90). The overall rate of participants who reported pain at 1 year was 20%. Of those who did not report any pain at baseline, 23% reported de novo dyspareunia, 4% reported de novo pain, and 3% reported both at 1 year. Of participants who reported pain or dyspareunia at baseline prior to surgery, 66% reported resolution of their symptoms at 1 year. There were no differences in most characteristics, including mesh/suture exposure (7% vs 5%,p = 0.56) between patients who did and did not report any pain at 1 year. On multiple logistic regression controlling for age, baseline dyspareunia, and baseline pain, baseline dyspareunia was associated with a nearly 4-fold increased odds of reporting any pain at 1 year (OR 3.8, 95%CI 1.7-8.9). Conclusions The majority of women report resolution of pain 1 year following TLH + SCP with a low rate of de novo pain.

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PT J

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TI Implementation of robotic gynecological surgery in a German University

Hospital: patient safety after 110 procedures

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic hysterectomy; Robotic sacrocolpopexy; Implementation; Robotic

complications; Polyvinylidene fluoride (PVDF)

ID VAGINAL CUFF DEHISCENCE

AB Purpose Robotic surgery represents the latest development in the field of minimally invasive surgery and offers many technical advantages. Despite the higher costs, this novel approach has been applied increasingly in gynecological surgery. Regarding the implementation of a new operative method; however, the most important factor to be aware of is patient safety. In this study, we describe our experience in implementing robotic surgery in a German University Hospital focusing on patient safety after 110 procedures. Methods We performed a retrospective analysis of 110 consecutive robotic procedures performed in the University Hospital of Wurzburg between June 2017 and September 2019. During this time, 37 patients were treated for benign general gynecological conditions, 27 patients for gynecological malignancies, and 46 patients for urogynecological conditions. We evaluated patient safety through standardized assessment of intra- and postoperative complications, which were categorized according to the Clavien-Dindo classification. Results No complications were recorded in 90 (81.8%) operations. We observed Clavien-Dindo grade I complications in 8 (7.3%) cases, grade II complications in 5 (4.5%) cases, grade IIIa complications in 1 case (0.9%), and grade IIIb complications in 6 (5.5%) cases. No conversion to laparotomy or blood transfusion was needed. Conclusion Robotic surgery could be implemented for complex gynecological operations without relevant problems and was accompanied by low complication rates.

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JI Arch. Gynecol. Obstet.

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TI Impact of obesity on surgical and oncologic outcomes in patients with

endometrial cancer treated with a robotic approach

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE endometrial cancer; obesity; postoperative complications; robotic

surgery; survival

ID BODY-MASS INDEX; UTERINE-CANCER; SURGERY; COMPLICATIONS; SURVIVAL;

WOMEN; LAPAROSCOPY; RECURRENCE; MORTALITY; COHORT

AB Aim The surgical treatment of endometrial cancer (EC) can be more complicated in obese patients. Robotic surgery could simplify the surgical approach in these patients. The aim of our study was to compare the outcomes of robotic surgery in obese (body mass index >= 30 kg/m(2)) and nonobese patients. Methods We performed a retrospective study on patients with EC benefitting from a robotic approach in our institution. The primary outcome was the 5-year overall survival (OS). We also assessed the 5-year recurrence-free survival (RFS), type of surgery, laparotomy conversion rate, adjuvant treatment and postoperative morbidity. Results We analyzed 175 consecutive patients with EC who underwent robotic surgery, 42 patients with obesity and 133 patients without. The median follow-up length was 37 months [1-120]. The OS rate was 97% in the whole population and the RFS was 74%. Obesity did not impact prognosis. Laparotomy conversion rate was low in both groups (5% in patients with obesity vs 3%,P= 0.619). There were no significant differences in terms of postoperative complications (5 vs 9%,P= 0.738). There were significantly less pelvic lymphadenectomies in patients with obesity (5 vs 12%,P= 0.005). In the subgroup of patients with high-risk EC, rate of lymphadenectomy and of adjuvant treatments did not differ between patients with or without obesity. Conclusion Obese patients with EC can be safely treated with a robotic approach, with a low complication rate and similar oncological outcomes compared to nonobese patients.

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TI Usefulness of sentinel lymph node mapping using indocyanine green and

fluorescent imaging in the diagnosis of lymph node metastasis in

endometrial cancer

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Endometrial cancer; lymph node metastasis; sentinel lymph node mapping;

indocyanine green; fluorescence imaging; near-infrared imaging

ID EARLY-STAGE ENDOMETRIAL; LYMPHADENECTOMY; UTERINE; SURGERY;

MICROMETASTASIS; CARCINOMA; BIOPSY; TRIAL; CT

AB The lymph node status is the most important prognostic factor for endometrial cancer. This study aimed to assess whether sentinel lymph node mapping (SLNM) is applicable in endometrial cancer. A retrospective review of patients with endometrial cancer who were diagnosed and treated in Asan Medical Centre from September 2015 to December 2017 was conducted. One hundred patients underwent robotic (da Vinci (R)) or laparoscopic surgical treatment, including SLNM with indocyanine green (ICG) fluorescence detection using the Firefly (R) and NIR/ICG systems. At least one lymph node area was observed in 100% of SLNM cases. Sentinel node detection and frozen biopsy were performed in all cases, and all patients with metastasis were found on SLNM. The sensitivity and negative predictive value were both 100% in the patient-by-patient and station-by-station analyses. SLNM appears to be a feasible method to reduce the morbidity and increase the detection rate in early-stage endometrial carcinoma. What is already known on this subject?There are studies that it is safe to diagnose the possibility of lymph node metastasis through sentinel lymph node mapping in endometrial cancer. What do the results of this study add?In this study, it is shown that the accuracy of sentinel lymph node mapping is 100% accurate. What are the implications of these findings for clinical practise and/or further research?Therefore, total lymphadenectomy will not be necessary for the future.

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Z9 7

U1 0

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ER

PT J

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TI Minimally Invasive Surgery and Surgical Smoke, Decoding Fear and

Ensuring Safety: Adaptations and Safety Modifications During COVID

Pandemic

SO INDIAN JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Covid pandemic; MIS; Laparoscopic and robotic surgery; Surgical smoke;

Safe practices; Smoke evacuators

AB The most fearful word starting from C, Cancer has now been replaced with COVID-19 owing to its associated physical, emotional and financial hardships as well as its social stigma. Never before we as medical fraternity been challenged to take care of patients and at the same time consider the safety of ourselves, family members and our fellow healthcare workers. Emotions and fear-driven treatments that are otherwise inefficacious may contribute to a false sense of security, unwarranted side-effects, divert resources and delay research into treatments that may actually work. Decoding fear with available evidence i.e. practicing evidence-based medicine will guide us in better handling of situations in this pandemic. The objective of this review is to discuss the modifications required in the operating theatre during COVID-19 times for minimal access, laparoscopy and robotic surgery, especially with regard to the handling of surgical smoke, minimally invasive surgical instruments, trocars with smoke evacuator and special personal protection equipment. Although there is no evidence of viral transmission through laparoscopic or open approaches, we recommend modifications to surgical practice such as the use of safe smoke evacuation and minimizing energy device use. We have come up with Rule of 20 for 2020 pandemic in operation theatres and modification of trocar for safe handling of surgical smoke in MIS which can be used in resource-limited settings. Hospitals must follow specific protocols and arrange suitable training of the healthcare workers. We believe that "Fears are educated into us, and can, if we wish, be educated out".

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Z9 1

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TI Comparison between laparoscopic and robotic surgery for sentinel lymph

node mapping in endometrial cancer using indocyanine green and near

infra-red fluorescence imaging

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Sentinel lymph node mapping; indocyanine green; minimally invasive

surgery; detection rate; endometrial cancer

ID UTERINE

AB Indocyanine green (ICG) and near infra-red fluorescence imaging in minimally invasive surgery is an option to map sentinel lymph nodes (SLN). The aim of this study was to compare the outcomes of SLN mapping between laparoscopic and robotic surgery. One-hundred-and-forty women with histologically confirmed endometrial cancer, were treated with a minimally invasive hysterectomy, bilateral salpingo-oophorectomy and SLN mapping. After anaesthetic induction, ICG was superficially injected into cervical submucosa and deeply injected into the cervical stroma at the 3 and 9 o'clock positions (1.25 mg/site). Eleven cases were abandoned after ICG injection (laparoscopic surgery seven cases and robotic surgery four cases) because of obesity, technical difficulty and peritoneal disease. One-hundred-and-eleven patients were analysed. Seventy-six patients had a laparoscopic procedure and 33 patients had robotic surgery. The overall and bilateral detection rates were 97% and 83% for laparoscopic surgery and 88% and 73% for robotic surgery. Laparoscopic surgery was superior to robotic surgery in terms of overall detection (p-value .046). There was no significant difference in the intra-operative SLN identification time or SLN dissection time between laparoscopy and robotic surgery (p-value .247 and .145, respectively). Further research is required to compare laparoscopy and robotic surgery in terms of SLN detection.Impact Statement What is already known on this subject?Sentinel lymph node (SLN) mapping aims to avoid complications and provide useful staging information for endometrial cancer. ICG has been shown to improve the detection rate and NPV compared with other tracers (blue dye and technetium 99). No data exists comparing SLN mapping rates using ICG in laparoscopy and robotic surgery. What do the results of this study add?The overall and bilateral detection rates were 97% and 83% for laparoscopic surgery and 88% and 73% for robotic surgery. Laparoscopic surgery was superior to robotic surgery in terms of overall detection. There was no significant difference in the intra-operative SLN identification time or SLN dissection time between laparoscopy and robotic surgery. What are the implications of these findings for clinical practice and/or further research?: This study confirms that laparoscopy and robotic surgery are not different in terms of bilateral detection rate and SLN operating time; the study population is small.

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PT J

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TI Is it enough in ovarian cancer staging surgery to laparoscopic surgery?

Comparison of surgical methods

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Ovarian cancer; Laparotomy; Laparoscopy; Cancer staging

ID MANAGEMENT; WOMEN

AB Objective: This study was carried out to compare conventional laparotomy with laparoscopic surgery for ovarian cancer and identify no difference between conventional laparotomy and laparoscopic surgery for advanced ovarian cancer. Materials and Methods: Targeting 249 patients, who had been diagnosed with ovarian cancer and had undergone treatment in general university hospitals over ten years, this study was conducted with two gynecologic oncologists. The patients were placed in a laparotomy group (group 1) and a laparoscopic surgery group (including robotic surgery) (group 2). Results: One hundred ninety-two of a total of 249 patients belonged to the laparotomy group and 57 patients belonged to the laparoscopic surgery group. With regards to ovarian cancer staging, 80 of 249 (32.1%) patients were in Stage I-II and 129 of 249 patients were in Stage III-IV. Twenty of 249 (8%) patients (16 of 192 patients in group 1, 4 of 57 patients in group 2) suffered from operative complications and one great vessel injury was found in group 1. Sixty-nine of 249 patients (27.7%) [58 of 192 patients in group 1 (30.2%) and 11 of 57 patients in group 2 (19.2%)] had a relapse. In terms of the correlation between recurrence and operative methods, and risk, the hazard risk (BR) was measured at 0.552 (0.267-5.343), indicating that there was no close correlation. Conclusion: Laparoscopic surgery is not inferior to laparotomy for advanced ovarian cancer and it is therefore anticipated that laparoscopic surgery can be considered a treatment for early stage and unidentified stage ovarian cancer with low HE 4 and CA 125.

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ER

PT J

AU Wang, CW

Chen, CH

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AF Wang, Cheng-Wei

Chen, Ching-Hui

Liu, Wei-Min

TI Incidental small ovarian surface serous carcinoma with Miliary abdominal

seeding during robotically-assisted total hysterectomy

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Small ovarian surface tumor; Abdominal miliary seeding; Robotic staging

surgery

AB Objective: To report a case in which an incidental finding of an extremely small ovarian surface tumor with abdominal miliary seeding was managed using robotic staging surgery. Case Report: A 53-year-old women, gravida 0 para 0, who was experiencing dysmenorrhea and adenomyosis, was admitted initially for robotically-assisted total hysterectomy. Intraoperatively, an incidental discovery of a 0.5-cm right ovarian surface tumor with pelvic wall miliary tumors was noted. An intraoperative frozen-section diagnosis revealed carcinoma both for the ovarian tumor and pelvic sidewall tumors. A final pathological report revealed serous carcinoma, Stage IIIA2. Conclusion: A preoperatively undetectable small ovarian tumor (0.5 cm) could behave malignantly with metastasis that is already widespread. The authors have reported this case to identify the imperative need for early detection of ovarian cancer.

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PT J

AU Salman, L

Guy, L

Borovich, A

Raban, O

Sabah, G

Yeoshoua, E

Jakobson-Setton, A

Eitan, R

AF Salman, Lina

Guy, Liora

Borovich, Adi

Raban, Oded

Sabah, Gad

Yeoshoua, Effi

Jakobson-Setton, Ariella

Eitan, Ram

TI Robotic Surgery Versus Laparotomy in Elderly Patients with Endometrial

Cancer: Perioperative Outcomes and Complications

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE elderly; endometrial cancer; robotic surgery; laparotomy; complications

ID MINIMALLY-INVASIVE SURGERY; LAPAROSCOPIC HYSTERECTOMY; LYMPHADENECTOMY

AB Objective: To evaluate perioperative outcomes and complications in elderly patients with endometrial cancer undergoing surgical staging with robotic assisted laparoscopy (RAL) versus laparotomy.

Design: A retrospective cohort study.

Materials and Methods: We included all elderly patients (>= 70 years old) with endometrial cancer in one university-affiliated medical center (2009-2017). We compared outcomes between patients undergoing RAL with those undergoing laparotomy. We excluded cases who underwent vaginal hysterectomy or conventional laparoscopy. Our primary outcomes were perioperative outcome and complications, including operation time, anesthesia duration, estimated blood loss, intraoperative complications, length of stay, postoperative complications, and rates of readmission.

Results: Overall, 125 patients met inclusion criteria. Of whom, 45 (36%) had RAL and 80 (64%) underwent laparotomy. There was no difference between groups in age, body mass index, stage, or histology,p > 0.05 for all. Patients undergoing RAL had significantly longer operation time (142 vs. 94 minutes,p < 0.001). Rates of lymph node sampling were higher in the RAL group than in the laparotomy group (77.7% vs. 52.5%,p = 0.006). Compared with those undergoing RAL, patients undergoing laparotomy had significantly longer length of stay (7 vs. 2 days,p < 0.001) with significantly higher rates of intraoperative and postoperative complications (18.7% vs. 4.4%,p = 0.02, and 17.5% vs. 2.2%,p = 0.001, respectively).

Conclusions: Elderly patients with endometrial cancer undergoing RAL are more likely to undergo oncologic staging. Despite the potentially more morbid procedure, these patients have lower perioperative complications, with shorter hospital stay, compared with patients undergoing laparotomy.

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U2 1

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ER

PT J

AU Berger, AA

Tan-Kim, J

Menefee, SA

AF Berger, Alexander A.

Tan-Kim, Jasmine

Menefee, Shawn A.

TI Anchor vs suture for the attachment of vaginal mesh in a

robotic-assisted sacrocolpopexy: a randomized clinical trial

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons (SGS)

CY JUL 09-12, 2020

CL ELECTR NETWORK

DE mesh attachment; minimally invasive; novel; sacrocolpopexy

ID HYSTERECTOMY

AB BACKGROUND: Vaginal mesh attachment can be one of the most time-consuming components of a minimally invasive sacrocolpopexy.

OBJECTIVE: To assess the impact on the duration vaginal mesh attachment of using absorbable anchors compared to interrupted sutures for vaginal mesh attachment in robotic-assisted sacrocolpopexy.

STUDY DESIGN: This was a single-masked, randomized clinical trial of women with pelvic organ prolapse that underwent a robotic-assisted sacrocolpopexy at 2 clinical sites. The participants were randomized to receive either interrupted delayed absorbable anchors or sutures during the vaginal mesh attachment portion of the surgery. The participants completed validated questionnaires at baseline and at 6 weeks, 6 months, and 12 months after the surgery. A certified examiner, masked to the attachment technique that was used, performed a clinical examination using the Pelvic Organ Prolapse Quantification system and also assessed for mesh exposure and the overall appearance of the vaginal walls using a 10-cm visual analog scale at each follow-up visit. The primary outcome was the vaginal mesh attachment time. The categorical variables were compared using chi-square or Fischer's Exact test, whereas the continuous variables were compared using Student's t-test or Mann-Whitney U test where appropriate. An intention-to-treat analysis was performed.

RESULTS: Fifty-three participants were randomized, 26 to mesh attachment with anchor, 27 to mesh attachment with suture, and 81% (21/26) and 93% (25/27) had 12-month follow up respectively. There were no significant differences between the groups with regard to age (P=.12), body mass index (P=.23), stage of prolapse (P=.97), or other preoperative factors. Mesh attachment interval time was faster in the anchor compared to suturing study arm (12.2 +/- 7.8 vs 21.2 +/- 5.2 minutes; P<.001), while sacrocolpopexy times (107.6 +/- 33.2 vs 109.8 +/- 21.2 minutes; P=.774) were not different. The ease of placement for the surgeon based on a visual analog scale (P=.16), the appearance of the mesh attachment (P=.07), and the overall satisfaction with the use of the specific attachment type (P=.65) were similar for the arms. There was no difference in perioperative adverse events rates between arms and by 12 months follow-up there were no sacrocolpopexy mesh, anchor, or suture exposures. There was no difference in outcomes at 12 months including composite failure (10% vs 12%; P=.79), patient global impression of improvement (1.06 vs 1.19; P=.27), or patient pelvic pain (9.81 vs 9.67; P=.56).

CONCLUSION: In patients undergoing a robotic-assisted sacrocolpopexy, the anchor vaginal mesh attachment technique required significantly less time than suturing. There was no difference between techniques in complications, failure, surgeon, or patient-reported outcomes through 12 months of follow-up. Mesh attachment during sacrocolpopexy can be performed in less time by using the anchor technique, providing surgeons with an alternative surgical technique for this procedure.

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Z9 5

U1 0

U2 1

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ER

PT J

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Sangaralingham, Lindsey R.

Borah, Bijan J.

Dowdy, Sean C.

TI Use of bowel preparation does not reduce postoperative infectious

morbidity following minimally invasive or open hysterectomies

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 50th Annual Meeting of the Society-of-Gynecologic-Oncologists (SGO) on

Women's Cancer

CY MAR 16-20, 2019

CL Honolulu, HI

SP Soc Gynecol Oncol

DE abdominal hysterectomy; anastomotic leak; bowel resection; cancer;

combination bowel preparation; mechanical bowel preparation; minimally

invasive hysterectomy; oral antibiotics; postoperative ileus; surgical

site infection

ID SURGICAL SITE INFECTION; PREOPERATIVE ORAL ANTIBIOTICS; ELECTIVE

COLORECTAL SURGERY; ENHANCED RECOVERY; CARE; METAANALYSIS; PREVENTION;

GUIDELINES; COLECTOMY; INCREASE

AB BACKGROUND: Literature on the use of bowel preparation in gynecologic surgery is scarce and limited to minimally invasive gynecologic surgery. The decision on the use of bowel preparation before benign or malignant hysterectomies is mostly driven by extrapolating data from the colorectal literature.

OBJECTIVE: Bowel preparation is a controversial element within enhanced recovery protocols, and literature investigating its efficacy in gynecologic surgery is scarce. Our aim was to determine if mechanical bowel preparation alone, oral antibiotics alone, or a combination are associated with decreased rates of surgical site infections or anastomotic leaks compared to no bowel preparation following benign or malignant hysterectomy.

STUDY DESIGN: We identified women who underwent hysterectomy between January 2006 and July 2017 using OptumLabs, a large US commercial health plan database. Inverse propensity score weighting was used separately for benign and malignant groups to balance baseline characteristics. Primary outcomes of 30-day surgical site infection, anastomotic leaks, and major morbidity were assessed using multivariate logistic regression that adjusted for race, census region, household income, diabetes, and other unbalanced variables following propensity score weighting.

RESULTS: A total of 224,687 hysterectomies (benign, 186,148; malignant, 38,539) were identified. Median age was 45 years for the benign and 54 years for the malignant cohort. Surgical approach was as follows: benign: laparoscopic/robotic, 27.2%; laparotomy, 32.6%; vaginal, 40.2%; malignant: laparoscopic/robotic, 28.8%; laparotomy, 47.7%; vaginal, 23.5%. Bowel resection was performed in 0.4% of the benign and 2.8% of the malignant cohort. Type of bowel preparation was as follows: benign: none, 93.8%; mechanical bowel preparation only, 4.6%; oral antibiotics only, 1.1%; mechanical bowel preparation with oral antibiotics, 0.5%; malignant: none, 87.2%; mechanical bowel preparation only, 9.6%; oral antibiotics only, 1.8%; mechanical bowel preparation with oral antibiotics, 1.4%. Use of bowel preparation did not decrease rates of surgical site infections, anastomotic leaks, or major morbidity following benign or malignant hysterectomy. Among malignant abdominal hysterectomies, there was no difference in the rates of infectious morbidity between mechanical bowel preparation alone, oral antibiotics alone, or mechanical bowel preparation with oral antibiotics, compared to no preparation.

CONCLUSION: Bowel preparation does not protect against surgical site infections or major morbidity following benign or malignant hysterectomy, regardless of surgical approach, and may be safely omitted.

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Z9 7

U1 0

U2 2

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AU Matsuo, K

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TI Minimally invasive radical hysterectomy for early-stage cervical cancer:

Volume-outcome relationship in the early experience period

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Radical hysterectomy; Minimally invasive surgery;

Surgical volume; Volume outcome relationship; Complication

ID SURGICAL VOLUME; ASSOCIATION; SURVIVAL; SURGERY

AB Objective. Minimally invasive radical hysterectomy (MIS-RH) for early-stage cervical cancer is a relatively new surgical procedure with increased utilization in the mid-/late-2000s. This study examined the association between hospital surgical volume for MIS-RH and perioperative outcomes for early-stage cervical cancer in the period of early adoption.

Methods. This population-based retrospective study queried the National Inpatient Sample from 2007 to 2011. Cervical cancer cases treated with MIS-RH were examined (n = 2202 from 163 hospitals). Annualized hospital surgical volume was defined as the average number of procedures performed per year in which at least one case was performed. Characteristics and outcomes related to MIS-RH use were assessed. The comparator cohort included RH by laparotomy (Open-RH: n =11,187 from 405 hospitals).

Results. Among MIS-RH-offering centers, 42.3% had average 1 case/year and surgical volume of >4 cases/year represented the top decile. When stratified by MIS-RH types, on average 31.3 centers performed robotic-assisted approach per year versus 11.5 centers for the traditional approach. Small bed capacity centers were most likely to perform robotic-assisted RH (adjusted-odds ratio 4.07, P < 0.001). In the traditional MIS-RH group, higher hospital surgical volume was associated with lower surgical morbidity (P = 0.025) whereas in the robotic-assisted approach higher hospital surgical volume was associated with higher surgical morbidity (P < 0.001). In the OpenRH cohort, higher hospital surgical volume was significantly associated with decreased surgical morbidity and mortality (both, P < 0.001).

Conclusion. In the mid-/late-2000s, MIS-RH surgical volume was modest in the United States. Small bed capacity centers adopted robotic-assisted MIS-RH more frequently, and there was a statistically significant association of increased perioperative complications among higher volume centers. In contrast, higher surgical volume was associated with improved perioperative outcomes with the traditional MIS-RH and open-RH approaches. (C) 2020 Elsevier Inc. All rights reserved.

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PT J

AU Misal, M

Delara, R

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AF Misal, Meenal

Delara, Ritchie

Wasson, Megan N.

TI Cost-effective minimally invasive gynecologic surgery: emphasizing

surgical efficiency

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE healthcare costs; hysterectomy; surgical efficiency

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; OPERATING-ROOM TIME; VAGINAL CUFF

DEHISCENCE; OUTCOMES; SUTURE

AB Purpose of review The United States has the highest healthcare costs among developed countries. This review evaluates surgical practices and equipment choices during endoscopic hysterectomy, highlighting opportunities for the gynecologic surgeon to reduce costs and maximize surgical efficiency. Recent findings There are opportunities to economize at every step of the endoscopic hysterectomy. When surgeons are provided education about instrumentation costs, the cost of hysterectomy has been shown to decrease. Colpotomy has been found to be the rate-limiting step in laparoscopic hysterectomy; use of a uterine manipulator likely saves time and money. When evaluating the economic impact of route of surgery, the cost differential between laparoscopic and robotic-assisted hysterectomy has decreased. Robotic-assisted hysterectomy may be more cost-effective in some cases, such as for larger uteri. From a systems-level perspective, dedicating a specific operating room team to the gynecology service can decrease operative time. The gynecologic surgeon is best equipped to control surgery-related costs by making choices that improve surgical efficiency and decrease operating room time. If a costlier piece of equipment leads to a more efficient case, the choice may be more cost-effective. There are multiple systems-level changes that can be implemented to decrease surgery-related costs.

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Z9 4

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U2 2

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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PT J

AU Narducci, F

Bogart, E

Hebert, T

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Lambaudie, Eric

TI Severe perioperative morbidity after robot-assisted versus conventional

laparoscopy in gynecologic oncology: Results of the randomized

ROBOGYN-1004 trial

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Conventional laparoscopy; Gynecologic oncology; Morbidity; Randomized

phase III trial; Robot-assisted laparoscopy

ID SPARING RADICAL HYSTERECTOMY; LAPAROTOMY; CANCER; LYMPHADENECTOMY;

CLASSIFICATION; FEASIBILITY; EXPERIENCE; STANDARD; BENIGN; COST

AB Objective. In gynecologic oncology, minimally invasive surgery using conventional laparoscopy (CL) decreases the incidence of severe morbidity compared to open surgery. In 2005, robot-assisted laparoscopy (RL) was approved for use in gynecology in the US. This study aimed to assess whether RL is superior to CL in terms of morbidity incidence.

Methods. ROBOGYN-1004 (ClinicalTrials.gov, NCT01247779) was a multicenter, phase III, superiority randomized trial that compared RL and CL in patients with gynecologic cancer requiring minimally invasive surgery. Patients were recruited between 2010 and 2015. The primary endpoint was incidence of severe perioperative morbidity (severe complications during or 6 months after surgery).

Results. Overall, 369 of 385 patients were included in the as-treated analysis: 176 and 193 underwent RL and CL, respectively. The median operating time for RI. was 190 (range, 75-432) minutes and for CL was 145 (33-407) minutes (p < 0.001). The blood loss volumes for the corresponding procedures were 100 (0-2500) and 50 (0-1000) ml, (p = 0.003), respectively. The overall rates of conversion to open surgery for the corresponding procedures were 7% (10/176) and 5% (10/193), respectively (p - 052). Severe perioperative morbidity occurred in 28% (49/176) and 21% (41/192) of patients who underwent RL and CL, respectively (p = 0.15). At a median follow-up of 25.1 months (range, 0.6-78.2), no significant differences in overall and disease-free survival were observed between the groups.

Conclusions. RL was not found superior to CL with regard to the incidence of severe perioperative morbidity in patients with gynecologic cancer. In addition, RI involved a longer operating time than CL. (C) 2020 Elsevier Inc. All rights reserved.

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ER

PT J

AU Nobre, SP

Mueller, JJ

Gardner, GJ

Roche, KL

Brown, CL

Soslow, RA

Alektiar, KM

Sonoda, Y

Broach, VA

Jewell, EL

Zivanovic, O

Chi, DS

Abu-Rustum, NR

Leitao, MM

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Jewell, Elizabeth L.

Zivanovic, Oliver

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Leitao, Mario M., Jr.

TI Comparison of minimally invasive versus open surgery in the treatment of

endometrial carcinosarcoma

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE carcinosarcoma; gynecologic surgical procedures; postoperative

complications; surgical oncology; surgical procedures; operative

ID MIXED MULLERIAN TUMORS; UTERINE CARCINOSARCOMA; CANCER; SURVIVAL;

HYSTERECTOMY; LAPAROTOMY; WOMEN

AB Objective The aim of this study was to compare perioperative and oncologic outcomes between minimally invasive and open surgery in the treatment of endometrial carcinosarcoma. Methods We retrospectively identified all patients with newly diagnosed endometrial carcinosarcoma who underwent primary surgery via any approach at our institution from January 2009 to January 2018. Patients with known bulky disease identified on preoperative imaging were excluded. The chi(2)and Mann-Whitney U tests were used to compare categorical and continuous variables, respectively. Kaplan-Meier curves were used to estimate survival, and compared using the log rank test. Results We identified 147 eligible patients, of whom 37 (25%) underwent an open approach and 110 (75%) underwent minimally invasive surgery. Within the minimally invasive group, 92 (84%) of 110 patients underwent a robotic procedure and 14 (13%) underwent a laparoscopic procedure. Four minimally invasive cases (4%) were converted to open procedures. Median age, body mass index, operative time, stage, complication grade, and use of adjuvant treatment were clinically and statistically similar between groups. Median length of hospital stay in the open group was 4 days (range 3-21) compared with 1 day (range 0-6) in the minimally invasive group (p<0.001). The rates of any 30-day complication were 46% in the open and 8% in the minimally invasive group (p<0.001). The rates of grade 3 or higher complications were 5.4% and 1.8%, respectively (p=0.53). Median follow-up for the entire cohort was 30 months (range 0.4-121). Two-year progression-free survival rates were 52.8% (SE +/- 8.4) in the open group and 58.5% (SE +/- 5.1) in the minimally invasive group (p=0.7). Two-year disease-specific survival rates were 66.1% (SE +/- 8.0) and 81.4% (SE +/- 4.1), respectively (p=0.8). Conclusions In patients with clinical stage I endometrial carcinosarcoma, minimally invasive compared with open surgery was not associated with poor oncologic outcomes, but with a shorter length of hospital stay and a lower rate of overall complications.

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PT J

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TI Robotic-assisted laparoscopic splenectomy for recurrent ovarian cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE gynecology; ovarian cancer; spleen; postoperative care; surgical

procedures; operative

ID SECONDARY CYTOREDUCTION; SURGERY; FEASIBILITY; MANAGEMENT; SPLEEN

AB Purpose Recurrent ovarian cancer frequently involves the spleen. Our aims were to describe the technique of robotic-assisted laparoscopic splenectomy and to evaluate outcomes including progression-free and overall survival in patients who underwent this procedure for recurrent ovarian cancer. Methods Chart reviews were performed on all consecutive patients who underwent robotic splenectomy (April 2012 to May 2019) for recurrent ovarian cancer. Patients had <= 3 sites of disease and no ascites. Extent of disease was confirmed by positron emission tomography-computed tomography (PET-CT) pre-operatively and platinum-doublet chemotherapy was initiated post-operatively. Peri- and post-operative outcomes, progression-free survival, and overall survival were assessed. Two video links are included to demonstrate variations in technique and anatomy. Results A total of 10 patients were included. The median age was 63.5 years (range 46-74) and median body mass index was 30 kg/m(2)(range 21.5-40.1). Disease was limited to the spleen in seven patients and three had evidence of up to two other sites of disease on imaging. The median robotic splenectomy operative time was 159 min (range 112-214) that included laparoscopic lysis of adhesions prior to robotic port placement in seven cases, and excision of diaphragm or omental implants in three cases. There were no transfusions, laparotomy conversions, return to the operating room, abscesses, or pancreatic pseudocysts. The median length of stay was 2 days (range 1-4). The median time to resumption of chemotherapy was 40 days (range 25-78). After a median follow-up of 51 months (range 12-98), five patients had recurrence (two deaths, three alive with disease), with a median time to recurrence of 14 months (range 12-15). The median progression-free survival was 15 months (range 12-98) and the median overall survival was 51 months (range 12-98) post-splenectomy. Conclusions Robotic splenectomy was feasible, achieving complete cytoreduction of splenic recurrent ovarian cancer, short hospital length-of-stay, and acceptable morbidity.

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NR 24

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Z9 4

U1 0

U2 1

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Guevara, Magdalena Montt

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Falcone, Maria

Simoncini, Tommaso

TI Medium-term outcomes after robotic-assisted lateral suspension with mesh

for advanced multi-compartmental prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Abdominal lateral suspension; Anterior defect; Apical defect;

Multi-compartmental pelvic organ prolapse (POP); Robotic surgery

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC REPAIR; CONTINUOUS SERIES;

SACROCOLPOPEXY; CLASSIFICATION; METAANALYSIS; TERMINOLOGY; EROSION;

BOWEL

AB Introduction and hypothesis Robotic abdominal lateral suspension (RALS) is an innovative mini-invasive surgical technique that allows treating apical and anterior prolapse. The safety and efficacy of this strategy have not yet been tested. Methods We completed a prospective case series of 115 RALS to treat apical and anterior prolapse stage III or IV, with no or minimal (stage I) posterior defect. Clinical evaluation was performed with a simplified POP quantification system (POP-Q). Mean follow-up was 28 +/- 4 months. Primary outcomes were objective and subjective cure; secondary outcomes were reoperation rate for recurrence, erosion rate and complications. Objective cure was defined as POP-Q <= 1. Subjective cure was defined as absence of vaginal bulge. Patient's satisfaction was measured using the Patient Global Impression of Improvement Scale (PGI-I). Results There was a significant improvement in POP-Q score in all treated compartments with an objective cure rate of 88.7% for the anterior and 93.1% for the apical compartment (p < 0.0001). Subjective cure rate was 82%. The emergence of de novo high rectoceles was not significant in the cohort, as much as the development of de novo stress or urge urinary incontinence. Reoperation rate for POP was 11.3% (8 recurrent cystoceles without apical descent and 5 apical and anterior relapses). No postoperative complications of Clavien-Dindo grade >= 3a were seen. Mesh exposure rate was 0.9%; 58.2% patients compiled a PGI-I score at 18-24 months post-surgery, reporting high satisfaction rates. Conclusions RALS is highly effective at a mid-term follow-up for the treatment of advanced apical and anterior POP.

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TI The influence of learning curve of robot-assisted laparoscopy on

oncological outcomes in early-stage cervical cancer: an observational

cohort study

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Cervical cancer; learning curve; recurrence; risk-adjusted cumulative

sum analysis; robot-assisted laparoscopy; survival

ID OPEN RADICAL HYSTERECTOMY; SURVIVAL; SURGERY; COMPLICATIONS; EXPERIENCE;

DISEASE; TIME

AB Objective To investigate the learning curve of robot-assisted laparoscopy in early-stage cervical cancer and quantify impact on oncological outcomes. Design Observational cohort study. Setting Tertiary referral centre with one surgical team. Population All women with early-stage cervical cancer treated consecutively with robot-assisted laparoscopy between 2007 and 2017. Methods With multivariate risk-adjusted cumulative sum analysis (RA-CUSUM), we assessed the learning curve of robot-assisted laparoscopy of a single surgical team based on cervical cancer recurrence. Subsequently, a survival analysis was conducted comparing oncological outcomes of women treated during different phases of the learning curve. Main outcome measures Surgical proficiency based on recurrence, survival rates in the different learning phases. Results One hundred and sixty-five women with cervical cancer underwent robot-assisted laparoscopy, with a median follow up of 57 months (range 3-132 months). The RA-CUSUM analysis demonstrated two phases of the learning curve: a learning phase of 61 procedures (group 1) and an experienced phase representing the 104 procedures thereafter (group 2). The 5-year disease-free survival was 80.2% in group 1 and 91.1% in group 2 (P = 0.040). Both the 5-year disease-specific survival and overall survival significantly increased after the learning phase. Conclusion The learning phase of robot-assisted laparoscopy in early-stage cervical cancer in this institutional cohort is at least 61 procedures, with higher survival rates in the women treated thereafter. The learning curve of robot-assisted laparoscopy affects oncological outcomes and warrants more attention in the design of future studies. Tweetable abstract The learning curve of robot-assisted laparoscopy in early-stage cervical cancer affects oncological outcomes and warrants more attention.

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JI BJOG

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ER

PT J

AU Weishaupt, J

Saidi, S

Carter, J

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Saidi, Samir

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TI An Australian, single-centre study of surgical management outcomes for

early-stage cervical cancer

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE cervical cancer; minimally invasive surgery; laparotomy; recurrence

AB Background: The Laparoscopic Approach to Cervical Cancer (LACC) trial is the first phase III randomised, multicentred trial to compare oncologic outcomes associated with open radical hysterectomy vs minimally invasive surgery (MIS) for treatment of early cervical cancer.

Aim: To evaluate our surgical experience in patients with early cervical cancer.

Methods and Materials: The Lifehouse Gynaecologic Oncology database was queried based upon the eligibility criteria of the LACC study and included all FIGO 2009 stage (1A1 with lymph vascular space invasion, 1A2, 1B1) cervical cancer women from 2008-2018. Patients were also included in our study if they had abdominal radical trachelectomy (ART), laparoscopic radical hysterectomy (TLRH) and robotic radical trachelectomy (RRT).

Results: Forty-six women were identified with four exclusions. Thirty-seven women had stage 1B1 disease, 24 had a squamous cell carcinoma, 15 had an adenocarcinoma and three had an adenosquamous carcinoma of the cervix. Of the 42 eligible patients, 32 underwent an open abdominal approach (26 total abdominal radical hysterectomy (TARH), six ART) and ten a MIS approach (nine TLRH and one RRT) with a mean follow-up of 4.8 years. All 42 women had a pelvic lymph node dissection, eight women had nodal metastases and 16 patients received adjuvant chemoradiation. Two of the nine women in the laparoscopic radical hysterectomy group had a recurrence. Both had adenocarcinoma, stage 1B1 disease. There were no recurrences in the TARH group or radical trachelectomy groups.

Conclusion: Our data, albeit limited in number, have reflected the results of the LACC trial that MIS was associated with a lower disease-free survival than open radical hysterectomy.

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NR 20

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Z9 1

U1 0

U2 1

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JI Aust. N. Z. J. Obstet. Gynaecol.

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PT J

AU Yoo, HK

Cho, A

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Cho, Ahyoung

Cho, Eun H.

Kim, Soo J.

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Moon, Hye-Sung

TI Robotic single-site surgery in benign gynecologic diseases: Experiences

and learning curve based on 626 robotic cases at a single institute

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE feasibility; gynecology; robotic single-site surgery

ID HYSTERECTOMY; SACROCOLPOPEXY

AB Aim The purpose of this study was to report on 626 cases of successful robotic single-site (RSS) surgeries to address various types of gynecologic disease and to evaluate the outcomes and learning curve inherent to RSS surgery in the gynecology field. Methods A total of 626 cases of RSS surgeries were performed by 3 gynecologic surgeons at Ewha Womans University Medical Center, Robot Surgery Center from November 2014 to January 2018 were collected retrospectively. All of the patients' charts were reviewed, and the clinical characteristics and surgical variables were analyzed. Results Among the total of 626 cases, there were 220 cases of RSS myomectomy (RSSM), 182 cases of RSS hysterectomy (RSSH), 195 of RSS adnexectomy, 24 of RSS sacrocolpopexy (RSS SCP) and 5 were classified as other RSS surgeries. The patient's mean age was 38.98 +/- 10.07 years. There was 3.99 +/- 2.15 min of mean docking time and 117.78 +/- 51.18 min of mean operating time. The surgical variables were analyzed annually. The total operating time was seen to decrease significantly according to each period. The docking time declined significantly and gradually after 1 year. We also analyzed each of the surgical types by time. The operating time of RSSH, RSSM, RSS adnexectomy and RSS SCP fell over time. The tendency found was for operating time to decline sharply following the first 10 cases. When we analyzed the data at annual intervals, the operating time was most significantly less and stable following the first year. There were a few intraoperative or perioperative complications in 16 cases (2.6%). Conclusion Robotic single-site surgery is a feasible and safe procedure for treating various kinds of gynecologic diseases. The learning curve was approximately 10 cases of RSS surgery in gynecologic disease, having a greater amount of experience at performing RSS surgery was revealed to be key to achieving better surgical outcomes.

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NR 17

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Z9 6

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JI J. Obstet. Gynaecol. Res.

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ER

PT J

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TI Ureteric mapping with Indocyanine green: A new tool to prevent ureteral

injury in complex gynecological surgery

SO JOURNAL OF ENDOMETRIOSIS AND PELVIC PAIN DISORDERS

LA English

DT Article

DE Ureteric dissection; surgical treatment; Indocyanine green dye;

fluorescence; endometriosis; medical treatment

AB Introduction: The aim of this video is to show that ureteric injection of Indocyanine green dye in difficult gynecological operations is a useful tool to identify and safeguard ureters. Case description: A 56-year-old lady with a large 10.5 x 14.5 x 13 cm(3)multiloculated endometriotic cyst in the right adnexa was scheduled for robotic-assisted hysterectomy with bilateral salphingooophorectomy. She had undergone a laparotomy and three laparoscopic surgeries for endometriosis and fibroid uterus. Before starting surgery, cystoscopy was performed and with 6 Fr ureteral catheter inserted into ureteral orifice, 5 mL of 0.5% Indocyanine green dye (Aurolab, Madurai, India) was injected into both ureters. Intraoperatively bilateral adnexal cysts were seen densely adherent to omentum, sigmoid colon, sigmoid mesocolon, bladder, and lateral pelvic wall. Bladder and rectosigmoid were pulled up both anteriorly and posteriorly, respectively, and densely adherent to uterus and to adnexal cysts. During surgery, the course of ureter was identified by the green fluorescence emitted by the Indocyanine green dye under near-infrared light on da Vinci Xi camera. During this difficult surgery, the real-time visualization of ureteric course helped to identify and safeguard ureter during adhesiolysis and surgery could be completed without any injury to ureter. Patient did not experience any side effects due to the ureteric Indocyanine green injection. Conclusion: Endometriosis can distort the pelvic anatomy making surgery very challenging. Identifying the course of ureter during surgery can help in avoiding injuries and reduce surgical morbidity.

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U2 1

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J9 J ENDOMETR PELVIC PA

JI J. Endometr. Pelvic Pain Disord.

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WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

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GA NV7OZ

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ER

PT J

AU Bogani, G

Brusadelli, C

Guerrisi, R

Lopez, S

Signorelli, M

Ditto, A

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AF Bogani, Giorgio

Brusadelli, Claudia

Guerrisi, Rocco

Lopez, Salvatore

Signorelli, Mauro

Ditto, Antonino

Raspagliesi, Francesco

TI Gynecologic oncology at the time of COVID-19 outbreak

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE COVID-19; SARS-CoV-2; Gynecologic Oncology; Surgery

ID OVARIAN-CANCER; CERVICAL-CANCER; SURGERY; RISK; MULTICENTER; PREDICTORS;

DIAGNOSIS; SURVIVAL; OUTCOMES; WOMEN

AB The World Health Organization (WHO) classified the novel coronavirus (i.e., coronavirus disease 2019 [COVID-19]) as a global public health emergency. COVID-19 threatens to curtail patient access to evidence-based treatment. Medicine is changing, basically due to the limited available resources. In the field of gynecologic oncology, we have to re-design our treatments' paradigm. During COVID-19 pandemic outbreak, the highest priority is to achieve the maximum benefit from less demanding procedures. Extensive procedures should be avoided, in order to reduce hospitalization and postoperative events that might increase the in-hospital spread of the virus. There are ongoing concerns on the use of laparoscopic procedures, related to the possible contamination of the staff working in the operation room. Other minimally invasive techniques, including, vaginal surgery as well as robotic-assisted and isobaric procedures would be preferred over laparoscopy. A fair allocation of resources is paramount adequate treatments.

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NR 39

TC 19

Z9 21

U1 1

U2 9

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Hong, CSX

Halani, PK

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Harvie, HS

Arya, LA

Andy, UU

AF Hong, Christopher X.

Halani, Priyanka K.

Gutkind, Naomi

Harvie, Heidi S.

Arya, Lily A.

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TI Perioperative adverse events in women over age 65 undergoing

robot-assisted sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Clavien-Dindo complications; Older women; Perioperative complications;

Robotic sacrocolpopexy

ID PELVIC FLOOR DISORDERS; POSTOPERATIVE MORBIDITY; RECONSTRUCTIVE SURGERY;

OLDER WOMEN; COMPLICATIONS; PROLAPSE; OUTCOMES; PREVALENCE; MORTALITY

AB Introduction and hypothesis Pelvic floor disorders are common among and disproportionately affect older women. There are limited data regarding perioperative adverse events in older women undergoing robot-assisted sacrocolpopexy (RASC) specifically. The aim of this study was to compare the rate of perioperative adverse events in younger (age <65 years) versus older (age >65 years) women who underwent RASC. Methods We conducted a retrospective cohort study of women who underwent RASC between 2013 and 2018. Postoperative adverse events were categorized according to the Clavien-Dindo classification. Our primary outcome was the rate of intraoperative adverse events and postoperative adverse events with Clavien-Dindo grade II or greater. Outcomes were compared using univariate and multivariate analysis. Results Of the 327 patients included in the study, 227 were <65 years of age and 100 were >= 65 years of age. Women >= 65 years of age had higher rates of hypertension, higher American Society of Anesthesiologist (ASA) class, and higher Charlson Comorbidity Index (CCI) scores compared with women <65 years of age; these were not associated with increased likelihood of adverse events. The overall rate of any perioperative adverse event was 18.3%. There was no statistically significant difference in the overall rate of perioperative adverse events between younger and older women (18.5% vs 18.0%,p = 0.91). Conclusions There is no difference in rate of adverse events between women >= 65 years of age undergoing RASC and their younger counterparts.

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NR 32

TC 2

Z9 2

U1 0

U2 0

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PG 8

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA ME0LT

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ER

PT J

AU Moss, EL

Sarhanis, P

Ind, T

Smith, M

Davies, Q

Zecca, M

AF Moss, Esther L.

Sarhanis, Panos

Ind, Thomas

Smith, Michael

Davies, Quentin

Zecca, Massimiliano

TI Impact of Obesity on Surgeon Ergonomics in Robotic and Straight-Stick

Laparoscopic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Straight-stick laparoscopic surgery; Robotic-assisted surgery; Obesity;

Ergonomics; Work-related musculoskeletal symptoms

ID MINIMALLY INVASIVE SURGERY; POSTURAL ERGONOMICS; DISCOMFORT; PAIN; NEED

AB Study Objective: Work-related musculoskeletal symptoms (WMSs) are reported to be increasing in surgeons performing minimally invasive procedures. Therefore, we investigated the use of inertial measurement units (IMUs) and electromyography (EMG) sensor recorders to record real-time information on the muscle movement/activity required to perform training exercises in simulated in normal and high body mass index (BMI) models.

Design: Prospective study.

Setting: University hospital.

Participants: Four consultant gynecologic oncology surgeons experienced in complex straight-stick (SS) laparoscopic and robotically assisted (RA) surgery.

Interventions: Three exercises (hoops onto pegs and wire chase) using SS and RA surgery on 2 abdominal models: normal BMI and high BMI.

Measurements and Main Results: We measured time to complete exercise and surgeon muscle movement/activity. The time to complete all exercises was significantly lower for RA surgery as compared with SS laparoscopy (p <.05 or better). The movement of the surgeons' core was significantly greater in high BMI SS laparoscopy compared with normal BMI SS laparoscopy for exercises 1 and 2 (p <.001). Muscle usage, as determined by EMG peak, was significantly higher in normal BMI SS laparoscopy and even higher in high BMI SS laparoscopy but was generally flat for all normal and high BMI RA surgery exercises (p <.05 or better).

Conclusion: Detailed real-time information can be collected through IMUs/EMG sensors. Our results indicate that RA surgery requires less surgeon movements and muscle activity to complete tasks compared with SS laparoscopy, particularly in a high BMI model. The implications of these results are that RA surgery in high BMI patients may therefore have less physical impact on the surgeon compared with SS laparoscopy and may result in lower WMS rates. (C) 2019 AAGL. All rights reserved.

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NR 29

TC 21

Z9 21

U1 0

U2 6

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Koops, SES

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Verheijen, Paul M.

Broeders, Ivo A. M. J.

Consten, Esther C. J.

Lenters, Egbert

Koops, Steven E. Schraffordt

TI Long-term mesh erosion rate following abdominal robotic reconstructive

pelvic floor surgery: a prospective study and overview of the literature

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Erosion; Mesh exposure; Pelvic organ prolapse; Robotic; Sacrocolpopexy;

Sacrocolporectopexy

ID QUALITY-OF-LIFE; LAPAROSCOPIC SACRAL COLPOPEXY; VAGINAL VAULT PROLAPSE;

RANDOMIZED CONTROLLED-TRIAL; ORGAN PROLAPSE; ASSISTED SACROCOLPOPEXY;

SUPRACERVICAL HYSTERECTOMY; ANATOMIC OUTCOMES; FASCIA LATA; MANAGEMENT

AB Introduction and hypothesis The use of synthetic mesh in transvaginal pelvic floor surgery has been subject to debate internationally. Although mesh erosion appears to be less associated with an abdominal approach, the long-term outcome has not been studied intensively. This study was set up to determine the long-term mesh erosion rate following abdominal pelvic reconstructive surgery. Methods A prospective, observational cohort study was conducted in a tertiary care setting. All consecutive female patients who underwent robot-assisted laparoscopic sacrocolpopexy and sacrocolporectopexy in 2011 and 2012 were included. Primary outcome was mesh erosion. Preoperative and postoperative evaluation (6 weeks, 1 year, 5 years) with a clinical examination and questionnaire regarding pelvic floor symptoms was performed. Mesh-related complications were assessed using a transparent vaginal speculum, proctoscopy, and digital vaginal and rectal examination. Kaplan-Meier estimates were calculated for mesh erosion. A review of the literature on mesh exposure after minimally invasive sacrocolpopexy was performed (>= 12 months' follow-up). Results Ninety-six of the 130 patients included (73.8%) were clinically examined. Median follow-up time was 48.1 months (range 36.0-62.1). Three mesh erosions were diagnosed (3.1%; Kaplan-Meier 4.9%, 95% confidence interval 0-11.0): one bladder erosion for which mesh resection and an omental patch interposition were performed, and two asymptomatic vaginal erosions (at 42.7 and 42.3 months) treated with estrogen cream in one. Additionally, 22 patients responded solely by questionnaire and/or telephone; none reported mesh-related complaints. The literature, mostly based on retrospective studies, described a median mesh erosion rate of 1.9% (range 0-13.3%). Conclusions The long-term rate of mesh erosion following an abdominally placed synthetic graft is low.

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NR 91

TC 13

Z9 14

U1 1

U2 6

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PG 11

WC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU Guo, XM

Runge, M

Miller, D

Aaby, D

Milad, M

AF Guo, Xiaoyue Mona

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Miller, Deborah

Aaby, David

Milad, Magdy

TI A bundled intervention lowers surgical site infection in hysterectomy

for benign and malignant indications

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Hysterectomy; Minimally invasive surgery; Patient care bundles;

Postoperative complications; Quality improvement; Surgical site

infection

ID SURGERY; PREVENTION; OUTCOMES; REDUCE

AB Objective To evaluate the impact of a surgical site infection (SSI) prevention bundle on SSI rates after hysterectomy for benign and malignant indications at an urban academic medical center. Methods The bundled invention was implemented for all abdominal gynecologic surgeries at Prentice Women's Hospital, Chicago, USA, from August 2016 to January 2017, and officially incorporated in department-wide policy from February 1, 2017. SSI data were prospectively collected for any open, vaginal, laparoscopic, or robotic hysterectomy for benign or malignant indications performed from February 2017 to January 2018. A retrospective review of all hysterectomies performed from February 2015 to January 2016 was conducted to establish baseline pre-bundle SSI data. Results Among 532 hysterectomies performed post-bundle implementation, there were two SSIs. By contrast, there were 14 SSIs among 515 hysterectomies in the same period before bundle implementation, representing a decrease in SSI rate from 2.7% to 0.4% (odds ratio, 7.41; 95% confidence interval, 1.67-32.75). The two SSIs in the post-bundle period occurred in open hysterectomies, whereas 8 (57.1%) SSIs in the pre-bundle period occurred in minimally invasive hysterectomies. Conclusion An SSI prevention bundle was effective for reducing the SSI rate in hysterectomy for both benign and malignant indications.

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NR 25

TC 7

Z9 8

U1 0

U2 7

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JI Int. J. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

AU Gracia, M

García-Santos, J

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TI Value of robotic surgery in endometrial cancer by body mass index

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Body mass index; Endometrial cancer; Laparoscopic surgery; Minimally

invasive surgery; Obesity; Overweight; Robotic surgery

ID PERIOPERATIVE OUTCOMES; CONVENTIONAL-LAPAROSCOPY; MANAGEMENT;

LAPAROTOMY; IMPACT; OBESE; LYMPHADENECTOMY; CARCINOMA; COSTS

AB Objective To compare perioperative outcomes and complications in robotically assisted laparoscopy (RAL) and standard laparoscopy (SLP) approaches in the treatment of endometrial cancer by body mass index (BMI, calculated as weight in kilograms divided by the square of height in meters). Methods A comparative study was carried out of women treated for endometrial cancer at the Hospital Clinico San Carlos from January 2012 to December 2016: 133 patients were operated by RAL and 101 by SLP. Demographic characteristics of the patients, perioperative outcomes and complications were compared in both approaches. Results Hospital stay was significantly lower in patients with BMI <= 30 operated with RAL (2 days RAL vs 4 days SLP;P=0.002). Estimated blood loss was significantly lower in the group with BMI<25 (60 mL RAL vs 100 mL SLP;P=0.004) and in the group with BMI >= 30 (87.5 mL RAL vs 180 SLP;P=0.003) operated with RAL. RAL significantly reduced the conversion rate in patients with BMI >= 30 (2 [3.4%] patients RAL vs 6 [27.3%] patients SLP;P=0.004). Conclusions RAL has demonstrated advantages in treating obese women with endometrial cancer by reducing blood loss and conversion to laparotomy.

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NR 26

TC 10

Z9 10

U1 0

U2 2

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Wherley, SD

Chapman, GC

Mahajan, ST

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Slopnick, EA

Roberts, K

El-Nashar, S

AF Wherley, Susan D.

Chapman, Graham C.

Mahajan, Sangeeta T.

Hijaz, Adonis K.

Slopnick, Emily A.

Roberts, Kasey

El-Nashar, Sherif

TI Evaluation of the ACS NSQIP surgical risk calculator in patients

undergoing pelvic organ prolapse surgery

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Complication; NSQIP; Postoperative; Prolapse

AB Introduction and hypothesis The purpose of this study was to evaluate the accuracy of the American College of Surgeons National Surgery Quality Improvement Program (ACS NSQIP) surgical risk calculator in predicting postoperative complications in patients undergoing pelvic organ prolapse surgery. Methods We performed a retrospective review of 354 patients who underwent surgery for pelvic organ prolapse from 2013 to 2017 at a single academic institution. Patient medical information and surgical procedure were entered into the calculator to obtain predicted complication rates, which were compared with observed complications. Logistic regression, C-statistic, and Brier score were used to assess the accuracy of the calculator. Results Of 354 patients included in the analysis, 79.7% were under the age of 75, and 41.5% were classified as American Society of Anesthesiologists class >= 3. The majority of patients underwent robotic sacrocolpopexy (40.7%) or uterosacral ligament suspension (36.4%), followed by colpocleisis, abdominal sacrocolpopexy, and extraperitoneal suspension. Complications were experienced by 100 patients (28.3%). Most common complications were urinary tract infection (n = 57), surgical site infection (n = 42), and readmission (n = 16); other complications were rare. The surgical risk calculator displayed poor predictive ability for experiencing a complication (C-statistic = 0.547, Brier score = 0.25). Conclusions The NSQIP surgical risk calculator displayed poor predictive ability in our cohort of patients undergoing surgery for pelvic organ prolapse, suggesting that this tool might have limited clinical applicability to individual patients in this population.

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NR 10

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Z9 1

U1 0

U2 0

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WC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU Kaya, C

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Cengiz, H

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Baghaki, HS

Yasar, L

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Alay, Ismail

Cengiz, Huseyin

Yildiz, Gunes Ozlem

Baghaki, Hayriye Sema

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TI Comparison of hysterectomy cases performed <i>via</i> conventional

laparoscopy or vaginally assisted natural orifice transluminal

endoscopic surgery: a paired sample cross-sectional study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE hysterectomy; laparoscopy; natural orifice surgery

ID OUTCOMES

AB Hysterectomy is one of the most frequent gynaecological procedures performed for various uterine pathologies. There are several approaches for conducting hysterectomies, including abdominal, vaginal, laparoscopic and robotic. Recently, natural orifices transluminal endoscopic surgery (NOTES) has emerged as an alternative approach for conducting hysterectomies. In this study, we aimed to compare the results of total laparoscopic hysterectomy (TLH) and vaginally assisted-NOTES (vNOTES) hysterectomy procedures for the treatment of benign gynaecological diseases. Ninety-nine patients, who underwent conventional TLH or vNOTES hysterectomies, were included in this study. The operation time, presence of per/postoperative complications, visual analogue scale (VAS) scores at postoperative sixth and 24th hours, and the duration of hospital stays were all analysed. The duration of surgery was significantly shorter in the vNOTES hysterectomy group (79.56 +/- 32.54 min) compared to the TLH group (120.67 +/- 38.35 min) (p: < .001). Also, postoperative hospital stays were significantly shorter in favour of the vNOTES hysterectomy group (44 +/- 16.47 h) compared to the TLH group (57.86 +/- 21.31 h) (p: .002). These results indicate that vNOTES hysterectomy can be a promising approach for treating a variety of different uterine pathologies and, furthermore, that it can be an alternative to TLH.Impact statement What is already known on this subject?A hysterectomy can be done in a variety of different ways, such as abdominal, laparoscopic, vaginal, and robotic. Even though the standard practice guidelines recommend that a vaginal hysterectomy (VH) should be the first choice of treatment, it can be challenging in cases of non-descendent and large uteruses. In such cases, NOTES hysterectomy can be an alternative option. What do the results of this study add?The study has shown that vNOTES is associated with a shorter operation and briefer postoperative hospitalisation time, in comparison to TLH. What are the implications of these findings for clinical practice and/or further research?This study speculates that vNOTES is an approach which may offer better outcomes than a conventional laparoscopy. Further randomised controlled trials with larger sample sizes, however, should be conducted in order to establish the place of vNOTES in hysterectomy surgeries.

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U1 0

U2 2

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DA 2024-01-18

ER

PT J

AU Lee, HJ

Lee, JS

Lee, YS

AF Lee, Hyun Jung

Lee, Ji Sun

Lee, Yoon Soon

TI Comparison of serum antimullerian hormone levels after robotic-assisted

vs. laparoscopic approach for ovarian cystectomy in endometrioma

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrioma; antimullerian hormone; Robot; Laparoscopy

ID ANTI-MULLERIAN HORMONE; FOLLICLE GROWTH; EXCISION; RESERVE; CYSTS;

DECLINE; MARKER; MOUSE

AB Objective: Serum antimullerian hormone (sAMH) is regarded as a useful marker in predicting for ovarian functional reserve. To evaluate whether postoperative change in ovarian reserve differs between robotic-assisted and laparoscopic single-site ovarian cystectomy in patients with ovarian endometrioma by comparing sAMH levels.

Study design: The perioperative outcomes in 94 patients with ovarian endometrioma who underwent robotic assisted (n = 40) or laparoscopic (n = 54) cystectomy were compared retrospectively. The sAMH levels were measured by enzyme immunoassay preoperatively and at 3 months and 6 months after surgery. The difference and ratio of sAMH levels between preoperative and 3 months, 6 months after cystectomy were compared between robotic-assisted and laparoscopic approach for predicting which method is better for preservation of ovarian function.

Result(s): The sAMH levels were obviously decreased after the surgery (ratio of sAMH levels between preoperative and 3 months, 0.49 +/- 0.46 versus 0.52 +/- 0.28 ng/mL, mean +/- standard deviation) in both groups. There was no difference of the recovery sAMH level at 6 months (ratio of 6 months sAMH to preoperative sAMH level) after cystectomy in unilateral ovarian cystectomy. However, in patients with bilateral endometrioma, the recovery of sAMH level was higher in robotic assisted approach than those of laparoscopic surgery (0.40 +/- 0.24 versus 0.21 +/- 0.23, p = 0.009). In multivariate linear regression analysis, the coefficient of robot surgery was 0.442 (p = 0.028).

Conclusion(s): In our study, robotic-assisted cystectomy had higher preservation of ovarian function than the laparoscopic approach for bilateral ovarian endometrioma, but not for unilateral endometrioma. The robotic-assisted approach could be considered for preserving ovarian function in patients with bilateral ovarian endometrioma. (C) 2020 Elsevier B.V. All rights reserved.

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Z9 10

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

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Hua, KQ

AF Li, Chunbo

Hua, Keqin

TI The current status of sacrocolpopexy in the management of apical

prolapse

SO MINERVA GINECOLOGICA

LA English

DT Review

DE Pelvic organ prolapse; Minimally Invasive surgical procedures; Surgery

ID TRANSLUMINAL ENDOSCOPIC SURGERY; SACROSPINOUS LIGAMENT FIXATION;

ABDOMINAL SACROCOLPOPEXY; LAPAROSCOPIC SACROCOLPOPEXY; MCCALL

CULDOPLASTY; ASSISTED SACROCOLPOPEXY; VAGINAL HYSTERECTOMY; OUTCOMES;

SEGMENT

AB Pelvic organ prolapse (POP) is a prevalent condition that negatively affects women's quality of life. There is growing recognition that adequate support for the vaginal apex is an important component of a durable surgical repair for women with advanced prolapse, including the anterior and posterior wall prolapse. Surgical treatment options include abdominal and vaginal approaches, the former of which can be performed open, laparoscopically, and robotically. Sacrocolpopexy is a common procedure designed for the treatment of prolapse including uterine or vaginal vault prolapse and multiple-compartment prolapse. Although traditionally performed as an open abdominal procedure, minimally invasive sacrocolpopexy, whether laparoscopic or robotic, has been successfully performed in the clinical practice by many pelvic reconstructive surgeons. In order to require an outstanding cosmetic result, transumbilical/transvaginal single-port sacrocolpopexy has been developed to achieve the goal and initial outcomes have demonstrated their efficacy, safety and feasibility. However, up to date, there are many variations to these procedures, with different levels of evidence to support each of them. Herein we reviewed the current literatures on current surgical choices for women with apical prolapse.

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JI Minerva Ginecol.

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ER

PT J

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As-Sanie, S

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Griffith, Kendall C.

Travieso, Jennifer

As-Sanie, Sawsan

TI To Robot or Not To Robot: The Use of Robotics in Benign Gynecologic

Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic surgery; robotics; gynecology; minimally invasive surgery

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY; TERM OUTCOMES;

SACROCOLPOPEXY; ENDOMETRIOSIS; HYSTERECTOMY; PROLAPSE; METAANALYSIS

AB The use of robotic-assisted laparoscopic surgery has continued to grow since the Food and Drug Administration approval for robotic-assisted gynecologic surgery in 2005. However, despite this growth in utilization, the data supporting its use in benign gynecologic surgery has not strongly supported its advantages over conventional laparoscopy. Controversy exists between supporters of robotic-assisted laparoscopic surgery and conventional laparoscopy. This article discusses the current literature regarding the use of robotic-assisted surgery in benign gynecologic surgery.

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U2 6

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PT J

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Kuo, DY

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Goldberg, Gary L.

Nevadunsky, Nicole S.

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Van Arsdale, Anne R.

TI Risk factors associated with delayed discharge following robotic

assisted surgery for gynecologic malignancy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic assisted surgery; Gynecologic malignancy; Delayed discharge;

Diverse urban population; Pre-hospitalization risk stratification;

Post-operative length of stay

ID ENDOMETRIAL CANCER; HYSTERECTOMY; LAPAROTOMY; LAPAROSCOPY; SURVIVAL;

OUTCOMES; LENGTH; STAY; COST

AB Background. The risk factors for extended length of stay (LOS) have not been examined in a cohort of patients with complex social and medical barriers who undergo robotic assisted (RA) surgery for gynecologic malignancies. We sought to identify those patients with a LOS > 24 h after robotic surgery and the risk factors associated with delayed discharge. Then we aimed to develop a predictive model for clinical care and identify modifiable pre-operative risk factors.

Methods. After IRB approval, data was abstracted from medical records of all patients with a gynecologic malignancy who underwent a RA laparoscopic surgery from 2010 to 2015. Univariable and multivariable logistic regression was performed to identify independent risk factors associated with delayed discharge defined as LOS > 24 h. A multi-variable logistic regression model was performed using a stepwise backward selection for the final prediction model. All testing was two-sided and a p-value < 0.05 was considered statistically significant.

Results. Of the 406 eligible and evaluable patients, 194 (48%) had a LOS > 24 h. Age >= 60 years, a higher usage of narcotic medication, a longer surgical time, and a larger estimated blood loss were all associated with LOS > 24 h (p < 0.05). Many of these women had a social work consultation and went home with home care services despite no surgical or post-operative complications. Our prediction model has the potential to correctly classified 75% of the patients discharged within 24 h.

Conclusions. The development of a pre-hospitalization risk stratification and anticipating the possible need for home care services pre-operatively shows promise as a strategy to decrease LOS in patients classified as high-risk. These findings warrant prospective validation through the use of this prediction model in our institution. Published by Elsevier Inc.

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ER

PT J

AU Rusch, P

Kimmig, R

AF Rusch, Peter

Kimmig, Rainer

TI Robotics - "smart medicine" in minimally invasive gynecological surgery

SO GYNAKOLOGE

LA German

DT Article

DE Laparoscopy; Ergonomics; Artificial intelligence; Quality control;

Advanced training

ID GLOBAL EVALUATIVE ASSESSMENT; LEARNING-CURVE; DA VINCI; LAPAROSCOPY;

SKILLS; LYMPHADENECTOMY; HYSTERECTOMY; TECHNOLOGY; VALIDATION; CANCER

AB Robotic-assisted procedures are increasingly being applied in minimally invasive surgery. Ease of learning, intuitive use, optimized ergonomics and an interface for the implementation of artificial intelligence (AI) expand the possibilities of classical straight stick laparoscopy to a larger group of patients and make it fit for the future. Education and training are carried out according to new didactic principles, so that comparable scientifically valid treatment results can be expected. Competitive robotic systems promise further progress and a cost reduction is to be expected. Robotic-assisted surgery is becoming part of routine surgery.

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Z9 1

U1 0

U2 5

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J9 GYNAKOLOGE

JI Gynakologe

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PT J

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Scambia, Giovanni

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TI Real three-dimensional approach vs two-dimensional camera with and

without real-time near-infrared imaging with indocyanine green for

detection of endometriosis: A case-control study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE endometriosis; endometriosis surgical treatment; indocyanine green;

minimally invasive surgery; near-infrared radiation

ID SEGMENTAL RESECTION; FLUORESCENCE; CLASSIFICATION; SURGERY

AB Introduction The complete surgical removal of endometriosis lesions is not always feasible because some implants may be very small or hidden. The use of intraoperative near-infrared radiation (NIR) imaging after intravenous injection of indocyanine green (ICG) coupled with robotic technical advances, including 3-dimensional (3D) and high-resolution vision, might improve detection rates.

Material and methods This is a retrospective, multicenter case-control study (Canadian Task Force classification II-2) on medical records of women with endometriosis who underwent surgery at the Catholic University of Rome (Controls) and the University of Bologna (Cases) between January 2016 and March 2018. Surgical and post-surgical data from the procedures were collected. We compared the visual detection rate of endometriotic lesions using near-infrared radiation imaging after intravenous injection of indocyanine green (NIR-ICG) in Real 3D (Cases) with the 2D Camera approach (Controls) in symptomatic women with pelvic endometriosis.

Results Twenty cases were matched as closely as possible with 27 controls. The numbers of suspected lesions identified both with the white light and the NIR-ICG approach were 116 and 70 in the Controls (2D) and Cases (3D), respectively. Among them, 16 of 116 controls (13.8%) and 12 of 70 cases (17.1%) were identified using only NIR-ICG imaging and collected as occult lesions (P = .536). The overall NIR-ICG lesion identification showed a positive predictive value of 97.8%, negative predictive value of 82.3%, sensitivity of 82.0%, and specificity of 97.9% for the Control group, and a positive predictive value of 100%, negative predictive value of 97.1%, sensitivity of 97.1%, and specificity of 100% for the Case group, confirming that NIR-ICG imaging is a good diagnostic and screening test (P = .643 and P = .791, according to the Cohen kappa tests, respectively for the laparoscopic and robotic groups).

Conclusions The few differences observed did not seem to be clinically relevant, making the 2 procedures comparable in terms of the ability to visually detect endometriotic lesions. Further prospective trials are needed to confirm our results.

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U1 0

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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PT J

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TI Short-term outcomes of robot-assisted versus conventional laparoscopic

surgery for early-stage endometrial cancer: A retrospective,

single-center study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE complication; early-stage endometrial cancer; laparoscopic surgery;

learning curve; robotic surgery

ID MINIMALLY INVASIVE HYSTERECTOMY; LYMPHADENECTOMY; LAPAROTOMY;

MANIPULATOR; MANAGEMENT; OBESITY; IMPACT

AB Aim We compared the short-term outcomes between conventional laparoscopic surgery (CLS) and robot-assisted surgery (RAS) to assess the technical feasibility of the latter for early-stage endometrial cancer.

Methods We retrospectively compared the perioperative outcomes between two groups of 223 patients (CLS group, n = 102; RAS group, n = 121) with early-stage endometrial cancer. Surgical procedures included hysterectomy, bilateral salpingo-oophorectomy and retroperitoneal lymphadenectomy. We analyzed the data from intrapelvic surgery alone because para-aortic lymphadenectomy was performed via conventional endoscopic extraperitoneal approach without robot for both groups.

Results No differences were identified in patients' age and body mass index. The mean operative time was 133 +/- 28 versus 178 +/- 41 min (P < 0.01), mean blood loss was 196 +/- 153 versus 237 +/- 146 mL (P = 0.047), mean length of postoperative hospital stay was 9 +/- 4 versus 8 +/- 3 days (P = 0.01) and mean rate of perioperative complications of Clavien-Dindo grade III or higher was 2.0 versus 3.4% (P = 0.53) for the CLS versus RAS groups, respectively. There was no significant difference in the number of resected lymph nodes.

Conclusion The operative time was significantly longer and blood loss was significantly greater in the RAS group than in the CLS group, without a significant difference in the number of resected lymph nodes. These differences are within an acceptable clinical range, showing that RAS is feasible and safe for early-stage endometrial cancer, providing short-term outcomes comparable to those of conventional surgery. Future studies are warranted to compare the long-term oncological outcomes by extending the observation period and including para-aortic lymphadenectomy data.

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PT J

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Tewari, KS

AF Clair, Kiran H.

Tewari, Krishnansu S.

TI Robotic surgery for gynecologic cancers: indications, techniques and

controversies

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE gynecologic cancer; minimally invasive surgery; robotic surgery;

sentinel lymph node

ID SENTINEL LYMPH-NODE; TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL

CANCER; RADICAL HYSTERECTOMY; NEOADJUVANT CHEMOTHERAPY; CERVICAL-CANCER;

UTERINE MANIPULATOR; OVARIAN-CANCER; SURVIVAL; CARCINOMA

AB Minimally invasive surgery for gynecologic cancers is associated with fewer postoperative complications including less blood loss and quicker recovery time compared to traditional laparotomy. The robotic platform has allowed patients access to minimally invasive surgery due to its increased utilization by gynecologic oncologists. Many surgeons have embraced the robotic platform due to its technological advances over traditional laparoscopy including high-definition 3D optics, wristed instrumentation, camera stability and improved ergonomics. While robotic surgery continues as a mainstay in the management of gynecologic cancers, it remains controversial in regards to its cost effectiveness and more recently, its long-term impact on clinical and oncologic outcomes. A strong component of the justification of this surgical platform is based on extrapolated data from traditional laparoscopy despite limited prospective randomized trials for robotic-assisted surgery. In this review, we highlight the use of robotic surgery in the management of gynecologic cancers in special populations: fertility sparing patients, the morbidly obese, the elderly, and patients with a favorable response to neoadjuvant chemotherapy.

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Grijalva, CG

Alvarez, RD

Shu, XO

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Grijalva, Carlos G.

Alvarez, Ronald D.

Shu, Xiao-Ou

TI Survival outcomes for robotic-assisted laparoscopy versus traditional

laparoscopy in clinical stage I epithelial ovarian cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE FDA; gynecologic oncology; minimally invasive surgery; NCDB; surgical

oncology

ID PERIOPERATIVE OUTCOMES; FALLOPIAN-TUBE; MANAGEMENT; FEASIBILITY;

SURGERY; SAFETY

AB BACKGROUND: The US Food and Drug Administration recently called for studies addressing long-term survival after robotic-assisted laparoscopy in oncologic settings. Long-term clinical outcomes of robotic assisted laparoscopy among ovarian cancer patients are understudied.

OBJECTIVE(S): To investigate the long-term mortality of robotic assisted laparoscopy compared to traditional laparoscopy for clinical stage I epithelial ovarian cancer.

MATERIALS AND METHODS: Using data from the National Cancer Database, we identified a total of 1901 patients who received minimally invasive surgery (ie, robotic-assisted laparoscopy or traditional laparoscopy) for clinical stage I epithelial ovarian cancer between 2010 and 2014. Multivariable logistic or linear regression analyses were conducted to evaluate the short-term outcomes, including conversion-to-open surgery, number of lymph nodes examined, length of hospitalization, unplanned 30-day readmission, and 30- and 90-day mortality. Multivariable Cox proportional hazards models were used to derive adjusted hazard ratios and 95% confidence intervals for 1-, 3-, and 5-year total mortality associated with surgical approaches. Covariates adjusted for included age, tumor size and upstaging, number of lymph nodes evaluated, time from diagnosis to surgery, length of hospitalization, histologic subtype, insurance status, region, distance to care, surgical procedure type, and hospital experience with these procedures.

RESULTS: Compared to traditional laparoscopy, robotic-assisted laparoscopy was less likely to result in conversion-to-open surgery (conversion rate: 7.2% versus 17.9%, P <.001; adjusted odds ratio, 0.49; 95% confidence interval, 0.33-0.73). In multivariable analyses, there were no significant differences in survival between robotic-assisted laparoscopy and traditional laparoscopy treated patients. Compared with traditional laparoscopy, the adjusted hazard ratios for 1-, 3-, and 5-year mortality were 0.97 (95% confidence interval, 0.43-2.18), 0.68 (95% confidence interval, 0.43-1.08), and 0.78 (95% confidence interval, 0.53-1.16), respectively.

CONCLUSION(S): Robotic-assisted laparoscopy had comparable overall mortality in comparison to traditional laparoscopy when treating clinical stage I epithelial ovarian cancer.

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CA SERGS Council

TI Robot assisted surgery during the COVID-19 pandemic, especially for

gynecological cancer: a statement of the Society of European Robotic

Gynaecological Surgery (SERGS)

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robot Assisted Surgery; COVID-19; Personal Protective Equipment

AB All surgery performed in an epicenter of the coronavirus disease 2019 (COVID-19) pandemic, irrespective of the known or suspected severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) status of the patient, should be regarded as high risk and protection of the surgical team at the bedside should be at the highest level. Robot assisted surgery (RAS) may help to reduce hospital stay for patients that urgently need complex-oncological-surgery, thus making room for COVID-19 patients. In comparison to open or conventional laparoscopic surgery, RAS potentially reduces not only contamination with body fluids and surgical gasses of the surgical area but also the number of directly exposed medical staff. A prerequisite is that general surgical precautions under COVID-19 circumstances must be taken, with the addition of prevention of gas leakage:

Use highest protection level III for bedside assistant, but level II for console surgeon.

Reduce the number of staff at the operation room.

Ensure safe and effective gas evacuation.

Reduce the intra-abdominal pressure to 8 mmHg or below.

Minimize electrocautery power and avoid use of ultrasonic sealing devices.

Surgeons should avoid contact outside theater (both in and out of the hospital).

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U1 0

U2 26

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AF Matern, Tyson

Kang, Elizabeth

Lim, Peter C.

TI Factors in the feasibility and safety of outpatient robotic-assisted

hysterectomy for endometrial or cervical carcinoma

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic hysterectomy; Gynecologic oncology; Cervical cancer; Endometrial

cancer; Outpatient

ID SAME-DAY DISCHARGE; LAPAROSCOPIC HYSTERECTOMY; POSTOPERATIVE NAUSEA;

RISK-FACTORS; OPIOID USE; SURGERY; LAPAROTOMY; MANAGEMENT; CANCER; COSTS

AB Objective. Identify factors influencing the feasibility and safety of outpatient robotic-assisted hysterectomy for endometrial or cervical carcinoma.

Methods. A single-institution retrospective chart review of patients who underwent robotic hysterectomy for cervical or endometrial cancer between 2012 and 2016 was performed. Outcomes were measured by length of stay (LOS), which was categorized as an admit-to-discharge time of >12 h or <12 h. Past medical history, surgical history, social history, patient demographics, intraoperative course, and postoperative events were examined as possible factors associated with LOS >12 h. These factors were evaluated using multivariate logistic regression. Readmission rates were compared between the two groups using an independent-samples t-test.

Results. Of the 254 patients, 150 (59.1%) had a LOS >12 h and 104 (40.9%) had a LOS < 12 h. The factors associated with a LOS >12 h (p <0.05) included: Postoperative emesis, inadequate pain control, operating room (OR) time > 180 min, uterine mass > 150 g, start time after 15:00, history of venous thromboembolism (VIE), age > 75 years, body mass index (BMI) 35-40, and post-operative VIE formation. Patients discharged in <12-hours were not more likely than those discharged in >12-hours to be re-admitted (p = 0.92).

Conclusions. Robotic hysterectomy for the treatment of endometrial and cervical carcinoma is both feasible and safe in the outpatient setting, as >40% of patients were successfully discharged within 12 h with no increase in readmission. Multiple risk factors were identified for extended hospitalization, offering potential for the development of a risk stratification model to improve the efficacy of outpatient robotic hysterectomy. (C) 2020 Published by Elsevier Inc.

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PT J

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TI Outcomes of minimally invasive surgery for patients with endometrial

carcinoma involving the cervix

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE uterine cancer; laparoscopes; laparotomy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; LYMPHOVASCULAR SPACE INVASION; TOTAL

ABDOMINAL HYSTERECTOMY; DISEASE-FREE; SURVIVAL; CANCER; WOMEN;

RECURRENCE; PATTERNS; RISK

AB Objective

Most studies evaluating the oncologic safety of minimally invasive surgery for endometrial cancer focus on patients with stage I disease. The aim of this study was to investigate the outcomes of minimally invasive surgery for patients with endometrial carcinoma involving the cervix.

Methods

Patients diagnosed between January 2010 and December 2015, with clinical stage II endometrial carcinoma, who underwent hysterectomy with lymphadenectomy, were drawn from the National Cancer Database. Inclusion criteria were clinical International Federation of Gynecology and Obstetrics (FIGO 2009) stage II, patients who underwent hysterectomy with lymphadenectomy, and known route of surgery (open or minimally invasive). Patients who received radiation therapy prior to surgery, those who had subtotal/supracervical hysterectomy, or unknown type of hysterectomy were excluded. The exposure of interest was performance of minimally invasive surgery either laparoscopic or robotic-assisted. Overall survival (primary endpoint) was assessed for patients diagnosed between January 2010 and December 2014 following generation of Kaplan-Meier curves and compared with the log-rank test. A Cox model was constructed to control for confounders.

Results

A total of 2175 patients were identified and 1282 (58.9%) had minimally invasive surgery. Of these, 339 and 943 patients had laparoscopic or robotic-assisted laparoscopic hysterectomy, respectively. Minimally invasive surgery was converted to open surgery in 74 (5.8%) patients. Those undergoing minimally invasive surgery had shorter hospital stay (median 1 vs 3 days, p<0.001), lower unplanned readmission rate (2.7% vs 4.7%, p=0.014), and 90-day mortality (0.8% vs 1.8%, p=0.05). Patients who had open surgery (n=796) had worse overall survival compared with those who had minimally invasive surgery (n=1048, p=0.003); 3-year overall survival rates were 76.8% and 83.6%, respectively. After controlling for patient age, race, type of insurance, presence of co-morbidities, performance of extensive lymphadenectomy, presence of positive lymph nodes, tumor histology, presence of lymphovascular space invasion, tumor size, and administration of radiotherapy, performance of minimally invasive surgery was not associated with worse survival (HR 0.90, 95% CI 0.73 to 1.11).

Conclusions

In this retrospective analysis, minimally invasive surgery in patients with stage II endometrial carcinoma was associated with superior short-term peri-operative outcomes and improved 3-year overall survival.

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TI 30-Day unanticipated healthcare encounters after prolapse surgery impact

of same day discharge

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 46th Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

(SGS)

CY MAR 29-APR 01, 2020

CL Jacksonville, FL

SP Soc Gynecol Surg

DE prolapse surgery; same-day discharge; urogynecology

ID ENHANCED RECOVERY; IMPLEMENTATION; READMISSIONS; HYSTERECTOMY;

FEASIBILITY

AB BACKGROUND: Same-day discharge is becoming increasingly common in gynecologic surgery; however, data are limited for frequency, setting, and severity of unanticipated healthcare visits for women who are discharged on the day of surgery after major prolapse repair.

OBJECTIVE: The purpose of this study was to evaluate whether discharge on the day of surgery is associated with increased 30-day unanticipated healthcare encounters after major pelvic organ prolapse surgery compared with discharge on or after postoperative day 1.

STUDY DESIGN: This is a retrospective analysis of women who underwent pelvic organ prolapse surgery by 8 female pelvic medicine and reconstructive surgery surgeons from January 2016 to October 2017. Unanticipated healthcare encounter was a composite variable of any visit to the office, emergency department, or hospital readmission. Number of visits, visit diagnoses, and complication severity (Clavien-Dindo classification) were compared by day of discharge with the use of x2 tests. Multivariable analyses were performed.

RESULTS: Of 405 women, 258 (63.7%) were discharged on the day of surgery, and 147 (36.3%) were discharged on postoperative day 1 or later. Mean age was 66 11 years, body mass index was 27.9 4.8 kg/m2. Most had stage III prolapse (n=273; 67.4%). Procedures included laparoscopic or robotic sacrocolpopexy, (n=163; 40.2%), vaginal apical suspensions (n=115; 28.4%), obliterative (n=105; 25.9%), and concomitant hysterectomy (n=229; 56.5%). There was no increase in the number of women with at least 1 unanticipated healthcare encounter within 30 days of surgery, based on discharge on the day of surgery compared with postoperative day 1 (24.0% vs 26.5%; P=.572). The majority of visits occurred in the office (17.8% vs 19.0%; P=.760). There was no increase in 30-day readmissions (3.5% vs 4.8%; P=.527). The most common visit diagnosis was pain and accounted for 31.5% of all visits, followed by urologic and gastrointestinal symptoms. Diagnoses and complication severity did not vary by day of discharge, except that women who were discharged on the day of surgery were more likely to have a superficial wound separation (11.3% vs 0%; P=.011) and less likely to experience grade II complications (7.4% vs 15.6%, P=.009). Few women had >1 unscheduled visit, and rates were similar between the 2 groups (6.2% vs 6.8%; P=.810). On multivariable regression, younger women (adjusted odds ratio, 1.03; 95% confidence interval, 1.001-1.05), those with lower body mass index (adjusted odds ratio, 1.07; 95% confidence interval, 1.13-1.01), and higher initial postanesthesia recovery unit pain scores (adjusted odds ratio, 1.11; 95% confidence interval, 1.02-1.21) were more likely to have an unanticipated healthcare encounter. Pain complaints were evaluated most often in the office compared with the emergency department (41.1% vs 13.0%); medical complications such as cardiac (15.6% vs 0%) and respiratory (6.5% vs 0%) were more likely to be evaluated in the emergency department. Higher grade complications (II/III) were more likely to visit the emergence department (78.2% vs 27.1%; P<.0001).

CONCLUSION: Same-day discharge after prolapse surgery did not result in an increase in 30-day unanticipated healthcare encounters.

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TI Same-Day Discharge in Minimally Invasive Surgery Performed by

Gynecologic Oncologists: A Review of Patient Selection

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Genital neoplasms; Minimally invasive surgical procedures; Outpatient;

Patient discharges; Robotic surgical procedures

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; I ENDOMETRIAL CANCER; RADICAL

HYSTERECTOMY; FEASIBILITY; SAFETY; LAPAROTOMY; SURVIVAL

AB Objective: To review the literature about same-day discharge (SDD) in minimally invasive surgery performed by gynecologic oncologists and identify factors associated with SDD and admission to provide selection criteria.

Data Sources: Systematic review of PubMed, EMBASE, Cochrane Central Register of Controlled Trials, and SCOPUS between May 2007 and May 2019. The search included the following medical subject heading terms and keywords: "same day discharge," "patient discharge," "minimally invasive surgical procedures," "hysterectomy," "gynecologic malignancy," "gynecologic neoplasm," "cervical cancer," "ovarian cancer," and "endometrial cancer."

Methods of Study Selection: Articles published in English about women who underwent minimally invasive procedures for benign and malignant conditions of the reproductive tract performed by gynecologic oncologists (robotic or laparoscopic) and who received SDD or admission were included. The following were described: SDD and admission rate, readmission or unscheduled evaluation rates within 30 days after surgery, and associated factors for each one.

Tabulation, Integration, and Results: Nine studies with a total of 16 423 patients were included. The complication rates in the studies were variable, with only 2 studies showing advantages in the SDD group with respect to intraoperative complications and wound complications. There were no statistically significant differences in postoperative complications in the first 30 days after the adoption of SDD. There were no higher readmission rates within the first 30 days in the group of patients who were discharged on the same day vs those admitted. The common factors associated with admission were as follows: age < 70 years, surgery after 1 PM, duration of surgery more than 2 hours, and intraoperative complications. Other factors to consider were the presence of comorbidities that require follow-up within the hospital after surgery, adequate postoperative evaluation, and the patient accepting SDD.

Conclusion: SDD seems to be safe and feasible in minimally invasive surgery performed by gynecologic oncologists. The proposed selection criteria includes the following: younger than 70 years, surgery before 1 PM, procedure less than 2 hours, and no intraoperative complications. Journal of Minimally Invasive Gynecology (2020) 27, 816- 825. (c) 2019 AAGL. All rights reserved.

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ER

PT J

AU Kobayashi, E

Kakuda, M

Takiuchi, T

Kodama, M

Shiomi, M

Kakuda, S

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Kimura, T

AF Kobayashi, E.

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Takiuchi, T.

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Shiomi, M.

Kakuda, S.

Ueda, Y.

Sawada, K.

Tomimatsu, T.

Yoshino, K.

Kimura, T.

TI Indocyanine green is superior to blue colorimetric method for

identifying sentinel lymph nodes during laparoscopic surgery for uterine

malignancies: a pilot study

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Indocyanine green; Sentinel lymph node; Near-infrared fluorescence

imaging; Blue dye

ID ENDOMETRIAL CANCER; ROBOTIC SURGERY; CERVICAL-CANCER; DYE;

IDENTIFICATION; BIOPSY

AB Aim: The objective of this study was to compare indocyanine green (ICG) and blue colorimetric methods for detection of sentinel lymph nodes (SLN) during laparoscopic surgery for uterine malignancies. Materials and Methods: Over a two years and 3months period, laparoscopic surgery was performed on 16 cases of uterine malignancies using near infrared (NIR) fluorescence imaging of ICG tracer uptake to direct SLN biopsy (NIR-FI-SLNB). ICG was injected into the uterine cervix prior to surgery. For comparison of detection efficacy, blue dye used for traditional colorimetric method was injected concurrently into 14 of these 16 cases. After pneumoperitoneum, we opened the retroperitoneum to laparoscopically identify the SLN. After biopsy of the SLN, a systemic pelvic lymph node dissection was performed. Results: Using ICG, we were able to identify SLN in 15/16 cases (93.7%), and achieved bilateral pelvic mapping in 12/16 (75%). With the blue dye, we were also able to identify SLN in only 64.3% of the 14 cases so tested, and bilateral pelvic mapping in only 14.3%. There were no intraoperative complications during any of the procedures. For conducting a laparoscopic bilateral SLN biopsy, we found that use of ICG was significantly superior to the blue colorimetric method (14.3% vs. 75%, p = 0.0009). Conclusions: These pilot data provide suggestive evidence that the laparoscopic NIR fluorescence imaging for SLN biopsy provide superior efficacy, compared to the traditional blue colorimetric method, without additional complications.

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ER

PT J

AU Brännström, M

Dahm-Kähler, P

Kvarnström, N

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TI Live birth after robotic-assisted live donor uterus transplantation

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE human; infertility; pregnancy; robot; robotic-assisted laparoscopy;

transplantation; uterus; uterus transplantation

ID VENOUS DRAINAGE; VEINS

AB Introduction The proof-of-concept of uterus transplantation, as a treatment for absolute uterine factor infertility, came with the first live birth after uterus transplantation, which took place in Sweden in 2014. This was after a live donor procedure, with laparotomy in both donor and recipient. In our second, ongoing trial we introduced a robotic-assisted laparoscopic surgery of the donor to develop minimal invasive surgery for this procedure. Here, we report the surgery and pregnancy behind the first live birth from that trial.

Material and methods In the present study, within a prospective observational study, a 62-year-old mother was the uterus donor and her 33-year-old daughter with uterine absence as part of the Mayer-Rokitansky-Kuster-Hauser syndrome, was the recipient. Donor surgery was mainly done by robotic-assisted laparoscopy, involving dissections of the utero-vaginal fossa, arteries and ureters. The last part of surgery was by laparotomy. Recipient laparotomy included vascular anastomoses to the external iliac vessels. Data relating to in vitro fertilization, surgery, follow up, obstetrics and postnatal growth are presented.

Results Three in vitro fertilization cycles prior to transplantation gave 12 cryopreserved embryos. The surgical time of the donor in the robot was 360 minutes, according to protocol. The durations for robotic surgery for dissections of the utero-vaginal fossa, arteries and ureters were 30, 160 and 84 minutes, respectively. The remainder of donor surgery was by laparotomy. Recipient surgery included preparations of the vaginal vault, three end-to-side anastomoses (one arterial, two venous) on each side to the external iliacs and fixation of the uterus. Ten months after transplantation, one blastocyst was transferred and resulted in pregnancy, which proceeded uneventfully until elective cesarean section in week 36(+1). A healthy boy (Apgar 9-10-10) was delivered. Follow up of child has been uneventful for 12 months.

Conclusions This is the first report of a live birth after use of robotic-assisted laparoscopy in uterus transplantation and is thereby a proof-of-concept of use of minimal invasive surgery in this new type of transplantation.

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TC 40

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JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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ER

PT J

AU Mereu, L

Berlanda, V

Surico, D

Gardella, B

Pertile, R

Spinillo, A

Tateo, S

AF Mereu, Liliana

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Surico, Daniela

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Pertile, Riccardo

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Tateo, Saverio

TI Evaluation of quality of life, body image and surgical outcomes of

robotic total laparoscopic hysterectomy and sentinel lymph node mapping

in low-risk endometrial cancer patients - A Robotic Gyne Club study

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE endometrial cancer; quality of life; robotic surgery; sentinel lymph

node; single-site robotic surgery

ID SINGLE-SITE HYSTERECTOMY; OBESE-PATIENTS; SURGERY; FEASIBILITY;

DIAGNOSIS; BIOPSY; WOMEN

AB Introduction The aims of the study were to evaluate quality of life, cosmetic results and surgical outcomes of robotic single-site and robotic multiport total laparoscopic hysterectomy with sentinel lymph node mapping in women treated for low-risk endometrial cancer.

Material and methods The study is a prospective, multicenter, case-control study conducted at Ospedale Santa Chiara in Trento and Novara and Pavia University Hospitals. Seventy-six consecutive patients with a biopsy-confirmed diagnosis of low-risk endometrial cancer or atypical endometrial hyperplasia who between January 2017 and January 2019 had undergone robotic total laparoscopic hysterectomy and sentinel lymph node mapping were included. Data on surgical outcomes, quality of life and cosmetic results were prospectively collected and analyzed based on the surgical approach with robotic single-site vs robotic multiport assistance. Patients' clinical characteristics, intra-operative parameters, sentinel lymph node mapping results and postoperative findings were prospectively recorded. Clinical follow up was performed 4 weeks and 6 and 12 months after surgery. Fifty-one patients underwent a robotic multiport procedure and 25 patients a robotic single-site surgery.

Results There was one significant difference between the two groups in terms of patient characteristics: mean body mass index (BMI) in the multiport group was 29 kg/m(2) vs 24.8 kg/m(2) in the single-site group (P value <.001). After univariate and multivariate analysis on intraoperative and postoperative findings, a shorter surgical time was observed in the single-site cohort than in the multiport group (148.7 vs 158.2 minutes, P value .0182). BMI also had a significant effect on surgical time (P = .022). No differences were seen in terms of sentinel lymph node detection: the bilateral detection rate was 96.1% for multiport (66.7% bilateral, 29.4% monolateral) and 96% for single-site (76% bilateral, 20% monolateral) procedures. No differences between the two approaches were identified with regard to postoperative complications, pain, cosmetic results or quality of life comparisons.

Conclusions For the treatment of low-risk endometrial cancer and atypical endometrial hyperplasia with total hysterectomy and sentinel lymph node mapping, the robotic single-port approach is comparable to the multiport procedure in terms of intraoperative and postoperative findings, and has an advantage in terms of shorter surgical times. Further studies are required to identify possible differences in quality of life and cosmetic results.

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NR 30

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Z9 3

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U2 2

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ER

PT J

AU Gupta, N

Blevins, DM

Holcombe, J

Furr, R

AF Gupta, Natasha

Miranda Blevins, D.

Holcombe, Jenny

Furr, Robert

TI A comparison of surgical outcomes between single-site robotic, multiport

robotic and conventional laparoscopic techniques in performing

hysterectomy for Benign indications

SO GYNECOLOGY AND MINIMALLY INVASIVE THERAPY-GMIT

LA English

DT Article

DE Conventional laparoscopy; hysterectomy; laparoendoscopic single site;

robotic surgery; single incision

ID LEARNING-CURVE; SURGERY; FEASIBILITY; DISEASE

AB Objectives: Minimally invasive gynecologic surgery (MIGS) is the standard of care in performing hysterectomy for benign conditions. However, the choice of laparoscopic modality is largely dependent on surgeon's discretion, experience, and equipment availability. The objective of this study is: To compare outcomes between different minimally invasive approaches available for benign hysterectomies and to evaluate patient factors that influence the use of one approach over another. With this study, we sought to provide some objective criteria while deciding the appropriate MIGS technique. Materials and Methods: This is a retrospective study comparing perioperative outcomes between three techniques of minimally invasive hysterectomy: laparoscopy (LSC), multiport daVinci (MP-Rob) and single-site daVinci (SS-Rob). Patients undergoing benign hysterectomy (daVinci or conventional LSC) from January 2015 to July 2016 were included. 129 patients were identified and divided into: LSC (n = 44), MP-Rob (n = 36) and SS-Rob (n = 49). Results: There were statistically significant differences in age (MP-Rob46 not equal LSC39), body mass index (BMI) (MP-Rob33 not equal LSC27 or SS-Rob26.8), uterus weight (MP-Rob144 not equal LSC102 or SS-Rob105) and operative time (LSC192 not equal SS-Rob162.3 or MP-Rob163). Chi-square analyses revealed history of endometriosis and clinical endometriosis was statistically less common while leiomyomas were more common indications of MP-Rob. There was no statistically significant difference noted between length of stay, estimated blood loss, intraoperative, and post-operative complications between different surgical types. Conclusion: Patients with higher age, BMI, uterus weight and abnormal uterine bleeding were noted to undergo MP-Rob surgery. Patients with history of endometriosis were more likely to undergo LSC or SS-Rob surgery. Operative time was significantly less for daVinci hysterectomies (SS-Rob and MP-Rob) as compared to conventional LSC.

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AU Laughlin-Tommaso, SK

Lu, D

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Marsh, EE

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TI Short-term quality of life after myomectomy for uterine fibroids from

the COMPARE-UF Fibroid Registry

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE fibroids; hysteroscopy; laparoscopy myomectomy; quality of life

ID FOCUSED ULTRASOUND; TRIAL; WOMEN

AB BACKGROUND: Uterine fibroids may decrease quality of life in a significant proportion of affected women. Myomectomy offers a uterinesparing treatment option for patients with uterine fibroids that can be performed abdominally, laparoscopically (with or without robotic assistance), and hysteroscopically. Quality of life information using validated measures for different myomectomy routes, especially hysteroscopic myomectomy, is limited.

OBJECTIVE: To compare women's perception of their short-term health-related quality of life measures and reported time to return to usual activities and return to work for different routes of myomectomy.

MATERIALS AND METHODS: Comparing Options for Management: Patient-centered Results for Uterine Fibroids (COMPARE-UF) is a prospective nationwide fibroid registry that enrolled premenopausal women seeking treatment for uterine fibroids at 8 clinical sites. For this analysis, we included women undergoing hysteroscopic, abdominal, or laparoscopic myomectomy who completed the postprocedure questionnaire scheduled between 6 and 12 weeks after surgery. Health-related quality of life outcomes, such as pain, anxiety, and return to usual activitie, were assessed for each route. The hysteroscopic myomectomy group had large differences in demographics, fibroid number, and uterine size compared to the other groups; thus, a direct comparison of quality of life measures was performed only for abdominal and laparoscopic approaches after propensity weighting. Propensity weighting was done using 24 variables that included demographics, quality of life baseline measures, and fibroid and uterine measurements.

RESULTS: A total of 1206 women from 8 COMPARE-UF sites underwent myomectomy (338 hysteroscopic, 519 laparoscopic, and 349 abdominal). All women had substantial improvement in short-term health-related quality of life and symptom severity scores, which was not different among groups. Average symptom severity scores decreased about 30 points in each group. Return to usual activities averaged 0 days (interquartile range, 0-14 days) for hysteroscopic myomectomy, 21 days (interquartile range, 14-28 days) for laparoscopic myomectomy, and 28 days (interquartile range, 14-35 days) for abdominal myomectomy. After propensity adjustment, quality of life outcomes in the laparoscopic and abdominal myomectomy groups were similar except for more anxiety in the laparoscopic myomectomy group and slightly more pain in the abdominal myomectomy group. After propensity weighting, return to usual activities favored laparoscopic compared to abdominal procedures; median time was the same at 21 days, but the highest quartile of women in the abdominal group needed an additional week of recovery (interquartile range,14.0-28.0 for laparoscopic versus 14.0-35.0 for abdominal, P < .01). Time to return to work was also longer in the abdominal arm (median, 22 days; interquartile range, 14-40 days, versus median, 42; interquartile range, 27-56).

CONCLUSION: Women who underwent myomectomy had substantial improvement in health-related quality of life, regardless of route of myomectomy. After propensity weighting, abdominal myomectomy was associated with a nearly 2-week longer time to return to work than laparoscopic myomectomy.

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University; Inova Health System; Inova Health System; University of

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Michigan System; University of Michigan; Georgetown University;

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AU Lee, NH

Lee, SH

Kim, WY

AF Lee, Nae Hyun

Lee, San Hui

Kim, Woo Young

TI Comparison of Reduced-Port Robotic Surgery (RPRS) with conventional 2

port laparoscopy for myomectomy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE RPRS myomectomy; 2-Port laparoscopic myomectomy

ID UTERINE; MANAGEMENT; OUTCOMES

AB Objective: To compare the surgical outcomes between Reduced-Port Robotic Surgery (RPRS) using the Octo-Port system and conventional 2 port laparoscopy for myomectomy.

Study Design: This is a prospective, non-randomized study, which compared and analyzed data from 41 patients who underwent RPRS myomectomy and 22 patients who underwent conventional 2 port laparoscopic myomectomy from April 2016 through July 2019. We compared the myoma enucleation time, suture time, myoma type, and the location of the largest myoma between the two groups.

Results: The patients were not different between the two groups. The myoma enucleation time (26.7 +/- 20.9 vs. 22.0 +/- 13.7, p = 0.380), hemoglobin drop (2.38 +/- 0.9 vs 2.1 +/- 0.8, p = 0.280), weight of the myomas (205.3 +/- 161.5 vs. 163.4 +/- 89.1, p = 0.261), and estimated blood loss (181.1 +/- 163.4 vs. 187.3 +/- 77.5, p = 0.840) were not significantly different between the two groups. Notably, only the suture time (15.5 (10-21.5) vs. 20 (18-27), p = 0.005) was lesser in women who underwent RPRS myomectomy than in those who underwent conventional 2 port myomectomy.

Conclusion: Our data suggest that RPRS myomectomy is comparable to conventional 2 port laparoscopic myomectomy in terms of safety and feasibility and may be more advantageous for suturing after myoma enucleation. (C) 2020 Elsevier B.V. All rights reserved.

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NR 17

TC 3

Z9 3

U1 1

U2 2

PU ELSEVIER

PI AMSTERDAM

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ER

PT J

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Vergote, I

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Salihi, Rawand Rokan

Van Nieuwenhuysen, Els

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TI Para-aortic lymph node surgical staging in locally-advanced cervical

cancer: comparison between robotic versus conventional laparoscopy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Para-aortic lymphadenectomy - Cervical cancer - Surgical staging - Robot

assisted surgery - Laparoscopy

ID POSITRON-EMISSION-TOMOGRAPHY; LYMPHADENECTOMY; CARCINOMA; METASTASES;

MORBIDITY; SURGERY; ERA

AB Objective

With the expansion of the use of minimally invasive surgical techniques within the field of gynecological oncology, a robot assisted procedure seems to be an attractive technique for para-aortic lymph node sampling. The aim of this study was to compare robotic versus conventional laparoscopic para-aortic lymphadenectomy in patients with locally advanced cervical cancer.

Methods

In this monocentric retrospective study, we included patients with locally-advanced cervical cancer (International Federation of Gynecology and Obstetrics (FIGO) 2009 stage IB2-IVA or IB1 with suspicious pelvic lymph nodes), who underwent a para-aortic lymphadenectomy up to the inferior mesenteric artery between December 1994 and December 2016 (robotic technique starting from December 2012).

Results

A total of 217 patients were included in the study (robotic, n=55 vs laparoscopic, n=162). When comparing conventional laparoscopic versus robotic para-aortic lymphadenectomy, the median age was 48 versus 49 years and the median body mass index was 24.4 vs 24.7 kg/m(2), respectively. In the robotic or laparoscopic group, 85% and 83% were squamous carcinomas, respectively. Patients who underwent a robotic procedure had a higher American Society of Anesthesiologists (ASA) score (ASA2: 62% vs 56%, ASA3: 20% vs 2%, p<0.001), more prior major abdominal surgery (18% vs 6%, p=0.016), less estimated blood loss (median, 25 mL vs 62.5 mL, p<0.001), more para-aortic lymph nodes removed (11 vs 6, p<0.001), shorter postoperative stay (1.8 vs 2.3 days, p=0.002), and a higher, but non-significant, rate of metastatic para-aortic lymph nodes (13% vs 5%, p=0.065) compared with the laparoscopic procedure, respectively. There was no difference in complication rates between the two approaches. The most frequent complications were grade I and grade II according to the Clavien Dindo classification. No difference was observed in progression-free survival between robotic and laparoscopic para-aortic lymphadenectomy after 2 years (both groups 66%) (p=0.472). Also, 2 year overall survival was similar between the groups (77% vs 81% for robotic vs conventional laparoscopy group, respectively) (p=0.749).

Conclusion

Robotic para-aortic lymphadenectomy in patients with locally-advanced cervical cancer resulted in better perioperative outcomes and similar survival outcomes when compared with a conventional laparoscopic approach.

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ER

PT J

AU Matanes, E

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TI Robotic laparoendoscopic single-site compared with robotic multi-port

sacrocolpopexy for apical compartment prolapse

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; laparoscopic single-site (LESS); multi-port robotic (MPR);

pelvic organ prolapse (POP); robotic laparoendoscopic single-site

(R-LESS); sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; LIFETIME RISK;

LAPAROSCOPIC SACROCOLPOPEXY; ASSISTED SACROCOLPOPEXY; SURGICAL OUTCOMES;

HYSTERECTOMY; QUESTIONNAIRE; SURGERY; INCONTINENCE

AB BACKGROUND: Sacrocolpopexy is a commonly performed procedure for repair of apical compartment prolapse. AY-shaped mesh is attached to the prolapsed cervix or vagina and suspended to the anterior longitudinal ligament of the sacrum. In addition to conventional laparoscopic and multi-port robotic routes, the robotic laparoendoscopic single-site approach has emerged as a viable, feasible, and widely applicable minimally invasive approach to sacrocolpopexy.

OBJECTIVE: To compare robotic laparoendoscopic single-site with multi-port robotic sacrocolpopexy for women with either utero-vaginal or vaginal apical prolapse.

MATERIALS AND METHODS: In this single-center randomized controlled trial, 70 women at Pelvic Organ Prolapse Quantitative stages 2-4 were assigned randomly to undergo sacrocolpopexy by robotic laparoendoscopic single-site or multi-port robotic approaches from August 2017 to November 2018. Of 35 women randomized to each group, 32 underwent sacrocolpopexy. Operating time was the primary outcome of the trial. Secondary outcomes included intraoperative bleeding, length of hospitalization, pain during the first postoperative 24 hours (according to a 0-10 visual analogue scale), need for analgesics, and intraoperative and postoperative adverse events. At 6 weeks and 6 months after surgery, patients underwent a physical examination according to Pelvic Organ Prolapse Quantitative measurements, to assess the anatomical success of the surgery. The Pelvic Floor Distress Inventory-20 and Pelvic Organ Prolapse/Urinary Incontinence Sexual-12 questionnaires were administered prior to surgery and at 6-month follow-up. The Patient Scar Assessment Questionnaire and the Activity Assessment Scale were administered at 6 weeks and 6 months after the surgery. Exclusion criteria included contraindication to general anesthesia, a history of prior sacrocolpopexy, suspicious adnexal masses, suspicious thickened endometrium, and morbid obesity (body mass index of 40 kg/m(2) or more).

RESULTS: The mean age of the patients was 58.4 years. More than half of the patients (54%) had stage III prolapse. Mean total operative times were 181.3 +/- 32.6 and 157.5 +/- 42 minutes for robotic laparoendoscopic single-site and multi-port robotic sacrocolpopexy, respectively; the difference was 23.8 minutes (95% confidence interval, 4.2-43.4, P= .018). The mean differences in duration between the procedures were as follows: 29.8 minutes, 95% confidence interval, 9.2-50.4, P= .005 for anesthesia time; 33.1 minutes, 95% confidence interval, 16.5-49.7, P < .0001 for console time; 8.6 minutes, 95% confidence interval, 1.1-16.3, P = .025 for supracervical hysterectomy time; 8.3 minutes, 95% confidence interval, 1.8-14.8, P = 0.03 for mesh suturing and fixation to the promontory; and 4.7 minutes, 95% confidence interval, 1.5-7.7, P = .004 for peritoneum suturing. Statistically significant differences were not observed between the groups in regard to estimated blood loss, intraoperative complications, and demand for analgesics during hospital stay. Quality-of-life parameters were similar. Patients' assessments of their scars were more favorable in the robotic laparoendoscopic single-site group.

CONCLUSION: For sacrocolpopexy, the operative time was longer for the robotic laparoendoscopic single-site than for the multi-port robotic approach. Both approaches are feasible, and short-term outcomes, quality-of-life parameters, and anatomic repair are comparable. Our results are generalizable only to the specific robotic platforms used in the study.

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ER

PT J

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TI Impact of time to radiation therapy in adjuvant settings in endometrial

carcinoma: A multicentric retrospective study

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrial cancer; Radiotherapy; Robotic surgery; Time to treatment;

Organization; Lymphadenectomy

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; OPEN-LABEL; CANCER; SURGERY;

RADIOTHERAPY; CHEMOTHERAPY; RECURRENCE; INITIATION; SURVIVAL; INTERVAL

AB Objective: Time to adjuvant treatment could have an impact on cancer prognosis. It is possible that robotic surgery lengthens the healing time of vaginal cuff after minimally invasive hysterectomy. The objective of this study was to state the impact of time to RT (TTR) on prognosis in endometrial carcinoma (EC) patients and to assess variables associated with TTR.

Study design: We conducted a multicentric retrospective study in two cancer centers. We included EC patients, between January 1996 and January 2016. We searched variables associated with TTR and impact of TTR on end-points: local recurrence-free survival, metastatic-free survival, event-free survival and overall survival.

Results: 329 patients were included and 279 were analyzed for TTR impact. Robotic surgery was associated with shorter TTR (8 weeks, 8.9 w for laparotomy, 9.2 w for laparoscopy). Pelvic lymphadenectomy, para-aortic lymphadenectomy, discussion in multidisciplinary meeting and treatment center was independently associated with TTR. No impact of TTR was shown on metastatic-free survival, event-free survival and overall survival but there was a trend of a decreased local recurrence rate in case of prolonged TTR (HRcontinuous variable = 1.08; CI95 %: 0.97-1.2).

Conclusion: Our study did not show any impact of treatment delay on survival end-points although prolonged TTR could moderate the benefit of radiotherapy on local control rate. Surgical route was not associated with TTR, particularly robot-associated laparoscopy did not lengthen treatment delay. TTR seems dependent of health-care organization and could represent a quality criterion of EC care for institutions. (C) 2020 Elsevier B.V. All rights reserved.

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NR 35

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Z9 2

U1 0

U2 1

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UT WOS:000528028900021

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OA hybrid

DA 2024-01-18

ER

PT J

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Rambhatla, Anupama

Nezhat, Farr

TI Reproductive and oncologic outcomes after fertility-sparing surgery for

early stage cervical cancer: a systematic review

SO FERTILITY AND STERILITY

LA English

DT Review

DE Cervical cancer; fertility sparing surgery; reproduction

ID ABDOMINAL RADICAL TRACHELECTOMY; LAPAROSCOPIC PELVIC LYMPHADENECTOMY;

VAGINAL TRACHELECTOMY; OBSTETRIC OUTCOMES; PRESERVING-OPTION; CASE

SERIES; PREGNANCY OUTCOMES; HYSTERECTOMY; PRESERVATION; MANAGEMENT

AB This review sought to evaluate the current literature on reproductive and oncologic outcomes after fertility-sparing surgery for early stage cervical cancer (stage IA1-IB1) including cold-knife conization/simple trachelectomy, vaginal radical trachelectomy, abdominal radical trachelectomy, and laparoscopic radical trachelectomy with or without robotic assistance. A systematic review using the preferred reporting items for systematic reviews and meta-analysis (PRISMA) checklist to evaluate the current literature on fertility-sparing surgery for early stage cervical cancer and its subsequent clinical pregnancy rate, reproductive outcomes, and cancer recurrence was performed. Sixty-five studies were included encompassing 3,044 patients who underwent fertility-sparing surgery, including 1,047 pregnancies with reported reproductive outcomes. The mean clinical pregnancy rate of patients trying to conceive was 55.4%, with the highest clinical pregnancy rate after vaginal radical trachelectomy (67.5%). The mean live-birth rate was 67.9% in our study. Twenty percent of pregnancies after fertility-sparing surgery required assisted reproductive technology. The mean cancer recurrence rate was 3.2%, and the cancer death rate was 0.6% after a median follow-up period of 39.7 months with no statistically significant difference across surgical approaches. Fertility-sparing surgery is a reasonable alternative to traditional radical hysterectomy for early-stage cervical cancer in women desiring fertility preservation. Vaginal radical trachelectomy had the highest clinical pregnancy rate, and minimally invasive approaches to fertility-sparing surgery had equivalent oncologic outcomes compared with an abdominal approach. The results of our study allow for appropriate patient counseling preoperatively and highlight the importance of a multidisciplinary approach to achieve the best outcomes for each patient. (C) 2020 by American Society for Reproductive Medicine.)

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NR 108

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U1 3

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JI Fertil. Steril.

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ER

PT J

AU Rosenbaum, AJ

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Louie, M

Schiff, LD

Carey, ET

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TI Postanesthesia Care Unit Stay and Complications After Same-Day Discharge

Laparoscopic Hysterectomy

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE complications; enhanced recovery after surgery; laparoscopic

hysterectomy; length of stay; postanesthesia care unit; robot-assisted

hysterectomy; same-day discharge

ID OUTCOMES

AB Objective: To identify associations between postanesthesia care unit (PACU) length of stay (LOS) and postoperative complications among same-day discharged (SDD) laparoscopic hysterectomy patients.

Materials and Methods: A retrospective cohort of women who underwent SDD laparoscopic or robot-assisted hysterectomy by academic minimally invasive gynecologic surgeons between January 2016 and July 2018 were analyzed. Patient preoperative, procedural, and postoperative information were collected. Patients were categorized into short (<2 hour), average (2-4 hour), and long (>4 hour) PACU LOS. Complications were categorized by severity. High-morbidity events were defined as readmissions, reoperations, or emergency department visits. Patient and procedure characteristics by PACU LOS were compared using chi(2), Fisher's exact, and analysis of variance, where appropriate. Complications among PACU LOS categories were evaluated by unadjusted and multivariable logistic regression. A sensitivity analysis among enhanced recovery after surgery (ERAS)-only patients was done.

Results: Of 304 patients, a majority (n = 185, 60.9%) had average PACU LOS, 81 (26.6%) short LOS, and 38 (12.5%) long LOS. Short PACU LOS was associated with increased odds of high-morbidity events versus average LOS in crude and adjusted models (crude: odds ratio [OR] 2.21; 95% confidence interval [CI] 1.02-4.77; adjusted: OR 2.39; 95% CI 1.07-5.33) and among ERAS-only patients (crude: OR 2.39; 95% CI 1.05-5.46; adjusted: OR 2.36; 95% CI 1.00-5.55). Long PACU LOS was not statistically significantly associated with high-morbidity complications.

Conclusions: Short PACU LOS among SDD laparoscopic hysterectomy patients was associated with high-morbidity events. Larger sample size is required to determine whether long PACU LOS is associated with high-morbidity complications.

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NR 24

TC 1

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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WC Obstetrics & Gynecology; Surgery

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology; Surgery

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ER

PT J

AU Schmitt, JJ

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TI Prospective Implementation and Evaluation of a Decision-Tree Algorithm

for Route of Hysterectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 43rd Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

(SGS)

CY MAR 26-29, 2017

CL San Antonio, TX

SP Soc Gynecol Surg

AB OBJECTIVE: To evaluate the rate of vaginal hysterectomy and outcomes after initiation of a prospective decision-tree algorithm to determine the optimal surgical route of hysterectomy. METHODS: A prospective algorithm to determine optimal route of hysterectomy was developed, which uses the following factors: history of laparotomy, uterine size, and vaginal access. The algorithm was implemented at our institution from November 24, 2015, to December 31, 2017, for patients requiring hysterectomy for benign indications. Expected route of hysterectomy was assigned by the algorithm and was compared with the actual route performed to identify compliance compared with deviation. Surgical outcomes were analyzed. RESULTS: Of 365 patients who met inclusion criteria, 202 (55.3%) were expected to have a total vaginal hysterectomy, 57 (15.6%) were expected to have an examination under anesthesia followed by total vaginal hysterectomy, 52 (14.2%) were expected to have an examination under anesthesia followed by robotic-assisted total laparoscopic hysterectomy, and 54 (14.8%) were expected to have an abdominal or robotic-laparoscopic route of hysterectomy. Forty-six procedures (12.6%) deviated from the algorithm to a more invasive route (44 robotic, two abdominal). Seven patients had total vaginal hysterectomy when robotic-assisted total laparoscopic hysterectomy or abdominal hysterectomy was expected by the algorithm. Overall, 71% of patients were expected to have a vaginal route of hysterectomy per the algorithm, of whom 81.5% had a total vaginal hysterectomy performed; more than 99% of the total vaginal hysterectomies attempted were successfully completed. CONCLUSION: Vaginal surgery is feasible, carries a low complication rate with excellent outcomes, and should have a place in gynecologic surgery. National use of this prospective algorithm may increase the rate of total vaginal hysterectomy and decrease health care costs.

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JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Laparoscopic metroplasty for unicornuate uterus with a functional

noncommunicating rudimentary horn

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Fertility; Laparoscopy; Metroplasty; Mullerian aplasia; Pregnancy

outcome; Reconstructive surgical procedures; Robotics

ID PREGNANCY OUTCOMES; UTERINE; REMOVAL

AB Objective To evaluate the feasibility of laparoscopic metroplasty for the treatment of unicornuate uterus with a functional noncommunicating rudimentary horn.

Methods Laparoscopic metroplasty was performed in one patient using traditional laparoscopy and four patients using robot-assisted laparoscopy from December 2013 to December 2017 at the Obstetrics and Gynecology Hospital of Fudan University. The records of the five patients were analyzed retrospectively.

Results In all five patients the unicornuate uterus and functional noncommunicating rudimentary horn were unified into a single cavity without intraoperative or postoperative complications. Average operative time was 281 minutes (range, 204-330 minutes) and average blood loss was 180 mL (range, 100-300 mL). Postoperative hospital stay was 7 days (range, 5-11 days) and there was no re-admission. All patients were relieved of pain and had regular menstruation after surgery. Average follow-up time was 44 months (range, 22-70 months). One patient conceived by in vitro fertilization and embryo transfer 2 years after the operation and delivered twins by cesarean at 33 weeks.

Conclusion Laparoscopic metroplasty, with or without robotic assistance, is an acceptable alternative to resection for a noncommunicating rudimentary horn with a functional endometrium.

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NR 13

TC 2

Z9 3

U1 0

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ER

PT J

AU Albanesi, G

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TI Robot-assisted laparoscopic ureteroneocystostomy combined to

hysterectomy for intrinsic ureteral and deep pelvic endometriosis: Video

presentation

SO JOURNAL OF ENDOMETRIOSIS AND PELVIC PAIN DISORDERS

LA English

DT Article

DE Eradication of endometriosis; robotic surgery; robotic hysterectomy;

total laparoscopic hysterectomy; ureteroneocystostomy; ureteral

endometriosis; surgical treatment; surgical technique; ureteral

resection; surgical video

ID URINARY-TRACT ENDOMETRIOSIS; PSOAS HITCH; MANAGEMENT

AB Introduction:

We present a case of posterior deep infiltrating endometriosis with intrinsic ureteral involvement in a 43-year-old patient treated by robot-assisted laparoscopic technique. To our knowledge, this is the second case of robot-assisted ureteroneocystostomy with concomitant hysterectomy reported in the literature(1-5), yet the first one to be described with a video presentation.

Case description:

A 43-year-old woman with a past history of endometriosis treated laparoscopically was referred to our clinic for grade II-III left hydronephrosis. Pelvic ultrasound and magnetic resonance imaging demonstrated a 3-cm paracervical endometriotic nodule causing ureteral compression, another 1.6-cm endometriotic nodule at the rectosigmoid junction, an adenomyotic nodule in the anterior uterine wall, and an endometrioma on the right ovary. Given that the patient had an absolute contraindication to hormonal therapy, we opted for robot-assisted laparoscopic complete eradication of endometriosis. The procedure consisted in total hysterectomy with concomitant removal of the rectovaginal nodule, right adnexectomy, left salpingectomy, and left ureteral resection with ureteroneocystostomy. After 8 days, a cystography was accomplished to confirm anastomosis integrity, and the bladder catheter was removed. The patient was discharged on day 8 after a regular postoperative period. One year after the surgery, the patient refers wellbeing.

Conclusion:

The robotic approach in such a complex procedure as surgical treatment of ureteral and deep infiltrating endometriosis is feasible and safe with acceptable postoperative outcome. Further investigations with larger comparative cohorts that include cost analysis are needed to fully assess the benefits achieved by robotic assistance in patients with ureteral and deep infiltrating endometriosis.

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ER

PT J

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Morrell, Alexander Charles

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Frare, Nathalia

Serafini, Paulo Cesar

Ferreira Rodrigues Ribeiro, Duarte Miguel

TI Robotic Natural Orifice Specimen Extraction with Totally Intracorporeal

Anastomosis Associated with Firefly Fluorescence: Bowel Resection for

Deep Infiltrating Endometriosis

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE bowel endometriosis; indocyanine green; transvaginal; transrectal;

colectomy

ID COLORECTAL SURGERY; LAPAROSCOPIC RIGHT; METAANALYSIS; LOCATION; LEAKAGE;

COLON

AB Objective: The aim of this study was to explore the effects and applications of a robotic minimally invasive bowel-segmental resection, following intracorporeal anastomosis for treatment of deep infiltrating endometriosis (DIE). The procedure reconciled a totally intracorporeal anastomosis (TIA) procedure and robotic natural-orifice specimen extraction (R-NOSE) associated with Firefly (TM) fluorescence (F) technology (Intuitive Surgical Inc., Sunnyvale, CA) for optimizing outcomes in colon and rectal resection. The authors' initial group experience is also mentioned.

Materials and Methods: Fifty-six patients with DIE of the colon and rectum underwent the surgical procedure in a tertiary-care referral institution for endometriosis. A standardized robotic procedure was performed with bowel resection and indocyanine green-induced F used for bowel-perfusion assessment. Specimen withdrawal was performed through natural orifices. Patients underwent the surgical procedures from December 2015 to October 2019. Surgical outcomes data and patient follow-ups are reported.

Results: All patients had robotic minimally invasive bowel segmental resection, following intracorporeal anastomosis. The group's mean age was 36.8 (range: 28-46 years); with a mean body mass index of 22.88 kg/m(2) (range: 18.9-28.3 kg/m(2)). In all cases, end-to-end position anastomoses were performed, using a circular stapler; no conversion or diverting stoma were needed. All patients had indocyanine F imaging assessment for bowel and anastomosis perfusion. Mean hospitalization was 4.5 days (range: 3-6 days), and no mortality occurred. No anastomotic leakage or rectovaginal fistula were observed.

Conclusions: R-NOSE with TIA including Firefly F is a safe and feasible minimally invasive approach to benign bowel disease, reconciling prevalent procedures for endometriosis and colorectal surgical treatment.

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TC 1

Z9 4

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GA LR4RO

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ER

PT J

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Wakefield, Dorothy B.

Shepherd, Jonathan P.

TI The impact of prior prolapse repairs on surgical outcomes with minimally

invasive sacral colpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Minimally invasive surgery; Sacrocolpopexy; Intraoperative

complications; Vaginal prolapse; Vaginal prolapse recurrence; Recurrent

prolapse

ID PELVIC ORGAN PROLAPSE; PERIOPERATIVE COMPLICATIONS; TERM OUTCOMES;

SACROCOLPOPEXY; SURGERY; RISK

AB Introduction and hypothesis To determine whether prior prolapse repair has an impact on operative time, surgical complications, and prolapse recurrence with minimally invasive sacral colpopexy (MISC). Methods This was a retrospective study of all laparoscopic and robotic MISC procedures performed from January 2009 to July 2014 at the University of Pittsburgh Medical Center. Patient demographics, clinical and surgical data were compared in women who underwent MISC for initial repair versus those undergoing MISC for recurrence after prior prolapse surgery. Our primary outcome was operating room (OR) time (skin incision to closure) using linear regression. Logistic regression compared complications (a composite variable considered present if any major complication occurred) and prolapse recurrence (any POP-Q point >= 0 or retreatment). Results Of 816 subjects, the mean age was 59.6 +/- 8.7, with mean BMI 27.0 +/- 3.0 in a primarily Caucasian population (97.8%). Subjects had predominantly POP-Q stage III prolapse (69.9%), and 21.3% reported prior prolapse repair. OR time was 205.0 +/- 69.0 min. Prior prolapse repair did not impact OR time (p = 0.25) after adjusting for age, concomitant procedures, POP-Q measurements, changes in OR personnel, case order in the day, and preoperative stress incontinence. Complications occurred in 15.8% but were not impacted by prior prolapse repair (OR = 0.94, 95% CI = 0.53-1.67) after adjusting for potential confounders. During a median follow-up of 31 weeks, 7.8% had recurrence with no impact from prior prolapse surgery (OR = 1.557, 95% CI = 0.67-3.64) after adjusting for potential confounders. Conclusions We were unable to demonstrate increased OR time, complications, or prolapse recurrence for MISC based on history of prior prolapse repair. Longer follow-up is needed to confirm the lack of difference in prolapse recurrence rates.

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PT J

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Buras, M

Magtibay, P

Magrina, J

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TI Mortality Rates in Benign Laparoscopic and Robotic Gynecologic Surgery:

A Systematic Review and Meta-analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Deaths; Minimally invasive surgery; Hysterectomy; Sacrocolpopexy

ID LIVE DONOR NEPHRECTOMY; INFORMED-CONSENT; HYSTERECTOMY; COMPLICATIONS;

EXPERIENCE; MANAGEMENT; MORBIDITY; OUTCOMES; CANCER; WOMEN

AB Objective: To review mortality rates in benign gynecologic minimally invasive laparoscopic and robotic surgery (MIS) and the rates associated with commonly performed MIS procedures.

Data Sources: An electronic-based search was performed on PubMed, Embase, Scopus, Web of Science, and Cochrane Database for articles published in the last 10 years in English, French, German, Spanish, and Italian.

Methods of Study Selection: All MIS articles in benign gynecology reporting operative mortality (within 30 days) were reviewed.

Tabulation, Integration, and Results: The articles identified through the aforementioned search criteria were independently evaluated by the first 2 authors. The Newcastle-Ottawa scale for observational studies and Cochrane risk-of-bias assessment tool for randomized controlled trials were used to assess the risk of bias. Meta-analysis was applied to calculate pooled mortality rates using the inverse-variance method. Twenty-one articles (124 216 patients) were included. Operative mortality from any benign MIS (laparoscopy and robotics) procedure was 1:6456 (95% confidence interval [CI]: 1:3946-1:10 562). Studies were then grouped based on the surgical procedure. The mortality rate for hysterectomy (119 721 patients), sacrocolpopexy, and adnexal surgery and diagnostic laparoscopy was 1:6814 (95% CI: 1:4119-1:11 275), 1:1246 (95% CI: 1:36-1:44 700), and 1:2245 (95% CI: 1:45-1:113 372), respectively. Eighteen articles reported operative mortality for laparoscopic surgery and 4 for robotic surgery.

Conclusion: Operative mortality in benign minimally invasive gynecologic surgery is low, and mortality for laparoscopic and robotic approaches appears to be similar. (C) 2019 AAGL. All rights reserved.

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Z9 6

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ER

PT J

AU Brandt, B

Sioulas, V

Basaran, D

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Mueller, JJ

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TI Minimally invasive surgery versus laparotomy for radical hysterectomy in

the management of early-stage cervical cancer: Survival outcomes

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Radical hysterectomy; Minimal invasive surgery;

Laparoscopy; Robotic surgery; Laparotomy

ID PELVIC RADIATION-THERAPY; ABDOMINAL HYSTERECTOMY; VAGINAL HYSTERECTOMY;

LYMPHADENECTOMY; NO

AB Objective. To compare oncologic and perioperative outcomes in patients who underwent minimally invasive surgery (MIS) compared to laparotomy for newly diagnosed early-stage cervical carcinoma.

Methods. We retrospectively identified patients who underwent radical hysterectomy for stage IA1 with lymphovascular invasion (LV1), IA2, or IB1 cervical carcinoma at our institution from 1/2007-12/2017. Clinicopathologic characteristics and surgical and oncologic survival outcomes were compared using appropriate statistical testing. Multivariable Cox regression analysis was used to control for potential confounders.

Results. We identified 196 evaluable cases-117 MIS (106 robotic [90.6%]) and 79 laparotomy cases. Cohorts had similar age, BMI, substage, histologic subtype, clinical and pathologic tumor size, positive margins, and presence of LVI. The MIS group had more cases with no residual tumor in the hysterectomy (24.8% vs. 10.1%, P = 0.01). The laparotomy group had more cases with positive nodes (29.1% vs. 17.1%, P = 0.046) and more patients who received adjuvant therapy (532% vs. 33.3%, P = 0.006). Median follow-up was -4 years. Five-year disease-free survival (DFS) rates were 87.0% in the MIS group and 86.6% in the laparotomy group (P = 0.92); 5-year disease-specific survival (DSS) rates were 96.5% and 93.9%, respectively (P = 0.93); and 5-year overall survival (OS) rates were 96.5% and 87.4%, respectively (P = 0.15). MIS was not associated with DFS, DSS, or OS on multivariable regression analysis. The rate of postoperative complications was significantly lower in the MIS cohort (11.1% vs. 20.3%; P = 0.04).

Conclusions. MIS radical hysterectomy for cervical carcinoma did not confer worse oncologic outcomes in our single-center and concurrent series of patients with early-stage cervical carcinoma. (C) 2020 Elsevier Inc. All rights reserved.

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PT J

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CA ESGE Special Interest Grp

TI Lasers in gynaecology - Are they still obsolete? Review of past, present

and future applications

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Review

DE Laser; laparoscopy; hysteroscopy; endometriosis

ID ANTI-MULLERIAN HORMONE; LAPAROSCOPIC CYSTECTOMY; DIODE-LASER; PELVIC

PAIN; ENDOMETRIOSIS; VAPORIZATION; RESECTION; SURGERY; IMPACT; FIBER

AB After the advent and the subsequent gradual disuse of laser technology in gynaecological surgery, in recent years, thanks to technical improvements, this technology is progressively reaffirming itself in various areas of minimally invasive gynaecological surgery ranging from laparoscopy to robotic surgery and hysteroscopy.

This paper, through a SWOT (strengths, weaknesses, opportunities and threats) analysis, shows positives and negatives of this technology with particular attention to present and future applications.

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ER

PT J

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TI Long-Term Outcomes of Robotic-Assisted Laparoscopic Sacrocolpopexy Using

Lightweight Y-Mesh

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic sacrocolpopexy; pelvic organ prolapse

ID PELVIC FLOOR DISORDERS; ABDOMINAL SACROCOLPOPEXY; ORGAN PROLAPSE;

PREVALENCE

AB Objective

The objective of this study was to describe anatomic and symptomatic outcomes at 5 years or longer after robotic-assisted laparoscopic sacrocolpopexy using very lightweight polypropylene Y-mesh.

Methods

A prospective analysis of consecutive patients who underwent surgery at a single center between 2007 and 2011 was performed. Patients consented to objective and subjective assessment at 5 years or longer postoperatively. Surgical success was defined as meeting all of the following: (1) no retreatment for pelvic organ prolapse (POP) since surgery, (2) no prolapse beyond the introitus, (3) no apical descent below -5, and (4) no prolapse symptoms reported. Secondary outcome measures included Sandvik Incontinence Severity Index, the PFDI-20, the PFIQ-7, the PISQ-12, and the SSQ-8), rates of dyspareunia, mesh complications, and subjects' need for any surgical or nonsurgical prolapse treatment since their index surgery.

Results

Eighty percent of the potential study group (253/316) presented for examination and subjective assessment at 5 years or longer after their index surgeries.

The surgical success rate was 226 (89.3%) of 253 with no apical failures. Only 4.4% (11/253) of the group met both objective and subjective failure criteria. Sixteen patients were classified as surgical failure owing to subjective criteria alone despite having no significant objective prolapse on examination. Ten patients (4%) elected to undergo subsequent POP repair. These operations consisted of 5 native tissue anterior repairs and 5 native tissue posterior repairs. In addition, 1 patient elected to use a pessary for recurrent anterior POP. The remaining 16 patients who experienced surgical failure elected no further prolapse treatment.

Conclusions

Robotic-assisted laparoscopic sacrocolpopexy using very lightweight mesh provided excellent long-term results with no mesh-related complications.

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NR 16

TC 18

Z9 22

U1 0

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

AU Ind, T

Mereu, L

Verheijen, R

Negre, RR

ZanagnoLo, V

Nassir, H

Kimmig, R

Scambia, G

AF Ind, T.

Mereu, L.

Verheijen, R.

Negre, R. Rovira

ZanagnoLo, V.

Nassir, H.

Kimmig, R.

Scambia, G.

TI The role of minimally invasive radical hysterectomy for cervical cancer:

ESGE-SERGS position document and joint-statement

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE radical hysterectomy; minimally invasive surgery; cervical cancer;

statement

ID OUTCOMES; SURGERY; LAPAROSCOPY; EXPERIENCE; WOMEN

AB Over the last two decades, minimal access techniques have gained widespread acceptance as an approach to radical hysterectomy for cervical cancer.

Two recent studies, the randomised study by Ramirez et al. (2018) and the epidemiologic study by Melamed et al. (2018) found that minimally invasive surgery radical hysterectomy for cervical cancer was associated with shorter overall survival than open surgery.

In this document we assess the importance of these two new studies and what their additional contribution is towards existing studies into the surgical approach to cervical cancer. Furthermore, we provide a consensus statement of the European Society Gynaecological Endoscopy (ESGE) and the Society of European Robotic Gynaecological Surgery (SERGS) as to the position of minimal access techniques (both standard and robotic) in light of this new evidence.

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J9 FACTS VIEWS VIS OBGY

JI Facts Views Vis. ObGyn

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WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

AU Liu, J

Kohn, J

Wu, CH

Guan, ZK

Guan, XM

AF Liu, Juan

Kohn, Jaden

Wu, Chunhua

Guan, Zhenkun

Guan, Xiaoming

TI Short-term Outcomes of Non-robotic Single-incision Laparoscopic

Sacrocolpopexy: A Surgical Technique

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; Single-incision laparoscopic surgery;

Sacrocolpopexy

ID SACRAL COLPOPEXY; MESH; EXPERIENCE

AB Study Objective: Our main purpose was to describe the surgical technique and short-term outcomes of single-incision laparoscopic sacrocolpopexy (S-LSC) for the treatment of pelvic organ prolapse (POP).

Design: This study consisted of a retrospective analysis of 49 consecutive cases.

Setting: This study was set at the Third Affiliated Hospital of Guangzhou Medical University from October 2016 to November 2017.

Patients: The population for this study consisted of women with stage II to IV POP who met eligibility criteria for laparoscopic surgery.

Interventions: S-LSC included the use of V-loc barbed suture and retroperitoneal tunneling, in addition to standard single-incision laparoscopic surgery techniques. All 49 cases were successfully completed. All cases included concomitant procedures; 42 (85.7%) had removal of the uterus and adnexa. The main measured outcomes include patient characteristics, peri-operative outcomes, and change in pelvic floor support (Pelvic Organ Prolapse Quantification System), and quality of life (Pelvic Floor Impact Questionnaire).

Measurements and Main Results: All patients were parous, and 42.9% had a history of previous abdominal surgery. The mean operative duration from skin to skin was 201.20 +/- 46.53 minutes. The mean estimated blood loss was 27.0 +/- 16.6 mL. The mean pre- and post-operative Pelvic Organ Prolapse Quantification System scores were 2.2 +/- 1.1 cm versus - 2.6 +/- 0.5 cm for the Aa point and 3.2 +/- 2.8 cm versus -4.6 +/- 0.8 cm for the C point (p < .05 for both). The mean pre- and post-operative Pelvic Floor Impact Questionnaire scores were 106.4 +/- 18.9 versus 8.9 +/- 4.26 (p < .05), suggesting that S-LSC significantly improved physical prolapse and quality of life. Four patients suffered from postoperative complications (3 mesh exposure and 1 lumbosacral pain). Six patients complained of new onset of stress urinary incontinence.

Conclusions: Single-incision laparoscopic sacrocolpopexy is a feasible method to manage POP. However, the long-term effects and complications need to be further investigated. (C) 2019 AAGL. All rights reserved.

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Z9 4

U1 0

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA Bronze

DA 2024-01-18

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PT J

AU Luko, L

Parush, A

Matanes, E

Lauterbach, R

Taitler, A

Lowenstein, L

AF Luko, Liel

Parush, Avi

Matanes, Emad

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TI An Efficient Single-session Spatial Skill Trainer for Robot-assisted

Surgery: A Randomized Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Surgical suturing; Tissue handling; Spatial skills; Surgeon training;

Cognitive simulator

ID MENTAL ROTATION; VALIDATION; DISSOCIATION; RELIABILITY; ORIENTATION

AB Study Objective: To introduce and examine a single session of spatial skill training as an efficient means of improving surgical suturing performance in robot-assisted surgery.

Design: A randomized, controlled trial.

Setting: A tertiary university medical center in Israel.

Participants: A purposive sample composed of 41 residents with no robotic suturing skills.

Interventions: A computer-based simulator training of spatial skills.

Measurements and Main Results: Participants were randomly assigned to training (n = 21: mean age of 34 years [standard deviation (SD) = 1.92]) and control (n = 20: mean age of 32 years [SD = 3.17]) conditions. The training group underwent a session of spatial skills training, whereas the control group engaged in a neutral activity. After 1 participant was lost to the follow-up of the posttraining performance test, data of 40 participants were analyzed. Robotic suturing task performance with the da Vinci Skills Simulator (Intuitive Surgical, Sunnyvale, CA) was evaluated using the da Vinci Skills Simulator built-in measure of "excess tissue piercing" and an expert rating of "tissue tearing." The mean number of excess tissue piercing after training (but not after the neutral activity) was significantly lower than before training (3.25 [SD = 1.996] vs 6.75 [SD = 3.68], respectively; p<.001), reflecting an improvement of 52% (decreasing the mean number of excess tissue piercing in a single suture by 3.5 excess piercing trials). After the interventions, the extent of tissue tearing was rated lower in the training group (p=.01), and there was no change in the control group (p=.14).

Conclusion: We showed the efficiency of a training approach that focuses on spatial skills critical in robot-assisted surgery. We showed that surgeons who received a 1 session spatial skill training with a cognitive spatial skill trainer immediately improved the performance of a robotic suturing task compared with surgeons who did not receive such training. (C) 2019 Published by Elsevier Inc. on behalf of AAGL.

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Z9 3

U1 0

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ER

PT J

AU Lyons, YA

Stephan, JM

Bosquet, JG

Goodheart, MJ

AF Lyons, Yasmin A.

Stephan, Jean-Marie

Gonzalez Bosquet, Jesus

Goodheart, Michael J.

TI Gynecologic Oncology: Challenges of Minimally Invasive Surgery In a

Field of Maximal Complexities

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE laparoscopic; robotic; obesity; sentinel lymph nodes; gynecologic

oncology

ID ENDOMETRIAL CANCER; LAPAROSCOPY; OVARIAN

AB Minimally invasive surgery has become a standard in the surgical treatment for many women with gynecologic cancers. Within the scope of minimally invasive surgery, several techniques exist. Here, we provide an overview of the challenging and controversial aspects of minimally invasive surgery in the field of gynecologic oncology, including single-site surgery, operating on morbidly obese patients, sentinel lymph node mapping, and recent trials and controversy of treating gynecologic cancer patients with a minimally invasive surgical approach.

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U2 7

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JI Clin. Obstet. Gynecol.

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PT J

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Legros, M

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Sallee, Camille

Legros, Maxime

Lacorre, Aymeline

Piver, Pascal

Aubard, Yves

Tardieu, Antoine

Gauthier, Tristan

TI Description of an initiation program to robotic in vivo gynecological

surgery for junior surgeons

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Dual-console; Residency training; Robotic surgery; Simulation; Teaching

program

ID SIMULATION

AB Introduction: Most gynecological residents or junior surgeons do not practice nor experience robotic surgery due to lack of access during residency or poor knowledge about this growing surgical technology. This study evaluated the feasibility and safety of a 3-half-day experiencing and training session for robot-assisted gynecological surgery designed for residents and fellows.

Materiel and Methods: This is a prospective, single-center observational study about a training course aimed at residents or fellows at the university teaching hospital of Limoges (France). It spreads over three consecutive half-days: one dedicated to simulation exercises involving the Da Vinci Skills Simulator(C) and the other two, to practice in two robot-assisted procedures with dual-console equipment supervised by a senior surgeon (as it is usually performed in a university teaching hospital). Complications during surgery, patient's medical records as well as the participants' performances during in vivo suturing acts were gathered. Feedback on the session was obtained with a questionnaire at the end of the course.

Results: Twelve sessions involving 24 patients operated on by 34 trainees from 16 different teaching university hospitals across the country took place. No conversion to laparotomy nor any major peri- or post-operative complication was reported. Time for stitching decreased significantly (p = .016) between the first and the second in vivo surgery. Use of the dual console was found helpful and most attendees (96.8%) would recommend this training session.

Conclusion: We showed this training course with both simulation and in vivo surgery was feasible, safe and was a well-liked initiation program for robotic surgery. (C) 2019 Elsevier Masson SAS. All rights reserved.

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FU Intuitive Surgical; Nordic Pharma; Gedeon Richter

FX Grants from companies (Intuitive Surgical, Nordic Pharma, Gedeon

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

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PT J

AU Mattson, JN

Bender, DP

AF Mattson, Jordan N.

Bender, David P.

TI Minimally Invasive Robotic Surgery for Gynecologic Cancers: A Review

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Review

DE robotic surgery; minimally invasive; gynecologic cancer

ID STAGE CERVICAL-CANCER; RADICAL HYSTERECTOMY; OVARIAN-CANCER; OUTCOMES;

LAPAROSCOPY; MANAGEMENT

AB Minimally invasive robotic surgery has become an effective surgical technique for the treatment of gynecologic malignancies. This article reviews the current utilization of robotic surgery and its role for future treatment in gynecologic oncology.

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JI Clin. Obstet. Gynecol.

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ER

PT J

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Orlando, M

Wang, J

Opoku-Anane, J

AF Movilla, Peter

Orlando, Megan

Wang, Jennifer

Opoku-Anane, Jessica

TI Predictors of Prolonged Operative Time for Robotic-Assisted Laparoscopic

Myomectomy: Development of a Preoperative Calculator for Total Operative

Time

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic-assisted laparoscopic myomectomy; Gynecologic surgery; Total

operative time

ID ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; SURGERY

AB Study Objective: To develop a preoperative calculator to predict the total operative time (TOT) for robotic-assisted laparoscopic myomectomy (RALM).

Design: Retrospective cross-sectional study.

Setting: University medical center.

Patients: Women who underwent RALM performed by 3 high-volume surgeons at a single institution between January 2014 and December 2017.

Interventions: Demographic characteristics, indication for surgery, surgical history, myoma burden on imaging, and TOT were collected. RALM operative time was classified as <3 hours, 3 to 5 hours, and >5 hours. We identified preoperative characteristics predictive of increased operative time and developed a preoperative calculator to estimate TOT.

Measurements and Main Results: A total of 126 women underwent RALM during the study period, with a mean TOT of 213 minutes +/- 66 minutes. The mean total weight of myomas removed was 264 g +/- 236 g, and mean largest myoma diameter was 8.5 cm +/- 2.6 cm. Overall, mean number of myomas removed was 2.5 +/- 2.4, and estimated blood loss (EBL) was 215 +/- 212 mL. Five patients (4.0%) received a blood transfusion, and 4 patients (3.2%) underwent conversion to laparotomy. Preoperative factors significantly associated with TOT included patient age, personal history of diabetes mellitus, uterine volume, number of myomas, number of myomas > 3 cm, diameter of the dominant myoma, and surgeon experience. The mean uterine volume was 282 cm(3) for procedures with a TOT < 3 hours, 461 cm(3) for procedures with a TOT of 3 to 5 hours, and 532 cm(3) for procedures with a TOT > 5 hours (p =.004). Body mass index, personal history of hypertension, previous abdominal/pelvic surgery, surgical indication, location of dominant myoma (anterior, posterior, or fundal) and classification of dominant myoma (submucosal, intramural, subserosal, or other) were not associated with TOT. Our preoperative calculator correctly predicted TOT category in 88% of the patients and estimated TOT within a 1-hour margin in 80% of patients.

Conclusion: RALM is becoming a more popular surgical approach for the management of uterine myomas. Preoperative radiographic evaluation and a thorough patient history may enhance patient counseling and surgical planning. Uterine volume and myoma number and size appear to be more predictive of TOT compared with myoma location. (C) 2019 AAGL. All rights reserved.

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Z9 9

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U2 0

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PT J

AU Shin, HJ

Yoo, HK

Lee, JH

Lee, SR

Jeong, K

Moon, HS

AF Shin, Hyun Joo

Yoo, Hae Kyung

Lee, Jung Hun

Lee, Sa Ra

Jeong, Kyungah

Moon, Hye-Sung

TI Robotic single-port surgery using the da Vinci SP® surgical system for

benign gynecologic disease: A preliminary report

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Gynecology; Laparoscopy; Robotic surgery; Single-port surgery

ID SITE HYSTERECTOMY; LEARNING-CURVE; FEASIBILITY; MYOMECTOMY

AB Objective: We aimed to present our initial experience with robotic single-port surgery performed using the da Vinci (R) SP surgical system for benign gynecologic diseases.

Materials and methods: This retrospective cohort study was performed at an academic tertiary care hospital From December 2018 to January 2019. Thirty-one women with benign gynecologic diseases underwent robotic single-port surgery performed using the da Vinci (R) SP surgical system.

Results: During the study period, hysterectomy, myomectomy, adnexectomy, and sacrocolpopexy were performed in seven, twelve, five, and seven women, respectively. The mean age and body mass index of patients, respectively, were 47.7 +/- 12.8 years and 22.7 +/- 3.1 kg/m(2). In terms of operative outcomes, the mean docking time, operating time, estimated blood loss, and hospitalization time were 2.2 +/- 2.1 min, 126.3 +/- 61.6 min, 93.9 +/- 76.9 mL, and 4.6 +/- 0.7 days. There was no laparoconversion or major complication.

Conclusion: Robotic single-port laparoscopy using the da Vinci (R) SP surgical system might be a suitable alternative surgical technique for various benign gynecologic diseases. However, further studies are required to clarify the feasibility and safety of the application of this novel robot surgical system. (C) 2020 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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Z9 24

U1 1

U2 5

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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ER

PT J

AU Stephens, AJ

Kennard, JA

Fitzsimmons, CK

Manyam, M

Kendrick, JE

Singh, C

McKenzie, ND

Ahmad, S

Holloway, RW

AF Stephens, Amanda J.

Kennard, Jessica A.

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Kendrick, James E.

Singh, Charanjeet

McKenzie, Nathalie D.

Ahmad, Sarfraz

Holloway, Robert W.

TI Robotic sentinel lymph node (SLN) mapping in endometrial cancer: SLN

symmetry and implications of mapping failure

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE SLN and lympadenectomy; lymph nodes; sentinel lymph node; uterine

cancer; surgical procedures; operative

ID LYMPHADENECTOMY; ALGORITHM; RISK

AB Purpose

To establish the bilateral pelvic concordance rate of the sentinel lymph node (SLN) and determine the likelihood of lymph node metastasis in cases of mapping failure.

Methods

A database analysis was performed on 414 patients with clinical stage I endometrial cancer who underwent SLN mapping followed by robotic hysterectomy and completion pelvic (n=414, 100%) and aortic (n=186, 44.9%) lymphadenectomy from March 2011 to August 2016. Stage, histology, SLN sites, and surgico-pathologic findings were analyzed. The bilateral concordance rate of SLN location, successful unilateral and bilateral mapping rates, false negative rate, and non-SLN metastasis associated with mapping failure were calculated.

Results

Histologies included 354 (85.5%) endometrioid, 39 (9.4%) serous, 16 (3.9%) carcinosarcoma, 4 (1.0%) clear cell, and 1 (0.2%) undifferentiated. Final stages included 262 (63.3%) IA, 36 (8.7%) IB, 15 (3.6%) II, 6 (1.4%) IIIA, 68 (16.4%) IIIC1, and 27 (6.5%) IIIC2. Bilateral SLN mapping was successful in 355 (85.7%) patients, and 266 (74.9%) demonstrated mapping to the symmetrical lymphatic group contralaterally. The mapping failure rate was 13.5% (56/414) unilaterally and 0.7% (3/414) bilaterally. SLN locations were external iliac (69.1%), obturator (25.1%), internal iliac (2.2%), common iliac (1.9%), pre-sacral (0.9%), aortic (0.4%), parametrial (0.3%), and para-rectal (0.1%). Lymph node metastases were identified in 95 (22.9%) pelvic and 27 (6.5%) aortic nodes. 10 (16.9%) cases with mapping failure had lymph node metastasis on completion lymphadenectomy, similar to the proportion of SLNs with metastases (p=0.35). However, macro-metastases were more common in mapping failure completion lymphadenectomies than in the positive SLNs (80% vs 22.3%, p<0.001).

Conclusion

The contralateral SLN location concordance rate was 75%. Most SLNs were along the medial external iliac or obturator locations. The rate of positive lymph nodes associated with SLN mapping failure was 16.9%, similar to the overall node-positive rate. The detection of pelvic node metastasis with SLN mapping failure was largely populated with macro-metastases and confirms the necessity of completion lymphadenectomy with mapping failure.

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U2 5

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AU Tucker, K

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TI Defining the learning curve for successful staging with sentinel lymph

node biopsy for endometrial cancer among surgeons at an academic

institution

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE sentinel lymph node; surgical procedures; operative; uterine cancer

ID LYMPHADENECTOMY; TRIAL; RISK

AB Background

Sentinel lymph node (SLN) biopsy is increasingly used in endometrial cancer staging; however, success of the technique is variable, and the learning curve needs to be better understood. Success is defined as identification of a SLN specimen containing nodal tissue in bilateral hemi-pelvises.

Objective

To assess the learning curve of surgeons at an academic institution in performing successful SLN mapping and biopsy during robotic staging for endometrial cancer.

Methods

After institutional review board approval, patients who underwent staging with robotic SLN mapping using indocyanine green at a single academic program between July 2012 and December 2017 were identified. Demographic, pathologic, and surgical data were retrospectively collected from the medical records. Descriptive and comparative statistics were performed. Surgeon rates of successful bilateral SLN mapping and removal of lymphoid-containing SLN specimens were compared. A logistic model was used to analyze the probability of successful SLN mapping and removal of lymph node-containing tissue with increasing number of procedures performed.

Results

Three hundred and seventeen patients met the eligibility criteria. Most had early-stage, low-grade endometrial cancer. A total of 194 (61%) patients had successful bilateral mapping. Among seven surgeons, a plateau in rates of successful bilateral mapping was achieved after 40 cases. No linear correlation was seen between the number of surgeries performed and the rate of removal of lymph node-containing tissue among surgeons. Each additional 10 procedures performed was associated with a 5% and an 11% increase in the odds of successful SLN mapping and removal of lymph node-containing tissue, respectively.

Discussion

The successful removal of lymph node-containing specimens appears to be a surgeon-specific phenomenon. The plateau of the learning curve for successful bilateral mapping seems to be reached at around 40 cases. These first 40 cases offer a time for auditing of individual rates of SLN mapping and removal to identify surgeons who may benefit from procedure-specific remediation.

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PT J

AU Narducci, F

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TI Risk Factors, Morbidity, and Quality of Life Associated with Same-Day

Discharge in Gynecologic Oncology

SO INDIAN JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Fast track surgery; Same-day discharge; Gynecological oncology;

Minimally invasive surgery; Single port; Robot-assisted laparoscopy;

Laparoscopy

ID INTRAVENOUS PARACETAMOL; EUROPEAN-ORGANIZATION; HYSTERECTOMY; CANCER;

PAIN; FEASIBILITY; MANAGEMENT; SURGERY; SAFETY

AB Purpose To determine the risk factors, morbidity, and quality of life associated with same-day surgery in gynecologic oncology. Methods In this prospective study, patients with a good performance status and an indication for a simple procedure [diagnostic laparoscopy (peritoneal carcinomatosis index, biopsy, and Port-A-Cath), adnexectomy or fimbriectomy] and a complex procedure [total hysterectomy, omentectomy with peritoneal staging, pelvic lymphadenectomy (or sentinel lymph node (SLN)), and/or paraaortic lymphadenectomy by minimally invasive surgery] were included. Univariate logistic regression analysis, multivariate analysis, and the Wilcoxon signed-rank test were used in the statistical analyses. Results There were 171 consecutive surgeries (55 complex and 116 simple procedures). The rate of readmissions on the same day and at 30 days postoperatively was, respectively, 8% versus 3% with simple procedures and 16% versus 11% with complex procedures. We modified our procedure to decrease complications by prescribing prophylactic low molecular weight heparin (LMWH) the next day at 8 am at home instead of the evening before discharge (fewer vaginal hematomas after hysterectomy: 2 hematomas/5 hysterectomies with LMWH on the same day versus 0/22 with LMWH on the next day, P = 0.03). The following factors were significantly associated with readmission: complex procedure (odds ratio [OR] 4.25, 95% confidence interval [CI] 1.66-10.85, P = 0.003), absence of an exsufflation drain (OR 2.96, 95% CI 1.19-7.31, P = 0.019), and end of surgery after 2 pm (OR 5.82, 95% CI 2.13-15.94, P = 0.001). Conclusion We modified our protocol to decrease complications (vaginal hematomas after hysterectomy) by prescribing prophylactic LMWH the next day at 8 am at home instead of the evening before discharge.

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NR 19

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PT J

AU Budden, A

Ravendran, K

Abbott, JA

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TI Identifying the Problems of Randomized Controlled Trials for the

Surgical Management of Endometriosis-associated Pelvic Pain

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Endometriosis and pain; Surgical treatment; Randomized controlled trial

ID QUALITY-OF-LIFE; DEEPLY INFILTRATING ENDOMETRIOSIS; LAPAROSCOPIC OVARIAN

CYSTECTOMY; UTERINE NERVE ABLATION; DOUBLE-BLIND; COLORECTAL RESECTION;

CONSERVATIVE SURGERY; PRESACRAL NEURECTOMY; SEVERE DYSMENORRHEA; LASER

LAPAROSCOPY

AB Objective: To report on randomized controlled trials (RCTs) that examine the surgical treatment of endometriosis-associated pelvic pain and to highlight their strengths and weaknesses.

Data Sources: We performed a systematic review of English-language, full-text articles addressing the surgical management of pain symptoms associated with endometriosis. The terms endometriosis, pain, surgery, laparoscopy, plasma, and laser were used for searches in Cochrane, MEDLINE, EMBASE, and clinical trial databases. Additional studies were identified from references in electronically located articles.

Methods of Study Selection: A literature search was conducted by 2 authors, and abstracts were independently screened for inclusion, with the resolution of any discrepancy by a third author. Randomized studies that reported pain before and after surgery were eligible for inclusion. Supporting data from nonrandomized trials were used for discussion. The Cochrane risk-of-bias assessment was performed on included studies.

Tabulation, Integration, and Results: Search results for available articles from 1996 to October 2019 revealed 594 potential studies, with 20 studies meeting the final inclusion criteria. Comparative studies of surgery vs no surgery for an effect on pain, surgical approach, the effect of different locations of disease on pain, nerve-dividing techniques for pain, and nerve-sparing effects for pain were studied. RCTs reported a substantial reduction in pain compared with no surgery in up to 80% of women; however, up to a third of women in these studies reported a placebo response. There was no evidence of a difference in pain reduction with the mode of surgery (laparoscopy, laparotomy, or robot-assisted laparoscopy). There is limited evidence stating that excision is superior to ablative surgery; however, there are confounders in the reporting of disease location and depth and the pain symptoms most affected. We need to reconsider the hypothesis that disc excision results in fewer complications and has superior outcomes to those of segmental resection in light of the first RCT on this subject. Nerve-dividing surgery for pain has been demonstrated to be of no value for uterosacral nerve ablation and/or division and of limited (if any) value for presacral neurectomy.

Conclusion: Although surgical RCTs have always been difficult to undertake, there are 16 RCTs on endometriosis-associated pain. Ethical considerations, the equipoise of surgeons and participants, and follow-up duration are important parameters in establishing RCTs. In addition, we must be willing to accept and adopt the evidence when it does demonstrate a particular outcome, such as the fact that surgical uterosacral nerve disruption does not improve pain or that disc excision does not substantially reduce complications compared with segmental resection for bowel disease, as suggested by previous nonrandomized studies. If we accept that a well-conducted RCT provides best-quality evidence, then we should at least be open to the possibility that our long-held views may be challenged and changed with new science in our practice. (C) 2019 AAGL. All rights reserved.

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PT J

AU Casarin, J

Song, C

Multinu, F

Cappuccio, S

Liu, E

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TI Implementing robotic surgery for uterine cancer in the United States:

Better outcomes without increased costs

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Endometrial cancer; Morbidity; Costs; Minimally

invasive surgery; Laparoscopy

ID MINIMALLY INVASIVE SURGERY; QUALITY-OF-LIFE; ENDOMETRIAL CANCER;

LAPAROSCOPIC HYSTERECTOMY; SURVIVAL; LAPAROTOMY; MANAGEMENT; MORBIDITY;

SAFETY; WOMEN

AB Objective: To examine the effect of robotic-assisted surgery implementation for treatment of endometrial cancer in the United States on 30-day clinical outcomes and costs.

Methods: We retrospectively reviewed data of adult patients who underwent total hysterectomy for endometrial cancer in the US hospitals in Premier Healthcare Database between January 1, 2008 and September 30, 2015. We conducted trend analyses comparing the proportions of surgical approaches with the associated clinical outcomes and costs over the study period using Mann-Kendall tests. Clinical outcomes and costs of robotic-assisted surgery, laparoscopic and open surgery have been compared after propensity score 1:1 matching in the most recent 3 years (January 1, 2013-September 30, 2015).

Results: Of a total of 35,224 patients, use of robotic-assisted surgery increased from 9.48% to 56.82% while open surgery decreased from 70.4% to 28.1% over the study period. A 2.5% decrease in major complications (P < .001), a 2.9% decrease in minor complications (P = .001), and a 2.0% decrease 30-day readmissions (P = .001) was observed across all surgical approaches. Perioperative 30-day total cost slightly decreased from US $11,048 to US $10,322 (P = .08). Among propensity-score matched patients, robotic-assisted surgery was associated with shorter hospitalization than open surgery (median [interquartile range], 2.0 [2.0-3.0] vs 4.0 [3.0-6.0] days) and laparoscopic surgery (2.0 [2.0-3.0] vs 3.0 [2.0 -4.0] days), fewer 30-day complications (20.1% vs 33.7%) (all P < .001), and comparable perioperative 30day total costs (median [interquartile range], US $12,200 [US $9,509-US $16,341] vs US $12,018 [US $8,996-US $17,162]; P = .34) with open surgery.

Conclusion: Robotic-assisted surgery facilitated the widespread diffusion of a minimally invasive approach nationally for endometrial cancer, with reduction of perioperative morbidity and no increase in overall treatment-related 30-day costs at national level. (C) 2019 Elsevier Inc. All rights reserved.

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PT J

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TI Comparing laparoscopic and robotic sacrocolpopexy surgical outcomes with

prior versus concomitant hysterectomy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Hysterectomy; Minimally invasive surgery; Intraoperative complications;

Sacrocolpopexy; Vaginal prolapse; Vaginal prolapse recurrence

ID PERIOPERATIVE COMPLICATIONS; TERM OUTCOMES; PROLAPSE; SURGERY; IMPACT

AB Introduction and hypothesis The objective was to compare surgical outcomes after prior hysterectomy versus concomitant hysterectomy with laparoscopic/robotic minimally invasive sacral colpopexy (MISC). Methods Using all MISC from 2009 to 2014, patient sociodemographic and surgical data were compared between MISC with prior versus concomitant hysterectomy. Operative time (skin incision to closure) was compared with linear regression. Logistic regression compared complications, a composite variable including >= 1 transfusion, infection, readmission, reoperation, bowel obstruction/ileus, conversion to laparotomy, bowel/bladder injury, or mesh complication. Logistic regression compared prolapse recurrence defined as retreatment (pessary/surgery) or postoperative POP-Q points >= 0. Results Eight hundred and sixteen patients were 59.6 +/- 8.7 years old and predominantly Caucasians (97.8%), with BMI 27.4 +/- 4.5 and predominantly POP-Q stage III prolapse (69.9%). Operative time was 205.0 +/- 69.0 min. Concomitant hysterectomy increased operative time 17.8 min (p = 0.004) adjusting for age, POP-Q stage, total vaginal length, perineal body, lysis of adhesions or perineorrhaphy, changes in operating personnel (scrub tech/circulating nurse), case order during the day, and preoperative stress incontinence. Complications occurred in 15.8% and were more likely with prior hysterectomy (odds ratio [OR] = 2.30, 95% confidence interval [CI] = 1.43-3.70) adjusting for preoperative genital hiatus and perineal body, concomitant midurethral sling, obesity, and immunosuppression. During a follow-up of 31 weeks, 7.8% had prolapse recurrence with no impact from concomitant hysterectomy (OR = 0.96, 95% CI 0.41-2.24). Post-hoc power calculation would have required an unattainable size of >2,800 per group for this outcome. Conclusions For MISC, concomitant hysterectomy is associated with longer operative time but lower risk of complications. There was no impact of concomitant hysterectomy on prolapse recurrence, but longer follow-up may be needed for this outcome.

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TI Surgeon-Team Separation in Robotic Theaters: A Qualitative Observational

and Interview Study

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE surgeon; team; separation; robotic; theater

ID OPERATING-ROOM; COMMUNICATION; EXPERIENCE

AB Background

The rapid uptake of robotic surgery has largely been driven by the improved technical aspects of minimally invasive surgery including improved ergonomics, wristed instruments, and 3-dimensional vision. However, little attention has been given to the effect of physical separation of the surgeon from the rest of the operating team.

Purpose

The aim of this study was to examine in depth how this separation affected team dynamics and staff emotions.

Methods

Robotic procedures were observed in 2 tertiary hospitals, and laparoscopic/open procedures were added for comparison; field notes were taken instantaneously. One-to-one interviews with theater team members were audio recorded and transcribed verbatim. Qualitative analysis was conducted via grounded theory approach using NVIVO11.

Results

Twenty-nine participants (26 interviewed) were recruited to the study (11 females) and 134 (109 robotic) hours of observation were completed across gynecology, urology, and colorectal surgery.

The following 3 main themes emerged with compounding factors identified: (a) communication challenge, (b) immersion versus distraction, and (c) emotional impact. Compounding factors included the following: individual and team experience, staffing levels, and the physical theater environment.

Conclusions

Our emergent theory is that "surgeon-team separation in robotic theaters poses communication challenges which impacts on situational awareness and staff emotions." These can be ameliorated by staff training, increased experience, and team/procedure consistency.

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NR 24

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Z9 9

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA KL1UA

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DA 2024-01-18

ER

PT J

AU Maheux-Lacroix, S

Belanger, M

Pinard, L

Lemyre, M

Laberge, P

Boutin, A

AF Maheux-Lacroix, Sarah

Belanger, Mathieu

Pinard, Lorence

Lemyre, Madeleine

Laberge, Philippe

Boutin, Amelie

TI Diagnostic Accuracy of Intraoperative Tools for Detecting Endometriosis:

A Systematic Review and Meta-analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Imaging tool; Laparoscopy; 5-Aminolevulinic acid; Narrow-band imaging;

White light

ID LAPAROSCOPIC SURGERY; LESIONS; PAIN; MANAGEMENT; EXCISION; CANCER; WOMEN

AB Objective: To evaluate the diagnostic accuracy of intraoperative laparoscopic imaging tools in reference to that of histopathology for detecting endometriotic lesions and to compare them with conventional white-light inspection by performing a systematic review with meta-analysis.

Data Sources: We searched the MEDLINE, EMBASE, and CENTRAL databases in addition to citations and reference lists until the end of February 2019.

Methods of Study Selection: Two authors screened 1038 citations for eligibility. We included randomized controlled trials or prospective cohort studies published in English, assessing the accuracy of intraoperative imaging tools for diagnosing endometriosis during laparoscopy. We considered studies using histopathologic evaluation as a standard criterion.

Tabulation, Integration, and Results: Seven studies were eligible, including 472 women and 1717 histopathologic specimens, and they involved study of the use of narrow-band imaging (2 studies), 5-aminolevulinic acid-induced fluorescence (2 studies), autofluorescence imaging (1 study), indocyanine green (1 study), and a 3-dimensional robotic laparoscopy (1 study). Two authors extracted data and assessed the validity of the included studies. Bivariate random-effects models and McNemar's test were used to compare the tests and evaluate sources of heterogeneity. Four studies were attributed a high risk of bias, and biopsies of normal-looking peritoneum were not performed to verify the results in 3 studies; both factors were identified as significant sources of heterogeneity, leading to the overestimation of the sensitivity and underestimation of the specificity of imaging tools. In all studies, additional endometriotic lesions were diagnosed with the enhanced imaging tool compared with white-light inspection alone. In the 4 studies that appropriately performed control biopsies (171 women, 448 specimens), enhanced imaging techniques were associated with a higher sensitivity and specificity compared with white-light inspection (0.84 and 0.89 compared with 0.75 and 0.76, respectively, p <= .001). Adverse events were uncommon (n = 5) and reported only with the use of exogeneous photosensitizers. There were no reports of long-term changes in patient-reported outcomes arising from better detection of endometriosis lesions.

Conclusion: Studies report that enhanced imaging allows for the detection of additional endometriotic lesions missed by conventional white-light laparoscopy. The benefits of finding these additional lesions using enhanced imaging compared with white-light inspection alone on long-term postoperative outcomes have not been determined, and these tools should be considered only in a research context at this time. (C) 2019 AAGL. All rights reserved.

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FU Fonds de Recherche Quebec-Sante

FX Sarah Maheux-Lacroix is the recipient of a Career Award from the Fonds

de Recherche Quebec-Sante.

NR 25

TC 4

Z9 4

U1 0

U2 4

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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GA KH4RZ

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ER

PT J

AU Song, J

Le, T

Hopkins, L

Fung-Kee-Fung, M

Lupe, K

Gaudet, M

Choan, E

Samant, R

AF Song, Jiheon

Le, Tien

Hopkins, Laura

Fung-Kee-Fung, Michael

Lupe, Krystine

Gaudet, Marc

Choan, E.

Samant, Rajiv

TI A comparison of disease recurrence between robotic versus laparotomy

approach in patients with intermediate-risk endometrial cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; MINIMALLY INVASIVE SURGERY; ABDOMINAL

HYSTERECTOMY; TREATMENT TIME; RADIATION TREATMENT; CERVICAL-CANCER;

SURVIVAL; BRACHYTHERAPY; RADIOTHERAPY; INTERVAL

AB Objective Advances in minimally invasive surgery, particularly with robotic surgery, have resulted in improved peri-operative outcomes in patients with endometrial cancer. In addition, randomized trials have shown that addition of adjuvant radiotherapy following surgery improves loco-regional disease control among stage I intermediate-risk endometrial cancer patients. We aimed to investigate the efficacy and safety of combined treatment of robotic surgery and adjuvant radiotherapy in this patient population.

Methods A single-center retrospective study was conducted on stage I endometrioid-type endometrial cancer patients with intermediate-risk features (<50% myometrial involvement and grade 2-3 histopathology, or >50% myometrial involvement and grade 1-2 histopathology) treated with hysterectomy and adjuvant radiotherapy between January 2010 and December 2015. Data on surgery and radiotherapy were collected and correlated with clinical and surgical outcomes using log-rank. Oncologic outcomes were then compared between robotic surgery and laparotomy.

Results A total of 179 intermediate-risk endometrial cancer patients were identified, of whom 135 (75.4%) received adjuvant radiotherapy and were included in the final analysis. Median age at diagnosis was 63 years (range 40-89) and median follow-up was 4.7 years (range 1.1-8.8). Seventy-seven patients (57%) underwent robotic surgery and 58 patients (43%) underwent laparotomy. Surgical staging with lymph node dissection was performed on 79.3% of the patients. The majority of patients (79.3%) received vaginal brachytherapy as part of adjuvant radiotherapy, while 20.7% received external-beam radiotherapy. Among the entire cohort, eight (5.9%) patients recurred and all eight recurrences occurred in the robotic surgery group; no recurrence was found in the laparotomy group. This translated into 5 year disease-free survival of 100% in the laparotomy group, compared with 91.8% in the robotic surgery group (p=0.005). No difference in overall survival was found between the two groups (p=0.51).

Conclusion Oncologic outcomes for stage I intermediate-risk endometrial cancer treated with hysterectomy and adjuvant radiotherapy at our institution are comparable to the previously published literature. The higher recurrence rate observed with robotic surgery at our institution has not been observed previously and requires further investigation.

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Z9 22

U1 0

U2 2

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA KT8OX

UT WOS:000519272300002

PM 31871112

OA Bronze

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ER

PT J

AU Brueseke, TJ

Wilkins, MF

Willis-Gray, MG

Husk, KE

Peedin, AR

Geller, EJ

Wu, JM

AF Brueseke, Taylor J.

Wilkins, Maggie F.

Willis-Gray, Marcella G.

Husk, Katherine E.

Peedin, Alexis R.

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Wu, Jennifer M.

TI Transfusion Rates and the Utility of Type and Screen for Pelvic Organ

Prolapse Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE antibody; prolapse; surgery; transfusion; type and screen

ID PERIOPERATIVE COMPLICATIONS; ALLOIMMUNIZATION; GUIDELINES; MEDICINE;

OUTCOMES; WOMEN; RISK

AB Objectives Limited data exist directly comparing the likelihood of blood transfusion by route of apical pelvic organ prolapse (POP) surgery. In addition, limited evidence is available regarding the risk of not ordering preoperative type and screen (T&S) in apical POP surgery. The objectives of the study are to (1) provide baseline data regarding the current need for preoperative T&S by comparing perioperative blood transfusion rates between 3 routes of apical POP surgery and (2) determine the rate of a positive preoperative antibody screen in women who underwent apical POP surgery. Methods This was a retrospective cohort study of women who underwent apical POP surgery by 3 different routes: abdominal (abdominal sacrocolpopexy), robotic (robotic sacrocolpopexy), or vaginal (uterosacral or sacrospinous ligament fixation). Results Among 610 women who underwent apical POP surgeries between May 2005 and May 2016, 24 women (3.9%) received a perioperative blood transfusion. The rate of transfusion was higher in the abdominal group (11.1%) compared with robotic (0.5%, P < 0.001) and vaginal (0.5%, P < 0.001). In a logistic regression model, abdominal route of POP surgery remained significantly associated with transfusion (odds ratio, 20.7; 95% confidence interval, 2.7-156.6). Among the 572 women who had a preoperative T&S performed, 9 (1.5%) had a positive antibody screen. Conclusions Blood transfusion was significantly more common in abdominal compared with robotic and vaginal apical POP surgeries. The rate of a positive antibody screen was low, suggesting that type O blood is low risk if cross-matched blood is not available. Thus, it may be reasonable to not order a preoperative T&S prior to robotic or vaginal apical POP surgery.

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NR 25

TC 4

Z9 4

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U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA KB3GQ

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ER

PT J

AU Casarin, J

Multinu, F

Tortorella, L

Cappuccio, S

Weaver, AL

Ghezzi, F

Cilby, W

Kumar, A

Langstraat, C

Glaser, G

Mariani, A

AF Casarin, Jvan

Multinu, Francesco

Tortorella, Lucia

Cappuccio, Serena

Weaver, Amy L.

Ghezzi, Fabio

Cilby, William

Kumar, Amanika

Langstraat, Carrie

Glaser, Gretchen

Mariani, Andrea

TI Sentinel lymph node biopsy for robotic-assisted endometrial cancer

staging: further improvement of perioperative outcomes

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE complications; endometrial cancer; morbidity; robotic surgery; sentinel

lymph node

ID LYMPHADENECTOMY; SURGERY; FEASIBILITY; SAFETY

AB Objectives It is unclear if sentinel lymph node biopsy is associated with improved surgical outcomes compared with lymphadenectomy in patients with endometrial cancer. In this study we aimed to compare peri-operative surgical outcomes and treatment-related morbidity in patients who underwent robotic-assisted sentinel lymph node biopsy versus systematic pelvic lymphadenectomy or hysterectomy alone for apparent early-stage endometrial cancer. Methods Records were reviewed of consecutive patients with International Federation of Gynecology and Obstetrics stages I-III endometrial cancer undergoing robotic-assisted staging from January 1, 2009, through June 30, 2016. For the purpose of this analysis we focused on the actual patients who had sentinel node biopsy only (ie, excluding those who had an associated lymphadenectomy either for failed mapping or during the learning curve). We also excluded patients who had para-aortic lymph node dissection from the lymphadenectomy group. Perioperative and 30-day surgical outcomes were compared between patients who underwent sentinel lymph node assessment and those who had pelvic lymphadenectomy or hysterectomy alone, respectively. Inverse probability of treatment weighting derived from propensity scores was used to minimize allocation bias in the comparison of outcomes between groups. Results A total of 621 patients were analyzed: 188 (30.3%) with sentinel lymph node biopsy, 198 (31.9%) with pelvic lymphadenectomy, and 235 (37.8%) with hysterectomy alone. Inverse probability of treatment weights analysis balanced for baseline characteristics (age, body mass index, American Society of Anesthesiologists score, Charlson co-morbidity index, parity, prior cesarean section, and previous abdominal operation) showed no significant differences in intra-operative and post-operative complications, re-admissions, and re-operations between the groups. Compared with pelvic lymphadenectomy, the sentinel lymph node biopsy group had a shorter mean operative time (138.0 vs 222.8 min, p<0.001) and less median blood loss (50 vs 100 mL, p<0.001). Sentinel lymph node biopsy also was not associated with worse morbidity compared with hysterectomy alone. Conclusions Introduction of sentinel lymph node biopsy reduces operative times and improves peri-operative surgical outcomes of robotic-assisted staging for apparent early-stage endometrial cancer without worsening the morbidity of hysterectomy alone.

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NR 24

TC 28

Z9 29

U1 1

U2 3

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JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA KD9JN

UT WOS:000508177700008

PM 31780567

DA 2024-01-18

ER

PT J

AU Fornalik, H

Fornalik, N

AF Fornalik, Hubert

Fornalik, Nicole

TI Robotic debulking of confluent pelvic lymph nodes

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE uterine cancer; lymphatic metastasis; surgical oncology; carcinosarcoma;

laparoscopes

ID CYTOREDUCTIVE SURGERY; CANCER

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WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA KD9JN

UT WOS:000508177700028

PM 31900286

OA Bronze

DA 2024-01-18

ER

PT J

AU Hwang, JH

Kim, BW

Kim, SR

Kim, JH

AF Hwang, Jong Ha

Kim, Bo Wook

Kim, Soo Rim

Kim, Jang Heub

TI Robotic Radical Hysterectomy Is Not Superior to Laparoscopic Radical

Hysterectomy in Perioperative Urologic Complications: A Meta-Analysis of

23 Studies

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopic radical hysterectomy; Meta-analysis; Perioperative urologic

complications; Robotic radical hysterectomy

ID CERVICAL-CANCER PATIENTS; CONVENTIONAL LAPAROSCOPY; SURGICAL OUTCOMES;

SURGERY; LYMPHADENECTOMY; LAPAROTOMY; SAFETY

AB Objective: This study aimed to compare the risks of intraoperative and postoperative urologic complications after robotic radical hysterectomy (RRH) compared with laparoscopic radical hysterectomy (LRH).

Data Sources: We searched Pubmed, EMBASE, and the Cochrane Library for studies published up to March 2019. Related articles and relevant bibliographies of published studies were also checked.

Methods of Study Selection: Two researchers independently performed data extraction. We selected comparative studies that reported perioperative urologic complications.

Tabulation, Integration, and Results: Twenty-three eligible clinical trials were included in this analysis. When all studies were pooled, the odds ratio for the risk of any urologic complication after RRH compared with LRH was .91 (95% confidence interval [CI],.64-1.28; p =.585). The odds ratios for intraoperative and postoperative complications after RRH versus LRH were.86 (95% CI,.48-1.55; p = .637) and.94 (95% CI,.64-1.38; p = .767), respectively. In a secondary analysis study quality, study location, and the publication year were not associated with intraoperative or postoperative urologic complications.

Conclusion: Current evidence suggests that RRH is not superior to LRH in terms of perioperative urologic complications. (C) 2019 AAGL. All rights reserved.

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Z9 2

U1 1

U2 7

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA JY3TU

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PM 31315060

OA Bronze

DA 2024-01-18

ER

PT J

AU Lim, EK

Ibeanu, O

Malhotra, T

Liang, D

Miller, MA

AF Lim, Eav K.

Ibeanu, Okechukwu

Malhotra, Tani

Liang, Derek

Miller, Mark A.

TI Lower Uterine Segment Involvement Is a Prognostic Factor for Recurrence

in Endometrial Cancer <i>A Study of Patient Cohort Treated with Open and

Minimally Invasive Surgery</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE cesarean section; endometrial cancer; gynecologic surgical procedures;

hysterectomy; laparoscopy; neoplasm recurrence; robotic surgical

procedures; uterine cancer

ID POSTOPERATIVE RADIATION-THERAPY; CESAREAN-SECTION; CORPUS; CARCINOMA;

PATTERNS; SPREAD; WOMEN; TRIAL

AB OBJECTIVE: To determine whether lower uterine segment involvement is associated with an increased risk of recurrence in endometrial cancer.

STUDY DESIGN: Case-controlled retrospective review of patients with endometrioid adenocarcinoma of the endomtetrium. Recurrence rates in patients with lower uterine segment involvement (LUSI) were compared to those without LUSI. Patients were stratified to disease stage, recurrence, mode of surgery, and history of cesarean delivery. Pearson's chi(2) test was used to compare populations, and multivariate analysis was performed using a logistic regression model.

RESULTS: Complete medical records were available for 469 patients. Of those, 230 patients had lower uterine segment involvement and 239 patients did not. A total of 221 underwent laparotomies as compared to 248 who underwent minimally invasive approach. Twenty-three patients in stage I and 27 with advanced stage had recurrence. In 91 patients with advanced stage, 69 had LUSI (p<0.001). Laparotomy patients had more association with LUSI as compared to laparoscopy/robotic (p =0.049). However, patients with LUSI undergoing laparoscopy robotics had higher recurrence (p= 0.026).There was no correlation between history of cesarean delivery and risk for development of LUSI (p=0.731).

CONCLUSION: Lower uterine segment involvement is associated with risk of recurrence in patients with stage IA endometrioid adenocarcinoma of the endometrium and laparoscopic/robotic approach.

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U2 2

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WC Obstetrics & Gynecology

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ER

PT J

AU Madueke-Laveaux, OS

Advincula, A

Grimes, CL

Walters, R

Kim, JH

Simpson, K

Truong, M

Young, C

Landau, R

Ryntz, T

AF Madueke-Laveaux, Obianuju S.

Advincula, Arnold

Grimes, Cara L.

Walters, Ryan

Kim, Jin Hee

Simpson, Khara

Truong, Mireille

Young, Constance

Landau, Ruth

Ryntz, Timothy

TI Comparison of Carbon Dioxide Absorption Rates in Gynecologic Laparoscopy

with a Valveless versus Standard Insufflation System: Randomized

Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Carbon dioxide (CO2) absorption; Insufflation; Laparoscopy; Shoulder

pain

ID LOW-PRESSURE PNEUMOPERITONEUM; ACID-BASE; CHOLECYSTECTOMY

AB Study Objective: The primary objective was to compare carbon dioxide (CO2) absorption rates in patients undergoing gynecologic laparoscopy with a standard versus valveless insufflation system (AirSeal; ConMed, Utica, NY) at intraabdominal pressures (IAPs) of 10 and 15 mm Hg. Secondary objectives were assessment of surgeons' visualization of the operative field, anesthesiologists' ability to maintain adequate end-tidal CO2 (etCO(2)), and patients' report of postoperative shoulder pain.

Design: A randomized controlled trial using an equal allocation ratio into 4 arms: standard insufflation/IAP 10 mm Hg, standard insufflation/IAP 15 mm Hg, valveless insufflation/IAP 10 mm Hg, and valveless insufflation/IAP 15 mm Hg.

Setting: Single tertiary care academic institution.

Patients: Women >= 18 years old undergoing nonemergent conventional or robotic gynecologic laparoscopic surgery.

Interventions: A standard or valveless insufflation system at IAPs of 10 or 15 mm Hg.

Measurements and Main Results: One hundred thirty-two patients were enrolled and randomized with 33 patients per group. There were 84 robotic cases and 47 conventional laparoscopic cases. CO2 absorption rates (mL/kg\*min) did not differ across groups with mean rates of 4.00 +/- 1.3 in the valveless insufflation groups and 4.00 +/- 1.1 in the standard insufflation groups. The surgeons' rating of overall visualization of the operative field on a 10-point Likert scale favored the valveless insufflation system (median visualization, 9.0 +/- 2.0 cm and 9.5 +/- 1.8 cm at 10 and 15 mm Hg, respectively) over standard insufflation (7.0 +/- 3.0 cm and 7.0 +/- 2.0 cm at 10 and 15 mm Hg, respectively; p <. 001). The anesthesiologists' ability to maintain adequate etCO(2) was similar across groups (p =.417). Postoperative shoulder pain scores were low overall with no significant difference across groups (p >. 05).

Conclusion: CO2 absorption rates, anesthesiologists' ability to maintain adequate etCO(2), and postoperative shoulder pain did not differ based on insufflation system type or IAP. Surgeons' rating of visualization of the operative field was significantly improved when using the valveless over the standard insufflation system. (C) 2019 AAGL. All rights reserved.

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ER

PT J

AU Matecha, J

Chmel, R

Novácková, M

Pastor, Z

Chmel

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TI Simplification of the uterus retrieval for transplantation:

robotic-assisted approach and the graft outflow using ovarian veins

SO CESKA GYNEKOLOGIE-CZECH GYNAECOLOGY

LA Czech

DT Article

DE absolute uterine factor infertility; living donor; nerve-sparing

surgery; robotic-assisted hysterectomy; uterus transplantation

ID CYNOMOLGUS-MACAQUES; 1ST REPORT; AUTOTRANSPLANTATION; FERTILITY

AB Objective: An analysis of assumptions and current results of a robotic-assisted approach to minimize the surgical morbidity and maintain the postoperative quality of life in living donors of uterus undergoing graft retrieval for transplantation.

Design: Review article.

Setting: Department of Obstetrics and Gynaecology, First Faculty of Medicine, Charles University and Hospital Bulovka, Prague and Department of Obstetrics and Gynaecology, Second Faculty of Medicine, Charles University and Motol University Hospital, Prague.

Methods: Literature search using the Web of Science, Google Scholar and Pubmed databases with keywords: absolute uterine factor infertility, donor surgery, living donor, robotic-assisted hysterectomy and, uterus transplantation, and an analysis of the articles published in peer-reviewed journals with impact factor.

Results: The experience with open, laparoscopic and robotic-assisted nerve-sparing radical hysterectomies to maintain the quality of life in women undergoing surgery confirms the need to preserve hypogastric and pelvic splanchnic nerves, including the vesical branches of the pelvic plexus. Precise robotic dissection of the ureters and uterine arteries should prevent injury to these nerve structures even in the procurement of the uterus for transplantation. It should help to the reduction of postoperative side effects as the bladder and rectum evacuation disorders as well as sexual dysfunction in the living donors of uterus. The preparation of uterine veins is the most difficult, time-consuming and worst predictable part of the uterine retrieval. In comparison, the preparation of the ovarian veins is technically simpler as well as effective in venous outflow from the uterine graft.

Conclusion: The simplification of the technique of uterine graft retrieval in the living donor should be one of the basic steps to introduce uterine transplantation as a causal treatment of infertility in women without uterus. Robotic-assisted procurement of the uterus and, moreover, the use of venous outflow from the graft exclusively via ovarian veins could contribute to the higher availability of the uterine transplantation, particularly due to a better reproducibility of the procurement surgeries in the living donors.

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U1 0

U2 1

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J9 CES GYNEKOL

JI Ces. Gynekol.

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ER

PT J

AU Tantchev, L

Yordanov, A

Marinov, V

Kotzev, A

AF Tantchev, Latchezar

Yordanov, Angel

Marinov, Veselin

Kotzev, Andrey

TI Stage one adenocarcinoma of uterine cervix in a patient with systemic

lupus erythematosus - a clinical case

SO MENOPAUSE REVIEW-PRZEGLAD MENOPAUZALNY

LA English

DT Article

DE systemic lupus erythematosus; adenocarcinoma of uterine cervix; robotic

surgery

ID RISK; CANCER; WOMEN; DYSPLASIA; LESIONS

AB Introduction: The systemic lupus erythematosus (SLE) is a comparatively rare chronic autoimmune disease in women of reproductive age, the pathogenesis and therapy of which also conditions the increased risk of development of malignant diseases.

Case report: We present a clinical case of a 38-year-old female patient with lupus and stage 1B1 adenocarcinoma of uterine cervix, in which robotic radical hysterectomy with pelvic lymph node dissection has been successfully performed. The strict primary and secondary prophylaxis for pathological changes of uterine cervix are of essential significance for patients with lupus.

Conclusions: SLE is a chronic autoimmune disease, which is frequently treated with immunosuppressors, and affects most often women in reproductive age. The combination of these conditions is associated with higher risk of infecting with HPV and occurrence of pre-cancer and cancer of uterine cervix. Based on these reasons women with SLE must undergo strict screening follow-up and vaccination against high-risk strains of HPV. In the cases of cancer of uterine cervix diagnosed in initial stage, the striving towards minimal traumatism and better quality of life of patient - and, at the same time, towards achievement of optimal radicality - directs to the choice of minimally invasive operative method such as the robotic surgery.

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JI Prz. Menopauzalny

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AU Vitale, SG

Ludwin, A

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Ludwin, Artur

Vilos, George Angelos

Torok, Peter

Tesarik, Jan

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TI From hysteroscopy to laparoendoscopic surgery: what is the best surgical

approach for symptomatic isthmocele? A systematic review and

meta-analysis

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Caesarean scar defect; Hysteroscopy; Isthmocele; Laparoscopy; Niche;

Vaginal repair

ID CESAREAN-SECTION SCAR; LAPAROSCOPIC REPAIR; VAGINAL REPAIR; OPERATIVE

HYSTEROSCOPY; ULTRASOUND FINDINGS; DEFECTS; WOMEN; RESECTION; DELIVERY;

PREGNANCY

AB Purpose To investigate the effectiveness and risks of different surgical therapies for isthmocele in symptomatic women with abnormal uterine bleeding, infertility, or for the prevention of obstetric complications, considering safety and surgical complications. Methods PubMed/MEDLINE, Scopus, Embase, Science Direct, and Cochrane Library were systematically searched (n degrees CRD4201912035) for original articles on the surgical treatment of isthmocele published between 1950 and 2018. Data synthesis was completed using MedCalc 16.4.3. The body of evidence was assessed using the GRADE methodology. Results We retrieved 33 publications: 28 focused on a single surgical technique, and five comparing different techniques. Meta-analysis showed an improvement of symptoms in 85.00% (75.05-92.76%) of women after hysteroscopic correction, 92.77% (85.53-97.64%) after laparoscopic/robotic correction, and 82.52% (67.53-93.57%) after vaginal correction. Hysteroscopic surgery was associated with the lowest risk of complications (0.76%, 0.20-1.66%). Conclusions We found adequate evidence supporting the use of surgery for the treatment of symptomatic isthmocele, as it was found to improve the bleeding symptoms in more than 80% of patients. Differently, we found a lack of evidence regarding the role of surgery with the purpose of improving fertility or reducing the risk of obstetric complications in women with asymptomatic isthmocele. The hysteroscopic correction of isthmocele may be the safest and most effective strategy in those patients with adequate residual myometrial thickness overlying the isthmocele. Laparoscopic and vaginal surgeries may be the preferred options for patients with a thinner residual myometrium over the defect (< 2.5 mm) and when hysteroscopic treatment is inconclusive.

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U2 8

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PT J

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TI Safety and efficacy of contained manual morcellation during laparoscopic

or robotic gynecological surgery

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Contained morcellation; Manual morcellation; Specimen removal

ID SUPRACERVICAL HYSTERECTOMY; POWER MORCELLATION

AB Objective To assess the safety and efficacy of contained manual morcellation (CMM) with a tissue pouch during minimally invasive robotic or laparoscopic surgeries. Methods A retrospective cohort study included women who underwent robotic or laparoendoscopic single-site surgery at a tertiary referral center between February 2014 and April 2017. The specimen was postoperatively contained, sliced into one or more long strips, and then pulled out. The surgical type, specimen containment time, containment failure rate, specimen weight, manual morcellation time, and overall CMM speed (g/min) were recorded. Surgical complications related (bowel or bladder injury, ureteral injury, vascular injuries, and tumor dissemination) or not related (delayed wound healing, infection, and hernia) to CMM were also documented. The patients were followed up for 2 years. Results A total of 165 cases were recorded, comprising 149 cases that underwent laparoscopic and 16 that underwent robotic gynecological surgeries. The average time for specimen containment and manual morcellation in CMM was 6.7 +/- 5.0 and 13.2 +/- 11.2 min, respectively. The mean morcellation speed was 25.1 +/- 8.5 g/min. Among the specimens, those of the uterus with adenomyosis had the lowest CMM speed (21.4 +/- 8.0 g/min), whereas those of the uterus with myoma had the highest speed (27.5 +/- 8.9 g/min). The pouch perforation rate after CMM was 13.3% and no pouch-related complication was noted. Conclusion CMM is an efficient method for specimen removal.

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Z9 12

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U2 1

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JI Int. J. Gynecol. Obstet.

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PT J

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Papini, F

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TI Sentinel-lymph-node mapping with indocyanine green in robotic-assisted

laparoscopic surgery for early endometrial cancer: a retrospective

analysis

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Gynecological malignancy; lymphadenectomy; robotic surgery; surgical

staging; indocyanine green

ID EARLY-STAGE ENDOMETRIAL; ASTEC TRIAL; LYMPHADENECTOMY; UTERINE;

RADIOTRACER; METASTASIS; GUIDELINES; MANAGEMENT; BIOPSY

AB Background: The therapeutic value of lymphadenectomy in early stage endometrial cancer (EC) is still debated. Sentinel-h mph-node identified with indocyanine green (ICG) can replace lymphadenectomy in the staging of endometrial cancer minimizing the potential morbidity of a complete lymphadenectomy. The aim of this study was to analyze our initial experience using indocyanine green for sentinel-lymph-node mapping in a minimally robotic-assisted laparoscopic approach with Da Vinci XI near-infrared (MR) fluorescence imaging system.

Methods: A total of 23 patients who underwent robot-assisted laparoscopic surgery with the Da Vinci Xi Surgical System (Intuitive Surgical, Sunny ale, CA, USA) with NM imaging and ICG fluorescence detection for early stage EC were retrospectively analyzed.

Results: Sentinel-lymph-node mapping was achieved in 18 patients for a detection rate of 78.26%, bilateral pelvic detection was possible in 14 patients (60.9%) and no sentinel-lymph-node mapping was noted in 4 patients (17.4%). We compared 11 patients (Group 1) at intermediate and high- risk of recurrence who underwent sentinel-lymphnode mapping and pelvic lymphadenectomy and 12 patients (Group 2) at low risk of recurrence who underwent only sentinel-lymph-node mapping. A statistically significant difference was found for the average operation time and for the hospital stays.

Conclusion: The high detection rate, absence of intraoperative or postoperative complications, the short time required for mapping and removal of the sentinel-lymph-nodes and the short duration of the hospital stay, support performing sentinel-lymph-node in all women with early endometrial cancer.

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JI Facts Views Vis. ObGyn

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TI Impact of surgical approach on oncologic outcomes in women undergoing

radical hysterectomy for cervical cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cervical cancer; hysterectomy; laparoscopy; laparotomy; minimally

invasive surgical procedures; robotic surgical procedures; uterine

cervical neoplasms

ID OPEN SURGERY; SURVIVAL; CARCINOMA; VOLUME

AB BACKGROUND: Recent studies demonstrating shorter survival among cervical cancer patients undergoing minimally invasive versus open radical hysterectomy could not account for surgeon volume and require confirmation in other jurisdictions with larger sample sizes, longer follow-up, and data on disease recurrence.

OBJECTIVE: To determine if surgical approach is associated with oncologic outcomes in cervical cancer patients undergoing minimally invasive or open radical hysterectomy, while accounting for mechanistic factors including surgeon volume.

STUDY DESIGN: We performed a population-based retrospective cohort study of cervical cancer patients undergoing primary radical hysterectomy by a gynecologic oncologist from 2006 to 2017 in Ontario, Canada. A multivariable marginal Cox proportional hazards model and cause-specific hazards model were used to evaluate the association of surgical approach with all-cause death and recurrence respectively, clustering at the surgeon level. We tested for interactions between surgical approach and either pathologic stage or surgeon volume.

RESULTS: We identified 958 patients (minimally invasive 475; open 483) with mean age 45.9 and a median follow-up of 6 years. Of minimally invasive procedures, 89.6% were performed laparoscopically and 10.4% robotically. The unadjusted 5-year cumulative incidences of all-cause death (minimally invasive 12.5%; open 5.4%), cervical cancer death (minimally invasive 9.3%; open 3.3%), and recurrence (minimally invasive 16.2%; open 8.4%) were significantly increased for minimally invasive radical hysterectomy in patients with stage IB disease, but not the cohort overall. After adjusting for patient factors and surgeon volume, minimally invasive radical hysterectomy was associated with increased rates of death (hazard ratio [HR], 2.20; 95% confidence interval [CI], 1.15-4.19) and recurrence (HR, 1.97; 95% CI, 1.10-3.50) compared to open radical hysterectomy in patients with stage IB disease (n = 534), but not IA disease (n = 244; HR, 0.73; 95% CI, 0.13-4.01; HR, 0.34; 95% CI, 0.10-1.10).

CONCLUSION: Minimally invasive radical hysterectomy is associated with increased rates of death and recurrence in patients with stage IB cervical cancer even after controlling for surgeon volume; open radical hysterectomy should be the recommended approach in this population. Although there may be a subset of patients with microscopic early-stage disease for whom minimally invasive radical hysterectomy remains safe, additional studies are required.

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AU Damiani, GR

Villa, M

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Muzzupapa, Giuseppe

Pellegrino, Antonio

TI Outcomes of robotic surgery performed in patients with high BMI class:

experience by a single surgeon

SO MINERVA GINECOLOGICA

LA English

DT Article

DE Endometrial neoplasms; Robotic surgical procedures; Morbid obesity

ID ENDOMETRIAL CANCER; POSTOPERATIVE RECOVERY; RADICAL HYSTERECTOMY;

OVARIAN-CANCER; FOLLOW-UP; RISK; PREHABILITATION; OBESITY; LAPAROSCOPY;

MORTALITY

AB BACKGROUND: Advanced laparoscopic procedures have been shown to be safe in patients with high Body Mass Index (BMI), but conversion rates remain high. This analysis aimed to evaluate the feasibility and clinical outcomes in terms of long- and short-term complications. pain relief of robotic surgery in morbidly obese patients.

METHODS: Patients with BMI class I-II-III with endometrial cancer or hyperplasia were treated with robotic hysterectomy (RH). Patients' characteristics, operating room time (an. type of surgery. length of hospital stay, and incidence of complications were recorded. Records were reviewed for demographic data, medical/surgical history and comorbidities, perioperative findings and outcomes. as well as long-term complications and recurrences. Regarding stage, according to 2009 FIGO. 26 of cases were IA. while eight and five of cases were, respectively, IB. II stage.

RESULTS: A total of 87 consecutive RH were analyzed. The more frequent comorbidity was hypertension. Twenty percent of the patients had multiple comorbidities (>2). The mean age was 63 +/- 10 years, with a mean BMI of 36 +/- 8.2 kg/m(2). The more frequent BMI group treated was II class. The median OT was 114 minutes (range: 49-270). According to the Dindo Classification, there were no differences in major or minor complications between the 3 BMI classes. This series had a median follow-up of 60 months (range: 8-96) with an overall survival rate of 100%. The RRH+PLH was feasible and pathology confirmed the adequacy of the surgical specimen, with a median count of 20 nodes.

CONCLUSIONS: Our data support the adoption of the surgical management of the morbidly obese patient. Although short term complication rates are higher with increasing obesity (II-III class), a majority of procedures can still be completed with minimally invasive approach.

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NR 32

TC 1

Z9 1

U1 0

U2 4

PU EDIZIONI MINERVA MEDICA

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PA CORSO BRAMANTE 83-85 INT JOURNALS DEPT., 10126 TURIN, ITALY

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J9 MINERVA GINECOL

JI Minerva Ginecol.

PD DEC

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VL 71

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PG 7

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

GA KN4OC

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DA 2024-01-18

ER

PT J

AU Gest, R

Timoh, KN

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TI Robotic surgery program in gynecology: Lessons from the first 100

procedures

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Article

DE Robotic surgery; Oncologic gynecologic surgery; Learning curve

ID ASSISTED LAPAROSCOPY; LAPAROTOMY; IMPACT

AB Introduction - The objective of this work is to report the first 6 months of a robotic program in a surgical gynecological team, trained in advanced laparoscopy, in terms of operating times, complication rate, analgesic consumption and average duration of hospitalization.

Methods - This is a prospective observational study, intended to treat.

Results - During the study period, 98 women underwent laparoscopic robot assisted surgery. The average BMI was 27.2 kg/m(2) (+/- 7). Malignant diseases accounted for 41% of operative indications. Comparing the first 30 procedures to the last 30 procedures, there is a significant decrease in docking times: 14.7 min (+/- 7.0) vs 8.9 min (+/- 5.0), P = 0.009. There is also a trend towards a decrease in operative times for hysterectomy: 151.9 min (+/- 56.2) vs 113 min (+/- 51.4), P = 0.08. The rates of complications were not significantly different at the beginning and end of inclusion during the study (10.0% vs 16.7%).

Conclusion - The implementation of a robotic surgery program in a gynecological surgery department does not lead to an increase in complications for the patients, including for the first procedures. The learning curve mainly allows a reduction in the robot's installation time. (C) 2019 Elsevier Masson SAS. All rights reserved.

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Z9 2

U1 0

U2 1

PU ELSEVIER FRANCE-EDITIONS SCIENTIFIQUES MEDICALES ELSEVIER

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J9 GYNECOL OBST FERT SE

JI Gynecol. Obstet. Fertil. Senol.

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WC Obstetrics & Gynecology

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PT J

AU Göçmen, A

Sanlikan, F

AF Gocmen, Ahmet

Sanlikan, Fatih

TI Robotic Surgery in Endometrial Cancer

SO CURRENT OBSTETRICS AND GYNECOLOGY REPORTS

LA English

DT Article

DE Robotic surgery; Endometrial cancer; Minimal invasive surgery

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; LAPAROTOMY; OUTCOMES

AB Purpose of Review The number of minimal invasive gynecological oncological operations performed especially for endometrial cancer is increasing rapidly parallel with the increase in robotic systems in hospitals. This paper focuses on evaluating the studies comparing robotic surgery with laparoscopic and open surgery in patients with endometrial cancer in light of current literature. Recent Findings When the current literature is examined, it is seen that the results of robotic surgery have similar results to laparoscopy such as length of hospital stay, postoperative pain, recovery in a short time, and less blood vessels, and they are disadvantageous in terms of cost compared with laparoscopy. When compared with laparotomy, it is emphasized that there is no difference in terms of intraoperative oncologic surgery results and it is a method that can be chosen as a minimally invasive surgery option especially in obese patients because of its ergonomics. Although there is no randomized controlled study comparing the results of laparoscopic and open surgery with robotic surgery, retrospective data suggests that perioperative morbidity in robotic surgery is less and improves in terms of intraoperative surgical outcomes. As with benign gynecological procedures, randomized controlled trials are needed to identify patients who may benefit from robotic surgery and to better define clinical outcomes. It should be noted that randomized controlled trials comparing surgical and robotic-assisted surgery with laparoscopy are lacking and most of them are derived from retrospective data.

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NR 34

TC 0

Z9 0

U1 0

U2 2

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J9 CURR OBSTET GYNECOL

JI CURR. OBSTET. GYNECOL. REP.

PD DEC

PY 2019

VL 8

IS 4

BP 130

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DI 10.1007/s13669-019-00271-y

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA KU4JN

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DA 2024-01-18

ER

PT J

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TI Preemptive Oral Compared With Intravenous Acetaminophen for

Postoperative Pain After Robotic-Assisted Laparoscopic Hysterectomy <i>A

Randomized Controlled Trial</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID VISUAL ANALOG SCALE

AB OBJECTIVE: To compare pain after robotic-assisted laparoscopic hysterectomy when giving preoperative oral compared with intravenous acetaminophen.

METHODS: This double-blind randomized trial included women undergoing robotic-assisted laparoscopic hysterectomy for benign indications. Participants received either acetaminophen 1 g orally then normal saline 100 mL intravenously before surgery, or a placebo orally then acetaminophen 1 g intravenously. The primary outcome measured was difference in pain between the groups 2 hours postoperatively. A sample size of 74 participants (37/group) was needed to achieve 80% power to detect noninferiority using a one-sided, two-sample t-test with an alpha of 0.025 and a noninferiority margin of 10 mm.

RESULTS: From April 2016 through August 2017, 77 patients were enrolled, with 75 participants included in the final analysis. Characteristics were similar between groups. No difference in average pain score was noted 2 hours after surgery, nor at any of the measured time points. Average scores for the oral and intravenous group, respectively, at 2 hours were 35 and 36 mm (P =.86), at 4 hours 36 and 37 mm (P =.96), and at 24 hours 35 and 36 mm (P =.79). Thirty-eight percent of participants in the oral group and 19% of participants in the intravenous group experienced nausea (P =.12). The oral group used 9.7 morphine equivalents in the recovery room, and the intravenous group used 9.5 morphine equivalents (P=.9). The oral group requested analgesia in 45 minutes on average, and the intravenous group requested analgesia in 43 minutes (P=.79).

CONCLUSION: No difference in pain was observed 2 hours postoperatively when comparing preoperative administration of oral compared with intravenous acetaminophen. Given the ease of administration and lower cost of oral dosing, this study supports the oral route as part of the enhanced recovery after surgery protocol for minimally invasive gynecologic surgery.

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NR 13

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Z9 15

U1 0

U2 0

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JI Obstet. Gynecol.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA Bronze

DA 2024-01-18

ER

PT J

AU Querleu, D

Rychlik, A

AF Querleu, Denis

Rychlik, Agnieszka

TI Technical Aspects of Endosurgical Extraperitoneal Aortic Lymph Node

Dissection in Gynaecologic Oncology

SO INDIAN JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparoscopic surgery; Aortic lymph node dissection; Gynecologic oncology

ID LAPAROSCOPIC PARAAORTIC LYMPHADENECTOMY; ADVANCED CERVICAL-CANCER;

SINGLE-PORT LAPAROSCOPY; CONVENTIONAL LAPAROSCOPY; TRANSPERITONEAL;

MALIGNANCIES; FEASIBILITY; CARCINOMA; SURGERY; SAFETY

AB Introduction Laparoscopic aortic node dissection can be performed using extraperitoneal techniques. The surgical technique has been made much easier by the development of multifunction instruments, combining sophisticated bipolar thermal fusion and sharp incision, or using harmonic hemostasis. These instruments improve ergonomy, and may reduce the lymphocyst formation rate, the more frequent complication of extraperitoneal lymph node dissection. Robotic assistance is feasible and safe, but that does not provide significant improvement in perioperative outcomes. Laparoscopic or robot-assisted single port has been used by several investigators, which led to the same conclusions. Interestingly, the left lateral extraperitoneal approach can be extended to the left pelvic sidewall, allowing to resect suspicious nodes, sentinel nodes or to complete left pelvic lymph node dissection. Materials and Methods In this paper, a review of the technical aspects including surgical steps, instrumentation, and comparative studies of perioperative outcomes has been carried out. A PubMed search was carried out from the year 1995, including the terms "extraperitoneal" "aortic" "lymph node dissection". Comparative studies investigating the benefits of the extraperitoneal approach compared to the transperitoneal approach were carefully screened. One animal randomized study and one clinical randomized study are available, along with meta-analyses or reviews of retrospective comparative studies. Results No difference was observed in terms of duration of the surgery, blood loss, postoperative complications, hospital stay, and node yield. The extraperitoneal technique overall generates less adhesions, and the intraoperative complication rate is significantly lower than in the transperitoneal approach. The proportion of patients in whom the operation can be satisfactorily completed by this approach is over 90%. The advantages of the extraperitoneal approach are more in obese patients, in relation to the absence of interference of the bowel loops in the operative field, and a higher feasibility. Conclusion The extraperitoneal endosurgical approach is an indispensable tool which must be mastered by gynaecologic oncologists. Extraperitoneal aortic lymph node dissection can be used as a staging procedure, or a part of a full endoscopic operation encompassing intraperitoneal steps like omentectomy and hysterectomy in the surgical staging of endometrial and ovarian cancer.

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NR 32

TC 0

Z9 0

U1 0

U2 7

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J9 INDIAN J GYNECOL ONC

JI Indian J. Gynecol. Oncol.

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WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

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GA JL6OP

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DA 2024-01-18

ER

PT J

AU Souders, CP

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Hannemann, A

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Cohen, T

Weigl, M

Anger, JT

AF Souders, Colby P.

Catchpole, Ken

Hannemann, Alex

Lyon, Ronit

Eilber, Karyn S.

Bresee, Catherine

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Weigl, Matthias

Anger, Jennifer T.

TI Flow disruptions in robotic-assisted abdominal sacrocolpopexy: does

robotic surgery introduce unforeseen challenges for gynecologic

surgeons?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Da Vinci system; Flow disruptions; Human factors research; Robotic

surgical procedures; Sacrocolpopexy

ID PATIENT SAFETY; OPERATING-ROOM; PERFORMANCE; FAILURES; SKILLS

AB Introduction and hypothesis The purpose of this study was to apply a human factors research approach to identify flow disruptions, deviations in the optimal course of care, in robotic abdominal sacrocolpopexy procedures with the ultimate goal of developing system interventions to improve the safety and efficiency of robotic surgery. Methods Twenty-four robotic abdominal sacrocolpopexy procedures were observed for flow disruptions. Surgeries were divided into four phases: (1) patient arrival and induction of anesthesia; (2) port placement and robot docking; (3) console time; (4) undocking of robot, incision closure, and patient exiting the OR. Results Flow disruptions were observed at a rate of 10.9 +/- 5.1 per hour. The most frequently observed flow disruptions involved training issues (2.8 +/- 2.4 flow disruptions per hour), equipment (2.2 +/- 1.6 flow disruptions per hour), and poor coordination (2.0 +/- 1.3 flow disruptions per hour). The rate of flow disruptions was highest in phase 2 (19.2 +/- 14.4 flow disruptions per hour). Cases with more experienced surgeons involved shorter console times by 1.5 h (95% CI: 0.1, 3.0, p = 0.033) and 1.8 fewer (95% CI: 1.2, 2.6, p = 0.001) flow disruptions per hour. Surgeries were 1 h shorter on average (95% CI: 0.1, 1.9, p = 0.034) in cases in which the patient was > 65 years old. Da Vinci S console times were 0.8 h longer (95% CI: 0.01, 1.5, p = 0.047) than Si. Conclusions Flow disruptions in robotic abdominal sacrocolpopexy surgery occur about every 6 min. Flow disruption rates are highest during the most complex portions of the surgery. More experienced surgeons have lower flow disruption rates and operate more quickly.

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FX This study was funded by National Institute of Biomedical Imaging &

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Medical Student Training in Aging Research Program-the National

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NR 15

TC 12

Z9 12

U1 0

U2 5

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J9 INT UROGYNECOL J

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ER

PT J

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TI Updates and Controversies of Robotic-Assisted Surgery in Gynecologic

Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic surgery; gynecology; minimally invasive surgery; controversies;

MIS utilization; MIS costs

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; MINIMALLY INVASIVE SURGERY; OPEN

RADICAL HYSTERECTOMY; PELVIC RADIATION-THERAPY; TELELAP ALF-X;

ENDOMETRIAL CANCER; ABDOMINAL MYOMECTOMY; RANDOMIZED-TRIAL;

CERVICAL-CANCER; COST

AB minimally invasive surgery (MIS) is the standard approach to performance of several gynecologic procedures, including hysterectomy, gynecologic cancer staging procedures, myomectomy, pelvic organ prolapse repair, and select adnexal procedures. Robotic-assisted surgery, a computer-based MIS approach, has been adopted widely in the United States and several other countries. Robotics may offer technological and ergonomic benefits that overcome limitations associated with conventional laparoscopy; however, it is not clear that reported claims of superiority translate into improved gynecologic patient outcomes compared with other MIS approaches. This review critically appraises the evolving role, benefits, limitations, and controversies of robotic-assisted surgery utilization in benign and oncologic gynecology settings.

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FU NCI NIH HHS [P50 CA098252] Funding Source: Medline

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TC 23

Z9 25

U1 2

U2 7

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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SC Obstetrics & Gynecology

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ER

PT J

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Pauls, Rachel N.

TI Associating genital hiatus size with long-term outcomes after apical

suspension

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Wide genital hiatus; Apical support; Concurrent posterior repair;

Long-term outcomes; Prolapse recurrence

ID PELVIC ORGAN PROLAPSE; UROGENITAL HIATUS; WOMEN; SACROCOLPOPEXY;

INCONTINENCE; SURGERY

AB Introduction and hypothesis To describe associations between postoperative genital hiatus (GH) measurements and long-term anatomical and subjective outcomes following pelvic reconstructive surgery involving apical suspension. Methods This IRB-approved secondary analysis reports outcomes 3-7 years following robotic sacrocolpopexy (RSC) and uterosacral ligament suspension (USLS). Objective and subjective measures were obtained through clinical examinations and validated questionnaires. Subjective success was defined as the absence of a symptomatic bulge or retreatment. Objective success was defined as all Pelvic Organ Prolapse Quantification (POP-Q) points at or above -1 at the long-term examination. Postoperative GH measures were obtained at 6 weeks (early) and 3-7 years (long term) postoperatively. GH measurements were classified as either normal (<4 cm) or wide (>= 4 cm). Logistic regression identified associations between postoperative GH measurements and long-term subjective and objective outcomes. Results A total of 154 subjects completed long-term POP-Q examinations (74 RSC and 80 USLS). The median time to follow-up (minimum, maximum) was 59 months (range 34-89); 97.4% were Caucasian. Subjective success was achieved in 134 (87%), and objective success in 139 (90.2%) subjects. The majority (79%) underwent a posterior repair during their index surgery. An early postoperative GH of less than 4 cm was associated with an 11-fold higher likelihood of subsequent objective success (11.8, 2.7-51.7; p = 0.001). Furthermore, a postoperative GH less than 4 cm was not associated with dyspareunia at long-term follow-up. Conclusions Early postoperative GH <4 cm was associated with superior long-term objective success, without increasing dyspareunia. These data support correcting GH to <4 cm during prolapse repair with apical suspension to reduce objective long-term failure.

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FU TriHealth Medical Education Research Fund

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NR 27

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Z9 12

U1 0

U2 0

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SC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU Abitbol, J

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TI Incorporating robotic surgery into the management of ovarian cancer

after neoadjuvant chemotherapy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE cystadenocarcinoma; serous

ID ADVANCED-STAGE OVARIAN; INTERVAL DEBULKING SURGERY; MINIMALLY INVASIVE

SURGERY; CYTOREDUCTIVE SURGERY; SURGICAL-MANAGEMENT; FALLOPIAN-TUBE; I

OVARIAN; LAPAROSCOPY; OUTCOMES; LAPAROTOMY

AB Introduction With the rapid uptake of robotic surgery in surgical oncology, its use in the treatment of epithelial ovarian cancers is being evaluated. Complete cytoreduction represents the goal of surgery either at primary cytoreduction or after neoadjuvant chemotherapy in the setting of interval cytoreduction. In selected patients, the extent of disease would enable minimally invasive surgery. The objective of this study was to evaluate the impact of introducing robotic surgery for interval cytoreduction of selected patients with stage III-IV ovarian cancer.

Methods All patients who underwent surgery from November 2008 to 2014 (concurrent time period when robotic and open surgery were used simultaneously) after receiving neoadjuvant chemotherapy for advanced ovarian cancer (stage III-IV) were compared with all consecutive patients who underwent cytoreductive surgery by laparotomy after neoadjuvant chemotherapy between January 2006 and November 2008. Inclusion criteria included an interval cytoreductive surgery by laparotomy or robotic assistance for stage III-IV non-mucinous epithelial ovarian, fallopian tube, or primary peritoneal cancer. Exclusion criteria included patients treated concurrently for a non-gynecologic cancer, as well as secondary cytoreductive surgeries and diagnostic surgeries without an attempt at tumor reduction. Overall survival, progression-free survival, and peri-operative outcomes were compared for the entire patient cohort with those with advanced ovarian cancer who received neoadjuvant chemotherapy immediately before and after the introduction of robotic surgery.

Results A total of 91 patients were selected to undergo interval cytoreduction either via robotic surgery (n=57) or laparotomy (n=34) after the administration of neoadjuvant chemotherapy. The median age of the cohort was 65 years (range 24-88), 78% had stage III disease, and the median follow-up time was 37 months (5.6-91.4 months). The median survival was 42.83.1 months in the period where both robotic surgery and laparotomy were offered compared with 37.9 +/- 9.8 months in the time period preceding when only laparotomy was performed (p=0.6). All patients selected to undergo interval robotic cytoreduction following neoadjuvant chemotherapy had a reduction of cancer antigen 125 by at least 80%, resolution of ascites, and CT findings suggesting the potential to achieve optimal interval cytoreduction. All these patients achieved optimal cytoreduction with <1 cm residual disease, including 82% with no residual disease. The median blood loss was 100 mL (mean 135 mL, range 10-1250 mL), and the median hospital stay was 1 day.

Conclusion Robotic interval cytoreductive surgery is feasible in well-selected patients. Future studies should aim to define ideal patients for minimally invasive cytoreductive surgery.

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PT J

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AF Avondstondt, Andrea M.

Ezzedine, Dima

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TI Perineal hernia repair using permanent suture and mesh: a video case

presentation

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT Owen Wangensteen Scientific Forum / 104th Annual Clinical Congress of

the American-College-of-Surgeons (ACS)

CY OCT 21-25, 2018

CL Boston, MA

SP Amer Coll Surg

DE Hernia; Minimally invasive surgery; Perineal hernia; Polypropylene mesh;

Transabdominal

AB Introduction Perineal hernias are an uncommon cause of pelvic bulge symptoms in women with no established ideal surgical approach. We present the case of a posterior perineal hernia repaired robotically using permanent sutures and mesh. Methods A 67-year-old woman with a posterior perineal hernia and stage III uterovaginal prolapse presented to our office and underwent minimally invasive robotics-assisted abdominal surgery. Her levator plate defect was closed primarily using permanent sutures and reinforced using polypropylene mesh. A concomitant supracervical hysterectomy and sacrocolpopexy were performed. Results Robotics-assisted transabdominal perineal hernia repair offered excellent intra-operative visualization and complete delineation of the defect. Conclusions Robotics-assisted abdominal primary repair of the perineal hernia and overlying mesh placement offered a safe and effective repair of this rare disorder.

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PT J

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TI Mortality Rates in Laparoscopic and Robotic Gynecologic Oncology

Surgery: A Systemic Review and Meta-analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Gynecologic oncology; Minimally invasive surgery; Mortality

ID STAGE CERVICAL-CANCER; ABDOMINAL RADICAL HYSTERECTOMY; ENDOMETRIAL

CANCER; OVARIAN-CANCER; DISEASE RECURRENCE; SURVIVAL OUTCOMES;

NEOADJUVANT CHEMOTHERAPY; SURGICAL-COMPLICATIONS; IMPACT; MANAGEMENT

AB Objective: To review early operative mortality (<30 days) for minimally invasive surgery (MIS), laparoscopic and robotic, in gynecologic oncology.

Data Sources: An electronic-based search was performed in PubMed, Embase, Scopus, Web of Science, and Cochrane Database in the last 10 years.

Methods of Study Selection: All MIS studies in gynecologic oncology reporting operative mortality from any cause (within 30 days) were included. Studies were excluded if mortality was not reported for MIS or included benign gynecology.

Tabulation, Integration, and Results: Meta-analysis was applied to calculate pooled mortality rates using the inverse-variance method. The relative risks and their corresponding 95% confidence intervals (CIs) were calculated using the MantelHaenszel method. Sixty-five studies were included (39 183 patients) for an operative mortality of 1:381 (95% CI, 1:306 -1:474). Studies were subselected and analyzed by procedures, malignancy, and surgical approach. Of 39 183 patients, 38 619 underwent any type of hysterectomy for a mortality of 1:379 (95% CI, 1:304-1:472). The mortality was 1:281 (95% CI, 1:169-1:469) for a laparoscopic approach and 1:476 (95% CI, 1:365-1:620) for a robotic approach. There were 3369 patients with early cervical cancer undergoing radical hysterectomy with a mortality of 1:2049 (95% CI, 1:356-1:11 832). There were 3501 patients with endometrial cancer undergoing hysterectomy with lymph node dissection with a mortality of 1:195 (95% CI, 1:109-1:349). There were 418 patients with ovarian cancer undergoing MIS procedures with a mortality of 1 in 685 (95% CI, 1:44-1:10971). Eleven studies with 4037 patients compared mortality of gynecologic oncology surgery of any type (laparoscopic [1:626] vs robotic [1:716] for a relative risk of 1.12 [95% CI, 0.35-3.49]).

Conclusion: The overall operative mortality for minimally invasive surgery in gynecologic oncology is 1 in 381 (95% CI, 1:306-1:474). For patients with early cervical cancer, it is 1:2049 (95% CI, 1:356-1: 11832), for endometrial cancer with node dissection it is 1:195 (95% CI, 1:109-1:349), and for ovarian cancer it is 1 in 685 (95% CI, 1:44-1:10 971). There is no difference between the type of MIS approach for patients undergoing any type of gynecologic oncology surgery. (C) 2019 AAGL. All rights reserved.

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TI Voiding Trial in Office after Unsuccessful Voiding Trial in

Postoperative Unit: How Many More Days Is Enough?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Voiding trial; Outpatient hysterectomy; Urinary retention; Minimally

invasive hysterectomy

ID LONG-TERM CATHETERIZATION; URINARY-TRACT-INFECTION; COMPARING SHORT;

RISK-FACTORS; RETENTION; HYSTERECTOMY; OUTPATIENT; SURGERY

AB Study Objective: To determine the incidence of a successful in-office voiding trial after minimally invasive hysterectomy.

Design: A retrospective cohort study.

Setting: A tertiary care academic center.

Patients: All patients undergoing minimally invasive hysterectomies (vaginal, laparoscopic, or robotic) from January 2013 to July 2018 who have an unsuccessful voiding trial in the postoperative unit.

Interventions: A voiding trial.

Measurements and Main Results: Of 558 outpatient hysterectomies (with same-day discharge) performed in the time period of interest, 174 patients were discharged home with a Foley catheter (31%). Of those patients, 37% presented for a repeat in-office voiding trial at less than 3 postoperative days, 31% presented at 3 postoperative days, and 31.6% presented at more than 3 postoperative days. Eighty-six percent of patients presenting for their first in-office voiding trial were successful at voiding. There were no differences noted in age, gravity, parity, the use of hormone replacement therapy, menopausal status, smoking, hypertension, or diabetes in patients who passed their first in-office voiding trial compared with those who did not. Vaginal hysterectomy was the most common route of hysterectomy and was performed in 57% of cases followed by robotic hysterectomy in 32%. There were no differences noted in the indication or route of hysterectomy between patients who pass or fail their first in-office voiding trial. At the time of hysterectomy, 47% of patients had concomitant female pelvic medicine and reconstructive surgery procedures performed (midurethral sling, periurethral injections, or colporrhaphy). The incidence of urinary tract infections in this patient cohort was 12%, but the incidence was significantly higher in patients who failed compared with those who passed their first in-office voiding trial (37.3% vs 7.3%, p <.001). After adjusting for age, hysterectomy route, and concomitant female pelvic medicine and reconstructive surgery procedures performed, the number of postoperative days at the time of the first in-office voiding trial does not predict success.

Conclusion: The timing of the repeat in-office voiding trial in posthysterectomy patients who fail their initial voiding trial in the postanesthesia care unit was not related to success. The incidence of urinary tract infections is higher in patients who fail their repeat voiding trial because recatheterization and a longer duration of catherization are necessary. (C) 2019 Published by Elsevier Inc. on behalf of AAGL.

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PT J

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TI Minimally Invasive Pelvic Exenteration for Gynecologic Malignancies: A

Multi-Institutional Case Series and Review of the Literature

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 27th Annual Congress of European-Society-for-Gynaecological-Endoscopy

CY OCT 07-10, 2018

CL Vienna, AUSTRIA

SP European Soc Gynaecol Endoscopy

DE Laparoscopic pelvic exenteration; Minimally invasive pelvic

exenteration; Robotic pelvic exenteration; Surgical complications;

Survival

ID RECURRENT CERVICAL-CARCINOMA; CANCER; EXPERIENCE; SURGERY; LAPAROSCOPY;

RESECTION; LIFE

AB Study Objective: To assess the feasibility and efficacy of minimally invasive pelvic exenteration (MIPE) in a multi-institutional Italian case series of women with gynecologic cancer and a review of the literature.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Three Italian university/teaching hospitals: "Agostino Gemelli" Foundation University Hospital in Rome, "ARNAS Civico Di Cristina Benfratelli" Hospital in Palermo, and "Maggiore della Carita" Hospital in Novara.

Patients: We reviewed all consecutive cases with gynecologic malignancies in this multi-institutional setting recorded between March 2014 and June 2017. Women with primary or central recurrent/persistent gynecologic cancer considered suitable for exenterative surgery after multidisciplinary tumor board discussion were included. Clinicopathological, perioperative, and survival data were retrieved from the institutional electronic database (STAR center).

Interventions: All patients underwent total or anterior MIPE with a laparoscopic or robotic approach.

Measurements and Main Results: Twenty-three patients underwent MIPE during the study period, including 12 (52.1%) by a laparoscopic approach and 11 (47.9%) by a robotic approach. All but 1 woman underwent MIPE for recurrent disease. The overall median operative time was 540 minutes (range, 310-720 minutes) with laparoscopy, slightly longer than with the robotic approach (p = .04). Median estimated blood loss was 400 mL (range, 200-600 mL). R0 resection was achieved in 17 of 23 patients (73.9%). There were no perioperative deaths. Early major postoperative complications occurred in 2 patients (8.7%). The median duration of hospitalization was 10 days (range, 6-33 days). With a median follow-up of 15 months, 11 patients (47.8%) developed recurrence. The median disease-free survival was 11 months (range, 5-18 months). To date, 155 MIPEs for gynecologic cancers have been reported in the literature. Among these, 12.6% had major postoperative complications, and overall postoperative mortality was 0.6%.

Conclusion: MIPE is a feasible procedure with low rate of intraoperative and postoperative complications. Careful patient selection is crucial to balance perioperative risks and potential survival benefits and to achieve complete tumor resection. (C) 2019 AAGL. All rights reserved.

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ER

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TI Laparoscopic and robotic hysterectomy in endometrial cancer patients

with obesity: a systematic review and meta-analysis of conversions and

complications

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Review

DE complication; conversion to laparotomy; endometrial cancer;

hysterectomy; laparoscopy; obesity

ID BODY-MASS-INDEX; MINIMALLY INVASIVE SURGERY; SURGICAL OUTCOMES;

ABDOMINAL HYSTERECTOMY; GYNECOLOGIC-ONCOLOGY; WOMEN; LAPAROTOMY; IMPACT;

FEASIBILITY; MANAGEMENT

AB OBJECTIVE DATA: Robotic assistance may facilitate completion of minimally invasive hysterectomy, which is the standard of care for the treatment of early-stage endometrial cancer, in patients for whom conventional laparoscopy is challenging. The aim of this systematic review was to assess conversion to laparotomy and perioperative complications after laparoscopic and robotic hysterectomy in patients with endometrial cancer and obesity (body mass index, >= 30 kg/m(2)).

STUDY: We systematically searched MEDLINE, EMBASE, and Evidence-Based Medicine Reviews (January 1, 2000, to July 18, 2018) for studies of patients with endometrial cancer and obesity (body mass index, >= 30 kg/m(2)) who underwent primary hysterectomy.

STUDY APPRAISAL AND SYNTHESIS METHODS: We determined the pooled proportions of conversion, organ/vessel injury, venous thromboembolism, and blood transfusion. We assessed risk of bias with the Institute of Health Economics Quality Appraisal Checklist for single-arm studies, and Newcastle-Ottawa Quality Scale for double-arm studies.

RESULTS: We identified 51 observational studies that reported on 10,800 patients with endometrial cancer and obesity (study-level body mass index, 31.0-56.3 kg/m(2)). The pooled proportions of conversion from laparoscopic and robotic hysterectomy were 6.5% (95% confidence interval, 4.3-9.9) and 5.5% (95% confidence interval, 3.3-9.1), respectively, among patients with a body mass index of >= 30 kg/m(2), and 7.0% (95% confidence interval, 3.2-14.5) and 3.8% (95% confidence interval, 1.4-9.9) among patients with body mass index of >= 40 kg/m(2). Inadequate exposure because of adhesions/visceral adiposity was the most common reason for conversion for both laparoscopic (32%) and robotic hysterectomy (61%); however, intolerance of the Trendelenburg position caused 31% of laparoscopic conversions and 6% of robotic hysterectomy conversions. The pooled proportions of organ/vessel injury (laparoscopic, 3.5% [95% confidence interval, 2.2-5.5]; robotic hysterectomy, 1.2% [95% confidence interval, 0.4-3.4]), venous thromboembolism (laparoscopic, 0.5% [95% confidence interval, 0.2-1.2]; robotic hysterectomy, 0.5% [95% confidence interval, 0.1-2.0]), and blood transfusion (laparoscopic, 2.8% [95% confidence interval, 1.5-5.1]; robotic hysterectomy, 2.1% [95% confidence interval, 1.6-3.8]) were low and not appreciably different between arms.

CONCLUSION: Robotic and laparoscopic hysterectomy have similar rates perioperative complications in patients with endometrial cancer and obesity, but robotic hysterectomy may reduce conversions because of positional intolerance in patients with morbid obesity. Existing literature is limited by selection and confounding bias, and randomized trials are needed to inform practice standards in this population.

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TI Successful robotic surgery for primary resection of a vaginal

leiomyosarcoma: A case report

SO GYNECOLOGIC ONCOLOGY REPORTS

LA English

DT Article

AB Primary vaginal leiomyosarcoma (LMS) is a rare entity with limited data on optimal treatment approach. Most previously reported cases utilize an open or transvaginal surgical approach for primary tumor resection. Minimally invasive surgery is an important tool in complex pelvic surgery and the limits of its utility continue to expand. Here, we report a rare case of an 11.7 cm primary vaginal LMS in a 45-year-old female that was successfully resected with a robotic approach. Our case demonstrates an innovative use of the robot and the feasibility and efficacy of this approach for primary resection of large vaginal tumors.

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PG 3

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PT J

AU Khadraoui, W

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Zeybek, Burak

Mutlu, Levent

Menderes, Gulden

TI Robotic type II B posterior exenteration for recurrent vaginal cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Posterior exenteration; Robotic; Laparoscopic; Vaginal cancer

AB Objective: To demonstrate a surgical video, wherein a robotic-assisted posterior exenteration was performed for management of recurrent vaginal cancer.

Methods: We present a case of a 55 year-old female with a history of stage II squamous cell vaginal carcinoma. Patient recurred two years after completion of her primary chemoradiation at the posterior upper vagina. Pelvic MRI showed an approximately 4 cm tumoral nodule, without invasion into rectum or to bilateral parametria. PET-CT ruled out any metastatic disease. She was explained of the palliative systemic treatment versus potentially curative pelvic exenteration, as her options. After extensive counseling, she opted for the surgical option. Given her extensive comorbidities, including poorly controlled diabetes, COPD, obesity and heavy smoking, decision was made to attempt the procedure with a robotic approach (Behbehani et al.; Kammar et al. [1,2]).

The technical steps of posterior Type IIB exenteration have been detailed in the video with an emphasis on anatomic landmarks by utilizing visual illustrations (Cibula [3]). The surgical margins were deemed to be negative with frozen section evaluation. Intravenous indocyanine green injection confirmed adequate blood supply to the end colostomy site. Patency of bilateral ureters was confirmed at the end of the procedure.

Results: Robotic-assisted Type IIB posterior pelvic exenteration was successfully completed without any intra-operative complications. Patient was discharged home on post-operative day 8. She has been dispositioned to surveillance.

Conclusions: Robotic approach to highly morbid pelvic exenteration procedures should be considered in selected patients with recurrent gynecologic malignancies, who present without evidence of distant metastatic disease. (C) 2019 Elsevier Inc. All rights reserved.

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ER

PT J

AU Kim, S

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AF Kim, Soorin

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TI Uterine Artery-sparing Minimally Invasive Radical Trachelectomy: A Case

Report and Review of the Literature

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopy; Robotic; Trachelectomy; Uterine artery; Fertility sparing;

Surgery; Gynecology

ID STAGE CERVICAL-CANCER; BILATERAL PELVIC LYMPHADENECTOMY; VAGINAL

TRACHELECTOMY; PREGNANCY OUTCOMES; FERTILITY; SERIES; PRESERVATION;

WOMEN

AB Radical trachelectomy is considered in patients with early-stage cervical cancer who desire future fertility. This article is accompanied by a video that provides step-by-step demonstration of a uterine artery-sparing robotic-assisted radical trachelectomy in a patient with stage IB1 squamous cell carcinoma of the cervix, a 2-cm mass, and a desire for future fertility. We also conducted a review of the literature examining the use of uterine artery-sparing techniques among minimally invasive radical trachelectomies. Using PubMed, Google Scholar, and Ovid search tools, 28 total publications were reviewed, of which 16 were eligible for use in our comparison. With the addition of our case report, a total of 154 cases sparing the uterine artery and 40 cases sacrificing the uterine artery were examined, including both conventional laparoscopic and robotic-assisted approaches. Data describing patient demographics as well as surgical, oncologic, and fertility outcomes were collected. The mean age was 30 years for the spared group and 32 years for the sacrificed group. At least 42% of the women in the spared and 53% of the uterine artery-sacrificed group were nulliparous. The majority of cases in both the spared and sacrificed groups represented squamous cell histology (71% for spared and 51% for sacrificed) followed by adenocarcinoma (24% vs 43%). The majority of the patients in both groups had stage IB1 disease (79% for spared vs 65% for sacrificed). The operative times among the 2 groups were similar, with a mean time of 314 minutes (range, 170-420 minutes) in the spared group and 283 minutes (range, 172-345 minutes) in the sacrificed group. The mean estimated blood loss was 173 mL (range, 23-300 mL) in the spared group and 77 mL (range, 50-250 mL) in the sacrificed group. The recurrence rates for the uterine artery-sparing and -sacrificing groups were equal at 2.6% after a mean follow-up of 42 months and 26 months, respectively. The methods of reporting fertility outcomes were varied among the different publications, with 41 patients achieving pregnancy in the spared group and 2 patients achieving pregnancy in the sacrificed group. Among patients who were not trying to conceive or had not conceived, 15 patients in the spared group and 6 patients in the sacrificed group were reported to have normal menses. The successful preservation of uterine arteries supports the maintenance of uterine arterial blood flow and is used by many gynecologic surgeons performing minimally invasive radical trachelectomy, with promising oncologic and obstetric outcomes. (C) 2019 AAGL. All rights reserved.

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PT J

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Occhino, JA

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Gebhart, JB

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TI Assessing the impact of procedure-specific opioid prescribing

recommendations on opioid stewardship following pelvic organ prolapse

surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 45th Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

(SGS)

CY MAR 31-APR 03, 2019

CL Tuccson, AZ

SP Soc Gynecol Surg

DE Female; opioid; pelvic organ prolapse; prescribing; sacrocolpopexy;

surgery

ID WIDE VARIATION; UNITED-STATES; PRESCRIPTION; PATTERNS; PAIN

AB BACKGROUND: Nationally, there is increasing concern regarding the volume of opioid medications prescribed postoperatively and the rate of prescription opioid-related adverse events. In evaluation of this, several reports have identified significant variability in postoperative opioid-prescribing patterns, including quantities exceeding patient's needs, especially after minor surgical procedures. However, data regarding patient's postoperative opioids needs following surgery for pelvic organ prolapse are sparse.

OBJECTIVE: To design procedure-specific opioid-prescribing recommendations for pelvic organ prolapse surgeries and evaluate their impact on opioid stewardship.

STUDY DESIGN: We prospectively evaluated opioid-prescribing patterns, patient use, medication refills, and patient satisfaction in women undergoing prolapse surgery (ie, vaginal, abdominal, or robotic) during an 8-month time period. Two cohorts of women, stratified by whether they had surgery before or after implementation of procedure-specific opioid-prescribing recommendations, were evaluated. Postoperative opioid usage (assessed via pill count), medication refills, and satisfaction with pain management after hospital dismissal were evaluated by telephone call 2 weeks after surgery. Postoperative opioid prescribing and use were recorded after conversion to oral morphine equivalents.

RESULTS: Overall, 96 women were included, 57 in the initial baseline cohort, and 39 following implementation of the prescribing recommendations. In the initial cohort, 32.8% of the prescribed oral morphine equivalents (3607/11,007 mg) were consumed. Following implementation of the prescribing recommendations, median oral morphine equivalents prescribed decreased from 200 mg oral morphine equivalents (interquartile range 150, 225) to 112.5 mg oral morphine equivalents (interquartile range 22.5, 112.5; P<.0001). The total oral morphine equivalents prescribed decreased by 45% when compared with the volume that would have been prescribed before implementing the recommendations. The amount of leftover opioids per patient significantly decreased as well (P<.0001). Pain medication refills increased after the intervention (18% vs 3.5%; P=.03), whereas satisfaction scores were similar in both cohorts (P=.87).

CONCLUSIONS: By using procedure-specific opioid prescribing recommendations, we decreased the number of opioids prescribed at hospital dismissal by roughly one half. Decreased opioid prescribing did not adversely impact patient satisfaction.

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FU Rochester Sisters of Saint Francis

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ER

PT J

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Magtibay, PM

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TI Minimally Invasive Surgery for Resection of Diaphragm Metastases in

Ovarian Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Diaphragm resection; Laparoscopy; Ovarian cancer; Robotics

ID ADVANCED-STAGE OVARIAN; GROSS RESIDUAL DISEASE; PRIMARY PERITONEAL; HELP

PLAN; CYTOREDUCTION; CARCINOMATOSIS; RADIOLOGIST; MANAGEMENT; SURVIVAL;

OUTCOMES

AB Study Objective: To estimate pulmonary complications and diaphragm recurrence after resection of diaphragm metastases by minimally invasive surgery (MIS) for epithelial ovarian cancer (EOC).

Design: Retrospective analysis (Canadian Task Force classification III).

Setting: Mayo Clinic in Scottsdale, Arizona, from January 1, 2004, through January 31, 2014.

Patients: Selected cohort of 29 patients.

Interventions: Diaphragm resection by MIS (robotics, 21; laparoscopy, 8) for EOC.

Measurements and Main Results: To assess for pulmonary complications most likely due to diaphragm resection, patients were excluded if they had preoperative pleural effusions or pulmonary disease or had undergone additional upper abdominal procedures. Mean patient age was 58.7 years (standard deviation, 14.9) and mean BMI was 24.2 kg/m(2) (standard deviation, 3.4). The mean size of diaphragm metastases was 56.7 mm (range, 2-145). Full-thickness resection was performed in 6 patients; 23 had peritoneal resection. Complete resection was achieved in all patients with no conversions to laparotomy. Two patients (6.9%) had pulmonary complications (pleural effusion). Six patients (20.7%) had diaphragm recurrence; 10 patients (34.5%) had recurrence at other abdominal sites.

Conclusion: Resection of diaphragm metastases by MIS appears to be feasible and safe for selected patients, with similar recurrence as other abdominal sites. (C) 2019 Published by Elsevier Inc. on behalf of AAGL.

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PT J

AU Scott, VCS

Oliver, JL

Raz, S

Kim, JH

AF Scott, Victoria C. S.

Oliver, Janine L.

Raz, Shlomo

Kim, Ja-Hong

TI Robot-assisted laparoscopic sacrocolpopexy with autologous fascia lata:

technique and initial outcomes

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robot-assisted laparoscopic sacrocolpopexy; Fascia lata

ID MESH-RELATED COMPLICATIONS; ABDOMINAL SACROCOLPOPEXY;

SURGICAL-MANAGEMENT; POLYPROPYLENE MESH; APICAL SUPPORT; PROLAPSE;

ANTERIOR; EXCISION; WOMEN

AB Introduction and hypothesis Pelvic reconstructive surgery is increasingly being performed with autologous grafts to avoid complications of synthetic mesh and improve the durability of a native tissue repair. Autologous fascia lata (AFL) provides a reliable source of robust connective tissue to improve surgical outcomes. We present our technique and initial experience with performing robotic sacrocolpopexy (RSC) augmented with AFL. Methods A retrospective review was conducted of patients who underwent RSC with AFL between January 2015 and November 2017. Outcomes evaluated include recurrence of prolapse on physical examination, prolapse symptoms, urinary incontinence, patient satisfaction based on the Patient Global Impression of Improvement (PGI-I) and complications. Results Twelve patients were identified with a median age of 68 years (range, 46-77 years) at the time of RSC with AFL. Eleven patients had a history of prior sling and/or vaginal mesh. The median operative time was 225 min (177-302 min). There were no intra- or postoperative complications. After a median follow-up of 14.7 months (5.7 to 39 months), the median PGI-I response was 2 (range, 1-3, very much to a little better). No recurrent or persistent apical prolapse was observed. Three patients (25%) reported recurrence of sensation of a vaginal bulge, which were all due to anterior vaginal wall prolapse. Conclusions RSC can be performed with AFL and should be considered in patients with a history of mesh complications. Overall patient satisfaction was high. While these short-term outcomes are encouraging, further studies are needed to assess long-term durability of anatomic results.

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Z9 8

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U2 2

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AU Souders, C

Nik-Ahd, F

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Chugtai, B

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Zhao, Hanson

Eilber, Karyn

Chugtai, Bilal

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TI Robotic sacrocolpopexy: adverse events reported to the FDA over the last

decade

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT Winter Meeting of the

Society-of-Urodynamics-Female-Pelvic-Medicine-and-Urogenital-Reconstruct

ion (SUFU)

CY FEB 27-MAR 03, 2018

CL Austin, TX

SP Soc Urodynam Female Pelv Med & Urogenital Reconstruct

DE Abdominal sacrocolpopexy; Adverse events; Pelvic organ prolapse; Robotic

surgery

ID FAILURES; FOOD

AB Introduction and hypothesis As surgeons increase the volume of robotic abdominal sacrocolpopexies (rASCs) and become more experienced, a subsequent decrease in the number of adverse events is expected over time. Further, as the leading manufacturer of the operative robot (Intuitive Surgical) improves the technology, adverse events should also decrease. We hypothesized that there has been a decrease in adverse event reporting for rASCs and that serious adverse events are rare. Methods We performed a search of the FDA Manufacturer and User Facility Device Experience (MAUDE) database. All entries with the manufacturer "Intuitive Surgical" were exported from 2007 to 2017. All entries with "sacrocolpopexy" were then isolated and analyzed. Results The number of adverse events reported for rASC peaked in 2013 and 2014, at 107 and 124 respectively. In 2015 and 2016, the number dropped to 11 and 7 respectively. There were 334 reported adverse events from 2007 to 2017. Five (1.50%) were categorized as death, 33 (9.88%) as injury, and 296 (88.62%) as malfunction. Analysis of the malfunction reports found that 15 out of 296 (5.07%) were converted to open surgery, 4 out of 296 (1.3%) were converted to laparoscopic surgery, 4 out of 296 (1.3%) cases were aborted, and 6 out of 296 (2.03%) malfunctions resulted in patient injury. Conclusions Although the MAUDE database has its limitations, it does indicate that the number of adverse events reported for rASC peaked in 2013 and 2014 and has decreased annually since then. This may be due to improved proficiency of the surgeon and surgical team, in addition to improvements in the robot. When malfunctions do occur, they infrequently cause serious injury or have an impact on surgical approach.

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NR 11

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Z9 4

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TI Learning curve of robot-assisted laparoscopic sacrocolpo(recto)pexy: a

cumulative sum analysis

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE CUSUM; learning curve; robot-assisted surgery; sacrocolpopexy;

sacrocolporectopexy

ID PELVIC ORGAN PROLAPSE; SACROCOLPOPEXY; OUTCOMES; IMPACT; IDENTIFICATION;

MANAGEMENT

AB BACKGROUND: Determination of the learning curve of new techniques is essential to improve safety and efficiency. Limited information is available regarding learning curves in robot-assisted laparoscopic pelvic floor surgery.

OBJECTIVE: The purpose of this study was to assess the learning curve in robot-assisted laparoscopic pelvic floor surgery.

STUDY DESIGN: We conducted a prospective cohort study. Consecutive patients who underwent robot-assisted laparoscopic sacrocolpopexy or sacrocolporectopexy were included (n=372). Patients were treated in a teaching hospital with a tertiary referral function for gynecologic/multicompartment prolapse. Procedures were performed by 2 experienced conventional laparoscopic surgeons (surgeons A and B). Baseline demographics were scored per groups of 25 consecutive patients. The primary outcome was the determination of proficiency, which was based on intraoperative complications. Cumulative sum control chart analysis allowed us to detect small shifts in a surgeon's performance. Proficiency was obtained when the first acceptable boundary line of cumulative sum control chart analysis was crossed. Secondary outcomes that were examined were shortening and/or stabilization of surgery time (measured with the use of cumulative sum control chart analysis and the moving average method).

RESULTS: Surgeon A performed 242 surgeries; surgeon B performed 137 surgeries (n=7 surgeries were performed by both surgeons). Intraoperative complications occurred in 1.9% of the procedures. The learning curve never fell below the unacceptable failure limits and stabilized after 23 of 41 cases. Proficiency was obtained after 78 cases for both surgeons. Surgery time decreased after 24-29 cases in robot-assisted sacrocolpopexy (no distinct pattern for robot-assisted sacrocolporectopexy). Limitations were the inclusion of 2 interventions and concomitant procedures, which limited homogeneity. Furthermore, analyses treated all complications in cumulative sum as equal weight, although there are differences in the clinical relevance of complications.

CONCLUSION: After 78 cases, proficiency was obtained. After 24-29 cases, surgery time stabilized for robot-assisted sacrocolpopexy. In this age of rapidly changing surgical techniques, it can be difficult to determine the learning curve of each procedure. Cumulative sum control chart analysis can assist with this determination and prove to be a valuable tool. Training programs could be individualized to improve both surgical performance and patient benefits.

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ER

PT J

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Vega, Mario

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Vetere, Patrick F.

TI Perioperative Outcomes in Robotic-Assisted Versus Conventional

Laparoscopic Treatment of Endometrial Cancer

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE endometrial cancer; robotic-assisted laparoscopy; conventional

laparoscopy; perioperative outcomes

ID UTERINE-CANCER; LAPAROTOMY; SURGERY; OBESE; HYSTERECTOMY; MANAGEMENT;

SURVIVAL; IMPACT; WOMEN; COST

AB Objective: To compare perioperative outcomes of robotic-assisted laparoscopic surgery (RALS) versus conventional laparoscopic surgery (CLS) in endometrial cancer. Methods: This is a retrospective analysis of a prospectively maintained database of procedures performed from January 2009 to January 2014 by a single surgeon experienced in both minimally invasive techniques. One hundred five patients underwent surgical staging of endometrial cancer through either conventional laparoscopy (CL) or robotic-assisted laparoscopy. Characteristics such as age, body mass index (BMI), prior abdominal surgery, number of comorbidities, stage of disease, and extent of surgery were compared. Outcomes, including estimated blood loss (EBL), operating room time (ORT), length of stay (LOS), number of lymph nodes resected, conversion rates, and intraoperative and postoperative complications, were analyzed. Results: Fifty-seven patients received RALS; 48 had CLS. RALS patients had a higher mean BMI (38.1 +/- 11.8 vs. 30.1 +/- 7.5 kg/m(2); p = 0.0003) and more comorbidities. Median ORT was longer for RALS patients [277 (135-660) vs. 223.5 (120-547) minutes; p = 0.0012]. RALS ORT remained significantly longer for BMI >= 25 kg/m(2) to <30 kg/m(2), and appeared near significance in the BMI 35 kg/m(2) groups. Only in the BMI >= 30 kg/m(2) to <35 kg/m(2) group there was no apparent difference in the ORT. Among patients with endometrioid adenocarcinoma histology, ORT was longer in the RALS group [273 (135-660) vs. 222 (120-420) minutes; p = 0.0018]. There was no difference in EBL or LOS between the two surgical approaches. Conclusions: In our experience, perioperative outcomes of endometrial cancer staging are comparable between RALS and CL. Furthermore, the overall ORT is significantly longer in the RALS group. Further studies of patients stratified by BMI are needed. (J GYNECOL SURG 00:000).

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NR 36

TC 2

Z9 2

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U2 2

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J9 J GYNECOL SURG

JI J. Gynecol. Surg.

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GA KM1LL

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ER

PT J

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TI Urinary incontinence and quality of life in endometrial cancer patients

after robotic-assisted laparoscopic hysterectomy with lymph node

dissection

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Endometrial cancer; hysterectomy; lymph node dissection; quality of

life; urinary incontinence

ID WOMEN; IMPACT

AB To determine the long-term effects of lymph node dissection on lower urinary tract symptoms in patients treated for endometrial cancer. We conducted a retrospective cohort study of 74 patients with International Federation of Gynaecology and Obstetrics (FIGO) Stage I endometrial cancer who underwent surgical intervention with and without lymph node dissection, and evaluated them with the Urinary Distress Inventory-6 (UDI-6) and Incontinence Impact Questionnaire-7 (IIQ-7). Patients who underwent lymph node dissection reported higher but not statistically different rates of bother by lower urinary tract symptoms compared to those without lymph node dissection. The scores for the lymph node dissection group and the control group were a mean IIQ-7 score of 14.9 +/- 23 and 10.5 +/- 22.9 (p=.419) and a mean UDI-6 score of 30.0 +/- 25.3 and 20.7 +/- 22.9 (p=.104), respectively. Lymph node dissection at the time of robotic-assisted surgery did not have a significant effect on lower urinary tract symptoms nor did it affect patient responses on quality of life questionnaires.IMPACT STATEMENT What is already known on this subject? The aetiology of urinary incontinence is multifactorial and there has been debate on how a patient's surgical history affects their risk of developing urinary incontinence. Prior studies have highlighted the relationship between hysterectomy and urinary incontinence (Milsom et al. 1993). Additional research has also been done to elucidate the prevalence of pelvic floor disorders in patients who have been surgically treated for endometrial cancer (Erekson et al. 2009; Nosti et al. 2012). There is limited information on how robotic-assisted lymphadenectomy during surgical staging for endometrial cancer affects patients' urinary function and their quality of life. What do the results of this study add? In this manuscript, we demonstrate that patients who underwent robotic-assisted total laparoscopic hysterectomy (TLH) with lymphadenectomy neither had significant difference in lower urinary tract symptoms nor on quality of life questionnaires as compared to those who did not undergo lymphadenectomy. Worsening of quality of life in regards to urinary incontinence should not be considered a factor of long term surgical morbidity associated with lymph node dissection.

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NR 15

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Z9 8

U1 0

U2 9

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J9 J OBSTET GYNAECOL

JI J. Obstet. Gynaecol.

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ER

PT J

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Jernigan, AM

Michener, CM

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TI Does surgical platform impact recurrence and survival? A study of

utilization of multiport, single-port, and robotic-assisted laparoscopy

in endometrial cancer surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial cancer; laparoscopy; minimally invasive surgery;

robotic-assisted laparoscopy; single-port laparoscopy

ID MINIMALLY INVASIVE SURGERY; STANDARD LAPAROSCOPY; OUTCOMES; GYNECOLOGY;

LAPAROTOMY; ADOPTION; WOMEN; COST; LESS

AB BACKGROUND: Minimally invasive hysterectomy is the standard of care in the majority of women diagnosed with endometrial cancer via robotic-assisted, multiport, and single-port laparoscopy technology. Although safe and efficacious, it is unclear how oncologic outcomes are impacted by surgical platform.

OBJECTIVE: To identify differences in progression-free survival and overall survival in women undergoing minimally invasive surgery for endometrial cancer staging via either multiport, single-port, or robotic-assisted laparoscopy.

STUDY DESIGN: A multicenter, single-institution retrospective cohort study was performed in women with a diagnosis of endometrial cancer who underwent minimally invasive surgery from 2009 to 2015. Data were collected for demographics, pathologic information, adjuvant treatment, and disease status. Pearson chi(2) and Fisher exact tests were used to evaluate risk factors for outcomes, Kaplan-Meier estimates and Cox proportional hazards were used to evaluate differences in time to progression or death, and multivariate regression analysis was performed.

RESULTS: In total, 1150 women with endometrial cancer underwent robotic-assisted laparoscopy (n = 652), multiport laparoscopy (n = 214), or single-port laparoscopy (n = 284). The median age and body mass index of women was 62.0 years and 33.5 kg/m(2), respectively. The majority of patients had endometrioid histology (88.1%), stage IA (74.7%) or IB disease (13.1%) and International Federation of Gynecology and Obstetrics grade 1 (57.4%) or 2 (26.0%) histology. Lymphovascular space invasion was present in 24.7% (n = 283). Adjuvant radiation was given in 34.2% of cases, with 21.9% receiving vaginal brachytherapy, 6.6% pelvic radiation, and 5.4% both. For the entire cohort, there were no differences in progression-free survival at 2, 3, and 5 years for multiport laparoscopy 94.2%, 91.4%, 87.4%), robotic-assisted laparoscopy (94.5%, 92.9%, 88.8%), and single-port laparoscopy (93.6%, 91.2%, 90.0%) (P=.93), respectively. Similarly, there were no differences in overall survival at 2, 3, and 5 years for multiport laparoscopy (94.4%, 91.8%, 91.8%), robotic-assisted laparoscopy (95.6%, 93.4%, 90.7%), and single-port laparoscopy (95.0, 93.1, 91.8) (P=.99), respectively. Among women with stage IA and IB disease, no difference existed for progression-free survival at 2, 3, and 5 years for multiport laparoscopy (94.2%, 91.4%, 87.4%), robotic-assisted laparoscopy (94.5%, 92.9%, 88.8%), and single-port laparoscopy (93.6, 91.2, 90.0) (P=.93), respectively. Similarly, among women with stage I disease, there was no difference in overall survival at 2, 3, and 5 years for multiport laparoscopy (96.2%, 95.0%, 95.0%), robotic-assisted laparoscopy (96.6%, 95.4%, 93.3%), and single-port laparoscopy (96.6%, 95.0%, 93.4%) (P=.89). Rather, progression-free survival and overall survival were predicted by age >65 years, stage, grade, and histology (P<.05). On multivariate analysis, modality of surgery did not impact overall survival or progression-free survival (robotic-assisted laparoscopy, hazard ratio, 1.28, P=.50; single-port laparoscopy, hazard ratio, 0.84, P=.68 vs multiport laparoscopy). Age >65 years (hazard ratio, 5.42, P<.001) and advanced stage disease (P=.003) were associated with decreased overall survival.

CONCLUSION: In this retrospective cohort, there was no difference in progression-free survival or overall survival in women undergoing surgery for endometrial cancer via robotic-assisted laparoscopy, single-port laparoscopy, or multiport laparoscopy.

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TC 17

Z9 19

U1 0

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ER

PT J

AU Culligan, PJ

Haughey, S

Lewis, C

Priestley, J

Salamon, C

AF Culligan, Patrick J.

Haughey, Sean

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Priestley, Jennifer

Salamon, Charbel

TI Sexual Satisfaction Changes Reported by Men After Their Partners'

Robotic-Assisted Laparoscopic Sacrocolpopexies

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; robotic-assisted laparoscopic sacrocolpopexy;

sexual function; male sexual satisfaction

AB Objectives This study aimed to compare the preoperative and postoperative sexual satisfaction reported by male sexual partners of women undergoing surgical correction of pelvic organ prolapse. Methods This was a single-center prospective cohort study. Heterosexual, sexually active English-speaking couples in which the women were planning to undergo robotic-assisted laparoscopic sacrocolpopexy for correction of pelvic organ prolapse were eligible for enrollment in the study. Validated sexual function questionnaires-the Sexual Experience Questionnaire (SEX-Q; Mulhall et al. J Sex Med. 2008) and Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire-12 (Rogers, et al. Int Urogynecol J Pelvic Floor Dysfunct. 2003)-were used to evaluate preoperative and postoperative male and female sexual experience, respectively. These preoperative scores were compared using paired t tests. The Student t and the Mann-Whitney tests were used to compare study-eligible couples with noneligible couples and to compare study participants with nonparticipants. Results During the study enrollment period, 92 couples met the inclusion criteria and 45 of those were enrolled. Complete data sets of preoperative and postoperative questionnaires were obtained for 36 couples. After their partners' successful reconstructive surgery, male study subjects reported improved total SEX-Q scores (mean +/- SD, 71 +/- 16.7 vs 76.5 +/- 17.8; P = 0.025). Within the subscales of the SEX-Q, there was significant improvement between preoperative and postoperative "individual satisfaction" scores (mean +/- SD, 65.7 +/- 16.8 vs 78.9 +/- 17.5; P < 0.0001), but not within the "erectile dysfunction" or "couple satisfaction" subscales. Female partners reported improved Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire-12 scores after surgery (mean +/- SD, 36.6 +/- 5.5 vs 40.0 +/- 4.6; P = 0.003). Conclusions Sexually active heterosexual men and women reported improved sexual experience after successful prolapse repair.

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TC 6

Z9 6

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U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

AU Estes, SJ

Lindheim, SR

AF Estes, Stephanie J.

Lindheim, Steven R.

TI Reproductive surgery: glimpses into the past and thoughts for the future

(part 2)

SO FERTILITY AND STERILITY

LA English

DT Article

DE Reproductive surgery; laparoscopy; hysteroscopy; robotic surgery;

minimally invasive surgery

AB This month's Views and Reviews continues with part two of the series regarding reproductive surgery. The roles of reproductive surgery in mullerian anomalies, tubal and pelvic disease, fertility preservation, and male reproductive surgery are included. Augmenting each contribution, authors have added images and videos to their reflections. ((C) 2019 by American Society for Reproductive Medicine.)

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U2 2

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

AU Jansen, LJ

Clark, NV

Dmello, M

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Einarsson, JI

Cohen, SL

AF Jansen, L. Joya

Clark, Nisse V.

Dmello, Monalisa

Gu, Xiangmei

Einarsson, Jon I.

Cohen, Sarah L.

TI Perioperative Outcomes of Myomectomy for Extreme Myoma Burden:

Comparison of Surgical Approaches

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Laparoscopy; Laparotomy; Myoma burden; Myomectomy;

Minimally invasive surgery; Robotic surgery

ID LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY; COMPLICATIONS; COHORT

AB Study Objective: To describe the perioperative outcomes of various modes of myomectomy (abdominal [AM], laparoscopic [LM], or robotic [RM]) in cases of extreme myoma burden.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: A tertiary academic center in Boston, Massachusetts.

Patients: All women who underwent an AM, LM, or RM for extreme myoma burden, defined as representing the upper quartile for specimen weight (>= 434.6 g) or myoma count (>= 7 myomas), between 2009 and 2016.

Interventions: Baseline demographics and perioperative outcomes were collected from review of medical records, including estimated blood loss, operative time, length of stay, and complications. Univariate linear and logistic regression analyses were conducted.

Measurements and Main Results: During the study period 659 women underwent myomectomy for extreme myoma burden; 47.2% of cases were AM, 28.1% LM, and 24.7% RM. Overall myoma burden differed across the 3 routes and was greatest in the AM group (mean weight: 696.2 +/- 784.5 g for AM vs 586.6 +/- 426.1 g for LM and 586.6 +/- 426.1 g for RM; mean number: 16.8 +/- 15.0 for AM vs 7.2 +/- 7.0 for LM and 6.7 +/- 4.7 for RM; p <.001 for both). The 3 routes differed in operative time and length of stay, with RM having the longest operative time (mean, 239.7 minutes; p <.001) and AM the longest length of stay (mean, 2.2 +/- .9 days; p <.001). Other perioperative outcomes were similar across the surgical approaches. Increasing myoma burden was associated with an increased risk of perioperative complications for all surgical approaches, with a threshold of 13 myomas associated with an almost 2-fold higher risk of perioperative complications (odds ratio, 1.77; 95% confidence interval, 1.17-2.70; p = .009). Cumulative incidence of perioperative complications with increasing specimen weight was greater in the RM cases as compared with AM (p = .002) or LM (p = .020), whereas the cumulative incidence of perioperative complications with increasing myoma count was lowest with AM compared with LM (p <.001) or RM (p <.001).

Conclusion: Myomectomy for extreme myomas is feasible using an abdominal, laparoscopic, or robotic approach. Increased myoma burden is associated with an increased risk of perioperative complications. A threshold of 13 myomas was associated with an almost 2-fold higher risk of perioperative complications for all modes. Perioperative complication outcomes were more favorable in AM or LM over RM with increased myoma weight and AM over LM or RM with increased myoma number. (C) 2018 AAGL. All rights reserved.

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Z9 10

U1 0

U2 1

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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PT J

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Visco, AG

Siddiqui, NY

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Polin, Michael R.

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Siddiqui, Nazema Y.

TI Same-Day Discharge After Robotic-Assisted Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE same-day discharge; robotic surgery; sacrocolpopexy

ID LAPAROSCOPIC HYSTERECTOMY; FEASIBILITY; SAFETY

AB Objective The aim of the study was to compare unplanned postoperative encounters in women discharged same day versus later after robotic-assisted sacrocolpopexy (RA-SCP). Methods This is a retrospective cohort study of women who underwent RA-SCP at a tertiary care center January 2013 to September 2015. Women were divided into 2 cohorts based on their day of discharge: (1) same day or (2) postoperative day 1 (POD >= 1) or later. Our primary outcome was unplanned provider visits (clinic, urgent care, emergency department, or hospital readmission) during the 6 weeks after surgery. Secondary outcomes included unplanned postdischarge nurse or physician phone calls. Logistic regression models were created to control for potential confounders. Results Two hundred seventy-two women were included; 80 underwent same-day discharge versus 192 discharged POD 1 or later (187 on POD 1, 5 on POD 2). Women discharged same day were older (61.3 vs 58.5 years, P < 0.05), more likely to have a start time before noon (85% vs 67.6%, P < 0.01), received less intraoperative intravenous fluids (1153 mL vs 1536 mL, P < 0.01), had shorter procedures (237 vs 256 minutes, P < 0.01), and spent more time in the postanesthesia care unit (213 vs 158 minutes, P < 0.01). There were no differences in unplanned provider visits between women discharged same day versus later (18.8% vs 27.6%, P = 0.12). No differences were observed in unplanned clinic visits, emergency department visits, or readmissions. In logistic regression models, unplanned provider visits (odds ratio = 0.35, 95% confidence interval = 0.30-1.54) and phone calls (odds ratio = 0.69, 95% confidence interval = 0.54-2.58) were not significantly different between groups. Conclusions Same-day discharge after RA-SCP is safe and does not result in increased health care utilization (provider visits or postoperative phone calls).

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AU Linder, BJ

Gershman, B

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AF Linder, Brian J.

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TI A National Contemporary Analysis of Perioperative Outcomes for Vaginal

Vault Prolapse: Minimally Invasive Sacrocolpopexy Versus Nonmesh Vaginal

Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE outcomes; pelvic organ prolapse; robotic sacrocolpopexy; sacrocolpopexy;

surgery

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; ASSISTED

SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY

AB Objective The aim of this study was to compare the perioperative morbidity of minimally invasive sacrocolpopexy (MISC) and nonmesh apical vaginal surgeries for repair of vaginal vault prolapse using data from a contemporary nationwide cohort. Methods The American College of Surgeons' National Surgical Quality Improvement Program database was used to identify women who underwent apical prolapse surgery via vaginal approach or MISC from 2010 to 2016. Those undergoing concomitant hysterectomy or transvaginal mesh placement were excluded. Associations of surgical approach with 30-day complications, prolonged hospitalization, and reoperation were evaluated using logistic regression. Readmission within 30 days was calculated using the person-years method and Cox proportional hazards models. Results Overall, 6390 women underwent surgery, including 3852 (60%) via vaginal approach and 2538 (40%) via MISC. Patients undergoing MISC were younger (P < 0.0001) and less likely to have hypertension (P = 0.04) or chronic obstructive pulmonary disease (P = 0.008), with lower American Society of Anesthesiologists scores (P < 0.0001) and higher preoperative hematocrit (P = 0.009). The MISC cohort had a lower unadjusted rates of minor complications (3.9% vs 5.6%; P = 0.004), urinary tract infection (3.3% vs 4.8%; P = 0.004), and prolonged hospitalization (5.2% vs 7.9%; P < 0.0001), with a higher rate of nephrologic (P = 0.01) complications. On multivariable analysis, there were no significant associations of MISC with the risk of 30-day complications (odds ratio [OR], 1.51; 95% confidence interval [CI], 0.92-2.51; P = 0.11), prolonged hospitalization (OR, 0.96; 95% CI, 0.76-1.21; P = 0.72), readmission (HR 1.03; 95% CI, 0.71-1.49;P = 0.88), or reoperation (OR, 0.95; 95% CI, 0.57-1.60; P = 0.86). Conclusions Minimally invasive sacrocolpopexy is associated with similar rates of 30-day complications, prolonged hospitalization, readmission, and reoperation compared with nonmesh vaginal surgeries for apical prolapse.

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TC 11

Z9 11

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Timing of robotic hysterectomy after cervical excisional procedure

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE gynecology; postoperative complications; surgical procedures; operative;

cervical cancer

ID LOOP ELECTROSURGICAL EXCISION; RADICAL HYSTERECTOMY; TIME-INTERVAL;

SUBSEQUENT HYSTERECTOMY; CONE BIOPSY; CONIZATION; MORBIDITY; LAPAROSCOPY

AB Introduction While traditional teaching has been to wait 6weeks between cervical excisional procedure and hysterectomy, studies have produced conflicting evidence, with data supporting a delay of anywhere between 48hours to 6weeks depending on surgical approach. Our study sought to evaluate if the time between cervical excisional procedure and robotic hysterectomy impacts peri-operative complication rates.

Methods A retrospective cohort of patients who underwent robotic hysterectomy from August 2006 to December 2013 for cervical dysplasia or International Federation of Gynecology and Obstetrics (FIGO) 2009 stage IA1-B1 cervical cancer at a single tertiary care center was performed. Patients were categorized into three groups: early surgical intervention (<6 weeks from excisional procedure), delayed surgical intervention (<greater than or equal to>6 weeks from excisional procedure), and no excisional procedure. Secondary analysis was performed by hysterectomy type (simple vs radical). Peri-operative outcomes and complications were compared. Statistical analysis included Chi-square, Fisher's exact test, and Wilcoxon rank sum test.

Results A total of 160 patients were identified. Of these, 32 (20.0%) had early surgical intervention, 52 (32.5%) had delayed surgical intervention, and 76 (47.5%) had no excisional procedure. There was no difference between groups in complication rates, including average estimated blood loss (82vs 55vs 71mL; p=0.07), urologic injury (0% in all groups; p=1.0), anemia (3% vs 0% vs 1%; p=0.47), infection (0% vs 2% vs 3%; p=1.0), vaginal cuff separation (0% in all groups; p=1.0), or venous thromboembolism (0% vs 0% vs 1%; p=1.0). Additionally, there were no differences in length of stay (p=0.18) or 30-day readmission rates (p=1.0). Finally, there were no significant differences in peri-operative outcomes when stratified by radical versus simple hysterectomy.

Discussion Waiting 6 weeks between cervical excisional procedure and robotic hysterectomy does not impact peri-operative complication rates. This suggests that the time from excisional procedure should not factor into surgical planning for those who undergo robotic hysterectomy.

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Z9 1

U1 0

U2 4

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J9 INT J GYNECOL CANCER

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PG 6

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA IZ1KT

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PM 31366570

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ER

PT J

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Callec, Ronan

Bresler, Laurent

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Judlin, Philippe

Morel, Oliver

TI Deep infiltrating endometriosis: Interest of the robotic approach for a

fledgling team

SO JOURNAL OF ENDOMETRIOSIS AND PELVIC PAIN DISORDERS

LA English

DT Article

DE Endometriosis; medical treatment; robotics; surgical treatment; pain;

women's health; assisted reproduction; infertility

ID ASSISTED LAPAROSCOPY; STANDARD LAPAROSCOPY; LEARNING-CURVE;

RECTAL-CANCER; SURGERY; HYSTERECTOMY; MANAGEMENT; RESECTION

AB Introduction: Mini-invasive surgery of deep endometriosis is challenging. Surgical difficulties related to the technical limitations of classical laparoscopic approach might be overcome with the use of robotic assistance. The aim of this study was to evaluate the safety and feasibility of robotic surgery for deep infiltrating endometriosis in the learning phase of our team. Methods: The 20 first cases of robotic-assisted laparoscopies for endometriosis were included over a 2-year period. Baseline characteristics of patients and surgical data were reviewed. Surgical outcomes and follow-up information of the patients were analyzed. Results: Twenty women were included. The mean age was 31.9 years (range: 25-44) and mean body mass index was 23 kg/m(2) (range: 16-35). Ten patients had rectovaginal or uterosacral location only (50%) and nine women had deep infiltrating endometriosis with digestive or urinary tract lesions (45%). In addition to the gynecologic surgeon, urologic or visceral surgeons were required in 10 cases, and there were 3 cases where the three specialties were needed. The mean operative time was 183.9 min (range: 85-398) and no difference was observed between the first five cases and the last five cases. There was one laparoconversion, and only two urologic postoperative complications occurred. Conclusion: Thanks to the use of robotic surgical assistance and a multidisciplinary approach, and despite the start of the team for deep endometriosis care, no learning curve effect was observed regarding surgical procedures' success, safety, or duration. The use of robotic assistance might improve the quality of care for women facing deep endometriosis.

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J9 J ENDOMETR PELVIC PA

JI J. Endometr. Pelvic Pain Disord.

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PY 2019

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PG 6

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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UT WOS:000483866200006

DA 2024-01-18

ER

PT J

AU Shafa, A

Kumar, A

Torres, D

McKenzie, TJ

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Kumar, Amanika

Torres, Diogo

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TI Minimally Invasive Hysterectomy and Bariatric Surgery to Improve

Endometrial Cancer Survivorship

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT Fall Conference of the Minnesota-Surgical-Society

CY NOV 09-10, 2018

CL St Paul, MN

SP Minnesota Surg Soc

ID MORTALITY; DISEASE; OBESITY; WOMEN

AB BACKGROUND: Surgery is curative for the majority of early-stage endometrial cancers. Postoperatively, patients are actually at much higher risk of mortality from obesity-related comorbidities unless they have sustained weight loss.

CASE: A 54-year-old woman with class III obesity, type II diabetes mellitus complicated by neuropathy and retinopathy, hypertension, sleep apnea, and fatty liver disease was diagnosed with grade 1 endometrioid uterine cancer. She underwent dual surgery with laparoscopic bariatric surgery and robotic-assisted laparoscopic hysterectomy. The perioperative period was uncomplicated, and final pathology was consistent with a stage IA grade 1 endometrial cancer. In 12 months, the patient lost 41.3 kg and required less insulin, metformin, and antihypertensive medication.

CONCLUSION: Combined minimally invasive hysterectomy and bariatric surgery for obese women with endometrial cancer can promote sustained weight loss and improve survivorship.

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TC 8

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JI Obstet. Gynecol.

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PG 3

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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AF Wallin, Emelie

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TI Sexual, bladder, bowel and ovarian function 1 year after robot-assisted

radical hysterectomy for early-stage cervical cancer

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE bowel function; cervical cancer; ovarian function; robotic radical

hysterectomy; sexual function; urinary function

ID ANTI-MULLERIAN HORMONE; POSTMENOPAUSAL WOMEN; VAGINAL CHANGES;

POPULATION; TESTOSTERONE; DYSFUNCTION; LYMPHEDEMA; OUTCOMES; HISTORY;

QUALITY

AB Introduction Surgery by open radical hysterectomy for cervical cancer is associated with sexual dysfunction as well as lymphedema and bladder problems. Our aim was to assess the impact of robot-assisted laparoscopic radical hysterectomy (RRH) with pelvic lymphadenectomy for early-stage cervical cancer on sexual, bowel, bladder, and lymphatic function and to measure ovarian function after RRH. Material and methods Twenty-six women with early-stage cervical cancer during 2011-2013 were investigated before and 1 year after RRH using a validated questionnaire measuring psychological well-being and sexual, bowel, bladder, and lymphatic function. Blood samples for follicle-stimulating hormone (FSH), luteinizing hormone (LH), sex-hormone-binding globulin (SHBG), estradiol, total testosterone, androstenedione, and anti-Mullerian hormone (AMH) were analyzed at baseline and 1 year after treatment. Results Anxiety and depression increased in 17/26 (62%) and 16/26 (65%) of the women respectively. Sexual distress symptoms reported 1 year after RRH were numbness of the labia (P = 0.04) and deep pain during intercourse (P = 0.02). Twelve of 26 (46%) had lymphedema, and 10/26 (35%) had bladder problems 1 year after surgery. Levels of FSH and LH were significantly increased (P < 0.01) and AMH decreased (P = 0.02) 1 year after RRH in women <45 years with preserved ovaries. Androgen levels were unchanged. Conclusions In our study, RRH was associated with minor sexual dysfunction. RRH may facilitate the preservation of posterior branches from the hypogastric nerve that are important for arousal and orgasm. Bladder problems and lymphedema remain the most frequently reported sequelae. Women with preserved ovaries after RRH may have an early onset of menopause.

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TC 19

Z9 20

U1 2

U2 11

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

AU Gargiulo, AR

Bhagavath, B

AF Gargiulo, Antonio R.

Bhagavath, Bala

TI Reproductive surgery: decreasing skills and advancing technology-an

existential conundrum

SO FERTILITY AND STERILITY

LA English

DT Article

DE Reproductive surgery; laparoscopy; robotics; laser; morcellator

ID DIOXIDE LASER FIBER; LAPAROSCOPIC SURGERY; MORCELLATION; MYOMECTOMY

AB Our article endeavors to be both a review of the recent past and a preview of the future of reproductive surgery. By reflecting on the rate of technological advancement over the past decade, we attempt to predict the trajectory of the next. We also delve into the changing nature and practical challenges of the practice of gynecologic surgery for the reproductive endocrinology and infertility subspecialist. We will explain how technological advances may alter our perception and expectations regarding the indications, timing and extent of surgical intervention in the infertile patient and in the patient seeking preservation of fertility. This review does not aim to be comprehensive, choosing instead to focus on those innovations that hold, in our view, true potential to shape the future of surgical practice. Ours is primarily a technology review. As such, it does not focus on novel surgical techniques, including uterine transplantation and ovarian tissue transplantation. (C) 2019 by American Society for Reproductive Medicine.

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA IL1PK

UT WOS:000477073000005

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OA hybrid

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ER

PT J

AU Kasabwala, K

Goueli, R

Culligan, PJ

AF Kasabwala, Khushabu

Goueli, Ramy

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TI A live porcine model for robotic sacrocolpopexy training

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Porcine model; Robotic sacrocolpopexy; Robotic

surgery; Surgical training

AB Introduction and hypothesisRobotic sacrocolpopexy is an effective and durable technique for pelvic organ prolapse repair. However, the learning curve for this procedure has underscored the need for an effective surgical training module. Given the cost, infection risk, poor tissue compliance, and scarcity of human cadavers, the live porcine model represents a realistic, available, and cost-effective alternative. This article describes a live porcine model for teaching robotic sacrocolpopexy to determine whether it teaches key aspects of live human robotic sacrocolpopexy to the learner.MethodsThis robotic sacrocolpopexy model was created using the Da Vinci Xi or Si robotic system on domestic pigs under general anesthesia. The main steps of the model include: (1) creating the porcine cervix and (2) performing robotic sacrocolpopexy. The model was evaluated with a survey given to 18 board-certified surgeons who attended the training course between December 2016 and April 2018.ResultsAll of the participants reported improvements in their economy of motion, tissue handling ability, suturing efficiency, and overall performance of robotic sacrocolpopexy. Furthermore, a majority of participants were likely to incorporate aspects of the model into their practice (88.8%) and recommend the model to colleagues (94.2%).ConclusionsThe porcine model provides a feasible tool for teaching robotic sacrocolpopexy to physicians.

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JI Int. Urogynecol. J.

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PY 2019

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IS 8

BP 1371

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DI 10.1007/s00192-019-03936-7

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WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA IK5EY

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ER

PT J

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TI Long term resource consequences of a nationwide introduction of robotic

surgery for women with early stage endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Costs of care; Resource consumption; Long follow-up; Endometrial cancer;

Robotic surgery

ID SAME-DAY DISCHARGE; ASSISTED HYSTERECTOMY; LAPAROSCOPIC SURGERY;

COST-ANALYSIS; REGISTERS; BENEFITS; ONCOLOGY; CHARGES; HEALTH

AB Objective. The majority of cost-studies related to robotic surgery has a short follow-up and primarily report the costs from the index surgery. The aim of this study was to evaluate the long-term resource consequences of introducing robotic surgery for early stage endometrial cancer in Denmark.

Methods. The study included all women with early stage endometrial cancer who underwent robotic, laparoscopic and open access surgery from January 2008 to June 2015. Data was linked from national databases to determine resource consumption and costs from hospital treatments, outpatient contacts, primary health care sector visits, labor market affiliation and prescription of medication. Each patient was observed in a period of 12 months before- and after surgery. The key exposure variable was women who were exposed to robotic surgery compared to those who were not.

Results. A total of 4133 women underwent surgery for early stage endometrial cancer. The study found additional costs of $7309 (95% confidence interval ICI] 2100-11,620, P = 0.001) per patient in the group exposed to robotic surgery including long-term costs post-surgery compared to the non-exposed group (non-robotic group). When controlling for time trends, the introduction of robotic surgery did not reduce the number of bed days (mean diff -0.42, 95% CI -3.03-2.19, P = 0.752).

Conclusions. The introduction of robotic surgery for early stage endometrial cancer did not generate any long-term cost savings. The additional costs of robotic surgery were primarily driven by the index surgery. Any reduction in bed days could be explained by time trends. (C) 2019 Elsevier Inc. All rights reserved.

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PT J

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Wiener, Zeev

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TI Single-port versus multi-port robotic sacrocervicopexy: Establishment

Chock for of a learning curve and short-term outcomes

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Apical prolapse; Robotic sacrocervicopexy; Multi-port robotic;

Single-port robotic

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACRAL COLPOPEXY; LAPAROSCOPIC

SACROCOLPOPEXY; MANAGEMENT; SURGERY; IMPLEMENTATION; DEFECTS; UROLOGY

AB Objectives: The purpose of this study was to compare the learning curves, surgical outcomes and complications of multi-port access robotic-assisted laparoscopic sacrocervicopexy (MP-RSC) to single-port robotic access (SP-RSC) for vaginal apex prolapse.

Methods: A retrospective study of the first 52 MP-RSC procedures compared with the first 52 SP-RSC procedures performed at one medical center. Primary outcomes were intraoperative bleeding, operative time, and hospitalization. Secondary outcomes were surgical complications.

Results: There was a statistically significant difference in mean operative times between the MP-RSC and SP-RSC procedures: 206.5 +/- 39.4 and 187.8 +/- 46.2, respectively, P = 0.028. The mean estimated intraoperative blood loss was 35 [20-87.5] ml and 20 [10-47.5] ml, respectively, P = 0.008. Respective mean operative times decreased from the first 15 to the subsequent 15 cases: in the MP-RSC group from 224.2 +/- 43.2 to 198.4 +/- 36.3 min, P = 0.088, and in the SP-RSC group from 222.4 +/- 53.1 to 161.3 +/- 28.2 min, P < 0.001. The subsequent 22 cases showed different trends. Hospitalization (days) and level of pain at 24 h postoperative, according to a 1-10 point visual analogue scale, did not differ. Adverse events were rare in both groups.

Conclusions: MP-RSC and SP-RSC are feasible and the short term outcomes and learning curves for both procedures are comparable. (C) 2019 Elsevier B.V. All rights reserved.

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PU ELSEVIER SCIENCE BV

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Taner, U

Aysel, O

Ahmet, K

Gulfem, B

AF Taner, Usta

Aysel, Ozkaynak

Ahmet, Kale

Gulfem, Basol

TI Robot-assisted laparoscopic management of a vascular entrapment of the

sacral nerve roots causing pelvic pain

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE laparoscopy; neurovascular entrapment; pelvic pain; robotic surgery;

sciatic nerve

AB The aim of this case report is to demonstrate the robot-assisted laparoscopic decompression approach to treat the aberrant vessels entrapping the sacral nerves causing pelvic pain. A 34-year-old female patient had been complaining about pelvic pain on the left perineal region which was radiating to the sacral 1-2 nerves dermatome for 3 years. Decompression of sacral nerve roots and sciatic nerve was performed via robot-assisted and a four-arm Da Vinci Si Surgical System laparoscopic approach. This case report is the first presentation of robot-assisted laparoscopic management of a vascular entrapment of the sacral nerve roots. The robotic technique offers, three-dimensional vision, improved maneuverability and enhanced ergonomics in the deepest area in the pelvis and could be a valid alternative to laparoscopy in the treatment of intrapelvic neurovascular entrapments.

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NR 10

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U2 2

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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AU Klapdor, R

Hertel, H

Hillemanns, P

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Soergel, P

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AF Klapdor, Ruediger

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TI Peritoneal contamination with ICG-stained cervical secretion as

surrogate for potential cervical cancer tumor cell dissemination: A

proof-of-principle study for laparoscopic hysterectomy

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE cervical cancer; colpotomy; indocyaningreen; laparoscopy; radical

hysterectomy; tumor cell dissemination

ID RADICAL HYSTERECTOMY; ENDOMETRIAL; METASTASIS; RECURRENCE

AB Introduction Intracorporal colpotomy during radical hysterectomy for cervical cancer is discussed to be a risk factor for peritoneal dissemination of tumor cells. It might lead to increased recurrence rates after laparoscopic radical hysterectomy compared with abdominal hysterectomy, as shown by the recent LACC study. Data on the frequency or mechanisms of peritoneal contamination are missing. We aimed to analyze peritoneal contamination of cervical secretion during intracorporal colpotomy with a novel indocyaningreen (ICG)-based technique. Material and methods In this prospective proof-of-principle study, patients undergoing routine laparoscopic or robot-assisted hysterectomy were selected. ICG was specifically applied to the cervical surface and routine surgery was performed. During colpotomy, pictures under white and fluorescence light were taken to evaluate frequency of contamination. Results By using cervically applied ICG we were able to visualize directly peritoneal contamination with cervical secretion during intracorporal colpotomy. We detected peritoneal contamination in 9/12 (75%) patients undergoing routine laparoscopic hysterectomy. Contamination of laparoscopic instruments occurred in 60% of the patients. When contamination occurred, it was routinely detectable during all steps of colpotomy. There were no adverse effects during surgery. Conclusions Peritoneal contamination with cervical secretion frequently occurs during intracorporal colpotomy. This novel technique represents a promising tool for feasible and direct visualization of peritoneal contamination during colpotomy. The technique may be easily implemented in further studies on laparoscopic and abdominal hysterectomy and serve as a quality assessment tool for surgeons and surgical techniques.

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U2 3

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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ER

PT J

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Cardeman, Leon

Brandao Salomao, Alice C. C.

Fonseca, Marlon de Freitas

TI Endometriosis infiltrating the pelvic floor muscles with

histopathological correlation-A case report

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE histopathology; laparoscopy; levator ani; pelvic pain; robotic surgery

AB We report the case of a 29-year-old woman with deep infiltrating endometriosis who underwent robotic nerve-sparing surgery for resection of all visible lesions infiltrating pelvic and extrapelvic sites. Painful symptoms included severe dysmenorrhea, menstrual dyschezia and stranguria, with no improvement in response to hormonal treatment. The location on physical examination of a painful retrocervical nodule was identified by magnetic resonance imaging to be infiltrating the right parametrium/paracervix. During surgery, this nodule was recognized as an important retrocervical/rectovaginal lesion infiltrating the pelvic floor (i.e. levator ani and coccygeus), and was histopathologically confirmed as endometriosis infiltrating the skeletal pelvic floor muscles. A Pubmed search of the MEDLINE database in March (2019) found no publication reporting histopathologic confirmation of endometriosis infiltrating the pelvic floor muscles.

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NR 12

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U1 0

U2 1

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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SC Obstetrics & Gynecology

GA JB2AW

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ER

PT J

AU Obermair, HM

Borg, EJ

AF Obermair, Helena M.

Borg, Emma J.

TI Salpingectomy at the time of hysterectomy for benign gynaecological

disease: A comparison of surgical approaches

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE hysterectomy; minimally invasive surgical procedures; ovarian neoplasms;

prophylactic surgical procedures; salpingectomy

ID OVARIAN-CANCER; BILATERAL SALPINGECTOMY; ORIGIN; WOMEN; RISK

AB Given that a significant percentage of high-grade serous cancers develop in the fallopian tube, it has been suggested that salpingectomy may prevent some of these malignancies. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists guidelines recommend prophylactic salpingectomy to be discussed with or offered to patients undergoing hysterectomy for benign indications. This study compares rates of salpingectomy at the time of hysterectomy for benign indications across different surgical approaches among Australian and New Zealand gynaecologists. Data were collected via SurgicalPerformance, a web-based surgical outcomes review and feedback software used by independent gynaecologic surgeons. Of 11 477 hysterectomy records available, 6608 were eligible for analysis. Rates of salpingectomy at vaginal hysterectomy (13%) were significantly lower (P < 0.001) compared to open abdominal (65%), laparoscopic (70%), laparoscopic-assisted vaginal (78%), or robotic hysterectomies (73%) and also lower than in hysterectomies converted to an open abdominal approach (73%).

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NR 19

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J9 AUST NZ J OBSTET GYN

JI Aust. N. Z. J. Obstet. Gynaecol.

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ER

PT J

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Dahm-Kähler, P

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TI Laparotomy or minimal invasive surgery in uterus transplantation: a

comparison

SO FERTILITY AND STERILITY

LA English

DT Review

DE Uterus; transplantation; minimal invasive surgery; laparoscopy; robotic

ID VENOUS DRAINAGE; RADICAL HYSTERECTOMY; LIVING DONATION; FOLLOW-UP;

ALOPECIA; DONORS; CANCER; VEINS

AB Uterus transplantation (UTx) is the first available treatment for absolute uterine factor infertility, a condition due to absence of the uterus or presence of a non-functional uterus. The proof-of-concept of UTx as an infertility treatment for this group of patients occurred in 2014 in Sweden by the first birth after human UTx. That and subsequent cases of the Swedish trial were live-donor UTx procedures with laparotomy of both donor and recipient. Although results of the initial Swedish clinical UTx trial were very favorable in terms of take-home-baby rate, the drawback was the long duration (>10 h) of donor surgeries and associated long recovery periods. There exist three later publications, with uterus procurements from live donors by laparotomy with a range of surgical durations of 5.3 hours to 13 hours. Our collaborative Swedish-French team has initiated efforts to introduce minimal invasive surgery in one trial in Sweden and one in France. The principle of these UTx trials is to use modern concepts of robotic-assisted laparoscopy primarily in the live donor. There also exists a small number of published UTx procedures with donor surgery by partial conventional laparoscopy and one published case with total robotic-assisted laparoscopy procedure. This review discusses open versus minimal invasive surgery in relation to the accumulated knowledge in the field. Moreover, we propose some future directions for the development of this surgery in UTx. ((C) 2019 by American Society for Reproductive Medicine.)

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AU Chen, CW

Chang, HC

Huang, TF

Liao, CC

Huang, RL

Lai, HC

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Chang, Heng-Cheng

Huang, Tzu-Fei

Liao, Chi-Chun

Huang, Rui-Lan

Lai, Hung-Cheng

TI Transition from multiport to single-site surgery: A single institution

experience in robotic supracervical hysterectomy for benign

gynecological diseases

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Robotic hysterectomy; Robotic-assisted single-site laparoscopy;

Supracervical hysterectomy

ID LAPAROSCOPIC SUBTOTAL HYSTERECTOMY; ENDOMETRIAL CANCER; LEARNING-CURVE;

FEASIBILITY; OUTCOMES; MANAGEMENT

AB Objective: To share our experience of transition from multiport to single-site robotic surgery for benign gynecological conditions as well as to assess the selection criteria of candidates for robotic single-site supracervical hysterectomy (RSSH).

Materials and methods: A retrospective review was conducted on patients undergoing robotic supracervical hysterectomy by a single surgeon in a single institute between June 2014 and December 2017. Patients who underwent additional procedures along with supracervical hysterectomy and who had unexpectant corpus malignancy proved pathologically were excluded from comparisons between patients undergoing RSSH and robotic multiport supracervical hysterectomy (RMSH).

Results: Between June 2014 and December 2017, we accomplished 26 RSSH and 57 RMSH. There were no conversions, intraoperative complications, and readmissions within 30 days after surgery. In the RSSH group, the mean uterine weight was 264.6 +/- 140.9 g with mean docking time of 15.8 +/- 5.5 min, mean console time of 61.1 +/- 35.6 min and mean operative time of 140.3 +/- 34.4 min. In comparison to the RMSH group, the percentage of overweight/obese patients was lower (p = 0.018) and the uterine size was smaller (p < 0.001) with adenomyosis diagnosed more frequently (p = 0.002) in the RSSH group. While the operative time in the RSSH group was significantly shorter (p = 0.002), the RSSH group took longer time in docking (p < 0.001) and comparable time in console (p = 0.254). In view of chronological change, docking time and console time in the RMSH group remained steady, whereas steep decreases were observed in the RSSH group. The intraoperative blood loss and hemoglobin drop were comparable. The length of hospital stay was significantly shorter in the RSSH group (p = 0.005).

Conclusion: Transition from multiport to single-site surgery can be smooth for a surgical team experienced in the conventional multiport robotic system. RSSH is safe and feasible in properly selected patients. (C) 2019 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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NR 24

TC 5

Z9 6

U1 0

U2 1

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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PT J

AU Chu, CM

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Pilkinton, Marjorie L.

Chan, Robert C.

Lebrun, Emily E. Weber

Arya, Lily A.

TI Patients' Knowledge of and Attitude Toward Robotic Surgery for Pelvic

Organ Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE attitudes; knowledge; prolapse; robotic surgery; treatment for pelvic

organ prolapse

ID INFORMED-CONSENT; FLOOR DISORDERS; TERM OUTCOMES; SACROCOLPOPEXY; WOMEN

AB Objectives Robotic sacrocolpopexy for pelvic organ prolapse (POP) has increased, along with marketing and media coverage. It is unknown whether this exposure influences patients' opinions on POP repair. This study describes the preference for and knowledge of robotic surgery in women with POP. Methods We performed a cross-sectional survey of new patients presenting with POP at 7 academic sites. Subjects had no prior surgical counseling. A self-administered questionnaire was designed to investigate robotic surgery knowledge, preference, and exposure. Subjects expressed their preferred route of POP repair (robotic, vaginal, abdominal, laparoscopic, or no preference). Knowledge was determined by the number of correctly answered questions (range, 0-7). Perception of robotic surgery was compared with other surgical routes. Results One hundred seventy-six subjects were included. Most had no surgical preference (66.3%), whereas 27.3% preferred nonrobotic and 6.4% preferred robotic routes. The mean knowledge score was 2.3 (SD, 1.7). Women preferring robotic surgery were more likely to view it as faster than laparoscopic surgery (P < 0.001). These same subjects did not perceive any advantages for robotic surgery related to blood loss, pain, and organ injury (P > 0.05). Most reported no prior exposure to robotic surgery information (56.2%) or advertisements (65.2%). Those with prior exposure most frequently obtained information via the Internet and encountered hospital advertisements. Conclusions The majority of women with POP reported no preference for robotic approach to POP surgery. Knowledge about robotic surgery was low, even among subjects who expressed preference. Comprehensive counseling may help patients make informed decisions even when surgical preferences exist.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

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Espinal, M

Heckman, MG

Vargas, ER

Robertson, MA

AF DeStephano, Christopher C.

Gajarawala, Shilpa P.

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TI Discharge Readiness after Robotic and Laparoscopic Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Patient satisfaction; Laparoscopy; Hysterectomy; Robotic;

Patient-reported Outcomes

ID OUTPATIENT VAGINAL HYSTERECTOMY; SAME-DAY DISCHARGE

AB Study Objective: To evaluate which factors may be predictive of patient readiness of discharge after robotic and laparoscopic hysterectomy.

Design: A prospective cohort study (Canadian Task Force classification II-2).

Setting: A single tertiary care center in the United States.

Patients: All 230 patients undergoing robotic and laparoscopic hysterectomy between November 2015 and April 2017.

Interventions: The primary outcome measure was whether or not the patient felt ready for discharge when she was sent home, and this was assessed using a survey 4 to 6 weeks after surgery. Secondary outcomes included the number of postoperative phone calls, 30-day readmission, and also whether the patient felt knowledgeable about postoperative symptoms and restrictions (both assessed via a 4- to 6-week survey). Associations of baseline, operative, and postoperative characteristics with outcomes were evaluated using regression models appropriate for the nature of the given outcome measure.

Measurements and Main Results: Of the 230 patients, 207 (90%) reported they felt ready for discharge on the postoperative survey. The majority of patients strongly agreed that they felt knowledgeable about what symptoms to expect postoperatively (60%) and about postoperative restrictions (71%). The median number of postoperative phone calls was 1 (range, 0-11), with 104 patients (45%) having more than 1 postoperative call. The only factor that was significantly associated with a lack of readiness for discharge was a longer total operating room time (p = .011). Factors associated with more postoperative phone calls were a urogynecologic indication (p = .005), a cancer indication (p = .024), a longer total operative room time (p = .014), a postoperative complication (p < .001), and not seeing a patient education video (p = .018). Knowledge of postoperative restrictions was significantly worse for older patients (p = .004) and varied significantly according to surgeon (p = .038). No significant predictors of knowledge of postoperative symptoms were identified.

Conclusions: Discharge readiness and knowledge of postoperative restrictions and symptoms were high in patients who underwent laparoscopic and robotic hysterectomies. The risk factors for outcomes that were identified highlight groups of patients who can be targeted for preemptive interventions both preoperatively and postoperatively. (C) 2018 Published by Elsevier Inc. on behalf of AAGL.

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PT J

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TI Robot-assisted approach to cervical cancer (RACC): an international

multi-center, open-label randomized controlled trial

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE cervical cancer; surgical oncology

ID RADICAL HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY; CLASSIFICATION;

COMPLICATIONS

AB Background Radical hysterectomy with pelvic lymphadenectomy represents the standard treatment for early-stage cervical cancer. Results from a recent randomized controlled trial demonstrate that minimally invasive surgery is inferior to laparotomy with regards to disease-free and overall survival. Primary Objective To investigate the oncologic safety of robot-assisted surgery for early-stage cervical cancer as compared with standard laparotomy. Study Hypothesis Robot-assisted laparoscopic radical hysterectomy is non-inferior to laparotomy in regards to recurrence-free survival with the advantage of fewer post-operative complications and superior patient-reported outcomes. Trial Design Prospective, multi-institutional, international, open-label randomized clinical trial. Consecutive women with early-stage cervical cancer will be assessed for eligibility and subsequently randomized 1:1 to either robot-assisted laparoscopic surgery or laparotomy. Institutional review board approval will be required from all participating institutions. The trial is coordinated from Karolinska University Hospital, Sweden. Major Inclusion/Exclusion Criteria Women over 18 with cervical cancer FIGO (2018) stages IB1, IB2, and IIA1 squamous, adenocarcinoma, or adenosquamous will be included. Women are not eligible if they have evidence of metastatic disease, serious co-morbidity, or a secondary invasive neoplasm in the past 5 years. Primary Endpoint Recurrence-free survival at 5 years between women who underwent robot-assisted laparoscopic surgery versus laparotomy for early-stage cervical cancer. Sample Size The clinical non-inferiority margin in this study is defined as a 5-year recurrence-free survival not worsened by >7.5%. With an expected recurrence-free survival of 85%, the study needs to observe 127 events with a one-sided level of significance (alpha) of 5% and a power (1-beta) of 80%. With 5 years of recruitment and 3 years of follow-up, the necessary number of events will be reached if the study can recruit a total of 768 patients. Estimated Dates for Completing Accrual and Presenting Results Trial launch is estimated to be May 2019 and the trial is estimated to close in May 2027 with presentation of data shortly thereafter.

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TI Safety and effectiveness of robotic hysterectomy versus conventional

laparoscopic hysterectomy in patients with cervical cancer in China

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Cervical cancer; Robotic hysterectomy; Conventional laparoscopic

hysterectomy

ID RADICAL VAGINAL HYSTERECTOMY; ASSISTED SURGERY; PELVIC LYMPHADENECTOMY;

LAPAROTOMY; COSTS

AB ObjectiveThe aim of this study was to compare the safety and effectiveness of robotic hysterectomy (RH) with conventional laparoscopic hysterectomy (LH) for the treatment of cervical cancer using multivariate regressions.MethodsWe designed a retrospective single-center study and consecutively collected patients with cervical cancer from February 2014 to October 2017. Data extraction was performed by two independent researchers. The surgical outcomes include operative time, estimated blood loss, number of lymph nodes, time to first flatus, time to a full diet, time to remove drainage tube, length of hospital stay, and postoperative complication.ResultsA total of 152 patients with cervical cancer were collected in our study including 92 patients who underwent RH and 60 patients who underwent LH. Both groups have similar characteristics. The RH group showed shorter operative time (Coe -42.89; 95% CI -74.39 to 11.39; P=0.008) and more number of lymph nodes (Coe 6.06; 95% CI 2.46-9.66; p=0.001) than the LH group. As for the postoperative parameters, the RH group showed shorter time to remove drainage tube (Coe -0.89; 95% CI -1.62 to -0.15; p=0.019) and length of hospital stay (Coe -6.40; 95% CI -10.19 to -2.95; p=0.001). No significant difference was found between the groups in estimated blood loss (Coe 34.64; 95% CI -33.08 to 102.37; p=0.314), time to first flatus (Coe 0.11; 95% CI -0.38 to 0.61; p=0.652), time to a full diet (Coe -0.24; 95% CI -0.54 to 0.06, p=0.118), and postoperative complication (OR 0.84; 95% CI 0.35-1.98; p=0.685).ConclusionThe results from this study suggest that RH is safe and effective as LH but robotic surgery significantly contributed to the feasibility of alternative treatment options for cervical cancer patients.

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NR 30

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Z9 3

U1 0

U2 5

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JI Arch. Gynecol. Obstet.

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ER

PT J

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TI Robot-assisted surgery for the management of apical prolapse: a

bi-centre prospective cohort study

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; robot-assisted; sacral colpopexy;

sacrocervicopexy; sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; SACROCOLPOPEXY; CLASSIFICATION; COMPLICATIONS;

HYSTERECTOMY; VALIDATION

AB Objective Robot-assisted surgery is a recognised treatment for pelvic-organ prolapse. Many of the surgical subgroup outcomes for apical prolapse are reported together, leading to a paucity of homogenous data. Design Prospective observational cohort study (NCT01598467, ) assessing outcomes for homogeneous subgroups of robot-assisted apical prolapse surgery. Setting Two European tertiary referral hospitals. Population Consecutive patients undergoing robot-assisted sacrocolpopexy (RASC) and supracervical hysterectomy with sacrocervicopexy (RSHS). Methods Anatomical cure (simplified Pelvic Organ Prolapse Quantification, sPOPQ, stage 1), subjective cure (symptoms of bulge), and quality of life (Pelvic Floor Impact Questionnaire, PFIQ-7). Main outcome measures Primary outcome: anatomical and subjective cure. Secondary outcomes: surgical safety and intraoperative variables. Results A total of 305 patients were included (RASC n = 188; RSHS n = 117). Twelve months follow-up was available for 144 (RASC 76.6%) and 109 (RSHS 93.2%) women. Anatomical success of the apical compartment occurred for 91% (RASC) and in 99% (RSHS) of the women. In all compartments, the success percentages were 67 and 65%, respectively. Most recurrences were in the anterior compartment [15.7% RASC (symptomatic 12.1%); 22.9% RSHS (symptomatic 4.8%)]. Symptoms of bulge improved from 97.4 to 17.4% (P < 0.0005). PFIQ-7 scores improved from 76.7 +/- 62.3 to 13.5 +/- 31.1 (P < 0.0005). The duration of surgery increased significantly for RSHS [183.1 +/- 38.2 versus 145.3 +/- 29.8 (P < 0.0005)]. Intraoperative complications and conversion rates were low (RASC, 5.3 and 4.3%; RSHS, 0.0 and 0.0%). Four severe postoperative complications occurred after RASC (2.1%) and one occurred after RSHS (1.6%). Conclusions This is the largest reported prospective cohort study on robot-assisted apical prolapse surgery. Both procedures are safe, with durable results. Tweetable abstract European bi-centre trial concludes that robot-assisted surgery is a viable approach to managing apical prolapse.

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U2 1

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TI A Comparison of the Clinical Outcomes in Uterine Cancer Surgery After

the Introduction of Robotic-Assisted Surgery

SO JOURNAL OF OBSTETRICS AND GYNECOLOGY OF INDIA

LA English

DT Article

DE Uterine malignancy; Open surgery; Robotic surgery; Intraoperative

complication; Postoperative complications

ID ENDOMETRIAL CANCER; LAPAROSCOPY; LAPAROTOMY; SURVIVAL

AB ObjectiveTo compare the rates of intraoperative and postoperative complications of open and robotic-assisted surgery in the treatment of endometrial cancer.MethodsThis retrospective study was performed at a single academic institution from January 2014 to February 2017 in the Department of Gynecology Oncology at Amrita Institute of Medical Science, Kerala, India. The study included patients with clinically early stage uterine malignancy undergoing open or robotic-assisted surgery. Data collected included clinicopathological factors, intraoperative data, length of hospital stay and intraoperative and postoperative (early and late and severity according to Clavien-Dindo classification). Morbidity was compared between two groups.ResultsThe study included 128 patients, of whom 61 underwent open surgery and 67 underwent robotic-assisted surgery. Mean operative time (P=0.112), mean estimated blood loss (P<0.001), number of patients requiring blood transfusion (P<0.001) and mean length of hospital stay (P<0.001) were significantly lower in robotic group. None of the patients in robotic group experienced intraoperative hemorrhage (P=0.010). The early postoperative complications, SSI (P<0.001), infection (P=0.002), and urinary complications (P=0.030) and late postoperative complications lymphoedema (P=0.002), vault-related complications (1.5% robotic vs. 6.6% open) and incisional hernia (none in robotic vs. 4.9% in open) were significantly lower in robotic group. Grade-II complications (Clavien-Dindo classification) were significantly lower in robotic group (P<0.001).ConclusionRobotic-assisted surgical staging for uterine cancer is feasible and safe in terms of short-term outcomes and results in fewer complications and shorter hospital stay.

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NR 20

TC 5

Z9 6

U1 0

U2 1

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Singh, Preeti Bala

Sahani, Neelam

TI Aggressive Angiomyxoma: A Rare Cause of Recurrent Vulval Swelling

SO INDIAN JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Angiomyxoma; Mesenchymal tumor; Vulval swelling; Recurrent tumor;

Bartholin's duct cyst

AB This is a case report of a 28-year female with aggressive angiomyxoma who presented with recurrent vulval swelling for which she was operated four times. First time, at the age of 19years thinking it to be a Bartholin's duct cyst, that on histopathology found to be angiomyxoma. Swelling recurred as left labial mass within a year of surgery. Second time, she underwent wide excision of the left labial mass, and on immunohistochemistry, it was positive for estrogen and progesterone receptors for which she was offered hormonal treatment, but she denied. Third time, she underwent robotic surgery because upper extent of tumor was deep in the pelvis and was not approachable by perineal route. After 2years, swelling recurred again for which she got operated fourth time after her pregnancy. Now she has been given GnRH agonist and is being followed up for recurrence.

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NR 8

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Z9 0

U1 0

U2 1

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PT J

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AF Han, Esther S.

Advincula, Arnold P.

TI Safety in Minimally Invasive Surgery

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Post-operative neuropathy; Trocar injury; Patient optimization; Safety;

Minimally invasive surgery

ID PATIENT DISPLACEMENT; RISK; NEUROPATHIES; HYSTERECTOMY; ADHESIONS;

INJURIES; TROCAR

AB Conventional and robot-assisted laparoscopic gynecologic surgery offers many advantages over a traditional laparotomy. However, these minimally invasive approaches can present their own particular risks. To ensure patient safety, procedures must be properly planned and performed by a skilled surgeon. Pre-operative patient optimization can help ensure safety and efficiency. Additional risks before starting the actual procedure arise from unique requirements for patient positioning and the need for peritoneal access. The authors discuss these risks and the importance of a thorough working knowledge of anatomy and surgical equipment (specifically conventional laparoscopic devices) to mitigate them.

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Z9 3

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ER

PT J

AU Kohler, C

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TI Laparoscopic radical hysterectomy with transvaginal closure of vaginal

cuff - a multicenter analysis

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID STAGE CERVICAL-CANCER; UTERINE MANIPULATOR; SURVIVAL OUTCOMES;

LYMPHADENECTOMY; MANAGEMENT; MORBIDITY; PATHOLOGY

AB Objective Laparoscopic/robotic radical hysterectomy has been historically considered oncologically equivalent to open radical hysterectomy for patients with early cervical cancer. However, a recent prospective randomized trial (Laparoscopic Approach to Cervical Cancer, LACC) has demonstrated significant inferiority of the minimally invasive approach. The aim of this study is to evaluate the oncologic outcomes of combined laparoscopic-vaginal radical hysterectomy.

Methods Between August 1994 and December 2018, patients with invasive cervical cancer were treated using minimally-invasive surgery at the Universities of Jena, Charite Berlin (Campus CCM and CBF) and Cologne and Asklepios Clinic Hamburg. 389 patients with inclusion criteria identical to the LACC trial were identified. In contrast to the laparoscopic/robotic technique used in the LACC trial, all patients in our cohort underwent a combined transvaginal-laparoscopic approach without the use of any uterine manipulator.

Results A total of 1952 consecutive patients with cervical cancer were included in the analysis. Initial International Federation of Gynecology and Obstetrics (FIGO) stage was IA1 lymphovascular space invasion (LVSI+), IA2 and IB1/IIA1 in 32 (8%), 43 (11%), and 314 (81%) patients, respectively, and histology was squamous cell in 263 (68%), adenocarcinoma in 117 (30%), and adenosquamous in 9 (2%) patients. Lymphovascular invasion was confirmed in 106 (27%) patients. The median number of lymph nodes was 24 (range 2-86). Lymph nodes were tumor-free in 379 (97%) patients. Following radical hysterectomy, 71 (18%) patients underwent adjuvant chemoradiation or radiation. After a median follow-up of 99 (range 1-288) months, the 3-, 4.5-, and 10-year disease-free survival rates were 96.8%, 95.8%, and 93.1 %, and the 3-, 4.5-, and 10-year overall survival rates were 98.5%, 97.8%, and 95.8%, respectively. Recurrence location was loco-regional in 50% of cases with recurrence (n=10). Interestingly, 9/20 recurrences occurred more than 39 months after surgery.

Conclusion The combined laparoscopic-vaginal technique for radical hysterectomy with avoidance of spillage and manipulation of tumor cells provides excellent oncologic outcome for patients with early cervical cancer. Our retrospective data suggest that laparoscopic-vaginal surgery may be oncologically safe and should be validated in further randomized trials.

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TI Chronic Postoperative Pain After Robot-Assisted Laparoscopic

Hysterectomy for Endometrial Cancer

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE chronic postoperative pain; robot-assisted laparoscopic hysterectomy

ID CHRONIC PELVIC PAIN; QUALITY-OF-LIFE; RISK-FACTORS; UTERINE CERVIX;

SURGERY; WOMEN; OUTCOMES

AB Objective: Chronic postoperative pain poses a significant clinical challenge and is associated with a reduced quality of life and increased use of health services. The present study was conducted to determine the prevalence of chronic postoperative pain and potential risk factors for developing chronic postoperative pain after robot-assisted laparoscopic hysterectomy. Materials and Methods: This was a questionnaire-based, cross-sectional retrospective study. Patients treated for endometrial cancer with robot-assisted laparoscopic hysterectomy from January 2010 until July 2015 received a validated questionnaire. The questionnaire had 32 questions related to preoperative and the postoperative conditions and was used to assess the presence of preoperative pelvic pain, chronic postoperative pelvic pain, pain intensity ratings, frequency and location of pain, pain during everyday activities, and demographic data. The medical records were reviewed for details concerning body mass index, duration of surgery, blood loss during surgery, histopathologic diagnoses, and stages of cancer. Results: Questionnaires were sent to 272 patients and 207 (76.1%) responded. The prevalence of chronic postoperative pain was 14.9%. It was predominantly localized to dermatomes T-12-L-3 and S2-S4. Significant risk factors for chronic postoperative pain were preoperative pelvic pain (odds ratio [OR]: 4.99) and a high level of acute postoperative pain (OR: 1.27) (p < 0.05). Conclusions: The prevalence of chronic postoperative pain after robot-assisted laparoscopic hysterectomy was 14.9%. Risk factors were preoperative pelvic pain and a high level of acute postoperative pain, indicating that these factors should be included when counseling patients and that research efforts should be taken to find ways to minimize the postoperative impact of these factors.

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ER

PT J

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Bora, Rashmi Rekha

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TI Detection of Regional Lymph Node Metastasis by 18-FDG PET/CT in Patients

with Endometrial Cancer

SO INDIAN JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; PET; CT; Nodal metastasis; Imaging

AB PurposeTo evaluate the accuracy of F-18-FDG PET/CT in detecting regional lymph node metastasis in patients with endometrial cancer. MethodsA retrospective analysis was done for 50 patients having biopsy-proven endometrial cancer who underwent FDG PET/CT as a part of preoperative evaluation. All of these underwent Type I hysterectomy with lymphadenectomy either by open or robot-assisted surgery. PET/CT findings were then compared with the final histopathology. The criterion for malignancy on PET/CT images was increased FDG uptake by a lymph node independent of its size.ResultsHyper-metabolic FDG-avid lymph nodes were present in 9 out of 50 patients. Twelve patients had metastasis to lymph nodes on histopathology, and 38 were negative for nodal metastasis. The overall sensitivity, specificity, positive and negative predictive value and accuracy of PET/CT for detecting nodal metastases were 66.67, 97.4, 88.9, 90.24 and 90%, respectively.ConclusionThough FDG PET/CT has a high specificity and negative predictive value, its accuracy in diagnosing nodal metastasis in patients with endometrial cancer is limited because of its low sensitivity.

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PT J

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Cormier, Beatrice

TI Green versus blue: Randomized controlled trial comparing indocyanine

green with methylene blue for sentinel lymph node detection in

endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Sentinel lymph node; Endometrial cancer; Indocyanine green; Methylene

blue; Blue dye

ID CERVICAL INJECTION; MAPPING ALGORITHM; ACCURACY; SURGERY; UTERINE;

MULTICENTER; BIOPSY

AB Objective. To ascertain the increase in detection rate of sentinel lymph node (SLN) associated with the use of indocyanine green (ICG) in comparison with methylene blue dye in women with endometrial cancer.

Methods. For this randomized controlled trial, all patients underwent SLN mapping after injection of blue dye on one side of the cervix and ICG on the other side. Randomization was for the side (right vs. left) on which ICG was used so that each patient's contralateral hemipelvis (HP) served as a control to her ipsilateral HP. We performed a two-tailed, normal-approximate McNemar test for paired-matched data. The primary endpoint was the difference in SLN detection rate for each HP according to the dye used.

Results. This trial included 132 patients, and 46 patients underwent robotic-assisted surgery while 86 had standard laparoscopic surgery. Successful detection of SLN was 90.9% using ICG and 64.4% using blue dye (p < 0.0001). There were no differences in the duration of the SLN procedure (median 10 min per HP) and number of SLN per HP (mean 1.2) according to the dye used. The SLN detection rates for either dye were very similar whether the surgical approach was robotic (mean BMI 45) or laparoscopic (mean BMI 29). Crossover of dye to the contralateral HP was present in 3% of cases.

Conclusion. The use of ICG instead of blue dye results in a 26.5% (95% CI 17.4%-35.6%) increase of SLN detection rates per HP in women with endometrial cancer. (C) 2019 Published by Elsevier Inc.

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A.R. contributed to the present study.

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PT J

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Jain, Vandana

Naithani, Amita

Rawal, Sudhir K.

TI Clinical Outcomes of Robotic Versus Open Radical Hysterectomy in

Endometrial Cancer Staging: An Experience at a Tertiary Referral Care

Center

SO JOURNAL OF GYNECOLOGIC SURGERY

LA English

DT Article

DE endometrial cancer; robotic staging; laparotomy; lymphadenectomy

ID LAPAROSCOPIC HYSTERECTOMY; LAPAROTOMY; CLASSIFICATION; COMPLICATIONS;

OBESE; COST

AB Objective: Comprehensive surgical staging is the mainstay of initial treatment for most patients with endometrial cancer. This study compared hysterectomy and lymphadenectomy for endometrial-cancer staging via robotics and open routes in terms of clinicopathologic factors, perioperative outcomes, recurrences, and survival. Materials and Methods: Patients were identified retrospectively to find those with clinically uterus-confined endometrial cancers, who underwent staging via a robotic approach between October 2011 and October 2016. These patients were matched in a 1:1 ratio with patients staged via conventional laparotomy during the same time period. Data were analyzed for demographics, operative time, blood loss, surgicopathologic factors, complications, conversions, length of hospital stay, adjuvant treatment, recurrences, and follow-up. Results: The study included 150 patients (75 in a robotic-surgery group and 75 in an open-surgery group). The overall rate of complications was much higher in the open-surgery group (38.6%), compared to the robotic surgery group (9.3%; p = 0.0001). Statistically significant differences occurred in both groups in terms of reduced estimated blood loss in the robotic-surgery group (149.99 +/- 85.77 mL), compared to the open-surgery group (444.2 +/- 273.09 mL; p < 0.0001), leading to transfusions in 10.6% patients in the robotic-surgery group and 49.3% patients in the open-surgery group (p < 0.0001). There was a lower median operative time in the robotic-surgery group than in the open-surgery group (160 minutes versus 180 minutes; p = 0.038). The median length of stay in the hospital was 3 versus 5 days in the robotic-surgery and open-surgery groups, respectively (p < 0.0001). The age and body mass indices were similar in both groups (p = 0.073 and p = 0.18, respectively). The nodal yields (27 versus 26; p = 0.869), grades (p = 0.11), International Federation of Gynecology and Obstetrics stages (p = 0.78), and histology (p = 0.546) were similar in both groups as were deep myometrial invasions (p = 0.51) and lymphovascular-space invasions (p = 0.54). Recurrences occurred in 9.3% of robotic-surgery and 14.6% of open-surgery cases (p = 0.451), with death due to disease in 6.6% versus 10.6% in the robotic-surgery and open-surgery groups (p = 0.608). Conclusions: Robotic staging for endometrial cancer has clear advantages over conventional laparotomy in terms of less operative time, reduced blood loss, shorter hospital stay, and fewer complications without compromising the oncologic outcomes. Recurrences and disease related-mortality are not influenced by this minimally invasive modality. (J GYNECOL SURG 20XX:000)

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PT J

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TI Cystoscopy at the Time of Hysterectomy for Benign Indications and

Delayed Lower Genitourinary Tract Injury

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID UNIVERSAL CYSTOSCOPY; GYNECOLOGIC SURGERY

AB OBJECTIVE: To compare the rate of delayed 30-day lower genitourinary tract injury in women who underwent cystoscopy at the time of hysterectomy for benign indications to those who did not.

METHODS: This was a retrospective cohort study of patients who underwent hysterectomy without a concomitant procedure for prolapse or incontinence for benign pathology with a general obstetrician-gynecologist (ob-gyn) recorded in the National Surgical Quality Improvement Program targeted hysterectomy file between 2015 and 2017. The primary outcome was a delayed lower genitourinary tract injury in the 30 days after hysterectomy. Secondary outcomes included urinary tract infection and operative time. The exposure of interest was cystoscopy at the time of hysterectomy. Stratified analysis was performed by route of surgery. Bivariable tests were used to examine associations.

RESULTS: We identified 39,529 women who underwent hysterectomy for benign indications with a general ob-gyn. Surgical approach was open (26%), laparoscopic or robotic assisted laparoscopic (46%), and vaginal or vaginally assisted (28%). Overall, 25% of women underwent cystoscopy at the time of hysterectomy; cystoscopy was more commonly performed in laparoscopic or robotic (32%) and vaginal hysterectomy (25%) as compared with open hysterectomy (11%) (P<.001). There was no difference in delayed lower genitourinary tract injury between patients who underwent cystoscopy at time of hysterectomy compared with those who did not undergo cystoscopy (0.27% vs 0.24%, P=.64). Patients who underwent cystoscopy were more likely to be diagnosed with a urinary tract infection (2.6% vs 2.0%, RR 1.27 95% CI 1.09-1.47). Median operative time was increased by 17 minutes in cases where cystoscopy was performed (132 vs 115 minutes, P<.001).

CONCLUSION: Cystoscopy at the time of hysterectomy for benign indications does not result in a lower rate of 30-day delayed lower genitourinary tract injury compared with no cystoscopy.

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TI New insights into early recovery after robotic surgery for endometrial

cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial Cancer; Uterine neoplasms; Gynecologic surgical procedures;

Minimal access surgical procedures; Minimally invasive surgery; Robotic

surgical procedures; Robotics; Health-related quality of life; Health

status; EORTC CAT Core

ID QUALITY-OF-LIFE; EORTC QLQ-C30; CAT; EXPECTATIONS; OUTCOMES; PEOPLE

AB Objective. To assess early recovery of physical health after robotic minimally invasive surgery (RMIS) for early-stage endometrial cancer using the European Organisation of Research and Treatment of Cancer Computer Adaptive Test Core questionnaire (EORTC CAT Core). The EORTC CAT Core provides individualised measurements while maintaining comparability. A hypothesis of individual complete recovery to baseline within three post-surgical weeks was evaluated.

Methods. Ninety-four women who underwent RMIS for early-stage endometrial cancer were included consecutively. The EORTC CAT Core was distributed before surgery and prospectively every week during the first post-operative month. Repeated measures models were fitted for each of the four domains (physical functioning, role function, fatigue, and pain) and tested for impact of age, ASA score, minor/major surgery, and the individual baseline scores (poorest, intermediate, best).

Results. Women with the lowest physical functioning, lowest role function, highest fatigue level, and highest pain level at baseline all recovered within three weeks. Women with the highest physical functioning, highest role function, lowest level of fatigue, and lowest level of pain at baseline did not reach their individual baselines within the first post-operative month but had the most favourable domain-scores three weeks post-operatively.

Conclusion. The individual woman's physical health baseline score is predictive for her postoperative recovery following RMIS for early-stage endometrial cancer. Women with the best physical health had the best postoperative functions and lowest level of symptoms; however their recovery to baseline was prolonged. Computer adaptive testing may be a valuable tool for individualised pre-operative information and supportive care during surveillance. (C) 2019 Published by Elsevier Inc.

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Council Odense University Hospital Denmark [A2024]; Danish Cancer

Society [R130-A8288]

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ER

PT J

AU Lundin, ES

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Nilsson, L

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Wodlin, Ninnie Borendal

Nilsson, Lena

Kjolhede, Preben

TI A prospective randomized assessment of quality of life between open and

robotic hysterectomy in early endometrial cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; ERAS(R) SOCIETY RECOMMENDATIONS;

SURGERY ENHANCED RECOVERY; ABDOMINAL HYSTERECTOMY; POSTOPERATIVE

SYMPTOMS; HIGH-RISK; CARE; LAPAROTOMY; GUIDELINES; ONCOLOGY

AB Objective There are limited prospective data on the evaluation of quality of life in patients undergoing robotic hysterectomy for endometrial cancer. Our objective was to determine whether post-operative recovery differs between robotic and abdominal hysterectomy.

Methods At a Swedish tertiary referral university hospital, 50 women with low-risk endometrial cancer scheduled for surgery between February 2012 and May 2016 were included in a randomized trial. Surgery was performed according to principles for minimal invasive surgery. Anesthesia and peri-operative care followed a standardized enhanced recovery after surgery program in both groups. The EuroQol Group form EQ-5D and the Short Form-36 were used to evaluate patients' health-related quality of life. The Swedish Postoperative Symptoms Questionnaire assessed symptoms pre-operatively, daily for 7 days from the day of surgery, and then weekly until 6 weeks post-operatively. Data were analyzed by means of non-parametric tests and repeated measures ANOVA. To evaluate the time-dependent occurrence of complications, Kaplan-Meier survival and Cox proportional-hazard models were used.

Results A total of 50 women were enrolled in the study (25 robotic and 25 abdominal hysterectomy). Median age (68 years vs 67 years), estimated blood loss (50 mL vs 50 mL), length of hospital stay de facto (53 hours vs 51 hours), and time to meet discharge criteria (36 hours vs 36 hours) in the robotic and abdominal groups, respectively, did not differ significantly (p>0.05) Women in the robotic hysterectomy group recovered significantly faster (p=0.01) in the EQ-5D health index, and reached their pre-operative level after approximately 3 weeks, nearly 2 weeks earlier than the abdominal group. Differences regarding improvement in health-related quality of life (Short Form-36) were statistically significant in general health and social functioning only, and were in favor of robotic hysterectomy. Consumption of analgesics, pain intensity, and symptom sum score post-operatively were equal. Occurrence of complications was an independent risk factor and influenced significantly the EQ-5D health index, length of hospital stay, pain intensity, opioid consumption, and symptom sum score adversely.

Conclusion Robotic hysterectomy in the setting of an enhanced recovery after surgery program led to faster recovery in health-related quality of life compared with abdominal hysterectomy.

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FU Medical Research Council of South East Sweden; County Council of

Ostergotland; Linkoping University; manufacturer of the robotic

equipment Intuitive Surgery

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U2 3

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JI Int. J. Gynecol. Cancer

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TI Robotic Sacrocolpopexy Simulation Model and Associated Hierarchical Task

Analysis

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 43rd Scientific Meeting of the

American-Association-of-Gynecologic-Laparoscopists

CY NOV 11-15, 2018

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists

ID LAPAROSCOPIC SACROCOLPOPEXY; METAANALYSIS; VALIDITY; SURGERY

AB BACKGROUND: There are limited robotic dry lab training resources that include presacral dissection with vaginal and sacral mesh attachment for robotic sacrocolpopexy. Our objective was to create a simulation model to resemble the anatomy encountered during robotic sacrocolpopexy. Additionally, we sought to outline the steps required to complete a robotic sacrocolpopexy by performing a hierarchical task analysis. With the results of the hierarchical task analysis, we assessed the model's ability to provide an adequate platform for completion of robotic sacrocolpopexy procedural steps.

METHOD: This observational simulation study was divided into two phases. Phase 1 included model development. Phase 2 involved development of the hierarchical task analysis and assessment of the model.

EXPERIENCE: After model creation, six experts each performed a robotic sacrocolpopexy using the model. Overall, experts agreed that the model replicated opening the peritoneum, presacral dissection, suturing on the anterior and posterior vagina, and presacral mesh attachment.

CONCLUSION: We demonstrate construction and use of a robotic sacrocolpopexy simulation model to aid surgeons in training. Further, the hierarchical task analysis provides a method to assess the model's ability to replicate each step of robotic sacrocolpopexy.

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FX Supported by internal institutional funding from Research Innovation and

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Z9 7

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U2 1

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JI Obstet. Gynecol.

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SC Obstetrics & Gynecology

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PT J

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Matthews, CA

AF Schachar, Jeffrey S.

Matthews, Catherine A.

TI Updates in Minimally Invasive Approaches to Apical Pelvic Organ Prolapse

Repair

SO CURRENT OBSTETRICS AND GYNECOLOGY REPORTS

LA English

DT Article

DE Apical prolapse; Minimally invasive; Update; Sacrocolpopexy; Pelvic

organ prolapse

ID LAPAROSCOPIC SACROCOLPOPEXY; ABDOMINAL SACROCOLPOPEXY; PERIOPERATIVE

COMPLICATIONS; VAGINAL PROLAPSE; ROBOTIC SURGERY; BOWEL INJURY;

OUTCOMES; WOMEN; HYSTERECTOMY; FEASIBILITY

AB Purpose of ReviewThe purpose of this article is to review and comment on the recent medical evidence regarding minimally invasive procedures for apical pelvic organ prolapse repair.Recent FindingsSacrocolpopexy remains the gold standard repair for apical prolapse for those who desire to maintain sexual function, and minimally invasive approaches offer equal efficacy with lower risk than open sacrocolpopexy. Similar to the impact on hysterectomy rates, the introduction of robotic technology has converted a large number of open abdominal sacrocolpopexy procedures to a minimally invasive approach in the USA. Newer surgical approaches such as nerve-sparing techniques of dissection at the sacral promontory, use of the iliopectineal ligaments, and natural orifice vaginal sacrocolpopexy offer potential improvements for apical repair. Whether using traditional laparoscopy or robotic assistance, prolapse recurrence is consistently noted in at least 10% of patients. Recent evidence has confirmed that ancillary factors including pre-operative prolapse stage, retention of the cervix and/or uterus, type of mesh implant, and genital hiatus size all adversely affect surgical efficacy. Minimally invasive apical repair procedures seem well suited to early recovery after surgery protocols. While overall complication rates are low, small bowel injury is higher with any abdominal approach and aggressive evaluation of women not meeting routine post-operative goals is advised.SummaryMinimally invasive sacrocolpopexy has achieved similar outcomes to the traditional abdominal route and should be considered the new gold standard in apical prolapse repair. Alterations in surgical techniques can reduce the risk of constipation.

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NR 62

TC 2

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U2 0

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J9 CURR OBSTET GYNECOL

JI CURR. OBSTET. GYNECOL. REP.

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PT J

AU van Zanten, F

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Hartog, FE

Aalders, KIM

Lenters, E

Broeders, IAMJ

Koops, SES

AF van Zanten, Femke

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Hartog, Francis E.

Aalders, Karin I. M.

Lenters, Egbert

Broeders, Ivo A. M. J.

Koops, Steven E. Schraffordt

TI Mesh Exposure After Robot-Assisted Laparoscopic Pelvic Floor Surgery: A

Prospective Cohort Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Mesh erosion; Pelvic organ prolapse; Sacrocervicopexy; Sacrocolpopexy

ID QUALITY-OF-LIFE; ABDOMINAL SACROCOLPOPEXY; ORGAN PROLAPSE; SUPRACERVICAL

HYSTERECTOMY; RECONSTRUCTIVE SURGERY; ANATOMIC OUTCOMES; APICAL SUPPORT;

TERM OUTCOMES; COMPLICATIONS; CLASSIFICATION

AB Study Objective: To prospectively evaluate the mesh exposure rate after robot-assisted laparoscopic pelvic floor surgery for the treatment of female pelvic organ prolapse (POP) in a large cohort.

Design: Prospective observational cohort study (Canadian Task Force classification II-2).

Setting: Two large teaching hospitals with a tertiary referral function for pelvic floor disorders.

Patients: Patients with symptomatic POP and simplified POP quantification (S-POP) stage >= 2. Patients with a history of mesh repair or concomitant insertion of a tension-free vaginal tape were excluded.

Interventions: Robot-assisted laparoscopic sacrocolpopexy or robot-assisted laparoscopic supracervical hysterectomy with a sacrocervicopexy.

Measurements and Main Results: A blinded vaginal examination with the aid of a transparent speculum was performed to look for mesh-related complications. Mesh exposures were described following the International Urogynecological Association/International Continence Society classification system. One hundred and ninety-two patients were included, of whom 166 (86.5%) were seen for follow-up examination. The median duration of follow-up was 15.7 months (range, 8.2-44.4 months). Two vaginal mesh exposures (1.2%) were detected, both of which were treated in the outpatient clinic. One patient without any complaints had a suture exposure, which was removed in the outpatient clinic.

Conclusion: The safety of the use of mesh in pelvic floor surgery is a matter of debate owing to the occurrence of mesh-related complications. Based on the current literature, mesh-related complications seem to be lower in transabdominal mesh surgery than in transvaginal mesh surgery. In this study, a low mesh exposure rate was observed in robot-assisted abdominal pelvic floor surgery for POP. (C) 2018 AAGL. All rights reserved.

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Z9 10

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U2 3

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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GA HU7EC

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ER

PT J

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Rajanbabu, A

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TI Undifferentiated Sarcoma of Fallopian Tube Managed with Robotic-Assisted

Surgery

SO JOURNAL OF OBSTETRICS AND GYNECOLOGY OF INDIA

LA English

DT Article

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Z9 0

U1 0

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J9 J OBSTET GYN INDIA

JI J. Obstet. Gynecol. India

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PT J

AU Baba, T

Mandai, M

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TI Early feasibility surveillance of gynecologic robotic-assisted surgeries

in Japan

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE Japanese Society of Obstetrics and Gynecology; para-aortic node

excision; radical hysterectomy; robotic-assisted surgery

ID PARAAORTIC LYMPHADENECTOMY; ENDOMETRIAL CANCER

AB Aim To evaluate the clinical relevance of robotic-assisted surgeries (RAS) for gynecologic malignancies in a Japanese multi-institutional cohort. Methods A retrospective review of perioperative outcomes of 357 gynecologic RAS procedures was conducted in 24 hospitals accredited to perform RAS by the Japanese Society of Obstetrics and Gynecology (JSOG) over a 4-year period, January 2014 to December 2017. Results More than 25 (high), 10-24 (middle) and less than 10 cases (low) were enrolled from 3, 8 and 13 hospitals, respectively. A total of 247 patients underwent RAS for malignant indications. Radical hysterectomy (RH) was conducted for 200 patients, while para-aortic node excision (PAN) for 47 patients. RAS with RH or PAN was more feasible in high-volume centers with significantly shorter operation time and lesser blood loss than that in middle-volume centers. The total rate of perioperative injury and complications in RAS with PAN reached 33.3% in high-volume centers, which was almost equal to those in middle-volume centers (35.5%) but much higher than RAS without PAN (8.5%). Conclusion Perioperative surveillance demonstrated high feasibility of gynecologic RAS procedures conducted in JSOG accredited hospitals for these 4 years. It is mandatory for RAS conducting hospitals to have careful attitudes to realize their learning curves in conducting advanced procedures.

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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ER

PT J

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Ridgeway, BM

Shepherd, JP

AF Cadish, Lauren A.

Ridgeway, Beri M.

Shepherd, Jonathan P.

TI Cystoscopy at the time of benign hysterectomy: a decision analysis

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 39th Annual Scientific Meeting of the American-Urogynecologic-Society

(AUGS) / Pelvic Floor Disorders (PFD) Week

CY OCT 09-13, 2018

CL Chicago, IL

SP Amer Urogynecol Soc

DE cystoscopy; decision analysis; hysterectomy; urinary tract injury

ID URINARY-TRACT INJURY; URETERAL INJURY; LAPAROSCOPIC HYSTERECTOMY;

UNIVERSAL CYSTOSCOPY; RISK-FACTORS

AB BACKGROUND: Gynecologists debate the optimal use for intraoperative cystoscopy at the time of benign hysterectomy. Although adding cystoscopy leads to additional up-front cost, it may also enable intraoperative detection of a urinary tract injury that may otherwise go unnoticed. Prompt injury detection and intraoperative repair decreases morbidity and is less costly than postoperative diagnosis and treatment. Because urinary tract injury is rare and not easily studied in a prospective fashion, decision analysis provides a method for evaluating the cost associated with varying strategies for use of cystoscopy.

OBJECTIVE: The objective of the study was to quantify costs of routine cystoscopy, selective cystoscopy, or no cystoscopy with benign hysterectomy.

STUDY DESIGN: We created a decision analysis model using TreeAge Pro. Separate models evaluated cystoscopy following abdominal, laparoscopic/robotic, and vaginal hysterectomy from the perspective of a third-party payer. We modeled bladder and ureteral injuries detected intraoperatively and postoperatively. Ureteral injury detection included false-positive and false-negative results. Potential costs included diagnostics (imaging, repeat cystoscopy) and treatment (office/emergency room visits, readmission, ureteral stenting, cystotomy closure, ureteral reimplantation). Our model included costs of peritonitis, urinoma, and vesicovaginal/ureterovaginal fistula. Complication rates were determined from published literature. Costs were gathered from Medicare reimbursement as well as published literature when procedure codes could not accurately capture additional length of stay or work-up related to complications.

RESULTS: From prior studies, bladder injury incidence was 1.75%, 0.93%, and 2.91% for abdominal, laparoscopic/robotic, and vaginal hysterectomy, respectively. Ureteral injury incidence was 1.61%, 0.46%, and 0.46%, respectively. Hysterectomy costs without cystoscopy varied from $884.89 to $1121.91. Selective cystoscopy added $13.20-26.13 compared with no cystoscopy. Routine cystoscopy added $51.39-57.86 compared with selective cystoscopy. With the increasing risk of injury, selective cystoscopy becomes cost saving. When bladder injury exceeds 4.48-11.44% (based on surgical route) or ureteral injury exceeds 3.96-8.95%, selective cystoscopy costs less than no cystoscopy. Therefore, if surgeons estimate the risk of injury has exceeded these thresholds, cystoscopy may be cost saving. However, for routine cystoscopy to be cost saving, the risk of bladder injury would need to exceed 20.59-47.24% and ureteral injury 27.22-37.72%. Model robustness was checked with multiple 1-way sensitivity analyses, and no relevant thresholds for model variables other than injury rates were identified.

CONCLUSION: While routine cystoscopy increased the cost $64.59-83.99, selective cystoscopy had lower increases ($13.20-26.13). These costs are reduced/eliminated with increasing risk of injury. Even a modest increase in suspicion for injury should prompt selective cystoscopy with benign hysterectomy.

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U2 6

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PT J

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Kogan, Liron

Octeau, David

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Salvador, Shannon

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TI Oncologic and Surgical Outcomes of Robotic Versus Open Radical

Hysterectomy for Cervical Cancer

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY CANADA

LA English

DT Article

DE Radical hysterectomy; cervical cancer; robotics; laparotomy; survival

outcome

ID PELVIC LYMPHADENECTOMY; LAPAROSCOPY; EXPERIENCE; SURGERY; WOMEN

AB Objective: In view of the recent controversy concerning the use of minimally invasive radical hysterectomy as primary treatment for early stage cervical cancer, this study compared the survival and perioperative outcomes in a cohort of patients who underwent radical hysterectomy either by laparotomy or by robotics.

Methods: This retrospective study compared all consecutive patients with early stage cervical cancer since the beginning of the Division of Gynecologic Oncology at the Jewish General Hospital in 2003, who underwent robotic radical hysterectomy (n = 74) with a cohort of all consecutive patients from the immediate past who underwent open radical hysterectomy (n = 24) for early stage cervical cancer. All patients were treated at the Jewish General Hospital in Montreal (Canadian Task Force Classification II-2).

Results: The median follow-up time for the robotic group was 46 months. During that time, 7% and 17% of patients in the robotic group and the laparotomy group had disease recurrence, respectively (P = 0.12). Cox multivariate regression showed no statistically significant effect of surgical approach on overall survival (hazard ratio 1.50, P = 0.63) or on progression-free survival (hazard ratio 0.29, P = 0.07). Patients in the robotic cohort had significantly shorter median hospital stays (1 day vs. 7 days, P < 0.001), and their overall incidence of postoperative complications was lower (13% vs. 50%, P < 0.001). Median estimated blood loss for robotics was also significantly lower (82 mL vs. 528 mL, P < 0.001).

Conclusion: Based on the data on a limited number of patients in a Canadian context, robotic radical hysterectomy did not lead to worse oncologic outcomes and was associated with improved short-term surgical outcomes. One might consider the evaluation of more personalized surgical decision making. (C) 2019 The Society of Obstetricians and Gynaecologists of Canada/La Societe des obstetriciens et gynecologues du Canada. Published by Elsevier Inc. All rights reserved.

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ER

PT J

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Tyan, P

Marfori, C

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TI Effect of postoperative partial bladder filling after minimally invasive

hysterectomy on postanesthesia care unit discharge and cost: a

single-blinded, randomized controlled trial

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE health care costs; hysterectomy; postanesthesia care unit; postoperative

bladder backfilling

ID SAME-DAY DISCHARGE; LAPAROSCOPIC HYSTERECTOMY; VAGINAL HYSTERECTOMY

AB BACKGROUND: Hysterectomy is one of the most common surgical procedures performed each year with substantial related health care costs. This trial studied the effect of postoperative bladder backfilling to submicturition level in the operating room and its effect on early postoperative patient care and related cost.

OBJECTIVE: The objective of the study was to compare the effect of bladder backfilling on early postoperative patient care and related cost.

STUDY DESIGN: This was a randomized, single-blinded, controlled trial conducted between April 2016 and February 2017 at a single urban university hospital providing tertiary care for minimally invasive gynecologic surgery. Ninety-one patients undergoing straight-stick laparoscopic and robot-assisted hysterectomy by minimally invasive gynecologic surgeons for benign indications were recruited. The bladder was partially backfilled with 150 mL of normal saline postoperatively in the intervention group and drained in the control group, as per standard of care. Main outcomes studied were time needed to void, time spent in the postanesthesia care unit, and postanesthesia care unit cost after minimally invasive hysterectomy. Our secondary outcomes were postoperative complications.

RESULTS: Forty-six patients (50.5%) were randomized to the intervention group, and 45 patients (49.5%) to the control group. Baseline comparative analysis of demographics and preoperative patient-specific variables, surgical history, intraoperative characteristics, and administered medications found the 2 groups to be largely homogenous. After regression analyses for adjustment, we found a significant reduction in the time needed to void, time spent in the postanesthesia care unit, and postanesthesia care unit-associated cost in the intervention group. Patients voided 64.9 minutes earlier than the control group (P = .015) ans spent 64 fewer minutes in the postanesthesia care unit (P = .006), resulting in $401.5 (USD) saving per patient (P = .006). None of the patients encountered any postoperative complications.

CONCLUSION: Based on the findings of this randomized clinical trial, postoperative bladder backfilling to submicturition level shortens the time needed for patients to void in the postanesthesia care unit, resulting in shorter postanesthesia care unit stay and resultant cost savings. Conservatively projecting our findings on minimally invasive hysterectomy procedure is estimated to result in $69 million to $139 million (USD) per year in savings. Initiating similar investigations in other ambulatory surgical fields will likely result in a more substantial impact.

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Z9 13

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PT J

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TI Long-term follow-up of laparoscopic sacrocolpopexy: comparison of two

different techniques used in urology and gynecology

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Laparoscopic sacrocolpopexy; Long-term follow-up; Gynecology; Urology

ID VAGINAL VAULT PROLAPSE; ABDOMINAL SACROCOLPOPEXY; ROBOTIC

SACROCOLPOPEXY; HYSTERECTOMY; OUTCOMES; SURGERY; REPAIR; WOMEN; COST;

MESH

AB Introduction and hypothesisNumerous studies have found that the short-term results of laparoscopic sacrocolpopexy for pelvic organ prolapse are safe and effective. This study evaluates the long-term results of the laparoscopic sacrocolpopexy operation between the urology and gynecology branches.MethodsA prospective study enrolling 206 patients was conducted to evaluate laparoscopic sacrocolpopexy as a surgical treatment for vaginal vault prolapse from 2011 to 2014. Two different surgical branches (urology and gynecology) applied laparoscopic sacrocolpopexy to their patients with their own techniques. The long-term results were assessed postoperatively after 4years by pelvic examinations, including the Pelvic Organ Prolapse Quantification system (POP-Q) and quality-of-life assessments using validated questionnaires.ResultsA total of 190 patients (94 urology and 96 gynecology patients) received a full clinical follow-up examination between April 2014-June 2018. Postoperative pelvic organ prolapse recurrence rates in each compartment were similar in both groups during the 4years; 87.2% of the urology and 86.5% of the gynecology patients had no prolapse in any compartment according to the POP-Q system. The reoperation rate was 5.3% for the urology and 6.2% for the gynecology group. Mesh erosion was detected in two patients in both groups. Three patients responded to local estrogen therapy, and we removed the mesh vaginally in one patient. The subjective cure rate was 89.4% in the urology and 88.5% in the gynecology group after 4years.ConclusionsAlthough different surgical branches perform laparoscopic sacrocolpopexy with their own techniques, long-term anatomical and functional results are similar between the branches. From a urogynecological point of view, laparoscopic sacrocolpopexy is a gold standard surgical procedure that can be performed by both urologists and gynecologists with similar long-term outcomes.

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PT J

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Murji, A

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TI No. 377-Hysterectomy for Benign Gynaecologic Indications

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY CANADA

LA English

DT Article

DE Hysterectomy; gynaecology; oophorectomy; surgery; quality

ID URINARY-TRACT INJURY; TUBAL INTRAEPITHELIAL CARCINOMA; TOTAL

LAPAROSCOPIC HYSTERECTOMY; TOTAL VAGINAL HYSTERECTOMY; SAME-DAY

DISCHARGE; SEROUS CARCINOMA; OVARIAN-CANCER; ABDOMINAL HYSTERECTOMY;

SURGICAL OUTCOMES; BLOOD-TRANSFUSION

AB Objective: To assist physicians performing gynaecologic surgery in decision making surrounding hysterectomy for benign indications.

Intended Users: Physicians, including gynaecologists, obstetricians, family physicians, general surgeons, emergency medicine specialists; nurses, including registered nurses and nurse practitioners; medical trainees, including medical students, residents, and fellows; and all other health care providers.

Target Population: Adult women (18 years and older) who will undergo hysterectomy for benign gynaecologic indications.

Options: The approach to hysterectomy and utility of concurrent surgical procedures are reviewed in this guideline.

Evidence: For this guideline relevant studies were searched in the PubMed, Medline, and Cochrane Library databases. The following MeSH search terms and their variations for the last 5 years (2012-2017) were used: vaginal hysterectomy, laparoscopic hysterectomy, robotic hysterectomy, laparoscopically assisted vaginal hysterectomy, total laparoscopic hysterectomy, standard vaginal hysterectomy, and total vaginal hysterectomy.

Validation methods: The content and recommendations were drafted and agreed upon by the principal authors and members of the Gynaecology Committee. The Board of the Society of Obstetricians and Gynaecologists of Canada approved the final draft for publication. The quality of evidence was rated using the criteria described in the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology framework (Tables 1 and 2). The Summary of Findings is available upon request.

Benefits, Harms, and Costs: Hysterectomy is common, yet surgical practice still varies widely among gynaecologic physicians. This guideline outlines preoperative and perioperative considerations to improve the quality of care for women undergoing benign gynaecologic surgery.

Guideline Update: This Society of Obstetricians and Gynaecologists of Canada clinical practice guideline will be automatically reviewed 5 years after publication. However, authors can propose another review date if they feel that 5 years is too short/long based on their expert knowledge of the subject matter.

Sponsors: This guideline was developed with resources funded by the Society of Obstetricians and Gynaecologists of Canada.

Summary Statements:

1. Technicity is defined as the proportion of hysterectomies performed by a minimally invasive route (laparoscopic, laparoscopic-assisted, and vaginal). Increased technicity index is associated with improved surgical quality and patient care (High).

2. Minimally invasive approaches to hysterectomy are associated with fewer perioperative complications compared to laparotomy (High).

3. Higher-volume hospitals and surgeons are more likely to have higher technicity and lower complication rates (High).

4. Same-day discharge protocols following minimally invasive hysterectomy are cost-effective, do not increase complications or readmission rates, and are associated with high patient satisfaction (Moderate).

5. Urinary tract injuries are comparable among surgical approaches to hysterectomy (Moderate).

6. Laparotomy or mini-laparotomy may be appropriate as an alternative approach in specific circumstances depending on patient factors, indication for surgery, and underlying pathology (Moderate).

7. The risk of vaginal cuff dehiscence is rare and not related to the choice of suture material or route of closure (Moderate).

8. Supracervical hysterectomy has not been shown to preserve sexual function, decrease pelvic organ prolapse, or reduce incidence of urinary tract injuries compared to total hysterectomy (Moderate).

9. For women with uterine leiomyomas, preoperative medical treatment with leuprolide acetate or ulipristal acetate can reduce myoma size, decrease bleeding, and correct anemia. Risks and benefits of medical treatment should be discussed preoperatively (High).

10. Mechanical bowel preparation is not routinely required prior to gynaecologic surgery for benign disease (High).

11. Removal of normal ovaries at the time of hysterectomy decreases the risk of ovarian cancer but may be associated with health ramifications. Bilateral oophorectomy may lead to acute development of menopausal symptoms in premenopausal women and has not been shown to offer a survival benefit in the absence of genetic predisposition to ovarian cancer (High).

12. Hysterectomy alone affects ovarian reserve (High).

13. Opportunistic salpingectomy at the time of hysterectomy is expected to decrease the incidence of high-grade serous ovarian cancer (Low).

14. There is no strong evidence to support routine uterosacral or vaginal vault suspension at the time of hysterectomy in patients without pelvic organ prolapse (Low).

Recommendations:

1. Hysterectomy for benign indications should preferably be approached by either vaginal or laparoscopic routes (Strong, High).

2. Vaginal hysterectomy is still considered the preferred route of hysterectomy, but laparoscopic hysterectomy is an appropriate alternative minimally invasive approach (Strong, Moderate).

3. Correction of preoperative anemia (hemoglobin <120 g/L) is indicated to reduce morbidity and mortality in the perioperative period when elective surgery is planned (Strong, High).

4. Preoperative antibiotic prophylaxis and measures to decrease risk of venous thromboembolism are recommended for all patients undergoing hysterectomy (Strong, High).

5. Women should be counselled about the benefits and risks of removing the ovaries at the time of the hysterectomy. This should include discussion about the risk of ovarian cancer as well as the long-term health implications of earlier menopause linked to bilateral oophorectomy (Strong, Moderate).

6. Opportunistic salpingectomy can be considered at the time of hysterectomy but the planned surgical approach should not be changed for this sole purpose (Strong, Low).

7. Urinary tract injury is a known complication of hysterectomy, and clinicians should have a low threshold for further investigation in cases where injury is suspected. Surgeons performing hysterectomy should have access to diagnostic cystoscopy, individually or though consultation, to evaluate for bladder and ureteric integrity (Strong, Moderate).

8. If patients with endometriosis are planning to undergo hysterectomy, full excision of local endometriosis should be performed concurrently (Strong, Moderate).

RI Murji, Ally/C-1442-2016

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Z9 21

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PT J

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TI Treatment of vaginal vault prolapse in The Netherlands: a clinical

practice survey

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vaginal vault prolapse; Treatment; Sacrocolpopexy; Trans vaginal mesh;

Sacrospinous fixation; Pessary

ID PELVIC ORGAN PROLAPSE; PESSARY TREATMENT; SACRAL COLPOPEXY;

HYSTERECTOMY; SURGERY; WOMEN; MESH; SACROCOLPOPEXY; MANAGEMENT; REPAIR

AB Introduction and hypothesisA great variety of conservative and surgical procedures to correct vaginal vault prolapse have been reported. The aim of this study was to describe practice pattern variationthe difference in care that cannot be explained by the underlying medical conditionamong Dutch gynecologists regarding treatment of vaginal vault prolapse.MethodsA clinical practice survey was conducted from March to April 2017. The questionnaire was developed to evaluate treatment of vaginal vault prolapse. All members of the Dutch Society for Urogynaecology were invited to participate in a web-based survey.ResultsOne hundred four Dutch gynecologists with special interest in urogynecology responded to the survey (response rate, 44%). As first-choice therapy for vaginal vault prolapse, 78% of the respondents chose pessary treatment, whereas sacrospinous fixation was the second most common therapy choice according to 64% of the respondents. Preferences on how to approach vaginal vault prolapse surgically are conflicting. Overall, the most performed surgery for vaginal vault prolapse is sacrospinous fixation, followed by laparoscopic and robotic sacrocolpopexy.ConclusionsGynecologists in The Netherlands manage vaginal vault prolapse very differently. No standardized method could be determined for the treatment of vaginal vault prolapse in The Netherlands, and we observed practice pattern variations.

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Z9 6

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TI Analysis of Robotic Procedural Times Using Colpassist Versus End-to-End

Anastomosis Sizer for Robotic-Assisted Sacrocolpopexy: A Randomized

Controlled Trial

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacrocolpopexy; robotic surgery; Colpassist; vaginal manipulator

ID SHORT-TERM OUTCOMES; LAPAROSCOPIC SACROCOLPOPEXY; PERFORMANCE; TRENDS

AB Objective The impact of vaginal instrumentation on operative time for robotic-assisted sacrocolpopexy (RSC) is not well understood. Colpassist (Boston Scientific, Quincy, Mass) is a vaginal positioning device designed to improve exposure with a curved double-sided handle that can be adapted to patient anatomy with 2 different sized functional ends. We sought to compare operative time for RSC using a Colpassist compared with a traditional end-to-end anastomosis sizer (EEAS). Methods This was a single-center randomized controlled trial of consecutive women undergoing RSC for apical pelvic organ prolapse. Participants were randomized to undergo RSC using either Colpassist or EEAS. The primary outcome was total operative time for the steps of RSC requiring use of a vaginal positioning device. Secondary outcomes included injury rates and satisfaction of the participants. Results Fifty-two women were enrolled (25 Colpassist, 27 EEAS). For the primary outcome, there was no significant difference in total operative time between procedures performed with Colpassist versus EEAS (P = 0.15). However, 16 (64%) of the 25 Colpassist arm versus 0 of EEAS (P < 0.01) required use of an alternative vaginal positioning device intraoperatively. Comparing secondary outcomes, there were no differences in rate of intraoperative injury between groups. Surgeon and fellow satisfaction scores were lower with Colpassist (P < 0.01). Surgical vaginal assistants were equally satisfied with both vaginal positioning devices (P > 0.05). Conclusions Colpassist is a potential alternative to EEAS with no significant difference in operative time or complication rate. However, case completion with Colpassist was significantly lower than EEAS and was associated with lower surgeon and fellow satisfaction.

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NR 20

TC 1

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U2 3

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JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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PT J

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TI Clinical Outcomes of Robotic Versus Open Myomectomy Performed by One

Surgeon <i>A Total of 350 Patients</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE gynecologic surgery; gynecologic surgical procedures; infertility;

leiomyoma; myoma; robotic surgical procedures; robotics; uterine

myomectomy

AB OBJECTIVE: To compare clinical outcomes of robotic versus open myomectomy.

STUDY DESIGN: This is a retrospective cohort study. A total of 350 patients un- derwent myomectomy by a single surgeon at a community hospital from 2001 to 2015: 128 open and 222 robotic-assisted. Data were gathered from hospital records. Operating room (OR) time, estimated blood loss (EBL), body mass index (BMI), fibroid number/weight, surgical complications, and length of stay (LOS) were compared.

RESULTS: BMI was similar between the 2 groups. OR time was significantly longer for robotic myomectomy despite fibroid number and weight being significantly lower in the robotic group. EBL was significantly lower and LOS was significantly shorter in the robotic group. In addition, there were significantly fewer complications in the robotic group.

CONCLUSION: Robotic-assisted myomectomy enables patients to undergo an outpatient procedure rather than a major abdominal surgery. While there was an increase in OR time when compared to open myomectomy, there was also significantly less blood loss, a shorter LOS, and fewer complications in the robotic group. This method appears to be an excellent alternative to open myomectomy.

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TI Retrospective Cohort Study on the Perioperative Risk Factors for

Transient Voiding Dysfunction After Apical Prolapse Repair

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE prolapse; surgery; voiding dysfunction; urinary tract infection

ID URINARY RETENTION

AB Objectives The primary aim was to compare the incidence of transient voiding dysfunction (TVD) between vaginal uterosacral ligament suspension, sacrospinous ligament fixation, and robotic sacrocolpopexy. Secondarily, we identified risk factors for TVD and associated postoperative complications. Methods This was a retrospective cohort study of women who underwent apical repair at 1 institution. Data were collected from electronic medical records and were presented as means (SD) or numbers (percent) as appropriate. Univariate and multivariate analyses were performed to identify risk factors for TVD and its associated postoperative complications. Results Three hundred sixty women were included in analysis. Two hundred nineteen (60.8%) passed their voiding trial and 141 (39.2%) experienced TVD. The TVD group demonstrated a higher age, age-adjusted Charlson Comorbidity Index score, and preoperative postvoid residual (all P < 0.05). Univariate analysis demonstrated higher rates of TVD in the vaginal uterosacral ligament suspension and sacrospinous ligament fixation groups compared with the robotic sacrocolpopexy group (P = 0.012). Transient voiding dysfunction occurred more frequently with a concomitant anti-incontinence procedure, anterior repair, and/or posterior repair (all P < 0.05). In multivariate analysis, only an anti-incontinence procedure and concomitant anterior repair were independently associated with a risk of TVD (odds ratio [OR], 2.23; 95% confidence interval [CI], 1.37-3.62, and OR, 2.20; CI, 1.14-4.27, respectively). Transient voiding dysfunction was associated with a culture-proven urinary tract infection within 6 weeks (OR, 3.2; CI, 1.3-8.55). Conclusions There was no difference in TVD between types of apical repair. Concomitant anti-incontinence procedure and anterior repair were associated with TVD. Women with TVD have an increased risk of postoperative urinary tract infections.

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TC 8

Z9 9

U1 0

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA HO0AU

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PM 30807422

DA 2024-01-18

ER

PT J

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Paraiso, MFR

AF Ferrando, Cecile A.

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TI A Prospective Randomized Trial Comparing Restorelle Y Mesh and Flat Mesh

for Laparoscopic and Robotic-Assisted Laparoscopic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT Annual Scientific Meeting of the American-Urogynecologic-Society (AUGS)

/ Pelvic Floor Disorders (PFD) Week

CY OCT 09-13, 2018

CL Chicago, IL

SP Amer Urogynecol Soc

DE mesh; operating time; pelvic reconstructive surgery; sacrocolpopexy

ID ABDOMINAL SACROCOLPOPEXY

AB Objective The primary objective of this study was to compare case and mesh placement times between Restorelle Y mesh and flat mesh. The secondary objective was to compare subjective and objective outcomes between the 2 mesh configurations. Methods This is a randomized trial of women undergoing laparoscopic (LSC) or robotic (RSC) sacrocolpopexy for posthysterectomy vaginal prolapse. Subjects were predetermined to undergo either an LSC or RSC and randomized to Y mesh or flat mesh. Case and mesh placement times were defined as incision time to time of closure and time from mesh introduced into the abdomen to placement of the last sacral stitch, respectively. All subjects underwent Pelvic Organ Prolapse Quantification System examination and completed the 20-item Pelvic Floor Disability Index preoperatively, at 6, 12, and 24 months. Results Sixty-two patients were enrolled, and 59 patients were implanted with mesh: 30 with Y mesh (17 LSC, 13 RSC) and 29 with flat mesh (18 LSC, 11 RSC). There were no differences in patient characteristics between mesh groups. Mean case and mesh placement times for all subjects were 204.4 +/- 48 and 46.1 +/- 13.5 minutes, respectively, with no differences between the groups. At 6 months, 20-item Pelvic Floor Disability Index scores improved significantly for all subjects with no differences by mesh type. Three subjects (5.5%) reported vaginal bulge symptoms, and no subjects were retreated for prolapse or were found to have recurrent prolapse on examination. There were also no mesh erosions. Conclusions Case and mesh placement times do not differ in patients undergoing LSC or RSC with either Restorelle Y mesh or flat mesh. At 6 months, subjective and objective successes were 94% and 100%, respectively.

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SC Obstetrics & Gynecology

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ER

PT J

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TI Radical Hysterectomy: Efficacy and Safety in the Dawn of Minimally

Invasive Techniques

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Laparoscopy; Nerve sparing; Robotic surgery; Survival

ID STAGE CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; CONVENTIONAL LAPAROSCOPY;

ROBOTIC SURGERY; CLASSIFICATION; LAPAROTOMY; CARCINOMA

AB Study Objective: To analyze the effect that the introduction of minimally invasive procedures has had on surgical and oncologic outcomes when compared with conventional open radical hysterectomy (ORH) in a national reference cancer after 17 years of experience in radical hysterectomy.

Design: A prospective controlled study (Canadian Task Force classification II-2).

Setting: A university teaching hospital.

Patients: All patients who underwent radical hysterectomy as primary treatment for cervical cancer in our institution between May 1999 and June 2016, with a total of 188 patients.

Interventions: Patients underwent ORH or minimally invasive surgery (MIS) (i.e., laparoscopic or robotically assisted radical hysterectomy).

Measurements and Main Results: Seventy-six patients underwent ORH, 90 laparoscopic radical hysterectomy, and 22 robotically assisted radical hysterectomy. Blood loss and hospital stay were inferior in the MIS group (p <.0001). The laparotomic group presented shorter operation times (p = .0001). With a median follow-up of 112.4 months, a total of 156 patients (83%) were alive and free of disease at the time of the data analysis. Overall survival was higher in the MIS group when compared with the ORH group (91 vs 78.9, p = .026). There were no differences regarding recurrence rates between the surgical approaches.

Conclusion: With 1 of the largest follow-up periods in the literature, this study provides added evidence that MIS could become the preferable surgical approach for early-stage cervical cancer since it appears to reduce morbidity without affecting oncologic results. (C) 2018 AAGL. All rights reserved.

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U2 8

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ER

PT J

AU Hassani, DB

Mangel, JM

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Sheyn, David

TI Survey of pelvic reconstructive surgeons on performance of opportunistic

salpingectomy at the time of pelvic organ prolapse repair

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Opportunistic salpingectomy; Pelvic organ prolapse; Ovarian cancer

ID PROPHYLACTIC OOPHORECTOMY SPECIMENS; BILATERAL SALPINGECTOMY; SEROUS

CARCINOMA; TUBAL-LIGATION; OVARIAN-CANCER; HYSTERECTOMY; RISK;

EXPERIENCE; FIMBRIA; WOMEN

AB Introduction and hypothesisOpportunistic salpingectomy (OS) at the time of benign hysterectomy has recently emerged as a potential primary preventive modality for ovarian cancer. Our objective was to determine whether the reported rate of OS at the time of prolapse surgery is similar to the rate of OS at the time of gynecologic surgery for non-prolapse indications.MethodsAn anonymous online survey was sent to the Society of Gynecologic Surgery members. Responses were divided into surgeons who did and did not perform OS at the time of prolapse repair. Differences between surgeons who did and did not perform OS were evaluated using the chi-square test. Multivariable logistic regression was used to identify which responses related to increased odds of performing OS.ResultsThere were 117(33.1%) completed responses; of these, 98 (83.8%) reported performing OS at the time of prolapse repair, which was similar to the reported rate of OS at the time of hysterectomy for non-prolapse indications, 82.1%. After multivariable logistic regression, performance of salpingectomy at the time of hysterectomy for a non-prolapse indication (aOR: 17.9, 95% CI: 3.11-42.01), use of a laparoscopic or robotic surgical approach (aOR 14.1, 95% CI: 1.81-32.21) and completion of an FPMRS fellowship (aOR: 3.47, 95% CI: 1.20-10.02) were associated with a higher likelihood of performing OS at the time of prolapse repair.ConclusionsOS at the time prolapse repair is performed more frequently with concomitant hysterectomy compared with OS at the time of post-hysterectomy prolapse repair and is similar to rates of OS performed at the time of hysterectomy for non-prolapse indications.

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ER

PT J

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TI Safety of robotic-assisted gynecologic surgery and early hospital

discharge in elderly patients

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE early hospital discharge; elderly; robotic-assisted surgery

ID SAME-DAY DISCHARGE; ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY;

RISK-FACTORS; METAANALYSIS; MULTICENTER; MORBIDITY

AB BACKGROUND: A minimally invasive surgical approach has proven to decrease peri-and postoperative complications and shorten duration of hospital stay; however, there are limited data evaluating the safety of robotic-assisted surgery and early hospital discharge in the elderly population. Because age is a well-known, independent risk factor for perioperative morbidity and gynecologists treat many elderly patients, this is an important area of study.

OBJECTIVE: The objective of the study was to evaluate discharge timing and surgical outcomes in elderly compared with younger patients undergoing robotic-assisted gynecologic surgery.

STUDY DESIGN: This was a retrospective cohort study of all patients who underwent robotic-assisted gynecologic surgery at a high-volume, single institution from January 2013 through May 2016. Demographic information, discharge timing, and peri-and postoperative outcomes were compared for patients <65 years with those >= 65 years using univariate and multivariate analyses.

RESULTS: There were 2757 patients included, with 2521 <65 years and 236 >= 65 years. Median age of the younger group was 42 years, while the median age of the elderly group was 69 years. Elderly patients had a higher body mass index (kilograms per square meter) (28 vs 26, P <. 001) and higher American Society of Anesthesia classification (P < .001). Elderly were more likely to have malignancy as the indication for surgery (68% vs 11%, P<.001) and to undergo hysterectomy (81% vs 38%, P<.001) or surgery with lymph node dissection (44.5% vs 7.1%, P < .001). Elderly patients had a higher incidence of intraoperative complications (9% vs 4.6%, P = .002) and longer median hospital stay (17 vs 7 hours, P <.001) compared with younger patients. Same-day discharge was more common in younger patients (76% vs 45%, P < .001), and elderly patients were more likely to have admissions lasting >23 hours (13% vs 3%, P < .001) on univariate and multivariate analysis. Analysis of postoperative outcomes included 2023 patients with available postoperative data (80% of total population) (1794 < 65 years, 229 >= 65 years). There were no differences between elderly and younger patients in overall postoperative complications, reoperations, intensive care unit admissions, emergency room visits, or hospital readmission within 6 weeks of surgery.

CONCLUSION: Despite having more preoperative risk factors and more surgically complex procedures, elderly patients undergoing robotic-assisted gynecologic surgery had similar postoperative complication rates, and almost half of elderly patients were safely discharged the day of surgery. Our data suggest that robotic-assisted gynecologic surgery and early hospital discharge are safe in elderly patients.

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ER

PT J

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TI Infectious complications of laparoscopic and robotic hysterectomy: a

systematic literature review and meta-analysis

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

ID CERVICAL-CANCER PATIENTS; RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER;

ASSISTED HYSTERECTOMY; PERIOPERATIVE OUTCOMES; CONVENTIONAL LAPAROSCOPY;

VAGINAL HYSTERECTOMY; ABDOMINAL-SURGERY; SURGICAL OUTCOMES; BENIGN

DISEASE

AB Objective We performed a systematic review of the literature and meta-analysis of the infectious complications of hysterectomy, comparing robotic-assisted hysterectomy to conventional laparoscopic-assisted hysterectomy.

Methods We searched PubMed, CINAHL, CDSR, and EMBASE through July 2018 for studies evaluating robotic-assisted hysterectomy, laparoscopic-assisted hysterectomy, and infectious complications. We employed random-effect models to obtain pooled OR estimates. Heterogeneity was evaluated with I-2 estimation and the Cochran Q statistic. Pooled ORs were calculated separately based on the reason for hysterectomy (eg, benign uterine diseases, endometrial cancer, and cervical cancer).

Results Fifty studies were included in the final review for the meta-analysis with 176 016 patients undergoing hysterectomy. There was no statistically significant difference in the number of infectious complication events between robotic-assisted hysterectomy and laparoscopic-assisted hysterectomy (pooled OR 0.97; 95 % CI 0.74 to 1.28). When we performed a stratified analysis, similar results were found with no statistically significant difference in infectious complications comparing robotic-assisted hysterectomy to laparoscopic-assisted hysterectomy among patients with benign uterine disease (pooled OR 1.10; 95 % CI 0.70 to 1.73), endometrial cancer (pooled OR 0.97; 95 % CI 0.55 to 1.73), or cervical cancer (pooled OR 1.09; 95 % CI 0.60 to 1.97).

Conclusion In our meta-analysis the rate of infectious complications associated with robotic-assisted hysterectomy was no different than that associated with conventional laparoscopic-assisted hysterectomy.

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PG 13

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TI Minimally Invasive Staging of Apparent Stage I Malignant Ovarian Germ

Cell Tumors: Prevalence and Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Germ cell tumor; Laparoscopy; Ovary

ID MANAGEMENT

AB Study Objective: Evaluate the prevalence, trends, and outcomes of minimally invasive surgical (MIS) staging of malignant ovarian germ cell tumors (MOGCTs) apparently confined to the ovary.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Participating hospitals in the National Cancer Data Base.

Patients: Women diagnosed between 2010 and 2014 with a MOGCT apparently confined to the ovary with information on the planned surgical approach.

Interventions: Staging with MIS or laparotomy.

Measurement and Main Results: A total of 918 patients were identified. MIS was planned for 294 patients (32%): a laparoscopic approach for 237 patients and a robotic-assisted approach for 57 patients. Rate of conversion to laparotomy was 11% (46 cases), 1.7% and 15.6% in the robotic and laparoscopy groups, respectively (p = .003). No difference in the use of MIS was noted based on year of diagnosis (p = .38). By multivariate analysis white race, higher level of education, and smaller tumor size were associated with the receipt of MIS. Patients in the MIS group were less likely to undergo lymph node dissection (39.6% vs 51.3%, p = .001) and omentectomy (18.7% vs 28.5%, p = .002). Hospital stay after surgery was shorter for patients who had MIS (median, 2 vs 3 days; p <.001). Unplanned 30-day readmission rate was also lower in the MIS group (1.4% vs 3.9%, p = .043). No difference in overall survival was noted between the 2 groups (p = .81).

Conclusion: MIS for apparent early-stage MOGCTs was less comprehensive but associated with a decreased hospital stay and unplanned readmission rate. (C) 2018 AAGL. All rights reserved.

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Z9 3

U1 0

U2 2

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SC Obstetrics & Gynecology

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OA Bronze

DA 2024-01-18

ER

PT J

AU Ozcan, AA

Ulas, B

AF Ozcan, Altan A.

Ulas, Burak

TI Ischemic optic neuropathy in robotic-assisted gynaecologic surgery: A

case report

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE ischemic optic neuropathy; perioperative visual loss; robotic surgery

ID PERIOPERATIVE VISUAL-LOSS; OCULAR COMPLICATIONS

AB The study was aimed to present a rare case of who developed non arteritic anterior ischemic optic neuropathy (NAION) following robotic-assisted gynaecologic surgery. A 58-year-old female patient presented with vision loss in right eye after non-complicated robotic-assisted total hysterectomy and bilateral salpingo-oopherectomy. We observed on fundoscopy optic disc edema and splinter hemorrhages at the optic disc edges. Fluorescein angiography showed hypofluorescence of the optic disc in the early phases due to filling delay followed by hyperfluorescence with leakage from disc capillaries in the late phases of the angiogram. From these findings, we diagnosed NAION in the right eye. When NAION was diagnosed, the patient received intravenous methylprednisolone. Topical brimonidin and coenzyme-Q were given. On 1-month follow-up, recovery of visual loss was observed. Here, we present a case of NAION that is an uncommon cause of perioperative visual loss after robotic-assisted gyneacologic surgery.

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NR 9

TC 0

Z9 0

U1 0

U2 0

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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WC Obstetrics & Gynecology

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GA HN4UZ

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ER

PT J

AU Piedimonte, S

Czuzoj-Shulman, N

Gotlieb, W

Abenhaim, HA

AF Piedimonte, Sabrina

Czuzoj-Shulman, Nicholas

Gotlieb, Walter

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TI Robotic Radical Hysterectomy for Cervical Cancer: A Population-Based

Study of Adoption and Immediate Postoperative Outcomes in the United

States

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 20th Biennial Meeting of the European-Society-of-Gynaecological-Oncology

(ESGO)

CY NOV 04-07, 2017

CL Vienna, AUSTRIA

SP European Soc Gynaecol Oncol

DE Cervical cancer; Minimally invasive surgery; Robotic radical

hysterectomy

ID MULTIINSTITUTIONAL EXPERIENCE; GYNECOLOGIC ONCOLOGY; SURGERY; SOCIETY

AB Study Objective: To compare the use of robotic radical hysterectomy (RRH) and abdominal radical hysterectomy (ARH) in the United States, with secondary outcomes of perioperative complications, hospital length of stay (LOS), immediate postoperative mortality, cost and a subanalysis compared with laparoscopic radical hysterectomy (LRH).

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Data from the National Inpatient Sample (NIS), a government-funded database of hospitalization in the United States.

Patients and Interventions: All women with cervical cancer undergoing RH between 2008 and 2015 in the United States and included in the NIS database.

Measurements and Main Results: Trends in surgical modality, baseline characteristics, LOS, perioperative outcomes, mortality, and hospital charges were compared between RRH and ARH. Regression models were adjusted for baseline characteristics. Among 41,317 women with cervical cancer, 3563 underwent RH, including 21.0% with a robotic procedure, 6.5% with a laparoscopic procedure, and 72.5% with open surgery. The annual rates of ARH declined significantly over the study period, whereas those of RRH increased. Baseline characteristics were comparable between the RRH and ARH groups. Compared with the ARH group, women undergoing RRH had a lower rate of cumulative postoperative complications (18.16% vs 21.21%; odds ratio [OR], 0.81; 95% confidence interval [CI], 0.6-1.0; p=.05), including lower rates of wound infection (0.27% vs 1.82%; OR, 0.14; 95% CI, 0.03-0.6; p<.01), sepsis (0.27% vs 1.20%; OR, 0.22; 95% CI, 0.05-0.9; p=.03), fever (1.87% vs 4.06%; OR, 0.44, 95% CI, 0.3-0.8; p<.01), and ileus (2.8% vs 9.13%; OR, 0.28; 95% CI, 0.12-0.4; p<.01). The LOS was significantly shorter in the RRH group (median, 2 days vs 4 days; p<.01). The total median hospitalization charge was $47,218 for the RRH group, compared with $38,877 for the ARH group (p<.01).

Conclusion: RRH is being increasingly performed in the United States and is associated with shorter LOS and less postoperative morbidity; however, long-term oncologic outcomes require additional attention. (C) 2018 AAGL. All rights reserved.

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ER

PT J

AU Polan, RM

Rossi, EC

Barber, EL

AF Polan, Rosa M.

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TI Extent of lymphadenectomy and postoperative major complications among

women with endometrial cancer treated with minimally invasive surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE Clavien-Dindo; endometrial cancer; minimally invasive surgery;

postoperative complication; sentinel lymph node

ID LOWER-LIMB LYMPHEDEMA; LONGER OPERATIVE TIME; QUALITY-OF-LIFE; PELVIC

LYMPHADENECTOMY; ROBOTIC HYSTERECTOMY; RISK-FACTORS; IMPACT; TRIAL

AB BACKGROUND: In patients with endometrial cancer, sentinel lymphadenectomy is used to accurately prognosticate extent of disease, and has been proposed as a method to decrease the incidence of medical and surgical complications associated with more extensive lymphadenectomy. It is unknown whether patients who undergo traditional lymphadenectomy experience major postoperative complications at the same rates as those who undergo sentinel lymphadenectomy or those who do not undergo lymphadenectomy.

OBJECTIVE: The aim of this study was to compare the incidence of major postoperative complications among endometrial cancer patients undergoing total laparoscopic hysterectomy with traditional lymphadenectomy vs sentinel or no lymphadenectomy.

MATERIALS AND METHODS: Patients with endometrial cancer who underwent total laparoscopic hysterectomy recorded in the National Surgical Quality Improvement Program (NSQIP) database between 2015 and 2016 were identified using Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes. Primary exposure was extent of lymphadenectomy. The primary outcome was major postoperative complications as defined by the Clavien - Dindo scale. Associations were examined with bivariable tests and multivariable logistic regression.

RESULTS: A total of 3282 women with endometrial cancer who underwent total laparoscopic hysterectomy were identified; of these, 2049 (62.4%) did not undergo lymphadenectomy, 1089 (33.2%) underwent traditional lymphadenectomy, and 144 (4.4%) underwent sentinel lymphadenectomy. Traditional lymphadenectomy had the highest rate of major complications (3.6%) compared with sentinel lymphadenectomy (2.0%) and no lymphadenectomy (2.0%) (P = .03). Patients who underwent traditional lymphadenectomy also had the longest operating room times and procedures that were most surgically complex (171 minutes, 30.6 relative value units [RVU]) compared with patients who underwent sentinel lymphadenectomy (166 minutes, 24.9 RVU) or no lymphadenectomy (141 minutes, 15.0 RVU) (all P < .001). Patients who underwent traditional lymphadenectomy had nearly twice the odds of a major complication (adjusted odds ratio [aOR], 1.8; 95% confidence interval [CI], 1.2e2.9) and need for readmission (aOR, 2.2; 95% CI, 1.5-3.4) compared to those who underwent sentinel or no lymphadenectomy. The incidence of readmission after traditional lymphadenectomy was higher (4.6%) than after sentinel lymphadenectomy (1.4%) and no lymphadenectomy (2.2%) (P < 0.001).

CONCLUSION: Sentinel lymphadenectomy among patients undergoing total laparoscopic hysterectomy for endometrial cancer was associated with a decreased incidence of major postoperative complications and need for readmission when compared with traditional lymphadenectomy.

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AU Rusch, P

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TI Recommendations for a standardised educational program in robot assisted

gynaecological surgery: Consensus from the Society of European Robotic

Gynaecological Surgery (SERGS)

SO FACTS VIEWS AND VISION IN OBGYN

LA English

DT Article

DE Delphi; training; robot assisted surgery; consensus

ID MINIMALLY-INVASIVE-SURGERY; TECHNICAL SKILL; VALIDATION; SIMULATION;

TIME; HYSTERECTOMY; RISKS

AB Background: The Society of European Robotic Gynaecological Surgery (SERGS) aims at developing a European consensus on core components of a curriculum for training and assessment in robot assisted gynaecological surgery.

Methods: A Delphi process was initiated among a panel of 12 experts in robot assisted surgery invited through the SERGS. An online questionnaire survey was based on a literature search for standards in education in gynaecological robot assisted surgery. The survey was performed in three consecutive rounds to reach optimal consensus. The results of this survey were discussed by the panel and led to consensus recommendations on 39 issues, adhering to general principles of medical education.

Results: On review there appeared to be no accredited training programs in Europe, and few in the USA. Recommendations for requirements of training centres, educational tools and assessment of proficiency varied widely. Stepwise and structured training together with validated assessment based on competencies rather than on volume emerged as prerequisites for adequate and safe learning. An appropriate educational environment and tools for training were defined. Although certification should be competence based, the panel recommended additional volume based criteria for both accreditation of training centres and certification of individual surgeons.

Conclusions: Consensus was reached on minimum criteria for training in robot assisted gynaecological surgery. To transfer results into clinical practice, experts recommended a curriculum and guidelines that have now been endorsed by SERGS to be used to establish training programmes for robot assisted surgery.

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J9 FACTS VIEWS VIS OBGY

JI Facts Views Vis. ObGyn

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PT J

AU Salvo, G

Ramirez, PT

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Pareja, Rene

TI International radical trachelectomy assessment: IRTA study

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID STAGE CERVICAL-CANCER; OUTCOMES; SURGERY; HYSTERECTOMY; LAPAROTOMY;

SERIES

AB Background Radical trachelectomy is considered a viable option for fertility preservation in patients with low-risk, early-stage cervical cancer. Standard approaches include laparotomy or minimally invasive surgery when performing radical trachelectomy.

Primary Objective To compare disease-free survival between patients with FIGO (2009) stage IA2 or IB1 (<= 2cm) cervical cancer who underwent open versus minimally invasive (laparoscopic or robotic) radical trachelectomy.

Study Hypothesis We hypothesize that minimally invasive radical trachelectomy has similar oncologic outcomes to those of the open approach.

Study Design This is a collaborative, multi-institutional, international, retrospective study. Patients who underwent a radical trachelectomy and lymphadenectomy between January 1, 2005 and December 31, 2017 will be included. Institutional review board approval will be required. Each institution will be provided access to a study-specific REDCap (Research Electronic Data Capture) database maintained by MD Anderson Cancer Center and will be responsible for entering patient data.

Inclusion Criteria Patients with squamous, adenocarcinoma, or adenosquamous cervical cancer FIGO (2009) stages IA2 and IB1 (<= 2 cm) will be included. Surgery performed by the open approach or minimally invasive approach (laparoscopy or robotics). Tumor size <= 2 cm, by physical examination, ultrasound, MRI, CT, or positron emission tomography (at least one should confirm a tumor size <= 2 cm). Centers must contribute at least 15 cases of radical trachelectomy (open, minimally invasive, or both).

Exclusion Criteria Prior neoadjuvant chemotherapy or radiotherapy to the pelvis for cervical cancer at any time, prior lymphadenectomy, or pelvic retroperitoneal surgery, pregnant patients, aborted trachelectomy (intra-operative conversion to radical hysterectomy), or vaginal approach.

Primary Endpoint The primary endpoint is disease-free survival measured as the time from surgery until recurrence or death due to disease. To evaluate the primary objective, we will compare disease-free survival among patients with FIGO (2009) stage IA2 or IB1 (<= 2cm) cervical cancer who underwent open versus minimally invasive radical trachelectomy.

Sample Size An estimated 535 patients will be included; 256 open and 279 minimally invasive radical trachelectomy. Previous studies have shown that recurrence rates in the open group range from 3.8% to 7.6%. Assuming that the 4.5-year disease-free survival rate for patients who underwent open surgery is 95.0%, we have 80% power to detect a 0.44 HR using a level 0.10. This corresponds to an 89.0% disease-free survival rate at 4.5 years in the minimally invasive group.

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TI Uterosacral Ligament Suspension Versus Robotic Sacrocolpopexy for

Treatment of Apical Pelvic Organ Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE uterosacral ligament suspsension; robotic sacrocolpopexy; surgical

outcomes; surgery; mesh

ID PERIOPERATIVE BEHAVIORAL-THERAPY; VAGINAL PROLAPSE; VAULT SUSPENSION;

URINARY-INCONTINENCE; NON-INFERIORITY; OUTCOMES; SURGERY; REPAIR; WOMEN

AB Objective The aim of the study was to compare long-term outcomes of uterosacral ligament suspension (USLS) versus robotic sacrocolpopexy (RSC) in patients with pelvic organ prolapse. Methods This was an institutional review board-approved retrospective cohort study. Women 3 to 7 years after USLS or RSC were contacted for enrollment. Participants were asked to complete validated questionnaires and physical examinations. The primary outcomes were no symptoms of bulge or retreatment for prolapse (subjective) and POP-Q examination demonstrating prolapse above or equal to -1 (objective). For the subjective outcome, a noninferiority calculation with 10% noninferiority margin deemed 91 subjects in each group were required. Results We identified the following 770 eligible subjects: 205 were contacted, 19 declined, 186 subjects agreed to participate, and 2 were excluded. There were 92 subjects per group in the analysis for the primary subjective outcome, and 84% underwent examinations for the objective outcome. Baseline characteristics were overall similar; however, previous prolapse surgery was more common in the RSC group (P < 0.001). Subjective success was achieved in 83 subjects in the USLS group and 78 subjects in the RSC group (90.2% vs 84.4%, respectively, P = 0.265 [95% confidence interval = -0.036 to 1.000]). Objective success was noted in 93.2% and 91.3% of the USLS and RSC groups, respectively (P = 0.869). Postoperative complication rates were low and did not differ between groups. Mesh complications were noted in 6.6% of the RSC group. One subject in the USLS group reported pain related to surgery. Conclusion Uterosacral ligament suspension was noninferior to RSC at 3- to 7-year postsurgery for subjective symptoms and similar for objective outcomes. Both approaches showed high success rates and strong patient satisfaction.

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NR 31

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U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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GA HO0AU

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ER

PT J

AU Whiteside, JL

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AF Whiteside, James L.

Kaeser, Carson T.

Ridgeway, Beri

TI Achieving high value in the surgical approach to hysterectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID REGIONAL-VARIATION; TRENDS; GUIDELINES; OBSTETRICS; OUTCOMES; ROUTE

AB Value-based care, best clinical outcome relative to cost, is a priority in correcting the high costs for average clinical outcomes of health care delivery in the United States. Hysterectomy represents the most common and identifiable nonobstetric major surgical procedure among women. Surgical approaches to hysterectomy in the United States have changed in recent decades. For benign indications, clinical evidence identifies the superiority of vaginal hysterectomy over all other routes. These conclusions rest on clinical outcomes; however, cost differentials also exist across hysterectomy approaches, with the vaginal approach consistently incurring the lowest overall costs. Taken together, vaginal hysterectomy has the highest value, whereas the robotic (given high costs) and abdominal approaches (given less favorable clinical outcomes) have less value. Traditional laparoscopic hysterectomy holds an intermediate value. Increasing the use of high-value hysterectomy approaches can be achieved by adopting multimodal strategies, with changes in the payment models being the most important.

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NR 28

TC 9

Z9 9

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U2 2

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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OA Bronze

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ER

PT J

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Haworth, LR

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MacKoul, Paul

Baxi, Rupen

van der Does, Louise Q.

Haworth, Leah R.

TI Value-based assessment of hysterectomy approaches

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE cost; hysterectomy; laparoscopic; retroperitoneal; value

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; COST; VOLUME

AB Aim By evaluating operative outcomes relative to cost, we compared the value of minimally invasive hysterectomy approaches, including a technique discussed less often in the literature, laparoscopic retroperitoneal hysterectomy (LRH), which incorporates retroperitoneal dissection and ligation of the uterine arteries at their vascular origin. Methods Retrospective chart review of all women (N = 2689) aged greater than or equal to 18 years who underwent hysterectomy for benign conditions from 2011 to 2013 at a high-volume hospital in Maryland, USA. Procedures included: laparoscopic supracervical hysterectomy, robotic-assisted laparoscopic hysterectomy (RALH), total laparoscopic hysterectomy, laparoscopic-assisted vaginal hysterectomy, total vaginal hysterectomy (TVH), and LRH. Results Total vaginal hysterectomy had the highest intraoperative complication rate (9.6%; P < 0.0001) but the lowest postoperative complication rate (1.8%; P < 0.0001). Robotics had the highest postoperative complication rate (11.4%; P < 0.0001). LRH had the shortest operative time (71.2 min; P < 0.0001) and the lowest intraoperative complication rates (2.1%; P < 0.0001). LRH and TVH were the least costly (averaging $4061 and $6416, respectively), while RALH was the most costly ($9354). Taking both operative outcomes and cost into account, LRH, TVH and laparoscopic-assisted vaginal hysterectomy yielded the highest value scores; total laparoscopic hysterectomy, RALH, and laparoscopic supracervical hysterectomy yielded the lowest. Conclusion Understanding the value of surgical interventions requires an evaluation of both operative outcomes and direct hospital costs. Using a quality-cost framework, the LRH approach as performed by high-volume laparoscopic specialists emerged as having the highest calculated value.

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NR 32

TC 6

Z9 6

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U2 0

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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PT J

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Propst, K

Wechter, ME

Kho, RM

AF Das, Deepanjana

Propst, Katie

Wechter, Mary Ellen

Kho, Rosanne M.

TI Evaluation of Positioning Devices for Optimization of Outcomes in

Laparoscopic and Robotic-Assisted Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Patient positioning; Nerve injury; Laparoscopy; Robotic surgery; Safety

ID PATIENT DISPLACEMENT; INJURY; NEUROPATHY; FOAM

AB In this review, we evaluate techniques, devices, and equipment for patient positioning and their effect on patient outcomes, such as cephalad slide and neuropathy, in laparoscopic and robotic-assisted gynecologic surgery. We conducted a systematic review by searching MEDLINE, Embase, and Cochrane Library for relevant articles published over a 15-year period. Study selection, data extraction, and quality assessment were performed by 2 reviewers independently. Seven articles, including 3 randomized controlled trials and 4 case series, were included in our analysis. Four studies evaluated cephalad patient slide. In 2 randomized controlled trials (n = 103), the mean slide with various devices (i.e., memory foam, bean bag with shoulder braces, egg crate, and gel pad) ranged from 1.07 +/- 1.93 cm to 4.5 +/- 4.0 cm. The use of a bean bag with shoulder supports/braces was associated with minimal slide, with a median slide of 0 cm (range, 0-2 cm) in a retrospective series and with mean slide of 1.07 +/- 1.93 cm in a randomized controlled trial (vs memory foam). No conclusive effect of body mass index on slide could be identified. Five studies evaluating the incidence of neuropathy found an overall incidence of 0.16% and no differences among slide-preventing devices. The minimal slide described across studies supports the conclusion that any of the currently used devices and techniques for safe patient positioning are within reason. The low overall incidence of neuropathy is also reassuring. Best evidence recommendations cannot be made for a specific device or technique; our findings suggest the importance of strict adherence to the basic tenets of safe patient positioning to minimize slide and prevent nerve injury. (c) 2018 AAGL. All rights reserved.

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TC 9

Z9 9

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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SC Obstetrics & Gynecology

GA HN0RC

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ER

PT J

AU Dubuisson, J

AF Dubuisson, Jean

TI The current place of mini-invasive surgery in uterine leiomyoma

management

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Review

DE Uterine leiomyoma; Myomectomy; Minimally-invasive surgery; Hysteroscopy;

Laparoscopy; Robot assisted laparoscopy

ID MYOMECTOMY

AB Uterine leiomyomas are the most common benign tumors in women of reproductive age. Most of leiomyomas are asymptomatic. They are often found incidentally, and require neither monitoring nor treatment. For symptomatic women who wish to become pregnant, surgical myomectomy remains the conservative treatment of choice. It can be performed in various routes depending on the location and the number of leiomyomas and the experience of the surgeon. A minimally invasive procedure should always be the preferred option so as to improve woman satisfaction and to decrease perioperative morbidity. In selected patients, medical therapy prior to surgery can be useful to correct anemia, to improve the quality of life and to decrease the volume of the leiomyomas. The use of blood saving techniques need to be mastered to prevent or to treat perioperative haemorrhage. Patients must be aware of uterine rupture in case of subsequent pregnancy, even if the risk seems to be very low. Future research challenges include the development of three-dimensional models and augmented reality that could be able to specifically treat leiomyomas without damaging the unaffected part of the uterus. (C) 2018 Elsevier Masson SAS. All rights reserved.

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TC 12

Z9 12

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ER

PT J

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TI A Prospective Study of Minimally Invasive Paravaginal Repair of

Cystocele and Associated Pelvic Floor Defects: Our Experience

SO JOURNAL OF OBSTETRICS AND GYNECOLOGY OF INDIA

LA English

DT Article

DE Laparoscopy; Robotic; Paravaginal repair; Cystocele; Prolapse

AB Aims and objectivesTo assess the outcome of minimally invasive paravaginal repair of symptomatic cystocele and to correlate postoperative outcome with preoperative presentation. The primary outcome was the anatomical outcome measured by postoperative physical examination and the functional outcome was assessed by subjective symptoms and questionnaires. The secondary outcomes were perioperative and postoperative complications.Materials and methodsIn this longitudinal prospective observational study, 44 women underwent laparoscopic or robotic paravaginal cystocele repair from January 2016 to July 2016 and they were followed up to 1year after surgery in a tertiary advanced laparoscopic center. All patients had a symptomatic lateral cystocelegrade 2 according to Baden-Walker classification. Other coexisting defects like apical cystocele or combined defects were corrected concomitantly. The anatomical outcome was measured by physical examination and functional outcome was assessed by questionnairesPelvic Organ Prolapse Distress Inventory 6 and Urinary Distress Inventory 6 preoperatively and during postoperative follow-up.ResultsAll 44 patients were followed up to 12months after surgery. The anatomical cure rate for cystocele was 97.7%. There were no major complications. All subjective symptoms and quality of life scores improved significantly during postoperative follow-up. The anatomical recurrence rate in our study was 2.3%.ConclusionMinimally invasive paravaginal repair of cystocele is an effective advanced laparoscopic procedure. It can be concomitantly performed with other surgical procedures to correct coexisting defects. The anatomical and functional results were outstanding with minimum perioperative morbidity and encouraging long-term outcome.

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J9 J OBSTET GYN INDIA

JI J. Obstet. Gynecol. India

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WC Obstetrics & Gynecology

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ER

PT J

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TI Role of robotic surgery on pelvic floor reconstruction

SO MINERVA GINECOLOGICA

LA English

DT Review

DE Robotics; Surgery; Pelvic organ prolapse; Reconstructive surgical

procedures; Minimally invasive surgery

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; PROLAPSE SURGICAL TECHNIQUE;

APICAL LATERAL SUSPENSION; QUALITY-OF-LIFE; ORGAN PROLAPSE; ABDOMINAL

SACROCOLPOPEXY; VAGINAL HYSTERECTOMY; SUPPORT DEFECTS; LEARNING-CURVE;

MESH

AB Over the past two decades, minimally invasive surgery (MIS) abdominal surgery has increasingly been used to treat pelvic organ prolapse. Besides the several advantages associated with minimal invasiveness, this approach bridged the gap between the benefits of vaginal surgery and the surgical success rates of open abdominal procedures. The most commonly performed procedure for suspension of the vaginal apex for postoperative vaginal prolapse by robotic-assisted laparoscopy is the sacrocolpopexy. Conventional laparoscopic application of this procedure was first reported in 1994 by Nezhat et al. and had not gained widespread adoption due to lengthy learning curve associated with laparoscopic suturing. Since FDA approval of the da Vinci (R) robot for gynecologic surgery in 2005, minimally invasive abdominal surgery for pelvic organ prolapse has become increasingly popular, as robotic-assisted laparoscopic sacrocolpopexy is an option for those surgeons without experience or training in the conventional route. Robotic surgery has made its way into the armamentarium of POP treatment and has allowed pelvic surgeons to adapt the "gold standard" technique of abdominal sacrocolpopexy to a minimally invasive approach with improved intraoperative morbidity and decreased convalescence. In fact, repair of pelvic organ prolapse can be performed robotically, and sometimes surgeons can feel suturing and dissection during the procedures less challenging with the assistance of the robot. However, even if robotic surgery may confer many benefits over conventional laparoscopy, these advantages should continue to be weighed against the cost of the technology. To date, as long-term outcomes, evidence about robotic sacrocolpopexy for a repair of pelvic organ prolapse are not conclusive, and much more investigations are needed to evaluate subjective and objective outcomes, perioperative and postoperative adverse events, and costs associated with these procedures. It is plausible to think that the main advantage is that robotics may lead to a widespread adoption of minimally invasive techniques in the field of pelvic floor reconstructive surgery. The following review will address the development and current state of robotic assistance in treating pelvic floor reconstruction discussing available data about the techniques of robotic prolapse repair as well as morbidity, costs and clinical outcomes.

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NR 63

TC 5

Z9 6

U1 0

U2 6

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J9 MINERVA GINECOL

JI Minerva Ginecol.

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PG 14

WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

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GA HP6HS

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DA 2024-01-18

ER

PT J

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TI Venous Thromboembolism in Minimally Invasive Gynecologic Surgery: A

Systematic Review

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Thromboprophylaxis; Venous thromboembolism; VTE

ID BLEEDING COMPLICATIONS; THROMBOSIS PROPHYLAXIS; ROBOTIC SURGERY;

CANCER-SURGERY; RISK-FACTORS; HYSTERECTOMY; ENDOMETRIAL;

THROMBOPROPHYLAXIS; PREVENTION; WOMEN

AB Venous thromboembolism (VTE) is the leading cause of preventable healthcare-related death after surgery. Although there is a large body of research on VTE in the general population as well as risk-assessment tools, evidence specific to the current practices in gynecologic surgery is more sparse. This review article seeks to discuss current literature on VTE in gynecologic surgery, with a focus on minimally invasive surgery. Evidence on risk factors for VTE in gynecologic surgery is evaluated as well as current recommendations use of thromboprophylaxis for prevention of VTE. Despite data showing that minimally invasive gynecologic surgery independently decreases risk of VTE compared with laparotomy, current clinical risk assessment tools and guidelines do not incorporate mode of surgery into recommendations for perioperative VTE prevention. (c) 2018 AAGL. All rights reserved.

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NR 57

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Z9 4

U1 0

U2 13

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JI J. Mimim. Invasive Gynecol.

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ER

PT J

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TI A pilot study of non-routine events in gynecological surgery: Type,

impact, and effect

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Non-routine events; Gynecological surgery; Teamwork; Human factors

ID OPERATING-ROOM; PATIENT SAFETY; FLOW DISRUPTIONS; SURGICAL FLOW; CARE;

COMMUNICATION; PERFORMANCE; TEAMWORK; FAILURES; ERRORS

AB Objective. Quantifying non-routine events (NREs) assists with identify underlying sociotechnical factors that could lead to adverse events. NREs are considered any event that is unusual or atypical during surgical procedures. This study aimed to use prospective observations to characterize the occurrence of non-routine events in gynecological surgeries.

Methods. Observational data were collected prospectively within one surgical gynecology department over a five month period. Researchers captured NREs in real time using a validated tablet PC-based tool according to the NRE type, impact, whom was affected, and duration. Researchers also noted what surgical approach (i.e. open, laparoscopic, robotic) was used.

Results. Across 45 surgical cases, 554 non-routine events (M = 12.31 NREs per case, SD = 9.81) were identified. The majority of non-routine events were external interruptions (40.3%), teamwork (26.7%), or equipment (213%). The circulating nurse was most frequently affected by NREs (43.2%) followed by the entire surgical team (13.7%). There was no statistically significant difference in non-routine events based on surgical approach.

Conclusion. Non-routine events are prevalent in the gynecological surgical setting. Identifying the sociotechnical factors that influence non-routine events are important in determining interventions that will combat the associated risks. Interventions focusing on teamwork, managing external interruptions, and coordinating equipment may have the greatest impact to reduce or eliminate NREs in gynecological surgeries. (C) 2018 Elsevier Inc. All rights reserved.

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PT J

AU Occhino, JA

Hokenstad, ED

Linder, BJ

AF Occhino, John A.

Hokenstad, Erik D.

Linder, Brian J.

TI Robot-assisted vesicovaginal fistula repair via a transvesical approach

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Fistula; Robot; Vesicovaginal; Urinary incontinence

ID HYSTERECTOMY; SURGERY; RISK

AB ObjectiveThe objective of this video is to demonstrate a technique for robot-assisted vesicovaginal fistula (VVF) repair utilizing a mini cystotomy with a transvesical approach.MethodsA 53-year-old female developed a VVF after she underwent an abdominal hysterectomy for uterine fibroids at an outside facility. She was referred to us following two failed VVF repairs (one vaginal, one abdominal with bladder bivalving and omental flap). After discussing options, she underwent a robotic VVF repair via a transvesical approach. Following port placement, the space of Retzius was mobilized. An intentional cystotomy was made and the camera and working arms advanced into the bladder. The fistula was identified and circumferentially mobilized. The fistula was closed in three layers using absorbable sutures, and care was taken to avoid the ureters.ResultsThe patient's postoperative recovery was uncomplicated. Follow-up imaging was performed via cystogram at 4weeks and showed resolution of the fistula.ConclusionsA robot-assisted transvesical approach using a mini cystotomy to VVF repair is a useful technique especially when previous surgical planes have been used in prior repairs and failed. It maintains a minimally invasive approach and may avoid complications associated with an open abdominal approach.

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TI Short-term outcomes of robotic-assisted versus conventional laparoscopic

radical hysterectomy for early-stage cervical cancer: A single-center

study

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE laparoscopic surgery; learning curve; radical hysterectomy; robotic

surgery; uterine cervical cancer

ID LEARNING-CURVE ANALYSIS; SURGICAL OUTCOMES

AB Aim Our hospital adopted laparoscopic surgery for early-stage cervical cancer in August 1998, with robot-assisted surgery implemented in October 2013. This study aimed to compare short-term outcomes for conventional laparoscopic radical hysterectomy (LRH) and robot-assisted radical hysterectomy (RARH) and assess the technical feasibility of RARH for early-stage cervical cancer. Methods We retrospectively compared operative time, blood loss, number of resected lymph nodes, length of postoperative hospital stay, rate of positive vaginal margin and perioperative complications between two groups of 121 patients (LRH group, n = 57; RARH group, n = 64) with stage IA2 to IIB, among 164 patients who underwent endoscopic radical hysterectomy for early-stage cervical cancer performed between January 2010 and December 2017 by an expert surgeon, excluding cases of para-aortic lymphadenectomy. Results No differences in patient background, in terms of age and body mass index, were identified. For the LRH/RARH groups (mean +/- standard deviation), results obtained were as follows: operative time, 211 +/- 38/280 +/- 59 min (P < 0.01); blood loss, 219 +/- 114/370 +/- 231 mL (P < 0.01); number of resected lymph nodes, 38.5 +/- 15.9/50.2 +/- 18.2 (P < 0.01); length of postoperative hospital stay, 11.6 +/- 3.3/11.3 +/- 4.8 days (P = 0.67); and perioperative complications with Clavien-Dindo classification of grade III or higher, 1.8/7.8% (P = 0.13). Conclusion The operative time was significantly longer and blood loss greater in the RARH than LRH group. A greater number of lymph nodes were removed in the RARH group. However, these differences seem to be within a clinically acceptable range, showing that RARH is as feasible and safe as LRH in terms of short-term outcomes.

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TI Advances in surgical strategies for prolapse

SO CLIMACTERIC

LA English

DT Article; Proceedings Paper

CT 16th World Congress on Menopause

CY JUN 06-09, 2018

CL Vancouver, CANADA

DE Pelvic organ prolapse; surgery; pelvic floor dysfunction; tailoring;

aging

ID PELVIC ORGAN PROLAPSE; FLOOR; WOMEN; METABOLISM; SYMPTOMS; COLLAGEN;

ANATOMY; TISSUE

AB Pelvic floor dysfunctions are a complex condition in elderly women; pelvic organ prolapse, urinary or fecal incontinence, constipation, pelvic pain, and sexual dysfunction are common problems. The goal of surgical treatment is functional reconstruction with symptom management and repair of anatomic defects. The recent advancements in surgical treatment of pelvic floor dysfunction allow several good options for choosing the best surgery for each patient. The vaginal procedure is traditionally the gold standard approach for elderly patients, but abdominal surgery is increasing as a mini-invasive approach and the robotic approach is gaining acceptance for treatment of pelvic floor dysfunctions. In elderly individuals, a multitude of factors affects the final result of any reconstructive surgery such as postmenopausal or aging-associated changes in muscle tone and nerve function or changes in the function of the bladder or of the rectum: an understanding of the underlining functional status of pelvic organs is very important in aging women before proceeding to surgery. In this context, pelvic floor dysfunction, particularly in elderly women, should be addressed in a multidisciplinary manner and, at the forefront, centers for surgical planning could be helpful to perform safer, patient-tailored surgery.

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CA ETIC Endometriosis Treatment

TI When more is not better: 10 'don'ts' in endometriosis management. An

<i>ETIC</i><SUP>\*</SUP> position statement

SO HUMAN REPRODUCTION OPEN

LA English

DT Article

DE endometriosis; low-value interventions; management; Endometriosis

Treatment Italian Club; treatment burden

AB A network of endometriosis experts from 16 Italian academic departments and teaching hospitals distributed all over the country made a critical appraisal of the available evidence and definition of 10 suggestions regarding measures to be de-implemented. Strong suggestions were made only when high-quality evidence was available. The aim was to select 10 low-value medical interventions, characterized by an unfavorable balance between potential benefits, potential harms, and costs, which should be discouraged in women with endometriosis. The following suggestions were agreed by all experts: do not suggest laparoscopy to detect and treat superficial peritoneal endometriosis in infertile women without pelvic pain symptoms; do not recommend controlled ovarian stimulation and IUI in infertile women with endometriosis at any stage; do not remove small ovarian endometriomas (diameter<4 cm) with the sole objective of improving the likelihood of conception in infertile patients scheduled for IVF; do not remove uncomplicated deep endometriotic lesions in asymptomatic women, and also in symptomatic women not seeking conception when medical treatment is effective and well tolerated; do not systematically request second-level diagnostic investigations in women with known or suspected non-subocclusive colorectal endometriosis or with symptoms responding to medical treatment; do not recommend repeated follow-up serum CA-125 (or other currently available biomarkers) measurements in women successfully using medical treatments for uncomplicated endometriosis in the absence of suspicious ovarian cysts; do not leave women undergoing surgery for ovarian endometriomas and not seeking immediate conception without post-operative long-term treatment with estrogen-progestins or progestins; do not perform laparoscopy in adolescent women (<20 years) with moderate-severe dysmenorrhea and clinically suspected early endometriosis without prior attempting to relieve symptoms with estrogen-progestins or progestins; do not prescribe drugs that cannot be used for prolonged periods of time because of safety or cost issues as first-line medical treatment, unless estrogen-progestins or progestins have been proven ineffective, not tolerated, or contraindicated; do not use robotic-assisted laparoscopic surgery for endometriosis outside research settings.

Our proposal is to better address medical and surgical approaches to endometriosis de-implementing low-value interventions, with the aim to prevent unnecessary morbidity, limit psychological distress, and reduce the burden of treatment avoiding medical overuse and allowing a more equitable distribution of healthcare resources.

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TI Controversies in the management of vesicovaginal fistula

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Vesicovaginal fistula; Urinary incontinence; Radiation injuries; Urinary

catheters

ID BLADDER CATHETERIZATION; VESICUVAGINAL FISTULA; URINARY-INCONTINENCE;

TRANSVAGINAL REPAIR; INTERPOSITION FLAPS; SURGICAL-TREATMENT; SLING

PROCEDURES; ROBOTIC REPAIR; CARE

AB Achieving 100% closure and continence rate in the management of vesicovaginal fistulas remains a challenge. There is still debate about several aspects of the care including the following:

How successful is conservative treatment with catheter drainage, and can it be improved with newer techniques?

When is the best time to operate?

What is the best surgical approach?

Are interpositional flaps helpful?

Is there any way to reduce the risk of future stress incontinence during the initial surgery?

How long does the bladder need to be drained after surgery?

What is the best way to manage radiation-induced fistulas?

Where and by whom should the patient be operated? (C) 2018 Published by Elsevier Ltd.

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AF Harold, J. A.

Uyar, D.

Rader, J. S.

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TI Adipose-only sentinel lymph nodes: a finding during the adaptation of a

sentinel lymph node mapping algorithm with indocyanine green in women

with endometrial cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID LEARNING-CURVE; LYMPHADENECTOMY; SURGERY; BIOPSY; TRIAL

AB Objective To identify factors that affect successful adaptation of sentinel lymph node mapping and those that lead to unintended adipose-only sentinel lymph node identification.

Methods Surgical and pathological data were prospectively collected on patients with endometrial cancer who underwent sentinel lymph node mapping with indocyanine green with or without pelvic and/or para-aortic lymph node dissection between November 2013 and April 2017. All mapping cases were performed with the robotic system. Adipose-only specimens were defined as a sentinel lymph node without a pathologically identified lymph node after ultrastaging.

Results A total of 202 patients were included: 83% had endometrioid pathology, 12% serous, 3% carcinosarcoma, and 2% clear cell, with mixed pathology noted in 2%. The bilateral sentinel lymph node detection rate was 66%, and the rate of mapping at least a unilateral sentinel lymph node was 86%. Neither the bilateral nor the unilateral sentinel lymph node mapping rate changed with increased surgeon experience. The rate of adipose-only sentinel lymph node identification was more frequent when comparing the first 10 cases (37%), cases 11 - 30 (28%), and > 30 cases (9%) (P = 0.006). Body mass index > 30 kg/m(2), uterine fibroids, The International Federation of Gynecology and Obstetrics (FIGO) grade, and histology were not found to have a statistically significant impact on either sentinel lymph node identification or adipose-only sentinel lymph node identification. Adipose-only sentinel lymph nodes were more likely with increased time from cervical injection to identification of the sentinel lymph node in the right hemipelvis. The median range was 28 min (14-73) for true sentinel lymph node identification vs 33 min (23-74) for adipose-only sentinel lymph node identification (P = 0.02).

Conclusion Patient and surgeon factors did not impact the identification of sentinel lymph nodes over time. Adipose-only sentinel lymph nodes were more frequently identified in the initial cases and represent a potential complication to adapting sentinel lymph node biopsy without lymphadenectomy. The increase in adipose-only sentinel lymph node identification that was associated with time from cervical injection may represent delayed or disrupted uptake of indocyanine green.

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NR 27

TC 6

Z9 6

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

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Kanmaz, Ahkam Goksel

TI The incidence, causes, and management of lower urinary tract injury

during total laparoscopic hysterectomy

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Laparoscopic hysterectomy; Complication; Bladder injury; Ureter injury;

Cesarean section; Endometriosis

ID URETERAL INJURY; SURGERY; PREVENTION

AB Objectives. - Determining the incidence and causes of lower urinary tract injury in patients undergoing total laparoscopic hysterectomy and examining the procedures applied for management.

Methods. - Patients who underwent total laparoscopic hysterectomy in a large referral center between 1 January 2015 and 31 October 2017 for benign gynecological reasons were included in the study. Patients who underwent laparoscopic supracervical hysterectomy, laparoscopy-assisted vaginal hysterectomy and robot-assisted laparoscopic hysterectomy were not included in this study. The hospital records of all patients included in the study were examined and the incidence, causes and management of lower urinary tract injuries were reviewed.

Results. - Total lower urinary tract injury rate was found as 2.01%, and these injuries were evaluated separately as bladder and ureter injuries. All the bladder injuries had occurred on the posterior wall of the bladder during vesicouterine dissection; six cases were intraoperatively detected and one case was detected on the first postoperative day. Most of ureteral injury cases were detected in the early postoperative period (75%). The rates of previous cesarean section and endometriosis were significantly higher in patients with injury to the bladder and ureter than in the control group (p<0,001). There was no significant difference between the patients with lower urinary tract injury and the control group regarding uterine weight, estimated blood loss, bilateral salpingo-oophorectomy, the presence and location of fibroids, and laparoscopic or vaginal closure of the vaginal cuff.

Conclusion. - Laparoscopic hysterectomy may be a good option in appropriate patients, but in case of previous cesarean section and endometriosis cases, patients should be informed about the possible complications in detail before the operation and care should be taken during dissection. (C) 2018 Elsevier Masson SAS. All rights reserved.

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NR 24

TC 14

Z9 14

U1 0

U2 3

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J9 J GYNECOL OBSTET HUM

JI J. Gynecol. Obstet. Hum. Reprod.

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WC Obstetrics & Gynecology

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ER

PT J

AU Kavvadias, T

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AF Kavvadias, Tilemachos

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TI Robotic sacrocolpopexy for recurrent vaginal vault prolapse after sex

reassignment surgery in a trans-woman

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

ID NEOVAGINAL PROLAPSE; REPAIR

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TC 1

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J9 J OBSTET GYNAECOL

JI J. Obstet. Gynaecol.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

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TI Pelvic organ prolapse surgery after different hysterectomy methods: a

population-based cohort study

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Pelvic organ prolapse; Hysterectomy; Prolapse repair

ID SUBSEQUENT; RISK; EPIDEMIOLOGY; REPAIR

AB Background: Pelvic floor disorders are expected to greatly increase in the coming years. Many factors have been implicated in the development of pelvic organ prolapse (POP). In the last decade, the route of hysterectomy performed has shifted more towards robotic/laparoscopic techniques, and the role that the hysterectomy route plays in the need for future POP repair remains uncertain. Here the authors investigate the association of POP repair following robotic/laparoscopic hysterectomies, as well as vaginal, supracervical, and abdominal modalities. Results: Patients living in the West were more likely to have a prolapse repair post-hysterectomy than those living in the Midwest (HR 1.39; 95% CI: 1.01-1.93). Patients with hospital stays >= 4 days following hysterectomies were more likely to require future prolapse repairs than those with <= 1-day stays (HR 1.71; 95% CI: 1.10-2.65). Compared to abdominal procedures, robotic/laparoscopic modalities were more likely to be associated with prolapse within 18 months of hysterectomies (HR 1.72, 95% CI: 1.13-2.61). However, between 18 and 36 months, both supracervical and vaginal hysterectomies were more likely to be associated with prolapse surgeries (HR 1.96, 95% CI: 1.15-3.34 and HR 1.94; 95% CI: 1.02-3.70, respectively). Conclusions: Region and length of hospital stay significantly impacted the need for future prolapse repair. Among modalities, the association with prolapse repair changes with time.

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NR 26

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Z9 1

U1 0

U2 0

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JI Clin. Exp. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Robotic paraaortic lymphadenectomy in oncogynecology. Double side

docking of daVinci S system increases the success rates of high

paraaortic lymph node dissection in endometrial cancer

SO CESKA GYNEKOLOGIE-CZECH GYNAECOLOGY

LA Czech

DT Article

DE paraaortic lymphadenectomy; endometrial cancer; robotic surgery;

transperitoneal

ID INFRARENAL AORTIC LYMPHADENECTOMY; CERVICAL-CARCINOMA; LAPAROSCOPIC

LYMPHADENECTOMY; ASSISTED-LAPAROSCOPY; DISEASE RECURRENCE;

LEARNING-CURVE; EXTRAPERITONEAL; TRANSPERITONEAL; SURGERY; METASTASIS

AB Objective: To present an overview of minimally invasive approaches to suprapelvic lymphadenectomy and compare two different methods of staging robotic transperitoneal paraaortic lymphadenectomies in patients with early stages of endometrial cancer.

Design: Retrospective study and literature review.

Setting: Department of Obstetrics and Gynecology, Faculty of Medicine and Dentistry, Palacky University Olomouc, University Hospital Olomouc.

Methods: In this retrospective study we enrolled 70 patients with early stages of endometrial cancer undergoing staging robotic surgery at the Department of Obstetrics and Gynecology, University Hospital Olomouc from January 2016 to March 2018. Primary systematic pelvic and paraaortic lymphadenectomy was suggested in all patients. In 39 out of 70 patients single docking was used for robotic staging surgery, whereas in 28 patients the procedure was done using double side docking approach. Number of patients with total and infra-renal suprapelvic lymphadenectomy, number of para-aortic lymphonodes retrieved and the rate of lymphadenectomy complications were compared.

Results: Robotic surgery was performed in 67 (96%) out of 70 patients. In three cases (0,4%) laparoscopy was converted to laparotomy. Single side docking was used in 39 cases (58%), whereas in 28 patients (42%) double side docking was used. Paraaortic lymhadenectomy was performed in 45 cases (67%). In 16 patients (24%) the upper limit of the left renal wein was reached. Upper limit of paraaortic lymphadenectomy was above inferior mesenteric artery but did not reach left renal vein in 19 cases (28%). Inferior mesenteric represented upper limit of paraaortic lymphadenectomy in 10 patients (15%). Number of paraaortic lymphonodes retrived (4,9 +/- 3,3 vs 3,7 +/- 4,9, p = 0,028) as well as number of paraaortic lymphadenectomies with upper limit at the left renal vein (p < 0,0001) was higher in double side docking cases. Complication rates were low in both groups and the differences were not significant.

Conclusion: Number of lymphonodes retrieved as well as the number of paraaortic lymphadenectomy cases with upper limit at the left renal vein was higher in double side docking group. Operating time, complication and conversion rates were low without differences between both groups.

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Z9 0

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JI Ces. Gynekol.

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WC Obstetrics & Gynecology

WE Emerging Sources Citation Index (ESCI)

SC Obstetrics & Gynecology

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ER

PT J

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TI Predictors of Overnight Admission after Minimally Invasive Hysterectomy

in the Expert Setting

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Same day discharge; Hysterectomy; Minimally invasive hysterectomy;

Predictors; Readmission; Reoperation; Safety

ID SAME-DAY DISCHARGE; LAPAROSCOPIC HYSTERECTOMY; BENIGN; SAFETY

AB Study Objective: To identify predictors of overnight admission after laparoscopic and robot-assisted hysterectomy to improve preoperative counseling and patient optimization.

Design: A single-center retrospective cohort study (Canadian Task Force classification III).

Setting: Academic university hospital.

Patients: Patients undergoing straight-stick laparoscopic and robot-assisted hysterectomy by fellowship-trained minimally invasive gynecologic surgeons for benign indications

Interventions: Straight-stick laparoscopic and robot-assisted hysterectomy.

Measurements and Main Results: Data from 396 consecutive minimally invasive hysterectomy procedures were collected for analysis. Three hundred twelve patients (79%) were discharged the same day, and 84 (21%) were admitted for at least 1 night. Data from the 2 groups were compared. Overnight stay compared with same-day discharge was associated with older age (47.3 vs 43.4 years, p < .001). lower preoperation hematocrit (35.8% vs 37.3%, p = .035), history of prior laparotomy (31% vs 14.1%, p = .003), prolonged operative time (190.5 vs 115.2 minutes. p < .001), estimated blood loss (244.6 vs 104.1 mL, p < .001), lysis of adhesion (27.4% vs 13.5%), and intraoperative organ injury (17% vs 3%, p = .005). Logistic regression analysis. adjusting for all included variables as confounders, showed that hematocrit increments of 5% were protective against any overnight stay (odds ratio, .622; p = .015), and a 30-minute increase in operative time increased the odds of an overnight stay by 1.6 (p < .001). History of a laparotomy remained a significant predictive factor for an overnight stay (odds ratio, 3.2; p = .006). Later surgery end time, in 60-minute increments, increased the odds of an overnight stay by 1.2 (p < .01).

Conclusion: Perioperative factors such as age, hematocrit, surgery time, and surgical history as well as intraoperative factors such as prolonged operative time arc predictive of overnight hospital stay. (C) 2018 AAGL. All rights reserved.

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Z9 16

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U2 1

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Ramphal, SR

AF Ramphal, S. R.

TI Laparoscopic approach to vesicovaginal fistulae

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Vesicovaginal fistula; Laparoscopy; Transvesical; Extravesical; Robotics

ID SINGLE-SITE SURGERY; VESICUVAGINAL FISTULA; EXTRAVESICAL REPAIR; ROBOTIC

REPAIR; INTERPOSITION; EXPERIENCE

AB The surgical repair of vesicovaginal fistula (VVF) over the last two decades has evolved from the transabdominal/transvaginal route to minimally invasive techniques of laparoscopy and robotic surgery. The indications for laparoscopic repair include supratrigonal fistulae, and stenotic/narrow vaginas that make vaginal access to the fistula site difficult. In the current published literature, comparable results have been reported with open surgery. The initial techniques were performed to simulate the open classic technique described by O'Conor, but with better imaging, exposure and magnification, the modified O'Conor (smaller cystotomy) and the extravesical approaches (no cystotomy) are being performed with comparable results. Difficulties such as depth perception, suturing and ergonomics together with the steep learning curve associated with laparoscopy have been overcome with the introduction of robotics. Reports on laparoendoscopic single site surgery (LESS) and transvesicoscopic VVF repairs with successful outcomes have been published, but studies on a large number of patients are needed to establish their effectiveness. Difficulties of managing suturing have been circumvented with the usage of the barbed suture; however, more data are required to establish its efficacy. Although the laparoscopic/robotic approach of a VVF repair offers numerous advantages, the best chance of success is achieved with the first surgical attempt using an approach that the surgeon is familiiar in performing. (C) 2018 Published by Elsevier Ltd.

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NR 47

TC 11

Z9 13

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JI Best Pract. Res. Clin. Obstet. Gynaecol.

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PY 2019

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SC Obstetrics & Gynecology

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ER

PT J

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TI Surgical approaches in women with endometrial cancer with a body mass

index greater than 35 kg/m<SUP>2</SUP>

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE endometrial cancer: obesity; laparotomy; minimally invasive surgery;

robotic assisted laparoscopy

ID ROBOTIC SURGERY; UTERINE-CANCER; OBESE-PATIENTS; LAPAROTOMY; OUTCOMES;

COMPLICATIONS; SURVIVAL; IMPACT; HYSTERECTOMY; LAPAROSCOPY

AB Aim Endometrial cancer is often associated with obesity. We want to compare the outcomes of surgical staging according to the surgical approach in patients with a body mass index >= 35 kg/m(2). Methods A retrospective cohort study with 138 patients with endometrial cancer and body mass index >= 35 kg/m(2) with different surgical staging routes: laparotomy (LPT; n = 94) and minimally invasive surgery (MIS): laparoscopy (LPC; n = 18) + robotic assisted laparoscopy (n = 26). Results Lymphadenectomy rate was similar in the three groups; there were no differences in the number of nodes removed. Decreased bleeding (P = 0.002) and hospital admission length (P < 0.001) was observed in the endoscopic group. Less early-postoperative complications were observed in the robotic approach (P = 0.007). Significant differences were not observed in recurrence-free survival or in overall survival. Conclusion Minimal invasive surgical staging in obese women with endometrial cancer could represent the surgical route of choice because it decreases operative bleeding, hospital admission length and the early postoperative complication rate without compromising recurrence-free survival or overall survival.

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NR 27

TC 12

Z9 12

U1 0

U2 2

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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WC Obstetrics & Gynecology

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GA HG1EY

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Kunselman, Allen R.

Harkins, Gerald J.

TI Surgical Excision Versus Ablation for Superficial

Endometriosis-Associated Pain: A Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometriosis; Chronic pelvic pain; Robotic surgery; Laparoscopy

ID LAPAROSCOPIC EXCISION; SHORT-FORM; MILD; WOMEN; MANAGEMENT; INFERTILE;

SURGERY

AB Study Objective: To compare surgical excision and ablation of endomettiosis for treatment of chronic pelvic pain.

Design: Randomized clinical trial with 12-month follow-up (Canadian Task Force classification I).

Setting: Single academic tertiary care hospital.

Patients: Women with minimal to mild endometriosis undergoing laparoscopy.

Interventions: Excision or ablation of superficial endometriosis at the time of robot-assisted laparoscopy.

Measurements and Main Results: Primary outcome was visual analog scale (VAS) scoring at baseline and 6 and 12 months for menstrual pain. nonmenstrual pain. dyspareunia. and dyschezia. Secondary outcomes included survey results at baseline and 6 and 12 months from the Short Form Health Survey, Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire, and the International Pelvic Pain Assessment. From December 2013 to October 2014, 73 patients were randomized intraoperatively to excision (n = 37) or ablation (n = 36) of endometriosis. Patients were followed at 6 and 12 months to evaluate the above outcomes. After ablation of endometriosis, dyspareunia (VAS scores) improved at 6 months (mean change [MC]. -14.07; 95% confidence interval [CI]. -25.93 to -2.21: p = .02), but improvement was not maintained at 12 months. Dysmenorrhea improved at 6 months (MC, -26.99; 95% CI, -41.48 to -12.50; p < .001) and 12 months (MC, -24.15; 95% CI, 39.62 to -8.68; p = .003) with ablation. No significant changes were seen in VAS scores after excision at 6 or 12 months. When comparing ablation and excision, the only significant difference was a change in dyspareunia at 6 months (MC, -22.96; 95% CI, -39.06 to -6.86; p = .01).

Conclusion: Treatment with ablation improved dysmenorrhea at 6 and 12 months and improved dyspareunia at 6 months as compared with preoperative data. However, only dyspareunia demonstrated a significant difference between ablation and excision. Excision and ablation showed similar effectiveness for the treatment of pain associated with superficial endometriosis, with ablation showing more significant individual changes. Careful patient counseling regarding expectations of surgical intervention is vital in the management of endometriosis. (C) 2018 AAGL. All rights reserved.

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FX Dr. Harkins was a product tester for Covidien. Mr. Kunselman has stock

in Merck. The study was supported in part through The Penn State

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U2 8

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Salehi, S

Åvall-Lundqvist, E

Brandberg, Y

Johansson, H

Suzuki, C

Falconer, H

AF Salehi, Sahar

Avall-Lundqvist, Elisabeth

Brandberg, Yvonne

Johansson, Hemming

Suzuki, Chikako

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TI Lymphedema, serious adverse events, and imaging 1 year after

comprehensive staging for endometrial cancer: results from the RASHEC

trial

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

ID QUALITY-OF-LIFE; EUROPEAN-ORGANIZATION; BREAST-CANCER; COMPLICATIONS;

LYMPHADENECTOMY; HYSTERECTOMY; WOMEN; LAPAROSCOPY; LAPAROTOMY; CARCINOMA

AB Background and Objectives In the Robot Assisted Surgery for High Risk Endometrial Cancer (RASHEC) trial, patients with high-risk endometrial cancer were randomly assigned to robot-assisted laparoscopic surgery (RALS) or laparotomy for pelvic and infrarenal para-aortic lymph node dissection. We here report on self-reported lower limb lymphedema (LLL), lymphocyst formation, ascites, and long-term serious adverse events 12 months after surgery.

Patients and methods Patients were enrolled between 2013 and 2016, and 96 patients were included in the per protocol analysis, evenly distributed between RALS and laparotomy. Self-reported LLL was recorded using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire for endometrial cancerEN24, assessed before and 12 months after surgery. Computed tomography was assessed at baseline, 3, and 12 months. Medical charts were reviewed for serious adverse events and hospital admissions 31 to 365 days after surgery.

Results At 12 months after laparotomy and RALS, 61% and 50% patients, respectively, reported LLL (p = 0.31). In univariate analysis, the mean score of LLL at 12 months was significantly higher for laparotomy than for RALS (p < 0.05) and for those without abdominal drainage (p = 0.02), but was not independently associated with LLL in the multivariate analysis. Imaging showed no significant difference in lymphocyst formation or ascites between surgical modalities. No difference was found in serious adverse events and admissions to hospital for any reason. There was no agreement between lymphocyst formation or ascites and self-reported LLL.

Conclusion Follow-up 1 year after comprehensive surgical staging for high-risk endometrial cancer showed no differences in self-reported LLL, findings on imaging, or SAE between laparotomy and robot-assisted surgery.

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U1 0

U2 4

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JI Int. J. Gynecol. Cancer

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ER

PT J

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Huang, K-G

Temtanakitpaisan, A.

TI Emerging role of sentinel lymph node mapping for gynecologic oncology in

the new era

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Sentinel lymph node; Vulvar cancer; Endometrial cancer; Cervical cancer;

Ovarian cancer; Gynecologic cancer

ID NEAR-INFRARED FLUORESCENCE; ENDOMETRIAL CANCER; INDOCYANINE GREEN;

CERVICAL-CANCER; PARAAORTIC LYMPHADENECTOMY; PROSPECTIVE MULTICENTER;

BIOPSY; WOMEN; MANAGEMENT; CARCINOMA

AB This study aims to update a review of the recent literature on sentinel lymph node biopsy (SLNB) in common gynecological cancer. Fifty-eight published English-language articles were obtained. Most of the well-designed studies were conducted in the patient with vulvar, endometrial, and cervical cancer, but SLNB data in ovarian cancer is limited. The result of diagnostic accuracy reported a satisfactory with a high detection rate, a high sensitivity, and an acceptable febrile neutropenia (FN) rate in all cancer types. The technique of SLNB in vulvar prefers combined radiocolloid and dye methods. The common technique in endometrial and cervical cancer is laparoscopic or robotic-assisted surgery with cervical indocyanine green (ICG) injection injection while laparotomy is the most frequently used in studies of ovarian cancer. This evidence supports that SLN mapping could replace the traditional lymphadenectomy in early-stage vulvar, endometrial, and cervical cancer. The result of feasibility and efficacy of this procedure in ovarian cancer is promising but more studies are required.

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NR 60

TC 0

Z9 0

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U2 8

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JI Eur. J. Gynaecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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GA JW4SW

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OA Bronze

DA 2024-01-18

ER

PT J

AU Tyan, P

Mourad, J

Wright, B

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Garza, D

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Brink, J

Wei, C

Moawad, G

AF Tyan, Paul

Mourad, Jamal

Wright, Brian

Winter, Marc

Garza, Devon

Smith, Rachael

Brink, Janel

Wei, Chapman

Moawad, Gaby

TI Robot-assisted transabdominal cerclage for the prevention of preterm

birth: A multicenter experience

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Minimally invasive cerclage; Abdominal cerclage; Laparoscopic cerclage;

Robot-assisted cerclage; Robotic cerclage; High-risk pregnancy; Preterm

delivery; Prevention

ID CERVICAL LENGTH; LAPAROSCOPY

AB Objective: High-risk pregnancy stratification and the use of Progesterone and prophylactic cerclage based on prior obstetrical outcomes and cervical length screening have been successful in curbing the impact of preterm birth. However, a large number of women will still suffer from preterm delivery even with optimal management. Experts agree that a transabdominal cerclage is the next best option for women who fail a transvaginal cerclage in a prior pregnancy. Our primary objective with this study is to assess the obstetric benefits and feasibility of robotic-assisted transabdominal cerclage in high-risk women projected to have poor obstetric outcomes.

Study design: A multicenter retrospective cohort analysis of consecutive patients undergoing a robotic assisted transabdominal cerclage (RA-TAC) for obstetric indications at two urban teaching university hospital and one academically affiliated community hospital. High-volume gynecologic surgeons performed all transabdominal cordage procedures (N = 68). To assess whether the transabdominal cerclage had any effect on subsequent pregnancies, we categorized gestational age into ordinal variables and used a two-proportion z-test to compare pregnancy outcomes and neonatal survival pre (n = 200) and post (n = 59) abdominal cerclage placement.

Results: A total of 68 consecutive patients undergoing a RA-TAC for obstetric indications were selected. We compared 200 pregnancies pre-robot-assisted cerclage to 59 pregnancies post-robot-assisted cerclage. The odds of delivering after 34 and 37 weeks gestational age was 4.0 and 3.6 times greater post robot-assisted cerclage, respectively (P < 0.001). The RA-TAC also had a significant effect on neonatal survival. The odds of neonatal survival was 12.6 times greater after RA-TAC placement when compared to prior pregnancy outcomes. Surgical outcomes were also favorable with no conversions to laparotomy or perioperative pregnancy loss.

Conclusion: The RA-TAC influences an increase in gestational age and improves neonatal survival in women projected to have poor pregnancy outcomes. The robot-assisted transabdominal cerclages provide excellent obstetric outcomes without the morbidity of a laparotomy or the technical challenges associated with a conventional straight-stick laparoscopy. This procedure is not intended to replace any other minimally invasive modality for cerclage placement but rather increase awareness of a less technically challenging option for transabdominal cerclage placement to help propagate the procedure to more patients. (C) 2018 Published by Elsevier B.V.

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U2 0

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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GA HH2OZ

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ER

PT J

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Spencer, RJ

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Reynolds, R. Kevin

Rice, Laurel W.

Spencer, Ryan J.

TI Trends and comparative effectiveness of inpatient radical hysterectomy

for cervical cancer in the United States (2012-2015)

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Radical hysterectomy; Cervical cancer; Minimally invasive radical

hysterectomy; Comparative effectiveness; National inpatient sample

AB Objective. Report the up-to-date trends in surgical approach for cervical cancer and compare outcomes between open and minimally invasive routes.

Methods. Radical Hysterectomy (RH) cases from the National Inpatient Sample (NIS) dataset between 2012 and 2015 were grouped into abdominal (ARH) and Minimally Invasive Surgery (MIS). The MIS group was subdivided as "Laparoscopic", "Robotic", and "Converted". Univariate and multivariable logistic regression were used to analyze differences in complication rates. The National Surgical Quality Improvement Dataset 2015 was used for validation.

Results. A total of 7180 cases from NIS were identified. Overall, there was 44% decline in RH cases from 2012 (n = 2220) to 2015 (n = 1255). A proportionate increase in robotic cases from 31.5% in 2012 to 41.4% in 2015 was noted. By intention to treat analysis, the rate of at least one complication for abdominal cases was 24.8% compared to 10% for MIS (p < 0.001). On multivariate analysis, abdominal cases had higher odd of any one complication (aOR 2.9,95% CI 2.12-4.00), medical complication (aOR 3.25,95% Cl 2.15-4.19), infectious complication (aOR 3.76,95% CI 2.1-6.1) but not for surgical complications (aOR 1.7,95% CI 0.5-5.6). AH resulted in longer hospital stay compared to MIS (4.3 vs 1.9 days, p < 0.001). Median cost of AH was $12,624, laparoscopic $12,873, robotic $14,029 and converted cases $17,036. NSQIP analysis supplemented the outcomes to 30-days and showed similar findings.

Conclusions. Perioperative complications are significantly lower for MIS procedures. These data should be used for contemporary cost-effective analysis and comprehensive counseling regarding risks and benefits of the surgical approach for cervical cancer. (C) 2018 Elsevier Inc. All rights reserved.

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U2 6

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ER

PT J

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Menefee, Shawn Adam

TI Ergonomics in gynecologic surgery

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE ergonomics guidelines; surgeon injury; surgeon safety; surgical

ergonomics; work-related musculoskeletal disorders

ID MINIMALLY INVASIVE SURGERY; POSTURAL MUSCLE-ACTIVITY; MUSCULOSKELETAL

DISORDERS; LAPAROSCOPIC SURGERY; OCCUPATIONAL INJURY; INSTRUMENTS;

PERFORMANCE; WORKLOAD; DESIGN; HANDLE

AB Purpose of review Work-related musculoskeletal disorders (WMSDs) are prevalent among surgeons and result in significant disability. We aimed to review the English-language literature regarding ergonomic risk, prevalence of WMSDs, and unique ergonomic considerations of gynecologic surgery. Recent findings Surgeon WMSDs are prevalent, with rates ranging from 66 to 94% for open surgery, 73-100% for conventional laparoscopy, 54-87% for vaginal surgery, and 23-80% for robotic-assisted surgery. Risk factors for injury in open surgery include use of loupes, headlamps, and microscopes. Unique risks in laparoscopic surgery include table and monitor position, long-shafted instruments, and poor instrument handle design. In vaginal surgery, improper table height and twisted trunk position create injury risk. Although robotic surgery offers some advantages in neck and shoulder strain, it remains associated with trunk, wrist, and finger strain. WMSDs are prevalent among surgeons but have received little attention because of under-reporting of injury and logistical constraints of studying surgical ergonomics. Future research must aim to develop objective surgical ergonomics instruments and guidelines and to correlate ergonomics assessments with pain and tissue-level damage in surgeons with WMSDs. Ergonomics training should be developed and implemented in order to protect surgeons from preventable, potentially career-altering injuries.

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Z9 18

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U2 15

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA HH7IC

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ER

PT J

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Torng, PL

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Chen, I. Hui

Torng, Pao-Ling

TI Robotic myomectomy for large uterine myomas

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Blood loss; Complication rate; Large myoma; Operative time; Robotic

myomectomy

ID ABDOMINAL MYOMECTOMY

AB Objective: To evaluate surgical outcomes and feasibility of robotic myomectomy in large uterine myomas.

Materials and methods: This is a retrospective study for robotic myomectomies performed from October 2012 to August 2017 by a single surgeon in a tertiary care referral hospital. Demographics, diagnosis, perioperative variables, operative outcomes and complications were recorded. Large uterine myoma was defined as the estimated diameter of dominant myoma equal to or larger than 10 cm by sonography.

Results: Seventy-four patients were included and 32 (43.2%) patients had large uterine myoma. Patients with myoma larger than 10 cm showed significantly heavier myoma weight (446.5 +/- 206.2 mg vs. 288.1 +/- 147.5, p < 0.001), similar blood loss (309.4 +/- 190.3 mL vs. 200.9 +/- 285.9 mL, p = 0.06), and longer operative time (263.4 +/- 83.7 min vs. 219.1 +/- 75.7 min, p = 0.02) compared with patients with myoma <10 cm. The largest myoma removed was 20 cm in diameter. Perioperative complications were rare.

Conclusion: Robotic myomectomy is feasible for managing large uterine myomas. It is a safe procedure with acceptable longer operative time. (C) 2018 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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NR 19

TC 7

Z9 7

U1 0

U2 2

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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DA 2024-01-18

ER

PT J

AU Matanes, E

Lauterbach, R

Boulus, S

Amit, A

Lowenstein, L

AF Matanes, Emad

Lauterbach, Roy

Boulus, Sari

Amit, Amnon

Lowenstein, Lior

TI Robotic laparoendoscopic single-site surgery in gynecology: A systematic

review

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Single-site; Robotic surgery; Gynecology; Systematic review; Minimally

invasive

ID TRANSUMBILICAL TOTAL HYSTERECTOMY; LYMPH-NODE BIOPSY; RADICAL

HYSTERECTOMY; ENDOMETRIAL CANCER; ASSISTED SACROCOLPOPEXY;

LEARNING-CURVE; INITIAL REPORT; MYOMECTOMY; FEASIBILITY; LAPAROSCOPY

AB Robotic laparoendoscopic single-site (R-LESS) seems to be the next route in advancing minimal invasive surgery, with the potential for better cosmetic results and reduced patient morbidity compared with multi port surgery. This review describes the history and development of (R-LESS) gynecologic surgery and outlines the latest advancements in the realm of gynecology. The review was conducted according to the PRISMA guidelines. Pubmed and ClinicalTrials.gov (www.clinicaltrials.gov) were the main search engines utilized for retrieval of study data (1990 - present). The following subject headings and keywords were searched: "robotic laparoscopic single incision", "robotic laparoendoscopic single site", "single incision robotic surgery" and "single-port robotic surgery". All original research articles including randomized, non-randomized controlled trials, cohort studies, patient series, and case reports were included. The search produced a total of 1127 results. After duplicate removal, 452 remained, and each title and abstract was reviewed by 2 reviewers. Subsequently, 56 full texts were selected for full review and an additional 20 excluded, leaving 36 studies that were included in the final review. Based on the data gathered we reached the conclusion that R-LESS surgery is feasible, safe and has equivalent surgical outcomes as conventional LESS surgery; in addition to shorter recovery times, less postoperative pain and better cosmetic outcomes than robotic multi-port surgery. To conclude, R-LESS is a feasible approach with low complication rates, minimal blood loss and postsurgical pain, fast recovery, and virtually scar-free results. However, the lack of large comparative prospective randomized controlled studies prevents drawing absolute conclusions. (C) 2018 Elsevier B.V. All rights reserved.

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NR 49

TC 20

Z9 24

U1 3

U2 15

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Blache, G

Jauffret, C

Mathis, J

Knight, S

Houvenaeghel, G

Lambaudie, E

AF Blache, G.

Jauffret, C.

Mathis, J.

Knight, S.

Houvenaeghel, G.

Lambaudie, E.

TI Can we use robotic surgery for the treatment of pelvic recurrence and

locally advanced tumors in gynecological surgery?

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Gynecologic cancer; Robotic surgery; Pelvic recurrence

ID CERVICAL-CANCER; EXENTERATION; EXPERIENCE

AB Over the past 20 years, feasibility of laparoscopic approaches has been validated in gynecologic surgery. This procedure has specific challenges due its longer learning curve and the limits imposed by the technique. For the surgical treatment of recurrent pelvic cancers or locally advanced tumors, open surgery remains the gold standard for most surgical teams. Robotic assistance could be an interesting alternative. The aim of this study is to present our department's robotic surgical procedures in this specific field and show its feasibility and reproducibility on several patients. (C) 2018 Elsevier Masson SAS. All rights reserved.

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JI J. Gynecol. Obstet. Hum. Reprod.

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Maggiore, Umberto Leone Roberti

Mariani, Andrea

TI Current landscape and future perspective of sentinel node mapping in

endometrial cancer

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Endometrial Neoplasms; Sentinel Lymph Node; Lymph Node Excision;

Laparoscopy; Robotic Surgical Procedures

ID LYMPH-NODE; PARAAORTIC LYMPHADENECTOMY; SELECTIVE LYMPHADENECTOMY;

ALGORITHM; BIOPSY; RISK; CARCINOMA; MANAGEMENT; IMPACT; DYE

AB Endometrial cancer (EC) represents the most common gynecological neoplasm in developed countries. Surgery is the mainstay of treatment for EC. Although EC is characterized by a high prevalence several features regarding its management are still unclear. In particular the execution of lymphadenectomy is controversial. The recent introduction of sentinel node mapping represents the mid-way between the execution and omission of node dissection in EC patients. In the present review we discuss the emerging role of sentinel node mapping in EC. In addition, we discussed how type of tracers utilized and site of injection impacted on sentinel node detection rates. Future perspective regarding EC management are also discussed.

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Z9 15

U1 0

U2 8

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J9 J GYNECOL ONCOL

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PT J

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Du, Angela L.

Ruppert, Kristine M.

Romanova, Anna L.

Zyczynski, Halina M.

TI Implementation of a urogynecology-specific enhanced recovery after

surgery (ERAS) pathway

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 44th Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

(SGS)

CY MAR 11-14, 2018

CL Orlando, FL

SP Soc Gynecol Surg

DE enhanced recover after surgery; pelvic floor reconstructive surgery;

pelvic organ prolapse; same-day discharge

ID SOCIETY RECOMMENDATIONS; CARE; METAANALYSIS; GUIDELINES

AB OBJECTIVE: Enhanced recovery after surgery protocols were developed for colorectal surgery to hasten postoperative recovery. Variations of the protocol are being adopted for gynecological procedures despite limited population and procedure-specific outcome data. Our objective was to evaluate whether implementation of an enhanced recovery after surgery pathway would facilitate reduced length of admission in a urogynecology population.

MATERIALS AND METHODS: In this retrospective analysis of patients undergoing pelvic floor reconstructive surgery by 7 female pelvic medicine and reconstructive surgeons, we compared same-day discharge, length of admission and postoperative complications before and after implementation of an enhanced recovery after surgery pathway at a tertiary care hospital. Groups were compared using chi(2) and Student t tests. Candidate variables that could have an impact on patient outcomes with P<.2 were included in multivariable logistic regression models. Satisfaction with surgical experience was assessed using a phone-administered questionnaire the day after discharge.

RESULTS: Mean age and body mass index of 258 women (137 before enhanced recovery after surgery and 121 enhanced recovery after surgery) were 65.5 +/- 11.3 years and 28.2 +/- 5.0 kg/m(2). The most common diagnosis was pelvic organ prolapse (n = 242, 93.8%) including stage III pelvic organ prolapse (n = 61, 65.1%). Apical suspension procedures included 58 transvaginal (25.1%), 112 laparoscopic/robotic (48.8%), and 61 obliterative (26.4%). Hysterectomy was performed in 57.4% of women. Demographic and surgical procedures were similar in both groups. Compared with before enhanced recovery after surgery, the enhanced recovery after surgery group had a higher proportion of same-day discharge (25.9% vs 91.7%, P<.001) and a 13.8 hour shorter duration of stay (25.9 +/- 13.5 vs 12.1 +/- 11.2 hours, P<.001). Operative and postsurgical recovery room times were similar (2.6 +/- 0.8 vs 2.6 +/- 0.9 hours, P=.955; 3.7 +/- 2.1 vs 3.6 +/- 2.2 hours, P=.879). Women in the enhanced recovery after surgery group were more likely to be discharged using a urethral catheter (57.9% enhanced recovery after surgery vs 25.4% before enhanced recovery after surgery, P=.005). There were no group differences in total 30 day postoperative complications overall and for the following categories: urinary tract infections, emergency room visits, unanticipated office visits, and return to the operating room. However, enhanced recovery after surgery patients had higher 30 day hospital readmission rates (n = 8, 6.7% vs n = 2, 1.5%, P=.048). Patients before enhanced recovery after surgery were readmitted for myocardial infarction and chest pain. Enhanced recovery after surgery patients were admitted for weakness, chest pain, hyponatremia, wound complications, nausea/ileus, and ureteral obstruction. Three enhanced recovery after surgery patients returned to the operating room for ureteral obstruction (n = 1), incisional hernia (n = 1), and vaginal cuff bleeding (n = 1). Enhanced recovery after surgery patients also had more postoperative nursing phone notes (2.6 +/- 1.7 vs 2.1 +/- 1.4, P=.030). On multivariable logistic regressions adjusting for age and operative time, same-day discharge was more likely in the enhanced recovery after surgery group (odds ratio, 32.73, 95% confidence interval [15.23-70.12]), while the odds of postoperative complications and emergency room visits were no different. After adjusting for age, operative time, and type of prolapse surgery, readmission was more likely in the enhanced recovery after surgery group (odds ratio, 32.5, 95% confidence interval [1.1-28.1]). In the enhanced recovery after surgery group, patient satisfaction (n = 77 of 121) was reported as very good or excellent by 86.7% for pain control, 89.6% for surgery preparedness, and 93.5% for overall surgical experience; 89.6% did not recall any postoperative nausea during recovery.

CONCLUSION: Enhanced recovery after surgery implementation in a urogynecology population resulted in a greater proportion of same-day discharge and high patient satisfaction but with slightly increased hospital readmissions within 30 days.

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PT J

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Frumovitz, Michael

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Ramirez, Pedro T.

TI Radical Hysterectomy and Age: Outcomes Comparison Based on a Minimally

Invasive vs an Open Approach

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Elderly patients; Laparoscopy; Radical hysterectomy

ID PELVIC RADIATION-THERAPY; CERVICAL-CANCER; WOMEN; PATTERNS; STAGE; CARE;

CARCINOMA; MORBIDITY; SURVIVAL

AB Study Objective: To compare outcomes of radical hysterectomy (RH) across age groups based on surgical approach: minimally invasive surgery (MIS) vs laparotomy (LP).

Design: Cross-sectional retrospective review (Canadian Task Force classification II-2).

Setting: Department of Gynecologic Oncology and Reproductive Medicine. The University of Texas M.D. Anderson Cancer Center.

Patients: Patients with early-stage cervical cancer who underwent RH at a tertiary cancer center between 1990 and 2013.

Interventions: Patients were stratified by age group (<50, 50-59, and >= 60 years) and by surgical approach (minimally invasive surgery [MIS] vs laparotomy [LP]).

Measurements and Main Results: Patients with early-stage cervical cancer who underwent RH were retrospectively reviewed to obtain demographic data, surgical data, and clinical outcomes. We used the Fisher exact, Wilcoxon rank-sum, and Cochran-Mantel-Haenszel tests to compare categorical and continuous variables stratified by surgical approach and age group. A total of 548 patients were evaluated, including 427 (77.9%) who underwent LP (age <50. 84.3%; 50-59, 11.2%; >= 60, 4.5%) and 121 (22.1%) who underwent MIS (age <50, 71.9%; 50-59, 17.3%; >= 60, 10.8%). In the MIS group, 71 pa- tients (58.7%) underwent laparoscopy and 50 (41.3%) underwent robotic surgery. Patients in the MIS group were significantly older and heavier than those in the LP group. The operative time was significantly longer in the MIS group. There was no between-group difference in intraoperative complications in any of the 3 age groups. LP patients had more infectious complications (respiratory, systemic, and wound) than MIS patients in the <50-year age group (53.3% vs 21.8%). The difference between the LP and MIS groups with respect to the postoperative noninfectious complication rate was greatest in the 60year age group (p = .0324).

Conclusion: The between-group difference in postoperative noninfectious complication rate in the oldest age group was twice that in either of the other 2 age groups (p = .0324), even though the MIS patients were older, heavier, and had a longer operative time compared with the LP patients. (C) 2018 AAGL. All rights reserved.

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TC 14

Z9 14

U1 0

U2 6

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WC Obstetrics & Gynecology

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ER

PT J

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Hershman, Dawn L.

Wright, Jason D.

TI Use and outcomes of minimally invasive hysterectomy for women with

nonendometrioid endometrial cancers

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cancer; endometrial hysterectomy; laparoscopic; robotic-assisted;

uterine

ID LAPAROSCOPIC HYSTERECTOMY; DATA-BASE; SURVIVAL; LAPAROTOMY

AB BACKGROUND: Minimally invasive hysterectomy is now used routinely for women with uterine cancer. Most studies of minimally invasive surgery for endometrial cancer have focused on low-risk endometrioid tumors, with few reports of the safety of the procedure for women with higher risk histologic subtypes.

OBJECTIVE: The purpose of this study was to examine the use of and survival associated with minimally invasive hysterectomy for women with uterine cancer and high-risk histologic subtypes.

STUDY DESIGN: We used the National Cancer Database to identify women with stages I-III uterine cancer who underwent hysterectomy from 2010-2014. Women with serous carcinomas, clear cell carcinomas, and sarcomas were examined. Women who had laparoscopic or robotic-assisted hysterectomy were compared with those who underwent open abdominal hysterectomy. After a propensity score inverse probability of treatment weighted analysis, the effect of minimally invasive hysterectomy on overall, 30-day, and 90-day mortality rates was examined for each histologic subtype of uterine cancer.

RESULTS: Of 94,507 patients who were identified, 64,417 patients (68.2%) underwent minimally invasive hysterectomy. Among women with endometrioid tumors (n=81,115), 70.8% underwent minimally invasive hysterectomy. The rates of minimally invasive surgery in those women with nonendometrioid tumors (n=13,392) was 57.6% for serous carcinomas, 57.0% for clear cell tumors, 47.3% for sarcomas, 32.2% for leiomyosarcomas, 47.9% for stromal sarcomas, and 48.5% for carcinosarcomas. Performance of minimally invasive surgery increased across all histologic subtypes between 2010 and 2014. For nonendometrioid subtypes, robotic-assisted procedures accounted for 47.9-75.7% of minimally invasive hysterectomies by 2014. In a multivariable model, women with nonendometrioid tumors were less likely to undergo minimally invasive surgery than those with endometrioid tumors (P<.05). There was no association between route of surgery and 30-day, 90-day, or overall mortality rates for any of the nonendometrioid histologic subtypes.

CONCLUSION: The use of minimally invasive surgery is increasing rapidly for women with stage I-III nonendometrioid uterine tumors. Performance of minimally invasive surgery does not appear to impact survival adversely.

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ER

PT J

AU Paek, J

Kang, E

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AF Paek, Jiheum

Kang, Elizabeth

Lim, Peter C.

TI Robotic lower pelvic port placement for optimal upper paraaortic lymph

node dissection

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic Surgical Procedures; Lymph Node Excision

ID INFRARENAL AORTIC LYMPHADENECTOMY; CANCER

AB Objective: Upper paraaortic lymph node dissection (UPALD) to the infrarenal level is one of the most challenging robotic procedures. Because robotic system has the limitation in robotic arm mobility. This surgical video introduces a novel robotic approach, lower pelvic port placement (LP3), to perform optimally and simultaneously both UPALD and pelvic procedures in gynecologic cancer patients using da Vinci Xi system.

Methods: The patient presented with high-grade endometrial cancer. She underwent robotic surgical staging operation. For the setup of the LP3, a line was drown between both anterior superior iliac spines. At 3 cm below this line, another line was drown and four robotic ports were placed on this line.

Results: After paraaortic lymph node dissection (PALD) was completed, the boom of robotic system was rotated 180 degrees to retarget for the pelvic lateral displacement. Robotic ports were placed and docked again. The operation was completed robotically without any complication.

Conclusion: The LP3 was feasible for performing simultaneously optimal PALD as well as procedures in pelvic cavity in gynecologic cancer patients. The advantage of LP3 technique is the robotic port placement that affords for multi-quadrant surgery, abdominal and pelvic dissection. The LP3 is facilitated by utilizing advanced technology of Xi system, including the patient clearance function, the rotating boom, and 'port hopping' that allows using every ports for a camera. The LP3 will enable surgeons to extend the surgical indication of robotic surgical system in the gynecologic oncologic field.

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NR 4

TC 2

Z9 2

U1 0

U2 3

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PG 4

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AU Fuglsang, K

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Blaakaer, Jan

TI Cervical cancer staging, pretreatment planning, and surgical treatment

in the Nordic countriesSurvey from the Surgical Subcommittee of the

Nordic Society of Gynecological Oncology

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE diagnostic imaging; gynecological surgical procedure; International

Federation of Gynecology and Obstetrics; neoplasm staging; Nordic

Society of Gynecological Oncology; pretreatment elaboration; sentinel

lymph node; uterine cervical neoplasm

ID CARCINOMA; RADIOTHERAPY; GUIDELINES; IB

AB IntroductionWomen with cervical cancer in the Nordic countries are increasingly undergoing pretreatment imaging by ultrasound, magnetic resonance imaging (MRI), positron emission tomography-computed tomography (PET-CT) or computed tomography, or sentinel lymph node procedure. The present survey reports the influence of pretreatment imaging findings on the recorded clinical International Federation of Gynecology and Obstetrics (FIGO) stage in Nordic countries and its impact on treatment planning and preferred surgical approach in cervical cancer.

Material and methodsThe Nordic Society of Gynecological Oncology Surgical Subcommittee developed a questionnaire-based survey that was conducted from 1 January to 31 March 2017. All the 22 Nordic Gynecological Oncology Centers (Denmark 5, Finland 5, Iceland 1, Norway 4, and Sweden 7) were invited to participate.

ResultsThe questionnaires were returned by 19 of 22 (86.3%) centers. The median number (range) of women with cervical cancer treated at each center annually was 32 (15-120). In 58% (11/19) of the centers, imaging findings were reported to influence the clinical staging. MRI in combination with PET-CT was the preferred imaging method and the results influenced treatment planning. Robotic-assisted radical hysterectomy was the preferred surgical method in 72% (13/18) of the centers. Sentinel lymph node procedure was not routinely implemented in the majority of the Nordic centers.

ConclusionMore than half of the Nordic Gynecological Oncology Centers already report a clinical FIGO stage influenced by pretreatment imaging findings. The trend in preferred treatment is robotic-assisted radical hysterectomy and the sentinel lymph node procedure is gradually being introduced.

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U1 0

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TI Vasovasostomy and vasoepididymostomy: Review of the procedures,

outcomes, and predictors of patency and pregnancy over the last decade

SO REPRODUCTIVE MEDICINE AND BIOLOGY

LA English

DT Review

DE male infertility; obstructive azoospermia; vasectomy reversal;

vasoepididymostomy; vasovasostomy

AB Background

In the era of improving assisted reproductive technology (ART), patients with obstructive azoospermia (OA) have 2 options: vasal repair or testicular sperm extraction with intracytoplasmic sperm injection. Vasal repair, including vasovasostomy (VV) and vasoepididymostomy (VE), is the only option that leads to natural conception.

MethodsMain findingsThis article reviews the surgical techniques, outcomes, and predictors of postoperative patency and pregnancy, with a focus on articles that have reported over the last 10years, using PubMed database searches.

The reported mean patency rate was 87% and the mean pregnancy rate was 49% for a patient following microscopic VV and/or VE for vasectomy reversal. Recently, robot-assisted techniques were introduced and have achieved a high rate of success. The predictors and predictive models of postoperative patency and pregnancy also have been reported. The obstructive interval, presence of a granuloma, and intraoperative sperm findings predict postoperative patency. These factors also predict postoperative fertility. In addition, the female partner's age and the same female partner correlate with pregnancy after surgery.

ConclusionIn the era of ART, the physician should present and discuss with both the patient with OA and his partner the most appropriate procedure to conceive by using these predictors.

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JI Reprod. Med. Biol.

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PT J

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TI Outcomes of minimally invasive abdominal sacrocolpopexy with resident

operative involvement

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT Annual Meeting of the American-Urological-Association (AUA)

CY MAY 06-10, 2016

CL San Diego, CA

SP Amer Urol Assoc

DE Minimally invasive surgical procedures; Outcome assessment (health

care); Pelvic organ prolapse

ID PELVIC FLOOR DISORDERS; SURGICAL-PROCEDURES; PATIENT SAFETY; ORGAN

PROLAPSE; RISK-FACTORS; ACS-NSQIP; US WOMEN; SURGERY; IMPACT; PREVALENCE

AB Resident involvement in complex surgeries is under scrutiny with increasing attention paid to health care efficiency and quality. Outcomes of urogynecological surgery with resident involvement are poorly described. We hypothesized that resident surgical involvement does not influence perioperative outcomes in minimally invasive abdominal sacrocolpopexy (ASC).

Using the 2006-2012 National Surgical Quality Improvement Program database, we identified 450 cases of laparoscopic or robotic ASC performed with resident involvement. Resident operative participation was stratified by experience (junior [PGY 1-3] vs senior level [PGY ae<yen>4]). The primary outcome was operative time, and multinomial logistic regression was used to determine the effects of resident involvement and experience. Chi-squared analyses were used to assess the relationship between resident participation with length of stay (LOS) and 30-day complications and readmissions.

Residents participated in 74% (n = 334) of these surgeries, and these cases were significantly longer (median 220 vs 195 min, p = 0.03). On multivariate analysis, senior level resident involvement was associated with longer operative times across all time intervals compared with < 2 h (2 to ae<currency>4 h relative risk reduction [RRR] 4.1, p = 0.007, CI 1.47-11.40; 4 to ae<currency>6 h RRR 6.6, p = 0.001, CI 2.23-19.44; ae<yen>6 h RRR 4.7, p = 0.020, CI 1.28-17.43). Resident participation was not associated with LOS, readmissions, or complications.

Senior level resident involvement in minimally invasive ASC is associated with longer operative times, with no association with LOS or adverse perioperative outcomes. The educational benefit of surgical training does not adversely affect patient outcomes for ASC.

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Z9 8

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ER

PT J

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TI Celecoxib versus ketorolac following robotic hysterectomy for the

management of postoperative pain: An open-label randomized control trial

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Pain management; Robotic hysterectomy; Opioid use

ID MULTIMODAL ANALGESIA; RECOVERY; PATHWAYS; ONCOLOGY; SURGERY

AB Objective. Compare postoperative pain scores following hysterectomy in patients receiving perioperative celecoxib versus postoperative ketorolac as part of a multimodal pain regimen.

Methods. Patients undergoing hysterectomy were randomized to receive scheduled intravenous ketorolac in the immediate postoperative period or oral celecoxib prior to surgery and continued for a total seven days. All patients received a common multimodal pain protocol consisting of scheduled acetaminophen, gabapentin, and opioids as needed. Inpatient pain scores and postoperative opioid use were analyzed. A questionnaire regarding outpatient opioid use and return to normal activities of daily living (ADLs) was returned two weeks post-operatively.

Results. 192 patients were assessed for eligibility and 170 patients were randomized. Enrollment of patients undergoing open hysterectomy was closed prematurely for poor accruement (n = 32). 138 patients undergoing robotic hysterectomy were included were analyzed. There were no differences for inpatient pain scores (2.7 +/- 1.9 v. 2.4 +/- 1.6, p = 0.21). Average length of stay was similar between the two arms (11.6 +/- 8.1 h v. 11.9 +/- 7.6 h, p = 0.41). Patients in the celecoxib arm used less prescription opioids (6.0 +/- 3.6 v. 8.1 +/- 4.0, p = 0.001) and stopped using oral opioids earlier (3.8 +/- 2.6 days v. 5.7 +/- 2.8 days, p < 0.001). No differences were seen in inpatient opioid or anti-emetic usage, perioperative complications, or days to return to ADLs.

Conclusions. There was no difference in inpatient pain scores between patients who received celecoxib or ketorolac as part of multimodal pain control following robotic hysterectomy. Patients who received scheduled celecoxib for seven days after surgery used less prescription narcotics. (C) 2018 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Robotic, Laparoscopic, or Open Hysterectomy: Surgical Outcomes by

Approach in Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Endometrial cancer; Surgical outcomes

ID MINIMALLY INVASIVE SURGERY; EPITHELIAL OVARIAN; UNITED-STATES;

RISK-FACTORS; COST; READMISSIONS; LAPAROTOMY; MANAGEMENT; OBESITY;

IMPACT

AB Study Objectives: To compare patient outcomes by surgical approach in the management of endometrial cancer (EC) in Washington State from 2008 to 2013.

Design: Population-based retrospective cohort study (Canadian Task Force classification II-2).

Setting: Washington State.

Patients: EC patients treated with robotic-assisted surgery (RAS), laparoscopy (LS), or laparotomy (XLAP).

Interventions: Comprehensive Hospital Abstract Reporting System to identify patients and assess the association of surgical approach with length of stay. readmissions. and perioperative complications.

Measurements and Results: We identified 3712 cases of EC managed with either RAS, LS, or XLAP. Mean length of stay was not clinically different for RAS (15 days) and LS (1.6 days) but was 2.31 days longer for XLAP compared with LS < .001). Odds of any readmission did not differ for either RAS or XLAP compared with LS; however, early readmissions were half as likely for RAS compared with LS (p = .014). Complications were more than 25 times as likely for XLAP versus LS (p < .001), whereas complications did not differ for RAS versus LS (p = .931).

Conclusions: RAS is as an alternative to LS in the treatment of EC and is preferable to XLAP. The use of RAS resulted in fewer early readmissions compared with LS and resulted in an increased proportion of cases via minimally invasive surgery. (C) 2018 AAGL. All rights reserved.

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PT J

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TI The impact of fellowship surgical training on operative time and patient

morbidity during robotics-assisted sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotics; Sacrocolpopexy; Pelvic organ prolapse

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; LEARNING-CURVE; TERM

OUTCOMES; SURGERY; OBSTETRICS

AB Abdominal sacrocolpopexy is commonly performed for the surgical correction of pelvic organ prolapse (POP) in the USA. Over the last decade, fellowship programs have increased the number of these procedures performed robotically. Currently, there is a paucity of literature exploring the impact of fellowship training on outcomes of robotic-assisted sacrocolpopexy (RASC). We sought to explore the impact of an expert surgeon operating alone versus with a fellow on operative time and perioperative morbidity associated with RASC.

This is an analysis of a retrospectively collected cohort of all RASCs performed to treat POP from June 2010 to August 2015 by a single attending surgeon. Outcomes were compared by expert surgeon alone and with a fellow.

We identified 208 RASCs, of which 124 (59.6%) were performed by an expert surgeon alone and 84 (40.4%) with a fellow. Eight fellows were included, with a median of 7 cases (interquartile range 5-13.5). Cases with fellows were 31.1 min longer than an expert surgeon alone (155.6 vs 124.5 min, p < 0.001), a 25% increase. Increased operative time for fellows remained significant on multivariate regression (34.2 min, p < 0.001) after adjusting for case order postmenopausal status, hysterectomy, mid-urethral sling, and bowel injury. Years in fellowship did not have an impact on operative time (p = 0.80).

Complications were seen in 34 women (16.4%). On univariate regression, fellows did not have an impact on complications (OR 1.49, 95% CI [0.65-3.43]), which was unchanged on multivariate regression (OR 0.628, 95% CI [0.26-1.54]). Prolapse recurrence was seen in 19 women (9.5%). Fellows had no impact on prolapse recurrence (OR 0.478, 95% CI [0.17-1.38]), which was unchanged on multivariate regression (OR 0.266, 95% CI [0.17-1.49]).

When an expert surgeon operated together with a fellow, operative time increased by 34 min without increasing prolapse recurrence or complications.

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TI Visuospatial Aptitude Testing Differentially Predicts Simulated Surgical

Skill

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Simulation; Surgical aptitude; Visuospatial test

ID VISUAL-SPATIAL ABILITY; LAPAROSCOPIC SURGERY; PERFORMANCE; RESIDENTS;

PREPAREDNESS; HYSTERECTOMY; EXPERIENCE; TRENDS

AB Objective: To determine whether visuospatial perception (VSP) testing is correlated to simulated or intraoperative surgical performance as rated by the American College of Graduate Medical Education (ACGME) milestones.

Design: (Canadian Task Force classification II-2).

Setting: Two academic training institutions.

Participants: Forty-one residents, including 19 from Brigham and Women's Hospital and 22 from the Mayo Clinic, from 3 different specialties: obstetrics and gynecology, general surgery, and urology.

Intervention: Participants underwent 3 different tests: visuospatial perception testing (VSP), Fundamentals of Laparoscopic Surgery (FLS) peg transfer, and da Vinci robotic simulation peg transfer. Surgical grading from the ACGME milestones tool was obtained for each participant. Demographic and background information was also collected, including specialty, year of training, previous experience with simulated skills, and surgical interest. Standard statistical analyses were performed using Student's t test, and correlations were determined using adjusted linear regression models.

Measurements and Main Results: In univariate analysis, Brigham and Women's Hospital and Mayo Clinic training programs differed in times and overall scores for both the FLS peg transfer and da Vinci robotic simulation peg transfer tests (p < .05 for all). In addition, type of residency training affected time and overall score on the robotic peg transfer test. Familiarity with tasks correlated with higher score and faster task completion (p = .05 for all except VSP score). There were no differences in VSP scores by program, specialty, or year of training. In adjusted linear regression modeling, VSP testing was correlated only to robotic peg transfer skills (average time, p = .006; overall score, p = .001). Milestones did not correlate to either VSP or surgical simulation testing.

Conclusion: VSP score was correlated with robotic simulation skills, but not with FLS skills or ACGME milestones. This suggests that the ability of VSP score to predict competence differs between tasks. Therefore, further investigation of aptitude testing is needed, especially before its integration as an entry examination into a surgical subspecialty. (C) 2018 AAGL. All rights reserved.

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Z9 5

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PT J

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TI Robotic surgery in endometrial cancer: Feasibility in, obese patients

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Article

DE Robotic surgery; Endometrial cancer; Obesity

ID BODY-MASS INDEX; LAPAROSCOPIC HYSTERECTOMY; COMPLICATIONS

AB Objective. - Minimally invasive surgery is a technique frequently used in gynecologic surgery. The robot-assisted surgery is a recent approach, and the benefits are not yet proven. The objective of this study was to evaluate the feasibility to use robot-assisted surgery for obese patient with endometrial cancer.

Methods. - All patients undergoing a robotic surgery for uterus malignant indication between March 2013 and May 2016 in our center were retrospectively included. Patients were divided in two groups, according to their body mass index (BMI). The group with BMI < 30 kg/m(2) was the reference for this comparative study. The main criteria was the robot operative time. The other criteria were total operating time, hospital stay and intraoperative and postoperative complications.

Results. - Seventy-seven patients met inclusion criteria for analysis. The median robot operative time was 110 minutes for all patients [21-341], without difference between the five groups (P = 0.60). There was no difference for the total operative time (P = 0.50). The median hospital stay was 3 days (P = 0.92). There were ten intraoperative complications. One patient had a conversion (1.3%). There was no statistical difference for postoperative complications (P = 1).

Conclusion. - Our study found few differences in the surgical management by laparoscopic robot assisted between obese and non obese women. Robot-assisted surgery seems to be feasible for uterine cancer treatment of obese patients. Prospective and randomized studies are needed to assess the benefit of the robotic surgery. (C) 2018 Elsevier Masson SAS. All rights reserved.

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NR 24

TC 1

Z9 1

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U2 3

PU ELSEVIER FRANCE-EDITIONS SCIENTIFIQUES MEDICALES ELSEVIER

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J9 GYNECOL OBST FERT SE

JI Gynecol. Obstet. Fertil. Senol.

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PG 7

WC Obstetrics & Gynecology

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PM 30115552

DA 2024-01-18

ER

PT J

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TI Outcomes in women undergoing robotic-assisted laparoscopic hysterectomy

compared to conventional laparoscopic hysterectomy at a tertiary

hospital in Western Australia

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE gynaecological oncology; gynaecology; laparoscopy; outcomes;

robotic-assisted laparoscopic hysterectomy

ID STAGE CERVICAL-CANCER; GYNECOLOGICAL SURGERY; RADICAL HYSTERECTOMY;

ENDOMETRIAL CANCER; TIME; COMPLICATIONS; STANDARD

AB BackgroundRobotic-assisted laparoscopic hysterectomy (RALH) is associated with improved outcomes compared to open surgery in patients with endometrial cancer but data are conflicting when comparing RALH to conventional total laparoscopic hysterectomy (TLH). In October 2014, a RALH program was established in Perth, Western Australia.

AimTo compare outcomes in patients undergoing RALH with a matched cohort undergoing TLH.

Materials and methodsA retrospective matched cohort study compared outcomes in 45 patients who underwent RALH with 45 controls who were patients treated with TLH.

ResultsMean operating time was longer in the RALH group compared to controls (75.42min vs 53.18min, mean difference 22.24min, P <0.001, 95% Cl, 11.07-33.42). No differences were observed in mean pain scores (RALH 1.47 vs TLH 1.84 P=0.31), mean parenteral and oral opioid use (RALH 14.3mg and 42.4mg vs TLH 17.5mg and 52.57mg, P= 0.42 and 0.42, respectively), and mean length of stay (RALH 1.51 vs TLH 1.67days, P=0.49). Two patients in the RALH group and one patient in the TLH group sustained iatrogenic bladder injuries (P=0.62).

ConclusionThe establishment of the RALH program at our institution appeared to be associated with equivalent morbidity, post-operative pain, opioid use and length of stay compared to conventional laparoscopy. A surgical learning curve for RALH was observed. Well-designed prospective studies are needed to further evaluate short- and long-term patient function, morbidity, quality of life and oncologic outcomes.

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NR 25

TC 3

Z9 3

U1 0

U2 4

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JI Aust. N. Z. J. Obstet. Gynaecol.

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OA Bronze

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ER

PT J

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TI Extraperitoneal Para-Aortic Lymphadenectomy by Robot-Assisted

Laparoscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Endometrial cancer; Gynecologic cancer; Lymph node;

Lymphocyst; Ovarian cancer; Vaginal cancer

ID ADVANCED CERVICAL-CARCINOMA; CONVENTIONAL-LAPAROSCOPY; CANCER; SURGERY;

TRANSPERITONEAL; COMPLICATIONS; ENDOMETRIAL; EXPERIENCE; ONCOLOGY

AB Study Objective: To evaluate the outcomes of extraperitoneal para-aortic lymphadenectomy by robot-assisted laparoscopy.

Design: A retrospective study (Canadian Task Force classification III).

Setting: An academic institution.

Patients: Twenty-three consecutive patients with gynecologic cancer who presented for para-aortic lymphadenectomy between March 2016 and May 2017 were reviewed retrospectively.

Interventions: Extraperitoneal para-aortic lymphadenectomy by robot-assisted laparoscopy was performed.

Measurements and Main Results: Of the 23 patients reviewed retrospectively, 10 had cervical cancer, 7 had endometrial cancer, 5 had adnexal cancer, and 1 had vaginal cancer. Data regarding patient characteristics, indication for para-aortic lymphadenectomy, type of surgery (infrarenal or inframesenteric), operative time, surgical complications, number of nodes retrieved, and postoperative hospital length of stay were collected. Two patients were excluded because of early perforation of the peritoneum. In total, 21 para-aortic lymphadenectomies were performed (16 infrarenal and 5 inframesenteric). The median skin-to-skin operating time of infrarenal extraperitoneal para-aortic lymphadenectomy by robot-assisted laparoscopy was 170 minutes (range, 90-225 minutes), the median lymph node count was 18 (range, 11-38). and the median estimated blood loss was 50 mL (range. 10-600 mL). The median skin-to-skin operating time of inframesenteric extraperitoneal para-aortic lymphadenectomy by robot-assisted laparoscopy was 120 minutes (range, 90-220 minutes), the median lymph node count was 10 (range, 7-19). and the median estimated blood loss was 30 mL. (range, 10-100). Intraoperative complications included 1 thermal lesion of the left genitofemoral nerve, 1 thermal lesion of the left mesoureter (a ureteral stent was placed to avoid ureteric necrosis and fistula without after effect), and 1 lesion of the inferior vena cava that was sutured by robot-assisted laparoscopy. There were 2 additional cases of perforation of the peritoneum that occurred in the infrarenal group. The median hospital length of stay was 1 day (range, 0-7 days). Three patients were readmitted for symptomatic lymphocysts.

Conclusion: Extraperitoneal para-aortic lymphadenectomy by robot-assisted laparoscopy provides good visualization of the operative field without arm conflict. Still, perforation of the peritoneum and symptomatic lymphocysts are a postoperative concern. (C) 2018 AAGL. All rights reserved.

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Z9 5

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JI J. Mimim. Invasive Gynecol.

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ER

PT J

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TI Robotic Surgery in Elderly and Very Elderly Gynecologic Cancer Patients

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic oncology; Elderly patients; Robotic surgery

ID ENDOMETRIAL CANCER; RISK-FACTORS; MORBIDITY; OUTCOMES

AB Study Objective: To investigate the feasibility, safety, and short-term outcomes of robotic surgery (RS) for gynecologic oncologic indications (cervical, endometrial, and ovarian cancer) in elderly patients, especially women age 65 to 74 years (elderly group [EG]) compared with women age >= 75years (very elderly group [VEG]).

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Catholic University of the Sacred Heart, Rome, Italy.

Patients: Between May 2013 and April 2017, 204 elderly and very elderly patients underwent RS procedures for gynecologic malignancies.

Results: The median age was 71 years (range, 65-74 years) in the EG and 77 years (range, 75-87 years) in the VEG. The incidence of cardiovascular disease was higher in the VEG (p = .038). The EG and VEG were comparable in terms of operative time, blood loss, and need for blood transfusion. Almost all (98.5%) of the patients underwent total/radical hysterectomy. 109 patients (55.6% of the EG vs 48.3% of the VEG) underwent pelvic lymphadenectomy, and 19 patients (10.5% of the EG vs 6.7% of the VEG) underwent aortic lymphadenectomy. A total of 7 (3.4%) conversions to open surgery were registered. Only 3 patients required postoperative intensive care unit admission. The median length of hospital stay was 2 days in each group. A total of 11 patients (5.6%) had early postoperative complications. Four patients (2.8%) in the EG and 2 patients (3.3%) in the VEG experienced grade complications. At the time of analysis, median follow-up was 18 months (range, 6-55 months). Eleven patients (5.6%) experienced disease relapse, 2 (1%) died of disease, and 3 (1.5%) died of cardiovascular disease.

Conclusions: This study demonstrates the feasibility, safety, and good short-term outcomes of RS in elderly and very elderly gynecologic cancer patients. No patient can be considered too old for a minimally invasive robotic approach, but a multidisciplinary approach is the best management pathway; efforts to reduce associated morbidity are essential. (C) 2018 AAGL. All rights reserved.

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TC 31

Z9 32

U1 0

U2 0

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WC Obstetrics & Gynecology

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ER

PT J

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TI Robotic-Assisted Laparoscopic Abdominal Cerclage Placement During

Pregnancy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cerclage; Cervical incompetence; Robot

ID TRANSABDOMINAL CERVICAL CERCLAGE; COST-ANALYSIS; HYSTERECTOMY; SURGERY

AB Study Objective: The objective of this study is to report our center's series of robotic-assisted laparoscopic abdominal cerclage (RALAC) placement during pregnancy.

Design: Descriptive study (Canadian Task Force classification III).

Setting: Single academic institution.

Patients: Patients undergoing RALAC placement during pregnancy.

Interventions: Eleven patients underwent RALAC.

Measurements and Main Results: Nine out of 11 (81.8%) primary RALAC procedures resulted in a viable live-born neonate: 8 (72.7%) were born at >34 weeks of gestation. Three patients (27.3%) had preterm premature rupture of membranes on postoperative day one, 2 of whom subsequently underwent a dilation and curettage, and 1 patient carried the pregnancy to 29 weeks and delivered a live-born neonate. Four patients had subsequent pregnancies after placement of a RALAC in the antepartum period, all of whom carried successfully beyond 36 weeks, for a total of 16 pregnancies. Fourteen pregnancies (875%) resulted in a live birth, and 13 pregnancies (81.3%) were delivered beyond 34 weeks.

Conclusion: RALAC is a minimally invasive procedure with an acceptable risk profile and comparable efficacy to traditional open abdominal cerclage. RALAC may be considered an acceptable alternative to open abdominal cerclage in pregnancy, and may be a particularly favorable option in certain settings. (C) 2017 AAGL. All rights reserved.

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Z9 7

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OA Bronze

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ER

PT J

AU Hoke, TP

Goldstein, H

Saks, EK

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Goldstein, Howard

Saks, Emily K.

Vakili, Babak

TI Surgical Outcomes of Paravaginal Repair After Robotic Sacrocolpopexy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 44th Global Congress on Minimally Invasive Gynecology of the

American-Association-of-Gynecologic-Laparoscopists

CY NOV 15-19, 2015

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists

DE Laparoscopy; Pelvic organ prolapse questionnaire; Prolapse

ID ABDOMINAL SACROCOLPOPEXY

AB Study Objective: To evaluate surgical outcomes of robotic sacrocolpopexy with and without paravaginal repair for pelvic organ prolapse (POP).

Design: A retrospective cohort study with a 3-month postoperative follow-up (Canadian Task Force classification II-3).

Setting: An academic-affiliated community hospital with a practice comprised of 3 surgeons board certified in female pelvic medicine and reconstructive surgery.

Patients: Patients undergoing robotic sacrocolpopexy for POP from April 2013 through November 2014.

Interventions: Robotic paravaginal repair (RPVR) after robotic sacrocolpopexy. The decision to perform a paravaginal repair was at the discretion of the surgeon.

Measurements and Main Results: One hundred fifty-six patients underwent a robotic sacrocolpopexy. Twenty-four patients were excluded because of a lack of a 3-month postoperative follow-up. Nine patients underwent concomitant vaginal paravaginal repair and were also excluded. Outcomes were defined by comparing preoperative characteristics with those at the 3-month follow-up. Of the 123 patients in this cohort, 21 patients underwent a concomitant RPVR, and 102 did not. All Pelvic Organ Prolapse Questionnaire (POP-Q) points improvedwithin groups (p <.001) except for the total vaginal length (TVL) in the RPVR group (p =.940). The Patient Global Impression of Improvement (PGI-I) did not differ between groups (1.2 vs 1.5, p =.128). Subgroup analysis was performed on patients with preoperative anterior wall prolapse of stage 3 or greater. Baseline characteristics and perioperative data were not remarkably different from the main cohort. All POP-Q points improved within groups (p <.001) except for the TVL in the RPVR group (p =.572). The PGI-I did not differ between groups (1.2 vs 1.3, p =.378).

Conclusion: In both groups, anatomic markers substantially improved within each group. There were significant differences in postoperative POP-Q findings, which may have been influenced by the fact that patients undergoing RPVR usually had worse baseline prolapse. This selection bias creates difficulty with interpretation. Although in this study RPVR did not change subjective outcomes, further study is necessary to control for the severity of prolapse. (C) 2018 AAGL. All rights reserved.

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TC 2

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U2 1

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PG 4

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Learning Needs of Women Who Undergo Robotic Versus Open Gynecologic

Surgery

SO JOGNN-JOURNAL OF OBSTETRIC GYNECOLOGIC AND NEONATAL NURSING

LA English

DT Article

DE clinical outcomes; gynecologic conditions; laparotomy; learning needs;

postoperative nursing care; robotic surgery

ID CANCER; PATIENT

AB Objectives: To compare the learning needs of women undergoing robotic versus open (laparotomy) gynecologic surgery for benign and cancerous conditions.

Design: Descriptive exploratory study.

Setting: A tertiary care hospital in Orlando, Florida.

Participants: Women undergoing gynecologic surgery (N = 226; n = 71 laparotomy and n = 155 robotic).

Methods: All consenting procedures and data collection occurred in two study visits. Instruments included a demographics questionnaire and the Patient Learning Needs Scale. Bivariable sociodemographic and clinical differences between surgical groups were assessed with Pearson's chi-square test. Multiple linear regression was used to assess differences in total Patient Learning Needs Scale scores and subscores between surgical groups and to evaluate the association of demographic and clinical variables with total Patient Learning Needs Scale scores within surgical groups.

Results: White and non-Hispanic women were more likely to receive robotic surgery. Women who underwent robotic surgery were more likely to ambulate and have their first oral intake on the day of surgery. Women in the robotic surgery group were also significantly more likely to have a hospital length of stay of 1 day or less (90.3% vs. 4.2%, p<.001). At discharge, participants in the robotic surgery group had significantly more learning needs overall (179.67 vs. 159.66, p<.001) and for the subscales of Medication, Activities of Daily Living, Feelings Related to Condition, Treatment/Complications, Quality of Life, and Skin Care than participants in the laparotomy group. For women in the robotic surgery group, those with a hospital length of stay longer than 1 day had significantly greater learning needs. For women in the laparotomy group, Asian women had greater learning needs than White women.

Conclusion: Participants who underwent robotic gynecologic surgery had greater learning needs than those who underwent laparotomy. Nurses and other health care providers may perceive robotic surgery as a less invasive procedure with fewer adverse effects, shorter length of stay, and faster recovery that requires fewer postoperative care instructions.

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TI Role of Intraoperative Ultrasound to Extend the Application of Minimally

Invasive Surgery for Treatment of Recurrent Gynecologic Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Cancer; Recurrence; Relapse; Ultrasound; Minimally invasive

surgery

ID OVARIAN-CANCER; SECONDARY CYTOREDUCTION; LAPAROTOMY; DEBULKING; TUMORS;

LIVER; ULTRASONOGRAPHY

AB Study Objective: To describe the potential role of intraoperative ultrasound (IOUS) in the detection and localization of recurrent disease in gynecologic cancer patients during minimally invasive surgery (MIS).

Design: A prospective cohort study (Canadian Task Force classification II-I).

Setting: A university hospital.

Patients: Fifty-one gynecologic cancer patients with isolated recurrent disease.

Interventions: IOUS during secondary cytoreductive surgery (SCS) by MIS.

Measurements and Main Results: From November 2015 to February 2017 51 gynecologic cancer patients with isolated recurrent disease and candidates for SCS were treated by MIS. Recurrent tumor was preoperatively assessed at clinical examination, transvaginal and transabdominal sonography, and radiologic evaluation in all women. Twelve of 51 women (23.5%) needed IOUS. Type of disease was ovarian in 5 women (42%). endometrial in 4 (33%), cervical in 1 (8%), vaginal cancer in 1 (8%), and uterine sarcoma in 1 (8%). Recurrence was localized deep in the pelvis in 7 cases (58%), lymph nodes in 3 (25%), and extraperitoneal in 2 cases (17%). Recurrence was dimmed in the surgical field, due to either presence of adherence), deep anatomic position, small size, and/or lack of tactile feeling. IOUS was able to identify the lesions in all women, allowing MIS (83% laparoscopy and 17% robotic) complete cytoreduction, with no conversion to laparotomy. Median operative time was 150 minutes (range, 77-280). No intraoperative/postoperative complications occurred. Histologic examination confirmed the presence of recurrence in 11 of 12 cases (92%), whereas the remaining case showed inflammatory tissue. With a median follow-up time of 15 months (range, 6-19), all patients except 2 were still alive.

Conclusions: About 1 of 4 patients (25%) with single gynecologic cancer recurrence needs IOUS to benefit from MIS for complete secondary cytoreduction. (C) 2018 AAGL. All rights reserved.

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TI Simple trachelectomy with pelvic lymphadenectomy as a viable treatment

option in pregnant patients with stage IB1 (≥2 cm) cervical cancer:

Bridging the gap to fetal viability

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID FERTILITY-SPARING SURGERY; LAPAROSCOPIC CHOLECYSTECTOMY; CONSERVATIVE

TREATMENT; RADICAL TRACHELECTOMY; NEOADJUVANT CHEMOTHERAPY; MANAGEMENT;

OUTCOMES; ADENOCARCINOMA; CONIZATION; TRIMESTER

AB Objective. Cervical cancer is the most common gynecologic cancer in pregnancy. This study aims to evaluate simple trachelectomy and pelvic lymphadenectomy in patients with stage IB1 (>= 2 cm) cervical cancer wishing to maintain their pregnancy.

Methods. We included patients with stage IB1 (>= 2 cm) cervical cancer who underwent simple trachelectomy and minimally invasive pelvic lymphadenectomy during pregnancy from January 2004 to August 2016. Data analysis included demographics, perioperative, obstetrics, and oncologic outcomes.

Results. A total of 5 patients were included. Median age was 30 years (range; 26-38). Median gestational age (GA) at diagnosis was 12 weeks (range; 7-18) and at treatment intervention 16.5 weeks (range; 12-19). Histologic subtypes included: adenocarcinoma (3 patients) and squamous cell carcinoma (2 patients). Median tumor size by clinical exam was 27 mm (range; 20-40), grade 2 (range; 2-3) and depth of invasion 10 mm (range; 1.5-12). All patients underwent laparoscopic (1) or robotic (4) pelvic lymphadenectomy followed by vaginal simple trachelectomy. Median operative time was 193 min (range; 155-259), estimated blood loss 100 ml (range; 50-550) and length of stay 2 days (range; 1-3). There were no intraoperative or postoperative complications (<30 days). Median number of lymph nodes removed was 14 (range; 5-15). One patient had bilateral microscopic positive nodes. The median gestational age at delivery was 39 weeks (range; 28-40.6). After median follow-up of 75 months (range; 18-168), all patients are alive without disease.

Conclusion. Simple trachelectomy with pelvic lymph node dissection may be a safe option in pregnant patients with stage IB1 (>2 cm) cervical cancer wishing to maintain their pregnancy. (C) 2018 Elsevier Inc. All rights reserved.

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TI Perioperative Outcomes of 3-Arm Versus 4-Arm Robotic Radical

Hysterectomy in Patients with Cervical Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Laparoscopy; Robotics

ID ASSISTED SURGERY; PELVIC LYMPHADENECTOMY; SINGLE INSTITUTION;

CLASSIFICATION; COMPLICATIONS; LAPAROSCOPY; EXPERIENCE; RESIDENCY; PORT

AB Study Objective: To investigate and compare surgical outcomes of the 3 versus 4 robotic arm approaches for robotic surgery in patients with cervical cancer.

Design: A retrospective analysis of prospectively collected data (Canadian Task Force classification II-2).

Setting: An academic tertiary hospital.

Patients: A total of 142 patients with stage 1A1 to IIB cervical carcinoma who underwent robotic surgery were included for analysis. The subjects were divided according to the surgical approach (i.e., the number of robotic arms), and the 2 groups were compared in terms of intraoperative data and postoperative outcomes.

Interventions: Robotic radical hysterectomy (RRH) with lymphadenectomy using 3 robotic arms (n = 101) versus 4 robotic arms (n = 41).

Measurements and Main Results: Perioperative surgical outcomes. The 3-arm robotic approach consisted of a camera arm, 2 robotic arms, and 1 conventional assistant port. An additional robotic arm was placed on the right side of the patient's abdomen for the 4-arm robotic approach. The mean age, body mass index, cell type, Federation Internationale de Gynecologic et d'Obstetrique stage, and type of surgery were not significantly different between the 2 cohorts. The 3-arm approach showed favorable outcomes over the 4-arm approach in terms of postoperative pain at 6 and 24 hours (3.8 +/- 1.8 vs 4.5 +/- 1.7 and 2.8 +/- 1.7 vs 3.4 +/- 1.6, respectively; p = .033 and .049) and postoperative hemoglobin difference (1.8 +/- 0.9 vs 2.6 +/- 1.3 and 1.9 +/- 1.1 vs 2.4 +/- 0.9 on days 1 and 3, respectively; p = .002 and .004). The median length of postoperative hospital stay, total operative time, docking time, lymph node yield, and intraoperative and postoperative complication rates were comparable between the 2 cohorts.

Conclusion: Surgical outcomes and complications rates of RRH for cervical cancer using the 4-arm approach were comparable with that of the 3-arm approach with decreased early postoperative pain in the 3-arm group. Cost-benefit analysis and the impact on surgical training are needed in the future. (C) 2017 AAGL. All rights reserved.

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TI Comparison of Different Surgical Approaches for Stage IB1 Cervical

Cancer Patients: A Multi-institution Study and a Review of the

Literature

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

DE Abdominal radical hysterectomy; Early-stage cervical cancer; Minimally

invasive radical hysterectomy

ID ROBOTIC RADICAL HYSTERECTOMY; ASSISTED LAPAROSCOPIC HYSTERECTOMY;

CONVENTIONAL LAPAROSCOPY; PELVIC LYMPHADENECTOMY; LAPAROTOMY; SURGERY;

SAFETY

AB Objective The aim of this retrospective study was to assess the surgical and oncological outcome of 3 different surgical approaches (laparotomy, laparoscopy, and robotic surgery) in the treatment of early-stage cervical cancer International Federation of Gynecology and Obstetrics (FIGO) stage IB1.

Methods All patients with a histologically confirmed diagnosis of early-stage cervical cancer, FIGO stage IB1, who underwent abdominal radical hysterectomy (ARH), laparoscopic radical hysterectomy, or robotic radical hysterectomy with or without pelvic and aortic lymphadenectomy were included in the study. A review of the literature was conducted.

Results Three hundred forty-one patients, between January 2001 and December 2016, were included in this study: 101 patients were submitted to ARH, 152 to laparoscopic radical hysterectomy, and 88 to robotic radical hysterectomy. In 97% and 11.5% of cases, bilateral pelvic and aortic lymph node dissections were performed, respectively. The 3 groups were similar in regard to clinical characteristics. Compared with ARH, the minimally invasive surgery group was safer in terms of estimated blood loss, transfusion rates, and hospital stay. Above all, robotic surgery was equivalent to laparoscopy in terms of intraoperative and postoperative complications, hospital stay, conversions, and reintervention. On the other hand, robotic surgery had better outcomes compared with laparoscopy in terms of transfusion rates and was equivalent to abdominal surgery and laparoscopy in regard to oncological outcomes.

Conclusions Our study confirmed that minimally invasive surgery (laparoscopy or robotics) was as adequate and effective as abdominal surgery in terms of surgical and oncological outcomes in the surgical treatment of EEC FIGO stage IB1.

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TI Health resource utilization and costs during the first 90 days following

robot-assisted hysterectomy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Hysterectomy costs; Hysterectomy route; Robot-assisted hysterectomy

ID BENIGN GYNECOLOGIC DISEASE; LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL

HYSTERECTOMY; FINANCIAL ANALYSIS; SURGERY; OUTCOMES

AB Introduction and hypothesis To compare health resource utilization, costs and readmission rates between robot-assisted and non-robot-assisted hysterectomy during the 90 days following surgery.

Methods The study used 2008-2012 Truven Health MarketScan data. All patients admitted as inpatients with a CPT code for hysterectomy between January 2008 and September 2012 were identified and the first hysterectomy-related admission in each patient was included. Patients were categorized based on the route of their hysterectomy and the use of laparoscopy as: total abdominal hysterectomy, vaginal hysterectomy (VH), laparoscopy-assisted supracervical hysterectomy, laparoscopy-assisted vaginal hysterectomy' and total laparoscopic hysterectomy (TLH). Hospitalization costs, including hospital, physician, pharmacy and facility costs, were calculated for the index admissions and for the 90-day follow-up periods. Health resource utilization was determined in terms of inpatient readmissions, outpatient visits, and emergency room visits,

Results There were 302,923 hysterectomies performed over 5 years for benign indications in the inpatient setting (55% abdominal, 17% vaginal, and 28% laparoscopic). Concurrent use of robot assistance steadily increased and was reported in 50% of TLH procedures in 2012. The rates of readmission overall were 4.9% for robot-assisted procedures and 4.3% for procedures without robot assistance (OR 0.89, CI 0.82-0.97). Readmission rates were lowest for VH (3.2%) and highest for TLH (5.6%). Following robot-assisted hysterectomy and VH, 8.3% and 4.6% of patients, respectively, had more than ten outpatient visits in the 90-day follow-up period. The average total cost for 90 days was $16,820 for robot-assisted hysterectomy and $13,031 for procedures without robot assistance. Of the additional costs for robot-assisted surgery, 25% were incurred in the 90-day follow-up period.

Conclusions The study using private insurance data found that robot-assisted hysterectomy was associated with higher health resource utilization and costs than other minimally invasive approaches. Given the high costs associated with robot-assisted hysterectomy, it is important to understand the specific indications for this approach and to identify the patients who may benefit.

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TI Prospective cohort study comparing quality of life and sexual health

outcomes between women undergoing robotic, laparoscopic and open surgery

for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Patient-reported outcomes; Quality of life; Sexual

health; Minimally invasive surgery

ID MINIMALLY IMPORTANT DIFFERENCES; INDEX FSFI; PAIN; HYSTERECTOMY;

VALIDATION; EUROQOL; UTILITY; SCALE; EQ-5D

AB Objective. To evaluate patient-reported outcomes (PROs) between women treated by laparoscopic, robotic and open approaches for endometrial cancer.

Methods. Prospective cohort study comparing PRO at baseline, short- (1 and 3 weeks) and long-term (12 and 24 weeks) follow-up postoperatively. Quality of life (QOL) measures were the Functional Assessment of Cancer Therapy (FACT-G), EuroQol Five Dimensions (EQ-5D), and Brief Pain Inventory (BPI). Sexual health measures were the Female Sexual Function Index (FSFI) and the Sexual Adjustment and Body Image Scale for Gynecologic Cancer (SABIS-G).

Results. 468 eligible patients (laparotomy = 92, laparoscopy = 152, robotic = 224) were recruited. There were no significant differences between the laparoscopy and robotic groups for any PRO (P> 0.05). At short-term follow-up, patients who underwent minimally invasive surgery (robotic or laparoscopy) had significantly higher FACT-G (P < 0.0001) and EQ-5D (P < 0.0001) scores, with less pain (P = 0.02) and improved pain interference (P = 0.0008), than patients undergoing laparotomy. At long-term follow-up, there were sustained improvements in the FACT-G (P = 0.035) and the health state EQ-5D visual analogue scale (P = 0.022). Surgical approach had no impact on sexual health (P> 0.05); however the mean FSFI score for the entire cohort met clinical cut-offs for sexual dysfunction.

Conclusion. Minimally invasive approaches result in improved QOL beyond the short-term postoperative period, with benefits noted up to 12 weeks after surgery. This prolonged QOL advantage provides further evidence that MIS should be the standard surgical approach for women with early stage endometrial cancer. (C) 2018 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

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PT J

AU Fornalik, H

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Wright, Gary

TI Can Teamwork and High-Volume Experience Overcome Challenges of

Lymphadenectomy in Morbidly Obese Patients (Body Mass Index of 40 kg/m2

or Greater) with Endometrial Cancer?: A Cohort Study of Robotics and

Laparotomy and Review of Literature

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

DE Robotic lymphadenectomy; Morbidly obese; BMI greater than 40;

Endometrial cancer; High volume

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; OPEN SURGERY; OUTCOMES; IMPACT; WOMEN;

MANAGEMENT

AB Objective This study aimed to compare surgical outcomes and the adequacy of surgical staging in morbidly obese women with a body mass index (BMI) of 40 kg/m(2) or greater who underwent robotic surgery or laparotomy for the staging of endometrioid-type endometrial cancer.

Methods This is a retrospective cohort study of patients who underwent surgical staging between May 2011 and June 2014. Patients' demographics, surgical outcomes, intraoperative and postoperative complications, and pathological outcomes were compared.

Results Seventy-six morbidly obese patients underwent robotic surgery, and 35 underwent laparotomy for surgical staging. Robotic surgery was associated with more lymph nodes collected with increasing BMI (P < 0.001) and decreased chances for postoperative respiratory failure and intensive care unit admissions (P = 0.03). Despite a desire to comprehensively stage all patients, we performed successful pelvic and paraaortic lymphadenectomy in 96% versus 89% (P = 0.2) and 75% versus 60% (P = 0.12) of robotic versus laparotomy patients, respectively. In the robotic group, with median BMI of 47 kg/m(2), no conversions to laparotomy occurred. The robotic group experienced less blood loss and a shorter length of hospital stay than the laparotomy group; however, the surgeries were longer.

Conclusions In a high-volume center, a high rate of comprehensive surgical staging can be achieved in patients with BMI of 40 kg/m(2) or greater either by laparotomy or robotic approach. In our experience, robotic surgery in morbidly obese patients is associated with better quality staging of endometrial cancer. With a comprehensive approach, a professional bedside assistant, use of a monopolar cautery hook, and our protocol of treating morbidly obese patients, robotic surgeries can be safely performed in the vast majority of patients with a BMI of 40 kg/m(2) or greater, with lymph node counts being similar to nonobese patients, and with conversions to laparotomy reduced to a minimum.

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NR 28

TC 14

Z9 14

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U2 1

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TI Dual docking robotic surgical staging for high risk endometrial cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Surgical staging; Feasibility;

Perioperative data

ID MINIMALLY INVASIVE SURGERY; PARAAORTIC LYMPHADENECTOMY; MANAGEMENT;

EXTRAPERITONEAL; COMPLICATIONS; FEASIBILITY; LAPAROSCOPY; LAPAROTOMY;

DIAGNOSIS; OUTCOMES

AB Objective: The standard of care for patients with high intermediate and high risk endometrial cancer is surgical staging including total hysterectomy with bilateral salpingo-oophorectomy, and pelvic and paraaortic lymphadenectomy. Over the past decade, laparoscopic or robot-assisted minimally invasive surgery has showed many benefits in the management of endometrial cancer. Few studies have specifically assessed the use of minimally invasive surgery for staging of high risk endometrial cancer. The objective of this study was to evaluate the feasibility, the morbidity and oncologic outcomes of dual docking robot-assisted surgical staging of high risk endometrial cancer.

Methods: We conducted a retrospective observational study from January 2014 to March 2016 in patients with high risk endometrial cancer who underwent dual docking robotic hysterectomy with pelvic and paraaortic lymphadenectomy (omentectomy). Patients' demographics, operative time, conversion rate, intra and postoperative complications, pathologic results, length of stay and survival were analyzed.

Results: Twenty patients met the inclusion criteria. Staging surgical procedure was performed robotically with a dual docking in 18 patients. Two patients were converted to laparotomy (1 for bladder extension, 1 for exposure reasons) and no patient had a laparoconversion for complication (conversion rate 10%). One patient was post operatively re-operated within 30 days because of port hernia. In one case, paraaortic lymphadenectomy was not performed because of hemorrhage risk. When the procedure was performed with robot-assisted surgery, the median number of paraaortic nodes was 19.5 (3-45). The median operative time was 240 min (180-300). Eighty-five percent (17/20) of patients were discharged at day 4 or before. The median time to start adjuvant treatments, when indicated, was 5.5 weeks. With a median follow up of 8 months (1-18 months), no tumor recurrence was reported.

Conclusion: Robotic surgical staging with dual docking in women with high risk endometrial cancer seems to be feasible with few complications. More studies are required to assess the safety of robotic surgery and its impact on survival. (C) 2018 Published by Elsevier B.V.

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PT J

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TI Robotic-Assisted Infrarenal Para-aortic Lymphadenectomy in Gynecological

Cancers: Technique and Surgical Outcomes

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial carcinoma; Infrarenal para-aortic lymphadenectomy;

Para-aortic lymphadenectomy; Robotic-assisted surgery; Transperitoneal

approach

ID ENDOMETRIAL CANCER; CARCINOMA; EXTRAPERITONEAL; COMPLICATIONS; OVARIAN

AB Objective Mini-invasive surgery has essentially replaced open laparotomy in surgery for endometrial and cervical carcinoma. Of the procedures needed for a complete staging, especially para-aortic lymphadenectomy (PALND) is challenging to perform. The present study was undertaken to investigate the technical and surgical outcomes of robotic-assisted PALND for gynecological cancers in the setting of a tertiary university hospital in Finland.

Methods This was a retrospective chart review of 283 robotic-assisted para-aortic lymphadenectomies using the single-docking transperitoneal technique performed at the Department of Obstetrics and Gynecology of Tampere University Hospital, in 2009-2016. The primary outcome measure was the extent of the operation in terms of the height, that is, how often the level cranial to the inferior mesenteric artery (IMA) was achieved. The secondary outcome measures included operation time and surgical outcome.

Results The majority of operations (n = 239 [84.4%]) were performed for endometrial carcinoma. The most common operation type was robotic-assisted hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymphadenectomy and PALND, which took a median of 3:38 hours or 218 minutes (range, 140-341 minutes) to perform. The high PALND (above the level of IMA) succeeded in 235 operations (83%). In the total cohort, the median number of para-aortic lymph nodes removed was 12 (range, 0-38), with a learning curve approximately more than 40 operations. Para-aortic lymph node metastases were found in 43 patients (15.2%). Seven conversions to laparotomy (2.5%) were done. The conversion and intraoperative complication rates were 2.5% and 3.5%, respectively, and postoperative complications was 18%, according to the classification of Clavien-Dindo. The median length of the postoperative hospital stay was 2 days (range, 1-8 days).

Conclusions Using the transperitoneal technique for PALND, the area between IMA and the renal veins can be reached in more than 80% of the operations, with a very low or 2.5% conversion rate.

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Z9 5

U1 0

U2 2

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DA 2024-01-18

ER

PT J

AU Moon, HS

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TI Tips on robotic single-site surgery suture technique Screwing and

clockwise direction suture technique for Robotic single-site surgery

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Robotic single-site; New vaginal cuff suture techniques; Screwing and

clockwise direction

ID GYNECOLOGY

AB Objectives: Using the da Vinci single-site platform, surgeons can perform more minimally invasive surgery. However, surgical challenges exist due to the limitations of single-site instrumental movements. To aid in the performance of successful robotic single-site hysterectomy, a new suturing technique using the current set of limited instruments is introduced in this study.

Material & methods: New vaginal cuff suturing techniques have been used in 55 robotic single-site hysterectomies in our institute over the past 2 years. A needle driver approach utilizing screwing and advancing the needle driver in the correct direction at an increasing angle from the transverse cuff margin with dragging and formation of an adequate loop of thread was used when suturing the vaginal cuff.

Results: Using the new vaginal suturing techniques, easy and firm vaginal cuff closure with reduced operative time relative to previous hysterectomies was achieved.

Conclusion: The new vaginal cuff suturing techniques may convince more surgeons to perform robotic single-site hysterectomies more frequently and with greater ease. (c) 2018 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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TC 4

Z9 8

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WC Obstetrics & Gynecology

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ER

PT J

AU Peng, J

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TI The Feasibility of Laparoscopic Surgery in Gynecologic Oncology for

Obese and Morbidly Obese Patients

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Gynecology; Laparoscopy; Obesity; Oncology; Operative outcomes

ID BODY-MASS-INDEX; ENDOMETRIAL CANCER; SURGICAL COMPLICATIONS;

HYSTERECTOMY; CLASSIFICATION; MANAGEMENT; OUTCOMES; IMPACT; WOMEN

AB Background Surgical interventions are the mainstay of treatment for many gynecological cancers. Although minimally invasive surgery offers many potential advantages, performing laparoscopic pelvic surgery in obese patients remains challenging. To overcome this, many centers have shifted their practice to robotic surgery; however, the high costs associated with robotic surgery are concerning and limit its use.

Objective This study aimed to examine the feasibility of performing laparoscopic gynecologic oncology procedures in obese and morbidly obese patients.

Materials and Methods This retrospective study evaluated patients who underwent laparoscopic surgeries by a gynecologic oncologist from January 2012 to June 2016 at a designated gynecologic oncology center. Patients were categorized as nonobese (body mass index [BMI] < 30 kg/m(2)), obese (BMI 30-39.9 kg/m(2)), and morbidly obese (BMI 40 kg/m(2)). Intra and postoperative complications and outcomes were recorded. Group differences were computed with Kruskal-Wallis nonparametric test (continuous) or Fisher exact test (categorical).

Results Of 497 patients, 288 were nonobese (58%), 162 obese (33%), and 47 morbidly obese (9%). Complex surgical procedures were performed in 57.4% of obese patients and 55.3% of morbidly obese patients. Although morbidly obese and obese patients had longer operative times (mean of 181 and 166 minutes vs 144 minutes, P = 0.014), conversion from laparoscopy to laparotomy occurred in 9.05% of all patients, with no group differences. Low intraoperative (9%-11%) and severe postoperative (2.41%) complication rates were observed overall, with no group differences. There was no statistically significant difference in the rate of emergency room visits 30 days postoperation between the 3 BMI groups (P = 0.6108). Average length of postoperative stay was statistically significant (P = 0.0003) but was low overall (1-2 days). Hospital readmission rates were low, with the lowest rate among morbidly obese patients (2.13%).

Conclusions Our data suggest that laparoscopic gynecologic-oncology procedures for obese patients are feasible and safe.

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TI Sexual function after robot-assisted prolapse surgery: a prospective

study

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; PISQ-12; Robot-assisted; Sacrocervicopexy;

Sacrocolpopexy; Sexual function

ID PELVIC ORGAN PROLAPSE; QUALITY-OF-LIFE; LAPAROSCOPIC SACROCOLPOPEXY;

WOMEN; FLOOR; REPAIR; VALIDATION; MANAGEMENT; OUTCOMES; SUPPORT

AB Introduction and hypothesis Female pelvic organ prolapse (POP) can severely influence sexual function. Robot-assisted surgery is increasingly used to treat POP, but studies describing its effect on sexual function are limited. The objective of this study was to evaluate sexual function after robot-assisted POP surgery.

Methods This prospective cohort study included all patients who underwent a robot-assisted sacrocolpopexy (RASC) or supracervical hysterectomy with sacrocervicopexy (RSHS). Exclusion criteria were unknown preoperative sexual activity status or concomitant surgery. In sexually active women, sexual function was measured with the translated validated version of the Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire (PISQ-12). Changes in sexual activity were scored. Prolapse stages were described using the simplified Pelvic Organ Prolapse Quantification (S-POP) system.

Results A total of 107 women were included (median follow-up 15.3 months). No difference was found in the total number of sexually active women before and after surgery [63 (58.9%) vs. 61 (63.5%), p = 0.999]. Significantly fewer women avoided sexual intercourse postoperatively compared with preoperatively. Preoperatively, sexual intercourse was avoided due to vaginal bulging (2% vs. 24%, respectively, p = 0.021). Total mean PISQ-12 scores improved significantly 1 year after prolapse correction (33.5 vs. 37.1; p = 0.004), mainly due to improved scores on the physical and behavioral-emotive domain. No significant difference in pre- and postoperative complains of dyspareunia was found.

Conclusion Robot-assisted middle-compartment surgery improved sexual function 1 year after surgery according to enhanced physical and emotional scores. The total number of sexually active women and complains of dyspareunia before and after surgery did not differ.

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TI Robotic-assisted sacrocolpopexy: early postoperative outcomes after

surgical reduction of enlarged genital hiatus

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE genital; hiatus; posterior; repair; robotics; sacrocolpopexy

ID ABDOMINAL SACROCOLPOPEXY; POSTERIOR COMPARTMENT; VAGINAL PROLAPSE; WOMEN

AB BACKGROUND: Currently, the decision to perform a concurrent posterior repair/perineoplasty at the time of robotic-assisted sacrocolpopexy is not standardized.

OBJECTIVE: We sought to compare anatomic failure after robotic-assisted sacrocolpopexy among 3 groups of patients categorized by their preoperative and postoperative genital hiatus size.

STUDY DESIGN: We performed a retrospective cohort study of women who underwent robotic-assisted sacrocolpopexy, from January 2013 through September 2016. We defined a wide genital hiatus as >= 4 cm and a normal genital hiatus as <4 cm. We compared 3 groups: (1) wide preoperative and postoperative genital hiatus (persistently wide); (2) wide preoperative and normal postoperative genital hiatus (improved); and (3) normal preoperative and postoperative genital hiatus (stably normal). Our primary outcome was composite anatomic failure defined as either recurrent prolapse in any compartment past the hymen or retreatment for prolapse with either surgery or pessary. Our data were analyzed using 1-way analysis of variance and chi(2) test. Logistic regression was performed to evaluate for independent risk factors for anatomic failure among the 3 groups. P < .05 was considered significant.

RESULTS: Our study population consisted of 452 women with a mean age of 59.3 +/- 10.0 years and a mean body mass index of 27.8 +/- 5.3 kg/m(2). Of the women with reported race, 394/447 (88.1%) were white. The genital hiatus groups were distributed as follows: 57 (12.6%) were persistently wide, 296 (65.5%) were improved, and 99 (21.9%) were stably normal. The stably normal group had less advanced preoperative prolapse (stage >= 3) than the other groups (P < .01). A similar percentage of patients among groups had a concomitant posterior repair/perineoplasty (P = .09) with a total of 84 (18.6%) women undergoing this procedure. There was a statistically significant difference in overall composite anatomic failure among the groups (P = .03). There was an increase in failure in the persistently wide group (14.0%) compared to the improved group (5.7%, P = .04) and compared to the stably normal group (4.0%, P = .03). In a logistic regression model, controlling for number of vaginal deliveries and posterior repair/perineoplasty, there was a 5.3-fold increased odds of composite anatomic failure in the persistently wide group (adjusted odds ratio, 5.3; 95% confidence interval, 1.4-19.1; P = .01) compared to the stably normal group. In a subanalysis of failure by compartment, there was an increase in failure of the posterior compartment in the persistently wide group compared to the improved group (8.8% vs 2.0%, P < .01), but not the stably normal group (3.0%, P = .12). There was not a statistically significant difference in failure of the combined apical and anterior compartments among groups (P = .29).

CONCLUSION: Surgical reduction of an enlarged preoperative genital hiatus decreases early composite anatomic failure, after robotic sacrocolpopexy, specifically related to the posterior compartment. Studies investigating the correlation of intraoperative measurement of genital hiatus to postoperative genital hiatus are needed to help clinicians determine who may benefit from a concomitant posterior repair/perineoplasty at the time of robotic-assisted sacrocolpopexy.

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Z9 31

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WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

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TI Robotic vs Open Surgery for Endometrial Cancer in Elderly Patients:

Surgical Outcome, Survival, and Cost Analysis

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Surgery; Robotic; Costs; Elderly; Minimally invasive

surgery

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; TOTAL ABDOMINAL HYSTERECTOMY;

GYNECOLOGIC-ONCOLOGY; FAST-TRACK; LAPAROTOMY; LYMPHADENECTOMY;

MANAGEMENT; WOMEN; RECURRENCE; IMPACT

AB Objective This study aimed to compare robotic and open surgery in elderly women diagnosed as having endometrial cancer, in terms of costs, survival, surgical outcome, and operating time.

Methods Women 70 years or older undergoing open and robotic surgery for endometrial cancers were included consecutively before and after the introduction of robotic surgery at a tertiary center. Costs were calculated using the case-costing system, cost per patient, including the first 30 postoperative days. Relative and overall survival outcomes were obtained from the Swedish National Cancer Registry and analyzed using the Kaplan-Meier method. Surgical outcomes including operating and anesthesia times, estimated blood loss, hospital stay, and intraoperative and postoperative complications were reviewed.

Results In all, 137 and 141 women 70 years or older were identified to have undergone open and robotic surgery, respectively. The groups showed similar body mass index, comorbidities, and tumor characteristics. No statistically significant differences were seen in costs (robotic Euro11,874 vs open Euro11,521, P = 0.463) or 5-year survival outcomes (robotic 94% [95% confidence interval {CI}, 84-105] vs open 87% [95% CI, 78-98], P = 0.529). Robotic surgery was associated with significantly lower estimated blood loss (P < 0.001) and shorter hospital stay (P < 0.001) but longer anesthesia time (186 vs 174 minutes; P < 0.05) and operating theater time (205 vs 190 minutes; P < 0.05). There were no significant differences in intraoperative complications, but robotic surgery resulted in fewer postoperative Clavien-Dindo grade II complications.

Conclusions Elderly women can safely undergo robotic surgery for endometrial cancer and could be offered this technique to the same extent as younger patients. They may benefit from shorter hospital stay, decreased blood loss, and postoperative complications, without resulting in higher costs to the health care system or jeopardizing their survival.

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ER

PT J

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TI Efficacy and safety outcomes of robotic radical hysterectomy in Chinese

older women with cervical cancer compared with laparoscopic radical

hysterectomy

SO BMC WOMENS HEALTH

LA English

DT Article

DE Cervical cancer; Chinese older women; Laparoscopic radical hysterectomy;

Robotic radical hysterectomy

ID PELVIC LYMPHADENECTOMY; GYNECOLOGIC SURGERY

AB Background: Recently, as a complex integrating a number of modern high-tech means, robotic surgery system is a well-deserved revolutionary tool in globally minimally invasive surgical field. For the first time in China, the objective of this study was to evaluate the efficacy and safety outcomes of robotic radical hysterectomy (RRH) in Chinese older women with cervical cancer compared with laparoscopic radical hysterectomy (LRH).

Methods: In this prospective, randomized and double-blinded study, 60 Chinese older women with cervical cancer were evenly divided to accept the RRH or LRH. Follow-up period lasted for 24 months.

Results: Median age for the entire cohort was 65 (range: 61-69) years. There was no difference in International Federation of Gynecology and Obstetrics (FIGO) stages and cell types between two groups (p > 0.05 for all). Uterine size, tumor size, vaginal length and numbers of left and right pelvic lymph nodes did not differ between two groups (p > 0.05 for all). No difference was observed in numbers of left and right lymph node metastasis (p > 0.05 for all). All patients had negative margins without conversion to laparotomy. There were significantly less postoperative complications in the RRH group than in the LRH group (p < 0.05). Shorter indwelling time of bladder and drain catheters was observed in the RRH group than in the LRH group (p < 0.05 for all). Length of postoperative hospital stay in the RRH group was significantly shorter compared with that in the LRH group (p < 0.05). Patients in two groups similarly experienced the recurrence and death (p > 0.05 for all).

Conclusions: This study demonstrated that RRH provided additional benefits for Chinese older women with cervical cancer because of less complications and faster recovery compared with LRH. Meanwhile, this study supported an equivalence of surgical qualities and survival outcomes of RRH to LRH. Robotics-assisted surgical method is effective, safe and feasible for Chinese older women with cervical cancer.

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U2 7

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J9 BMC WOMENS HEALTH

JI BMC Womens Health

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TI The safety and feasibility of minimally invasive sentinel lymph node

staging using indocyanine green in the management of endometrial cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrial cancer; Disease staging; Sentinel lymph node mapping;

Indocyanine green

ID INFRARED FLUORESCENCE; BIOPSY; MULTICENTER; CARCINOMA; COHORT; TRIAL

AB Objectives: The purpose of this study was to report on the feasibility of laparoscopic sentinel lymph node (SLN) staging using indocyanine green (ICG) in the management of endometrial cancer.

Study design: We retrospectively evaluated the charts of presumed, clinical stage I endometrial cancer patients who underwent robotic-assisted surgery that incorporated mapping with ICG and SLN dissection from January 2016 until February 2017. Patient demographics, operative characteristics (e.g., complications, lymph node counts) and pathology data were evaluated.

Results: There were 87 patients who were included in the study. A total of 370 lymph nodes were removed, of which 245 were SLNs; unilateral and bilateral mapping of the SLNs was achieved in 84 (96.5%) and 71 (81.6%) of subjects, respectively. There were 10 (11.5%) patients who had metastatic disease identified within 22(5.9%) of the total (n = 370) lymph nodes extracted, 19 (7.7%) of which were sentinel lymph nodes. We did not observe any intraoperative complications.

Conclusion: The results from our study suggest that minimally invasive SLN staging using ICG is a feasible procedure that is potentially effective at detecting metastases, which may ultimately attenuate the incidence of surgical morbidity. (C) 2018 Elsevier B.V. All rights reserved.

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WC Obstetrics & Gynecology; Reproductive Biology

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GA GG5UT

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TI Correlation of Virtual Reality Simulation and Dry Lab Robotic Technical

Skills

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Education; Robotics; Simulation

ID SURGICAL EDUCATION; SURGERY SIMULATOR; VALIDATION; RELIABILITY;

VALIDITY; FACE

AB Study Objective: To examine whether a set of virtual reality (VR) surgical simulation drills have correlative validity when compared with the validated Robotic Objective Structured Assessment of Technical Skills (R-OSATS) dry lab drills.

Design: A prospective methods comparison study (Canadian Task Force classification II-2).

Setting: A teaching hospital.

Participants: Thirty current residents, fellows, and faculty from the Departments of Obstetrics and Gynecology, Urology, and General Surgery.

Interventions: Participants completed 5 VR drills on the da Vinci Skills Simulator and 5 dry lab drills. Participants were randomized to the order of completion.

Measurements and Main Results: VR drills were scored automatically by the simulator. Dry lab drills were recorded, reviewed by 3 blinded experts, and scored using the R-OSATS assessment tool. Spearman correlation coefficients were calculated comparing simulator scores and R-OSATS scores for the same surgeon. The correlation for overall summary scores between VR and dry lab drills was strong (r = 0.83; p < .01). Each of the 5 VR drills was also found to have a statistically significant correlation to its corresponding dry lab drill, with correlation coefficients ranging from r = 0.49 to 0.73 (p < .01 for all). The performance on VR drills also confirmed construct validity. Faculty and fellows had consistently higher overall scores than residents (median VR scores: 458 for faculty, 425 for fellows, 339 for residents; p < .01).

Conclusion: We selected a core set of VR drills that reliably correlate with validated dry lab R-OSATS drills. Because dry lab drills require significant time and effort on the part of the trainees and the evaluators, this set of VR drills could serve as an ancillary method of determining trainee competence. (C) 2017 AAGL. All rights reserved.

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WC Obstetrics & Gynecology

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ER

PT J

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TI A prospective evaluation of the sentinel node mapping algorithm in

endometrial cancer and correlation of its performance against

endometrial cancer risk subtypes

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Sentinel node mapping; Endometrial cancer; Risk-subtypes; Indocyanine

green dye

ID INDOCYANINE GREEN; LYMPH-NODES; TRIAL; LYMPHADENECTOMY; BRACHYTHERAPY;

SURGERY

AB Objective: Sentinel node mapping is emerging as the alternative to lymphadenectomy in endometrial cancer. The objective of our study is to validate of the sentinel node mapping surgical algorithm and also to compare the performance of the algorithm against endometrial cancer risk subtypes.

Design: This is a prospective interventional study carried out at a Single University teaching hospital. All patients with apparent early stage endometrial cancer who underwent robotic assisted surgical staging were included. Intracervical injection of Indocyanine Green dye and sentinel node identification and biopsy was done for all study patients. The node positive rate when using SLN mapping alone versus SLN mapping algorithm were compared. The node positivity was compared against various risk subtypes of endometrial cancer.

Results: 69 patients were included in the study. In 95.7% patients SLN was detected with a bilateral detection rate of 87.9% 10 patients had nodal positivity, among which 7 were identified by SLN mapping alone. The algorithm captured all 10 patients with positive LNs, yielding a node positivity rate of 14.9%, sensitivity and NPV of 100%. For SLN mapping alone the sensitivity was 77.8%, false negative rate (FNR) 22.2%, and NPV 96.6%. In low- and intermediate-risk subtypes SLN mapping as well as algorithm identified all node positive patients, but in high-risk endometrial cancers the SLN mapping technique alone had a sensitivity of 57.1% and false-negative rate of 42.9% when compared with 100% sensitivity for the SLN mapping algorithm.

Conclusions: When doing SLN mapping and biopsy during endometrial cancer staging surgery it is essential that the steps mentioned in the SLN mapping algorithm are followed as SLN mapping alone seems to have a limitation in detecting positive nodes especially in high risk subtypes of endometrial cancer. Even with the lack of survival data, based on the performance of SLN mapping surgical algorithm (even if ultrastaging facility is not available), it seems to be a better technique in detecting metastatic nodes, giving prognostic information, and enabling accurate adjuvant treatment. (C) 2018 Elsevier B.V. All rights reserved.

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PT J

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TI Case of Psoas Abscess after Robotic-Assisted Laparoscopic Hysterectomy

and Pelvic Lymphadenectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Complications; Malignancy; Sentinel lymph node

ID ENDOMETRIAL CANCER

AB Iliopsoas abscess (IPA) is a rare condition seen in a variety of specialties that presents with nonspecific complaints. Presented herein is the development of an IPA after robotic staging with sentinel lymphadenectomy for endometrial carcinoma. The patient was a 61-year-old woman with history of prolonged immunosuppressive therapy due to psoriasis. She presented with an IPA 8 weeks after a robotic-assisted laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and sentinel lymph node dissection. The patient was treated and cured with empiric antibiotics and drainage by interventional radiology. Although infrequent, one must keep IPA as a possible diagnosis in immunosuppressed patients who have undergone dissection of the retroperitoneal space during gynecologic surgery. (C) 2017 AAGL. All rights reserved.

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ER

PT J

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TI Estimating potential for savings for low risk endometrial cancer using

the Endometrial Cancer Alternative Payment Model (ECAP): A companion

paper to the Society of Gynecologic Oncology Report on the Endometrial

Cancer Alternative Payment Model

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Uterine cancer; Alternative payment models; Cost

AB Objective. To design an endometrial cancer (EC) alternative payment (ECAP) model focused on surgical management of EC, as well as identify drivers of cost in order to develop opportunities for cost-savings while maintaining quality of care.

Methods. National practice patterns and reimbursements were compared between private payers (MarketScan data, years 2009-13) and public payers (Medicare, year 2014) of EC patients who underwent hysterectomy. An episode of care for EC included the hysterectomy, stratified by surgical approach (laparotomy versus robotic versus laparoscopy), and in- and outpatient reimbursements from 30 days preoperatively to 60 days postoperatively. Reimbursements were categorized into cost centers. A decision model informed modifiable components influencing overall reimbursements for EC surgical care. Variations in length of stay (LOS), emergency department (ED visits), and readmissions were analyzed to create an optimal care model.

Results. A total of MarketScan (n = 29,558) and Medicare (n = 377) patients were included. Mean total reimbursement for an episode of care was $19,183 (SD $10,844) for Medicare and $30,839 (SD $19,911) for MarketScan. Mean reimbursements were greatest for abdominal cases in Medicare ($25,553; SD $11,870) and MarketScan ($35,357; SD $21,670), followed by robotic and laparoscopic. Among MarketScan patients, 7.6% of women were readmitted within 60 days after surgery and 11.7% had an evaluation in the ED. The median reimbursement per patient for readmission was $14,474 (IQR $8584 to $26,149), and for ED visit was $6327 (IQR $1369 to $29,153). In an optimized care model, increasing the rate of minimally invasive surgery by 5% while reducing LOS by 10% and ED visits/readmissions by 10%, lowered the average case reimbursement by $903 (2.9%) for MarketScan and $1243 (5.9%) for Medicare.

Conclusion. An ECAP model demonstrates that reimbursements vary by public versus commercial payers in the U.S. for the surgical management of endometrial cancer patients, and that opportunities for cost savings exist. Nominal increases in the rate of minimally invasive surgery and reduction in the rate of ED visits/readmissions and length of stay can result in substantial savings for endometrial cancer care. (C) 2018 Elsevier Inc. All rights reserved.

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U2 5

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TI Laparoscopy decreases the disparity in postoperative complications

between black and white women after hysterectomy for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Hysterectomy; Laparoscopy; Racial disparity

ID UTERINE LEIOMYOMA; RACIAL DISPARITY; SURVIVAL; SURGERY

AB Objectives. Black race has been associated with increased 30-day morbidity and mortality following surgery for endometrial cancer. Black women are also less likely to undergo laparoscopy when compared to white women. With the development of improved laparoscopic techniques and equipment, including the robotic platform, we sought to evaluate whether there has been a change in surgical approach for black women, and in turn, improvement in perioperative outcomes.

Methods. Using the American College of Surgeons' National Surgical Quality Improvement Project's database, patients who underwent hysterectomy for endometrial cancer from 2010 to 2015 were identified. Comparative analyses stratified by race and hysterectomy approach were performed to assess the relationship between race and perioperative outcomes.

Results. A total of 17,692 patients were identified: of these, 13,720 (77.5%) were white and 1553 (8.8%) were black. Black women were less likely to undergo laparoscopic hysterectomy compared to white women (493% vs 71.3%, p <0.0001). Rates of laparoscopy in both races increased over the 6-year period; however these consistently remained lower in black women each year. Black women had higher 30-day postoperative complication rates compared to white women (22.5% vs 13.6%, p < 0.0001). When laparoscopic hysterectomies were isolated, there was no difference in postoperative complication rates between black and white women (9.2% vs 7.5%, p = 0.1).

Conclusions. Overall black women incur more postoperative complications compared to white women undergoing hysterectomy for endometrial cancer. However, laparoscopy may mitigate this disparity. Efforts should be made to maximize the utilization of minimally invasive surgery for the surgical management of endometrial cancer. (C) 2017 Elsevier Inc All rights reserved.

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ER

PT J

AU Linder, BJ

Frank, I

Occhino, JA

AF Linder, Brian J.

Frank, Igor

Occhino, John A.

TI Extravesical robotic ureteral reimplantation for ureterovaginal fistula

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Fistula; Robot; Ureteroneocystostomy; Ureter; Urinary incontinence;

Iatrogenic injury

ID EXPERIENCE; SURGERY

AB We present a video describing the technical considerations for performing an extravesical robotic ureteral reimplantation.

A 55-year old woman presented with urinary incontinence secondary to a ureterovaginal fistula after robotic-assisted hysterectomy. After failure of more conservative measures, she proceeded to a robotic ureteral reimplantation. Following port placement, the ureter is identified at the level of the iliac vessels and dissected circumferentially. The ureter is dissected free to the level of the ureterovaginal fistula, transected, and the distal remnant ligated. The ureter is spatulated, a cystotomy created, and a running anastomosis with mucosa-to-mucosa apposition performed over a stent. Care is taken to ensure it is tension free. The integrity of the anastomosis is tested with retrograde filling of the bladder. Postoperatively, a drainage catheter is left to allow for adequate healing. Follow-up imaging is performed to ensure a patent anastomosis.

The patient had an uncomplicated postoperative course. A cystogram showed adequate healing at 10 days, and the stent was removed at 6 weeks. A follow-up renal ultrasound 6 weeks later showed no hydronephrosis.

Extravesical robotic ureteral reimplantation is a useful technique for managing ureterovaginal fistula; here we highlight pertinent technical considerations.

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ER

PT J

AU Takmaz, O

Asoglu, MR

Gungor, M

AF Takmaz, Ozguc

Asoglu, Mehmet Resit

Gungor, Mete

TI Patient positioning for robot-assisted laparoscopic benign gynecologic

surgery: A review

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Patient positioning; Robotic surgery; Trendelenburg; Complications

ID PERIPHERAL-NERVE INJURIES; TRENDELENBURG POSITION; RADICAL

PROSTATECTOMY; INTRAOCULAR-PRESSURE; UTERINE MANIPULATORS; LITHOTOMY

POSITIONS; SHOULDER RESTRAINTS; HOHL INSTRUMENT; ARM ABDUCTION;

HYSTERECTOMY

AB Robotic surgical platforms are now in widespread use in the practice of gynecology all over the world. The introduction of robotic surgery has required some modifications of patient positioning when compared to standard laparoscopic surgery. Optimal patient positioning is likely to be the most essential step of robotic surgery as it provides the technical feasibility to have adequate access to the pelvic structures for performing the surgery. It is prudent to pay attention to preventing patient shifting in Trendelenburg position because of tendency of sliding down toward the direction of the head. Inappropriate patient positioning is associated with inadequate exposure of the operative field as well as detrimental complications that may lead to long-term side effects. These issues can be reduced with use of proper or strategic positioning technique. The purpose of this review is to highlight important points to properly position patient for robot-assisted laparoscopic benign gynecologic surgery and protect patient from position-related injuries. (C) 2018 Elsevier B.V. All rights reserved.

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ER

PT J

AU Ballester, M

Roman, H

AF Ballester, M.

Roman, H.

TI Surgical management of deep endometriosis with colorectal involvement:

CNGOF-HAS Endometriosis Guidelines

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Article

DE Endometriosis; Colorectal; Complications; Surgical route; Pain; Quality

of life; Recurrence; Fertility

ID QUALITY-OF-LIFE; LAPAROSCOPIC RECTAL RESECTION; RANDOMIZED

CONTROLLED-TRIAL; INFILTRATING ENDOMETRIOSIS; BOWEL RESECTION;

PROSPECTIVE COHORT; ADHESION BARRIER; SURGERY; FERTILITY; COMPLICATIONS

AB Deep endometriosis with colorectal involvement is considered one of the most severe forms of the disease due to its impact on patients' quality of life and fertility but also by the difficulties encountered by the clinicians when proposing a therapeutic strategy. Although the literature is very rich, evidence based medicine remains poor explaining the great heterogeneity concerning the management of such patients. Surgery therefore remains a therapeutic option. It improves the intensity of gynecological, digestive and general symptoms and the quality of life. Concerning the surgical approach, it appears that laparoscopy should be the first option; the laparoscopic robot-assisted route can also be proposed. The techniques of rectal shaving, discoid resection and segmental resection are the three techniques used for surgical excision of colorectal endometriosis. The parameters taken into account for the use of either technique are: the surgeon's experience, the depth of infiltration of the lesion within the rectosigmoid wall, the lesion size and circumference, multifocality and the distance of the lesion from the anal margin. In the case of deep endometriosis with colorectal involvement, performing an incomplete surgery increases the rate of pain recurrence and decreases postoperative fertility. In case of surgery for colorectal endometriosis, pregnancy rates are similar to those obtained after ART in non operated patients. Existing data are insufficient to formally recommend first line surgery or ART in infertile patients with colorectal endometriosis. The surgery for colorectal endometriosis exposes to a risk of postoperative complications and recurrence of which the patients should be informed preoperatively. (C) 2018 Published by Elsevier Masson SAS.

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PT J

AU Bergstrom, J

Aloisi, A

Armbruster, S

Yen, TT

Casarin, J

Leitao, MM

Tanner, EJ

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Wethington, SL

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Machado, Karime Kalil

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Soliman, Pamela T.

Wethington, Stephanie L.

Stone, Rebecca L.

Levinson, Kimberly L.

Fader, Amanda N.

TI Minimally invasive hysterectomy surgery rates for endometrial cancer

performed at National Comprehensive Cancer Network (NCCN) Centers

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID EPITHELIAL OVARIAN-CANCER; ABDOMINAL HYSTERECTOMY; RACIAL DISPARITIES;

UTERINE-CANCER; UNITED-STATES; EARLY-STAGE; SURVIVAL; CARE; QUALITY;

WOMEN

AB Objectives. Minimally invasive surgery (MIS) is a quality measure for endometrial cancer (EC) established by the Society of Gynecologic Oncology and the American College of Surgeons. Our study objective was to assess the proportion of EC cases performed by MIS at National Comprehensive Cancer Network (NCCN) centers and evaluate perioperative outcomes.

Methods. A retrospective cohort study of women who underwent surgical treatment for EC from 2013 to 2014 was conducted at four NCCN centers. Multivariable mixed logistic regression models analyzed factors associated with failure to perform MIS and perioperative complications.

Results. In total 1621 patients were evaluated; 86.5% underwent MIS (robotic-assisted 72.5%, laparoscopic 20.9%, vaginal 6.6%). On multivariable analysis, factors associated with failure to undergo MIS were uterine size >12 cm (Odds Ratio PR]: 0.17, 95% CI 0.03-0.9), stage III (OR: 0.16, 95% CI 0.05-0.49) and IV disease (OR: 0.07, 95% CI 0.02-0.22). For stage I/II disease, complications occurred in 5.1% of MIS and 21.7% of laparotomy cases (p < 0.01). Laparotomy was associated with increases in any complication (OR: 6.0, 95% CI 3.3-10.8), gastrointestinal (OR: 7.2,95% CI 2.6-19.5), wound (OR: 3.7, 95% CI 1.5-9.2), respiratory (OR 37.5, 95% CI 3.9-358.0), VTE (OR 10.5, 95% CI 1.3-82.8) and 30-day readmission (OR: 2.6, 95% CI 1.4-4.9) compared to MIS.

Conclusions. At NCCN-designated centers, the MIS hysterectomy rate in EC is higher than the published national average, with low perioperative complications. Previously identified disparities of age, race, and BMI were not observed. A proposed MIS hysterectomy benchmark of >80% in EC care is feasible when performed at high volume centers. (C) 2018 Elsevier Inc. All rights reserved.

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PT J

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Lindkvist, H

Stjerndahl, JH

Ankardal, M

AF Billfeldt, Nina K.

Borgfeldt, Christer

Lindkvist, Hakan

Stjerndahl, Jan-Henrik

Ankardal, Maud

TI A Swedish population-based evaluation of benign hysterectomy, comparing

minimally invasive and abdominal surgery

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Hysterectomy; Surgical route; Minimally invasive approach; Robotic;

Laparoscopy

ID ROBOTICALLY ASSISTED HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY;

GYNECOLOGIC DISEASE; LARGE UTERI; OUTCOMES; LIFE

AB Objective: The aim was to evaluate surgical routes for benign hysterectomy in a Swedish population, including abdominal and minimally invasive surgery.

Study design: Prospectively collected data from the Swedish National GynOp Registry 2009-2015: 13 806 hysterectomy cases were included: abdominal (AH, n = 7485), vaginal (VH, n = 3767), conventional laparoscopic (LH, n = 1539) and robotically-assisted (RAH, n = 1015).

Results: The VH group had the shortest operation time at 75 min, AH 97 min and RAH 104 min. LH was longest at 127 min (p < 0.005). The mean estimated blood loss was higher in the AH group (250 ml) compared to all minimally invasive surgery (MIS, 65-172 ml): p < 0.005).

Conversion rates were 10% for LH, 4.8% for VH and 1.6% for RAH (p < 0.005). Hospitalization and patient reported time to normal activities of daily living (ADL) were longer for AH compared to MIS (p < 0.005). Time to return to work was eight days longer in the AN group (35 days) compared with the MIS groups (p < 0.005).

Complications were fewest in the VH group at 5.4% compared with AH 7.6% and RAH 8.7% (both p < 0.001), but did not significantly differ from the LH group at 6.6%. Overall patient satisfaction was reported to be 86-94% one year after surgery.

Conclusion: Women operated on for benign hysterectomy with minimally invasive methods in Sweden 2009-2015 had reduced length of hospitalization, as well as time to resuming normal ADL and return to work, compared to AH. Postoperative outcome measures were improved by minimally invasive methods and MIS should preferably be used. (C) 2018 Elsevier B.V. All rights reserved.

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ER

PT J

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Paparel, P

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TI Urinary tract involvement by endometriosis. Techniques and outcomes of

surgical management: CNGOF-HAS Endometriosis Guidelines

SO GYNECOLOGIE OBSTETRIQUE FERTILITE & SENOLOGIE

LA French

DT Article

DE Urinary endometriosis; Partial cystectomy; Ureterolysis; Ureteral

resection; Kidney loss; Ureterohydronephrosis; Urinary stent

ID DEEP-INFILTRATING ENDOMETRIOSIS; LAPAROSCOPIC PARTIAL CYSTECTOMY;

TERM-FOLLOW-UP; ROBOTIC-ASSISTED LAPAROSCOPY; ACUTE-RENAL-FAILURE;

BLADDER ENDOMETRIOSIS; URETERAL ENDOMETRIOSIS; AROMATASE INHIBITORS;

RESECTION; SURGERY

AB Urinary tract involvement by endometriosis is reported in 1% of endometriosis patients (NP3). Consequences range from pelvic pain for bladder localizations to silent kidney loss in case of chronic ureteral obstruction (NP3). The feasibility of laparoscopic management was widely proven (NP3) and may reduce hospital stay length (NP4). Radical surgery with partial cystectomy for bladder localizations was shown to significantly and durably reduce pain symptoms with low risk of a severe postoperative complications (NP3). Medical hormonal treatment also shows short-term reduction of pain symptoms (NP4). Transureteral resection of bladder endometriosis nodule is not recommended (grade C) because of a high postoperative recurrence rate (NP4). Given a high risk of silent kidney loss, it is recommended that patients with ureteral involvement by-endometriosis are managed by a multidisciplinary team considering urinary and potential extra-urinary localizations of endometriosis (grade C). No recommendation can be made on which technique to prefer between conservative (ureterolysis) or radical surgical techniques or on benefit and length of ureteral stents in case of ureteral involvement. Surgical management of bladder and ureteral localizations of endometriosis do not seem to be associated with altered or improved postoperative fertility (NP4). Since late postoperative ureteral anastomosis stenosis were reported with silent kidney loss, repeated postoperative imaging monitoring is justified (expert opinion). (C) 2018 Elsevier Masson SAS. All rights reserved.

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PT J

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TI Robotic Placement of the FENIX Continence Restoration System in a

Patient with Previous Radiation to the Pelvis: A Case Report

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Anal canal; Anal canal carcinoma; Case report; Fecal incontinence;

Pelvic radiation

ID ANAL-SPHINCTER AUGMENTATION; QUALITY-OF-LIFE; FECAL INCONTINENCE; WOMEN

AB Fecal incontinence (FI) is a disabling problem affecting women. Conservative treatment includes dietary modification, antimotility agents, and pelvic floor physical therapy. If conservative medical management is unsuccessful, surgical intervention may be required. Surgical options include rectal sphincteroplasty, bulking agent injection, radiofrequency anal sphincter remodeling, and sacral nerve stimulation therapy. Recently, a new therapy for FI, the FENIX Continence Restoration System (Torax Medical, Inc., Shoreview, MN), has become available. The FENIX device is placed through a perineal incision; however, pelvic radiation and previous anal carcinoma are both contraindications. We report the case of a 62-year-old woman with FI after anal carcinoma. Treatment included surgery, chemotherapy, and pelvic radiation. Initially, she was treated with conservative therapy and sacral nerve stimulation, which were only partially effective. A physical examination showed perineal skin changes consistent with previous radiation, which increased the patient's risk of infection and a nonhealing wound. Therefore, a robotic approach was used to place the FENIX device and improve the patient's quality of life. Our case sets a precedent for expanding the treatment options of FI in patients with previous pelvic radiation and using a robotic approach for the placement of the FENIX device. (C) 2017 AAGL. All rights reserved.

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PT J

AU Geppert, B

Lönnerfors, C

Bollino, M

Persson, J

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Lonnerfors, Celine

Bollino, Michele

Persson, Jan

TI Sentinel lymph node biopsy in endometrial cancer-Feasibility, safety and

lymphatic complications

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Lymphatic metastases; Lymphadenectomy; Lymphatic

system; Sentinel lymph node biopsy; Indocyanine green; Lymphedema;

Lymphocele; Chylous ascites

ID LOWER-EXTREMITY LYMPHEDEMA; GYNECOLOGIC MALIGNANCIES; SURGICAL

ALGORITHM; CERVICAL-CANCER; UTERINE-CANCER; RISK-FACTORS;

LYMPHADENECTOMY; ADENOCARCINOMA; PREVALENCE; MANAGEMENT

AB Objective. To compare the rate of lymphatic complications in women with endometrial cancer undergoing sentinel lymph node biopsy versus a full pelvic and infrarenal paraaortic lymphadenectomy, and to examine the overall feasibility and safety of the former.

Methods. A prospective study of 188 patients with endometrial cancer planned for robotic surgery. Indocyanine green was used to identify the sentinel lymph nodes. In low-risk patients the lymphadenectomy was restricted to removal of sentinel lymph nodes whereas in high-risk patients also a full lymphadenectomy was performed. The impact of the extent of the lymphadenectomy on the rate of complications was evaluated.

Results. The bilateral detection rate of sentinel lymph nodes was 96% after cervical tracer injection. No intraoperative complication was associated with the sentinel lymph node biopsy per se. Compared with hysterectomy alone, the additional average operative time for removal of sentinel lymph nodes was 33 min whereas 91 min were saved compared with a full pelvic and paraaortic lymphadenectomy. Sentinel lymph node biopsy alone resulted in a lower incidence of leg lymphedema than infrarenal paraaortic and pelvic lymphadenectomy (1.3% vs 18.1%, p = 0.0003).

Conclusion. The high feasibility, the absence of intraoperative complications and the low risk of lymphatic complications supports implementing detection of sentinel lymph nodes in low-risk endometrial cancer patients. Given that available preliminary data on sensitivity and false negative rates in high-risk patients are confirmed in further studies, we also believe that the reduction in lymphatic complications and operative time strongly motivates the sentinel lymph node concept in high-risk endometrial cancer. (C) 2017 Published by Elsevier Inc.

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PT J

AU Geynisman-Tan, J

Brown, O

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Kenton, K

AF Geynisman-Tan, Julia

Brown, Oluwateniola

Mueller, Margaret

Bochenska, Katarzyna

Collins, Sarah

Lewicky-Gaupp, Christina

Kenton, Kimberly

TI Operating Room Efficiency: Examining the Impact of Personnel Handoffs

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT 38th Annual Scientific Meeting of the American-Urogynecologic-Society

(AUGS) / PFD Week

CY OCT 02-07, 2017

CL Providence, RI

SP Amer Urogynecol Soc

DE prolapse; minimally invasive surgery; patient safety; operating room

utilization; medical education

ID TIME

AB Objectives: This study aimed to determine if personnel handoffs or number of learners in the operating room (OR) are associated with longer OR times in women having pelvic organ prolapse surgery.

Methods: A retrospective review of women undergoing prolapse surgery in 2016 was conducted. Demographics; procedure; OR, anesthetic, and surgical time; number of handoffs between anesthesia members, circulators, and surgical technologies; and number of learners were abstracted.

Results: One hundred forty-eight women underwent pelvic organ prolapse surgery. Mean age was 54 +/- 14 years, and most women were healthy and white. Procedures performed were as follows: 31% laparoscopic sacrocolpoexies (LASCs), 28% robotic sacrocolpopexies (RASCs), 19% colpocleises, and 22% native tissue reconstructions. For minimally invasive sacrocolpopexies (LASC + RASC), mean OR time was 270 +/- 65 minutes. Median anesthesia, surgical technology, and circulator handoffs for sacrocolpopexies were 2 (interquartile range, 0-4), 1 (0-3), and 2 (2-6). Median number of learners in the OR for sacrocolpopexies was 4 (interquartile range, 1-7). Patient comorbidities and American Society of Anesthesiologists class were not associated with longer OR times (P = 0.9 and P = 0.4). Longer OR times were positively correlated with increasing numbers of anesthesia, surgical technology, and circulator handoffs, but not with the number of learners (Spearman = 0.34, P = 0.001; = 0.34, P < 0.001; = 0.59, P < 0.001, and = 0.16, P = 0.43). For LASC, every technology handoff was associated with 23 additional minutes of OR time (P = 0.004). For RASC, every technology handoff was associated with 31 additional minutes of OR time (P = 0.007), and each circulator handoff was associated with 15 additional minutes (P = 0.05).

Conclusion: Handoffs between OR personnel are associated with longer OR times, independent of patient factors.

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U2 2

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JI Female Pelvic Med. Reconstr. Surg.

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PT J

AU Hagemann, AR

McCourt, CK

Varaday, SS

Moore, KN

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Moore, Kathleen N.

TI Defining,and mitigating the challenges of an older and obese population

in minimally invasive gynecologic cancer surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Minimally-invasive surgery; Obesity; Aging population; Endometrial

cancer

ID MECHANICAL BOWEL PREPARATION; VALVELESS TROCAR SYSTEM; ENDOMETRIAL

CANCER; INTRAOCULAR-PRESSURE; STEEP TRENDELENBURG; BARIATRIC SURGERY;

ROBOTIC HYSTERECTOMY; LAPAROSCOPIC SURGERY; ENHANCED RECOVERY;

PERIOPERATIVE OUTCOMES

AB The incidence of endometrial cancer (EC) is steadily increasing due in large part to an aging world population and rise in rates of obesity. Patients with obesity and advancing age can be seen as vulnerable populations, as they are both often subject to physician bias regarding surgical choices and assumptions regarding long-term outcomes. As we operate on an older and/or obese patient population, it is increasingly important that we adopt peri-operative management strategies and surgical techniques to best serve this complex patient population. Careful orchestration pre-, intra- and postoperatively is key to successful outcomes in robotic and laparoscopic surgery. Here, we review existing literature regarding EC in women with older age and/or obesity, outline recommendations for peri-operative management and common intra-operative issues specifically common anesthetic issues surrounding cardiovascular, respiratory and neuromuscular systems that are of heightened importance in women with older age and/or obesity. The goal of this review is to help define and mitigate common complications for these vulnerable patients with an EC diagnosis who, in accordance with carefully assessed health risks, can and should be offered standard of care surgery and treatment. (C) 2017 Elsevier Inc. All rights reserved.

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PT J

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Cohen, SL

Meurs, EAIM

Cox, M

Vitonis, A

Jansen, FW

Einarsson, JI

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Cohen, Sarah L.

Meurs, Elsemieke A. I. M.

Cox, Mary

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Einarsson, Jon I.

TI Trends in readmission rate by route of hysterectomy - a single-center

experience

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Hysterectomy; laparoscopy; readmission; retrospective analysis; risk

factors

ID LAPAROSCOPIC HYSTERECTOMY; SURGICAL COMPLICATIONS; HOSPITAL READMISSION

AB IntroductionThe aim of this study was to assess the 60-day readmission rates after hysterectomy according to route of surgery and analyze risk factors for postoperative readmission.

Material and methodsThis retrospective study included all women who underwent hysterectomy due to benign conditions from 2009 to 2015 at a large academic center in Boston. Readmission rates were compared among the following four types of hysterectomies: abdominal, laparoscopic, robotic and vaginal.

ResultsThere were 3981 hysterectomy cases over the study period (628 abdominal hysterectomy, 2500 laparoscopic hysterectomy, 155 robotic hysterectomy and 698 vaginal hysterectomy). Intraoperative complications occurred more frequently in women undergoing abdominal hysterectomy (4.8%), followed by robotic hysterectomy (3.9%), vaginal hysterectomy (1.9%) and laparoscopic hysterectomy (1.6%) (p<0.0001). Readmission rates were not significantly different among the groups; women receiving abdominal hysterectomy had an overall readmission rate of 3.5%, compared with 3.2% after robotic hysterectomy, 2.9% after vaginal hysterectomy and 1.9% after laparoscopic hysterectomy (p=0.06). When stratifying for relevant variables, women who had an laparoscopic hysterectomy had a twofold reduction of readmission compared with abdominal hysterectomy (odds ratio 0.52, 95% confidence interval 0.31-0.87; p=0.01). There was no significant difference in readmission when robotic hysterectomy or vaginal hysterectomy were compared individually with abdominal hysterectomy. Regarding risk factors related to readmission it was observed that perioperative complications were the largest driver of readmissions (odds ratio 667, 95% confidence interval 158-99; p<0.0001).

ConclusionThe laparoscopic approach to hysterectomy was associated with fewer hospital readmissions compared with the abdominal route; vaginal, robotic and abdominal approaches had a similar risk of readmission. Perioperative complications represent the main driver of readmissions. After adjusting for perioperative factors such as surgeon type and complications, no difference in readmissions between the different routes of hysterectomy were found.

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AU Lee, HJ

Lee, YH

Chong, GO

Hong, DG

Lee, YS

AF Lee, Hyun Jung

Lee, Yoon Hee

Chong, Gun Oh

Hong, Dae Gy

Lee, Yoon Soon

TI Comparison of robotic-assisted versus laparoscopy for transperitoneal

infrarenal para-aortic lymphadenectomy in patients with endometrial

cancer

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE endometrial cancer; robotic surgery; transperitoneal infrarenal

para-aortic lymphadenectomy

ID PERIOPERATIVE OUTCOMES; GYNECOLOGIC ONCOLOGY; LEARNING-CURVE;

HYSTERECTOMY; LAPAROTOMY; EXPERIENCE; PARADIGM; SURGERY; COST

AB AimThis study was conducted to evaluate the clinical feasibility of robotic-assisted transperitoneal infrarenal para-aortic lymphadenectomy (TIPAL) in patients with endometrial cancer.

MethodsFrom June 2006 to October 2016, we retrospectively analyzed 42 patients who underwent laparoscopic (n=16) or robotic-assisted (n=26) staging operations, including TIPAL for endometrial cancer. Perioperative data including age; body mass index; operation duration; the number of lymph nodes retrieved and the ratio of time to lymph node retrieval during pelvic, infrarenal para-aortic and total lymphadenectomy; estimated blood loss and postoperative complications were compared.

ResultsThe operative duration of pelvic (21.75.31 vs 30.7 +/- 10.8min; P=0.002), and total (62.6 +/- 14.0 vs 87.0 +/- 30.4min; P=0.010) lymphadenectomy was significantly shorter in the robotic-assisted than the laparoscopic group, whereas there was no statistical difference in the duration of infrarenal para-aortic lymphadenectomy. By contrast, the number of infrarenal para-aortic lymph nodes retreived was significantly higher (29.4 +/- 10.7 vs 23.3 +/- 9.16; P=0.016) in the robotic-assisted group. Consequently, the ratio of time to number of lymph nodes retrieved during infrarenal (1.51 +/- 0.49 vs 2.62 +/- 1.34; P=0.002) and total (1.43 +/- 0.48 vs 2.15 +/- 0.93; P=0.014) lymphadenectomy was lower in the robotic-assisted compared to the laparoscopic group.

ConclusionsThe robotic-assisted approach took less time per infrarenal para-aortic and total lymph nodes retrieved compared to the conventional laparoscopic approach. Robotic-assisted TIPAL could be feasible and effective for the staging and treatment of patients with endometrial cancer.

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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ER

PT J

AU Yao, SE

Manolitsas, T

AF Yao, Shih-Ern

Manolitsas, Tom

TI A Novel Method to Facilitate Uterine Delivery at Robotic Hysterectomy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic Surgery; Hysterectomy; Fibroids; Uterine Cancer; Morcellation

AB Minimally invasive platforms have afforded women undergoing hysterectomy the advantages of improved postoperative pain control, reduced complication rates, and shorter inpatient recovery time. In patients where malignancy has been confirmed or suspected, the necessity for uterine delivery per vagina is imperative to maintain these advantages without compromising oncological outcome. A previously unreported technique of enlarging the apical circumference of the vagina during robotic hysterectomy facilitates intact uterine passage after extended reflection of the bladder and/or rectum. Significant increases in vault circumference can be gained through even small midline incisions of the vaginal wall, with an additional 5-cm incision almost doubling the apical aperture in certain cases. We present our series of 21 cases that support this safe, reliable, and simple method for intact uterine delivery during robotic hysterectomy in minimally invasive gynecological oncology practice.

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J9 INT J GYNECOL CANCER

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PT J

AU Chong, GO

Lee, YH

Lee, HJ

Hong, DG

Lee, YS

AF Chong, Gun Oh

Lee, Yoon Hee

Lee, Hyun Jung

Hong, Dae Gy

Lee, Yoon Soon

TI Comparison of the Long-Term Oncological Outcomes Between the Initial

Learning Period of Robotic and the Experienced Period of Laparoscopic

Radical Hysterectomy for Early-Stage Cervical Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical cancer; Laparoscopic radical hysterectomy; Long-term

oncological outcomes; Robotic radical hysterectomy

ID SURGERY; CURVE; LYMPHADENECTOMY; CARCINOMA

AB Objectives: To compare the long-termoncological outcomes, complication rates, and recurrence patterns of robotic radical hysterectomy (RRH) with laparoscopic radical hysterectomy (LRH) for the treatment of early-stage cervical cancer.

Methods: Between January 2008 and December 2013, 65 consecutive patients underwent RRH during the learning period, and 60 consecutive patients underwent LRH during the experienced period.

Results: Both groups were similar with respect to clinicopathologic characteristics. The mean operative time in the RRH group was significantly longer than that in the LRH group (277.8 +/- 57.3 vs 199.6 +/- 45.0 minutes; P < 0.0001). Postoperative complication rates were significantly higher in the RRH group than in the LRH group (47.7% vs 27.1%; P = 0.0188). No difference in the estimated disease-free survival rates was observed between the 2 groups (P = 0.3152); however, the estimated overall survival of RRH was lower than that of LRH with marginal significance (P = 0.0762). There was no significant difference in terms of recurrence pattern between the 2 groups (P = 0.7041). However, peritoneal recurrences occurred only in the RRH group.

Conclusions: Despite RRH being performed by an experienced laparoscopic oncologist, RRH showed inferior long-term oncological outcomes and postoperative complication rates compared with those of LRH during the learning period.

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PT J

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AF Gingold, Julian A.

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TI Minimally Invasive Approaches to Myoma Management

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopic myomectomy; Laparoscopy; Minimally invasive myomectomy;

Myoma; Robotic-assisted myomectomy; Robotic surgery; Surgical technique

ID GUIDED FOCUSED ULTRASOUND; ASSISTED LAPAROSCOPIC MYOMECTOMY; VOLUMETRIC

THERMAL ABLATION; REDUCING BLOOD-LOSS; UTERINE FIBROID EMBOLIZATION;

ABDOMINAL MYOMECTOMY; ADHESION FORMATION; RANDOMIZED-TRIAL; BARBED

SUTURE; MINILAPAROTOMY MYOMECTOMY

AB Patients affected by the presence of leiomyomas may incur a substantial physical, emotional, social, and financial toll as well as losses in their quality of life. Although many myomas are not amenable to medical therapy or hysteroscopic resection, many others are amenable to minimally invasive surgical approaches. In patients who prefer to retain their fertility, laparoscopic myomectomy should be considered the intervention of choice. In this review, we expand on the surgical techniques of both conventional laparoscopic and robotic-assisted myomectomies. We discuss port placement, enucleation of myomas, tissue extraction, minimization of blood loss, adhesion prevention, and the technique for closure of uterine incisions. Finally, we discuss the available data supporting the use of these 2 approaches as the preferred, safe, and effective fertility-sparing surgical option. We also briefly discuss the emerging technologies of uterine artery embolization, ultrasound surgery, and radiofrequency ablation. (C) 2017 AAGL. All rights reserved.

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PT J

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Verheijen, R

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Lecuru, Fabrice

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Ponce, Jordi

Degueldre, Michel

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TI The Society of European Robotic Gynaecological Surgery (SERGS) Pilot

Curriculum for robot assisted gynecological surgery

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Educational program; Robotic; Fellowship; Training

ID GLOBAL EVALUATIVE ASSESSMENT; MINIMALLY INVASIVE SURGERY; TRAINING

METHODS; SKILLS; VALIDATION; VALIDITY; ASSOCIATION; SIMULATOR; SYSTEM

AB To set forth experiences in the context of the SERGS Pilot Curriculum-the first standardized educational program for robotic use in gynecological surgery-in terms of feasibility, effectiveness and potential for certification.

The Society of European Robotic Gynecological Surgery (SERGS) outlined a Pilot Curriculum for standardized education in robot-assisted laparoscopic gynecological surgery. Its feasibility and acceptance were checked in the form of a fellowship pilot program conducted at four European Centers of Excellence for robot-assisted surgery. Results and conclusions derived from this pilot program are presented.

The SERGS Pilot Curriculum defines criteria for a standardized training and assessment of performance, boosts the learning curve of the candidate and increases contentment at work. Regarding face validity, it proves valuable as finally all candidates could perform the outlined procedure safely and efficiently without supervision.

Due to the immense increase of robotic procedures in gynecology standardized training curricula are indispensable. This seems highly necessary to ensure patients' safety and surgical outcome. The SERGS Pilot Curriculum sets standards for a stepwise theoretical and practical training in gynecological robotic procedures. It seems feasible as instrument for accreditation as gynecologic robotic surgeon. Though as a general applicable guideline for systematic training in robot-assisted surgery, a definite curriculum should have a more definite timeline and implementation of a structured assessment of performance.

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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PT J

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Chen, Chi-Huang

Yeh, Shauh-Der

Lin, Yun-Ho

Tzeng, Chii-Ruey

TI Pregnancy following robot-assisted laparoscopic partial cystectomy and

gonadotropin-releasing hormone agonist treatment within three months in

an infertile woman with bladder endometriosis

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Bladder endometriosis; Deep-infiltrating endometriosis;

Endometriosis-associated infertility; Gonadotropin-releasing hormone

agonist; Robot-assisted partial cystectomy

ID DEEP INFILTRATING ENDOMETRIOSIS; SURGERY; WOMEN; MANAGEMENT; RESECTION

AB Objective: To report an infertility case of deep-infiltrating bladder endometriosis conceiving following robot-assisted surgery and modified gonadotropin-releasing hormone agonist (GnRHa) treatment.

Case report: A 33 year-old infertile female presenting with dysmenorrhea was found to have a bladder mass by pelvic ultrasound. Cystoscopy revealed a protruding tumor from the posterior bladder wall, and endometriosis was highly suspected. Robot-assisted laparoscopic partial cystectomy was performed for the deep-infiltrating bladder endometriosis. With postoperative half-dose GnRHa treatment and timed intercourse, she got pregnant within 3 months.

Conclusion: Robot-assisted complete resection of deep-infiltrating endometriosis and bladder repair immediately followed by GnRHa therapy and medical assistance improves reproductive outcomes efficiently in women with endometriosis-associated infertility. (C) 2018 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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NR 21

TC 4

Z9 4

U1 0

U2 0

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Grisaru, D.

TI Robotic radical trachelectomy with sentinel lymph node mapping using ICG

in early cervical cancer - a brief report

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Fertility preservation; ICG; Radical trachelectomy; Robotic laparoscopy;

Sentinel lymph node

ID INDOCYANINE GREEN; BLUE-DYE; FERTILITY; PRESERVATION

AB Objective: To describe the implementation of robotic radical trachelectomy with sentinel lymph node mapping utilizing indocyanine green (ICG) in patients with early cervical cancer. Materials and Methods: This retrospective analysis studied six cases of robotic assisted laparoscopy with the use of the da Vinci-Firefly fluorescence imaging to detect sentinel lymph nodes. Results: Six patients with cervical cancer clinical Stages IA2 to IB1were included. All patients underwent fertility preserving surgery in which complete tumor resection with free pathological margins was confirmed by final pathology (including an obese patient with a BMI of > 40). There were no major surgical complications. Conclusion: Robotic radical trachelectomy with sentinel lymph node mapping using ICG is an effective and safe method to treat early cervical cancer.

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Z9 0

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U2 3

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J9 EUR J GYNAECOL ONCOL

JI Eur. J. Gynaecol. Oncol.

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ER

PT J

AU Bedaiwy, MA

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TI The Effect of Age and Body Mass Index on the Surgical Anatomy of

Supraumbilical Port Insertion: Implications for Laparoscopic and Robotic

Surgery

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Supraumbilical; Anatomy; Aorta; Inferior vena cava; Laparoscopy;

Robotics; Laparoscopic entry

ID INJURIES; ENTRY

AB Background: Minimally invasive surgery is the preferred approach for performing many gynecologic procedures. Occasionally, supraumbilical port placement may be preferable to optimize visibility and maneuverability although the risks of complications are less well characterized compared to umbilical entry. Methods: We conducted a retrospective review of computed tomograms from 92 patients to evaluate the anatomic considerations for umbilical and supraumbilical port entry based on patient age, body mass index (BMI), parity, abdominal wall thickness, and distance to the great vessels. Results: Supraumbilical entry was not associated with differences in distance to the great vessels compared to the umbilicus. However, supraumbilical location and BMI were associated with greater abdominal wall thickness. Age and BMI were associated with greater distance to the great vessels, while age was associated with thinner abdominal wall. Multiple linear regression confirmed independent effects of age and BMI. No association between parity and distance to retroperitoneal vessels was observed. Conclusion: Younger patients may be at increased risk for great vessel injury and pre-peritoneal insufflation. Obese patients may be at risk for pre-peritoneal insufflation, while patients with BMI <30, particularly with a skin-to-aorta distance <7 cm, may be at an increased risk for great vessel injury. Surgeons should consider these factors when considering supraumbilical port entry. (c) 2018 S. Karger AG, Basel

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NR 16

TC 2

Z9 2

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JI Gynecol.Obstet.Invest.

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ER

PT J

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Tan-Kim, J

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TI Ergonomics in Surgery: A Review

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Review

DE surgical ergonomics; work-related musculoskeletal disorders; surgeon

injury; ergonomics guidelines; surgeon safety

ID POSTURAL MUSCLE-ACTIVITY; MINIMAL ACCESS SURGERY; MUSCULOSKELETAL

DISORDERS; LAPAROSCOPIC SURGERY; OCCUPATIONAL INJURY; INSTRUMENTS;

DESIGN; INTERVENTIONS; WORKLOAD; HANDLE

AB Objective: Work-related musculoskeletal disorders (WMSDs) are prevalent among surgeons and may result in practice modification. We aimed to perform a comprehensive review of the English-language literature regarding ergonomic risk, prevalence of WMSDs, and unique ergonomic considerations by route of surgery.

Methods: Multiple searches were performed of PubMed and University library resources to access English-language publications related to surgeon ergonomics. Combinations of keywords were used for each mode of surgery, including the following: "ergonomics," "guidelines," "injury," "operating room," safety," "surgeon," and "work-related musculoskeletal disorders." Each citation was read in detail, and references were reviewed.

Results: Surgeon WMSDs are prevalent, with rates ranging from 66% to 94% for open surgery, 73% to 100% for conventional laparoscopy, 54% to 87% for vaginal surgery, and 23% to 80% for robotic-assisted surgery. Risk factors for injury in open surgery include use of loupes, headlamps, and microscopes. Unique risks in laparoscopic surgery include table and monitor position, long-shafted instruments, and poor instrument handle design. In vaginal surgery, improper table height and twisted trunk position create injury risk. Although robotic surgery offers some advantages, it remains associated with trunk, wrist, and finger strain. Surgeon WMSDs often result in disability but are under-reported to institutions. Additionally, existing research tools face limitations in the operating room environment.

Conclusions: Work-related musculoskeletal disorders are prevalent among surgeons but have received little attention owing to under-reporting of injury and logistical constraints of studying surgical ergonomics. Future research must aim to develop objective surgical ergonomics instruments and guidelines and to correlate ergonomics assessments with pain and tissue-level damage in surgeons with WMSDs. Ergonomics training should be developed to protect surgeons from preventable, potentially career-altering injuries.

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NR 106

TC 93

Z9 97

U1 6

U2 48

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

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TI Robotic Assistance Confers Ambidexterity to Laparoscopic Surgeons

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Ambidexterity; daVinci Surgical System; Intraoperative handedness;

Laparoscopic surgery; Robotic surgery

ID SKILL ACQUISITION; HAND DOMINANCE; PERFORMANCE; DEXTERITY; GENDER;

IMPACT

AB Study Objective: To examine whether a robotic surgical platform can complement the fine motor skills of the nondominant hand, compensating for the innate difference in dexterity between surgeon's hands, thereby conferring virtual ambidexterity.

Design: Crossover intervention study (Canadian Task Force classification II-1).

Setting: Centers for medical simulation in 2 tertiary care hospitals of Harvard Medical School.

Participants: Three groups of subjects were included: (1) surgical novices (medical graduates with no robotic/laparoscopic experience); (2) surgeons in training (postgraduate year 3-4 residents and fellows with intermediate robotic and laparoscopic experience); and (3) advanced surgeons (attending surgeons with extensive robotic and laparoscopic experience).

Interventions: Each study group completed 3 dry laboratory exercises based on exercises included in the Fundamentals of Laparoscopic Surgery (FLS) curriculum. Each exercise was completed 4 times: using the dominant and nondominant hands, on a standard laparoscopic FLS box trainer, and in a robotic dry laboratory setup. Participants were randomized to the handedness and setting order in which they tackled the tasks.

Measurements and Main Results: Performance was primarily measured as time to completion, with adjustments based on errors. Means of performance for the dominant versus nondominant hand for each task were calculated and compared using repeated-measures analysis of variance. A total of 36 subjects were enrolled (12 per group). In the laparoscopic setting, the mean overall time to completion of all 3 tasks with the dominant hand differed significantly from that with the nondominant hand (439.4 seconds vs 568.4 seconds; p = .0008). The between-hand performance difference was nullified with the robotic system (374.4 seconds vs 399.7 seconds; p = .48). The evaluation of performance for each individual task also revealed a statistically significant disparate performance between hands for all 3 tasks when the laparoscopic approach was used (p = .003, .02, and .01, respectively); however, no between-hand difference was observed when the tasks were performed robotically. On analysis across the 3 surgeon experience groups, the performance advantage of robotic technology remained significant for the surgical novice and intermediate-level experience groups.

Conclusion: Robot-assisted laparoscopy may eliminate the operative handedness observed in conventional laparoscopy, allowing for virtual ambidexterity. This ergonomic advantage is particularly evident in surgical trainees. Virtual ambidexterity may represent an additional aspect of surgical robotics that facilitates mastery of minimally invasive skills. (c) 2017 AAGL. All rights reserved.

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Z9 24

U1 2

U2 11

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JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Vizza, Enrico

TI The Patient and Observer Scar Assessment Scale to Evaluate the Cosmetic

Outcomes of the Robotic Single-Site Hysterectomy in Endometrial Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; POSAS; Robotic single-site hysterectomy

ID SURGERY; MANAGEMENT

AB Objective The objective of this study was to evaluate the cosmetic outcome of robotic single-site hysterectomy (RSSH) in early-stage endometrial cancer.

Methods We prospectively collected patient demographics, operative times, complications, pathologic results, and length of stay on all patients who underwent RSSH for early-stage endometrial cancer. The Patient and Observer Scar Assessment Scale (POSAS) was used for the evaluation of the cosmetic outcome.

Results Forty-five patients were included in our study from January 2012 to October 2015. The median age of patients was 63 years (range, 35-84 years), and the median body mass index was 26.5 kg/m(2) (range, 18-39 kg/m(2)). No laparoscopic/laparotomic conversion was registered. The median docking time, console time, and total operative time were 7 minutes (range, 4-14 minutes), 46 minutes (range, 20-100 minutes), and 90 minutes (range, 45-150 minutes), respectively. The median blood loss was 50 mL (range, 10-150 mL). Nine patients underwent pelvic lymphadenectomy, and the median number of pelvic lymph nodes was 13 (range, 10-32). The median time to discharge was 3 days (range, 2-6 days). No intraoperative complications occurred, whereas we did observe 1 early postoperative complication. The oncological outcome was directly comparable to the literature. Patients reported low pain scores and high satisfaction in terms of postoperative scarring. The POSAS scores confirmed excellent cosmetic outcome of RSSH.

Conclusion Robotic single-site hysterectomy provided an efficient option for gynecologic oncologic surgery. The POSAS revealed high objective and patient-evaluated outcome, and patients were highly satisfied with the overall outcome of the appearance of their scars.

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NR 22

TC 18

Z9 18

U1 0

U2 3

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

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ER

PT J

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Ascher-Walsh, C

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TI Comparison of the Memory Foam Pad Versus the Bean Bag with Shoulder

Braces in Preventing Patient Displacement during Gynecologic

Laparoscopic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Bean bag; Laparoscopy; Nerve injury; Memory foam pad; Patient

positioning; Robotic surgery

ID TRENDELENBURG POSITION; NEUROPATHIES; INJURY

AB Study Objective: To compare the amount of patient displacement when a memory foam pad is used versus a bean bag with shoulder braces. The secondary aim was to evaluate for postoperative extremity symptoms including pain, numbness, and weakness.

Design: A prospective randomized pilot study (Canadian Task Force classification I).

Setting: A single academic institution.

Patients: Women >= 18 years of age undergoing laparoscopic or robotic gynecologic surgery.

Interventions: Patients were randomized to be positioned on the memory foam pad (group A) or the bean bag with shoulder braces (group B) preoperatively. The patients' positions were measured before and after the procedure, and the displacement was recorded. Patients were followed postoperatively and questioned regarding upper extremity or lower extremity weakness, numbness, and pain. Demographic characteristics were collected using the electronic medical record.

Measurements and Main Results: Forty-three patients were included in the study (22 in group A and 21 in group B). The demographic and intraoperative characteristics of the patients were similar in both groups. The patients in group A moved a mean distance of 3.80 +/- 3.32 cm, whereas those in group B moved a mean distance of 1.07 +/- 1.93 cm (p = .002). A Pearson correlation coefficient did not yield a correlation between patient displacement and age, body mass index, length of surgery, or pathology weight. In group A, 2 patients had lower extremity numbness, and 1 patient had upper extremity numbness. In group B, 1 patient had upper extremity pain, and 1 patient had both upper and lower extremity numbness. These patients had complete resolution of their symptoms within the first 2 weeks postoperatively, with the exception of 1 patient in group A whose lower extremity numbness resolved 3 months postoperatively.

Conclusion: Positioning patients on the bean bag with shoulder braces resulted in significantly less displacement during gynecologic laparoscopic surgery when compared with the memory foam pad. All postoperative extremity numbness, weakness, and pain were temporary and resolved completely in our cohort. A larger study would be necessary to determine the true incidence of peripheral nerve injuries because these are rare complications of laparoscopic surgeries. Published by Elsevier Inc. on behalf of AAGL.

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Z9 5

U1 0

U2 1

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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AF Feuer, G. A.

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Glasgow, M. A.

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Lakhi, N. A.

TI Robotic-assisted colorectal procedures in a gynecologic oncology setting

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Robotic surgery; Gynecologic oncology; Colorectal surgery; Minimally

invasive surgery; Surgical technique

ID CONVENTIONAL LAPAROSCOPIC SURGERY; CANCER FARGHALYS TECHNIQUE; RECURRENT

OVARIAN-CANCER; PELVIC EXENTERATION; ENDOMETRIAL CANCER; RECTAL-CANCER;

CERVICAL-CANCER; PERIOPERATIVE OUTCOMES; LEARNING-CURVE; MANAGEMENT

AB Purpose: Despite potential benefits, gynecologic oncology has not fully embraced use of the robot for concomitant colorectal procedures. The authors describe the robotic technique and outcomes of colorectal surgeries from an experienced gynecologic oncologist's practice. Materials and Methods: A review of robotic-assisted gynecologic surgeries between 2011 and 2016 was undertaken to identify patients with colorectal procedures and findings. Results: Sixteen patients had robotic-assisted colorectal procedures, including end-sigmoid colostomy (n=8), colon resection with anastomosis (n=5), low anterior resection with end-to-end anastomosis (n=3), and cecectomy (n=1). Median operative time was 130 minutes, blood loss 50 ml, and length-of-stay three days. There were no intra-operative complications or conversions. One postoperative ileus resolved with supportive care and one intermittent partial bowel obstruction not requiring hospitalization occurred. Conclusions: Robotic-assisted colorectal procedures by a gynecologic oncologist can be done safely and in reasonable operative time. Gynecologic oncology calls for overlapping training in multiple domains with a minimally invasive approach.

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NR 32

TC 0

Z9 0

U1 0

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JI Eur. J. Gynaecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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PT J

AU Gkegkes, ID

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Pechlivani, F.

Antoniou, E.

Bakalianou, K.

TI Robotic management of endometriosis: discussion of use, criteria, and

advantages. Review of the literature

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE Da Vinci robot; Endometriosis; Treatment; Advantages; Criteria; Quality

of life

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; DEEP ENDOMETRIOSIS;

SURGERY; OUTCOMES; WOMEN

AB Endometriosis is a very common benign condition affecting fertility and quality of life. Different methods, either definitive or fertility sparing are used for its management by using open, laparoscopic, and robotic techniques. This is a literature review presenting the role and the advantages of robotic surgery in endometriosis. Such a management is effective, safe, and feasible in hands of well-trained multidisciplinary teams even for severe cases of endometriosis.

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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PG 3

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PT J

AU Hanes, CR

AF Hanes, Charles R., II

TI Vaginal Sacral Colpopexy: A Natural Orifice Approach to a Gold Standard

Procedure

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Apical prolapse; Colpopexy; Prolapse; Sacral colpopexy; Sacrocolpopexy;

Vaginal vault prolapse

ID ABDOMINAL SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; VAULT PROLAPSE; TERM

OUTCOMES; REPAIR; COHORT

AB Study Objective: A transvaginal approach to sacral colpopexy has a natural appeal to those interested in minimally invasive pelvic reconstructive surgery. Development of an effective technique has been frustrated because of the technical difficulty of confining the dissection and placement of mesh to the retroperitoneal space. The objective of this prospective study is to describe the technique and report the outcomes of a transvaginal, retroperitoneal sacral colpopexy.

Design: Prospective cohort study (Canadian Task Force Design classification II-2).

Setting: Urogynecology of Southern Alabama private practice.

Patients: Women with stage 2 or greater apical prolapse.

Interventions: Surgical repair of apical prolapse using vaginal sacral colpopexy.

Measurements and Results: Over a 1-year period, 15 posthysterectomy patients with stage 2 or greater vaginal prolapse were recruited and consented to vaginal sacral colpopexy. Primary outcome was success of the repair, with success defined as a combination of objective and subjective parameters using pelvic organ prolapse quantification measures, and quality of life questionnaires. Secondary outcomes were complications and operating time. One case converted to a native tissue repair. The vaginal sacral colpopexy was completed in the remaining 14. Eleven patients have been followed for 1 year or longer. Two patients did not return after their 6-week examination because of chronic illness. They were contacted by telephone over 2 years after the surgery and expressed total satisfaction with the operation and the outcome. One patient was seen at 3 months and was noted to have an excellent anatomic result; however, a pelvic organ prolapse quantification evaluation was not done. She has been totally lost to further follow-up. There was 1 mechanical failure in which the titanium tacks securing the apex to the anterior longitudinal ligament dislodged and a second case with a stage 2 posterior compartment defect. One incidental cystotomy, and 1 incidental proctotomy occurred. These were both small, remote from the site of the vaginal mesh, and did not prevent completion of the procedure. There were no mesh-related complications. Mean operating time was 123 minutes.

Conclusion: In this small pilot study, a transvaginal retroperitoneal sacral colpopexy is described and is demonstrated to be feasible and safe. Based on the experience gained, changes in technique have been implemented to prevent future mechanical tack failures. Assuming that these changes will be successful in preventing apical recurrence due to dislodgement of mesh from the anterior longitudinal ligament, a larger study is planned to determine efficacy. Inherent advantages of the transvaginal approach are discussed, including a favorable morbidity profile, full access to all compartments, short operating times, and decreased costs. (C) 2017 AAGL. All rights reserved.

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Z9 8

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OA Bronze

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ER

PT J

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Baran, FS

AF Kadioglu, Berrin Goktug

Kumtepe, Yakup

Baran, Firdevs Sekerci

TI Gynaecological robotic surgery at a state hospital - our own experience

SO GINEKOLOGIA POLSKA

LA English

DT Article

DE robotic surgery; benign gynaecological disease

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; BENIGN

AB Objectives: In recent years, the rapid development of minimally invasive surgical methods, including robotic surgery, has resulted in a marked decline of the traditional methods in gynaecological surgery. The aim of the study was to share our experience with robotic surgery at a state hospital.

Material and methods: A total of 40 patients, who underwent robotic gynaecological surgery (GS) between 2015 and 2017, were included. Age, BMI, previous abdominal operations (PAO), operation indications (OI), operative time (OT), pathological evaluation, uterine weight (UW), blood loss during surgery (BL), complications, and duration of the hospitalization (DoH) were analyzed. The Da Vinci XI was used during surgery.

Results: A total of 40 patients were analyzed. Mean values were as follows: age - 48 years, BMI - 28, and PAO - 12%. The most common OI included uterine fibroids (52%) and abnormal uterine bleeding (45%). Mean OT, docking time and console time values were 166 min, 15 min, and 123 min, respectively. Mean BL was 93 mL. Mean UW was 256 gr, and DoH was 4 days. Perioperative and postoperative complications were observed in 10% and 20% of the cases, respectively.

Conclusions: Robotic-assisted surgery is invaluable in gynaecology, especially in the case of endometriosis, extensive adhesion, and in some oncological patients, as it allows for better visualization and higher maneuverability. In order for a surgeon to prepare for such cases, the use of the robot in benign cases is necessary to complete the learning curve and gain speed.

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J9 GINEKOL POL

JI Ginekol. Pol.

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PT J

AU Klimczak, AM

Crochet, JR

AF Klimczak, Amber M.

Crochet, John R.

TI Cesarean Scar Pregnancy: A Novel Approach to Management &ITA Case

Report&IT

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE cesarean section; laparoscopy; patient care management; pregnancy;

ectopic; robotic surgical procedures; robotics

ID ECTOPIC PREGNANCIES; METHOTREXATE; DIAGNOSIS

AB BACKGROUND: Cesarean scar pregnancy (CSP) is a rare form of ectopic pregnancy that occurs when a blastocyst implants in a defect of the hysterotomy site. Despite becoming increasingly more common, there is no consensus for management of CSP. Options include medical or surgical management. While traditional open surgical techniques are often utilized in these cases, new minimally invasive approaches need to be explored.

CASE: A 42-year-old woman with a history of infertility presented with CSP. Initially she underwent medical treatment with methotrexate and leucovorin, which ultimately failed. She elected to have a robotic resection of her CSP to maintain future fertility. She underwent an uncomplicated procedure and subsequently conceived and delivered via cesarean at 32 weeks' gestation due to preterm labor.

CONCLUSION: While several options exist for management of CSP, robotic resection offers many benefits. The patient recovers quickly, has decreased follow-up time, and is able to quickly move forward with subsequent pregnancy if so desired. Providers should be aware of this novel, minimally invasive technique as well as other current treatment options.

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PT J

AU Lonnerfors, C

AF Lonnerfors, Celine

TI Robot-assisted myomectomy

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE Myomectomy; Robotic surgery; Single-site; Uterine fibroids; Uterine

myomas

ID SINGLE-SITE MYOMECTOMY; LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY;

SHORT-TERM; REPRODUCTIVE OUTCOMES; SURGICAL OUTCOMES; UTERINE FIBROIDS;

FERTILITY; MULTICENTER; SURGERY

AB Uterine fibroids are the most common tumors of the uterus and the female pelvis and are associated with substantial morbidity for several women. In women with a wish to preserve fertility, a myomectomy is the surgical procedure of choice when medical therapy is inadequate. Despite evidence that minimally invasive surgery is preferable to laparotomy, most myomectomies are still performed by laparotomy. Robotic surgery was introduced to overcome some of the difficulties associated with laparoscopic surgery. A myomectomy is a suture-intensive surgery where the properties of a surgical robot have been suggested to be of particular value. Robotic myomectomy is feasible and safe, with similar outcome to laparoscopic surgery, although a robotic procedure is associated with a higher cost.

The introduction of robotic surgery has expanded the indications for minimally invasive myomectomy to more complex cases previously performed by laparotomy. Randomized trials comparing different approaches to myomectomy are yet to be published. More studies are needed to determine the patients in whom a robotic approach is most beneficial, both in terms of patient outcomes and cost efficiency. (C) 2017 Published by Elsevier Ltd.

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JI Best Pract. Res. Clin. Obstet. Gynaecol.

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PT J

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Lauterbach, R

Amit, A

Wiener, Z

Lowenstein, L

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Weissman, Amir

Rivlin, Aleksandr

Lauterbach, Roy

Amit, Amnon

Wiener, Zeev

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TI Effects of Pneumoperitoneum and the Steep Trendelenburg Position on

Heart Rate Variability and Cerebral Oxygenation during Robotic

Sacrocolpopexy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Heart rate variability; Sacrocolpopexy; Laparoscopy;

Minimally invasive; Cerebral oxygenation

ID CARDIAC-FUNCTION; HEMODYNAMIC-CHANGES; PRESSURE; PROSTATECTOMY;

PULMONARY; ANESTHESIA

AB Study Objective: The aim of this study was to investigate how steep Trendelenburg positioning with pneumoperitoneum modifies brain oxygenation and autonomic nervous system modulation of heart rate variability during robotic sacrocolpopexy.

Design: Prospective study (Canadian Task Force classification III).

Setting: Rambam Health Care Campus.

Patients: Eighteen women who underwent robotic sacrocolpopexy for treatment of uterovaginal or vaginal apical prolapse.

Interventions: Robotic sacrocolpopexy.

Measurements and Main Results: A 5-minute computerized electrocardiogram, cerebral O-2 saturation (cSO(2)), systemic O-2 saturation, heart rate (HR), diastolic blood pressure (BP), systolic BP, and end-tidal CO2 tension were recorded immediately after anesthesia induction (baseline phase) and after alterations in positioning and in intra-abdominal pressure. HR variability was assessed in time and frequency domains. Cerebral oxygenation was measured by the technology of near-infrared spectrometry. cSO(2) at baseline was 73% +/- 9%, with minor and insignificant elevation during the operation. Mean HR decreased significantly when the steep Trendelenburg position was implemented (66 +/- 10 vs 55 +/- 9 bpm, p < .05) and returned gradually to baseline with advancement of the operation and the decrease in intra-abdominal pressure. Concomitant with this decrease, the power of both arms of the autonomic nervous system increased significantly (2.8 +/-.8 vs 3.3 +/- .9 ms(2)/Hz and 2.5 +/- 1.2 vs 3.2 +/- .9 ms(2)/Hz, respectively, p < .05). All these effects occurred without any significant shifts in systolic or diastolic BP or in systemic or cerebral oxygenation.

Conclusion: This study supports the safety of robotic sacrocolpopexy performed with steep Trendelenburg positioning with pneumoperitoneum. Only minor alterations were observed in cerebral oxygenation and autonomic perturbations, which did not cause clinically significant alterations in HR rate and HR variability. (c) 2017 AAGL. All rights reserved.

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Z9 8

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OA Bronze

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PT J

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TI Ogilvie's Syndrome after Robotic-Assisted Radical Hysterectomy for

Cervical Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Acute colonic pseudo-obstruction; Ogilvie's syndrome; Robotic surgery;

Radical hysterectomy

ID ACUTE PSEUDOOBSTRUCTION; PSEUDO-OBSTRUCTION; COLON; SURGERY;

DECOMPRESSION; MANAGEMENT; ILEUS

AB Acute colonic pseudo-obstruction (ACPO), also known as Ogilvie's syndrome, is defined by poor peristaltic activity of the colon that mimics mechanical obstruction in the absence of any mechanical occlusive gut lesion. This case report is the first to be published on ACPO occurring after robotic-assisted radical hysterectomy. Given that robotic-assisted laparoscopic surgery has become the next major stage of advancement for a range of operations, especially in gynecologic oncology surgery, this report emphasizes the importance of recognizing precipitating factors associated with this syndrome, including minimally invasive surgery. (c) 2017 AAGL. All rights reserved.

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PM 28711762

OA Bronze

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ER

PT J

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Thiagamoorthy, G

Cardozo, L

AF Robinson, Dudley

Thiagamoorthy, Gans

Cardozo, Linda

TI Post-hysterectomy vaginal vault prolapse

SO MATURITAS

LA English

DT Review

DE Post-hysterectomy; Prolapse; Vault; Apical; Urogynaecology; Review

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; GENITAL PROLAPSE;

ABDOMINAL SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; MCCALL CULDOPLASTY;

SACRAL COLPOPEXY; RISK-FACTORS; WOMEN; OUTCOMES

AB Post-hysterectomy vaginal vault prolapse (PHVP) is a recognised although rare complication following both abdominal and vaginal hysterectomy and the risk is increased in women following vaginal surgery for urogenital prolapse. The management of PHVP remains challenging and whilst many women will initially benefit from conservative measures, the majority will ultimately require surgery.

The purpose of this paper is to review the prevalence and risk factors associated with PHVP as well to give an overview of the clinical management of this often complicated problem. The role of prophylactic primary prevention procedures at the time of hysterectomy will be discussed as well as initial conservative management.

Surgery, however, remains integral in managing these complex patients and the vaginal and abdominal approach to managing PHVP will be reviewed in detail, in addition to both laparoscopic and robotic approaches.

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JI Maturitas

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Baiocco, Ermelinda

Zampa, Ashanti

Bufalo, Arabella

Corrado, Giacomo

TI Robotic single site radical hysterectomy plus pelvic lymphadenectomy in

gynecological cancers

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic Surgical Procedures; Hysterectomy; Lymph Node Excision; Uterine

Cervical Neoplasms; Endometrial Neoplasms

ID ADVANCED CERVICAL-CANCER; NEOADJUVANT CHEMOTHERAPY; ENDOMETRIAL CANCER;

MULTI-INSTITUTION; SURGERY; LAPAROTOMY; ONCOLOGY

AB Objective: To evaluate the feasibility and the safety of robotic single-site radical hysterectomy (RSSRH) plus pelvic lymphadenectomy (PL) in endometrial or cervical cancer.

Methods: Patients with endometrial cancer (EC) International Federation of Gynecology and Obstetrics (FIGO) stage II, early cervical cancer (ECC) FIGO stage IB1 or locally advanced cervical cancer (LACC) FIGO stage IB2-IIB with clinical response >= 50% after neo-adjuvant chemotherapy (NACT) were enrolled in a prospective cohort trial. All cases were performed using the da Vinci Si Surgical Single Site System (R).

Results: Between April 2014 and November 2016, twenty patients were included in our pilot study. Three and 17 patients underwent type B1 or C1 RSSRH plus PL, respectively. The median age of patients was 46 years (range, 36-68 years) and the median body mass index was 23.5 kg/m(2) (range, 19.1-36.3 kg/m(2)). The median total operative time was 190 minutes (range, 90-310 minutes). The median blood loss was 75 mL (range, 20-700 mL) and the median number of pelvic lymph nodes removed was 16 (range, 5-27). No laparoscopic/laparotomic conversions were reported and the median time to discharge was 6 days (range, 4-16 days). No intra-operative complications occurred while 4 (20%) post-operative complications were reported: one pelvic abscess, one lymphorrea, one bowel perforation, and one vaginal dehiscence.

Conclusion: RSSRH plus PL is technically feasible in patients affected by gynecological cancer.

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NR 27

TC 17

Z9 20

U1 0

U2 10

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

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AU Yeung, J

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TI Liposomal Bupivacaine During Robotic Colpopexy and Posterior Repair <i>A

Randomized Controlled Trial</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID PLACEBO-CONTROLLED TRIAL; DOUBLE-BLIND; POSTSURGICAL PAIN;

NATIONAL-SURVEY; LAPAROSCOPY; MANAGEMENT; INJECTION; SURGERY;

INFILTRATION; ANESTHESIA

AB OBJECTIVE: To evaluate the effect of liposomal bupivacaine on postoperative pain among patients undergoing robotic sacrocolpopexy with posterior repair.

METHODS: This was a randomized, patient-blinded, placebo-controlled trial of women undergoing robotic sacrocolpopexy with posterior repair. Liposomal bupivacaine or normal saline placebo was injected into laparoscopic and vaginal incisions at completion of surgery. Perioperative care was standardized. Visual analog scales were collected at 4, 18, and 24 hours postoperatively in hospital. Starting on postoperative day 1, participants completed twice-daily pain scales and a pain medication diary up until the evening of postoperative day 3. The primary outcome was a 20-mm change in the visual analog scale 18 hours postoperatively. Secondary measures included additional pain scores, satisfaction, and narcotic use. Sample size calculation revealed that 32 patients per arm were required to detect the 20-mm difference with 90% power and an a of 0.05. To allocate for dropout, a goal of 70 was set.

RESULTS: Between March 2015 and April 2016, 100 women were screened and 70 women were enrolled: 35 women were randomized to liposomal bupivacaine and 35 to placebo, of whom 64 (91%) were included in the final analysis: 33 liposomal bupivacaine and 31 placebo. No difference in demographics, surgical data, or satisfaction between groups was noted. Median VAS at 18 hours after surgery was not statistically different in those who received liposomal bupivacaine compared with normal saline (15 mm compared with 20 mm; P=.52). Other pain scales and total morphine equivalents were also similar (P=.90).

CONCLUSION: In this study of robotic sacrocolpopexy with posterior repair, there were no differences in pain scores or narcotic use between liposomal bupivacaine and placebo injected into laparoscopic and vaginal incisions. Given its lack of clinical benefit, routine use of liposomal bupivacaine is not supported for this surgical intervention.

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ER

PT J

AU Zhong, XZ

Wang, ZQ

Tang, J

Shi, JL

Li, HB

Wang, JL

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Wang, Zhi-Qi

Tang, Jun

Shi, Jing-Li

Li, He-Bei

Wang, Jian-Liu

TI Port site metastasis after minimally invasive surgery of cervical

carcinoma: case report and review of the literature

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Port site metastasis; Cervical cancer; Minimally invasive surgery

ID PARAAORTIC LYMPHADENECTOMY; LAPAROSCOPIC SURGERY; GYNECOLOGICAL

MALIGNANCIES; ROBOTIC SURGERY; CANCER; ADENOCARCINOMA; HYSTERECTOMY

AB Port site metastasis after minimally invasive surgery in cervical cancer is rare. The authors report a case of port site metastasis in a 45 year-old woman with Stage Ib2 squamous caner of the cervix, together with an update of past 15-year published 12 cases in the literature. It occurred at the port site 18 months after laparoscopic surgery and completion of radiation and chemotherapy. Local excision of the mass was performed and histopathologic examination revealed metastasis of the squamous cell carcinoma of the cervix. The patient was still alive without recurrence and still participating in the follow-up. The authors searched the Medline database to evaluate the incidence, mechanism, relevant factors, preventive measures, treatment, and prognosis of port site metastasis in cervical cancer.

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NR 26

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Z9 1

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U2 7

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ER

PT J

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Petersen, C

Ure, B

AF Madadi-Sanjani, Omid

Petersen, Claus

Ure, Benno

TI Minimally Invasive Hepatobiliary Surgery

SO CLINICS IN PERINATOLOGY

LA English

DT Article

DE Hepatobiliary disease; Laparoscopy; Choledochal cyst excision;

Hepaticoduodenostomy; Hepaticojejunostomy; Kasai procedure;

Cholecystectomy; Hepatic biopsy

ID CONGENITAL CHOLEDOCHAL CYST; EN-Y HEPATICOJEJUNOSTOMY; CONVENTIONAL

KASAI PORTOENTEROSTOMY; ROBOT-ASSISTED RESECTION; BILIARY ATRESIA;

LAPAROSCOPIC CHOLECYSTECTOMY; SINGLE-INCISION; CHILDREN; EXCISION;

OUTCOMES

AB Comparative studies and large-scale case series that confirm the advantages of laparoscopy in children with hepatobiliary diseases are scarce, and the use of laparoscopy remains a matter of debate. This article reviews the current literature on the role of laparoscopic and robotic surgery in pediatric patients with choledochal cyst, biliary atresia, gallbladder diseases, and hepatobiliary malignancies. Studies were identified through a search of the MEDLINE database. Laparoscopy may be beneficial for resection of choledochal cyst and cholecystectomy. However, more data are required before recommendations on the use of minimally invasive techniques for other hepatobiliary conditions can be published.

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NR 85

TC 8

Z9 7

U1 0

U2 8

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AU Torng, PL

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Hwang, JS

Shih, HJ

Chen, CL

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Pan, Song-Po

Hwang, Jing-Shiang

Shih, Ho-Jun

Chen, Chi-Ling

TI Learning curve in concurrent application of laparoscopic and

robotic-assisted hysterectomy with lymphadenectomy in endometrial cancer

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Laparoscopy; Learning curve; Staging surgery;

Robotic-assisted

ID PELVIC LYMPHADENECTOMY; SURGERY; LAPAROTOMY; OUTCOMES; MANAGEMENT;

SURVIVAL; IMPACT; COHORT; TRIAL; COST

AB Objective: To evaluate the concurrent interaction of laparoscopic and robotic-assisted surgery in the initial learning period of endometrial cancer staging.

Materials and methods: A retrospective cohort study was performed for the first 44 consecutive patients with endometrial cancer underwent laparoscopic (LSS) or robotic-assisted staging surgery (RSS) from February 2012 to October 2015 by a single surgeon in a tertiary care referral hospital. Demographics, diagnosis, perioperative variables, and complications were recorded. Quality of surgery was determined by the number of lymph nodes dissected and learning curve was estimated by operative time with respect to chronologic order of operation.

Results: Twenty-four patients received LSS and 20 patients received RSS. RSS required longer operative time, but obtained more total number of lymph nodes compared with LSS (286.9 vs. 201.9 min (p < 0.001); 26.2 vs. 20.7 (p < 0.05), respectively. There were no difference in blood loss, number of paraaortic nodes removed, complications and hospital stay between the two types of surgery. An additive model based on tumor grade, body mass index, estimated blood loss and chronological order of operation was constructed to fit operative time of these two types of surgery. Proficiency of achievement was not observed for LSS and was 6 for RSS.

Conclusions: Operative time was longer but Lymph node dissection was easier in RSS. Learning curve for LSS to maintain similar surgical quality as RSS was not observed. The concurrent use of robotic platform in the initial practice of minimally invasive staging surgery could optimize surgical technique for LSS. (C) 2017 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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NR 35

TC 11

Z9 11

U1 0

U2 3

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ER

PT J

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Chowdhary, SK

Sreedhar, B

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Chowdhary, Sujit K.

Sreedhar, Biji

TI Minimally Invasive Management for Vesicoureteral Reflux in Infants and

Young Children

SO CLINICS IN PERINATOLOGY

LA English

DT Article

DE Vesicoureteric reflux; Antenatal hydronephrosis; Voiding

cystourethrography; Management; Infants; Children; Minimally invasive

procedures; Urinary tract infection

ID EXTRAVESICAL URETERAL REIMPLANTATION; URINARY-TRACT-INFECTION;

LICH-GREGOIR TECHNIQUE; INITIAL-EXPERIENCE; DEXTRANOMER/HYALURONIC ACID;

LAPAROSCOPIC CORRECTION; OUTCOMES; METAANALYSIS; SURGERY; PIG

AB Minimally invasive ureteral reimplantation is an attractive and useful tool in the armamentarium for the management of complicated vesicoureteral reflux (VUR). Subureteric dextranomer/hyaluronic acid injection, laparoscopic extravesical ureteric reimplantation, and pneumovesicoscopic intravesical ureteral reimplantation with or without robotic assistance are established minimally invasive approaches for the management of VUR. The high cost and the limited availability of robotics have restricted accessibility to these approaches. Laparoscopic and/or robotic ureteral reimplantation continues to evolve and will have a significant bearing on the management of complicated VUR in infants and young children.

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Z9 11

U1 0

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PT J

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Schiavone, MB

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TI Trocar site hernia development in patients undergoing robotically

assisted or standard laparoscopic staging surgery for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Trocar site; Hemia; Endometrial cancer; Staging; Robotic staging;

Laparoscopic staging

ID LAPAROTOMY

AB Objectives. To compare the incidence and potential risk factors of trocar site hernia formation in women undergoing robotically assisted versus standard laparoscopic staging (RBT vs. LSC, respectively) for endometrial cancer.

Methods. We retrospectively identified all patients who underwent MIS staging for endometrial cancer at our institution from 01/09-12/12. Data collection involved the review of all operative notes, postoperative follow-up visit notes, and postoperative imaging reports. Appropriate statistical tests were used.

Results. We identified 760 eligible patients (LSC, 193: RBT, 567). The overall median age was 61 years (range, 33-90). The median BMI was 28.5 kg/m(2) for LSC (range, 16.6-67.6) and 29.5 kg/m(2) for RBT (range, 17.9-66) patients (p = 0.8).A trocar site hernia developed in 16 patients (2.1%)-5 (2.6%) of 193 LSC and 11 (1.9%) of 567 RBT patients (p = 0.6). Median time to hernia diagnosis was 13 months (range, 5-20.5) and 18 months (range, 3-49), respectively (p = 0.5). All hemias in the LSC cohort developed at the camera trocar site. In the RBT cohort, 10 developed at the camera trocar site and 1 at a lateral trocar site. Only BMI was associated with the development of hernias. A hernia was diagnosed in 7 (6.9%) of 101 patients with a BMI kg/m2 compared with 9 (1.4%) of 659 with a BMI <40 kg/m(2) (p = 0.001).

Conclusion. MIS for endometrial cancer is associated with a low rate of trocar site hernia formation, with similar rates associated with RBT and standard LSC. Higher BMI is associated with the development of postoperative trocar site hernias. (C) 2017 Elsevier Inc. All rights reserved.

C1 [Cybulska, Paulina; Schiavone, Maria B.; Sawyer, Brandon; Gardner, Ginger J.; Zivanovic, Oliver; Brown, Carol L.; Jewell, Elizabeth L.; Sonoda, Yukio; Barakat, Richard R.; Abu-Rustum, Nadeem R.; Leitao, Mario M., Jr.] Mem Sloan Kettering Canc Ctr, Dept Surg, Gynecol Serv, New York, NY 10065 USA.

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TI A Comparison of Robotic Simulation Performance on Basic Virtual Reality

Skills: Simulator Subjective Versus Objective Assessment Tools

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Minimally invasive surgery; Performance assessment; Robotic surgery;

Surgical education; Surgical simulation; Virtual reality robotic

simulator

ID CROWD-SOURCED ASSESSMENT; TECHNICAL SKILLS; SURGICAL PERFORMANCE;

VALIDITY; CONSTRUCT; FACE

AB Study Objective: To answer the question of whether there is a difference between robotic virtual reality simulator performance assessment and validated human reviewers. Current surgical education relies heavily on simulation. Several assessment tools are available to the trainee, including the actual robotic simulator assessment metrics and the Global Evaluative Assessment of Robotic Skills (GEARS) metrics, both of which have been independently validated. GEARS is a rating scale through which human evaluators can score trainees' performances on 6 domains: depth perception, bimanual dexterity, efficiency, force sensitivity, autonomy, and robotic control. Each domain is scored on a 5-point Likert scale with anchors. We used 2 common robotic simulators, the dV-Trainer (dVT; Mimic Technologies Inc., Seattle, WA) and the da Vinci Skills Simulator (dVSS; Intuitive Surgical, Sunnyvale, CA), to compare the performance metrics of robotic surgical simulators with the GEARS for a basic robotic task on each simulator.

Design: A prospective single-blinded randomized study.

Setting: A surgical education and training center.

Participants: Surgeons and surgeons in training.

Interventions: Demographic information was collected including sex, age, level of training, specialty, and previous surgical and simulator experience. Subjects performed 2 trials of ring and rail 1 (RR1) on each of the 2 simulators (dVSS and dVT) after undergoing randomization and warm-up exercises. The second RR1 trial simulator performance was recorded, and the deidentified videos were sent to human reviewers using GEARS. Eight different simulator assessment metrics were identified and paired with a similar performance metric in the GEARS tool. The GEARS evaluation scores and simulator assessment scores were paired and a Spearman rho calculated for their level of correlation.

Measurements and Main Results: Seventy-four subjects were enrolled in this randomized study with 9 subjects excluded for missing or incomplete data. There was a strong correlation between the GEARS score and the simulator metric score for time to complete versus efficiency, time to complete versus total score, economy of motion versus depth perception, and overall score versus total score with rho coefficients greater than or equal to 0.70; these were significant (p < .0001). Those with weak correlation (rho >= 0.30) were bimanual dexterity versus economy of motion, efficiency versus master workspace range, bimanual dexterity versus master workspace range, and robotic control versus instrument collisions.

Conclusion: On basic VR tasks, several simulator metrics are well matched with GEARS scores assigned by human reviewers, but others are not. Identifying these matches/mismatches can improve the training and assessment process when using robotic surgical simulators. (C) 2017 AAGL. All rights reserved.

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Z9 21

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ER

PT J

AU Hignett, S

Gyi, D

Calkins, L

Jones, L

Moss, E

AF Hignett, Sue

Gyi, Diane

Calkins, Lisa

Jones, Laura

Moss, Esther

TI Human Factors Evaluation of Surgeons' Working Positions for Gynecologic

Minimal Access Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Musculoskeletal disorders; Surgery; Postural analysis;

Bariatric

ID LAPAROSCOPIC SURGERY; ERGONOMICS; PAIN; STRAIN

AB Study Objective: To investigate work-related musculoskeletal disorders (WRMSD) in gynaecological minimal access surgery (MAS), including bariatric (plus size) patients

Design: Mixed methods (Canadian Task Force classification III).

Setting: Teaching hospital in the United Kingdom.

Measurements: Survey, observations (anthropometry, postural analysis), and interviews.

Results: Work-related musculoskeletal disorders (WRMSDs) were present in 63% of the survey respondents (n = 67). The pilot study (n = 11) identified contributory factors, including workplace layout, equipment design, and preference of port use (relative to patient size). Statistically significant differences for WRMSD-related posture risks were found within groups (average-size mannequin and plus-size mannequin) but not between patient size groups, suggesting that port preference may be driven by surgeon preference (and experience) rather than by patient size.

Conclusion: Some of the challenges identified in this project need new engineering solutions to allow flexibility to support surgeon choice of operating approach (open, laparoscopic or robotic) with a workplace that supports adaptation to the task, the surgeon, and the patient. (C) 2017 AAGL. All rights reserved.

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ER

PT J

AU Iavazzo, C

Gkegkes, ID

AF Iavazzo, Christos

Gkegkes, Ioannis D.

TI Cost-benefit analysis of robotic surgery in gynaecological oncology

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotics; gynaecology; health care economics; gynaecological; oncology;

outcomes; costs

ID ENDOMETRIAL CANCER; ASSISTED LAPAROSCOPY; RADICAL HYSTERECTOMY;

PERIOPERATIVE OUTCOMES; LAPAROTOMY; CHARGES

AB Robotic approach is a rather new technique that can be used to optimise the management of patients with gynaecological cancer. However, concerns have been raised regarding the cost of such an approach compared to laparoscopic or open techniques. The aim of our chapter is to review the data of papers published so far that analyse the cost of robotic gynaecological oncology. A systematic review of the current literature was performed trying to assess the cost of the robotic technique including parameters that affect it and ways to minimise it in favour of the patients and health care systems. (C) 2017 Published by Elsevier Ltd.

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NR 33

TC 13

Z9 15

U1 0

U2 4

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J9 BEST PRACT RES CL OB

JI Best Pract. Res. Clin. Obstet. Gynaecol.

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ER

PT J

AU Kim, S

Luu, TH

Llarena, N

Falcone, T

AF Kim, Suejin

Thanh Ha Luu

Llarena, Natalia

Falcone, Tommaso

TI Role of robotic surgery in treating fibroids and benign uterine mass

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE fibroid; myomectomy; hysterectomy; robot; laparoscopy; gynecology

ID LAPAROSCOPIC HYSTERECTOMY; ARTERY EMBOLIZATION; SURGICAL-TREATMENT; OPEN

MYOMECTOMY; BARBED SUTURE; MANAGEMENT; OUTCOMES; EPIDEMIOLOGY;

ALTERNATIVES; ADENOMYOSIS

AB Fibroid uterus can be managed medically, surgically, or through non-extirpative procedures, depending on the clinical situation. Myomectomy may be beneficial, especially to those desiring to preserve the uterus and/or fertility, with outcomes comparable to those of hysterectomy, with a laparoscopic approach being favored when feasible. For definitive therapy, hysterectomy can be pursued where the surgical approach should be individualized. Comparison of robotic-assisted laparoscopic approach shows that the robotic approach may be favored for cases with higher complexity and multiple fibroids in myomectomy; however, no clear advantage is seen with hysterectomy at this time, necessitating further research in the area of robotics for hysterectomy in benign uterine mass treatment to justify the cost. (C) 2017 Published by Elsevier Ltd.

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NR 52

TC 6

Z9 6

U1 0

U2 2

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DA 2024-01-18

ER

PT J

AU Lenihan, JP

AF Lenihan, John P., Jr.

TI How to set up a robotic-assisted laparoscopic surgery center and

training of staff

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic-assisted surgery; hysterectomy; myomectomy; credentialing and

privileging; robotic surgery program development

ID BENIGN INDICATIONS; LEARNING-CURVE; HYSTERECTOMY; GYNECOLOGY; OUTCOMES;

TRENDS

AB The use of computers to assist surgeons in the operating room has been an inevitable evolution in the modern practice of surgery. Robotic-assisted surgery has been evolving now for over two decades and has finally matured into a technology that has caused a monumental shift in the way gynecologic surgeries are performed. Prior to robotics, the only minimally invasive options for most Gynecologic (GYN) procedures including hysterectomies were either vaginal or laparoscopic approaches. However, even with over 100 years of vaginal surgery experience and more than 20 years of laparoscopic advancements, most gynecologic surgeries in the United States were still performed through an open incision. However, this changed in 2005 when the FDA approved the da Vinci Surgical Robotic System(tm) for use in gynecologic surgery. Over the last decade, the trend for gynecologic surgeries has now dramatically shifted to less open and more minimally invasive procedures. Robotic-assisted surgeries now include not only hysterectomy but also most all other commonly performed gynecologic procedures including myomectomies, pelvic support procedures, and reproductive surgeries. This success, however, has not been without controversies, particularly around costs and complications. The evolution of computers to assist surgeons and make minimally invasive procedures more common is clearly a trend that is not going away. It is now incumbent on surgeons, hospitals, and medical societies to determine the most cost-efficient and productive use for this technology. This process is best accomplished by developing a Robotics Program in each hospital that utilizes robotic surgery. (C) 2017 Published by Elsevier Ltd.

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NR 24

TC 10

Z9 10

U1 0

U2 2

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J9 BEST PRACT RES CL OB

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Lim, PC

Kang, E

AF Lim, Peter C.

Kang, Elizabeth

TI How to prepare the patient for robotic surgery: before and during the

operation

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE laparoscopic; robotic-assisted; preoperative assessment; positioning;

port placement

ID INTRAOCULAR-PRESSURE; STEEP TRENDELENBURG; RADICAL PROSTATECTOMY;

ENDOMETRIAL CANCER; ASSISTED SURGERY; RISK; LYMPHADENECTOMY;

COMPLICATIONS; OUTCOMES; DISEASE

AB Robotic surgery in the treatment of gynecologic diseases continues to evolve and has become accepted over the last decade. The advantages of robotic-assisted laparoscopic surgery over conventional laparoscopy are three-dimensional camera vision, superior precision and dexterity with EndoWristed instruments, elimination of operator tremor, and decreased surgeon fatigue. The drawbacks of the technology are bulkiness and lack of tactile feedback. As with other surgical platforms, the limitations of robotic surgery must be understood. Patient selection and the types of surgical procedures that can be performed through the robotic surgical platform are critical to the success of robotic surgery. First, patient selection and the indication for gynecologic disease should be considered. Discussion with the patient regarding the benefits and potential risks of robotic surgery and of complications and alternative treatments is mandatory, followed by patient's signature indicating informed consent. Appropriate preoperative evaluation including laboratory and imaging tests and bowel cleansing should be considered depending upon the type of robotic-assisted procedure. Unlike other surgical procedures, robotic surgery is equipment-intensive and requires an appropriate surgical suite to accommodate the patient side cart, the vision system, and the surgeon's console. Surgical personnel must be properly trained with the robotics technology. Several factors must be considered to perform a successful robotic assisted surgery: the indication and type of surgical procedure, the surgical platform, patient position and the degree of Trendelenburg, proper port placement configuration, and appropriate instrumentation. These factors that must be considered so that patients can be appropriately prepared before and during the operation are described. (C) 2017 Published by Elsevier Ltd.

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NR 21

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Z9 4

U1 0

U2 5

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ER

PT J

AU Lucidi, A

Chiantera, V

Gallotta, V

Ercoli, A

Scambia, G

Fagotti, A

AF Lucidi, A.

Chiantera, V.

Gallotta, V.

Ercoli, A.

Scambia, G.

Fagotti, A.

TI Role of robotic surgery in ovarian malignancy

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic surgery; ovarian cancer; minimally invasive surgery; gynecologic

oncology

ID TELELAP ALF-X; STAGE OVARIAN; ENDOMETRIAL CANCER; SECONDARY

CYTOREDUCTION; PERIOPERATIVE OUTCOMES; PELVIC EXENTERATION;

CERVICAL-CANCER; MANAGEMENT; HYSTERECTOMY; FEASIBILITY

AB As part of minimally invasive surgery, robotic-assisted approach is becoming increasingly popular in gynecologic oncology. It has been shown to be effective and feasible for staging and treating endometrial and cervical cancer, but its role in the context of primary and recurrent ovarian cancers is presently debated. Scanty data are available in the literature, and, the level of evidence supporting its use in ovarian cancer is quite low. However, from a retrospective case control series, robotic surgery seems to be safe and feasible for early-stage ovarian cancer. Its use in treating patients with advanced-stage or relapsed ovarian cancer is still highly controversial, suggesting the choice of robotic approach in a highly selected population. (C) 2017 Published by Elsevier Ltd.

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Z9 10

U1 1

U2 5

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ER

PT J

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Kuo, CL

Kaye, L

Luciano, D

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Ulrich, Amanda

LaMonica, Rachel

Kuo, Chia-Ling

Kaye, Leah

Luciano, Danielle

TI Does the Difference in Fascial Closure Technique Affect Postoperative

Pain?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Fascial closure device; Robotic surgery; Postoperative pain

AB Study Objective: To compare postoperative incisional pain on postoperative days (PODs) 1 and 14 when using a fascial closure device (FCD) versus a traditional fascial closure (TFC) of the 12-mm upper quadrant port during robotic surgery. Time required to close the incision was also compared.

Design: Randomized controlled trial (Canadian Task Force classification I).

Setting: Two academic affiliated hospitals, The Hospital of Central Connecticut and The University of Connecticut.

Patients: Women undergoing robotic surgery for benign indications by minimally invasive gynecologists at our institutions between November 2012 and October 2014 were enrolled in the study at their preoperative visit.

Interventions: Patients were randomized to either an FCD or TFC immediately before closure of the fascial incision. Pain score using a 10-point analog pain scale was recorded on POD 1 and POD 14. Time to close the fascial incision, length of surgery, and body mass index were also recorded.

Measurements and Main Results: Sixty-seven patients were enrolled, and 65 were randomized at the time of the fascial closure, whereas 2 enrolled patients converted to laparotomy. Statistical analysis demonstrated that pain scores differed by fascial closure technique. Mean pain scores on POD 1 were 3.43 +/- 2.48 and 2.06 +/- 2.03 for the FCD and TFC, respectively (p = .028). On POD 14 the mean pain scores were 1.97 +/- 2.48 and .83 +/- 1.42 for the FCD and TFC, respectively (p = .102). Times to close fascia were 106.5 +/- 102.28 seconds and 141.97 +/- 102.85 seconds for the FCD and TFC, respectively (p = .138).

Conclusion: Our study demonstrates that at POD 1 the use of the fascia closure device results in higher pain scores without a significant difference in closure time. (C) 2017 AAGL. All rights reserved.

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Z9 1

U1 0

U2 0

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Madueke-Laveaux, OS

Advincula, AP

AF Madueke-Laveaux, Obianuju Sandra

Advincula, Arnold P.

TI Robot-assisted laparoscopy in benign gynecology: Advantageous device or

controversial gimmick?

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robot-assisted laparoscopic surgery; hysterectomy; gynecology

ID HYSTERECTOMY; SURGERY

AB The growth of robot-assisted laparoscopic surgery has been exponential since its FDA approval for use in gynecologic surgery in the spring of 2005; however, controversy surrounding its use has been associated with this rise in utilization. Much of this discussion has pitted the conventional laparoscopist against the robotic surgeon particularly as it relates to issues such as operative time, costs, and the current scientific evidence. Although drawbacks exist in robotic technology, there are also clear and obvious advantages that are difficult to quantify in the scientific literature but evident to users. This chapter highlights the current state of affairs regarding the scientific literature with an evidence-based focus on the most commonly applied application benign hysterectomy. (C) 2017 Published by Elsevier Ltd.

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NR 22

TC 13

Z9 14

U1 0

U2 1

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JI Best Pract. Res. Clin. Obstet. Gynaecol.

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DA 2024-01-18

ER

PT J

AU Nie, JC

Yan, AQ

Liu, XS

AF Nie, Ji-Chan

Yan, An-Qi

Liu, Xi-Shi

TI Robotic-Assisted Radical Hysterectomy Results in Better Surgical

Outcomes Compared With the Traditional Laparoscopic Radical Hysterectomy

for the Treatment of Cervical Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic-assisted radical hysterectomy; Cervical cancer; Traditional

laparoscopic radical hysterectomy

ID VAGINAL HYSTERECTOMY; GYNECOLOGIC-ONCOLOGY; PELVIC LYMPHADENECTOMY;

ABDOMINAL HYSTERECTOMY; SURGERY; CARCINOMA; LAPAROTOMY; EXPERIENCE;

RADIATION

AB Objective: The aim of this study was to compare the surgical outcomes of robotic-assisted radical hysterectomy (RRH) with traditional laparoscopic radical hysterectomy (TLRH) for the treatment of early-stage cervical cancer in a large retrospective cohort of a total of 933 patients.

Methods: We have enrolled 100 patients into the RRH and 833 patients into the TLRH group. The surgical outcomes include operating time, blood loss, transfusion rate, pelvic lymph node yield, hospitalization days, duration of bowel function recovery, catheter removal before and after 3 weeks, conversion to laparotomy, and intraoperative and postoperative complications. Follow-up results were also analyzed for all patients.

Results: Both groups have similar patient and tumor characteristics but patients with a larger lesion size were preferably enrolled in the TLRH treatment group. The treatment with RRH was generally superior to TLRH with respect to operating time, blood loss, length of hospitalization, duration of bowel function recovery, and postoperative complications. On follow-up of patients, there were no relapses reported in the RRH group compared with 4% of relapse cases and 2.9% of deaths because of metastasis in the TLRH group. No conversion of laparotomy occurred in the RRH group. No significant difference was found with respect to intraoperative complications and blood transfusion between both groups.

Conclusions: The results from this study suggest that RRH is superior to TLRH with regard to surgical outcome and may pose a safe and feasible alternative to TLRH. The operating time and lymph node yield is acceptable. Our study is one of the largest single-center studies of surgical outcomes comparing RRH with TLRH during cervical cancer treatment and will significantly contribute to the safety of alternative treatment options for patients. Furthermore, the difference detected between TLRH and RRH group is further strengthened by the great expertise of the surgeon performing laparoscopic surgeries.

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FU National Science Foundation of China [81571416]

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TC 20

Z9 23

U1 0

U2 13

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Park, JY

Nam, JH

AF Park, Jeong-Yeol

Nam, Joo-Hyun

TI Role of robotic surgery in cervical malignancy

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic surgery; robotic radical hysterectomy; robotic radical

trachelectomy; cervical cancer

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; BILATERAL PELVIC LYMPHADENECTOMY;

MULTIINSTITUTIONAL EXPERIENCE; REPRODUCTIVE OUTCOMES; SURVIVAL OUTCOMES;

YOUNG-WOMEN; OBESE WOMEN; CASE SERIES; STAGE IB2; TRACHELECTOMY

AB Surgical treatment is the mainstay of the management of early stage cervical cancer. Abdominal radical hysterectomy and trachelectomy have long been the standard surgical approach to early-stage cervical cancer, achieving excellent survival outcomes. Recently, laparoscopic radical hysterectomy and trachelectomy have become the preferred alternative to abdominal surgery because laparoscopic approaches lead to better surgical outcomes without compromising survival outcomes. Since the robotic surgery platform was approved for the use of gynaecologic surgery in 2005, robotic radical hysterectomy and trachelectomy have been increasingly used in the surgical management of early-stage cervical cancer. However, the role of robotic surgery is poorly defined. This review examines the role of robotic surgery in the surgical management of cervical cancer by comparing the published data on its use with those of abdominal and laparoscopic surgeries. (C) 2017 Published by Elsevier Ltd.

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NR 81

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WC Obstetrics & Gynecology

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ER

PT J

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TI Social determinants of access to minimally invasive hysterectomy:

reevaluating the relationship between race and route of hysterectomy for

benign disease

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE disparities; ethnicity; hysterectomy; income; insurance; minimally

invasive; race; socioeconomic status

ID LAPAROSCOPIC HYSTERECTOMY; RACIAL DISPARITIES; TRENDS; WOMEN;

ASSOCIATION; SURGERY; OBESITY

AB BACKGROUND: Racial and socioeconomic disparities exist in access to medical and surgical care. Studies of national databases have demonstrated disparities in route of hysterectomy for benign indications, but have not been able to adjust for patient-level factors that affect surgical decision-making.

OBJECTIVE: We sought to determine whether access to minimally invasive hysterectomy for benign indications is differential according to race independent of the effects of relevant subject-level confounding factors. The secondary study objective was to determine the association between socioeconomic status and ethnicity and access to minimally invasive hysterectomy.

STUDY DESIGN: A cross-sectional study evaluated factors associated with minimally invasive hysterectomies performed for fibroids and/or abnormal uterine bleeding from 2010 through 2013 at 3 hospitals within an academic university health system in Philadelphia, PA. Univariate tests of association and multivariable logistic regression identified factors significantly associated with minimally invasive hysterectomy compared to the odds of treatment with the referent approach of abdominal hysterectomy.

RESULTS: Of 1746 hysterectomies evaluated meeting study inclusion criteria, 861 (49%) were performed abdominally, 248 (14%) vaginally, 310 (18%) laparoscopically, and 327 (19%) with robot assistance. In univariate analysis, African American race (odds ratio, 0.80; 95% confidence interval, 0.65-0.97) and Hispanic ethnicity (odds ratio, 0.63; 95% confidence interval, 0.39-1.00) were associated with lower odds of any minimally invasive hysterectomy relative to abdominal hysterectomy. In analyses adjusted for age, body mass index, income quartile, obstetrical and surgical history, uterine weight, and additional confounding factors, African American race was no longer a risk factor for reduced minimally invasive hysterectomy (odds ratio, 0.82; 95% confidence interval, 0.61-1.10), while Hispanic ethnicity (odds ratio, 0.45; 95% confidence interval, 0.27-0.76) and Medicaid enrollment (odds ratio, 0.59; 95% confidence interval, 0.38-0.90) were associated with significantly lower odds of treatment with any minimally invasive hysterectomy. In adjusted analyses, African American women had nearly half the odds of receiving robot-assisted hysterectomy compared to whites (adjusted odds ratio, 0.57; 95%, confidence interval 0.39-0.82), while no differences were noted with other hysterectomy routes. Medicaid enrollment (compared to private insurance; odds ratio, 0.51; 95% confidence interval, 0.28-0.94) and lowest income quartile (compared to highest income quartile; odds ratio, 0.57; 95% confidence interval, 0.38-0.85) were also associated with diminished odds of robot-assisted hysterectomy.

CONCLUSION: When accounting for the effect of numerous pertinent demographic and clinical factors, the odds of undergoing minimally invasive hysterectomy were diminished in women of Hispanic ethnicity and in those enrolled in Medicaid but were not discrepant along racial lines. However, both racial and socioeconomic disparities were observed with respect to access to robot-assisted hysterectomy despite the availability of robotic assistance in all hospitals treating the study population. Strategies to ensure equal access to all minimally invasive routes for all women should be explored to align delivery of care with the evidence supporting the broad implementation of these procedures as safe, cost-effective, and highly acceptable to patients.

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U1 0

U2 6

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ER

PT J

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AF Schmitt, Jennifer J.

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TI Vaginal versus Robotic Hysterectomy for Commonly Cited Relative

Contraindications to Vaginal Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Robotic surgical procedures; Treatment outcome

ID COST; HISTORY; RISK

AB Study Objective: To compare outcomes of vaginal hysterectomy (VH) and robotic-assisted hysterectomy (RH) among women with conditions perceived as contraindications to VH (uterine size >= 12 weeks' gestation, no vaginal parity, prior cesarean delivery, and obesity).

Design: Retrospective chart review (Canadian Task Force classification II-2).

Setting: Tertiary US medical center.

Patients: Women with VH or RH. Women with conditions perceived as contraindications affecting surgical choice were excluded.

Interventions: VH or RH for benign uterine disease at our institution during 2009 through 2013.

Measurements and Main Results: Among women with the perceived contraindications, a logistic regression model was fit to compare each binary outcome between VH and RH. Models were weighted using inverse probability of treatment weights derived from propensity scores to adjust for covariate imbalance between procedures. The cohort had 692 VHs and 472 RHs. Among 160 women with uterine size >= 12 weeks' gestation, RH patients were less likely to have uterine debulking (adjusted odds ratio [aOR], .37; 95% confidence interval [CI], .15-.95]) than VH patients and more likely to have accordion grade >= 2 postoperative complications (aOR, 7.20; 95% CI, 1.46-35.42) and readmission (aOR, 15.55; 95% CI .85-285.20). Among 272 women with prior cesarean section, RH patients were more likely to have grade >= 2 postoperative complications (aOR, 2.85; 95% CI, 1.29-6.30). No outcomes were significantly different between surgical routes among women with no vaginal parity or obesity. Mean operative time was significantly longer for RH.

Conclusion: VH is a surgical option for patients with the conditions perceived as contraindications for vaginal surgery evaluated herein. (C) 2017 AAGL. All rights reserved.

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U2 2

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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ER

PT J

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TI Surgical and oncologic outcomes after robotic radical hysterectomy as

compared to open radical hysterectomy in the treatment of early cervical

cancer

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Early stage cervical cancer; Robotic surgery; Chemotherapy; Radiation

ID PELVIC LYMPHADENECTOMY; MULTIINSTITUTIONAL EXPERIENCE; GYNECOLOGIC

ONCOLOGY; ASSISTED SURGERY; ENDOMETRIAL; SURVIVAL; WOMEN; LAPAROSCOPY;

MANAGEMENT; MORBIDITY

AB Objective: The use of robotic radical hysterectomy has greatly increased in the treatment of early stage cervical cancer. We sought to compare surgical and oncologic outcomes of women undergoing robotic radical hysterectomy compared to open radical hysterectomy.

Methods: The clinic-pathologic, treatment, and recurrence data were abstracted through an Institutional Review Board-approved protocol at 2 separate large tertiary care centers in Seattle, Swedish Medical Center and the University of Washington. Data were collected from 2001-2012. Comparisons between the robotic and open cohorts were made for complications, recurrence, progression-free survival (PFS), and overall survival (OS).

Results: In the study period, 109 robotic radical hysterectomies were performed. These were compared to 202 open radical hysterectomies. The groups were comparable in terms of age and body mass index (BMI). Length of stay (LOS) was considerably shorter in the robotic group (42.7 vs. 112.6 hours, p<0.001) as was estimated blood loss (EBL; 105.9 vs. 482.6 mL, p<0.001). There were more complications in the open radical hysterectomy group, 23.4% vs. 9.2% in the robotic group (p=0.002). The recurrence rate was comparable between the groups (10.1% vs. 10.4%, p=0.730). In multivariate adjusted analysis, robotic surgery was not a statistically significant predictor of PFS (p=0.230) or OS (0.85).

Conclusion: Our study, one of the largest multi-institution cohorts of patients undergoing robotic radical hysterectomy, suggest robotic radical hysterectomy leads to comparable oncologic outcomes in the treatment of early stage cervical cancer with improved short-term surgical outcomes such as decreased LOS and EBL.

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NR 35

TC 85

Z9 92

U1 0

U2 6

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

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Ngan, Hextan Yuen Sheung

Lim, Peter Christopher

TI Robot-assisted gynaecological cancer surgery-complications and

prevention

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE laparoscopic; robot-assisted; laparotomy; gynaecological cancer;

complications

ID PORT-SITE METASTASES; LAPAROSCOPIC RADICAL HYSTERECTOMY; STEEP

TRENDELENBURG POSITION; MECHANICAL BOWEL PREPARATION; ENHANCED RECOVERY

PATHWAYS; VAGINAL CUFF DEHISCENCE; LONG-TERM MORBIDITY; RISK-FACTORS;

SUBCUTANEOUS EMPHYSEMA; URETERAL CATHETERIZATION

AB Ever since the US Food and Drug Administration approval of the use of da Vinci surgical systems (Intuitive Surgical Inc., Sunnyvale, California) in gynaecology in 2005, robot-assisted surgery has been widely adopted in different countries. Some of the applications in benign and oncological gynaecology include myomectomy, sacrocolpopexy, tubal anastomosis, simple hysterectomy, radical hysterectomy, radical trachelectomy, pelvic and/or para-aortic lymphadenectomy and even debulking surgery for ovarian cancer and pelvic exenteration for recurrent cervical and vaginal cancer. Although there is robust evidence on the safety and treatment outcomes in robot-assisted surgery, complications still rarely occur. Team approach is particularly important in robotic surgery and thorough communication between the bedside assistant and the console surgeon cannot be stressed any more. Thus, complications can be due to miscommunication between the console surgeon and bedside assistant, positioning of the patients, the length of the operations, the malfunction of the instrument and the risks specific to the types of anaesthesia and surgery per se, leading to thromboembolism, haemorrhage, organ damage, and so on. The most important strategies that can prevent complications are to have thorough preoperative assessment of the patients' fitness, good communication between surgical team members, caution regarding the positioning, a good knowledge of the pelvic and abdominal anatomy, careful and meticulous manipulation of the instrument and early recognition of the complications. In this article, different types of complications and the preventive measures are described. (C) 2017 Published by Elsevier Ltd.

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Z9 7

U1 0

U2 16

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PT J

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Karacan, T

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Tiryaki, T

AF Usta, Taner

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Tiryaki, Talha

TI Robot-assisted laparoscopic pectouteropexy: an alternative

uterus-sparing technique for pelvic organ prolapse surgery

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pectouteropexy; Robotic surgery; Minimally invasive surgery

ID LOCATION

AB The aim of this video is to demonstrate the alternative technique of robot-assisted laparoscopic pectouteropexy for uterus preservation in obese patients with pelvic organ prolapse. We present the case report of a 44-year-old patient with apical pelvic organ prolapse. A pelvic examination was performed during a Valsalva maneuver in the dorsal lithotomy position and in the standing position, and the patient was diagnosed with stage III apical prolapse in accordance with the Pelvic Organ Prolapse Quantification system of the International Continence Society (POP-Q: Aa -1, Ba 0, Bp 0,C +2). We performed the procedure, which was developed as an alternative to sacrocolpopexy or sacrouteropexy, as described by Banerjee and Noc (Arch Gynecol Obstet 284: 2428, 2011). Pectouteropexy is a new method for prolapse surgery that uses the lateral parts of the iliopectineal ligament for bilateral mesh fixation of the descended structures and provides strong apical support. We believe that robot-assisted laparoscopic pectouteropexy is a valuable alternative approach for uterus-preserving pelvic organ prolapse surgery owing to its better robot maneuverability, reduced operating time, and better visualization in obese patients.

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NR 9

TC 1

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U1 0

U2 0

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WC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

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TI Indications and techniques for robotic pelvic and para-aortic

lymphadenectomy with sentinel lymph. node mapping in gynecologic

oncology

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic surgery; cervical cancer; endometrial cancer; lymphadenectomy;

sentinel lymph node mapping; surgical algorithm

ID INFRARENAL AORTIC LYMPHADENECTOMY; ENDOMETRIAL CANCER; LAPAROSCOPIC

HYSTERECTOMY; RADICAL HYSTERECTOMY; CERVICAL-CANCER; DOUBLE DOCKING;

CARCINOMA; METASTASIS; RECURRENCE; SURGERY

AB Robotic-assisted laparoscopic surgery is the most common approach for the treatment of early-stage endometrial and cervical cancers in the US. Surgical staging requires pelvic and often aortic lymphadenectomy, depending on the primary tumor characteristics. Pelvic and aortic lymphadenectomy procedures may also be indicated for debulking of larger metastases to improve disease control. The infra-renal basin is an important anatomic site of metastasis" from pelvic tumors, and robotic dissection techniques for this site have been described. In recent years, sentinel lymph node (SLN) mapping has been adopted into the National Comprehensive Cancer Network guidelines' surgical algorithm for uterine and cervical cancers. SLN mapping has higher sensitivity for the detection of nodal metastasis, despite removing fewer lymph nodes, and potentially reduces morbidities such as lower extremity lymphedema. This article reviews current robotic pelvic and para-aortic lymphadenectomy dissection techniques for endometrial and cervical cancers and discusses the recent integration of pelvic SLN mapping in the surgical algorithm. (C) 2017 Published by Elsevier Ltd.

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Z9 8

U1 0

U2 9

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ER

PT J

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TI Preoperative Vaginal Metronidazole Decreases the Risk of Pelvic

Infections After Radical Robotic Hysterectomy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Hysterectomy; Infection; Metronidazole; Radical; Robotic

ID CANCER

AB Objectives: Risk factors and infection rates of radical robotic procedures have yet to be described in gynecology. A practice improvement strategy using a solitary dose of vaginal metronidazole the night before surgery was initiated to determine if it decreased the risk of pelvic infection.

Methods: A retrospective chart review of robotic radical hysterectomies for gynecologic malignancy at our institution from April 2010 through April 2016 was performed. Demographic data, operative data, and data on use of metronidazole before surgery were collected. chi(2) Statistical analysis, Student t test, and multivariate analysis were performed to analyze the data.

Results: Ninety-four patients met the inclusion criteria, and 46 patients received vaginal metronidazole. Demographic and clinical factors were similar between the 2 groups. The pelvic infection rate was significantly higher in nonusers at 13% (6/46) compared with users at 0% (0/42) ( P <= 0.05). The genitourinary infection rate was also significantly higher in nonusers at 20% as compared with users at 2.2% ( P = 0.02). Operative risk factors found to be associated with pelvic infection included hospital length of stay, blood loss, and metronidazole use. Multivariate regression analysis determined that only vaginal metronidazole had a clinically significant reduction of pelvic and genitourinary infection.

Discussion: A single dose of preoperative vaginal metronidazole reduces the risk of pelvic and genitourinary infection after robotic radical hysterectomy.

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PT J

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Barbara, G

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TI 'Money for nothing'\*. The role of robotic-assisted laparoscopy for the

treatment of endometriosis

SO REPRODUCTIVE BIOMEDICINE ONLINE

LA English

DT Review

DE Endometriosis-related costs; Endometriosis treatment; Laparoscopic

surgery; Robotic-assisted laparoscopy

ID DEEP INFILTRATING ENDOMETRIOSIS; STAGE IV ENDOMETRIOSIS; CONVENTIONAL

LAPAROSCOPY; PERIOPERATIVE OUTCOMES; STANDARD LAPAROSCOPY; SUTURING

PERFORMANCE; HYBRID TECHNIQUE; SURGERY; RESECTION; HYSTERECTOMY

AB Despite higher costs for robotic-assisted laparoscopy (RAL) than standard laparoscopy (SL), RAL treatment of endometriosis is performed without established indications. PubMed/MEDLINE was searched for 'robotic surgery' and 'endometriosis' or 'gynaecological benign disease' from January 2000 to December 2016. Full-length studies in English reporting original data were considered. Among 178 articles retrieved, 17 were eligible: 11 non-comparative (RAL only) and six comparative (RAL versus SL). Non-comparative studies included 445 patients. Mean operating time, blood loss and hospital stay were 226 min, 168 ml and 4 days. Major complications and laparotomy conversions were 3.1% and 1.3%. Eight studies reported pain improvement at 15-month follow-up. Comparative studies were all retrospective; 749 women underwent RAL and 705 SL. Operating time was longer for RAL in five studies. Major complications and laparotomy conversions for RAL and SL were 1.5% versus 0.3% and 0.3% versus 0.5%. One study reported pain reduction for RAL at 6-month follow-up. RAL treatment of endometriosis did not provide benefits over SL, overall and among subgroups of women with severe endometriosis, peritoneal endometriosis and obesity. Available evidence is low-quality, and data regarding long-term pain relief and pregnancy rates are lacking. RAL treatment of endometriosis should be performed only within controlled studies. (C) 2017 Reproductive Healthcare Ltd. Published by Elsevier Ltd. All rights reserved.

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Z9 19

U1 1

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PT J

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Callegari, L

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TI Trends in hysterectomy rates among women veterans in the US Department

of Veterans Affairs

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; minimally invasive; women veterans

ID UNITED-STATES; LAPAROSCOPIC HYSTERECTOMY; CARE; MILITARY; DISEASE; AGE

AB BACKGROUND: Prior studies demonstrate a higher prevalence of hysterectomy among veterans compared with nonveterans. While studies identify overall decreasing hysterectomy rates in the United States, none report rates of hysterectomy among women veterans. Given the increasing numbers of women veterans using Veterans Affairs health care, there is an ongoing need to ensure high-quality gynecology care. Therefore, it is important to examine current hysterectomy trends, including proportion of minimally invasive surgeries, among veterans using Veterans Affairs health care.

OBJECTIVE: Our objective was to describe hysterectomy trends and utilization of minimally invasive hysterectomy in the Veterans Affairs healthcare system.

STUDY DESIGN: This longitudinal study used Veterans Affairs clinical and administrative data from fiscal year 2008 to 2014 to identify hysterectomies provided or paid for by Veterans Affairs. Crude and age-adjusted hysterectomy rates were calculated by indication (benign or malignant), mode (abdominal, laparoscopic, vaginal, robotic assisted, unspecified), and source of care (provided vs paid for by Veterans Affairs). Mode and indication for hysterectomy were classified using International Classification of Diseases, ninth revision, codes. The distribution of hysterectomy mode in each year was calculated by indication and source of care.

RESULTS: Between fiscal year 2008 and fiscal year 2014, the total hysterectomy rate decreased from 4.0 per 1000 to 2.6 per 1000 unique women veteran Veterans Affairs users. Age-adjusted rates of abdominal hysterectomy for benign indications decreased over the study period from 1.54 per 1000 (95% confidence interval, 1.40-1.69) to 0.77 per 1000 (95% confidence interval, 0.69-0.85) for procedures provided by Veterans Affairs and 0.77 per 1,000 (95% confidence interval, 0.69-0.85) to 0.29 per 1,000 (95% confidence interval, 0.23-0.34) for those paid for by Veterans Affairs. Among hysterectomies for benign indications provided by (n = 5296) or paid for (n = 2610) by Veterans Affairs, the percentage of hysterectomies performed abdominally decreased from 67.2% to 46.8% and from 68.9% to 57.6%, respectively.

CONCLUSION: These findings suggest that gynecology care provided within Veterans Affairs has kept pace with national trends in reducing hysterectomy rates and increasing utilization of minimally invasive surgical techniques.

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Health at the San Francisco Veterans Affairs Health Care System.

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PT J

AU Kim, JS

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Hurteau, JA

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Tenney, Meaghan E.

TI Venous Thromboembolism in Patients Receiving Extended Pharmacologic

Prophylaxis After Robotic Surgery for Endometrial Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE endometrial cancer; venous thromboembolism; robotic hysterectomy

ID MINIMALLY INVASIVE SURGERY; GYNECOLOGIC-ONCOLOGY; WOMEN; HYSTERECTOMY;

PREVENTION; SOCIETY; RISK

AB Objective: This study aims to determine the rate of postoperative venous thromboembolism (VTE) in endometrial cancer patients undergoing robotic hysterectomy with or without extended pharmacologic VTE prophylaxis.

Methods/Materials: A retrospective chart review of women undergoing robotic hysterectomy with or without other procedures for endometrial cancer from January 2010 to February 2015 was conducted at 2 institutions. Charts were manually abstracted, and rates of VTE within 30 and 60 days after surgery were determined. Patients were then stratified by those who did and did not receive extended VTE prophylaxis.

Results: A total of 403 patients were included, of which 367 patients (91%) received extended pharmacologic prophylaxis and 36 patients (9%) did not. Low molecular weight heparin prescriptions ranged from 7 to 30 days. Patients receiving extended prophylaxis (EP) were older (63 +/- 11 vs 57 +/- 12; P = 0.004), more frequently underwent lymphadenectomy (67% vs 34%; P G 0.001), and had higher-grade tumors compared with patients not receiving EP. Overall 30-day and 60-day VTE rates were 0.7% and 1.2%, respectively. There were no significant differences in 30-day and 60-day VTE rates among patients that did and did not receive EP, although a trend toward lower VTE rates in the EP group was observed (30-day rates 0.5% vs 2.8% respectively, P = 0.25; 60-day rates 0.8% vs 5.6%, P = 0.07).

Conclusions: In this study, 30-day and 60-day VTE rates after minimally invasive surgery for endometrial cancer were low. Rates were also similar to those of previous reports in this setting in which the majority of patients did not receive extended VTE prophylaxis. Given the consistent finding that postoperative VTE in this population is rare regardless of prophylaxis use and the variability in practice patterns for VTE prophylaxis, the development of best practice guidelines for EP use specific to this setting is warranted.

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U1 0

U2 3

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ER

PT J

AU Nicklin, J

AF Nicklin, James

TI The future of robotic-assisted laparoscopic gynaecologic surgery in

Australia - A time and a place for everything

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Review

DE gynaecology; review; robotic surgery

ID STAGE CERVICAL-CANCER; LEARNING-CURVE; HYSTERECTOMY; SACROCOLPOPEXY;

COST; METAANALYSIS; LAPAROTOMY; PROLAPSE; OUTCOMES

AB There has been a significant increase in minimally invasive surgery in gynaecology over the last 15 years, with approximately only one-third of hysterectomies for benign disease now performed via laparotomy. While robotic surgery offers considerable technical advantages over conventional laparoscopy and is associated with only a modest learning curve, the improvement in clinical outcomes is marginal and there are several disadvantages. There are increased set-up and operating times, the need to accommodate and maintain large sophisticated equipment, and the requirement for additional training. The preeminent issue regarding the place of robotic gynaecological surgery is cost. How this is addressed and contained will ultimately determine uptake in Australia. From the published literature to date, robotic surgery compared with conventional laparoscopic surgery is associated with marginal improvements in clinical outcomes for benign hysterectomy and endometrial cancer surgery, but little improvement for other benign gynaecological surgery or for cervical cancer surgery. Robotic surgery probably does improve clinical outcomes in obese and morbidly obese patients and is associated with improved ergonomics for the surgeon. It is likely that there will be continued substantial improvements in robotic surgical platforms into the foreseeable future and that robotic surgery will play an increasingly important role in gynaecological surgery in Australia.

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Z9 8

U1 0

U2 3

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WC Obstetrics & Gynecology

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ER

PT J

AU Persson, J

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Lonnerfors, Celine

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Masback, Anna

TI Description of a reproducible anatomically based surgical algorithm for

detection of pelvic sentinel lymph nodes in endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Lymphatic metastases; Lymphadenectomy; Lymphatic

system; Anatomy; Sentinel lymph node biopsy; Indocyanine green

ID HYSTEROSCOPIC INJECTION; INDOCYANINE GREEN; LYMPHADENECTOMY; METASTASIS;

CARCINOMA; COHORT; TRIAL; ADENOCARCINOMA; COMPLICATIONS; ACCURACY

AB Objective. To describe and evaluate a reproducible, anatomically based surgical algorithm, including reinjection of tracer to enhance technical success rate, for detection of pelvic sentinel lymph nodes (SLNs) in endometrial cancer (EC).

Methods. A prospective study of 102 consecutive women with high risk EC scheduled for robotic surgery was conducted. Following cervical injection of a fluorescent dye, an algorithm for trans- and retroperitoneal identification of tracer display in the lower and upper paracervical pathways was strictly adhered to. To enhance the technical success rate, this included ipsilateral reinjection of tracer in case of non-display of any lymphatic pathway. The lymphatic pathways were kept intact by opening the avascular planes. To minimize disturbance from leaking dye, removal of SLNs was first performed along the lower paracervical (presacral) pathways followed by the more caudal upper paracervical pathways. In each pathway, the juxtauterine node with an afferent lymph vessel was defined as an SLN. After removal of SLNs, a complete pelvic and, unless contraindicated, infrarenal paraaortic lymph node dissection was performed.

Results. The bilateral detection rate including tracer reinjection was 96%. All 24 (23.5%) node positive patients had at least one metastatic SLN. Presacral lymph node metastases were discovered in 33.3% of the node positive patients. One patient (4.2%) had an isolated presacral lymph node metastasis.

Conclusions. The described cranial-to-caudal anatomically based surgical SLN algorithm, including a presacral dissection and reinjection of tracer, results in a high SLN detection rate and identified all patients with lymph node metastases. (C) 2017 Elsevier Inc. All rights reserved.

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FU Skane County Council's Research and Development Foundation

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ER

PT J

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TI Sexual function after prolapse repair

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE dyspareunia; pelvic organ prolapse repair; sexual function

ID PELVIC ORGAN PROLAPSE; QUALITY-OF-LIFE; PROSPECTIVE MULTICENTER;

URINARY-INCONTINENCE; FLOOR DISORDERS; RISK-FACTORS; WOMEN; SURGERY;

MESH; HYSTERECTOMY

AB Purpose of reviewThe purpose of this review is to summarize available literature (from the last 18 months) assessing sexual function following pelvic reconstructive surgery for pelvic organ prolapse (POP). We include vaginal native tissue repair, abdominal/laparoscopic sacrocolpopexy, transvaginal mesh repair, and obliterative procedures. The goal is to assist providers in counseling patients and to identify areas needed for further research.Recent findingsWhen compared with pessary management, women who undergo POP surgical repair achieve their sexual function goals more often. In particular, vaginal native tissue repair has consistently been shown to improve sexual function. Furthermore, there does not appear to be a difference between uterosacral ligament suspension and sacrospinous ligament suspension (with or without uterine conservation) with regard to postoperative sexual function. Although less robust, literature evaluating the impact of abdominal/robotic sacrocolpopexy also supports benefit from surgical correction. However, data are conflicted with regard to transvaginal mesh repair and suggest the potential for a negative impact.SummaryPOP often affects a woman's sexual function. Following surgical repair, most patients experience improvements in their sexual response. However, surgical approaches involving abdominal or transvaginal mesh may result in a decline in sexual function and worsening dyspareunia.

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JI Curr. Opin. Obstet. Gynecol.

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TI Costs of Robotic-Assisted Versus Traditional Laparoscopy in Endometrial

Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic-assisted surgery; Endometrial cancer; Cost analysis; Gynecologic

oncology

ID GYNECOLOGIC ONCOLOGY; HYSTERECTOMY; SURGERY

AB Objectives: The purpose of this study was to compare the costs of traditional laparoscopy and robotic-assisted laparoscopy in the treatment of endometrial cancer.

Methods and Materials: A total of 101 patients with endometrial cancer were randomized to the study and operated on starting from 2010 until 2013, at the Department of Obstetrics and Gynecology of Tampere University Hospital, Tampere, Finland. Costs were calculated based on internal accounting, hospital database, and purchase prices and were compared using intention-to-treat analysis. Main outcome measures were item costs and total costs related to the operation, including a 6-month postoperative follow-up.

Results: The total costs including late complications were 2160 (sic) higher in the robotic group (median for traditional 5823(sic), vs robot median 7983(sic), P < 0.001). The difference was due to higher costs for instruments and equipment as well as to more expensive operating room and postanesthesia care unit time. Traditional laparoscopy involved higher costs for operation personnel, general costs, medication used in the operation, and surgeon, although these costs were not substantial. There was no significant difference in in-patient stay, laboratory, radiology, blood products, or costs related to complications.

Conclusions: According to this study, robotic-assisted laparoscopy is 37% more expensive than traditional laparoscopy in the treatment of endometrial cancer. The cost difference is mainly explained by amortization of the robot and its instrumentation.

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AF Anand, Mallika

Weaver, Amy L.

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TI Symptom Relief and Retreatment After Vaginal, Open, or Robotic Surgery

for Apical Vaginal Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE apical prolapse; Mayo-McCall culdoplasty; posthysterectomy vaginal

prolapse; sacrocolpopexy

ID LIGAMENT SUSPENSION; SEXUAL FUNCTION; VAULT PROLAPSE; SACROCOLPOPEXY;

OUTCOMES; REPAIR; FORM

AB Objectives: The aim of this work was to determine the degree of symptom relief and survival free of retreatment afterMayo-McCall culdoplasty (MMC), open abdominal sacrocolpopexy (ASC), and robotic sacrocolpopexy (RSC) for posthysterectomy vaginal vault prolapse.

Methods: We retrospectively studied patients who had undergone surgery for posthysterectomy apical vaginal prolapse from January 1, 2000, through June 30, 2012, at our institution. Baseline characteristics and perioperative outcomes were abstracted from electronic health records. Cross-sectional data for current pelvic floor symptoms were collected by using validated questionnaires. Survival free of retreatment was estimated with the Kaplan-Meier method. To account for selection bias, adjusted analyses using inverse probability weighting (IPW) were performed to compare outcomes for MMC versus ASC, MMC versus RSC, and ASC versus RSC.

Results: Of 512 patients, 337 completed at least a validated or abbreviated questionnaire. Among MMC, ASC, and RSC groups, overall Pelvic Floor Distress Inventory 20, Pelvic Floor Impact Questionnaire Short Form 7, and Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire 12 summary scores were not significantly different. There was no significant difference in 5-year survival free of retreatment for MMC (94.0%) versus RSC (95.5%) and ASC (94.8%) versus RSC (92.1%). However, patients who had MMC were more likely to have retreatment than patients who had ASC during the first 10 years (10-year survival free of retreatment: 81.1% vs 95.4%; hazard ratio, 3.68 [95% confidence interval, 1.51-8.98]); the 10-year data were not available for RSC comparisons, given the later initiation of RSC.

Conclusions: Symptom relief was comparable after MMC, ASC, and RSC. Among all groups, most patients were free of retreatment for prolapse at 5 years. Between the MMC and ASC groups, survival free of retreatment (%) within 10 years was still favorable, but ASC had greater durability, particularly after accounting for selection bias.

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TI Minilaparotomy Versus Laparoscopic Myomectomy After Cessation of Power

Morcellation: Rate of Wound Complications

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic myomectomy; Laparoscopy; Minilaparotomy; Minimally invasive

surgery; Morcellation; Myomectomy; Robotic myomectomy; Wound

complication; Wound infection

ID HYSTERECTOMY; OUTCOMES; FDA

AB Study Objective: After the US Food and Drug Administration statement warning against electronic morcellation devices, gynecologic surgeons are performing laparoscopic and robotic myomectomies with minilaparotomy incisions for tissue morcellation and removal. No data exist that focus on the superficial wound complications as a result of these larger incisions. The objective of this study is to compare the rate of wound complications for myomectomy via minilaparotomy versus laparoscopic or robotic myomectomy.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Kaiser Permanente Northern California, a large integrated healthcare delivery system.

Patients: Women > 18 years of age who underwent a myomectomy from either complete laparoscopic or robotic approach (LR) were compared with minilaparotomy myomectomy (MM), comprising complete minilaparotomy (ML) and laparoscopic or robotic assisted by a minilaparotomy for morcellation purposes only (LRM) from January 2011 through December 2014.

Intervention: Myomectomy via LR, complete ML, and LRM.

Measurements and Main Results: Medical records were reviewed for outcomes of interest, including superficial wound complications and surgical and demographic data. After exclusion criteria were met, 405 cases were included in the study; 270 cases were classified as MM, which included ML (n = 224), or LRM (n = 46). One hundred thirty-five cases were classified as LR. Parametric and nonparametric analyses were used to compare the 2 groups. There was no significant difference between the groups insofar as patient morbidity, including the primary outcome of wound complications and other postoperative complications; emergency visits; or readmissions. There were 2 (1.5%) wound complications in the LR group and 7 (2.6%) in the MM group (p = .72). Similarly, there were no significant differences in the subcategories of wound complications, including cellulitis, seroma, hematoma, skin separation, wound infection, or postprocedure wound complication. The distribution of estimated blood loss was significantly different between LR and MM groups with an interquartile range of 50 to 150 mL in the LR group versus 50 to 300 mL in the MM group (p < .01). The MM group experienced a shorter procedure time with a median procedure time of 125 minutes compared with 169.5 minutes in LR surgeries (p < .01). The LR group demonstrated a significantly shorter median length of hospital stay (LR 5.0 hours vs MM 23 hours; p < .01).

Conclusion: Compared with MM, LR is associated with a shorter length of hospital stay and longer operating time but no reduction in wound complication or other patient morbidity. (C) 2017 AAGL. All rights reserved.

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TI Promoting Same-Day Discharge for Gynecologic Oncology Patients in

Minimally Invasive Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Ambulatory; Education; Hysterectomy; Laparoscopic; Minimally invasive;

Patient complexity; Safety; Same-day discharge; Satisfaction; TLH; Video

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; OUTPATIENT VAGINAL HYSTERECTOMY;

OUTCOMES; IMPACT; SATISFACTION; COMPLEXITY; SAFETY

AB Study Objective: Despite clear data demonstrating feasibility, safety, and cost-effectiveness of same-day discharge after minimally invasive hysterectomy, a paucity of data suggests ways to increase same-day discharge rates. Our objectives were to promote same-day discharge after minimally invasive hysterectomy using preoperative patient education videos, provider same-day discharge awareness initiatives, and standardization of postoperative management and to investigate reasons for overnight admission after surgery (non same-day discharge).

Design: A quality improvement project measured rates of same-day discharge, patient satisfaction, and readmission during the 5 months before and after video implementation. Readmission rates were calculated as a surrogate for safety. A retrospective chart review was conducted of patients who underwent minimally invasive hysterectomy during the 5 months after video implementation, comparing 43 same-day discharges to 26 non same-day discharge patients who met criteria for same-day discharge. Differences between groups were analyzed using 2-tailed t tests or logistic regression (continuous variables) and Fisher's exact test or x(2) test (categorical variables). Next, providers were educated about same-day discharge, and initiatives were implemented to standardize postoperative care. Same-day discharge rates were then calculated to evaluate these additional interventions (Canadian Task Force classification II-2).

Setting: A gynecologic oncology division based at an academic institution and performing surgery at 2 hospitals.

Patients: All patients undergoing minimally invasive hysterectomy for both benign and malignant disease, using robot assisted, straight laparoscopic, and radical hysterectomy procedures.

Interventions: Patient education video, provider education about same-day discharge, and initiatives to standardize postoperative care.

Measurements and Main Results: Overall, same-day discharge rates decreased from 47% to 35% and readmission rates from 1.7% to 0% after video implementation. Greater than 87% of both groups were very or somewhat satisfied with their care (p = .71). Excluding patients who did not qualify for same-day discharge, the prevideo implementation same-day discharge rate was 72% (n = 78) and the postvideo implementation same-day discharge rate was 62%.(n = 69). Higher patient complexity (p = .003), later case end time (p = .001), longer operative time (p = .001), and robot-assisted cases (p = .002) significantly predicted non same-day discharge. After implementing initiatives to increase provider same-day discharge awareness and to standardize postoperative management, in addition to video implementation, the same-day discharge rate increased to 86% (n = 51).

Conclusion: Same-day discharge in a select population is safe and feasible, with at least similar patient satisfaction as non same-day discharge patients. Shorter operative time, earlier case end time, lower patient complexity, and non robot-assisted approach increase the likelihood of same-day discharge. Patient education videos alone did not increase same-day discharges but maintained acceptable readmission rates. Communication with providers regarding the same-day discharge initiative and standardization of postoperative management with preoperative video implementation may lead to increased same-day discharge rates. (C) 2017 AAGL. All rights reserved.

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TI Evaluating the Impact of Intraoperative Surgical Team Handoffs on

Patient Outcomes

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; minimally invasive sacrocolpopexy; handoffs;

surgical outcomes

ID MINIMALLY INVASIVE SACROCOLPOPEXY; COMPLICATIONS

AB Objective: The aim of the study was to assess the impact of intraoperative personnel handoffs on clinical outcomes in patients undergoing minimally invasive sacrocolpopexy (SCP).

Methods: We retrospectively reviewed SCPs performed at an academic center between 2009 and 2014. We analyzed the number of staff handoffs, defined as any instance a scrub technician (tech) or circulating nurse handed off responsibility for a break or shift change. Outcomes included operative (OR) time and composite variables for major complications (conversion to an open procedure, bladder injury, bowel injury, blood transfusion, infection, ileus, bowel obstruction, readmission, or mesh complication) and prolapse recurrence (prolapse at or beyond the hymen or retreatment). Postoperative complications were defined as being within 6 weeks of surgery. Mesh complications and prolapse recurrence were recorded for the entire 68-month study period.

Results: Of 814 patients, 97.4% were white, 85.3% postmenopausal, mean (SD) age 59.7(8.8) years, and mean (SD) body mass index 27.5 (4.5) kg/m(2). Most had stage 3 prolapse (n = 563, 69.9%). There were 478 (58.7%) laparoscopic and 336 (41.3%) robotic SCPs. The median scrub tech and nurse handoff per case was 1.0 (interquartile range [IQR], 0.0-1.0) and 1.0 (IQR, 1.0-2.0), respectively. Mean (SD) OR time was 204.8(69.0) minutes. One hundred twenty-nine patients (15.8%) had a major complication and 45 (7.5%) experienced prolapse recurrence over a median follow-up interval of 41.0 weeks (IQR, 12.0-101.0). On multivariable linear regression, each tech and nurse handoff was associated with an increased OR time of 13.6 (P < 0.001) and 9.4 minutes (P < 0.001), respectively. Thus, the median of 1 tech and 1 nurse handoff per case will increase OR time by 23.0 minutes (11.2%). On multivariable logistic regression, staff handoffs were not associated with major complications or prolapse recurrence.

Conclusions: Intraoperative scrub technician and circulating nurse handoffs increased OR time for minimally invasive SCP procedures.

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PT J

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TI Feasibility of Reduced-Port Robotic Surgery for Myomectomy with the da

Vinci Surgical System

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic myomectomy; RPRS; Uterine myomas

ID LAPAROSCOPIC MYOMECTOMY; SINGLE-SITE(R) PLATFORM; SINGLE-PORT; OUTCOMES

AB Study Objective: To present our initial experience with reduced-port robotic surgery (RPRS) for myomectomy using the Octo-Port system (DalimSurgNet, Seoul, Korea).

Design: Prospective and noncomparative study (Canadian Task Force classification II-3).

Setting: University hospital.

Patients: Nineteen consecutive patients with symptomatic uterine myomas desiring conservative minimally invasive robotic surgery from October 2015 to December 2016.

Interventions: An 8.5-mm or 12-mm robotic camera cannula was inserted through 1 of the Octo-Port channels and an 8-mm conventional robotic port was inserted into a 10-mm channel of the Octo-Port through a 3-cm transumbilical incision. An additional 8-mm conventional robotic port was inserted into a typical robotic port site in the patient's right abdomen.

Measurements and Main Results: Feasibility and operative outcomes of RPRS myomectomy. The median docking time and console time were 10 minutes (range, 4-22) and 90 minutes (range, 29-198). The largest myoma was located on the anterior uterine wall in 11 patients (57.9%). The median myoma size and weight were 7.2 cm (range, 4.1-10.5) and 141 g (range, 42-590), respectively. Median operative blood loss and change in hemoglobin were 100 mL (range, 30-700) and 2.6 mg/dL (range,.1-3.8), respectively. The procedure was successfully performed via RPRS in 89.5% of patients; 2 patients required placement of 1 to 2 additional robotic ports, resulting in a return to traditional multiport robotic surgery. There were no major postoperative complications or postoperative hernias.

Conclusion: Our experience demonstrated the feasibility of RPRS for myomectomy using the Octo-Port system in selected patients. (C) 2017 AAGL. All rights reserved.

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ER

PT J

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TI Does a robotic surgery approach offer optimal ergonomics to gynecologic

surgeons?: a comprehensive ergonomics survey study in gynecologic

robotic surgery

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic Surgical Procedures; Human Engineering; Surveys and

Questionnaires; Medically Unexplained Symptoms; Gynecology

ID WORKLOAD; STANDARD; OUTCOMES; NEED

AB Objective: To better understand the ergonomics associated with robotic surgery including physical discomfort and symptoms, factors influencing symptom reporting, and robotic surgery systems components recommended to be improved.

Methods: The anonymous survey included 20 questions regarding demographics, systems, ergonomics, and physical symptoms and was completed by experienced robotic surgeons online through American Association of Gynecologic Laparoscopists (AAGL) and Society of Robotic Surgery (SRS).

Results: There were 289 (260 gynecology, 22 gynecology-oncology, and 7 urogynecology) gynecologic surgeon respondents regularly practicing robotic surgery. Statistical data analysis was performed using the t-test, chi(2) test, and logistic regression. One hundred fifty-six surgeons (54.0%) reported experiencing physical symptoms or discomfort. Participants with higher robotic case volume reported significantly lower physical symptom report rates (p<0.05). Gynecologists who felt highly confident about managing ergonomic settings not only acknowledged that the adjustments were helpful for better ergonomics but also reported a lower physical symptom rate (p<0.05). In minimizing their symptoms, surgeons changed ergonomic settings (32.7%), took a break (33.3%) or simply ignored the problem (34%). Fingers and neck were the most common body parts with symptoms. Eye symptom complaints were significantly decreased with the Si robot (p<0.05). The most common robotic system components to be improved for better ergonomics were microphone/speaker, pedal design, and finger clutch.

Conclusion: More than half of participants reported physical symptoms which were found to be primarily associated with confidence in managing ergonomic settings and familiarity with the system depending on the volume of robotic cases. Optimal guidelines and education on managing ergonomic settings should be implemented to maximize the ergonomic benefits of robotic surgery.

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WC Oncology; Obstetrics & Gynecology

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TI Comparing Single-Site and Multiport Robotic Hysterectomy with Sentinel

Lymph Node Mapping for Endometrial Cancer: Surgical Outcomes and Cost

Analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic laparoendoscopic single-site surgery;

Robotic surgery; Sentinel lymph node; Single site

ID SURGERY; FEASIBILITY; WOMEN

AB Study Objective: To compare operative times, surgical outcomes, and costs of robotic laparoendoscopic single-site (R-LESS) vs multiport robotic (MPR) total laparoscopic hysterectomy (TLH) with sentinel lymph node (SLN) mapping for low-risk endometrial cancer.

Design: Retrospective cohort study (Canadian Task Force classification 11-2). Setting: Academic university hospital.

Patients: Patients with a biopsy-proven diagnosis of complex atypical hyperplasia (CAH) or low-grade (1 or 2) endometrial cancer with body mass index <30 kg/m(2) and undergoing robotic TLH and SLN mapping between 2012 and 2016 were included.

Interventions: Surgical outcomes and cost data were collected retrospectively and analyzed based on the surgical approach with R-LESS vs MPR assistance.

Measurements and Main Results: Twenty-seven patients who met the inclusion criteria were identified, including 14 patients who underwent R-LESS TLH with SLN mapping and 13 patients who underwent MPR TLH with SLN mapping. Median uterine weight was comparable in the 2 cohorts (111.3 g vs 83.8 g; p =.33). Operative and console times were equivalent with the R-LESS and MPR approaches (median, 175 minutes vs 184 minutes, p =.61 and 136 vs 140 minutes, p =.12, respectively). Median estimated blood loss was 50 mL in both cohorts. Successful bilateral SLN mapping occurred in 85.7% of the R-LESS procedures and 76.9% of MPR procedures. No intraoperative or 30-day complications were encountered, and all patients were discharged within 23 hours of surgery. MPR was associated with additional disposable instrument and drape costs of $460 to $660 compared with R-LESS, depending on the surgeon's instrument selection. Average total hospital charges were lower for R-LESS procedures ($13,410 vs $15,952; p <.05).

Conclusion: In highly selected patients with CAH or low-grade endometrial cancer undergoing TLH and SLN mapping, R-LESS appears to result in equivalent perioperative outcomes as a MPR approach while offering a more cost-effective option. Further research is needed to determine the benefits of R-LESS procedures in the gynecologic oncology setting. (C) 2017 AAGL. All rights reserved.

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TI A Comparison of Outcomes Between Open Hysterectomy and Robotic-Assisted

Hysterectomy for Endometrial Cancer Using the National Cancer Database

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Robotic surgery; National Cancer Database

ID GYNECOLOGIC-ONCOLOGY; SURGERY; LAPAROTOMY; LAPAROSCOPY; LYMPHADENECTOMY;

MANAGEMENT; RECURRENCE; SURVIVAL

AB Purpose The purpose of this study is to evaluate usage patterns and outcomes of women who underwent open hysterectomy (OH) versus robotic assisted-hysterectomy (RAH) for the treatment of endometrial cancer.

Methods Women with nonmetastatic endometrial adenocarcinoma diagnosed between 2010 and 2012, who either underwent an OH or RAH, were selected from the National Cancer Database. The (2), Fisher exact, or Mann-Whitney U tests were used where appropriate to compare outcomes between groups. Multivariable logistic regression was used to analyze for predictors for RAH and other outcome variables.

Results A total of 43,985 women were included in this study with a median age of 61 years. Of these, 23,872 (54.3%) underwent RAH and 20,113 (45.7%) underwent OH. The usage of RAH increased from 43.0% in 2010 to 63.8% in 2012 (P < 0.001). Women receiving RAH were more commonly found to have a Charlson comorbidity score of 0 to 1, lower pathologic stage, nonblack race, treatment at a comprehensive center, and had insurance other than Medicaid. Robotic-assisted hysterectomy was associated with a shorter inpatient stay, lower readmission rates, and lower 30- and 90-day mortality rates (P < 0.001 for all comparisons). There was a significant improvement in overall survival favoring RAH, 96.1% versus 94.0%, which persisted on multivariable logistic regression (P < 0.001).

Conclusions In this large, hospital-based analysis, RAH was associated with decreased length of stay, lower readmission rates, and less perioperative mortality. However, socioeconomic status continues to remain a barrier to equal treatment allocation. Overall survival was improved with RAH, but the follow-up is limited, and this finding must be interpreted with caution.

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PT J

AU Sloth, SB

Schroll, JB

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TI Systematic review of the limited evidence for different surgical

techniques at benign hysterectomy: A clinical guideline initiated by the

Danish Health Authority

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Hysterectomy; Surgical technique; Guideline; Benign gynecology;

Endoscopic surgery; Laparoscopy

ID ASSISTED VAGINAL HYSTERECTOMY; RANDOMIZED-CONTROLLED-TRIAL; LAPAROSCOPIC

HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; FOLLOW-UP; SUPRACERVICAL

HYSTERECTOMY; MYOMATOUS UTERI; RISK; SALPINGECTOMY; WOMEN

AB Hysterectomy for benign gynecological conditions is a common operation that has developed extensively through the last 20 years. Methods and surgical techniques vary throughout the regions in Denmark as well as internationally. Consequently, the Danish Health Authority initiated a national clinical guideline on the subject based on a systematic review of the literature. A guideline panel of Seven gynecologists formulated the clinical questions for the guideline. A search specialist performed the comprehensive literature search. The guideline panel reviewed the literature and rated the quality of evidence according to the Grading of Recommendations Assessment, Development and Evaluation (GRADE). Finally, the panel weighted the evidence and formulated the clinical recommendations. Based on the limited available literature and the corresponding quality of evidence according to GRADE, the guideline panel gave the following recommendations: down arrow Subtotal hysterectomy should only be preferred over total hysterectomy after careful consideration because there are documented disadvantages such as persistent cyclic vaginal bleeding (circle plus O;O). up arrow Consider vaginal hysterectomy rather than conventional laparoscopic hysterectomy for non-prolapsed uteri when feasible (circle plus OOO). down arrow Robot-assisted laparoscopic hysterectomy should only be preferred over conventional laparoscopic hysterectomy after careful consideration because the beneficial effect is uncertain and because of the longer operating time (circle plus circle plus OO). up arrow Consider concomitant bilateral salpingectomy at the time of hysterectomy if the procedure is not considered to increase the risk of complications significantly (circle plus OOO). up arrow Consider vaginal vault suspension to the cardinal and the uterosacral ligaments when performing hysterectomy for non-prolapsed uteri (circle plus OOO). Though supporting evidence is missing, the guideline panel emphasizes that it is good practice not to morcellate uteri with presumed fibroids inside the peritoneal cavity (root). The recommendations serve as professional advice in specific clinical situations. The implementation of the guideline in Denmark will be monitored through the national Danish Hysterectomy and Hysteroscopy Database. (C) 2017 Elsevier B.V. All rights reserved.

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PT J

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TI Reducing surgical site infections after hysterectomy: metronidazole plus

cefazolin compared with cephalosporin alone

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cephalosporin; hysterectomy; metronidazole; surgical site infection

ID BACTEROIDES-FRAGILIS GROUP; ANTIBIOTIC-PROPHYLAXIS; ABDOMINAL

HYSTERECTOMY; BACTERIAL VAGINOSIS; CHOICE; RISK; CEFUROXIME; COHORT

AB BACKGROUND: Organisms that are isolated from vaginal cuff infections and pelvic abscesses after hysterectomy frequently include anaerobic vaginal flora. Metronidazole has outstanding coverage against nearly all anaerobic species, which is superior to both cefazolin and second-generation cephalosporins. Cefazolin plus metronidazole has been demonstrated to reduce infectious morbidity compared with either cefazolin or second-generation cephalosporins in other clean-contaminated procedures, which include both as colorectal surgery and cesarean delivery.

OBJECTIVE: The purpose of this study was to evaluate whether the combination of cefazolin plus metronidazole before hysterectomy was more effective in the prevention of surgical site infection than existing recommendations of cefazolin or second-generation cephalosporin.

STUDY DESIGN: This was a retrospective cohort study of patients in the Michigan Surgical Quality Collaborative from July 2012 through February 2015. The primary outcome was surgical site infection. Patients who were > 18 years old and who underwent abdominal, vaginal, laparoscopic, or robotic hysterectomy for benign or malignant indications were included if they received 1 of the following prophylactic antibiotic regimens: cefazolin, second-generation cephalosporin, or cefazolin plus metronidazole. Multivariate logistic regression modeling was performed to evaluate the independent effect of an antibiotic regimen, and propensity score matching was used to validate the findings.

RESULTS: The study included 18,255 hysterectomies. The overall rate of surgical site infection was 1.8% (n=329). The unadjusted rate of surgical site infection was 1.8% (n=267) for cefazolin, 2.1% (n=49) for second-generation cephalosporin, and 1.4% (n=13) for cefazolin plus metronidazole. After adjustment for differences in patient and operative factors among the antibiotic cohorts, compared with cefazolin plus metronidazole, we found the risk of surgical site infection was significantly higher for patients who received cefazolin (odds ratio, 2.30; 95% confidence interval, 1.06-4.99) or second-generation cephalosporin (odds ratio, 2.31; 95% confidence interval, 1.21-4.41).

CONCLUSION: In this large cohort, the use of prophylactic cefazolin plus metronidazole resulted in lower surgical site infection rates after hysterectomy compared with cefazolin or second-generation cephalosporin.

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Xiong, Li-Ze

Chen, Bi-Liang

TI Modified human uterus transplantation using ovarian veins for venous

drainage: the first report of surgically successful robotic-assisted

uterus procurement and follow-up for 12 months

SO FERTILITY AND STERILITY

LA English

DT Article

DE Infertility; uterine factor infertility; uterine transplantation;

DaVinci Robota; human

ID UTERINE TRANSPLANTATION; KIDNEY-TRANSPLANTATION; MYCOPHENOLATE-MOFETIL;

PREGNANCY; SURGERY; RECIPIENTS; GRAFT; AUTOTRANSPLANTATION; OUTCOMES;

SHEEP

AB Objective: To report the 12-month results of the first human uterus transplantation case using robot-assisted uterine retrieval. This type of transplantation may become a treatment for permanent uterine factor infertility.

Design: Case study.

Setting: University hospital.

Patient(s): A 22-year-old woman with complete mullerian agenesis who underwent a previous surgery for vaginal reconstruction. The live uterine donor was her mother.

Intervention(s): The uterus transplantation procedure consisted of robot-assisted uterine procurement, orthotopic replacement and fixation of the retrieved uterus, revascularization, and end-to-side anastomoses of bilateral hypogastric arteries and ovarian-uterine vein to the bilateral external iliac arteries and veins.

Main Outcome Measure(s): Data from preoperative investigations, surgery, and follow-up (12 months).

Result(s): The duration of the donor and recipient surgeries were 6 and 8 hours, 50 minutes, respectively. No immediate perioperative complications occurred in the recipient or donor. The recipient experienced menarche 40 days after transplant surgery, and she has had 12 menstrual cycles since the surgery. No rejection episodes occurred in the recipient.

Conclusion(s): These results demonstrate the feasibility of live-donor uterine transplantation with a low-dose immunosuppressive protocol and the role of DaVinci robotic assistance during human uterine procurement. (C) 2017 by American Society for ReproductiveMedicine.)

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OA hybrid

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ER

PT J

AU Wesol, A

Woolley, S

AF Wesol, Adrianne

Woolley, Shauna

TI Impact of power morcellator removal on hysterectomy practice patterns

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article; Proceedings Paper

CT 83rd Annual Meeting of the

Pacific-Coast-Obstetrics-and-Gynecology-Society

CY SEP 28-OCT 02, 2016

CL Sun Valley, ID

SP Pacific Coast Obstetr & Gynecol Soc

DE Hysterectomy; Laparoscopic surgery; Vaginal morcellation

ID WOMEN

AB Objective: This study was a quality improvement project investigating patterns of hysterectomy practice including changes in surgical techniques and patient outcomes after manufacturer withdrawal of a laparoscopic power morcellator from our hospitals in July 2014.

Study design: This time-series pre and post retrospective review examined data from electronic health records, comparing one year when a laparoscopic power morcellator was available (Year 1, mid-2013 to mid-2014) to one year after withdrawal (Year 2, mid-2014 to mid-2015). Data were from patients of 8 gynecologists in a multispecialty group associated with a large, integrated care and coverage delivery system in Washington State. Analyzed were 100 patients for Year 1 and 133 patients for Year 2. Analysis was by two-sided chi-square tests comparing practice patterns and outcomes in the two years.

Results: For hysterectomy route, no significant difference was seen between Years 1 and 2 in percent surgeries that were abdominal or laparoscopic (including robotic). For minimally invasive hysterectomies, significantly more transvaginal hysterectomies were performed in Year 2 (22%) than Year 1 (14%) (p < 0.05). In Year 2, no laparoscopic supracervical hysterectomies occurred, with total laparoscopic or vaginal hysterectomies performed instead. Transvaginal uterus morcellation increased from 13% in Year 1 to 24% in Year 2 (p < 0.05). Bilateral salpingectomies increased in Year 2 as well (p < 0.05). Among patient factors, estimated blood loss, surgical site infection, total operative time, and hospital length of stay were not significantly different between Years 1 and 2. Body mass index, race/ethnicity, and age did not differ between years. No patients had occult uterine sarcoma.

Conclusion: Surgical practice patterns changed for our group of 8 gynecologists in the year after a laparoscopic power morcellator was withdrawn. Though open hysterectomies did not increase, no laparoscopic supracervical hysterectomies were performed. Total laparoscopic and vaginal hysterectomies and bilateral salpingectomies increased, with reliance on transvaginal uterine tissue-removal techniques. Patient outcomes including surgical infections, length of surgery, estimated blood loss and total hospital stay did not change. Our results suggest that experienced vaginal surgeons can adapt to removal of important surgical equipment and continue to provide minimally invasive hysterectomies without compromising patient outcomes and safety. (C) 2017 Elsevier B.V. All rights reserved.

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PT J

AU Yaghnam, I

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AF Yaghnam, Ibrahim

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TI The feasibility of transvaginal robotic surgery in the repair of pelvic

organ prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic transvaginal surgery; Cystocele; Rectocele; Pelvic organ

prolapse

AB Introduction and hypothesis Pelvic organ prolapse (POP), the descent of one or more pelvic organs, occurs in an estimated 40 to 60% of parous women. Conventional transvaginal surgery for POP has been plagued with high failure rates. The purpose was to determine the safety and feasibility of robotic transvaginal POP surgery.

Methods The da Vinci Surgical Robot, SI was used in the POP surgical procedures. There were two cadavers (aged 18 and 78 years of age; BMI 17.2 and 19.2 respectively). POP-Q scores before intervention were stage 1 for both cadavers.

Results The visualization of anatomical landmarks and the placement of sutures at these locations were successful.

Conclusion Robotic transvaginal POP is a feasible option for POP surgery. Further studies are warranted to determine the role of robotic transvaginal POP repair.

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ER

PT J

AU Zwain, O

Aoun, J

Eisenstein, D

AF Zwain, Omar

Aoun, Joelle

Eisenstein, David

TI Minimally invasive surgery in pelvic floor repair

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE laparoscopy; prolapse; robotics; sacral colpopexy

ID STRESS URINARY-INCONTINENCE; RANDOMIZED CONTROLLED-TRIAL; APICAL VAGINAL

PROLAPSE; RISK-FACTORS; ABDOMINAL SACROCOLPOPEXY; BURCH COLPOSUSPENSION;

ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY;

UTEROVAGINAL PROLAPSE

AB Purpose of review To review the use and efficacy of minimally invasive surgery in pelvic organ prolapse (POP) repair. This review summarizes surgical options for management of POP with special emphasis on minimally invasive surgical approach and discusses the recent experience and feasibility of integrating robot-assisted technology.

Recent findings

Minimally invasive approaches have equal efficacy and less morbidity than laparotomy for POP repair, particularly apical prolapse. Robotics may facilitate the rate of minimally invasive surgery for POP repair with greater cost and as yet no proven superiority for conventional laparoscopy.

Summary

Minimally invasive surgery is the preferred approach to POP repair. Conventional laparoscopic or robotic sacral colpopexy is recommended for apical defect and procidentia.

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J9 CURR OPIN OBSTET GYN

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PT J

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TI Robotic-Assisted Conservative Excision of Retrocervical-Rectal Deep

Infiltrating Endometriosis: A Case Series

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Colorectal endometriosis; Deep infiltrating endometriosis; Rectal

nodulectomy; Robotic-assisted laparoscopy

ID COLORECTAL RESECTION; COMPLICATIONS; BOWEL; CLASSIFICATION; MORBIDITY;

RISK

AB Deep infiltrating endometriosis (DIE) is a complex disease that impairs the quality of life and the fertility of women. Colorectal DIE accounts for 70% to 93% of all the intestinal endometriotic sites and frequently needs a surgical approach. However, the indications for the surgical management of this condition are still controversial. From March 2010 to June 2014, we scheduled 33 consecutive patients presenting with retrocervical-rectal DIE of any diameter not involving the mucosa nor producing rectal stenosis >50% for laparoscopic robotic-assisted nerve-sparing rectal nodulectomy (LRN). All patients were examined preoperatively, at 3 months and 6 months postoperatively, and yearly thereafter. Dysmenorrhea, dyschezia, dyspareunia, and dysuria were evaluated on a 10-point visual analog scale. Among the 33 enrolled patients, 3I (93.9%) fulfilled the selection criteria and were submitted to LRN. In 1 out of 31 available patients (3.2%), a segmental bowel resection was considered necessary for prudential purpose at the end of the nodulectomy procedure. No laparotomic conversion was performed in any case. A wide variety of associated surgical procedures were performed in 25 of 30 patients (83.3%). No intraoperative complications were observed. One grade 3b and 2 grade I postoperative complications were recorded. The mean larger axis of the excised nodules measured on the formalin-fixed specimen was 26.4 mm. We found significant improvements in patient symptoms at a 3-month follow-up which persisted over the time. We observed 2 (6.7%) recurrences of intestinal endometriosis and I (3.3%) recurrence of chronic pelvic pain without clinical and/or radiologic evidence of endometriotic lesions. The mean follow-up time was 27.6 months. We believe that LRN is feasible and safe and shows promising results in terms of radicality, anatomic recurrence rate, and pain recurrence rate for treating isolated retrocervical-rectal DIE not involving the mucosa, without limiting this procedure to nodules smaller than 3 cm. (C) 2017 AAGL. All rights reserved.

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Z9 18

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ER

PT J

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Gargiulo, AR

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Waldman, Ian

Gargiulo, Antonio R.

TI Robotics and Reproductive Surgery

SO SEMINARS IN REPRODUCTIVE MEDICINE

LA English

DT Review

DE robotic surgery; reproductive surgery; minimally invasive surgery;

gynecology; infertility

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; FERTILITY-SPARING SURGERY;

ANTI-MULLERIAN HORMONE; MICROSURGICAL TUBAL REANASTOMOSIS; TRANSLUMENAL

ENDOSCOPIC SURGERY; DEEP INFILTRATING ENDOMETRIOSIS; SPONTANEOUS UTERINE

RUPTURE; OVARIAN RESERVE; ABDOMINAL MYOMECTOMY; VASECTOMY REVERSAL

AB Robotic technology applied to laparoscopy augments the armamentarium of the reproductive specialist. Uterine leiomyomas, adenomyosis, endometriosis, adnexal masses, sterilization reversal, and fertility preservation techniques can all be addressed with a robotic surgery skill set. Additionally, new approaches with single site and natural orifice surgery will continue to maximize advanced opportunities for safe, effective, and cosmetically conscious (patient-centered) approaches to surgical care. Enhanced postoperative recovery pathways are fully adaptable to these robotic procedures and improve patient acceptability while controlling costs.

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J9 SEMIN REPROD MED

JI Semin. Reprod. Med.

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ER

PT J

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TI Does Surgical Teaching Take Time? Resident Participation in Minimally

Invasive Hysterectomy for Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Minimally invasive surgery; Resident involvement

ID IMPACT; COMPLICATIONS; OUTCOMES

AB Study Objective: To determine the association between resident involvement and operative time for minimally invasive surgery (MIS) for endometrial cancer.

Design: A retrospective cohort study (Canadian Task Force classification 11-2).

Setting: An integrated health care system in Northern California.

Patients: A total of 1433 women who underwent MIS for endometrial cancer and endometrial intraepithelial neoplasia from January 2009 to January 2014.

Interventions: Resident participation in 430 of 688 laparoscopic cases (62%) and 341 of 745 robotic cases (46%).

Measurements and Main Results: The primary outcome was the impact of resident involvement on surgical time. When residents were involved in laparoscopic and robotic surgery, there was an increase of 61 minutes (median operative time, 186 vs 125 minutes; p < .001) and 31 minutes (median operative time, 165 vs 134 minutes; p < .001), respectively. Resident participation was associated with increased operative times in all levels of surgical complexity from hysterectomy alone to hysterectomy with pelvic and para-aortic lymph node dissection. Resident participation was also associated with increased major intraoperative complications (3.4% vs 1.8%, p = .02) as well as major postoperative complications (6.4% vs 3.8%, p = .003).

Conclusion: The presence of a resident was associated with a 32% increase in operative time for minimally invasive cases in gynecologic oncology for endometrial cancer. Because of the retrospective nature, we cannot infer causality of operative outcomes because residents were also involved in more high-risk patients and complex cases. For health care systems using surgical metrics, there may be a need to allocate more time for resident involvement. (C) 2017 AAGL. All rights reserved.

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Z9 6

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ER

PT J

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TI Does Ulipristal Acetate Affect Surgical Experience at Laparoscopic

Myomectomy?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Myomas; Selective progesterone receptor modulator; Surgery

ID 3-MONTH TREATMENT; HYSTEROSCOPIC MYOMECTOMY; UTERINE MYOMAS

AB Study Objective: To compare surgical experience of laparoscopic/robotic myomectomy in premenopausal patients pretreated with ulipristal acetate (UPA) with women not hormonally pretreated.

Design: A retrospective, multicenter cohort study of laparoscopic/robotic myomectomy procedure videos (Canadian Task Force Classification III).

Setting: Multiple university-affiliated tertiary care hospitals.

Patients: Fifty-five premenopausal women who underwent laparoscopic/robotic myomectomy for intramural myomas and were either pretreated with 3 months of UPA or had no hormonal pretreatment.

Interventions: Laparoscopic/robotic myomectomy surgical videos were independently reviewed by 2 gynecologists blinded to whether or not patients received pretreatment with UPA. Each procedure was scored using a novel 22-point surgical global rating tool containing 6 subscales: depth of myometrial incision, ease of myoma-myometrium cleavage plane identification, ease of myoma detachment, blood loss during myoma detachment, myometrial blood loss after myoma detachment, and myoma consistency.

Measurements and Main Results: Participating surgeons submitted 55 videos of laparoscopic/robotic myomectomy procedures recorded over a 3-year period (2012-2015). Fifty met the inclusion criteria (25 UPA-treated patients and 25 patients without hormonal pretreatment). Patients treated with UPA were more likely to be older than patients with no medical pretreatment (mean age = 33.5 vs 38.3 years, p =.002). There were no statistically significant differences regarding other baseline characteristics such as the largest diameter of myoma removed, the number of myomas removed, or the estimated blood loss. There was no difference in the physician assessors' mean global rating score for patients with UPA pretreatment versus no pretreatment (12.4 vs 13.4, p =.23). Within the 6 subscales, no differences were observed between the 2 groups. Each video was graded independently by 2 assessors, and there was high inter-rater agreement for the total score and each subscale.

Conclusion: There was no difference in surgical experience for myomectomies of patients pretreated with UPA versus those without medical pretreatment. (C) 2017 AAGL. All rights reserved.

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TI Comparison of Morcellation Techniques at the Time of Laparoscopic

Hysterectomy and Myomectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Laparoscopy; Minilaparotomy; Morcellation; Myomectomy

AB Study Objective: To compare perioperative outcomes associated with the use of 3 techniques for tissue removal at the time of laparoscopic hysterectomy and myomectomy.

Design: A retrospective cohort study (Canadian Task Force classification 11-2).

Setting: An academic hospital in Boston, MA. Patients: Women who underwent a laparoscopic or robot-assisted laparoscopic hysterectomy or myomectomy involving tissue morcellation in 2014.

Interventions: One of 3 morcellation techniques: electronic power morcellation (PM), manual vaginal tnorcellation via the vagina (VM), or manual morcellation via minilaparotomy (ML).

Measurements and Main Results: Of the 297 cases included in this study (137 myomectomies, 62 total laparoscopic hysterectomies, and 98 laparoscopic supracervical hysterectomies), 96% of the cases were performed by fellowship trained surgeons using conventional laparoscopy. Containment bags were used at the time of tissue extraction in 77% of the cases. Baseline characteristics and perioperative outcomes were similar in all groups. In hysterectomy cases, the average specimen size was largest in the ML group (591 +/- 419 gin the ML group compared with 368 +/- 293 gin the PM group and 449 +/- 175 g in the VM group, p = .0009). After multivariate regression, no significant difference was found in blood loss, length of stay, or complications. The operative time was shorter in the PM group compared with the ML group by 16 minutes (mean = 140 minutes [95% confidence interval, 130-149 minutes] compared with 156 [95% confidence interval, 146-167], p = .02); this association remained significant once additionally adjusting for the use or nonuse of containment bags (p = .05).

Conclusion: We did not detect a significant difference between the 3 morcellation techniques when comparing the perioperative complications although the longest operative times were noted for the minilaparotomy approach. All 3 morcellation techniques represent viable options for tissue extraction at the time of minimally invasive surgery. (C) 2017 AAGL. All rights reserved.

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Z9 23

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PT J

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TI Robotic Radical Parametrectomy With Upper Vaginectomy and Pelvic

Lymphadenectomy in Patients With Occult Cervical Carcinoma After

Extrafascial Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Radical parametrectomy; Robotic surgery

ID PARAMETRIAL INVOLVEMENT; SURGICAL-TREATMENT; RADIATION-THERAPY;

LOW-RISK; CANCER; STAGE; MANAGEMENT; SURGERY; IDENTIFICATION;

RADIOTHERAPY

AB Study Objective: To confirm the safety and feasibility outcomes of robotic radical parametrectomy and pelvic lymphadenectomy and compare the clinicopathological features of women requiring adjuvant treatment with the historical literature.

Design: Retrospective cohort study and review of literature (Canadian Task Force classification II-2).

Setting: Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill.

Patients: All patients who underwent robotic radical parametrectomy with upper vaginectomy (RRPV), and pelvic lymphadenectomy for occult cervical cancer discovered after an extrafascial hysterectomy at our institution between January 2007 and December 2015.

Interventions: RRPV and pelvic lymphadenectomy for occult cervical cancer discovered after an extrafascial hysterectomy. We also performed a literature review of the literature on radical parametrectomy after occult cervical carcinoma.

Measurements and Main Results: Seventeen patients with invasive carcinoma of the cervix discovered after extrafascial hysterectomy underwent RRPV with bilateral pelvic lymphadenectomy. There were 2 intraoperative complications, including I bowel injury and 1 bladder injury. One patient required a blood transfusion of 2 units. Three patients underwent adjuvant treatment with chemoradiation with radiation-sensitizing cisplatin. One of these patients had residual carcinoma on the upper vagina, I patient had positive parametria and pelvic nodes, and 1 patient had positive pelvic lymph nodes. No patients experienced recurrence, and 1 patient died from unknown causes at 59.4 months after surgery. We analyzed 15 studies reported in the literature and found 238 women who underwent radical parametrectomy; however, no specific preoperative pathological features predicted outcomes, the need for adjuvant treatment, or parametrial involvement.

Conclusion: RRPV is a feasible and safe treatment option. As reflected in the literature, RRPV can help avoid empiric adjuvant chemoradiation; however, no pathological features predict the need for adjuvant treatment after surgery. (C) 2017 AAGL. All rights reserved.

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Z9 3

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U2 6

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TI Robot-assisted vesicovaginal fistula repair: a safe and feasible

technique

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic surgery; Vesicovaginal fistula; Case series

ID LAPAROSCOPIC REPAIR

AB Open transabdominal repair of vesicovaginal fistula (VVF) requires a long cystotomy incision, suprapubic drainage and delayed recovery. Laparoscopic repair is limited by difficult suturing in pelvic procedures. Therefore, the utility of robotic assistance is being increasingly explored. We share our initial experience of robot-assisted laparoscopic VVF repair.

The data from patients who underwent robot-assisted VVF repair from December 2014 to August 2016 were recorded and analyzed. Patients underwent standard preoperative evaluation. After cystovaginoscopy and placement of an access catheter across the fistula, a four-port transperitoneal approach was used. Following adhesiolysis, limited posterior cystotomy was performed. The vaginal and bladder flaps were separated and repaired in the transverse and vertical directions, respectively. V-Loc sutures were used for bladder closure. Omental/sigmoid colon epiploicae or a peritoneal flap was interposed. A pelvic drain was placed.

During the study period, 30 patients underwent surgery, of whom 11 (36.7 %) had complex VVF (9 with failure of a previous repair, 1 following radiotherapy, and 1 with a large defect following obstructed labor), and 27 had supratrigonal VVF. The mean age of the patients was 43.5 +/- 8.6 years. The mean operative time was 133 +/- 48 min. Median blood loss was 50 ml (IQR 50 ml). No suprapubic catheter was placed. The median durations of drain placement and hospital stay were 3 days (IQR 2 days) and 7.5 days (IQR 4.5 days), respectively. The median duration of follow up was 38 weeks (IQR 46 weeks). No recurrence was seen in 28 patients (93.3 %).

Current data suggest that robot-assisted VVF repair is safe and feasible and probides the advantages of minimally invasive surgery.

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Z9 20

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PT J

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TI Minimally Invasive Myomectomy

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE uterine fibroids; myomectomy; minimally invasive surgery; robotic

myomectomy; laparoscopic myomectomy

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; ABNORMAL UTERINE PERISTALSIS; OF-LIFE

QUESTIONNAIRE; RANDOMIZED-TRIAL; MINILAPAROTOMIC MYOMECTOMY;

REPRODUCTIVE OUTCOMES; ABDOMINAL MYOMECTOMY; INTRAMURAL FIBROIDS;

ADHESION FORMATION; SINGLE-CENTER

AB Uterine fibroids can significantly impact a woman's health, fertility, and quality of life. When medical therapy fails, surgery is recommended; the gold standard in uterine-sparing surgery is myomectomy. The evidence-based benefits of minimally invasive myomectomy are detailed in this manuscript. Minimally invasive myomectomy techniques are reviewed, including laparoscopic, robotic-assisted, and laparoscopic or robotic-assisted with mini-laparotomy. Criteria for minimally invasive myomectomy are outlined and preoperative planning is discussed. Both institutional data and data from systematic reviews are included to compare outcomes. Each myomectomy case should take into account clinical characteristics of the myomas, patient preference, and surgeon skill and experience.

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Z9 18

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SC Obstetrics & Gynecology

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ER

PT J

AU Matthews, CA

AF Matthews, Catherine A.

TI New Developments in Robotics and Single-site Gynecologic Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE gynecology; emerging technology; new developments; robotic surgery;

natural orifice surgery; NOTES; single-site; single-port; cost;

complications

ID TRANSLUMINAL ENDOSCOPIC SURGERY; CONVENTIONAL LAPAROSCOPIC HYSTERECTOMY;

MINIMALLY INVASIVE HYSTERECTOMY; VAGINAL HYSTERECTOMY; PERIOPERATIVE

COMPLICATIONS; SURGICAL OUTCOMES; RANDOMIZED-TRIAL; BENIGN DISEASE;

UNITED-STATES; SACROCOLPOPEXY

AB Within the last 10 years there have been significant advances in minimal-access surgery. Although no emerging technology has demonstrated improved outcomes or fewer complications than standard laparoscopy, the introduction of the robotic surgical platform has significantly lowered abdominal hysterectomy rates. While operative time and cost were higher in robotic-assisted procedures when the technology was first introduced, newer studies demonstrate equivalent or improved robotic surgical efficiency with increased experience. Single-port hysterectomy has not improved postoperative pain or subjective cosmetic results. Emerging platforms with flexible, articulating instruments may increase the uptake of single-port procedures including natural orifice transluminal endoscopic cases.

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PT J

AU Moore, R

Moriarty, C

Chinthakanan, O

Miklos, J

AF Moore, Robert

Moriarty, Christopher

Chinthakanan, Orawee

Miklos, John

TI Laparoscopic sacrocolpopexy: operative times and efficiency in a

high-volume female pelvic medicine and laparoscopic surgery practice

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Sacrocolpopexy; Laparoscopic sacrocolpopexy; Prolapse; Operative time;

Mesh

ID ROBOT-ASSISTED SACROCOLPOPEXY; VAGINAL VAULT PROLAPSE; ORGAN PROLAPSE;

HYSTERECTOMY; EPIDEMIOLOGY; OUTCOMES; COSTS; RISK

AB There has been a trend toward robotic sacrocolpopexy in the United States despite longer operating times and higher costs compared with traditional laparoscopy. The current study objective was to evaluate incision to closure times of laparoscopic sacrocolpopexy in a urogynecologic practice with extensive experience in the laparoscopic approach for pelvic reconstruction.

We conducted a single-center retrospective evaluation of consecutive patients undergoing laparoscopic sacrocolpopexy for vaginal vault prolapse using a permanent polypropylene Y-mesh over a 1-year period. Standard operative technique for sacrocolpopexy was used. Four to six sutures were placed on the anterior leaflet of the mesh, and six to eight sutures were placed posteriorly. Two sutures were placed in the presacral ligament. Mesh was retroperitonealized with a running 2-0 monocryl suture. Primary outcomes were total operating time and time to complete laparoscopic sacrocolpopexy.

One hundred and twenty-seven consecutive patients with an average age of 60.04 +/- 10.14 years, body mass index (BMI) 25.79 +/- 4.52 kg/m(2), underwent laparoscopic sacrocolpopexy for vaginal vault prolapse. Ninety-two patients had other procedures performed intraoperatively: laparoscopic-assisted vaginal hysterectomy, laparoscopic paravaginal repair, laparoscopic enterocele repair, and/or laparoscopic enterolysis. Mean total operative time for all laparoscopic procedures completed was 107.45 +/- 34.00 min. The average time to perform sacrocolpopexy, including incision and closure, was 52.78 +/- 13.09 min.

This retrospective evaluation provides further evidence that traditional laparoscopic sacrocolpopexy should be considered a primary therapy for vaginal vault prolapse.

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accepted travel expenses and speaking fees, payment for research, and

acted as a consultant to American Medical Systems, Christopher Moriarty

none, Orawee Chinthakanan none, John Miklos accepted travel expenses and

speaking fees, payment for research, and acted as a consultant to

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AU Nam, SH

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Choi, C

Nam, SH

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Choi, Chahien

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Kim, Woo Young

TI A comparison between reduced-port robotic surgery and multiport

robot-assisted laparoscopy for myomectomy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Robotic myomectomy; RPRS; Perioperative outcome

ID SINGLE-SITE PLATFORM; TOTAL HYSTERECTOMY; OUTCOMES; CHOLECYSTECTOMY

AB Objective: To compare the surgical outcomes between reduced-port robotic surgery (RPRS) using the Octo-Port channel and multiport robot-assisted laparoscopy for myomectomy.

Study design: This prospective study compared and analyzed data from 15 consecutive women who underwent RPRS for myomectomy and 15 consecutive women who underwent multiport robot-assisted laparoscopy to treat symptomatic uterine myoma from January 2016 to June 2016. The patients were treated by two surgeons at two institutions.

Results: The two study groups did not differ demographically. The differences in surgical outcomes, such as docking time, console time, hospital stay, estimated blood loss, Hb change, myoma count, and weight, also did not differ between the two groups. On the contrary, the number of port site was only 2 in RPRS compared with 4-5 in multiport robot-assisted laparoscopic myomectomy.

Conclusion: RPRS for myomectomy seems technically feasible and safe, with short-term perioperative outcomes similar to those from multiport robot-assisted laparoscopic myomectomy. (C) 2017 Elsevier B.V. All rights reserved.

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TI Vaginal vs. robotic hysterectomy for patients with endometrial cancer: A

comparison of outcomes and cost of care

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive surgery; Vaginal hysterectomy;

Robotic hysterectomy; Cost of care

ID ABDOMINAL HYSTERECTOMY; CUFF DEHISCENCE; RISK; LYMPHADENECTOMY;

METASTASIS; MORBIDITY; SURGERY; QUALITY; IMPROVE

AB Objective. To compare outcomes and cost for patients with endometrial cancer undergoing vaginal hysterectomy (VH) or robotic hysterectomy (RH), with or without lymphadenectomy (LND).

Methods. Patients undergoing planned VH (and laparoscopic LND) or RH (and robotic LND) between January 2007 and November 2012 were reviewed. Patients with stage IV disease, synchronous cancer, synchronous surgery, or treated with palliative intent were excluded. Patients were objectively triaged to LND per institutional protocol based on frozen section. Outcomes were compared between VH and RH groups matched 1:1 on propensity scores.

Results. VH was planned in 153 patients; 60 (39%) had concurrent LND while 93 (61%) were low risk and did not require LND. RH was planned in 398 patients; 225 (56%) required concurrent LND and 173 (44%) did not. Among 50 PS-matched pairs without LND, there was no significant difference in complications, length of stay, readmission, or progression free survival. However, median operative time was 13 h longer and median 30-day cost $3150 higher for RH compared to VH (both p < 0.001). Among patients requiring LND, 42 PS-matched pairs were identified. Median operative time was not different when pelvic and para-aortic LND was performed, and 12 min longer in the VH group for pelvic LND alone (p = 0.03). Median 30-day cost was $921 higher for RH compared to VH when LND was required (p = 0.08).

Conclusion. Utilization of vaginal hysterectomy for endometrial cancer results in similar surgical and oncologic outcomes and lower costs compared to RH and should be considered for appropriate patients with a low risk of requiring LND. (C) 2017 Published by Elsevier Inc.

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TI Trends in Mode of Hysterectomy After the US Food and Drug Administration

Power Morcellation Advisory

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT Annual Meeting of the European-Society-for-Gynaecological-Endoscopy

CY OCT 02-05, 2016

CL Brussels, BELGIUM

SP European Soc Gynaecol Endoscopy

AB OBJECTIVE: To evaluate the trends in mode of surgery for benign hysterectomy after the 2014 U.S. Food and Drug Administration (FDA) morcellation guidelines.

METHODS: This is a retrospective review of all patients who underwent a hysterectomy for benign indications, specifically for leiomyomas, at Brigham and Women's Hospital from 2013 to 2015. The rates of abdominal, vaginal, laparoscopic, and robotic-assisted laparoscopic hysterectomy as well as the perioperative outcomes were compared over the study period. Analysis was performed using multi-variable linear, multinomial, and logistic regression. Regression models were adjusted for potential confounders.

RESULTS: From 2013 to 2015, 1,530 patients underwent a hysterectomy for benign indications and 639 patients underwent the procedure for the indication of uterine leiomyomas; there was a decrease in the number of hysterectomy cases in the later years. Focusing on the patients with leiomyomas alone, there was a 40-60% decreased odds of a minimally invasive procedure in 2014 or 2015 compared with 2013 [adjusted odds ratio (OR) 0.53 (0.29-0.97) in 2014 and adjusted OR 0.40 (0.22-0.74) in 2015, P=.003]. A 24% decrease in the supracervical approach to hysterectomy was also noted. Despite these trends, the majority of cases in each year were still performed in a minimally invasive fashion. The factor most strongly associated with undergoing a minimally invasive hysterectomy was having a fellowship-trained surgeon perform the procedure [adjusted OR 6.80 (3.65-12.7), P<.001]. There was no significant difference between the year of surgery and occurrence of intraoperative complications or reoperation.

CONCLUSION: Although key perioperative outcomes remained similar, the overall rate of minimally invasive surgery declined at our institution after the FDA's recommendations. With changing practice patterns and vigilance surrounding power morcellation, gynecologic surgeons may still offer patients minimally invasive procedures with all of the accompanying advantages.

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NR 12

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Z9 40

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U2 1

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ER

PT J

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TI Temporal trends in minimally invasive myomectomy before and after the US

Food and Drug Administration recommendation against electric

morcellation

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Food and Drug Administration; Laparoscopy; Minimally invasive surgery;

Morcellation; Myomectomy; Robotic surgery

ID CONTAINED POWER MORCELLATION; LAPAROSCOPIC MYOMECTOMY; HYSTERECTOMY

AB Objective: To investigate the temporal trends in minimally invasive myomectomy at one reproductive medicine center before and after the US Food and Drug Administration (FDA) recommendation against electric morcellation.

Methods: A retrospective chart review was undertaken of patients undergoing minimally invasive myomectomy between April 1, 2012, and April 30, 2016, at a center in New York. Temporal trends in laparoscopic myomectomy (LM), robot-assisted laparoscopic myomectomy (RAM), and laparoscopically assisted myomectomy (LAM), and intraoperative and postoperative outcomes before and after the April 2014 recommendation were compared.

Results: Minimally invasive myomectomy was performed in 73 patients. No difference was noted in the rates of minimally invasive myomectomy 2years before (35/74 [47.3%]) and after (38/79 [48.1%]) the FDA's recommendation. The ratio of abdominal to minimally invasive myomectomy remained relatively constant before (68/59=1.15) and during the study period (80/73=1.10). There was a significant decrease in LM and RAM and a corresponding rise in LAM immediately after the recommendation (P<0.001).

Conclusion: The rates of minimally invasive myomectomy before and after the FDA's recommendation did not differ, indicating that technical modifications to laparoscopic technique can allow surgeons to offer minimally invasive myomectomy to patients with symptomatic leiomyomas.

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PT J

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TI New Developments in Minimally Invasive Gynecologic Oncology Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE minimally invasive surgery; laparoscopy; robotic surgery; single-site

surgery; sentinel lymph node; gynecologic oncology

ID LAPAROENDOSCOPIC SINGLE-SITE; LAPAROSCOPIC RADICAL HYSTERECTOMY; STAGE

CERVICAL-CANCER; EARLY ENDOMETRIAL CANCER; PELVIC LYMPHADENECTOMY;

ROBOTIC SURGERY; CONVENTIONAL LAPAROSCOPY; VAGINAL HYSTERECTOMY;

INCISION LAPAROSCOPY; SURGICAL-MANAGEMENT

AB Minimally invasive surgery continues to transform the field of gynecologic oncology and has now become the standard of care for many early-stage malignancies. The proven benefits of minimally invasive surgery are driving the rapid introduction and dissemination of novel technologies and the increasing ability to perform even the most complex procedures less invasively. In this article, we will review the current literature on traditional multiport laparoscopy, robotic-assisted laparoscopy, laparoendoscopic single-site surgery as well as robotic-assisted laparoendoscopic single-site surgery, with a specific focus on their role in the treatment of gynecologic malignancies.

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TI New Developments in Surgery for Endometriosis and Pelvic Pain

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometriosis; pelvic pain; laparoscopy; fluorescence imaging; surgery

ID SURGICAL-TREATMENT; DEEP ENDOMETRIOSIS; EXCISION; MANAGEMENT; TRIAL

AB Endometriosis is a common disease affecting reproductive age women. Pain is one of the most common symptoms associated with endometriosis. When medical therapy has failed or in known deeply infiltrating endometriosis, surgical management is warranted. Laparoscopy is the gold standard for diagnosis and treatment of endometriosis. Recent developments in surgery have shown the feasibility of robotic surgery for endometriosis, although these methods have not been shown to be superior to conventional laparoscopy. Enhanced imaging techniques including fluorescence imaging and narrow band imaging have also been studied. However, long-term clinical benefits have yet to be demonstrated.

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PT J

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TI Increasing Utilization of Minimally Invasive Hysterectomy

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE minimally invasive hysterectomy; vaginal; laparoscopic

ID VAGINAL HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY; TRENDS; WOMEN;

COMPLICATIONS; TRIAL; ROUTE

AB Once the decision to perform a hysterectomy has been made, the type and route of hysterectomy must be chosen, and efforts made to accomplish the surgery as safely as possible. Hysterectomy can be performed vaginally, abdominally with laparoscopic or robotic assistance, or open. The main goal of gynecologic surgeons should be to lower the rate of open abdominal hysterectomy and increase use of both vaginal and laparoscopic hysterectomy in their patients. We discuss efforts to accomplish a greater use of minimally invasive hysterectomy.

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NR 40

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Z9 7

U1 0

U2 3

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PT J

AU Wright, JD

Cham, S

Chen, L

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Hou, JY

Tergas, AI

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Ananth, CV

Neugut, AI

Hershman, DL

AF Wright, Jason D.

Cham, Stephanie

Chen, Ling

Burke, William M.

Hou, June Y.

Tergas, Ana I.

Desai, Vrunda

Hu, Jim C.

Ananth, Cande V.

Neugut, Alfred I.

Hershman, Dawn L.

TI Utilization of sentinel lymph node biopsy for uterine cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial cancer; lymphadenectomy; sentinel lymph node; uterine cancer

ID ENDOMETRIAL CANCER; TREATMENT FAILURE; LYMPHADENECTOMY; HYSTERECTOMY;

TRIAL; WOMEN; RISK

AB BACKGROUND: To limit the potential short and long-term morbidity of lymphadenectomy, sentinel lymph node biopsy has been proposed for endometrial cancer. The principle of sentinel lymph node biopsy relies on removal of a small number of lymph nodes that are the first drainage basins from a tumor and thus the most likely to harbor tumor cells. While the procedure may reduce morbidity, efficacy data are limited and little is known about how commonly the procedure is performed.

OBJECTIVE: We examined the patterns and predictors of use of sentinel lymph node biopsy and outcomes of the procedure in women with endometrial cancer who underwent hysterectomy.

STUDY DESIGN: We used the Perspective database to identify women with uterine cancer who underwent hysterectomy from 2011 through 2015. Billing and charge codes were used to classify women as having undergone lymphadenectomy, sentinel lymph node biopsy, or no nodal assessment. Multivariable models were used to examine clinical, demographic, and hospital characteristics with use of sentinel lymph node biopsy. Length of stay and cost were compared among the different methods of nodal assessment.

RESULTS: Among 28,362 patients, 9327 (32.9%) did not undergo nodal assessment, 17,669 (62.3%) underwent lymphadenectomy, and 1366 (4.8%) underwent sentinel lymph node biopsy. Sentinel lymph node biopsy was performed in 1.3% (95% confidence interval, 1.0-1.6%) of abdominal hysterectomies, 3.4% (95% confidence interval, 2.7-4.1%) of laparoscopic hysterectomies, and 7.5% (95% confidence interval, 7.0-8.0%) of robotic-assisted hysterectomies. In a multivariable model, more recent year of surgery was associated with performance of sentinel lymph node biopsy. Compared to abdominal hysterectomy, those undergoing laparoscopic (adjusted risk ratio, 2.45; 95% confidence interval, 1.89-3.18) and robotic-assisted (adjusted risk ratio, 2.69; 95% confidence interval, 2.19-3.30) hysterectomy were more likely to undergo sentinel lymph node biopsy. Among women who underwent minimally invasive hysterectomy, length of stay and cost were lower for sentinel lymph node biopsy compared to lymphadenectomy.

CONCLUSION: The use of sentinel lymph node biopsy for endometrial cancer increased from 2011 through 2015. The increased use was most notable in women who underwent a robotic-assisted hysterectomy.

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RI Hershman, Dawn/AAG-2114-2020; Hou, June/L-6992-2019

NR 33

TC 20

Z9 21

U1 0

U2 6

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EI 1097-6868

J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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PG 13

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA FA2MN

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ER

PT J

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Lee, SR

Jeong, K

Moon, HS

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Rho, A. Mi

Lee, Sa Ra

Jeong, Kyungah

Moon, Hye-Sung

TI Robotic Single-Site Myomectomy: Clinical Analysis of 61 Consecutive

Cases

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Myoma; Robotic single-site myomectomy

ID LAPAROSCOPIC SURGERY; HYSTERECTOMY

AB Study Objectives: To report 61 consecutive cases of successful robotic single-site myomectomy (RSSM), and to evaluate the feasibility and safety of RSSM.

Design: Retrospective analysis of 61 cases involving RSSM (Canadian Task Force classification III).

Setting: Department of Obstetrics and Gynecology, College of Medicine, Robot Surgery Center, Ewha Womans University, Seoul, Republic of Korea.

Patients: Sixty-one patients who underwent RSSM performed by 3 gynecologic surgeons at Ewha Womans University between December 2014 and May 2016.

Interventions: We analyzed the patients' baseline characteristics and surgical variables and the trends in operation-related variables according to surgeon's level of experience with RSSM.

Measurements and Main Results: There were no cases of conversion to laparotomy or robotic multisite myomectomy. RSSM was successful for multiple uterine myomas up to 12 in number and for large myomas up to 12.8 cm in longest diameter. In terms of myoma location, RSSM was successful for all types of myomas, including subserosal, intramural, and intra-ligamentary. The mean docking time was 5.45 +/- 2.84 minutes (2.0 similar to 12.0 minutes), mean total operation time was 135.98 +/- 59.62 minutes (60 similar to 295 minutes), mean estimated blood loss was 182.62 +/- 153.02 mL (10 similar to 600 mL), and mean skin incision length was 2.70 +/- 0.19 cm (2.4 similar to 3.10 cm). The mean time to postoperative gas passage was 28.71 +/- 12.99 hours (3.33 similar to 76.50 hours), and the mean duration of hospitalization was 4.21 +/- 0.84 days (3 similar to 6 days). No patient required additional analgesics other than applied intravenous patient-controlled analgesia. The mean change in hemoglobin level was 2.43 +/- 0.87 g/dL, and the incidence of postoperative anemia requiring blood transfusion was only 3.3% (2 cases). No intraoperative or perioperative complications were noted.

Conclusion: RSSM is a feasible and safe procedure even in cases large, multiple, and intramural type myomas. Therefore, this option could be extended to appropriately selected patients. (C) 2017 AAGL. All rights reserved.

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NR 22

TC 23

Z9 26

U1 0

U2 2

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EI 1553-4669

J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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BP 632

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PG 8

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA EV1IK

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ER

PT J

AU Eriksson, AG

Beavis, A

Soslow, RA

Zhou, Q

Abu-Rustum, NR

Gardner, GJ

Zivanovic, O

Roche, KL

Sonoda, Y

Leitao, MM

Jewell, EL

AF Eriksson, Ane Gerda

Beavis, Anna

Soslow, Robert A.

Zhou, Qin

Abu-Rustum, Nadeem R.

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Zivanovic, Oliver

Roche, Kara Long

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TI A Comparison of the Detection of Sentinel Lymph Nodes Using Indocyanine

Green and Near-Infrared Fluorescence Imaging Versus Blue Dye During

Robotic Surgery in Uterine Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Uterine cancer; Sentinel lymph nodes; Indocyanine green; Near-infrared

fluorescence imaging; Robotic surgery

ID ENDOMETRIAL CANCER; LYMPHADENECTOMY; RISK

AB Objectives The objective of this study was to assess and compare the sentinel lymph node (SLN) detection rate with indocyanine green (ICG) and near-infrared fluorescence imaging versus blue dye using the robotic platform in patients with uterine cancer.

Methods We identified all patients with uterine cancer undergoing SLN mapping using ICG or blue dye on the robotic platform from January 2011 to December 2013. Our institutional SLN algorithm and pathologic processing protocol were adhered to uniformly. We compared detection rates of SLNs stratified by dye used. Appropriate statistical tests were used.

Results A total of 472 patients were identified. ICG was used in 312 patients (66%) and blue dye in 160 patients (34%). Successful mapping was achieved in 425 (90%) of 472 patients. Mapping was bilateral in 352 patients (75%) and unilateral in 73 patients (15%); 47 patients (10%) did not map. Successful mapping was achieved in 295 (95%) of 312 patients using ICG compared with 130 (81%) of 160 patients using blue dye (P < 0.001). Mapping was bilateral in 266 (85%) of 312 patients in the ICG group compared with 86 (54%) of 160 in the blue dye group (P < 0.001). Additional lymph node dissection beyond removal of the SLNs was performed in 122 patients (39%) mapped with ICG compared with 98 patients (61%) mapped with blue dye (P < 0.001).

Conclusions The SLN detection rate was superior when mapping with ICG rather than blue dye. Bilateral mapping was significantly improved, resulting in a lower rate of additional lymphadenectomy.

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FU National Institutes of Health/National Cancer Institute Cancer Center

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FX This research was funded in part through the National Institutes of

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Z9 40

U1 1

U2 5

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

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PG 5

WC Oncology; Obstetrics & Gynecology

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GA EU0GD

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ER

PT J

AU Kammerer-Doak, D

Svabik, K

Bazi, T

AF Kammerer-Doak, Dorothy

Svabik, Kamil

Bazi, Tony

TI Variability in practice patterns in stress urinary incontinence and

pelvic organ prolapse: results of an IUGA survey

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Practice patterns; Physician survey; Academic practice; Pelvic floor

disorders; Stress urinary incontinence; Urodynamic studies

ID INTERNATIONAL-UROGYNECOLOGICAL-ASSOCIATION; RANDOMIZED CONTROLLED-TRIAL;

RECONSTRUCTIVE SURGERY; SACROCOLPOPEXY; FLOOR

AB Members of the International Urogynecological Association (IUGA) come from different geographic locations and practice settings. A member survey regarding practice patterns provides valuable information for practitioners and researchers alike, and allows the IUGA to discover areas to focus on education and information dissemination.

A questionnaire was developed by the IUGA Research and Development committee and distributed electronically to IUGA surgeons. Answers were analyzed in reference to demographics, geographic distribution, and academic affiliation.

Five hundred sixty-four members answered the questionnaire, representing a 28 % response rate, and closely reflecting the geographic distribution of IUGA membership. Preferred surgical treatment for uncomplicated SUI was the mid-urethral trans-obturator sling (49.7 %). Vaginal mesh was mainly used for repair of recurrent POP (20.4 %). Pessary use was offered "always" or "frequently" by 61.5 %, with no difference in academic affiliation, but significant differences based on region of practice. Compared to practitioners in non-academic centers, those with academic affiliation utilized Urodynamic studies (UDS) and Magnetic Resonance Imaging (MRI) more frequently in the evaluation of POP. Regions of practice significantly influenced the majority of practice patterns, with the highest impact found in the use of robotic assistance.

Many practice patterns in the evaluation and treatment of POP and SUI depend on academic affiliation and geographic location. Practice patterns are not always based on most recent evidence-based data.

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FU Astellas Pharmaceuticals

FX D. Kammerer-Doak: none; K. Svabik: Astellas Pharmaceuticals (paid travel

expenses or honoraria); T. Bazi: none.

NR 15

TC 12

Z9 13

U1 0

U2 6

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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PG 10

WC Obstetrics & Gynecology; Urology & Nephrology

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PM 27752749

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ER

PT J

AU Kimmig, R

Buderath, P

Mach, P

Rusch, P

Aktas, B

AF Kimmig, Rainer

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TI Surgical treatment of early ovarian cancer with compartmental resection

of regional lymphatic network and indocyanine-green-guided targeted

compartmental lymphadenectomy (TCL, paraaortic part)

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Sentinel Lymph Node; Lymph Node Excision; Indocyanine Green; Robotic

Surgery; Ovarian Neoplasms

ID SENTINEL NODES; MALIGNANCIES; MANAGEMENT; SURGERY

AB Objective: Whether pelvic and para-aortic lymphadenectomy is of therapeutic benefit in advanced ovarian cancer will remain unclear until the publication of the Arbeitsgemeinschaft Gynakologische Onkologie lymphadenectomy in ovarian neoplasms (AGO LION) trial. In early ovarian cancer, however, lymphadenectomy seems mandatory for diagnostic and also therapeutic reasons [1-3].

Methods: Complete systematic lymphadenectomy is accompanied by morbidity which may be reduced by sentinel node biopsy already established for several solid tumors [4-6]. In ovarian cancer there are 2 main pathways in lymphatic drainage: along the ovarian vessels to the para-aortic nodes and the uterine vessels to the iliac lymph compartments [7]. Following injection of radioactive dye into the ovarian ligaments this could be confirmed suggesting that there is bidirectional flow at this level of the ovarian and uterine lymphatic pathways [8]. Indocyanine-green-guided (ICG) injection to the uterine corpus seems to be equally effective in labelling the "uterine Mullerian" and the "ovarian mesonephric" lymphatic drainage of the ovary [9,10].

Results: This technique [9] was applied and will be outlined in the video showing the procedure with respect to the para-aortic lymphatic drainage. Isolated sentinel node biopsy and tumor excision will not resect the organ compartment together with its super-ordinated draining lymphatic system at risk.

Conclusion: Thus, the authors suggest to remove the malignancy together with its draining lymphatic vessels and at least the first 2 sentinel nodes in each channel en bloc; we propose to analyze this procedure consistent with the ontogenetic approach [11, 12] with respect to diagnostic accuracy and loco-regional control. This could potentially avoid most of systematic lymphadenectomies in early ovarian cancer.

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FU Ewha Womans University Research Grant; manufacturer, Baxter Ltd

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manufacturer, Baxter Ltd.

NR 12

TC 8

Z9 9

U1 0

U2 4

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

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EI 2005-0399

J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

PD MAY

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

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TI Single Port Robotic Assisted Sacrocolpopexy: Our Experience With the

First 25 Cases

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic surgery; single port; sacrocolpopexy; laparoscopy; minimal

invasive

ID TOTAL HYSTERECTOMY; IMPLEMENTATION; PROLAPSE; SURGERY; SITE

AB Objectives In single-port surgery, the surgeon operates almost exclusively through a single entry point, typically the patient's navel, leaving only a single small scar. The aims of this study were to share some tips and tricks of single-port robotic-assisted sacrocolpopexy and to evaluate the learning curve of mastering the skills to operate this procedure.

Methods This is a retrospective study of the first 25 single-port; robotic-assisted sacrocolpopexy surgeries performed during July to December 2015 at Rambam Health Care Campus by a single surgeon. Primary points of interest included intraoperative bleeding, length of surgery, length of hospitalization, and surgical complications.

Results The median age was 59 years (range, 35-74); the median pelvic organ prolapse quantification stage was 3 (range, 2-4). The median total operative time was 190 minutes (range, 114-308), and console time was 130 minutes (85-261). Comparisons between the first 15 cases and the following 10 cases demonstrated significant decreases in median total operative and console times: 226 minutes (range, 142-308) versus 156 minutes (range, 114-180), and 170 minutes (range, 85-261) versus 115 minutes (range, 90-270), respectively (P < 0.008). There were no intraoperative adverse events. Postoperative adverse events were also rare, including 1 case of small bowel adhesions that required a second laparoscopic surgery for adhesiolysis. After this incident, we peritonalized the mesh in all 13 successive cases; median time was 8 minutes (range, 5-15 minutes).

Conclusions Single-port robotic-assisted sacrocolpopexy is a feasible procedure with low complication rates, minimal blood loss and postsurgical pain, fast recovery, short hospitalization, and virtually scar-free results. Outcomes of long-term follow-up should be investigated.

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NR 19

TC 26

Z9 28

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U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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BP E14

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Mehta, A

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Tanner, EJ

Stone, RL

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Fader, AN

AF Mehta, Ambar

Xu, Tim

Hutfless, Susan

Makary, Martin A.

Sinno, Abdulrahman K.

Tanner, Edward J., III

Stone, Rebecca L.

Wang, Karen

Fader, Amanda N.

TI Patient, surgeon, and hospital disparities associated with benign

hysterectomy approach and perioperative complications

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE benign indication; complications; hysterectomy; minimally-invasive;

surgeon volume

ID MINIMALLY INVASIVE SURGERY; HIGH-VOLUME HOSPITALS; ENDOMETRIAL CANCER;

MORTALITY; CARE

AB BACKGROUND: Hysterectomy is among the most common major surgical procedures performed in women. Approximately 450,000 hysterectomy procedures are performed each year in the United States for benign indications. However, little is known regarding contemporary US hysterectomy trends for women with benign disease with respect to operative technique and perioperative complications, and the association between these 2 factors with patient, surgeon, and hospital characteristics.

OBJECTIVE: We sought to describe contemporary hysterectomy trends and explore associations between patient, surgeon, and hospital characteristics with surgical approach and perioperative complications.

STUDY DESIGN: Hysterectomies performed for benign indications by general gynecologists from July 2012 through September 2014 were analyzed in the all-payer Maryland Health Services Cost Review Commission database. We excluded hysterectomies performed by gynecologic oncologists, reproductive endocrinologists, and female pelvic medicine and reconstructive surgeons. We included both open hysterectomies and those performed by minimally invasive surgery, which included vaginal hysterectomies. Perioperative complications were defined using the Agency for Healthcare Research and Quality patient safety indicators. Surgeon hysterectomy volume during the 2-year study period was analyzed (0-5 cases annually = very low, 6-10 = low, 11-20 = medium, and >= 21 = high). We utilized logistic regression and negative binomial regression to identify patient, surgeon, and hospital characteristics associated with minimally invasive surgery utilization and perioperative complications, respectively.

RESULTS: A total of 5660 hospitalizations were identified during the study period. Most patients (61.5%) had an open hysterectomy; 38.5% underwent a minimally invasive surgery procedure (25.1% robotic, 46.6% laparoscopic, 28.3% vaginal). Most surgeons (68.2%) were very lowe or low-volume surgeons. Factors associated with a lower likelihood of undergoing minimally invasive surgery included older patient age (reference 45-64 years; 20-44 years: adjusted odds ratio, 1.16; 95% confidence interval, 1.05-1.28), black race (reference white; adjusted odds ratio, 0.70; 95% confidence interval, 0.63-0.78), Hispanic ethnicity (adjusted odds ratio, 0.62; 95% confidence interval, 0.48-0.80), smaller hospital (reference large; small: adjusted odds ratio, 0.26; 95% confidence interval, 0.15-0.45; medium: adjusted odds ratio, 0.87; 95% confidence interval, 0.79-0.96), medium hospital hysterectomy volume (reference =200 hysterectomies; 100-200: adjusted odds ratio, 0.78; 95% confidence interval, 0.71-0.87), and medium vs high surgeon volume (reference high; medium: adjusted odds ratio, 0.87; 95% confidence interval, 0.78-0.97). Complications occurred in 25.8% of open and 8.2% of minimally invasive hysterectomies (P < .0001). Minimally invasive hysterectomy (adjusted odds ratio, 0.22; 95% confidence interval, 0.17-0.27) and large hysterectomy volume hospitals (reference >= 200 hysterectomies; 1-100: adjusted odds ratio, 2.26; 95% confidence interval, 1.60-3.20; 101-200: adjusted odds ratio, 1.63; 95% confidence interval, 1.23-2.16) were associated with fewer complications, while patient payer, including Medicare (reference private; adjusted odds ratio, 1.86; 95% confidence interval, 1.33-2.61), Medicaid (adjusted odds ratio, 1.63; 95% confidence interval, 1.30-2.04), and self-pay status (adjusted odds ratio, 2.41; 95% confidence interval, 1.40-4.12), and very-low and low surgeon hysterectomy volume (reference >= 21 cases; 1-5 cases: adjusted odds ratio, 1.73; 95% confidence interval, 1.22-2.47; 6-10 cases: adjusted odds ratio, 1.60; 95% confidence interval, 1.11-2.23) were associated with perioperative complications.

CONCLUSION: Use of minimally invasive hysterectomy for benign indications remains variable, with most patients undergoing open, more morbid procedures. Older and black patients and smaller hospitals are associated with open hysterectomy. Patient race and payer status, hysterectomy approach, and surgeon volume were associated with perioperative complications. Hysterectomies performed for benign indications by high-volume surgeons or by minimally invasive techniques may represent an opportunity to reduce preventable harm.

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TI Geographic Variance of Cost Associated With Hysterectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID LAPAROSCOPIC HYSTERECTOMY; UNITED-STATES; ABDOMINAL HYSTERECTOMY;

SERVICES; CANCER; OUTCOMES; SURGERY; RATES; WOMEN

AB OBJECTIVE: To estimate whether the cost of hysterectomy varies by geographic region.

METHODS: This was a cross-sectional, population-based study using the 2013 Healthcare Cost and Utilization Project National Inpatient Sample of women older than 18 years undergoing inpatient hysterectomy for benign conditions. Hospital charges obtained from the National Inpatient Sample database were converted to actual costs using cost-to-charge ratios provided by the Healthcare Cost and Utilization Project. Multivariate regression was used to assess the effects that demographic factors, concomitant procedures, diagnoses, and geographic region have on hysterectomy cost above the median.

RESULTS: Women who underwent hysterectomy for benign conditions were identified (N=38,414). The median cost of hysterectomy was $13,981 (interquartile range $9,075-29,770). The mid-Atlantic region had the lowest median cost of $9,661 (interquartile range $6,243-15,335) and the Pacific region had the highest median cost, $22,534 (interquartile range $15,380-33,797). Compared with the mid-Atlantic region, the Pacific (adjusted odds ratio [OR] 10.43, 95% confidence interval [CI] 9.44-11.45), South Atlantic (adjusted OR 5.39, 95% CI 4.95-5.86), and South Central (adjusted OR 2.40, 95% CI 2.21-2.62) regions were associated with the highest probability of costs above the median. All concomitant procedures were associated with an increased cost with the exception of bilateral salpingectomy (adjusted OR 1.03, 95% CI 0.95-1.12). Compared with vaginal hysterectomy, laparoscopic and robotic modes of hysterectomy were associated with higher probabilities of increased costs (adjusted OR 2.86, 95% CI 2.61-3.15 and adjusted OR 5.66, 95% CI 5.11-6.26, respectively). Abdominal hysterectomy was not associated with a statistically significant increase in cost compared with vaginal hysterectomy (adjusted OR 1.01, 95% CI 0.91-1.09).

CONCLUSION: The cost of hysterectomy varies significantly with geographic region after adjusting for confounders.

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TI Long-Term Effectiveness of Uterosacral Colpopexy and Minimally Invasive

Sacral Colpopexy for Treatment of Pelvic Organ Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; uterosacral colpopexy; sacral colpopexy

ID VAGINAL VAULT PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; ABDOMINAL

SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; OUTCOMES; SURGERY; REPAIR

AB Objectives The objective of this study was to estimate rates of recurrent pelvic organ prolapse (POP) 6 years after patients underwent transvaginal uterosacral colpopexy, or laparoscopic or robotic sacral colpopexy at a large tertiary care center. We hypothesized that recurrence rates would be higher than those previously reported.

Methods This is a retrospective study of women who underwent uterosacral colpopexy, laparoscopic, and robotic sacral colpopexy for treatment of POP between 2006 and 2012. A composite outcome for recurrent POP was defined as subjective failure (vaginal bulge symptoms), objective failure (prolapse to or beyond the hymen), or any retreatment for POP (reoperation or use of a pessary). Kaplan-Meier survival curves were generated from each patient's date of follow-up, and parametric survival modeling was used to estimate recurrent POP over 6 years. Annual estimated recurrence rates by type of colpopexy are reported using the composite and individual definitions for recurrent POP.

Results One thousand three hundred eighty-one subjects met inclusion criteria: 983 (71.1 %) uterosacral, 256 (18.5%) laparoscopic, and 142 (11.2%) robotic colpopexies. Median (range) months to failure using composite recurrence were as follows: uterosacral, 17.1 (7.6-41); laparoscopic, 10.1 (4.7-25.1); robotic, 9.7 (1.6-17.2). By year 6 in the model, the estimated composite recurrence rates for the uterosacral colpopexy, robotic, and laparoscopic sacral colpopexy groups were 43%, 49%, and 57%, respectively.

Conclusions Estimated recurrence rates for uterosacral ligament colpopexy, laparoscopic, and robotic sacral colpopexy may be as high as 40% to 60% 6 years after surgery.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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TI Tubal anastomosis after previous sterilization: a systematic review

SO HUMAN REPRODUCTION UPDATE

LA English

DT Review

DE sterilization reversal; tubal anastomosis; re-anastomosis;

refertilization; IVF; pregnancy rate; fallopian tubes

ID ASSISTED REPRODUCTIVE TECHNOLOGY; IN-VITRO-FERTILIZATION; MICROSURGICAL

REVERSAL; RE-ANASTOMOSIS; FALLOPIAN-TUBES; PREGNANCY RATE;

REANASTOMOSIS; FERTILITY; LIGATION; LAPAROSCOPY

AB BACKGROUND: Female sterilization is one of the most common contraceptive methods. A small number of women, however, opt for reversal of sterilization procedures after they experience regret. Procedures can be performed by laparotomy or laparoscopy, with or without robotic assistance. Another commonly utilized alternative is IVF. The choice between surgery and IVF is often influenced by reimbursement politics for that particular geographic location.

OBJECTIVE AND RATIONALE: We evaluated the fertility outcomes of different surgical methods available for the reversal of female sterilization, compared these to IVF and assessed the prognostic factors for success.

SEARCH METHODS: Two search strategies were employed. Firstly, we searched for randomized and non-randomized clinical studies presenting fertility outcomes of sterilization reversal up to July 2016. Data on the following outcomes were collected: pregnancy rate, ectopic pregnancy rate, cost of the procedure and operative time. Eligible study designs included prospective or retrospective studies, randomized controlled trials, cohort studies, case-control studies and case series. No age restriction was applied. Exclusion criteria were patients suffering from tubal infertility from any other reason (e.g. infection, endometriosis and adhesions from previous surgery) and studies including <10 participants. The following factors likely to influence the success of sterilization reversal procedures were then evaluated: female age, BMI and duration and method of sterilization. Secondly, we searched for randomized and non-randomized clinical studies that compared reversal of sterilization to IVF and evaluated them for pregnancy outcomes and cost effectiveness.

OUTCOMES: We included 37 studies that investigated a total of 10 689 women. No randomized controlled trials were found. Most studies were retrospective cohort studies of a moderate quality. The pooled pregnancy rate after sterilization reversal was 42-69%, with heterogeneity seen from the different methods utilized. The reported ectopic pregnancy rate was 4-8%. The only prognostic factor affecting the chance of conception was female age. The surgical approach (i.e. laparotomy [microscopic], laparoscopy or robotic) had no impact on the outcome, with the exception of the macroscopic laparotomic technique, which had inferior results and is not currently utilized. For older women, IVF could be a more cost-effective alternative for the reversal of sterilization. However, direct comparative data are lacking and a cut-off age cannot be stated.

WIDER IMPLICATIONS: In sterilized women who suffer regret, surgical tubal re-anastomosis is an effective treatment, especially in younger women. However, there is a need for randomized controlled trials comparing the success rates and costs of surgical reversal with IVF.

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PT J

AU Lan, YP

Chen, HH

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AF Lan, Yen-Po

Chen, Huang-Hui

Liu, Wei-Min

Chen, Ching-Hui

TI Delayed postcoital vaginal cuff dehiscence with small bowel evisceration

after robotic-assisted staging surgery

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE chemotherapy; postcoital vaginal evisceration; robotic surgery; vaginal

cuff dehiscence

ID ENDOMETRIAL CANCER; DIFFERENT MODES; HYSTERECTOMY

AB Objective: We report a rare case of vaginal cuff dehiscence with small bowel evisceration at 7 months post robotic-staging surgery.

Case Report: A 41-year-old woman was sent to the emergency room with sudden onset of abdominal pain, vaginal bleeding, and vaginal protruding mass after sexual activity. She had a history of synchronous uterine and ovarian cancer treated with robotic-staging surgery 7 months before. Then she received six courses of postoperative adjuvant chemotherapy, and the last chemotherapy ended 1 month ago. At the operation room, some small bowel loops were noted in the vaginal tip with cuff dehiscence and bleeding. After repositioning of the small bowel, a 2.5-cm vaginal cuff dehiscence was repaired trans vaginally. The patient recovered well, and is free of disease and has normal sexual activity 2 months after repairs.

Conclusion: Unusual delayed-type vaginal cuff dehiscence hints the possibility that a combination of robotic surgery and postoperative chemotherapy might result in delayed healing of the vaginal cuff. (C) 2017 Taiwan Association of Obstetrics & Gynecology. Publishing services by Elsevier B.V.

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JI Taiwan. J. Obstet. Gynecol.

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PT J

AU Leung, A

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Gotlieb, Walter H.

TI Outside the operating room: How a robotics program changed resource

utilization on the inpatient Ward

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Cost; Resource utilization

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; COST; OUTCOMES;

SURGERY; LAPAROTOMY

AB Objective. To analyze the changes in the composition of the gynecologic oncology inpatient ward following the implementation of a robotic surgery program and its impact on inpatient resource utilization and costs.

Methods. Retrospective review of the medical charts of patients admitted onto the gynecologic oncology ward the year prior to and five years after the implementation of robotics. The following variables were collected: patient characteristics, hospitalization details (reason for admission and length of hospital stay), and resource utilization (number of hospitalization days, consultations, and imaging).

Results. Following the introduction of robotic surgery, there were more admissions for elective surgery yet these accounted for only 21% of the inpatient ward in terms of number of hospital days, compared to 36% prior to the robotic program. This coincided with a sharp increase in the overall number of patients operated on by a minimally invasive approach (15% to 76%, p < 0.0001). The cost per surgical admission on the inpatient ward decreased by 59% ($9827 vs. $4058) in the robotics era. The robotics program contributed to a ward with higher proportion of patients with complex comorbidities (Charlson >= 5: RR 1.06), Stage IV disease (RR 1.30), and recurrent disease (RR 1.99).

Conclusion. Introduction of robotic surgery allowed for more patients to be treated surgically while simultaneously decreasing inpatient resource use. With more patients with non-surgical oncological issues and greater medical complexity, the gynecologic oncology ward functions more like a medical rather than surgical ward after the introduction of robotics, which has implications for hospital-wide resource planning. (C) 2017 Elsevier Inc. All rights reserved.

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TI Sensitivity and negative predictive value for sentinel lymph node biopsy

in women with early-stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Lymphahtic mapping; Sentinel lymph node; Indocyanine

green; Laparoscopy; Robotic assisted

ID ABDOMINAL RADICAL HYSTERECTOMY; GYNECOLOGIC-ONCOLOGY-GROUP;

SQUAMOUS-CELL CARCINOMA; BREAST-CANCER; UTERINE; ALGORITHM; SURGERY;

OBESITY; VULVAR; TRIAL

AB Objective. The role of sentinel lymph node (SLN) biopsy alone for staging of early-stage cervical cancer remains controversial. We aimed to determine the validity of this technique in women with early-stage cervical cancer.

Methods. We retrospectively reviewed women with early-stage cervical cancer who underwent SLN mapping followed by complete pelvic lymphadenectomy as part of initial surgical management from August 1997 through October 2015. All modes of surgical approach were included. Lymphatic mapping was performed using blue dye, technetium-99 m sulfur colloid (Tc-99), and/or indocyanine green (ICG). We determined SLN detection rates, sensitivity and negative predictive value.

Results. One hundred eighty-eight patients were included, and 35 (19%) had lymph node metastases. At least one SLN was identified in 170 patients (90%), and bilateral SLNs were identified in 117 patients (62%). The majority of SLNs (83%) were found in the pelvis. There was no difference in detection rates between mapping agents, surgical approach, patients with and without prior conization or between patient with tumors <2 cm and >= 2 cm. The detection rate for bilateral SLNs was significantly lower in Women with body mass index (BMI) > 30 kg/m(2) than in women with lower BMI (p = 0.03). Metastatic disease in sentinel nodes was detected by H&E staining in 78% of cases and required ultrastaging/immunohistochemistry in 22% of cases. Only one patient had a false-negative result, yielding a sensitivity of 96.4% (95% CI 79.8%-99.8%) and negative predictive value of 99.3% (95% CI 95.6%-100%). The false-negative rate was 3.6%.

Conclusions. In these women with early-stage cervical cancer, SLN biopsy had very high sensitivity and negative predictive value. We believe it is time to change the standard of care for women with early-stage cervical cancer to SLN biopsy only. (C) 2017 Elsevier Inc. All rights reserved.

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ER

PT J

AU Soto, E

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Cohen, SL

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AF Soto, Enrique

Thanh Ha Luu

Liu, Xiaobo

Magrina, Javier F.

Wasson, Megan N.

Einarsson, Jon I.

Cohen, Sarah L.

Falcone, Tommaso

TI Laparoscopy vs. Robotic Surgery for Endometriosis (LAROSE): a

multicenter, randomized, controlled trial

SO FERTILITY AND STERILITY

LA English

DT Article

DE Endometriosis; laparoscopy; perioperative outcomes; quality of life;

robot-assisted surgery

ID QUALITY-OF-LIFE; CONVENTIONAL LAPAROSCOPY; PERIOPERATIVE OUTCOMES;

PELVIC ENDOMETRIOSIS; BLADDER; MANAGEMENT; RESECTION

AB Objective: To determine whether the use of the robot for surgical treatment of endometriosis is better than traditional laparoscopy in terms of operative length, perioperative parameters, and quality of life outcomes.

Design: Multicenter, randomized clinical trial.

Setting: University teaching hospitals.

Patient(s): Women aged > 18 years with suspected endometriosis who elected to undergo surgical management.

Intervention(s): Randomization to conventional or robot-assisted laparoscopic removal of endometriosis.

Main Outcome Measure(s): The primary outcome measured was operative time. Secondary outcomes were perioperative complications and quality of life.

Result(s): The mean operative time for robotic vs. laparoscopic surgery for endometriosis was 106.6 +/- 48.4 minutes vs. 101.6 +/- 63.2 minutes. There were no differences in blood loss, intraoperative or postoperative complications, or rates of conversion to laparotomy in the two arms. Both groups reported significant improvement on condition-specific quality of life outcomes at 6 weeks and 6 months.

Conclusion(s): There were no differences in perioperative outcomes between robotic and conventional laparoscopy.

Clinical Trial Registration Number: NCT01556204. (C) 2017 by American Society for Reproductive Medicine.

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J9 FERTIL STERIL

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OA hybrid

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ER

PT J

AU Swailes, AL

Gockley, A

Phaëton, R

Kesterson, JP

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Gockley, Allison

Phaeton, Rebecca

Kesterson, Joshua P.

TI The Wertheim hysterectomy: Development, modifications, and impact in the

present day

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Wertheim hysterectomy; Radical abdominal hysterectomy; Cervical cancer

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC NODE DISSECTION; STAGE

CERVICAL-CANCER; MINIMALLY INVASIVE SURGERY; CLASS-III; TRACHELECTOMY;

MANAGEMENT; CARCINOMA

AB Ernst Wertheim was a pioneer in the history of the surgical treatment of cervical cancer. His English-language manuscript "The extended abdominal operation for carcinoma uteri (based on 500 operative cases)," which was published in 1912, detailed his standardization of the radical hysterectomy and formed the basis of the current treatment for early stage cervical cancer. We contextualize the Wertheim hysterectomy, emphasizing medical advances that allowed for its development and subsequent modification. We then discuss modifications to the originally proposed procedure, including a maximally extended parametrical resection pioneered by Takayama, and the addition of the Taussig en bloc lymph node dissection by Meigs, both of which afforded an improved mortality profile due to decreased disease recurrence. Finally, we discuss progress that has been made in the present day, such as the development of nerve-sparing and fertility-sparing surgeries, as well as the introduction of the robotic platform. In this way, we hope to provide a historical background for the Wertheim hysterectomy a cornerstone of gynecologic oncology. (C) 2017 Elsevier Inc. All rights reserved.

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ER

PT J

AU Watts, KL

Ho, R

Ghavamian, R

Abraham, N

AF Watts, Kara L.

Ho, Richard

Ghavamian, Reza

Abraham, Nitya

TI Robot-assisted extravesical vesicovaginal fistula repair utilizing

laparoscopically mobilized omental flap interposition

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Omental flap; Robotic; Vesicovaginal fistula

AB High vesicovaginal fistulas (VVF) in the setting of good apical support are best repaired via a transabdominal approach. Laparoscopic VVF repair was first reported in 1998. Several series of robot-assisted VVF repairs have since been published. The robot-assisted approach allows repair of high apical vaginal fistulas while avoiding the morbidity of laparotomy, shortening convalescence, and facilitating the use of omental interposition flaps. This video presents the technique for robot-assisted extravesical VVF repair utilizing a laparoscopically mobilized omental flap.

A 43-year-old woman developed a VVF after a total abdominal hysterectomy for fibroids. Pre-operative CT urogram and office cystoscopy confirmed the diagnosis and ruled out ureteral involvement. She underwent a robot-assisted extravesical VVF repair utilizing a laparoscopically mobilized omental flap.

The surgery was uncomplicated, and the patient was discharged on post-operative day 1. A cystogram 2 weeks post-operatively revealed no evidence of a fistula. At 3 months follow-up, the patient denied any urinary incontinence.

Robot-assisted extravesical VVF repair avoids the morbidity of a laparotomy, provides excellent exposure, and avoids a large cystotomy. It maintains vaginal length and allows for significantly better visualization compared with the transvaginal approach. This repair offers improved outcomes for certain patients depending on their history, anatomy, and the surgeon's experience.

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Z9 5

U1 0

U2 0

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PT J

AU Diver, E

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Gockley, A

Melamed, A

Contrino, L

Feldman, S

Growdon, W

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Hinchcliff, Emily

Gockley, Allison

Melamed, Alexander

Contrino, Leah

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TI Minimally Invasive Radical Hysterectomy for Cervical Cancer Is

Associated With Reduced Morbidity and Similar Survival Outcomes Compared

With Laparotomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical cancer; Laparoscopy; Radical hysterectomy; Robotic surgery

ID GYNECOLOGIC-ONCOLOGY; SURGERY; LAPAROSCOPY; EXPERIENCE

AB Study Objective: To assess outcomes of women with cervical cancer undergoing upfront radical hysterectomy (RH) via a minimally invasive surgery (MIS) or a traditional laparotomy (XL) approach at 2 large US academic institutions to determine whether the mode of surgery affects patient outcomes.

Design: Retrospective cohort study (Canadian Task Force classification II-1).

Setting: Two academic medical institutions in the United States.

Patients: Women undergoing upfront RH for cervical cancer between 2000 and 2013.

Intervention: Minimally invasive techniques (laparoscopic and robotic) for RH compared with XL,

Measurements and Main Results: A total of 383 women met the eligibility requirements. Of these, 101 underwent an MIS (i.e., traditional laparoscopy, laparoendoscopic single site, or robotic) approach, and 282 underwent an XL approach. Overall survival (median not reached; p =.29) was not different between the 2 groups. Recurrence was rare and equivalent in the 2 groups, affecting 5.0% of patients in the MIS group and 6.4% of those in the XL group (p = .86). Pelvic lymph nodes were dissected in 98% of patients in the MIS group and 97% of those in the XL group (p > .99) and were found to be positive in 10.9% and 8.5% of those patients, respectively (p =.55). The mean number of pelvic lymph nodes retrieved was higher in the MIS group (19.4 vs 16.0; p < .001). There was no between -group difference in the rate of postoperative chemotherapy (p = .32) or radiation therapy (p = .28). Surgical margins were positive in 5.0% of specimens in the MIS group and in 4.6% of specimens in the XL group (p = .54). Although there was no difference in the overall rate of complications (15.1% and 17.2%, respectively; p = .87), laparotomy was associated with a higher median estimated blood loss (EBL) (50 cm(3) vs 500 cm(3)) and a higher rate of perioperative blood transfusion (3.0% vs 26.2%; p < .001). Length of perioperative hospital stay was significantly shorter in the MIS group (1.9 days vs 4.9 clays; p <.001).

Conclusion: MIS RH does not compromise patient outcomes, including overall survival, rate of recurrence, and the frequency of pelvic lymph node dissection or positivity. Morbidity was decreased in the MIS group, including decreased EBL, fewer blood transfusions, and shorter hospital stay. (C) 2016 AAGL. All rights reserved.

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JI J. Mimim. Invasive Gynecol.

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ER

PT J

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Kehlet, H

Hogdall, CK

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Hogdall, Claus K.

Lajer, Henrik

TI Robot-assisted surgery in gynecological oncology: current status and

controversies on patient benefits, cost and surgeon conditions - a

systematic review

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Review

DE Cervical cancer; costs; endometrial cancer; ergonomics; gynecological

oncology; ovarian cancer; robot-assisted surgery; robotic surgery;

training

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; STAGE CERVICAL-CANCER; RECURRENT

OVARIAN-CANCER; ENDOMETRIAL CANCER; LEARNING-CURVE; PERIOPERATIVE

OUTCOMES; DISEASE RECURRENCE; SURGICAL OUTCOMES; WOMEN; LAPAROTOMY

AB Introduction. Robot-assisted surgery has become more widespread in gynecological oncology. The purpose of this systematic review is to present current knowledge on robot-assisted surgery, and to clarify and discuss controversies that have arisen alongside the development and deployment. Material and methods. A database search in PubMed and EMBASE was performed up until 4 March 2016. The search strategy was developed in collaboration with an information specialist, and by application of the PRISMA guidelines. Human participants and English language were the only restrictive filters applied. Selection was performed by screening of titles and abstracts, and by full text scrutiny. From 2001 to 2016, a total of 76 references were included. Results. Robot-assisted surgery in gynecological oncology has increased, and current knowledge supports that the oncological safety is similar, compared with previous surgical methods. Controversies arise because current knowledge does not clearly document the benefit of robot-assisted surgery, on perioperative outcome compared with the increased costs of the acquisition and application. Conclusions. The rapid development in robot-assisted surgery calls for long-term detailed prospective cohorts or randomized controlled trials. The costs associated with acquisition, application, and maintenance have an unfavorable impact on cost-benefit evaluations, especially when compared with laparoscopy. Future developments in robot-assisted surgery will hopefully lead to competition in the market, which will decrease costs.

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NR 78

TC 15

Z9 18

U1 1

U2 16

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PT J

AU Mabuchi, S

Kimura, T

AF Mabuchi, Seiji

Kimura, Tadashi

TI Extraperitoneal Radical Trachelectomy With Pelvic Lymphadenectomy <i>A

Novel Fertility-Preserving Option for Early Stage Cervical Cancer

Patients</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical cancer; Radical trachelectomy; Extraperitoneal approach;

Fertility preservation

ID OUTCOMES; LAPAROTOMY; PREGNANCY; WOMEN

AB Objective: Radical trachelectomy combined with pelvic lymphadenectomy has been used to treat early stage cervical cancer patients who wish to preserve their fertility. Although vaginal, abdominal, laparoscopic, and robotic approaches have been used during this procedure, all of these approaches cause peritoneal damage, which could result in periadnexal adhesion. The aim of the present study was to introduce and discuss a novel fertility-preserving option, extraperitoneal radical trachelectomy with pelvic lymphadenectomy.

Methods: To minimize peritoneal damage, we developed a new surgical approach for radical trachelectomy combined with pelvic lymphadenectomy. All surgical procedures associated with radical trachelectomy and pelvic lymphadenectomy were performed via an extraperitoneal approach. During this procedure, the uterine arteries, inferior hypogastric nerve, and pelvic splanchnic nerve were preserved.

Results: Extraperitoneal nerve-sparing radical trachelectomy with pelvic lymphadenectomy was performed in 3 Japanese women with International Federation of Gynecology and Obstetrics stage IA2 and IB1 cervical cancers. In all patients, complete resection of the disease was achieved without causing any intraoperative complications. Although an infected lymphocele developed in a patient that was managed conservatively, no severe postoperative complications were noted. No adjuvant treatments were given, and the patients are currently free of disease.

Conclusions: To the best of our knowledge, this is the first report about extraperitoneal radical trachelectomy in patients with early stage cervical cancer. Extraperitoneal radical trachelectomy combined with pelvic lymphadenectomy can be safely performed. Because peritoneal damages, which can cause periadnexal adhesion, could be avoided, we consider that this surgical approach may be an ideal treatment option for women with early stage cervical cancer who wish to preserve their fertility.

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Z9 6

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U2 6

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ER

PT J

AU Minig, L

Achilarre, MT

Garbi, A

Zanagnolo, V

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TI Minimally Invasive Surgery to Treat Gynecological Cancer <i>Conventional

Laparoscopy and/or Robot-Assisted Surgery</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

DE Ovarian cancer; Endometrial cancer; Cervical cancer; Cost effective

analysis; Robotic surgery; Gynecological cancer; Learning curve;

Minimally invasive surgery

ID STAGE CERVICAL-CANCER; ABDOMINAL RADICAL HYSTERECTOMY; DIAGNOSED

UTERINE-CANCER; ENDOMETRIAL CANCER; PERIOPERATIVE OUTCOMES; SURGICAL

OUTCOMES; OVARIAN-CANCER; PARAAORTIC LYMPHADENECTOMY; COMPLICATION

RATES; LAPAROTOMY

AB Robotic-assisted surgery is a technological advancement derived from conventional laparoscopy, which facilitates the application of minimally invasive techniques for complex operations in the field of gynecological oncology. However, its introduction in gynecological cancer has been scarce in most hospitals worldwide. Most publications on robotic surgery are still retrospective or descriptive in nature. Some studies compare robotic-assisted laparoscopy with open procedures, which is a questionable analysis, because the advantages of minimally invasive surgery have been already well established. Robotic surgery should be directly compared with conventional laparoscopy to determine whether its additional direct and indirect costs are in accordance with some improvements within patient clinical outcomes. On the other hand, the role of robotic-assisted surgery in allowing more patients to receive the benefits of the minimally invasive approach should also be considered. The objective of this article was, therefore, to review the literature regarding the role of conventional and robotic-assisted laparoscopy to treat women with gynecologic cancer.

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Z9 15

U1 1

U2 15

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PT J

AU Pulman, KJ

Dason, ES

Philp, L

Bernardini, MQ

Ferguson, SE

Laframboise, S

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AF Pulman, Katherine J.

Dason, Ebernella S.

Philp, Lauren

Bernardini, Marcus Q.

Ferguson, Sarah E.

Laframboise, Stephane

Atenafu, Eshetu G.

May, Taymaa

TI Comparison of three surgical approaches for staging lymphadenectomy in

high-risk endometrial cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE High-risk endometrial cancer; Lymphadenectomy; Minimally invasive

surgery; Surgical approach; Surgical staging

ID LAPAROSCOPY; LAPAROTOMY

AB Objective: To compare laparotomy, laparoscopy, and robotic surgical approaches to lymphadenectomy for high-risk endometrial cancer staging.

Methods: A retrospective cohort study enrolled patients who underwent surgery for pathologic high-risk endometrial carcinoma at the University Health Network, Toronto, Canada, between January 1, 2005 and December 31, 2013. The primary outcome, the median number of nodes retrieved, was compared based on surgical technique. The secondary outcome was the detection of metastatic nodes.

Results: A total of 176 patients who underwent surgery for high-risk endometrial cancer were included, of whom 147 (83.5%) had pelvic and 78 (44.3%) had para-aortic lymphadenectomy. Laparotomy, laparoscopy, and robotic approaches were applied for 69 (39.2%), 44 (25.0%), and 63 (35.8%) patients, respectively. Minimally-invasive staging was associated with an increased proportion of patients undergoing pelvic lymphadenectomy compared with laparotomy (P=0.005). The median number of nodes removed in the pelvis and para-aortic regions did not differ between surgical approaches. The detection of metastatic nodes was also similar between the groups. Increased blood loss (P<0.001) and longer hospital admission (P< 0.001) were observed with-laparotomy procedures.

Conclusion: All three techniques demonstrated adequate staging of high-risk endometrial carcinoma. Based on improved peri-operative outcomes, the use of minimally-invasive techniques is advocated where appropriate.

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NR 10

TC 13

Z9 14

U1 0

U2 6

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA FB3DA

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PM 28078775

DA 2024-01-18

ER

PT J

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Nawfal, AK

Aoun, J

Taylor, A

Fisher, J

Theoharis, E

Eisenstein, D

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Dahlman, Marisa

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Taylor, Andrew

Fisher, Jay

Theoharis, Evan

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TI Long-term outcomes for different vaginal cuff closure techniques in

robotic-assisted laparoscopic hysterectomy: A randomized controlled

trial

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Vaginal closure techniques; Robotic hysterectomy; Vaginal cuff

dehiscence; Barbed suture; Braided suture

ID BIDIRECTIONAL BARBED SUTURE; HISTOLOGIC CHARACTERISTICS; DIFFERENT

MODES; DEHISCENCE

AB Objective: This randomized controlled trial aimed to evaluate the outcomes of different vaginal cuff closure techniques in robotic-assisted total laparoscopic hysterectomy.

Study design: Ninety women undergoing robotic-assisted total laparoscopic hysterectomy for benign disease were randomized to three vaginal cuff closure techniques: running 2.0 V-Lock (TM) (Arm 1), 0 Vicryl (TM) figure-of-eight (Arm 2), and running 0 Vicryl (TM) with Lapra-Ty (R) (Arm 3). Patients' records were reviewed for age, body mass index, smoking status and relevant co-morbidities. Operative times for vaginal closure and total length of surgery, estimated blood loss, and ped-operative complications were collected. Patients were evaluated at 2 and 6 weeks post-operatively, and interviewed 1 year following surgery by a telephone survey. Outcomes evaluated were vaginal cuff dehiscence, pain, dyspareunia and bleeding.

Results: The study arms did not differ with respect to estimated blood loss (50 mL in each arm; p = 0.34), median vaginal cuff closure time (14.5,12 and 13 min, respectively; p = 0.09) or readmission (p = 0.55). In the 1-year follow-up (54/90 respondents; 60%), there were no significant differences among study arms for vaginal bleeding, cuff infection or dyspareunia. Only women belonging to arm 3 reported vaginal pain (0%, 0% and 23%, respectively; p = 0.01). No cases of vaginal cuff dehiscence were observed.

Conclusions: The type of closure technique has no significant impact on patient outcomes. In the absence of a clear advantage of one technique over the others, the decision regarding the preferred method to close the vaginal cuff in robotic-assisted total laparoscopic hysterectomy should be based on surgeons' preference and cost effectiveness. (C) 2016 Published by Elsevier Ireland Ltd.

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NR 20

TC 8

Z9 8

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U2 2

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EI 1872-7654

J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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VL 210

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA EV6KO

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ER

PT J

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Misa, Nana Yaa

Margulies, Samantha

Opoku-Anane, Jessica

Khalil, Elias Abi

Marfori, Cherie

TI Transferability of Virtual Reality, Simulation-Based, Robotic Suturing

Skills to a Live Porcine Model in Novice Surgeons: A Single-Blind

Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 45th Annual Global Congress on Minimally Invasive Gynecology of the

American-Association-of-Gynecologic-Laparoscopists (AAGL)

CY NOV 13-18, 2016

CL Orlando, FL

SP Amer Assoc Gynecol Laparoscopists

DE Robotic surgery; Virtual reality simulation; da Vinci Surgical

Simulator; Simulation; Proficiency-based training; da Vinci Surgical

System

ID VALIDATION; PERFORMANCE

AB Study Objective: To assess whether a robotic simulation curriculum for novice surgeons can improve performance of a suturing task in a live porcine model.

Design: Randomized controlled trial (Canadian Task Force classification I).

Setting: Academic medical center.

Patients: Thirty-five medical students without robotic surgical experience.

Interventions: Participants were enrolled in an online session of training modules followed by an in-person orientation. Baseline performance testing on the Mimic Technologies da Vinci Surgical Simulator (dVSS) was also performed. Participants were then randomly assigned to the completion of 4 dVSS training tasks (camera clutching 1, suture sponge 1 and 2, and tubes) versus no further training. The intervention group performed each dVSS task until proficiency or up to 10 times. A final suturing task was performed on a live porcine model, which was video recorded and blindly assessed by experienced surgeons. The primary outcomes were Global Evaluative Assessment of Robotic Skills (GEARS) scores and task time. The study had 90% power to detect a mean difference of 3 points on the GEARS scale, assuming a standard deviation (SD) of 2.65, and 80% power to detect a mean difference of 3 minutes, assuming an SD of 3 minutes.

Measurements and Main Results: There were no differences in demographics and baseline skills between the 2 groups. No significant differences in task time in minutes or GEARS scores were seen for the final suturing task between the intervention and control groups, respectively (9.2 [2.65] vs 9.9 [2.07] minutes, p = .406; and 15.37 [2.51] vs 15.25 [3.38], p = .603). The 95% confidence interval for the difference in mean task times was 2.36 to .96 minutes and for mean GEARS scores 1.91 to 2.15 points.

Conclusions: Live suturing task performance was not improved with a proficiency-based virtual reality simulation suturing curriculum compared with standard orientation to the da Vinci robotic console in a group of novice surgeons.

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FU Medical and Health Science Education Research

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U1 0

U2 9

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WC Obstetrics & Gynecology

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GA EO6MR

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ER

PT J

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TI Comparative Perioperative Pain and Recovery in Women Undergoing Vaginal

Reconstruction Versus Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT Annual Scientific Meeting of the American-Urogynecologic-Society (AUGS)

CY SEP 27-OCT 01, 2016

CL Denver, CO

SP Amer Urogynecol Soc

DE pain; prolapse; quality of life; recovery; robotic; vaginal surgery

ID PELVIC FLOOR DYSFUNCTION; VISUAL ANALOG SCALES; CONTROLLED-TRIAL; SEXUAL

FUNCTION; VALIDATION; PROLAPSE; SURGERY; LONG; TERM

AB Background: In this study of patients undergoing vaginal hysterectomy with either robotic or vaginal prolapse repair, there was no difference in quality of life in the weeks following surgery; however, less narcotics were used, less pain was documented by nurses and Surgical Pain Scale (SPS), and better performance on voiding trials was noted in those undergoing robotic sacrocolpopexy.

Objectives: Minimally invasive surgery for pelvic organ prolapse is the preferred surgical route for optimal recovery. However, information regarding patient-centered outcomes among various techniques is lacking. We sought to describe pain and quality of life in patients undergoing vaginal hysterectomy with uterosacral ligament suspension (USLS) compared with robotic-assisted sacrocolpopexy (RSC).

Methods: This institutional review board-approved prospective cohort study enrolled consecutive patients undergoing vaginal hysterectomy with USLS or with RSC. The primary outcome was pain on postoperative day 1 using the SPS. Nursing verbal pain scores, narcotic usage, surgical data, and Short-Form Health Survey 12 at baseline and 2 and 6 weeks after surgery were collected. A sample size calculation revealed 37 subjects per group would be required.

Results: Seventy-eight women were enrolled (USLS, n = 39; RSC, n = 39). There were no significant differences in scores on the SPS between groups. Subjects undergoing RSC had lower nursing verbal pain scores (P = 0.04), less narcotic consumption (P = 0.02), and lower estimated blood loss (P = 0.01) and were less likely to fail voiding trials (P < 0.001); however, surgery duration was longer (P < 0.001). After controlling for age, regression analysis revealed SPS worst pain was lower in the robotic arm (P = 0.01), but not in other scales of the SPS. At 2 and 6 weeks postoperatively, Short-Form Health Survey 12 scores were not different between cohorts.

Conclusions: Both USLS and RSC are minimally invasive, with similar quality-of-life scores after surgery. However, the robotic approach may be associated with less pain, less narcotic use, and better performance in voiding trials. Surgeons should consider these findings when counseling patients regarding treatment options.

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NR 18

TC 18

Z9 18

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U2 3

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JI Female Pelvic Med. Reconstr. Surg.

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PY 2017

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA EM8RX

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ER

PT J

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Garbi, A

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Garbi, Annalisa

Achilarre, Maria Teresa

Minig, Lucas

TI Robot-assisted Surgery in Gynecologic Cancers

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Cervical cancer; Cost-effective analysis; Endometrial cancer;

Gynecologic cancers; Learning curve; Minimally invasive surgery; Ovarian

cancer; Robotic surgery

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; STAGE CERVICAL-CANCER; MINIMALLY

INVASIVE SURGERY; SYSTEMATIC PELVIC LYMPHADENECTOMY; RECURRENT

OVARIAN-CANCER; ENDOMETRIAL CANCER; PERIOPERATIVE OUTCOMES; SURGICAL

OUTCOMES; LEARNING-CURVE; CONSENSUS STATEMENT

AB Robotic-assisted surgery is a technological advancement that facilitates the application of minimally invasive techniques for complex operations in gynecologic oncology. The objective of this article was to review the literature regarding the role of robotic-assisted surgery to treat women with gynecologic cancers. The majority of publications on robotic surgery are still retrospective or descriptive in nature; however, the data for managing patients with a robotic-assisted approach show comparable, and at times improved, outcomes compared with both laparoscopy (2-dimensional) and laparotomy approaches. Robotic-assisted surgery has been used for patients with endometrial cancer and resulted in the increased use of minimally invasive surgery with improved outcomes compared with laparotomy and partially with laparoscopy. This has been shown in large cohorts of patients as well as in obese patients in whom the complication rates have significantly decreased. For early cervical cancer, robotic radical hysterectomy seems to be safe and feasible and to be preferable to laparotomy with seemingly comparable oncologic outcomes. Robotic-assisted surgery and conventional laparoscopy to stage women with early-stage ovarian cancer seem to have similar surgical and oncologic outcomes, with a shorter learning curve for robotic-assisted surgery. However, robotic-assisted surgery appears to be more expensive than laparotomy and traditional laparoscopy. In conclusion, robotic-assisted surgery appears to facilitate the surgical approach for complex operations to treat women with gynecologic cancers. Although randomized controlled trials are lacking to further elucidate the equivalence of robot assisted surgery with conventional methods in terms of oncologic outcome and patients' quality of life, the technology appears to be safe and effective and could offer a minimally invasive approach to a much larger group of patients. (C) 2017 AAGL. All rights reserved.

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TC 25

Z9 28

U1 1

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PG 18

WC Obstetrics & Gynecology

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GA EO6MR

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ER

PT J

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TI Evaluation of Pulmonary Complications in Robotic-Assisted Gynecologic

Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Pulmonary complications; Robotic surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; TRENDELENBURG

POSITION; RADICAL PROSTATECTOMY; ANESTHESIA; OUTCOMES

AB Study Objective: To conduct a study to assess the incidence of pulmonary complications associated with robotic-assisted surgeries in women with various gynecologic conditions.

Design: Retrospective study.

Setting: Tertiary care center.

Patients: There were 296 patients included in this study. Patient characteristics and comorbidities were noted. Surgical characteristics and respiratory parameters were recorded for all patients. Intraoperative complications and postoperative complications were noted for up to 30 days after surgery. Patients were followed for a median of 231 days in an effort to detect any long-term complications. The primary outcome was postoperative pulmonary complications, and the secondary outcome measure was all complications.

Interventions: None.

Measurements and Main Results: The study was composed of 296 patients. Only 5 patients (2%) experienced a pulmonary complication. Overall, 38 patients (13%) experienced complications, including both major and minor complications. Average airway pressure and maximum airway pressure were both associated with a significantly higher risk of pulmonary complications (p =.02 and p =.008, respectively). Age, body mass index, tidal volume, respiratory rate, estimated blood loss, and length of procedure were all found to not be statistically significant in patients who experienced a pulmonary complication versus patients who did not experience one.

Conclusion: Robotic gynecologic surgery is safe and tolerated well by most patients. This study supports that there is a low rate of pulmonary complications in those who undergo robotic-assisted surgery for gynecologic indications, as well as a low overall complication rate. (C) 2016 Published by Elsevier Inc. on behalf of AAGL.

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NR 19

TC 4

Z9 5

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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TI Feasibility and Learning Curve of Robotic Laparoendoscopic Single-Site

Surgery in Gynecology

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Robotic; Single-site laparoendoscopy

ID HYSTERECTOMY; COMPLICATIONS; EXPERIENCE; OUTCOMES; CLOSURE; OBESE; LESS

AB Single-site laparoscopy has proven to be a desirable option for patients undergoing gynecologic surgery, with some studies indicating improved cosmesis and less perioperative pain compared with standard approaches. This study describes the safety and feasibility of a novel robotic laparoendoscopic single-site surgery (R-LESS) platform as it is incorporated into a surgeon's practice with extensive multiport robotic surgical experience but limited LESS experience. We reviewed 83 women undergoing R-LESS by a single surgeon from September 2013 through August 2015. Operative times (total operative time, console time, docking time) were collected prospectively for the first 53 cases, and total operative time was collected retrospectively for the next 30 cases. Clinical parameters, including age, estimated blood loss, body mass index (BMI), prior abdominal surgeries, conversion to laparotomy, procedure type, uterine weight, length of hospital stay, and complications, were retrospectively collected from medical charts. Eighty-two of 83 surgeries were completed successfully with a single incision. One surgery was converted to multiport robotics for para-aortic lymph node dissection. Twelve surgeries were performed for cancer (ovary 1, uterus 8, and cervix 3). Eight patients underwent pelvic lymph node biopsy. The median total operative time for hysterectomies was 128 minutes (range, 60-275). After the first 13 hysterectomies the total operative time and the console time decreased significantly from 165.3 to 131.1 minutes (p = .032) and from 84.9 to 57.1 minutes (p = .028), respectively. Mean docking time halved from 7.8 minutes to 3.4 minutes comparing the first 10 cases to the last 10 cases. Surgical times were longer with larger BMIs, but the console time decreased with experience regardless of BMI. The mean uterine weight was 164 g (range, 30-460). Complications included 2 umbilical hernias (2.4%) and 1 conversion to multiport. In conclusion, R-LESS is a feasible and safe surgical platform for gynecologic procedures. A small number of cases are needed to significantly improve operative times when it is introduced on a surgeon's practice with limited experience in LESS but familiar with robotic surgery. Further study is needed to investigate the cost, benefits, and long-term outcomes of R-LESS. Published by Elsevier Inc. on behalf of AAGL.

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Z9 26

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WC Obstetrics & Gynecology

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ER

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TI Robotic Versus Laparoscopic Staging for Early Ovarian Cancer: A

Case-Matched Control Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Early ovarian cancer; Laparoscopy; Robotic surgery

ID LYMPH-NODE METASTASIS; AORTIC LYMPHADENECTOMY; SURGICAL TECHNIQUE;

RISK-FACTORS; OUTCOMES; COMPLICATIONS; LAPAROTOMY; RESECTION; SURGERY

AB Study Objective: To evaluate the feasibility, surgical outcome, and oncologic results observed after robotic staging compared with conventional laparoscopic staging for patients with early-stage ovarian cancer patients.

Design: A retrospective cohort study (Canadian Task Force classification II-2).

Setting: Catholic University of the Sacred Heart, Rome, Italy.

Patients: Ninety-six patients underwent minimally invasive staging for presumed stage I ovarian cancer; 32 underwent the robotic approach (cases), and 64 underwent the laparoscopic approach (controls).

Measurements and Main Results: There was no statistically significant difference between the 2 approaches with regard to final Federation Internationale de Gynecologie et d'Obstetrique stage, histology, and grade of tumors. In the whole series, 15 patients (15.6%) were upstaged, with no statistically significant difference between the 2 groups. The median number of pelvic lymph nodes removed was 14 (range, 3-42) and 11 (range, 2-29) in the robotic and laparoscopic groups (p = .235), respectively. The median number of aortic lymph nodes removed was 11 (range, 3-26) and 12 (range, 1-39) in the robotic and laparoscopic groups (p = .263), respectively. The operative time was significantly shorter in the robotic group compared with the laparoscopic group (p = .043), whereas the amount of estimated blood loss was similar (p = .691). No difference was found in terms of early and postoperative complications. Overall, 72 patients were considered as requiring adjuvant treatment. Two patients experienced peritoneal recurrence.

Conclusion: The present study suggests that there is no relevant difference between the robotic and laparoscopic approaches in staging early-stage ovarian cancer. Further prospective trials are needed to confirm our results. (C) 2016 AAGL. All rights reserved.

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AU Gan, C

Bossart, M

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TI Robotic and Advanced Laparoscopic Surgical Training in European

Gynecological Oncology Trainees

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Gynecological oncology trainees; Robotic surgery; Laparoscopic surgery;

Accredited; Survey

ID ENDOMETRIAL CANCER; LEARNING-CURVE; ASSISTED HYSTERECTOMY; SURGERY;

LYMPHADENECTOMY; LAPAROTOMY; OUTCOMES; PROGRAM; NETWORK; SOCIETY

AB Introduction: Advanced minimal access surgical training is an important component of training in gynecological oncology (GO). Europe-wide data on this topic are lacking. We present data on availability and trainee experience of advanced laparoscopic surgical (ALS) and robotic surgical (RS) training in GO across Europe.

Method: A prospective web-based anonymized survey of European GO trainees was sent to the European Network of Young Gynaecological Oncologists members/trainees. It included sociodemographic information and specific questions pertaining to training experience or satisfaction in laparoscopic and robotic surgery. X-2 test was used for evaluating categorical variables and Mann-Whitney/Kruskal-Wallis (nonparametric) tests for continuous variables between 2 and more independent groups.

Results: A total of 113 GO trainees from 29 countries responded. The mean (standard deviation) age was 35.2 (6.1) years, 59.3% were men, 40.7% were women, and 46% were in accredited training posts. The ALS and RS training was offered in only 43% and 23% of institutes respectively, and 54% and 23% of trainees had undergone some form of formal or informal training in ALS and RS respectively. A total of 62.4% felt that RS should be a formal component of GO training programs. A total of 61% and 35% planned to go outside their institute for ALS or RS training respectively. Trainees rating (1-5 scale) of their open surgery and ALS or RS skills (3.3/2.6/1.9) and training experience (3.5/2.8/2.1), respectively, were higher for open surgery than ALS or RS (P < 0.0005). Accredited posts were more likely than nonaccredited posts to offer ALS training (60%/31%, P = 0.002), formal training schedules (27.9%/4.4%, P = 0.003), and use of logbooks (46%/23%, P = 0.035).

Conclusions: Training and experience in ALS and RS are poorly rated by GO trainees across Europe, and only few centers offer this. There is an urgent need to expand and harmonize training opportunities for ALS and RS. Most trainees want RS included as a formal component of their training.

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TI A retrospective cohort study of hemostatic agent use during hysterectomy

and risk of post-operative complications

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Blood transfusions; Complications; Hemostatic agents; Hospital

readmissions; Hysterectomy; Pelvic abscess; Propensity score matching

ID SMALL-BOWEL OBSTRUCTION; THROMBIN MATRIX SEALANT; GYNECOLOGIC SURGERY;

PELVIC ABSCESS; FLOSEAL; READMISSION

AB Objective: To determine if the use of intraoperative hemostatic agents was a risk factor for post-operative adverse events within 30 days of patients undergoing hysterectomy.

Method: A population-based retrospective cohort study included data from patients undergoing hysterectomy for any indication between January 1, 2013, and December 31, 2014, at 52 hospitals in Michigan, USA. Any individuals with missing covariate data were excluded, and multivariable logistic regression and propensity score-matching were used to estimate the rate of post- operative adverse events associated with intra-operative hemostatic agents independent of demographic and surgical factors.

Results: There were 17 960 surgical procedures included in the analysis, with 4659 ( 25.9%) that included the use of hemostatic agents. Hemostatic agent use was associated with an increase in predicted hospital re-admissions ( P= 0.007).Among all hysterectomy approaches, and after adjusting for demographic and surgical factors, hemostatic agent use during robotic--assisted laparoscopic hysterectomy was associated with an increased predicted rate of blood transfusions ( P=0.019),an increased predicted rate of pelvic abscess diagnoses (P=0.001),an increased predicted rate of hospital re-admission (P=0.001), and an increased predicted rate of re-operation (P=0.021).

Conclusion: Hemostatic agents should be used carefully owing to associations with increased post-operative re-admissions and re-operations when used during hysterectomy.

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FU Blue Cross and Blue Shield of Michigan/Blue Care Network; Robert Wood

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Jeppesen, Mette M.

Lysdal, Vibeke K.

Traen, Koen

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TI Systematic review of same-day discharge after minimally invasive

hysterectomy

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Review

DE Gynecologic oncology; Hysterectomy; Laparoscopic; Minimally invasive;

Review; Robotic; surgery; Same-day discharge

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ROBOTIC-ASSISTED HYSTERECTOMY;

ENDOMETRIAL CANCER; UNITED-STATES; SUPRACERVICAL HYSTERECTOMY; RADICAL

HYSTERECTOMY; CLINICAL-OUTCOMES; SURGERY; OUTPATIENT; EXPERIENCE

AB Background: Same-day discharge has been suggested to safe and acceptable following minimally invasive hysterectomy.

Objectives: To evaluate the feasibility of same-day discharge following minimally invasive hysterectomy and to identify associated factors.

Search strategy: Medline, Embase and the Cochrane Central Register of Controlled Trials were systematically searched using the terms "same day discharge", "minimally invasive surgery", and "hysterectomy" between October 1 and October 31, 2015. No language or publication date restrictions were included.

Selection criteria: Randomized controlled trials and observational studies evaluating same-day discharge before midnight on the day of minimally invasive hysterectomy were included.

Data collection and analysis: Study characteristics, pre-operative selection criteria, and predictive factors for same-day discharge were analyzed.

Main results: There were 15 observational studies with 11 992 patients-included. Significant heterogeneity was observed in the studies, and publication and selection bias could have potentially affected the results. All the studies concluded that same-day discharge was feasible. However, some factors were associated with a decreased possibility of same-day discharge; these were older age, beginning surgery later than 1: 00 pm and completing surgery later than 6: 00 pm, longer duration of operation, and high estimated blood loss.

Conclusions: Same-day discharge appears feasible for a majority of patients who undergo minimally invasive hysterectomies if adequate emphasis is placed on pre-surgical planning and careful patient selection.

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AU Moukarzel, LA

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AF Moukarzel, Lea A.

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TI Feasibility of Robotic-Assisted Laparoendoscopic Single-Site Surgery in

the Gynecologic Oncology Setting

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic laparoendoscopic single-site surgery; R-LESS

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; RANDOMIZED-TRIAL;

CERVICAL-CANCER; LEARNING-CURVE; INITIAL REPORT; COST-ANALYSIS;

OUTCOMES; WOMEN

AB Study Objective: To assess the feasibility of incorporating robotic laparoendoscopic single-site (R-LESS) surgery into gynecologic oncology care.

Design: Retrospective study (Canadian Task Force classification II-3).

Setting: Academic university hospital.

Patients: Patients undergoing R-LESS hysterectomy for gynecologic malignancies, preinvasive disease, or risk reduction performed by a single gynecologic oncologist between 2014 and 2016.

Interventions: We incorporated R-LESS as part of standard surgical management for highly selected patients undergoing hysterectomy for common gynecologic oncology indications.

Measurements and Main Results: We identified 30 patients undergoing R-LESS hysterectomy meeting study criteria over a 2-year period. Indications for surgery included uterine cancer (n = 13), preinvasive cervical or uterine disease (n = 9), cervical cancer (n = 3), and hereditary gynecologic cancer risk (n = 5). Median patient age was 52 years (range, 35-77), and body mass index was 26 kg/m(2) (range, 19-34). Median uterine size was 8 cm (range, 5.5-11). Eighteen patients had prior abdominal surgery (60%). Twenty-seven patients underwent R-LESS extrafascial hysterectomy, 11 of whom underwent only robotic-assisted total laparoscopic hysterectomy +/- bilateral salpingo-oophorectomy with a median operative time of 140 minutes (range, 115-179). Procedures performed concurrently for the remainder included pelvic sentinel lymph node mapping (n = 14) and pelvic lymphadenectomy (n = 2), with respective median operative times of 175 (range, 150-230) and 233 minutes. One patient with endometrial cancer was converted to multiport robotic surgery to complete a pelvic and para-aortic lymphadenectomy due to high-risk disease on frozen section. Three patients underwent R-LESS radical hysterectomy, bilateral salpingo-oophorectomy, sentinel lymph node mapping, and pelvic lymphadenectomy with a median operative time of 412 minutes (range, 336-451). No perioperative complications were encountered, and all patients were discharged within 24 hours of surgery.

Conclusion: In highly selected patients, R-LESS extrafascial and radical hysterectomy is associated with acceptable operative times and perioperative outcomes. With additional experience, surgeons may offer this approach to patients undergoing increasingly complex procedures, even in the gynecologic oncology setting. (C) 2016 AAGL. All rights reserved.

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AU Roman, H

AF Roman, H.

CA FRIENDS Grp French ColoRectal Infi

TI A national snapshot of the surgical management of deep infiltrating

endometriosis of the rectum and colon in France in 2015: A multicenter

series of 1135 cases

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Deep endometriosis; Colorectal endometriosis; Rectal shaving; Disc

excision; Colorectal resection

ID QUALITY-OF-LIFE; COLORECTAL RESECTION; ASSISTED LAPAROSCOPY; SURGERY;

BOWEL; COMPLICATIONS; FEASIBILITY; PREGNANCY; SYMPTOMS; NODULES

AB Objective. - To perform a survey on the characteristics of the surgical management of patients with deep infiltrating endometriosis of the rectum and the sigmoid colon (DIERS) in France in 2015.

Method. - Case-series study enrolling patients with DIERS involving muscularis, submucosa or mucosa, operated on from January 1st to December 31st 2015, in 56 healthcare facilities in France. Surgeons filled in questionnaires concerning the number of patients, deep endometriosis localizations, surgical route and techniques used on digestive tract, associated surgical procedures and major complications. Data were pooled in a single database.

Results. - A total of 1135 patients from 56 healthcare facilities were enrolled in the series (33 university hospitals, 4 general hospitals and 19 private hospitals). Deep endometriosis infiltrated only the rectum in 56.8% of cases, the rectum and the sigmoid colon in 36.3% and only the sigmoid colon in 6.9%. Associated localizations involved the cecum in 6.6% of cases, small bowel in 4.7%, bladder in 9%, and were responsible for stenosis of the ureters in 13.4% and for hydronephrosis in 6.8%. Surgery was performed using conventional laparoscopy in 82.2% of cases, robotic-assisted laparoscopy in 9.7% and open surgery in 8.1%. Rectal shaving was carried out in 48.1% of cases, disc excision in 7.3%, colorectal segmental resection in 40.4% and sigmoid colon segmental resection in 6.4% (2 different procedures could be associated in the same patient). Ureter resection was carried out in only 4% of cases, representing 29.6% of cases with stenosis of the ureters. Bladder resection was carried out in 6.9%. Vaginal resection and hysterectomy were performed in 33 and 14.7% of cases respectively, while temporary stoma was used in 19.1%. Anastomotic leakage occurred in 0.8% of cases, pelvic abscess in 3.4%, rectovaginal fistula in 2.7%, ureter fistula in 0.7%, while 8.6% of patients either required catheterization after recovery or had a post voiding bladder volume superior to 100 mL. According to the surgical procedure used, the risk of rectovaginal fistula was 1.3, 3.6 and 3.9% after shaving, disc excision and segmental resection respectively. Intensive care was required in 1.1% and blood transfusion in 2.2%. One patient died (0.1%) after rectal shaving.

Conclusions. - Our 2015 survey of a large number of patients managed for DIERS in France confirms that DIERS is far from being a rare disease. Even in the setting of complex procedures requiring multidisciplinary teams, a laparoscopic approach can achieve successful surgical treatment in 9 out of 10 patients with an acceptable risk of major postoperative complications. (C) 2017 Elsevier Masson SAS. All rights reserved.

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TI Feasibility, Safety, and Prediction of Complications for Minimally

Invasive Myomectomy in Women With Large and Numerous Myomata

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Laparoscopy; Minimally invasive surgery; Myomata;

Myomectomy; Predictors; Robotic surgery

ID LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY; MORCELLATION

AB Objective: To assess perioperative outcomes and identify predictors of complications for minimally invasive surgery (MIS) myomectomy in a cohort of women with large and numerous myomata.

Design: Case-control study (Canadian Task Force classification II-2).

Setting: Academic tertiary care medical center.

Patients: Women undergoing MIS myomectomy performed by 3 high-volume surgeons between April 2011 and December 2014.

Interventions: Characteristics were compared between women who experienced complications and those who did not. Factors predictive of complications were then identified.

Measurements and Main Results: A total of 221 women underwent an MIS myomectomy, 47.5% via a laparoscopic approach and 52.5% via robotic surgery. The mean SD specimen weight was 408.1 +/- 384.9 g, uterine volume was 586.1 +/- 534.1 cm(3), dominant myoma diameter was 9.6 +/- 5.1 cm, and number of myomata removed was 4.5 +/- 4.1. The most common complications were hemorrhage >1000 mL (8.6%) and blood transfusion (4.1%). The conversion rate was 1.8%. A dominant myoma diameter of >= 12 cm and a uterine volume of >= 750 cm(3) increased the odds of complications (odds ratio [OR], 7.44; 95% confidence interval [CI], 2.03-31.84; p = .004 and OR, 6.15; 95% CI, 1.55-30.02; p =.014 respectively). A receiver operating characteristic curve considering dominant myoma diameter and uterine volume had an area under the curve of 0.81. A combination of dominant myoma diameter of >= 10 cm and uterine volume of 600 cm3 predicted complications with 79% sensitivity and 79% specificity.

Conclusion: Our cohort had large and numerous myomata with high specimen weights, but complications were comparable to those reported in previous studies of MIS myomectomy with less complex pathology. Hemorrhage and transfusion accounted for the majority of complications, and a combination of dominant myoma diameter and uterine volume was predictive of complications. Both factors can be easily defined before surgery and may be used to guide patient counseling, referrals, and implementation of preventative measures for hemorrhage and transfusion. Published by Elsevier Inc. on behalf of AAGL.

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ER

PT J

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TI Minimizing pain medication use and its associated costs following

robotic surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Pain; Analgesics; Costs

ID MINIMALLY INVASIVE SURGERY; ENDOMETRIAL CANCER; POSTOPERATIVE PAIN;

LAPAROSCOPY; REQUIREMENTS; MANAGEMENT; STANDARD; CARE

AB Introduction. Minimally invasive surgery (MIS) has been associated with diminished postoperative pain and analgesia requirements. The objective of the current study was to evaluate the use of analgesia in the post-operative period following robotic surgery for endometrial cancer.

Methods. All consecutive patients who underwent robotic surgery for the treatment of endometrial cancer were included in this study. The timing, dose, and type of analgesics administered postoperatively were recorded from patients' electronic medical record. Data was compared to a matched historical cohort of patients who underwent laparotomy before the introduction of the robotic program.

Results. Only eight patients (2.4%, 5 during the first 25 cases and 3 following mini-laparotomy) received patient-controlled analgesia (PCA) following robotic surgery. Most patients' pain was alleviated by over-the-counter analgesics (acetaminophen, non-steroidal anti-inflammatories). In comparison to laparotomy, patients who underwent robotic surgery required significantly less opioids (71 mg vs. 12 mg IV morphine, p < 0.0001) and non-opioids (4810 mg vs. 2151 mg acetaminophen, 1892 vs. 377 mg ibuprofen, and 1470 mg vs. 393 mg naproxen; all p < 0.0001).

Conclusion. Patients require less analgesics (opioids and non-opioids) following robotic surgery in comparison to conventional laparotomy, including the elderly and the obese. The diminished pain medication use is associated with some cost savings. (C) 2016 Elsevier Inc. All rights reserved.

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U1 0

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Marpeau, L.

Darwish, B.

TI Management of deep infiltrating endometriosis by laparoscopic route with

robotic assistance: 3-year experience

SO JOURNAL OF GYNECOLOGY OBSTETRICS AND HUMAN REPRODUCTION

LA English

DT Article

DE Robotic assistance; Da Vinci; Deep endometriosis; Rectal shaving;

Ureterolysis

ID QUALITY-OF-LIFE; MICROSURGICAL TUBAL ANASTOMOSIS; COLORECTAL

ENDOMETRIOSIS; SURGICAL-TREATMENT; PLASMA ENERGY; FERTILITY; RESECTION;

ABLATION; SURGERY; SCALE

AB Objective. - To assess the feasibility of deep endometriosis surgery using robotic assistance, benefits and limits of this approach.

Method. - Case-series study enrolling patients managed for deep infiltrating endometriosis (DIE) using robotic assistance in our department between September 2011 and March 2014 (NCT02294825). Self-questionnaires including pain and digestive symptoms were filled in pre-operatively and 1 year after surgery.

Results. - Thirty-five patients were enrolled in the series. They represented 54% of patients managed for gynecological disease by laparoscopic route with robotic assistance during the study period, and 14% of patients managed for deep endometriosis in our department. Followup averaged 24 +/- 8 months, and no patient was lost to follow-up. Thirty-two patients had rectal involvement: rectal shaving was performed in 25 patients, disc excision in 3 and colorectal resection in 4. Three patients had bladder resection. Thirteen patients presented with deep endometriosis of the ureters: ureterolysis was performed in 11 of them, and resection of the ureter followed by reimplantation into the bladder in 2 patients. One major complication(Clavien IIIb) was recorded in a patient presenting with necrosis of the right ureter on postoperative day 5. Nine patients tried to conceive after surgery and 8 have already become pregnant (88.9%). One year after surgery, self-questionnaires revealed a significant decrease in pain symptoms and significant improvement in several item values of gastrointestinal standardized questionnaires.

Conclusions. - Surgical management of DIE is feasible using robotic assistance. However, data available in the literature and our own experience do not definitively support the hypothesis of the superiority of robotic assistance in the management of DIE. (C) 2015 Elsevier Masson SAS. All rights reserved.

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FX The North-West inter-regional female cohort for patients with

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ER

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TI Perioperative Complications and Cost of Vaginal, Open Abdominal, and

Robotic Surgery for Apical Vaginal Vault Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE Mayo-McCall culdoplasty; sacrocolpopexy; uterosacral ligament

ID MEDICAL-RECORDS-LINKAGE; REPAIR

AB Objectives: To determine the rate of perioperative complications and cost associated with Mayo-McCall culdoplasty (MMC), open abdominal sacrocolpopexy (ASC), and robotic sacrocolpopexy (RSC) for posthysterectomy vaginal vault prolapse.

Methods: We retrospectively searched for the records of patients undergoing posthysterectomy apical vaginal prolapse surgery (MMC, ASC, or RSC) between January 1, 2000, and June 30, 2012, at our institution. For all patients identified, perioperative complications, length of hospital stay, and inpatient costs to patients were abstracted from the medical records and compared by procedure. Inverse-probability-of-procedure weighting using propensity scores was used to obtain less-biased comparisons of outcomes between procedures.

Results: A total of 512 patients met the inclusion criteria (174MMC, 237 ASC, and 101 RSC). Using inverse-probability weighting, the MMC group had a significantly lower intraoperative complication rate (3.3% vs 11.6% for ASC, 3.4% vs 24.1% for RSC), median operative time (94 vs 217 min for ASC, 100 vs 228 min for RSC), and median cost (US $8,776 vs $ 12,695 for ASC, US $ 8,773 vs $ 13,107 for RSC) than the ASC and RSC groups (all P < 0.01). In addition, the MMC group had significantly fewer postoperative grade 3+ complications than the RSC group (1.1% vs 9.4%, P < 0.01).

Conclusions: In the treatment of posthysterectomy vaginal vault prolapse, MMC is associated with decreased non-urinary tract infection, less perioperative morbidity, and lower cost to patients compared with sacrocolpopexy.

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JI Female Pelvic Med. Reconstr. Surg.

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PT J

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TI Post-operative fever in open compared with robotic hysterectomies for

endometrial cancer

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Robotic hysterectomy; Laparotomy; Fever

ID PULMONARY COMPLICATIONS; DIAGNOSTIC-ACCURACY; ATELECTASIS

AB Objective: There are numerous explanations behind the presence of post-operative fever that patients may experience. The aim of this study was to determine if temperatures >= 38.0 degrees C were more common in patients undergoing open or robotic surgery for endometrial cancer. Materials and Methods: 150 women were retrospectively analyzed; half underwent robotic hysterectomy and the other half underwent an open approach. A febrile episode was a single temperature of >= 38.3 degrees C or a sustained temperature of >= 38.0 degrees C for more than one hour. Temperatures were recorded and compared for 48 hours postoperatively. Results: Febrile episodes of 38.0-38.3 degrees C were seen in 33.3% of patients undergoing an open approach and 12% of patients undergoing robotic surgery (p = 0.003) within two days of surgery. Temperatures of >= 38.3 degrees C were only seen in three patients in the open arm and one in the robotic arm (4% vs. 1.3%, p = 0.3). Those few who experienced temperatures >= 38.3 degrees C were all found to have infections. Conclusions: There is a significantly decreased incidence of a post-operative fever in a patient who undergoes a robotic hysterectomy instead of an open abdominal hysterectomy for the treatment of endometrial cancer.

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JI Eur. J. Gynaecol. Oncol.

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TI Surgical Competency for Robot-Assisted Hysterectomy: Development and

Validation of a Robotic Hysterectomy Assessment Score (RHAS)

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Assessment; Evaluation; Feedback; Hysterectomy; Robot-assisted; Robotic

ID RELIABILITY; SKILLS

AB Study Objective: To develop and validate a procedure-specific scoring algorithm to objectively measure robotic surgical skills during robot-assisted hysterectomy and to facilitate robotic surgery training and education.

Design: (Canadian Task Force classification III).

Setting: A National Comprehensive Cancer Network designated comprehensive cancer center.

Patients: Deidentified videos for robot-assisted hysterectomies were evaluated.

Interventions: Videos from 26 robotic hysterectomies performed by surgeons with varying degrees of experience using the scoring system were evaluated. In phase I, critical elements of a robotic hysterectomy were deconstructed into 6 key domains to assess technical skills for procedure completion. Anchor descriptions were developed for each domain to match a 5-point Liken scale. Delphi methodology was used for content validation. A panel of 5 expert robotic surgeons refined this scoring system. In phase II, video recordings of procedures performed by surgeons with varying degrees of experience (expert, advanced beginner, and novice) were evaluated by blinded expert reviewers using the scoring system. Descriptive statistics were used to summarize the scores for each domain. Intraclass correlation was used to determine the interrater reliability. A p value <.05 was considered significant.

Measurements and Main Results: The average score for the 3 classes of surgeon was 75.6 for expert, 71.3 for advanced beginner, and 69.0 for novice (p = .006). There were significant differences in scores of most individual domains among the various classes of surgeons. Novice surgeons took significantly longer than expert surgeons to complete their half of a hysterectomy (22.2 vs 12.0 minutes; p = .001).

Conclusion: This pilot study demonstrates the feasibility of using a standardized rubric for clinical skills assessment in robotic hysterectomy. Blinded expert reviewers were able to differentiate between varying levels of surgical experience using this assessment tool. (C) 2016 AAGL. All rights reserved.

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TI Robotic Radical Hysterectomy After Concomitant Chemoradiation in Locally

Advanced Cervical Cancer: A Prospective Phase II Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Chemoradiation; Locally advanced cervical cancer; Robotic radical

hysterectomy

ID NEOADJUVANT CHEMOTHERAPY; CONCURRENT CHEMORADIOTHERAPY; COMPLETION

SURGERY; MULTIINSTITUTIONAL EXPERIENCE; STAGE; THERAPY; COMPLICATIONS;

BRACHYTHERAPY; MULTICENTER; MORBIDITY

AB Study Objective: To assess the feasibility of total robotic radical surgery (TRRS) in patients with locally advanced cervical cancer (LACC) who receive chemoradiation therapy (CT/RT).

Design: A prospective (preplanned) study of a nonrandomized controlled trial (Canadian Task Force classification level 2).

Setting: Catholic University of the Sacred Hearth, Rome, Italy.

Patients: Between September 2013 and January 2016, a total of 40 patients with LACC (Federation Internationale de Gynecologic et d'Obstetrique stage IB2-111) were enrolled in the study.

Interventions: Robotic radical hysterectomy (RRH) plus pelvic and/or aortic lymphadenectomy was attempted within 6 weeks after CT/RT. The feasibility of TRRS as well as the rate, pattern, and severity of early and late postoperative complications were analyzed.

Measurements and Main Results: After CT/RT, 29 patients (72.5%) underwent type B2 RRH, and 11 (27.5%) underwent type CI RRH. Pelvic lymphadenectomy was performed in all cases. TRRS was successful in 39 of 40 cases (feasibility rate = 97.5%). In patients successfully completing TRRS, the median operating time was 185 minutes (range, 100-330 minutes), and the median blood loss was 100 mL (range, 50-300 mL). The median time of hospitalization counted from the first postoperative day was 2 days (range, 1-4 days). No intraoperative complications were recorded. During the observation period (median = 18 months; range, 4-28 months), 9 of 40 (22.5%) experienced postoperative complications, for a total number of 12 complications. As of April 2016, recurrence of disease was documented in 5 cases (12.5%).

Conclusion: TRRS is feasible in LACC patients administered preoperative CT/RT, providing perioperative outcomes comparable with those registered in early-stage disease, and LACC patients receiving neoadjuvant chemotherapy. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Incidence and Risk Factors for Pelvic Pain After Mesh Implant Surgery

for the Treatment of Pelvic Floor Disorders

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Mesh; Pelvic pain; Prolapse; Stress urinary incontinence

ID FEMALE SEXUAL FUNCTION; TRANSVAGINAL MESH; ORGAN PROLAPSE; VAGINAL

REPAIR; COLPORRHAPHY; WOMEN; INDEX

AB Study Objective: Our aim was to assess incidence and risk factors for pelvic pain after pelvic mesh implantation.

Design: Retrospective study (Canadian Task Force classification II-2).

Setting: Single university hospital.

Patients: Women who have undergone surgery with pelvic mesh implant for treatment of pelvic floor disorders including prolapse and incontinence.

Interventions: Telephone interviews to assess pain, sexual function, and general health.

Measurements and Main Results: Pain was measured by the McGill Short-Form Pain Questionnaire for somatic pain, Neuropathic Pain Symptom Inventory for neuropathic pain, Pennebaker Inventory of Limbic Languidness for somatization, and Female Sexual Function Index (FSFI) for sexual health and dyspareunia. General health was assessed with the 12-item Short-Form Health Survey. Among 160 enrolled women, mean time since surgery was 20.8 +/- 10.5 months, mean age was 62.1 +/- 11.2 years, 93.8% were white, 86.3% were postmenopausal, and 3.1% were tobacco users. Types of mesh included midurethral sling for stress incontinence (78.8%), abdominal/robotic sacrocolpopexy (35.7%), transvaginal for prolapse (6.3%), and perirectal for fecal incontinence (1.9%), with 23.8% concomitant mesh implants for both prolapse and incontinence. Our main outcome, self-reported pelvic pain at least 1 year after surgery, was 15.6%. Women reporting pain were younger, with fibromyalgia, worse physical health, higher somatization, and lower surgery satisfaction (all p < .05). Current pelvic pain correlated with early postoperative pelvic pain (p < .001), fibromyalgia (p = .002), worse physical health (p = .003), and somatization (p = .003). Sexual function was suboptimal (mean FSFI, 16.2 +/- 12.1). Only 54.0% were sexually active, with 19.0% of those reporting dyspareunia.

Conclusion: One in 6 women reported de novo pelvic pain after pelvic mesh implant surgery, with decreased sexual function. Risk factors included younger age, fibromyalgia, early postoperative pain, poorer physical health, and somatization. Understanding risk factors for pelvic pain after mesh implantation may improve patient selection. (C) 2016 AAGL. All rights reserved.

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TI The Effect of Vertical Versus Horizontal Vaginal Cuff Closure on Vaginal

Length After Laparoscopic Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Laparoscopy; Pelvic organ prolapse; Vaginal length

ID SEXUAL FUNCTION; RANDOMIZED-TRIAL; CERVICAL-CANCER; SURGERY; PROLAPSE

AB Study Objective: To determine whether vertical versus horizontal closure of the vaginal cuff during laparoscopic hysterectomy has an effect on postoperative vaginal length and pelvic organ prolapse.

Design: A prospective randomized controlled trial. Subjects were randomly assigned to vertical or horizontal vaginal cuff closure at the time of total laparoscopic hysterectomy. Pelvic organ prolapse quantization (POP-Q) tests were performed before surgery, 2 to 4 weeks after surgery, and 3 to 4 months after surgery (Canadian Task Force classification I).

Setting: An academic university-affiliated community hospital.

Patients: Patients undergoing laparoscopic or robotic-assisted laparoscopic total hysterectomy for benign or malignant disease, excluding those undergoing radical hysterectomy or concomitant pelvic floor procedure.

Interventions: Subjects were randomized into the vertical or horizontal vaginal cuff closure group. Total hysterectomy was Completed with traditional laparoscopic techniques or with robotic assistance. A colpotomy ring was used in each subject. Vaginal cuff closure was performed with barbed suture in a running fashion according to the group assignment.

Measurements and Main Results: A total of 43 subjects were enrolled and randomized. One patient was excluded because the vaginal cuff was closed vaginally, 1 cancelled surgery, and 1 was completed without a uterine manipulator. The mean change in vaginal length was -0.89 cm (standard deviation ISM = 1.03) in the horizontal group and -0.86 cm (SD = 1.19) in the vertical group (p =.57). POP-Q evaluation revealed no differences between groups and an overall trend toward improved POP-Q measurements. The average duration of vaginal cuff closure did not differ (p =.45), and there were no intraoperative complications related to vaginal cuff closure.

Conclusion: Horizontal and vertical laparoscopic closure of the vaginal cuff after laparoscopic hysterectomy results in similar Changes in vaginal length and other POP-Q scores. (C) 2016 AAGL. All rights reserved.

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TI Robotic-Assisted Video Endoscopic Inguinal Lymphadenectomy in Carcinoma

Vulva: Our Experiences and Intermediate Results

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Carcinoma vulva; Robotic assisted video endoscopic inguinal

lymphadenectomy; surgical morbidity

ID PENILE CARCINOMA; MORBIDITY; COMPLICATIONS; DISSECTION; CANCER

AB Objectives: To describe the technique of robotic-assisted video endoscopic inguinal lymphadenectomy (R-VEIL) in patients with carcinoma vulva and discuss the advantages of the technique and oncological outcome.

Methods: Twelve patients of squamous cell cancer of vulva underwent 22 R-VEIL procedures from February 2011 to February 2015. Their preoperative, intraoperative, and postoperative data were retrospectively analysed.

Results: The mean age of patients was 61 years (range, 32-78 years). The mean operative time was 69.3 minutes (range, 45-95 minutes). The mean blood loss was 30 mL (range, 15-50 mL). No intraoperative complication was observed. The mean drain output was 119 mL (range, 50-250 mL), and the drains were removed at a mean of 13.9 days (range, 8-38 days). The average number of superficial and deep inguinofemoral lymph nodes retrieved was 11 (range, 4-26). Two patients had positive lymph nodes on histopathology (16.67%). Postoperative complications were lymphocele (6 groins), chronic lower limb lymphedema (6 cases), prolonged lymphorrhea (1 groin), and cellulitis (2 groins). Over a follow-up period ranging from 7 to 67 months, 1 patient developed recurrence in the inguinal nodes and died 7 months after the recurrence.

Conclusions: The R-VEIL allows the removal of inguinal lymph nodes within the same limits as the open procedure for inguinal lymph node dissection and has a potential to reduce the surgical morbidity associated with the open procedure. Long-term oncological results are not available though our initial results appear promising. Prospective multi-institutional studies are required to prove its efficacy over open inguinal lymph node dissection.

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NR 20

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Z9 14

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U2 1

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JI Int. J. Gynecol. Cancer

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AU Jeon, JH

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TI Robot-assisted laparoscopic adenomyomectomy of adenomyotic nodule

implanted in the uterine endometrium manifesting as endometrial cancer:

a case report and literature review

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Adenomyoma; Robot-assisted laparoscopic surgery; Adenomyomectomy

ID TRANSVAGINAL SONOGRAPHY; DIAGNOSIS; FERTILITY

AB Thickened uterine endometrium with abnormal uterine bleeding highly suggests endometrial hyperplasia or endometrial carcinoma. A case of 35-year-old nulliparous woman came to our department with endometrial mass manifesting as endometrial cancer. Transrectal ultrasonography and magnetic resonance imaging (MRI) showed an 8x6 cm multicystic, ill-defined mass compacted at the uterine endometrium, the anterior wall of the uterus, and 3x3 cm heterogenous mass at the left adnexa. The edometrial mass showed multiple septations with enhancement and low-signal intensity on T2-weighted images. After endometrial biopsy was done and simple hyperplasia without atypia was observed at the histopathologic finding, the patient underwent robot-assisted laparoscopy and diagnosed as adenomyoma at the frozen pathology. After adenomyomectomy, permanent pathologic analysis revealed the same result and she recovered without any complications and responded well to gonadotropin-releasing hormone (GnRH) agonist therapy.

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U2 7

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JI Eur. J. Gynaecol. Oncol.

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TI Outcomes of Robotic Sacrocolpopexy Using Only Absorbable Suture for Mesh

Fixation

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; vaginal vault prolapse; sacrocolpopexy; outcomes

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; PELVIC ORGAN PROLAPSE;

VAGINAL-VAULT PROLAPSE; ABDOMINAL SACROCOLPOPEXY; OSTEOMYELITIS; REPAIR

AB Objective: The optimal suture selection for mesh attachment during robotic sacrocolpopexy (RSC) is currently unknown. Here, we sought to evaluate the outcomes of RSC using absorbable sutures for vaginal and sacral mesh attachment.

Methods: We retrospectively reviewed 132 RSC surgeries that were performed for vaginal vault prolapse in the Division of Gynecologic Surgery at our institution from February 2007 to December 2013. All cases were performed with absorbable suture (polyglactin) for vaginal and sacral mesh fixation. Sacrocolpopexy failure was defined as patients undergoing either repeat prolapse surgery or pessary use for recurrent prolapse. The durability of RSC was assessed via Kaplan-Meier method.

Results: The median age at surgery was 61.1 years (interquartile range [IQR], 55.6-68.2) and the median length of postoperative follow-up was 33 months (IQR, 15.7-57). The median body mass index was 26.5 kg/m(2) (IQR, 24.3-29.7). During follow-up, 10 patients underwent prolapse retreatment. There were 2 apical recurrences, 4 distal anterior recurrences, 2 posterior recurrences, and, in 2 cases, the location was unknown. One apical recurrence was confirmed to be secondary to detachment of the mesh from the sacral promontory. Among thosewith recurrence, the median time to recurrence was 15.5 months (IQR, 4.22-35.9). Overall, the 1-year and 3-year freedom from repeat surgery rates were 96% and 93%, respectively.

Conclusions: With a median follow-up of 33 months, the use of absorbable suture for both vaginal and sacral attachments during RSC is effective. Further studies evaluating suture selection and mesh attachment techniques for RSC are needed.

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FU Mayo Clinic Foundation

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U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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Lee, SR

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Lee, S. R.

TI Robotic-assisted single incision myomectomy in large myoma cases

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Robotic single-site; Myomectomy; Large myoma; da Vinci surgical system

ID INITIAL REPORT

AB Introduction: Laparo-endoscopic single-incision surgery (LESS) has been developed and gradually adopted for both benign and malignant gynecological procedures. However, LESS has been hindered for use in procedures like myomectomy by limitations in natural architecture and instrumentation, especially in suturing. The da Vinci system features a single-site platform and wristed needle driver, which may help overcome conventional LESS limitations. This case report study describes the feasibility of this robotic single-site (RSS) platform in large myoma cases and offers suggestions. Results: Two cases of myomectomy with large myomas (with maximum diameters of 160 and 120 mm) with different locations, were addressed by RSS. Operative time was 180 and 240 minutes. Estimated blood loss was 200 and 150 ml. Pathologic analysis revealed uterine leiomyomas of 910 and 870 grams. No serious peri- or post-operative complications occurred. Discussion: Myomectomy with large myoma has presented a surgical challenge. RSS myomectomy appears to be a safe and feasible technique for it regardless of its localization. Advantages include less postoperative pain, fast recovery, less impact on quality of life, and improved cosmesis. LESS surgery has been challenging concerning suturing and multi-laparoscopic or multi-port robotic myomectomy can be difficult to extract myoma, especially with morcellation. RSS could be a solution that enables ease of manipulation and extraction.

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Z9 1

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JI Clin. Exp. Obstet. Gynecol.

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Ramirez, Pedro T.

TI Bowel injury in robotic gynecologic surgery: risk factors and management

options. A systematic review

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Review

DE bowel surgery; robotic surgery; surgical complications

ID PELVIC ORGAN PROLAPSE; ASSISTED LAPAROSCOPIC HYSTERECTOMY; SPARING

RADICAL HYSTERECTOMY; SINGLE-SITE HYSTERECTOMY; STAGE CERVICAL-CANCER;

QUALITY-OF-LIFE; ENDOMETRIAL CANCER; LEARNING-CURVE; SURGICAL OUTCOMES;

INITIAL-EXPERIENCE

AB OBJECTIVE: We sought to analyze the published literature on bowel injuries in patients undergoing gynecologic robotic surgery with the aim to determine its incidence, predisposing factors, and treatment options.

DATA SOURCES: Studies included in this analysis were identified by searching PubMed Central, OVID Medline, EMBASE, Cochrane, and ClinicalTrials. gov databases. References for all studies were also reviewed. Time frame for data analysis spanned from November 2001 through December 2014.

STUDY ELIGIBILITY CRITERIA: All English-language studies reporting the incidence of bowel injury or complications during robotic gynecologic surgery were included. Studies with data duplication, not in English, case reports, or studies that did not explicitly define bowel injury incidence were excluded.

STUDY APPRAISAL AND SYNTHESIS METHODS: The Guidelines for Meta-Analyses and Systematic Reviews of Observational Studies were used to complete the systematic review with the exception of scoring study quality and a single primary reviewer.

RESULTS: In all, 370 full-text articles were reviewed and 144 met the inclusion criteria. There were 84 bowel injuries recorded in 13,444 patients for an incidence of 1 in 160 (0.62%; 95% confidence interval, 0.50-0.76%). There were no significant differences in incidence of bowel injury by procedure type. The anatomic location of injury, etiology, and management were rarely reported. Of the bowel injuries, 87% were recognized intraoperatively and the majority (58%) managed via a minimally invasive approach. Of 13,444 patients, 3 (0.02%) (95% confidence interval, 0.01-0.07%) died in the immediate postoperative period and no deaths were a result of a bowel injury.

CONCLUSION: The overall incidence of bowel injury in robotic-assisted gynecologic surgery is 1 in 160. When the location of bowel injuries were specified, they most commonly occurred in the colon and rectum and most were managed via a minimally invasive approach.

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U2 7

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Bakkum-Gamez, Jamie N.

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TI Determining Optimal Route of Hysterectomy for Benign Indications

<i>Clinical Decision Tree Algorithm</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 42nd Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

CY APR 10-14, 2016

CL Palm Springs, CA

SP Soc Gynecol Surg

ID VAGINAL HYSTERECTOMY; VOLUME; GUIDELINES; UTERUS; TRENDS; COSTS

AB OBJECTIVE: To evaluate practice change after initiation of a robotic surgery program using a clinical algorithm to determine the optimal surgical approach to benign hysterectomy.

METHODS: A retrospective postrobot cohort of benign hysterectomies (2009-2013) was identified and the expected surgical route was determined from an algorithm using vaginal access and uterine size as decision tree branches. We excluded the laparoscopic hysterectomy route. A prerobot cohort (2004-2005) was used to evaluate a practice change after the addition of robotic technology (2007). Costs were estimated.

RESULTS: Cohorts were similar in regard to uterine size, vaginal parity, and prior laparotomy history. In the prerobot cohort (n=473), 320 hysterectomies (67.7%) were performed vaginally and 153 (32.3%) through laparotomy with 15.1% (46/305) performed abdominally when the algorithm specified vaginal hysterectomy. In the postrobot cohort (n=1,198), 672 hysterectomies (56.1%) were vaginal; 390 (32.6%) robot-assisted; and 136 (11.4%) abdominal. Of 743 procedures, 38 (5.1%) involved laparotomy and 154 (20.7%) involved robotic technique when a vaginal approach was expected. Robotic hysterectomies had longer operations (141 compared with 59 minutes, P<.001) and higher rates of surgical site infection (4.7% compared with 0.2%, P<.001) and urinary tract infection (8.1% compared with 4.1%, P=.05) but no difference in major complications (P=.27) or readmissions (P=.27) compared with vaginal hysterectomy. Algorithm conformance would have saved an estimated $800,000 in hospital costs over 5 years.

CONCLUSION: When a decision tree algorithm indicated vaginal hysterectomy as the route of choice, vaginal hysterectomy was associated with shorter operative times, lower infection rate, and lower cost. Vaginal hysterectomy should be the route of choice when feasible.

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Margulies, Rebecca U.

Ramm, Olga

TI Titanium Surgical Tacks: Are They Safe? Do They Work?

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacrocolpopexy; surgical tack; pelvic organ prolapse

ID LAPAROSCOPIC SACRAL COLPOPEXY; PELVIC ORGAN PROLAPSE; ABDOMINAL

SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; TERM OUTCOMES; OSTEOMYELITIS;

SURGERY

AB Objectives: Minimally invasive approaches to sacrocolpopexy have transformed it into a primary procedure for treatment of pelvic organ prolapse. Certain modifications are commonly used to facilitate the laparoscopic approach, but have not yet been widely studied. In this study, we investigated the efficacy and safety of titanium surgical tacks for the attachment of mesh to the anterior longitudinal ligament in laparoscopic sacrocolpopexy.

Methods: This retrospective cohort study involved all patients within 1 health care system who underwent laparoscopic sacrocolpopexy between January 2009 and December 2012. Each medical record was reviewed and abstracted.

Results: Of the 231 patients included in our study, 190 (82%) had titanium surgical tacks, and 41 (18%) had suture for mesh attachment to the anterior longitudinal ligament. The demographics of the 2 subgroups as well as concomitantly performed procedures were comparable. There was no significant difference found between the 2 cohorts in regards to operative time, estimated blood loss, complication rates, rate of recurrent pelvic organ prolapse symptoms or the rate of reoperation for pelvic organ prolapse.

Conclusions: Surgical tacks are a safe alternative to suture for the attachment of mesh to the anterior longitudinal ligament in laparoscopic sacrocolpopexy. Although we saw no advantage to using tacks over suture, tacking the mesh to the anterior longitudinal ligament may make the laparoscopic approach more accessible to a wider range of gynecologic surgeons. Further studies about the long-term impact of surgical tacks on bone and disk disease are needed.

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U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

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Heim, J

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Rivard, C

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TI Evaluation of the American College of Surgeons National Surgical Quality

Improvement Program Surgical Risk Calculator in Gynecologic Oncology

Patients Undergoing Minimally Invasive Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic oncology; Minimally invasive surgery; Surgical risk

calculator

ID SAME-DAY DISCHARGE; LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER;

OF-LIFE; ABDOMINAL HYSTERECTOMY; HOSPITAL READMISSION; ROBOTIC SURGERY;

OUTCOMES; SAFETY; FEASIBILITY

AB Study Objective: To evaluate the ability of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) surgical risk calculator to predict discharge to postacute care and perioperative complications in gynecologic oncology patients undergoing minimally invasive surgery (MIS).

Design: A retrospective chart review (Canadian Task Force classification II-1).

Setting: A university hospital.

Patients: All patients undergoing MIS on the gynecologic oncology service from January I, 2009, to December 30, 2013.

Interventions: Surgical procedures were reviewed, and appropriate Common Procedural Terminology codes were assigned. Twenty-one preoperative risk factors were abstracted from the chart and entered into the ACS NSQIP surgical risk calculator. The predicted risk of discharge to postacute care and 8 additional postoperative complications were calculated and recorded. Actual postoperative complications were abstracted from the medical record. The association between the calculated risk and the actual outcome was determined using logistic regression. The ability of the calculator to accurately predict a particular event was assessed using the c-statistic and Brier score. Measurements and Main

Results: Of the 876 patients reviewed, a majority underwent hysterectomy (71.6%), with almost half of those patients undergoing additional cancer staging procedures (34.8%). Although the calculator was a poor predictor of postoperative complications, it was a strong predictor for discharge to postacute care (c-statistic = 0.91, Brier score = 0.02) with an odds ratio of 2.31 (95% confidence interval, 1.65-3.25; p < .0001).

Conclusion: The ACS NSQIP surgical risk calculator does not accurately predict postoperative complications or length of stay in gynecologic oncology patients undergoing MIS. Although it was a strong predictor of need for discharge to postacute care, it vastly overestimated the number of patients requiring this service. Therefore, the calculator's risk score for discharge to postacute care may be considered during preoperative counseling but should not be a predictor of whether or not the patient should proceed with surgery. (C) 2016 AAGL. All rights reserved.

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Villefranque, Vincent

Deffieux, Xavier

TI Outcomes of laparoscopic sacropexy in women over 70: A comparative study

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Elderly; Functional results; Genital prolapse; Laparoscopy;

Sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; ROBOT-ASSISTED SACROCOLPOPEXY; FLOOR DISORDERS;

UROGYNECOLOGIC SURGERY; SACRAL COLPOPEXY; AGE; COMPLICATIONS;

SPONDYLODISCITIS; HYSTERECTOMY; TERMINOLOGY

AB Objective: Precise data are lacking concerning laparoscopic sacropexy in the elderly population. The purpose of this study was to compare the outcomes and complications associated with laparoscopic sacropexy (colpopexy or hysteropexy) in women aged under 70 and 70 or over.

Study design: Retrospective review of data on patients who underwent laparoscopic sacropexy in two tertiary centers. Peri-and postoperative complications were recorded and described using the IUGA classification. Surgery was considered successful if the patient was symptomatically satisfied or very satisfied and if the POP-Q (Pelvic Organ Prolapse-Quantification) stage score at the follow-up visit was below stage 2 for all compartments.

Results: Among the 191 women studied, 47 (24.6%) were aged 70 or more. According to the ICS/IUGA classification of POP complications, perioperative and postoperative complication rates were similar in the older versus younger groups (bladder injuries (0 vs. 1.39%, p = 1) (4A T1 S2), rectal injuries (0% vs. 0.69%, p = 1) (5BT1S5), vaginal injuries (2.13% vs. 0%, p = 0.246) (2A T1 S1)). No laparotomy conversion was required in either group. At two months of follow-up, the success rate was 97.9% and 95.1% in the older and younger groups, respectively (p = 0.68). At 24 months of follow-up, the overall reoperation rate was 12.8% for the older group versus 11.8% in the younger group (p = 0.80).

Conclusions: Our findings suggest that laparoscopic sacropexy is a valid option in elderly women presenting with genital prolapse. (C) 2016 Elsevier Ireland Ltd. All rights reserved.

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TI Indocyanine green fluorescence imaging of lymph nodes during

robotic-assisted laparoscopic operation for endometrial cancer. A

prospective validation study using a sentinel lymph node surgical

algorithm

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic hysterectomy; Sentinel lymph node;

Indocyanine green; Fluorescence imaging; Surgical algorithm

ID BIOPSY; SURGERY; LYMPHADENECTOMY; RECOMMENDATIONS; UTERINE; ICG

AB Objective. A sentinel lymph node (SLN) strategy may have particular value in endometrial cancer (EC) because a therapeutic effect of lymphadenectomy per se is unproven. The aim was to evaluate indocyanine green (ICG) and near-infrared (NIR) fluorescence mapping using a surgical algorithm.

Methods. From November 2012 through December 2015, women with apparently early stage EC underwent robot-assisted laparoscopic hysterectomy including ICG fluorescence SLN mapping following the Memorial Sloane Kettering Cancer Center (MSKCC) surgical algorithm.

Results. Among 108 patients included, >= 1 SLNs was identified in 104 (96%), bilaterally in 84 (78%) and unilaterally in 20 patients (18%). Four patients failed SLN mapping. All SLN-positive patients had pelvic SLNs. Median number of nodes were 4.0 and 6.0 (p < 0.001), when SLNs only and SLNs plus non-SLNs were removed, respectively. Lymph node metastases were detected in 17 patients (16%). One patient who failed SLN mapping had a non-SLN metastasis. The remaining 16 patients had metastases in SLNs, 12 in SLNs only and four in both SLNs and non-SLNs. Routine pathology detected 75% of patients with cancer positive SLNs while 25% were based on extended pathology. Lymph node metastases were found among 9% with low-, 11% with intermediate- and 32% with high-risk profiles, respectively.

Conclusions. We have reproduced the high total and bilateral SLN mapping using cervical ICG injection and NIR fluorescence. Practical application of the MSKCC algorithm allowed high lymph node metastasis detection in combination with a low extent of lymph node removal. (C) 2016 Elsevier Inc. All rights reserved.

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U2 20

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ER

PT J

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TI Anatomical and functional changes to the pelvic floor after robotic

versus laparoscopic ventral rectopexy: a randomised study

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Magnetic resonance defecography; Pelvic floor dysfunction; Pelvic organ

mobility; POP-Q; Robot-assisted procedure; Ventral rectopexy

ID OBSTRUCTED DEFECATION SYNDROME; INTERNAL RECTAL PROLAPSE; SURGERY;

WOMEN; SACROCOLPOPEXY; INCONTINENCE; DYSFUNCTION; SYMPTOMS

AB To compare the effect of laparoscopic and robot-assisted ventral rectopexy for posterior compartment procidentia on the pelvic floor anatomy and function.

A prospective randomised single-centre study was carried out of 29 female patients, who underwent robot-assisted or laparoscopic ventral mesh rectopexy for external or internal rectal prolapse with symptoms of obstructive defecation and/or faecal incontinence. Anatomical changes were measured by Pelvic Organ Prolapse Quantification (POP-Q) and magnetic resonance defecography. Functional changes were evaluated using symptom questionnaires before and 3 months after surgery.

After rectopexy, changes in POP-Q measurements were statistically significant for points Ap, Bp, C, D and Ba. The descent of the anorectum and cervix/vaginal cuff during straining were significantly reduced with regard to the reference line (mean, -10.4 +/- 14.9 mm, p = 0.001) and (-13.3 +/- 18.1 mm, p < 0.001) respectively. Pelvic organ mobility (POM) was reduced statistically significantly for the posterior (mean, -16.6 +/- 20.8 mm, p < 0.001) and apical compartments (mean, -13.1 +/- 14.8, p < 0.001). The PFDI-20, PFIQ-7 and PISQ-12 questionnaires showed statistically significant improvement of symptoms and sexual function. No significant differences were observed between the robot-assisted and laparoscopic techniques in terms of anatomical or functional parameters.

Ventral mesh recto-colpo-sacropexy effectively corrects the anatomy of the posterior compartment, elevates the vaginal apex and reduces pelvic organ mobility of the posterior and middle compartments. The robot-assisted and laparoscopic techniques had similar anatomical and functional outcomes.

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ER

PT J

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TI Risk factors for robotic gynecologic procedures requiring conversion to

other surgical procedures

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Robotic-assisted laparoscopy; Robotic hysterectomy; Robotic surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; LEARNING-CURVE; OUTCOMES; SURGERY;

SACROCOLPOPEXY

AB Objective: To determine the incidence of, and risk factors for, conversion from robotic gynecologic procedures to other procedure types. Methods: A retrospective cohort study included data from women who underwent any robotic gynecologic procedures between January 1, 2011 and December 31, 2012 at a tertiary care referral center in the USA. Demographic data, perioperative data, and surgeon experience (monthly case volume) data were retrieved; potential risk factors were compared between robotic procedures that were converted to other procedures and those completed as robotic procedures. Results: There were 942 robotic procedures during the study period. Conversion from robotic to any other type of procedure was recorded for 47 (5.0%, 95% confidence interval 3.8-6.6) procedures and robotic-to-open-surgery conversion occurred in 16 (1.7%, 95% confidence interval 1.0-2.7) procedures. Conversion from robotic surgery to another approach was associated with higher body mass index (P < 0.001), previous laparotomy (P = 0.042), and surgeons having a lower monthly robotic surgical case volume (P = 0.011). Asthma (P = 0.008), intra-operative bowel injury (P < 0.001), intra-operative vascular injury (P = 0.003), and single-port robotic surgery (P = 0.034) were associated with increased odds of requiring conversion from robotic procedures. Conclusion: The overall incidence of conversion from robotic surgery to laparotomy was low. Higher body mass index, previous laparotomy, history of asthma, using a single-port approach, and surgeon case volume were associated with the risk of conversion. (C) 2016 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd.-All rights reserved.

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TI Computed Tomography Morphometrics and Pulmonary Intolerance in

Endometrial Cancer Robotic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Computed tomography morphometrics; Endometrial cancer; Pulmonary

intolerance; Robotic pelvic surgery; Visceral adiposity

ID VISCERAL FAT ACCUMULATION; LAPAROSCOPIC SURGERY; COLORECTAL SURGERY;

MORBIDLY OBESE; INCREASED RISK; COLON-CANCER; PNEUMOPERITONEUM;

COMPLICATIONS; DISEASE; OUTCOMES

AB Study Objectives: To identify morphometric characteristics of obese patients that best predict pulmonary intolerance to robotic pelvic surgery using a novel method for quantifying adipose distribution.

Design: Retrospective study (Canadian Task Force classification II-2).

Setting: University hospital.

Patients: Fifty-nine patients with endometrial cancer who underwent robotic hysterectomy and lymphadenectomy between April 2008 and May 2014 and also underwent perioperative computed tomography (CT) imaging within 1 year.

Intervention: Visceral fat volume (VFV) and subcutaneous fat volume (SFV) were quantified through waist circumference measurements along with average volume estimation of slices taken at 3 levels: mid-waist, L2-L3, and L4-L5. Mean and maximum values were obtained for intraoperative physiological data.

Measurements and Main Results: The patients' mean body mass index (BMI) was 34 (range, 20-59). Along with waist circumference, VFV and SFV quantified by CT at the mid-waist, L2 -L3, and L4-L5 levels were all significant independent predictors for peak airway pressure (PAP; average and maximum) and plateau airway pressure (Pplat; average and maximum) on multivariate regression analysis after adjustment for age, ethnicity, diabetes, hypertension, pulmonary disease, smoking, obstructive sleep apnea, American Society of Anesthesiologists classification, and duration of anesthesia. Compared with the other CT parameters, L2 -L3 VFV was the best predictor of average PAP (beta = 0.398; p =.002), maximum PAP (beta = 0.493; p <.001), average Pplat (beta = 0.536; p <.001), and maximum Pplat (beta = 0.573; p <.001).

Conclusion: These novel CT morphometric measurements represent valid predictors of pulmonary intolerance to robotic surgery in obese patients. Of the measures analyzed, VFV at L2-L3 best predicts pulmonary tolerance in obese patients. Published by Elsevier Inc. on behalf of AAGL.

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ER

PT J

AU Backes, FJ

ElNaggar, AC

Farrell, MR

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Ahmad, S

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Cohn, DE

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ElNaggar, Adam C.

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Salani, Ritu

Cohn, David E.

Holloway, Robert W.

Fowler, Jeffrey M.

O'Malley, David M.

TI Perioperative Outcomes for Laparotomy Compared to Robotic Surgical

Staging of Endometrial Cancer in the Elderly <i>A Retrospective

Cohort</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Surgery; Robotic surgery

AB Objective: This study aimed to compare outcomes of endometrial cancer (EMCA) staging in elderly patients performed either robotically or via laparotomy.

Methods: A retrospective, multi-institutional chart review was conducted of all robotic and laparotomy staging surgeries for EMCA between 2003 and 2009. Charts were reviewed for intraoperative and postoperative complications and morbidities.

Results: Seven hundred forty-six women were identified who had undergone EMCA staging either robotically or via laparotomy; 89 and 93 patients 70 years or older underwent staging for EMCAvia robotic and laparotomy, respectively. Both groups had similar age and body mass index. Among elderly patients being staged robotically, a higher incidence of pelvic lymphadenectomy, and decreased blood loss, incidence of blood transfusion, and overall complications were seen compared to laparotomy. Postoperatively, elderly patients staged robotically had a shorter median hospital stay (1 vs 4 days, P < 0.001), with no increase in readmission or return to the operating theater. No vessel, bowel, or genitourinary injuries occurred. Vaginal cuff dehiscence after robotic surgery was not significantly different, but wound and fascial complications were significantly increased in patients undergoing laparotomy. Thromboembolism rates were similar between both groups.

Conclusions: Elderly patients can safely undergo robotic EMCA staging with improved outcomes compared to laparotomy. The benefits of robotic staging include higher incidence of completion of lymphadenectomy, decreased hospital stay (without an increase in readmissions or reoperations), decreased transfusions, and decreased wound and fascial complications.

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NR 15

TC 22

Z9 22

U1 0

U2 1

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J9 INT J GYNECOL CANCER

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WC Oncology; Obstetrics & Gynecology

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GA EB1JG

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ER

PT J

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TI Classification of Postoperative Complications in Robotic-assisted

Compared With Laparoscopic Hysterectomy for Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive hysterectomy; Robotic surgery;

Surgical complications

ID OUTCOMES; LAPAROTOMY; COST

AB Study Objective: To compare intraoperative and postoperative surgical complications and outcomes between robotic assisted and laparoscopic surgical management of endometrial cancer using a standardized classification system.

Design: A retrospective cohort study (Canadian Task Force classification II-2).

Setting: An integrated health care system in Northern California.

Patients: One thousand four hundred thirty-three women with a diagnosis of complex atypical hyperplasia and endometrial cancer managed by minimally invasive hysterectomy and surgical staging from January 2009 to January 2014.

Interventions: Seven hundred forty-five robotic-assisted and 688 laparoscopic hysterectomies were evaluated.

Measurements and Main Results: The primary outcome was intraoperative and postoperative complications within 30 days. All complications were categorized using the Clavien-Dindo classification system. Secondary outcomes included total operative time, estimated blood loss, transfusion rates, length of stay, conversion to laparotomy, and number of pelvic and para-aortic lymph nodes retrieved. The modality of hysterectomy was not associated with either overall intraoperative complications or major postoperative complications (p>.1). However, there were significantly fewer minor postoperative complications with robotic surgery (16.6% vs 25.6%, p<.01). Statistically significant differences were also noted in the following outcomes: decreased median operative time, length of stay, estimated blood loss, conversion to laparotomy, and median number of lymph nodes retrieved in the robotic group when compared with the laparoscopic group.

Conclusion: There was no difference in the rate of major complication between robotic and laparoscopic surgery using the Clavien-Dindo system of categorizing surgical complications; however, there were clinically significant differences favoring the robotic approach, including a lower rate of minor complications and conversion rate to laparotomy. (C) 2016 AAGL. All rights reserved.

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WC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Beavis, AL

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Sinno, AK

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Tanner, Edward J., III

TI Sentinel lymph node detection rates using indocyanine green in women

with early-stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Fluorescence imaging; Indocyanine green; Robotic

hysterectomy; Sentinel lymph node

ID RADICAL HYSTERECTOMY; UTERINE; CARCINOMA; BIOPSY; LYMPHADENECTOMY;

SURGERY; DISEASE; IIA; IB

AB Objective. Our study objective was to determine feasibility and mapping rates using indocyanine green (ICG) for sentinel lymph node (SLN) mapping in early-stage cervical cancer.

Methods. We performed a retrospective review of all women who underwent SLN mapping with ICG during primary surgical management of early-stage cervical cancer by robotic-assisted radical hysterectomy (RA-RH) or fertility-sparing surgery. Patients were treated at two high-volume centers from 10/2012 to 02/2016. Completion pelvic lymphadenectomy was performed after SLN biopsy; additionally, removal of clinically enlarged/suspicious nodes was part of the SLN treatment algorithm.

Results. Thirty women with a median age of 42.5 and BMI of 26.5 were included. Most (90%) had stage IB disease, and 67% had squamous histology. RA-RH was performed in 86.7% of cases. One patient underwent fertility sparing surgery. Median cervical tumor size was 2.0 cm. At least one SLN was detected in all cases (100%), with bilateral mapping achieved in 87%. SLN detection was not impacted by tumor size and was most commonly identified in the hypogastric (403%), obturator (26.0%), and external iliac (20.8%) regions. Five cases of lymphatic metastasis were identified (16.7%): three in clinically enlarged SLNs, one in a clinically enlarged non-SLN, and one case with cytokeratin positive cells in an SLN. All metastatic disease would have been detected even if full lymphadenectomy had been omitted from our treatment algorithm,

Conclusions. SLN mapping with ICG is feasible and results in high detection rates in women with early-stage cervical cancer. Prospective studies are needed to determine if SLN mapping can replace lymphadenectomy in this setting. (C) 2016 Elsevier Inc. All rights reserved.

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Z9 52

U1 0

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PT J

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Mourik, SL

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Martens, J

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TI Long-term follow-up and quality of life after robot assisted

sacrohysteropexy

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Uterine prolapse; Quality of life; Robotic surgery; Sacrohysteropexy;

Anatomical outcome

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROHYSTEROPEXY; UTEROVAGINAL

PROLAPSE; ABDOMINAL SACROHYSTEROPEXY; UTERINE PRESERVATION; UTERUS

PRESERVATION; RISK-FACTORS; SACROCOLPOPEXY; WOMEN; HYSTERECTOMY

AB Objective: The aim of this study is to investigate the effect of robot assisted laparoscopic sacrohysteropexy (RALS), with preservation of the uterus, in patients with pelvic organ prolapse on short and long term outcome. We report on (anatomical) status of the prolaps and the associated health related quality of life of women treated with RALS before and five years after surgery.

Study design: A prospective cohort study in a teaching hospital in The Netherlands was performed. Quality of life was assessed pre-operative, post-operative and five years after RALS using the UDI/IIQ validated self-questionnaire designed for Dutch-speaking patients. Clinical and operative data were prospectively collected up to five years. Statistical analysis of categorical data was performed with the paired T-test. Descriptive statistics were computed with the use of standard methods for means, median and proportions.

Results: Hundred women with utero vaginal prolapse were treated with RALS with preservation of the uterus. The overall success rate of pelvic organ prolapse (POP) was 89.2%. After surgery the quality of life improved (P < 0.05) Overall health status, based on a 0-100% visual analogue scale (VAS), improved from 72.6% pre-operative to 82.2% six weeks postoperative (P < 0.05). Postoperative patients experienced less feelings of nervousness (P = 0.01), shame (P < 0.05) and frustration (P < 0.05). The positive effects on these feelings remained present after five years. The learning curve shows a decrease in operating time with gained experience.

Conclusion: RALS has proven to be a safe and effective treatment for uterine preserving surgery in cases of pelvic organ prolapse. The long term anatomical outcomes and quality of life after RALS compare favorably with laparoscopic and open hysteropexy. (C) 2016 Elsevier Ireland Ltd. All rights reserved.

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U2 0

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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OA Bronze

DA 2024-01-18

ER

PT J

AU Kakos, A

Allen, V

Whiteside, J

AF Kakos, Andrea

Allen, Valerie

Whiteside, James

TI Factors Associated With Hemostatic Agent Use During Laparoscopic

Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Fibrin sealants; Hemostats; Hysterectomy

ID SEALANTS; SURGERY

AB Study Objective: To evaluate factors associated with the use of hemostatic agents during traditional laparoscopic or robotic hysterectomy.

Design: A retrospective cohort trial (Canadian Task Force classification III).

Setting: A single medical center in Cincinnati, OH, from August 1, 2013, to July 31, 2014.

Patients: Women undergoing traditional laparoscopic or robotic hysterectomies with and without the use of hemostatic agents.

Intervention: The use of a hemostatic agent at the time of hysterectomy.

Measurements: Patient characteristics and pre-and postoperative metrics were recorded for each subject. Associations between categoric variables were analyzed using chi-square testing, whereas continuous variables were analyzed using analysis of variance. Modeling of study variables to predict hemostatic agent use was performed using chi-square assisted interaction detection methods.

Main Results: The study sample included 176 cases performed by 30 surgeons. In our sample, 42% of minimally invasive hysterectomies were performed with the surgical robot (robotic-assisted laparoscopic hysterectomy); the remainder of minimally invasive hysterectomies by approach was as follows: total laparoscopic hysterectomy, 27%; laparoscopic-assisted vaginal hysterectomy, 16%; and laparoscopic supracervical hysterectomy, 15%. Forty-six percent (81/176) of cases recorded the use of a fibrin hemostat, 26% (46/176) involved an alternative hemostat, and 28% (49/176) of cases did not use any hemostat. By surgical approach, no hemostatic agent use was noted most often among laparoscopic-assisted hysterectomy; alternative hemostats were most often used during total laparoscopic hysterectomy. Robotic-assisted laparoscopic hysterectomy and laparoscopic supracervical hysterectomy were most often associated with fibrin-based hemostats. The use of any hemostatic agent did not result in clinical significant blood loss relative to cases in whino product was used. The study variable identified most predictive of hemostat use by the chi-square assisted interaction detection regression tree model was surgeon identity.

Conclusion: Hemostatic agent use during traditional laparoscopic and robotic hysterectomy does not appear to be associated with operative bleeding but is related to surgeon identity. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Robotic-assisted vs traditional laparoscopic surgery for endometrial

cancer: a randomized controlled trial

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial cancer; gynecologic surgery; operation time;

robotic-assisted surgery; traditional laparoscopic surgery

ID MINIMALLY INVASIVE SURGERY; HYSTERECTOMY; LAPAROTOMY; OUTCOMES;

MANAGEMENT; COST

AB BACKGROUND: Previous studies comparing robotic-assisted laparoscopic surgery to traditional laparoscopic or open surgery in gynecologic oncology have been retrospective. To our knowledge, no prospective randomized trials have thus far been performed on endometrial cancer.

OBJECTIVE: We sought to prospectively compare traditional and robotic-assisted laparoscopic surgery for endometrial cancer.

STUDY DESIGN: This was a randomized controlled trial. From December 2010 through October 2013, 101 endometrial cancer patients were randomized to hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymphadenectomy either by robotic-assisted laparoscopic surgery or by traditional laparoscopy. The primary outcome measure was overall operation time. The secondary outcome measures included total time spent in the operating room, and surgical outcome (number of lymph nodes harvested, complications, and recovery). The study was powered to show at least a 25% difference in the operation time using 2-sided significance level of.05. The differences between the traditional laparoscopy and the robotic surgery groups were tested by Pearson chi(2) test, Fisher exact test, or Mann-Whitney test.

RESULTS: In all, 99 patients were eligible for analysis. The median operation time in the traditional laparoscopy group (n = 49) was 170 (range 126-259) minutes and in the robotic surgery group (n = 50) was 139 (range 86-197) minutes, respectively (P<.001). The total time spent in the operating room was shorter in the robotic surgery group (228 vs 197 minutes, P<.001). In the traditional laparoscopy group, there were 5 conversions to laparotomy vs none in the robotic surgery group (P = .027). There were no differences as to the number of lymph nodes removed, bleeding, or the length of postoperative hospital stay. Four (8%) vs no (0%) patients (P = .056) had intraoperative complications and 5 (10%) vs 11 (22%) (P = .111) had major postoperative complications in the traditional and robotic surgery groups, respectively.

CONCLUSION: In patients with endometrial cancer, robotic-assisted laparoscopic surgery was faster to perform than traditional laparoscopy. Also total time spent in the operation room was shorter in the robotic surgery group and all conversions to laparotomy occurred in the traditional laparoscopy group. Otherwise, the surgical outcome was similar between the groups. Robotic surgery offers an effective and safe alternative in the surgical treatment of endometrial cancer.

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TC 98

Z9 104

U1 0

U2 11

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA Bronze

DA 2024-01-18

ER

PT J

AU Nahas, S

Feigenberg, T

Park, S

AF Nahas, Samar

Feigenberg, Tomer

Park, Susan

TI Feasibility and safety of same-day discharge after minimally invasive

hysterectomy in gynecologic oncology: A systematic review of the

literature

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Same-day discharge; Laparoscopic; Robotic; Hysterectomy; Gynecologic

oncology; Minimal invasive staging; Gynecologic malignancy outpatient

ID OUTPATIENT VAGINAL HYSTERECTOMY; ENDOMETRIAL CANCER; ROBOTIC SURGERY;

LAPAROSCOPY; MANAGEMENT

AB Objective. To compare same-day discharge (SDD) versus traditional admission to the hospital following minimally invasive hysterectomy (conventional laparoscopy and robotic assisted laparoscopy) for the treatment of gynecologic malignancies.

Methods. A systematic review was conducted in which MEDLINE and Cochrane Center Register of Controlled Trials were searched using terms related to same-day discharge, outpatient, and hysterectomy. We reviewed published English language trials and studies that compared safety, feasibility, readmission rate, emergency department (ED) visits, complication rate, and associated risk factors for admission. Studies of any design that included at least 20 patients who underwent minimally invasive hysterectomy (conventional laparoscopy and robotic laparoscopy) for gynecologic oncology indications were included.

Results. The literature review yielded 421 citations, of which 27 full-text articles were reviewed. Six comparative studies met eligibility criteria. Study data were abstracted and inputted into structural electronic forms.

Conclusion. Our results suggest that in comparison to admission post minimally invasive hysterectomy with or without full staging, SDD in gynecologic oncology procedures is safe, and feasible. It is associated with low complication and readmissions rates, few visits, and low rates of unscheduled visits within the follow up period of two to six weeks after surgery. (C) 2016 Elsevier Inc. All rights reserved.

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Siddiqui, NY

Comstock, BA

Hesham, H

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Lendvay, TS

Martino, MA

AF Polin, Michael R.

Siddiqui, Nazema Y.

Comstock, Bryan A.

Hesham, Helai

Brown, Casey

Lendvay, Thomas S.

Martino, Martin A.

TI Crowdsourcing: a valid alternative to expert evaluation of robotic

surgery skills

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 44th Global Congress on Minimally Invasive Gynecology of the

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CY NOV 15-19, 2015

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists

DE crowdsourcing; robotic surgery; simulation; surgical training

ID CROWD-SOURCED ASSESSMENT; OBJECTIVE STRUCTURED ASSESSMENT; TECHNICAL

SKILLS; SURGICAL SKILL; LEARNING-CURVE; PERFORMANCE

AB BACKGROUND: Robotic-assisted gynecologic surgery is common, but requires unique training. A validated assessment tool for evaluating trainees' robotic surgery skills is Robotic-Objective Structured Assessments of Technical Skills.

OBJECTIVE: We sought to assess whether crowdsourcing can be used as an alternative to expert surgical evaluators in scoring Robotic-Objective Structured Assessments of Technical Skills.

STUDY DESIGN: The Robotic Training Network produced the Robotic-Objective Structured Assessments of Technical Skills, which evaluate trainees across 5 dry lab robotic surgical drills. Robotic-Objective Structured Assessments of Technical Skills were previously validated in a study of 105 participants, where dry lab surgical drills were recorded, de-identified, and scored by 3 expert surgeons using the Robotic-Objective Structured Assessments of Technical Skills checklist. Our methods-comparison study uses these previously obtained recordings and expert surgeon scores. Mean scores per participant from each drill were separated into quartiles. Crowdworkers were trained and calibrated on Robotic-Objective Structured Assessments of Technical Skills scoring using a representative recording of a skilled and novice surgeon. Following this, 3 recordings from each scoring quartile for each drill were randomly selected. Crowdworkers evaluated the randomly selected recordings using Robotic-Objective Structured Assessments of Technical Skills. Linear mixed effects models were used to derive mean crowdsourced ratings for each drill. Pearson correlation coefficients were calculated to assess the correlation between crowdsourced and expert surgeons' ratings.

RESULTS: In all, 448 crowdworkers reviewed videos from 60 dry lab drills, and completed a total of 2517 Robotic-Objective Structured Assessments of Technical Skills assessments within 16 hours. Crowd-sourced Robotic-Objective Structured Assessments of Technical Skills ratings were highly correlated with expert surgeon ratings across each of the 5 dry lab drills (r ranging from 0.75-0.91).

CONCLUSION: Crowdsourced assessments of recorded dry lab surgical drills using a validated assessment tool are a rapid and suitable alternative to expert surgeon evaluation.

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NR 20

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Z9 47

U1 0

U2 11

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA EE3RK

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OA Bronze

DA 2024-01-18

ER

PT J

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Domínguez, AM

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Bourdel, N

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TI Indocyanine green and infrared fluorescence in detection of sentinel

lymph nodes in endometrial and cervical cancer staging - a systematic

review

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Sentinel lymph node; Indocyanine green; Endometrial or endometrium;

Cervix; Gynecologic; Cancer/carcinoma/neoplasms

ID ROBOTIC SURGERY; BIOPSY; UTERINE; MALIGNANCIES; EXPERIENCE; IMPROVES;

ICG

AB Objective: Sentinel lymph node (SLN) mapping for endometrial (EC) and cervical cancers (CC) is a current technique that could provide benefits over traditional lymphadenectomy. Near-infrared (NIR) fluorescence imaging is a promising technique to perform this procedure. We conducted a systematic review of the evidence regarding the technique and the effectiveness of indocyanine green (ICG) during SLN biopsy, using robotic and laparoscopic assisted surgery and laparotomy.

Materials and methods: We conducted a computer literature search for published English language studies in humans using PubMed since January 2010 up to May 2015. The initial search came up with 17 articles, of which 10 articles used ICG as tracer in SLN biopsy in EC and CC.

Results: 422 patients were included in 10 studies, ranging from 1 to 227 patients. The main surgical approach used in ICG SLN biopsy was robotic-assisted surgery in 368 patients. Laparotomy was performed in 39 patients and laparoscopy in 15. The detection rate in SLN mapping using ICG ranged from 78% to 100% for cervical injection and from 33% to 100% for hysteroscopic injection. Sensitivity and negative predictive value (NPV) vary from 50% to 100% and 88% to 100%, respectively. The most common site of injection was the cervix (two quadrants); this technique is correlated with a high detection rate (ranging from 78% to 95%). The cervical submucosal and stromal injections were the most frequent sites used. No complications related to ICG administration were described.

Conclusions: NIR fluorescence imaging using ICG is performed in robotic-assisted surgery in laparoscopy and in laparotomy, being a feasible, safe, time-efficient and seemingly reliable method for lymphatic mapping in early stage of CC and EC. Although it has promising results in SLN mapping, randomized studies, with larger patient samples, are needed. (C) 2016 Elsevier Ireland Ltd. All rights reserved.

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NR 29

TC 43

Z9 48

U1 3

U2 31

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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GA ED3VG

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OA Bronze

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ER

PT J

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Shah, N

Park, A

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Falcone, T

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Rardin, C

Iglesia, C

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Shah, Nemi

Park, Amy

Chen, Beatrice

Emery, Stephen

Falcone, Tommaso

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TI Core Privileging and Credentialing: Hospitals' Approach to Gynecologic

Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Credentialing; Gynecologic surgery; Hospital privileges; Laparoscopic

surgery; Medical regulation; Robotic surgery

ID SKILL

AB Study Objective: Privileging and credentialing requirements are determined by medical staff leadership at the hospital level to ensure clinicians provide safe healthcare services. No standardized guidelines exist for gynecologic surgery. The objective of this study is to examine the variability of the criteria used to grant surgical privileges and credentials for gynecologic procedures at 5 high-volume academic and community-based US hospitals.

Design: We conducted a cross-sectional study (Canadian Task Force classification III).

Setting: Data was obtained from obtained from 5 geographically diverse hospital systems.

Intervention: We examined criteria for designating core gynecologic privileges, credentialing, and other training requirements as well as minimum and annual case numbers for initial granting and maintenance of surgical privileges.

Measurements and Main Results: Major inconsistencies in privileging were found across the 5 institutions. Hospitals varied widely in procedures designated as core versus those requiring advanced training. Institutions greatly contrasted in the case numbers and temporal factors used to define experience. Of particular concern was absent privileging criteria for 38.4% to 76.9% of minor procedures, 26.7% to 46.7% of endoscopic procedures, and 6.67% to 56.7% of major procedures. Initial and maintenance privileging requirements for special procedures (i.e., robotic-assisted surgery) were likewise discrepant, with minimum annual case numbers ranging from 3 to 48 across hospitals.

Conclusion: Considerable variability exists in the criteria used by hospitals for granting and maintaining surgical privileges for gynecologic procedures. Standardization will likely require efforts at a national leadership level. (C) 2016 AAGL. All rights reserved.

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TC 6

Z9 6

U1 0

U2 3

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GA EB8KA

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ER

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Campbell, DA

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Morgan, DM

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Mahnert, Nichole

Lim, Courtney S.

Mullard, Andrew J.

Campbell, Darrell A.

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TI A Favorability Score for Vaginal Hysterectomy in a Statewide

Collaborative

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Surgical approach

ID ROUTE

AB Study Objective: Because it is associated with fewer complications and more rapid recovery, the vaginal approach is preferred for benign hysterectomy. Patient characteristics that traditionally favor a vaginal approach include adequate vaginal access, small uterine size, and low suspicion for extrauterine disease. However, the low proportion of hysterectomies performed vaginally in the United States suggests that these data are not routinely applied in clinical practice. We sought to analyze the association of parity, prior pelvic surgery, and uterine weight with the use of the vaginal, laparoscopic, robotic, and abdominal approaches to hysterectomy.

Design: A retrospective cohort study (Canadian Task Force classification II-2).

Setting: The Michigan Surgical Quality Collaborative is a statewide organization of 52 academic and community hospitals in Michigan funded by Blue Cross and Blue Shield of Michigan/Blue Care Network, including patients from all insurance payers.

Patients: Five thousand six hundred eight women undergoing hysterectomy for benign gynecologic conditions from January 1, 2013, through December 8, 2013, and included in the Michigan Surgical Quality Collaborative.

Interventions: To assess potential for vaginal hysterectomy, a favorability score of 0, 1, 2, or 3 was calculated by summing 1 point each for parity >= 1, no prior pelvic surgery, and uterine weight <250 g. Frequencies of surgical approaches to hysterectomy were compared using chi-square tests across favorability scores.

Measurements and Main Results: The use of robotic hysterectomy was most frequent (41.9%, n = 2349/5608) followed by abdominal (19.7%, n = 1103/5608), laparoscopic (14.4%, n = 809/5608), vaginal (13.5%, n = 758/5608), and laparoscopic-assisted vaginal (10.5%, n = 589/5608) hysterectomy. With favorability scores of 0, 1, 2, and 3, vaginal hysterectomy was performed in 0.6% (n = 1/167), 5% (n = 66/1324), 13.7% (n = 415/3036), and 25.5% (n = 276/1081) of cases and abdominal hysterectomy in 41.9% (n = 70/167), 30.8% (n = 408/1324), 17.5% (n = 531/3036), and 8.7% (n = 94/1081), respectively. There was little variation in the rates of laparoscopic hysterectomy (13.3%-16.8%, p = .429) and robotic hysterectomy (39.5%-42.4%, p = .518) across favorability scores.

Conclusion: In a population of women undergoing hysterectomy in the state of Michigan, the use of vaginal and abdominal hysterectomy varied with respect to parity, prior pelvic surgery, and uterine weight, but there was little variation in the use of laparoscopic and robotic approaches. The favorability score could potentially be used as a quality improvement tool to evaluate practice patterns with respect to the use of various surgical approaches to hysterectomy. (C) 2016 AAGL. All rights reserved.

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Z9 1

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U2 0

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WC Obstetrics & Gynecology

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ER

PT J

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TI Does the Robotic Platform Reduce Morbidity Associated With Combined

Radical Surgery and Adjuvant Radiation for Early Cervical Cancers?

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical cancer; Morbidity; Radical hysterectomy; Radiation; Robotic

ID CONCURRENT CHEMOTHERAPY; HYSTERECTOMY; STAGE; THERAPY; IB2; CARCINOMA;

CHEMORADIATION; RADIOTHERAPY

AB Objective Open radical hysterectomy followed by adjuvant radiation for cervical cancer has been associated with significant rates of morbidity. Radical hysterectomy is now often performed robotically. We sought to examine if the robotic platform decreased the morbidity associated with radical hysterectomy followed by adjuvant radiation.

Materials/Methods A retrospective cohort of patients with cervical cancer undergoing radical hysterectomy from 1995 to 2013 was evaluated. Complications were assessed using electronic record review and graded. (2) tests and Student t tests were used for analysis.

Results Overall, 243 patients underwent radical hysterectomy for cervical cancer. Surgical approach was 43% open and 57% robotic. Eighty-three patients (34.2%) required adjuvant radiation. Overall, radical hysterectomy plus adjuvant radiation was associated with increased risk of complication (29%) compared to radical hysterectomy alone (7%) (P < 0.001). Complications included lymphedema (n = 18), bowel-associated complications (n = 10), and urinary complications (n = 7). There was no difference in time to initiation of radiation between open and robotic surgery (43 vs 47 days; P = 0.33). There was no difference in grade 2/3 complications in patients receiving adjuvant radiation between open and robotic surgery (27.5% vs 27.9%; P = 0.97). Patients undergoing open surgery followed by radiation experienced a trend toward increased adhesion-related complications, such as bowel obstruction and ureteral stricture (10% vs 2.3%; P = 0.19); whereas patients undergoing robotic surgery followed by radiation experienced a trend toward increased lymphedema (19% vs 8%; P = 0.20).

Conclusions We found no difference in long-term complications between patients who underwent robotic surgery compared to open radical hysterectomy with adjuvant radiation. There may be fewer adhesion-related complications with robotic surgery. However, as many radiation-related complications occur at later time points, continued follow-up to evaluate for potential differences between the 2 groups is necessary.

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FX ELB has salary support from NIH 5 T32 HD040672-15.

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JI Int. J. Gynecol. Cancer

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PT J

AU Foote, JR

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AF Foote, Jonathan R.

Valea, Fidel A.

TI Robotic surgical training: Where are we?

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Robotic surgery; Education; Gynecologic oncology; Minimally invasive

surgery

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; DA VINCI SKILLS; GYNECOLOGIC

ONCOLOGY; ENDOMETRIAL CANCER; LEARNING-CURVE; SURGERY; SIMULATOR;

VALIDATION; PROGRAM; LAPAROTOMY

AB Background and objective. Over the past 10 years, robotic surgery has revolutionized the advancement of MIS in gynecologic oncology. As the use of robotic surgery has increased, so has the interest in the surgical training of gynecologic oncology fellows. The purpose of this review is to summarize the state of robotic surgical education in Gynecologic Oncology.

Methods. Several electronic databases were searched to identify studies that discussed robotic surgical education in gynecologic oncology. Particular attention was given to articles that discussed educational curriculum. The various curriculums were compared and summarized.

Results. The first reports of robotic surgery curriculums in gynecologic oncology emerged in 2008. Prior to that the early adapters had to rely on less structured curriculums that essentially used live animal models and cadaveric dissections on the robot to simulate live surgery. More recent surgical curriculums are more structured and include the same basic components: didactics and a graduated hands-on experience. There is also an accredited robotic educational curriculum, the Fundamentals of Robotic Surgery (FRS), which combine an on-line curriculum with dry lab and operating room components that can be scored using a validated assessment tool.

Conclusions. Robotic surgical education has come a long way in the decade that the robotic platform has been available in the U.S. Although there is still no standardized curriculum, most fellowship training programs in gynecologic oncology have fairly consistent training. Simulation training is another tool that can help a surgeon achieve proficiency quicker. (C) 2016 Elsevier Inc. All rights reserved.

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JI Gynecol. Oncol.

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

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Unger, Cecile A.

TI The effect of surgical start time in patients undergoing minimally

invasive sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Laparoscopic sacrocolpopexy; Operating time; Perioperative

complications; Pelvic organ prolapse; Robotic sacrocolpopexy

AB Introduction and hypothesis The objective was to determine if the surgical start time affects operating room time and the incidence of perioperative adverse events in patients undergoing minimally invasive sacrocolpopexy.

Methods This is a retrospective cohort of 396 women who underwent laparoscopic and robotic sacrocolpopexy at a tertiary care center between January 2006 and December 2012. Cases were divided into those with a first, second or third start time. Operating room (OR) time was defined as time the patient entered the room to time out of the room (minutes) and the case time was defined as the period between incision and closure (minutes). Adverse events were defined a priori and also reported using the Clavien-Dindo grading scale. Logistic regression analysis was performed for categorical variables and multiple linear regression analysis for continuous variables.

Results A total of 145 robotic and 261 conventional laparoscopic minimally invasive sacrocolpopexies were performed. Operating room time data were available for 396 cases. Of the cases, 63.9 % (253 out of 396) had a first start, 32.1 % (127 out of 396) had a second start, and 4 % (16 out of 396) had a third start. Robotic and concomitant rectopexy cases were more likely to be performed as first-start cases and operating room time and case time were longest for first-start cases. However, after adjusting for mode of surgery, concomitant procedures, previous surgeries, BMI, and age, this finding was no longer statistically significant. There was no difference in the rate of perioperative adverse events among first-, and second-/third-start cases.

Conclusion Surgical case start time does not appear to be associated with operating time or the incidence of perioperative adverse events in patients undergoing minimally invasive sacrocolpopexy.

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NR 12

TC 11

Z9 11

U1 1

U2 2

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GA EA1LR

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ER

PT J

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Cox, MKB

Cohen, SL

Einarsson, JI

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Einarsson, Jon I.

TI The Use of CystoSure to Enable Posthysterectomy Cystoscopic Evaluation:

A Case Series

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cytoscopy; Hysterectomy; Urinary catheter

ID URINARY-TRACT INJURY; HYSTERECTOMY

AB Cystoscopy can be used to diagnose urologic injuries at the time of gynecologic surgery. Current cystoscopy setup involves removing the indwelling catheter placed for the procedure and assembling a multicomponent cystoscope. The objective of this study was to evaluate and report on our initial experience with CystoSure (Emmy Medical, Holliston, MA), a new Food and Drug Administration approved device designed to facilitate perioperative diagnostic cystoscopy. The CystoSure catheter is an 18F quad-port silicone transurethral catheter with a central sealed port for the cystoscope and a side port that allows for bladder filling. A retrospective chart review was performed of women who underwent benign laparoscopic or robotic gynecologic surgery with cystoscopy at Brigham and Women's Faulkner Hospital, Boston, MA, from May 1, 2015, to August 31, 2015. Thirty women underwent cystoscopy during the study period. The CystoSure catheter is placed at the beginning of the procedure. Total laparoscopic hysterectomy was the most common procedure, representing 90% of cases (27/30). Using the CystoSure system, full bladder survey and bilateral ureteral jets were easily evaluated in 87% (26/30) of the patients. Of the 26 cystoscopies performed successfully, 1 intravesical suture was diagnosed and addressed. In the remaining 4 patients, the 18F CystoSure catheter was too large for the urethral orifice, and a 16F catheter was used for the case. The CystoSure device allows for minimal setup and efficient performance of diagnostic cystoscopy postgynecologic surgery. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Feasibility and surgical outcomes of conventional and robot-assisted

laparoscopy for early-stage ovarian cancer: a retrospective, multicenter

analysis

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Early-stage ovarian cancer; Laparoscopic surgery; Robot-assisted

laparoscopy; Outcomes; Complications; Feasibility

ID FALLOPIAN-TUBE; I OVARIAN; LAPAROTOMY; CARCINOMA; SURGERY; METASTASES;

EFFICACY; SAFETY; WOMEN

AB Purpose We aimed to investigate the safety, adequacy and oncological outcomes of laparoscopic surgery (LS) and robot-assisted laparoscopic (RALS) approach for the treatment of early-stage ovarian cancer.

Methods We performed a multicentric, retrospective cohort study, enrolling patients affected by early-stage ovarian cancer who underwent laparoscopic management for early-stage ovarian cancer between 2006 and 2014. Surgical, pathologic and oncologic outcome data were analyzed to compare LS and RALS performances for early-stage ovarian cancer management.

Results 39 patients underwent laparoscopic staging for presumed stage I ovarian cancer: 23 underwent LS and 16 underwent RALS. The mean operative time was 281 +/- 81 min (LS 288 +/- 88 min; RALS 270 +/- 72 min; p = 0.49). No conversion to laparotomy occurred, and one patient had intraoperative hemorrhage requiring blood transfusion. Four patients (10.2 %) experienced postoperative complications of grade 3 according to the Clavien-Dindo classification. The median hospital stay was 3 days (1-15); the differences were not statistically significant between two groups [LS = 4 (1-15); RALS = 3 (1-7); p = 0.43]. During a mean follow-up period of 19.4 months, tumor recurrence occurred in 3 patients: 2 (8.7 %) in the LS group and 1 (6.25 %) in the RALS group. Overall survival and disease-free survival for the entire cohort were 97.4 and 92.3 %, respectively.

Conclusions LS and RALS seem to be adequate and feasible for the treatment of early-stage ovarian cancer in terms of the surgical outcomes and oncological safety. Furthermore, in our experience, perioperative outcomes are comparable between LS and RALS making them an acceptable approach in selected patients.

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U2 12

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JI Arch. Gynecol. Obstet.

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ER

PT J

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TI Robotic Sigmoid Vaginoplasty in an Adolescent Girl With

Mayer-Rokitansky-Kuster-Hauser Syndrome

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic vaginoplasty; vaginal reconstruction;

Mayer-Rokitansky-Kuster-Hauser syndrome

ID VAGINAL RECONSTRUCTION; CONSTRUCTION; COLON

AB Background: Sigmoid vaginoplasty has carved a niche for itself in reconstructive genitoplasty. We describe the successful use of a robotically assisted sigmoid vaginoplasty in an adolescent girl with Mayer-Rokitansky-Kuster-Hauser syndrome.

Case: An 18-year-old girl was referred to our hospital with the complaint of primary amenorrhea. She was thoroughly evaluated and magnetic resonance imaging was done, which revealed absence of a vagina and uterus but bilateral normal ovaries. Because cytogenetic analysis was "normal 46, XX" karyotype, Mayer-Rokitansky-Kuster-Hauser syndrome was diagnosed. She was successfully managed by the use of robot-isolated sigmoid colon segment for vaginal replacement and robot-sewn colon-colon anastomosis. A follow-up was done at the 3rd and 6th months, which revealed a large capacious vagina even without self-dilatation.

Conclusions: The robotic approach is feasible and can produce satisfying postoperative outcomes and might be a minimally invasive technique in future vaginoplasty surgery.

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NR 23

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Z9 1

U1 0

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

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Trabuco, Emanuel C.

TI Evidence Basis for Hysterectomy

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Hysterectomy; Cuff dehiscence; Robotic; Vaginal; Laparoscopic; Costs

ID VAGINAL CUFF DEHISCENCE; LAPAROSCOPIC HYSTERECTOMY; DIFFERENT MODES;

ENLARGED UTERI; ASSISTANCE; TRENDS

AB Although vaginal hysterectomy has long been championed by the American College of Obstetricians and Gynecologists as the preferred mode of uterine removal, nationwide vaginal hysterectomy utilization has steadily declined. This article reviews the evidence comparing vaginal with other modes of hysterectomy and highlights areas of ongoing controversy regarding contraindications to vaginal surgery, risk of subsequent prolapse development, and impacts of changing hysterectomy trends on resident education.

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PT J

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TI Total Laparoscopic (S-LPS) versus TELELAP ALF-X Robotic-Assisted

Hysterectomy: A Case-Control Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Laparoscopy; Robotic; TELELAP ALF-X

ID SURGERY

AB Study Objective: To compare the feasibility and safety of the TELELAP ALF-X system and standard laparoscopy for total hysterectomy to treat patients with benign and early malignant gynecologic disease.

Design: Single-institution retrospective case-control study (Canadian Task Force classification II-2).

Setting: Catholic University of the Sacred Heart, Rome, Italy.

Patients: Between October 2013 and May 2015, 203 women underwent TELELAP-ALF X (group 1) or standard laparoscopic (group 2) total hysterectomy and were enrolled.

Interventions: Total standard laparoscopy vs TELELAP ALF-X robot-assisted hysterectomy for benign and early malignant gynecologic disease.

Measurements and Main Results: In group 1, the median age was 55 years (range, 40-79 years), median body mass index (BMI) was 25 kg/m2 (range, 17-38 kg/m(2)), and 51 patients (58%) had undergone previous abdominal surgery. In the control group, the median age was 55 years (range, 34-90 years), median BMI was 25 kg/m(2) (range, 17-41 kg/m2), and 31 patients (27%) had previous abdominal surgery. The median operative time was 147 minutes (range, 58-320 minutes) in group 1 and 80 minutes (range, 22-300 minutes) in group 2 (p = .055). The median estimated blood loss was 57 mL (range, 0-600 mL) in group 1 and 99 mL (range, 0-400 mL) in group 2, with no significant differences between the 2 groups (p = .963). Procedures were successfully performed without conversion in 94.3% of cases in the group 1 and in all cases in group 2. Early postoperative pain was significantly lower in group 2.

Conclusion: TELELAP ALF-X hysterectomy in patients with benign and early malignant gynecologic disease is feasible and safe, and can be considered a valid option for these patients. (C) 2016 AAGL. All rights reserved.

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U1 1

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ER

PT J

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TI Delayed Diagnosis of Vesicouterine Fistula After Treatment for Mixed

Urinary Incontinence: Menstrual Cup Management and Diagnosis

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE vesicouterine fistula; urinary incontinence; menouria; menstrual cup

ID LAPAROSCOPIC REPAIR; EXPERIENCE

AB Introduction: Avesicouterine fistula is a rare form of urogenital fistula, yet there is increasing prevalence in the United States because of the rising rate of cesarean deliveries. Vesicouterine fistulas have various presentations including menouria, hematuria, or urinary incontinence.

Case Presentation: A 39-year-old multiparous woman presented with urine leakage after her third cesarean delivery. She had been treated for mixed urinary incontinence with overactive bladder medications and a midurethral sling with continued complaints of urine leakage. The patient noticed her symptoms of urine leakage improved during menses when she used a menstrual cup. After confirmation of vesicouterine fistula, the patient underwent robotic-assisted surgery and her symptoms of insensible urine leakage resolved.

Conclusions: When evaluating women with urinary incontinence and a history of cesarean deliveries, use of menstrual cup may aid in the diagnosis of vesicouterine fistula. Robotic-assisted laparoscopic repair with tissue interposition flap is an efficacious minimally invasive method for treatment of vesicouterine fistula.

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TC 4

Z9 5

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U2 4

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TI One-Year Outcomes After Minimally Invasive Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE minimally invasive sacrocolpexy; laparoscopic sacrocolpexy; robotic

sacrocolpexy; mesh exposure; polypropylene mesh; outcomes

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; ROBOTIC

SACROCOLPOPEXY; INCONTINENCE; MESH

AB Objective: The primary aim of this study was to report anatomic, symptom, and quality of life outcomes in women with symptomatic stage 2 or greater prolapse 1 year after randomization to robotic and laparoscopic sacrocolpopexy.

Methods: This is a planned ancillary analysis of the Abdominal Colpopexy: Comparison of Endoscopic Surgical Strategies trial, a randomized comparative effectiveness trial comparing costs and outcomes of robotic and laparoscopic sacrocolpopexy at 2 academic medical centers. At baseline and 1 year after surgery, women underwent standardized assessment including validated subjective pelvic floor outcomes and physical examination with prolapse assessment.

Results: Sixty six (85%) of 78 randomized participants completed 1-year follow-up: 33 (87%) of 38 in the laparoscopic arm and 33 (83%) of 40 in the robotic arm (P = 0.59). Ninety-seven percent (32/33) in the laparoscopic group and 100% (33/33) in the robotic arm considered that their prolapse symptoms improved (P = 0.999). The cohort had significant improvement in all pelvic floor symptom and quality of life measures, which did not differ by treatment arm. Of women who were sexually active at 1 year, sexual function improved in both cohorts. No new serious adverse events, including mesh exposure or reoperation for prolapse, were identified between 6 months and 1 year after surgery. No women had a sacrocolpopexy mesh complication or reoperation for mesh exposure.

Conclusions: Minimally invasive sacrocolpopexy is associated with significant improvement in pelvic floor symptoms, anatomy, and sexual function. In addition, mesh exposure rateswith light weight polypropylene mesh seem to be lower than those reported with multifilament and heavier polypropylene mesh.

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FU National Institute of Biomedical Imaging and Bioengineering Recovery Act

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OA Green Accepted

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PT J

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TI Robotic-Assisted Gynecologic Surgery and Perioperative Morbidity in

Elderly Women

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Elderly; Laparoscopy; Robotic surgery

ID ENDOMETRIAL CANCER; UROGYNECOLOGIC SURGERY; SURGICAL OUTCOMES;

RISK-FACTORS; HYSTERECTOMY; LAPAROSCOPY; MORTALITY; AGE

AB Study Objective: To assess perioperative complications, conversions, and operative times in patients age >= 75 years undergoing robotic-assisted gynecologic surgery.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: High-volume, 2-physician gynecologic oncology practice.

Patients: A total of 705 women who underwent any robot-assisted gynecologic procedure for benign (n = 380) or malignant (n = 325) conditions between July 2008 and May 2014. Fifty patients age >= 75 years (elderly group) were compared with 655 patients age <75 years (younger group).

Interventions: Operative data were gathered prospectively for all robotic -assisted procedures. Demographic and perioperative outcomes were analyzed retrospectively for this study.

Measurements and Main Results: The mean age was 81.3 +/- 4.2 years (range, 75.0-90.5 years) in the elderly group and 52.8 +/- 11.5 years (range, 22.9-74.6 years) in the younger group. The elderly group had higher rates of surgery for malignancy (90.0% vs 43.2%; p < .01) and lymphadenectomy (44.0% vs 23.4%; p < .01), and was more likely to have cardiovascular disease (88.0% vs 37.6%; p < .01). There were no between-group differences in body mass index or history of chronic obstructive pulmonary disease, diabetes mellitus, or more than 1 previous abdominal surgical procedure. The elderly group was more likely to have a length of stay greater than postoperative day one (30.0% vs 14.8%; p = .01) and had a higher incidence of postoperative cardiac arrhythmia (8.0% vs 1.2%; p < .01). The elderly group also had a smaller median uterine size (83.0 +/- 49.1 g vs 126.0 +/- 189.5 g; p < .01), but total operative time, rate of conversion (6.0% vs 1.8%) and rate of blood transfusion (2.0% vs 1.5%) were not significantly different between the 2 groups. Rates of bowel and genitourinary injury were <1% in both groups, and there was no between-group difference in postoperative infectious morbidity, vaginal cuff complications, or reoperation.

Conclusion: The perioperative complication rates of robotic -assisted surgery are comparable in elderly women and younger women, despite a longer hospital length of stay and greater likelihood of postoperative arrhythmia in elderly women. (C) 2016 AAGL. All rights reserved.

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U2 4

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TI Cosmetic Appearance of Port-site Scars 1 Year After Laparoscopic Versus

Robotic Sacrocolpopexy: A Supplementary Study of the ACCESS Clinical

Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic; Prolapse; Robotic; Sacrocolpopexy; Scar; Wound healing

ID RANDOMIZED-CONTROLLED-TRIAL

AB Study Objective: To prospectively measure trocar site appearances 1 year after surgery in women participants in the Abdominal Colpopexy: Comparison of Endoscopic Surgical Strategies Trial, a 2-center randomized surgical trial (NCT01124916).

Design: Supplementary analysis of a surgical trial that randomized women to robotic or laparoscopic sacrocolpopexy (Canadian Task Force classification I).

Setting: Operative trial.

Patients: Women undergoing clinically indicated sacrocolpopexy for symptomatic stage >= II pelvic organ prolapse were randomized to laparoscopic abdominal sacrocolpopexy (LASC) or robotic abdominal sacrocolpopexy (RASC). Trocar skin incision closure was standardized by using Dermabond (Ethicon, Somerville, NJ).

Measurements and Main Results: Photographs of all incision sites were taken at baseline (immediately), 6 weeks, 6 months, and 1 year after surgery. Study coordinators scored each incision with the validated Stony Brook Evaluation Scale (SBES), a 5-point wound evaluation scale. We calculated the average of all scars scores per case to determine the percent of optimal wound healing (0%-100%) for each case as well as the proportion of cases meeting 100% wound repair scoring. Wound repair scores across groups were tested with the Wilcoxon rank sum test. The overall proportion of cases in each group meeting "optimal" wound recovery (scores of 100%) was tested with the Fisher exact test. Seventy-eight women with a mean age of 59 years (range, 26-79 years) were randomized to LASC (n = 38) or RASC (n = 40). We did not detect significant differences in baseline characteristics or rates of dropout between the 2 study groups (5 in LASC and 7 in RASC, p = .60). Pain in the initial postoperative period was higher in the robotic arm although groups were similar at 2 weeks. Nearly all cases (75/78) contributed wound repair data (36 laparoscopic and 39 robotic). Laparoscopic surgeries require significantly fewer incisions (median = 4; range, 4-6) than robotic surgeries (median = 5; range, 4-6; p < .001). SBES scores at 6 weeks were not different for LASC and RASC (p = .426). By 6 months, the scores were better in the LASC group (84.8% +/- 8.8% vs 78.5% +/- 7.2%, p = .031), and this finding remained at 1 year (93.4% +/- 7.2% vs 85.9% +/- 8.8%, p = .001). The proportion of cases with optimal wound repair (score of 100%) was higher in the laparoscopic arm at 1 year after surgery (12/27 vs 4/33, p = .008).

Interventions: Women were randomized to robotic assisted laparoscopy or laparoscopy.

Conclusion: Wound appearance using the SBES was better in the LASC group, suggesting that there may be alterations in the mechanism for wound initiation and/or healing based on the minimally invasive route used for sacrocolpopexy. (C) 2016 AAGL. All rights reserved.

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Sung, Vivian

TI Comparison of Perioperative Complications by Route of Hysterectomy

Performed for Benign Conditions

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE hysterectomy complications; laparoscopic hysterectomy; robotic

hysterectomy; vaginal hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; OUTCOMES

AB Objective: The aim of this study was to compare perioperative complications by route of hysterectomy before and after the introduction of robotic surgery.

Methods: This is an ancillary analysis of a multicenter, retrospective cohort study with historical controls through the Fellows' Pelvic Research Network. Hysterectomies performed for benign conditions were collected prior to introduction of the robot (prerobot) and the year after introduction of the robot (postrobot) at each institution. To obtain a representative annual case distribution for each institution, a maximum of 20 cases per month were selected using stratified random sampling. Patient demographics and intraoperative and postoperative complication data were collected.

Results: One thousand four hundred forty cases were included in this study, 732 in the prerobot and 708 in the postrobot period. Intraoperative complications in the prerobot group were highest in the abdominal group (7.4%) followed by vaginal (3.9%) and laparoscopic (3.7%) groups. Postoperative complications were higher in the vaginal (8.3%) and abdominal (7.4%) groups compared with laparoscopic (1.8%) groups (P = 0.03), because of a higher proportion of infections. In the postrobot period, intraoperative complications were lower in the vaginal (2.8%), robotic (3%), and laparoscopic (4.6%) groups compared with abdominal (10.8%) (P = 0.04). Postoperative complications were lowest in the vaginal (5.1%), laparoscopic (3.6%), and robotic (3%) approaches compared with the abdominal (13.9%) approach (P = 0.003).

Conclusions: Vaginal hysterectomy has comparable rates of perioperative complications when compared with robotic and laparoscopic approaches and should be considered as a primary surgical approach in the growing armamentarium of minimally invasive approaches for hysterectomy for benign conditions.

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ER

PT J

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Carlan, SJ

Vaught, J

Greves, CE

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Carlan, Stephen J.

Vaught, Jessica

Greves, Christine E.

TI Robot-Assisted Laparoscopic Myomectomy Versus Abdominal Myomectomy <i>A

Retrospective Comparison of Short-Term Surgical Outcomes</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE gynecologic surgical procedures; gynecologic surgery; gynecology;

laparoscopic surgery; laparoscopic surgical procedures; laparoscopy;

leiomyoma; minimally invasive surgery; morbidity; robotic surgical

procedures; robotics; uterine myomectomy

AB OBJECTIVE: To compare intraoperative and postoperative surgical outcomes of robotic versus abdominal myomectomy.

STUDY DESIGN: A retrospective chart review was performed using electronic medical records from January 1, 2008-December 31, 2011, with 2008 being the first year that robotic assisted myomectomy was performed at our institution. Intraoperative outcome data and postoperative complications were reviewed as well as length of hospital stay.

RESULTS: A total of 214 abdominal myomectomy cases and 165 robotic-assisted laparoscopic cases were available for review. Total operating time in minutes was significantly longer for the robotic-assisted cases (236 +/- 96) versus the abdominal cases (110 +/- 46). Total myoma weight in grams removed was significantly greater in the abdominal myomectomy cases (391 +/- 518) versus the robot-assisted cases (229 +/- 253): Length of stay in days was longer for abdominal cases as compared to robotic (3.3 +/- 1.2 vs. 1.6 +/- 1). Estimated blood loss in milliliters was similar between abdominal and robotic cases (258 +/- 335 vs. 241 +/- 370).

CONCLUSION: Robotic-assisted and abdominal myomectomies have similar surgical outcomes. However, the longer total operating time for robotic-assisted myomectomies is a drawback which may not be completely offset by the benefit of a shorter hospital stay.

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ER

PT J

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TI The Essential Elements of a Robotic-Assisted Laparoscopic Hysterectomy

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Robotics; Laparoscopy; Hysterectomy; Minimally invasive surgery

ID PERIOPERATIVE OUTCOMES; ECONOMIC-ANALYSIS; LEARNING-CURVE; BENIGN; COSTS

AB Robotic-assisted laparoscopic hysterectomies are being performed at higher rates since the da Vinci Surgical System (Intuitive Surgical, Inc, Sunnyvale, CA, USA) received US Food and Drug Administration approval in 2005 for gynecologic procedures. Despite the technological advancements over traditional laparoscopy, a discrepancy exists between what the literature states and what the benefits are as seen through the eyes of the end-user. There remains a significant learning curve in the adoption of safe and efficient robotic skills. The authors present important considerations when choosing to perform a robotic hysterectomy and a step-bystep technique. The literature on perioperative outcomes is also reviewed.

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NR 44

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U2 1

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ER

PT J

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TI The Impact of Obesity on Intraoperative Complications and Prolapse

Recurrence After Minimally Invasive Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE minimally invasive surgery; sacrocolpopexy; intraoperative

complications; obesity; body mass index; vaginal prolapse

ID BODY-MASS-INDEX; PERIOPERATIVE COMPLICATIONS; LAPAROSCOPIC

SACROCOLPOPEXY; OUTCOMES; PREVALENCE; CONVERSION; SURGERY; TRENDS

AB Objective: Our objective was to compare the risk of intraoperative complications and prolapse recurrence among normal-weight, overweight, and obese women after minimally invasive sacrocolpopexy.

Methods: This is a retrospective study of all laparoscopic and robotic sacrocolpopexies performed at a large academic center from 2009 to 2014. Patient demographics and clinical and surgical data were compared between normal-weight, overweight, and obese women using chi(2) test, analysis of variance (ANOVA), and logistic regression.

Results: Of the 556 subjects, 187 (33.6%) were normal weight, 248 (44.6%) were overweight, and 121 (21.8%) were obese. Compared with normal-weight and overweight women, obese women had more medical comorbidities (56.2% vs 29.4% and 39.5%, P < 0.001) and were more likely to undergo robotic surgery (odds ratio, 1.40; 95% confidence interval, 1.01-1.94). Obese women experienced greater blood loss compared with overweight women (82.4 [76.1] vs 63.8 [51.6] mL, P = 0.03) and longer operative times compared with both normal-weight and overweight women (250.7 [57.0] vs 233.8 [58.2] minutes, P = 0.04, and 250.7 [57.0] vs 233.8 [57.2] minutes, P = 0.03). Obesity was a significant predictor of intraoperative complications even after correcting for surgeon experience, estimated blood loss, and concomitant hysterectomy (adjusted odds ratio, 3.42; 95% confidence interval, 1.21-9.70). Few women (7.6%) experienced recurrence of prolapse. Obesity was not a significant predictor of prolapse recurrence.

Conclusions: In women undergoing minimally invasive sacrocolpopexy, obesity is associated with increased blood loss, longer operative times, and more intraoperative complications, specifically conversions to laparotomy. Even after correcting for blood loss, surgeon experience, and concomitant hysterectomy, obesewomen were 3 times as likely to have an intraoperative complication. Our data did not show that obesity was associated with increased risk of prolapse recurrence; however, postoperative follow-up was limited.

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TI Hysterectomy for Uterine Cancer in the Elderly: A Comparison Between

Laparoscopic and Robot-Assisted Techniques

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic surgery; Laparoscopy; Uterine cancer; Elderly

ID ENDOMETRIAL CANCER; SURGICAL-MANAGEMENT; SURGERY; OUTCOMES; PATIENT;

SAFE

AB Objective The mainstay of treatment for uterine corpus cancer is surgical, and the gold standard approach has become minimally invasive surgery. The aim of this study is to compare the perioperative complications and demographics of patients 80 years old or more undergoing robotic and laparoscopic hysterectomy for uterine cancer.

Materials and Methods Using the Nationwide Inpatient Sample, we retrospectively identified all women aged 80 years or older who had hysterectomies for uterine cancer by either modality. The complication rates of surgery in both groups were adjusted for potential confounding and compared using logistic regression analyses.

Results There were 915 women aged 80 years or older identified with uterine corpus cancer who had either laparoscopic or robotic surgery. Robotically treated patients were more likely to be obese (8.8% vs 3.5%) but were otherwise similar in terms of mean age, comorbidities, income, ethnicity, and insurance status. Those undergoing robotic surgery were less likely to have admissions beyond 3 days (29.0% vs 38.2%; adjusted odds ratio, 0.66; P < 0.01) and had a lower composite incidence of any complication (24.3% vs 31.6%; adjusted odds ratio, 0.7; P < 0.05). When looking at those who had lymph node dissections, there was a lower rate of postoperative ileus, and a trend toward fewer venous thromboembolic events.

Conclusions Among octogenarians and nonagenarians with uterine corpus cancer, robotic surgery is associated with a shorter hospital admission and a better complication profile than laparoscopy.

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Z9 8

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U2 3

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JI Int. J. Gynecol. Cancer

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PT J

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TI Robotic Versus Open Radical Hysterectomy in Women With Locally Advanced

Cervical Cancer After Neoadjuvant Chemotherapy: A Single-institution

Experience of Surgical and Oncologic Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Abdominal radical hysterectomy; Complications; Locally advanced cervical

cancer; Neoadjuvant chemotherapy; Robotic radical hysterectomy

ID PELVIC LYMPHADENECTOMY; CARCINOMA; SURGERY; CLASSIFICATION;

COMPLICATIONS; LAPAROSCOPY; PACLITAXEL; MANAGEMENT; CISPLATIN

AB Study Objective: To compare the surgical and oncologic outcomes of robotic radical hysterectomy (RRH) versus laparotomy in women with locally advanced cervical cancer (LACC) after neoadjuvant chemotherapy (NACT).

Setting: Oncology referral center.

Design: A retrospective comparative observational study was performed in 30 patients with LACC Federation Internationale de Gynecologie et d'Obstetrique stage 1B2-IIB who underwent RRH after NACT between February 2008 and December 2014. This group was compared with a cohort of 44 patients with similar characteristics who underwent abdominal radical hysterectomy after NACT (Canadian Task Force classification II2).

Patients: Patients with LACC FIGO stage IB2-IIB.

Interventions: A retrospective comparative observational study.

Measurements and Main Results: The mean (standard deviation [SD]) operative time was significantly longer in the robotic group (307.8 minutes [40.2] vs 233.7 minutes [61.9], p <= .001). On the contrary, the mean (SD) estimated blood loss was significantly lower in the robotic group (111.0 mI, [69.6] vs 286.9 mL [159.1], p <= .001), and length of stay was significantly shorter (4.1 [2.4] days vs 5.8 days [3.3], p = .015). The incidence of intraoperative and early and late complications was not statistically significantly different between the 2 groups. The mean (SD) follow-up of patients was 35.6 months (28.4) and 43.7 months (23.2) in the open and robotic groups, respectively (p = .137). The disease recurrence rate (27.2% vs 20%) was similar between the 2 groups; sites and types of recurrences were also similar. Kaplan-Meier survival analysis for median progression-free survival and median overall survival were not statistically different comparing cohorts by surgery type.

Conclusions: RRH after NACT in women with LACC is associated with similar perioperative and oncologic outcomes to open procedure. These results require further investigation to establish a more robust conclusion. (C) 2016 AAGL. All rights reserved.

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Löfgren, M

Högberg, T

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Kalapotharakos, Grigorios

Asciutto, Katrin C.

Lofgren, Mats

Hogberg, Thomas

TI A population-based registry study evaluating surgery in newly diagnosed

uterine cancer

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Cancer; hysterectomy; laparoscopy; lymphadenectomy; obesity; surgical

techniques; training

ID ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL HYSTERECTOMY;

ROBOTIC SURGERY; LAPAROTOMY; OUTCOMES; OBESE; COST; PATIENT; WOMEN

AB IntroductionThe aim was to evaluate surgical treatment of newly diagnosed uterine cancer in a Swedish population.

Material and methodsData in the GynOp registry from 2008 to 2014 were analyzed.

ResultsIn total, 3443 cases were included: 430 (12%) were robotic-assisted laparoscopic, 272 (8%) laparoscopic, and 2741 (80%) abdominal operations. There was an increasing trend in minimally invasive surgery from 2008 to 2014 (41%). Women with lymph nodes removed in the robotic-assisted laparoscopic group experienced less blood loss (mean 105 vs. 377 mL), shorter length of hospital stay (2.4 vs. 4.1 days), and fewer days to normal activities of daily living (6.5 vs. 12.7 days) (all p < 0.001) compared with the abdominal group, but operating time did not differ. Similar results were found in women with no lymph node removal and in women with body mass index 35. Major complications during hospital stay, reoperations, and time to work were less in both minimally invasive groups. More lymph nodes were retrieved in the abdominal (mean 34.4) than in the robotic-assisted laparoscopic (mean 26.0) group, but the number of women with lymph node metastases did not differ, totaling 211/960 (21.9%; 95% CI 19.4-24.7%). Isolated para-aortic lymph node metastases were found in 3.9% (95% CI 2.4-5.6%) of women.

ConclusionsMinimally invasive surgery in uterine cancer patients reduces days to normal activities of daily living, number of days to return to work, length of hospital stay, and blood loss in patients without and with lymph node dissection and in obese patients.

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Cancer Foundation

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WC Obstetrics & Gynecology

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ER

PT J

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Shah, JS

Fleming, ND

Nick, AM

Soliman, PT

Chisholm, GB

Schmeler, KM

Ramirez, PT

Frumovitz, M

AF Brown, Alaina J.

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Nick, Alpa M.

Soliman, Pamela T.

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Schmeler, Kathleen M.

Ramirez, Pedro T.

Frumovitz, Michael

TI Role of cervical cytology in surveillance after radical trachelectomy

for cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Radical trachelectomy; Surveillance; Pap test

ID FOLLOW-UP; WOMEN

AB Objective. There are currently no standard guidelines on the use of Papanicolaou (Pap) tests for surveillance after radical trachelectomy for cervical cancer. The goal of this study was to determine the usefulness of Pap tests in routine surveillance after radical trachelectomy for cervical cancer.

Methods. Cervical cancer patients who underwent radical trachelectomy from January 2004 through October 2015 and subsequently had at least one Pap test were retrospectively identified. Demographic and clinical characteristics were described and compared between patients with and without at least one abnormal Pap test. The Kaplan-Meier method was used to estimate time to first abnormal Pap test.

Results. Forty-one patients met inclusion criteria. Of these, 30 (73%) had at least one year in which more than, one Pap test per year was obtained. Twenty-four (59%) had at least one abnormal Pap test. Of 238 total Pap tests collected, 44 (18%) were abnormal. The most common abnormality was ASCUS (52%, n = 23). Other findings included LSIL (20%, n = 9), HSIL (2%, n = 1), and AGUS (25%, n = 11). Median time from radical trachelectomy to first abnormal Pap test was 17.2 months (range, 11.8-86.3). No patient had disease recurrence. Surgery type (laparoscopic, open, or robotic), trachelectomy specimen size, histology, device for stenosis prevention (pediatric Foley catheter or Smit Sleeve), and cerclage placement were not significant predictors of an abnormal Pap test.

Conclusions. The rate of abnormal Pap tests after radical trachelectomy is high; however, the clinical significance of such abnormalities appears limited. The routine use of cervical cytology as surveillance after radical trachelectomy does not appear to substantially impact management decisions. (C) 2016 Elsevier Inc. All rights reserved.

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AU Chen, SH

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Li, Zhao-Ai

Huang, Rui

Xue, Hui-Qin

TI Robot-assisted versus conventional laparoscopic surgery for endometrial

cancer staging: A meta-analysis

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE conventional laparoscopy; endometrial cancer; endometrial cancer

staging; laparoscopy; robot assisted

ID SURGICAL OUTCOMES; STANDARD LAPAROSCOPY; OBESE WOMEN; LAPAROTOMY;

HYSTERECTOMY; LYMPHADENECTOMY; MANAGEMENT; COST

AB This meta-analysis broadly compared the safety and efficacy of robot-assisted laparoscopy (RAL) with that of conventional laparoscopy (CL) for endometrial cancer staging. The advantages of RAL were evaluated through the outcomes in terms of conversion rates, complications, length of operation, blood loss, number of lymph nodes harvested, and length of hospitalization. Three electronic databases (PubMed, MEDLINE, and EmBASE) were searched to identify eligible studies. We selected all retrospective studies documenting a comparison between RAL and CL for endometrial cancer staging between 2005 and 2015, and tallied with meta-analyses criteria. Only studies published in English were included in this analysis. The outcomes of the extracted data were pooled and estimated by the Review Manager version 5.1 software. Seventeen studies met the eligibility criteria. Among the 2105 patients reported, 912 underwent RAL and the other 1193 underwent CL for endometrial cancer staging. Compared with CL, RAL had lower conversion rates [risk ratio, 0.4; 95% confidence interval (CI), 0.25-0.64; p = 0.0002]. Its complications were also less than that of CL (risk ratio, 0.72; 95% CI, 0.56-0.94; p = 0.02). RAL was associated with significantly less intraoperative blood loss (weighted mean difference, -79.2 mL; 95% CI, from -103.43 to -54.97; p < 0.00001) and a shorter length of hospitalization (weighted mean difference, -0.37 days: 95% CI, from -0.57 to -0.17; p = 0.0003). We found no significant differences in the length of operation and number of lymph nodes harvested between the two groups. From our meta-analysis results, RAL is a safe and effective alternative to CL for endometrial cancer staging. Further studies are required to determine potential advantages or disadvantages of RAL. Copyright (C) 2016, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC.

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NR 32

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Z9 23

U1 0

U2 3

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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DA 2024-01-18

ER

PT J

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Tulandi, T

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Tulandi, Togas

TI Uterine myomata: Organ-preserving surgery

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE myoma; laparoscopic myomectomy; operative hysteroscopy; robotic

myomectomy; radiofrequency ablation

ID LAPAROSCOPIC MYOMECTOMY; BOWEL OBSTRUCTION; THERMAL ABLATION; BARBED

SUTURE; PREVENTION; ADHESIONS; METAANALYSIS; VASOPRESSIN; MORCELLATOR;

LEIOMYOMAS

AB Most women with uterine myoma are asymptomatic and do not require any treatment. However, myoma can also lead to menorrhagia, pressure symptoms, abdominal pain, and infertility. Management of symptomatic women with myoma depends on several factors, including age, desire for fertility, and myoma characteristics. Uterine myoma that distorts the uterine cavity, either sub mucous myoma or intramural myoma, with a submucous component reduces fertility, and is associated with increased uterine bleeding. The treatment of choice is hysteroscopic myomectomy or abdominal myomectomy, preferably by laparoscopy. Robotic assistance in laparoscopic myomectomy leads to outcomes similar to conventional laparoscopic myomectomy. However, it is expensive. Newer techniques include either laparoscopic or transcervical radiofrequency thermal ablation. (C) 2015 Elsevier Ltd. All rights reserved.

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NR 49

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ER

PT J

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Powell, CB

AF Freeman, Alexandra H.

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Lyon, Liisa

Littell, Ramey D.

Garcia, Christine

Conell, Carol

Powell, C. Bethan

TI Venous thromboembolism following minimally invasive surgery among women

with endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial neoplasms; Minimally invasive surgical procedures;

Thromboembolism

ID GYNECOLOGIC ONCOLOGY; LAPAROSCOPIC SURGERY; RISK-FACTORS; PROPHYLAXIS;

LAPAROTOMY

AB Objective. To determine the rate of venous thromboembolism (VTE) among women undergoing minimally invasive surgery (MIS) for endometrial cancer.

Methods. Women undergoing robotic or laparoscopic hysterectomy for endometrial carcinoma or complex hyperplasia with atypia were identified between January 2009 and 2014 in a community based health care system. Patient data including age, race, cancer stage, grade, procedure type, length of hospital stay, use of prophylaxis, and diagnosis of VTE were collected retrospectively. The primary outcome was the rate of VTE within 30 days following surgery. Fischer's exact tests were performed to evaluate factors associated with VTE.

Results. During the study period, 1433 patients underwent MIS for endometrial cancer, with 20 excluded due to known thrombophilia, VTE history, or long-term anticoagulation. A total of 1413 patients were included (739 robotic and 674 laparoscopic cases). All women received mechanical prophylaxis per hospital policy and 61% had additional pharmacologic prophylaxis. The rate of VTE was 0.35% (5/1413), which did not differ among those who received pharmacologic compared to mechanical prophylaxis (0.23% [2/865] versus 0.55% [3/548] respectively, p = 038). No factors were associated with increased risk of VTE due to the low event rate.

Conclusion. VTE in patients undergoing MIS for endometrial cancer was very low irrespective of the mode of prophylaxis received in this large cohort. National guidelines for VTE prophylaxis need to differentiate the low risk associated with MIS surgery from the risk associated with laparotomy for endometrial cancer. We recommend mechanical prophylaxis is sufficient for these women undergoing MIS. (C) 2016 Elsevier Inc. All rights reserved.

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ER

PT J

AU Louie, M

Toubia, T

Schiff, LD

AF Louie, Michelle

Toubia, Tarek

Schiff, Lauren D.

TI Considerations for minimally invasive gynecologic surgery in obese

patients

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE complications; gynecologic surgery; minimally invasive surgery; obesity;

perioperative care

ID CLINICAL-PRACTICE GUIDELINES; BODY-MASS INDEX; ENDOMETRIAL CANCER;

VENOUS THROMBOEMBOLISM; ROBOTIC HYSTERECTOMY; OUTCOMES; LAPAROSCOPY;

ASSOCIATION; THROMBOPROPHYLAXIS; MULTICENTER

AB Purpose of review

The purpose is to review the key anatomical and physiological changes in obese patients and their effects on preoperative, intraoperative, and postoperative care and to highlight the best practices to safely extend minimally invasive approaches to obese patients and provide optimal surgical outcomes in this high-risk population.

Recent findings

Minimally invasive surgery is safe, feasible, and cost-effective for obese patients. Obesity is associated with anatomical and physiological changes in almost all organ systems, which necessitates a multimodal approach and an experienced, multidisciplinary team. Preoperative counseling, evaluation, and optimization of medical comorbidities are critical. The optimal minimally invasive approach is primarily determined by the patient's anatomy and pathology. Specific intraoperative techniques and modifications exist to maximize surgical exposure and panniculus management. Postoperatively, comprehensive medical management can help prevent common complications in obese patients, including hypoxemia, venous thromboembolism, acute kidney injury, hyperglycemia, and prolonged hospitalization.

Summary

Given significantly improved patient outcomes, minimally invasive approaches to gynecological surgery should be considered for all obese patients with particular attention given to specific perioperative considerations and appropriate referral to an experienced minimally invasive surgeon.

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Z9 4

U1 0

U2 5

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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PT J

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Paoletti, MC

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Frizzi, Jacopo

Villari, Donata

Paoletti, Maria Cristina

TI Robotic vesico-vaginal fistula repair with no omental flap interposition

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vesico-vaginal fistula; Robotic; Minimally invasive repair

AB A vesico-vaginal fistula (VVF) is a fistulous tract that connects bladder and vagina, causing urine leakage via the vagina. In the developed world, iatrogenic postoperative VVF is the most common case. Classically, when treating a VVF via the abdominal route, an abdominal flap is mobilized and interposed between the bladder and the vagina.

In our video, we describe a robotic VVF repair technique with no omental flap interpositioning for a vaginal vault-located fistula.

Duration of surgery was 95 min, estimated blood loss was < 50 ml. The postoperative course was uneventful. At the 6-month follow-up, which included clinical and cystographic examinations, the patient had not experienced any recurrence.

In our opinion, a two-layered suturing technique using two semi-continuous sutures for vaginal closure and perpendicular interrupted stitches for bladder closure does not require omental flap mobilization, reducing operating time and possible complications related to accidental peritoneal injuries.

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J9 INT UROGYNECOL J

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Lakhi, N

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Lakhi, Nisha

TI Learning Experiences in Robotic-Assisted Laparoscopic Surgery

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic-assisted laparoscopic surgery; learning experiences; simulation;

learning curve; fellowship programs; credentialing

ID MINIMALLY INVASIVE SURGERY; SURGICAL SYSTEM; POSTGRADUATE UROLOGISTS;

RADICAL PROSTATECTOMY; CONCURRENT VALIDITY; DV-TRAINER; SIMULATOR;

VALIDATION; CURVE; FACE

AB With the use and adoption of computer-assisted laparoscopic technology gaining more prominence, important issues pertaining to the learning process are raised. Several modalities can be incorporated into a training program for robotic surgical development. The role and utility of various methods, including didactic instruction, virtual reality simulators, dry and wet laboratories, bedside assistance, mentoring, as well as proctorship, are still in the process of being assessed and validated. Integration of robotic training in residency and fellowship programs as well as the formation of a structured didactic robotic curriculum continues to be a challenge. Finally, methods to assess competency of training and the process for credentialing robotic surgeons still require further structuring and codification. (C) 2015 Elsevier Ltd. All rights reserved.

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Magrina, Javier F.

TI Trocar in conventional laparoscopic and robotic-assisted surgery as a

major cause of iatrogenic trauma to the patient

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE first trocar entry; trocar injuries

ID LEFT UPPER QUADRANT; GYNECOLOGICAL LAPAROSCOPY; ENTRY; SAFETY;

PNEUMOPERITONEUM; MORBIDITY; INJURIES; NEEDLE

AB All laparoscopic procedures, laparoscopic or robotic-assisted, start with a trocar entry. Unfortunately unknown to most, this is an extremely important part of the surgery, as 80% of major vascular injuries and 50% of intestinal injuries occur during this procedure. Laparoscopic first entry is often delegated to trainees with little experience, wrongly assuming that laparoscopic entry is similar to incisional entry at laparotomy. This may result in patient death (mortality of major vascular injuries is 11% and unrecognized intestinal injuries is 5%) or significant temporary or permanent morbidity. (C) 2015 Elsevier Ltd. All rights reserved.

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ER

PT J

AU Truong, M

Kim, JH

Scheib, S

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Kim, Jin Hee

Scheib, Stacey

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TI Advantages of robotics in benign gynecologic surgery

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE advantages; gynecology; minimally invasive surgery; robotic surgery;

robotics

ID VISION FIELD CONTROL; LAPAROSCOPIC HYSTERECTOMY; SINGLE-SITE;

ENDOMETRIAL CANCER; TUBAL ANASTOMOSIS; RANDOMIZED-TRIAL; SURGICAL ROBOT;

MYOMECTOMY; OUTCOMES; SYSTEM

AB Purpose of review

The purpose of this article is to review the literature and discuss the advantages of robotics in benign gynecologic surgery.

Recent findings

Minimally invasive surgery has become the preferred route over abdominal surgery. The laparoscopic or robotic approach is recommended when vaginal surgery is not feasible. Thus far, robotic gynecologic surgery data have demonstrated feasibility, safety, and equivalent clinical outcomes in comparison with laparoscopy and better clinical outcomes compared with laparotomy. Robotics was developed to overcome challenges of laparoscopy and has led to technological advantages such as improved ergonomics, visualization with three-dimensional capabilities, dexterity and range of motion with instrument articulation, and tremor filtration. To date, applications of robotics in benign gynecology include hysterectomy, myomectomy, endometriosis surgery, sacrocolpopexy, adnexal surgery, tubal reanastomosis, and cerclage. Though further data are needed, robotics may provide additional benefits over other approaches in the obese patient population and in higher complexity cases. Challenges that arose in the earlier adoption stage such as the steep learning curve, costs, and operative times are becoming more optimized with greater experience, with implementation of robotics in high-volume centers and with improved training of surgeons and robotic teams. Robotic laparoendoscopic single-site surgery, albeit still in its infancy where technical advantages compared with laparoscopic single-site surgery are still unclear, may provide a cost-reducing option compared with multiport robotics. The cost may even approach that of laparoscopy while still conferring similar perioperative outcomes.

Summary

Advances in robotic technology such as the single-site platform and telesurgery, have the potential to revolutionize the field of minimally invasive gynecologic surgery. Higher quality evidence is needed to determine the advantages and disadvantages of robotic surgery in benign gynecologic surgery. Conclusions on the benefits and risks of robotic surgery should be made with caution given limited data, especially when compared with other routes. Route of surgery selection should take into consideration the surgeons' skill and comfort level that allows for the highest level of safety and efficiency. Ultimately, the robotic device is an additional minimally invasive surgical tool that can further the goal of minimizing laparotomy in gynecology.

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NR 63

TC 40

Z9 42

U1 0

U2 14

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Yusuf, F

Leeder, S

Wilson, A

AF Yusuf, Farhat

Leeder, Stephen

Wilson, Andrew

TI Recent estimates of the incidence of hysterectomy in New South Wales and

trends over the past 30years

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE abdominal hysterectomy; laparoscopically-assisted hysterectomy; vaginal

hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL ABLATION

AB BackgroundHysterectomy remains one of the frequently used surgical operations on women in Australia despite new therapeutic approaches for most of the common conditions for which hysterectomy is indicated.

AimsTo determine whether the surgical approach to hysterectomy has changed in New South Wales (NSW) over the period 1981 to 2010-2012.

Data and methodsDe-identified individual records for hysterectomy patients during the three-year period (January 2010 to December 2012) provided by the NSW Ministry of Health were used. Robotic assistance with surgery was not recorded in the hysterectomy data. Analysis largely involved the method of indirect standardisation.

ResultsThe average annual hysterectomy rate during 2010-2012 was 3.07 per 1000 females per annum; the majority of patients stayed an average of fourdays in hospital. Total abdominal and vaginal hysterectomies were the two most frequently used procedures. One-in-four procedures involved the use of laparoscopes. Principal diagnoses (in descending order) were disorders of menstruation and other abnormal bleeding, genital prolapse, leiomyoma of uterus, malignant neoplasm of genital organs and endometriosis. While declining trends in hysterectomy rates were noted since 1981, an increasing trend in the use of laparoscopy was evident.

ConclusionsThe 45% decrease in hysterectomy rates was indeed the most striking finding of our analysis. This is probably due to the development of alternative nonsurgical procedures such as oral hormone suppression of menstruation and the levonorgestrel-releasing intrauterine system.

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TC 16

Z9 18

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U2 4

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JI Aust. N. Z. J. Obstet. Gynaecol.

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GA DS7IH

UT WOS:000380956200017

PM 27297684

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ER

PT J

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Gebhart, John B.

TI Factors Influencing Selection of Vaginal, Open Abdominal, or Robotic

Surgery to Treat Apical Vaginal Vault Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT 41st Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

CY MAR 22-25, 2015

CL Orlando, FL

SP Soc Gynecol Surg

DE apical prolapse; Mayo-McCall culdoplasty; posthysterectomy vaginal

prolapse; sacrocolpopexy

AB Objectives: This study aimed to determine factors influencing the selection of Mayo-McCall culdoplasty (MMC), open abdominal sacrocolpopexy (ASC), or robotic sacrocolpopexy (RSC) for posthysterectomy vaginal vault prolapse.

Methods: We retrospectively searched for the records of patients undergoing posthysterectomy apical vaginal prolapse surgery between January 1, 2000, and June 30, 2012, at our institution. Baseline characteristics and explicit selection factors were abstracted from the electronic medical records. Factors were compared between groups using X-2 tests for categorical variables, analysis of variance for continuous variables, and Kruskal-Wallis tests for ordinal variables.

Results: Among the 512 patients identified who met inclusion criteria, the MMC group (n = 174) had more patients who were older, had American Society of Anesthesiologists class 3+ or greater, had anterior vaginal prolapse grade 3+, desired to avoid abdominal surgery, and did not desire a functional vagina. Patients in the ASC (n = 237) and RSC (n = 101) groups had more failed prolapse surgeries, suspected abdominopelvic pathologic processes, and chronic pain. Advanced prolapse was more frequently cited as an explicit selection factor for ASC than for either MMC or RSC.

Conclusions: The most common factors that influenced the type of apical vaginal vault prolapse surgery overlapped with characteristics that differed at baseline. In general, MMC was chosen for advanced anterior vaginal prolapse and baseline characteristics that increased surgical risks, ASC for advanced apical prolapse, and ASC or RSC for recurrent prolapse, suspected abdominal pathology, and patients with chronic pain or lifestyles including heavy lifting. Thus, efforts should be made to attempt to control for selection bias when comparing these procedures.

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NR 12

TC 10

Z9 10

U1 0

U2 6

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

PD JUL-AUG

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PT J

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Ceyhan, M

AF Api, Murat

Boza, Aysen

Ceyhan, Mehmet

TI Robotic Versus Laparoscopic Radical Trachelectomy for Early-Stage

Cervical Cancer: Case Report and Review of Literature

SO Journal of Minimally Invasive Gynecology

LA English

DT Review

DE Cervical cancer; Fertility; Laparoscopy; Radical trachelectomy; Robotic

ID BILATERAL PELVIC LYMPHADENECTOMY; SURGICAL TECHNIQUE; FERTILITY;

OUTCOMES; PRESERVATION; LAPAROTOMY; SURGERY; SERIES

AB We conducted a literature review to evaluate the minimally invasive fertility-sparing procedures, namely robotic radical trachelectomy (RRT) and laparoscopic radical trachelectomy (LRT), in patients with early-stage cervical cancer. We searched PubMed, MEDLINE, Ovid, Google Scholar, and Scopus up to July 2015 using the following key words and their combinations: cervical cancer, early stage, fertility-sparing surgery, radical trachelectomy, robotic trachelectomy, and laparoscopic trachelectomy. Papers providing details of RRT and LRT separately were included. Extracted papers and their bibliographies were reviewed according to the purpose of the study, and demographic, surgical, and clinical parameters were analyzed. Our review comprised 45 cases of RRT and 216 cases (including our case) of LRT. The median (range) patient age was 29 (9) years in the RRT group and 32 (10) years in the LRT group (p < .001). Histological types and stages were significantly different in the 2 groups (p < .001 for both). The median length of excised parametrial tissue was significantly higher in the RRT group (p < .001). The hysterectomy conversion rate on the results of frozen section examination was significantly higher in the RRT group (37% vs 6.5%; p < .001). There was a significant difference in median lymph node count based on the surgical approach (RRT: 22 [range, 21] vs LRT: 32 [range, 14]; p = .02). Estimated blood loss and length of hospital stay were significantly higher in the LRT group (both p < .001). The mean (range) operative time was 308 (188) minutes in the RRT group and 296 (143) minutes in the LRT group (p < .001). Pregnancy, preterm, and term birth rates were similar in the 2 groups (RRT: 18.5%, 7.4%, and 0, respectively; LRT: 29%, 8%, and 8%, respectively). Thirteen women experienced recurrent cervical cancer in the LRT group, and no recurrence was seen in the RRT group. The median (range) duration of follow-up was 8 (7.5) months in the RRT group and 34 (20) months in the LRT group (p < .001). Based on the reported data, LRT seems comparable to RRT for treating patients with early-stage cervical cancer who wish to preserve fertility. (C) 2016 AAGL. All rights reserved.

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TC 7

Z9 10

U1 0

U2 4

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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ER

PT J

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TI Venous Thromboembolism in Minimally Invasive Compared With Open

Hysterectomy for Endometrial Cancer

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 47th Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncology

CY MAR 19-22, 2016

CL San Diego, CA

SP Soc Gynecol Oncol

ID LAPAROSCOPIC SURGERY; GYNECOLOGIC-ONCOLOGY; COLORECTAL SURGERY;

PROPHYLAXIS; RISK; VALIDATION

AB OBJECTIVE: To evaluate whether minimally invasive surgery for endometrial cancer is independently associated with a decreased odds of venous thromboembolism compared with open surgery.

METHODS: We performed a secondary analysis cohort study of prospectively collected quality improvement data and examined patients undergoing hysterectomy for endometrial cancer from 2008 to 2013 recorded in the National Surgical Quality Improvement Program database. Patients undergoing minimally invasive (laparoscopic or robotic) surgery were compared with those undergoing open surgery with respect to 30-day postoperative venous thromboembolism. Demographic and procedure variables were examined as potential confounders. Data regarding receipt of perioperative venous thromboembolism prophylaxis were not available. Bivariable tests and logistic regression were used for analysis.

RESULTS: Of 9,948 patients who underwent hysterectomy for the treatment of endometrial cancer, 61.9% underwent minimally invasive surgery and 38.1% underwent open surgery. Patients undergoing minimally invasive surgery had a lower venous thromboembolism incidence (0.7%, n=47) than patients undergoing open surgery (2.2%, n=80) (P<.001). In a multivariate model adjusting for age, body mass index, race, operative time, Charlson comorbidity score, and surgical complexity, minimally invasive surgery remained associated with decreased odds of venous thromboembolism (adjusted odds ratio 0.36, 95% confidence interval 0.24-0.53) compared with open surgery.

CONCLUSION: Minimally invasive surgery for the treatment of endometrial cancer is independently associated with decreased odds of venous thromboembolism compared with open surgery.

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NR 29

TC 39

Z9 42

U1 0

U2 3

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JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Enhanced Recovery Pathways for Improving Outcomes After Minimally

Invasive Gynecologic Oncology Surgery

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID PERIOPERATIVE CARE; GUIDELINES; METAANALYSIS

AB OBJECTIVE: To estimate whether an enhanced recovery after surgery pathway facilitates early recovery and discharge in gynecologic oncology patients undergoing minimally invasive surgery.

METHODS: This was a retrospective case-control study. Consecutive gynecologic oncology patients undergoing laparoscopic or robotic surgery between July 1 and November 5, 2014, were treated on an enhanced recovery pathway. Enhanced recovery pathway components included patient education, multimodal analgesia, opioid minimization, nausea prophylaxis as well as early catheter removal, ambulation, and feeding. Cases were matched in a one-to-two ratio with historical control patients on the basis of surgery type and age. Primary end-points were length of hospital stay, rates of discharge by noon, 30-day hospital readmission rates, and hospital costs.

RESULTS: There were 165 patients included in the final cohort, 55 of whom were enhanced recovery pathway patients. Enhanced recovery patients were more likely to be discharged on postoperative day 1 compared with patients in the control group (91% compared with 60%, P<.001, odds ratio 6.7, 95% confidence interval 2.46-18.04). Fifteen percent of enhanced recovery patients achieved discharge by noon compared with 4% of historical control patients (P=.03). Postoperative pain scores decreased (2.6 compared with 3.12, P=.03) despite a 30% reduction in opioid use. Average total hospital costs were decreased by 12% in the enhanced recovery group ($13,771 compared with $ 15,649, P=.01). Readmission rates, mortality, and reoperation rates did not differ between the two groups.

CONCLUSION: An enhanced recovery pathway in patients undergoing gynecologic oncology minimally invasive surgery is associated with significant improvements in recovery time, decreased pain despite reduced opioid use, and overall lower hospital costs.

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TC 77

Z9 82

U1 0

U2 10

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WC Obstetrics & Gynecology

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ER

PT J

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TI Robotic single site versus robotic multiport hysterectomy in early

endometrial cancer: a case control study

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial Neoplasms; Minimally Invasive Surgical Procedures; Robotic

Hysterectomy; Robotic Single Site Hysterectomy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; LEARNING-CURVE; SURGERY; OUTCOMES;

LESS; COST

AB Objective: To compare surgical outcomes and cost of robotic single-site hysterectomy (RSSH) versus robotic multiport hysterectomy (RMPH) in early stage endometrial cancer.

Methods: This is a retrospective case-control study, comparing perioperative outcomes and costs of RSSH and RMPH in early stage endometrial cancer patients. RSSH were matched 1: 2 according to age, body mass index, comorbidity, the International Federation of Gynecology and Obstetric (FIGO) stage, type of radical surgery, histologic type, and grading. Mean hospital cost per discharge was calculated summarizing the cost of daily hospital room charges, operating room, cost of supplies and length of hospital stay.

Results: A total of 23 women who underwent RSSH were matched with 46 historic controls treated by RMPH in the same institute, with the same surgical team. No significant differences were found in terms of age, histologic type, stage, and grading. Operative time was similar: 102.5 minutes in RMPH and 110 in RSSH (p=0.889). Blood loss was lower in RSSH than in RMPH (respectively, 50 mL vs. 100 mL, p=0.001). Hospital stay was 3 days in RMPH and 2 days in RSSH (p=0.001). No intraoperative complications occurred in both groups. Early postoperative complications were 2.2% in RMPH and 4.3% in RSSH. Overall cost was higher in RMPH than in RSSH (respectively, $7,772.15 vs. $5,181.06).

Conclusion: Our retrospective study suggests the safety and feasibility of RSSH for staging early endometrial cancer without major differences from the RMPH in terms of surgical outcomes, but with lower hospital costs. Certainly, further studies are eagerly warranted to confirm our findings.

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NR 24

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Z9 24

U1 0

U2 2

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WC Oncology; Obstetrics & Gynecology

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PT J

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Salehi, S

Falconer, H

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TI Improving Double Docking for Robot-assisted Para-aortic Lymphadenectomy

in Endometrial Cancer Staging: Technique and Surgical Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Para-aortic lymphadenectomy; Robotic surgery

ID INFRARENAL AORTIC LYMPHADENECTOMY

AB Robot-assisted para-aortic lymphadenectomy (PALND) may prove to be a challenging procedure, and the ability to reach the planned anatomic landmarks is critical. In this retrospective study between 2012 and 2015, we present surgical data using a modified technique to perform infrarenal PALND for endometrial cancer using double side docking. All women with high risk endometrial cancer scheduled for complete robotic staging including infrarenal PALND were included in the analysis. During the study period, a total of 76 women were identified. Three patients had disseminated disease and were treated with palliative hysterectomy only. The remaining 73 women underwent surgery with the intention to perform infrarenal PALND. In 7 cases, PALND was aborted because of technical inability to reach the left renal vein (10%). A median of 36 lymph nodes were harvested (pelvic n = 20, para-aortic n = 16). The median operating time (skin to skin) for patients with completed infrarenal PALND was 228 minutes (range, 181-371 minutes). Among all 76 patients, postoperative complications according to the Clavien-Dindo nomenclature were observed in 27 (36%) patients, with 6 (8%) having grade III complications. No patient died within 30 days from surgery. Our technique of double docking for robot-assisted PALND was associated with a success rate of 90%. The described technique seems to be a useful strategy to maximize the likelihood of completing the planned procedure. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Robotic Single-Site and Conventional Laparoscopic Surgery in Gynecology:

Clinical Outcomes and Cost Analysis of a Matched Case-Control Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Conventional laparoscopic surgery; da Vinci single-site platform;

Incremental cost analysis; Perioperative outcomes; Robotic single-site

surgery; Total hospital charges

ID HYSTERECTOMY; VOLUME

AB Study Objective: To assess the clinical outcomes and costs associated with robotic single-site (RSS) surgery compared with those of conventional laparoscopy (CL) in gynecology.

Design: Retrospective case-control study (Canadian Task Force classification II-2).

Setting: University-affiliated community hospital.

Patients: Female patients undergoing RSS or CL gynecologic procedures.

Interventions: Comparison of consecutive RSS gynecologic procedures (cases) undertaken between October 2013 and March 2014 with matched CL procedures (controls) completed during the same time period by the same surgeon.

Measurements and Main Results: Patient demographic data, operative data, and hospital financial data were abstracted from the electronic charts and financial systems. An incremental cost analysis based on the use of disposable equipment was performed. Total hospital charges were determined for matched RSS cases vs CL cases. RSS surgery was completed in 25 out of 33 attempts; 3 cases were aborted before docking, and 5 were converted to a multisite surgery. There were no intraoperative complications or conversions to laparotomy. The completed cases included 11 adnexal cases and 14 hysterectomies, 3 of which included pelvic lymph node dissection. Compared with the CL group, total operative times were higher in the RSS group; however, there were no significant between-group differences in estimated blood loss, length of hospital stay, or complication rates. Disposable equipment cost per case, direct costs, and total hospital charges were evaluated. RSS was associated with an increased disposable cost per case of $248 to $378, depending on the method used for vaginal cuff closure. The average total hospital charges for matched outpatient adnexal surgery were $15,450 for the CL controls and $18,585 for the RSS cases (p <.001), and the average total hospital charges for matched outpatient benign hysterectomy were $14,623 for the CL controls and $21,412 for the RSS cases (p <.001).

Conclusion: Although RSS surgery and CL have comparable clinical outcomes in selected patients, RSS surgery remains associated with increased incremental disposable cost per case and total hospital charges. Careful case selection and judicious use of equipment are necessary to maximize cost-effectiveness in RSS gynecologic surgery. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Robotic assisted vs laparoscopic and/or open myomectomy: systematic

review and meta-analysis of the clinical evidence

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Robotic myomectomy; Abdominal myomectomy; Laparoscopic myomectomy;

Metanalysis; Open myomectomy; Myoma

ID ABDOMINAL MYOMECTOMY; OUTCOMES; EXPERIENCE; MISOPROSTOL; PREGNANCY;

SURGERY

AB Introduction Uterine myomas are relative frequent in premenopausal women. The development of advanced minimally invasive surgical techniques proposed robotic-assisted myomectomy as an equally safe and effective treatment option.

Methods PubMed, Scopus and Cochrane databases were systematically searched and 15 studies met the inclusion criteria for our meta-analysis.

Results Eight studies compared robotic technique to laparoscopic, while nine studies to open/abdominal technique. In total, 2,027 patients were included. In studies referring to the comparison between the robotic myomectomy and the open one, the robotic technique showed a significant inferiority in operative time [84.85 min per operation (95 % confidence intervals (CI) 60.41-109.29)], but superiority in estimated blood loss [92.78 ml/operation (95 % CI 47.26-138.29)], the need for transfusion [981 patients; odd ratio (OR) 0.20; 95 % CI 0.09-0.43], total complications (1101 patients; OR 0.31; 95 % CI 0.11-0.87) and in the length of hospital stay [1.84 days/patient (95 % CI 1.40-2.29)] over the open myomectomy.

Conclusion Regarding the comparison between robotic assisted and laparoscopic technique, no significant difference was found between the two in comparison groups. Minimally invasive techniques have the advantage of less blood loss, less need for blood transfusion and less hospital stay. Additionally, long-term outcomes still need to be clarified including pain control, fertility and pregnancy rates postoperatively, as well as possible recurrence rates.

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Z9 74

U1 0

U2 7

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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TI Embryologically based radical hysterectomy as peritoneal mesometrial

resection (PMMR) with pelvic and para-aortic lymphadenectomy for

loco-regional tumor control in endometrial cancer: first evidence for

efficacy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Endometrial cancer; Peritoneal mesometrial resection; PMMR; Pelvic and

para-aortic lymphadenectomy; Embryologically based compartmental

surgery; Indocyanine-green; ICG; Robotic surgery

ID RADIATION-THERAPY; CERVICAL-CANCER; COMPARTMENT; PORTEC-1; OUTCOMES;

TRIAL; RISK

AB Objective To evaluate the feasibility and efficacy of embryologically based compartmental surgery for locoregional tumor control in intermediate and high risk endometrial cancer: peritoneal mesometrial resection with therapeutic pelvic and para-aortic lymphadenectomy by robotically assisted laparoscopy.

Methods 75 consecutive surgically treated patients with uterine malignancies have been analyzed. 68 patients with histologically proven endometrial cancer and complete robotically assisted surgery have been included in this study on morbidity and oncological outcome. 56 % of the patients were at intermediate/high risk with either stage IAG3 or IB (n = 22) or stage II-IV (n = 16). Adjuvant EBRT was offered to three patients only (4 %), whereas five received isolated vaginal brachytherapy (7 %). Indocyanine-green (ICG) fluorescence lymphography is demonstrated being useful for additional intraoperative visualization of the compartment borders and lymphatic drainage to the postponed lymph compartments.

Results After a mean follow-up of 32 months, there were only two loco-regional recurrences (2.9 %). Both recurrences were apparently cured by salvage therapy. 9 patients died; 6 (8.8 %) from metastatic disease (5) or unknown cause (1), 3 (4.4 %) from intercurrent disease without evidence of disease. One patient (1.4 %) experienced a peritoneal carcinosis and is alive. There were 8/68 perioperative complications (12 %). No perioperative mortality was observed.

Conclusions Embryologically defined compartmental surgery by robotically assisted laparoscopy seems to be feasible and safe in endometrial cancer. The low loco-regional recurrence rate of 2.9 % in spite of a very low percentage of adjuvant radiotherapy and 56 % of intermediate/high risk tumors should stimulate to initiate a multicentre trial to evaluate the value of compartmental surgery for prevention of locoregional recurrence in endometrial cancer.

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TI Outcomes in 450 Women After Minimally Invasive Abdominal Sacrocolpopexy

for Pelvic Organ Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacrocolpopexy; minimally invasive surgery; postoperative complications

ID LAPAROSCOPIC SACROCOLPOPEXY; VAULT PROLAPSE

AB Objective: To report outcomes and complications in approximately 450 women who underwent isolated minimally invasive abdominal sacrocolpopexy (ASC) for the management of pelvic organ prolapse (POP).

Material and Methods: We retrospectively reviewed the electronic medical records of women who underwent minimally invasive ASC (laparoscopic ASC [LASC] or robotic ASC [RASC]) for symptomatic POP at Loyola University Chicago Medical Center from 2007 to 2012. Polypropylene mesh was used and the decision to reperitonealize the mesh was left to surgeon discretion. Data collected included demographics, Pelvic Floor Distress Inventory questionnaire, intraoperative and postoperative details, and POP quantification.

Results: Four hundred twenty-eight women underwent minimally invasive ASC-232 LASC and 226 RASC. Most women (86%) did not undergo reperitonealization of the mesh. Median follow-up was 13 weeks (range, 2-268 weeks) for complications and 13 weeks (range, 2-104 weeks) for anatomic outcomes.

Postoperatively, 88.6% of women had stage 0/ I, 10.7% had stage II, and 2 women had stage III POP. Twelve (2.6%) underwent reoperation, 6 for POP (3 posterior repairs, 2 repeat ASC, 1 perineorrhaphy) and 6 for bowel complications. Fourteen women had postoperative bowel complications; half of which resolved with conservative treatment. There were no differences between anatomic and functional outcomes or bowel complications between LASC and RASC. Reoperation rates for bowel complications in women who underwent reperitonealization of the mesh were similar to those who did not (1.5% vs 1.0%, P = 0.86).

Conclusions: Minimally invasive ASC without concomitant vaginal repair is an effective and safe procedure for the surgical management of POP with low rates of reoperation and complications.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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TI A prospective investigation of fluorescence imaging to detect sentinel

lymph nodes at robotic-assisted endometrial cancer staging

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial carcinoma; robotic surgery; sentinel node mapping

ID GYNECOLOGIC-ONCOLOGY-GROUP; INDOCYANINE GREEN; NODAL METASTASIS;

BREAST-CANCER; ASTEC TRIAL; LYMPHADENECTOMY; MULTICENTER; MALIGNANCIES;

DISSECTION; MORBIDITY

AB BACKGROUND: The accuracy of sentinel lymph node mapping has been shown in endometrial cancer, but studies to date have primarily focused on cohorts at low risk for nodal involvement. In our practice, we acknowledge the lack of benefit of lymphadenectomy in the low-risk subgroup and omit lymph node removal in these patients. Thus, our aim was to evaluate the feasibility and accuracy of sentinel node mapping in women at sufficient risk for nodal metastasis warranting lymphadenectomy and in whom the potential benefit of avoiding nodal procurement could be realized.

OBJECTIVE: To evaluate the detection rate and accuracy of fluorescence-guided sentinel lymph node mapping in endometrial cancer patients undergoing robotic-assisted staging.

STUDY DESIGN: One hundred twenty-three endometrial cancer patients undergoing sentinel lymph node sentinel node mapping using indocyanine green were prospectively evaluated. Two mL (1.0 mg/mL) of dye were injected into the cervical stroma divided between the 2-3 and 9-10 o'clock positions at the time of uterine manipulator placement. Before hysterectomy, the retroperitoneal spaces were developed and fluorescence imaging was used for sentinel node detection. Identified sentinel nodes were removed and submitted for touch prep intraoperatively, followed by permanent assessment with routine hematoxylin and eosin levels. Patients then underwent hysterectomy, bilateral salpingo-oophorectomy, and completion bilateral pelvic and periaortic lymphadenectomy based on intrauterine risk factors determined intraoperatively (tumor size >2 cm, >50% myometrial invasion, and grade 3 histology).

RESULTS: Of 123 patients enrolled, at least 1 sentinel node was detected in 119 (96.7%). Ninety-nine patients (80%) had bilateral pelvic or periaortic sentinel nodes detected. A total of 85 patients met criteria warranting completion lymphadenectomy. In 14 patients (16%) periaortic lymphadenectomy was not feasible, and the mean number of pelvic nodes procured was 13 (6 -22). Of the 71 patients undergoing pelvic and periaortic lymphadenectomy, the mean nodal count was 23.2 (8 - 51). Of patients undergoing lymphadenectomy, 10.6% had lymph node metastasis on final hematoxylin and eosin evaluation. Notably, the sentinel node was the only positive node in 44% of cases. There were no cases in which final pathology of the sentinel node was negative and metastatic disease was detected upon completion lymphadenectomy in the non-sentinel nodes (no false negatives), yielding a sensitivity of 100%. Of the 14 sentinel nodes ultimately found to harbor metastases, 3 were negative on touch prep, yielding a sensitivity of 78.6% for intraoperative detection of sentinel node involvement. In all 3 of the false-negative touch preps, final pathology detected a single micrometastasis (0.24 mm, 1.4 mm, 1.5 mm). As expected, there were no false-positive results, yielding a specificity of 100%. No complications related to sentinel node mapping or allergic reactions to the dye were encountered.

CONCLUSION: Intraoperative sentinel node mapping using fluorescence imaging with indocyanine green in endometrial cancer patients is feasible and yields high detection rates. In our pilot study, sentinel node mapping identified all women with Stage IIIC disease. Low false-negative rates are encouraging, and if confirmed in multi-institutional trials, this approach would be anticipated to reduce the morbidity, operative times, and costs associated with complete pelvic and periaortic lymphadenectomy.

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TI Genetic Mutation that May Contribute to Failure of Prolapse Surgery in

White Women: A Case-Control Study

SO Journal of Minimally Invasive Gynecology

LA English

DT Article

DE Genetics; Prolapse; Robotic sacrocolpopexy; Surgical failure

ID PELVIC ORGAN PROLAPSE; ROBOTIC SACROCOLPOPEXY; Y-MESH; EXPRESSION;

MARFAN

AB Objective: To identify a potential genetic basis for early failure after prolapse surgery.

Design: Case-control study (Canadian Task Force classification II).

Setting: This study was carried out in 1 academic community medical center referral practice, and all patients had surgery at 1 of 2 hospitals.

Patients: Ten women with early, multicompartment prolapse recurrence after robotic sacrocolpopexy compared with 40 control subjects with known success after the same procedure.

Interventions: Patients were treated with robotic sacrocolpopexy.

Measurements and Main Results: DNA was isolated and initially genotyped on a single nucleotide polymorphism (SNP) array to direct more detailed exome analyses. Exome sequences were mapped to the Human Genome Reference Sequence (GRCh37), and variants were compared between groups and to participants in the 1000 Genomes Project. Statistical analyses were performed using a software package commonly used in genetics research. TaqMan assay was used for verification, and p values were adjusted using the false discovery rate. Demographics of groups were compared using chi(2), Mann-Whitney U, and t tests. A SNP [rs171821] located near the ZFYVE16 gene was associated with patients but not control subjects, and the false discovery rate adjusted p value was .046 (odds ratio, 45.2; 95% confidence interval, 5.06-403). Exome analyses of this gene yielded another SNP [rs249038 (G/A)] in 6 of 10 patients and none of the control subjects (p = .02). This SNP causes a heterozygous missense mutation of glycine to serine predicted to be deleterious by the Protein Variation Effect Analyzer and was also very rare among participants in the 1000 Genomes Project (p < .001).

Conclusions: Two SNPs located near the ZFYVE16 gene on chromosome 5 may have played a role in the early, multicompartment sacrocolpopexy failure experienced by our patients. (C) 2016 AAGL. All rights reserved.

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AU Thubert, T

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TI Surgical treatment: Myomectomy and hysterectomy; Endoscopy: A major

advancement

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE fibroids; hysteroscopy; hysterectomy; laparoscopy; myomectomy;

gynecology

ID ASSISTED VAGINAL HYSTERECTOMY; HYALURONIC-ACID GEL; TOTAL LAPAROSCOPIC

HYSTERECTOMY; LOOP HYSTEROSCOPIC MYOMECTOMY; TERM-FOLLOW-UP; OPERATIVE

HYSTEROSCOPY; INTRAUTERINE ADHESIONS; SUBMUCOUS MYOMAS; SUBFERTILE

WOMEN; RANDOMIZED-TRIAL

AB Uterine fibroids affect 25% of women worldwide. Symptomatic women can be treated by either medical or surgical treatment. Development of endoscopic surgery has widely changed the management of myoma. Currently, although laparoscopic or laparoscopic robot-assisted myomectomies or hysterectomies are common, there has been no consensual guideline concerning the surgical techniques, operative route, and usefulness of preoperative treatment. Hysteroscopy management is a major advancement avoiding invasive surgery. This study deals with a literature review concerning surgical management of fibroids. (C) 2016 Published by Elsevier Ltd.

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NR 114

TC 17

Z9 18

U1 0

U2 9

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SN 1521-6934

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J9 BEST PRACT RES CL OB

JI Best Pract. Res. Clin. Obstet. Gynaecol.

PD JUL

PY 2016

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PG 18

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA DT7ED

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DA 2024-01-18

ER

PT J

AU Vizzielli, G

Lucidi, A

Gallotta, V

Petrillo, M

Dessole, M

Fagotti, A

Costantini, B

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AF Vizzielli, Giuseppe

Lucidi, Alessandro

Gallotta, Valerio

Petrillo, Marco

Dessole, Margherita

Fagotti, Anna

Costantini, Barbara

Scambia, Giovanni

Chiantera, Vito

TI Robotic Total Mesometrial Resection versus Laparoscopic Total

Mesometrial Resection in Early Cervical Cancer: A Case-Control Study

SO Journal of Minimally Invasive Gynecology

LA English

DT Article

DE Cervical cancer; Laparoscopy; Robotic surgery; Total mesometrial

resection (TMMR)

ID LOCAL TUMOR SPREAD; RADICAL HYSTERECTOMY; SURGICAL ANATOMY; COMPARTMENT;

SURGERY; ORGANOGENESIS; ASSOCIATION; DEFINITION; RECURRENCE; EXCISION

AB Study Objective: To report our experience with robotic total mesometrial resection (R-TMMR) comparing perioperative results with a series of laparoscopic total mesometrial resections (L-TMMRs).

Design: Multicenter retrospective case-control study (Canadian Task Force classification II-2).

Setting: Catholic University of the Sacred Heart of Rome (Italy) and Campobasso (Italy).

Patients: From July 2013 to August 2015 all cervical cancer patients with preoperative FIGO stage IA2 to IB1 were assessed at preoperative magnetic resonance imaging scan and clinically confirmed by investigation under anesthesia, complying strictly with the FIGO criteria. Surgical and postsurgical data of the TMMR procedures were collected.

Interventions: R-TMMR and L-TMMR for early cervical cancer were performed.

Measurements and Main Results: Twenty-one women underwent R-TMMR (cases) and 42 patients were submitted to L-TMMR (control subjects) for early cervical cancer. The median estimated blood loss was 150 mL in the cases and 200 mL in the control subjects (p =.992). The median operative time, calculated from the beginning of intraperitoneal procedures to skin closure, was 246 minutes in the cases and 260 minutes in the control subjects (p =.913). The median time to discharge from the hospital was postoperative days 4 (range, 2-5) and 6 (range, 4-15) for R-TMMR and L-TMMR, respectively (p =.001).

Conclusion: The few differences we registered do not seem to be clinically relevant, thus making the 2 procedures comparable. Further prospective trials are needed to confirm our results. (C) 2016 AAGL. All rights reserved.

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U2 1

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA ED7CG

UT WOS:000389012700030

PM 27109189

DA 2024-01-18

ER

PT J

AU Iavazzo, C

Gkegkes, ID

AF Iavazzo, Christos

Gkegkes, Ioannis D.

TI Robotic assisted hysterectomy in obese patients: a systematic review

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Robotics; Obesity; Hysterectomy; Obese; Robotic assisted laparoscopy

ID BODY-MASS INDEX; ENDOMETRIAL CANCER; SURGICAL OUTCOMES; LAPAROSCOPIC

HYSTERECTOMY; GYNECOLOGIC SURGERY; WOMEN; RECURRENCE; LAPAROTOMY;

IMPACT; RISK

AB Robotic hysterectomy is an alternative approach to the management of female genital tract pathology.

A systematic literature review was performed to evaluate the till now available literature evidence on robotic assisted hysterectomy in obese and morbidly obese patients.

In total, robotic assisted hysterectomy was performed on 2769 patients. The most frequent indication for robotic hysterectomy was endometrial carcinoma (1832 out of 2769 patients, 66.2 %). Hypertension, diabetes mellitus, obstructive sleep apnea, chronic obstructive pulmonary disease and venous thromboembolism were the most common comorbidities reported. The conversion rate to laparotomy was 92 out of 2226 patients (4.1 %). The most frequent intraoperative complications for robotic hysterectomy were gastrointestinal injury (17 out of 2769 patients, 0.6 %), haemorrhage (five out of 2769 patients, 0.2 %) and bladder injury (five out of 2769 patients, 0.2 %). Wound infections/dehiscence (66 out of 2769 patients, 2.4 %), fever (56 out of 2769 patients, 2 %), pulmonary complications (55 out of 2769 patients, 1.9 %), urogenital complications (36 out of 2769 patients, 1.3 %) and postoperative ileus (28 out of 2769 patients, 1 %) were the most common postoperative complications. Death was reported in three out of 2769 patients (0.1 %). The ICU admitted patients were eight of 2226 patients (0.4 %).

The robotic technique, especially in obese, can optimize the surgical approach and recovery of such patients with equally if not better outcomes compared to open and/or laparoscopic techniques.

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NR 45

TC 32

Z9 33

U1 0

U2 3

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 15

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GA DM1HX

UT WOS:000376097400003

PM 26861466

DA 2024-01-18

ER

PT J

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Merlot, B

Robin, VB

Rubod, C

Collinet, P

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Rubod, C.

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TI Partial cystectomy for bladder endometriosis: Robotic assisted

laparoscopy versus standard laparoscopy

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Bladder endometriosis; Surgery; Partial cystectomy; Robot-assisted

laparoscopy

ID URINARY-TRACT ENDOMETRIOSIS; TERM-FOLLOW-UP; DETRUSOR ENDOMETRIOSIS;

RADICAL PROSTATECTOMY; DEEP ENDOMETRIOSIS; MANAGEMENT; OUTCOMES;

SURGERY; QUESTIONNAIRE; PATHOGENESIS

AB Objectives. - To compare robot-assisted laparoscopy (RL) and conventional laparoscopy (CL) in surgery for bladder endometriosis.

Methods. - A retrospective study was conducted between January 2007 and December 2013, including patients with bladder endometriosis receiving at least a partial cystectomy by RL or CL. The primary endpoint was the presence of a radiological recurrence at bladder level.

Results. - We included 15 patients in the RL group and 22 in the CL group. The median age was 29 years +/- 7 years. The symptoms were similar in the 2 groups. Pre-surgical mapping of the lesions was carried out with MRI. Sixty percent of patients in the RL group vs 91% in the CL group had other associated endometriosis lesions, P = 0.04. The median size of the bladder lesion was 30 +/- 8 mm in the RL group vs 23 +/- 7 mm in the CL group, P = 0.03. The median operative time was 210 vs 225 min, P = 0.8. We did not find any significant difference in intraoperative and early and late postoperative complications between the 2 groups. The median length of stay was 5 days vs 6 days. The proportion of relapse was 20 vs 23%, P > 0.05. Clinical improvement was similar. between the groups, i.e. 93 vs 86%, P = 0.6 and the pregnancy rate was 93 vs 86%, P = 0.6.

Conclusions. - Robot-assisted laparoscopy in the surgical treatment of bladder endometriosis as compared to traditional laparoscopy doe's not seem to have an adverse effect neither on the risk of recurrence nor on the occurrence of intra- and postoperative complications. (C) 2016 Elsevier Masson SAS. All rights reserved.

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U1 0

U2 1

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J9 GYNECOL OBSTET FERTI

JI Gynecol. Obstet. Fertil.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA DQ7GB

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PM 27032760

DA 2024-01-18

ER

PT J

AU Lowenstein, L

Mustafa-Mikhail, S

Gartman, I

Gruenwald, I

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Mustafa-Mikhail, Susana

Gartman, Irena

Gruenwald, Ilan

TI The effect of pelvic organ prolapse repair on vaginal sensation

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Genital sensation; Pelvic organ prolapse; Sacrocolpopexy; Robotic

surgery; Sexual dysfunction

ID GENITAL SENSATION; INCONTINENCE; DYSFUNCTION; THRESHOLDS; WOMEN

AB Introduction and hypothesis The objective was to evaluate vaginal and clitoral sensation before and after robotic sacrocolpopexy for the repair of pelvic organ prolapse.

Methods Twenty-two women, mean age 63 years (range 41-77), were admitted for robotic sacrocolpopexy repair of pelvic organ prolapse; 4 were lost to follow-up. Quantitative sensory thresholds for warm, cold, and vibratory sensations were measured at the vagina (anterior and posterior areas) and clitoris 1 day before and a mean of 12 +/- 4 months following surgery. Student's paired t test was used to compare sensory thresholds before and after surgery.

Results For the 18 women who completed follow-up, sensitivity was significantly higher after surgery (sensory threshold decreased) at the clitoral and vaginal regions, to cold and warm stimuli. In contrast, the vaginal and clitoral vibratory sensory thresholds did not change significantly following surgery.

Conclusion The repair of pelvic organ prolapse by robotic sacrocolpopexy could potentially play a role in restoring clitoral and vaginal wall sensation. The effects of these sensory changes on sexual function and the quality of sexual life need further investigation.

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NR 11

TC 4

Z9 4

U1 0

U2 3

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JI Int. Urogynecol. J.

PD JUN

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PG 4

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA DQ2IQ

UT WOS:000379026400012

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DA 2024-01-18

ER

PT J

AU Singh, R

Schmitt, JJ

Knoedler, JJ

Occhino, JA

AF Singh, Ruchira

Schmitt, Jennifer J.

Knoedler, John J.

Occhino, John A.

TI Management of a vesicovaginal fistula using holmium laser ablation

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Holmium; Laser ablation; Vesicovaginal fistula

ID HYSTERECTOMY

AB Introduction and hypothesis The objective was to demonstrate a surgical technique for the management of a small vesicovaginal fistula (VVF) involving a combination of cystoscopic holmium laser ablation and vaginal repair.

Methods A 55-year-old morbidly obese female presented with complaints of menometrorrhagia and complex adnexal mass. She underwent an attempted robotic hysterectomy, which was converted to open hysterectomy, omentectomy, and lymphadenectomy owing to an intraoperative diagnosis of endometrioid carcinoma of the endometrium and dense pelvic adhesions. Postoperatively, the patient developed intermittent urinary leakage associated with position change. On evaluation, a speculum examination did not reveal any fistulous tract or leakage of fluid in the vagina. A tampon test was positive, but no evidence of a fistula was noted on a CT urogram. Cystourethroscopy was performed and identified a small VVF. The patient subsequently underwent repair of her VVF using a combination of cystoscopic holmium laser ablation and transvaginal excision of the suspected fistula opening.

Results About 2 weeks after the surgery, a tampon test was negative and cystourethroscopy revealed healing bladder mucosa. The patient remains fistula-free at 12 months post-operatively.

Conclusion Holmium laser ablation combined with partial vaginal excision may be considered as a management option for a small VVF.

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NR 10

TC 4

Z9 5

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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VL 27

IS 6

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PG 3

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA DQ2IQ

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ER

PT J

AU Aslam, MF

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Edwards, SR

Matthews, C

Gregory, WT

AF Aslam, Muhammad F.

Osmundsen, Blake

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Matthews, Catherine

Gregory, William T.

TI Preoperative Prolapse Stage as Predictor of Failure of Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article; Proceedings Paper

CT Annual Joint Scientific Meeting of the American-Urogynecologic-Society

(AUGS) / International-Urogynecological-Association (IUGA)

CY JUL 21-26, 2014

CL Washington, DC

SP Amer Urogynecol Soc, Int Urogynecol Assoc

DE prolapse recurrence; sacrocolpopexy; prolapse surgery; failure after

sacrocolpopexy; preoperative risk factors

ID PELVIC ORGAN PROLAPSE; APICAL VAGINAL PROLAPSE; RISK-FACTORS; GENITAL

HIATUS; ABDOMINAL SACROCOLPOPEXY; RECURRENT PROLAPSE; LIFETIME RISK;

SURGERY

AB Objectives: Our aim was to determine if there was a correlation between the preoperative prolapse stage and postoperative recurrence of prolapse 1 year after sacrocolpopexy. Our null hypothesis is that the preoperative stage of prolapse does not increase the risk of recurrence.

Methods: This is a multicenter cohort study from 3 centers. We included subjects who underwent robotic-assisted sacrocolpopexy and completed a standardized 1-year follow-up from 2009-2014. All subjects underwent a complete preoperative evaluation and completed 12 months of follow-up with the pelvic organ prolapse quantification examination. We compared those subjects who met the definition of recurrence with those who did not, analyzing the following covariates: stage of prolapse using International Continence Society (ICS) definitions, individual pelvic organ prolapse quantification points, age, body mass index, race, exogenous estrogen use, menopause, smoking, vaginal parity, cesarean section, and performance of concomitant procedures. We defined recurrence as any prolapse beyond the hymen.

Results: We had 125 women from 3 centers who met our criteria, with 23.2% of them having recurrence at 1 year. We found that recurrence increased as the preoperative ICS stage of prolapse increased (P = <0.001 in the univariate model). In the multivariate model, using logistic regression, we found that the risk of recurrence of pelvic organ prolapse increased as the presurgery clinical stage increased with an odds ratio of 3.8 (95% confidence interval, 1.5-9) when controlling for age, menopausal status, and genital hiatus (P = 0.004).

Conclusions: Much like a higher stage of disease in oncology, we found that increasing stage of prolapse preoperatively increased the risk of recurrence at 1 year after sacrocolpopexy.

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TC 23

Z9 23

U1 0

U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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IS 3

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PM 26571435

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ER

PT J

AU Bogani, G

Multinu, F

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TI Incorporating robotic-assisted surgery for endometrial cancer staging:

Analysis of morbidity and costs

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Costs; Endometrial cancer; Lymphadenectomy; Robotic surgery

ID PARAAORTIC LYMPHADENECTOMY; ECONOMIC-ANALYSIS; HYSTERECTOMY;

LAPAROSCOPY; OUTCOMES

AB Objective. To evaluate how the introduction of robotic-assisted surgery affects treatment-related morbidity and cost of endometrial cancer (EC) staging.

Methods. We retrospectively reviewed the records of consecutive patients with stage I-III EC undergoing surgical staging between 2007 and 2012 at our institution. Costs (from surgery to 30 days after surgery) were set based on the Medicare cost-to-charge ratio for each year and inflated to 2014 values. Inverse probability weighting (IPW) was used to decrease the allocation bias when comparing outcomes between surgical groups.

Results. We focused our analysis on the 251 EC patients who had robotic-assisted surgery and the 384 who had open staging. During the study period, the use of robotic-assisted surgery increased and open staging decreased (P < 0.001). Correcting group imbalances by using IPW methodology, we observed that patients undergoing robotic-assisted staging had a significantly lower postoperative complication rate, lower blood transfusion rate, longer median operating time, shorter median length of stay, and lower readmission rate than patients undergoing open staging (all P < 0.001). Overall 30-day costs were similar between the 2 groups, with robotic assisted surgery having significantly higher median operating room costs ($2820 difference; P < 0.001) but lower median room and board costs ($2929 difference; P < 0.001) than open surgery. Increasing experience with robotic-assisted staging was significantly associated with a decrease in median operating time (P = 0.002) and length of stay (P = 0.003).

Conclusions. The implementation of robotic-assisted surgery for EC staging improves patient outcomes. It provides women the benefits of minimally invasive surgery without increasing costs and potentially improves patient turnover. (C) 2016 Elsevier Inc. All rights reserved.

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FU Small Grant Program, Mayo Clinic, Rochester, Minnesota

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U2 2

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JI Gynecol. Oncol.

PD MAY

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PG 7

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA DL0YJ

UT WOS:000375358200007

PM 26896826

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PT J

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Signorelli, Mauro

Chiappa, Valentina

Sabatucci, Ilaria

Scaffa, Cono

Lorusso, Domenica

Raspagliesi, Francesco

TI Extraperitoneal Robotic-Assisted Para-Aortic Lymphadenectomy in

Gynecologic Cancer Staging: Current Evidence

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Extraperitoneal; Retroperitoneal; Robotic; Para-aortic lymphadenectomy

ID ADVANCED CERVICAL-CANCER; ENDOMETRIAL CANCER; FEASIBILITY; LAPAROSCOPY;

COMPLICATIONS; MULTICENTER; EXPERIENCE; CARCINOMA; SAFETY; COHORT

AB We reviewed the current evidence on the safety, effectiveness, and applicability of extraperitoneal robotic-assisted para-aortic lymphadenectomy (ExtRA-PAL) as the staging procedure of gynecologic malignancies. PubMed (MEDLINE), Scopus, Web of Science databases, and ClinicalTrails.gov were searched for original studies reporting outcomes of ExtRA-PAL. Quality of the included studies and their level of recommendation were assessed using the Grading of Recommendations, Assessment, Development, and Evaluation and the American College of Obstetricians and Gynecologists guidelines, respectively. Overall, 62 studies were identified; after a process of evidence acquisition 5 original investigations were available for this review that included 98 patients undergoing ExtRA-PAL. The main surgical indication was staging for cervical cancer (n = 71, 72%). The mean (SD) number of para-aortic node yielded was 15.4 (+/- 4.7) nodes. Blood transfusion and intraoperative complication rates were 2% and 6%, respectively. ExtRA-PAL was completed in 88 patients (90%). Six (6%) and 4 (4%) patients had conversion to other minimally invasive procedures and open surgery, respectively. Success rate was 99% among patients undergoing ExtRA-PAL without concomitant procedures. Overall, mean (SD) length of hospital stay was 2.8 (+/- 0.5) days. Twenty-four patients (24%) developed postoperative events. According to the Clavien-Dindo grading system, grades IIIa and IIIb morbidity rates were 12% and 2%, respectively. No grades IV and V morbidity occurred. ExtRA-PAL is associated with a high success rate and a relative low morbidity rate. However, because of the limited data on this issue, further studies are warranted to assess the long-term effectiveness of this procedure. (C) 2016 AAGL. All rights reserved.

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AU Bogliolo, S

Ferrero, S

Cassani, C

Musacchi, V

Zanellini, F

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AF Bogliolo, Stefano

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TI Single-site Versus Multiport Robotic Hysterectomy in Benign Gynecologic

Diseases: A Retrospective Evaluation of Surgical Outcomes and Cost

Analysis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Costs; Robotic-assisted laparoscopy; Robotic

hysterectomy; Single-port robotic hysterectomy; Single-site robotic

hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; RANDOMIZED-TRIAL;

LEARNING-CURVE; SURGERY; PORT

AB Objective: To compare the surgical outcomes and costs of robotic-assisted hysterectomy with the single-site (RSSH) or multi port approach (RH).

Design: A retrospective analysis of a prospectively collected database (Canadian Task Force classification Ill).

Setting: A university hospital.

Patients: Consecutive women who underwent robotic-assisted total laparoscopic hysterectomy and bilateral salpingo-oophorectomy for the treatment of benign gynecologic diseases.

Interventions: Data on surgical approach, surgical outcomes, and costs were collected in a prospective database and retrospectively analyzed.

Measurements and Main Results: The total operative time, console time, docking time, estimated blood loss, conversion rate, and surgical complications rate were compared between the 2 study groups. Cost analysis was performed. One hundred four patients underwent total robotic-assisted hysterectomy and bilateral salpingo-oophorectomy (45 RSSH and 59 RH). There was no significant difference in the indications for surgery and in the characteristics of the patients between the 2 study groups. There was no significant difference between the single-site and multiport approach in console time, surgical complication rate, conversion rate, and postoperative pain. The docking time was lower in the RH group (p = .0001). The estimated blood loss and length of hospitalization were lower in the RSSH group (p = .0008 and p = .009, respectively). The cost analysis showed significant differences in favor of RSSH.

Conclusion: RSSH should be preferred to RH when hysterectomy is performed for benign disease because it could be at least as equally effective and safe with a potential cost reduction. However, because of the high cost and absence of clear advantages, the robotic approach should be considered only for selected patients. (C) 2016 AAGL. All rights reserved.

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PT J

AU Holloway, RW

Gupta, S

Stavitzski, NM

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Takimoto, EL

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Brudie, LA

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Kendrick, James E.

Ahmad, Sarfraz

TI Sentinel lymph node mapping with staging lymphadenectomy for patients

with endometrial cancer increases the detection of metastasis

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 46th Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncology (SGO)

CY MAR 28-31, 2015

CL Chicago, IL

SP Soc Gynecol Oncol

DE Endometrial cancer; Robotic surgery; Sentinel lymph node mapping; Lymph

node metastasis; Adjuvant treatments

ID BIOPSY; MICROMETASTASIS; MALIGNANCIES; PREVALENCE; WOMEN

AB Objectives. To compare the performance of sentinel lymph node (SLN) mapping with staging lymphadenectomy versus staging lymphadenectomy alone for the detection of metastasis and the use of adjuvant therapies in patients with endometrial cancer.

Methods. All patients with apparent early-stage endometrial cancer (n = 780) who underwent robotic assisted hysterectomy with pelvic +/- aortic lymphadenectomy from July-2006 to June-2013 were compared [pelvic +/- aortic lymphadenectomy (n = 661) versus SLN-mapped cases with pelvic aortic lymphadenectomy (n = 119)]. Isosulfan-blue and indocyanine-green with near-infrared imaging were used for SLN mapping. Clinico-pathological data, FIGO stage, GOG risk category, and adjuvant therapies were compared.

Results. Non-mapped and mapped cases were comparable with respect to BMI, histology, depth-of-invasion, and lympho-vascular space invasion. The mapped group had more pelvic lymph node (LN) harvested compared to non-mapped group (26.4 +/- 10.5 vs. 18.8 +/- 8.5, p < 0.001). Aortic LN yields were identical for both groups (9.0 +/- 5.6 vs. 9.0 +/- 6.0). The mapped group had more LN metastasis detected (30.3% vs. 14.7%, p < 0.001), more stage IIIC (30.2% vs. 14.5%, p < 0.001), more GOG high-risk cases (32.8% vs. 21.8%, p = 0.013), and received more chemotherapy + radiation (28.6% vs. 16.3%, p < 0.003). The SLN was the only metastasis in 18 (50%) mapped cases with positive nodes. The SLN false negative rate was 1/36 (2.8%). Micrometastases or isolated tumor cells were identified in 22/35 (62.9%) SLN metastases. Multivariate analysis demonstrated that SLN mapping imparted a significant effect on the detection of metastatic disease [adjusted OR = 3.29, p < 0.001].

Conclusions. The performance of SLN mapping with staging lymphadenectomy increased the detection of lymph node metastasis and was associated with more use of adjuvant therapies. (C) 2016 Elsevier Inc. All rights reserved.

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Kow, N

Goldman, HB

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AF Kow, Nathan

Goldman, Howard B.

Ridgeway, Beri

TI Uterine Conservation During Prolapse Repair: 9-Year Experience at a

Single Institution

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE hysteropexy; pelvic organ prolapse; uterine preservation

ID SACROSPINOUS HYSTEROPEXY; VAGINAL HYSTERECTOMY; SURGICAL-TREATMENT;

SACROHYSTEROPEXY; SUSPENSION; WOMEN

AB Objectives: The primary aim is to compare safety and long-term outcomes between uterine-sparing prolapse procedures performed using 4 different surgical routes over a 9-year period.

Methods: This is a retrospective cohort study of women who underwent uterine-sparing prolapse procedures performed by 10 female pelvic medicine and reconstructive surgeons between January 2003 and December 2011. Demographic information, operative characteristics, complications (intraoperative and postoperative), and prolapse recurrence were obtained by chart review. Additional information collected included subsequent uterine or cervical pathology, procedures, and pregnancies.

Results: Two hundred forty uterine-sparing prolapse procedures were performed in the 9-year period. One hundred two patients (42.5%) underwent a vaginal procedure, 95 patients (39.6%) underwent a conventional laparoscopic procedure, 28 patients (11.7%) underwent a robotic-assisted laparoscopic procedure, and 15 patients (6.3%) underwent an abdominal procedure. Median follow-up time and interquartile range for abdominal, vaginal, laparoscopic, and robotic surgical routes were 16.4 (3.9-23.9), 14 (3.3-36.4), 22.6 (2.9-64.5), and 6.1 (3-24.4) months, respectively. Prolapse recurrence rates were similar for all groups (abdominal 13.3%, vaginal 14.7%, laparoscopic 11.6%, robotic 3.6%; P = 0.39). Intraoperative, postoperative, and long-term complications rates were similar between all groups (P = 0.63, P = 0.43, P = 0.10). The rate of benign gynecologic conditions encountered after surgery was similar among all groups, with an overall rate of abnormal uterine bleeding/postmenopausal bleeding of 5.4% and overall rate of cervical dysplasia of 0.8%. Two pregnancies were reported, both undergoing cesarean delivery at term.

Conclusions: Uterine-sparing prolapse procedures appear to have good long-term safety and a low risk of future gynecologic pathology.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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Kaplan, J

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Eun, D

AF Lee, Ziho

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Giusto, Laura

Eun, Daniel

TI Prevention of iatrogenic ureteral injuries during robotic gynecologic

surgery: a review

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Review

DE gynecology; indocyanine green; injuries; robotic surgical procedures;

ureter

ID URINARY-TRACT INJURY; INDOCYANINE GREEN; COLON SURGERY; HYSTERECTOMY;

CATHETERIZATION; CYSTOSCOPY; STENTS; LITIGATION; PLACEMENT

AB Iatrogenic ureteral injuries, more than half of which occur during gynecologic surgery, may have devastating consequences for both patients and physicians. Gynecologists have employed various techniques such as cystoscopy, ureteral stents, and lighted ureteral stents to prevent ureteral injuries. The emergence and increasing prevalence of robotic surgery necessitates that we not only reevaluate the utility of these techniques, but also develop new ones specific for the robotic modality. In the robotic setting, the surgeon lacks tactile feedback and must rely primarily on visual cues. The use of intraureteral indocyanine green and subsequent visualization under near-infrared fluorescence appears to be a promising technique to primarily and secondarily prevent ureteral injuries during robotic gynecologic surgery.

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PT J

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TI Sacrocolpopexy: is there a consistent surgical technique?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Laparoscopic; Robot-assisted; Sacrocolpopexy; Surgical technique

ID PELVIC ORGAN PROLAPSE; SACRAL COLPOPEXY; VAULT PROLAPSE; MESH; REPAIR

AB Sacrocolpopexy is the gold standard treatment for vault prolapse. Current reported standards regarding surgical approach and technique vary. Our aim was to evaluate the surgical techniques used and identify any consistency.

Electronic surveys were sent to 148 candidates enrolled in a sacrocolpopexy workshop at the 2012 American Urogynecologic Society (AUGS) annual meeting and as a link in the International Urogynecology Association (IUGA) e-magazine. The survey assessed demographics, specific surgical steps including dissection techniques, number and type of sutures, graft materials, and the approach to intraoperative complications.

Within the AUGS group, 61 candidates responded (41 %). From the IUGA membership, 128 responded for a total of 189. Overall, 59 % identified their primary practice as urogynaecology, 43 % having completed a fellowship. Only 33 % reported performing sacrocolpopexy as the primary surgery for vault prolapse. Technical aspects: 99.4 % used polypropylene mesh, with 57 % attaching it to the vagina using non-absorbable monofilament sutures. An average of 3-4 sutures were used on the anterior and posterior walls respectively. Suture location: 22.5 % reported not placing apical sutures and 55.7 % place their anterior wall sutures midway down the vagina. Posteriorly, 47 (30 %) placed sutures through the uterosacral ligaments, 19 (12.4 %) through the levator ani and 15 % extend the mesh to the perineal body. The mesh was attached to the sacrum using permanent sutures by 75 %. Dissection of the sacrum was deemed the most technically difficult aspect.

Surgical technique varies widely despite the level of expertise and training. This study highlights the need for an evaluation of the effect of surgical technique on outcomes.

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AU Ponce, J

Barahona, M

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TI Robotic Transperitoneal Infrarenal Para-Aortic Lymphadenectomy With

Double Docking: Technique, Learning Curve, and Perioperative Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Aortic lymphadenectomy; Gynecologic carcinoma; Robotic surgical

procedures

ID ENDOMETRIAL CANCER; SURGERY; HYSTERECTOMY; LAPAROSCOPY; LAPAROTOMY

AB Para-aortic lymphadenectomy (PAL) is a challenging procedure performed by minimally invasive surgery in very few centers, owing to its intrinsic technical complexity. We describe and assess the feasibility and learning curve of robotic double-docking transperitoneal infrarenal PAL combined with oncological pelvic surgery. Fifty patients who underwent this procedure using the Da Vinci S surgical system between March 2010 and May 2013 were included. The mean operating time for PAL surgery was 76 minutes (range, 32-150 minutes), and the mean number of lymph nodes per patient was 11.8 (range, 1-44). There were no conversions to laparotomy or laparoscopy. The mean length of hospital stay was 2 days (range, 1-25 days). Statistically significant decreases were noted for mean table rotation time (17 +/- 6.8 minutes vs 13 +/- 3.6 minutes; p = .02) and mean PAL operating time (85.4 +/- 25.8 minutes vs 69.8 +/- 24.6 minutes; p = .04) when comparing the first 20 patients and the last 30 patients. The number of nodes was similar in the first 20 patients and last 30 patients. The double-docking transperitoneal infrarenal PAL technique combined with oncological pelvic surgery is feasible, with minimal morbidity and a short learning curve. (C) 2016 AAGL. All rights reserved.

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AU Siddiqui, NY

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Hur, HC

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Tarr, Megan E.

Geller, Elizabeth J.

Advincula, Arnold P.

Galloway, Michael L.

Green, Isabel C.

Hur, Hye-Chun

Pitter, Michael C.

Burke, Emily E.

Martino, Martin A.

TI Establishing Benchmarks For Minimum Competence With Dry Lab Robotic

Surgery Drills

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Objective Structured Assessment of Technical Skills; Robotic Objective

Structured Assessment of Technical Skills; Robotic surgery; Simulation;

Surgical education; Technical skills

ID RELIABILITY; PERFORMANCE; STANDARD; ASSESSMENTS; VALIDITY

AB The Robotic Objective Structured Assessment of Technical Skills (R-OSATS) is a previously validated assessment tool that is used to assess 5 standardized inanimate robotic surgery drills. R-OSATS is used to evaluate performance on surgical drills, with scores of 0 to 20 for each drill. Our objective was to establish the minimum threshold score that denotes competence on these drills.. Thus, we performed a standard setting study using data from surgeons and trainees in 8 academic medical centers. Cutoff scores for the minimal level of competence using R-OSATS were established using 2 techniques: the modified Angoff and the contrasting groups methods. For the modified Angoff method, 8 content experts met and, in an iterative process, derived the scores that a minimally competent trainee should receive. After 2 iterative rounds of scoring and discussion with the modified Angoff method, we established a minimum competence score per drill with high agreement (r(wG) range, 0.92-0.98). There was unanimous consensus that a trainee needs to achieve competence on each independent drill. A second method, the contrasting groups method, was used to verify our results. In this method, we compared R-OSATS scores from "inexperienced" (34 postgraduate year 1 and 2 trainees) with "experienced" (22 faculty and fellow) robotic surgeons. The distributions of scores from both groups were plotted, and a cutoff score for each drill was determined from the intersection of the 2 curves. Using this method, the minimum score for competence would be 14 per drill, which is slightly more stringent but confirms the results obtained from the modified Angoff approach. In conclusion, using 2 well-described standard setting techniques, we have established minimum benchmarks designating trainee competence for 5 dry lab robotic surgery drills. (C) 2016 AAGL. All rights reserved.

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TI Peritoneal Washings After Power Morcellation in Laparoscopic Myomectomy:

A Pilot Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic myomectomy; Minimally invasive surgery; Morcellation;

Pelvic washings; Peritoneal washings; Power morcellation

AB Study Objective: To evaluate if peritoneal washings of the abdominopelvic cavity during laparoscopic myomectomy can detect leiomyoma cells after power morcellation.

Design: Prospective cohort pilot study.

Setting: University of North Carolina Hospitals, an academic, tertiary referral center (Canadian Task Force classification II-2).

Patients: Patients undergoing laparoscopic or robotic myomectomy for suspected benign leiomyoma by members of the Minimally Invasive Gynecologic Surgery division between September 2014 and January 2015.

Intervention: Washings of the peritoneal cavity were collected at 3 times during surgery: the beginning of the procedure once the peritoneal cavity was accessed laparoscopically, after the myoma was excised and myometrial incision closed, and after uncontained power morcellation.

Measurements and Main Results: Twenty patients were included in the analysis. The median morcellation time was 16 minutes (range, 2-36). The median specimen weight was 283.5 g (range, 13-935). Cytologic evaluation (ThinPrep with Papanicolaou staining) did not detect any smooth muscle cells. Cell block histology, however, detected spindle cells in 6 postmorcellation samples. Three of these 6 cases also had spindle cells detected on the postmyomectomy closure samples. When performed on the postmorcellation samples, desmin and smooth muscle actin immunostaining were positive, confirming the presence of smooth muscle cells.

Conclusion: Cell block histology, but not cytology, can detect leiomyoma cells in peritoneal washings after power morcellation. With myomectomy, there is some tissue disruption that seems to cause cell spread even in the absence of morcellation. Further protocol testing might allow peritoneal washings to be used in assessing containment techniques and testing comparative safety of different morcellation methods. (C) 2016 AAGL. All rights reserved.

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TI Reproductive and oncologic outcome following robot-assisted laparoscopic

radical trachelectomy for early stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robot; Trachelectomy; Fertility; Pregnancy outcome; Recurrence

ID VAGINAL TRACHELECTOMY; YOUNG-WOMEN; FERTILITY PRESERVATION; GYNECOLOGIC

CANCER; SURGERY; SERIES

AB Objective. To investigate the reproductive and oncologic outcome following robotic radical trachelectomy for early stage cervical cancer.

Methods. All women with early stage cervical cancer planned for fertility-sparing robotic trachelectomy between December 2007 and April 2015 at two tertiary referral centers in Sweden were identified. Perioperative- and follow-up data was retrieved from prospective databases used for all robotic procedures at the respective institution and an additional review of computerized patient files was performed. Reproductive outcome evaluation was restricted to women with months follow-up and an active wish to conceive. Oncological outcome was evaluated for all patients.

Results. Fifty-six women (3 stage IA1, I4 stage IA2 and 39 stage IB1) were included. The median age was 29 years (range 23-41). Median follow-up was 24 months (range 1-89). Seven trachelectomies were aborted in favor of a radical hysterectomy and/or chemoradiation due to nodal metastases or insufficient margins; two distant recurrences occurred in these women. A local recurrence was seen in two of the 49 women (4%) in whom the procedure was completed as planned. Seventeen of the 21 women (81%) in the reproductive follow-up group conceived - 16 naturally and one following IVF. Sixteen women (94%) delivered in the third trimester, 12 women (71%) in gestational week >= 36. One (6%) second trimester delivery occurred.

Conclusion. The high fertility rate, low rate of premature deliveries and an acceptable rate of recurrence support the feasibility of robotic fertility-sparing radical trachelectomy in women with early stage cervical cancer. (C) 2016 Elsevier Inc. All rights reserved.

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TI Robotic or laparoscopic sacrohysteropexy versus open sacrohysteropexy

for uterus preservation in pelvic organ prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT 40th IUGA Meeting in conjunction with 2nd World Congress on Abdominal

and Pelvic Pain

CY JUN 09-13, 2015

CL Nice, FRANCE

SP IUGA

DE Laparoscopic sacrohysteropexy; Pelvic organ prolapse; Robotic

ID NON-INFERIORITY TRIAL; SHORT-TERM OUTCOMES; UTEROVAGINAL PROLAPSE;

ABDOMINAL SACROCOLPOPEXY; SACROSPINOUS HYSTEROPEXY; APICAL SUPPORT;

SURGERY; WOMEN; HYSTERECTOMY; SACROCERVICOPEXY

AB The aim of this study was to compare robotic or laparoscopic sacrohysteropexy (RLSH) and open sacrohysteropexy (OSH) as a surgical treatment for pelvic organ prolapse (POP).

Among 111 consecutive patients who had undergone sacrohysteropexy for POP, surgical outcomes and postoperative symptoms were compared between the RLSH (n = 54; robotic 14 cases and laparoscopic 40 cases) and OSH (n = 57). groups The medical records of enrolled patients were reviewed retrospectively.

Compared with the OSH group, the RLSH group had shorter operating time (120.2 vs 187.5 min, p < 0.0001), less operative bleeding (median estimated blood loss 50 vs 150 ml; p < 0.0001; mean hemoglobin drop 1.4 vs 2.0 g/dl; p < 0.0001), and fewer postoperative symptoms (13 vs 45.6 %; p < 0.0001). Patients' overall satisfaction (94.4 vs 91.2 %; p = 0.717) and required reoperation due to postoperative complications (3.7 vs 1.8 %; p = 0.611) did not differ between groups.

RLSH could be a feasible and safe procedure in patients with POP and should be considered as a surgical option that allows preservation of the uterus. Prospective randomized trials will permit the evaluation of potential benefits of RLSH as a minimally invasive surgical approach.

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TI Telelap ALF-X total hysterectomy for early stage endometrial cancer: New

frontier of robotic gynecological surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Endoscopy; Robotic; ALF-X; Hysterectomy

AB Objective: In the last decade robotic surgery has acquired a more important role in gynecologic surgery [1]. Recently, the new robotic platform Telelap ALF-X (TRANSENTERIX Inc., USA) has been proposed as an alternative system to bridge the gap between robotic and laparoscopic features. This new robotic device provides a novel approach to endoscopy thanks to remote 3D vision with an eye-tracking camera control system, an incorporated haptic interaction and high configuration versatility due to total robotic arms independency. These technical characteristics, combined with fully reusable instruments and conventional 5-mm ports.

The aim is to show the new surgical approach in treatment of early stage endometrial cancer using new robotic platform ALF-X.

Methods: The patient was 70 years old women affected by endometrioid endometrial carcinoma stage IA (FIGO 2009) diagnosed by endometrial biopsy and radiologic examinations. She had no past medical history and the body mass index was 29.14 kg/m(2). We performed laparoscopic Class A Querleu-Morrow total Hysterectomy [2] and bilateral salpingo-oophorectomy using Telelap ALF-X [3].

Results: Total operative time was 98 min and 9 min for docking time. The estimated blood loss was 50 mL. The patient was discharged home on postoperative day 2 and no complications were noted according to Dindo classification [4].

Conclusions: Despite the absence of articulated instrument, total hysterectomy performed using Telelap ALF-X is technically feasible and the use of this novel robotic platform allowed to maintain the standard laparoscopic setting. Further studies are mandatory to define the benefits, advantages, and costs of this novel approach.

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TI Telelap ALF-X vs Standard Laparoscopy for the Treatment of Early-Stage

Endometrial Cancer: A Single-Institution Retrospective Cohort Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE ALF-X; Endometrial cancer; Endoscopy; Laparoscopy; Robotic surgery

ID PERIOPERATIVE OUTCOMES; ASSISTED LAPAROSCOPY; HYSTERECTOMY; LAPAROTOMY;

COST

AB Study Objective: To compare the surgical and clinical outcomes of patients affected by early-stage endometrial cancer treated using the Telelap ALF-X platform versus conventional laparoscopic surgery.

Design: Single institution retrospective cohort study (Canadian Task Force classification II-2).

Setting: Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Catholic University of the Sacred Heart, Rome, Italy.

Patients: The study involved 89 patients affected by early-stage endometrial cancer who underwent elective surgical staging between October 2013 and September 2014. Among them, 43 (48.3%) underwent Telelap ALF-X staging (ALF-X group), and 46 (51.7%) underwent conventional laparoscopic staging (laparoscopic group).

Interventions: All selected patients underwent laparoscopic staging with radical hysterectomy (class A sec Querleu-Morrow), bilateral salpingo-oophorectomy, and pelvic lymphadenectomy if required. The 2 surgical groups were further divided into patients who did not require pelvic lymphadenectomy (subgroup 1) and those who underwent pelvic lymphadenectomy (subgroup 2).

Measurements and Main Results: In the ALF-X group, the median operative time was 128 minutes (range, 69-260 minutes) for subgroup 1 and 193 minutes (range, 129-290 minutes) for subgroup 2. In the laparoscopic group, the median operative time was 82 minutes (range, 25-180 minutes) in subgroup 1 and 104 minutes (range, 36-160 minutes) in subgroup 2. The difference in operative time between subgroups was statistically significant in both the ALF-X and laparoscopic groups (p = .000). In subgroup 1 of the ALF-X group, there was 1 conversion to standard laparoscopy (2.3%) and 2 conversions to laparotomy (4.7%) (p = .234). No conversions to laparotomy occurred in the laparoscopic group. Postoperative complications included 1 case of pelvic hematoma (2.3%) in subgroup 1 of the ALF-X group and 1 case of subocclusion and 1 case of pulmonary edema (4.3%) in subgroup 1 of the laparoscopic group.

Conclusion: Based on operative outcomes and complication rates, our results suggest that the Telelap ALF-X approach is feasible and safe for endometrial cancer staging; however, further studies are needed to definitively assess the role of Telelap ALF-X early-stage endometrial cancer staging. (C) 2016 AAGL. All rights reserved.

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TI A Prospective, Comparative Study for the Evaluation of Postoperative

Pain and Quality of Recovery in Patients Undergoing Robotic Versus Open

Hysterectomy for Staging of Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Laparotomy; Postoperative pain; Quality of recovery;

Robotic surgery

ID LAPAROSCOPIC HYSTERECTOMY; RADICAL HYSTERECTOMY; LAPAROTOMY; TRENDS;

COST

AB Study Objective: To measure and compare postoperative pain and patient satisfaction in patients undergoing either robotic or open laparotomy for surgical staging of endometrial cancer.

Design: Prospective, comparative study (Canadian Task Force classification II).

Setting: University hospital.

Patients: A total of 142 patients undergoing either robotic or open laparotomy for surgical staging of endometrial cancer.

Interventions: Patients scheduled for surgical staging of endometrial cancer at a single institution were identified. The patients underwent either robotic or open hysterectomy for staging of endometrial cancer. The choice of operative approach (robotic vs laparotomy) was made by the faculty physician before enrollment. Patients participated in the study for up to 48 hours for pain assessments and up to 10 +/- 3 days postoperatively for quality of recovery assessments.

Measurements and Main Results: The following measurements were performed: postoperative pain with the visual analog scale (VAS), 24-hour opioid consumption, and quality of recovery using the Quality of Recovery Questionnaire (QoR-40). The study was terminated owing to futility, given the lack of open procedures at our institution. Despite that lack of statistically significant difference between VAS scores at rest and with leg extension, there was a significant decrease in 24-hour opioid consumption in the robotic group. In addition, the QoR-40 showed an increased perception of recovery in patients within the robotic group compared with the laparotomy group.

Conclusion: Patients with endometrial cancer who underwent robotic surgery had decreased postoperative opioid consumption and improved quality of recovery compared with those who underwent surgery via laparotomy. (C) 2016 AAGL. All rights reserved.

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

AU Corrado, G

Cutillo, G

Saltari, M

Mancini, E

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Baiocco, E

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Baiocco, Ermelinda

Vizza, Enrico

TI Surgical and Oncological Outcome of Robotic Surgery Compared With

Laparoscopic and Abdominal Surgery in the Management of Locally Advanced

Cervical Cancer After Neoadjuvant Chemotherapy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robot-assisted radical hysterectomy; Neoadjuvant chemotherapy; Locally

advanced cervical cancer; Minimally invasive surgery

ID RADICAL HYSTERECTOMY; GYNECOLOGIC ONCOLOGY; PACLITAXEL; CISPLATIN; TRIAL

AB Objective

The primary aim is to evaluate the surgical and oncological outcome of robotic radical hysterectomy (RRH) plus pelvic lymphadenectomy in locally advanced cervical cancer (LACC) after neoadjuvant chemotherapy (NACT). The secondary aim is to compare the surgical and oncological results of RRH after NACT with a historical cohort of patients undergoing laparoscopic radical hysterectomy or abdominal radical hysterectomy plus pelvic lymphadenectomy for LACC after NACT.

Methods

We enrolled a total of 41 patients in this study with LACC undergoing RRH, who achieved a clinical partial or complete response to NACT. The surgical and oncological outcomes of 2 historical groups were compared: the laparoscopic group (41 patients) with the laparotomic group (43 patients).

Results

The median estimated blood loss, operative time, and length of hospital stay were statistically significant and in favor of the robotic group. No conversion to laparotomy in the robotic group was necessary. There were no significant differences between the 3-year overall survival and disease-free survival rates in the minimally invasive groups; nevertheless, the robotic group showed the same recurrence rate of laparoscopic in a short-interval follow-up.

Conclusions

The robotic approach could be considered a feasible and safe alternative to other surgical options. Multicenter randomized clinical trials with longer follow-ups are necessary to evaluate the overall oncologic outcomes of this procedure.

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

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Claydon, Leica Sarah

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Dolcet Artahona, Maria Angelica

TI Robotic versus laparoscopic sacrocolpopexy for treatment of prolapse of

the apical segment of the vagina: a systematic review and meta-analysis

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Apical prolapse; Laparoscopy; Robotic surgery; Sacropexy

ID PELVIC ORGAN PROLAPSE; HYSTERECTOMY; OUTCOMES; COST

AB Introduction and hypothesis Pelvic organ prolapse shows an increasing prevalence (3-50 %). The gold standard treatment for apical prolapse is sacrocolpopexy, which can be performed via minimal access (conventional laparoscopy or robotic surgery) or open sacrocolpopexy. The objective is to appraise the effectiveness and safety of robotic surgery compared with laparoscopic sacropexy in the treatment of apical prolapse.

Methods Keywords were searched in: CINAHL, MEDLINE, CENTRAL, Cochrane MDSG Trials Register, Cochrane Library, Current Controlled Trials, ClinicalTrials.gov, WHO International Trials Registry Platform search portal, LILACS, and Google Scholar. A hand-search was also performed from IUJ and JMIG. Randomised and non-randomised controlled trials evaluating all women who underwent robotic sacropexy (RSC) or laparoscopic sacropexy (LSC) were included. A data extraction tool was used for data collection. RSC was compared with LSC. Narrative analysis and meta-analysis (RevMan) were conducted where appropriate.

Results Nine papers compared RSC with LSC, involving 1, 157 subjects. No significant difference was found between approaches for anatomical outcomes, mortality, hospital stay (MD: -0.72/ 95 % CI 1.72, 0.28], p=0.16), and postoperative quality of life. However, robotic sacropexy had more postoperative pain and longer operating times, although fewer overall complications when performed concomitantly with hysterectomy (OR 0.35; 95 % CI 0.19-0.64).

Conclusions Robotic sacropexy was related to more postoperative pain and longer operating times. However, no significant differences were found regarding anatomical outcomes, mortality, hospital stay or postoperative quality of life. Cautious interpretation of results is advised because of the risk of bias caused by the inclusion of non-randomised studies. More research comparing RSC with LSC is mandatory, particularly draw conclusions regarding estimated blood loss and complication rate.

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TC 22

Z9 22

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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SC Obstetrics & Gynecology; Urology & Nephrology

GA DF2OD

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ER

PT J

AU Guy, MS

Sheeder, J

Behbakht, K

Wright, JD

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TI Comparative outcomes in older and younger women undergoing laparotomy or

robotic surgical staging for endometrial cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE comparative outcomes; endometrial cancer; morbidity and mortality; older

patients; robotic surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; RANDOMIZED CONTROLLED-TRIALS; TOTAL

ABDOMINAL HYSTERECTOMY; OBESE WOMEN; SURGERY; METAANALYSIS; MORBIDITY;

COMPLICATIONS; SURVIVAL

AB BACKGROUND: Older patients are at increased risk of perioperative morbidity and mortality. There are limited data on the safety of a robotic approach in the staging for endometrial cancer.

OBJECTIVE: We compared outcomes in women undergoing laparotomy or robotic surgical staging for endometrial cancer.

STUDY DESIGN: Using the Healthcare Cost and Utilization Project National Inpatient Sample database from 2008 through 2010, we abstracted records for patients who had surgery for endometrial cancer with either a robotic approach or laparotomy. Patients were categorized by age (<65 vs >= 65 years and 5-year increments). Medical comorbidity scores were calculated using the Charlson Comorbidity Index. Outcomes included intraoperative/perioperative/medical complications, death, length of stay (LOS), and discharge disposition. Student t and chi(2) tests were used to compare groups and approach. Multiple analysis of variance models were used to compare differences between robotics and laparotomy and age groups.

RESULTS: We identified 16,980 patients who had surgery for endometrial cancer with either a robotic approach (age >= 65 years, n = 1228; age < 65 years, n = 1574) or laparotomy (age >= 65 years, n = 5914; age < 65 years, n = 8264). Older patients had a higher Charlson Comorbidity Index score at the time of surgery (2.6 vs 2.5, P < .001). In laparotomy cases, intraoperative complication rates were similar (4.1% vs 3.7%, P = .17). Older patients had higher rates of perioperative surgical (20.5% vs 15.4%, P < .001) and medical (23.3% vs 15.5%, P < .001) complications, longer LOS (5.1 vs 4.2 days, P < .001), and lower rates of discharge to home (71.2% vs 90.1%, P < .001). In robotic cases, rates of intraoperative complications were similar (5.9% vs 6.8%, P = .32). Older patients had higher rates of perioperative surgical (8.3% vs 5.2%, P = .001) and medical (12.3% vs 6.7%, P = .001) complications, longer LOS (2.00 vs 1.67 days, P < .001), and lower rates of discharge to home (88.8% vs 96.8%, P < .001). With both approaches, as age increased, perioperative surgical and medical complications also increased in a linear fashion. In a subanalysis of older patients (n = 7142), there were lower rates of perioperative surgical (8.3% vs 20.5%, P < .001) and medical (12.3% vs 23.3%, P < .001) complications, death (0.0% vs 0.8%, P < .001), shorter LOS (2.00 vs 5.13 days, P < .001) and higher rate of discharge to home (88.8% vs 71.2%, P <.001) in robotic compared to laparotomy cases.

CONCLUSION: Although the risks of surgery increase with age, in patients age >= 65 years, a robotic approach for endometrial cancer appears to be safe given current selection criteria utilized in the United States.

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Z9 34

U1 0

U2 5

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WC Obstetrics & Gynecology

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ER

PT J

AU Herling, SF

Palle, C

Moller, AM

Thomsen, T

Sorensen, J

AF Herling, Suzanne F.

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Moller, Ann M.

Thomsen, Thordis

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TI Cost-analysis of robotic-assisted laparoscopic hysterectomy versus total

abdominal hysterectomy for women with endometrial cancer and atypical

complex hyperplasia

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Robotics; hysterectomy; costs and cost analysis; postoperative

complications; endometrial neoplasms; economics; medical

ID HEALTH ECONOMIC-EVALUATION; SURGERY; LAPAROTOMY; OUTCOMES

AB IntroductionThe aim of this study was to analyse the hospital cost of treatment with robotic-assisted laparoscopic hysterectomy and total abdominal hysterectomy for women with endometrial cancer or atypical complex hyperplasia and to identify differences in resource use and cost.

Material and methodsThis cost analysis was based on two cohorts: women treated with robotic-assisted laparoscopic hysterectomy (n=202) or with total abdominal hysterectomy (n=158) at Copenhagen University Hospital, Herlev, Denmark. We conducted an activity-based cost analysis including consumables and healthcare professionals' salaries. As cost-drivers we included severe complications, duration of surgery, anesthesia and stay at the post-anesthetic care unit, as well as number of hospital bed-days. Ordinary least-squares regression was used to explore the cost variation. The primary outcome was cost difference in Danish kroner between total abdominal hysterectomy and robotic-assisted laparoscopic hysterectomy.

ResultsThe average cost of consumables was 12642 Danish kroner more expensive per patient for robotic-assisted laparoscopic hysterectomy than for total abdominal hysterectomy (2014 price level: 1Euro=7.50 Danish kroner). When including all cost-drivers, the analysis showed that the robotic-assisted laparoscopic hysterectomy procedure was 9386 Danish kroner (17%) cheaper than the total abdominal hysterectomy (p=0.003). When the robot investment was included, the cost difference reduced to 4053 Danish kroner (robotic-assisted laparoscopic hysterectomy was 7% cheaper than total abdominal hysterectomy) (p=0.20). Increasing age and Type 2 diabetes appeared to influence the overall costs.

ConclusionFor women with endometrial cancer or atypical complex hyperplasia, robotic-assisted laparoscopic hysterectomy was cheaper than total abdominal hysterectomy, mostly due to fewer complications and shorter length of hospital stay.

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NR 24

TC 24

Z9 25

U1 1

U2 14

PU WILEY

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

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Gargiulo, AR

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TI The Role of Hysteroscopic and Robot-assisted Laparoscopic Myomectomy in

the Setting of Infertility

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE fibroids; leiomyoma; minimally invasive surgery; hysteroscopy;

robotic-assisted surgery; infertility; myomectomy

ID TRANSCERVICAL RESECTION; INTRAUTERINE ADHESIONS; ABDOMINAL MYOMECTOMY;

ENDOMETRIAL CAVITY; LEARNING-CURVE; UTERINE CAVITY; FIBROIDS; OUTCOMES;

PLACEBO; MYOMAS

AB Fibroids, the most common gynecologic condition in women of reproductive age, have traditionally been treated with hysterectomy. As more women delay childbearing, myomectomy becomes an essential component of the gynecologist's armamentarium. Minimally invasive approaches to myomectomy have been shown to decrease morbidity and reduce care-related costs, while improving reproductive outcomes. Hysteroscopic myomectomy is a reproducible and easily learned technique for the treatment of submucosal fibroids. Robot-assisted laparoscopic myomectomy overcomes most of the technical challenges of laparoscopic myomectomy for intramural and subserosal fibroids. The combined adoption of these technologies will allow more patients with fibroids to benefit from a minimally invasive approach.

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NR 62

TC 10

Z9 10

U1 0

U2 3

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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SC Obstetrics & Gynecology

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ER

PT J

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Zorrero, C

Zanagnolo, V

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TI Robotic Surgery in Women With Ovarian Cancer: Surgical Technique and

Evidence of Clinical Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Advanced stage; Early stage; Ovarian cancer; Robotic surgery; Surgical

staging

ID PORT-SITE METASTASES; STAGE OVARIAN; FALLOPIAN-TUBE; PERIOPERATIVE

OUTCOMES; GYNECOLOGIC-ONCOLOGY; CONSENSUS STATEMENT; ASSISTED SURGERY;

MANAGEMENT; LAPAROSCOPY; EXTRAPERITONEAL

AB Robotic surgery is a new technology that has been progressively implemented to treat endometrial and cervical cancer. However, the use of robotic surgery for ovarian cancer is limited to a few series of cases and comparative studies with laparoscopy or laparotomy. The technical issues concerning robotic surgery, as well as clinical evidence, are described in this review. Robotic surgery in early stage, advanced stage, and relapsed ovarian cancer is discussed separately. In conclusion, evidence regarding the use of robotic-assisted surgical treatment for women with ovarian cancer is still scarce, but its use is progressively growing. Robotic-assisted staging in selected patients with early stage disease has an important role in referral institutions when well-trained gynecologists perform surgeries. However, minimally invasive surgery in patients with advanced stage or relapsed ovarian cancer requires further investigation, even in selected cases. (C) 2016 AAGL. All rights reserved.

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ER

PT J

AU Pan, K

Zhang, Y

Wang, YZ

Wang, YL

Xu, HC

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Zhang, Yao

Wang, Yanzhou

Wang, Yunle

Xu, Huicheng

TI A systematic review and meta-analysis of conventional laparoscopic

sacrocolpopexy versus robot-assisted laparoscopic sacrocolpopexy

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Review

DE Laparoscopy; Pelvic organ prolapse; Robotics; Sacrocolpopexy

ID ABDOMINAL SACROCOLPOPEXY; PROLAPSE; OUTCOMES; QUALITY; TRIALS; COSTS;

WOMEN

AB Background: Robot-assisted laparoscopic sacrocolpopexy (RALSC) has spread rapidly without the availability of comprehensive and systematically recorded outcome data. Objective: To systematically review and compare the outcomes of laparoscopic sacrocolpopexy (LSC) and RALSC. Search strategy: PubMed and Scopus were searched for reports published from 2000 to 2014, using the search terms "robotic sacrocolpopexy," "laparoscopic sacrocolpopexy," and "sacral colpopexy." Selection criteria: Studies were included if they directly compared the outcomes of RALSC and LSC, the sample size in each group was more than 15, the follow-up duration was longer than 3 months, and the report was in English. Data collection and analysis: The studies' characteristics, quality, and outcomes were recorded. Random-/fixed-effects models were used to combine data. Main results: Data on 264 RALSC and 267 LSC procedures were collected from seven studies. The mean operative time was longer in the RALSC group (245.9 minutes vs 205.9 minutes; P < 0.001). The estimated blood loss in the two groups was similar (114.4 mL vs 160.1 mL; P = 0.36). The differences in incidence of intraoperative/postoperative complications were also similar (P = 0.85 vs P = 0.92). The costs of RALSC were significantly higher than were those of LSC series in each of three studies (P < 0.01 for all). Conclusions: The clinical outcomes of prolapse surgery are similar with RALSC and LSC, but RALSC is less efficient in terms of cost and time. (C) 2015 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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NR 39

TC 43

Z9 46

U1 0

U2 9

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ER

PT J

AU Schiavone, MB

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Abu-Rustum, NR

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TI Herniation formation in women undergoing robotically assisted

laparoscopy or laparotomy for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Gynecologic surgery; Laparotomy; Trocar site

herniation; Ventral herniation; Endometrial cancer

ID TROCAR SITE HERNIA; MINIMALLY INVASIVE SURGERY; INCISIONAL HERNIAS;

OUTCOMES; SURVIVAL; COST

AB Objective. To compare the incidence of trocar site hernia in women who underwent robotically assisted laparoscopic surgery (RBT) for endometrial cancer staging with the incidence of ventral hernia formation in patients who underwent laparotomy (LAP) for the same indication. To analyze risk factors for hernia formation in women undergoing RBT for endometrial cancer.

Methods. We retrospectively identified all patients who underwent surgical staging for endometrial cancer via RBT or LAP from 2009-2012. Clinicopathologic data were analyzed. Appropriate statistical tests were used.

Results. 738 patients were staged via RBT (n = 567) or LAP (n = 171). Overall median age was 61 years (RBT range, 33-90; LAP range,28-86; p = 0.4). Median BMI was 29.5 kg/m(2) (range, 17.9-66) and 303 kg/m(2) (range, 16.8-67.2), respectively (p = 1.0). Eleven (1.9%) of 567 patients in the RBT cohort developed a trocar site hernia compared with 11 (6.4%) of 171 LAP patients who developed a ventral hernia (p = 0.002). Median time to diagnosis was 18 months (range, 3-49) and 17 months (range, 7-30), respectively (p = 0.7). Of the 11 RBT patients who developed a trocar site hernia, 10 (91%) were midline defects and 1 (9%) was a lateral defect of a prior inferior epigastric port site. No hernias required emergent operative intervention. Four (0.7%) of 567 RBT patients compared with 2 (1.2%) of 171 LAP patients required surgical hernia repair (p = 0.4).

Conclusions. Trocar site herniation after RBT staging for endometrial cancer is uncommon and less likely to occur than ventral hernia formation with LAP staging. Furthermore, surgical revision rates are low. (C) 2016 Elsevier Inc. All rights reserved.

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TI Robotic Surgery in Patients With Locally Advanced Cervical Cancer After

Neoadjuvant Chemotherapy <i>Survival Outcomes</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical cancer; Neoadjuvant chemotherapy; Robotics; Minimally invasive

surgery; Radical hysterectomy

ID RADICAL HYSTERECTOMY; STAGE IB; RANDOMIZED-TRIAL; CARCINOMA; CISPLATIN;

PACLITAXEL; LYMPHADENECTOMY; IFOSFAMIDE; EPIRUBICIN

AB Aim

To evaluate the survival outcomes of consecutive patients with locally advanced cervical cancer (LACC) who underwent comprehensive robotic surgery after neoadjuvant chemotherapy (NACT).

Materials and Methods

Since 2009, patients with LACC (FIGO [International Federation of Gynecology and Obstetrics] stages IB2-IIB) were submitted to robotic surgical staging after 3 cycles of NACT. Clinical objective tumor response was assessed according to the Response Evaluation Criteria in Solid Tumors, whereas pathologic responses were defined according to the criteria of the European study SNAP01. Univariable and multivariable analyses were performed to assess potential clinicopathologic prognostic factors affecting progression-free survival and overall survival (OS).

Results

During the study period, 32 patients meeting the inclusion criteria were managed. The median (range) age and body mass index were 47.3 (8.6-75.5) years and 22.7 (17.5-37.1) kg/m(2), respectively. Overall, 28.0 (range, 12-58) lymph nodes were retrieved. According to the final pathologic examination, 6 (18.8%) women had positive pelvic lymph nodes, whereas 16 (50.0%) patients achieved an optimal pathological response. After a median follow-up of 36.3 (range, 5.2-71.1) months, 6 (18.8%) patients had a recurrence and subsequently died of disease.

Positive nodal status was the only independent predictor of both progression-free survival (12.5 [2.3-69.1]; P < 0.0001) and OS (12.0 [2.0-60.4]; P < 0.0001) at multivariable analysis.

Conclusions

Nodal status represents the strongest predictor of survival in women with LACC. Similarly, NACT including 3 agents (TIP [paclitaxel 175 mg/m(2) + ifosfamide 5 g/m(2) + cisplatin 75 mg/m(2)] and TEP [paclitaxel 175 mg/m(2) + epirubicin 80 mg/m(2) + cisplatin 75 mg/m(2)] regimens) warranted better OS than those achieved by other schedules.

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TI Clinical and Oncologic Outcomes of Robotic Versus Abdominal Radical

Hysterectomy for Women With Cervical Cancer Experience at a Referral

Cancer Center

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic radical hysterectomy; Abdominal radical hysterectomy; Overall

survival; Progression-free survival; Cervical cancer; Complications

ID PELVIC LYMPHADENECTOMY; RADIATION-THERAPY; LAPAROSCOPY; SURGERY

AB Objectives

To compare the clinical and oncologic outcomes of robotic radical hysterectomy (RRH) vs abdominal radical hysterectomy (ARH) in patients with cervical carcinoma.

Methods

A retrospective analysis of women who underwent radical hysterectomy for cervical cancer from December 2006 to December 2014 at European Institute of Oncology was performed. Patients who underwent RRH were compared with women operated on by ARH. The groups were matched by age, body mass index, tumor size, International Federation of Gynecology and Obstetrics stage, comorbidity, previous neoadjuvant chemotherapy, histology type, and tumor grade.

Results

A total of 203 and 104 women who underwent RRH and ARH, respectively, were analyzed. Baseline characteristics, stage of disease, histology type, and grade of differentiation were similar between groups. Surgical time was significantly shorter in the ARH group (208 vs 282 minutes, P <= 0.001). Robotic radical hysterectomy was associated with significantly less estimated blood loss (219 vs 104 mL, P = 0.001) and with significantly shorter hospital stay (5.2 vs 3.9 days, P <= 0.001). Abdominal radical hysterectomy was correlated with a significantly higher number of lymph nodes removed (25.8 vs 22, P = 0.003). None of the robotic procedures required conversion to laparotomy. A significantly higher number of patients in ARH required postoperative transfusion (11 [10.5%] vs 6 [2.9%], P = 0.006). Lower extremity lymphedema was significantly higher in ARH (28 [27.5%] vs 17 [8.3%], P = 0.001). Recurrence rates as well as progression-free survival and overall survival were similar between groups at a median follow-up of 41.64 months.

Conclusions

Robotic radical hysterectomy is safe and feasible and is associated with improved clinical outcomes. Although longer follow-up is needed, early data show equivalent oncologic outcomes compared with other surgical modalities.

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TI Rates of colpopexy and colporrhaphy at the time of hysterectomy for

prolapse

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE apical suspension; colpopexy; colporrhaphy; pelvic organ prolapse;

surgical quality measures

ID PELVIC ORGAN PROLAPSE; UTEROVAGINAL PROLAPSE; SURGICAL-MANAGEMENT;

APICAL-SUPPORT; SURGERY

AB BACKGROUND: It has been shown that addressing apical support at the time of hysterectomy for pelvic organ prolapse (POP) reduces recurrence and reoperation rates. In fact, national guidelines consider hysterectomy alone to be inadequate treatment for POP. Despite this, anterior and posterior colporrhaphy are frequently performed without a colpopexy procedure and hysterectomy alone is often utilized for treatment of prolapse.

OBJECTIVE: The objectives of this study were to: (1) determine rates of concomitant procedures for POP in hysterectomies performed with POP as an indication, (2) identify factors associated with performance of a colpopexy at the time of hysterectomy for POP, and (3) identify the influence of surgical complexity on perioperative complication rates.

STUDY DESIGN: This is a retrospective cohort study of hysterectomies performed for POP from Jan. 1, 2013, through May 7, 2014, in a statewide surgical quality database. Patients were stratified based on procedures performed: hysterectomy alone, hysterectomy with colporrhaphy and without apical suspension, and hysterectomy with colpopexy with or without colporrhaphy. Demographics, medical history and intraoperative care, and perioperative care were compared between the groups. Multivariable logistic regression models were created to identify factors independently associated with use of colpopexy and factors associated with increased rates of postoperative complications.

RESULTS: POP was an indication in 1557 hysterectomies. Most hysterectomies were vaginal (59.6%), followed by laparoscopic or robotic (34.1%), and abdominal (6.2%). Hysterectomy alone was performed in 43.1% (95% confidence interval [CI], 40.6-45.6) of cases, 32.8% (95% CI, 30.4-35.1) had a colporrhaphy without colpopexy, and 24.1% (95% CI, 22-26.3) had a colpopexy with or without colporrhaphy. Use of colpopexy was independently associated with patient age> 40 years, POP as the only indication for surgery (odd ratio [OR], 1.6; 95% CI, 1.185-2.230), laparoscopic surgery (OR, 3.2; 95% CI, 2.860-5.153), and a surgeon specializing in urogynecology (OR, 8.2; 95% CI, 5.156-12.923). The overall perioperative complication rate was 6.6%, with the majority being considered minor. Complications were more likely when the procedure was performed with an abdominal approach (OR, 2.3; 95% CI, 1.088-4.686), with the use of a colpopexy procedure (OR, 3.1; 95% CI, 1.840-5.194), and by a surgeon specializing in urogynecology (OR, 2.2; 95% CI, 1.144-4.315).

CONCLUSION: Colpopexy and colporrhaphy may be underutilized and are potential targets for quality improvement. Performance of additional procedures at the time of hysterectomy increased the rate of perioperative complications. Long-term consequences of these surgical practices deserve additional study.

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TI Assessing the learning curve of robotic sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Learning curve; Robotic; Sacrocolpopexy

ID LAPAROSCOPIC SACROCOLPOPEXY; ASSISTED SACROCOLPOPEXY; COMPLICATIONS;

SURGERY; PERFORMANCE; CUSUM

AB The aim was to evaluate the learning curve of robotic sacrocolpopexy, adjusted for surgical risk.

The charts of 145 robotic sacrocolpopexies performed by urogynecologists at Mayo Clinic, Rochester, MN, USA, from 2007 to 2013, were reviewed. Outcomes of interest included operative time, intraoperative complications, and postoperative complications with a Clavien-Dindo grade 2 or higher. Risk-adjusted cumulative summation analysis was performed by comparing a calculated complication risk score with observed patient outcomes, and then cumulatively recalculating the rate of expected vs observed complications after each procedure. Proficiency was defined as the point at which the surgeon's complication rates were better than expected, given the patient's risk factors.

The median operative time decreased significantly, from 5.3 to 3.6 h, during the 7-year period, and plateaued after the first 60 cases. A higher ASA classification was associated with an increased risk of intraoperative complications (p = 0.02), and a higher Charlson comorbidity index was associated with an increased risk of intraoperative or postoperative complications (p = 0.01). In risk-adjusted CUSUM analyses, accounting for these factors, and for body-mass index and vaginal parity, proficiency was identified at 55 cases for intraoperative complications and 84 cases for intraoperative or postoperative complications.

Operative time plateaued after the first 60 cases, whereas complication rates continued to decrease beyond this. Proficiency, as determined by a risk-adjusted CUSUM analysis for complication rates, was achieved after approximately 84 cases. Evaluation of postoperative complications in addition to intraoperative complications, in a risk-adjusted model, is critical in depicting the surgical learning curve.

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TI Survey of Current Practice Patterns in the Treatment of Early-Stage

Endometrial Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Adjuvant therapy; Practice patterns; Radiation

therapy; Surgical techniques

ID PHASE-III TRIAL; ADJUVANT RADIATION-THERAPY; INTERMEDIATE-RISK;

CHEMOTHERAPY; RADIOTHERAPY; CARCINOMA; BRACHYTHERAPY; SURGERY; SOCIETY;

MEMBERS

AB Objectives: Our aim was to assess current surgical practices and use of adjuvant therapy in the treatment of FIGO (International Federation of Gynecology and Obstetrics) stage I endometrioid endometrial cancer.

Methods: A 19-question survey was developed and sent to all Society of Gynecologic Oncologist members by e-mail. Data were collected anonymously using Internet-based survey software. Respondents were asked questions regarding preoperative evaluation, surgical approach, lymph node dissection (LND), and adjuvant therapy.

Results: A total of 1399 surveys were distributed, 320 (23%) members completed the survey. Ninety-seven percent of respondents were gynecologic oncologists or fellows, and 87% treat 30 or more endometrial cancer patients yearly. Respondents were more likely to order preoperative tests such as computed tomography abdomen/pelvis and CA-125 for biopsy-proven grade 3 disease versus grade 1 (82% vs 29%). Robot-assisted laparoscopy was the preferred surgical approach (66%), followed by conventional laparoscopy (21%). Twenty-six percent of respondents perform LND in all cases. Forty-eight percent describe their LND as complete, to the level of the inferior mesenteric artery. Adjuvant therapy was recommended more often with increasing myometrial invasion, tumor grade, and lymphovascular space invasion. Vaginal brachytherapy was the most commonly recommended adjuvant therapy for stage IA. For stage IB, grade 3, positive lymphovascular space invasion disease, respondents were more likely to combine vaginal brachytherapy with external beam radiotherapy and/or chemotherapy. Older patients were more likely to have adjuvant therapy in earlier stages of disease than younger patients.

Conclusions: Our findings demonstrate that respondents are individualizing care based on preoperative, intraoperative, and pathologic findings. As expected, adjuvant treatment is recommended for patients with higher stage and grade disease. Robot-assisted hysterectomy and chemotherapy are now commonly used in the management of this disease. We anticipate that new trends will continue to emerge as results from additional studies become available.

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PT J

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TI Robotic Versus Laparoscopic Hysterectomy for Benign Disease: A

Systematic Review and Meta-Analysis of Randomized Trials

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopic hysterectomy; Meta-analysis; Robotic surgery; Systematic

review

ID ASSISTED HYSTERECTOMY; COSTS

AB We conducted a systematic review and meta-analysis to assess the safety and effectiveness of robotic vs laparoscopic hysterectomy in women with benign uterine disease, as determined by randomized studies. We searched MEDLINE, EMBASE, the Cochrane Library, ClinicalTrials.gov, and Con trolled-Trials.com from study inception to October 9, 2014, using the intersection of the themes "robotic" and "hysterectomy." We included only randomized and quasi-randomized controlled trials of robotic vs laparoscopic hysterectomy in women for benign disease. Four trials met our inclusion criteria and were included in the analyses. We extracted data, and assessed the studies for methodological quality in duplicate. For meta-analysis, we used random effects to calculate pooled risk ratios (RRs) and weighted mean differences. For our primary outcome, we used a modified version of the Expanded Accordion Severity Grading System to classify perioperative complications. We identified 41 complications among 326 patients. Comparing robotic and laparoscopic hysterectomy, revealed no statistically significant differences in the rate of class 1 and 2 complications (RR, 0.66; 95% confidence interval [CI] 0.23-1.89) or in the rate of class 3 and 4 complications (RR, 0.99; 95% CI, 0.22-4.40). Analyses of secondary outcomes were limited owing to heterogeneity, but showed no significant benefit of the robotic technquie over the laparoscopic technique in terms of length of hospital stay (weighted mean difference, 0.39 day; 95% CI, 0.92 to 0.14 day), total operating time (weighted mean difference, 9.0 minutes; 95% CI, 31.27 to 47.26 minutes), conversions to laparotomy, or blood loss. Outcomes of cost, pain, and quality of life were reported inconsistently and were not amenable to pooling. Current evidence demonstrates neither statistically significant nor clinically meaningful differences in surgical outcomes between robotic and laparoscopic hysterectomy for benign disease. The role of robotic surgery in benign gynecology remains unclear. Journal of Minimally Invasive Gynecology (C) 2016 AAGL. All rights reserved.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Berkowitz, RL

Minkoff, H

AF Berkowitz, Richard L.

Minkoff, Howard

TI A Call for Change in a Changing World

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

AB The practice of obstetrics and gynecology in the United States has changed substantially over the past 50 years, but the structure of our residency programs has not evolved at a comparable pace. The number of hours available for training during the workweek has decreased significantly, whereas the amount of essential material to learn and clinical skills to acquire has increased dramatically. The switch to minimally invasive surgical approaches has reduced the number of open abdominal cases available for training, and the aptitude required to perform difficult laparoscopic and robotic cases for benign disease is such that many programs do not have enough surgical patients to teach all of their residents how to adequately master those procedures. Obstetric patients are older and heavier than those encountered several decades ago, and the comorbidities of some of these women make their antepartum and intrapartum management extremely complex. Furthermore, the explosion of genetic knowledge has made prenatal counseling infinitely more challenging. In this commentary we review these and related issues and then address the question of whether current training programs are preparing our graduates to optimally perform in the clinical arena they will enter after finishing their residencies. Some ways in which the current system could be modified are suggested, and a plea is made for the creation of a high-level task force to address this problem on a national level.

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TC 5

Z9 5

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U2 0

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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GA CZ2DG

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ER

PT J

AU Chen, SH

Li, ZA

Du, XP

AF Chen, Shao-Hui

Li, Zhao-Ai

Du, Xiu-Ping

TI Robot-assisted versus conventional laparoscopic surgery in the treatment

of advanced stage endometriosis: a meta-analysis

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Robot-assisted; Laparoscopy; Endometriosis; Advanced stage

endometriosis; Conventional laparoscopy

ID COLORECTAL ENDOMETRIOSIS; HYSTERECTOMY; MANAGEMENT; OUTCOMES; DISEASE

AB Objective: To evaluate the safety and efficacy of robot-assisted laparoscopy (RAL) versus conventional laparoscopy (CL) in the treatment of advanced stage endometriosis. Materials and Methods: Utilizing electronic databases (PubMed, Embase, and Elsevier), a systematic literature review was performed between 2008 and 2015 to compare the RAL surgery with CL surgery (CLS) in the treatment of advanced stage endometriosis. According to meta-analysis criteria, two comparative clinical trials were selected. Outcome measures including length of operation, blood loss, operative complications, and the length of hospitalization, were estimated by the RevMan 5.1 software. Results: In the meta-analysis, there were no significant differences in blood loss, complication, and hospital stay between RAL and CL surgeries in the treatment of advanced stage endometriosis. However, RAL surgery required a higher mean operating time than CL surgery (WMD: 73.85, 95% CI: 56.77-90.94; p < 0.00001). Comparative studies demonstrated that RAL displayed no outstanding advantages. Conclusions: As a new minimally invasive method, RAL technology is safe and efficient alternative to CL in the treatment of advanced stage endometriosis. The latent benefits of RAL technology for the treatment of advanced stage endometriosis remain uncertain.

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TC 15

Z9 16

U1 0

U2 6

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J9 CLIN EXP OBSTET GYN

JI Clin. Exp. Obstet. Gynecol.

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PT J

AU Chong, GO

Lee, YH

Hong, DG

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Lee, YS

AF Chong, Gun Oh

Lee, Yoon Hee

Hong, Dae Gy

Cho, Young Lae

Lee, Yoon Soon

TI Long-Term Efficacy of Laparoscopic or Robotic Adenomyomectomy with or

without Medical Treatment for Severely Symptomatic Adenomyosis

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Adenomyosis; Adenomyomectomy; Efficacy; Long-term follow-up

ID UTERINE ARTERY EMBOLIZATION; FOLLOW-UP; QUESTIONS; SURGERY

AB Background/Aims: To determine the long-term efficacy of laparoscopic or robotic adenomyomectomy with or without gonadotropin-releasing hormone (GnRH) for the treatment of severely symptomatic adenomyosis. Methods: Between August 2008 and May 2011, we prospectively observed 33 patients who underwent laparoscopic or robotic adenomyomectomy with uterine artery ligation for the treatment of symptomatic adenomyosis. Seventeen patients (52%) received 3-course GnRH agonist treatment after the adenomyomectomy. Results: The mean operating time was 147.4 +/- 52.0 min, and the mean blood loss was 36.1 +/- 37.4 ml. Postoperative complications occurred in 5 patients, including 4 cases of febrile morbidity, 1 case of ileus and 1 case of pelvic abscess. Patients had statistically significant symptom relief during the 3-year follow-up period. Four of the 33 patients (12%) showed symptom relapse; 3 patients showed a relapse with dysmenorrhea and 1 patient showed a relapse with menorrhagia. There were no significant differences in terms of therapeutic outcomes between surgical-only and surgical-medical treatment. Conclusion: Laparoscopic or robotic adenomyomectomy was feasible and safe for women with severely symptomatic adenomyosis who requested uterine preservation. Moreover, this procedure provided long-term symptom control, regardless of postoperative GnRH agonist administration. (C) 2016 S. Karger AG, Basel

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TC 14

Z9 15

U1 0

U2 5

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J9 GYNECOL OBSTET INVES

JI Gynecol.Obstet.Invest.

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PT J

AU Collins, GG

Gadzinski, JA

Fitzgerald, GD

Sheran, J

Wagner, S

Edelstein, S

Mueller, ER

AF Collins, Gretchen G.

Gadzinski, Jill A.

Fitzgerald, Garrett D.

Sheran, Jordan

Wagner, Sarah

Edelstein, Steven

Mueller, Elizabeth R.

TI Surgical Pain Control With Ropivacaine by Atomized Delivery (Spray): A

Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Hysterectomy; Pain; Ropivacaine

ID LAPAROSCOPIC CHOLECYSTECTOMY; DOUBLE-BLIND; POSTOPERATIVE PAIN;

BUPIVACAINE; SACROCOLPOPEXY; INSTILLATION; HYSTERECTOMY; REDUCTION;

INFUSION; SURGERY

AB Study Objective: To investigate the role of intraoperative atomized intraperitoneal ropivacaine (AIR) as an adjuvant to anesthetic agents at the time of minimally invasive pelvic surgery.

Design: Double-blind, randomized controlled trial.

Design: Classification: Randomized controlled trial (Canadian Task Force classification I).

Setting: Tertiary care teaching hospital.

Participants: Fifty-five patients who underwent laparoscopic and robotic gynecologic procedures.

Intervention: Patients received AIR or atomized intraperitoneal saline (AIS) (dose, 2 mg/kg) immediately after the initiation of pneumoperitoneum.

Measurements and Main Results: Visual analog scale (VAS) pain scores and narcotic use (in morphine equivalents) were collected and recorded at 2, 4, 8, and 12 hours postoperatively.

Results: Fifty-five patients completed the study protocol and data collection, with 30 patients allocated to the AIS group and 25 patients allocated to the AIR group. Demographic and surgical variables did not vary between the groups, with the exception of median operative duration. Postoperative VAS scores at 2, 4, 8, and 12 postoperative hours were higher in the AIS group, but the difference failed to reach statistical significance. Narcotic use was also similar in the 2 groups.

Conclusion: The use of intraperitoneal ropivacaine was not associated with a statistically significant difference in patients' postoperative VAS scores. Thus, in contrast to findings of similar studies performed in general surgery, AIR might not confer a benefit in women undergoing minimally invasive gynecologic procedures. Journal of Minimally Invasive Gynecology (C) 2016 AAGL. All rights reserved.

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Z9 12

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TI Robotic Hysterectomy in Severely Obese Patients With Endometrial Cancer:

A Multicenter Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Morbidity obese; Robotic hysterectomy

ID BODY-MASS INDEX; LYMPHADENECTOMY; OUTCOMES; SURGERY; IMPACT

AB Study Objective: The aim of this study was to evaluate the surgical and oncologic outcomes of robotic hysterectomy with or without or less pelvic and aortic lymphadenectomy in severely obese patients (body mass index [BMI] >= 40 kg/m(2)) with endometrial cancer.

Material and Methods: Between August 2010 and November 2014, patients with histologically confirmed endometrial cancer and BMI >= 40 kg/m(2) were deemed eligible for the study and underwent RH with or without pelvic and aortic lymphadenectomy.

Results: Seventy patients were divided into 3 groups according to their BMI: group A, BMI between 40 and 45 kg/m(2) (50 patients); group B, BMI between 45 and 50 kg/m(2) (10 patients); and group C, BMI above 50 kg/m(2) (10 patients). No significant statistical differences were found between the 3 groups in terms of operation time, blood loss, hospital stay, and oncologic results. Pelvic lymphadenectomy was performed in 42%, 30%, and 20% of patients in groups A, B, and C, respectively. An intraoperative complication occurred in 1 patient in group A, early postoperative complications in 4 patients in group A and in 1 patient in group C, and a late postoperative complication occurred in 1 patient in group A. No conversions to laparotomy were necessary; however, 3 patients underwent conversions to laparoscopy in group A and 1 patient in both groups B and C.

Conclusion: Our study showed that robotic surgery in severely obese patients with endometrial cancer is safe and feasible. Moreover, it seems that an increase in BMI does not change the surgical and oncologic outcomes. However, randomized controlled trials are needed to confirm these results. (C) 2016 AAGL. All rights reserved.

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ER

PT J

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TI Laparoscopic versus open sacrocolpopexy for treatment of prolapse of the

apical segment of the vagina: a systematic review and meta-analysis

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Apical prolapse; Laparoscopy; Robotic surgery; Sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; VAULT PROLAPSE; OUTCOMES; COST; HYSTERECTOMY;

SURGERY

AB Pelvic organ prolapse is showing an increasing prevalence (3 - 50 %). The gold standard treatment of apical prolapse is sacrocolpopexy which can be performed via minimal access (laparoscopy or robotics) or open approaches. The aim of this review was to appraise the effectiveness of minimal access surgery versus the open approach in the treatment of apical prolapse.

Keywords were searched in: CINAHL, MEDLINE, CENTRAL, Cochrane MDSG Trials Register, Cochrane Library, Current Controlled Trials, ClinicalTrials.gov, WHO International Trials Registry Platform search portal, LILACS, and Google Scholar databases. Data up to 31 April 2014 were considered. Randomized and nonrandomized controlled trials evaluating all women who underwent minimally invasive sacropexy (MISC) and open sacropexy (OSC) were included. A data extraction tool was used for data collection. MISC was compared with OSC using narrative analysis and meta-analysis (RevMan) where appropriate.

MISC and OSC were compared in 12 studies involving 4,757 participants. MISC and OSC were equally effective in terms of point-C POP-Q measurements and recurrence rate. MISC was associated with a lower transfusion rate (odds ratio 0.41, 95 % CI 0.20 - 0.83), shorter length of hospital stay (mean difference -1.57 days, 95 % CI -1.91 - -1.23 days), and less blood loss (mean difference -113.27 mL, 95 % CI -163.67 - -62.87 mL) but a longer operating time (mean difference 87.47, 95 % CI 58.60 - 116.34, p < 0.0001).

MISC showed similar anatomic results to OSC with a lower transfusion rate, shorter length of hospital stay and less blood loss. The rate of other complications was similar between the approaches. Cautious interpretation of results is advised due to risk of bias caused by the inclusion of nonrandomized studies.

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TC 63

Z9 63

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U2 4

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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PT J

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Moller, Ann M.

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TI Health-related quality of life after robotic-assisted laparoscopic

hysterectomy for women with endometrial cancer - A prospective cohort

study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Hysterectomy; Quality of life; Endometrial neoplasms;

Patient-reported outcome measures

ID PATIENT-REPORTED OUTCOMES; SURGERY; CONSEQUENCES; LYMPHEDEMA; SURVIVORS;

IMPACT; TRIALS

AB Objective. The aim of this prospective cohort study using patient-reported outcome measures (PROMs) was to detect short term changes in functioning, symptoms and health-related quality of life (HRQoL) after roboticassisted laparoscopic hysterectomy (RALH) for endometrial cancer or atypical complex hyperplasia.

Methods/materials. A total of 139 women answered the EORTC C-30, EN-24 and EQ-5D-3L preoperatively (baseline) by face to face interview and again 1 week, 5 weeks and 4 months postoperatively by telephone interview. The women furthermore reported their level of activity compared to their habitual level in a diary during the first 5 weeks after surgery.

Results. We found a clinically relevant decrease in HRQoL after 1 week. At 5 weeks postoperatively, HRQoL was again at the preoperative level. Fatigue, pain, constipation, gastrointestinal symptoms, and appetite were all negatively affected 1 week postoperatively, but back to baseline level at 5 weeks. Ability to perform work or hobbies and change of taste were still affected at 5 weeks.

Conclusions. HRQoL and postoperative symptoms were overall back to the preoperative level 5 weeks after.RALH. These findings indicate fatigue, pain, constipation, gastrointestinal symptoms, appetite, ability to perform work and hobbies, change of taste and sexually related problems should be addressed in future research and in the pre- and postoperative care for women undergoing RALH. (c) 2015 Elsevier Inc. All rights reserved.

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SC Oncology; Obstetrics & Gynecology

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PT J

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TI Patterns of recurrence and survival after abdominal versus

laparoscopic/robotic radical hysterectomy in patients with early

cervical cancer

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE Intracorporeal colpotomy; intraperitoneal spread; laparoscopic; robotic

radical hysterectomy; vaginal colpotomy

ID VAGINAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY; PROGNOSTIC-FACTORS;

STAGE-IB; ADENOCARCINOMA; LAPAROSCOPY; OUTCOMES; PNEUMOPERITONEUM;

EXPERIENCE; CARCINOMA

AB AimThis study investigates the pattern of disease recurrence and identifies the clinicopathologic prognostic factors for patients with International Federation of Gynecology and Obstetrics (FIGO) stage IB and IIA cervical carcinoma treated with laparoscopic/robotic radical hysterectomy (LRH/RRH).

MethodsWe conducted a retrospective analysis of 128 patients with FIGO stage IB and IIA cervical cancer. Preoperative examination did not uncover definitive evidence of parametrial invasion or lymph node metastasis in any of the patients; therefore, all patients underwent LRH/RRH with retroperitoneal lymphadenectomy between April 2006 and December 2013. Sites of disease recurrence and all possible clinicopathologic factors related to the risk of disease recurrence were determined.

ResultsMultivariate analysis demonstrated that laparoscopic intracorporeal colpotomy (P<0.041, odds ratio 7.038, 95% confidence interval1.059-15.183) represented a strong prognostic factor related to disease recurrence. We categorized the minimally invasive surgery group into LRH through vaginal colpotomy (LRH-VC; 79 patients) and LRH/RRH through intracorporeal colpotomy (LRH/RRH-IC; 49 patients) according to the colpotomic approaches. Disease recurrence was higher in the LRH/RRH-IC group than in the LRH-VC group (16.3% vs 5.1%, P=0.057), with five patients in the LRH/RRH-IC group experiencing intraperitoneal spreads.

ConclusionsTotal laparoscopic/robotic intracorporeal colpotomy under CO2 pneumoperitoneum may carry a risk of positive vaginal cuff margin, as well as intraperitoneal tumor spreads in patients with early-stage cervical cancer treated with LRH/RRH.

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U1 0

U2 10

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JI J. Obstet. Gynaecol. Res.

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Pauls, Rachel

Eschenbacher, Michaela

Crisp, Catrina

TI The Impact of Robotic-Assisted Surgery on Training Gynecology Residents

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic hysterectomy; gynecology resident training

AB Introduction: To investigate the changes in surgical route of hysterectomy after implementation of robotics and to assess the impact on the surgical training of gynecology residents.

Methods: This was an institutional review board-approved retrospective analysis at 2 large academic community hospitals. Subjects undergoing hysterectomy during 2005 and 2011 were identified. A stratified random sample representative of the overall number of hysterectomies, 20 per month for each year, was obtained. Charts were reviewed for route of hysterectomy and resident involvement. Chi-square analysis was used for main outcomes.

Results: A total of 193 cases from 2005 and 146 cases from 2011 were included. A significant decline in vaginal hysterectomies was noted from 2005 to 2011: 62.2% (n = 120) to 27.4% (n = 40) (P < 0.001). Laparoscopic hysterectomies also declined from 30.1% to 19.9% during the same period (P < 0.026). In addition, although no robotic hysterectomies were performed in 2005, by 2011, this approach accounted for more than one fourth of all such surgeries. Of all cases examined, 40 in 2005 and 45 in 2011 were not attended by a resident. In 2005, 52% (21 of 40) of the uncovered cases were vaginal hysterectomies. However, in 2011, 55% (25 of 45) of the uncovered cases were robotic-assisted and only 11% (5 of 45) were vaginal hysterectomies.

Conclusions: The resultant decline in vaginal and laparoscopic hysterectomies coupled with an additional procedure to master places an increased burden on training programs. Although the impact of the changes on surgical competency is not yet known, our results identify potential areas for focus in training to ensure surgically competent physicians.

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NR 3

TC 8

Z9 8

U1 0

U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Oktay, K

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Pacheco, F

Turan, V

Emirdar, V

AF Oktay, Kutluk

Bedoschi, Giuliano

Pacheco, Fernanda

Turan, Volkan

Emirdar, Volkan

TI First pregnancies, live birth, and in vitro fertilization outcomes after

transplantation of frozen-banked ovarian tissue with a human

extracellular matrix scaffold using robot-assisted minimally invasive

surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE AlloDerm; fertility preservation; in vitro fertilization; ovarian

cryopreservation and transplantation; robotic surgery; translational

research

ID FERTILITY PRESERVATION; ENDOCRINE FUNCTION; CHEMOTHERAPY;

CRYOPRESERVATION; RESTORATION; AUTOTRANSPLANTATION; WORLDWIDE; HORMONE;

RESERVE; PATIENT

AB BACKGROUND: Ovarian tissue cryopreservation is an experimental fertility preservation method and the transplantation techniques are still evolving.

OBJECTIVE: We attempted to improve the technique with the utility of a human decellularized extracellular tissue matrix (ECTM) scaffold, robot-assisted minimally invasive surgery, and perioperative pharmacological support.

STUDY DESIGN: We prospectively studied 2 subjects with hemophagocytic lymphohistiocytosis (patient A) and non-Hodgkin lymphoma (patient B) who underwent ovarian tissue cryopreservation at the age of 23 years, before receiving preconditioning chemotherapy for hematopoietic stem cell transplantation. Both experienced ovarian failure postchemotherapy and we transplanted ovarian cortical tissues to the contralateral menopausal ovary 7 and 12 years later, using a human ECTM scaffold and robotic assistance. The ECTM scaffold tissue compatibility was shown in preclinical studies. Patients also received estrogen supplementation and baby aspirin preoperatively to aid in the revascularization process.

RESULTS: Ovarian follicle development was observed approximately 10 (patient A) and 8 (patient B) weeks after ovarian tissue transplantation. Following 8 and 7 cycles of in vitro fertilization, 9 and 10 day-3 embryos were cryopreserved (patients A and B, respectively). While the baseline follicle-stimulating hormone (range 3.6-15.4 mIU/mL) levels near normalized by 7 months and remained steady postovarian transplantation in patient A, patient B showed improved but elevated follicle-stimulating hormone levels throughout (range 21-31 mIU/mL). Highest follicle yield was achieved 14 (8 follicles; patient A) and 11 (6 follicles; patient B) months postintervention. Patient A experienced a chemical pregnancy after the third frozen embryo transfer attempt. She then conceived following her first fresh in vitro fertilization embryo transfer and the pregnancy is currently ongoing. Patient B conceived after the first frozen embryo transfer attempt and delivered a healthy girl at term.

CONCLUSION: We report the first pregnancies after the minimally invasive transplantation of previously cryopreserved ovarian tissue with an ECTM scaffold. This approach seems to be associated with steady ovarian function after a follow-up of up to 2 years.

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NR 31

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Z9 93

U1 0

U2 20

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ER

PT J

AU Prendergast, E

Silver, H

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Kielb, S

Hairston, J

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Johnson, Lisa Labin

Simon, Melissa

Feinglass, Joseph

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TI Anatomic Outcomes of Robotic Assisted Supracervical Hysterectomy and

Concurrent Sacrocolpopexy at a Tertiary Care Institution at Initial

Adaptation of the Procedure

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; robotic assisted supracervical hysterectomy;

sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; LONG-TERM OUTCOMES; QUALITY-OF-LIFE; LAPAROSCOPIC

SACROCOLPOPEXY; ABDOMINAL SACROCOLPOPEXY; UNITED-STATES; MANAGEMENT;

SURGERY

AB Objective: The aim of the study was to review anatomic and surgical outcomes of robotic-assisted supracervical hysterectomy (RASCH) with concurrent sacrocolpopexy in the treatment of primary pelvic organ prolapse (POP) on initial adaption of this procedure.

Study Design: A retrospective chart review of patients undergoing RASCH with concurrent sacrocolpopexy between 2009 and 2012 was performed at a tertiary care academic institution, after initial adaption of this procedure. The primary outcome was change in vaginal support (assessed with the pelvic organ prolapse quantification [POP-Q]) at 3 months and 1 year postoperatively. Secondary measures assessed included estimated blood loss, operative times, hospital length of stay, and operative complications.

Results: Forty patients (N = 40) underwent RASCH with concurrent sacrocolpopexy. Twenty-six patients (65%) had preoperative stage II POP, and 35% had stage III POP. Three months after undergoing the procedure, 55% had achieved stage 0 POP. An additional 35% were categorized as stage I POP. At 1 year, 72.7% were stage I POP or lower. The mean (SD) operating time was 275 (82.3) minutes. Estimated blood loss and mean (SD) length of hospital stay were 163 (114.9) mL and 1.3 (0.8) days, respectively. There were no intensive care unit admissions. The most common postoperative complication was immediate urinary retention in 10% of patients; all cases resolved with time-limited intermittent self-catheterization.

Conclusions: Even with initial adaptation of the procedure, RASCH with concurrent sacrocolpopexy for the repair of primary POP is effective in restoring anatomic support in the short term. Operative complications are minimal.

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NR 30

TC 5

Z9 5

U1 0

U2 5

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ER

PT J

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Petko, Maciej

Kobus, Konrad

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Golabek, Tomasz

Chlosta, Piotr

Basta, Antoni

TI Regenerative medicine-techniques and methods of administering autologous

derived stem cells in urinary incontinence

SO GINEKOLOGIA POLSKA

LA English

DT Review

DE stem cells; stress urinary incontinence; endoscopy; robotic systems

ID 1-YEAR FOLLOW-UP; POSTPROSTATECTOMY INCONTINENCE; PERIURETHRAL

INJECTION; SURGICAL-TREATMENT; PROSTATECTOMY; DIAGNOSIS; MYOBLAST;

THERAPY

AB The aim of the work is to present regenerative medicine achievement as an alternative SUI treatment and the variety of injected cells type as well as injection techniques itself with the analysis of their quality and possible the mechanism in which they reduce urinary incontinence symptoms.

For over a decade numerous authors declare use of different type of autologous mesenchymal-derived stem cells (AMDC) in male and female SUI. The leakage improvement reached 80%, despite the number of injected cells as well as the injection technique. Important subject in the AMDC treatment is the precise cell material injection into the selected spot which might be possible with the use of the endoscopic assisting robot.

The robotic supported system for cells procedure might bring the missing percentage in reaching the goal in SUI treatment.

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NR 25

TC 2

Z9 2

U1 1

U2 5

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J9 GINEKOL POL

JI Ginekol. Pol.

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OA gold, Green Submitted

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ER

PT J

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Richard, T

Robinson, PS

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AF Barron, Kenneth I.

Richard, Tere

Robinson, Patricia S.

Lamvu, Georgine

TI Association of the US Food and Drug Administration Morcellation Warning

With Rates of Minimally Invasive Hysterectomy and Myomectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID LAPAROSCOPIC MYOMECTOMY; POWER

AB OBJECTIVE:To evaluate whether there was a change in surgical practice immediately after the U.S. Food and Drug Administration (FDA) warning statement discouraging the use of power morcellation in the surgical treatment of uterine leiomyomas.METHODS:We performed a time-series analysis. Surgical case logs from the Florida Hospital operating room documentation system were used to retrospectively identify patients who underwent a hysterectomy or myomectomy between August 1, 2013, and December 31, 2014. Cases performed during the 8 months before the FDA announcement on April 17, 2014, were compared with cases performed during the 8 months after the FDA announcement. Six hospitals and 98 surgeons were included. We compared the proportion of minimally invasive surgery cases (vaginal, laparoscopic, or robotic-assisted) for each study period.RESULTS:There was a 5.8% decrease in minimally invasive hysterectomies after the FDA warning statement (85.7% [1,451/1,694] compared with 79.9% [1,350/1,690]; P<.001) and an 8.7% decrease when oncologist cases were excluded (90.2% [985/1,092] compared with 81.5% [834/1,023]; P<.001). There was a 19% decrease in minimally invasive myomectomies (62.7% [64/102] compared with 43.7% [38/87]; P=.009). Analysis by subspecialty showed a significant decrease in minimally invasive hysterectomies by obstetrician-gynecologists (ob-gyns) and minimally invasive gynecologic specialists but not urogynecologists or oncologists and a significant decrease in minimally invasive myomectomies by reproductive endocrinologists and minimally invasive gynecologic specialists but not ob-gyns.CONCLUSION:There was a significant decrease in the proportion of minimally invasive hysterectomies and myomectomies performed during the 8 months after the FDA warning statement on the use of power morcellation.LEVEL OF EVIDENCE:II

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NR 17

TC 54

Z9 55

U1 0

U2 2

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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GA CW9EQ

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ER

PT J

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Kamath, MS

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Kamath, Mohan S.

TI Review of nonsurgical/minimally invasive treatments and open myomectomy

for uterine fibroids

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE hysteroscopic myomectomy; laparoscopic myomectomy; magnetic

resonance-guided focused ultrasound; radiofrequency ablation; uterine

artery embolization

ID VOLUMETRIC THERMAL ABLATION; FOCUSED ULTRASOUND SURGERY; ARTERY

EMBOLIZATION; LAPAROSCOPIC MYOMECTOMY; HYSTEROSCOPIC MYOMECTOMY;

RADIOFREQUENCY MYOLYSIS; COST-EFFECTIVENESS; OUTCOMES; PREGNANCY; TRIAL

AB Purpose of reviewThe main purpose of this review is to collect the most recent evidence with regards to safety and effectiveness of the nonsurgical and minimally invasive treatment options for uterine fibroids.Recent findingsAmong the nonsurgical options, uterine artery embolization (UAE), and in eligible patients, magnetic resonance-guided high-intensity focused ultrasound (MRgFUS) are emerging as effective alternatives to surgical options for treatment of symptomatic fibroids. MRgFUS is comparable to UAE, and appears to be a cost effective treatment option, especially in older women, although long-term data are awaited. The transvaginal route for radiofrequency ablation is a promising new nonsurgical alternative, which needs to be studied in larger trials to establish its safety and efficacy.The laparoscopic myomectomy results in less postoperative pain, reduced febrile morbidity, and shorter hospital stay when compared with open laparotomy. The newer robotic approach is comparable to traditional laparoscopic technique in short surgical outcomes but is associated with higher costs. Hysteroscopic myoma resection is an effective surgical intervention for submucous fibroids and prior misoprostol use can help in reducing cervical lacerations.SummaryUAE and MRgFUS can be offered as an alternative nonsurgical option for eligible women with symptomatic fibroids. Laparoscopic myomectomy remains a safe and effective surgical option with advantage of less postoperative pain and faster recovery compared with open laparotomy for women who wish to retain their fertility options.

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NR 53

TC 21

Z9 25

U1 0

U2 7

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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PT J

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Yen, CF

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Su, Hsuan

Han, Chien-Min

Huang, Chen-Ying

Yen, Chih-Feng

TI Robot-assisted natural orifice transluminal endoscopic surgery for

hysterectomy

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE robot; NOTES; hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; FEASIBILITY; OUTCOMES; CANCER

AB Objective: To describe the surgical procedures of robot-assisted natural orifice transluminal endoscopic surgery (NOTES) for hysterectomy and to evaluate its feasibility.

Materials and methods: From December 2014 to February 2015, four patients with benign diseases who were eligible for robot-assisted NOTES at Chang Gung Memorial Hospital were recruited to this study. Intraoperative and postoperative surgical outcomes were evaluated.

Results: Robot-assisted NOTES hysterectomy was successfully performed in all these patients. None of the patients had vaginal delivery, with two being nulliparous. The mean standard error of the mean uterine weight was 365.5 +/- 69.2 g, the mean operative time was 198.8 +/- 39.0 minutes, the mean docking time was 38.3 +/- 2.4 minutes, the mean blood loss was 180.0 +/- 56.1 mL, and the mean postoperative hospital stay was 2.5 +/- 0.3 days. The final pathologic diagnoses were adenomyosis and/or leiomyomas.

Conclusion: The novel robot-assisted NOTES technology created scarless skin wounds. More importantly, the device allows the surgeon to reach deeper places to achieve hemostasis, and perform surgery on larger tumors using the curved cannulae-wristed instrument. However, its implementation is limited by the lack of appropriate instrumentation, which requires further development and break through. At this stage, robot-assisted NOTES is only useful for limited applications in highly selected patients. Copyright (C) 2015, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. All rights reserved.

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NR 22

TC 17

Z9 23

U1 0

U2 6

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JI Taiwan. J. Obstet. Gynecol.

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OA gold

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ER

PT J

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Flowerdew, Gordon

TI Urinary Tract Injury at Benign Gynecologic Surgery and the Role of

Cystoscopy <i>A Systematic Review and Meta-analysis</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Review

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; IDENTIFY URETERAL INJURY; SUPRACERVICAL

HYSTERECTOMY; PERIOPERATIVE OUTCOMES; UTERINE PATHOLOGIES;

COMPLICATIONS; MORBIDITY; SACROCOLPOPEXY; MULTICENTER; EXPERIENCE

AB OBJECTIVE:To calculate the rates of urinary tract injury detected during and after benign gynecologic surgery. To explore the role of routine intraoperative cystoscopy and determine if it helps in reducing injuries detected postoperatively.DATA SOURCES:We conducted a literature search for urinary tract injuries at benign gynecologic surgery in PubMed, EMBASE, ClinicalTrials.gov, and Web of Science from January 2004 to August 2014. We combined our results with a database from a previously published systematic review to include earlier studies.METHODS OF STUDY SELECTION:A total of 79 studies met our inclusion criteria. Excluded were letters to the editor, studies involving only selective cystoscopy in higher risk patients, case reports, and reports that included injuries resulting from obstetric or oncologic procedures.TABULATION, INTEGRATION, AND RESULTS:Data from each report were classified according to type of surgery into vaginal hysterectomy, abdominal hysterectomy, laparoscopic hysterectomy, other (nonrobotic) gynecologic and urogynecologic surgery, robotic hysterectomy, and other robotic gynecologic and urogynecologic surgery. We determined the ureteric and bladder injury rates for each surgery type from studies in which routine intraoperative cystoscopy was performed and separately from studies in which it was not performed. Intraoperatively detected rates of ureteric and bladder injury were markedly higher with routine intraoperative cystoscopy. We obtained an adjusted ureteric injury rate of 0.3% and a bladder injury rate of 0.8%. The estimated postoperative ureteric injury detection rates per 1,000 surgeries were 1.6 without routine cystoscopy and 0.7 with routine cystoscopy. Postoperative bladder injury detection rates per 1,000 surgeries were 0.8 without routine cystoscopy and 1.0 with routine cystoscopy.CONCLUSION:Although routine cystoscopy clearly increases the intraoperative detection rate of urinary tract injuries, this systematic review of 79 mostly retrospective studies shows that it does not appear to have much effect on the postoperative injury detection rate.

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NR 44

TC 91

Z9 97

U1 0

U2 8

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J9 OBSTET GYNECOL

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WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

AU Chan, JK

Gardner, AB

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Thompson, CA

Blansit, K

Yu, XH

Kapp, DS

AF Chan, John K.

Gardner, Austin B.

Taylor, Katie

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Blansit, Kevin

Yu, Xinhua

Kapp, Daniel S.

TI Robotic versus laparoscopic versus open surgery in morbidly obese

endometrial cancer patients - A comparative analysis of total charges

and complication rates

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Morbid obesity; Robotic surgery; Laparoscopic

surgery; Surgical complications; Hospital charges

ID BODY-MASS INDEX; SURGICAL OUTCOMES; ECONOMIC-ANALYSIS; ASSISTED SURGERY;

UNITED-STATES; STATISTICS; IMPUTATION; LAPAROTOMY; IMPACT; COST

AB Objective. To compare the complications and charges of robotic vs. laparoscopic vs. open surgeries in morbidly obese patients treated for endometrial cancer.

Methods. Data were obtained from the Nationwide Inpatient Sample from 2011. Chi-squared, Wilcoxon rank sum two-sample tests, and multivariate analyses were used for statistical analyses.

Results. Of 1087 morbidly obese (BMI L-40 kg/m(2)) endometrial cancer patients (median age: 59 years, range: 22 to 89), 567 (52%) had open surgery (05), 98 (9%) laparoscopic (LS), and 422(39%) robotic surgery (RS). 23% of OS, 13% of LS, and 8% of RS patients experienced an intraoperative or postoperative complication including: blood transfusions, mechanical ventilation, urinary tract injury, gastrointestinal injury, wound debridement, infection, venous thromboembolism, and lymphedema (p < 0.0001). RS and IS patients were less likely to receive blood transfusions compared to OS (5% and 6% vs. 14%, respectively; p < 0.0001). The median lengths of hospitalization for OS, IS, and RS patients were 4, 1, and 1 days, respectively (p <0.0001). Median total charges associated with OS, IS, and RS were $39,281, $40,997, and $45,030 (p = 0.037), respectively.

Conclusions. In morbidly obese endometrial cancer patients, minimally invasive robotic or laparoscopic surgeries were associated with fewer complications and less days of hospitalization relative to open surgery. Compared to laparoscopic approach, robotic surgeries had comparable rates of complications but higher charges. 2015 Published by Elsevier Inc.

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GA CV9PO

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ER

PT J

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Gargiulo, AR

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TI Flexible Carbon Dioxide Laser Fiber Versus Ultrasonic Scalpel in

Robot-Assisted Laparoscopic Myomectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Carbon dioxide laser; Laparoscopic myomectomy; Robot-assisted

myomectomy; Ultrasonic scalpel

ID CO2-LASER; ELECTROSURGERY; MONOPOLAR; COMPLICATIONS; DIATHERMY; TISSUE;

MILD

AB Study Objective: To compare the effectiveness and safety of a flexible carbon dioxide (CO2) laser fiber to the ultrasonic scalpel when employed through a robotic surgical system.

Design: Retrospective cohort study.

Design Classification: Level II-2 evidence.

Setting: Reproductive surgery practice at an academic hospital.

Patients: Two hundred thirty-six women who had undergone robot-assisted laparoscopic myomectomy with either CO2 laser (n = 85) or the ultrasonic scalpel (n = 151).

Interventions: Robot-assisted laparoscopic myomectomy employing either a flexible CO2 laser fiber or a robotic ultrasonic scalpel as the primary energy tool.

Measurements and Main Results: Perioperative outcomes (estimated blood loss, operative time, length of hospital stay) of patients undergoing robot-assisted myomectomy with a flexible laser fiber or ultrasonic scalpel. Estimated blood loss and operative time were comparable (p = .95 and p = .55, respectively) between the 2 groups after adjusting for all confounders, whereas length of hospital stay remained significantly different (p = .004). Odds ratio for complications was 0.35 (95% confidence interval 0.08-1.56; p = .17), which denotes no difference in the risk for complications between the 2 groups.

Conclusion: Robot-assisted laparoscopic myomectomy with a flexible CO2 laser fiber is safe and has comparable operative outcomes to the ultrasonic scalpel. The small size and flexibility of this device allows robotic surgeons to employ safe focal energy without sacrificing operative ergonomics. (C) 2015 AAGL. All rights reserved.

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ER

PT J

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AF Hoste, Griet

Van Trappen, Philippe

TI Robotic hysterectomy using the Vessel Sealer for myomatous uteri:

technique and clinical outcome

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Robotic; Hysterectomy; Sealing devices; Vessel Sealer; Myomatous uteri;

Benign gynaecology

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; PERIOPERATIVE

OUTCOMES; LEARNING-CURVE; SURGERY

AB Objective: Robotic procedures using the Vessel Sealer are not well reported in the literature, especially given the advantages of sealing devices already studied in standard laparoscopic procedures. This study reports our experience with the EndoWrist (R) One (TM) Vessel Sealer in robotic hysterectomy for myomatous uteri.

Study design: In this retrospective cohort study of the first 50 consecutive patients with myomatous uteri undergoing a robotic hysterectomy, we report our experience with the EndoWrist (R) One (TM) Vessel Sealer (Intuitive Surgical Inc., Sunnyvale, CA) during this procedure. The learning curve was evaluated, and the operative times as well as the complications were recorded.

Results: After the first 10 cases, the median console and total (skin-to-skin) operative time dropped significantly from 110 to 60 min and from 158 to 105 min, respectively (p = 0.018 and p = 0.008 respectively). The body mass index (<= or >30 kg/m(2)), uterine weight (<= or >250 g), and uterine size had no statistical significant effect on the total operative time. Median blood loss during surgery was 63 mL in all cases (range: 0-400 mL). The morbidity was low, and approximately 50% of cases could be discharged from the hospital after one to two days.

Conclusion: Robotic hysterectomy using the Vessel Sealer has, after a short learning curve of 10 cases, similar operative times than other published reports on robotic hysterectomy or laparoscopic hysterectomy using a sealing device for myomatous or large uteri. (C) 2015 Elsevier Ireland Ltd. All rights reserved.

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PT J

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AF Liu, Zhongyu

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TI Robotic nerve-sparing radical hysterectomy for locally advanced cervical

cancer after neoadjuvant chemotherapy

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Cervical cancer; Neoadjuvant chemotherapy; Nerve-sparing; Pelvic

lymphadenectomy; Radical hysterectomy; Robotic surgery

ID CARCINOMA; FEASIBILITY; LAPAROSCOPY

AB Objective: To evaluate the feasibility and safety of robotic nerve-sparing radical hysterectomy for locally advanced cervical cancer (LACC). Methods: In a retrospective study, data were analyzed for patients treated for cervical cancer at a center in Beijing, China, between December 2011 and September 2013. Patients were subdivided into those with early-stage disease (FIGO stage IA2-IB1) who were treated by robotic surgery (group 1), and those with LACC (stage IB2-IIB) who were treated by robotic surgery after neoadjuvant chemotherapy (NACT; group 2). Therapeutic outcomes and complications were compared. Results: Group 1 included 32 patients and group 2 included 22 patients. Two patients in group 2 did not respond to NACT and did not undergo surgery. The operative outcomes and incidences of complications did not differ significantly between the two groups (P> 0.05 for all). There were no differences in nodal yield, lengths of parametrium removed, or vaginal cuff length (P> 0.05 for all). During a mean follow-up of 26 months, no patient experienced recurrence. Conclusion: Robotic nerve-sparing radical hysterectomy was found to be feasible and safe for LACC after NACT. A larger case series with longer follow-up data is needed to justify its widespread application. (C) 2015 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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U2 6

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ER

PT J

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Finamore, PS

AF Martin, Lindsay Ann

Calixte, Rose

Finamore, Peter S.

TI Reoperation After Robotic and Vaginal Mesh Reconstructive Surgery <i>A

Retrospective Cohort Study</i>

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE transvaginal; mesh; robotic; sacrocolpopexy; pelvic organ prolapse

ID SACROCOLPOPEXY; PROLAPSE

AB Objectives: Our primary objective was to compare reoperations after robotic-assisted sacrocolpopexy and transvaginal mesh for apical prolapse repair. Our secondary aim was to record perioperative complications after robotic and vaginal surgeries.

Methods: We reviewed medical records of women who underwent vaginal apical mesh support procedures or robotic sacrocolpopexy at Winthrop University Hospital between August 2009 and August 2013. We compared reoperations and perioperative complications between the 2 groups.

Results: There were 245 eligible cases during the 4-year study period. One hundred eighty-one women underwent robotic-assisted sacrocolpopexy and 64 women underwent transvaginal mesh. Women who underwent robotic surgery were younger and had decreased blood loss. Patients were followed up for a median of 3 months after robotic surgery and 11.5 months after transvaginal mesh. We found no difference in overall rate of reoperation between robotic and transvaginal mesh repair for apical prolapse. Specifically, there was no difference in the rate of reoperation for mesh exposure.

Conclusions: Despite recent controversies, transvaginal mesh offers the benefit of an effective minimally invasive procedure with shorter operative times, and may not pose additional risk for reoperation when compared to robotic-assisted sacrocolpopexy.

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Z9 3

U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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Garely, Alan

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Ascher-Walsh, Charles

TI Patient Preferences for Abdominal Incisions Used for Pelvic Organ

Prolapse Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE abdominal incisions; cosmetic; surgical approach; urogynecology

ID SACROCOLPOPEXY

AB Objectives Approaches for performing sacrocolpopexy (laparotomy, laparoscopy, and robotically assisted) differ with regard to length of surgery, postoperative pain, and cosmetic appearance of skin incisions. The aim of our study is to better understand what factors influence patient preferences for surgical approach.

Methods A cross-sectional study was performed using a survey. Females 18 years or older presenting to gynecologic offices were asked to complete a survey that included photographs of patient incisions 6 weeks postoperatively along with a schematic representation of each incision type (laparotomy with low transverse incision, traditional laparoscopy, and robotically assisted). Patients were first asked to rank each incision based on cosmetic appearance only. They were next given varying clinical scenarios associated with each surgical approach and asked if their preference of incision changed. A sample size of 90 subjects was needed in order to detect a 30% difference in incision preference based on appearance with an of 0.05 and 80% power.

Results One hundred fifty patients completed the survey. Based on cosmetic appearance alone, 70% chose laparoscopic surgery, 23% chose open, and 7% chose the robotic approach (P < 0.0001). The majority of the subjects would not change their incision preference of laparoscopy based on differing scenarios of postoperative pain (62.6%), length of surgery (65.3%), and length of hospital stay (73.6%). When asked to rank factors important in decision making, complication rate (53.9%) and surgeon experience with the procedure (32.8%) were ranked as most important.

Conclusions Based on cosmetic appearance, patients prefer the laparoscopic approach for abdominal sacrocolpopexy for pelvic organ prolapse surgery. However, complication rates and surgeon experience with the procedure are important factors in the patient's decision making.

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Z9 5

U1 0

U2 3

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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Choi, Soo Beom

Kim, Deok Won

Kim, Young Tae

Kim, Sang Wun

Nam, Eun Ji

Cho, Hee Young

TI Exposure of Surgeons to Magnetic Fields during Laparoscopic and Robotic

Gynecologic Surgeries

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic gynecologic surgery; Magnetic field hazard; Robotic

gynecologic surgery; da Vinci Surgical System

ID ELECTROMAGNETIC-FIELDS; RISK; LEUKEMIA; CANCER

AB Study Objective: To measure and compare levels of extremely-low-frequency magnetic field (ELF-MF) exposure to surgeons during laparoscopic and robotic gynecologic surgeries.

Design: Prospective case-control study.

Design Classification: Canadian Task Force I.

Setting: Gynecologic surgeries at the Yonsei University Health System in Seoul, Korea from July to October in 2014.

Patients: Ten laparoscopic gynecologic surgeries and 10 robotic gynecologic surgeries.

Intervention: The intensity of ELF-MF exposure to surgeons was measured every 4 seconds during 10 laparoscopic gynecologic surgeries and 10 robotic gynecologic surgeries using portable ELF-MF measuring devices with logging capability.

Measurement and Main Results: The mean ELF-MF exposures were .1 +/- .1 mG for laparoscopic gynecologic surgeries and .3 +/- .1 mG for robotic gynecologic surgeries. ELF-MF exposure levels to surgeons during robotic gynecologic surgery were significantly higher than those during laparoscopic gynecologic surgery (p < .001) after adjustment for duration of measurement.

Conclusion: The present study demonstrated low levels of ELF-MF exposure to surgeons during robotic gynecologic surgery and conventional laparoscopic surgery, hoping to alleviate concerns regarding the hazards of MF exposure posed to surgeons and hospital staff. (C) 2015 AAGL. All rights reserved.

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PT J

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TI Robotic Shaving Technique in 25 Patients Affected by Deep Infiltrating

Endometriosis of the Rectovaginal Space

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Deep infiltrating endometriosis; Endometriotic nodules; Rectovaginal

septum; Robotic; Shaving

ID COLORECTAL ENDOMETRIOSIS; BOWEL RESECTION; LAPAROSCOPIC EXCISION; ENZIAN

CLASSIFICATION; ASSISTED LAPAROSCOPY; MANAGEMENT; FERTILITY; SURGERY

AB Minimally invasive surgery represents the gold standard for the management of deep infiltrating endometriosis (DIE) involving the rectovaginal septum (RVS). This analysis aimed to evaluate the feasibility of robotic-assisted laparoscopy (RAL) and clinical outcomes in terms of long-term complications, pain relief, and recurrence rate for the treatment of DIE of the RVS. A prospective cohort study of robotic procedures was performed between October 2010 and July 2014, including removal of endometriotic nodules from the RVS with rectal shaving alone or in combination with accessory procedures. In all cases, the revised American Society for Reproductive Medicine (rASRM) score for endometriosis was >40 points (stage IV). Twenty-five consecutive patients underwent RAL, with a successful complete nodule debulking by the wall shaving technique. Pathology confirmed the adequacy of the surgical specimen and the median largest endometriotic nodule was of 21 mm (range, 10-60 mm), with free margins in all cases. The median operative time from skin opening to closure was 174 minutes (range, 75-300 minutes), and blood loss was close to 0 mL. The median revised Enzian score for location A (RVS) was 2 (range, 1-3). The most frequent Enzian class was A2B0C0 (48%), followed by A3B0C0 (12%). In 3 cases (12%), partial vaginal resection was required to remove endometriotic nodules of the RVS (1 each in classes A3B0C1FI, A3B0C0FO, and A3B0C0). No intraoperative complications occurred. This series has a median long-term follow up of 22 months (range,, 6-50 months) currently available with an optimal operative time, demonstrating good long-term outcomes. Our data support robotics as a safe and attractive alternative for comprehensive surgical treatment of DIE. (C) 2015 AAGL. All rights reserved.

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TI Robot-Assisted Radical Hysterectomy in Cervical Carcinoma <i>The Belgian

Experience</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robot-assisted management; Cervical cancer; Radical hysterectomy

ID NEOADJUVANT CHEMOTHERAPY; PELVIC LYMPHADENECTOMY; LEARNING-CURVE;

CANCER; SURGERY; LAPAROSCOPY; ONCOLOGY; OUTCOMES

AB Objective The purpose of this study was to report the experience and oncological outcome of robot-assisted radical hysterectomies (RRHs) for cervical cancer performed in Belgium.

Methods Patients undergoing RRH for cervical cancer (n = 109) were prospectively collected between July 2007 and April 2014 in the 5 Belgian centers performing RRH for cervical cancer.

Results The median age of the patients was 46 years (range, 31-80 years). Histological types included squamous cell carcinoma in 61 patients, adenocarcinoma in 22 patients, adenosquamous in 8 patients, endometrioid carcinoma in 2 patients, and other types (n = 16). The International Federation of Gynecology and Obstetrics stage distribution was IA (n = 9), stage IB1 (n = 71), stage IB2 (n = 4), stage II (n = 24), and unknown (n = 1). Twenty-four patients received adjuvant therapy, 17 patients underwent radiochemotherapy, and 7 underwent adjuvant radiation. Eighteen patients relapsed, and 5 died of disease. The median follow-up was 27.5 months (range, 3-82 months). The 2- and 5-year overall survivals were 96% and 89%, respectively. The 2- and 5-year disease-free survivals (DFSs) were 88% and 72%, respectively. The 2-year DFS per stage was 100% for IA, 88% for IB1, 100% for IB2, and 83% for II. The 5-year DFS per stage was 100% for stage IA and 75% for IB1. The complications were as expected for radical hysterectomy.

Conclusions This series confirms the feasibility and safety of RRH not only in cervical cancer stage IA to IB1, but also after neoadjuvant chemotherapy in stage IB2 to IIB.

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TI Laparoscopic and robot-assisted hysterectomy for uterine cancer: a

comparison of costs and complications

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cancer; laparoscopy; robotic surgery; uterine cancer

ID ENDOMETRIAL CANCER; LEARNING-CURVE; SURGERY; LAPAROTOMY; ANESTHESIA;

OBESITY; SKILLS

AB OBJECTIVE: Increasingly, robotic surgery is being used for total hysterectomy, bilateral salpingo-oophorectomy, and lymph node dissection for uterine cancer. The purpose of this study was to compare the costs and complications among women undergoing robotic and laparoscopic hysterectomy for uterine cancer.

STUDY DESIGN: We carried out a cohort study using the Nationwide Inpatient Sample (NIS) database between 2008 and 2012 on all women diagnosed with uterine cancer, classifying women as either laparoscopically or robotically treated, excluding laparotomies or vaginal approaches. Logistic regression analyses were used to evaluate the adjusted effect of surgical approach on complication rates.

RESULTS: There were 10,347 women who underwent hysterectomies for uterine cancer either laparoscopically (39%) or robotically (61%). The rate of robotic surgery consistently increased over the 5 year period. Women undergoing robotic surgery had more comorbid conditions (diabetes, hypertension, cardiovascular disease, renal disease, obesity or morbid obesity, and pulmonary disease). In adjusted analyses, women undergoing robotic surgery were more likely to have a lymph node dissection (73.01% vs 66.04%; P < .0001) and an admission lasting <3 days (86.01% vs 82.5%; P < .0001) compared with those undergoing laparoscopic surgery. The composite endpoint of any complication was similar between both cohorts (20.56% robotic vs 21.00% laparoscopy). In overall and subset analyses, robotic surgery was more costly, with median charges of $38, 161.00 compared with $31, 476.00 in those undergoing laparoscopic surgery (P < .0001).

CONCLUSION: Despite the considerably greater burden of comorbidities in those undergoing robotic surgery compared with laparoscopy, the former have shorter hospital admissions, a greater rate of lymph node dissection, and similar postoperative morbidity and mortality, albeit at greater total cost.

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TI Hand-Assisted Robotic Surgery for Staging of Ovarian Cancer and Uterine

Cancers With High Risk of Peritoneal Spread <i>A Retrospective Cohort

Study</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic staging; Ovarian cancer; Uterine cancer; Hand-assisted robotic

surgery; Peritoneal spread

ID LAPAROSCOPIC SURGERY; LAPAROTOMY

AB Objective This study aimed to determine surgical outcomes related to hand-assisted robotic surgery (HARS) for staging of ovarian cancer and uterine cancers with high risk of peritoneal spread and compare them to laparotomy and standard robotic-assisted surgery.

Methods A retrospective cohort study of women undergoing staging for uterine and ovarian cancer between January 2011 and July 2013 at a major metropolitan teaching hospital was reviewed. Patients undergoing HARS were matched with patients undergoing staging laparotomy [exploratory laparotomy (XLAP)] for the same indications and with patients undergoing traditional robotic surgery (RS) for staging of endometrioid endometrial cancer. In HARS, a longer incision is used to allow palpation of the peritoneal surfaces, to exteriorize the small bowel, to examine the mesentery, and to perform omentectomy.

Results One hundred five patients were analyzed (15 HARS, 45 RS, 45 XLAP). Compared with XLAP, HARS was associated with decreased blood loss (200 vs 400 mL, P = 0.011) and shorter hospital stay (1 vs 4 days, P < 0.001). Patients who had undergone HARS had fewer major complications, but those results did not reach statistical significance (0% vs 27%, P = 0.063). Hand-assisted robotic surgery was associated with higher blood loss and length of stay as compared to robotic staging of endometrioid endometrial cancer (RS). Minor wound complications were also more common (27% vs 2%, P = 0.012).

Conclusions Hand-assisted robotic surgery allows for thorough visual and tactile assessment of peritoneal surfaces. It represents a safe alternative to laparotomy for staging of ovarian and uterine cancers with high risk of peritoneal spread. Long-term follow-up study is needed to determine oncologic adequacy of HARS.

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TI Robotic infrarenal paraaortic and pelvic nodal staging for endometrial

cancer: feasibility and lymphatic complications

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Endometrial cancer; robotic infrarenal paraaortic and pelvic

lymphadenectomy; lymphatic complications; robotic surgery; gyne-oncology

ID LONG-TERM MORBIDITY; AORTIC-LYMPHADENECTOMY; HYSTERECTOMY; LAPAROSCOPY;

METASTASIS; LYMPHEDEMA; SURVIVAL; RISK; DISSECTION; CARCINOMA

AB Introduction. This study was designed to evaluate the feasibility and lymphatic complications of robotic pelvic and infrarenal paraaortic lymphadenectomy in endometrial cancer patients. Material and methods. All patients diagnosed with high risk endometrial cancer during the study period were identified (n = 212). Clinical prospective data, with reassessment of lymphatic complications, was analysed for all cases (n = 140) planned for a complete robotic nodal staging. The outcome measures were: success rate of infrarenal paraaortic lymphadenectomy, the rate of lymphatic complications and factors associated with nodal yield. Results. Of the 212 women, an open or restricted robotic procedure was performed in 57 women (27%) and no operation in 15 (7%), the latter due to disseminated disease or comorbidity. In 140 women (66%) in whom staging was intended, the lymphadenectomy included the infrarenal area in 70%, was restricted to the inframesenteric area in 21% and aborted or incomplete in 9%. The median number of paraaortic nodes was 10 (range 2-39). An unsuccessful staging was associated with high BMI and the surgeon's inexperience. At 1 year, three patients (2%) had developed a grade two lower limb lymphedema. Eleven women (8%) demonstrated pelvic lymphocysts; seven (64%) resolved spontaneously. Only one paraaortic lymphocyst was found; this required drainage. No cases of chylous ascites occurred. Conclusions. An infrarenal robotic paraaortic lymphadenectomy is feasible in 70% of high risk endometrial cancer cases when intended (88% in non-obese patients operated by experienced surgeons), but is restricted in obese patients and by surgeon's inexperience.

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PT J

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TI Apical prolapse repair: weighing the risks and benefits

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE apical prolapse; apical support; sacrocolpopexy; sacrospinous colpopexy;

uterosacral colpopexy

ID ROBOT-ASSISTED SACROCOLPOPEXY; ABDOMINAL SACRAL COLPOPEXY; VAGINAL VAULT

PROLAPSE; PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; LIGAMENT

SUSPENSION; TERM OUTCOMES; FIXATION; ILIOCOCCYGEUS; COLPOCLEISIS

AB Purpose of review

This article reviews the current literature regarding surgical repair of vaginal apical prolapse and discusses the risks and benefits of various surgical approaches.

Recent findings

Vaginal uterosacral ligament suspension has similar anatomic and subjective outcomes to sacrospinous ligament fixation at 1 year. Native tissue vaginal repairs offer decreased morbidity compared with mesh-augmented sacrocolpopexy; however, sacrocolpopexy has greater anatomic success. Minimally invasive sacrocolpopexy appears to be equivalent to open abdominal sacrocolpopexy. Native tissue repairs and transvaginal mesh kits support the vaginal apex with similar results; however, long-term follow-up is needed. Robotic and laparoscopic sacrocolpopexy are equally effective in restoring the vaginal apex.

Summary

Surgical restoration of the vaginal apex can be accomplished via a variety of approaches and techniques. When deciding on the proper surgical intervention, the surgeon must carefully calculate the risks and benefits of each procedure while incorporating the patient's individual medical and surgical risk factors. Lastly, a discussion regarding the patient's overall goals of care is paramount to the decision-making process.

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TI Tele lap Alf-X-Assisted Laparoscopy for Ovarian Cyst Enucleation: Report

of the First 10 Cases

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Ovarian cyst; Robotic surgery; Telelap ALF-X

ID HYSTERECTOMY; ROBOT

AB This prospective single-institutional clinical trial sought to assess the safety and feasibility of laparoscopic benign ovarian cyst enucleation with a novel robotic-assisted laparoscopic system. Here we report a series of 10 patients treated using the Telelap ALF-X system in the first clinical application on patients at the Division of Gynecologic Oncology, Catholic University of the Sacred Heart of Rome. The primary inclusion criterion was the presence of monolateral ovarian cyst without a preoperative assessment suspicious for malignancy. Intraoperative data, including docking time, operative time, estimated blood loss, intraoperative and perioperative complications, and conversion to either standard laparoscopy or laparotomy, were collected. The cysts were removed with an ovary-sparing technique with respect to conservative surgical principles. The median operative time was 46.3 minutes, and patients without postoperative complications were discharged at 1 or 2 days after the procedure. Telelap ALF-X laparoscopic enucleation of benign ovarian cysts with an ovary-sparing technique is feasible, safe, and effective; however, more clinical data are needed to determine whether this approach can offer any other benefits over other minimally invasive surgical techniques. (C) 2015 AAGL. All rights reserved.

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TI Improvement in quality of life after robotic surgery results in patient

satisfaction

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Gynecologic surgery; Minimally invasive surgery; Quality of life;

Patient reported outcomes; Robotic surgery

ID LAPAROSCOPIC HYSTERECTOMY; CANCER

AB Background. There are well-described benefits to minimally invasive surgery including decreased blood loss, shorter hospital-stay, and faster recovery. The role of robotic surgery in gynecologic oncology has become increasingly prominent; however limited data are available on quality of life (QOL) after robotic surgery.

Methods. In this prospective, IRB-approved study, women scheduled for robotic surgery for a gynecologic indication between May 2008 and February 2012 completed validated QOL measures at baseline, 6 weeks (6 wk), and 4 months postoperative (4 mo). Functional status (SF-12), symptom severity and interference (MDASI), sexual function (FSFI), and satisfaction with decision (SWD) were assessed at relevant time points. Differences between groups were evaluated using the Mann-Whitney test.

Results. Among 408 women who underwent robotic surgery 278 (68%) completed the QOL measures. Median age was 55.6 years (range 25.7-85.1). Median BMI was 31.3 kg/m(2). The majority of patients were white (75%). The most common indication for surgery was endometrial cancer/hyperplasia (59.7%). While physical functioning declined from baseline to 6 wk (51.4 to 41.6, p <0.001), it improved by 4 mo (53.5). Mental functioning improved over time (baseline 48.6, 6 wk 52.8, and 4 ma 55.6, p < 0.001). Symptom severity decreased over time (p <0.001) as did symptom interference (p <0.001). Sexual function improved significantly from baseline (8.6) to 4 ma (20.2, p <0.001). Patients were satisfied with their decision making (SWD = 30).

Conclusion. In this prospective study, general health, symptom burden and sexual function returned to or improved beyond baseline levels within 6 weeks of surgery. Overall, women were satisfied with their decision to undergo robotic surgery. (C) 2015 Elsevier Inc. All rights reserved.

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PT J

AU Backes, FJ

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TI Robotic Hysterectomy for Endometrial Cancer in Obese Patients With

Comorbidities <i>Evaluating Postoperative Complications</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Complications; Endometrial cancer; Minimally invasive surgery; Obesity;

Robotic hysterectomy; Robotic surgery

ID OUTCOMES; LIFE

AB Objectives The objective of this study is to determine (1) if there is a relationship between increasing body mass index (BMI) and postoperative complications in patients undergoing robotic hysterectomy for endometrial cancer and (2) if there are additional patient characteristics, specifically preoperative comorbidities, which increase the risk of postoperative complication

Methods A retrospective chart review was conducted on women who underwent a robotic staging surgery for endometrial cancer from 2006 to 2012. Basic demographics and preoperative and postoperative complications were extracted from the medical records. Obesity was divided into 4 categories, and complication rates were compared across these subgroups. Patients were also divided by the number of comorbidities and compared.

Results The cohort included 543 patients. The BMI ranged from 17.3 to 69.5 kg/m(2). Three hundred eighty patients (70%) were obese (BMI >30 kg.m(2)). One hundred ninety patients (35%) had no comorbidities other than obesity, and 180 patients (33%) had only 1 comorbidity other than obesity (Table 1). Postoperative complications occurred in 102 (18.7%) of the patients. Severe postoperative complications, including intensive care unit admission, reintubation, reoperation, and perioperative death, occurred in 14 patients (2.6%). Of the nonobese patients, 27 (16.5%) had postoperative complications; of the obese patients, 75 (19.7%) had a complication (P = 0.38). In patients with no comorbidities, 16.3% had a complication; 18% of patients with 1 to 2 comorbidities had a complication, and 28% of patients with 3 or more comorbidities had a complication (P = 0.08).

Conclusions The postoperative complication rate based on BMI or number of comorbidities was not statistically significant, but patients with greater number of comorbidities had an increased rate of postoperative complications. Patients with certain comorbidities, cardiac and renal specifically, had the highest rates of postoperative complications.

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Gardella, Barbara

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TI Barbed suture in minimally invasive hysterectomy: a systematic review

and meta-analysis

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Vaginal cuff closure; Laparoscopic hysterectomy; Robotically assisted

hysterectomy; Minimally invasive surgery; Barbed suture

ID VAGINAL CUFF CLOSURE; TOTAL LAPAROSCOPIC HYSTERECTOMY; DEHISCENCE;

EVISCERATION; INJURIES

AB Total laparoscopic or robotic hysterectomy represents one of the most performed gynecological procedures nowadays. Minimally invasive procedures seem to increase the risk of vaginal cuff dehiscence (VCD). Barbed suture is a new class of suture introduced to aid surgeons during laparoscopic suturing, with the aim to reduce operative time, blood loss, and vaginal dehiscence.

We identified all articles that report a series of laparoscopic or robotic-assisted hysterectomy using barbed suture compared to conventional suture for vaginal cuff closure. The main outcome measures were vaginal cuff suturing time, vaginal bleeding, and vaginal dehiscence with or without small bowel evisceration. Suturing time was meta-analyzed as the standardized mean difference, which is the difference in means of two arms divided by pooled standard deviation with 95 % confidence intervals. For vaginal bleeding and dehiscence risk difference were calculated for each study and then meta-analyzed. Fixed models were considered if heterogeneity was low (I (2) < 50 %), otherwise random models were preferred.

We show that minor bleeding (RD = 0, 95 % CI 0.03-0.03; p value = 0.907) and VCD (RD = -0.01, 95 % CI 0.02-0.00; p value = 0.119) are comparable in minimally invasive hysterectomy with or without the use of barbed suture. The major bleeding (RD = -0.03; 95 % CI 0.05-0.00; p value = 0.047) appears borderline significant, but the difference between the two types of sutures is not high and the upper limit of 95 % IC is equal to 0 so they were considered comparable. Instead, meta-analysis on vaginal cuff suturing time demonstrates that suturing time is reduced with the use of barbed suture (SMD = -0.96, 95 % CI 1.26-0.70; p value < 0.001).

Barbed suture is safe and well tolerated as traditional sutures and is associated with reduced operative time of laparoscopic vaginal vault closure.

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U2 10

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TI Longer Operative Time During Benign Laparoscopic and Robotic

Hysterectomy Is Associated With Increased 30-Day Perioperative

Complications

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic surgery; Laparoscopic hysterectomy; Operative time;

Perioperative complications

ID TOTAL ABDOMINAL HYSTERECTOMY; LEARNING-CURVE; RISK-FACTORS; VENOUS

THROMBOEMBOLISM; MORBIDITY; OUTCOMES; SURGERY; IMPACT

AB Study Objective: The relationship between operative time and perioperative morbidity has not been fully characterized in gynecology. We aimed to determine the impact of operative time on 30-day perioperative complications after laparoscopic and robotic hysterectomy.

Design: Patients undergoing laparoscopic and robotic hysterectomy for benign disease from 2006 to 2011 within the National Surgical Quality Improvement Program (NSQIP) database were identified by Current Procedural Terminology code. Operative times were stratified into 60-minute intervals and complication rates analyzed. Primary outcomes included 30-day overall, medical, and surgical complications. Bivariate analyses using chi(2), Fisher's exact, and one-way analysis of variance tests were performed to compare clinical and procedural characteristics associated with longer operative time and complications. Multivariable logistic regression analyses were then performed to determine the independent association between operative time and perioperative complications.

Design Classification: Canadian Task Force classification II-2 (Evidence obtained from well-designed cohort or case-control studies preferably from more than 1 center or research group).

Setting: American College of Surgeons NSQIP.

Patients: Patients who underwent laparoscopic or robotic hysterectomy for benign disease from 2006 to 2011 at any institution participating in NSW.

Interventions: None, retrospective database study.

Measurements and Main Results: Of the 7630 laparoscopic and robotic hysterectomies identified, 399 patients (5.2%) experienced complications, most commonly urinary tract infection (UTI; 2.1%), superficial surgical site infection (1.0%), and blood transfusion (1.0%). Return to the operating room was required in 97 patients (1.3%), and there were 4 deaths, for a mortality rate of .05%. Complications increased steadily with longer operative time. Operative time 240 minutes was associated with increased overall complications (13.8% vs 4.6%, p < .001), surgical complications (5.4% vs 1.5%, p < .001), medical complications (10.4% vs 3.2%, p < .001), return to the operating room (2.7% vs 1.2%, p = .002), deep venous thrombosis (.5% vs.06%, p = .011), pulmonary embolism (.7% vs.1%, p = .012), and blood transfusion (3.4% vs.8%, p < .001). These associations remained statistically significant after multivariable regression analysis. Based on continuous regression modeling, each additional hour of operative time would be expected to increase odds of overall complications (odds ratio [On 1.4; 95% confidence interval [CI], 1.28-1.54; p < .001), medical complications (OR, 1.42; 95% CI, 1.28-1.57; p < .001), surgical complications (OR, 1.32; 95% CI, 1.17-1.49; p < .001), venous thromboembolism (OR, 1.47; 95% CI, 1.12-1.92; p = .005), UTI (OR, 1.20; 95% CI, 1.05-1.36; p = .006), blood transfusion (OR, 1.42; 95% CI, 1.18-1.71; p < .001), and return to the operating room (OR, 1.25; 95% CI, 1.08-1.45; p = .003).

Conclusion: We demonstrated a direct, independent association between operative time and 30-day complications after laparoscopic and robotic hysterectomy. Future research should aim to further delineate risk factors for prolonged operative time and morbidity in laparoscopic hysterectomy to allow surgeons to maximize preoperative planning and optimize patient selection for minimally invasive hysterectomy. (C) 2015 AAGL. All rights reserved.

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TI TELELAP ALF-X Robotic-assisted Laparoscopic Hysterectomy: Feasibility

and Perioperative Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Laparoscopy; Robotic

ID SURGERY; SYSTEM

AB Study Objective: To show the safety, feasibility, and perioperative outcomes of total TELELAP ALF-X hysterectomy (SOFAR S.p.A., ALF-X Surgical Robotics Department, Trezzano Rosa, Milan, Italy).

Design: Phase II study (Canadian Task Force II-2).

Setting: Catholic University of the Sacred Heart, Rome, Italy.

Patients: From October 2013 to May 2014, 80 women underwent total TELELAP ALF-X hysterectomy. The study population was divided into 2 groups according to surgical procedures: total hysterectomy bilateral salpingo-oophorectomy (group 1) and endometrial cancer patients staged with pelvic lymphadenectomy (group 2).

Interventions: Total TELELAP ALF-X hysterectomy bilateral salpingo-oophorectomy with or without pelvic lymphadenectomy.

Measurements and Main Results: The median age was 51 years (range, 48-79), and the median body mass index was 24 kg/m(2) (range, 17.3-34.2). Forty-five patients (56.2%) had previous surgery. The median operative time was 140 minutes (range, 58-320) in group 1 and 197 minutes (range, 129-290) in group 2 (p < .001). The median docking time was 8 minutes (range, 3-25). During the study period, a significant trend in operative time reduction was observed. Procedures were successfully performed without conversion in 93.7% of cases. We observed 2 (2.5%) intraoperative complications, 3 (3.7%) conversions to standard laparoscopy, and 2(2.5%) to laparotomy. The median time to discharge was 2 days (range, 1-5). One patient (1.2%) was readmitted in the early postoperative period.

Conclusion: As new technology evolves, critical appraisal of patient-related outcomes, use, cost, and access to minimally invasive hysterectomy must remain a priority. Despite the relative small number of our series, we showed the feasibility and safety of total TELELAP ALF-X hysterectomy for benign and malignant disease. (C) 2015 AAGL. All rights reserved.

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TI Midterm results of robot-assisted sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Robot-assisted laparoscopy; Stress incontinence

ID PELVIC ORGAN PROLAPSE; VAGINAL VAULT PROLAPSE; LAPAROSCOPIC

SACROCOLPOPEXY; ABDOMINAL SACROCOLPOPEXY; OUTCOMES; QUESTIONNAIRE;

SURGERY; COHORT; WOMEN

AB Introduction and hypothesis Robotic assistance simplifies laparoscopic procedures. We hypothesize that robot-assisted sacrocolpopexy is a rapid and safe procedure with satisfying short-term and midterm functional results.

Methods After informed consent, we enrolled 101 consecutive patients undergoing sacrocolpopexy at Alfried Krupp Hospital, Essen, Germany. After a median follow-up of 22 months, we assessed midterm functional results as the primary endpoint. Secondary endpoints included surgical duration, blood loss, intraoperative complications, and postoperative complications. We described frequencies as counts (percent) and continuous data as median [interquartile range (Q1-Q3)] or mean [standard deviation (SD)], as appropriate.

Results We enrolled 101 patients. The mean age was 69 years (SD 11); 75 women (74.3 %) had undergone previous abdominal surgery. Among the patients, 95 (94.1 %) presented with anterior vaginal wall prolapse Baden-Walker grade 2-3, 74 (73.3 %) vaginal vault prolapse, and 9 (8.9 %) concomitant rectocele. Fifty (50 %) patients underwent a modified Burch procedure in addition to sacrocolpopexy. The median surgical duration was 96 min (Q1-Q3 83-130). There were six (5.9 %) minor intraoperative complications but no conversions to open surgery. Postoperatively, we registered five (4.9 %) Clavien-Dindo grade I complications, three (3.0 %) grade II complications, and one (1.0 %) grade III complication. After a median follow-up of 22 months (Q1-Q3 12-49), the patients reported significant decreased impact of pelvic organ prolapse (POP) on quality of life as well as bother resulting from POP symptoms. The overall success rate, defined as none or minor impact of POP on quality of life, was 75 %.

Conclusions In this single-surgeon study, robot-assisted sacrocolpopexy was a safe and rapidly performed procedure that achieved good medium-term functional results.

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U2 2

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TI Ultrasound guided subcostal transversus abdominis plane (TAP)

infiltration with liposomal bupivacaine for patients undergoing robotic

assisted hysterectomy: A prospective randomized controlled study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic; Hysterectomy; Transversus abdominis plane; Liposomal

bupivacaine; Post-operative pain; Acute pain

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; RISK-FACTORS; BLOCK; SURGERY

AB Introduction. Optimal pain control after major surgery contributes to a patient's recovery and satisfaction. The use of liposomal bupivacaine in subcostal transversus abdominis plane (TAP) blocks for postoperative pain control after robot assisted abdominal surgery has yet to be studied.

Methods. We conducted a prospective randomized controlled observer-blinded study comparing bilateral subcostal TAP blocks with bupivacaine to bilateral subcostal TAP blocks with liposomal bupivacaine. These were performed prior to the patient undergoing robot assisted hysterectomy. The patients' pain scores, opioid use, side effects, and satisfaction were followed for 72 h after injection.

Results. Total opioid use in the first 72 h after injection was significantly decreased in the group that received liposomal bupivacaine compared to bupivacaine. Patients in the liposomal bupivacaine group had significantly lower maximal pain scores at all time periods studied as well as decreased incidence of nausea/vomiting. There was a trend toward decreased length of stay in the liposomal bupivacaine group.

Conclusion. Subcostal TAP blocks with liposomal bupivacaine decreased the total opioid requirement for the first 72 h after robot assisted hysterectomy when compared to subcostal TAP blocks with bupivacaine. (C) 2015 Elsevier Inc. All rights reserved.

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TI Surgical Excision of Advanced Endometriosis: Perioperative Outcomes and

Impacting Factors

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometriosis; Laparoscopy; Pelvic surgery; Robotics

ID STAGE IV ENDOMETRIOSIS; RESECTION; LAPAROSCOPY; BLADDER; BOWEL;

FEASIBILITY; MANAGEMENT; DIAGNOSIS; ROBOTICS; SURGERY

AB Objective: To determine perioperative outcomes and factors impacting operating time, length of hospital stay, and complications of patients undergoing surgery for stage 3 or 4 endometriosis.

Design: Retrospective review of medical records (Canadian Task Force classification II-2).

Setting: Mayo Clinic Hospital, Phoenix, Arizona.

Patients: Women (n = 493) with endometriosis stage 3 and 4 undergoing surgical excision between March 15, 2005, and December 31, 2011.

Interventions: Robotic-assisted (n = 331) or laparoscopic (n = 162) excision.

Measurements: Age, body mass index, comorbidities, number and type of procedures per patient, type of surgical approach, operating time, blood loss, intraoperative and postoperative complications (within 42 days), and length of hospital stay.

Main Results: The mean patient age was 39.5 years; body mass index, 25.9; number of procedures, 3.3; operating time, 130.4 minutes; blood loss, 88.5 mL; and hospital stay, 1.0 days. Major complications occurred in 5 patients (1.5%). Fifty-nine patients (12.0%) underwent modified radical hysterectomy, 90 (18.3%) underwent ureteral and/or intestinal resection, and 3 (0.6%) underwent diaphragm resection. Factors significantly associated with operating time included age (p = .008) and blood loss, number of procedures per patient, and robotics (all p < .001). Length of stay was affected by age, operating time, and blood loss (all p < .001). Operating time was the only significant factor associated with postoperative complications (p < .001).

Conclusion: Operating time is an independent and significant factor for postoperative complications and hospital stay. (C) 2015 AAGL. All rights reserved.

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ER

PT J

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TI Tension-Free Vaginal Tape Failure After Robotic Sacrocolpopexy and

Tension-Free Vaginal Tape for Concomitant Prolapse and Stress

Incontinence

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

ID URINARY-INCONTINENCE; RISK-FACTORS; SURGERY; COLPOSUSPENSION; WOMEN

AB Objective

Evidence of surgical cure with tension free vaginal tape (TVT) is robust for isolated stress urinary incontinence, but rigorous studies investigating combined prolapse and incontinence are lacking. Our study measured cure of stress incontinence in concomitant robotic sacrocolpopexy and retropubic sling (TVT). We hypothesized a higher rate of objective failure as measured by the cough stress test (CST) compared to failures reported in recent randomized trials of TVT in patients without prolapse (aggregate 8% failure).

Methods

Prospective cohort of patients with stress incontinence and prolapse, scheduled for robotic sacrocolpopexy and TVT. Outcomes assessed at 12 months: CST (primary aim), Patient Global Impression of Improvement (PGI-I), Pelvic Floor Distress Inventory, and the Sandvik questionnaire.

Results

Sixty-six of 77 subjects (86%) completed follow-up. Average age was 65 years, 96% were white, with mean body mass index of 28.1 kg/m(2). Mean parity was 2.7, 50% had a previous hysterectomy. Mean leading edge of prolapse was +2.3 cm. All patients underwent the planned surgery; additionally, 50% underwent hysterectomy and 38% posterior colporrhaphy.

The TVT failure (+CST) was 19.7% (95% confidence interval, 11.3%-31.7%; P < 0.001 compared to 8%). Neither preoperative disease severity, nor preoperative prolapse stage affected risk of failure of TVT. Eighty-three percent of the subjects were happy or very happy (PGI-I). However, those with a positive CST (failure) had significantly less satisfaction on PGI-I, UDI-6, and Pelvic Floor Distress Inventory-20.

Conclusions

In this population with advanced prolapse, cure of stress urinary incontinence by TVT in setting of robotic sacrocolpopexy is lower compared to published trials where prolapse is absent. Women are less satisfied when the postoperative CST is positive.

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TC 4

Z9 4

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

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TI A Comparison of Survival and Recurrence Outcomes in Patients With

Endometrial Cancer Undergoing Robotic Versus Open Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Laparotomy; Recurrence; Robotics; Survival

ID PERIOPERATIVE OUTCOMES; LAPAROTOMY; LAPAROSCOPY; WOMEN; COST;

HYSTERECTOMY

AB Objective: To compare recurrence and survival outcomes in women who underwent either robotic or open surgical procedures to treat endometrial cancer.

Design: A retrospective chart review (Canadian Tack Force classification II-2).

Setting: A single academic institution.

Patients: A total of 936 patients who underwent surgical staging for endometrial cancer between 2001 and 2013.

Intervention: Through retrospective chart review, data were collected on patient characteristics, surgical procedures, intra-operative and postoperative complications, histopathology, adjuvant therapies, and recurrence and survival outcomes. Estimated 3-year progression-free survival and 5-year overall survival were calculated using Kaplan-Meier curves.

Main Results: Of the 936 patients who underwent endometrial cancer surgery, 350 had robotic-assisted surgery and 586 had laparotomy. Both groups were comparable in terms of age, race, body mass index, and comorbid conditions. The laparotomy group had significantly more patients with grade 2-3 tumors, nonendometrioid histology, and stage III-IV disease. In a multivariate analysis, operative type was not an independent prognostic factor for intraoperative complications, but robotic surgery was associated with decreased postoperative complications and readmission rate. Median duration of follow-up was 30 months in the robotic cohort and 42 months in the laparotomy cohort. Estimated 3-year progression-free survival was 90.87% for the robotic group and 78.30% for the laparotomy group, and estimated 5-year overall survival was 89.14%for the robotic group and 79.47% for the laparotomy group. In a multivariate analysis, including stage, grade, histology, operative type, and adjuvant therapy, operative type was not an independent prognostic factor for recurrence or overall survival.

Conclusion: Compared with laparotomy, robotic staging for endometrial cancer is associated with less postoperative morbidity without compromising short-term recurrence rates or survival outcomes. (C) 2015 AAGL. All rights reserved.

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Z9 23

U1 0

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ER

PT J

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Kesterson, J

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TI Robotic-assisted Laparoscopic Management of Chemoresistant Myoinvasive

Complete Molar Pregnancy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gestational trophoblastic disease; Hysterectomy; Laparoscopy; Robotic

surgical procedures

ID GESTATIONAL TROPHOBLASTIC NEOPLASIA; DISEASE

AB Postmolar malignant conditions are rare after evacuation of a complete molar pregnancy. Both medical and surgical management have a role in the treatment of persistent gestational trophoblastic neoplasia. Treatment decisions must account for the natural history of the disease, previous therapies, site of disease, and the patient's desire for uterine preservation. We report on a woman who presented with chemotherapy-refractory persistent gestational trophoblastic disease (GTD). She was found to have isolated, persistent trophoblastic tissue within the uterine myometrium. She underwent a robotic-assisted laparoscopic hysterectomy with curative results. Minimally invasive surgical management may be an option for treatment of women with isolated myoinvasive GTD. (C) 2015 AAGL. All rights reserved.

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TC 0

Z9 1

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ER

PT J

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TI Factors associated with successful bilateral sentinel lymph node mapping

in endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Fluorescence imaging; Indocyanine green; Obesity;

Robotic hysterectomy; Sentinel lymph node

ID HYSTEROSCOPIC INJECTION; INDOCYANINE GREEN; BIOPSY; SURGERY; WOMEN;

ALGORITHM; FAILURE; UTERINE; TRIAL

AB Objective. As our understanding of sentinel lymph node (SLN) mapping for endometrial cancer (EC) evolves, tailoring the technique to individual patients at high risk for failed mapping may result in a higher rate of successful bilateral mapping (SBM). The study objective is to identify patient, tumor, and surgeon factors associated with successful SBM in patients with EC and complex atypical hyperplasia (CAR).

Methods. From September 2012 to November 2014, women with EC or CAH underwent SLN mapping via cervical injection followed by robot-assisted total laparoscopic hysterectomy (RA-TLH) at a tertiary care academic center. Completion lymphadenectomy and ultrastaging were performed according to an institutional protocol. Patient demographics, tumor and surgeon/intraoperative variables were prospectively collected and analyzed. Univariate and multivariate analyses were performed evaluating factors known or hypothesized to impact the rate of successful lymphatic mapping.

Results. RA-TLH and SLN mapping was performed in 111 women; 93 had EC and 18 had CAH. Eighty women had low grade and 31 had high grade disease. Overall, at least one SLN was identified in 85.6% of patients with SBM in 62.2% of patients. Dye choice (indocyanine green versus isosulfan blue), odds ratio (OR: 4.5), body mass index (OR: 0.95), and clinically enlarged lymph nodes (OR: 0.24) were associated with SBM rate on multivariate analyses. The use of indocyanine green dye was particularly beneficial in patients with a body mass index greater than 30.

Conclusion. Injection dye, BMI, and clinically enlarged lymph nodes are important considerations when performing sentinel lymph node mapping for EC. (C) 2015 Elsevier Inc. All rights reserved.

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ER

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TI Postoperative Pain Scores and Narcotic Use in Robotic-assisted Versus

Laparoscopic Hysterectomy for Endometrial Cancer Staging

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive surgery; Perioperative outcomes

ID ABDOMINAL HYSTERECTOMY; VAGINAL HYSTERECTOMY; MANAGEMENT; SURVIVAL;

WOMEN; REQUIREMENTS; INFILTRATION; LAPAROTOMY; OUTCOMES; SURGERY

AB Study Objective: To retrospectively evaluate perioperative pain and analgesic and antiemetic use in patients who underwent surgical staging for endometrial cancer using traditional versus robotic-assisted laparoscopy.

Design: We identified women in a single institution who underwent minimally hysterectomy for endometrial cancer from 2008 to 2012. Patient characteristics and perioperative outcomes, including analgesic and antiemetic use and pain scores, were analyzed. After univariate analysis, a multivariate linear regression model was generated to determine factors associated with narcotic use in the post anesthesia care unit (PACU) (Canadian Task Force Classification II-3).

Setting: A single academic institution in the United States from 2008 to 2012.

Patients: Women undergoing total laparoscopic hysterectomy or robotic-assisted laparoscopic hysterectomy for endometrial cancer.

Interventions: Laparoscopic or robotic-assisted laparoscopic hysterectomy.

Measurements and Main Results: Three hundred thirty-five women were included (213 laparoscopy and 122 robotic-assisted laparoscopy). There was no difference in pain scores at 0 to 6 and 6 to 12 hours after surgery; at 12 to 24 hours, robotic-assisted surgery was associated with higher median pain scores (5/10 vs 4/10, p = .012). Robotic-assisted surgery was associated with a longer anesthesia time (289 vs 255 minutes, p < .001), similar antiemetic use (p = .40), and lower narcotic use in the postanesthesia care unit (PACU) (1.3 mg vs 2.5 mg morphine equivalents, p = .003). There was no difference in narcotic use on the postoperative floor (p = .46). In multivariate analysis controlling for age, menopausal status, anesthesia duration, and local anesthetic use, hysterectomy type was not a significant predictor of PACU narcotic use (p = .86).

Conclusions: In a retrospective analysis, a robotic-assisted approach to endometrial cancer was not associated with reduced PACU narcotic or antiemetic use compared with the traditional laparoscopic approach. Twenty-four-hour narcotic and antiemetic use was also not different between the 2 approaches. (C) 2015 AAGL. All rights reserved.

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ER

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TI Radical trachelectomy in early-stage cervical cancer: A comparison of

laparotomy and minimally invasive surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

ID FERTILITY; OUTCOMES; CARCINOMA; SERIES

AB Objectives. Radical trachelectomy is considered standard of care in patients with early-stage cervical cancer interested in future fertility. The goal of this study was to compare operative, oncologic, and fertility outcomes in patients with early-stage cervical cancer undergoing open vs. minimally invasive radical trachelectomy.

Methods. A retrospective review was performed of patients from four institutions who underwent radical trachelectomy for early-stage cervical cancer from June 2002 to July 2013. Perioperative, oncologic, and fertility outcomes were compared between patients undergoing open vs. minimally invasive surgery.

Results. A total of 100 patients were included in the analysis. Fifty-eight patients underwent open radical trachelectomy and 42 patients underwent minimally invasive surgery (MIS = laparoscopic or robotic). There were no differences in patient age, body mass index, race, histology, lymph vascular space invasion, or stage between the two groups. The median surgical time for MIS was 272 min [range, 130-441 min] compared with 270 min [range, 150-373 min] for open surgery (p = 0.78). Blood loss was significantly lower for MIS vs. laparotomy (50 mL [range, 10-225 mL] vs. 300 mL [50-1100 mL]) (p <0.0001). Nine patients required blood transfusion, all in the open surgery group (p = 0.010). Length of hospitalization was shorter for MIS than for laparotomy (1 day [1-3 days] vs. 4 days [1-9 days]) (p <0.0001). Three intraoperative complications occurred (3%): 1 bladder injury, and 1 fallopian tube injury requiring unilateral salpingectomy in the MIS group and 1 vascular injury in the open surgery group. The median lymph node count was 17 (range, 5-47) for MIS vs. 22 (range, 7-48) for open surgery (p = 0.03). There were no differences in the rate of postoperative complications (30% MIS vs. 31% open surgery). Among 83 patients who preserved their fertility (33 MIS vs. 50 open surgery), 34 (41%) patients attempted to get pregnant. Sixteen (47%) patients were able to do so (MIS: 2 vs. laparotomy: 14, p = 0.01). The pregnancy rate was higher in the open surgery group when compared to the MIS group (51% vs. 28%, p = 0.018). However, median follow-up was shorter is the MIS group compared with the open surgery group (25 months [range, 10-69] vs. 66 months [range, 11-147]). To date, there has been one recurrence in the laparotomy group and none in the MIS group.

Conclusions. Our results suggest that radical trachelectomy via MIS results in less blood loss and a shorter hospital stay. Fertility rates appear higher in patients undergoing open radical trachelectomy. (C) 2015 Elsevier Inc. All rights reserved.

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ER

PT J

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Gkegkes, ID

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TI Port-site metastases in patients with gynecological cancer after

robot-assisted operations

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Metastasis; Port site; Robotic-assisted surgery; Gynecology; Cancer

ID NEGATIVE LYMPH-NODES; LAPAROSCOPIC SURGERY; MALIGNANT-DISEASE;

HYSTERECTOMY; ADENOCARCINOMA; RECURRENCES; CERVIX

AB Port-site metastasis is an extremely rare event in patients with cancer treated with robotic-assisted surgery. However, as robotic procedures are increasing, the incidence of port-site metastases might also increase. The purpose of our review is to evaluate the up-to-now existing literature data on robotic port-site metastasis in the field of gynecological oncology.

The authors retrieved the included results of the study after performing a systematic search in PubMed, Scopus, and Cochrane Library.

In total, 20 patients were included in the study. The mean age of them was 56.3 (range 27-82) years. In the majority of the cases, endometrial cancer was responsible for port-site recurrences. The port-site metastasis occurred after 1-36 months postoperatively with the tumor measuring from 0.8 to 10.5 cm. As far as the management of this type of local recurrence, the most common therapeutic strategy adopted was the local excision followed by combined radiotherapy/chemotherapy.

Robotic surgery is a rather new technique and port-site metastasis is a rare complication of it. Due to this fact, we could not reach safe conclusions. The purpose of this study was to raise doctor's clinical suspicion level to such a rare complication. Additional studies should be performed with the intention to clarify both port-site metastasis rates in gynecological oncology patients, as well as to elucidate the possible mechanisms of this type of local recurrence.

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Z9 14

U1 0

U2 7

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

AU Majd, HS

Ferrari, F

Gubbala, K

Campanile, RG

Tozzi, R

AF Majd, Hooman Soleymani

Ferrari, Federico

Gubbala, Kumar

Campanile, Riccardo Garruto

Tozzi, Roberto

TI Latest developments and techniques in gynaecological oncology surgery

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE endoscopy; gynaecology oncology; robotic; surgical advances; survival

ID STAGE CERVICAL-CANCER; SITE RADICAL HYSTERECTOMY; PELVIC EXENTERATION;

ENDOMETRIAL CANCER; COST-EFFECTIVENESS; OVARIAN-CANCER; NEOADJUVANT

CHEMOTHERAPY; LAPAROSCOPY; MANAGEMENT; LYMPHADENECTOMY

AB Purpose of review

To highlight the advances and the data published in the field of gynaecological oncology surgery in the last few years. The review includes not only newly introduced surgical techniques but also data that consolidate recent developments.

Recent findings

Ultimate data on the use of laparoscopy in the treatment of gynaecologic malignancies have proven similar survival outcomes to the traditional surgical route and confirmed the benefits in terms of faster recovery and lower morbidity. Thanks to a faster learning curve, the use of robotic surgery has contributed to the increase in the number of surgeons who moved away from open surgery. A few pioneers are expanding the indications of laparoscopy to exenterative surgery and treatment of ovarian cancer.

Summary

Laparoscopic surgery has become the gold standard treatment for patients with primary endometrial or cervical cancer. The advent of robotic surgery has reinforced the domain of endoscopic surgery.

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U1 0

U2 4

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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ER

PT J

AU Rabinovich, A

AF Rabinovich, Alex

TI Minimally invasive surgery for endometrial cancer

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE endometrial carcinoma; laparoscopy; minimally invasive surgery;

robotically assisted laparoscopy

ID PORT-SITE METASTASIS; ROBOTIC SURGERY; LAPAROSCOPIC SURGERY; DISEASE

RECURRENCE; UTERINE-CANCER; WOMEN; SURVIVAL; LAPAROTOMY; OUTCOMES;

HYSTERECTOMY

AB Purpose of review

To critically appraise the pertinent literature on traditional laparoscopy and robotically assisted laparoscopy for the treatment of endometrial cancer.

Recent findings

Multiple retrospective and prospective studies on traditional laparoscopy and retrospective studies on robotically assisted laparoscopy for the treatment of uterine cancers have shown reduced blood loss, shorter length of hospital stay and decreased incidence and severity of postoperative surgical complications compared with laparotomy. Minimally invasive techniques maintain equivalent oncologic results with regard to the number of dissected lymph nodes and overall and disease-free survival rates. Compared with traditional laparoscopy, robotic surgery has a lower rate of conversion to laparotomy, lower blood loss and presents significant ergonomic advantages for the surgeon facilitating execution of complex oncologic procedures. Minimally invasive techniques are particularly advantageous in obese patients, reducing perioperative and postoperative abdominal wound complications.

Summary

A thorough review of the literature indicates that minimally invasive approach has a number of established advantages over laparotomy that makes it the surgical treatment option of choice in endometrial carcinoma patients.

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NR 46

TC 19

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U1 0

U2 5

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J9 CURR OPIN OBSTET GYN

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ER

PT J

AU Shazly, SAM

Murad, MH

Dowdy, SC

Gostout, BS

Famuyide, AO

AF Shazly, Sherif A. M.

Murad, Mohammad H.

Dowdy, Sean C.

Gostout, Bobbie S.

Famuyide, Abimbola O.

TI Robotic radical hysterectomy in early stage cervical cancer: A

systematic review and meta-analysis

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Robotic; Radical hysterectomy; Laparoscopic hysterectomy; Early stage

cervical cancer; Metaanalysis

ID PELVIC LYMPHADENECTOMY; ASSISTED HYSTERECTOMY; LAPAROSCOPIC SURGERY;

ENDOMETRIAL CANCER; LAPAROTOMY; OUTCOMES; WOMEN

AB Objective. To compare intraoperative and short-term postoperative outcomes of robotic radical hysterectomy (RRH) to laparoscopic and open approaches in the treatment of early stage cervical cancer.

Methods. A search of MEDLINE, EMBASE (using Ovid interface) and SCOPUS databases was conducted from database inception through February 15, 2014. We included studies comparing surgical approaches to radical hysterectomy (robotic vs. laparoscopic or abdominal, or both) in women with stages IA1-IIA cervical cancer. Intraoperative outcomes included estimated blood loss (EBL), operative time, number of pelvic lymph nodes harvested and intraoperative complications. Postoperative outcomes were hospital stay and surgical morbidity. The random effects model was used to pool weighted mean differences (WMDs) and odds ratios (OR).

Results. Twenty six nonrandomized studies were included (10 RRH vs abdominal radical hysterectomy [ARK 9 RRH vs laparoscopic radical hysterectomy [LRH] and 7 compared all 3 approaches) enrolling 4013 women (1013 RRH, 710 LRH and 2290 ARH). RRH was associated with less EBL (WMD = 384.3, 95% CI = 233.7, 534.8) and shorter hospital stay (WMD = 3.55, 95% CI = 2.10, 5.00) than ARH. RRH was also associated with lower odds of febrile morbidity (OR = 0.43,95% CI = 0.20-0.89), blood transfusion (OR = 0.12, 95% CI 0.06, 0.25) and wound-related complications (OR = 0.31, 95% CI = 0.13, 0.73) vs. ARH. RRH was comparable to LRH in all intra- and postoperative outcomes.

Conclusion. Current evidence suggests that RRH may be superior to ARH with lower EBL, shorter hospital stay, less febrile morbidity and wound-related complications. RRH and LRH appear equivalent in intraoperative and short-term postoperative outcomes and thus the choice of approach can be tailored to the choice of patient and surgeon. (C) 2015 Elsevier Inc. All rights reserved.

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ER

PT J

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Ngan, HYS

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Ngan, Hextan Y. S.

TI The role of laparoscopy in staging of different gynaecological cancers

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE laparoscopic; robot-assisted; laparotomy; staging; gynaecological

cancers

ID SENTINEL LYMPH-NODE; ADVANCED CERVICAL-CANCER; PORT-SITE METASTASES;

ROBOTIC-ASSISTED LAPAROSCOPY; MINIMALLY INVASIVE SURGERY; ENDOMETRIAL

CANCER; OVARIAN-CANCER; PARAAORTIC LYMPHADENECTOMY; RADICAL

HYSTERECTOMY; EPITHELIAL OVARIAN

AB Apart from cervical and vaginal cancers that are staged by clinical examination, most gynaecological cancers are staged surgically. Not only can pelvic and para-aortic lymphadenectomy offer accurate staging information that helps determine patients' prognosis and hence their treatment plan, but it may also provide a therapeutic effect under certain circumstances. In the past, such a procedure required a big laparotomy incision. With the advent of laparoscopic lighting and instrument, laparoscopic lymphadenectomy became popular since the late 1980s. Dargent et al. published the first report on laparoscopic staging in cervical cancers, and many studies then followed. To date, there are numerous case series and trials evaluating the efficacy and safety of laparoscopic surgery in managing gynaecological cancers. In general, compared with laparotomy, laparoscopic lymphadenectomy has less intraoperative blood loss and post-operative pain, fewer wound complications, shorter length of hospital stay and more speedy recovery. However, this is at the expense of longer operative time. The incidence of port-site metastasis is extremely low, although it may be higher in advanced ovarian cancer. Preliminary data showed that there was no significant effect on recurrence and survival, but long-term data are lacking. In this article, the roles of laparoscopy in staging of uterine, cervical and ovarian cancers, the three most common gynaecological cancers, will be reviewed. Novel technologies such as robot-assisted surgery, single-port surgery and sentinel node biopsy will also be discussed. (C) 2015 Elsevier Ltd. All rights reserved.

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PT J

AU Chan, JK

Gardner, AB

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Yu, XH

Kapp, DS

AF Chan, John K.

Gardner, Austin B.

Taylor, Katie

Blansit, Kevin

Thompson, Caroline A.

Brooks, Rebecca

Yu, Xinhua

Kapp, Daniel S.

TI The centralization of robotic surgery in high-volume centers for

endometrial cancer patients - A study of 6560 cases in the US

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Laparoscopic surgery; High-volume

hospitals; Centralization; Race and socioeconomic factors

ID NATIONAL TRENDS; DISPARITIES; OUTCOMES; IMPACT; MANAGEMENT; IMPUTATION;

QUALITY; SAMPLE; COST

AB Objective. To evaluate the hospital and patient factors associated with robotic surgery for endometrial cancer in the United States.

Methods. Data was obtained from the Nationwide Inpatient Sample from the year 2010. Chi-squared and multivariate analyses were used for statistical analysis.

Results. Of the 6560 endometrial cancer patients who underwent surgery, the median age was 62 (range: 22 to 99). 1647 (25%) underwent robotic surgery, 820 (13%) laparoscopic, and 4093 (62%) had open surgery. The majority was White (65%). Hospitals with 76 or more hysterectomy cases for endometrial cancer patients per year (4% of hospitals in the study) performed 31% of all hysterectomies and 40% of all robotic hysterectomies (p < 0.01). 29% of Whites had robotic surgery compared to 15% of Hispanics, 12% of Blacks, and 11% of Asians (p < 0.01). Patients with upper-middle and high incomes underwent robotic surgery more than patients with low or middle incomes (p < 0.01). 27% of Medicare patients and 26% of patients with private insurance had robotic surgery compared to only 14% of Medicaid patients and 12% of uninsured patients (p <0.01).

Conclusions. The majority of robotic surgeries for endometrial cancer were performed at a small number of high-volume hospitals in the United States. Socioeconomic status, insurance type, and race were also important predictors for the use of RS. Further studies are warranted to better understand the barriers to receiving minimally invasive surgery. 2015 Published by Elsevier Inc.

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SC Oncology; Obstetrics & Gynecology

GA CL3HN

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ER

PT J

AU Conrad, LB

Ramirez, PT

Burke, W

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AF Conrad, Lesley B.

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TI Role of Minimally Invasive Surgery in Gynecologic Oncology <i>An Updated

Survey of Members of the Society of Gynecologic Oncology</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Minimally invasive surgery; Gynecologic oncology; Robotic surgery; LESS;

Ovarian cancer; Uterine cancer; Cervical cancer

ID ROBOTIC RADICAL HYSTERECTOMY; STAGE CERVICAL-CANCER; ENDOMETRIAL CANCER;

STANDARD LAPAROSCOPY; LAPAROTOMY; OBESE

AB Objectives To evaluate the current patterns of use of minimally invasive surgical procedures, including traditional, robotic-assisted, and single-port laparoscopy, by Society of Gynecologic Oncology (SGO) members and to compare the results to those of our 2004 and 2007 surveys.

Methods The Society of Gynecologic Oncology members were surveyed through an online or mailed-paper survey. Data were analyzed and compared with results of our prior surveys.

Results Four hundred six (32%) of 1279 SGO members responded. Eighty-three percent of respondents (n = 337) performed traditional laparoscopic surgery (compared with 84% in 2004 and 91% in 2007). Ninety-seven percent of respondents performed robotic surgery (compared with 27% in 2007). When respondents were asked to indicate procedures that they performed with the robot but not with traditional laparoscopy, 75% indicated radical hysterectomy and pelvic lymphadenectomy for cervical cancer. Overall, 70% of respondents indicated that hysterectomy and staging for uterine cancer was the procedure they most commonly performed with a minimally invasive approach. Only 17% of respondents who performed minimally invasive surgery performed single-port laparoscopy, and only 5% of respondents indicated that single-port laparoscopy has an important or very important role in the field.

Conclusions Since our prior surveys, we found a significant increase in the overall use and indications for robotic surgery. Radical hysterectomy or trachelectomy and pelvic lymphadenectomy for cervical cancer and total hysterectomy and staging for endometrial cancer were procedures found to be significantly more appropriate for the robotic platform in comparison to traditional laparoscopy. The indications for laparoscopy have expanded beyond endometrial cancer staging to include surgical management of early-stage cervical and ovarian cancers, but the use of single-port laparoscopy remains limited.

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FU National Institutes of Health through MD Anderson's Cancer Center

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JI Int. J. Gynecol. Cancer

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AU Kim, TJ

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Lee, Yoo-Young

Choi, Chel Hun

Lee, Jeong-Won

Bae, Duk-Soo

Kim, Byoung-Gie

TI Robotic high para-aortic nymph node dissection with high port placement

using same port for pelvic surgery in gynecologic cancer patients

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial Neoplasms; Intraoperative Complications; Lymph Node

Excision; Robotics; Surgical Instruments; Uterine Cervical Neoplasms

ID INFRARENAL AORTIC LYMPHADENECTOMY; ENDOMETRIAL CANCER; EXPERIENCE

AB Objective: This study reports our initial experience of robotic high para-aortic lymph node dissection (PALND) with high port placement using same port for pelvic surgery in cervical and endometrial cancer patients.

Methods: Between July 2013 and January 2014, we performed robotic high PALND up to the left renal vein during staging surgeries. With high port placement and same port usage for pelvic surgery, high PALND was successfully performed without repositioning the robotic column. All data were registered consecutively and analyzed retrospectively.

Results: All patients successfully underwent robotic high PALND, followed by hysterectomy and pelvic lymph node dissection. Median age was 45 years (range, 39 to 51 years) and median body mass index was 22 kg/m(2) (range, 19.3 to 23.1 kg/m(2)). Median operative time for right PALND and left PALND was 37 minutes (range, 22 to 65 minutes) and 44 minutes (range, 36 to 50 minutes), respectively. Median number of right and left para-aortic lymph node by pathologic report was 12 (range, 8 to 15) and 13 (range, 5 to 26).

Conclusion: With high port placement and one assistant port, robotic high PALND with the same port used in pelvic surgery is feasible to non-obese patients.

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Z9 0

U1 0

U2 1

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AU Marino, P

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TI Cost-Effectiveness of Conventional vs Robotic-Assisted Laparoscopy in

Gynecologic Oncologic Indications

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Economic evaluation; Robotic surgery; Laparoscopy; Gynecology

ID HYSTERECTOMY; OUTCOMES

AB Objective Robotic surgical techniques are known to be expensive, but they can decrease the cost of hospitalization and improve patients' outcomes. The aim of this study was to compare the costs and clinical outcomes of conventional laparoscopy vs robotic-assisted laparoscopy in the gynecologic oncologic indications.

Methods Between 2007 and 2010, 312 patients referred for gynecologic oncologic indications (endometrial and cervical cancer), including 226 who underwent conventional laparoscopy and 80 who underwent robot-assisted laparoscopy, were included in this prospective multicenter study. The direct costs, operating theater costs, and hospital costs were calculated for both surgical strategies using the microcosting method.

Results Based on an average number of 165 surgical cases performed per year with the robot, the total extra cost of using the robot was Euro1456 per intervention. The robot-specific costs amounted to Euro2213 per intervention, and the cost of the robot-specific surgical supplies was Euro957 per intervention. The cost of the surgical supplies specifically required by conventional laparoscopy amounted to Euro1432, which is significantly higher than that of the robotic supplies (P < 0.001). Hospital costs were lower in the case of the robotic strategy (Euro2380 vs Euro2841, P < 0.001) because these patients spent less time in intensive care (0.38 vs 0.85 days). Operating theater costs were higher in the case of the robotic strategy (Euro1490 vs Euro1311, P = 0.0004) because the procedure takes longer to perform (4.98 hours vs 4.38 hours).

Conclusions The main driver of additional costs is the fixed cost of the robot, which is not compensated by the lower hospital room costs. The robot would be more cost-effective if robotic interventions were performed on a larger number of patients per year or if the purchase price of the robot was reduced. A shorter learning curve would also no doubt decrease the operating theater costs, resulting in financial benefits to society.

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ER

PT J

AU Mearini, L

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Di Biase, Manuel

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TI The SACS (Satisfaction-Anatomy-Continence-Safety) score for evaluating

pelvic organ prolapse surgery: a proposal for an outcome-based scoring

system

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Surgery; Cure; Score

ID ROBOT-ASSISTED SACROCOLPOPEXY; FLOOR DYSFUNCTION SURGERY;

URINARY-INCONTINENCE; UROGENITAL PROLAPSE; SEXUAL FUNCTION; PATIENT;

VALIDATION; CLASSIFICATION; EXPECTATIONS; TERMINOLOGY

AB To date, there is no overall consensus on the definition of cure after surgery for pelvic organ prolapse (POP). The aim of the study was to design and test the scoring system S.A.C.S. (Satisfaction-Anatomy-Continence-Safety) to assess and compare the outcomes of POP repair.

A total of 233 women underwent open sacrocolpopexy. The S.A.C.S. outcome scoring system was scheduled at 24 months of follow-up, and each component was detected according to: Satisfaction by mean of Patient Global Improvement Inventory scale, Anatomy by mean of POP Quantification system and bulge symptom, Continence by mean of pad use, and Safety by mean of the Clavien-Dindo classification of surgical complications. Each component produced a binary nominal categorical variable (1 or 0), with a total score of 4 representing cure. As a comparative tool, patients answered a simple yes/no question: "If you had to undergo surgery all over again, would you still do it?". The degree of concordance was estimated using Cohen's Kappa test.

According to the S.A.C.S. scoring system, only 160 patients (68.6 %) reached the maximum score of cure. Sensitivity of the S.A.C.S. score was 74.1 %, specificity was 90 %, total diagnostic capacity was 75.5 %. The S.A.C.S. score internal consistency was good; the k-coefficient was higher for the satisfaction component of the score (k = 0.560).

This study proposes an original, simple post-operative scoring system integrating satisfaction, anatomy, continence, and safety reports for patients undergoing surgery for POP, providing a complete, although perfectible, method to accurately report outcomes in all clinical scenarios.

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TC 5

Z9 7

U1 0

U2 2

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ER

PT J

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TI Laparoscopic and Robotic-assisted Vesicovaginal Fistula Repair: A

Systematic Review of the Literature

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Bladder fistula; Laparoscopic vesicovaginal fistula repair; O'Conor;

Omental flap; Robotic vesicovaginal fistula repair; Vesicouterine

fistula; Vesicovaginal fistula

ID SINGLE-SITE SURGERY; VESICUVAGINAL FISTULA; INTERPOSITION; CLOSURE;

FLAP; EXPERIENCE; CYSTOTOMY

AB Two types of laparoscopic or robotic-assisted vesicovaginal fistula (VVF) repairs, the traditional transvesical (O'Conor) and extravesical techniques, dominate the literature. The objectives of this study are to compare success rates between laparoscopic or robotic transvesical and extravesical laparoscopic VVF repair techniques and to evaluate the impact of the number of layers in the closure, interposition flaps, and intraoperative testing of the integrity of the bladder repair. Eligible studies, published between 1994 and March 10, 2014, were retrieved through Medline and bibliography searches. All study designs of laparoscopic/robotic VVF repair were included. Open laparotomy and vaginal approaches were excluded. Only 1 retrospective cohort study was included, with the remaining articles consisting of case reports and case series. Ultimately, only 44 studies were included in a systematic review: 9 articles of robotic-assisted approach, 3 laparoscopic single-site surgeries, and 32 conventional laparoscopic approaches. A literature review revealed a balanced number of reports for both transvesical and extravesical approaches. Statistical meta-analysis was not performed because of high heterogeneity. The overall success rate of laparoscopic VVF repair was 80% to 100% with a follow-up period of 1 to 74 months. The success rate of transvesical and extravesical techniques were 95.89% and 98.04% (relative risk,.98; 95% confidence interval,.94-1.02). There was no statistical difference in success rates of VVF repair with different number of layers in the fistula closure or with use of interposition flaps, but there was a small increase in success in the cases that documented intraoperative bladder filling to test the integrity of the bladder closure. In conclusion, transperitoneal extravesical VVF repair has cure rates similar to the traditional transvesical approach. Laparoscopic extravesical VVF repair is a safe, effective, minimally invasive technique with excellent cure rates similar to those of the conventional transvesical approach in experienced surgeons' hands. (C) 2015 AAGL. All rights reserved.

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ER

PT J

AU Ring, KL

Ramirez, PT

Conrad, LB

Burke, W

Naumann, RW

Munsell, MF

Frumovitz, M

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Ramirez, Pedro T.

Conrad, Lesley B.

Burke, William

Naumann, R. Wendel

Munsell, Mark F.

Frumovitz, Michael

TI Make New Friends But Keep the Old <i>Minimally Invasive Surgery Training

in Gynecologic Oncology Fellowship Programs</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Minimally invasive surgery; Robotic surgery; Fellows; Gynecologic

oncology; Trainees; Uterine cancer; Cervical cancer; Ovarian cancer

ID ABDOMINAL RADICAL HYSTERECTOMY; ROBOTIC SURGERY; LAPAROSCOPY; SURVIVAL;

CANCER; LYMPHADENECTOMY; LAPAROTOMY; OUTCOMES; SKILLS; WOMEN

AB Objectives To evaluate the role of minimally invasive surgery (MIS) in gynecologic oncology fellowship training and fellows' predictions of their use of MIS in their future practice.

Methods All fellows-in-training in American Board of Obstetrics and Gynecology-approved training programs were surveyed in 2012 through an online or mailed-paper survey. Data were analyzed and compared to results of a similar 2007 survey.

Results Of 172 fellows, 69 (40%) responded. Ninety-nine percent of respondents (n = 68) indicated that MIS was either very important or important in gynecologic oncology, a proportion essentially unchanged from 2007 (100%). Compared to 2007, greater proportions of fellows considered laparoscopic radical hysterectomy and node dissection for cervical cancer (87% vs 54%; P < 0.0001) and trachelectomy and staging for cervical cancer (83% vs 32%; P < 0.0001) appropriate for MIS. Of the respondents, 92% believed that maximum or some emphasis should be placed on robotic-assisted surgery and 89% on traditional laparoscopy during fellowship training. Ten percent rated their fellowship training in laparoendoscopic single-site surgery as very poor; 44% said that the question was not applicable. Most respondents (60%) in 2012 performed at least 11 procedures per month, whereas most respondents (45%) in 2007 performed 6 to 10 procedures per month (P = 0.005). All respondents at institutions where robotic surgery was used were allowed to operate at the robotic console, and 63% of respondents reported that in robotic-assisted surgery cases when a fellow sat at the robot, the fellow performed more than 50% of the case at the console.

Conclusions These findings indicate that MIS in gynecologic oncology is here to stay. Fellowship programs should develop a systematic approach to training in MIS and in individual MIS platforms as they become more prevalent. Fellowship programs should also develop and apply an objective assessment of minimum proficiency in MIS to ensure that programs are adequately preparing trainees.

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AU Sheyn, D

Abouassaly, R

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Paspulati, Raj

Sanses, Tatiana

TI Multidisciplinary approach for management of obstructed hemivagina and

ipsilateral renal anomaly (OHVIRA) syndrome and rectal prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Mullerian anomaly; Robotic/laparoscopic surgery; MRI

AB Mullerian duct anomalies are frequently associated with congenital anomalies of other organ systems, and in particular, the urinary system. A multidisciplinary approach is often required for successful diagnosis and surgical management of complex pelvic anomalies. The objective of this video is to provide a guide for diagnosis of complex female pelvic anomalies and robotic-assisted approach to surgical management with a multidisciplinary team of surgeons.

The patient presented is a 24-year-old nulligravida with obstructed hemivagina and ipsilateral renal dysplasia, ipsilateral ectopic ureter, and rectal prolapse. This video outlines the methods used to obtain the correct diagnosis and steps for successful treatment using a robotically assisted surgical approach.

Complex Mullerian anomalies involving multiple organ systems may require the use of advanced three-dimensional imaging to achieve the correct diagnosis, and a minimally invasive surgical approach with robotic assistance is an effective strategy for management.

A multidisciplinary approach is often required to successfully diagnose and treat women with complex Mullerian anomalies.

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TC 2

Z9 2

U1 0

U2 2

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ER

PT J

AU Stephan, JM

Goodheart, MJ

McDonald, M

Hansen, J

Reyes, HD

Button, A

Bender, D

AF Stephan, Jean-Marie

Goodheart, Michael J.

McDonald, Megan

Hansen, Jean

Reyes, Henry D.

Button, Anna

Bender, David

TI Robotic surgery in supermorbidly obese patients with endometrial cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial cancer; obesity; robotic surgery

ID BODY-MASS INDEX; ASSISTED LAPAROSCOPIC HYSTERECTOMY; SURGICAL OUTCOMES;

LAPAROTOMY; LYMPHADENECTOMY; MORTALITY; TRIAL; WOMEN

AB OBJECTIVE: Morbid obesity is a known risk factor for the development of endometrial cancer. Several studies have demonstrated the overall feasibility of robotic-assisted surgical staging for endometrial cancer as well as the benefits of robotics compared with laparotomy. However, there have been few reports that have evaluated robotic surgery for endometrial cancer in the supermorbidly obese population (body mass index [BMI], >= 50 kg/m(2)). We sought to evaluate safety, feasibility, and outcomes for supermorbidly obese patients who undergo robotic surgery for endometrial cancer, compared with patients with lower body mass indices.

STUDY DESIGN: We performed a retrospective chart review of 168 patients with suspected early-stage endometrial adenocarcinoma who underwent robotic surgery for the management of their disease. Analysis of variance and univariate logistic regression were used to compare patient characteristics and surgical variables across all body weights. Cox proportional hazard regression was used to determine the impact of body weight on recurrence-free and overall survival.

RESULTS: The mean BMI of our cohort was 40.9 kg/m(2). Median follow up was 31 months. Fifty-six patients, 30% of which had grade 2 or 3 tumors, were supermorbidly obese with a BMI of >= 50 kg/m(2) (mean, 56.3 kg/m(2)). A comparison between the supermorbidly obese and lower-weight patients demonstrated no differences in terms of length of hospital stay, blood loss, complication rates, numbers of pelvic and paraaortic lymph nodes retrieved, or recurrence and survival. There was a correlation between BMI and conversion to an open procedure, in which the odds of conversion increased with increasing BMI (P = .02).

CONCLUSION: Offering robotic surgery to supermorbidly obese patients with endometrial cancer is a safe and feasible surgical management option. When compared with patients with a lower BMI, the supermorbidly obese patient had a similar outcome, length of hospital stay, blood loss, complications, and numbers of lymph nodes retrieved.

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Z9 45

U1 0

U2 4

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PT J

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Boggess, John F.

Soper, John T.

Huh, Warner K.

TI Obesity and perioperative pulmonary complications in robotic gynecologic

surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE complications; obesity; pulmonary complications; robotic surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; SURGICAL OUTCOMES;

WOMEN; LAPAROTOMY; PREVALENCE; PATIENT; COHORT; ADULTS; RISK

AB OBJECTIVE: Robotic gynecological surgery is feasible in obese patients, but there remain concerns about the safety of this approach because the positioning required for pelvic surgery can exacerbate obesity-related changes in respiratory physiology. The objective of our study was to evaluate pulmonary and all-cause complication rates in obese women undergoing robotic gynecological surgery and to assess variables that may be associated with complications.

STUDY DESIGN: A retrospective chart review was performed on obese patients (body mass index of >= 30 kg/m(2)) who underwent robotic gynecological surgery at 2 academic institutions between 2006 and 2012. The primary outcome was pulmonary complications and the secondary outcome was all-cause complications. Univariate and multivariate logistic regression analyses were used to determine the associations between patient baseline variables, operative variables, ventilator parameters, and complications.

RESULTS: Of 1032 patients, 146 patients (14%) had any complication, whereas only 33 patients (3%) had a pulmonary complication. Median body mass index was 37 kg/m(2). Only age was significantly associated with a higher risk of pulmonary complications (P = .01). Older age, higher estimated blood loss, and longer case length were associated with a higher rate of all-cause complications (P = .0001, P < .0001, and P = .004, respectively). No other covariates were strongly associated with complications.

CONCLUSION: The vast majority of obese patients can successfully tolerate robotic gynecological surgery and have overall low complications rates and even lower rates of pulmonary complications. The degree of obesity was not predictive of successful robotic surgery and subsequent complications.

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PT J

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Sanz-Lomana, CM

Ramirez, PT

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Rendon, Gabriel J.

Vasquez, Monica

Echeverri, Lina

Millan Sanz-Lomana, Carlos

Ramirez, Pedro T.

TI Immediate radical trachelectomy versus neoadjuvant chemotherapy followed

by conservative surgery for patients with stage IB1 cervical cancer with

tumors 2 cm or larger: A literature review and analysis of oncological

and obstetrical outcomes

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Cervical cancer; Neoadjuvant; Conservative

ID FERTILITY-SPARING SURGERY; VAGINAL TRACHELECTOMY; PRESERVING OPTION;

WOMEN; PREGNANCY; SAFE; LYMPHADENECTOMY; HYSTERECTOMY; PRESERVATION

AB Radical trachelectomy is the treatment of choice in women with early-stage cervical cancer wishing to preserve fertility. Radical trachelectomy can be performed with a vaginal, abdominal, or laparoscopic/robotic approach. Vaginal radical trachelectomy (VRT) is generally not offered to patients with tumors 2 cm or larger because of a high recurrence rate. There are no conclusive recommendations regarding the safety of abdominal radical trachelectomy (ART) or laparoscopic radical trachelectomy (LRT) in such patients. Several investigators have used neoadjuvant chemotherapy in patients with tumors 2 to 4 cm to reduce tumor size so that fertility preservation may be offered. However, to our knowledge, no published study has compared outcomes between patients with cervical tumors 2 cm or larger who underwent immediate radical trachelectomy and those who underwent neoadjuvant chemotherapy followed by radical trachelectomy. We conducted a literature review to compare outcomes with these 2 approaches. Our main endpoints for evaluation were oncological and obstetrical outcomes. The fertility preservation rate was 82.7%, 85.1%, 89%; and 91.1% for ART (tumors larger than >2 cm), ART (all sizes), NACT followed by surgery and VRT (all sizes); respectively. The global pregnancy rate. was 16.2%, 24% and 30.7% for ART, VRT, and NACT followed by surgery; respectively.

The recurrence rate was 3.8%, 4.2%, 6%, 7.6% and 17% for ART (all sizes), VRT (all sizes), ART (tumors >2 cm), NACT followed by surgery, and VRT (tumors >2 cm). These outcomes must be considered when offering a fertility sparing technique to patients with a tumor larger than 2 cm. (C) 2015 Elsevier Inc. All rights reserved.

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PT J

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TI Radical Trachelectomy for Early-Stage Cervical Cancer <i>A Survey of the

Society of Gynecologic Oncology and Gynecologic Oncology

Fellows-in-Training</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Radical trachelectomy; Conservative surgery; Cervical cancer

ID VAGINAL TRACHELECTOMY; NEOADJUVANT CHEMOTHERAPY; REPRODUCTIVE OUTCOMES;

HYSTERECTOMY; RECURRENCE; OPTIONS; PRESERVATION; METASTASES; MANAGEMENT;

CARCINOMA

AB Objective The aim of this study was to survey gynecologic oncologists and fellows-in-training regarding the role of radical trachelectomy (RT) and conservative surgery in patients with early-stage cervical cancer.

Materials and Methods From June 2012 to September 2012, the Society of Gynecologic Oncology member practitioners (n = 1353) and gynecologic oncology fellows (n = 156) were sent group-specific surveys investigating current practice, training, and the future of RT for early-stage cervical cancer management.

Results Twenty-two percent of practitioners (n = 303) and 24.4% of fellows (n = 38) completed the surveys. Of the practitioners, 50% (n = 148) report performing RT, 98% (n = 269) support RT as treatment for squamous carcinoma, and 71% (n = 195) confirm the use of RT for adenocarcinoma. Most practitioners offer RT treatment for stages IA2 to IB1 smaller than 2 cm (n = 209, 76.8%) regardless of grade (77.7%) or lymph vascular space invasion (n = 211, 79.3%). Only 8% (n = 23) of practitioners feel that RT is appropriate for stage IBI larger than 2 cm. Respectively, both practitioners and fellows most frequently perform robotic-assisted (47.0%, n = 101 and 59.1%, n = 13) and abdominal (40.5%, n = 87 and 68.2%, n = 15) RT approaches. After training, fellows project the use of robotic-assisted (71%, n = 22) or abdominal methods (58.1%, n = 18). Overall, 75% (n = 227) of practitioners and 60% (n = 23) of fellows speculate that over the next 5 years, less radical procedures will be used to manage early-stage cervical cancer.

Conclusions Our findings suggest that practitioners and fellows believe RT remains an option for early-stage cervical cancer patients. However, a significant proportion of all respondents believe that less radical surgery may be a future consideration for patients with low-risk early-stage cervical cancer.

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PT J

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TI Robotic single-site myomectomy: initial report and technique

SO FERTILITY AND STERILITY

LA English

DT Article

DE Robotic surgery; single-site surgery; myomectomy; morcellation

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; TRANSUMBILICAL TOTAL HYSTERECTOMY;

CONVENTIONAL LAPAROSCOPY; ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; LESS

PAINFUL; PORT; SURGERY; ACCESS; PREFERENCES

AB Objective: To report the first cases of robotic single-site (RSS) myomectomy with the use of the Da Vinci Si Surgical System with wristed semirigid instrumentation.

Design: Case series.

Setting: University hospital.

Patient(s): Four patients with symptomatic uterine fibroids desiring conservative minimally invasive surgical treatment.

Intervention(s): Four RSS myomectomies were performed with the Da Vinci Single-Site platform. Data regarding patient characteristics, indication of surgery, and perioperative outcomes were collected.

Main Outcome Measure(s): Safety and reproducibility of RSS myomectomy.

Result(s): All RSS procedures were completed successfully. Median operative time was 210 minutes (range 202-254 min). Median blood loss was 103 mL (range 75-200 mL). No instrument failures were noted during the procedures. No operative or major postoperative complications occurred. Two patients were discharged on the day of surgery, and two were discharged after overnight observation.

Conclusion(s): RSS myomectomy with the use of wristed semi-rigid instrumentation is a feasible procedure. Indications, safety, and use of the technique will be confirmed by growing experience. (C) 2015 by American Society for Reproductive Medicine.

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U2 4

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PT J

AU Liang, MI

Rosen, MA

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Salani, R

O'Malley, DM

Fowler, JM

Cohn, DE

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TI Predicting Inpatient Stay Lasting 2 Midnights or Longer After Robotic

Surgery for Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Inpatient stay; Prolonged hospitalization; Robotic

surgery

ID HYSTERECTOMY; OUTCOMES; COST

AB Objective: To estimate the rate of inpatient stay and the factors predicting inpatient status after robotic surgery for endometrial cancer following the change in the Medicare definition of "inpatient" to include hospitalization spanning 2 midnights.

Design: Retrospective chart review (Canadian Task Force classification II-1).

Setting: Academic hospital.

Patients: All patients (n = 395) with endometrial cancer who underwent robotic surgical management between 2006 and 2010.

Intervention: The outpatient stay group with hospitalization spanning 1 midnight was compared with the inpatient stay group with hospitalization spanning 2 midnights or longer through estimation of the adjusted relative risk (aRR) for various characteristics of interest.

Results: Ninety-six of 395 patients (24.3%) stayed at least 2 midnights and thus were deemed inpatients. Clinical factors associated with inpatient stay were increasing age, history of myocardial infarction (aRR, 2.0; 95% confidence interval [CI], 1.0-3.7), surgery start time at or after 12 noon (aRR, 1.7; 95% CI, 1.2-2.4), perioperative blood transfusion (aRR, 3.2; 95% CI, 2.3-4.5), and surgery performed in the year 2010 (aRR, 0.5; 95% CI, 0.3-0.7). Age >= 60 years was associated with at least a 2-fold adjusted risk of prolonged hospitalization. Body mass index, other medical comorbidities, operative duration, estimated blood loss, and performance of lymphadenectomy or additional:surgical procedures were not identified as significant risk factors.

Conclusion: Approximately 75% of the patients undergoing robotic surgery for endometrial cancer were discharged as outpatients. Recognition of factors predicting inpatient stay can improve hospital resource allocation and throughput in women undergoing robotic surgery for endometrial cancer. (C) 2015 AAGL. All rights reserved.

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Mäenpää, JU

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Nieminen, Kari

Tomas, Eija

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Maenpaa, Johanna U.

TI Implementing robotic surgery to gynecologic oncology: the first 300

operations performed at a tertiary hospital

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Learning curve; robotic-assisted laparoscopic surgery; endometrial

cancer; operative time; lymphadenectomy; lymph node; gynecology

ID ENDOMETRIAL CANCER; ASSISTED HYSTERECTOMY; RADICAL HYSTERECTOMY;

LEARNING-CURVE; LYMPHADENECTOMY; LAPAROSCOPY; LAPAROTOMY; OUTCOMES;

MORBIDITY; PROGRAM

AB ObjectiveTo investigate the initial experience with robotic-assisted laparoscopic surgery in gynecologic oncology.

DesignA retrospective survey.

SettingTertiary referral center.

PopulationThe first 300 patients operated on using robotic assistance at the Department of Obstetrics and Gynecology of Tampere University Hospital, from March 2009 through January 2013.

MethodsRetrospective patient chart review.

Main outcome measuresThe primary outcome measure was the learning curve events, and the complication and conversion rates were secondary outcome measures.

ResultsThe commonest type of operation was hysterectomy, bilateral salpingoophorectomy and pelvic lymphadenectomy (LH+BSO+PLND, n=89), followed by the same procedure amended by para-aortic lymphadenectomy (PALND, n=74), type II radical hysterectomy (n=24), and PLND+PALNDomentectomy (n=15). A learning curve was most evident for LH+BSO+PLND: whereas the median operative time of all 89 operations was 167min (range 403-104), it was 260 (range 403-135) and 153 (range 247-104) min in the case of the first and last 20 operations, respectively. The learning curve was short, or 10 procedures. A learning curve was also seen for the preoperative time in the operation room and for the number of lymph nodes harvested. The median blood loss during all 300 operations was 100mL (range 5-3200). The median postoperative hospital stay was 1day. The conversion rate was 4.0%, and the complication rate 19.3% (major in 9%).

ConclusionThe learning curve of robotic-assisted laparoscopic surgery appears to be short, or 10 operations. Robotic-assisted procedures seem to offer a safe and useful alternative to traditional techniques.

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Z9 16

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U2 6

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PT J

AU Yaribakht, S

Guillemin, F

Harter, V

Malartic, C

Marchal, F

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TI New approach to the learning curve in robot- assisted gynecological

oncology surgery

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Robotic assisted-surgery; Learning curve; CUSUM analysis; Endometrial

cancer; Cervical cancer

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; OUTCOMES;

EXPERIENCE; WOMEN

AB Objectives. - Define the phases composing the learning curve of total hysterectomy (TH) and radical hysterectomy with pelvic lymphadenectomy (RHPL) robot-assisted performed by a single surgeon with no prior experience in laparoscopic surgery.

Methods. - We retrospectively analyzed 72 procedures (TH, n =34 and RHPL, n = 38) conducted between 2002 and 2011. The surgeon console time (CT) was used to determine the learning curve of TH and RHPL using CUSUM analysis. Epidemiological data, perioperative and.postoperative complications were compared from the different phases of the learning curve.

Results. CUSUM analysis of surgeon console time (CUSUMcr) identified two learning phases for the TH group (phase 1: initial learning, phase 2: surgical skill increase). For the RHPL group, three learning phases were identified (phase 1: initial learning, phase 2: extending surgical indications, phase 3: control of surgical skills). Perioperative and postoperative complication rates did not differ significantly between the learning phases. Surgeon CT decreased from the 9th case (P = 0.01) for the TH group and from the 13th case (P = 0.04) for the RHPL group.

Discussion. CUSUM analysis of the learning curve in robotic-assisted gynecologic oncology surgery identified two phases of learning curve for simple procedures such as total hysterectomy and three phases for more complex procedures as radical hysterectomy with pelvic lymphadenectomy. 2015 Elsevier Masson SAS. All rights reserved.

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TI Outcome of Robotic Surgery for Endometrial Cancer as a Function of

Patient Age

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Age; Elderly; Endometrial cancer; Robotic surgery; Morbidity; Survival;

Quality of life

ID QUALITY-OF-LIFE; GYNECOLOGIC-ONCOLOGISTS; ELDERLY-PATIENTS;

HYSTERECTOMY; CARCINOMA; MORBIDITY; COHORT

AB Objective This study aimed to evaluate and compare robot-assisted surgical staging on clinical outcomes, including quality of life and survival, as a function of patient age.

Methods Evaluation and comparison of perioperative morbidity, survival, and postoperative quality of life after prospective accumulation of clinical information including outcome measures for patients with endometrial cancer during the first 5 years of a robotic program, based on the following 3 age categories: women older than 80 years, women between 70 and 80 years, and women younger than 70 years.

Results All consecutive patients with endometrial cancer undergoing robotic surgery (n = 303) were included, with 197 women younger than 70 years, 75 women between 70 and 80 years, and 31 women older than 80 years. There were significantly more patients with advanced stage (stage II to IV in 17%, 34%, and 35%, P = 0.02) and grade 3 disease (26%, 43%, and 58%, P = 0.002) with increasing age. The perioperative data showed similar grade I or II complications (Clavien-Dindo classification) between the groups, but significantly more grade III and IV complications for women older than 80 years compared with women 80 years or younger (10% vs 1%, P = 0.004). The time needed to resume chore activities was significantly shorter for patients 70 years or older than patients younger than 70 years [8.9 (8.7) vs 18.8 (25.5) days, P = 0.048]. Overall, all patients irrespective of age were highly satisfied with the procedure. There was no difference between young and elderly patients for disease-free survival (P = 0.99).

Conclusions Patient's age did not influence minor postoperative morbidity or overall satisfaction after robotic assisted surgery for endometrial cancer. Elderly patients had more major postoperative morbidity but resumed activities quicker than younger patients.

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Z9 23

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U2 3

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TI Influence of pneumoperitoneum pressure on surgical field during robotic

and laparoscopic surgery: a comparative study

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Pneumoperitoneum; CO2; Robotic surgery; Laparoscopy; Visualization;

Operative field

ID HYSTERECTOMY; FEASIBILITY

AB Studies on the influence of CO2 pneumoperitoneum on the abdominal cavity during robotic procedures are lacking. This is the first study to evaluate surgical field modifications related to CO2 pressure, during laparoscopic and robotic surgery.

Consecutive patients scheduled for laparoscopic or robotic hysterectomy were enrolled in the study. To evaluate the level of operative field visualization, a dedicated form has been designed based on the evaluation of four different areas: Douglas space, vesico-uterine fold and, bilaterally, the broad ligament. During the initial inspection, an assistant randomly set the CO2 pressure at 15, 10 and 5 mmHg, and the surgeon, not aware of the CO2 values, was asked to give an evaluation of the four areas for each set pressure.

In laparoscopic group, CO2 pressure significantly influenced the surgical field visualization in all four areas analyzed. The surgeon had a good visualization only at 15 mmHg CO2 pressure; visualization decreased with a statistically significant difference from 15 to 5, 15-10 and 10-5 mmHg. In robotic group, influence of CO2 pressure on surgical areas visualization was not straightforward; operative field visualization remained stable at any pressure value with no significant difference.

Pneumoperitoneum pressure significantly affects the visualization of the abdomino-pelvic cavity in laparoscopic procedures. Otherwise, CO2 pressure does not affect the visualization of surgical field during robotic surgery. These findings are particularly significant especially at low CO2 pressure with potential implications on peritoneal environment and the subsequent post-operative patient recovery.

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NR 16

TC 25

Z9 25

U1 0

U2 2

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ER

PT J

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Hébert, T

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Ouldamer, L.

Body, G.

TI Robotic assisted laparoscopy: Comparison of segmentary colorectal

resection and shaving for colorectal endometriosis

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Robotic laparoscopy; Endometriosis; Resection; Shaving

ID SURGERY; BOWEL

AB Objectives. - To compare perioperative complications of two surgical methods for digestive endometriosis management: "shaving" and colorectal resection in robotic-assisted laparoscopy.

Methods. - Twenty-eight women underwent robotic-assisted laparoscopy for digestive endometriosis, confirmed histologically. Six women had a digestive resection and twenty-one women had a shaving procedure. Short-term and long-term results and complications were compared between the two groups.

Results. - Operative time was significantly shorter (P = 0.0002) and estimated blood loss was significantly lower (200 ml vs 560 ml, P = 0.04) in the shaving procedure group in comparison with the resection group. We observed one conversion to laparotomy in the resection group and one case of bladder injury in the shaving group. Length of hospital stay was longer (P = 0.0001) in the resection group than in the shaving group. At the two-month re-evaluation, there was no significant difference between the two groups for the number of women in full remission for pelvic pain, urinary or gastrointestinal symptoms or dyspareunia. Two women of the resection group reported functional gastrointestinal signs that persisted 24 months after the intervention.

Conclusion. - Both immediate and delayed operative morbidity are more frequent in case of resection. Surgery for deep infiltrating endometriosis, even if operated with robotic assisted laparoscopy, is associated with significant morbidity. (C) 2015 Elsevier Masson SAS. All rights reserved.

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NR 15

TC 7

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J9 GYNECOL OBSTET FERTI

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ER

PT J

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Osmundsen, B

Geller, E

Matthews, CA

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Siff, Lauren

Osmundsen, Blake

Geller, Elizabeth

Matthews, Catherine A.

TI Differences in recurrent prolapse at 1 year after total vs supracervical

hysterectomy and robotic sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic surgery; Sacrocolpopexy; Supracervical hysterectomy; Total

hysterectomy

ID TERM OUTCOMES

AB Optimal management of the cervix at the time of hysterectomy and sacrocolpopexy for primary uterovaginal prolapse is unknown. Our hypothesis was that recurrent prolapse at 1 year would be more likely after a supracervical robotic hysterectomy (SRH) compared with a total robotic hysterectomy (TRH) at the time of robotic sacrocolpopexy (RSCP) for uterovaginal prolapse.

This was a retrospective cohort analysis of 83 women who underwent hysterectomy with RSCP over a 24-month period (40 with TRH and 43 with SRH). At 1 year post-procedure, subjects completed validated questionnaires regarding pelvic floor symptoms, sexual function, and global satisfaction, and underwent a pelvic examination to identify mesh exposure and evaluate pelvic floor support.

Demographics of the two groups were similar, except for a higher mean body mass index in the TRH group (31.9 TRH vs 25.8 SRH kg/m(2), p < 0.001). The rate of recurrent prolapse a parts per thousand yen stage II was higher for women who underwent SRH compared with TRH (41.9 % vs 20.0 %, p = 0.03; OR 2.8, 95 % CI, 1.07-7.7). However, when this was analyzed as recurrence a parts per thousand yen hymen, there was no difference between groups (12.5 % TRH vs 18.6 % SRH, p = 0.45). Likewise, there was no difference between groups when a composite measure of success was used (30 out of 40 [75 %] TRH vs 29 out of 43 [67.4 %] SRH, p = 0.45).

Women who underwent an SRH were 2.8 times more likely to have a recurrent prolapse, a parts per thousand yen stage II, at 1 year, compared with those who underwent a TRH, but when composite assessment scores were used there was no difference between the groups.

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NR 17

TC 34

Z9 37

U1 0

U2 0

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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ER

PT J

AU Rabinovich, A

AF Rabinovich, Alex

TI Minimally invasive surgery for endometrial cancer: a comprehensive

review

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Endometrial carcinoma; Minimally invasive surgery; Laparoscopy;

Robotically assisted laparoscopy

ID UTERINE-CANCER; ROBOTIC SURGERY; LAPAROSCOPIC TREATMENT; RADICAL

HYSTERECTOMY; DISEASE RECURRENCE; OBESE WOMEN; MANAGEMENT; SURVIVAL;

LAPAROTOMY; OUTCOMES

AB The objective of this article is to review the recently published literature on the use of minimally invasive surgical approaches for patients with endometrial cancer.

Narrative review of the pertinent literature on traditional laparoscopy and robotically assisted laparoscopy for the treatment of endometrial cancer.

Multiple studies have shown that minimally invasive surgical approaches for the treatment of endometrial cancer reduce blood loss, length of hospital stay and the incidence and severity of post-operative surgical complications compared with laparotomy. Minimally invasive techniques maintain equivalent oncologic results with regard to the number of dissected lymph nodes and overall and disease-free survival rates. Robotically assisted laparoscopy compared to traditional laparoscopy reduced the conversion rate to laparotomy, further reduces intra-operative blood lose and has significant ergonomic advantages for the surgeon. Laparoscopic and robotic surgery techniques are particularly advantageous in obese patients, reducing peri-operative and post-operative abdominal wound complications.

A thorough review of the literature indicates that minimally invasive approach has a number of established advantages over laparotomy that makes it the surgical treatment option of choice in endometrial carcinoma patients.

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NR 47

TC 15

Z9 16

U1 0

U2 8

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ER

PT J

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TI Learning Curve Analysis of Intracorporeal Cuff Suturing During Robotic

Single-Site Total Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE da Vinci Single-Site Platform; Intracorporeal cuff suturing;

Laparoendoscopic single-site surgery; Learning curve; Total hysterectomy

ID ENDOMETRIAL CANCER; SURGERY

AB Study Objective: To analyze the learning curve of intracorporeal cuff suturing during robotic single-site total hysterectomy.

Design: Retrospective study (Canadian Task Force classification

Setting: University hospital.

Patients: Twenty-four patients with benign indications for hysterectomy.

Interventions: Twenty-four patients who underwent robotic single-site total hysterectomy to treat benign indications were included in the study. Surgical procedures were performed by a single surgeon with extensive experience in laparoscopy, using the single-site platform of the da Vinci Surgical System. All vaginal cuffs were closed intracorporeally using semi-rigid single-site instruments.

Measurements and Main Results: An exponential learning curve technique was used to analyze the learning curve. The overall mean (SD) vaginal cuff closure time was 23.2 (7) minutes. Learning curve analysis revealed a decrease in vaginal closure time after 14 procedures.

Conclusions: An experienced robotic surgeon requires approximately 14 procedures to achieve proficiency in intracorporeal cuff suturing during robotic single-site total hysterectomy. Novel instruments that create perfect triangulation are needed to overcome the current challenges of suturing and to shorten operative time. (C) 2015 AAGL. All rights reserved.

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TC 15

Z9 15

U1 0

U2 3

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WC Obstetrics & Gynecology

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ER

PT J

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AF Asciutto, Katrin C.

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TI Robot-assisted surgery in cervical cancer patients reduces the time to

normal activities of daily living

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Cervical cancer; robot; laparoscopy; surgery; activities of daily living

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY; CARCINOMA;

WOMEN

AB ObjectiveTo evaluate current surgical cervical cancer treatment in Sweden 2008-12.

Design and settingAnalysis of data in the Swedish National Quality Register for Gynecological Surgery (GynOP).

SampleA total of 249 cervical cancer patients undergoing surgery.

MethodsAnalysis of prospectively gathered preoperative and postoperative data including patient-reported information.

Main outcome measuresMean operating time, blood loss/transfusion, length of hospital stay, return to activities of daily living.

ResultsThe patients undergoing laparoscopic robot-assisted surgery (n=64) or laparotomy (n=185) did not differ in age, body mass index, American Society of Anesthesiologists score, International Federation of Gynecology and Obstetrics (FIGO) stage or mean operating time. Blood loss was higher in the laparotomy group (p<0.001). Thirteen patients in the laparotomy group (7%) received a blood transfusion, but none in the robot group. Intraoperative complications were more common in the laparotomy group (p=0.03). Re-admission or operations did not differ between the groups. The number of pelvic lymph nodes removed was significantly higher in the laparotomy group (median 31 vs. 24, p<0.001). There was no difference regarding the number of patients with lymph node metastases in the two groups. The postoperative length of hospital stay was longer in the laparotomy group compared with the robot group (6.1days vs. 2.1days, p=0.01). The patient-reported time to resume normal activities of daily living was longer in the laparotomy than the robot group (13.4days vs. 9.7days, p=0.04).

ConclusionsLaparoscopic robotic-assisted surgery is preferable to laparotomy for cervical cancer patients because it entails a significantly shorter hospital stay, less blood loss, fewer intraoperative complications and shorter time to normal daily activities.

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NR 29

TC 16

Z9 18

U1 0

U2 9

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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PT J

CA Comm Gynecologic Practice Soc

TI Robotic Surgery in Gynecology

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

AB The field of robotic surgery has developed rapidly, and its use for gynecologic conditions has grown exponentially. Surgeons should be skilled at abdominal and laparoscopic approaches for a specific procedure before undertaking robotic approaches. Surgeon training, competency guidelines, and quality metrics should be developed at the institutional level. Robot-assisted cases should be appropriately selected based on the available data and expert opinion. As with any surgical procedure, repetition drives competency. Ongoing quality assurance is essential to ensure appropriate use of the technology and, most importantly, patient safety. Adoption of new surgical techniques should be driven by what is best for the patient, as determined by evidence-based medicine rather than external pressures. Well-designed randomized controlled trials or comparably rigorous nonrandomized prospective trials are needed to determine which patients are likely to benefit from robot-assisted surgery and to establish the potential risks.

NR 67

TC 5

Z9 5

U1 1

U2 2

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ER

PT J

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TI Minimally Invasive Secondary Cytoreduction Plus HIPEC Versus Open

Surgery Plus HIPEC in Isolated Relapse From Ovarian Cancer: A

Retrospective Cohort Study on Perioperative Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE HIPEC; Isolated platinum-sensitive relapse; Laparoscopy; Minimally

invasive surgery; Ovarian cancer; Robotic

ID HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY; SURGICAL-MANAGEMENT;

MULTICENTER; LAPAROSCOPY; CARCINOMA; SURVIVAL

AB Study Objective: To compare the perioperative outcomes of minimally invasive secondary cytoreduction surgery (SCS) plus hyperthermic intraoperative intraperitoneal chemotherapy (HIPEC) versus open surgery plus HIPEC in a group of platinumsensitive patients with advanced epithelial ovarian cancer (AEOC) with isolated relapse.

Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Catholic University of the Sacred Heart, Rome, Italy.

Patients: We selected 22 patients with a peritoneal cancer index value of 2. The laparoscopic group consisted of 11 patients who underwent laparoscopic and/or robotic complete cytoreduction plus HIPEC, whereas the laparotomic group consisted of 11 patients who underwent complete laparotomic cytoreduction plus HIPEC.

Interventions: The minimally invasive surgery (MIS) group were platinum-sensitive single recurrent ovarian cancer patients who underwent either laparoscopic or robotic complete secondary cytoreduction plus HIPEC, whereas the open group were women with similar clinical characteristics who underwent complete secondary cytoreduction plus HIPEC by laparotomy.

Measurements and Main Results: The median operative time, calculated from the skin incision to the end of SCS (i.e., excluding HIPEC phase) was 125 min (range 95-150 min) in the MIS group and 295 min (range 180-420) in the open group (p = .001), with a median estimated blood loss of 50 mL (range 50-100) and 500 mL (range 50-1300), respectively (p = .025). The median length of hospital stay was 4 days (range 3-17) in the MIS group and 8.5 days (range 4-30) in the open group (p = .002). No statistically significant differences were registered in terms of intra- and postoperative complications between the 2 groups.

Conclusion: The minimally invasive approach for SCS plus HIPEC is safe and efficient in terms of toxicity and postoperative outcomes for single isolated relapse. HIPEC should not be considered a major contraindication to a minimally invasive approach. (C) 2015 AAGL. All rights reserved.

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U2 9

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ER

PT J

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TI Comparison of Two Minimally Invasive Approaches to Endometrial Cancer

Staging <i>A Single-Surgeon Experience</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE endometrial cancer; laparoscopic surgical procedure; laparoscopy;

robotic surgical procedures; traditional laparoscopy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; LYMPHADENECTOMY;

LAPAROTOMY; OUTCOMES; TRIAL

AB OBJECTIVE: To compare the clinical outcomes of endometrial cancer staging procedures performed by a single surgeon utilizing traditional and robotic-assisted laparoscopic techniques.

STUDY DESIGN: A retrospective review of minimally invasive endometrial cancer staging performed by a single surgeon.

RESULTS: There were no significant differences in operative time, blood loss, surgical complications, or length of hospitalization between laparoscopic (n = 45) and robotic-assisted (n = 77) procedures. On multivariable analysis controlling for surgical chronology, robotic assistance was independently associated with a significantly greater number of lymph nodes (23 vs. 19, p < 0.05; beta 0.163, p < 0.05). When comparing the first chronologic half of robotic-assisted surgeries to the second half, the latter had shorter operative time (208 vs. 246 min, p = 0.01) and a greater number of lymph nodes (27 vs. 19, p = 0.001). Finally, compared to the laparoscopic cases, the second half of robotic-assisted cases had a greater number of total (27 vs. 19, p < 0.001) and pelvic (23 vs. 17, p < 0.001) lymph nodes harvested.

CONCLUSION: There was a learning curve associated with robotic-assisted laparoscopic endometrial cancer staging, with decreased operative time and increased lymph node yield over time. In our study population, robotic assistance was independently associated with a greater lymph node harvest with no increase in operative time or perioperative complications.

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AU Hotujec, BT

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TI Transversus abdominis plane block in robotic gynecologic oncology: A

randomized, placebo-controlled trial

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Transversus abdominis plane block; Postoperative analgesia; Robotic

surgery

ID ANALGESIC EFFICACY; LAPAROSCOPIC CHOLECYSTECTOMY; POSTOPERATIVE PAIN;

TAP BLOCK; SURGERY; HYSTERECTOMY; METAANALYSIS; RECOVERY; QUALITY; BLIND

AB Objective. Although robotic surgery decreases pain compared to laparotomy, postoperative pain can be a concern near the site of a larger assistant trocar site. The aim of this study was to determine the efficacy of transversus abdominis plane (TAP) block on 24-hour postoperative opiate use after robotic surgery for gynecologic cancer.

Methods. Sixty-four subjects with gynecologic malignancies who were scheduled to undergo robotic surgery were enrolled into the study. They were randomized to receive a unilateral TAP block to the side of the assistant port via ultrasound guidance. The block was comprised of 30 cc of 0.25% bupivacaine with 3 mcg/mL epinephrine or saline. Opiate use was measured and converted into IV morphine equivalents. Patient-reported pain was measured using the Brief Pain Inventory (BPI) and VisualAnalog Scale (VAS).

Results. The treatment group used a mean of 64.9 mg morphine in the first 24 h compared to 69.3 mg for controls (primary outcome, p = 0.52). After age-adjustment, the treatment group used a mean of 11.1 mg morphine less than controls (p = 0.09). Postoperative pain scores assessed by the BPI (6.44 vs. 6.97, p = 0.37) and the VAS (3.12 vs. 3.61, p = 0.30) were equivalent. Block placement was uncomplicated in 98.4% of participants with mean BMI of 35.3 kg/m(2). Linear regression revealed an approximate 8.1 mg decrease in morphine equivalents used per additional decade of life (p = 0.0008). There was a positive correlation between the amount of opiates and BMI with an additional 8.8 mg of morphine per 10 kg/m(2) increase in BMI (p = 0.0012).

Conclusions. TAP block is safe and feasible in this patient population with a large proportion of morbid obesity. Preoperative TAP block does not significantly decrease opiate use. However; based on these data, a clinically useful nomogram has been created to aid clinicians in postoperative opiate-dosing for patients based on age and BMI. (C) 2014 Elsevier Inc All rights reserved.

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TI Robotically Assisted Para-aortic Lymphadenectomy: Surgical Results <i>A

Cohort Study of 487 Patients</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic surgery; Para-aortic lymphadenectomy; Surgical outcomes;

Endometrial cancer; Cervical cancer

ID ADVANCED CERVICAL-CANCER; SINGLE-PORT LAPAROSCOPY; ENDOMETRIAL CANCER;

GYNECOLOGIC-ONCOLOGY; EXTRAPERITONEAL; SURGERY; MORBIDITY; CARCINOMA;

MALIGNANCIES; FEASIBILITY

AB Objectives: The aim of this study was to evaluate perioperative outcomes of robotic-assisted laparoscopic para-aortic lymphadenectomy (PAL) in patients with gynecologic cancers during the learning phases of robotic surgery programs and to compare results of extraperitoneal versus transperitoneal approaches of PAL.

Materials and Methods: This study is a retrospective multicentric study of patients who underwent robotically assisted laparoscopic PAL (N = 487). Eleven European centers and 1 US center participated in the study. Abstracted data included age, body mass index, indication, type of surgical approach (transperitoneal or extraperitoneal), associated surgical procedures, operative time, estimated blood loss, lymph node count, hospital length of stay (LOS), and complications. Para-aortic lymphadenectomy was performed by an extraperitoneal approach in 58 cases (12%) and transperitoneal in 429 cases (88%).

Results: The mean (SD) para-aortic lymph node count was 12.6 (8.1), operative time was 217 (85) minutes, estimated blood loss was 105 (110) mL, and LOS was 2.8 (3.2) days. Four (0.8%) conversions to open and 2 (0.4%) conversions to laparoscopy were described. There were 32 lymphocysts (6.6%), 3 deep venous thromboses (0.6%), and 10 transfusions (2.1%). For transperitoneal approach, the average number of lymph nodes removed was higher in isolated PAL group than the hysterectomy combined group (report node counts 95% confidence interval, -7.29 to -3.52, P = 1.5 x 10(-6)). For isolated PAL, the LOS was shorter in the extraperitoneal group than in the transperitoneal group (report data 95% CI, -1.35 to -0.35, P = 0.001).

Conclusions: Robotic-assisted PAL seems safe and feasible. More lymph nodes were removed during an isolated transperitoneal PAL dissection compared with a combined procedure with hysterectomy. Extraperitoneal approach seems attractive relative to transperitoneal dissection, but the superiority of one or the other way is not demonstrated by our study.

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TI One-Year Functional and Anatomic Outcomes of Robotic Sacrocolpopexy

Versus Vaginal Extraperitoneal Colpopexy With Mesh

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacral colpopexy; vaginal mesh; pelvic organ prolapse; abdominal mesh

ID ABDOMINAL SACROCOLPOPEXY; ANTERIOR COLPORRHAPHY; TERM OUTCOMES;

PROLAPSE; POPULATION; REPAIR

AB Objectives: This study aimed to evaluate and compare 1-year anatomic and functional outcomes in patients undergoing transvaginal versus transabdominal repair of pelvic organ prolapse (POP) with synthetic mesh reinforcement.

Methods: We conducted a retrospective, matched cohort study of patients undergoing robotic-assisted laparoscopic sacrocolpopexy (RALSC) and vaginal extraperitoneal colpopexy (VEC) with synthetic mesh from December 2008 to March 2011. We compared the preoperative to postoperative changes in anatomic, quality of life, and functional outcomes between groups after 1 year of follow-up. One-year surgical satisfaction was also assessed.

Results: Thirty-eight RALSC patients met the inclusion criteria and were matched by age and month of surgery to 38 VEC patients. Of those, 31 RALSC and 30 VEC patients (80%) had complete 1-year data. Preoperative to postoperative outcomes were similar in both groups with similar improvement seen in anatomic Pelvic Organ Prolapse Quantification measures as well as functional questionnaire scores. Both groups demonstrated high surgical satisfaction. Symptom distress inventory scales revealed 84% and 90% resolution of symptomatic "bulge'' in RALSC and VEC patients, respectively (P = 0.74). The RALSC group had a significantly greater operative time by approximately 96 minutes and greater use of general anesthesia (P = <0.001). No difference was noted in blood loss, hospital days, or return to normal voiding between groups.

Conclusions: Transabdominal and transvaginal techniques of colpopexy using synthetic mesh implants for POP have been shown in this retrospective cohort study to improve quality of life and anatomic measures with similar outcomes. Robotic-assisted laparoscopic sacrocolpopexy results in a greater use of general anesthesia and longer operative time.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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TI Comparison of Two Simulation Systems to Support Robotic-Assisted

Surgical Training: A Pilot Study (Swine Model)

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE da Vinci Surgical System; dV-Trainer; Robotic surgery; Simulation;

Virtual reality

ID PERFORMANCE; VALIDATION; TOOL

AB Objective: To compare the efficacy of simulation-based training between the Mimic dV- Trainer and traditional dry lab da Vinci robot training.

Design: A prospective randomized study analyzing the performance of 20 robotics-naive participants. Participants were enrolled in an online da Vinci Intuitive Surgical didactic training module, followed by training in use of the da Vinci standard surgical robot. Spatial ability tests were performed as well. Participants were randomly assigned to 1 of 2 training conditions: performance of 3 Fundamentals of Laparoscopic Surgery dry lab tasks using the da Vinci or performance of 4 dV-Trainer tasks. Participants in both groups performed all tasks to empirically establish proficiency criterion. Participants then performed the transfer task, a cystotomy closure using the daVinci robot on a live animal (swine) model. The performance of robotic tasks was blindly assessed by a panel of experienced surgeons using objective tracking data and using the validated Global Evaluative Assessment of Robotic Surgery (GEARS), a structured assessment tool.

Results: No statistically significant difference in surgeon performance was found between the 2 training conditions, dV-Trainer and da Vinci robot. Analysis of a 95% confidence interval for the difference in means (-0.803 to 0.543) indicated that the 2 methods are unlikely to differ to an extent that would be clinically meaningful.

Conclusion: Based on the results of this study, a curriculum on the dV- Trainer was shown to be comparable to traditional da Vinci robot training. Therefore, we have identified that training on a virtual reality system may be an alternative to live animal training for future robotic surgeons. Published by Elsevier Inc. on behalf of AAGL.

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TI Robotic-assisted laparoscopic complex myomectomy: A single medical

center's experience

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE complex myomectomy; laparoscopic myomectomy; robotic myomectomy

ID SURGERY; HYSTERECTOMY

AB Objective: Conventional laparoscopic myomectomy (LM) has inherent limitations due to its rigid structure. The robotic system is a newly developed technology equipped with a flexible EndoWrist that offers good performance in delicate motions. Our objective was to share our clinical experience in the management of complex myomectomy using this robotic system.

Materials and methods: From October 2010 to March 2012, 21 patients with symptomatic complex uterine myomas were evaluated. Complex myomectomy was defined as surgery involving more than two fibroids, large fibroids, or preexisting pelvic adhesions. We recorded and analyzed the preoperative characteristics of the patients and the fibroids, the detailed surgical time, and several postoperative outcomes to evaluate the feasibility and efficacy of robotic-assisted LM (RALM) for complex fibroids.

Results: A total of 21 patients were enrolled in this study. The mean age of the patients was 40.1 +/- 4.5 years and the mean size of the largest fibroid was 7.3 +/- 3.5 cm. RALM achieved satisfactory results, including a short postoperative hospital stay (3.1 +/- 0.9 days), a low conversion rate (none of our patients required conversion to either a minilaparotomy or conventional open surgery), and a low complication rate (1 case in 21 patients, 4.8%). The average estimated blood loss was 235.7 +/- 2833 mL.

Conclusion: Our study results demonstrated that RALM is a safe and effective method for handling complex fibroids. Copyright (C) 2014, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. All rights reserved.

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JI Taiwan. J. Obstet. Gynecol.

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PT J

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TI A Prospective, Comparative Study on Robotic Versus Open-Surgery

Hysterectomy and Pelvic Lymphadenectomy for Endometrial Carcinoma

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic surgery; Endometrial cancer; Patient satisfaction; Cost;

Surgical outcome

ID CANCER; OUTCOMES; COST; LAPAROTOMY; WOMEN; PATIENT; CARE

AB Objectives: The aim of this study was to compare surgical outcome, patient recovery, and costs between robot-assisted laparoscopy and laparotomy in women undergoing hysterectomy, bilateral salpingo-oophorectomy (BSOE), and pelvic lymphadenectomy for endometrial carcinoma.

Methods: Women undergoing hysterectomy, BSOE, and pelvic lymphadenectomy for endometrial carcinoma, according to regional guidelines, were prospectively, concurrently, and consecutively included from September 2010 to December 2012. Surgical outcomes such as operative time, estimated blood loss (EBL), number of lymph nodes retrieved, and complications were analyzed together with hospital stay, days until normal active daily living was retrieved, patient satisfaction with the length of the hospital stay, and cost per patient. Robot-assisted laparoscopy was performed on all cases at the Sahlgrenska University Hospital, and laparotomy was performed on all cases at 3 regional hospitals.

Results: Forty women underwent robot-assisted laparoscopy, and 48 underwent laparotomy. There were no differences in age, body mass index, histology, or retrieved lymph nodes. Operative time was significantly shorter in the robot-assisted laparoscopy group (P < 0.0001). The EBL was lower and hospital stay was shorter in the robot-assisted laparoscopy group (P < 0.0001). There was no statistical difference in complications between the groups, and both groups found hospital stay duration satisfactory. In the robot-assisted laparoscopy group, active daily living was normal within 5 days postoperatively, compared with 14 days in the laparotomy group (P < 0.0001). Calculated costs per treated patient did not differ statistically between the groups.

Conclusions: Compared with laparotomy and robot-assisted laparoscopic hysterectomy, BSOE pelvic lymphadenectomy for endometrial carcinoma was associated with significantly shorter operative time, hospital stay, and lower EBL. Patients recovered more quickly after robot-assisted laparoscopy, with equal costs number of retrieved lymph nodes, compared with laparotomy.

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U1 0

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ER

PT J

AU Franké, O

Narducci, F

Chereau-Ewald, E

Orsoni, M

Jauffret, C

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Lambaudie, E

AF Franke, Oona

Narducci, Fabrice

Chereau-Ewald, Elisabeth

Orsoni, Marion

Jauffret, Camille

Leblanc, Eric

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TI Role of a Double Docking to Improve Lymph Node Dissection <i>When

Robotically Assisted Laparoscopy for Para</i>-<i>aortic Lymphadenectomy

Is Associated to a Pelvic Procedure</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic surgery; Para-aortic lymphadenectomy; Cervical cancer;

Endometrial cancer; Minimal invasive surgery

ID PARAAORTIC LYMPHADENECTOMY; GYNECOLOGIC ONCOLOGY; CERVICAL-CANCER;

LEARNING-CURVE; SURGERY; LAPAROTOMY; HYSTERECTOMY

AB Objective: The objective of this study was to demonstrate that robotically assisted laparoscopy for aortic lymph node dissection was improved when double docking (DD) of the Da Vinci system is used for combined surgical procedures [defined by the combination of a pelvic procedure and a para-aortic lymphadenectomy (PAL)].

Methods: From February 2007 to February 2013, 41 patients underwent combined procedures including PAL up to the left renal vein in 2 cancer centers. We used 2 different approaches as follows: a single docking (SD) of the Da Vinci system (transperitoneal PAL and pelvic surgery) during the first period (22 patients) and a DD during the second period (19 patients). We recorded retrospectively the lymph node count (main criteria), operative time, estimated blood loss, hospital stay, and postoperative complications.

Results: We observed a statistical difference between SD and DD concerning aortic lymph node count (5.86 vs 10.89, P < 0.005). Operative time is longer in the DD group (326.1 vs 239.4 minutes, P < 0.05). No difference was observed concerning estimated blood loss. Hospital stay was longer in the DD group (4.9 vs 3.2 days, P < 0.05). Only 1 conversion to open was described in the SD group.

Conclusions: In our experience of robotically assisted laparoscopy, when PAL is combined to a pelvic procedure, the use of a DD seems to improve aortic lymph node count. Despite a longer operative time compared to SD, DD seems to be a good solution to combine the advantages of robotic assistance to our quality criteria of aortic dissection. Synopsis: We compare 2 techniques to realize robotic assisted para-aortic lymphadenectomy combined with pelvic procedure. Double docking seems to improve histological results compared to single docking.

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ER

PT J

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TI Immediate Repair of an Incompletely Transected Obturator Nerve During

Robotic-assisted Pelvic Lymphadenectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Obturator nerve injury; Robotic surgery

ID LAPAROSCOPIC TRANSECTION

AB Intraoperative injury of the obturator nerve may occur in gynecologic oncologic procedures when extensive pelvic side wall dissection is performed. In this case, we report an immediate repair of an incompletely transected obturator nerve during robotic-assisted pelvic lymphadenectomy. A 62-year-old gravida 3, para 3 woman was admitted to our clinic for postmenopausal bleeding. The result of an endometrial biopsy was complex endometrial hyperplasia with atypia, and a robotic-assisted laparoscopic hysterectomy was performed. A frozen section of the specimen revealed grade 1 endometrioid adenocarcinoma with > 1/2 myometrial invasion. During the pelvic lymphadenectomy, the left obturator nerve was incompletely transected. The obturator nerve edges were oriented and reapproximated end-to-end with two 6/0 polypropylene sutures. The operation and console times were 244 and 223 minutes, respectively. The final pathologic finding was a stage IB endometrial adenocarcinoma. The number of the obtained lymph nodes was 38. Postoperatively, the patient did not exhibit any clinically apparent loss of adductor function or any other neurologic deficiency. Over 6 months of follow-up, the patient experienced no residual neuropathy or deficit in the left thigh. Robotic-assisted repair of a transected obturator nerve during surgery is. feasible, and immediate repair of the damaged nerve may result in no neurologic deficit postoperatively. (C) AAGL. All rights reserved.

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U2 0

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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ER

PT J

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TI Robotic transperitoneal infra-renal aortic lymphadenectomy in

early-stage endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Trans-peritoneal; Infra-renal

aortic lymphadenectomy; Early-stage

ID EXTRAPERITONEAL PARAAORTIC LYMPHADENECTOMY; LYMPH-NODE DISSECTION;

GYNECOLOGIC CANCER; CERVICAL-CARCINOMA; LAPAROSCOPY; FEASIBILITY; RISK

AB Objectives. To assess the clinical performance of robotic-assisted infra-renal aortic lymphadenectomy (IRL) using a single center-docked approach for patients with endometrial cancer.

Methods. Robotic-assisted hysterectomy with pelvic and aortic lymphadenectomy was performed in 97 clinical stage I endometrial cancer (EC) patients with the intent to remove infra-renal aortic lymph nodes. Pen-operative data was contemporaneously accessioned and a retrospective database analysis was performed to examine clinical outcomes.

Results. IRL versus infra-mesenteric artery (IMA) dissections were accomplished in 88 (90.7%) and nine (93%) cases, respectively. There were no laparotomy conversions. Histology included 20.6% G1, 41.2% G2, and 38.1% G3 (endometrioid and Type II histologies). Forty-four (45.4%) cases had >50% depth-of-invasion and 43 (44.3%) cases had lymphovascular space invasion. Lymph node metastases were detected in 39 (40.2%) cases [37 (38.1%) pelvic, 16 (16.5%) pelvic + aortic, two (2.1%) isolated aortic lymph nodes]. Aortic metastasis was identified in 16/37 (43.2%) pelvic node positive cases, and 6/34 (17.7%) IRL cases with positive pelvic nodes had infra-renal metastasis, yet normal aortic nodes below the IMA. Harvested aortic lymph nodes for IRL exceeded IMA cases (15.9 +/- 6.3 vs. 8.9 +/- 4.6; p < 0.01). Mean BMI for IMA cases exceeded IRL cases (37.4 +/- 3.3 vs. 31.4 +/- 7.1 kg/m(2); p <0.001). Twenty-five (81%) patients with BMI >35 kg/m(2) underwent successful IRL (range 36-47 kg/m(2)) compared to 95% of cases <35 kg/m(2) (p = 0.03).

Conclusions. IRL was accomplished in 95% of EC patients with BMI <35 kg/m(2) and 81% with BMI >35 kg/m(2) using a single center-docked approach. A strict 35 kg/m(2) BMI cut-off for avoiding IRL is therefore not advised. (C) 2014 Elsevier Inc. All rights reserved.

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PT J

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TI Same-day discharge is feasible and safe in patients undergoing minimally

invasive staging for gynecologic malignancies

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cervical cancer; endometrial cancer; laparoscopic staging; minimally

invasive comprehensive surgical staging; robotic-assisted laparoscopic

staging; same-day discharge

ID LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; RADICAL HYSTERECTOMY;

CERVICAL-CANCER; SURGERY; OUTCOMES

AB OBJECTIVE: The objective of the study was to evaluate the feasibility and safety of same-day discharge of patients undergoing minimally invasive comprehensive surgical staging for endometrial and cervical cancer.

STUDY DESIGN: We performed a retrospective review of consecutive patients from January 2008 to December 2011 undergoing comprehensive staging for endometrial or cervical cancer by traditional laparoscopy or robotic-assisted laparoscopy and intended for same-day discharge. Patients accomplishing same-day discharge were compared with those who required admission. Clinical and demographic data, perioperative outcomes, and postoperative patient contacts within 6 weeks were collected. Multivariate logistic regression modeling was used to determine factors associated with admission and unscheduled patient contacts within 2 weeks of surgery.

RESULTS: A total of 141 patients were identified. One hundred eighteen patients (83.7%) underwent same-day discharge and 23 (16.3%) required overnight admission. The variables that significantly predicted overnight admission were severe pain in the postanesthesia care unit (odds ratio [OR], 6.81; 95% confidence interval [CI], 1.74-26.6; P = .006), delayed ability to tolerate oral intake (OR, 9.3; 95% CI, 2.25-38.6, P = .002), traditional laparoscopic vs roboticassisted surgical approach (OR, 9.05; 95% CI, 2.34-35.1; P = .001), and surgery start time at 2: 00 PM or later (OR, 36.8; 95% CI, 6.19-219.3; P < .0001). There was no difference in the readmission rate between patients undergoing same-day discharge compared with overnight admission (11% vs 17%, P = .48). No variables significantly predicted unscheduled patient contact within 2 weeks of surgery at P < .01.

CONCLUSION: Same-day discharge for patients undergoing laparoscopic or robotic-assisted laparoscopic staging for endometrial or cervical cancer is feasible and safe. There are low complication rates and few readmissions or unscheduled patient contacts within 2 weeks of surgery.

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U2 5

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PT J

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TI Factors Influencing Same-day Hospital Discharge and Risk Factors for

Readmission After Robotic Surgery in the Gynecologic Oncology Patient

Population

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecologic oncology; Robotic surgery; Same-day discharge

ID ENDOMETRIAL CANCER; ASSISTED HYSTERECTOMY

AB Study Objective: To determine the factors that allow for a safe outpatient robotic-assisted minimally invasive gynecologic oncology surgery procedure.

Design: Retrospective chart review (Canadian Task Force classification II-1).

Setting: University hospital.

Patients: All patients (140) undergoing robotic-assisted minimally invasive surgery with the gynecologic oncology service from January 1, 2013, to December 31, 2013.

Interventions: Risk factors for unsuccessful discharge within 23 hours of surgery and same-day discharge were assessed using logistic regression models.

Measurements and Main Results: All patients were initially scheduled for same-day discharge. The outpatient surgery group was defined by discharge within 23 hours of the surgery end time, and a same-day surgery subgroup was defined by discharge before midnight on the day of surgery. One hundred fifteen (82.1%) were successfully discharged within 23 hours of surgery, and 90 (64.3%) were discharged the same day. The median hospital stay was 5.3 hours (range, 1-48 hours). Unsuccessful discharge within 23 hours was associated with a preoperative diagnosis of lung disease and intraoperative complications; unsuccessful same-day discharge was associated with older age and later surgery end time. Only 2 patients (1.4%) were readmitted to the hospital within 30 days of surgery.

Conclusions: Outpatient robotic-assisted minimally invasive surgery is safe and feasible for most gynecologic oncology patients and appears to have a low readmission rate. Older age, preoperative lung disease, and later surgical end time were risk factors for prolonged hospital stay. These patients may benefit from preoperative measures to facilitate earlier discharge. (C) 2015 AAGL. All rights reserved.

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PT J

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AF Scheib, Stacey A.

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TI Gynecologic robotic laparoendoscopic single-site surgery: prospective

analysis of feasibility, safety, and technique

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE laparoendoscopic single-site surgery; robotic surgery; single-port

surgery

ID ENDOMETRIAL CANCER; TOTAL HYSTERECTOMY; LAPAROSCOPY; LESS; RISK;

MANAGEMENT; LAPAROTOMY

AB OBJECTIVE: Multiple reports suggest that laparoendoscopic single-site surgery is technically feasible, safe, and effective in treating a variety of gynecological disease processes. The study purpose was to assess the feasibility and safety of a novel robotic single-site platform (R-LESS) for the surgical treatment of benign and malignant gynecological conditions.

STUDY DESIGN: A single-institution, prospective analysis of 40 women treated with R-LESS on the gynecology and gynecological oncology services from June 2013 through March 2014. Women undergoing hysterectomy or adnexal surgery for either a benign or malignant gynecological condition were offered robotic single-site surgery during the study period of June 1, 2013, through April 1, 2014. Patients underwent surgery through a single 2.5-3.0 cm umbilical incision with a multichannel port and utilizing the da Vinci robotic single-site platform. Two surgeons with extensive laparoendoscopic single-site experience participated.

RESULTS: Forty patients had R-LESS performed. Procedures included total laparoscopic hysterectomy, laparoscopic supracervical hysterectomy, salpingo-oophorectomy, ovarian cystectomy, excision of endometriosis, and a combined case of total laparoscopic hysterectomy and cholecystectomy. Median age and body mass index were 42 years and 28.2 kg/m(2), respectively. Median operating time, defined as the interval between incision start to closure, was 134 minutes (range, 84-311 minutes). Median vaginal cuff closure was 21 minutes (range, 9-77 minutes). Overall, there appeared to be a linear relationship between vaginal cuff closure time, console time, and operating time with number of cases performed. Procedures were successfully performed via R-LESS in 92.5% of cases; 2 cases required 1 additional port and there was 1 conversion to traditional multiport robotic surgery. There was 1 major postoperative complication (2.5%) and 1 readmission (2.5%). After a median follow-up period of 230 days (range, 61-256), there have been no postoperative hernias diagnosed.

CONCLUSION: We present one of the first series of robotic laparoendoscopic single-site surgery for the treatment of various gynecological conditions. When performed by experienced minimally invasive surgeons, R-LESS is feasible and safe in select patients. Further studies are needed to better define the ideal gynecological procedures to perform using robotic single-site surgery and to assess the benefits and costs of R-LESS compared with multiport robotic and conventional laparoscopic approaches.

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U2 24

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PT J

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TI Is cervix removal associated with patient-centered outcomes of pain,

dyspareunia, well-being and satisfaction after laparoscopic

hysterectomy?

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Hysterectomy; Laparoscopy; Supracervical; Patient-centered outcomes

research; Quality of life

ID SUPRACERVICAL HYSTERECTOMY

AB To determine the effect of cervix removal at hysterectomy on patient-centered outcomes including post-operative pain, dyspareunia, well-being, and overall satisfaction during the 3-month post-operative period.

This is a prospective cohort study of 228 women who underwent elective abdominal, laparoscopic and robotic hysterectomy without concomitant urogynecological or cancer-related procedures, at the Henry Ford Hospital (Detroit, MI). Participants completed a baseline survey evaluating quality of life measures including pain, well-being, sexual and daily function and repeated this survey at serial intervals through 12 weeks post-operatively. Medical record review was performed to confirm demographic and obtain surgical data.

Hierarchical generalized linear models were used to model the trajectory of pain, well-being and satisfaction over the course of the post-surgical period. Subanalysis including only laparoscopic cases was performed. There was no difference in satisfaction (p = 0.48, OR 0.80 [CI 95% 0.43, 1.48]), well-being (p = 0.55, OR 1.12 [CI 95% 0.84, 1.79]), or dyspareunia (p = 0.57, OR 0.75 [CI 95% 0.27, 2.04]) scores between laparoscopic/robotic supracervical and total hysterectomy groups. This was unchanged when all hysterectomy approaches were included in analysis. Cervix removal was associated with higher pain scores with all surgical approaches although this did not reach statistical significance.

Patient-centered outcomes suggest overall equivalent tolerance of supracervical and total hysterectomy procedures with a trend towards short-term pain improvement with cervical retention.

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NR 18

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Z9 11

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U2 2

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TI Comparison of Postural Ergonomics Between Laparoscopic and Robotic

Sacrocolpopexy: A Pilot Study

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Ergonomics; Laparoscopic; Robotic; Sacrocolpopexy

ID ENDOSCOPIC SURGERY; PERFORMANCE

AB Study Objective: To compare resident, fellow, and attending urologic and gynecologic surgeons' musculoskeletal and mental strain during laparoscopic and robotic sacrocolpopexy.

Design: Prospective cohort study (Canadian Task Force classification 11-2).

Setting: Academic medical center.

Patients: Patients who underwent robotic or laparoscopic sacrocolpopexy from October 2009 to January 2011.

Interventions: The Body Part Discomfort (BPD) survey was completed before cases, and the National Aeronautics and Space Administration Task Load Index and BPD survey were completed after cases. Higher scores on BPD and the National Aeronautics and Space Administration Task Load Index indicate greater musculoskeletal discomfort and mental strain. BPD scores were averaged over the following body regions: head/neck, back, hand/wrist, arms, and knees/ankles/feet. Changes in body region specific discomfort scores were the primary outcomes.

Measurements and Main Results: Multivariable analysis was performed using mixed-effects linear regression with surgeon as a random effect. Sixteen surgeons participated (53% fellows, 34% residents, and 13% attendings). Thirty-three robotic and 53 laparoscopic cases were analyzed, with a median surgical time of 231 minutes (interquartile range, 204-293 minutes) versus 227 minutes (interquartile range, 203-272 minutes; p = .31), a median estimated blood loss of 100 mL (interquartile range, 50-175 mL) versus 150 mL (interquartile range, 50-200 mL; p = .22), and a mean patient body mass index of 27 4 versus 26 4 kg/m2 (p = .26), respectively. Robotic surgeries were associated with lower neck/shoulder (-0.19 [interquartile range, -0.32 to -0.01], T = -2.49) and back discomfort scores (-0.35 [interquartile range, -0.58 to 0], T = -2.38) than laparoscopic surgeries. Knee/ankle/foot and arm discomfort increased with case length (0.18 [interquartile range, 0.02-0.3], T = 2.81) and (0.07 [interquartile range, 0.01-0.14], p = .03), respectively.

Conclusion: Surgeons performing minimally invasive sacrocolpopexy experienced less neck, shoulder, and back discomfort when surgery was performed robotically. (C) 2015 AAGL. All rights reserved.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Xie, Y

AF Xie, Yue

TI Cost-effectiveness of robotic surgery in gynecologic oncology

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE cost-effectiveness; costs; outcomes; reimbursement policy; robotic

surgery

ID PERIOPERATIVE OUTCOMES; OVARIAN-CANCER; ENDOMETRIAL; HYSTERECTOMY;

LAPAROSCOPY; MANAGEMENT

AB Purpose of review

Robotically assisted surgeries have flourished in the United States, especially in gynecological procedures. Current robotic systems have high upfront and procedure costs that have led many in the medical community to question the new technology's cost-effectiveness.

Recent findings

Recent research continues to find that robotically assisted gynecological cancer treatments have comparable outcomes to traditional laparoscopy and similar or better outcomes than that of laparotomy in the cases studied. However, robotic surgery costs remain higher than that of traditional laparoscopy.

Summary

Under the current reimbursement climate, practicing physicians and hospitals should collaborate on identifying cost-effective uses of robotic systems and pushing manufacturers to lower purchase and procedure costs to a level that may be accepted by all stakeholders.

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NR 32

TC 12

Z9 16

U1 0

U2 6

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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PG 4

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA AX9WZ

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ER

PT J

AU Zechmeister, JR

Pua, TL

Boyd, LR

Blank, SV

Curtin, JP

Pothuri, B

AF Zechmeister, Jenna R.

Pua, Tarah L.

Boyd, Leslie R.

Blank, Stephanie V.

Curtin, John P.

Pothuri, Bhavana

TI A prospective comparison of postoperative pain and quality of life in

robotic assisted vs conventional laparoscopic gynecologic surgery

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE laparoscopic surgery; postoperative pain; quality of life; robotic

surgery

ID HYSTERECTOMY

AB OBJECTIVE: We sought to compare robotic vs laparoscopic surgery in regards to patient reported postoperative pain and quality of life.

STUDY DESIGN: This was a prospective study of patients who presented for treatment of a new gynecologic disease requiring minimally invasive surgical intervention. All subjects were asked to take the validated Brief Pain Inventory-Short Form at 3 time points to assess pain and its effect on quality of life. Statistical analyses were performed using Pearson chi(2) and Student's t test.

RESULTS: One hundred eleven were included in the analysis of which 56 patients underwent robotic assisted surgery and 55 patients underwent laparoscopic surgery. There was no difference in postoperative pain between conventional laparoscopy and robotic assisted surgery for gynecologic procedures. There was a statistically significant difference found at the delayed postoperative period when evaluating interference of sleep, favoring laparoscopy (ROB 2.0 vs LSC 1.0; P = .03). There were no differences found between the robotic and laparoscopic groups of patients receiving narcotics (56 vs 53, P = .24, respectively), route of administration of narcotics (47 vs 45, P > .99, respectively), or administration of nonsteroidal antiinflammatory medications (27 vs 21, P = .33, respectively).

CONCLUSION: Our results demonstrate no difference in postoperative pain between conventional laparoscopy and robotic assisted surgery for gynecologic procedures. Furthermore, pain did not appear to interfere consistently with any daily activity of living. Interference of sleep needs to be further evaluated after controlling for bilateral salpingo-oophorectomy.

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NR 8

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Z9 16

U1 0

U2 5

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ER

PT J

AU Akdemir, A

Yildirim, N

Zeybek, B

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Sendag, F

AF Akdemir, Ali

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Zeybek, Burak

Karaman, Semra

Sendag, Fatih

TI Single Incision Trans-Umbilical Total Hysterectomy: Robotic or

Laparoscopic?

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Hysterectomy; Laparoscopy; Robotic surgery; Single-port laparoscopy

ID TRANSUMBILICAL TOTAL HYSTERECTOMY; ENDOMETRIAL CANCER; INITIAL REPORT;

SITE PLATFORM; UNITED-STATES; SURGERY; FEASIBILITY; EXPERIENCE

AB Objective: The aim of this study was to compare the early surgical outcomes in patients who underwent total hysterectomy with laparoendoscopic single-site surgery (LESS-TH) versus robotic single-site total hysterectomy (RSSTH). Methods: Twenty-four patients who underwent RSSTH and thirty-four patients who underwent LESS-TH were retrospectively evaluated. Patient characteristics, operation time, intraoperative data (conversions, complications, estimated blood loss, etc.) and postoperative pain scores were compared. Results: The total operation time was significantly longer in the robotic surgery group, with a time of 98.5 vs. 86 min (p = 0.013), while vaginal closure time was significantly higher in the laparoscopic surgery group (p = 0.011). Intraoperative outcomes and postoperative pain scores were similar in the two groups. Conclusion: RSS-TH helps surgeons to overcome the technical disadvantages of LESS-TH, particularly vaginal cuff closure, ergonomics and instrument crowding and clashing. Early surgical outcomes are comparable in the two groups, and both techniques are safe and feasible. (C) 2015 S. Karger AG, Basel

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NR 23

TC 16

Z9 16

U1 0

U2 3

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J9 GYNECOL OBSTET INVES

JI Gynecol.Obstet.Invest.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Ansari, A

Ahmad, S

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Jeppson, CN

Holloway, RW

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Ahmad, Sarfraz

James, Jeffrey A.

Jeppson, Corinne N.

Holloway, Robert W.

TI Robotic-assisted Laparoscopic Resection of Cornual Ectopic Pregnancy

<i>A Case Report</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE cornual ectopic pregnancy; cornual pregnancy; cornuostomy; ectopic

pregnancy; gynecologic surgery; laparoscopy; laparotomy;

minimally-invasive surgery; robotic-assisted laparoscopy;

robotic-assisted surgery; robotics; robots in medicine; salpingectomy;

surgical technology

ID MANAGEMENT; METHOTREXATE; INJECTION

AB BACKGROUND: Interstitial or cornual ectopic pregnancy is an uncommon variant of ectopic pregnancy. Herein we describe the first robotic-assisted laparoscopic resection of a cornual ectopic pregnancy and review the relevant peer-reviewed English literature involving minimally invasive surgery for this condition.

CASE: A 37-year-old woman, G3, P2, presented to the emergency room with an 8.5week, 4.5-cm cornual ectopic pregnancy and underwent a of cornual pregnancy was feasible and was associated with minimal blood loss, aided with the use of an endoscopic vascular clamp and intramural vasopressin. successful robotic-assisted surgical excision and repair without complications. The technical description of the robotic-assisted laparoscopic cornual resection and uterine repair is presented. Thirteen peer-reviewed literature citations involving 183 cases of laparoscopic management of cornual ectopic pregnancy were identified from the year 1988 to the present, and are discussed herein.

CONCLUSION: Robotic-assisted laparoscopic resection of cornual pregnancy was feasible and was associated with minimal blood loss, aided with the use of an endoscopic vascular clamp and intramural vasopressin.

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GA AZ8WE

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ER

PT J

AU Chen, CH

Chiu, LH

Chan, C

Liu, WM

AF Chen, Ching-Hui

Chiu, Li-Hsuan

Chan, Cindy

Liu, Wei-Min

TI Management of Ovarian Cancer in 14th Gestational Week of Pregnancy by

Robotic Approach with Preservation of the Fetus

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Ovarian cancer; Pregnancy; Robotic surgery

ID CHEMOTHERAPY; SURGERY; STATISTICS; GUIDELINES; WOMEN

AB The objective of this study is to present a rare case of pregnancy complicated with ovarian cancer managed by robotic surgery. A 36-year-old woman suffered from sudden onset of lower abdominal pain during her pregnancy at 14 weeks of gestation. As malignancy was highly suspected, left salpingo-oophorectomy, bilateral pelvic lymph node dissection, and omentectomy were performed by robotic approach. The uterus and fetus were preserved. After surgery, 5 courses of carboplatin and paclitaxel were given, and the patient was delivered by cesarean section at 37 weeks of pregnancy. Follow-up at 18 months showed no signs of cancer recurrence. As there is limited report of pregnancy complicated with ovarian cancer managed by robotic surgery, we provide this rare case and suggest that surgical staging for ovarian malignancy can be safely accomplished by robotic approach at 14 weeks of pregnancy. (C) 2015 S. Karger AG, Basel

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ER

PT J

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TI Robotic Burch colposuspension: a surgical case and instructional video

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Burch colposuspension; Robotic surgery; Stress urinary incontinence;

Surgical management of stress urinary incontinence

AB The Burch colposuspension is a well-studied and proven surgical treatment for stress urinary incontinence without intrinsic sphincter deficiency. The advent of the minimally invasive mid-urethral sling has given rise to diminished surgical experience in performing the Burch. Recent anti-mesh media and FDA notifications have caused patients to demand mesh-free surgery, resulting in an opportunity for the resurgence of the Burch procedure. The objective of this video is to demonstrate surgical technique and instruction for a robotic Burch colposuspension as well as recommendations for successful completion of the procedure. Additionally, the video reviews and illustrates pertinent surgical anatomy regardless of approach.

The patient is a 53-year-old woman who presented with symptoms of vaginal pressure, urinary incontinence, and constipation. She had symptoms and urodynamics consistent with mixed urinary incontinence without intrinsic sphincter deficiency and had been treated with antimuscarinics for overactive bladder. On examination she was found to have stage II prolapse. She desired surgical management of both her prolapse and stress incontinence.

Robotic Burch colposuspension can be completed in a safe and effective manner and should be considered as an option for patients in whom an anti-incontinence procedure is indicated and who are already undergoing robotic surgery.

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TC 10

Z9 10

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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ER

PT J

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Jenkins, TR

AF Lagrew, David C., Jr.

Jenkins, Todd R.

TI The future of obstetrics/gynecology in 2020: a clearer vision.

Transformational forces and thriving in the new system

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID BREAST-CANCER; VETERANS; SATISFACTION; TECHNOLOGY; POPULATION;

MANAGEMENT; PROGRAMS; OUTCOMES; SURGERY; QUALITY

AB Revamping the delivery of women's health care to meet future demands will require a number of changes. In the first 2 articles of this series, we introduced the reasons for change, suggested the use of the 'Triple Aim' concept to (1) improve the health of a population, (2) enhance the patient experience, and (3) control costs as a guide post for changes, and reviewed the transformational forces of payment and care system reform. In the final article, we discuss the valuable use of information technology and disruptive clinical technologies. The new health care system will require a digital transformation so that there can be increased communication, availability of information, and ongoing assessment of clinical care. This will allow for more cost-effective and individualized treatments as data are securely shared between patients and providers. Scientific advances that radically change clinical practice are coming at an accelerated pace as the underlying technologies of genetics, robotics, artificial intelligence, and molecular biology are translated into tools for diagnosis and treatment. Thriving in the new system not only will require time-honored traits such as leadership and compassion but also will require the obstetrician/gynecologist to become comfortable with technology, care redesign, and quality improvement.

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Z9 7

U1 0

U2 35

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J9 AM J OBSTET GYNECOL

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ER

PT J

AU Lönnerfors, C

Reynisson, P

Persson, J

AF Lonnerfors, Celine

Reynisson, Petur

Persson, Jan

TI A Randomized Trial Comparing Vaginal and Laparoscopic Hysterectomy vs

Robot-Assisted Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Laparoscopic hysterectomy; Minimally invasive surgery;

Robot-assisted laparoscopy; Vaginal hysterectomy

ID RADICAL HYSTERECTOMY; LEARNING-CURVE; OUTCOMES; COSTS

AB Study Objective: To investigate the hospital cost and short-term clinical outcome of traditional minimally invasive hysterectomy vs robot-assisted hysterectomy in women primarily not considered candidates for vaginal surgery.

Design: Randomized controlled trial (Canadian Task Force classification I).

Setting: University Hospital in Sweden.

Patients: One hundred twenty-two women with uterine size <16 gestational weeks scheduled to undergo minimally invasive hysterectomy because of benign disease.

Interventions: Robot-assisted hysterectomy or traditional vaginal or laparoscopic minimally invasive hysterectomy.

Measurements and Main Results: All women underwent surgery as randomized. There were no demographic differences between the 2 groups. Vaginal hysterectomy was possible in 41% in the traditional minimally invasive group, at a mean hospital cost of $4579 compared with $7059 for traditional laparoscopic hysterectomy. This was reflected in a mean hospital cost of $993 more per robotic-assisted hysterectomy than for traditional minimally invasive hysterectomy when the robot was a preexisting investment. This hospital cost increased by $1607 when including investments and cost of maintenance. A perprotocol subanalysis comparing laparoscopy and robotics demonstrated similar hospital cost when the robot was a preexisting investment ($7059 vs $7016). Robotic-assisted hysterectomy was associated with less blood loss and fewer postoperative complications.

Conclusion: A similar hospital cost can be attained for laparoscopy and robotics when the robot is a preexisting investment. From the perspective of hospital costs, robotic-assisted hysterectomy is not advantageous for treating benign conditions when a vaginal approach is feasible in a high proportion of patients. (C) 2015 AAGL. All rights reserved.

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NR 30

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Z9 108

U1 1

U2 18

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ER

PT J

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Azodi, M

Schwartz, P

Silasi, DA

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Azodi, Masoud

Schwartz, Peter

Silasi, Dan-Arin

TI Comparison of Lymphedema Incidence Between 2 Lymphadenectomy Techniques

in Patients With Uterine Cancer Undergoing Robotic Staging

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Lymphedema; Pelvic lymphadenectomy; Uterine cancer; Robotics

ID ENDOMETRIAL CANCER; POSTOPERATIVE COMPLICATIONS; GYNECOLOGICAL CANCER;

CERVICAL-CANCER; SURGERY; MALIGNANCIES; LYMPHOCYSTS; PREVALENCE;

CARCINOMA; ETIOLOGY

AB Objective: This study aimed to compare the incidence of lower extremity lymphedema in patients with uterine cancer after robotic staging using the following 2 methods: standard and selective pelvic lymphadenectomy.

Materials and Methods: Three hundred forty-four consecutive patients who presented with endometrial cancer from March 2007 to October 2012 underwent robotic staging. Surgeon A performed standard pelvic lymphadenectomy and surgeon B performed selective lymphadenectomy. Selective pelvic lymphadenectomy spared the lateral chain of the external iliac lymph nodes (LNs). The incidence of lymphedema and staging adequacy between the 2 groups were analyzed.

Results: Standard pelvic lymphadenectomy was performed in 238/344 (69.2%) patients and selective pelvic lymphadenectomy was performed in 106/344 (30.8%) patients. Conversion to laparotomy occurred in 2/344 cases (0.6%). Mean age for 344 patients was 63.6 (10) years and body mass index was 34.8 (10.1) kg/m(2). The mean operative time was 162.3 (54.6) minutes. Postoperative hospitalization was 1.62 (1.93) days. Histology included 80.8% endometrioid adenocarcinomas and 19.2% clear cell, serous, and carcinosarcomas. Mean pelvic LN counts for the standard and selective pelvic lymphadenectomy groups were 16 (8.6) and 15.5 (7.1), respectively (P = 0.31). Mean numbers of para-aortic LNs retrieved for the standard and selective lymphadenectomy groups were 3.1 (4.1) and 4.9 (4.5), respectively (P < 0.01). Median follow-up was 29.3 months (interquartile range, 15.6-43.1 months). The difference in the incidence of lower extremity lymphedema was statistically significant: 4.6% (11/238 patients) in the standard lymphadenectomy group versus 0.9% (1/106 patients) in the selective lymphadenectomy group (P = 0.03).

Conclusions: When compared to the standard technique, selective pelvic lymphadenectomy with sparing of the lateral chain of the external iliac LNs is adequate and results in a lower incidence of lower extremity lymphedema.

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TC 7

Z9 7

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U2 9

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Nezhat, CR

Stevens, A

Balassiano, E

Soliemannjad, R

AF Nezhat, Camran R.

Stevens, Amanda

Balassiano, Erika

Soliemannjad, Rose

TI Robotic-Assisted Laparoscopy vs Conventional Laparoscopy for the

Treatment of Advanced Stage Endometriosis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Advanced stage endometriosis; Conventional laparoscopy; Robotic-assisted

laparoscopy

ID HYSTERECTOMY; MANAGEMENT; OUTCOMES; SURGERY; DISEASE; BOWEL

AB Study Objective: To compare robotic-assisted laparoscopy with conventional laparoscopy for treatment of advanced stage endometriosis insofar as operative time, estimated blood loss, complication rate, and length of hospital stay.

Study Design: Retrospective cohort study (Canadian Task Force classification 112). All procedures were performed by one surgeon between January 2004 and July 2012. Data was collected via chart review.

Setting: Tertiary referral center for treatment of endometriosis.

Patients: Four hundred twenty women with advanced endometriosis.

Interventions: Fertility-sparing surgery to treat advanced endometriosis, either via conventional or robotic-assisted laparoscopy.

Measurements and Main Results: Patient demographic data, operative time, estimated blood loss, complication rate, and length of hospital stay were compared between the 2 groups. Two hundred seventy-three patients underwent conventional laparoscopy and 147 patients underwent robotic-assisted laparoscopy for fertility-sparing treatment of advanced stage endometriosis. Patients in both groups had similar characteristics insofar as age, body mass index, and previous abdominal surgeries. There were no significant differences in blood loss or complication rate between the 2 groups. Mean operative time in the conventional laparoscopy group was 135 minutes (range, 115-156 minutes), and in the robotic-assisted laparoscopy group was 196 minutes (range, 185-209 minutes), with a mean difference in operative time of 61 minutes (p < .001). Length of hospital stay was also significantly increased in the robotic-assisted laparoscopy group. Most patients who underwent conventional laparoscopy were discharged to home on the day of surgery. Of 273 patients in the conventional laparoscopy group, only 63 remained in the hospital overnight, and all 147 patients in the robotic-assisted laparoscopy group were discharged on postoperative day 1.

Conclusion: Conventional laparoscopy and robotic-assisted laparoscopy are excellent methods for treatment of advanced stages of endometriosis. However, use of the robotic platform may increase operative time and might also be associated with longer hospital stay. Published by Elsevier Inc. on behalf of AAGL.

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ER

PT J

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Hull, T

Paraiso, MFR

AF Solomon, Ellen R.

Muffly, Tyler M.

Hull, Tracy

Paraiso, Marie Fidela R.

TI Laparoscopic repair of recurrent lateral enterocele and rectocele

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Enterocele; Rectocele; Laparoscopy; Polydiaxenone mesh

AB It is difficult to determine what types of procedures should be attempted in patients who have recurrent prolapse. We present a case of recurrent lateral enterocele and rectocele after the patient had undergone multiple surgeries for pelvic organ prolapse (POP), including a vaginal hysterectomy, bladder-neck suspension, anterior colporrhaphy, site-specific rectocele repair, apical mesh implant, iliococcygeus vault suspension, and transobturator suburethral sling procedure. With recurrence, the patient underwent robot-assisted laparoscopic sacral colpopexy, tension-free vaginal tape transobturator sling insertion, rectocele repair, and perineorrhaphy with cystoscopy. She then presented with defecatory outlet obstruction and constipation and subsequently was treated with a stapled transanal rectal resection. The patient returned with continued defecatory dysfunction and a recurrent lateral enterocele and rectocele. The recurrence was treated laparoscopically using a lightweight polypropylene mesh. The postoperative period was uneventful. Two years later, the patient reported decreased defecatory symptoms and no further symptomatic prolapse.

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Z9 0

U1 0

U2 2

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JI Int. Urogynecol. J.

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PT J

AU Turner, LC

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Shepherd, JP

AF Turner, Lindsay C.

Kantartzis, Kelly

Shepherd, Jonathan P.

TI Predictors of Postoperative Acute Urinary Retention in Women Undergoing

Minimally Invasive Sacral Colpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacral colpopexy; postoperative urinary retention

ID PELVIC RECONSTRUCTIVE SURGERY; FREE VAGINAL TAPE; RISK-FACTORS;

PROLAPSE; EFFICACY; REPAIR

AB Objectives: Our aim was to determine predictors of acute urinary retention in women undergoing laparoscopic and robotic sacral colpopexy.

Methods: Records from all minimally invasive sacral colpopexies performed from 2009 to 2012 were reviewed. All women had a retrograde fill voiding trial (RGVT) on postoperative day 1, except in cases of intra-operative bladder injury or chronic urinary retention. Patient demographics, medical comorbidities, and surgical factors were compared between women who did and did not pass the RGVT. Univariable and multivariable logistic regression analyses were used to identify predictors of postoperative voiding dysfunction.

Results: Three hundred two subjects met the inclusion criteria, but 12 were excluded because of planned prolonged catheterization. Of the remaining 290 subjects, 211 (72.8%) passed the RGVT. Themean (SD) for the duration of urinary retention in those ho failed was 3.7 (4.2) days. The mean (SD) for age was 58.5 (8.6) years, and the median preoperative prolapse was Pelvic Organ Prolapse Quantification stage III (76.1% with >= stage III) with mean Ba = +2.3. There were no significant independent risk factors identified on multivariable logistic regression to predict RGVT failure, with only concurrent midurethral sling approaching significance (6.1% vs 12.5%; adjusted odds ratio, 2.25; 95% confidence interval, 0.93-5.45; P = 0.07).

Conclusions: No significant predictors of acute urinary retention were identified among women undergoing minimally invasive sacral colpopexy. In contrast to published analyses of vaginal prolapse repairs, large preoperative cystocele and concurrent midurethral sling were not significantly associated with retention. Given the inability to predict who will have postoperative urinary retention, all patients should be counseled about the potential need for catheterization.

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U2 4

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ER

PT J

AU Vahanian, SA

Finamore, PS

Lazarou, G

AF Vahanian, Sevan A.

Finamore, Peter S.

Lazarou, George

TI Delayed Small Bowel Obstruction After Robotic-Assisted Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic sacrocolpopexy; barbed suture; delayed small bowel obstruction

AB We report 2 unusual cases of partial bowel obstruction resulting from adherence to a barbed suture presenting 3 to 4 weeks after robotic-assisted sacrocolpopexy for uterovaginal prolapse. Both patients underwent an uncomplicated robotic-assisted supracervical hysterectomy and sacrocolpopexy. Immediate postoperative recovery was uncomplicated. Three to four weeks after surgery, both patients presented with symptoms of nausea, vomiting, and abdominal pain and were found to have small bowel obstructions requiring a return to the operating room. Upon surgical exploration, a loop of small bowel was found to be adhered to a segment of the barbed suture at the sacral promontory, which had been used to close the peritoneum over the mesh. Subsequent to release, both patients had an uneventful recovery.

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PT J

AU Vogel, TJ

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TI An analysis of current treatment practice in uterine papillary serous

and clear cell carcinoma at two high volume cancer centers

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Adenocarcinoma; Clear Cell; Disease-free Survival; Endometrial

Neoplasms; Lymph Node Excision; Retrospective Studies

ID ENDOMETRIAL CANCER; SURVIVAL; PATTERNS; LYMPHADENECTOMY; RECURRENCE;

LAPAROTOMY; OUTCOMES; SURGERY

AB Objective: Despite the rarity of uterine papillary serous carcinoma (UPSC) and uterine clear cell carcinoma (UCCC), they contribute disproportionately to endometrial cancer deaths. Sufficient Clinical information regarding treatment and prognosis is lacking. The aim of this study is to evaluate treatment outcomes in a rare cancer cohort based on the experience at two tertiary care cancer centers.

Methods: Clinicopathologic data were retrospectively collected on 279 patients with UPSC and UCCC treated between 1995 to 2011. Mode of surgery, use of adjuvant treatment, and dissection of paraaoritc lymph nodes were evaluated for their association with overall survival (OS) and progression-free survival (PFS).

Results: 40.9% of patients presented with stage I disease, 6.8% of patients presented with stage II disease and 52.3% of patients presented with stages III and IV. Median follow-up was 31 months (range, 1 to 194 months). OS and PFS at 5 years were 63.0% and 51.9%, respectively. OS and PFS were not affected by mode of surgery (open vs. robotic approach; OS: hazard ratio [HR], 0.68; 95% confidence interval [CI], 0.28 to 1.62; PFS: HR, 0.78; 95% CI, 0.40 to 1.56). Adjuvant treatment was associated with improved OS in stages IB-II (HR, 0.14; 95% CI, 0.02 to 0.78; p=0.026) but not in stage IA disease. There was no difference in OS or PFS based on the performance of a paraaoritc lymph node dissection.

Conclusion: Minimally invasive surgical staging appears a reasonable strategy for patients with non-bulky UPSC and UCCC and was not associated with diminished survival. Adjuvant treatment improved 5-year survival in stages IB-II disease.

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NR 27

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Z9 30

U1 0

U2 3

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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PG 7

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Lee, Jeong-Won

Bae, Duk-Soo

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TI Single-site robotic surgery in gynecologic cancer: a pilot study

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Gynecology; Minimally Invasive Surgical Procedures; Operation Time;

Postoperative Complications; Robotic Surgical Procedure; Single-site

ID INITIAL REPORT; ONCOLOGY; HYSTERECTOMY; PLATFORM

AB Objective: To discuss the feasibility of single-site robotic surgery for benign gynecologic tumors and early stage gynecologic cancers.

Methods: In this single institution, prospective analysis, we analyzed six patients who had undergone single-site robotic surgery between December 2013 and August 2014. Surgery was performed using the da Vinci Si Surgical System. Patient characteristics and surgical outcomes were analyzed.

Results: Single-site robotic surgery was performed successfully in all six cases. The median patient age was 48 years, and the median body mass index was 25.5 kg/m(2) (range, 22 to 33 kg/m(2)). The median total operative time was 211 minutes, and the median duration of intracorporeal vaginal cuff suturing was 32 minutes (range, 22 to 47 minutes). The median duration of pelvic lymph node dissection was 31 minutes on one side and 27 minutes on the other side. Patients' postoperative courses were uneventful. The median postoperative hospital stay was 4 days. No postoperative complications occurred.

Conclusion: When used to treat benign gynecologic tumors and early stage gynecologic cancers, the single-site da Vinci robotic surgery is feasible, safe, and produces favorable surgical outcomes.

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TC 15

Z9 16

U1 0

U2 7

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JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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PT J

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TI Position-related injury is uncommon in robotic gynecologic surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Gynecology; Surgical complications

ID LAPAROSCOPIC HYSTERECTOMY; COMPARTMENT SYNDROME; LITHOTOMY POSITION;

NEUROPATHIES; CANCER

AB Objective. To assess the rate and risk factors for position-related injury in robotic gynecologic surgery.

Methods. A prospective database from 12/2006 to 1/2014 of all planned robotic gynecologic procedures was retrospectively reviewed for patients who experienced neurologic injury, musculoskeletal injury, or vascular compromise related to patient positioning in the operating room. Analysis was performed to determine risk-factors and incidence for position-related injury.

Results. Of the 831 patients who underwent robotic surgery during the study time period, only 7 (0.8%) experienced positioning-related injury. The injuries included minor head contusions (n = 3), two lower extremity neuropathies (n = 2), brachial plexus injury (n = 1) and one large subcutaneous ecchymosis on the left flank and thigh (n = 1). There were no long term sequelae from the positioning-related injuries. The only statistically significant risk factor for positioning-related injury was prior abdominal surgery (P = 0.05). There were no significant associations between position-related injuries and operative time (P = 0.232), body mass index (P = 0.847), age (P = 0.152), smoking history (P = 0.161), or medical comorbidities (P = 0.229-0.999).

Conclusions. The incidence of position-related injury among women undergoing robotic surgery was extremely low (0.8%). Due to the low incidence we were unable to identify modifiable risk factors for position-related injury following robotic surgery. A standardized, team-oriented approach may significantly decrease position-related injuries following robotic gynecologic surgery. (C) 2014 Elsevier Inc. All rights reserved.

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PT J

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Prabhu, Pradeep

Butler-Manuel, Simon

Tailor, Anil

TI Cerebral oedema following robotic surgery: a rare complication

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

ID TRENDELENBURG POSITION; RADICAL PROSTATECTOMY; INTRACRANIAL-PRESSURE;

ANESTHESIA

AB Introduction We present an unusual complication following robotic assisted radical hysterectomy.

Case report A 51-year-old female with stage 1B1 cervical cancer underwent a robotic assisted radical hysterectomy. The procedure was prolonged with difficulties dissecting the left parametrium and vaginal fornix with persistent bleeding from the left vaginal vault. Post-operatively the patient was electively sedated and ventilated. Extubation was difficult due to patient agitation but achieved on day 2. Agitation persisted and a head CT scan was performed and a diagnosis of cerebral oedema was made.

Discussion Factors contributing to this case include prolonged operating time, prolonged Trendelenburg position with high pressures of CO2 pneumoperitoneum and excessive blood loss. These factors may contribute to poor cerebral venous outflow, increasing intracranial pressure leading to increased risk of cerebral oedema.

Conclusion The mechanics of robotic assistance may be used to reduce these risks by significantly reducing intra-abdominal pressure improving venous return.

Summary The use of robotics in surgery has been increasing over the last 10 years, and the benefits have been well documented. We present an unusual complication following robotic assisted radical hysterectomy performed for cervical cancer.

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NR 15

TC 16

Z9 18

U1 0

U2 5

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

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Lewis, C

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Culligan, Patrick

Salamon, Charbel

TI A prospective study of a single-incision sling at the time of robotic

sacrocolpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Robotic sacrocolpopexy; Single-incision sling;

Stress urinary incontinence

ID STRESS URINARY-INCONTINENCE; RANDOMIZED-CONTROLLED-TRIAL; PELVIC ORGAN

PROLAPSE; FREE VAGINAL TAPE; SURGERY; COMPLICATIONS; WOMEN; MESH

AB Introduction and hypothesis The objective of this study was to evaluate the efficacy and safety of the Miniarc Precise (R) single-incision sling (American Medical Systems, Minnetonka, MN, USA) placed at the time of a robotic sacrocolpopexy.

Methods This was a prospective study of a single-incision suburethral sling placed at the time of robotic sacrocolpopexy in women with stress urinary incontinence (SUI) and pelvic organ prolapse. Primary outcome measure was cure at 1 year, defined objectively by a negative cough stress test (CST) and subjectively by a score of "0 or 1" on question 17 of the Pelvic FloorDistress Inventory (PFDI-20): "Do you experience urine leakage related to coughing/sneezing/laughing?" Secondary outcome measures included the change in Urinary Distress Inventory (UDI-6) and Urinary Impact Questionnaire (UIQ-7) scores at 1 year. All sling-related complications were reported. Paired Student's t test and the Wilcoxon signed-rank test were used for statistical analysis.

Results One hundred and one patients were included between August 2010 and July 2012. One-year follow-up was available for 97 out of 101 patients (96 %). Objective cure was 90 % and subjective cure was 87 %. Baseline UDI-6 scores improved from 34.8 +/- 25.1 to 6.7 +/- 11.2 at 1 year (p<0.001). Similarly, UIQ-7 scores improved from 21.1 +/- 22.8 to 2.4 +/- 8.2 at 1 year (p<0.001). There were no intraoperative cystotomies, no mesh erosions, no sling revisions, and no cases of urinary retention. The retreatment rate for persistent SUI was 8 % (8 out of 97).

Conclusions The addition of a single-incision suburethral sling at the time of robotic sacrocolpopexy in women with SUI resulted in an 87 % cure rate at 1 year.

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NR 16

TC 4

Z9 4

U1 0

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PT J

AU Danford, JM

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AF Danford, Jill McHenry

White, Nicola Claire

New, Melinda

Fletcher, Sarah

Blume, Jeffrey D.

Ward, Renee Melva

TI The fellowship effect: how the establishment of a fellowship in female

pelvic medicine and reconstructive surgery affected resident vaginal

hysterectomy training

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

CY MAR 23-28, 2014

CL Scottsdale, AZ

SP Soc Gynecol Surg

DE residency training; surgical fellowship; vaginal hysterectomy

ID TRENDS

AB OBJECTIVE: We report on trends in resident-performed vaginal hysterectomies before and after the establishment of a female pelvic medicine and reconstructive surgery fellowship at Vanderbilt University Medical Center.

STUDY DESIGN: We examined medical records and resident self-reports concerning all hysterectomies at our institution in an 8-year period: 4 years before fellowship and 4 years after. Route of hysterectomy, resident and fellow involvement, and division of attending surgeon were recorded from the electronic medical record. Resident Accreditation Council for Graduate Medical Education (ACGME) case log data were used to estimate the number of hysterectomies where residents reported themselves as the primary surgeon.

RESULTS: During the 8-year period of this study, 3317 hysterectomies were performed at our institution, 41% (1371) before and 59% (1946) after fellowship. Prior to fellowship, 29% (393) were vaginal, 56% (766) were abdominal, and 15% (212) were laparoscopic/robotic. After addition of fellowship, 23% (449) were vaginal, 31% (597) were abdominal, and 46% (900) were laparoscopic/robotic. Of the total vaginal hysterectomies (TVH), there was resident involvement in 98.0% (385) cases before fellowship and 98.2% (441) cases after fellowship. From the ACGME case log data, the resident identified himself/herself as the primary surgeon in 388 cases before and 393 cases after fellowship. During this time period, medical records indicate a fellow was involved in 42% (189) of TVH, with resident involvement in all but 5 of these procedures.

CONCLUSION: Frequency of resident involvement in TVH cases, either as primary surgeon or team member, remained constant after the addition of the female pelvic medicine and reconstructive surgery fellowship.

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ER

PT J

AU De La Cruz, JF

Myers, EM

Geller, EJ

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TI Vaginal Versus Robotic Hysterectomy and Concomitant Pelvic Support

Surgery: A Comparison of Postoperative Vaginal Length and Sexual

Function

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic hysterectomy; Sacrocolpopexy; Sexual function; Vaginal

hysterectomy; Vaginal length

ID PROLAPSE; RATES

AB Study Objective: To compare the change from pre- to postoperative total vaginal length (TVL) in women who underwent either a total vaginal hysterectomy (TVH) with uterosacral ligament suspension (USLS) or a robotic hysterectomy (RH) with colpopexy (SCP). Secondary objectives included comparing sexual function, pelvic floor function, and prolapse recurrence between routes of surgery.

Design: This was a retrospective cohort study (Canadian Task Force classification II-2).

Setting: This was conducted at 1 tertiary academic medical center over a 2-year period.

Patients: Women who underwent either TVH/USLS or RH/SCP.

Interventions: Baseline and postoperative POP-Q Pelvic Organ Prolapse Quantification exams were recorded as well as postoperative validated questionnaires. Twenty-nine subjects were needed in each group to detect a 1.5-cm difference in TVL.

Measurements and Main Results: There were 38 TVH/USLS and 46 RH/SCP participants. RHs were either total (28/46 [61%]) or supracervical (18/46 [39%]). The mean postoperative follow-up was 9.5 +/- 3.1 months. For the primary outcome, women in the TVH/USLS group had a decrease in TVL, whereas women in the RH/SCP group had an increase in TVL (-0.6 +/- 1.0 cm vs 0.5 +/- 0.8 cm, p < .001). Among sexually active women (55/84, 65.5%), there was no difference in postoperative sexual function between groups based on Pelvic Organ Prolapse/Urinary incontinence Sexual Function Questionnaire short form scores, with good sexual function in both groups (32.6 +/- 6.2 TVH/USLS vs 35.1 +/- 7.3 RH/SCP, p = .22). Although both groups showed good postoperative apical support, the TVH/USLS group had a slightly lower mean C point compared with the RH/SCP group (-6.8 +/- 1.2 vs -7.7 +/- 1.8, p = .02). Both groups showed good postoperative pelvic floor function, with no difference in mean postoperative Pelvic Organ Prolapse Distress Inventory scores (42.2 +/- 45.4 vs 52.7 +/- 46.6, p = .44). Recurrent prolapse (defined as any prolapse at or beyond the hymen) was not different between groups (13.2% for TVH/USLS vs 6.5% for RH/SCP, p = .46).

Conclusion: Vaginal length decreased after vaginal hysterectomy with pelvic support surgery compared with RH with pelvic support surgery, with no differences in postoperative sexual function or pelvic floor function between groups. (C) 2014 AAGL. All rights reserved.

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TI Accuracy of robotic sentinel lymph node detection (RSLND) for patients

with endometrial cancer (EC)

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic; Sentinel lymph node detection; Ultrastaging

ID GYNECOLOGIC-ONCOLOGY-GROUP; BIOPSY; RISK; INJECTION; CARCINOMA; TRIAL;

MALIGNANCIES; SURGERY

AB Objectives. Lymphadenectomy as a part of the staging for EC patients is controversial. Sentinel lymph node detection has been introduced to determine which patients would benefit from adjuvant therapy and to limit morbidities associated with a full pelvic nodal dissection. The purpose of this study is to evaluate diagnostic accuracy and detection rate of robotic sentinel lymph node detection (RSLND) as a part of the surgical staging for EC.

Methods. A retrospective database of all patients who underwent intraoperative lymphatic mapping using cervical injection methylene blue followed by RSLND as a part of their procedure was reviewed. Sentinel lymph node (SLN) was initially examined by routine Hematoxylin and Eosin (H&E) and ultrastaging by immunohistochemistry (IHC).

Results. Between 4/2011 and 6/2013, 120 patients with endometrial cancer underwent RSLND. The median age was 62 years (25-87); median BMI was 32 (18-76). Out of 120 patients, only one patient underwent RSLND with fertility preservation; and 119 patients underwent robotic hysterectomy and surgical staging with RSLND. None of the cases was converted to an open procedure. At least 1 SLN was detected in 86% (103/120) of the patients. Bilateral SLNs were detected in 52% (62/120). Positive nodes were identified in 8% (10/120) of the patients. Of those with SLN (+), 50% (5/10) were by ultrastaging (IHC) alone. No patients had positive regional nodes without SLN (+).

Conclusions. RSLND using methylene blue cervical injection can identify SLN in most patients with EC. IHC ultrastaging improves the detection of node positive disease when compared to traditional pathological evaluation. (C) 2014 Elsevier Inc. All rights reserved.

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PT J

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Collinet, P.

TI Robotic-assisted laparoscopy for deep infiltrating endometriosis: The

Register of the Society of European Robotic Gynaecological Surgery

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Deep infiltrating endometriosis; Robotic-assisted laparoscopy; Da Vinci

(R) system

ID SURGICAL-TREATMENT; RESECTION

AB Objectives. - To assess the interest of robotic-assisted laparoscopy in the context of deep infiltrating endometriosis and to investigate perioperative results.

Patients and methods. - From November 2008 to April 2012, 164 women with stage IV endometriosis who underwent robotic-assisted laparoscopy (DA VINCI Intuitive Surgical System (R)) were included by eight international participating clinical centers. Patients were divided in 4 groups according to the localization of the nodule(s): rectum (n = 88), bladder (n = 23), ureter and uterosacral ligaments (n = 115) et hysterectomy (n = 28). We evaluated the procedures performed, the duration of intervention, the complications, the recurrence and the impact on fertility.

Results. - In the rectum group, there was a laparotomy conversion, 2 sutured rectal injuries and a red cells blood transfusion. In the bladder group, there was a vesicovaginal hematoma and a prolongated intermittent self-catheterization. In the ureter and uterosacral ligaments group, there was 2 ureteral fistulas and there was no complication in the hysterectomy group.

Discussion and conclusion. - This study is the largest series published in the literature on robotic-assisted laparoscopy for deep infiltrating endometriosis. The interest of robotic-assisted laparoscopy in deep infiltrating endometriosis seems to be promising while no increase in surgical time, blood loss, and intra- and postoperative complications were observed. (C) 2014 Elsevier Masson SAS. All rights reserved.

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PT J

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Verheijen, RHM

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TI Oncological outcome and long-term complications in robot-assisted

radical surgery for early stage cervical cancer: an observational cohort

study

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Cervical cancer; complications; recurrence; robot-assisted laparoscopy;

survival

ID SENTINEL LYMPH-NODE; PELVIC LYMPHADENECTOMY; HYSTERECTOMY; WOMEN;

LAPAROSCOPY; DISEASE

AB ObjectiveTo report the oncological outcome and long-term complications of radical surgery by robot-assisted laparoscopy in early stage cervical cancer.DesignObservational cohort study.SettingTertiary referral centre.PopulationAbout 100 cervical cancer patients treated consecutively with robot-assisted radical surgery between 2008 and 2013.MethodsTwo gynaecological oncologists specialised in minimally invasive surgery performed all surgeries on a three/four-armed robotic system. Procedures consisted of pelvic lymph node dissection combined with a radical hysterectomy, radical vaginal trachelectomy or parametrectomy.Main outcome measuresRecurrence, survival and long-term complication rates.Results104 robot-assisted laparoscopies were performed in 100 patients (stage IA1-IIB), with a median follow-up of 29.5months (range 2.5-67.1months). Thirteen cases were diagnosed with a loco-regional (8%), distant (4%) or combined (1%) recurrence at a median of 14.4months (range 2.9-34.8months). All mortality (7%) was cervical cancer-related and due to recurrent disease. Four recurrences receive palliative care and two are in complete remission. The overall 5-year progression-free and disease-specific survival rates are 81.4 and 88.7%, respectively. Frequent complications were lymphoedema (26%), lower urinary tract symptoms (19%), urinary tract infection (17%) and sexual disorders (9%). Five patients had a vaginal cuff dehiscence. No complication-related mortality occurred.ConclusionThe recurrence, survival and long-term complication rates of robot-assisted radical surgery for early stage cervical cancer in this cohort are reassuring concerning its continued clinical use.

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U2 9

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JI BJOG

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA AS6KM

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ER

PT J

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TI Cost assessment of robotics in gynecologic surgery: A systematic review

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Review

DE cost; gynecology; health-care economics; outcome; robotics; training

ID RADICAL HYSTERECTOMY; TUBAL ANASTOMOSIS; LAPAROSCOPIC MYOMECTOMY;

ENDOMETRIAL; OUTCOMES; SACROCOLPOPEXY; LAPAROTOMY

AB AimThe application of robotics is an innovation in the field of gynecologic surgery. Our objective was to evaluate the currently available literature on the cost assessment of robotic surgery of various operations in the field of gynecologic surgery.

Material and MethodsPubMed and Scopus databases were systematically searched in order to retrieve the included studies in our review.

ResultsWe retrieved 23 studies on a variety of gynecologic operations. The mean cost for robotic, open and laparoscopic surgery ranged from 1731 to 48769, 894 to 20277 and 411 to 41836 Euros, respectively. Operative charges, in hysterectomy, for robotic, open and laparoscopic technique ranged from 936 to 33920, 684 to 25616 and 858 to 25578 Euros, respectively. In sacrocolpopexy, these costs ranged from 2067 to 7275, 2904 to 69792 and 1482 to 2000 Euros, respectively. Non-operative charges ranged from 467 to 39121 Euros. The mean total costs for myomectomy ranged from 27342 to 42497 and 13709 to 20277 Euros, respectively, for the robotic and open methods, while the mean total cost of the laparoscopic technique was 26181 Euros. Conversions to laparotomy were present in 79/36185 (0.2%) cases of laparoscopic surgery and in 21/3345 (0.62%) cases of robotic technique. Duration of robotic, open and laparoscopic surgery ranged from 50 to 445, 83.7 to 701 and 74 to 330min, respectively.

ConclusionRobotic surgery has the potential to become cost-effective in centers with many patients while industry competition could reduce the cost of the robotic instrumentation, making robotic technology more affordable and cost-effective.

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TC 45

Z9 45

U1 0

U2 6

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JI J. Obstet. Gynaecol. Res.

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WC Obstetrics & Gynecology

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ER

PT J

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TI Training the Next Generation of Robotic Surgeons Using Guided

Mentorship: A Randomized Controlled Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Guided mentorship; Robotic training; Surgical education

ID OBSTETRICS; HYSTERECTOMY; SKILLS; PERFORMANCE; VALIDATION

AB Study Objective: To evaluate the effect of expert guided mentorship on technical score and time for a set of robotic training drills.

Design: Prospective randomized controlled trial (Canadian Task Force classification I).

Setting: Academic institution.

Subjects: Fifty trainees in robotic surgery.

Intervention: Inexperienced trainees underwent either a 20-minute expert guided mentorship session or no intervention. The primary outcomes were technical score and time-to-drill completion for a set of dry lab robotic training drills evaluated at an initial and final skills assessment. The t-test, including paired analyses, was used to evaluate outcomes.

Measurements and Main Results: Forty-nine of 50 trainees (98%) completed the study. There were no significant differences in participant characteristics or initial performance between the 2 groups. During the final skills assessment, the intervention group demonstrated significantly better performance on 1 of 8 objective measures. They had a higher mean score for the bead transfer drill when compared with the control group (21.6 vs 19.9; p = .03). No differences in time-to-drill completion were noted between the 2 groups. Regardless of randomization, all participants had significantly improved scores for each of the drills on the final compared with the initial skills assessment (p < .01).

Conclusions: Although expert guided mentorship in a dry lab simulation environment seems feasible, further investigation is warranted before its widespread use because it may be more resource intensive than other teaching methods, without consistent objective improvements in technical performance. (C) 2014 AAGL. All rights reserved.

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J9 J MINIM INVAS GYN

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WC Obstetrics & Gynecology

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ER

PT J

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Harrington, P

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TI Economic evaluation of robot-assisted hysterectomy: a cost-minimisation

analysis

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Economic evaluation; hysterectomy; robot-assisted

ID LAPAROSCOPIC HYSTERECTOMY; PROSTATECTOMY

AB ObjectiveThe aim of this study was to carry out an economic evaluation of robot-assisted hysterectomy compared with the current standard of care in Ireland.

DesignCost-minimisation analysis of robot-assisted hysterectomy compared with a combination of traditional open and conventional laparoscopic surgery.

SettingThe publicly funded healthcare system in Ireland.

PopulationThe target population was women requiring hysterectomy that could be completed using robot-assisted surgery.

MethodsA simulation-based economic evaluation model including data derived from a systematic review and local databases was used to estimate surgical costs.

Main outcome measuresIncremental cost of robot-assisted surgery compared to current routine care.

ResultsThe incremental cost of robot-assisted hysterectomy is an estimated Euro3291 (95% confidence interval Euro2509-Euro4183) more than the existing mix of open and traditional laparoscopic surgery. The additional cost of robot-assisted surgery is primarily driven by the increased cost of surgical equipment, the robot, maintenance of the robot, and the cost of theatre staff due to longer operative times. The only significant factor reducing the cost of surgery is a shorter hospital stay relative to open surgery.

ConclusionsRobot-assisted hysterectomy is more costly than the current mix of open and traditional laparoscopic surgery. Without longer-term or functional outcome data, the additional expense associated with robot-assisted hysterectomy may not be justified in a budget-constrained health system.

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WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

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TI Comparative Effectiveness of Robotically Assisted Compared With

Laparoscopic Adnexal Surgery for Benign Gynecologic Disease

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID TREATMENT FAILURE; HYSTERECTOMY; LAPAROTOMY; CHOLECYSTECTOMY;

ADNEXECTOMY; CANCER; COSTS; RISK

AB OBJECTIVE: To perform a population-based analysis to compare the complications and cost of laparoscopic and robotically assisted adnexal surgery.

METHODS: A nationwide database was used to analyze the use and outcomes of robotically assisted adnexal surgery from 2009 to 2012. Multivariable mixed effects regression models were developed to examine predictors of use of robotic surgery. After propensity score matching, complications and cost were compared between robotically assisted and laparoscopic surgery.

RESULTS: Eighty-seven thousand five hundred fourteen women were identified. From 2009 to 2012, performance of robotic-assisted oophorectomy increased from 3.5% (95% confidence interval [CI] 3.2-3.8%) to 15.0% (95% CI 14.4-15.6%), whereas robotically assisted cystectomy rose from 2.4% (95% CI 2.0-2.7%) to 12.9% (95% CI 12.2-13.5%). The overall complication rate was 7.1% (95% CI 4.0-10.2%) for robotically assisted compared with 6.0% (95% CI 2.9-9.1%) for laparoscopic oophorectomy (odds ratio [OR] 1.20, 95% CI 1.00-1.45; P5.052). Robotic-assisted oophorectomy was associated with a higher rate of intraoperative complications (3.4% compared with 2.1%, OR 1.60, 95% CI 1.21-2.13). The overall complication rate was 3.7% (95% CI 20.8 to 8.2%) after robotically assisted compared with 2.7% (95% CI 21.8 to 7.2%) for laparoscopic cystectomy (OR 1.38, 95% CI 0.95-1.99). The intraoperative complication rate was higher for robotically assisted cystectomy (2.0% compared with 0.9%, OR 2.40, 95% CI 1.31-4.38). Compared with laparoscopy, robotically assisted oophorectomy was associated with $2,504 (95% CI $2,356-2,652) increased total costs and robotically assisted cystectomy $ 3,310 (95% CI $3,082-3,581) higher costs.

CONCLUSION: Use of robotically assisted adnexal surgery increased rapidly. Compared with laparoscopic surgery, robotically assisted adnexal surgery is associated with substantially greater costs and a small, but statistically significant, increase in intraoperative complications.

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U2 1

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ER

PT J

AU Alas, AN

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Anger, Jennifer T.

TI Role of apical support defect: correction in women undergoing vaginal

prolapse surgery

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE apical support; apical suspension; pelvic organ prolapse; sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; SACROSPINOUS LIGAMENT FIXATION; VAULT PROLAPSE;

ABDOMINAL SACROCOLPOPEXY; MEDICARE BENEFICIARIES; ANTERIOR; OUTCOMES;

REPAIR; MESH; HYSTERECTOMY

AB Purpose of review

The aim was to review most recent literature and provide updates in clinical management and surgical treatment of apical pelvic organ prolapse.

Recent findings

In patients who decline surgical intervention, formal referral to pelvic floor muscle training is beneficial over self-directed Kegel exercises. Systematic reviews revealed that sacrocolpopexy has better long-term outcomes than vaginal approaches. Uterosacral ligament suspension and sacrospinous ligament suspension have equal efficacy at 1 year. These procedures should be considered as acceptable alternatives to sacrocolpopexy. Two randomized controlled trials have demonstrated equal efficacy between robotic and laparoscopic sacrocolpopexy.

Summary

Minimally invasive sacrocolpopexy should be considered the gold standard for apical prolapse, but these techniques are associated with longer operating times and higher complication rates and longer convalescence than nonmesh vaginal surgery. Surgeons must individualize surgical technique for each patient and should consider a vaginal approach in patients who do not desire laparotomy and are not candidates for minimally invasive surgery.

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TC 4

Z9 5

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U2 8

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ER

PT J

AU Autorino, R

Zargar, H

Kaouk, JH

AF Autorino, Riccardo

Zargar, Homayoun

Kaouk, Jihad H.

TI Robotic-assisted laparoscopic surgery: recent advances in urology

SO FERTILITY AND STERILITY

LA English

DT Article

DE Andrology; indications; robotic surgery; robot-assisted laparoscopy;

urology

ID URETEROPELVIC JUNCTION OBSTRUCTION; SINGLE INSTITUTION EXPERIENCE;

NATIONWIDE INPATIENT SAMPLE; PARTIAL NEPHRECTOMY RAPN; OPEN RADICAL

CYSTECTOMY; PERIOPERATIVE OUTCOMES; INITIAL-EXPERIENCE; SURGICAL

OUTCOMES; BLADDER-CANCER; EAU GUIDELINES

AB The aim of the present review is to summarize recent developments in the field of urologic robotic surgery. A nonsystematic literature review was performed to retrieve publications related to robotic surgery in urology and evidence-based critical analysis was conducted by focusing on the literature of the past 5 years. The use of the da Vinci Surgical System, a robotic surgical system, has been implemented for the entire spectrum of extirpative and reconstructive laparoscopic kidney procedures. The robotic approach can be applied for a range of adrenal indications as well as for ureteral diseases, including benign and malignant conditions affecting the proximal, mid, and distal ureter. Current evidence suggests that robotic prostatectomy is associated with less blood loss compared with the open surgery. Besides prostate cancer, robotics has been used for simple prostatectomy in patients with symptomatic benign prostatic hyperplasia. Recent studies suggest that minimally invasive radical cystectomy provides encouraging oncologic outcomes mirroring those reported for open surgery. In recent years, the evolution of robotic surgery has enabled urologic surgeons to perform urinary diversions intracorporeally. Robotic vasectomy reversal and several other robotic andrological applications are being explored. In summary, robotic-assisted surgery is an emerging and safe technology for most urologic operations. The acceptance of robotic prostatectomy during the past decade has paved the way for urologists to explore the entire spectrum of extirpative and reconstructive urologic procedures. Cost remains a significant issue that could be solved by wider dissemination of the technology. (C) 2014 by American Society for Reproductive Medicine.

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ER

PT J

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Mimouni, M

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Douay-Hauser, Nathalie

Nos, Claude

Lecuru, Fabrice

TI Robotic Extraperitoneal Paraaortic Lymphadenectomy in Gynecological

Cancers <i>Feasibility, Safety, and Short-Term Outcomes of Isolated and

Combined Procedures</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic surgery; Paraaortic lymphadenectomy; Extraperitoneal route;

Gynecological oncology

ID AORTIC LYMPHADENECTOMY; LAPAROSCOPY; EXPERIENCE

AB Objective: The aim of our study was to report the technique, the feasibility, and perioperative results of robotic extraperitoneal paraaortic lymphadenectomy in gynecological cancers performed for isolated or combined procedures.

Methods: This is a retrospective study of 24 consecutive patients undergoing robotic extraperitoneal paraaortic lymphadenectomy using the Da Vinci Surgical system (Intuitive Inc, Sunnyvale, CA) (cervical cancer, n = 15; high-risk endometrial cancer, n = 8; and ovarian cancer, n = 2, including 1 synchronous tumor). Extraperitoneal paraaortic lymphadenectomy was performed using the surgical technique previously described by laparoscopy.

Results: Of the 24 included patients, 12 patients had isolated robotic extraperitoneal paraaortic lymphadenectomy, whereas the others underwent the following associated procedures: total hysterectomy with bilateral salpingo-oophorectomy, pelvic lymphadenectomy, and omentectomy (n = 7); pelvic transperitoneal lymphadenectomy (n = 3), laparotomic Bricker procedure (n = 1), and colpectomy (n = 1). The median age of patients was 55 (42-64) years, and body mass index was 24.1 kg/m(2) (20.9-26.1). The operation was completed in all patients except three with associated procedures. Perioperative difficulties were encountered in 9 patients (gas leakage, n = 7; adhesions, n = 2; and dissection difficulties, n = 1). The number of removed paraaortic lymph nodes was 18 (14-25). The operating times were 180 (150-210) minutes for isolated extraperitoneal paraaortic lymphadenectomy and 240 (180-300) minutes in case of associated procedures. There were 2 intraoperative (pneumothorax and renal artery injury) and 5 postoperative (3 grades 1-2 and 2 grade 3) complications.

Conclusions: If robotic-assisted extraperitoneal paraaortic lymphadenectomy seems feasible in case of isolated procedure, further studies are required to prove its benefit compared with conventional laparoscopy.

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NR 17

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Z9 13

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U2 4

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JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

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ER

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TI The Safety and Feasibility of Robotic-Assisted Lymph Node Staging in

Early-Stage Ovarian Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Epithelial ovarian cancer; Staging procedure; Lymphadenectomy; Robotic

surgery

ID RADICAL HYSTERECTOMY; STAGES I; LYMPHADENECTOMY; LAPAROSCOPY;

METASTASIS; LAPAROTOMY; OUTCOMES; SURGERY

AB Objectives: The purpose of this study was to report on the safety and feasibility of robotic-assisted systematic lymph node staging in the management of early-stage ovarian cancer.

Methods: We retrospectively reviewed the charts of presumed early-stage (International Federation of Gynecology and Obstetrics (FIGO) stages I and II) ovarian cancer patients who underwent robotic-assisted surgery that incorporated a systematic pelvic and para-aortic lymphadenectomy from January 2009 until December 2013. Patient demographics, operative characteristics, pathology, lymph node counts, surgical complications, and hospital stay were evaluated.

Results: A total of 26 early-stage ovarian cancer patients were identified. The mean operating time was 2.90 hours, and the estimated blood loss was 63 mL; there were no intraoperative complications although 1 patient's surgery was significantly prolonged due to pelvic adhesions. The mean number of pelvic and para-aortic lymph nodes removed was 14.6 (2.3% incidence of pelvic lymph node metastases) and 5.8 (3.3% incidence of para-aortic lymph node metastases), respectively. The patients' mean duration of hospital stay was 18.4 hours, and 2 patients were readmitted for either a postoperative wound infection or vaginal dehiscence.

Conclusions: The results from this study suggest that robotic-assisted surgical staging in the management of presumed early-stage ovarian cancer is both feasible and associated with a minimal patient complication rate. We encountered a low incidence of lymph node metastases, and the readmission rate was favorable. Nevertheless, because the prevalence of lymph node metastases can approach 20% in select patients, physicians should consider a systematic lymph node resection to confer an optimal clinical assessment.

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Gargiulo, AR

AF Gargiulo, Antonio R.

TI Computer-assisted reproductive surgery: why it matters to reproductive

endocrinology and infertility subspecialists

SO FERTILITY AND STERILITY

LA English

DT Article

DE Laparoscopy; robotic surgery; computer-assisted surgery; reproductive

surgery; infertility; fibroids; endometriosis; tubal reanastomosis

ID MICROSURGICAL TUBAL REANASTOMOSIS; LAPAROSCOPIC MYOMECTOMY; COLORECTAL

ENDOMETRIOSIS; ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; UTERINE RUPTURE;

ANASTOMOSIS; FIBROIDS; TERM; FERTILITY

AB Trained fertility specialists possess a unique clinical perspective and an extensive medical and technological armamentarium to overcome reproductive dysfunction: it is their privilege and ethical duty to lead the field of reproductive surgery. However, modern reproductive surgery can no longer exist outside of the realm of advanced laparoscopy. This has been a major hurdle to the thriving of surgery within our subspecialty, owing to the time and effort required to achieve and maintain proficiency in the antiergonomic environment of conventional laparoscopy. Computer-assisted surgery minimizes aptitudinal restrictions to the adoption of advanced laparoscopy. As such, it promotes strategy over technique and may hold the key to the continued success of high-specialty reproductive surgery. (C) 2014 by American Society for Reproductive Medicine.

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PT J

AU Letouzey, V

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AF Letouzey, V.

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TI Evaluation of a laparoscopic training program with or without robotic

assistance

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Laparoscopy; Surgical training; Surgical simulator; Robotic assisted

surgery; Time score

ID VIRTUAL-REALITY; SURGERY; SKILLS; HYSTERECTOMY; VALIDITY; FACE

AB The aim of the present study was to evaluate the value of a box trainer simulator in laparoscopy training. A further aim was to determine if robotic-assisted approaches further improved the young residents' skills in laparoscopic surgery.

The study was a prospective randomized study. Twelve residents in obstetrics & gynecology completed four laparoscopy-related procedures of varying complexity using a box trainer simulator. Participants were randomized into two groups; robotic-assisted laparoscopy (LRA) and traditional laparoscopy (TL). All subjects were assessed with a time and technical score, which are quantitative and qualitative approaches (respectively).

All residents completed the training and a satisfaction questionnaire, which confirmed that the training was well regarded. Regardless of the workshop type, there was a clear time and technical improvement for the difficult tasks. The improvement of time score was most apparent for simple tasks in LRA and for more complex tasks in TL. After training, we did not find a significant difference for the technical score between Novices and Experts in TL and LRA.

These findings suggest that training in laparoscopy surgery is useful, reproducible and well accepted by both novice and more advanced trainees. Furthermore, gynecological endoscopy center consider including robotic-assisted approaches in their surgical training program. (C) 2014 Elsevier Ireland Ltd. All rights reserved.

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U1 0

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ER

PT J

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Querleu, D.

TI Feasibility and fiability of laparoscopic surgery in the uterine cancers

in normal-weight patients

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Cervical cancer; Endometrial cancer; Laparoscopy; Fiability; Feasibility

ID ROBOTIC RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; PELVIC

LYMPHADENECTOMY; EXPERIENCE; MANAGEMENT

AB Objectives. - Evaluate the fiability and feasibility of laparoscopic surgery for the management of uterine cancers [endometrial cancer (EC) and early-stage cervical cancer (ESCC)] with patients who have a BMI <= 30 kg/m(2), within the setting of a gynaecological oncology department.

Patients and methods. - This retrospective, monocentric and descriptive study was carried out between January 2003 and May 2011 at the Institute Claudius-Regaud, a centre for cancer diagnosis, treatment and research. A policy promoting laparoscopy as a first choice treatment has been established at the institute since 2003.

Results. - Two hundred and three patients were included. Eighty-five patients were early-stage cervical cancer patients and 118 patients were endometrial cancer patients. The study shows a high fiability rate for laparoscopy in non-obese patients, with a 98.8% rate for EC patients and a 98.8% rate for ESCC patients. The feaibility rates were 80.1% and 96.6%, respectively. The incidence of laparoconversion was reported at 1.2% and 3.1% for ESCC and EC patients, respectively, while the incidence of peroperative complications was 5.9% and 7.4%. The incidence of postoperative complications rank >= 3 according to "Memorial secondary events grading system" was 3 (3.5%) for CCUP and 3 (2.5%) for CE.

Discussion and conclusion. - The results of this study show high fiability and feasibility levels for the laparoscopic treatment of uterine cancers in non-obese patients. There is no need to implement the more expensive robotic-assisted surgery in this group of patients. Mastering advanced laparoscopic surgery remains a mainstay in gynaecologic oncology. (C) 2014 Published by Elsevier Masson SAS.

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J9 GYNECOL OBSTET FERTI

JI Gynecol. Obstet. Fertil.

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BP 668

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA AR5MX

UT WOS:000343629700003

PM 25245841

DA 2024-01-18

ER

PT J

AU Mellano, EM

Tarnay, CM

AF Mellano, Erin M.

Tarnay, Christopher M.

TI Management of genitourinary fistula

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE fistula repair; genitourinary fistula; obstetrical fistula; post fistula

repair urinary incontinence

ID URINARY-TRACT INJURY; OBSTETRIC VESICOVAGINAL FISTULA; TISSUE

INTERPOSITION ALWAYS; SINGLE-SITE SURGERY; SURGICAL OUTCOMES FINDINGS;

FACTORS INFLUENCING CHOICE; PSHAK ET-AL.; UROGENITAL FISTULAS;

VESICOUTERINE FISTULA; TRANSVAGINAL REPAIR

AB Purpose of review

To review current literature on the management of genitourinary fistulae, specifically, the techniques for diagnosis, timing to repair, surgical approach and recent advancements in surgical technique.

Recent findings

Recent advancement in minimally invasive surgery has prompted surgeons to perform fistula repairs with laparoscopic or robotic-assisted laparoscopic techniques. Whereas there is a role for transabdominal fistula closure, the majority of fistulae are still best approached via a transvaginal route.

Summary

Genitourinary fistulae from obstetric trauma have received increased attention and funding to treat and prevent this devastating condition in developing countries. Despite multiple classification systems, a standardized classification that accurately identifies predictors of successful repair is lacking. In industrialized nations, genitourinary fistulae are rare and are most frequently associated with pelvic surgery, pelvic radiation, cancer or trauma. Surgical techniques to repair these fistulae have shifted from transabdominal laparotomy to minimally invasive laparoscopic procedures. Vascularized tissue flaps can play an important role in successful closure of complex fistulae. Despite advancements in surgical technology, overarching principles of fistula closure remain. The majority of fistulae can be closed through a transvaginal approach, with a tension-free, watertight, multilayer closure.

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NR 101

TC 25

Z9 26

U1 2

U2 5

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

PD OCT

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BP 415

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PG 9

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA AP1NB

UT WOS:000341836200015

PM 25105561

DA 2024-01-18

ER

PT J

AU Paraiso, MFR

AF Paraiso, Marie Fidela R.

TI Robotic-assisted laparoscopic surgery for hysterectomy and pelvic organ

prolapse repair

SO FERTILITY AND STERILITY

LA English

DT Article

DE Hysterectomy; laparoscopy; minimally invasive surgery; pelvic organ

prolapse; robotic-assisted surgery; sacrocolpopexy

ID VAGINAL CUFF DEHISCENCE; SACRAL COLPOPEXY; VAULT PROLAPSE;

SACROCOLPOPEXY; OUTCOMES; SUSPENSION; COSTS

AB The robotic platform is a tool that has enabled many gynecologic surgeons to perform procedures by minimally invasive route that would have otherwise been performed by laparotomy. Before the widespread use of this technology, a larger percentage of hysterectomies and sacrocolpopexies were completed via the open route because of the lack of training in traditional laparoscopic suturing, knot tying, and retroperitoneal dissection. Additional deterrents of traditional laparoscopic surgery adoption have included the lengthy learning curve associated with development of advanced laparoscopic skills; and surgeon preference for the open route because of surgical ergonomics, decreased operative time, and more experience with laparotomy. Level I evidence regarding robotic-assisted laparoscopy in benign gynecology is sparse, with most of the data supporting robotic surgery comprised of retrospective cohorts. The literature demonstrates the safety and efficacy of robotic-assisted laparoscopy for hysterectomy and pelvic organ prolapse repair; however, most level I data show increased operative time and cost. The true indications for robotic-assisted laparoscopy in benign gynecology have yet to be discerned. A review of the best available evidence is summarized. (C) 2014 by American Society for Reproductive Medicine.

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Z9 11

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U2 1

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA AQ8UD

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PM 25274486

OA hybrid

DA 2024-01-18

ER

PT J

AU Sinno, AK

Fader, AN

AF Sinno, Abdulrahman K.

Fader, Amanda N.

TI Robotic-assisted surgery in gynecologic oncology

SO FERTILITY AND STERILITY

LA English

DT Article

DE Robotic surgery; cervical cancer; endometrial cancer; ovarian cancer;

single site; sentinel lymph node

ID EARLY CERVICAL-CANCER; ABDOMINAL RADICAL TRACHELECTOMY; SENTINEL

LYMPH-NODES; BILATERAL PELVIC LYMPHADENECTOMY; MINIMALLY INVASIVE

SURGERY; EPITHELIAL OVARIAN-CANCER; RANDOMIZED CLINICAL-TRIAL;

SINGLE-SITE HYSTERECTOMY; RISK ENDOMETRIAL CANCER; OF-THE-LITERATURE

AB The quest for improved patient outcomes has been a driving force for adoption of novel surgical innovations across surgical subspecialties. Gynecologic oncology is one such surgical discipline in which minimally invasive surgery has had a robust and evolving role in defining standards of care. Robotic-assisted surgery has developed during the past two decades as a more technologically advanced form of minimally invasive surgery in an effort to mitigate the limitations of conventional laparoscopy and improved patient outcomes. Robotically assisted technology offers potential advantages that include improved three-dimensional stereoscopic vision, wristed instruments that improve surgeon dexterity, and tremor canceling software that improves surgical precision. These technological advances may allow the gynecologic oncology surgeon to perform increasingly radical oncologic surgeries in complex patients. However, the platform is not without limitations, including high cost, lack of haptic feedback, and the requirement for additional training to achieve competence. This review describes the role of robotic-assisted surgery in the management of endometrial, cervical, and ovarian cancer, with an emphasis on comparison with laparotomy and conventional laparoscopy. The literature on novel robotic innovations, special patient populations, cost effectiveness, and fellowship training is also appraised critically in this regard. (C) 2014 by American Society for Reproductive Medicine.

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TC 47

Z9 58

U1 0

U2 14

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DA 2024-01-18

ER

PT J

AU Anand, M

Woelk, JL

Weaver, AL

Trabuco, EC

Klingele, CJ

Gebhart, JB

AF Anand, Mallika

Woelk, Joshua L.

Weaver, Amy L.

Trabuco, Emanuel C.

Klingele, Christopher J.

Gebhart, John B.

TI Perioperative complications of robotic sacrocolpopexy for

post-hysterectomy vaginal vault prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article; Proceedings Paper

CT 39th Annual Scientific Meeting of the Society-of-Gynecologic-Surgeons

(SGS)

CY APR 08-10, 2013

CL Charleston, SC

SP Soc Gynecol Surg

DE Open abdominal sacrocolpopexy; Perioperative complications; Robotic

sacrocolpopexy

ID LAPAROSCOPIC SACROCOLPOPEXY; LEARNING-CURVE; OUTCOMES

AB Open abdominal sacrocolpopexy has been the preferred treatment for post-hysterectomy vaginal vault prolapse. In light of the rise in popularity of less invasive robotic sacrocolpopexy, our objective was to compare perioperative complications of robotic vs open sacrocolpopexy.

This was a single-institution, retrospective cohort study of robotic and open sacrocolpopexies. Robotic sacrocolpopexies performed between 1 January 2007 and 31 December 2009 were compared with open cases performed between 1 January 2002 and 31 December 2006. Baseline and intraoperative variables of the groups were compared. Complications were compared univariately and in a multivariable logistic regression model to adjust for prior transabdominal surgery.

A total of 50 robotic and 87 open sacrocolpopexies were analyzed. Baseline characteristics were similar, but patients in the open group had more prior transabdominal surgeries. The robotically assisted group had decreased estimated blood loss (median, 100 mL vs 150 mL; P = 0.002) and hospital stay (median, 2 days vs 3 days; P < 0.001), but increased operative time (median, 4.6 vs 2.9 h; P < 0.001), cystotomy (10.0 % [5 out of 50] vs 1.1 % [1 out of 87]; P = 0.02), and vaginotomy (24.0 % [12 out of 50] vs 5.7 % [5 out of 87]; P = 0.003). Two patients in the robotically assisted group had postoperative hernia. There were no differences in rates of ureteral or bowel injury, urinary tract infection, ileus, bowel obstruction, or overall complications.

Overall complication rates of robotic and open sacrocolpopexy were not significantly different. The robotically assisted group experienced shorter hospital stay but increased operative times and increased incidence of cystotomy and vaginotomy, possibly reflecting the learning curve of robotic sacrocolpopexy.

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU Cohen, SL

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Wang, KC

Brown, D

Boruta, D

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TI Contained Power Morcellation Within an Insufflated Isolation Bag

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY; UTERINE MORCELLATION; MANUAL

MORCELLATION; IN-VITRO; SURGERY; TISSUE; NEPHRECTOMY; MYOMECTOMY;

SARCOMA

AB OBJECTIVE: To describe a technique for contained power morcellation within an insufflated isolation bag at the time of uterine specimen removal during minimally invasive gynecologic procedures.

METHODS: Over the study period of January 2013 to April 2014, 73 patients underwent morcellation of the uterus or myomas within an insufflated isolation bag at the time of minimally invasive hysterectomy or myomectomy. This technique involves placing the specimen into a large plastic bag within the abdomen, exteriorizing the opening of the bag, insufflating the bag within the peritoneal cavity, and then using a power morcellator within the bag to remove the specimen in a contained fashion. Procedures were performed at four institutions and included multiport laparoscopy, single-site laparoscopy, multiport robot-assisted laparoscopy, or single-site robot-assisted laparoscopy. Demographic and perioperative characteristics were collected for the cases.

RESULTS: Surgical specimen morcellation within an insufflated isolation bag was successfully used in all cases. The median operative time was 114 minutes (range 32380 minutes), median estimated blood loss was 50 mL (range 10-500 mL), and the median specimen weight was 257 g (range 53-1,481 g). There were no complications related to the contained morcellation technique nor was there visual evidence of tissue dissemination outside of the isolation bag.

CONCLUSION: Morcellation within an insufflated isolation bag is a feasible technique. Methods for morcellating uterine tissue in a contained manner may provide an option to minimize the risks of open power morcellation while preserving the benefits of minimally invasive surgery.

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NR 22

TC 115

Z9 119

U1 0

U2 3

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

PD SEP

PY 2014

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IS 3

BP 491

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PG 7

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA AO4OV

UT WOS:000341320800003

PM 25162248

OA Bronze

DA 2024-01-18

ER

PT J

AU Song, TJ

Lee, SH

AF Song, Taejong

Lee, San-Hui

TI Barbed Suture vs Traditional Suture in Single-Port Total Laparoscopic

Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Barbed suture; Hysterectomy; Single-port; V-Loc

ID VAGINAL CUFF CLOSURE; ROBOTIC HYSTERECTOMY; EXPERIENCE; SURGERY

AB Study Objective: To compare surgical outcomes between barbed suture and traditional suture used in repair of the vaginal vault during single-port total laparoscopic hysterectomy (TLH).

Design: Case-control study (Canadian Task Force classification II-2).

Setting: Two institutions.

Patients: One hundred two patients with benign uterine disease.

Interventions: Single-port TLH using barbed suture (n = 43) or traditional suture (n = 59).

Measurements and Main Results: Patient characteristics (age, body mass index, demographic data), procedures performed, uterine weight, and uterine disease were similar between the 2 study groups. There were also no differences in operative complications, conversion to other surgical approaches, operative blood loss, postoperative pain, and duration of hospital stay between the 2 groups. Use of barbed suture significantly reduced the time required for vaginal cuff suturing (11.4 vs 22.5 minutes; p < .001), as well as total operative time (92.0 vs 105.2 minutes; p = .002). Use of barbed suture is less technically demanding than traditional suture (p < .001).

Conclusion: Use of barbed suture in single-port TLH may aid surgeons by reducing operative time, suturing time, and surgical difficulty. (C) 2014 AAGL. All rights reserved.

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Z9 22

U1 0

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

PD SEP-OCT

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IS 5

BP 825

EP 829

DI 10.1016/j.jmig.2014.03.012

PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA AP5KJ

UT WOS:000342117800019

PM 24681166

DA 2024-01-18

ER

PT J

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AF Tateo, Saverio

Nozza, Arrigo

Del Pezzo, Chiara

Mereu, Liliana

TI Robotic single-site pelvic lymphadenectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Single-site robotic laparoscopy; Lymphadenectomy; Single port; Robotics

ID ENDOMETRIAL CANCER; HYSTERECTOMY

AB Objective. : To examine the feasibility of performing pelvic lymphadenectomy with robotic single site approach. Recent papers described the feasibility of robotic-single site hysterectomy [1-3] for benign and malign pathologies but only with the development of new single site 5 mm instruments as the bipolar forceps, robotic single site platform can be safely utilized also for lymphadenectomy.

Methods. : A 65 year-old, multiparous patient with a body mass index of 22.5 and diagnosed with well differentiated adenocarcinoma of the endometrium underwent a robotic single-site peritoneal washing, total hysterectomy, bilateral adnexectomy and pelvic lymphadenectomy. The procedure was performed using the da Vinci Si Surgical System (Intuitive Surgical, Sunnyvale, CA) through a single 2,5 cm umbilical incision, with a multi-channel system and two single site robotic 5 mm instruments. A 3-dimensional, HD 8.5 mm endoscope and a 5 mm accessory instrument were also utilized.

Results. : Type I lymphonodes dissection for external iliac and obturator regions was performed [4]. Total operative time was 210 min; incision, trocar placement and docking time occurring in 12 min. Total console time was 183 min, estimated blood loss was 50 ml, no intra-operative or post-operative complications occurred. Hospital discharge occurred on post operative day 2 and total number of lymphnodes removed was 33. Difficulties in term of instrument's clashing and awkward motions have been encountered.

Conclusion. : Robotic single-site pelvic lymphadenectomy using bipolar forceps and monopolar hook is feasible. New developments are needed to improve surgical ergonomics and additional studies should be performed to explore possible benefits of this procedure. (C) 2014 Elsevier Inc. All rights reserved.

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TC 16

Z9 17

U1 0

U2 2

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

PD SEP

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VL 134

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BP 631

EP 631

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PG 1

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA AQ1OL

UT WOS:000342550600034

PM 24999106

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ER

PT J

AU Turner, LC

Kantartzis, K

Lowder, JL

Shepherd, JP

AF Turner, L. C.

Kantartzis, K.

Lowder, J. L.

Shepherd, J. P.

TI The effect of age on complications in women undergoing minimally

invasive sacral colpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Minimally invasive sacral colpopexy; Perioperative complications;

Elderly; Vaginal prolapse

ID SHORT-TERM OUTCOMES; PERIOPERATIVE COMPLICATIONS; UROGYNECOLOGIC

SURGERY; ELDERLY-WOMEN; PROLAPSE

AB Previous research has demonstrated similar complication rates in older and younger women undergoing abdominal sacral colpopexy via laparotomy. The objective of this study was to compare perioperative complications in older and younger women undergoing minimally invasive sacral colpopexy.

This was a retrospective study of laparoscopic and robotic sacral colpopexies performed from January 2009 to May 2012 at a large academic center. Patient demographics, surgical data, and perioperative complications were compared in women < 65 and a parts per thousand yen65 years of age. Primary outcome was the difference in major complications.

A total of 302 women underwent minimally invasive sacral colpopexy during the study period. Mean age was 58.5 +/- 8.8 years and 84 subjects (27.8 %) were a parts per thousand yen65 years. Older women were more likely to have had a prior hysterectomy (60.7 vs 39.0 %, p = 0.001) and had more severe preoperative prolapse (86.9 % vs 71.9 % a parts per thousand yen POPQ stage III, p = 0.01). There was no significant difference in duration of hospitalization (1.4 vs 1.4 days, p = 0.54). Overall, there were significantly more major complications in women a parts per thousand yenaEuro parts per thousand 65 years (unadjusted OR 1.84, 95 % CI 1.02-3.35, p = 0.04). After controlling for BMI, route of surgery, estimated blood loss (EBL), and operating room time, age a parts per thousand yenaEuro parts per thousand 65 remained a significant predictor of complications (adjusted OR 2.28, 95 % CI 1.21-4.29, p = 0.01).

Our findings suggest that older women have a higher rate of major complications following minimally invasive sacral colpopexy, even after controlling for BMI, route of surgery, EBL, and operating room time. This increased risk should be addressed during preoperative counseling and may influence surgical planning.

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U2 3

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ER

PT J

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Cornelia, JL

Magtibay, PM

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Kho, RM

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Mohd, Jasmine

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Cornelia, Jeffrey L.

Magtibay, Paul M.

Wilson, Jeffrey R.

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TI Complications in Robotic-Assisted Gynecologic Surgery According to Case

Type: A 6-Year Retrospective Cohort Study Using Clavien-Dindo

Classification

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Gynecologic surgery; Gynecology; Postoperative; Robotics

ID ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; SURGICAL COMPLICATIONS;

MULTIINSTITUTIONAL EXPERIENCE; RADICAL HYSTERECTOMY; CERVICAL-CANCER;

OUTCOMES; DISEASE

AB Study Objective: To estimate the risk of postoperative complications in robotic-assisted gynecologic surgery according to case type.

Study Design: Retrospective cohort study (Canadian Task Force classification II-2).

Setting: Mayo Clinic Arizona.

Patients: All 1155 patients who underwent robotic-assisted gynecologic surgery between March 2004 and December 2009 were included. Patients were primarily white (94.3%), with a mean (SD) age of 51.5 (15.4) years, and were overweight, with body mass index (BMI) of 27.2 (6.8).

Interventions: Risk of complications, overall and according to Clavien-Dindo grade, and incidence of specific complications were analyzed. Robotic-assisted gynecologic surgical procedures were categorized postoperatively according to case type as benign simple (e.g., oophorectomy, simple hysterectomy) in 552 (47.8%) patients, benign complex (e.g., excision of invasive endometriosis) in 262 (22.7%), urogynecologic in 121 (10.5%), and oncologic in 220 (19.1%).

Measurements and Main Results: Intraoperative complications occurred in 3.2% of patients. Postoperative complications of any type occurred in 18.4% of patients. Conversion to laparotomy was necessary in 2.7%. Urologic complications were more common in urogynecologic cases (5.8%) as compared with benign simple (0.5%), benign complex (2.7%), and oncologic (3.2%). Bleeding complications were most common in oncologic cases (5%). Clavien-Dindo grade >= 3 complications occurred in 5.2% of patients overall, and were >3-fold likely to occur in benign complex, urogynecologic, and oncologic cases than in benign simple cases. When adjusted for age, BMI, estimated blood loss, operative time, length of stay, and previous pelvic surgery, complications were nearly twice as common for benign complex (odds ratio [OR] 1.7; 95% confidence interval [CI], 1.1-2.7), urogynecologic (OR 1.9; 95% CI, 1.0-3.4), and oncologic (OR 1.9; 95% CI, 1.1-3.1) cases as for benign simple cases, although weakly significant. Case type, BMI, estimated blood loss, and length of stay remained important factors in predicting postoperative complications.

Conclusion: The incidence of complications in robotic-assisted gynecologic surgery varies according to case type. Defining the role of patient and surgical variables such as case type in the occurrence of complications may help in identification of cases with increased risk, to improve patient counseling and surgical outcome. (C) 2014 AAGL. All rights reserved.

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TI Safety Culture in the Gynecology Robotics Operating Room

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Checklist; Quality; Robotic assisted; Team cohesiveness

ID TEAMWORK; ATTITUDES; MORTALITY; THEATER

AB Study Objective: To measure the safety culture in the robotics surgery operating room before and after implementation of the Robotic Operating Room Computerized Checklist (RORCC).

Design: Prospective study.

Subjects: Gynecology surgical staff (n = 32).

Setting: An urban community hospital.

Interventions: The Safety Attitudes Questionnaire domains examined were teamwork, safety, job satisfaction, stress recognition, perceptions of management, and working conditions. Questions and domains were described using percent agreement and the Cronbach alpha. Paired t-tests were used to describe differences before and after implementation of the checklist.

Measurements and Main Results: Mean (SD) staff age was 46.7 (9.5) years, and most were women (78%) and worked full-time (97%). Twenty respondents (83% of nurses, 80% of surgeons, 66% of surgical technicians, and 33% of certified registered nurse anesthetists) completed the Safety Attitudes Questionnaire; 6 were excluded because of non-matching identifiers. Before RORCC implementation, the highest quality of communication and collaboration was reported by surgeons and surgical technicians (100%). Certified registered nurse anesthetists reported only adequate levels of communication and collaboration with other positions. Most staff reported positive responses for teamwork (48%; alpha = 0.81), safety (47%; alpha = 0.75), working conditions (37%; alpha = 0.55), stress recognition (26%; alpha = 0.71), and perceptions of management (32%; alpha = 0.52). No differences were observed after RORCC implementation.

Conclusion: Quality of communication and collaboration in the gynecology robotics operating room is high between most positions; however, safety attitude responses are low overall. No differences after RORCC implementation and low response rates may highlight lack of staff support. (C) 2014 Published by Elsevier Inc. on behalf of AAGL.

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PT J

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TI Robotically assisted laparoscopic repair of anterior vaginal wall and

uterine prolapse by lateral suspension with mesh: initial experience and

video

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Sacrocolpopexy; Hysteropexy; Robotic surgery; da

Vinci system; Uterine prolapse

ID ABDOMINAL SACROCOLPOPEXY

AB Sacral colpopexy/hysteropexy is a well-established approach to vaginal apex support and was the first technique used to treat pelvic organ prolapse (POP) with robotic assistance. However, dissection at the level of the promontory may be difficult, especially in obese patients, and associated with rare but potential serious morbidity such as life-threatening vascular injury. In an attempt to avoid this risk, we describe a new robotic approach for POP repair with lateral suspension.

From March 2012 through June 2013, ten patients with symptomatic anterior vaginal wall and uterine prolapse were operated by a single surgeon. The video presents the different steps of robotically assisted laparoscopic repair of POP by lateral suspension with mesh and uterine conservation using da Vinci S or Si system.

POP repair was successfully completed in all ten patients without any perioperative or postoperative complication.

Robotically assisted laparoscopic repair of POP by lateral suspension with mesh is a novel and feasible technique with promising short-term results. It may have several theoretical advantages over sacral colpopexy/hysteropexy and may represent an alternative in cases of difficult dissection of the promontory.

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TI Feasibility and perioperative outcomes of robotic-assisted surgery in

the management of recurrent ovarian cancer: A multi-institutional study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Minimally invasive surgery; Surgical technique

ID SECONDARY CYTOREDUCTIVE SURGERY; CARCINOMA; LAPAROSCOPY; SELECTION

AB Objectives. Minimally invasive surgery for recurrent ovarian cancer is generally not performed. The aim of this study was to assess the feasibility and surgical outcomes of robotic-assisted surgery in the management of recurrent ovarian cancer.

Methods. Eligible patients included those with confirmed recurrent ovarian cancer amenable to surgical resection and in which a complete resection was thought to be feasible with the use of the robotic platform. Patients with evidence of carcinomatosis were not considered for a robotic approach. Clinical and pathologic data were abstracted from the medical records. Appropriate statistical tests were performed using SPSS statistical software program (SPSS 20.0 Inc., Chicago, IL).

Results. A total of 48 patients were identified. Thirty-six (75%) patients had a recurrent mass or masses isolated to one anatomic region (pelvis or abdomen). Conversion to laparotomy was necessary in 4 (8.3%) cases. In cases not requiring conversion to laparotomy, the median operative time, EBL, and length of stay were 179.5 min, 50 cc, and 1 day, respectively. An optimal debulking was achieved in 36 (82%) cases. Complications occurred in 6 (13.6%) cases. The median operative time, EBL, length of stay, and complications were all statistically significantly lower in the cases not converted to laparotomy compared to those that were (p < 0.001).

Conclusions. This study suggests that select patients with recurrent ovarian cancer in the absence of carcinomatosis may be candidates for secondary surgical cytoreduction via a robotic approach. Surgical and postoperative outcomes appear to be favorable compared to reports of laparotomy in recurrent ovarian cancer. (C) 2014 Elsevier Inc. All rights reserved.

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PT J

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TI Conversion from robotic surgery to laparotomy: A case-control study

evaluating risk factors for conversion

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Minimally invasive surgery; Conversion

ID RADICAL HYSTERECTOMY; ENDOMETRIAL

AB Objectives. To determine risk factors associated with conversion to laparotomy for women undergoing robotic gynecologic surgery.

Methods. The medical records of 459 consecutive robotic surgery cases performed between December 2006 and October 2011 by 8 different surgeons at a single institution were retrospectively reviewed. Cases converted to laparotomy were compared to those completed robotically. Descriptive statistics were used to summarize the demographic and clinical characteristics.

Results. Forty of 459 (8.7%, 95% CI 6.3%-11.7%) patients had conversion to open surgery. Reason for conversion included poor visualization due to adhesions (13), inability to tolerate Trendelenburg (7), enlarged uterus (7), extensive peritoneal disease (5), bowel injury (2), ureteral injury (1), vascular injury (1), bladder injury (1), technical difficulty with the robot (2), and inability to access abdominal cavity (1).5% of cases were converted prior to docking the robot. On univariate analysis, preopeiative diagnosis (p = 0.012), non-White race (p = 0.004), history of asthma (p = 0.027), ASA score (p = 0.032), bowel injury (p = 0.012), greater BMI (p < 0.001), need for blood transfusion (p < 0.001), and expected blood loss (p < 0.001) were associated with conversion. On multivariate analysis, non-White race (OR 2.88, 95% CI 139-5.96, p = 0.004), bowel injury (OR 35.40,95% Cl 3.00-417.28, p = 0.005), and increasing BMI (OR 1.06,95% CI 1.03-1.09, p < 0.001) were significantly associated with increased risk for conversion. Prior surgery was not associated with conversion to open surgery (p = 0.347).

Conclusion. Conversion to laparotomy was required for 8.7% of patients undergoing robotic surgery for a gynecologic indication. Increasing BMI and non-white race were identified as the two preoperative risk factors associated with conversion. (C) 2014 Elsevier Inc. All rights reserved.

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TI Physician pain and discomfort during minimally invasive gynecologic

cancer surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparoscopy; Robotic surgery; Laparo-endoscopic single-site surgery

(LESS); Pain; Numbness; Discomfort; Fatigue

ID LAPAROSCOPIC SURGERY; ROBOTIC SURGERY; ONCOLOGY; NEED

AB Objective. Despite increasing awareness of physical strain to surgeons associated with minimally invasive surgery (MIS), its use continues to expand. We sought to gather information from gynecologic oncologists regarding physical discomfort due to MIS.

Methods. Anonymous surveys were e-mailed to 1279 Society of Gynecologic Oncology (SGO) members. Physical symptoms (numbness, pain, stiffness, and fatigue) and surgical and demographic factors were assessed. Univariate and multivariate analyses were performed to determine risk factors for physical symptoms.

Results. We analyzed responses of 350 SGO members who completed the survey and currently, performed >50% of procedures robotically (n = 122), laparoscopically (n = 67), or abdominally (n = 61). Sixty-one percent of members reported physical symptoms related to MIS. The rate of symptoms was higher in the robotic group (72%) than the laparoscopic (57%) or abdominal groups (49%) (p = 0.0052). Stiffness = 0.0373) and fatigue (p = 0.0125) were more common in the robotic group. Female sex (p < 0.0001), higher caseload (p = 0.0007), and academic practice (p = 0.0186) were associated with increased symptoms. On multivariate analysis, robotic surgery (odds ratio [OR] 2.38,95% CI 1.20-4.69) and female sex (OR 4.20, 95% CI 2.13-829) were significant predictors of symptoms. There was no correlation between seeking treatment and surgical modality (laparotomy 11%, robotic 20%, laparoscopy 25%, p = 0.12).

Conclusions. Gynecologic oncologists report physical symptoms due to MIS at an alarming rate. Robotic surgery and female sex appear to be risk factors for physical discomfort. As we strive to improve patient outcomes and decrease patient morbidity with MIS, we must also work to improve the ergonomics of MIS for surgeons. (C) 2014 Elsevier Inc. All rights reserved.

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TI A comparison of colorimetric versus fluorometric sentinel lymph node

mapping during robotic surgery for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Sentinel lymph node; Endometrial cancer; Fluorescence imaging; Obesity;

Robotic hysterectomy; Indocyanine green

ID HYSTEROSCOPIC INJECTION; DIAGNOSTIC-ACCURACY; LYMPHADENECTOMY; BIOPSY;

UTERINE; IDENTIFICATION; CARCINOMA; WOMEN

AB Objective. The study objective was to compare the ability to detect sentinel lymph nodes (SLNs) in women with endometrial cancer (EC) or complex atypical hyperplasia (CAH) using fluorometric imaging with indocyanine green (ICG) versus colorimetric imaging with isosulfan blue (ISB).

Methods. Women underwent SLN mapping, with either ISB or ICG, during robotic-assisted total laparoscopic hysterectomy (RA-TLH) from September 2012 to March 2014. SLNs were submitted for permanent pathologic analysis. Completion lymphadenectomy and ultrastaging were performed according to institutional protocols.

Results. RA-TLH and SLN mapping was performed in 71 women; 64 had EC (64) and 7 had CAH. Age, body mass index (BMI), stage and tumor characteristics were similar in the ICG versus the ISB cohorts. Overall, SLNs were-identified bilaterally (62.0%), unilaterally (21.1%), or neither (16.9%), and in 103 of 142 hemi-pelvises (72.5%). The mean number of SLNs retrieved per hemipelvis was 2.23 (SD 1.7). SLNs were identified in the hypogastric (76.8%), external iliac (14.2%), common iliac (4.5%) and paraaortic (4.5%) regions. ICG mapped bilaterally in 78.9% of women compared with 42.4% of those injected with ISB (p = 0.02). Five women (7%) had positive lymph nodes, all identified by the SLN protocol (false negative rate: 0%). On multivariate analysis, BMI was negatively correlated with bilateral mapping success (p = 0.02). When stratified by dye type, the association with BMI was only significant for ISB (p = 0.03).

Conclusions. Fluorescence imaging with ICG may be superior to colorimetric imaging with ISB in women undergoing SLN mapping for endometrial cancer. SLN mapping success is negatively associated with increasing patient BMI only when ISB is used. (C) 2014 Elsevier Inc. All rights reserved.

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DA 2024-01-18

ER

PT J

AU Smorgick, N

As-Sanie, S

AF Smorgick, Noam

As-Sanie, Sawsan

TI The benefits and challenges of robotic-assisted hysterectomy

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE learning curve; robotic-assisted hysterectomy; robotic surgery

ID LAPAROSCOPIC HYSTERECTOMY; LEARNING-CURVE; PERFORMANCE; RATES

AB Purpose of review

To analyze the recent evidence on robotic hysterectomy while highlighting its benefits and challenges.

Recent findings

Increased rates of robotic hysterectomy have led to decreasing rates of abdominal hysterectomy, after rates of the latter approach have been stagnant for many years. Robotic surgery has also the possible advantage of a relatively short learning curve, even though the case number required to reach proficiency may be actually closer to 100 cases. Recent studies comparing robotic and laparoscopic hysterectomy for benign indications have not demonstrated a clear advantage for either approach in terms of complications, blood loss, and hospital stay. The higher cost of robotic hysterectomy remains a significant disadvantage of this surgical approach, although the total cost may decrease with increasing surgeon's experience (via shorter operative time) and may be offset in some circumstances by reduced hospital stay and cost of complications compared with abdominal hysterectomy.

Summary

The place of robotic hysterectomy in the gynecologic surgical armamentarium is still evolving. Although recent studies highlight the comparative outcomes of robotic and laparoscopic hysterectomy for benign cases, most surgeons are unlikely to be equally proficient in both techniques. Future studies will need to question whether subgroups of patients with complex benign disease such as endometriosis and pelvic adhesive disease may benefit from the robotic assistance.

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U2 8

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J9 CURR OPIN OBSTET GYN

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ER

PT J

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Bautista, Erleine

Hansra, Barinder S.

Samuelson, Robert

Shahabi, Shohreh

TI Vulvar Metastasis of an Early-Stage Well-Differentiated Endometrial

Cancer After Minimally Invasive Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Metastasis; Minimally invasive surgery; Surgical

staging; Vulva

ID CELL CARCINOMA; RECURRENCE; SECONDARY; TUMORS

AB Endometrial cancer is the most common gynecologic malignancy, often manifesting as early-stage well-differentiated endometrioid adenocarcinoma associated with a high likelihood of long-term recurrence-free survival. Minimally invasive surgery for surgical staging of endometrial lesions is now routinely practiced, with laparoscopy the preferred surgical approach at many cancer centers. Recurrence or metastasis of early-stage well-differentiated endometrial endometrioid adenocarcinoma is uncommon, and may occur due to iatrogenic microscopic seeding of malignant cells during surgery, as suggested by previous reports of cancer metastasis to port sites after minimally invasive surgery, laparotomy incisions after open surgery, or intraperitoneal spread after hysteroscopy or uterine manipulation. Herein we report the only described case of isolated vulvar metastasis of an early-stage FIGO stage IB well-differentiated (histologic grade 1) endometrial endometrioid adenocarcinoma after minimally invasive surgery for surgical staging. The patient had recurrent endometrioid adenocarcinoma metastasis at the vulva 8 months after robotic-assisted total laparoscopic hysterectomy and surgical staging with specimen removal through the vagina. In selected cases, we suggest that use of a specimen bag during removal of the uterus through the vagina may limit seeding of malignant cells during minimally invasive surgery to treat cancer. (C) 2014 AAGL. All rights reserved.

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ER

PT J

AU Abitbol, J

Lau, S

Ramanakumar, AV

Press, JZ

Drummond, N

Rosberger, Z

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Gotlieb, R

How, J

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Lau, Susie

Ramanakumar, Agnihotram V.

Press, Joshua Z.

Drummond, Nancy

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Gotlieb, Walter H.

TI Prospective Quality of Life Outcomes Following Robotic Surgery in

Gynecologic Oncology

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; quality of life; outcome; body image

ID ENDOMETRIAL CANCER; OVARIAN-CANCER; WOMEN; POPULATION; PATIENT; FOCUS

AB Purpose. To characterize the health-related quality of life (HRQL) of patients undergoing robotic surgery for the treatment of gynecologic cancers.

Methods. 211 patients completed a quality of life questionnaire before surgery. Postoperative questionnaires, consisting of the same assessment with the addition of postoperative questions, were given at 1 week, 3 weeks, 3, 6, and 12 months after surgery. The Functional Assessment of Cancer Therapy General (FACT-G) and its subscales were used to evaluate HRQL. Patient-rated body image was evaluated using the Body Image Scale. Statistical significance was measured by the Wilcoxon signed-rank test. Minimally important difference (MID) values were analyzed to evaluate clinical significance.

Results. Overall HRQL and body image decreased at 1 week after surgery and returned to baseline by 3 weeks. Physical and functional well-being decreased at 1 week after surgery and returned to baseline by 3 months after surgery. However, using MID criteria, physical well-being returned to baseline by 3 weeks. Social well-being did not change significantly. Emotional well-being increased immediately by 1 week after surgery.

Conclusion. Patient reported HRQL outcomes following robotic surgery for the treatment of gynecologic cancers suggests a rapid return to pre-surgery values. (C) 2014 Elsevier Inc. All rights reserved.

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ER

PT J

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Bardsley, Tyler R.

Sharp, Howard T.

TI Urinary Tract Injuries in Laparoscopic Hysterectomy: A Systematic Review

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Cystoscopy; Gynecologic, laparoscopic, and robotic surgery; Ureteral,

bladder, and urinary tract injury; Urinary tract fistula

ID ASSISTED VAGINAL HYSTERECTOMY; BENIGN UTERINE PATHOLOGIES; SUPRACERVICAL

HYSTERECTOMY; URETERAL INJURIES; CONTINUOUS SERIES; COMPLICATIONS;

EXPERIENCE; RISK; CYSTOSCOPY; PREVENTION

AB The aim of this review was to estimate the incidence of urinary tract injuries associated with laparoscopic hysterectomy and describe the long-term sequelae of these injuries and the impact of early recognition. Studies were identified by searching the PubMed database, spanning the last 10 years. The key words "ureter" or "ureteral" or "urethra" or "urethral" or "bladder" or "urinary tract" and "injury" and "laparoscopy" or "robotic" and "gynecology" were used. Additionally, a separate search was done for "routine cystoscopy" and "gynecology." The inclusion criteria were published articles of original research referring to urologic injuries occurring during either laparoscopic or robotic surgery for gynecologic indications. Only English language articles from the past 10 years were included. Studies with less than 100 patients and no injuries reported were excluded. No robotic series met these 'criteria. A primary search of the database yielded 104 articles, and secondary cross-reference yielded 6 articles. After reviewing the abstracts, 40 articles met inclusion criteria and were reviewed in their entirety. Of those 40 articles, 3 were excluded because of an inability to extract urinary tract injuries from total injuries. Statistical analysis was performed using a generalized linear mixed effects model. The overall urinary tract injury rate for laparoscopic hysterectomy was 0.73%. The bladder injury rate ranged from 0.05% to 0.66% across procedure types, and the ureteral injury rate ranged from 0.02% to 0.4% across procedure type. In contrast to earlier publications, which cited unacceptably high urinary tract injury rates, laparoscopic hysterectomy appears to be safe regarding the bladder and ureter. (C) 2014 AAGL. All rights reserved.

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FU University of Utah Study Design and Biostatistics Center; National

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ER

PT J

AU Coronado, PJ

Fasero, M

Magrina, JF

Herraiz, MA

Vidart, JA

AF Coronado, Pluvio J.

Fasero, Maria

Magrina, Javier F.

Herraiz, Miguel A.

Vidart, Jose A.

TI Comparison of Perioperative Outcomes and Cost Between Robotic-Assisted

and Conventional Laparoscopy for Transperitoneal Infrarenal Para-aortic

Lymphadenectomy (TIPAL)

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cost; Infrarenal para-aortic lymphadenectomy; Laparoscopy; Perioperative

outcomes; Robotic

ID ENDOMETRIAL CANCER; GYNECOLOGIC-ONCOLOGY; RADICAL HYSTERECTOMY; SURGERY;

LAPAROTOMY; MANAGEMENT

AB Study Objective: To compare perioperative outcomes and cost of robotic-assisted and laparoscopic transperitoneal infrarenal para-aortic lymphadenectomy (TIPAL) for treatment of gynecologic malignant conditions.

Design: Prospective non-randomized study (Canadian Task Force classification II-2).

Setting: Tertiary center for women's health.

Patients: Sixty-two patients with gynecologic cancer operated on by the same surgical team.

Interventions: Thirty-two patients underwent TIPAL via robotic-assisted laparoscopy, and 30 via conventional laparoscopy. Comparison analyses of perioperative outcomes and estimated costs were performed.

Measurements and Main Results: There were no differences between robotic-assisted and laparoscopy insofar as age, body mass index, presurgical morbidity, operating time (92.5 minutes for robotics vs 96.6 minutes for laparoscopy), number of aortic nodes (12 vs 12), hospitalization stay (2 vs 2 days), or rate of complications (12.5% vs 13.3%). Blood loss tended to be lower in the robotic group (75.0 vs 92.5 mL; p = .08). Surgical cost was higher in the robotic group ($3.42 vs $2.55; p < .001), although hospitalization cost was similar.

Conclusion: Robotic-assisted and laparoscopy provide similar perioperative outcomes. However, the robotic-assisted approach is associated with higher surgical cost. (C) 2014 AAGL. All rights reserved.

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PT J

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Traut, Alexander

du Bois, Andreas

Kurzeder, Christian

TI Implementation of robot-assisted gynecologic surgery for patients with

low and high BMI in a German gynecological cancer center

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic surgery; Gynecologic; BMI; Hysterectomy; Complications

ID BODY-MASS INDEX; LAPAROSCOPIC HYSTERECTOMY; OBESE WOMEN; OUTCOMES

AB To present a single center outcome from an initial series of gynecological robotic cases with a special reference to obese patients.

A retrospective evaluation of 116 women, undergoing elective gynecologic robot-assisted surgery from February 2011 to December 2012. Procedures included hysterectomy (HE), radical HE, adnexectomy, myomectomy, pelvic lymphadenectomy and paraaortic lymphadenectomy, sentinel node extraction, and omentectomy. The feasibility and outcome were investigated in relation to normal and high body mass index (BMI < 30 and BMI a parts per thousand yen 30).

The overall complication rate was low (15/116; 12.9 %). The number of perioperative complications was not different between the patients with normal BMI compared to those with high BMI. Five operations were converted to open surgery due to vascular injury (2), intestinal injury (2) and one insufficiently exposed paraaortic field in an endometrial cancer patient. Urinary bladder was injured once. Late complications included vaginal dehisce (2), vaginal hemorrhage (1), cuff hematoma (4), lymphocyst (1) and two urinary tract injuries. The rate of the late complications was not significantly different in the two groups of patients (p = 0.139). A significant difference in patients' positioning time was observed between normal weighted and obese patients (35 and 55 min, p < 0.001).

Robotic procedure was feasible and could be implemented for treating the first setting of mixed indications for gynecologic surgery. Robotic surgery may offer particular advantages in obese patients with no conversions and no wound complications.

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TC 12

Z9 13

U1 0

U2 5

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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ER

PT J

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Weissman, A

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Mustafa, Mona

Burke, Yechiel Z.

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Segal, Dror

Weissman, Amir

TI Steep Trendelenburg position during robotic sacrocolpopexy and heart

rate variability

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Robotic surgery; Urogynecology; Autonomic nervous system; Trendelenburg;

Heart rate variability

ID DOWN BED REST; TILT; HUMANS

AB Objectives: The objective of this study was to evaluate heart rate variability and hemodynamic parameters following steep Trendelenburg positioning during robotic sacrocolpopexy.

Study design: For 19 women, median age 57 (range: 45-72), blood pressure and ECG were recorded during surgery. From the ECG signals interbeat intervals were used to assess heart rate variability, analyzed in time and frequency domains using the Fast Fourier transform. The low frequency and high frequency spectral bands were used to assess sympathetic and parasympathetic pathways respectively.

Results: All women underwent robotic supracervical hysterectomy and sacrocolpopexy. A statistically significant decrease in the mean values of the low-frequency and high-frequency spectral bands, representing sympathetic and parasympathetic activity, respectively were demonstrated 5 min following Trendelenburg positioning of the patients (from 3.6 +/- 1.4 to 2.9 +/- 0.8 ms(2)/Hz, and from 3.5 +/- 1.4 to 2.9 +/- 1 ms(2)/Hz, P < 0.05). These changes correlated with a mean 20% decrease in heart rate, which lasted for 30 min, and with a second drop in sympathetic and parasympathetic activity and heart rate,, commencing 2 h from the start of surgery, and lasting until the end of the operation.

Conclusions: Steep Tredelenburg positioning during robotic urogynecology surgery results in significant changes in the autonomic nervous system modulation of heart rate variability and in other hemodynamic parameters. (C) 2014 Elsevier Ireland Ltd. All rights reserved.

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NR 20

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U2 5

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JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PT J

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Fuchs-Weizman, N

Cohen, SL

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Wang, Karen C.

Einarsson, Jon

TI MAUDE: Analysis of Robotic-Assisted Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE da Vinci Surgical System; MAUDE

ID SURGICAL SYSTEM; COMPLICATIONS; FAILURE; HYSTERECTOMY; MALFUNCTION;

EXPERIENCE; DATABASE; FDA

AB Study Objective: To evaluate the adverse events encountered during robotic gynecologic surgery, as reported to the FDA MAUDE database from January 2006 to December 2012.

Design: Database search (Canadian Task Force classification III).

Intervention: A search of the FDA MAUDE database was performed by brand name "da Vinci" and manufacturer "Intuitive Surgical." Reports reflecting gynecologic procedures either by description or procedure name were included. A record of reports was kept to ensure that no duplicates were added. The date and type of event (operator-related error, technical system failure, or surgical injuries attributed to use of the robot) and the clinical outcome were recorded.

Measurements and Main Results: Twenty-six percent of reported events (n = 73) resulted in injury, and 8.5% (n = 24) resulted in death. Of note, although adnexal procedures were performed in <3% of the cohort, they accounted for 20% of the fatalities. Twenty-one percent of injuries were attributed to operator-related error, and 14% to technical system failure; 65% were not directly related to use of the robot. Fifteen deaths were reported during planned hysterectomy. Four of those were due to injury to a major blood vessel (iliac artery in 3, and aorta in 1), although a detailed description of how the injury occurred was absent from the event description.

Conclusion: It is important to continue to evaluate the occurrence of injuries during robot-assisted surgery in an effort to identify unique challenges associated with this advanced technology. Published by Elsevier Inc. on behalf of AAGL.

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ER

PT J

AU Parkes, IL

Shveiky, D

AF Parkes, Ilana L.

Shveiky, David

TI Sacrocolpopexy for Treatment of Vaginal Apical Prolapse: Evidence-Based

Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Evidence; Laparoscopy; Mesh; Robotic surgery; Sacrocolpopexy; Surgical

technique

ID PELVIC ORGAN PROLAPSE; RANDOMIZED-CONTROLLED-TRIAL; ASSISTED

LAPAROSCOPIC SACROCOLPOPEXY; POSTERIOR COMPARTMENT DEFECTS; ABDOMINAL

SACRAL COLPOPEXY; VAULT PROLAPSE; ROBOTIC SACROCOLPOPEXY; MESH

SACROCOLPOPEXY; POLYPROPYLENE MESH; WALL PROLAPSE

AB Pelvic organ prolapse is a common condition that negatively affects womens' quality of life. Sacrocolpopexy is an abdominal procedure designed to treat apical compartment prolapse including uterine or vaginal vault prolapse and multiple-compartment prolapse. Although traditionally performed as an open abdominal procedure, minimally invasive sacrocolpopexy, whether laparoscopic or robotic, has been successfully adopted in the practice of many pelvic reconstructive surgeons. There are many variations to this procedure, with different levels of evidence to support each of them. Herein we review the current literature on sacrocolpopexy, with emphasis on the minimally invasive approach. Procedural steps and controversies are examined in light of the existing literature, and recommendations are made on the basis of the level of existing evidence. (C) 2014 AAGL. All rights reserved.

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ER

PT J

AU Puntambekar, S

Lawande, A

Desai, R

Puntambekar, S

Joshi, GA

Joshi, SN

AF Puntambekar, Shailesh

Lawande, Akhil

Desai, Riddhi

Puntambekar, Seema

Joshi, Geetanjali A.

Joshi, Saurabh N.

TI Initial experience of robotic anterior pelvic exenteration at a single

institute

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Minimally invasive exenterative surgery; Pelvic cancer; Pelvic

exenteration; Robotics

ID CERVICAL-CANCER; MALIGNANT-DISEASE; BLADDER-CANCER; RECURRENT; SURVIVAL;

SURGERY; PALLIATION; OUTCOMES

AB Objective: To present the initial experience with robotic anterior pelvic exenteration in patients with advanced pelvic cancer at Galaxy Care Laparoscopy Institute, Pune, India. Methods: A retrospective chart review of data from 10 patients with advanced cervical carcinoma and bladder involvement or with vault recurrence following hysterectomy who were treated at the study hospital between November 2009 and May 2011. Clinicopathologic data and postoperative data including operative time, blood loss, blood transfusions, hospital stay, lymph node yield, and complications were recorded. Results: The mean operative time was 180 minutes, the mean blood loss was 110 mL, and the mean duration of hospital stay was 5 days. There were no treatment-related morbidities or mortalities. A mean parametrial clearance of 3 cm with a distal vaginal margin of 3.5 cm was achieved. All patients had tumor-free margins. The mean number of harvested lymph nodes was 24. Six patients had positive lymph nodes on pathologic examination and were treated with chemoradiotherapy. At a median follow-up of 11 months, 8 patients were disease-free. Conclusion: Robot-assisted anterior pelvic exenteration had favorable operative, pathologic, and short-term clinical outcomes. A large multicenter study is required to confirm the results. (C) 2014 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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NR 25

TC 16

Z9 18

U1 0

U2 2

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ER

PT J

AU Roque, DR

Wysham, WZ

Soper, JT

AF Roque, Dario R.

Wysham, Weiya Z.

Soper, John T.

TI The Surgical Management of Cervical Cancer: An Overview and Literature

Review

SO OBSTETRICAL & GYNECOLOGICAL SURVEY

LA English

DT Review

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; QUALITY-OF-LIFE;

GYNECOLOGIC-ONCOLOGY-GROUP; PELVIC RADIATION-THERAPY; LOWER

URINARY-TRACT; FIGO STAGE IB; NEOADJUVANT CHEMOTHERAPY; VAGINAL

TRACHELECTOMY; RANDOMIZED-TRIAL; PHASE-II

AB Importance: Surgery has evolved into the standard therapy for nonbulky carcinoma of the cervix. The mainstay of surgical management is radical hysterectomy; however, less radical procedures have a small but important role in the management of cervical tumors.

Objective: Our objective was to discuss the literature behind the different procedures utilized in the management of cervical cancer, emphasizing the radical hysterectomy. In addition, we aimed to discuss ongoing trials looking at the utility of less radical surgeries as well as emerging technologies in the management of this disease.

Evidence Acquisition: We performed a PubMed literature search for articles in the English language that pertained to the topic of surgical techniques and their outcomes in the treatment of cervical cancer.

Results: The minimally invasive approaches to radical hysterectomy appear to reduce morbidity without affecting oncological outcomes, although further data are needed looking at long-term outcomes with the robotic platform. Trials are currently ongoing looking at the role of less radical surgery for patients with low-risk disease and the feasibility of sentinel lymph node mapping.

Conclusions and Relevance: Radical hysterectomy with pelvic lymphadenectomy has evolved into the standard therapy for nonbulky disease, and there is a clear advantage in the use of minimally invasive techniques to perform these procedures. However, pending ongoing trials, less radical surgery in patients with low-risk invasive disease as well as sentinel lymph node mapping may emerge as standards of care in selected patients with cervical carcinoma.

Target Audience: Obstetricians and gynecologists, family physicians

Learning Objectives: After completing this CME activity, physicians should be better able to describe the role of cold knife cone and simple hysterectomy in the management of carcinoma of the cervix, identify the primary treatment options for patients with cervical cancer and their associated complications/adverse effects, compare the differences in surgical outcomes and complication rates between the different kinds of radical hysterectomies, and identify which patients qualify for fertility-sparing surgery.

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PT J

AU Sendag, F

Akdemir, A

Zeybek, B

Ozdemir, A

Gunusen, I

Oztekin, MK

AF Sendag, Fatih

Akdemir, Ali

Zeybek, Burak

Ozdemir, Asuman

Gunusen, Ilkben

Oztekin, Mehmet Kemal

TI Single-Site Robotic Total Hysterectomy: Standardization of Technique and

Surgical Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE da Vinci Single-Site Platform; Intracorporeal Suturing; Laparoendoscopic

single-site surgery; Total hysterectomy

ID TRANSUMBILICAL TOTAL HYSTERECTOMY; TOTAL LAPAROSCOPIC HYSTERECTOMY;

ENDOMETRIAL CANCER; GYNECOLOGIC LAPAROSCOPY; PLATFORM; SURGERY;

FEASIBILITY; EXPERIENCE

AB Study Objectives: To evaluate the safety and feasibility of robotic single-site total hysterectomy and to compare the outcomes of newly implemented robotic single-site bipolar and external vessel-sealing device.

Design: Retrospective study (Canadian Task Force classification II-1).

Setting: University hospital.

Patients: Twenty-four patients with benign indications for hysterectomy.

Interventions: All patients underwent robotic-assisted single-incision transumbilical total hysterectomy using the novel da Vinci Single-Site Platform. Vaginal cuff closures were performed intracorporeally using the same technique in all cases.

Measurements and Main Results: The median age of the patients was 49.5 years (range, 40-61), and body mass index was 28.5 (range, 21-34). Blood loss was 22.5 mL (range, 7-120 mL). Docking time was 5.5 minutes (range, 3-10 minutes), console time was 74.5 minutes (range, 60-160 minutes), vaginal cuff closure time was 25 minutes (range, 16-41 minutes), and total operative time was 98.5 minutes (range, 71-183 minutes). When 2 groups were created according to the energy devices used during the procedures, console time in the newly implemented bipolar group was shorter than in the external sealing device group (69.5 minutes vs 77 minutes; p = .03); however, no differences were found for uterus removal time (50.5 minutes vs 53.5 minutes; p = .13). Differences were observed in vaginal cuff closure time (18.5 minutes vs 23 minutes; p = .01).

Conclusion: Robotic single-site total hysterectomy using a newly implemented bipolar grasping instrument and even with intracorporeal cuff closure is a safe and feasible procedure in appropriately selected patients. Crown Copyright (C) 2014 Published by Elsevier Inc. All rights reserved.

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PT J

AU Tarr, ME

Rivard, C

Petzel, AE

Summers, S

Mueller, ER

Rickey, LM

Denman, MA

Harders, R

Durazo-Arvizu, R

Kenton, K

AF Tarr, Megan Elizabeth

Rivard, Colleen

Petzel, Amy E.

Summers, Sondra

Mueller, Elizabeth R.

Rickey, Leslie M.

Denman, Mary A.

Harders, Regina

Durazo-Arvizu, Ramon

Kenton, Kimberly

TI Robotic Objective Structured Assessment of Technical Skills: A

Randomized Multicenter Dry Laboratory Training Pilot Study

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE resident education; robotic surgery; OSATS; teaching curriculum

ID SURGICAL SKILLS; ACADEMIC INSTITUTION; GYNECOLOGY RESIDENTS;

LEARNING-CURVE; OBSTETRICS

AB Study Objective: The goal of this study was to determine if a robotic dry laboratory curriculum for gynecology and urology residents improved their basic robotic skills.

Methods: After the institution-specific institutional review board approval or exemption, 165 residents from 8 gynecology and/or urology programs were enrolled. Residents underwent standardized robotic orientation followed by dry laboratory testing on 4 unique robotic tasks. Residents were block randomized by program to unstructured or structured training programs. Regardless of group, residents were expected to practice for 15 minutes twice monthly over 7 months. Errors, time to completion, and objective structured assessment of technical skills global rating scores were recorded for each task before and after the training period. Statistics were calculated using the Student t tests, Pearson correlation, and analysis of variance with STATA systems (version 11.2).

Results: A total of 99 residents completed both the pretraining and post-training testing. A mean of 4 (range, 0-15) 15-minute training sessions per resident was self-reported. The structured group had faster posttraining times on the transection task, although the unstructured group had higher posttraining scores on the knot-tying task.

Conclusions: Overall, the residents' robotic skills improved after participating in a dry laboratory curriculum; however, robotic availability, duty hour restrictions, and clinical responsibilities limit the curriculum implementation.

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Z9 12

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U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

AU Yang, YS

Kim, SH

Jin, CH

Oh, KY

Hur, MH

Kim, SY

Yim, HS

AF Yang, Yun Seok

Kim, Seung Hyun

Jin, Chan Hee

Oh, Kwoan Young

Hur, Myung Haeng

Kim, Soo Young

Yim, Hyun Soon

TI Solo Surgeon Single-Port Laparoscopic Surgery With a Homemade

Laparoscope-Anchored Instrument System in Benign Gynecologic Diseases

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Benign gynecologic disease; Single-port laparoscopic surgery (SPLS);

Solo surgeon

ID CONTROLLED-TRIAL; SITE SURGERY; CHOLECYSTECTOMY; HOLDER; CAMERA; ROBOT;

PLATFORM

AB The objective of this study was to present the initial operative experience of solo surgeon single-port laparoscopic surgery (SPLS) in the laparoscopic treatment of benign gynecologic diseases and to investigate its feasibility and surgical outcomes. Using a novel homemade laparoscope-anchored instrument system that consisted of a laparoscopic instrument attached to a laparoscope and a glove wound retractor umbilical port, we performed solo surgeon SPLS in 13 patients between March 2011 and June 2012. Intraoperative complications and postoperative surgical outcomes were determined. The primary operative procedures performed were unilateral salpingo-oophorectomy (n = 5), unilateral salpingectomy (n = 2), adhesiolysis (n = 1), and laparoscopically assisted vaginal hysterectomy (n = 5). Additional surgical procedures included additional adhesiolysis (n = 4) and ovarian drilling (n = 1).The primary indications for surgery were benign ovarian tumors (n = 5), ectopic pregnancy (n = 2), pelvic adhesion (infertility) (n = 1), and benign uterine tumors (n = 5). Solo surgeon SPLS was successfully accomplished in all procedures without a laparoscopic assistant. There were no intraoperative or postoperative complications. Our laparoscope-anchored instrument system obviates the need for an additional laparoscopic assistant and enables SPLS to be performed by a solo surgeon. The findings show that with our system, solo surgeon SPLS is a feasible and safe alternative technique for the treatment of benign gynecologic diseases in properly selected patients. (C) 2014 AAGL. All rights reserved.

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ER

PT J

AU Chen, CH

Chiu, LH

Chang, CW

Yen, YK

Huang, YH

Liu, WM

AF Chen, Ching-Hui

Chiu, Li-Hsuan

Chang, Ching-Wen

Yen, Yuan-Kuei

Huang, Yan-Hua

Liu, Wei-Min

TI Comparing Robotic Surgery With Conventional Laparoscopy and Laparotomy

for Cervical Cancer Management

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical cancer; Radical hysterectomy; Laparotomy; Laparoscopic surgery;

Robotic surgery

ID MINIMALLY INVASIVE SURGERY; RADICAL HYSTERECTOMY; NEOADJUVANT

CHEMOTHERAPY; CONCURRENT CHEMOTHERAPY; PERIOPERATIVE OUTCOMES;

RADIATION-THERAPY; PELVIC RADIATION; CISPLATIN; CARCINOMA

AB Objective The aim of this study was to compare the outcomes of robotic surgery, laparoscopy, and laparotomy for the surgical treatment of stage IA to IIB cervical cancer.

Methods This retrospective study was carried out in a university-affiliated teaching hospital. A total of 100 women with an initial diagnosis of stage IA to IIB cervical cancer, without preoperative brachytherapy or chemotherapy, were included in this study. With selection of the cases, 44 patients received laparotomy surgery, 32 patients received laparoscopic surgery, and 24 patients received robotic surgery. The perioperative parameters measured included operation time, blood loss, transfusion rate, lymph node yield, adhesion score, laparotomy conversion rate, postoperative and 24-hour pain scores, time to full diet resumption, and hospital stay. The perioperative complication and disease-free survival were also evaluated.

Results The robotic group showed a shorter operation time, less blood loss, lower transfusion rate, and lower laparotomy conversion rate than the laparoscopic or laparotomy group. As for the postoperative parameters, the robotic group showed reduced postoperative and 24-hour pain scores, shortened length of hospital stay, and decreased time to full diet resumption compared with the other 2 surgical groups. No significant differences were found between the groups in perioperative complication rate or disease-free survival.

Conclusions The data suggested that robotic surgery is a feasible and potentially optimal option for the treatment of stage IA to IIB cervical cancer with favorable short-term surgical outcomes.

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JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

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PT J

AU Culligan, PJ

Gurshumov, E

Lewis, C

Priestley, JL

Komar, J

Shah, N

Salamon, CG

AF Culligan, Patrick J.

Gurshumov, Emil

Lewis, Christa

Priestley, Jennifer L.

Komar, Jodie

Shah, Nihar

Salamon, Charbel G.

TI Subjective and objective results 1 year after robotic sacrocolpopexy

using a lightweight Y-mesh

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robotic sacrocolpopexy; Lightweight mesh; Prolapse; Transabdominal mesh;

Pelvic organ prolapse

ID INCONTINENCE; PROLAPSE

AB The objective of this study was to assess outcomes following robotic sacrocolpopexy using a lightweight polypropylene Y-mesh.

During our study period, all patients who underwent robotic sacrocolpopexy were enrolled in this single-arm prospective trial. Endpoints included Pelvic Organ Prolapse Quantification (POP-Q) values; Pelvic Floor Distress Inventory, short form 20 (PFDI-20); Pelvic Floor Impact Questionnaire, short form 7 (PFIQ-7); Surgical Satisfaction scores; and the Sandvik Incontinence Severity Index. All surgeries were performed with a pre-configured monofilament type 1 polypropylene Y-mesh (AlyteA (c), C.R. Bard, Covington, GA, USA). Cure rates at 12 months were calculated using two separate definitions: (1) "clinical cure": no POP-Q points > 0, point C a parts per thousand currency sign -5, no prolapse symptoms on the PFDI-20, and no reoperations for prolapse and (2) "objective anatomic cure": POP-Q stage 0 or 1, point C of a parts per thousand currency sign -5, and no reoperations for prolapse.

A total of 150 patients underwent robotic sacrocolpopexy and 143 (95 %) were available for 12-month follow-up. Mean age was 58.6 +/- 9.8 and mean body mass index was 26.3 +/- 4.5. Mean operative time and blood loss were 148 +/- 27.6 min (range 75-250 min) and 51.2 +/- 32, respectively. There were no mesh erosions or exposures, and mesh edges were not palpable in any patient. At 12 months the clinical cure rate was 95 %, and the objective anatomic cure rate was 84 %. The PFDI-20 mean score improved from 98 at baseline to 17 at 12 months (p < 0.0001); PFIQ-7 scores improved from 59 to 6.5 (p < 0.0001).

Robotic sacrocolpopexy using this lightweight polypropylene Y-mesh offers excellent subjective and objective results at 1 year.

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Intuitive Surgical. Dr. Salamon is a paid consultant for American

Medical Systems. None of the other authors have any potential conflicts

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NR 11

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Z9 53

U1 0

U2 3

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JI Int. Urogynecol. J.

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AU Joyeux, L

Chalouhi, GE

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Sapin, E

AF Joyeux, L.

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Ville, Y.

Sapin, E.

TI Maternal-fetal surgery for spina bifida: Future perspectives

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Article

DE Fetal surgery; Spina bifida; Myelomeningocele; Fetoscopy; Prenatal

diagnosis

ID IN-UTERO REPAIR; INTRAUTERINE MYELOMENINGOCELE REPAIR; CONGENITAL

DIAPHRAGMATIC-HERNIA; FUNCTIONAL INDEPENDENCE MEASURE; INITIAL

CLINICAL-EXPERIENCE; TISSUE ENGINEERING APPROACH; NEURAL-TUBE DEFECTS;

HINDBRAIN HERNIATION; NEUROLOGICAL FUNCTION; ENDOSCOPIC COVERAGE

AB Open spina bifida or myelomeningocele (MMC) is a frequent congenital abnormality (450 cases per year in France) associated with high morbidity. Immediate postnatal surgery is aimed at covering the exposed spinal cord, preventing infection, treating hydrocephalus with a ventricular shunt. MMC surgical techniques haven't achieved any major progress in the past decades. Numerous experimental and clinical studies have demonstrated the MMC "two-hit" hypothetic pathogenesis: a primary embryonic congenital abnormality of the nervous system due to a failure in the closure of the developing neural tube, followed by secondary damages of spinal cord and nerves caused by long-term exposure to amniotic fluid. This malformation frequently develops cranial consequences, i.e. hydrocephalus and Chiari II malformation, due to leakage of cerebrospinal fluid. After 30 years of research, a randomized trial published in February 2011 proved open maternal-fetal surgery (OMFS) for MMC to be a real therapeutic option. Comparing prenatal to postnatal surgery, it confirmed better outcomes of MMC children after a follow up of 2.5 years: enhancement of lower limb motor function, decrease of the degree of hindbrain herniation associated with the Chiari II malformation and the need for shunting. At 5 years of age, MMC children operated prenatally seems to have better neurocognitive, motor and bladder-sphincter outcomes than those operated postnatally. However, risks of OMFS exist: prematurity for the fetus and a double hysterotomy at approximately 3-month interval for the mother. Nowadays, it seems crucial to inform parents of MMC patients about OMFS and to offer it in France. Future research will improve our understanding of MMC pathophysiology and evaluate long-term outcomes of OMFS. Tomorrow's prenatal surgery will be less invasive and more premature using endoscopic, robotic or percutaneous techniques. Beforehand, Achilles' heel of maternal-fetal surgery, i.e. preterm premature rupture of membranes, preterm labor and preterm birth, must be solved. (C) 2014 Elsevier Masson SAS. All rights reserved.

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AU Lavoue, V

Zeng, X

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Gotlieb, R

How, J

Wang, YF

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AF Lavoue, Vincent

Zeng, Xing

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Abitbol, Jeremie

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TI Impact of robotics on the outcome of elderly patients with endometrial

cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Elderly; Endometrial cancer; Robotic surgery; Open surgery; Morbidity;

Survival

ID GYNECOLOGIC-ONCOLOGISTS; ABDOMINAL HYSTERECTOMY; SURGICAL-MANAGEMENT;

OLDER PATIENTS; AGE; MORBIDITY; MORTALITY; SURGERY; LYMPHADENECTOMY;

COMPLICATIONS

AB Objective. To evaluate the impact of introducing a robotics program on clinical outcome of elderly patients with endometrial cancer.

Methods. Evaluation and comparison of pen-operative morbidity and disease-free interval in 163 consecutive elderly patients (>= 70 years) with endometrial cancer undergoing staging procedure with traditional open surgery compared to robotic surgery.

Results. All consecutive patients >= 70 years of age with endometrial cancer who underwent robotic surgery (n = 113) were compared with all consecutive patients >= 70 years of age (n = 50) before the introduction of a robotic program in December 2007. Baseline patient characteristics were similar in both eras. Patients undergoing robotic surgery had longer mean operating times (244 compared with 217 minutes, p = 0.009) but fewer minor adverse events (17% compared with 60%, p < 0.001). The robotics cohort had less estimated mean blood loss (75 vs 334 ml, p < 0.0001) and shorter mean hospital stay (3 vs 6 days, p < 0.0001). There was no difference in disease-free survival (p = 0.61) during the mean follow-up time of 2 years.

Conclusion. Transitioning from open surgery to a robotics program for the treatment of endometrial cancer in the elderly has significant benefits, including lower minor complication rate, less operative blood loss and shorter hospitalization without compromising 2-year disease-free survival. (C) 2014 Elsevier Inc. All rights reserved.

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FU Israel Cancer Research Foundation; Week-end to End Women Cancers; Levy

Family Fund; Gloria's Girls; INSERM (Institut National de la Sante et de

la Recherche Medicale)

FX The Israel Cancer Research Foundation, the Week-end to End Women

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AU Lee, SJ

Calderon, B

Gardner, GJ

Mays, A

Nolan, S

Sonoda, Y

Barakat, RR

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TI The feasibility and safety of same-day discharge after robotic-assisted

hysterectomy alone or with other procedures for benign and malignant

indications

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic-assisted hysterectomy; Same-day discharge; TLH; BSO

AB Objective. This study aimed to report the feasibility and safety of same-day discharge after robotic-assisted hysterectomy.

Methods. Same-day discharge after robotic-assisted hysterectomy was initiated 07/2010. All cases from then through 12/2012 were captured for quality assessment monitoring. The distance from the hospital to patients' homes was determined using http://maps.google.com. Procedures were categorized as simple (TLH +/- BSO) or complex (TEH +/- BSO with sentinel node mapping,. pelvic and/or aortic nodal dissection, appendectomy, or omentectomy). Urgent care center (UCC) visits and readmissions within 30 days of surgery were captured, and time to the visit was determined from the initial surgical date.

Results. Same-day discharge was planned in 200 cases. Median age was 52 years (range, 30-78), BMI was 26.8 kg/m(2) (range, 17.4-56.8), and ASA was class 2 (range, 1-3). Median distance traveled was 31.5 miles (range, 0.2-149). Procedures were simple in 109(55%) and complex in 91(45%) cases. The indication for surgery was: endometrial cancer (n = 82; 41%), ovarian cancer (n = 5; 2.5%), cervical cancer (n = 8; 4%), and non-gynecologic cancer/benign (n = 105; 53%). One hundred fifty-seven (78%) had successful same-day discharge. Median time for discharge for these cases was 4.8 h (range, 2.4-10.3). Operative time, case ending before 6 pm, and use of intraoperative ketorolac were associated-with successful same-day discharge. UCC visits occurred in 8/157 (5.1%) same-day discharge cases compared to 5/43 (11.6%) requiring admission (P = .08). Readmission was necessary in 4/157(2.5%) same-day discharge cases compared to 3/43(7.0%) requiring admission (P = .02).

Conclusions. Same-day discharge after robotic-assisted hysterectomy for benign and malignant conditions is feasible and safe. (C) 2014 Elsevier Inc. All rights reserved.

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PT J

AU Menderes, G

Azodi, M

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Lu, Lingeng

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Rutherford, Thomas J.

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Silasi, Dan-Arin

TI Impact of Body Mass Index on Surgical Outcomes and Analysis of Disease

Recurrence for Patients With Endometrial Cancer Undergoing

Robotic-Assisted Staging

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Robotic staging; Analysis of recurrence

ID OBESE WOMEN; LAPAROTOMY; LAPAROSCOPY; HYSTERECTOMY; CARCINOMA; SURVIVAL;

SURGERY; COHORT; RISK; AGE

AB Objective This study aimed to evaluate the impact of body mass index (BMI) on the short- and long-term outcomes of patients with endometrial cancer who underwent robotic-assisted staging and to analyze disease recurrence and recurrence-free survival (RFS).

Materials and Methods The charts of all consecutive patients with endometrial cancer who underwent robotic surgery from March 2007 to October 2012 were analyzed. Patients with follow-up less than 12 months after surgery were censored from the RFS analysis.

Results Mean (SD) age for the 364 patients was 63.6 (10) years, and mean (SD) BMI was 34.8 (10.1) kg/m(2). Conversions were in 3 (0.8%) of 364 cases. The mean (SD) operative time was 162.3 (54.6) minutes. Mean (SD) postoperative hospitalization was 1.6 (1.9) days. Histology included 80.5% endometrioid and 19.5% clear cell, serous, and carcinosarcomas. Mean (SD) pelvic and paraaortic lymph node counts were 15.9 (8.2) and 3.6 (4.3), respectively. Metastatic disease was diagnosed in 58 (16%) of 364 patients. The median follow-up was 29.3 months. The recurrence rates were 4.1% for the patients with endometrioid carcinoma and 14.1% for nonendometrioid histologies. Recurrences in patients with BMI less than 30 kg/m(2) accounted for 68.2% of all recurrences (15/22 patients). The rest of recurrences (7/22 patients, 31.8%) were in obese patients. Moreover, when analyzed for each histologic subtype, recurrence rates were consistently higher for patients with BMI less than 30 kg/m(2) when compared with patients with BMI greater than 30 kg/m(2). The 3-year overall survival was 98.2%, and the 3-year RFS was 92%.

Conclusions Obesity and morbid obesity did not affect adversely the operative outcomes for patients with endometrial cancer who were operated on using the robotic system. The recurrence rates were lower for patients with BMI greater than 30 kg/m(2) compared with patients with BMI less than 30 kg/m(2) for both endometrioid and nonendometrioid cancers.

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PT J

AU Rahbar, HM

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Gupta, N

Rogers, CG

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Kumar, Ramesh K.

Dalela, Deepansh

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Gupta, Nilesh

Rogers, Craig G.

TI Case report: Renal cell carcinoma with metastasis to the myometrium

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE metastasis; myometrium; renal cell carcinoma

ID OVARIAN METASTASIS; UTERINE CERVIX; TUMORS

AB Renal cell carcinoma (RCC) is well known for its ability to metastasize to different organs, but the involvement of gynecological organs is rare. Our case represents the first case of bilateral RCC with metastasis to the myometrium. The patient was a 60-year-old woman who underwent bilateral robotic partial nephrectomy surgeries for clear cell RCC, low-grade, low-stage with negative margins. Her 1-year postoperative computed tomography scan showed an enlarging necrotic uterine mass. She underwent a debulking excision, including hysterectomy, with pathology showing metastatic RCC to the uterus. The patient developed widespread metastatic disease, and died months later of metastatic RCC.

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Tarr, ME

Martino, MA

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Geller, Elizabeth J.

Green, Isabel C.

Hur, Hye-Chun

Langston, Kyle

Pitter, Michael C.

Tarr, Megan E.

Martino, Martin A.

TI Validity and Reliability of the Robotic Objective Structured Assessment

of Technical Skills

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT Annual Meeting of the

Association-of-Professors-of-Gynecology-and-Obstetrics/Council-on-Reside

nt-Education-in-Obstetrics-and-Gynecology

CY FEB 27-MAR 02, 2013

CL Phoenix, AZ

SP Assoc Prof Gynecol & Obstet, Council Resident Educ Obstet & Gynecol

ID LEARNING-CURVE; SURGERY; RESIDENTS; FEASIBILITY; VALIDATION; SIMULATION;

OSATS; TOOL

AB OBJECTIVE: Objective Structured Assessments of Technical Skills have been developed to measure the skill of surgical trainees. Our aim was to develop an Objective Structured Assessments of Technical Skills specifically for trainees learning robotic surgery.

METHODS: This is a multiinstitutional study conducted in eight academic training programs. We created an assessment form to evaluate robotic surgical skill through five inanimate exercises. Gynecology, general surgery, and urology residents, Fellows, and faculty completed five robotic exercises on a standard training model. Study sessions were recorded and randomly assigned to three blinded judges who scored performance using the assessment form. Construct validity was evaluated by comparing scores between participants with different levels of surgical experience; interrater and intrarater reliability were also assessed.

RESULTS: We evaluated 83 residents, nine Fellows, and 13 faculty totaling 105 participants; 88 (84%) were from gynecology. Our assessment form demonstrated construct validity with faculty and Fellows performing significantly better than residents (mean scores 89 +/- 8 faculty, 74 +/- 17 Fellows, 59 +/- 22 residents; P<.01). In addition, participants with more robotic console experience scored significantly higher than those with fewer prior console surgeries (P<.01). Robotic Objective Structured Assessments of Technical Skills demonstrated good interrater reliability across all five drills (mean Cronbach's Phi 0.79 +/- 0.02). Intra-rater reliability was also high (mean Spearman's correlation 0.91 +/- 0.11).

CONCLUSION: We developed a valid and reliable assessment form for robotic surgical skill. When paired with standardized robotic skill drills, this form may be useful to distinguish between levels of trainee performance.

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AF Tapper, Anna-Maija

Hannola, Mikko

Zeitlin, Rainer

Isojarvi, Jaana

Sintonen, Harri

Ikonen, Tuija S.

TI A systematic review and cost analysis of robot-assisted hysterectomy in

malignant and benign conditions

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Review

DE Robot-assisted hysterectomy; Laparoscopic hysterectomy; Vaginal

hysterectomy; Cost analysis; Malignant disease of uterus; Benign

conditions of uterus

ID LAPAROSCOPIC HYSTERECTOMY; RADICAL HYSTERECTOMY; STANDARD LAPAROSCOPY;

OPEN SURGERY; ENDOMETRIAL; OUTCOMES; LAPAROTOMY; CHARGES; SAFETY; WOMEN

AB In order to assess the effectiveness and costs of robot-assisted hysterectomy compared with conventional techniques we reviewed the literature separately for benign and malignant conditions, and conducted a cost analysis for different techniques of hysterectomy from a hospital economic database. Unlimited systematic literature search of Medline, Cochrane and CRD databases produced only two randomized trials, both for benign conditions. For the outcome assessment, data from two HTA reports, one systematic review, and 16 original articles were extracted and analyzed. Furthermore, one cost modelling and 13 original cost studies were analyzed.

In malignant conditions, less blood loss, fewer complications and a shorter hospital stay were considered as the main advantages of robot-assisted surgery, like any mini-invasive technique when compared to open surgery. There were no significant differences between the techniques regarding oncological outcomes. When compared to laparoscopic hysterectomy, the main benefit of robot-assistance was a shorter learning curve associated with fewer conversions but the length of robotic operation was often longer. In benign conditions, no clinically significant differences were reported and vaginal hysterectomy was considered the optimal choice when feasible.

According to Finnish data, the costs of robot-assisted hysterectomies were 1.5-3 times higher than the costs of conventional techniques. In benign conditions the difference in cost was highest. Because of expensive disposable supplies, unit costs were high regardless of the annual number of robotic operations. Hence, in the current distribution of cost pattern, economical effectiveness cannot be markedly improved by increasing the volume of robotic surgery. (C) 2014 Elsevier Ireland Ltd. All rights reserved.

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PT J

AU Anand, M

Tanouye, SL

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AF Anand, Mallika

Tanouye, Staci L.

Gebhart, John B.

TI Vesicosacrofistulization After Robotically Assisted Laparoscopic

Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE diskitis; mesh; osteomyelitis; sacral fistula; sacrocolpopexy

ID ABDOMINAL SACRAL COLPOPEXY; MESH EROSION; SINUS TRACT; OSTEOMYELITIS;

MANAGEMENT; ABSCESS; BLADDER

AB Diskitis after sacrocolpopexy for pelvic organ prolapse has been increasingly reported in the literature. We present a case of vesicosacrofistulization resulting in diskitis and osteomyelitis after robotically assisted laparoscopic sacrocolpopexy performed at an outside institution. A 70-year-old woman with uterovaginal prolapse and stress urinary incontinence underwent robotic supracervical hysterectomy with sacrocolpopexy and transobturator sling placement at an outside hospital. Postoperatively, she had recurrent urinary tract infections; by 3 months postoperatively, fevers and leg and back pain had developed. She was given a diagnosis of L5-S1 spondylodiskitis. After 3.5 weeks of intravenous antibiotic therapy failed, further evaluation revealed a fistulous tract to the sacrum. She was transferred to our institution and underwent sacrocolpopexy mesh removal, L5-S1 debridement, antibiotic treatment, and physical therapy. One year after this repair surgery, she has returned to her usual activities with no current symptoms of infection, prolapse, urinary incontinence, or back pain. Vesicosacrofistulization is a serious complication of sacrocolpopexy that can result in diskitis and osteomyelitis. Prevention involves avoiding placing mesh on the bladder and at the L5-S1 disk space during open or minimally invasive sacrocolpopexy. A high index of suspicion for diskitis, even several months after surgery, should be maintained to expedite evaluation. If fistulization of pelvic structures to the sacrum is suspected, a multidisciplinary evaluation and treatment approach should be considered to optimize patient care.

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Z9 11

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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TI Outcomes of Robotic Sacrocolpopexy Using Barbed Delayed Absorbable

Sutures

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Barbed suture; Robotic; Sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY

AB Study Objective: To evaluate 1-year outcomes of robotic sacrocolpopexy (RSC) for pelvic organ prolapse using barbed delayed absorbable sutures.

Design: Retrospective cohort study (Class II-3).

Settings: University-based hospital in Southeast Texas.

Patients: Patients with symptomatic apical pelvic organ prolapse who underwent RSC using barbed delayed absorbable sutures between January 2011 and August 2012. Patients were examined postoperatively at least twice (after 6 weeks and I year).

Interventions: RSC procedure.

Measurements and Main Results: The study included a total of 20 patients, of them 15 had grades 3 or 4 whereas 5 had grade 2 apical defects according to the Baden-Walker classification system. Fourteen patients (70%) underwent concomitant hysterectomy while 9 (45%) underwent concomitant anti-incontinence surgery. Mesh suturing times were 46.9 +/- 12.6 and 20.5 +/- 9.3 minutes in the first 10 versus the last 10 cases, respectively (p <.001). The mean follow-up duration was 17.3 months (range, 12-24 months). There were no recurrences of apical defects or mesh/suture exposure/erosion. However, 1 patient developed a grade 2 cystocele, and another developed new-onset urinary incontinence, both after I year. A third patient's urine leakage did not improve postoperatively. Lastly, a fourth patient developed port site incisional hernia and underwent repair 5 months later.

Conclusion: Our study suggests that barbed delayed absorbable sutures are safe and effective in RCS procedures over I year. Larger, comparative, and randomized trials are recommended for definitive conclusions. (C) 2014 AAGL. All rights reserved.

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CA Soc Gynecologic Surg Systematic Re

TI Systematic Review of Robotic Surgery in Gynecology: Robotic Techniques

Compared With Laparoscopy and Laparotomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Gynecologic surgery; Learning curve; Robotic surgery; Systematic review

ID ENDOMETRIAL CANCER; ASSISTED HYSTERECTOMY; SURGICAL OUTCOMES; RADICAL

HYSTERECTOMY; COST-ANALYSIS; LYMPHADENECTOMY; SACROCOLPOPEXY; QUALITY;

OBESE; STRENGTH

AB The Society of Gynecologic Surgeons Systematic Review Group performed a systematic review of both randomized and observational studies to compare robotic vs nonrobotic surgical approaches (laparoscopic, abdominal, and vaginal) for treatment of both benign and malignant gynecologic indications to compare surgical and patient-centered outcomes, costs, and adverse events associated with the various surgical approaches. MEDLINE and the Cochrane Central Register of Controlled Trials were searched from inception to May 15, 2012, for English-language studies with terms related to robotic surgery and gynecology. Studies of any design that included at least 30 women who had undergone robotic-assisted laparoscopic gynecologic surgery were included for review. The literature yielded 1213 citations, of which 97 full-text articles were reviewed. Forty-four studies (30 comparative and 14 noncomparative) met eligibility criteria. Study data were extracted into structured electronic forms and reconciled by a second, independent reviewer. Our analysis revealed that, compared with open surgery, robotic surgery consistently confers shorter hospital stay. The proficiency plateau scents to be lower for robotic surgery than for conventional laparoscopy. Of the various gynecologic applications, there seems to be evidence that renders robotic techniques advantageous over traditional open surgery for management of endometrial cancer. However, insofar as superiority, conflicting data are obtained when comparing robotics vs laparoscopic techniques. Therefore, the specific method of minimally invasive surgery, whether conventional laparoscopy or robotic surgery, should be tailored to patient selection, surgeon ability, and equipment availability. (c) 2014 AAGL. All rights reserved.

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TI Robotic Retroperitoneal Paraaortic Lymphadenectomy at Donostia

University Hospital

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cervical Cancer; Endometrial Adenocarcinoma; Lymphadenectomy;

Retroperitoneal Access; Robotic Surgery

ID ADVANCED CERVICAL-CANCER; EXTRAPERITONEAL APPROACH; CARCINOMA; SURGERY

AB The purpose of this study was to describe our robotic retroperitoneal para-aortic lymphadenectomy technique and its associated outcomes as well as the advantages and disadvantages. We prospectively collected data on all retroperitoneal aortocaval lymphadenectomy procedures performed at Donostia University Hospital from December 2011 to April 2013 using the da Vinci S robotic system (Intuitive Surgical, Sunnyvale,CA). A total of 13 of these procedures were performed. The mean patient age was 60.3 years (SD, 10.18). Most patients were obese with a mean body mass index of 31.95 kg/m(2) (SD, 5), and 9 had endometrial cancer. Five individuals were restaged: 4 because of lymphovascular space invasion and 1 because of lymphovascular space invasion with G3 histology. There were 2 cases of Federation Internationale de Gynecologie et d'Obstetrique stage IB endometrial cancer: 1 of papillary serous histology and 1 of G3. Two patients had advanced cervical cancer, and 2 had early-stage ovarian cancer. The median para-aortic lymph node yield was 12 (range, 4-21). In 3 patients, it was necessary to convert the procedure to transperitoneal access because of technical difficulties; 1 of these required laparotomy. The mean surgical time was 323 minutes (SD, 58) although this included additional complex procedures. Robotic para-aortic retroperitoneal lymphadenectomy is feasible and offers the advantages of retroperitoneal access. (C) 2014 AAGL. All rights reserved.

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PT J

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TI Detection of sentinel lymph nodes in minimally invasive surgery using

indocyanine green and near-infrared fluorescence imaging for uterine and

cervical malignancies

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 44th Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncology (SGO)

CY MAR 08-12, 2013

CL Los Angeles, CA

SP Soc Gynecol Oncol

DE Indocyanine green; Sentinel lymph node; Sentinel lymph node mapping;

Near-infrared fluorescence imaging; Uterine cancer; Cervical cancer

ID RISK ENDOMETRIAL CANCER; MAPPING ALGORITHM; BREAST-CANCER; VULVAR

CANCER; BIOPSY; IDENTIFICATION; FEASIBILITY; BLUE; LYMPHADENECTOMY;

DISSECTION

AB Objectives. Our primary objective was to assess the detection rate of sentinel lymph nodes (SLNs) using indocyanine green (ICG) and near-infrared (NIR) fluorescence imaging for uterine and cervical malignancies.

Methods. NIR fluorescence imaging for the robotic platform was obtained at our institution in 12/2011. We identified all cases planned for SLN mapping using fluorescence imaging from 12/2011-4/2013. Intracervical ICG was the fluorophobe in all cases. Four cc (1.25 mg/mL) of ICG was injected into the cervix alone divided into the 3- and 9-o'clock positions, with 1 cc deep into the stroma and 1 cc submucosally before initiating laparoscopic entry. Blue dye was concurrently injected in some cases.

Results. Two hundred twenty-seven cases were performed. Median age was 60 years (range, 28-90 years). Median BMI was 30.2 kg/m(2) (range, 18-60 kg/m(2)). The median SLN count was 3 (range, 1-23). An SLN was identified in 216 cases (95%), with bilateral pelvic mapping in 179 (79%). An aortic SLN was identified in 21(10%) of the 216 mapped cases. When ICG alone was used to map cases, 188/197 patients mapped, for a 95% detection rate compared to 93% (28/30) in cases in which both dyes were used (P = NS). Bilateral mapping was seen in 156/197 (79%) ICG-only cases and 23/30 (77%) ICG and blue dye cases (P = NS).

Conclusions. NIR fluorescence imaging with intracervical ICG injection using the robotic platform has a high bilateral SLN detection rate and appears favorable to using blue dye alone and/or other modalities. Combined use of ICG and blue dye appears unnecessary. (C) 2014 Elsevier Inc. All rights reserved.

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TI Cost-Effectiveness Analysis of Robotically Assisted Laparoscopy for

Newly Diagnosed Uterine Cancers

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ABDOMINAL HYSTERECTOMY; OUTCOMES

AB OBJECTIVE: To assess the direct costs of three surgical approaches in uterine cancer and the cost-effectiveness of incorporating robot-assisted surgery.

METHODS: A cost system that allocates the actual cost of resources used to treat each patient, as opposed to borrowing cost data from a billing system, was used to determine direct costs for patients who underwent surgery for uterine cancer from 2009 to 2010. These costs included all aspects of surgical care up to 6 months after discharge. Total amortized direct costs included the capital cost of three dual-console robotic platforms with 5 years of service contracts. Nonamortized costs were also calculated (excluded capital costs). Modeling was performed to estimate the mean cost of surgical care for patients presenting with endometrial cancer from 2007 to 2010.

RESULTS: Of 436 cases (132 laparoscopic, 262 robotic, 42 laparotomy), total mean amortized direct costs per case were $20,489 (laparoscopy), $23,646 (robot), and $24,642 (laparotomy) (P<.05 [robot compared with laparoscopy]; P=.6 [robot compared with laparotomy]). Total nonamortized costs per case were $20,289, $20,467, and $24,433, respectively (P=.9 [robot compared with laparoscopy]; P=.03 [robot compared with laparotomy]). The planned surgical approach in 2007 was laparoscopy, 68%; robot, 8%; and laparotomy, 24% compared with 26%, 64%, and 9%, respectively, in 2010 (P<.001). The modeled mean amortized direct costs per case were $21,738 in 2007 and $22,678 in 2010 (+$940). Nonamortized costs were $21,298 in 2007 and $20,573 in 2010 (-$725).

CONCLUSION: Laparoscopy is least expensive when including capital acquisition costs. Laparoscopy and robotic surgery are comparable if upfront costs are excluded. There is cost neutralization with the robot when it helps decrease laparotomy rates.

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TI A Comparison of Quality Outcome Measures in Patients Having a

Hysterectomy for Benign Disease: Robotic vs. Non-robotic Approaches

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Benign gynecologic surgery; Hysterectomy; Readmission; Robotic surgery

ID READMISSIONS

AB Objective: To measure procedure-related hospital readmissions within 30 days after discharge for patients who have a hysterectomy for benign disease. Secondary outcome quality measures evaluated were cost, estimated blood loss, length of stay and sum of costs associated with readmissions.

Design: Retrospective cohort study (Canadian Task Force classification 11-2).

Setting: Academic community hospital.

Patients: Patients who underwent hysterectomy to treat benign disease from January 2008 to December 2012.

Interventions: Patients were grouped according to route of hysterectomy: robotic-assisted laparoscopic hysterectomy (robotic), laparoscopic hysterectomy (laparoscopic), abdominal hysterectomy (open via laparotomy), and vaginal hysterectomy (vaginal).

Measurements and Main Results: Inclusion criteria were met by 2554 patients: 601 in the robotic group, 427 in the laparoscopic group, 1194 in the abdominal group, and 332 in the vaginal group. Readmission rates in the robotic cohort were significantly less (p<.05) than in non-robotic cohorts: Robotic (1%), laparoscopic (2.5%), open (3.5%), vaginal (2.4%). Estimated blood loss, length of stay, and sum of readmission costs were also significantly less in the robotic cohort (p<.05) compared with the other 3 cohorts.

Conclusion: Patients who undergo robotic-assisted laparoscopic hysterectomy have a significantly lower chance of readmission <30 days after surgery compared with those who undergo laparoscopic, abdominal (open) hysterectomy, and vaginal approaches. Patients in the robotics cohort also experienced a shorter length of stay, less estimated blood loss, and a cost savings associated with readmissions when compared to non-robotic approaches. Prospective registries describing quality outcomes, total sum of costs including 30 days follow-up, as well as patient-related quality of life benefits are recommended to confirm these findings and determine which surgical route offers the highest patient and societal value. (C) 2014 Published by Elsevier Inc. on behalf of AAGL.

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AU Rardin, CR

AF Rardin, Charles R.

TI The debate over robotics in benign gynecology

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE minimally invasive surgery; robotic surgery

ID LAPAROSCOPIC HYSTERECTOMY; OUTCOMES

AB The debate over the role of the da Vinci surgical robotic platform in benign gynecology is raging with increasing fervor and, as product liability issues arise, greater financial stakes. Although the best currently available science suggests that, in the hands of experts, robotics offers little in surgical advantage over laparoscopy, at increased expense, the observed decrease in laparotomy for hysterectomy is almost certainly, at least in part, attributable to the availability of the robot. In this author's opinion, the issue is not whether the robot has any role but rather to define the role in an institutional environment that also supports the safe use of vaginal and laparoscopic approaches in an integrated minimally invasive surgery program. Programs engaging robotic surgery should have a clear and self-determined regulatory process and should resist pressures in place that may preferentially support robotics over other forms of minimally invasive surgery.

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Z9 10

U1 0

U2 5

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JI Am. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

AU Vizza, E

Corrado, G

Zanagnolo, V

Tomaselli, T

Cutillo, G

Mancini, E

Maggioni, A

AF Vizza, Enrico

Corrado, Giacomo

Zanagnolo, Vanna

Tomaselli, Tiziana

Cutillo, Giuseppe

Mancini, Emanuela

Maggioni, Angelo

TI Neoadjuvant chemotherapy followed by robotic radical hysterectomy in

locally advanced cervical cancer: A multi-institution study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic radical hysterectomy; Minimally invasive surgery; Locally

advanced cervical cancer; Neo-adjuvant chemotherapy

ID LONG-TERM EFFICACY; RANDOMIZED-TRIAL; PHASE-II; SURGERY; PACLITAXEL;

CARCINOMA; CISPLATIN; LYMPHADENECTOMY; CHEMORADIOTHERAPY; IFOSFAMIDE

AB Objective. Minimally invasive surgery has been performed in locally advanced cervical cancer (LACC) without adverse effect in patient's overall prognosis and survival. The aim of this report is to evaluate the feasibility and morbidity of total robotic radical hysterectomy (TRRH) with pelvic lymphadenectomy in patients with LACC after neo-adjuvant chemotherapy (NACT).

Methods. From February 2008 to April 2013 a retrospective data collection of women undergoing TRRH for cervical cancer stage FIGO IB2 to IIB, after neo-adjuvant chemotherapy, was conducted at "Regina Elena" National Cancer Institute of Rome and European Institute of Oncology of Milan. All patients deemed operable underwent TRRH with pelvic lymphadenectomy within 4 weeks from the last chemotherapy cycle.

Results. Median operative time was 225 min (range, 105-387 min). The median blood loss was 150 mL (range, 30-700 mL). The median number of removed pelvic lymph nodes was 23 (range, 8-69). Sixteen patients had an optimal response (12 PCR, 4 pPR1) to chemotherapy, 33 patients had a pPR2 and 11 patient showed stable disease. Adjuvant therapy was administrated in 36 patients (60%). We experienced one intra-operative complication and 19 post-operative complications, but no conversions to laparotomy were necessary to manage these complications. Six patients received a blood transfusion. At the time of this report, with a median follow-up of 28.9 months, 50 patients (83%) are free from recurrence.

Conclusion. This experience demonstrates the feasibility of TRRH pelvic lymphadenectomy after NACT in LACC with good accuracy and safety. (C) 2014 Elsevier Inc. All rights reserved.

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JI Gynecol. Oncol.

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ER

PT J

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Hershman, Dawn L.

TI An Economic Analysis of Robotically Assisted Hysterectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID LAPAROSCOPIC HYSTERECTOMY; SURGICAL VOLUME; TREATMENT FAILURE;

LEARNING-CURVE; ENDOMETRIAL; OUTCOMES; PERFORMANCE; MORTALITY; COSTS

AB OBJECTIVE: To perform an econometric analysis to examine the influence of procedure volume, variation in hospital accounting methodology, and use of various analytic methodologies on cost of robotically assisted hysterectomy for benign gynecologic disease and endometrial cancer.

METHODS: A national sample was used to identify women who underwent laparoscopic or robotically assisted hysterectomy for benign indications or endometrial cancer from 2006 to 2012. Surgeon and hospital volume were classified as the number of procedures performed before the index surgery. Total costs as well as fixed and variable costs were modeled using multivariable quantile regression methodology.

RESULTS: A total of 180,230 women, including 169,324 women who underwent minimally invasive hysterectomy for benign indications and 10,906 patients whose hysterectomy was performed for endometrial cancer, were identified. The unadjusted median cost of robotically assisted hysterectomy for benign indications was $8,152 (interquartile range [IQR] $6,011-10,932) compared with $6,535 (IQR $5,127-8,357) for laparoscopic hysterectomy (P<.001). The cost differential decreased with increasing surgeon and hospital volume. The unadjusted median cost of robotically assisted hysterectomy for endometrial cancer was $9,691 (IQR $7,591-12,428) compared with $8,237 (IQR $6,400-10,807) for laparoscopic hysterectomy (P<.001). The cost differential decreased with increasing hospital volume from $2,471 for the first 5 to 15 cases to $924 for more than 50 cases. Based on surgeon volume, robotically assisted hysterectomy for endometrial cancer was $1,761 more expensive than laparoscopy for those who had performed fewer than five cases; the differential declined to $688 for more than 50 procedures compared with laparoscopic hysterectomy.

CONCLUSION: The cost of robotic gynecologic surgery decreases with increased procedure volume. However, in all of the scenarios modeled, robotically assisted hysterectomy remained substantially more costly than laparoscopic hysterectomy.

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RI Hershman, Dawn/AAG-2114-2020

FU National Cancer Institute [NCI R25 CA094061-11]; [NCI

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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PT J

AU Yamasato, K

Casey, D

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Hiraoka, M

AF Yamasato, Kelly

Casey, Duffy

Kaneshiro, Bliss

Hiraoka, Mark

TI Effect of Robotic Surgery on Hysterectomy Trends: Implications for

Resident Education

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Resident education; Robotic; Surgical training

AB Study Objective: To compare the surgical approach used for hysterectomy at 2 teaching hospitals before and after introduction of the robotic surgical system.

Design: Retrospective cohort study (Canadian Task Force classification 11-3).

Setting: Two gynecologic training sites at the University of Hawaii.

Patients: Women who underwent hysterectomy between January 1, 2005, and December 31, 2011.

Measurements and Main Results: ICD-9 procedural codes were used to identify hysterectomies performed between January 1, 2005, and December 31, 2011. Hysterectomies were categorized according to surgical approach: abdominal, vaginal, laparoscopic-assisted vaginal/total laparoscopic, and robotic. Each hysterectomy was also categorized according to primary preoperative diagnosis as general gynecology, gynecologic oncology, and urogynecology. The rates and numbers of hysterectomies performed during 2005-2006 (2 years before acquisition of the robot), 2007-2008 (first 2 years with the robot), and 2009-2011 (3-5 years after acquiring the robot) were compared using X-2 tests and analysis of variance. The numbers of hysterectomies reported in resident case logs were also collected and compared. A total of 5894 hysterectomies were performed between 2005 and 2011. The total number of hysterectomies performed at Hospital A, which acquired the robotic surgical system, increased over time (p=.04) but remained stable at Hospital B, which did not acquire the robotic surgical system. At Hospital A, the number of robotic hysterectomies increased as the number of abdominal hysterectomies decreased (p<.001), a trend consistent across all diagnostic categories. The number of vaginal and laparoscopic hysterectomies remained stable. Resident case logs also reflected a decrease in the number of abdominal hysterectomies (p=.002) and an increase in the number of combined laparoscopic/robotic hysterectomies (p<.001) performed. The total number of hysterectomies performed by residents was unchanged.

Conclusion: Introduction of the robotic surgical system was associated with significant changes in the numbers and types of hysterectomies performed in both general and subspecialty gynecology. Although abdominal hysterectomies decreased as robotic hysterectomies increased, other hysterectomies did not. These trends mirror reported resident surgical experience and have implications for resident education. (C) 2014 AAGL. All rights reserved.

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JI J. Minim. Invasive Gynecol.

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ER

PT J

AU Iavazzo, C

Gkegkes, I

AF Iavazzo, Christos

Gkegkes, Ioannis D.

TI Single-site port robotic-assisted hysterectomy: a systematic review

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Single port; Laparo-endoscopic single site; Robotics; Hysterectomy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; RADICAL HYSTERECTOMY; SURGERY;

PLATFORM; CANCER; ACCESS

AB Robotic single-port hysterectomy is a rather new technique.

We performed a systematic literature review to evaluate the till-now evidence regarding the use of robotic single-port hysterectomy technique as a method of management in gynecological pathologies.

The till-now used port systems are discussed. The advantages and disadvantages of such a technique, as well as the indications and contraindications of it are also presented. Such a technically challenging operation seems to have similar results regarding blood loss and surgical time while the cosmetic outcome is better compared to the classic robotic hysterectomy. The technical difficulties include loss of instrumental triangulation, reduced operative working place, reduced visualization, instrumental crowding and clashing. The ways to overcome such difficulties are also described.

The need of technique standardization is the future aim.

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NR 19

TC 20

Z9 20

U1 0

U2 6

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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GA AD0WT

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ER

PT J

AU Iavazzo, C

Gkegkes, ID

AF Iavazzo, Christos

Gkegkes, Ioannis D.

TI Robotic technology for pelvic exenteration in cases of cervical cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Review

DE Cervical cancer; Neoplasm; Pelvic exenteration; Robotics

ID PALLIATION; CARCINOMA; SURGERY

AB Background: Cervical cancer represents one of the most common types of neoplasia among women; the use of minimally invasive techniques in the treatment of cervical cancer is a challenge. Objectives: To present evidence regarding robotic technology in the performance of pelvic exenteration in cases of cervical cancer. Search strategy: PubMed and Scopus databases were searched. Selection criteria: Articles examining the use of robotic technology for pelvic exenteration in cases of cervical cancer were included. Data collection and analysis: Four studies were included. Main results: Most cancers treated with robotic-assisted pelvic exenteration were squamous cell carcinomas of the cervix. The stage of primary cancer ranged from IB2 to IVA. In 7 of the 8 patients, anterior pelvic exenteration was performed; the other patient underwent total pelvic exenteration. Procedure duration ranged from 375 to 600 minutes; blood loss was 200-550 mL. Postoperative complications occurred in 2 of the 8 patients and included perineal abscess, Miami pouch fistula, and ureteral stenosis. Postoperative hospital stay ranged from 3 to 53 days, and postoperative follow-up ranged from 2 to 31 months. Conclusions: The gold standard for pelvic exenteration remains the open surgical approach; however, the application of robotic technology could be an alternate choice associated with excellent results. (C) 2013 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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U2 1

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JI Int. J. Gynecol. Obstet.

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ER

PT J

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Turner, LC

Wang, L

Winger, DG

Shepherd, JP

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Turner, Lindsay C.

Wang, Li

Winger, Daniel G.

Shepherd, Jonathan P.

TI Changes in prolapse surgery trends relative to FDA notifications

regarding vaginal mesh

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE FDA public health notification; FDA safety communication; Pelvic organ

prolapse; Prolapse repair; Prolapse surgery trends; Surgical trends;

Vaginal mesh

ID RISK-FACTORS; REPAIR; SACROCOLPOPEXY; EROSIONS; SMOKING; AGE

AB In 2008 and 2011, the US Food and Drug Administration (FDA) released notifications regarding vaginal mesh. In describing prolapse surgery trends over time, we predicted vaginal mesh use would decrease and native tissue repairs would increase.

Operative reports were reviewed for all prolapse repairs performed from 2008 to 2011 at our large regional hospital system. The number of each type of prolapse repair was determined per quarter year and expressed as a percentage of all repairs. Surgical trends were examined focusing on changes with respect to the release of two FDA notifications. We used linear regression to analyze surgical trends and chi-square for demographic comparisons.

One thousand two hundred and eleven women underwent 1,385 prolapse procedures. Mean age was 64 +/- 12, and 70 % had stage III prolapse. Vaginal mesh procedures declined over time (p = 0.001), comprising 27 % of repairs in early 2008, 15 % at the first FDA notification, 5 % by the second FDA notification, and 2 % at the end of 2011. The percentage of native tissue anterior/posterior repairs (p < 0.001) and apical suspensions (p = 0.007) increased, whereas colpocleisis remained constant (p = 0.475). Despite an overall decrease in open sacral colpopexies (p < 0.001), an initial increase was seen around the first FDA notification. We adopted laparoscopic/robotic techniques around this time, and the percentage of minimally invasive sacral colpopexies steadily increased thereafter (p < 0.001). All sacral colpopexies combined as a group declined over time (p = 0.011).

Surgical treatment of prolapse continues to evolve. Over a 4-year period encompassing two FDA notifications regarding vaginal mesh and the introduction of laparoscopic/robotic techniques, we performed fewer vaginal mesh procedures and more native tissue repairs and minimally invasive sacral colpopexies.

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ER

PT J

AU Backes, FJ

Fowler, JM

AF Backes, Floor J.

Fowler, Jeffrey M.

TI Hysterectomy for the Treatment of Gynecologic Malignancy

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; minimally invasive surgery; endometrial cancer; cervical

cancer; robotic surgery; single-site surgery

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; POSITIVE PERITONEAL CYTOLOGY;

SINGLE-SITE HYSTERECTOMY; EARLY ENDOMETRIAL CANCER; ADVANCED

OVARIAN-CANCER; CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; ROBOTIC

SURGERY; NEOADJUVANT CHEMOTHERAPY; ASSISTED HYSTERECTOMY

AB The current literature shows that minimally invasive hysterectomy for cancer is relatively safe and provides benefits in terms of blood loss and length of stay with less or equal complication rates over laparotomy. These benefits may even be greater in the morbidly obese and those with other comorbidities. Available techniques include laparotomy, laparoscopy, single-site laparoscopy, robotics, and single-site robotics. Collection of comprehensive and reliable data on complications and outcomes will prove to be the key in defining the role of new techniques in the treatment of women with gynecologic malignancies.

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Z9 8

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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PT J

AU Carbonnel, M

Goetgheluck, J

Frati, A

Even, M

Ayoubi, JM

AF Carbonnel, Marie

Goetgheluck, Julie

Frati, Albane

Even, Marc

Ayoubi, Jean Marc

TI Robot-assisted laparoscopy for infertility treatment: current views

SO FERTILITY AND STERILITY

LA English

DT Article

DE Robotic laparoscopy; tubal anastomosis; myomectomy; deep infiltrating

endometriosis; adnexal surgery

ID TUBAL ANASTOMOSIS; ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; UTERINE

FIBROIDS; ENDOMETRIOSIS; SURGERY; STERILIZATION; METAANALYSIS;

EXPERIENCE; FEASIBILITY

AB To determine the interest of using robotic laparoscopic surgery in the management of female infertility, we reviewed our own activity and searched the Medline database for publications on robotic technology in infertility surgery, with the use of the following search words: robotic laparoscopy, tubal anastomosis, myomectomy, deep infiltrating endometriosis, and adnexal surgery. Robot-assisted laparoscopic surgery has seen rapid progression over the past few years. It has been mostly used for myomectomy, proximal tubal reanastomosis, and deep endometriosis surgery. Despite its increased range of indications, no randomized control studies are available. The place of robotic surgery in the management of infertility remains undetermined. (C) 2014 by American Society for Reproductive Medicine.

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Z9 23

U1 0

U2 10

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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OA hybrid

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ER

PT J

AU Hill, AJ

Carroll, AW

Matthews, CA

AF Hill, Audra Jolyn

Carroll, Ashley W.

Matthews, Catherine A.

TI Unanticipated Uterine Pathologic Finding After Morcellation During

Robotic-Assisted Supracervical Hysterectomy and Cervicosacropexy for

Uterine Prolapse

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pelvic organ prolapse; morcellation; unanticipated malignancy

ID SACROCOLPOPEXY; MALIGNANCY; REPAIR

AB Background: Identification of occult malignancy after intra-abdominal morcellation at the time of robotic-assisted supracervical hysterectomy and cervicosacropexy for uterine prolapse may lead to challenging postoperative management and leads one to question the need for preoperative evaluation.

Cases: We present 2 cases of occult endometrial carcinoma after robotic-assisted supracervical hysterectomy and cervicosacropexy with intra-abdominal uterine morcellation from January 2008 to December 2010. A total of 63 patients underwent the stated surgical procedure with 2 patients (3.17%) found to have abnormal uterine pathologic finding with International Federation of Gynecology and Obstetrics grade 1 endometrial adenocarcinoma. Both cases occurred in asymptomatic postmenopausal patients without risk factors for endometrial cancer, including no history of postmenopausal bleeding or hormone replacement therapy. Owing to intraoperative uterine morcellation and cervical retention, appropriate postoperative management was controversial and problematic. Each patient was referred to gynecologic oncology. To date, both patients are without evidence of residual disease.

Conclusion: Owing to the risk of occult uterine pathologic finding and complicated postoperative management, preoperative endometrial assessment should be considered on all postmenopausal patients undergoing intra-abdominal uterine morcellation, regardless of risk factors.

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NR 25

TC 31

Z9 32

U1 0

U2 2

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JI Female Pelvic Med. Reconstr. Surg.

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PG 3

WC Obstetrics & Gynecology

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ER

PT J

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Salamon, C

Priestley, JL

Gurshumov, E

Culligan, P

AF Lewis, Christa

Salamon, Charbel

Priestley, Jennifer L.

Gurshumov, Emil

Culligan, Patrick

TI Prospective Cohort Study of Bowel Function After Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE bowel function; prolapse; robotic sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; QUALITY-OF-LIFE; ABDOMINAL SACROCOLPOPEXY;

SURGERY; WOMEN; SYMPTOMS; OUTCOMES; SUCCESS

AB Objective: This study aimed to determine bowel function changes 12 months after robotic sacrocolpopexy.

Methods: We performed a single-center prospective cohort study evaluating bowel function 12 months after robotic sacrocolpopexy between 2007 and 2011. Bowel function symptoms were measured by the Colorectal-Anal Distress Inventory, Short Form 8 (CRADI-8). Specific impacts on quality of life with regard to bowel function were evaluated using the Colorectal-Anal Impact Questionnaire, Short Form 7 (CRAIQ-7). "Splinting to defecate'' was defined as any positive response to question 4 of the Pelvic Floor Distress Inventory-20 which reads, "do you ever have to push on the vagina or around the rectum to have or complete a bowel movement?.'' Lastly, patients were grouped according to perineorrhaphy versus no perineorrhaphy and bowel function scores were examined.

Results: Of 423 consecutive patients who underwent robotic sacrocolpopexy at our institution, 393 (93%) completed a 12-month follow-up. Mean CRADI-8 scores at baseline and 12 months were 21.1 (20) and 7.3 (11), respectively (P < 0.0001). Mean CRAIQ-7 scores at baseline and 12 months were 11.1 (20) and 2.4 (9), respectively (P < 0.0001). Preoperatively, 152 patients reported a need to splint the vagina or perineum to complete a bowel movement. At 12 months, 70% reported complete resolution of "splinting.'' Con comitant perineorrhaphy was performed on 87 patients and there were no differences in 12-month CRADI-8 or CRAIQ-7 scores between groups.

Conclusions: Robotic sacrocolpopexy was associated with significant improvements in bowel function as measured by CRADI-8 as well as improvements in impact on quality of life as measured by CRAIQ-7.

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Dr Salamon is a paid consultant for American Medical Systems and

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declared they have no conflicts of interest.

NR 16

TC 8

Z9 8

U1 0

U2 0

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SC Obstetrics & Gynecology

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ER

PT J

AU Minaglia, S

AF Minaglia, Steven

TI Vaginal Trachelectomy Following Laparoscopic Supracervical Hysterectomy

and Sacrocervicopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE mesh erosion; mesh extrusion; laparoscopic sacrocervicopexy;

laparoscopic sacrocolpopexy; trachelectomy; cervical pathology

ID PROLAPSE

AB Background: Current evidence supports cervical preservation at the time of abdominal prolapse repair using synthetic mesh to minimize vaginal mesh extrusion. This report aims to describe management of benign cervical disease following laparoscopic sacrocervicopexy including successful trachelectomy performed vaginally.

Case: A 70-year-old sexually active woman presented with symptomatic pelvic organ prolapse and stress urinary incontinence. Her Papanicolaou smears over several years were unremarkable, and she had a benign endocervical polyp removed in the office 3 months before surgery. She underwent an uncomplicated robotic-assisted laparoscopic supracervical hysterectomy and sacrocervicopexy. She presented 8 months after surgery with persistent vaginal spotting after intercourse and was found to have a recurrent endocervical polyp. Ultimately, she underwent uncomplicated trachelectomy performed vaginally with resolution of her symptoms.

Conclusions: Retention of the cervix at the time of mesh-augmented abdominal prolapse repairs introduces a unique set of evaluation and management considerations for benign cervical disease. Trachelectomy performed vaginally was successful and uncomplicated in this case.

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NR 9

TC 1

Z9 1

U1 0

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ER

PT J

AU Myers, EM

Geller, EJ

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AF Myers, Erinn M.

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Bowling, James Michael

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TI Robotic Sacrocolpopexy Performance and Cumulative Summation Analysis

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE Cumulative Summation (CUSUM); robotic sacrocolpopexy; surgical

proficiency

ID LEARNING-CURVE; EMBRYO-TRANSFER; COMPETENCE; PROFICIENT; SURGERY

AB Objectives: This study aimed to apply Cumulative Summation (CUSUM) analysis as a tool to monitor robotic sacrocolpopexy (RSCP) proficiency over time.

Methods: A retrospective analysis of all women who underwent RSCP between September of 2008 and December of 2011 at the University of North Carolina at Chapel Hill. The performance for 2 attending surgeons was analyzed sequentially over time. Intraoperative complications such as genitourinary or gastrointestinal tract injury, conversion to laparotomy, pulmonary embolus, hemorrhage, and blood transfusion, were identified by International Classification of Diseases, Ninth Revision and Current Procedural Terminology codes. A successful outcome was defined as no intraoperative complications. The target value of success was set at less than 10% complications. CUSUM analysis was then sequentially applied to all RSCP cases for 2 attending surgeons.

Results: Over 27 months, 169 RSCPs were performed. The first surgeon performed 107 RSCPs and the second surgeon performed 62 RSCPs with 8 (7.4%) and 3 (4.9%) intraoperative complications, respectively. Total complications included 7 (4.1%) cystotomies, 2 (1.2%) vaginal lacerations, 1 (0.6%) blood transfusion, and 1 (0.6%) bowel perforation. A CUSUM graph was created for each surgeon.

Conclusions: CUSUM analysis was successfully applied to monitor RSCP proficiency. Such testing of individual successive procedural outcomes with CUSUM may offer an objective tool to aid in physician self-assessment.

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FU American Medical Systems

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NR 21

TC 5

Z9 5

U1 0

U2 2

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WC Obstetrics & Gynecology

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ER

PT J

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Vetere, P

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Averbuch, L

Khalil, S

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Lax, D

AF Nezhat, Farr Reza

Finger, Tamara Natasha

Vetere, Patrick

Radjabi, Amir Reza

Vega, Mario

Averbuch, Lauren

Khalil, Susan

Altinbas, Sadiman Kiykac

Lax, Daniel

TI Comparison of Perioperative Outcomes and Complication Rates Between

Conventional Versus Robotic- Assisted Laparoscopy in the Evaluation and

Management of Early, Advanced, and Recurrent Stage Ovarian, Fallopian

Tube, and Primary Peritoneal Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Laparoscopy; Robotic-assisted laparoscopy; Ovarian cancer; Fallopian

tube cancer; Peritoneal cancer; Early stage; Advanced stage; Recurrent

stage; Perioperative outcomes; Complication rates

ID MINIMALLY INVASIVE SURGERY; LYMPHADENECTOMY; DEBULKING; EFFICACY; SAFETY

AB Objective The objective of this study was to examine perioperative outcomes, including complication rates, of conventional laparoscopy (CL) versus robotic-assisted laparoscopy (RALS) in the evaluation and management of early, advanced, and recurrent ovarian, fallopian tube, and peritoneal cancer.

Methods This is a retrospective analysis of a prospectively maintained database of surgery performed from July 2008 to December 2012. Sixty-three women had 83 surgeries performed; 22 surgeries for early-stage disease (International Federation of Gynecology and Obstetrics stage I) and 61 for advanced and/or recurrent disease.

Results Of the 22 for early stage, 10 were CL, 9 were RALS, and 3 were laparoscopy converted to laparotomy (LP). There was no significant difference between CL and RALS in estimated blood loss (EBL, P = 0.27) or length of stay (LOS, P = 0.43); however, both had significantly less EBL (P = 0.03 and 0.03, respectively) and LOS (P = 0.03 and 0.03) than LP. There was no difference in OR time among the groups (P = 0.79). One patient (33%) had an intraoperative complication in LP. One patient (10%) had a postoperative complication in CL, 2 (22%) in RALS, and 1 (33%) in LP, with no significant difference (P = 0.61). Among the 42 patients with advanced/recurrent disease, 61 surgeries were performed: 14 diagnostic procedures and 47 cytoreductive surgeries. Of the 47, there was no difference in operating room time (P = 0.10). There was no difference in EBL or LOS between CL and RALS (P = 0.82, P = 0.87); however, both were less in CL (P < 0.001 and P = 0.02) and RALS (P = 0.01 and P = 0.02) compared with LP. There were 5 (63%) intraoperative transfusions in LP and none in CL or RALS. When including all surgeries for advanced/recurrent disease, there was 1 intraoperative complication (12%) in LP. There was no difference in postoperative complications between groups (P = 0.89); 8 patients (19%) had postoperative complications in CL, 2 (18%) in RALS, and 2 (25%) in LP. Overall, there were no grade 4 or 5 complications and no perioperative or intraoperative deaths.

Conclusions In our experience, perioperative outcomes are comparable between CL and RALS in both early and advanced/recurrent disease and not inferior to laparotomy, making CL and RALS an acceptable approach in selected patients.

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NR 22

TC 35

Z9 41

U1 0

U2 12

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA AC4VK

UT WOS:000332519000031

PM 24557439

DA 2024-01-18

ER

PT J

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Falcone, T

AF Ridgeway, Beri

Falcone, Tommaso

TI Innovations in Minimally Invasive Hysterectomy

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; robotics; laparoendoscopic single-site surgery;

laparoscopy; hemostatic agents; laparoscopic energy sources

ID VAGINAL CUFF DEHISCENCE; CONVENTIONAL LAPAROSCOPIC HYSTERECTOMY;

HEMOSTATIC AGENT; RANDOMIZED-TRIAL; FIBRIN SEALANT; CLINICAL-TRIAL;

SURGERY; CLOSURE; SUTURE

AB Vaginal hysterectomy, when feasible, is the safest and most cost-effective route for hysterectomy, however, when this is not possible, minimally invasive hysterectomy is often the next best option. Laparoscopic hysterectomy has advanced significantly since 1988, when it was first introduced. Continued improvements in instrumentation, energy sources, hemostatic agents, and vaginal cuff closure techniques have expanded the use of minimally invasive hysterectomy. Variations of laparoscopy, specifically laparoendoscopic single-site surgery hysterectomy and robotic-assisted laparoscopic hysterectomy, have further expanded the role of minimally invasive hysterectomy with the goal of decreasing morbidity. As with any evolving technology, well-designed studies are needed to demonstrate safety, efficacy, and cost-effectiveness before wide-spread adoption.

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TC 13

Z9 13

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U2 3

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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PG 12

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA AJ8RI

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ER

PT J

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TI Laparoscopy in the Morbidly Obese: Physiologic Considerations and

Surgical Techniques to Optimize Success

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopy; Minimally invasive surgery; Obesity; Physiology; Robotic

surgery

ID BODY-MASS-INDEX; VENOUS THROMBOEMBOLISM PROPHYLAXIS; MECHANICAL BOWEL

PREPARATION; BARIATRIC SURGERY PATIENTS; MORTALITY RISK SCORE; Y GASTRIC

BYPASS; URINARY-INCONTINENCE; ENDOMETRIAL CANCER; CARDIOVASCULAR

EVALUATION; INTRAABDOMINAL PRESSURE

AB The objectives of this review were to analyze the literature describing the benefits of minimally invasive gynecologic surgery in obese women, to examine the physiologic Considerations associated with obesity, and to describe surgical techniques that will enable surgeons to perform laparoscopy and robotic surgery successfully in obese patients. The Medline database was reviewed for all articles published in the English language between 1993 and 2013 containing the search terms "gynecologic laparoscopy" "laparoscopy," "minimally invasive surgery and obesity," "obesity," and "robotic surgery." The incidence of obesity is increasing in the United States, and in particular morbid obesity in women. Obesity is associated with a wide range of comorbid conditions that may affect perioperative outcomes including hypertension, atherosclerosis, angina, obstructive sleep apnea, and diabetes mellitus. In obese patients, laparoscopy or robotic surgery, compared with laparotomy, is associated with a shorter hospital stay, less postoperative pain, and fewer wound complications. Specific intra-abdominal access and trocar positioning techniques, as well as anesthetic maneuvers, improve the likelihood of success of laparoscopy in women with central adiposity. Performing gynecologic laparoscopy in the morbidly obese is no longer rare. Increases in the heaviest weight categories involve changes in clinical practice patterns. With comprehensive and thoughtful preoperative and surgical planning, minimally invasive gynecologic surgery may be performed safely and is of particular benefit in obese patients. (c) 2014 AAGL. All rights reserved.

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NR 135

TC 55

Z9 57

U1 0

U2 12

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JI J. Minim. Invasive Gynecol.

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SC Obstetrics & Gynecology

GA AD7IN

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ER

PT J

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Nasir, H

Mustafa, S

Lowenstein, L

AF Segal, Dror

Awad, Nibal

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Mustafa, Susana

Lowenstein, Lior

TI Combined spinal and general anesthesia vs general anesthesia for robotic

sacrocervicopexy: a randomized controlled trial

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Combined anesthesia; Pain; Robotic surgeries; Sacrocolpopexy;

Sacrocervicopexy

ID INTRATHECAL MORPHINE; PAIN; SACROCOLPOPEXY; PROLAPSE

AB Gynecologic laparoscopic surgery is frequently accompanied by early postoperative pain. This study assessed the effect of combined general and spinal anesthesia on postoperative pain score, analgesic use, and patient satisfaction following robotic surgeries.

This was a randomized controlled trial. Thirty-eight consecutive women who underwent robotic surgeries for pelvic organ prolapse (sacrocolpopexy with or without subtotal hysterectomy) were randomly assigned to receive general anesthesia (control group, n = 20) or combined general with spinal anesthesia (study group, n = 18). Pain scores were assessed at rest and while coughing using a visual analog scale (VAS) 0-10. Dosage of analgesic medication consumption was retrieved from patients' charts.

There were no statistically significant differences between the two groups with respect to demographic data and intraoperative hemodynamic parameters. In the postanesthesia care unit (PACU) mean total IV morphine and meperidine dosages were significantly lower for the study than the control group (0.33 vs 7.59 mg, 1.39 vs 27.89 mg, respectively, P < 0.003, < 0.001, respectively). In addition, a significantly lower percentage of patients belonging to the study group demanded analgesic medications while in the PACU (33 vs 53 %, P = 0.042). Pain scores in the PACU and during postoperative day 1 were significantly lower in the study group than in the control group (delta VAS 1.9 vs 3.0, P = 0.04). Satisfaction with pain treatment among both patients and nurses was significantly higher in the study group.

Reported levels of pain and analgesic use during the first 24 h following robotic gynecologic surgery were significantly lower following general and spinal anesthesia compared to general anesthesia alone.

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NR 18

TC 14

Z9 16

U1 0

U2 4

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J9 INT UROGYNECOL J

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WC Obstetrics & Gynecology; Urology & Nephrology

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GA AC6UN

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PT J

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Chuang, Linus

Gretz, Herbert

Fishman, David

Rahaman, Jamal

Randall, Thomas

TI Survival analysis of robotic versus traditional laparoscopic surgical

staging for endometrial cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial carcinoma; robotic surgery; traditional laparoscopy

ID GYNECOLOGIC-ONCOLOGY; RECURRENCE; LAPAROTOMY; SURGERY; HYSTERECTOMY;

CARCINOMA; OUTCOMES; LYMPHADENECTOMY; METAANALYSIS; SAFETY

AB OBJECTIVE: The purpose of this study was to compare the survival of women with endometrial cancer managed by robotic- and laparoscopic-assisted surgery.

STUDY DESIGN: This was a retrospective study conducted at 2 academic centers. Primary outcomes were overall survival, disease-free survival (DFS), and disease recurrence.

RESULTS: From 2003 through 2010, 415 women met the study criteria. A total of 183 women had robotic and 232 women had laparoscopic-assisted surgery. Both groups were comparable in age, body mass index, comorbid conditions, histology, surgical stage, tumor grade, total nodes retrieved, and adjuvant therapy. With a median follow-up of 38 months (range, 4-61 months) for the robotic and 58 months (range, 4-118 months) for the traditional laparoscopic group, there were no significant differences in survival (3-year survival 93.3% and 93.6%), DFS (3-year DFS 83.3% and 88.4%), and tumor recurrence (14.8% and 12.1%) for robotic and laparoscopic groups, respectively. Univariate and multivariate analysis showed that surgery is not an independent prognostic factor of survival.

CONCLUSION: Robotic-assisted surgery yields equivalent oncologic outcomes when compared to traditional laparoscopic surgery for endometrial adenocarcinoma.

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ER

PT J

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TI Surgical site infections after hysterectomy among HIV-infected women in

the HAART era: a single institution's experience from 1999-2012

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE CD4 count; human immunodeficiency virus; hysterectomy; preoperative

albumin; surgical site infection

ID HUMAN-IMMUNODEFICIENCY-VIRUS; ABDOMINAL OPERATIONS; CD4 COUNT; SURGERY;

COMPLICATIONS; IMPROVEMENT; PREVENTION; RATES

AB OBJECTIVE: We sought to determine risk factors associated with surgical site infection (SSI) among a cohort of human immunodeficiency virus (HIV)-infected women undergoing hysterectomy during the era of highly active antiretroviral therapy.

STUDY DESIGN: This is a retrospective study of HIV-infected women who underwent a hysterectomy for benign indications at a tertiary care center. Electronic medical records were reviewed from January 1999 through December 2012. SSI was defined using Centers for Disease Control and Prevention criteria.

RESULTS: There were 77 HIV-infected women who underwent a hysterectomy: 47 (61%) were abdominal; 16 (21%) were laparoscopic or robot-assisted; and 14 (18%) were vaginal. Acquired immune deficiency syndrome was diagnosed in 58% of patients, and 75% of patients self-reported use of highly active antiretroviral therapy at the time of surgery. There were 17 (22%) SSIs; 5 (29%) superficial incisional wound infections, 3 (18%) vaginal cuff cellulitis, and 9 (53%) pelvic abscesses were diagnosed. After multivariable logistic regression, preoperative albumin level (adjusted odds ratio [aOR], 0.14; 95% confidence interval [CI], 0.02-0.86) and minimally invasive hysterectomy (aOR, 0.16; 95% CI, 0.03-0.84) were associated with decreased SSI. Preoperative absolute CD4 count was not associated with SSI (aOR, 0.99; 95% CI, 0.99-1).

CONCLUSION: Low preoperative serum albumin levels and abdominal hysterectomy are associated with increased risk of SSIs in HIV-infected women.

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Bottoni, C.

Scambia, G.

TI Minimally invasive secondary cytoreduction plus HIPEC for recurrent

ovarian cancer: A case series

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Isolated platinum sensitive relapse; Ovarian cancer; HIPEC; Minimally

invasive surgery; Laparoscopy; Robotic

ID INTRAPERITONEAL CHEMOTHERAPY HIPEC; INTRAABDOMINAL PRESSURE;

PROGNOSTIC-FACTORS; SURGERY; PHARMACOKINETICS; OXALIPLATIN; LAPAROSCOPY;

CARCINOMA; SURVIVAL

AB Objective. To analyze the feasibility of laparoscopic/robotic secondary cytoreductive surgery and hyperthermic intraperitoneal intra-operative chemotherapy (SCS + HIPEC) in a retrospective series of isolated platinum sensitive recurrent ovarian cancer.

Methods. We retrospectively evaluated a consecutive series of ovarian cancer patients with isolated platinum sensitive relapse. Isolated relapse was defined as the presence of a single nodule, in a single anatomic site. In all cases the presence of isolated relapse was assessed at pre-operative FDG-PET/CT scan, and confirmed with staging laparoscopy performed immediately before SCS + HIPEC.

Results. 84 women with platinum sensitive relapse received SCS + HIPEC during a 4-year period. Among them, 10 cases (11.9%) showed isolated relapse and were treated with laparoscopic/robotic SCS + HIPEC. In all cases complete debulking was achieved. In HIPEC treatment, 9 women received cisplatin at 75 mg/m(2), and the remaining patient oxaliplatin 460 mg/m(2). In 7 patients SCS was performed through the laparoscopic route, and in 3 cases with a robotic approach. The median operative time from skin incision to the end of cytoreductive surgery was 122 min (95-140), estimated blood loss was 50 cm(3) (50-100), and the median length of hospital stay was 4 days (3-7). The interval from surgery to adjuvant chemotherapy was 21 days (19-32). No grade 3/4 surgical, metabolic, or hematologic complications occurred. In all cases post-operative FDG-PET/CT scan was negative, and after a median time of 10 months (6-37) from SCS + HIPEC no secondary recurrence was observed.

Conclusions. Minimally invasive SCS + HIPEC can be safely performed in selected ovarian cancer patients with platinum sensitive isolated relapse. (C) 2013 Elsevier Inc. All rights reserved.

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TI A comparison of extraperitoneal versus transperitoneal laparoscopic or

robotic para-aortic lymphadenectomy for staging of endometrial carcinoma

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Uterine cancer; Extraperitoneal para-aortic lymphadenectomy; Robotic

surgery; Laparoscopic surgery

ID CERVICAL-CANCER

AB Objective. The optimal surgical approach for complete lymphadenectomy in patients with endometrial cancer is controversial. The objective of our study was to compare the surgical outcomes of extraperitoneal laparoscopic, transperitoneal laparoscopic, and robotic transperitoneal para-aortic lymphadenectomy in endometrial cancer staging.

Methods. A retrospective review was performed on patients who underwent extraperitoneal or transperitoneal para-aortic lymphadenectomy for endometrial cancer staging from January 2007 to November 2012. Three patient groups were compared: extraperitoneal laparoscopic para-aortic lymphadenectomy, robotic hysterectomy and pelvic lymphadenectomy ("extraperitoneal group"; N = 34); laparoscopic hysterectomy and transperitoneal pelvic and para-aortic lymphadenectomy ("transperitoneal laparoscopic group"; N = 108); and robotic hysterectomy and transperitoneal pelvic and para-aortic lymphadenectomy ("transperitoneal robotic group"; N = 52). Fisher's exact test and Kruskal-Wallis test were used for statistical analysis, and statistical significance was defined as P < 0.05.

Results. The median number of para-aortic lymph nodes obtained was higher in the extraperitoneal group than in the transperitoneal laparoscopic and robotic groups (10, 5, and 45 nodes, respectively; P < 0.001). BMI was higher in the extraperitoneal group (median, 35.1 kg/m(2)) than in the transperitoneal groups but did not differ between the transperitoneal laparoscopic group (median, 28.4 kg/m(2)) and the transperitoneal robotic group (median, 30.2 kg/m(2)). Among patients with a BMI <35 kg/m(2), the median number of para-aortic nodes harvested was higher in the extraperitoneal group than in the transperitoneal laparoscopic and robotic groups (9, 4, and 5 nodes, respectively; P < 0.01). The same pattern was observed among patients with a BMI >= 35 kg/m(2) (10, 6, and 3 nodes, respectively), but only the extraperitoneal group and the transperitoneal robotic group were significantly different (P = 0.001). There was no significant difference in median estimated blood loss between the extraperitoneal group and either the transperitoneal laparoscopic group (100 vs. 112.5 mL; P = 0.06) or the transperitoneal robotic group (100 vs. 67.5 mL; P = 0.23). The median operative time was longer in the extraperitoneal group (339.5 min; range, 242-453 min) than in the transperitoneal laparoscopic group (286 min; range, 101-480 min) and the transperitoneal robotic group (297.5 min, range 182-633 min) (P < 0.01).

Conclusion. Extraperitoneal laparoscopic para-aortic lymphadenectomy resulted in a higher number of para-aortic lymph nodes removed than transperitoneal laparoscopic or robotic lymphadenectomy. The extraperitoneal approach should be considered for endometrial cancer staging. (C) 2013 Elsevier Inc. All rights reserved.

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TI Robotic Compared With Laparoscopic Sacrocolpopexy <i>A Randomized

Controlled Trial</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID PELVIC ORGAN PROLAPSE; COST-MINIMIZATION ANALYSIS; QUALITY-OF-LIFE;

URINARY-INCONTINENCE; ABDOMINAL SACROCOLPOPEXY; WOMEN; SURGERY;

QUESTIONNAIRE; COLPOPEXY; CANCER

AB OBJECTIVE: Laparoscopic and robotic sacrocolpopexy are widely used for pelvic organ prolapse (POP) treatment. Evidence comparing outcomes and costs is lacking. We compared costs and clinically relevant outcomes in women randomized to laparoscopic sacrocolpopexy compared with robotic sacrocolpopexy.

METHODS: Participants with symptomatic stage POP II or greater, including significant apical support loss, were randomized to either laparoscopic or robotic sacrocolpopexy. We compared surgical costs (including costs for robot, initial hospitalization) and rehospitalization within 6 weeks. Secondary outcomes included postoperative pain, POP quantification, symptom severity and quality of life, and adverse events. RESULTS: We randomized 78 women (mean age 59 years): laparoscopic (n=538) and robotic (n=540). The robotic sacrocolpopexy group had higher initial hospital costs ($19,616 compared with $11,573, P <.001) and over 6 weeks, hospital costs remained higher for robotic sacrocolpopexy ($20,898 compared with $12,170, P <.001). When we excluded costs of robot purchase and maintenance, we did not detect a statistical difference in initial day of surgery costs of robotic compared with laparoscopic ($12,586 compared with $11,573; P=.160) or hospital costs over 6 weeks ($ 13,867 compared with $12,170; P=.060). The robotic group had longer operating room times (202.8 minutes compared with 178.4 minutes, P=.030) and higher pain scores 1 week after surgery (3.5 +/- 2.1 compared with 2.6 +/- 2.2; P=.044). There were no group differences in symptom bother by Pelvic Floor Distress Inventory, POP stage, or rate of adverse events.

CONCLUSION: Costs of robotic sacrocolpopexy are higher than laparoscopic, whereas short-term outcomes and complications are similar. Primary cost differences resulted from robot maintenance and purchase costs.

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ER

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TI Robotic Sacrocolpopexy for the Management of Pelvic Organ Prolapse: A

Review of Midterm Surgical and Quality of Life Outcomes

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Review

DE sacrocolpopexy; pelvic organ prolapse; apical prolapse; mesh extrusion;

robotic surgery

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; FLOOR DISORDERS; WOMEN;

INCONTINENCE; PREVALENCE; MESH

AB Introduction: Transabdominal sacrocolpopexy is a definitive treatment option for vaginal vault prolapse with durable success rates. The aim of our study was to review subjective and objective outcomes including complications after robotic assisted laparoscopic sacrocolpopexy for the repair of symptomatic pelvic organ prolapse.

Methods: Single-site retrospective cohort study of women undergoing robotic assisted laparoscopic sacrocolpopexy with and without concomitant robotic assisted supracervical hysterectomy was performed. Pelvic Floor Distress Inventory-20 and Pelvic Floor Impact Questionnaire-7 questionnaires were used preoperatively and postoperatively to evaluate patient subjective data, respectively. We established a strict improvement of greater than 70% on questionnaire's total score to determine clinical improvement.

Results: Complications were assessed at 6 months and 127 women were included in our review. Mesh extrusion occurred in 3 (2.4%) patients. Other complications reported were bowel injury (2.4%), readmission rate (2.4%), wound infection (1.6%), and postoperative hernia at port site (1.6%). Objective and subjective outcomes were assessed at 1 year in 92 women. Although there was no recurrent apical prolapse at 1 year, anterior prolapse was present in 7 patients. Clinical improvement was present in 72% by Pelvic Floor Impact Questionnaire-7 and in 68% by Pelvic Floor Distress Inventory-20. Predictors of poor clinical outcomes were lysis of adhesions (OR, 5.83; 95% confidence interval [CI], 1.2-27.4; P = 0.026), urethrolysis (OR, 11.91; 95% CI, 1.2-117.9; P = 0.034), current smoking (OR, 7.9; 95% CI, 1.1-58.7; P = 0.042), and older age (OR, 1.1; 95% CI, 1.0-1.18; P = 0.044).

Conclusions: Robotic assisted laparoscopic sacrocolpopexy represents a safe and effective surgical therapy to manage symptomatic apical pelvic organ prolapse. Serious complication rates are low but not rare when assessing short-term outcomes.

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JI Female Pelvic Med. Reconstr. Surg.

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CA FPRN

TI Surgical Privileging in Gynecology: A Fellows' Pelvic Research Network

Study

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE surgical privileging; credentialing

AB Objectives: This study aimed to describe the criteria used by US hospitals to grant surgical privileges for select gynecologic procedures and to compare the privileging processes between university-based and community-based hospitals.

Methods: We conducted a cross-sectional study from January 2011 to December 2012 that included institutions represented by Fellows' Pelvic Research Network members. A 5-page, anonymous survey was distributed to hospitals to determine the hospital criteria used for initial surgical privileges and for renewal of privileges for 13 gynecologic procedures. Information on training requirements, minimum number of supervised cases, and annual case number needed for maintenance was obtained. Criteria for privileging were described and compared between university-based and community-based hospitals.

Results: Of the 25 institutions that completed the surveys, 56% were university-based and 44% were community-based. Community hospitals differed significantly from university institutions with a larger portion of community hospitals requiring preceptorship for laparoscopic hysterectomy (70% vs 15%, P = 0.027), robotic hysterectomy (90% vs 25%, P = 0.012), robotic sacrocolpopexy (90% vs 20%, P = 0.009), and sacral neuromodulation (67% vs 0%, P = 0.004).

Conclusions: Considerable variability exists in the criteria used by US hospitals for surgical privileging in gynecology. When compared to university centers, a higher proportion of community hospitals required preceptorship for minimally invasive hysterectomy, robotic sacrocolpopexy, and sacral neuromodulation.

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TI Pneumomediastinum After Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE pneumomediastinum; sacrocolpopexy; robotic surgery

ID PNEUMOTHORAX

AB Background: Pneumomediastinum is a rare but potential complication of laparoscopy that is related to insufflation with carbon dioxide gas and may lead to life-threatening complications.

Case: A 76-year-old woman underwent robotic sacrocolpopexy to repair posthysterectomy prolapse without any apparent intraoperative complications. Postoperatively, she developed shortness of breath and tachycardia and was found to have subcutaneous emphysema and pneumomediastinum.

Conclusion: Pelvic surgeons should understand the risks associated with development of pneumomediastinum as well as associated signs and symptoms. In our case, pneumomediastinum likely developed as carbon dioxide tracked from the peritoneum into the mediastinum during prolonged robotic retroperitoneal surgery. Surgeons should have a low threshold to obtain radiographic tests in the early postoperative period, as close monitoring is essential to manage potentially life-threatening complications such as pneumothorax and cardiac arrest.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

AU Culligan, P

Gurshumov, E

Lewis, C

Priestley, J

Komar, J

Salamon, C

AF Culligan, Patrick

Gurshumov, Emil

Lewis, Christa

Priestley, Jennifer

Komar, Jodie

Salamon, Charbel

TI Predictive Validity of a Training Protocol Using a Robotic Surgery

Simulator

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE da Vinci; Morristown Protocol; robotic simulator; robotic surgery

ID VINCI SKILLS SIMULATOR; LAPAROSCOPIC HYSTERECTOMY; CONSTRUCT-VALIDATION;

FACE

AB Background: Robotic surgery simulation may provide a way for surgeons to acquire specific robotic surgical skills without practicing on live patients.

Methods: Five robotic surgery experts performed 10 simulator skills to the best of their ability, and thus, established expert benchmarks for all parameters of these skills. A group of credentialed gynecologic surgeons naive to robotics practiced the simulator skills until they were able to perform each one as well as our experts. Within a week of doing so, they completed robotic pig laboratory training, after which they performed supracervical hysterectomies as their first-ever live human robotic surgery. Time, blood loss, and blinded assessments of surgical skill were compared among the experts, novices, and a group of control surgeons who had robotic privileges but no simulator exposure. Sample size estimates called for 11 robotic novices to achieve 90% power to detect a 1 SD difference between operative times of experts and novices (alpha = 0.05).

Results: Fourteen novice surgeons completed the study-spending an average of 20 hours (range, 9.7-38.2 hours) in the simulation laboratory to pass the expert protocol. The mean operative times for the expert and novices were 20.2 (2.3) and 21.7 (3.3) minutes, respectively (P = 0.12; 95% confidence interval, -1.7 to 4.7), whereas the mean time for control surgeons was 30.9 (0.6) minutes (P < 0.0001; 95% confidence interval, 6.3-12.3). Comparisons of estimated blood loss (EBL) and blinded video assessment of skill yielded similar differences between groups.

Conclusions: Completing this protocol of robotic simulator skills translated to expert-level surgical times during live human surgery. As such, we have established predictive validity of this protocol.

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Colas, E.

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Magrina, J. F.

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TI Comparison of robotic-assisted vs conventional laparoscopy for

extraperitoneal paraaortic lymphadenectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic-assisted laparoscopy; Extraperitoneal paraaortic

lymphadenectomy; Cervical cancer

ID ADVANCED CERVICAL-CANCER; VASCULAR SPACE INVOLVEMENT; NODE METASTASES;

CARCINOMA; TOMOGRAPHY; IMPACT

AB Objective. To evaluate the perioperative outcomes of robotic-assisted extraperitoneal paraaortic lymphadenectomy for locally advanced cervical cancer and to compare to a previous series of patients from our institution undergoing the same procedure by conventional laparoscopy.

Methods. 17 patients with locally advanced cervical cancer (FIGO stages IB2, IIA2 and IIB-IVA) underwent pretherapeutic extraperitoneal paraaortic lymphadenectomy by robotic-assisted laparoscopy. Perioperative outcomes including age, BMI, FIGO stage, operating time, blood loss, complications and length of hospital stay were compared to a series of 83 patients from our institution undergoing the same procedure by conventional laparoscopy.

Results. The median values for operating time and hospital days for the robotic-assisted and conventional laparoscopy groups were 150 vs. 150 min and 2 vs 2 days, respectively. In the robotic group, blood loss was lower (90 vs 20 ml, p < 0.05) and more aortic nodes were removed (14 vs 17 nodes, p < 0.05). Docking time was 7 min (range 3-15). There were no intraoperative complications. There were no differences for postoperative complications (17.6% vs 8.4%).

Conclusion. Robotic-assisted and conventional laparoscopy provide similar perioperative outcomes other than lower blood loss and higher number of aortic nodes removed (both without clinical impact) in robotic patients for the performance of extraperitoneal paraaortic lymphadenectomy in patients with locally advanced cervical cancer. We believe that robotic surgery is an additional tool to perform the same surgical procedure.

Highlights. Robotic-assisted and conventional laparoscopic extraperitoneal paraaortic lymphadenectomy provide similar perioperative outcomes. (C) 2013 Elsevier Inc. All rights reserved.

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PT J

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AF Farghaly, S. A.

TI Single port access (SPA) robot-assisted laparoscopic posterior pelvic

exenteration for patients with advanced and recurrent ovarian cancer:

Farghaly's technique

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

ID ADVANCED GYNECOLOGICAL MALIGNANCIES; RECTAL-CANCER; EXPERIENCE;

CARCINOMA; ONCOLOGY; SURGERY

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NR 33

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Z9 0

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U2 6

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JI Eur. J. Gynaecol. Oncol.

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ER

PT J

AU Goebel, K

Goldberg, JM

AF Goebel, Kathryn

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TI Women's Preference of Cosmetic Results After Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cosmesis; Laparoscopy; Myomectomy

ID INCISIONS

AB Study Objective: To determine the cosmetic appeal of different incision types used in gynecologic surgery.

Design: One hundred women between the ages of 20 and 40 years were shown 4 color photographs of a female abdomen with incision sites marked for Pfannenstiel, minilaparotomy, traditional laparoscopy, and robotic-assisted laparoscopy. The women were asked to rank the photographs on cosmetic appeal alone. An additional photograph depicting single-port laparoscopy was then added, and patients were asked to again rank the photographs. Participants were also asked basic demographic information and prior surgical history.

Setting: Office practice.

Patients: One hundred women between the ages of 20 and 40.

Intervention: Participants.

Measurements and Main Results: Minilaparotomy was ranked as the most appealing incision among the first set of photographs by 74% of the participants, and the remaining 26% preferred traditional laparoscopy. Robotic-assisted laparoscopy was ranked as the least appealing scar type by 42%, and no patient selected it as their first choice. Sixty-four percent preferred the appearance of a single-port laparoscopic scar when that option was added. The only demographic variable that reached statistical significance was the presence of prior abdominal surgery. Patients without prior surgery ranked minilaparotomy as more cosmetically appealing.

Conclusions: When several minimally invasive surgical approaches are possible, the patient should be counseled regarding the cosmetic results of each. Patients in this study strongly preferred the appearance of minilaparotomy and single-port incisions over full Pfannenstiel or robotic incisions. (C) 2014 AAGL. All rights reserved.

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Z9 37

U1 0

U2 2

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JI J. Mimim. Invasive Gynecol.

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ER

PT J

AU Knight, J

Escobar, PF

AF Knight, Jason

Escobar, Pedro F.

TI Cost and robotic surgery in gynecology

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE cost analysis; economics; gynecologic surgery; healthcare cost; robotic

surgery

ID ENDOMETRIAL CANCER; RADICAL HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY;

OUTCOMES; TRENDS

AB Since the introduction of robotic technology, there have been significant changes to the field of gynecology. The number of minimally invasive procedures has drastically increased, with robotic procedures rising remarkably. To date several authors have published cost analyses demonstrating that robotic hysterectomy for benign and oncologic indications is more costly compared to the laparoscopic approach. Despite being more expensive than laparoscopy, other studies have found robotics to be less expensive and more effective than laparotomy. In this review, controversies surrounding cost-effectiveness studies are explored.

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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PT J

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Gutman, Robert E.

TI Outcomes of Abdominal and Minimally Invasive Sacrocolpopexy: A

Retrospective Cohort Study

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE complications; sacral colpopexy; sacrocolpopexy

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; ROBOTIC

SACROCOLPOPEXY; SACRAL COLPOPEXY; MESH EROSION; SURGERY; RISK

AB Objective: To compare perioperative and postoperative surgical outcomes between and among open and minimally invasive sacrocolpopexies (MISCs).

Methods: We performed a multicenter retrospective cohort study comparing abdominal sacrocolpopexy (ASC) and MISC from January 1999 to December 2010.

Results: A total of 1124 subjects underwent sacrocolpopexy, with 589 ASCs and 535 MISCs. Within the MISC group, 273 were laparoscopic (LSC) and 262 were robotic (RSC). Abdominal sacrocolpopexy was associated with greater overall complication rate compared with MISC (20.0% vs 12.7%; P = 0.001). After controlling for difference in length of follow-up, there was no significant difference in the rate of anatomical failure between the ASC and MISC groups. The MISC group had shorter hospitalization, less blood loss, but longer operative times compared with the ASC group. When comparing LSC to RSC, there was no difference in anatomic failures (7.7% vs 6.9%; P = 0.74). However, LSC was associated with more complications compared with RSC (18% vs 7%; P < 0.02). In addition, LSC had higher blood loss, less operative time, and shorter hospital stay compared with RSC.

Conclusion: Although anatomic results are similar, ASC is associated with a higher rate of complications compared with MISC.

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TI Fellowship learning curve associated with completing a robotic assisted

total laparoscopic hysterectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic assisted laparoscopic hysterectomy; Minimally invasive surgery;

Total laparoscopic hysterectomy

ID RADICAL HYSTERECTOMY; GYNECOLOGIC ONCOLOGY; CERVICAL-CARCINOMA; SURGERY;

LYMPHADENECTOMY; LAPAROTOMY

AB Objective. To describe the learning curve associated with training fellows in completing robotic assisted total laparoscopic hysterectomies.

Methods. All patients scheduled to undergo a robotic procedure at our institution from 5/15/07 to 5/22/12 were identified. Fellow participation per procedure was documented. The learning curve of fellows for the time to complete a hysterectomy (from initiation of developing the retroperitoneal space to the completion of the colpotomy) was analyzed.

Results. Of the 1754 planned robotic cases, 1626 were completed robotically and 128 were converted to laparotomy. Fifty-seven fellows participated in 99.7% of the cases. Eleven gynecologic oncology fellows completed at least 1 robotic assisted total laparoscopic hysterectomy. From 7/7/08 to 5/21/12, 981 hysterectomies were completed robotically, 254 of these (25.9%) by the 11 fellows. Prior to completing a hysterectomy, the median number of hysterectomies in which a fellow participated was 16 (range, 11-40). Median amount of time for a fellow to complete a hysterectomy decreased from 60 min in 2009 (N = 27 cases) to 31 min in 2011 (N = 148 cases). Based on the recorded completion times in which the 11 fellows completed a hysterectomy, it required similar to 33 cases per fellow to be able to perform the hysterectomy and overcome the learning curve.

Conclusions. The learning curve associated with hysterectomy requires completion of similar to 33 cases by the fellow after an initial median experience of 16 cases. Our data suggest that a minimum of 50 total cases is required during fellowship to complete a robotic hysterectomy. (C) 2013 Elsevier Inc. All rights reserved.

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TI Robotic Single-Incision Transumbilical Total Hysterectomy Using a

Single-Site Robotic Platform: Initial Report and Technique

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE da Vinci Single-Site Surgical Platform; Robotic surgery; Single port;

Total hysterectomy

ID SURGERY; LAPAROSCOPY

AB The benefits of laparoscopic surgery over open abdominal surgery have been well documented. Efforts continue for development of strategies that further reduce the size of abdominal incisions and the number of trocars used. Laparoendoscopic single-site surgery (LESS) is a promising approach that can further enhance cosmetic satisfaction and reduce the risks of laparoscopic surgery. Loss of triangulation, instrument crowding and clashing, poor visualization, and ergonomic problems are the most challenging issues associated with the use of LESS. The combination of LESS and the robotic system seems to be a promising choice to overcome the technical difficulties of LESS. The da Vinci Single-Site Surgical Platform is a novel semirigid robotic operating system. We present our initial clinical experience with robotic-assisted single-incision transumbilical total hysterectomy using the novel da Vinci Single-Site Surgical Platform. (C) 2014 AAGL. All rights reserved.

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Bensa茂d, C

Douay-Hauser, N

L茅curu, F

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Bats, Anne-Sophie

Huchon, Cyrille

Bensaid, Cherazade

Douay-Hauser, Nathalie

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TI Laparoscopy vs Robotics in Surgical Management of Endometrial Cancer:

Comparison of Intraoperative and Postoperative Complications

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Complications; Endometrial cancer; Laparoscopy; Outcomes; Robotics;

Surgery

ID ASSISTED VAGINAL HYSTERECTOMY; LAPAROTOMY; SURGERY; OUTCOMES; COST;

LYMPHADENECTOMY; CARCINOMA; SURVIVAL

AB Study Objective: To compare the rates of intraoperative and postoperative complications of robotic surgery and laparoscopy in the surgical treatment of endometrial cancer.

Design: Unicentric retrospective study (Canadian Task Force classification II-2).

Setting: Tertiary teaching hospital.

Patients: The study was performed from January 2002 to December 2011 and included patients with endometrial cancer who underwent laparoscopic or robotically assisted laparoscopic surgical treatment. Data collected included preoperative data, tumor characteristics, intraoperative data (route of surgery, surgical procedures, and complications), and postoperative data (early and late complications according to the Clavien-Dindo classification, and length of hospital stay). Morbidity was compared between the 2 groups.

Measurements and Main Results: The study included 146 patients, of whom 106 underwent laparoscopy and 40 underwent robotically assisted surgery. The 2 groups were comparable in terms of demographic and preoperative data. Intraoperative complications occurred in 9.4% of patients who underwent laparoscopy and in none who underwent robotically assisted surgery (p = .06). There was no difference between the 2 groups in terms of postoperative events.

Conclusion: Robotically assisted surgery is not associated with a significant difference in intraoperative and postoperative complications, even when there were no intraoperative complications of robotically assisted surgery. (C) 2014 AAGL. All rights reserved.

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NR 32

TC 17

Z9 19

U1 0

U2 7

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 292GC

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DA 2024-01-18

ER

PT J

AU Smorgick, N

Patzkowsky, KE

Hoffman, MR

Advincula, AP

Song, AH

As-Sanie, S

AF Smorgick, Noam

Patzkowsky, Kristin E.

Hoffman, Mark R.

Advincula, Arnold P.

Song, Arleen H.

As-Sanie, Sawsan

TI The increasing use of robot-assisted approach for hysterectomy results

in decreasing rates of abdominal hysterectomy and traditional

laparoscopic hysterectomy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Hysterectomy; Robotic surgery; Laparoscopy

ID EVALUATE

AB To compare the frequency of minimally invasive surgical approach to hysterectomy between two time periods, during which the use of the robotic technique has rapidly increased.

This study is a retrospective review of 623 consecutive patients who underwent hysterectomy for benign indications at the Division of Minimally Invasive Gynecologic Surgery via laparoscopic, robotic, laparotomy, mini-laparotomy and vaginal approaches from July 2004 to June 2010. "Early period" refers to the first 311 patients, and "late period" refers to the remaining 312 patients.

The characteristics of patients from the early and late periods were comparable in terms of age, BMI and uterine weight. The rates of hysterectomy by laparotomy, traditional laparoscopy, robotic, vaginal, and mini-laparotomy were significantly different between the early and late periods (17.7 to 5.4 %, 39.5 to 17.6 %, 23.8 to 64.1 %, 5.8 to 4.8 % and 13.2 to 8 %, respectively, P < 0.01), with the overall rates of hysterectomies completed via a minimally invasive approach increasing from 82.3 to 94.6 %, respectively (P < 0.01). There were no differences in surgical complications between the two periods.

Increased utilization of a robotic approach to hysterectomy correlates with decreasing rates of abdominal hysterectomy concurrent with decreasing rates of traditional laparoscopic hysterectomy. This shift in surgical approach to hysterectomy, while beneficial in increasing the rates of minimally invasive approach to hysterectomy, may have significant economic implications due to the higher cost of robotic surgery.

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NR 19

TC 22

Z9 24

U1 0

U2 5

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Desille-Gbaguidi, H

Hebert, T

Paternotte-Villemagne, J

Gaborit, C

Rush, E

Body, G

AF Desille-Gbaguidi, H.

Hebert, T.

Paternotte-Villemagne, J.

Gaborit, C.

Rush, E.

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TI Overall care cost comparison between robotic and laparoscopic surgery

for endometrial and cervical cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Cost analysis; Robotic assistance; Robotic versus laparoscopic; Robotic

hysterectomy; Laparoscopic hysterectomy

ID HYSTERECTOMY; LAPAROTOMY

AB Objective: The aim of our medico-economic study was to compare robotic surgery cost with conventional laparoscopic cost in endometrial and cervical cancer.

Study design: Our study included laparoscopic and robot-assisted procedures (radical hysterectomies and lymphadenectomies) for endometrial or cervical cancer ever since first using the Da Vinci (R) in 2008 within a hospital setting. In the hospital perspective, direct costs were determined by examining the overall medical pathway for each type of intervention. Actual costs were calculated for 27 conventional laparoscopic procedures and for 30 robot-assisted procedures including initial cost of the robot and its maintenance. We estimated the complete medical "overall care" costs by adding the costs of consultations, surgery and post-operative hospital stay to the costs of any eventual emergency consultation and/or hospitalisation within the two months that followed surgery. A sensitivity analysis was performed to evaluate the effects of variable modulations.

Results: For endometrial cancer, surgical procedure cost for robotic-assisted surgery was (sic)7402 compared to (sic)2733 for conventional laparoscopic surgery. When considering overall medical care, the patient treatment average cost was (sic)6666 for the laparoscopic group (with an average length of stay of 5.27 days) as compared to (sic)10,816 for robotic group (with an average hospital stay of 4.60 days), p = 0.39. For cervical cancer, average surgical cost with robotic-assisted surgery was (sic)8501 compared to conventional laparoscopic surgery at (sic)3239. For cervical cancer, overall care average cost was (sic)7803 for the laparoscopic group (with an average length of stay of 5.83 days) as compared to (sic)12,211 for the robotic group (with an average hospital stay of 4.70 days) p = 0.07. Sensitivity analysis results confirmed the cost overrun with the use of robotic assisted surgery.

Conclusions: Conventional laparoscopy was less expensive in our institution than robotic-assisted surgery for the surgery of endometrial (1:2.7) and cervical (1:2.6) cancers. When considering overall medical care, the use of robotic-assisted surgery was found to be 1.6 times more expensive than conventional surgery. (C) 2013 Elsevier Ireland Ltd. All rights reserved.

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FX We would like to thank financial department staff of Bretonneau Hospital

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Z9 52

U1 1

U2 10

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EI 1872-7654

J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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GA 288GC

UT WOS:000329599000031

PM 24135382

DA 2024-01-18

ER

PT J

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O'Reilly, B

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O'Reilly, B.

TI Robotic repair of vesico-vaginal fistula with perisigmoid fat flap

interposition: state of the art for a challenging case?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Fistula repair; Robotic surgery; Laparoscopic surgery; Incontinence;

Complications; Endoscopy

AB Since its introduction, robotic-assisted operations have established themselves in an increasingly wide range of procedures. We applied this approach as a viable surgical alternative for the management of a complex vesicovaginal fistula. We present the case of a patient with total urinary incontinence due to the formation of a vesicovaginal fistula, following total abdominal hysterectomy. The fistula was located at the vaginal vault and at approximately one cm from the right ureteric orifice. For this specific scenario a robotic approach was chosen over the vaginal-, laparotomic- and laparoscopic repair, as in our view it offered the best possibility to specifically treat the target anatomy with a reduced risk for involvement of the surrounding structures, while maintaining a low morbidity and a quick postoperative recovery.

In our video we show how the vesicovaginal fistula can be repaired by interposition of a vascularized flap of perisigmoid fat, in order to reduce the risk of recurrences [Ezzat et al., Repair of giant vesicovaginal fistulas, 181(3): 1184-1188, 2009].

The postoperative course was uneventful; on postoperative day 1 the patient reported pain of 2/10 on a VAS scale (0 = no pain; 10 = unbearable pain) and was mobilized. She was discharged on postoperative day two with bladder catheter in situ. The successful repair of the fistulous tract was confirmed via retrograde cystogram on postoperative day 10 and the patient was continent immediately after catheter removal. At the six month follow up visit the patient had no complaints.

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NR 3

TC 11

Z9 12

U1 0

U2 2

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

PD DEC

PY 2013

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IS 12

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PG 2

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA 267XS

UT WOS:000328132300006

PM 23867973

DA 2024-01-18

ER

PT J

AU Feuer, GA

Lakhi, N

Barker, J

Salmieri, S

Burrell, M

AF Feuer, Gerald A.

Lakhi, Nisha

Barker, James

Salmieri, Stephen

Burrell, Mathew

TI Perioperative and clinical outcomes in the management of epithelial

ovarian cancer using a robotic or abdominal approach

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Minimally invasive surgery; Advanced ovarian cancer; Debulking; Robotic

surgery

ID MINIMALLY INVASIVE SURGERY; GYNECOLOGIC ONCOLOGY; ENDOMETRIAL CANCER;

COMPLICATIONS; LAPAROSCOPY; LAPAROTOMY

AB Objective. To evaluate the feasibility and efficacy of robotic-assisted management of epithelial ovarian cancer.

Methods. Retrospective review of robotic-assisted or abdominal ovarian cancer cases presenting with pelvic mass, initial staging, or debulking after neoadjuvant chemotherapy performed by a single surgeon (2008-2012). Patient characteristics and outcomes were compared using chi-squared or Student's t-tests.

Results. There were 63 robotic and 26 abdominal cases. Patient characteristics were similar for age, uterine weight, and BMI, with prior abdominal surgery more common in the abdominal group (p = 0.0257). Robotic operative time was longer (p < 0.0001), while blood loss (p < 0.0001) and hospital stay (p = 0.0009) were reduced. Major complication rates (16% vs. 23%, p = 0.4209) and lymphadenectomy yields (13 vs. 11 nodes, p = 0.2310) were similar. Neoadjuvant chemotherapy was more common in the robotic group (52% vs. 15%, p = 0.0013). Residual disease rates for all cases (73% vs. 50%, p = 0.880) and for Stage II-IV cases (61% vs. 40%, p = 0.929) were equivalent. Follow-up was longer for the abdominal group; however, an equivalent percentage of patients had at least 1 year of follow-up (57% vs. 77%, p = 0.0789). At 1 year, survival and no evidence of disease (NED) rates were equivalent for all cases (survival: 97% vs. 90%, p = 0.2501; NED: 81% vs. 85%, p = 0.6773) and for Stage II-IV cases (survival: 96% vs. 88%, p = 0.3080; NED: 76% vs. 81%, p = 0.6920).

Conclusions. A robotic approach for the management of epithelial ovarian cancer, including patients treated with neoadjuvant chemotherapy, is feasible and effective. Debulldng, recurrence, and survival rates were similar to laparotomy at 1 year. (C) 2013 Elsevier Inc. All rights reserved.

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Northside Hospital; data collection, study design, data interpretation,

and manuscript review were performed by employees of Northside Hospital.

April E Hebert, Ph.D., a Scientific Consultant for Intuitive Surgical,

provided manuscript preparation assistance. The data were presented as

an abstract at the 2013 Annual SGO meeting.

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Z9 45

U1 0

U2 2

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JI Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 265AZ

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DA 2024-01-18

ER

PT J

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Huh, Seung Jae

Kim, Byoung-Gie

TI Port site metastasis after robotic-assisted laparoscopic hysterectomy

for uterine cervical cancer: A case report and literature review

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE port site metastasis; chemo-radiotherapy; robotic-assisted laparoscopic

surgery; uterine cervical cancer

ID SQUAMOUS-CELL CARCINOMA; PARAAORTIC LYMPHADENECTOMY; UMBILICAL

METASTASIS; SURGERY; ADENOCARCINOMA; RECURRENCES

AB Objective: The incidence of port site metastasis after robotic-assisted laparoscopic surgery for cervical cancer is not well known. According to recent studies of gynecological malignancies, the reported incidence is low and comparable to the results of conventional laparoscopic surgery. Here, we report the case of a patient who suffered port site metastasis after robotic-assisted laparoscopic hysterectomy for stage IB1 uterine cervical cancer.

Case report: The current case is, as we know, only the third episode of port site metastasis after robotic-assisted laparoscopic surgery for cervical cancer documented in the medical literature. Following diagnosis of the port site metastasis, the patient was treated with concurrent chemoradiotherapy (CRT) and experienced a remarkable early response. We reviewed the patient's medical chart and imaging studies, and searched the Medline database to evaluate the incidence, prognosis and treatment outcomes of such cases of port site metastasis in uterine cervical cancer patients.

Conclusion: CRT resulted in a rapid decrease in tumor size and relief of abdominal pain in our patient. CRT might be considered as a salvage or palliative modality in patients with port site metastasis and/or locoregional recurrence. Copyright (C) 2013, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. All rights reserved.

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NR 28

TC 9

Z9 10

U1 0

U2 7

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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BP 558

EP 563

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PG 6

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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OA gold

DA 2024-01-18

ER

PT J

AU Liang, MI

Rosen, MA

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Cohn, DE

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Cohn, David E.

TI Reducing readmissions after robotic surgical management of endometrial

cancer: A potential for improved quality care

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Hospital readmission; Robotic surgery; Endometrial cancer

ID HOSPITAL READMISSIONS; REHOSPITALIZATIONS; ACCOUNTABILITY; SURGERY;

OVARIAN

AB Objective. To describe readmission patterns after robotic surgery for endometrial cancer and identify risk factors for readmission within 90 days of discharge.

Methods. Patients with endometrial cancer who underwent robotic surgical management at an academic institution from 2006 to 2010 were identified. Patient characteristics, intraoperative data; and postoperative complications were analyzed. Student's t-test and Fisher's exact test were used to compare patients readmitted within 90 days to those who were not.

Results. Three hundred ninety-five patients were included. Thirty (7.6%) were readmitted within 90 days of surgical discharge. Length of stay greater than one day (40.0% vs. 23.0%, p = 0.04) and postoperative complication (63.3% vs. 13.4%, p < 0.01) were associated with readmission. The median interval to readmission was 9.5 days and median duration of subsequent hospitalization was 2.5 days. Fever (31.3%) and workup for vaginal drainage (25.0%) were the most common reasons for readmission. Only 2 of the 10 patients readmitted with fever had culture-proven infection, and no patients readmitted for vaginal drainage had a confirmed urinary tract injury. Of the 30 patients readmitted, 5 required a second operation -3 for vaginal cuff dehiscence and 2 for port site hernia.

Conclusions. Robotic surgery for endometrial cancer was associated with a 7.6% readmision rate. The most common reasons for readmission, fever and evaluation for urinary tract injury, were frequently not associated with severe illness. This supports additional education to consider raising the threshold for readmission by using more widespread outpatient evaluation for the potential complications of robotic endometrial cancer surgery. (C) 2013 Elsevier Inc. All rights reserved..

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TC 21

Z9 23

U1 0

U2 10

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

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Persson, Jan

TI Port-site metastases following robot-assisted laparoscopic surgery for

gynecological malignancies

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Gynecological cancer; port-site metastases; robotic surgery; cervical

cancer; endometrial cancer

ID RADICAL HYSTERECTOMY; TUMOR IMPLANTATION; ENDOMETRIAL CANCER; CLOSURE;

WOMEN

AB ObjectiveTo evaluate the incidence and possible predictors associated with port-site metastases following robotic surgery.

DesignProspective study.

SettingUniversity Hospital.

PopulationWomen with gynecological cancer.

MethodsThe occurrence of port-site metastases in the first 475 women undergoing robotic surgery for gynecological cancer was reviewed.

Main outcome measuresRate of port-site metastases.

ResultsA port-site metastasis was detected in nine of 475 women (1.9%). Eight women had either an unexpected locally advanced disease or lymph-node metastases at the time of surgery. All nine women received postoperative adjuvant therapy. Women with stage III endometrial cancer and women with node positive cervical cancer had a significantly higher risk of developing a port-site metastasis, as did women with high-risk histology endometrial cancer. Port-site metastases were four times more likely to occur in a specimen-retrieval port. One (0.2%) isolated port-site metastasis was detected. The median time to occurrence of a port-site metastasis was 6months (range 2-19months). Six of the nine women (67%) have died and their median time of survival from recurrence was 4months (range 2-16months).

ConclusionIn women with gynecological cancer, the incidence of port-site metastases following robotic surgery was 1.9%. High-risk histology and/or advanced stage of disease at surgery seem to be contributing factors.

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NR 21

TC 23

Z9 25

U1 1

U2 4

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Successful incorporation of robotic surgery into gynecologic oncology

fellowship training

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Gynecologic cancers; Minimally invasive surgery;

Fellowship training; Learning curve

ID LYMPHADENECTOMY; HYSTERECTOMY

AB Background. The increasing role of robotic surgery in gynecologic oncology may impact fellowship training. The purpose of this study was to review the proportion of robotic procedures performed by fellows at the console, and compare operative times and lymph node yields to faculty surgeons.

Methods. A prospective database of women undergoing robotic gynecologic surgery has been maintained since 2008. Intra-operative datasheets completed include surgical times and primary surgeon at the console. Operative times were compared between faculty and fellows for simple hysterectomy (SH), bilateral salpingo-oophorectomy (BSO), pelvic (PLND) and paraaortic lymph node dissection (PALND) and vaginal cuff closure (VCC). Lymph nodes counts were also compared.

Results. Times were recorded for 239 SH, 43 BSOs, 105 right PLNDs, 104 left PLNDs, 34 PALND and 269 VCC. Comparing 2008 to 2011, procedures performed by the fellow significantly increased; SH 16% to 83% (p <0.001), BSO 7% to 75% (p = 0.005), right PLND 4% to 44% (p < 0.001), left PLND 0% to 56% (p <0.001), and VCC 59% to 82% (p = 0.024). Console times (min) were similar for SH (60 vs. 63, p = 0.73), BSO (48 vs. 43, p = 0.55), and VCC (20 vs. 22, p = 0.26). Faculty times (min) were shorter for PLND (right 26 vs. 30, p = 0.04, left 23 vs. 27, p = 0.02). Nodal counts were not significantly different (right 7 vs. 8, p = 0.17 or left 7 vs. 7, p = 0.87).

Conclusions. Robotic surgery can be successfully incorporated into gynecologic oncology fellowship training. With increased exposure to robotic surgery, fellows had similar operative times and lymph node yields as faculty surgeons. (C) 2013 Elsevier Inc. All rights reserved.

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ER

PT J

AU Barber, MD

Maher, C

AF Barber, Matthew D.

Maher, Christopher

TI Apical prolapse

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Sacral colpopexy; Transvaginal mesh; Sacrospinous colpopexy; Vault

prolapse

ID VAGINAL VAULT PROLAPSE; ABDOMINAL SACRAL COLPOPEXY; PELVIC ORGAN

PROLAPSE; SACROSPINOUS LIGAMENT FIXATION; QUALITY-OF-LIFE;

TERM-FOLLOW-UP; LAPAROSCOPIC SACROCOLPOPEXY; SUPPORT DEFECTS; MESH

REPAIR; ROBOTIC SACROCOLPOPEXY

AB The aim was to review the safety and efficacy of pelvic organ prolapse surgery for vaginal apical prolapse.

Every 4 years and as part of the Fifth International Collaboration on Incontinence we reviewed the English-language scientific literature after searching PubMed, Medline, Cochrane library and Cochrane database of systematic reviews, published up to January 2012. Publications were classified as level 1 evidence (randomised controlled trials (RCT) or systematic reviews), level 2 (poor quality RCT, prospective cohort studies), level 3 (case series or retrospective studies) and level 4 case reports. The highest level of evidence was utilised by the committee to make evidence-based recommendations based upon the Oxford grading system. Grade A recommendation usually depends on consistent level 1 evidence. Grade B recommendation usually depends on consistent level 2 and or 3 studies, or "majority evidence" from RCTs. Grade C recommendation usually depends on level 4 studies or "majority evidenceaEuroY from level 2/3 studies or Delphi processed expert opinion. Grade D "no recommendation possible" would be used where the evidence is inadequate or conflicting and when expert opinion is delivered without a formal analytical process, such as by Delphi.

Abdominal sacral colpopexy (ASC) has a higher success rate than sacrospinous colpopexy with less SUI and postoperative dyspareunia for vault prolapse. ASC had greater morbidity including operating time, inpatient stay, slower return to activities of daily living and higher cost (grade A). ASC has the lowest inpatient costs compared with laparoscopic sacral colpopexy (LSC) and robotic sacral colpopexy (RSC). LSC has lower inpatient costs than RSC (grade B).In single RCTs the RSC had longer operating time than both ASC and LSC (grade B). In small trials objective outcomes appear similar although postoperative pain was greater in RSC. LSC is as effective as ASC with reduced blood loss and admission time (grade C). The data relating to operating time are conflicting. ASC performed with polypropylene mesh has superior outcomes to fascia lata (level I), porcine dermis and small intestine submucosa (level 3; grade B). In a single RCT, LSC had a superior objective and subjective success rate and lower reoperation rate compared with polypropylene transvaginal mesh for vault prolapse (grade B).Level 3 evidence suggests that vaginal uterosacral ligament suspension, McCall culdoplasty, iliococcygeus fixation and colpocleisis are relatively safe and effective interventions (grade C).

Sacral colpopexy is an effective procedure for vault prolapse and further data are required on the route of performance and efficacy of this surgery for uterine prolapse. Polypropylene mesh is the preferred graft at ASC. Vaginal procedures for vault prolapse are well described and are suitable alternatives for those not suitable for sacral colpopexy.

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PT J

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Koutrouvelis, A

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Kilic, GS

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Walsh, Teresa M.

Tarnal, Vijay

Koutrouvelis, Aristides

Vizzeri, Gianmarco

Jennings, Kristofer

Jerig, Sean

Kilic, Gokhan S.

TI Intraocular Pressure and Steep Trendelenburg During Minimally Invasive

Gynecologic Surgery: Is There a Risk?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Intraocular pressure; Robotic surgery; Trendelenburg

ID BODY POSITION

AB Study Objective: Steep Trendelenburg position is frequently used during gynecologic minimally invasive surgery (MIS). However, little attention has been given to the potential impact of this nonphysiologic positioning on patients, specifically intraocular pressure (TOP). The purpose of our study was to evaluate TOP changes during laparoscopic or robotic hysterectomy conducted in the steep Trendelenburg position.

Design: Prospective cohort study (Canadian Task Force classification II-2).

Setting: John Sealy Hospital at the University of Texas Medical Branch, Galveston, TX.

Patients: Female patients with no history of ocular pathology who underwent elective robotic or laparoscopic hysterectomy.

Interventions: The anesthesia protocol was standardized for all study patients. TOP and mean arterial pressure (MAP) were obtained before anesthesia, after general anesthesia and intubation were achieved, after 1 hour of steep Trendelenburg positioning, after 2 hours of steep Trendelenburg positioning, and after the patient was returned to the supine position. Ocular perfusion pressure (OPP) was calculated using the following equation: OPP = MAP TOP.

Main Results: A total of 10 patients were included in this prospective study. A significant increase in TOP from baseline was observed after 1 hour and 2 hours of steep Trendelenburg positioning (p = .005 and .002, respectively). There was a statistically significant trend of increasing the TOP from baseline to the second hour of steep Trendelenburg positioning (p < .001). The TOP remained significantly elevated once the patient was returned to the supine position when compared with the baseline TOP (p = .006). OPP significantly decreased from baseline after 2 hours of steep Trendelenburg positioning (p = .03).

Conclusions: TOP increases significantly when patients are placed in the steep Trendelenburg position. Although further studies are needed to better characterize this process, given the aging population of our MIS patients in whom risk for glaucoma is significant, preoperative ocular health assessment should be considered in certain cases. (C) 2013 AAGL. All rights reserved.

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AU Borahay, MA

Haver, MC

Eastham, B

Patel, PR

Kilic, GS

AF Borahay, Mostafa A.

Haver, Mary C.

Eastham, Benjamin

Patel, Pooja R.

Kilic, Gokhan S.

TI Modular Comparison of Laparoscopic and Robotic Simulation Platforms in

Residency Training: A Randomized Trial

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopic; Residency; Robotic; Simulation; Training

ID OPERATING-ROOM PERFORMANCE; VALIDATION; CURRICULUM

AB Study Objective: To compare minimally invasive surgery (MIS) skills acquired using laparoscopic and robotic simulation training platforms.

Design: Randomized trial (Canadian Task Force classification I).

Setting: University residency training program.

Subjects: PGY1 and PGY2 resident physicians in Obstetrics and Gynecology.

Interventions: All residents completed prestudy questionnaires (demographic data and previous experience in MIS) followed by simulation pretesting to assess baseline laparoscopic and robotic skills. Residents were then randomized to laparoscopic or robotic training cohorts in which they completed proctored training of 4 basic laparoscopic or 4 matching robotic modules (1 hour per module, 4 hours total). Thereafter, residents repeated the timed assessment of all skills. Finally, they completed poststudy questionnaires about the training experience. The primary outcome measure was the percentage of improvement in skill completion time. Secondary outcome measures were answers to poststudy questionnaires.

Measurements and Main Results: Sixteen residents completed the study. The laparoscopic and robotic training groups did not differ substantially on demographic measures, previous experience in MIS, or baseline laparoscopic and robotic completion times. Median improvement for individual laparoscopic modules was, respectively, 37.76%, 46.43%, 53.29%, and 66.48% in the laparoscopic cohort vs 21.84%, 21.80%, 38.15%, and 32.98% in the robotic cohort. Median improvement for individual robotic modules was, respectively, 35.42%, 26.08%, 22.33%, and 47.48% in the laparoscopic cohort vs 52.70%, 62.02%, 67.64%, and 71.62% in the robotic cohort. Median improvement in combined laparoscopic, robotic, and overall skills was, respectively, 50.56%, 34.83%, and 45.52% in the laparoscopic group vs 36.18%, 64.12%, and 49.86% in the robotic group. Residents predicted greater comfort performing surgical procedures using the platform in which they trained; however, the robotic training cohort liked their training more.

Conclusions: Laparoscopic and robotic simulation platforms each demonstrated improved performance in the same and other platform. The robotic platform seems to have an edge over the laparoscopic platform. Larger studies are required in addition to studies to compare the effectiveness of both platforms in more advanced skills and to compare their effect on proficiency in the operating room. (C) 2013 AAGL. All rights reserved.

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ER

PT J

AU Cheon, C

Maher, C

AF Cheon, Cecilia

Maher, Christopher

TI Economics of pelvic organ prolapse surgery

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Prolapse surgery; Cost; Transvaginal mesh

ID FLOOR DISORDERS; COST; PREVALENCE

AB The aim was to review the economic costs associated with pelvic organ prolapse surgery.

Every 4 years and as part of the Fifth International Collaboration on Incontinence we reviewed the English-language scientific literature after searching PubMed, Medline, Cochrane library and Cochrane database of systematic reviews, published up to January 2012. Publications were classified as level 1 evidence (randomised controlled trials [RCT] or systematic reviews), level 2 (poor quality RCT, prospective cohort studies), level 3 (case series or retrospective studies) and level 4 (case reports). The highest level of evidence was utilised by the committee to make evidence based recommendations based upon the Oxford grading system. Grade A recommendation usually depends on consistent level 1 evidence. Grade B recommendation usually depends on consistent level 2 and/or 3 studies, or "majority evidence" from RCTs. Grade C recommendation usually depends on level 4 studies or "majority evidence" from level 2/3 studies or Delphi processed expert opinion. Grade D "no recommendation possible" would be used where the evidence is inadequate or conflicting and when expert opinion is delivered without a formal analytical process, such as by Delphi.

The annual economic costs of pelvic organ prolapse surgeries are significant and over the next decades will grow at twice the rate of population growth because of our aging population. In a single institution study vaginal reconstructive surgery and pessary use were more cost-effective than expectant management, traditional abdominal sacral colpopexy (ASC) or robot-assisted sacral colpopexy (RSC; grade C). Two studies have demonstrated that ASC incurs lower inpatient costs than LSC or RSC (grade C). Data from a single RCT demonstrated the LSC to incur lower inpatient costs than RSC specifically relating to shorter operating times in the LSC group (grade B). Data from a single RCT demonstrated LSC to be a more effective cost-minimising surgery than total vaginal mesh for vaginal vault prolapse (grade B). Data from a meta-analysis of anterior vaginal compartment prolapse operations demonstrated that commercial mesh kits for anterior repair are less cost-effective than non-kit mesh and anterior colporrhaphy (grade B).

There is a paucity of good economic data relating to pelvic organ prolapse surgery. Transvaginal mesh surgeries have not been proven to be cost-effective. It is recommended that all randomised controlled trials relating to prolapse surgery include a formal cost analysis.

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FU International Consultation on Urological Diseases; European Association

of Urology

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Prolapse Surgery, part of the 5th International Consultation on

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support of the European Association of Urology.

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Z9 52

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U2 6

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PT J

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TI Incidence of trocar site herniation following robotic gynecologic

surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Trocar site hernia; Robotic surgery; Gynecologic surgery; Port site

hernia

ID INCISIONAL HERNIAS; BOWEL HERNIATION; PORT-SITE

AB Objective. Trocar site herniation is a recognized complication of minimally invasive surgery, but published data on trocar site herniation after robotic surgery are scarce. We sought to determine the incidence of trocar site herniation in women undergoing robotic surgery for gynecologic disease.

Methods. A retrospective review of robotic surgeries performed from January 1, 2006, through December 31, 2012, was conducted. Postoperative trocar site herniations were identified, along with time to presentation, location of herniation, and management. Patients were excluded if surgery was converted to laparotomy or traditional laparoscopy. The Wilcoxon rank-sum test was used to compare patients with and without herniation with respect to continuous variables, and Fisher's exact test was used to compare these 2 groups with respect to categorical variables.

Results. The study included 500 patients, 3 of whom experienced herniation at a single trocar site. The patients with and without herniation did not differ with respect to age, body mass index, smoking status, medical comorbidities, operating time, or estimated blood loss. All 3 herniations occurred at 12-mm trocar sites. Two herniations occurred at assistant port sites, and 1 occurred at the umbilical camera port site. The median time to herniation was 21 days (range, 8-38 days). One patient required immediate surgical intervention; the other 2 patients had conservative management

Conclusions. Trocar site herniation is a rare complication following robotic surgery. The most important risk factor for trocar site herniation appears to be larger trocar size, as all herniations occurred at 12-mm port sites. (C) 2013 Elsevier Inc. All rights reserved.

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Geller, EJ

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AF Crane, Andrea K.

Geller, Elizabeth J.

Matthews, Catherine A.

TI Trainee performance at robotic console and benchmark operative times

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Trainee; Hysterectomy; Sacrocolpopexy; Console surgeons

ID SACROCOLPOPEXY; RESIDENTS; OUTCOMES

AB It is an ongoing challenge to maintain surgical efficiency while integrating trainee participation. We hypothesize that a program of graduated surgical responsibility for trainees does not hinder operative efficiency.

This was a retrospective cohort study of trainee performance times, collected prospectively in real time, for robotic cases performed at one university hospital between September 2008 and August 2011. The primary aim was to compare overall operative times between cases performed by trainees versus attendings. Secondary aims were to compare operative times for major portions of each operation by level of training and to establish benchmark operative times for trainees.

During the study period, 98 cases had recorded trainee performance times. Total robot docked time was longer for trainees than for attendings (155 vs 132 min, p = 0.011), but mean performance times for hysterectomy (70 vs 59 min, p = 0.096) and sacrocolpopexy (76 vs 79 min, p = 0.545) were similar. Within the trainees, there was no correlation between surgical time and rank for each step of the procedures. Utilizing mean performance times for all trainees, benchmark operative times were established for each step of hysterectomy in minutes: right side (21), left side (21), bladder flap (10), colpotomy (15), and cuff closure (19); similarly, for sacrocolpopexy: sacral and peritoneal dissection (12), anterior cuff dissection (10), posterior cuff dissection (8), anterior mesh attachment (15), posterior mesh attachment (18), sacral mesh attachment (12), and peritoneal closure (9).

In a program of graduated surgical responsibility, robotic operative efficiency was comparable when trainees were involved as console surgeons.

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ER

PT J

AU Iavazzo, C

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Gkegkes, Ioannis D.

TI The role of uterine manipulators in endometrial cancer recurrence after

laparoscopic or robotic procedures

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Review

DE Uterine manipulator; Endometrial cancer; Recurrence; Robotics;

Laparoscopic surgery

ID VAGINAL CUFF RECURRENCE; POSITIVE PERITONEAL CYTOLOGY;

PROGNOSTIC-FACTORS; HYSTERECTOMY; SURGERY; COMPLICATIONS; HYSTEROSCOPY;

OUTCOMES

AB The evolution of minimally invasive surgery has been established and both laparoscopic- and robotic-assisted techniques can be presented as valuable alternatives to traditional approaches for the treatment of gynecological cancers, such as endometrial cancer. During laparoendoscopic procedures, the upward traction to the uterus is considered fundamental. The application of uterine manipulators in hysterectomy can facilitate diverse tasks to lead to a safe and successful surgical outcome. Some authors have raised their concern that the use of uterine manipulators might increase the incidence of tumor cell dissemination among patients with endometrial cancers.

We performed a literature search with terms related to the role of uterine manipulators in endometrial cancer recurrence in PubMed and Scopus.

Six articles were identified dealing with this issue. Even though, the available clinical evidence suggests that the application of uterine manipulators has no clear correlation with the recurrence of the endometrial carcinoma, the existing trials are of low methodological quality.

Further investigation is necessary for the clarification of the influence of the different types of uterine manipulators in cancer recurrence.

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NR 27

TC 17

Z9 18

U1 0

U2 6

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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PG 7

WC Obstetrics & Gynecology

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ER

PT J

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Pashos, CL

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AF Khan, Aqsa

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TI Comparative outcomes of open versus laparoscopic sacrocolpopexy among

medicare beneficiaries

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Claims data; Pelvic prolapse; Sacrocolpopexy; Laparoscopy

ID VAGINAL VAULT PROLAPSE; ABDOMINAL SACROCOLPOPEXY; SURGERY

AB Since the first reported laparoscopic sacrocolpopexy in 1991, a limited number of single-center studies have attempted to assess the procedure's effectiveness and safety. Therefore, we analyzed a national Medicare database to compare real-world short-term outcomes of open and laparoscopically assisted (including robotic) sacrocolpopexy in a United States sample of patients.

Public Use File data for a 5 % random national sample of all Medicare beneficiaries aged 65 and older were obtained from the Centers for Medicare and Medicaid Services for the years 2004-2008. Women with pelvic organ prolapse were identified using ICD-9 diagnosis codes. CPT-4 procedure codes were used to identify women who underwent open (code 57280) or laparoscopic (code 57425) sacrocolpopexy. Individual subjects were followed for 1 year post-operatively. Outcomes measured, using ICD-9 and CPT-4 codes, included medical and surgical complications and re-operation rates.

Seven hundred and ninety-four women underwent open and 176 underwent laparoscopic (including robotic) sacrocolpopexy. Laparoscopic sacrocolpopexy was associated with a significantly increased rate of re-operation for anterior vaginal wall prolapse (3.4 % vs 1.0 %, p = 0.018). However, more medical (primarily cardiopulmonary) complications occurred post-operatively in the open group (31.5 % vs 22.7 %, p = 0.023). When sacrocolpopexy was performed with concomitant hysterectomy, mesh-related complications were significantly higher in the laparoscopic group (5.4 % vs 0 %, p = 0.026).

Laparoscopic sacrocolpopexy resulted in an increased rate of reoperation for prolapse in the anterior compartment. When hysterectomy was performed at the time of sacrocolpopexy, the laparoscopic approach was associated with an increased risk of mesh-related complications.

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TI Role of Minimally Invasive Surgery in Ovarian Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Cytoreduction; Laparoscopy; Ovarian cancer; Robotic-assisted

laparoscopy; Staging

ID CYTOREDUCTIVE SURGERY; GYNECOLOGIC-ONCOLOGY; RECURRENT OVARIAN;

FALLOPIAN-TUBE; LAPAROSCOPY; CARCINOMA; MULTICENTER; DEBULKING;

LAPAROTOMY; SURVIVAL

AB The standard treatment of ovarian cancer includes upfront surgery with intent to accurately diagnose and stage the disease and to perform maximal cytoreduction, followed by chemotherapy in most cases. Surgical staging of ovarian cancer traditionally has included exploratory laparotomy with peritoneal washings, hysterectomy, salpingo-oophorectomy, omentectomy, multiple peritoneal biopsies, and possible pelvic and para-aortic lymphadenectomy. In the early 1990s, pioneers in laparoscopic surgery used minimally invasive techniques to treat gynecologic cancers, including laparoscopic staging of early ovarian cancer and primary and secondary cytoreduction in advanced and recurrent disease in selected cases. Since then, the role of minimally invasive surgery in gynecologic oncology has been continually expanding, and today advanced laparoscopic and robotic-assisted laparoscopic techniques are used to evaluate and treat cervical and endometrial cancer. However, the important question about the place of the minimally invasive approach in surgical treatment of ovarian cancer remains to be evaluated and answered. Overall, the potential role of minimally invasive surgery in treatment of ovarian cancer is as follows: i) laparoscopic evaluation, diagnosis, and staging of apparent early ovarian cancer; ii) laparoscopic assessment of feasibility of upfront surgical cytoreduction to no visible disease; iii) laparoscopic debulking of advanced ovarian cancer; iv) laparoscopic reassessment in patients with complete remission after primary treatment; and v) laparoscopic assessment and cytoreduction of recurrent disease. The accurate diagnosis of suspect adnexal masses, the safety and feasibility of this surgical approach in early ovarian cancer, the promise of laparoscopy as the most accurate tool for triaging patients with advanced disease for surgery vs upfront chemotherapy or neoadjuvant chemotherapy, and its potential in treatment of advanced cancer have been documented and therefore should be incorporated in the surgical methods of every gynecologic oncology unit and in the training programs in gynecologic oncology. (C) 2013 AAGL. All rights reserved.

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U2 12

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WC Obstetrics & Gynecology

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ER

PT J

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Rodolakis, Alexandros

Christakis, Dimitrios

Thomakos, Nikolaos

Vlachos, Georgios

Antsaklis, Aristides

TI Laparoscopically Assisted Vaginal Radical Hysterectomy: Systematic

Review of the Literature

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Coelio-Schauta; LAVRH; Radical hysterectomy; Vaginal; Wertheim

ID STAGE CERVICAL-CANCER; ABDOMINAL HYSTERECTOMY; COELIO-SCHAUTA;

LEARNING-CURVE; LYMPHADENECTOMY; EXPERIENCE

AB Laparoscopically assisted vaginal radical vaginal hysterectomy (LAVRH), a minimally invasive technique that seems to be an attractive alternative to traditional surgery, remains unexplored in the treatment of cervical cancer. We searched Medline (1966-2013) and Scopus (2004-2013) search engines, as well as reference lists from all included studies. Ten studies were retrieved; including 6 retrospective cohort studies, 2 prospective cohort studies, 1 retrospective randomized trial, and a phase II randomized control trial. LAVRH provided equal recurrence-free rates when performed in patients with tumors not exceeding 2 cm in greatest diameter. Its main advantages seem to be less intraoperative blood loss and more radical pelvic lymphadenectomy. The primary disadvantages, of the technique are a higher rate of disease-positive surgical margins, resulting in the need for adjuvant therapy, and the slow learning curve required for a surgeon to gain expertise. With use in minimally invasive surgery of newer techniques such as total laparoscopic radical hysterectomy and robotic-assisted radical hysterectomy, and possible future adoption of more conservative techniques such as cervical conization with pelvic lymphadenectomy, the question remains as to whether LAVRH will be adopted by the surgical community or lost to oblivion. (C) 2013 AAGL. All rights reserved.

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ER

PT J

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TI Venous Thromboembolic Events in Minimally Invasive Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Laparoscopy; Robotics; Thromboprophylaxis

ID MAJOR ABDOMINAL-SURGERY; PULMONARY-EMBOLISM; PROSPECTIVE COHORT;

PROPHYLAXIS; CANCER; ONCOLOGY; THROMBOSIS; DURATION; RISK; COMPLICATIONS

AB The rate of venous thromboembolic events (VTEs) including deep venous thrombosis and pulmonary embolism among women undergoing gynecologic surgery is high, particularly for women with a gynecologic malignancy. Current guidelines recommend VTE thrombopropylaxis in the immediate postoperative period for patients undergoing open surgery. However, the VTE prophylaxis recommendations for women undergoing minimally invasive gynecologic surgery are not as well established. The risk of VTEs in patients undergoing minimally invasive surgery appears to be low based on retrospective analyses. To date, there are no established guidelines that specifically provide a standard of care for patients undergoing minimally invasive gynecologic surgery for benign or malignant disease. (C) 2013 AAGL. All rights reserved.

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U2 4

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WC Obstetrics & Gynecology

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PT J

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TI Detection of Sentinel Nodes for Endometrial Cancer With Robotic Assisted

Fluorescence Imaging: Cervical Versus Hysteroscopic Injection

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Sentinel lymph nodes; Endometrial cancer; Robotic surgery

ID LYMPH-NODE; INDOCYANINE GREEN; BIOPSY; IDENTIFICATION; METAANALYSIS

AB Objective: Sentinel lymph node (SLN) mapping with indocyanine green (ICG) detected by robotic near infrared (NIR) imaging is a feasible technique. The optimal site of injection (cervical or endometrial) for endometrial cancer has yet to be determined. We prospectively evaluated SLN mapping after cervical and endometrial injections of ICG to compare the detection rates and patterns of nodal distribution.

Methods: Twenty-nine subjects with endometrial cancer undergoing robotic hysterectomy with lymphadenectomy by a single surgeon received SLN mapping with robotic fluorescence imaging. Seventeen patients received cervical injections of 1 mg of ICG and 12 patients received hysteroscopic endometrial injections of 0.5-mg ICG. Detection rates between the 2 groups were compared using Fisher exact tests. Continuous variables such as operating room times and body mass index were compared using t tests.

Results: The SLN detection rate was 82% (14/17) for cervical and 33% (4/12) for hysteroscopic injection (P = 0.027). Sentinel lymph nodes were seen bilaterally in 57% (8/14) of the cervical injection group and 50% (2/4) of the hysteroscopic group. Para-aortic SLNs were seen in 71% (10/14) of patients who mapped after cervical injection and 75% (3/4) patients who mapped after hysteroscopic injection. There was 1 false-negative SLN in the cervical injection group.

Conclusions: Cervical ICG injection achieves a higher SLN detection rate and a similar anatomic nodal distribution as hysteroscopic endometrial injection for SLN mapping in patients with endometrial cancer.

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JI Int. J. Gynecol. Cancer

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ER

PT J

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TI Development and Validation of a Ureteral Anastomosis Simulation Model

for Surgical Training

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE ureteral reimplantation; ureteral anastomosis; robotics; simulation

model; education

ID REIMPLANTATION; EDUCATION

AB Objective: To develop and validate a new ureteral anastomosis simulation model.

Methods: We designed a training model to simulate the task of ureteral anastomosis required for ureteroneocystostomy that is suitable for robotic and laparoscopic approaches. Face validity was measured using questions related to surgical authenticity and educational value of the model. Construct validity was measured by comparing scores using Global Operative Assessment of Laparoscopic Skills Scale (GOALS) scale between "procedure experts,'' "robotic experts,'' and "trainees'' groups. One-way analysis of variance was used to compare differences in the scores and operating times between the 3 groups. Associations between previous surgical experience and performance scores were measured using the Spearman rho correlation coefficient.

Results: Four urologists experienced with robotically assisted ureteroneocystostomies were included in the procedure experts group. The robotic experts group consisted of 5 gynecologists experienced in robotic surgery. The trainees group consisted of 12 urology and gynecology upper-level residents and fellows. All experts agreed or strongly agreed that the model was authentic to the live procedure and a useful training tool. Mean (SD) total GOALS scores were significantly better for the procedure experts group compared to the robotic experts group and to the trainees group (P= 0.02 vs P= 0.004, respectively). The robotic experts group's GOALS scores were also significantly higher than that of the trainees group (P=0.05). There were no differences in mean times required to complete the procedure. Surgical experience moderately correlated with scores on all 3 assessment scales.

Conclusions: Superior performance on the model by more experienced surgeons demonstrates evidence of construct validity. This authentic and useful model allows surgeons to learn and practice the ureteral anastomosis portion of the ureteral reimplantation surgeries before operating on a live patient.

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TC 18

Z9 19

U1 0

U2 3

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

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TI Incidence of port site hernias and/or dehiscence in robotic-assisted

procedures in gynecologic oncology patients

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Hernia; Dehiscence; Robotic; Laparoscopic; Fascia

ID LAPAROSCOPIC CHOLECYSTECTOMY; FASCIAL CLOSURE; SURGERY; TROCARS

AB Objectives. The incidence of port site hernia and/or dehiscence using bladeless trocars is 0-1.2%. Robotic surgery uses additional port sites and increases manipulation of instruments, raising the concern for more complications. We sought to characterize the incidence of port site complications following robotic surgery when fascia was not routinely closed.

Methods. Robotically-assisted (RA) procedures performed for suspected gynecologic malignancy between 1/2006 and 12/2011 were retrospectively reviewed. Bladeless 12 mm and 8 mm robotic trocars were used. Fascial closure was not routinely performed except after specimen removal through the port site. The decision to close the fascia remained at the discretion of the surgeon.

Results. Data from 842 procedures were included. Mean patient age was 55.6 years. Mean Body Mass Index was 33.6 kg/m(2). RA-total laparoscopic hysterectomy (TLH) +/- unilateral or bilateral salpingo-oophorectomy (BSO) +/- lymphadenectomy (LND) accounted for 91.6% of procedures. Final pathology confirmed malignancy in 58.6% of cases, primarily endometrial cancer. In 35 cases, the specimen was removed through the port site; fascia was closed in 54.3% of them and no port site hernias or dehiscences occurred. Only one patient underwent a RA-TLH/BSO/LND for endometrial adenocarcinoma and had a port site dehiscence of the 8 mm trocar site. No port site hernias occurred.

Conclusion. Port site hernias and dehiscences are rare in RA gynecologic oncology procedures. When bladeless dilating trocars are used, routine closure of even up to a 12 mm port site is unnecessary, even in cases requiring removal of the specimen through the trocar sites. (C) 2013 Elsevier Inc. All rights reserved.

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PT J

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TI Surgical treatment of pelvic organ prolapse: a historical review with

emphasis on the anterior compartment

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Review

DE Cystocele; Pelvic organ prolapse; Surgery

ID VAGINAL WALL PROLAPSE; STRESS-INCONTINENCE; CYSTOCELE; SURGERY; REPAIR;

MESH; EFFICACY

AB The objective of this work was to collect and summarize a detailed historical review of the surgical treatment of pelvic organ prolapse (POP) in which we specifically focused on the anterior compartment.

A literature search in English, Dutch, and German was carried out using the keywords pelvic organ prolapse, anterior colporrhaphy, cystocele, and interposition operations in several databases (e.g., PubMed and HathiTrust Digital Library). Other relevant journal and textbook articles were found by retrieving references cited in previous articles and textbooks.

Probably the first explanation of the treatment of POP dates from 1500 B.C. The Egyptians gave a description to "falling of the womb" in the Kahun Papyrus. More than a millennium later, Euryphon, a contemporary of Hippocrates (400 B.C.) described some interesting therapeutic options, from succussion (turning a women upside down for several minutes) to irrigating the displaced uterus with wine. A wide range of techniques has been attempted to repair the prolapsing anterior vaginal wall. By 1866, Sim had already performed a series of operations very similar to a modern anterior repair. The first reviews about the abdominal approach to correcting a cystocele were in 1890. The first description of using mesh to cystoceles was the use of tantalum mesh in 1955. In 1970, the first report of collagen mesh in urogynecology was described. Nowadays, robot-assisted surgery and cell-based tissue engineering are the latest interventions.

Many surgeons have tried to find the ideal surgical therapy for anterior compartment prolapse, but to date, this has not been achieved.

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NR 77

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Z9 27

U1 0

U2 12

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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GA 221HD

UT WOS:000324647700002

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DA 2024-01-18

ER

PT J

AU Rogo-Gupta, L

AF Rogo-Gupta, Lisa

TI Current trends in surgical repair of pelvic organ prolapse

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE incontinence; mesh; pelvic organ prolapse; surgery

ID TRANSVAGINAL MESH PROCEDURES; VAGINAL PROLAPSE; SEXUAL FUNCTION; ROBOTIC

SACROCOLPOPEXY; INCONTINENCE; COMPLICATIONS; OUTCOMES; SUPPORT; SURGERY

AB Purpose of reviewOver the past decade, surgical prolapse correction has evolved significantly, taking a sharp turn in 2011 when the USFDA publicly questioned synthetic graft safety. This controversy has been widely publicized and debated amongst laymen and experts alike. This review summarizes current trends in mesh implantation for prolapse repair, highlighting the impact of the current controversy.Recent findingsRecent studies revealed nonmesh prolapse repair may have better outcomes than previously reported; the USFDA states there is insufficient evidence to support vaginal mesh for apical or posterior compartment prolapse; mesh prolapse repair increased over the past decade, 75% of which was placed vaginally; approximately 30% of mesh prolapse repair is performed with hysterectomy and approximately 40% is performed with concomitant incontinence repair. Anterior and apical prolapse are most likely to include mesh and of apical repair procedures, minimally invasive approaches exceed laparotomy.SummaryThis year's population-based studies describe the impact of surgeon experience, prolapse compartment, and national trends in surgical technique on mesh prolapse repair. The impact of the recent investigation on future mesh use remains unknown.

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NR 39

TC 9

Z9 9

U1 0

U2 2

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JI Curr. Opin. Obstet. Gynecol.

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GA 247AX

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ER

PT J

AU Turunen, H

Pakarinen, P

Sj枚berg, J

Loukovaara, M

AF Turunen, H.

Pakarinen, P.

Sjoberg, J.

Loukovaara, M.

TI Laparoscopic vs robotic-assisted surgery for endometrial carcinoma in a

centre with long laparoscopic experience

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Cost analysis; endometrial carcinoma; laparoscopic surgery;

robotic-assisted surgery; surgical techniques

ID PELVIC LYMPHADENECTOMY; CANCER; HYSTERECTOMY; OUTCOMES; COST;

LAPAROTOMY; OBESE

AB Surgical outcomes and costs of laparoscopic and robotic hysterectomy for the treatment of endometrial carcinoma were compared in a centre with lengthy experience with laparoscopic surgery. The robotic cohort (n = 67) had a longer operative time than the laparoscopic cohort (n = 150) (p < 0.0001). Lymph node yields were similar for both surgical modalities, but the median of estimated blood loss was lower in the robotic group (50 ml vs 100 ml; p < 0.0001). The proportion of patients with hospital stay >2 days and rate of overall complications were similar in both groups. Operative costs were (Euros) (sic)1,680 and (sic)3,860 for the laparoscopic and robotic procedure, respectively. We conclude that robotic technology is feasible but does not provide short-term benefits for the treatment of endometrial carcinoma in a centre where laparoscopy has been established as the standardised minimally invasive surgical method.

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TC 16

Z9 17

U1 0

U2 8

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J9 J OBSTET GYNAECOL

JI J. Obstet. Gynaecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 236SE

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ER

PT J

AU Yim, GW

Kim, SW

Nam, EJ

Kim, S

Kim, YT

AF Yim, Ga Won

Kim, Sang Wun

Nam, Eun Ji

Kim, Sunghoon

Kim, Young Tae

TI Learning curve analysis of robot-assisted radical hysterectomy for

cervical cancer: initial experience at a single institution

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical neoplasms; Laparoscopic surgery; Learning curve; Robotics

ID CUMULATIVE SUMMATION TEST; SURGERY; OUTCOMES; LYMPHADENECTOMY;

ULTRASOUND; LESSONS

AB Objective: The aim of this study was to evaluate the learning curve and perioperative outcomes of robot-assisted laparoscopic procedure for cervical cancer.

Methods: A series of 65 cases of robot-assisted laparoscopic radical hysterectomies with bilateral pelvic lymph node dissection for early stage cervical cancer were included. Demographic data and various perioperative parameters including docking time, console time, and total operative time were reviewed from the prospectively collected database. Console time was set as a surrogate marker for surgical competency, in addition to surgical outcomes. The learning curve was evaluated using cumulative summation method.

Results: The mean operative time was 190 minutes (range, 117 to 350 minutes). Two unique phases of the learning curve were derived using cumulative summation analysis; phase 1 (the initial learning curve of 28 cases), and phase 2 (the improvement phase of subsequent cases in which more challenging cases were managed). Docking and console times were significantly decreased after the first 28 cases compared with the latter cases (5 minutes vs. 4 minutes for docking time, 160 minutes vs. 134 minutes for console time; p<0.001 and p<0.001, respectively). There was a significant reduction in blood loss during operation (225 mL vs. 100 mL, p<0.001) and early postoperative complication rates (28% vs. 8.1%, p=0.003) in phase 2. No conversion to laparotomy occurred.

Conclusion: Improvement of surgical performance in robot-assisted surgery for cervical cancer can be achieved after 28 cases. The two phases identified by cumulative summation analysis showed significant reduction in operative time, blood loss, and complication rates in the latter phase of learning curve.

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FU Korea Healthcare Technology R&D Project, Ministry for Health, Welfare &

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Z9 50

U1 0

U2 10

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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Gehrig, PA

AF Craven, Renatta

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Mosaly, Prithima

Gehrig, Paola A.

TI Ergonomic Deficits in Robotic Gynecologic Oncology Surgery: A Need for

Intervention

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Ergonomics; Occupational strain; Rapid upper limb assessment; Robotic

surgery; Strain Index

ID STRAIN INDEX; SURGICAL SYSTEM; DISORDERS; WORK; RISK

AB Study Objective: To evaluate surgeon strain using validated ergonomic assessment tools.

Design: Observational study (Canadian Task Force classification III).

Setting: Academic medical center.

Participants: Robotic surgeons performing gynecologic oncology surgical procedures.

Interventions: Videotape footage of surgeons performing robotic gynecologic oncology procedures was obtained. A human factors engineer experienced with health care ergonomics analyzed the video recordings and performed ergonomic evaluations of the surgeons.

Measurements and Main Results: An initial evaluation was conducted using the Rapid Upper Limb Assessment (RULA) survey, an ergonomic assessment and prioritization method for determining posture, force, and frequency concerns with focus on the upper limbs. A more detailed analysis followed using the Strain Index (SI) method, which uses multiplicative interactions to identify jobs that are potentially hazardous. Seventeen hours of video recordings were analyzed, and descriptive data based on RULA/SI analysis were collected. Ergonomic evaluation of surgeon activity resulted in a mean RULA score of 6.46 (maximum possible RULA score, 7), indicating a need for further investigation. The mean SI grand score was 24.34. SI scores >10 suggest a potential for hazard to the operator. Thus, the current use of the surgical robot is potentially dangerous with regards to ergonomic positioning and should be modified.

Conclusion: At a high-volume robotics center, there are ergonomics deficits that are hazardous to gynecologic surgeons and suggest the need for modification and intervention. A training strategy must be developed to address these ergonomic issues and knowledge deficiencies. (C) 2013 AAGL. All rights reserved.

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TC 48

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U1 0

U2 13

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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ER

PT J

AU Huang, HH

Liu, LC

Tan, SJ

Lai, HC

AF Huang, Hsin-Hui

Liu, Li-Chung

Tan, Shyn-Jen

Lai, Hung-Cheng

TI Robot-assisted excision of a symptomatic deep infiltrating cervical

endometrioma

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

ID SURGERY

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TC 1

Z9 1

U1 1

U2 2

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 236ZT

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PM 24075390

OA gold

DA 2024-01-18

ER

PT J

AU Vaccaro, CM

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Jackson, C

Kleeman, SD

Pavelka, J

AF Vaccaro, Christine M.

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Pavelka, James

TI Robotic Virtual Reality Simulation Plus Standard Robotic Orientation

Versus Standard Robotic Orientation Alone: A Randomized Controlled Trial

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic simulation; da Vinci Skills Simulator; Global Rating Scale;

Objective Structured Assessment of Technical Skill

AB Objective: The objective of this study was to compare the effect of virtual reality simulation training plus robotic orientation versus robotic orientation alone on performance of surgical tasks using an inanimate model.

Methods: Surgical resident physicians were enrolled in this assessor-blinded randomized controlled trial. Residents were randomized to receive either (1) robotic virtual reality simulation training plus standard robotic orientation or (2) standard robotic orientation alone. Performance of surgical tasks was assessed at baseline and after the intervention. Nine of 33 modules from the da Vinci Skills Simulator were chosen. Experts in robotic surgery evaluated each resident's videotaped performance of the inanimate model using the Global Rating Scale (GRS) and Objective Structured Assessment of Technical Skills- modified for robotic-assisted surgery (rOSATS).

Results: Nine resident physicians were enrolled in the simulation group and 9 in the control group. As a whole, participants improved their total time, time to incision, and suture time from baseline to repeat testing on the inanimate model (P = 0.001, 0.003, <0.001, respectively). Both groups improved their GRS and rOSATS scores significantly (both P < 0.001); however, the GRS overall pass rate was higher in the simulation group compared with the control group (89% vs 44%, P = 0.066).

Conclusions: Standard robotic orientation and/or robotic virtual reality simulation improve surgical skills on an inanimate model, although this may be a function of the initial "practice'' on the inanimate model and repeat testing of a known task. However, robotic virtual reality simulation training increases GRS pass rates consistent with improved robotic technical skills learned in a virtual reality environment.

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U2 8

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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WC Obstetrics & Gynecology

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ER

PT J

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Degueldre, M

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Vergote, Ignace

Vandromme, Jean

Petit, Philippe

Leunen, Karin

Degueldre, Michel

TI Multi-center experience of robot-assisted laparoscopic para-aortic

lymphadenectomy for staging of locally advanced cervical carcinoma

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Cervical neoplasms; disease-free survival; laparoscopy; lymph node

excision; para-aortic; robotics

ID POSITRON-EMISSION-TOMOGRAPHY; GYNECOLOGIC ONCOLOGY; CANCER;

HYSTERECTOMY; DISSECTION

AB Objectives. FIGO classification is commonly used for staging of locally advanced cervical cancer. Laparoscopic para-aortic lymphadenectomy is currently used as a diagnostic tool, since we know that presence of para-aortic lymph node metastases identifies patients with poor prognosis. The application of robotics during this procedure needs to be investigated. Design. Retrospective multi-center study. Setting. Three centers participated in building one database. Population. Thirty-seven patients with locally advanced cervical cancer underwent a robot-assisted laparoscopic para-aortic lymphadenectomy. Methods. Patients were prospectively enrolled in one register. Retrospective analysis of the whole database was performed. Main outcome measures. Surgical outcomes of the robot-assisted procedure and follow-up data. Results. Median number of lymph nodes collected was 27.5 (1-54) per patient. Five of 37 patients had para-aortic node metastases. The false negative rate for PET-CT diagnosing para-aortic node metastases was 11.4% (4/35). Two major intra-operative complications occurred (5.4%). Postoperative morbidity was low (13.5%). Median follow-up was 27 months [95% confidence interval (95% CI) was 24-30]. Median disease-free survival was 16 months (95% CI 2.4-29.6). Patients with negative nodes had a median disease-free survival of 24 months (not assessable), although patients with positive nodes had a median disease-free survival of 9 months (95% CI 6.9-11.9). Conclusions. In this series we report that robot-assisted laparoscopic para-aortic lymphadencetomy provided the surgeon with useful information, diagnosing 11.4% of occult para-aortic lymph node metastases in women with locally advanced cervical cancer. Intra-operative and postoperative morbidity were low. The presence of para-aortic lymph node metastases correlated with shorter disease-free survival.

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NR 30

TC 21

Z9 22

U1 0

U2 3

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

PD AUG

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 183MP

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ER

PT J

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AF Grabosch, Shannon

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TI Isolated Port-Site Metastasis After Robotic Hysterectomy for Stage IA

Endometrial Adenocarcinoma

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID LAPAROSCOPIC SURGERY

AB BACKGROUND: Port-site metastasis is a known complication of laparoscopic surgery, although it has been described less in robotic surgery. There are limited reports of such occurrences in current literature.

CASES: Two patients underwent robotic-assisted total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, and lymph node dissection for stage IA endometrial cancer. One patient's surgery was complicated by uterine perforation but the other surgery was uncomplicated. Both patients had development of isolated port-site metastasis and required resection followed by chemotherapy and radiation.

CONCLUSION: Port-site metastasis is a surgical complication with an unclear etiology. There are no clear data to suggest a lower incidence with robotic surgery. Patients at low risk for recurrence still may experience development of port-site metastasis.

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TC 11

Z9 11

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U2 1

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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PT J

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King, LP

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Modest, Anna M.

King, Louise P.

TI The role of the robot in treating urinary tract endometriosis

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE endometriosis; robotics; urinary tract

ID MINIMALLY INVASIVE SURGERY; LAPAROSCOPIC TREATMENT; INFILTRATING

ENDOMETRIOSIS; URETERAL ENDOMETRIOSIS; BLADDER ENDOMETRIOMA; PARTIAL

CYSTECTOMY; RESECTION; REPAIR; BOWEL

AB Purpose of reviewTo detail the recent advances in the use of computer-enhanced robotic technology to surgically treat urinary tract endometriosis.Recent findingsFew studies have been published in this field. The studies are severely limited in scope. Further study is warranted.SummaryRobotic-assisted laparoscopic techniques have proven useful in the treatment of extensive endometriosis and may prove useful in the treatment of urinary tract endometriosis.

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NR 35

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Z9 12

U1 0

U2 5

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JI Curr. Opin. Obstet. Gynecol.

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PT J

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AF Salicru, Sabina R.

de la Torre, Javier F. V.

Gil-Moreno, Antonio

TI The surgical management of early-stage cervical cancer

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE early cervical cancer; fertility-sparing surgery; nerve-sparing surgery;

radical hysterectomy; sentinel node

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; FERTILITY-SPARING SURGERY; OBESE

WOMEN; PELVIC LYMPHADENECTOMY; NODE DISSECTION; PARAMETRECTOMY;

PREGNANCY; TRACHELECTOMY; CARCINOMA; OUTCOMES

AB Purpose of reviewThe main objective is to update the literature data in the last year which may support a surgical approach to early cervical cancer [ECC; Stage International Federation of Gynecology and Obstetrics (FIGO) IA-IB1-IIA1]. Radical hysterectomy remains the gold standard by most international guidelines because surgical treatment has hardly changed in recent decades, except for stage IA1.Recent findingsTrends in clinical research in the past 12-18 months involve minimal invasive surgery (with laparoscopic surgery or robotic-assisted surgery), fertility preservation (in the initial stages and in the absence of bad prognostic factors), nerve-sparing and sentinel node techniques. Some institutions have published studies in specific groups such as older, obese or pregnant women.SummaryThere is a growing trend to practice less aggressive surgery in order to preserve fertility in young women and avoid an excess of treatment in some selected patients. Therefore, nerve-sparing techniques can help to improve the quality of life. More studies are needed to demonstrate oncologic results of the sentinel node technique. Laparoscopic and robotic-assisted surgery can substitute open surgical treatment.

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ER

PT J

AU Smorgick, N

Dalton, VK

Patzkowsky, KE

Hoffman, MR

Advincula, AP

As-Sanie, S

AF Smorgick, Noam

Dalton, Vanessa K.

Patzkowsky, Kristin E.

Hoffman, Mark R.

Advincula, Arnold P.

As-Sanie, Sawsan

TI Comparison of 2 minimally invasive routes for hysterectomy of large

uteri

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Hysterectomy; Minilaparotomy; Robot-assisted laparoscopy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; MINILAPAROTOMY

AB Objective: To compare the perioperative outcomes associated with 2 minimally invasive surgical routes for the hysterectomy of large fibroid uteri. Methods: Retrospective review of 84 women undergoing hysterectomy via minilaparotomy (n = 54) or robot-assisted laparoscopy (n = 30) for uteri weighing at least 500 g. Outcome measures included hemorrhage (blood loss of 500 mL or more) and postoperative length of stay. Results: Unadjusted mean blood loss (560.2 +/- 507.4 mL versus 165.0 +/- 257.5 mL, P < 0.001), rate of hemorrhage (40.7% versus 6.7%, P = 0.001, odds ratio 6.1 [95% confidence interval 1.5-24.2]), and rate of blood transfusion (14.8% versus 0%, P = 0.03) were all higher with minilaparotomy than with robot-assisted surgery, while the median postoperative stay was significantly shorter with robotic surgery (2 [range 1-4] days versus 1 [range 0-7] days, P < 0.01). After adjusting for differences in uterine weight using a multivariate linear regression analysis, the mean blood loss and the rate of hemorrhage were no longer significantly different between the 2 groups. Conclusion: The minilaparotomy approach may be used to remove very large uteri and does not require specialized and expensive equipment, or advanced endoscopic training. The robotic approach, when feasible, allows for early postoperative discharge. (c) 2013 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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AU Bharathan, R

Vali, S

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Vali, Saaliha

Setchell, Thomas

Miskry, Tariq

Darzi, Ara

Aggarwal, Rajesh

TI Psychomotor skills and cognitive load training on a virtual reality

laparoscopic simulator for tubal surgery is effective

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Virtual reality; Salpingectomy; Salpingotomy; Learning curve; Cognitive

load

ID OPERATING-ROOM; LEARNING-CURVE; ENVIRONMENT; COMPETENCE; CURRICULUM;

ROBOTICS

AB Objectives: Validation of a virtual reality (VR) simulator for the training and assessment of laparoscopic tubal surgery and mapping of cognitive load.

Study design: Prospective cohort study conducted at the Imperial College Virtual Reality Surgical Skills laboratory amongst 25 trainees and nine senior gynaecologists. Participants performed two sessions of salpingectomy and salpingotomy procedures on a VR simulator to assess construct validity. Nine novices performed ten such sessions to enable assessment of the learning curve. The relationship between cognitive load and the dexterity parameters was assessed. Simulator fidelity was reported by experienced and intermediate level gynaecologists. Statistical analyses utilised non-parametric tests, Kruskall-Wallis and Mann-Whitney U tests. Learning curves were assessed using the Friedman test and Wilcoxon Signed Ranks test. Relationship between dexterity metrics and cognitive load was performed using Spearman's rank order correlation.

Results: Salpingectomy demonstrated construct validity for time taken by experienced, intermediate and novice gynaecologists (median 170 vs. 191 vs. 313 s (P = 0.003) respectively) and movements (median 200 vs. 267 vs. 376 s, P = 0.045). Salpingotomy demonstrated construct validity for time taken (median 183 vs. 191 vs. 306 s, P = <0.001) and movements (median 210 vs. 233 vs. 328 s, P = 0.005). Learning curve analysis for salpingectomy displayed a plateau for time taken after the eighth session, and the fourth session for movements. Salpingotomy displayed a plateau after the eighth session for both time taken and movements. Cognitive load correlated significantly with dexterity parameters. The fidelity scores were not significantly different between the two procedures (P = 0.619).

Conclusion: The LAP Mentor VR laparoscopic simulator is a valid and effective tool for training novice surgeons in ectopic pregnancy surgery. Reduction in cognitive load significantly correlates with the learning curves. (C) 2013 Elsevier Ireland Ltd. All rights reserved.

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ER

PT J

AU Evans, JM

Karram, MM

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Robertshaw, D

AF Evans, Janelle Morgan

Karram, Mickey M.

Mahdy, Ayman

Robertshaw, Daniel

TI Urinary Tract Injury at the Time of Laparoscopic and Robotic Surgery:

Presentation and Management

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE fistula; robotic surgery; laparoscopic surgery

ID PELVIC ORGAN FISTULA; HYSTERECTOMY; RISK

AB Objective: To report a series of urinary tract injuries resultant of laparoscopic or robotic procedures performed for a gynecologic indication.

Methods: We identified 16 patients with urinary tract fistulas after laparoscopic or robotic gynecologic procedures between 2009 and 2012. We extracted demographic data and prior surgical data as well as reviewed our management of each case.

Results: Thirteen subjects had undergone robotic procedures, 2 traditional laparoscopies, and a single-port laparoscopy with time to presentation from 2 days to 9 months postoperatively. Seven patients presented with vesicovaginal fistulas (43%), of which one healed spontaneously. Eight patients had ureterovaginal fistulas. Two patients (25%) were managed with ureteroneocystotomy, 2 patients (25%) were managed with Boari flap, and 4 patients (50%) were managed with double-J stent placement. One patient had a vesicocervical fistula managed via trachelectomy and partial cystectomy.

Conclusion: The authors have seen an increase in referrals for urinary tract fistulas in minimally invasive surgery. It is imperative to investigate the effect of a steep learning curve, unfamiliarity with new energy sources, or poor patient selection as contributing factors.

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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Sindico, S.

Scambia, G.

Vizza, E.

TI Robotic single-site hysterectomy (RSS-H) vs. laparoendoscopic

single-site hysterectomy (LESS-H) in early endometrial cancer: A

double-institution case-control study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparoendoscopic single-site; Single-incision laparoscopic surgery;

Robotic surgery; Minimally invasive surgery; Hysterectomy; Endometrial

cancer

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; SURGERY; LYMPHADENECTOMY; EXPERIENCE

AB Objective. To report our experience with single-site robotic platform for IS3000 "Da Vinci" Si Surgical System to perform robotic single site hysterectomy (RSS-H), and to compare pen-operative results with a historical series of laparoendoscopic single site hysterectomies (LESS-H).

Methods. This is a retrospective case-control study, performed at the Gynecologic Oncologic Unit, National Cancer Institute "Regina Elena", Rome, and at the Gynecologic Oncologic Unit, Catholic University of the Sacred Heart, Rome, Italy between December 2011 and January 2013.

Results. 19 women underwent RSS-H (cases) and 38 patients were submitted to LESS-H (controls) for early endometrial cancer. Pre-surgical procedures (port placement and docking) required a median time of 8 min in the RSS-H group and a median time of 2 min in the LESS-H group (p = 0.0001). The median estimated blood loss was 75 ml in the cases and 30 ml in the controls (p = 0.005). The median operative time, calculated from the beginning of intraperitoneal procedures to the skin closure, was 90 min in the cases and 107 ml in the controls (p = ns). The median time to discharge from the hospital was postoperative day two for both techniques.

Conclusions. The few differences we registered do not seem clinically relevant, thus making the two procedures comparable. (C) 2013 Elsevier Inc. All rights reserved.

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ER

PT J

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Matthews, CA

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Matthews, Catherine A.

TI Impact of robotic operative efficiency on profitability

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 41st Annual Global Congress of Minimally Invasive Gynecology of the

American-Association-of-Gynecologic-Laparoscopists (AAGL)

CY NOV 05-09, 2012

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists

DE cost; efficiency; robotic surgery

ID COST-ANALYSIS; LAPAROSCOPIC SURGERY; OUTCOMES; SACROCOLPOPEXY; HOSPITALS

AB OBJECTIVE: We sought to determine the impact of robotic operative efficiency on profitability and assess the impact of secondary variables.

STUDY DESIGN: Financial data were collected for all robotic cases performed for fiscal years 2010 (FY10) and 2011 (FY11) at University of North Carolina at Chapel Hill, and included 9 surgical subspecialties. Profitability was defined as a positive operating income.

RESULTS: From July 2009 through June 2011, 1295 robotic cases were performed. Robotic surgery was profitable in both fiscal years, with an operating income of $386,735 in FY10 and $822,996 in FY11. In FY10, urogynecology and pediatric surgery were the only nonprofitable subspecialties. In FY11, all subspecialties were profitable. Profitability was associated with case time, payor mix, and procedure type (all P < .05). Urogynecology case time decreased from 220-179 minutes (P = .012) and pediatric surgery from 418-258 minutes (P = .019).

CONCLUSION: Robotic operative efficiency has a large impact on overall profitability regardless of surgical specialty.

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U2 1

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SC Obstetrics & Gynecology

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PT J

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TI Minimally Invasive Diagnosis and Treatment of Endometrial Cancer After

LeFort Colpocleisis

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE endometrial cancer; hysteroscopy; robotic surgery; minimal invasive

surgery; colpocleisis; pelvic organ prolapse

AB Background: Endometrial carcinoma is rare after LeFort colpocleisis. Standards for its diagnosis and treatment have not been established.

Case: A 74-year-old woman presented with postmenopausal bleeding 14 months after LeFort colpocleisis. Here, we describe the use of the colpocleisis channels in our novel 2-stage approach. In the first stage, endometrial carcinoma was diagnosed with vaginohysteroscopy and dilatation and curettage via the channels. In the second stage, the cancer was optimally treated with total robotic hysterectomy, bilateral salpingo-oophorectomy, and lymph node dissection. Assistance and specimen retrieval were achieved through the vaginal channels. The patient recovered without compromise to the pelvic floor.

Conclusions: Endometrial cancer after LeFort colpocleisis can be diagnosed and treated with minimally invasive approaches without disrupting the colpocleisis or the pelvic floor support.

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AU Kumar, S

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Dowdy, SC

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Sarangi, S.

Woelk, J.

Morris, R.

Munkarah, A.

Dowdy, S. C.

Mariani, A.

Cliby, W.

TI Risk of postoperative venous thromboembolism after minimally invasive

surgery for endometrial and cervical cancer is low: A

multi-institutional study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Venous thromboembolism; Minimally invasive surgery; Endometrial cancer;

Cervical cancer

ID GYNECOLOGIC SURGERY; PROPHYLAXIS; LAPAROSCOPY; LAPAROTOMY; OUTCOMES;

HYSTERECTOMY; DURATION; ONCOLOGY; SOCIETY

AB Objective. To determine the 30-day prevalence of venous thromboembolism (VTE) after minimally invasive surgery (MIS) for endometrial (EC) and cervical cancers (CC).

Methods. A retrospective cohort study at two large tertiary care centers between 2006 and 2011. Patients having MIS for EC or CC were included. Cases converted to laparotomy were excluded. The primary outcome measure was clinically diagnosed VTE within 30 days of operation.

Results. Of the 558 patients, 90% had EC and 10% had CC. Modalities of hysterectomy included robotic (88%), vaginal (9%), and laparoscopic (3%). A total of 66% had pelvic and 35% had paraaortic lymphadenectomy. The VTE prophylaxes were sequential compression devices (100%) and heparin (39%). There were no VTE events during hospital stay (95% CI, 0.0%-0.7%). The 30-day prevalence of VTE was (0.5%; 95% CI, 0.1%-1.6%). The hitherto recommended risk criteria for giving extended 30-day thromboprophylaxis by the American College of Obstetrics and Gynecologists (ACOG) or by the American Society of Clinical Oncology (ASCO) did not predict risk of VTE in our population.

Conclusions. The prevalence of VTE in EC and CC undergoing MIS is very low. The existing 30-day risk prediction models proposed by the ACOG and ASCO stem from open surgery patients and do not appear to apply to MIS patients. Certainly, we found no evidence supporting the use of extended prophylactic heparin in this setting. Further research is urgently needed to define the role of any duration of thromboprophylaxis in MIS patients with endometrial or cervix cancer. (C) 2013 ElseVTEr Inc. All rights reserved.

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PT J

AU Lipskind, ST

Gargiulo, AR

AF Lipskind, Shane T.

Gargiulo, Antonio R.

TI Computer-Assisted Laparoscopy in Fertility Preservation and Reproductive

Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Computer-assisted surgery; Fertility preservation; Myomectomy; Ovarian

tissue transplantation; Ovarian transposition; Reproductive surgery;

Robotic surgery; Robotics; Tubal reanastomosis

ID MICROSURGICAL TUBAL REANASTOMOSIS; OVARIAN TISSUE; ABDOMINAL MYOMECTOMY;

ADHESION FORMATION; SURGICAL OUTCOMES; UTERINE RUPTURE; TRANSPLANTATION;

ANASTOMOSIS; CRYOPRESERVATION; PREGNANCY

AB Current strategies for fertility preservation rely heavily on assisted reproductive technology and fertility-sparing surgery. Whether seeking to avert loss of fertility associated with excision of adnexal or uterine disease or to preempt gonadal failure resulting from chemotherapy or radiation, each woman is unique in her reproductive endeavor and will benefit from careful consideration of her fertility goals together with a specialist in assisted reproductive technology and reproductive surgery. Because avoidance of laparotomy reduces tissue trauma and adhesion formation, advanced laparoscopic surgery is an indispensable tool for all specialists who provide care for women seeking fertility preservation. Computer-assisted laparoscopy, commonly known as robotic surgery, addresses the practical limitations of conventional laparoscopic surgery and holds the promise of making complex fertility-sparing procedures safe and reproducible in the hands of reproductive specialists. Herein we illustrate the transforming capabilities of robotics in reproductive surgery and highlight the current and future potential of this technology in fertility preservation. (C) 2013 AAGL. All rights reserved.

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U1 0

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PG 11

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PM 23562471

DA 2024-01-18

ER

PT J

AU Mukati, M

Shobeiri, SA

AF Mukati, Marium

Shobeiri, S. Abbas

TI A Case of Silicone Mesh Extrusion Into the Bladder Associated With

Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic sacrocolpopexy; mesh erosion

ID COMPLICATION

AB Background: Over the past several years, the daVinci robot has been used in gynecologic surgery as a new surgical approach. The literature is being slowly populated with pros and cons of this technology.

Case: We report a 60-year-old woman with a history of pelvic organ prolapse who had a robotic sacrocolpopexy. She presented with mesh extrusion into her vagina, which was removed by exploratory laparotomy. Two years later, she presented with mesh erosion into her bladder, which was removed.

Conclusion: This case report provides an example of significant mesh complication associated with robotic sacrocolpopexy 4 years after surgery and then again 2 years later.

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NR 7

TC 2

Z9 2

U1 1

U2 1

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PG 2

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA V35XR

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ER

PT J

AU Plante, M

AF Plante, Marie

TI Evolution in Fertility-Preserving Options for Early-Stage Cervical

Cancer <i>Radical Trachelectomy</i>, <i>Simple Trachelectomy</i>,

<i>Neoadjuvant Chemotherapy</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

DE Radical trachelectomy; Cervical cancer; Neoadjuvant chemotherapy;

Fertility preservation; Simple trachelectomy

ID OF-THE-LITERATURE; VAGINAL TRACHELECTOMY; HYSTERECTOMY; CARCINOMA;

PRESERVATION; INFERTILITY; MANAGEMENT; PREGNANCY; WOMEN; SAFE

AB Fertility preservation is of paramount importance for young women diagnosed with early-stage cervical cancer. The radical trachelectomy procedure was developed to preserve uterine/reproductive function. The procedure has evolved significantly over the last 25 years. This review focuses on the various surgical techniques (vaginal, abdominal, laparoscopic, and robotic), highlighting advantages and disadvantages of each in relation to their respective obstetrical and oncologic outcomes. A trend toward even more conservative surgery (simple trachelectomy/large cone) has recently been advocated for patients with low-risk early lesions. Conversely, the option of neoadjuvant chemotherapy followed by fertility-preserving surgery for patients with larger-size lesions has also been proposed. Emerging data are presented.

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NR 34

TC 83

Z9 89

U1 0

U2 8

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J9 INT J GYNECOL CANCER

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 299CV

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ER

PT J

AU Reynisson, P

Persson, J

AF Reynisson, Petur

Persson, Jan

TI Hospital costs for robot-assisted laparoscopic radical hysterectomy and

pelvic lymphadenectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Hospital costs; Robot-assisted surgery; Radical hysterectomy

ID OUTCOMES

AB Objective. To compare robot-assisted laparoscopy and laparotomy for radical hysterectomy and pelvic lymphadenectomy in terms of hospital costs.

Methods. Consecutive women undergoing radical hysterectomy and pelvic lymphadenectomy as a sole procedure between January 2001 and February 2012 were included. We compared OR times, hospital stay, procedure specific costs, blood transfusions and cost for readmissions and re-interventions until three months after surgery for 231 women operated who received either an open (n = 51) or a robot-assisted laparoscopic radical hysterectomy (n = 180). The hospital internal charges and purchase costs were used for estimation. The specific robotic cost was based on an investment depreciation time of seven years, with 400 operations performed annually, costs for maintenance, robotic instruments, robot-specific assistant's instruments and robot draping.

Results. The estimated mean costs for an open radical hysterectomy was $12,986, for the first 30 robotic radical hysterectomies was $18,382, and for the last 30 was $12,759, with a break even in cost after 90 robotic procedures. The specific robot costs ($3469) was, for the last robot cohort, compensated mainly by an average of 22 min shorter OR time and 4.9 days shorter hospital stay.

Conclusion. Given 400 robot operations annually, and only after a substantial implementation period, it is feasible to perform robot-assisted radical hysterectomy at an equal hospital cost compared with open surgery. (C) 2013 Elsevier Inc. All rights reserved.

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NR 12

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U1 0

U2 6

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DA 2024-01-18

ER

PT J

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Sandbulte, JT

Geller, EJ

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Matthews, CA

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Sandbulte, Jennifer T.

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Matthews, Catherine A.

TI Robotic Versus Vaginal Urogynecologic Surgery: A Retrospective Cohort

Study of Perioperative Complications in Elderly Women

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE complications; elderly; robotic surgery

AB Objectives: The primary objective was to compare perioperative complications after robotic surgery (RS) versus vaginal surgery (VS) for apical prolapse repair in elderly women. The secondary objectives were to (1) assess whether tools designed to predict surgical morbidity, the American Society of Anesthesiologists (ASA) class and the Charlson Comorbidity Index (CCI), are useful in the elderly urogynecologic population and (2) to classify complications during urogynecologic apical procedures using the Dindo classification system.

Methods: We reviewed medical records of women 65 years or older who underwent RS or VS between March 2006 and April 2011. Procedures included robotic sacrocolpopexy and sacrocervicopexy, vaginal uterosacral ligament suspension, sacrospinous ligament suspension, colpocleisis, and Uphold vaginal mesh placement. We assessed preoperative risks using ASA and CCI classification and complications using Dindo grade.

Results: There were 136 eligible cases (RS, 70; and VS, 66) during the 5-year study period. Women who underwent RS were younger (70 vs 74 years; P G 0.001). Vaginal surgery had more severe comorbidities as measured by the CCI (P = 0.012) but similar ASA profiles (P = 0.10). Robotic surgery had longer operative times (P < 0.001) but a lower estimated blood loss (P < 0.001). There were fewer postoperative complications in RS (P = 0.005). However, complication severity based on Dindo grade was similar between RS and VS, with most surgeries having no complications.

Conclusions: In the elderly women, RS was associated with fewer postoperative complications than VS. Overall, all procedures were associated with few complications, and either route may be reasonable in the elderly population.

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U2 3

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WC Obstetrics & Gynecology

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PT J

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Surlin, V

Genazzani, A

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Cela, Vito

Pluchino, Nicola

Angelescu, Cristina

Surlin, Valeriu

Genazzani, Andrea

TI Robotic-assisted laparoscopic surgery in uterine pathology

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Robotic surgery; Da Vinci; Hysterectomy; Myomectomy

ID RADICAL HYSTERECTOMY

AB Objective: The feasibility and safety of robotic surgery have been demonstrated by numerous comparative studies. The aim of our study was to compare several parameters related to robotic surgical procedures in uterine pathology, and to analyse clinico-biological parameters that may influence the post-operative evolution of the patients.

Study design: Retrospective analysis of 100 patients with uterine pathology who had undergone robotic-assisted laparoscopic surgery at the Santa Chiara Hospital, Pisa, Italy, between 2008 and 2010.

Results: Duration of surgery, docking, hysterectomy, uterine suture, blood loss, and days of hospitalisation significantly improved in parallel with the increasing experience of the surgical team. Paradoxically, the length of myomectomy increased in the same time interval, probably due to operating on more complex clinical cases with this procedure as the surgical team's experience grew. None of the robotic surgeries was converted to laparotomy. No intra- or post-operative complications were noted.

Conclusion: Since robotic-assisted laparoscopic surgery is becoming the preferred surgical technique for uterine pathology treatment, more clinical studies and development of protocols are essential to increase the quality of surgical treatment. (C) 2013 Elsevier Ireland Ltd. All rights reserved.

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FU [POSDRU/88/1.5/S/52826]

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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PG 3

WC Obstetrics & Gynecology; Reproductive Biology

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GA 211MS

UT WOS:000323912900040

PM 23578812

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ER

PT J

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O'Sullivan, DM

Finnegan, KT

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Finnegan, Kyle T.

Steinberg, Adam C.

TI Can Visuospatial Ability Predict Performance and Learning Curves on a

Robotic Surgery Simulator?

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE learning curves; perceptual ability test; robotic surgery simulator;

spatial reasoning; visuospatial ability

ID SKILLS; VALIDATION

AB Objective: This study aimed to examine the correlation between visuospatial ability, measured with the Perceptual Ability Test (PAT), and da Vinci robot simulator performance on the da Vinci Skills Simulator.

Methods: Twenty-five consenting medical students naive to both the PAT and the da Vinci robot completed the PAT and then performed a single simulation (Ring-walk 2) 10 consecutive times. Raw PAT scores were compared with composite simulator scores for all subjects. Participants were divided into those with high and low visuospatial ability based on whether they scored above or below (or equal) to the median on the PAT. We compared the mean composite simulator scores and the time to complete each exercise between the high and the low PAT performers.

Results: The mean (SD) raw PAT score (out of 90) was 45.5 (18.3) (median, 43.0). The mean composite simulator score was 65.5 (24.1) (median, 72.2). The high (n = 12) and low (n = 13) PAT performers had a mean (SD) (median) simulator score of 79.1 (9.8) (80.3) and 53.0 (26.7) (65.9), respectively. On average, the high PAT performers scored 26.1 points (95% confidence interval, 9.2-43.0, P = 0.005), or 49.2%, higher on the simulation than the low PAT performers. The high PAT performers completed the exercise in 96.5 seconds (95% confidence interval, 26.0-167.0; P = 0.009), or 36.2%, faster than the low PAT performers.

Conclusions: Better visuospatial ability relates to improved performance on a robotic surgery simulator.

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NR 18

TC 6

Z9 6

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U2 3

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PT J

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Lowenstein, L

AF Awad, Nibal

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Amit, Amnon

Deutsch, Michael

Eldor-Itskovitz, Joseph

Lowenstein, Lior

TI Implementation of a new procedure: laparoscopic versus robotic

sacrocolpopexy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Laparoscopic sacrocolpopexy; Pelvic organ prolapse; Robotic

sacrocolpopexy

ID ABDOMINAL SACRAL COLPOPEXY; PELVIC ORGAN PROLAPSE; TERMINOLOGY;

MANAGEMENT; DEFECTS

AB Purpose The purpose of this study was to compare the implementation process and the learning curves of laparoscopic and robotic-assisted laparoscopic sacrocolpopexy (LSC and RSC, respectively) for vaginal apex prolapse.

Methods A retrospective study of the first 40 LSC and first 40 RSC procedures performed at one medical center. The primary outcomes were intraoperative bleeding, operative time, and hospitalization. Secondary outcomes were surgical complications. The independent t test, paired t test, chi(2) test, Fisher's exact test and Pearson's correlation were used to analyze the data. We assumed that 34 participants were needed in each group to detect a 50 ml or more difference in estimated blood loss between laparoscopic and robotic surgeries,

Main results Age, preoperative pelvic organ prolapse quantification (POPQ) staging, and concomitant medical disorders did not differ significantly by procedure type. For LSC and RSC, the mean estimated intraoperative blood loss was 206 +/- 107 and 48 +/- 55 ml, P < 0.0001; mean operative times were 176 (110-380 min) and 186 (105-345 min), P = 0.34; and mean length of hospital stay, 3.8 +/- 1 and 2.4 +/- 1 days, P < 0.0001, respectively. Adverse events were rare, not severe, and did not differ significantly by procedure type.

Conclusions RSC and LSC are feasible procedures with acceptable complication rates. RSC enables operating more anatomically with less bleeding.

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NR 24

TC 41

Z9 45

U1 0

U2 1

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 164BN

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ER

PT J

AU Bharathan, R

Aggarwal, R

Darzi, A

AF Bharathan, Rasiah

Aggarwal, Rajesh

Darzi, Ara

TI Operating room of the future

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE safety; surgical simulation; integrated OR; surgical navigation;

telemedicine

ID SENTINEL LYMPH-NODE; LAPAROSCOPIC CHOLECYSTECTOMY; ADVERSE EVENTS;

SURGERY; SIMULATION; SAFETY; SKILLS; CARE; ENVIRONMENT; PERFORMANCE

AB Development of surgical care in the 21st century is increasingly dependent on demonstrating safety, efficacy and cost effectiveness. Over the past 2 decades, the potential role of simulation in surgery has been explored with encouraging results; this can now be linked to direct improvement in the quality of care provision. Computer-assisted surgical platforms, such as robotic surgery, offer us the versatility to embrace a host of technical and technological developments. Rapid development in nanomedicine will expand the limits of operative performance through improved navigation and surgical precision. Integration of the multiple functions of the future operating room will be essential in optimising resource management. The key to bringing about the necessary paradigm shift in the design and delivery of modern surgical care is to appreciate that we now function in an information age, where the integrity of processes is driven by apt data management. (C) 2012 Elsevier Ltd. All rights reserved.

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Z9 32

U1 1

U2 3

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J9 BEST PRACT RES CL OB

JI Best Pract. Res. Clin. Obstet. Gynaecol.

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ER

PT J

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Eltahawy, EA

Mahdy, A

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Eltahawy, Ehab A.

Mahdy, Ayman

TI Vaginal repair of ureterovaginal fistula may be suitable for selected

cases

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Ureterovaginal fistula repair; Ureteral injury; Vaginal surgery

ID GENITOURINARY FISTULAS; URETERAL INJURIES; EXPERIENCE; MANAGEMENT

AB Ureterovaginal fistula (UVF) is an uncommon but devastating complication of gynecologic surgery. Management includes ureteral stenting for 6-8 weeks. For stent failure, ureteroneocystostomy (UNC) through an open, laparoscopic, or robotic abdominal approach is the classic alternative. Originally pioneered for repair of vesicovaginal fistulas (VVF), the use of the vaginal approach in UVF is scarcely reported in the literature. We report the successful repair of UVF performed exclusively through the vaginal approach in two women after robotic hysterectomy. In select clinical scenarios, this approach may be applied, as it provides a minimally invasive option for managing UVF after failure of ureteral stenting.

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NR 15

TC 7

Z9 9

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU De Wilde, RL

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TI Robotic surgery - Advance or gimmick?

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE robotic surgery; advantages; disadvantages; learning; costs; gynaecology

ID RADICAL HYSTERECTOMY; LEARNING-CURVE; DA VINCI; LAPAROSCOPY; COST;

LAPAROTOMY; HISTORY; TIME

AB Robotic surgery is increasingly implemented as a minimally invasive approach to a variety of gynaecological procedures. The use of conventional laparoscopy by a broad range of surgeons, especially in complex procedures, is hampered by several drawbacks. Robotic surgery was created with the aim of overcoming some of the limitations. Although robotic surgery has many advantages, it is also associated with clear disadvantages. At present, the proof of superiority over access by laparotomy or laparoscopy through large randomised- controlled trials is still lacking. Until results of such trials are present, a firm conclusion about the usefulness of robotic surgery cannot be drawn. Robotic surgery is promising, making the advantages of minimally invasive surgery potentially available to a large number of surgeons and patients in the future. (C) 2013 Elsevier Ltd. All rights reserved.

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PT J

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TI Vaginal Vault Dehiscence After Robotic Hysterectomy for Gynecologic

Cancers <i>Search for Risk Factors and Literature Review</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic-assisted hysterectomy; Vaginal cuff dehiscence

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; RADICAL HYSTERECTOMY; ENDOMETRIAL

CANCER; CUFF DEHISCENCE; OUTCOMES; SURGERY; EXPERIENCE; PROGRAM; COST

AB Introduction: Vaginal vault dehiscence following robotic-assisted hysterectomy for gynecologic cancer may be attributed to surgical techniques and postoperative therapeutic interventions. We searched for risk factors in patients with gynecologic cancers and complemented this with a literature review.

Methods: Evaluation of prospectively gathered information on all consecutive robotic surgeries for gynecologic cancers was performed in a tertiary academic cancer center between December 2007 and March 2012. The literature was reviewed for articles relevant to "gynecologic oncology'' and "robotics'' with "vaginal cuff dehiscence'' in the English and French languages. Respective authors were contacted to complete relevant information.

Results: Seven dehiscences were identified of 441 cases with established gynecologic cancers. The closures in these 7 were performed using interrupted 1-Vicryl (Ethicon Inc) (3/167; 1.8%), combination of interrupted 1-Vicryl and 1-Biosyn (Covidien Inc) (3/156, 1.9%), and V-Loc (Covidien Inc) (1/118, 0.8%) sutures. Associated risk factors included adjuvant chemotherapy and/or brachytherapy, early resumption of sexual activity, and low bodymass index (mean, 23 +/- 3.23 kg/m(2)). Dehiscences occurred regardless of suturing by staff or trainees. Review of operative videos did not reveal a detectable etiologic factor, such as excessive cautery damage to the vaginal cuff or shallow tissue sutured. All 7 colporrhexis repairs were performed through a vaginal approach without the need of laparoscopy or laparotomy.

Conclusions: Postoperative chemotherapy, brachytherapy, and early resumption of sexual activities are risk factors for vaginal vault dehiscence. Surgical technique, particularly the use of delayed absorbable sutures, deserves further evaluation

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TI Two-Port Access Laparoscopic Surgery in Gynecologic Oncology

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Two-port access; Minimally invasive surgical procedures; Laparoscopy;

Gynecologic neoplasms; Gynecologic surgery

ID ABDOMINAL RADICAL HYSTERECTOMY; SINGLE-PORT LAPAROSCOPY; STAGE

CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; ENDOMETRIAL CANCER; ROBOTIC

SURGERY; FALLOPIAN-TUBE; LAPAROTOMY; OVARIAN; EXPERIENCE

AB Purpose: The purpose of this study was to evaluate the feasibility and safety of 2-port access (TPA) laparoscopy in gynecologic oncology.

Methods: This was a retrospective review of 81 consecutive patients who underwent TPA laparoscopic surgery for various gynecologic cancers from March 2009 to September 2011. The TPA system consisted of a single multichannel port at the umbilicus and an ancillary 5-mm port in the suprapubic area.

Results: The surgical procedures included comprehensive ovarian cancer staging (33 patients), radical hysterectomy with pelvic lymph node dissection (19 patients), and endometrial cancer staging (29 patients). All surgical procedures were completed laparoscopically with no conversion to laparotomy. Two cases required 1 or 2 additional ports. The mean operating time, estimated blood loss, and number of lymph nodes were 253.8 minutes, 170.7 mL, and 34.9, respectively. Three patients (9.1%) with ovarian cancer and 4 patients (13.8%) with endometrial cancer were upstaged after surgery. The mean postoperative hospital stay was 6.6 days, and the mean postoperative pain scores (0-10 scale) were 3.4 at 6 hours, 3.0 at 24 hours, and 2.5 at 48 hours. Postoperative complications occurred at a low incidence (4.9%) and included one umbilical hernia, one vault dehiscence, and one lumbosacral nerve injury.

Conclusions: Two-port access laparoscopic surgery using a single multichannel port system is a feasible and safe procedure in selected patients with gynecologic cancers. Prospective randomized trials will permit the evaluation of the potential benefits of this minimally invasive surgical technique.

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TI Single port entry - Are there any advantages?

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE single port surgery; minimal invasive surgery; review; single port

access laparoscopy

ID ASSISTED VAGINAL HYSTERECTOMY; INCISION LAPAROSCOPIC SURGERY;

EXTRAPERITONEAL PARAAORTIC LYMPHADENECTOMY; NOTES TRANSVAGINAL

CHOLECYSTECTOMY; SITE SURGERY; ADNEXAL TUMORS; INITIAL-EXPERIENCE;

OVARIAN CYSTECTOMY; SURGICAL OUTCOMES; TUBAL PREGNANCY

AB Minimal-invasive, single-port laparoscopic surgery is a recent innovation that may improve surgical outcomes. In this chapter, we review published research on single-port surgery in gynaecology, and the different surgical instruments available. Challenges, advantages, indications and potential future rules of this new approach are also discussed. Sixty-five studies were available for review: 17 case reports, 32 case studies, 13 retrospective comparative studies, and three randomised-controlled trials (RCTs). The recent availability of advanced instruments has made single-port surgery safer and more feasible for most benign gynaecologic surgeries. Single-port surgery has many potential benefits, but comparative trials have found no differences between single-port surgery and conventional laparoscopy in postoperative complications, postoperative pain, hospital stay, and cosmetic results. Single-port surgery seems to provide another option in the area of minimal invasive surgery, and further development of this technique, along with robotics and natural orifice transgastric endoscopic surgery, will improve dissemination of this approach. (C) 2012 Elsevier Ltd. All rights reserved.

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PT J

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TI Advances in Gynaecological Oncology Surgery

SO BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE surgical oncology; endometrial cancer; ovarian cancer; cervical cancer;

exenteration

ID EPITHELIAL OVARIAN-CANCER; LAPAROSCOPIC RADICAL HYSTERECTOMY;

ENDOMETRIAL CANCER; PELVIC LYMPHADENECTOMY; CYTOREDUCTIVE SURGERY;

ROBOTIC SURGERY; TRACHELECTOMY; CARCINOMA; FERTILITY; CHEMOTHERAPY

AB Latest surgical advances in the field of gynaecological oncology, a sub-specialty of gynaecology, are reviewed in this chapter. The surgery is mainly practised in cancer centres by board-certified gynaecologists, and requires a 2-3 year period of additional training in gynaecological oncology. Surgical treatment of gynaecological malignancies has progressed in two directions: reduction of the invasiveness of the surgery and expansion of the number and type of procedures performed. Gynaecological oncology focuses on the pelvis to the upper abdomen and the thorax to target (all visible disease) the last cancer cell in women with advanced ovarian cancer. Minimal-access surgery has evolved to include any operation by laparoscopy. It uses fewer ports (single-port surgery), and robotic assistance improves the comfort of the surgeon. The concept of fertility-sparing surgery for women with cervical cancer is now supported by mature data. The indication and the aggressiveness of the exenterative surgery are also broader than originally recommended. The ideal timing of surgery is under investigation in several areas, mainly in women with ovarian and cervical cancer. The aim is to reduce morbidity and mortality of surgical procedures while maintaining the survival outcome. (C) 2013 Elsevier Ltd. All rights reserved.

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TI Robotic surgical staging for endometrial and cervical cancers in

medically ill patients

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Cervical cancer; Radical hysterectomy; Elderly;

Obese; Robotics

ID OUTCOMES; SURGERY; OBESE; WOMEN

AB Objectives. Patients with high anesthesiological risk due to old age, obesity and severe co-morbidities alone or in combination are considered as poor candidates for extensive surgical staging procedures, especially if through minimally invasive approach. We aimed to evaluate the feasibility and safety of robotic surgical staging of endometrial and cervical cancers in the medically ill patient.

Methods. Between 07-2007 and 12-2012, consecutive patients scheduled for staging for endometrial or cervical cancer were directed towards robotic staging and divided into two groups according to their starting score in the American Society for Anaesthesiologists (ASA): Group 1 (ASA 1-2) and Group 2 (ASA >= 3).

Results. Overall, 169 (71.9%) patients had ASA 1-2 whereas 66 (28.1%) had ASA >= 3. ASA >= 3 were older (p < 0.0001) with a greater proportion of co-morbidities (p < 0.0001), as well as of Class II (4.7% vs 19.7%; p = 0.0007) and Class III obesity (2.4% vs 31.8%; p < 0.0001). No differences were found between groups in terms of operative time, blood loss, intra- and post-operative complications, conversion rate and hospitalization. No differences were recorded either in terms of staging procedures performed or in terms of number of pelvic (p = 0.72) and para-aortic (p = 0.86) lymph nodes retrieved.

Conclusions. Despite theoretical concerns about the performance of robotic surgery in patients with high anesthesiological risk, our experience showed that robotics is a feasible, safe and viable option for the management of endometrial and cervical cancers also in this more vulnerable group of patients. (c) 2013 Published by Elsevier Inc.

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TI Robotic Resection of Adnexal Masses during Pregnancy

SO AMERICAN JOURNAL OF PERINATOLOGY

LA English

DT Article

DE adnexal mass; robot; robotic surgery; pregnancy

ID LAPAROSCOPIC MANAGEMENT; SURGERY

AB Objective To characterize the safety and feasibility of robotic adnexal surgery during pregnancy, and to compare surgical and obstetric outcomes for robotic versus laparoscopic treatment of adnexal masses during pregnancy.

Study Design A retrospective cohort study of all cases of robotic resection of adnexal masses in gravid patients performed at our institution between 2006 and 2009 compared with 50 consecutive historic laparoscopic controls performed between 1999 and 2007.

Results During the study period, 19 parturients underwent planned robotic resection of adnexal masses, all of which were uncomplicated. Compared with 50 consecutive laparoscopic controls, no differences in operative time, conversion to laparotomy, intraoperative or postoperative complications, or observed obstetric outcomes were apparent. The robotic cohort had a significantly shorter length of hospital stay (p < 0.01) and estimated blood loss (p = 0.02).

Conclusion Robotic resection of adnexal masses during pregnancy appears both safe and feasible, with similar surgical outcomes when compared with a historic laparoscopic cohort.

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TI Preoperative sentinel node mapping with <SUP>99m</SUP>Tc-nanocolloid

SPECT-CT significantly reduces the intraoperative sentinel node

retrieval time in robot assisted laparoscopic cervical cancer surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer surgery; Sentinel node procedure; Preoperative mapping;

Planar lymphoscintigraphy; SPECT-CT

ID LYMPH-NODE; RADICAL HYSTERECTOMY; INDOCYANINE GREEN; LYMPHOSCINTIGRAPHY;

LYMPHADENECTOMY; TOMOGRAPHY; METASTASIS; BIOPSY

AB Objective. To compare preoperative sentinel node (SN) mapping with planar lymphoscintigraphy (LSG) to single photon emission computed tomography with computed tomography (SPECT-CT) for differences in intraoperative SN retrieval time in surgically treated cervical cancer patients.

Methods. In cervical cancer patients planned for radical surgery, one day preoperatively, 220-290 MBq technetium-99m-nanocolloid was injected intracervically in four quadrants. Subsequent SN mapping was performed by either LSG (09.2009-03.2011) or SPECT-CT (03.2011-10.2012). The SN resection, by four armed robot assisted laparoscopy, was based on blue dye and technetium-99m and followed by pelvic lymph node dissection. Timing of perioperative care, including SN procedure times, was prospectively registered.

Results. Out of the 62 subjects included, 33 (53.2%) underwent LSG and 29 (46.8%) SPECT-CT. No significant differences in baseline characteristics were observed. Bi- and unilateral SN visualization rates were 75.8% and 15.2% for LSG versus 86.2% and 6.9% for SPELT-CT (p = 0.299 and p = 0.305, respectively). Intraoperative bi/unilateral SN detection occurred in 84.8% and 9.1% of LSG subjects versus 89.7% and 3.4% for SPELT-CT (p = 0.573 and p = 0.616). Correlation in SN location between mapping and surgery was low for LSG (Spearman rho = 0.098; p = 0.449) but high for SPECT-CT (rho = 0.798; p<0.001). Bilateral intraoperative SN retrieval times for LSG and SPELT-CT were 75.4 +/- 33.5 and 50.1 +/- 15.6 min, resulting in an average difference of 25.4 min (p = 0.003).

Conclusion. SPECT-CT significantly reduces intraoperative SN retrieval with a clinically relevant time compared to LSG. The trend towards better bilateral visualization rates and significantly higher anatomical concordance may partly explain the observed difference in SN retrieval time. (C) 2013 Published by Elsevier Inc.

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ER

PT J

AU Hsiao, SM

Lin, HH

Peng, FS

Jen, PJ

Hsiao, CF

Tu, FC

AF Hsiao, Sheng-Mou

Lin, Ho-Hsiung

Peng, Fu-Shaing

Jen, Pei-Jung

Hsiao, Chin-Fen

Tu, Fung-Chao

TI Comparison of robot-assisted laparoscopic myomectomy and traditional

laparoscopic myomectomy

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE blood loss; laparoscopic myomectomy; operation time; robot-assisted

laparoscopic myomectomy

ID ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; EXPERIENCE; SURGERY

AB Aim The benefit of robot-assisted laparoscopic myomectomy (RALM) over traditional laparoscopic myomectomy (TLM) remains undetermined. The aim of this study was to reveal any potential advantage of RALM over TLM. Material and Methods Between June 2010 and October 2011, all women presenting with symptomatic uterine myomas were enrolled in this study. Perioperative variables were compared between these two groups. The patients recruited in this study were allocated into the two groups based on their financial considerations. Results A total of 42 patients received RALM (n=20) or TLM (n=22) for symptomatic uterine myomas. The operation time was longer in the RALM group; but the total abdominal drainage amount on postoperative day 1 was significantly less in the RALM group than the TLM group. Multivariate analysis revealed that the RALM procedure (coefficient=79.1, P<0.001), number of myomas (coefficient=15.4, P=0.002), and the presence of a cervical myoma (coefficient=54.9, P=0.01) were independent factors affecting operation time; the maximum myoma diameter was the only factor affecting blood loss (coefficient=113.4, P=0.003). However, the RALM procedure was the only factor affecting the amount of abdominal drainage on postoperative day 1 (coefficient=86.3, P=0.006). Conclusions Although RALM is a longer operation than TLM, it might result in less postoperative abdominal drainage than TLM and help alleviate short-term morbidity.

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NR 21

TC 25

Z9 30

U1 0

U2 1

PU WILEY

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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PG 6

WC Obstetrics & Gynecology

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ER

PT J

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TI Analysis of secondary cytoreduction for recurrent ovarian cancer by

robotics, laparoscopy and laparotomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Ovarian cancer; Laparoscopy; Laparotomy

ID GYNECOLOGIC ONCOLOGY; FALLOPIAN-TUBE; ADNEXAL MASS; MANAGEMENT; SAFETY

AB Objective. Analysis of perioperative outcomes and survival of patients with recurrent ovarian cancer undergoing secondary cytoreduction by robotics, laparoscopy, or laparotomy.

Methods. Retrospective analysis of 52 selected patients with recurrent ovarian cancer undergoing secondary cytoreduction by laparoscopy (9), laparotomy (33) or robotics (10) between January 2006 and December 2010. Comparison was made by a total of 21 factors including age, BMI, number of previous surgeries, tumor type and grade, number of procedures, and 15 types of procedures performed at secondary cytoreduction.

Results. For all patients, the mean operating time was 213.8 min, mean blood loss 657.4 ml; and mean hospital stay 7.5 days. Complete debulking was achieved in 75% of patients. Postoperative complications were noted in 36.5% of patients. Overall and progression-free survival at 3-years were 58.8% and 34.1%, respectively. Laparoscopy and robotics had reduced blood loss and hospital stay, while no differences were observed among the three groups for operating time, complications, complete debulking, and survival.

Conclusion. Selected patients with recurrent ovarian cancer benefit from a laparoscopic or robotic secondary cytoreduction without compromising survival. Robotics and laparoscopy provide similar perioperative outcomes, and reduced blood loss and shorter hospital stay as compared to laparotomy. Laparotomy seems preferable for patients with widespread peritoneal implants, multiple sites of recurrence, and/or extensive adhesions. (C) 2013 Elsevier Inc. All rights reserved.

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NR 16

TC 61

Z9 70

U1 0

U2 9

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ER

PT J

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TI Robot-assisted hysterectomy compared to open and laparoscopic

approaches: systematic review and meta-analysis

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Hysterectomy; Meta-analysis; Robot-assisted; Systematic review

ID OPEN RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; CERVICAL-CANCER; SURGICAL

OUTCOMES; LAPAROTOMY; LYMPHADENECTOMY; SURGERY; COST; OBESE

AB To review the safety and effectiveness of robot-assisted hysterectomy compared to traditional open and conventional laparoscopic surgery, differentiating radical, simple total with node staging, and simple total hysterectomy.

Medline, Embase, the Cochrane library, and the Journal of Robotic Surgery were searched for controlled trials and observational studies with historic or concurrent controls. Data were pooled using random effects meta-analysis.

Compared to open surgery, robot-assisted radical hysterectomy is associated with reduced hospital stay and blood transfusions. For simple total hysterectomy with node staging, robot-assisted surgery is associated with reduced hospital stay, complications, and blood transfusions compared to open surgery. Compared to conventional laparoscopic surgery, robot-assisted simple total hysterectomy with node staging is associated with complications and conversions.

Compared to open surgery, robot-assisted hysterectomy offers benefits for reduced length of hospital stay and blood transfusions. The best evidence of improved outcomes is for simple total hysterectomy with node staging. Study quality was poor.

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FU Department of Obstetrics; Gynecology research fund

FX MON, PSM, CT, OEOS, MF, and MR have no conflicts of interest to declare.

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U2 22

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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ER

PT J

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TI A randomized trial comparing conventional and robotically assisted total

laparoscopic hysterectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; laparoscopic hysterectomy; laparoscopy; robotic-assisted

surgery laparoscopy

ID ABDOMINAL HYSTERECTOMY; VAGINAL HYSTERECTOMY; OUTCOMES; PERFORMANCE

AB OBJECTIVE: The purpose of this study was to compare operative time and intra- and postoperative complications between total laparoscopic hysterectomy and robotic-assisted total laparoscopic hysterectomy.

STUDY DESIGN: This study was a blinded, prospective randomized controlled trial conducted at 2 institutions. Subjects consisted of women who planned laparoscopic hysterectomy for benign indications. Preoperative randomization to total laparoscopic hysterectomy or robotic-assisted total laparoscopic hysterectomy was stratified by surgeon and uterine size (> or <= 12 weeks). Validated questionnaires, activity assessment scales, and visual analogue scales were administered at baseline and during follow-up evaluation.

RESULTS: Sixty-two women gave consent and were enrolled and randomly assigned; 53 women underwent surgery (laparoscopic, 27 women; robot-assisted, 26 women). There were no demographic differences between groups. Compared with laparoscopic hysterectomy, total case time (skin incision to skin closure) was significantly longer in the robot-assisted group (mean difference, +77 minutes; 95% confidence interval, 33-121; P < .001] as was total operating room time (entry into operating room to exit; mean difference, +72 minutes; 95% confidence interval, 14-130; P = .016). Mean docking time was 6 +/- 4 minutes. There were no significant differences between groups in estimated blood loss, pre- and postoperative hematocrit change, and length of stay. There were very few complications, with no difference in individual complication types or total complications between groups. Postoperative pain and return to daily activities were no different between groups.

CONCLUSION: Although laparoscopic and robotic-assisted hysterectomies are safe approaches to hysterectomy, robotic-assisted hysterectomy requires a significantly longer operative time.

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(C-SITE)

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TC 141

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U2 17

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JI Am. J. Obstet. Gynecol.

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OA Bronze

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ER

PT J

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TI Relationship Between Race and Abdominal Anatomy: Effect on Robotic Port

Placement

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE abdominal dimensions; CT scan; port placement; race; robotic surgery

ID RACIAL-DIFFERENCES; CESAREAN DELIVERY

AB Objectives: We sought to characterize differences between African American women and white women in abdominal wall dimensions that could affect robotic port placement. By better understanding these differences, surgeons could assess and adjust port placement to accommodate varying abdominal wall anatomy.

Methods: A radiologist blinded to race-reviewed abdominal/ pelvic computed tomographic scans of women aged 30 to 70 prescreened for demographic inclusion criteria. These consecutive scans were screened for radiologic exclusion criteria until 40 consecutive scans from each race were identified and included.

Results: Eighty of 663 patients, 40 of each race, met demographic inclusion criteria. The most common radiologic feature disqualifying the scans included absence of the xiphoid process on the scan and anterior abdominal wall deformity. Demographic variables including age, weight, height, and body mass index were similar between groups. Symphysis pubis to umbilicus measurement was shorter in the African American group (15.7 [2.1] vs 17.1 [2.0]; P < 0.001) and intra-anterior superior iliac spine distance was narrower (21.4 [1.2] vs 23.8 [2.0]; P = 0.003), creating an overall smaller lower abdomen in African American women. Total abdominal length was the same between groups (36.6 [2.6] vs 36.7 [2.8]; P = 0.851). Using linear regression, height, weight, and body mass index did not affect lower abdominal dimensions, whereas age (P < 0.001) had a significant inverse relationship with the symphysis pubis to umbilicus measurement.

Conclusions: Lower abdominal dimensions between races vary, with the umbilicus serving as an inconsistent landmark. Variance exists that can be attributed to racial differences. Assessment of these dimensions at the time of robotic surgery could lead to improved port spacing and therefore fewer arm collisions, improving robotic efficiency.

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NR 13

TC 3

Z9 3

U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PG 4

WC Obstetrics & Gynecology

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ER

PT J

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Rajakumar, C

AF Vilos, George A.

Rajakumar, Chandrew

TI Electrosurgical Generators and Monopolar and Bipolar Electrosurgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Bipolar electrosurgery; Electrosurgical generator; Electrosurgical unit;

Monopolar electrosurgery; Return/Dispersive electrode

ID LAPAROSCOPY; INJURIES

AB Electrosurgery is the most commonly used and misunderstood technology by all surgical and medical disciplines. A lack of basic knowledge or ignorance of principles of electrosurgery and equipment among obstetricians and gynecologists is reported. As a result, thermal injuries during laparoscopic electrosurgery occur, which frequently lead to significant morbidity and mortality and medicolegal actions. Surveys indicate that up to 90% of general surgeons and gynecologists use monopolar radiofrequency (RF) during laparoscopy, 18% have experienced visceral burns, and 13% admitted 1 or more ongoing cases of litigations associated with such burns. This article describes the basics of electrosurgery beginning with the generation of electrons and their physical characteristics and governing laws before their arrival in the operating room where they are fed to an electrosurgical unit (ESU) to boost their frequency with step-up transformers from 60 Hz to >500 000 Hz. This RF creates heat, resulting in dissection, desiccation, coagulation, and fulguration of tissues without neuromuscular stimulation, pain, or burn to the patient. The ESU delivers power (wattage = volts X amps) in monopolar or bipolar (1 vs 2 high-density electrodes) configuration. Because of RF, monopolar electrosurgery compared with other energy sources is associated with unique characteristics, inherent risks, and complications caused by the requirement of a return/dispersive electrode, inadvertent direct and/or capacitive coupling, or insulation failure of instruments. These dangers become particularly important with the popular and frequent use of monopolar electrodes (hook, needle, and scissors) during cholecystectomy; robot-assisted surgeries; and the re-emergence of single-port laparoscopy, which requires close proximity and crossing of multiple intraabdominal instruments outside the surgeon's field of view. Presently, we identify all these potential risks and complications associated with the use of electrosurgery and provide suggestions and solutions to mitigate/minimize these risks based on good clinical practice and sound biophysical principles. Journal of Minimally Invasive Gynecology (2013) 20, 279-287 (C) 2013 AAGL. All rights reserved.

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NR 30

TC 39

Z9 42

U1 1

U2 47

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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DA 2024-01-18

ER

PT J

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Borahay, MA

Fox, KA

Kilic, GS

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Borahay, Mostafa A.

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TI Robotic-Assisted, Ultrasound-Guided Abdominal Cerclage During Pregnancy:

Overcoming Minimally Invasive Surgery Limitations?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Abdominal cerclage; Cerclage; Cervical insufficiency; da Vinci robot;

Ultrasound

AB Herein, we report robotic abdominal cerclage placement under ultrasound guidance. The da Vinci Si system (Intuitive Surgical, Sunnyvale, CA) allows a simultaneous display of the operative field and transvaginal ultrasound images. Additionally, the vaginal ultrasound probe assisted in the manipulation of the uterus to improve visualization without placing excessive pressure on the gravid uterus. Ultrasound guidance improves needle placement accuracy and reduces potential for injuries. Published by Elsevier Inc. on behalf of AAGL.

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NR 3

TC 22

Z9 22

U1 0

U2 5

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 152RX

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DA 2024-01-18

ER

PT J

AU Falcone, T

Parker, WH

AF Falcone, Tommaso

Parker, William H.

TI Surgical Management of Leiomyomas for Fertility or Uterine Preservation

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; ARTERY LIGATION; BARBED SUTURE; WOMEN;

OUTCOMES; MULTICENTER; PREGNANCY; FIBROIDS; ADHESION; SURGERY

AB Leiomyomas are the most common pelvic tumors in women. These tumors are not always symptomatic but can cause abnormal uterine bleeding and anemia, pelvic pressure and pain, urinary frequency, and adverse reproductive outcomes-symptoms that can diminish the quality of life of women. Myomectomy is the primary treatment modality for women with symptomatic leiomyomas who are of reproductive age and desire future fertility. Myomectomy can significantly improve symptoms and quality of life and, in some clinical situations, improve reproductive outcomes. There are robust surgical outcome data supporting the use of a minimally invasive approach such as laparoscopy and hysteroscopy over laparotomy. Perioperative outcomes and return to normal activity are significantly better with a minimally invasive approach. Reproductive outcomes are not adversely affected. Detailed preoperative imaging is required for minimally invasive procedures to be successful. There are several evidence-based techniques that can be used to reduce blood loss during surgery. The role of robotic technology in enhancing surgical outcomes has not been clearly defined. (Obstet Gynecol 2013;121:856-68) DOI: http://10.1097/AOG.0b013e3182888478

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Health & Urology. Dr. Falcone did not report any potential conflicts of

interest.

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Z9 90

U1 0

U2 15

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Kilgore, JE

Jackson, AL

Ko, EM

Soper, JT

Van Le, L

Gehrig, PA

Boggess, JF

AF Kilgore, Joshua E.

Jackson, Amanda L.

Ko, Emily M.

Soper, John T.

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TI Recurrence-free and 5-year survival following robotic-assisted surgical

staging for endometrial carcinoma

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery

ID INTERNATIONAL-FEDERATION; CANCER; LAPAROSCOPY; HYSTERECTOMY; GYNECOLOGY;

OBESE; WOMEN; RISK

AB Objective. The aim of this study is to report recurrence-free and overall survival for women with endometrial adenocarcinoma who were surgically staged using robotic-assisted laparoscopy.

Methods. A retrospective chart review was performed for all consecutive endometrial adenocarcinoma patients surgically staged with robotic-assisted laparoscopy at the University of North Carolina Hospital from 2005 to 2010. Demographic data, 5-year survival, and recurrence-free intervals were analyzed. Statistical analysis using Chi-square, t-test, and Kaplan-Meier curves were performed with SAS software. Study results were compared to endometrial cancer statistics from the Surveillance Epidemiology and End Results database from the National Cancer Institute.

Results. A total of 499 patients were identified and included in the study. Recurrence-free intervals after robotic-assisted surgical staging were 85.2% for stage IA, 80.2% for stage IB, 69.8% for stage II, and 69% for stage III. Projected 5-year survival was 88.7% for all patients included in the study. Nearly 82% of cases were endometrioid adenocarcinoma, with papillary serous, clear cell or mixed histology comprising 17.4% of cases. Median follow up time was 23 months, with a range of 0 to 80 months. Among stage IA, IB, II, and III patients, projected overall survival was 94.2%, 85.9%, 77.4%, and 68.6%, respectively.

Conclusions. The results from this study demonstrate that robotic-assisted surgical staging for endometrial cancer does not adversely affect rates of recurrence or survival. These findings provide further evidence that robotic-assisted laparoscopic surgical staging is not associated with inferior results when compared to laparotomy or traditional laparoscopy. (C) 2012 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Uterosacral ligament and hypogastric nerve anatomical relationship.

Application to deep endometriotic nodules surgery

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Review

DE Uterosacral ligament; Hypogastric nerve; Deep infiltrating

endometriosis; Laparoscopy; Nerve sparing

ID SPARING RADICAL HYSTERECTOMY; INFILTRATING ENDOMETRIOSIS;

IDENTIFICATION; RESECTION; PLEXUS; WOMEN

AB Endometriosis is a concern for 10 to 15% of women of childbearing age. The uterosacral ligament is the most frequent localization of deep infiltrating endometriosis. Laparoscopic excision of endometriotic nodules may lead to functional consequences due to potential hypogastric nerve lesion. Our aim is to study the anatomical relationship between the hypogastric nerve and the uterosacral ligament in order to reduce the occurrence of such nerve lesions during pelvic surgeries. We based our study on an anatomical and surgical literature review and on the anatomical dissection of a 56-year-old fresh female subject. The hypogastric nerves cross the uterosacral ligament approximately 30 mm from the torus. They go through the pararectal space, 20 mm below the ureter and join the inferior hypogastric plexus at the level of the intersection between the ureter and the posterior wall of the uterine artery, at approximately 20 mm from the torus. No anatomical variation has been described to date in the path of the nerve, but in its presentation which may be polymorphous. Laparoscopy and robot-assisted laparoscopic surgery facilitate the pelvic nerves visualization and are the best approach for uterosacral endometriotic nodule nerve-sparing excision. Precise knowledge by the surgeon of the anatomical relationship between the hypogastric nerve and the uterosacral ligament is essential in order to decrease the risk of complication and postoperative morbidity for patient surgically treated for deep infiltrating endometriosis involving uterosacral ligament. (C) 2013 Elsevier Masson SAS. All rights reserved.

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PT J

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Osborne, SE

AF Azari, Laleh

Santoso, Joseph T.

Osborne, Shelby E.

TI Optimal Pain Management in Total Abdominal Hysterectomy

SO OBSTETRICAL & GYNECOLOGICAL SURVEY

LA English

DT Review

ID PATIENT-CONTROLLED ANALGESIA; REDUCES POSTOPERATIVE PAIN; PREOPERATIVE

WOUND INFILTRATION; DOUBLE-BLIND; PREEMPTIVE ANALGESIA; MORPHINE

CONSUMPTION; INTRATHECAL ADENOSINE; RANDOMIZED-TRIAL; OPIOID INFUSION;

GABAPENTIN

AB Effective postoperative pain management provides improved patient comfort and satisfaction, earlier mobilization, fewer pulmonary and cardiac complications, reduced risk of deep vein thrombosis, faster recovery, and reduced cost of care. Although many therapeutic modalities are available for pain management, the optimal combination in managing postoperative pain in total abdominal hysterectomy is controversial.

The objective of this study was to review the literature to formulate optimal, evidence-based preoperative, intraoperative, and postoperative pain management for women undergoing total abdominal hysterectomy.

Using the OVID platform, we searched in MEDLINE and PubMed using MeSH terms postoperative pain and total abdominal hysterectomy for published articles from 1960 to the present; we found 545 studies. We screened and included only randomized clinical trials, publications in English, human studies, and abdominal hysterectomy for noncancerous indications. We excluded 456 studies that reported on animal studies; laparoscopic, vaginal, supracervical, or robotic hysterectomy; pharmacokinetic studies; primary outcome other than pain management; and chronic pain management. Studies with inadequate power, poor methodology, or inconclusive results were further excluded from this review. Thus, 89 studies constituted the cohort for our article.

Pain control remains complex given variables such as age, anxiety, and extent of surgery. In general, regimens should be tailored to the needs of the individual patient, taking into account medical, psychological, and physical condition. A multimodality approach is better than conventional, single-agent narcotic in achieving optimal pain management.

After reading this article, the reader should be able to understand various modalities that can be considered for preoperative, intraoperative, and postoperative pain management in total abdominal hysterectomy.

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Z9 24

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U2 5

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ER

PT J

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TI Tumoral Displacement into Fallopian Tubes in Patients Undergoing

Robotically Assisted Hysterectomy for Newly Diagnosed Endometrial Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL PATHOLOGY

LA English

DT Article

DE Robotic hysterectomy; Tubal contaminants; Tumor displacement;

Endometrial carcinoma

ID POSITIVE PERITONEAL CYTOLOGY; LAPAROSCOPIC HYSTERECTOMY; SPECIMENS;

INVOLVEMENT; CARCINOMA

AB Robotic surgery is increasingly being performed for endometrial cancer. Robotic hysterectomies (RH), like traditional laparoscopic hysterectomies (LH), involve a significant amount of uterine manipulation. The use of a manipulator is thought to possibly increase the incidence of artifactual tumor displacement beyond the endometrium, including the fallopian tube. The objective of this study was to determine whether there is an association between RH and tumor present in the fallopian tube lumina. All RH and LH cases performed for endometrial cancer from May 2007 to August 2009 were reviewed. Of the cases not converted to laparotomy, 137 RH and 184 LH were identified. Age, body mass index, operative and hysterectomy time, type and grade of tumor, stage, pelvic wash results, and the presence of detached tumor fragments (contaminants) in the lumina of the fallopian tubes were recorded. Appropriate statistical tests were applied. Of the 184 LH, 4 (2.2%) were reported to have detached fragments of tumor in the lumina of the fallopian tubes compared with 16 of the 137 (11.7%) RH cases (P<0.001). The majority of the patients with RH and tumor present in the tubes had Stage I disease (9/16, 56.2%) and Grade 1 tumors (9/16, 56.2%). Four (4/16, 25%) patients had Stage IIIa disease detected by a pelvic wash. Patients with contaminants had a higher body mass index, but the difference was not statistically significant and was possibly due to small numbers. In conclusion, our data demonstrate an association between RH and tubal contamination. The clinical significance of this phenomenon remains to be determined.

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Z9 17

U1 0

U2 4

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GA 089LZ

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ER

PT J

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U莽ar, MG

AF Gocmen, Ahmet

Sanlikan, Fatih

Ucar, Mustafa Gazi

TI Robot-assisted tubal reanastomosis: Initial experience in a single

institution

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE robotic tubal ligation reversal; tubal reanastomosis

ID ANASTOMOSIS; FEASIBILITY

AB Objective: To assess surgical outcomes for robot-assisted tubal reanastomosis in a single institution.

Materials and Methods: Between March 2009 and January 2010, 10 patients underwent robot-assisted tubal ligation reversal (TLR) with a da Vinci S surgical system. Patient demographic data, including operative times, operative and postoperative complications, hospital stay, conversion to laparotomy and pregnancy rates were recorded.

Results: Mean age and body mass index for the patients were 37.7 (35-42) years and 28.9 (23.9-36.3) kg/m(2), respectively. The mean console time was 102.5 min and the mean total operation time was 130.6 (102-164) min. The mean hospital stay was 1.2 (1-2) days. There were no significant intra-operative or early-postoperative complications. All surgeries were completed robotically with no conversion to laparotomy. There were seven subsequent pregnancies in the study participants, representing a pregnancy rate of 70%, of which five were intrauterine pregnancies, one was an ectopic pregnancy, and one was an abortus.

Conclusion: Robot-assisted TLR is safe and feasible. This procedure may facilitate minimally invasive treatment for patients who want to regain their fertility without the aid of artificial reproductive techniques. Copyright (C) 2013, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. All rights reserved.

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NR 10

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Z9 6

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U2 12

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JI Taiwan. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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OA gold

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ER

PT J

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Sokol, AI

Park, AJ

AF Antosh, Danielle D.

Whyte, Tori

Ezzell, Ann

Chen, Beatrice A.

Sokol, Andrew I.

Park, Amy J.

TI Incidence of corneal abrasions during pelvic reconstructive surgery

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Meeting of

American-Association-of-Gynecologic-Laparoscopists (AAGL)

CY NOV 08, 2011

CL Hollywood, FL

SP Amer Assoc Gynecol Laparoscopists (AAGL)

DE Corneal abrasion; Risk; Sacral colpopexy; Surgery

ID GENERAL-ANESTHESIA; COMPLICATIONS; PREVENTION

AB Objectives: To compare the incidence of corneal abrasions after robotic/laparoscopic sacral colpopexies versus vaginal apical suspensions, and to determine risk factors associated with the development of corneal abrasions.

Study design: This retrospective cohort study included all women undergoing robotic/laparoscopic sacral colpopexy or vaginal apical suspensions over a 5-year period. The incidence of corneal abrasions was compared between groups and statistical analysis was performed.

Results: 5/216 (2.3%) patients developed corneal abrasions in the sacral colpopexy group compared to 1/332 (0.3%) in the vaginal group (p = 0.04). Eye protection was more frequently documented in the sacral colpopexy group compared to the vaginal group (98.6% vs. 83.4%, p < 0.001). Women in the sacral colpopexy group were younger, with longer operating times, more intravenous fluids, and lower estimated blood loss. Risk factors for corneal abrasion could not be identified due to the low number of patients with corneal abrasions.

Conclusion: More corneal abrasions occurred with laparoscopic and robotic sacral colpopexy compared to vaginal apical suspension procedures. Risk factors could not be identified in this study. (C) 2012 Elsevier Ireland Ltd. All rights reserved.

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PT J

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Fowler, Jeffrey M.

Holloway, Robert W.

TI Analysis of disease recurrence and survival for women with uterine

malignancies undergoing robotic surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Recurrence; Survival; Adjuvant

treatments; Clinico-pathological factors

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER; ABDOMINAL

HYSTERECTOMY; LYMPHADENECTOMY; LAPAROTOMY; OUTCOMES; MANAGEMENT;

CARCINOMA

AB Objectives. To evaluate recurrence-free survival (RFS) and overall survival (OS) for patients who underwent robotic-assisted laparoscopic hysterectomy (RALH) for uterine malignancies.

Methods. Medical records from 372 patients with uterine malignancies who underwent RALH from 3/06 to 3/09 at two institutions were reviewed for dinico-pathologic data, adjuvant therapies, disease recurrence, and survival. Median follow-up for survival analysis was 31 +/- 14 months. Thirty (8.1%) patients were lost to follow-up before 12 months and censored from the recurrence analysis.

Results. Mean age and BMI of 372 patients was 61.8 +/- 9.8 years and 32.2 +/- 8.4 kg/m(2) (range 19-70). Robotic procedures included RALH 16 (4.3%), RALH with pelvic lymphadenectomy (PL) 96 (25.8%), and RALH with pelvic-and-aortic lymphadenectomy (PAL) 252 (67.7%) cases. Histology included 319 (85.8%) endometrioid and 53 (12.6%) high-risk histologies. Mean pelvic and aortic lymph node counts were 16.8 +/- 8.7 and 8.4 +/- 4.5, respectively. Lymph node metastases were identified in 26 (7.3%) cases. Adjuvant therapies were prescribed for 108 (29.1%) of patients: 7.8% brachytherapy, 1.9% pelvic radiation + brachytherapy, 7.8% chemotherapy, 11.6% chemotherapy + radiation. Risk of recurrence for all patients was 8.3% and 17 (4.6%) patients died of disease. The estimated 3-year recurrence-free survival (RFS) for the entire study group was 89.3% and the estimated 5-year overall survival (OS) was 89.1%, compared to 92.5% and 93.4% for the endometrioid sub-set.

Conclusions. Patients with endometrial cancer undergoing robotic hysterectomy with staging lymphade-nectomies during our 3-years of robotic experience had low-risk for recurrence and excellent disease-specific survival at a median follow-up time of 31 months. (c) 2012 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Surgical Treatment of Vaginal Apex Prolapse

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID PELVIC ORGAN PROLAPSE; SACROSPINOUS LIGAMENT SUSPENSION; ABDOMINAL

SACROCOLPOPEXY; VAULT PROLAPSE; SUTURE HYSTEROPEXY; GENITAL PROLAPSE;

SUPPORT DEFECTS; FASCIA LATA; REPAIR; HYSTERECTOMY

AB Pelvic organ prolapse is a common problem in women that increases with age and adversely affects quality of life and sexual function. If conservative treatments fail, surgery becomes the main option for symptom abatement. For uterovaginal prolapse, treatment with or without hysterectomy can be offered, and operations must include a specific apical support procedure to be effective. Operations for apical prolapse include transvaginal, open, and laparoscopic or robotic options; few clinical trials have compared the effectiveness and risk of these various surgeries. Grafts can be used selectively for apical suspensions and may improve cure rates but also increase risk of some complications. Slings should be added selectively to reduce postoperative stress incontinence. For women interested in future sexual activity who require apical prolapse surgery, we suggest using transvaginal apical repairs for older patients, those with primary or less severe prolapse, and those at increased surgical risk. We recommend sacral colpopexy with polypropylene mesh (preferably by minimally invasive route) in younger women, those with more severe prolapse or recurrences after vaginal surgery, and women with prolapsed, short vaginas. In older women with severe prolapse who are not interested in sexual activity, obliterative operations are very effective and have high satisfaction rates. An interactive consent process is mandatory, because many decisions-about route of surgery; use of hysterectomy, slings, and grafts; and vaginal capacity for sexual intercourse-require an informed patient's input. Selective referral to specialists in Female Pelvic medicine and Reconstructive Surgery can be considered for complex and recurrent cases. (Obstet Gynecol 2013;121:354-74) DOI: http://10.1097/AOG.0b013e31827f415c

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TC 28

Z9 33

U1 0

U2 9

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PT J

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TI Sentinel node biopsy in endometrial cancer: systematic review and

meta-analysis of the literature

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Review

DE Endometrial cancer; Sentinel node biopsy; Meta-analysis; Systematic

review; False negative rate; Detection rate

ID LYMPH-NODE; HYSTEROSCOPIC INJECTION; DIAGNOSTIC-ACCURACY; BLUE-DYE;

IDENTIFICATION; UTERINE; MALIGNANCIES; EXPERIENCE; CARCINOMA; WOMEN

AB Purpose: Sentinel lymph node biopsy is a fairly new approach for staging of gynecological malignancies. In the current study, the authors comprehensively reviewed the available reports on sentinel node biopsy of endometrial cancer. Materials and Methods: The authors searched Medline, SCOPUS, ISI web of knowledge, Science Direct, Springer, OVID SP, and Google Scholar with the following search terms: "endometrium OR endometrial OR uterine OR uterus AND sentinel". The outcomes of interest were detection rate and sensitivity. Results: Overall, 35 studies had enough information for false negative rate evaluation and 51 studies (including the sub-groups of individual studies) for detection rate evaluation (2,071 patients overall). Pooled detection rate was 77.8% (95% CI: 73.5-81.5%) and pooled sensitivity was 89% (95% CI: 83-93%). Cervical injection, as well as using both blue dye and radiotracer, results in higher detection rate and sensitivity. New techniques such as fluorescent dye injection and robotic-assisted surgery showed high detection rate and sensitivity. Conclusion: Sentinel node mapping is feasible in endometrial cancer. Using both blue dye and radiotracer and cervical injection of the mapping material can optimize the sensitivity and detection rate of this technique. Larger studies are still needed to evaluate the false negative rate and the factors influencing the sensitivity before considering this method safe.

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U1 0

U2 6

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J9 EUR J GYNAECOL ONCOL

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ER

PT J

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Randall, TC

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Chuang, Linus

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TI Integration of robotics into two established programs of minimally

invasive surgery for endometrial cancer appears to decrease surgical

complications

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial neoplasms; Laparoscopic surgery; Robotics

ID ASSISTED HYSTERECTOMY; LAPAROTOMY; LAPAROSCOPY; OUTCOMES;

LYMPHADENECTOMY; COST

AB Objective: To compare peri- and postoperative outcomes and complications of laparoscopic vs. robotic-assisted surgical staging for women with endometrial cancer at two established academic institutions.

Methods: Retrospective chart review of all women that underwent total hysterectomy with pelvic and para-aortic lymphadenectomy by robotic-assisted or laparoscopic approach over a four-year period by three surgeons at two academic institutions. Intraoperative and postoperative complications were measured. Secondary outcomes included operative time, blood loss, transfusion rate, number of lymph nodes retrieved, length of hospital stay and need for re-operation or re-admission.

Results: Four hundred and thirty-two cases were identified: 187 patients with robotic-assisted and 245 with laparoscopic staging. Both groups were statistically comparable in baseline characteristics. The overall rate of intraoperative complications was similar in both groups (1.6% vs. 2.9%, p=0.525) but the rate of urinary tract injuries was statistically higher in the laparoscopic group (2.9% vs. 0%, p=0.020). Patients in the robotic group had shorter hospital stay (1.96 days vs. 2.45 days, p=0.016) but an average 57 minutes longer surgery than the laparoscopic group (218 vs. 161 minutes, p=0.0001). There was less conversion rate (0.5% vs. 4.1%; relative risk, 0.21; 95% confidence interval, 0.03 to 1.34; p=0.027) and estimated blood loss in the robotic than in the laparoscopic group (187 mL vs. 110 mL, p=0.0001). There were no significant differences in blood transfusion rate, number of lymph nodes retrieved, re-operation or re-admission between the two groups.

Conclusion: Robotic-assisted surgery is an acceptable alternative to laparoscopy for staging of endometrial cancer and, in selected patients, it appears to have lower risk of urinary tract injury.

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NR 24

TC 30

Z9 35

U1 1

U2 4

PU KOREAN SOC GYNECOLOGY ONCOLOGY & COLPOSCOPY

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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PG 8

WC Oncology; Obstetrics & Gynecology

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AU Perutelli, A

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Garibaldi, Silvia

Gargini, Antonio

Baldacci, Chiara

Basile, Stefano

Salerno, Maria Giovanna

TI Robotic Management of Major Vessel Injury During Pelvic Lymphadenectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Vessel injury; Bulldog clamps

ID LAPAROSCOPIC SURGERY; COMPLICATIONS

AB Laparoscopic management of major vessel lesion is a challenging task during pelvic lymphadenectomy, and conversion is frequently necessary. Robotic surgery overcomes the limits of laparoscopy in vascular suturing. We describe a case of a 79-year-old woman with stage IB G3 endometrial adenocarcinoma, where an external iliac vein injury occurred during pelvic lymphadenectomy. This is the first case report that describes robotic management of a major vascular injury during pelvic lymphadenectomy by use of endoscopic bulldog clamps and robotic intracorporeal vascular sutures. Journal of Minimally Invasive Gynecology (2013) 20, 115-118 (C) 2013 AAGL. All rights reserved.

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NR 10

TC 2

Z9 3

U1 0

U2 2

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ER

PT J

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Gargiulo, AR

Bonaventura, LM

Lehman, JS

Srouji, SS

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TI Pregnancy outcomes following robot-assisted myomectomy

SO HUMAN REPRODUCTION

LA English

DT Article

DE pregnancy; robotic surgery; laparoscopy; myomectomy

ID LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY; FERTILITY; DELIVERY;

COMPLICATIONS; MULTICENTER; FIBROIDS; MYOMAS; WOMEN

AB STUDY QUESTION: What are the characteristics of the pregnancy outcomes in women undergoing robot-assisted laparoscopic myomectomy (RALM) for symptomatic leiomyomata uteri?

SUMMARY ANSWER: Despite a high prevalence of women with advanced maternal age, obesity and multiple pregnancy in our cohort, the outcomes are comparable with those reported in the literature for laparoscopic myomectomy.

WHAT IS KNOWN ALREADY: Reproductive outcomes after traditional laparoscopic myomectomy are well documented. However, reproductive outcomes following robotic myomectomy are not well studied. This paper describes the pregnancy outcomes for a large cohort of women after robotic myomectomy.

STUDY DESIGN, SIZE, DURATION: This is a retrospective cohort of women who became pregnant after robot-assisted myomectomy at three centers. Of the 872 women who underwent robotic myomectomy during the period October 2005-November 2010, 107 subsequently conceived resulting in 127 pregnancies and 92 deliveries through 2011.

PARTICIPANTS/MATERIAL, SETTING, METHODS: Women of reproductive age with fibroids who wanted a minimally invasive treatment option and desired uterine preservation were recruited. We conducted a multicentre study with three centers, two in a private practice and one in an academic setting. Pregnancy outcomes and their relationship to myoma characteristics were analyzed.

MAIN RESULTS AND ROLE OF CHANCE: Mean +/- SD age at myomectomy was 34.8 +/- 4.5 years and 57.4% [ 95% confidence interval (CI) 48.0, 66.3] of women were overweight or obese. The mean number of myomas removed was 3.9 +/- 3.2 with a mean size of 7.5 +/- 3.0 cm and mean weight of 191.7 +/- 144.8 g. Entry of the myoma into the endometrial cavity occurred in 20.6% (95% CI 15.0, 27.7) of patients. The mean time to conception was 12.9 +/- 11.5 months. Assisted reproduction techniques were employed in 39.4% (95% CI 32.6, 46.7) of these women. Seven twin pregnancies and two triplet pregnancies occurred, for a multiple pregnancy birth rate of 9.8% (95% CI 5.0, 17.8). Spontaneous abortions occurred in 18.9% (95% CI 13.0, 26.6). Preterm delivery prior to 35 weeks of gestational age occurred in 17.4% (95% CI 10.9, 26.5). One uterine rupture (1.1%; 95% CI 0.3, 4.7) was documented. Pelvic adhesions were discovered in 11.4% (95% CI 7.0, 18.0) of patients delivered by Cesarean section. Higher preterm delivery rates were significantly associated with a greater number of myomas removed and anterior location of the largest incision (compared with all other sites) in logistic regression analyses (P = 0.01). None of the myoma characteristics were related to spontaneous abortion.

BIAS, CONFOUNDING AND OTHER REASONS FOR CAUTION: Given the retrospective nature of the data collection, some pregnancies may not have been captured. In addition, owing to the high prevalence of infertility patients in this cohort, the data cannot be used to counsel women who are undergoing RALM about fertility rates after surgery.

GENERALIZABILITY TO OTHER POPULATIONS: Prospective studies are needed to determine if the results shown in our cohort are generalizable to all women seeking a minimally invasive option for the conservative treatment of symptomatic fibroids with pregnancy as a desired outcome.

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NR 48

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U1 0

U2 14

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ER

PT J

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Fattizzi, N

Santoro, G

Rosati, R

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Fattizzi, Nicola

Santoro, Giuseppe

Rosati, Riccardo

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TI Robotic surgery and standard laparoscopy: A surgical hybrid technique

for use in colorectal endometriosis

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE bowel endometriosis; da Vinci surgical system; infertility; laparoscopy;

rectosigmoidal resection

ID QUALITY-OF-LIFE; TERM-FOLLOW-UP; BOWEL RESECTION; INFILTRATING

ENDOMETRIOSIS; INFERTILE WOMEN; FERTILITY; SYMPTOMS; TRIAL

AB Aim: The aim of our work was to assess the feasibility and possible benefits of a novel hybrid surgical technique in rectosigmoidal resection in patients with bowel endometriosis. Material and Methods: A total of seven symptomatic and infertile women with severe bowel endometriosis underwent segmental bowel resection using the da Vinci surgical system and conventional laparoscopy. Statistical analysis was performed by Friedman test for non-parametric multiple comparisons. Results: The surgical procedure has a determined short mean operative time (210 min) and short postoperative hospitalization (five days). In 100% of patients, the resected area showed disease-free margins. Follow-up, carried out at three, six and 12 months after operation, showed a regression of painful symptoms in all operated patients (100%). Two patients (28.6%) aged = 35 years eventually had natural pregnancies. Conclusion: To the best of our knowledge, this report is the first concerning the use of a hybrid technique for intestinal resection in severe endometriosis, and comparing our data with that in the literature, its methodological and clinical advantages are evident. Moreover, the complete removal of endometriotic implants seems to offer good results in terms of postoperative fertility, although the study data do not allow us to draw definitive conclusions on the management of fertility.

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NR 30

TC 17

Z9 19

U1 0

U2 7

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J9 J OBSTET GYNAECOL RE

JI J. Obstet. Gynaecol. Res.

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EP 222

DI 10.1111/j.1447-0756.2012.01891.x

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WC Obstetrics & Gynecology

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GA 066WA

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ER

PT J

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Casiano, ER

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Trabuco, EC

Gebhart, JB

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Weaver, Amy L.

Gostout, Bobbie S.

Trabuco, Emanuel C.

Gebhart, John B.

TI The Learning Curve of Robotic Hysterectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID RADICAL HYSTERECTOMY; OPERATIVE TIME; LAPAROSCOPY; LYMPHADENECTOMY;

SACROCOLPOPEXY; COMPLICATIONS; OUTCOMES

AB OBJECTIVE: To evaluate the learning curve of robotic hysterectomy using objective, patient-centered outcomes and analytic methods proposed in the literature.

METHODS: All cases of robotic hysterectomy performed at Mayo Clinic, Rochester, Minnesota, from January 1, 2007, through December 31, 2009, were collected. Experience was analyzed in 6-month periods. Operative time, complications, and length of stay longer than 1 day were compared between periods for significant change. For learning curve analysis, standard and risk-adjusted cumulative summation charting was used for the two most experienced robotic surgeons (A and B). Outcomes of interest were intraoperative complications and intraoperative or postoperative complications within 6 weeks. Proficiency was defined as the point at which each surgeon's curve crossed H-0 based on complication rates of abdominal hysterectomy. Cumulative summation parameters were p(0)=5.7% and p(1)=11.4% for outcome 1 and p(0)=36.0% and p(1)=550% for outcome 2.

RESULTS: In 325 cases, operative time decreased significantly from 3.5 to 2.7 hours during the 3-year period. The proportion of patients with length of stay longer than 1 day decreased significantly from 49.2% to 14.7%. Complications did not decrease significantly. The average number of procedures to cross H-0 was 91 for outcome 1 and 44 for outcome 2. Observed cumulative summation curves of surgeons A and B differed from the average number of attempts calculated from p(0) and p(1).

CONCLUSIONS: Operative time and length of stay decrease with 36 months of experience with robotic hysterectomy, whereas complications may not. Cumulative summation analysis provides an objective, individualized tool to evaluate surgical proficiency and suggests this occurs after performing approximately 91 procedures. (Obstet Gynecol 2013;121:87-95) DOI: http://10.1097/AOG.0b013e31827a029e

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FX Supported by the Mayo Clinic.

NR 22

TC 86

Z9 92

U1 0

U2 5

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI AAGL Position Statement: Robotic-Assisted Laparoscopic Surgery in Benign

Gynecology AAGL <i>ADVANCING MINIMALLY INVASIVE GYNECOLOGY WORLDWIDE</i>

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic-assisted laparoscopy in benign disease; Robotic surgery

ID ABDOMINAL MYOMECTOMY; TUBAL ANASTOMOSIS; SURGICAL OUTCOMES;

UNITED-STATES; SACROCOLPOPEXY; HYSTERECTOMY; PROLAPSE; COSTS

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NR 51

TC 48

Z9 48

U1 0

U2 0

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JI J. Minim. Invasive Gynecol.

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ER

PT J

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TI Comparison of perioperative outcomes and cost of robotic-assisted

laparoscopy, laparoscopy and laparotomy for endometrial cancer

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic; Laparoscopy; Survival; Cost

ID SURGICAL OUTCOMES; HYSTERECTOMY; LYMPHADENECTOMY; SURGERY; PROGRAM;

SAFETY; OBESE; WOMEN

AB Objective: To analyze the perioperative outcomes and cost of three surgical approaches in the treatment of endometrial cancer: robotic, laparoscopy and laparotomy.

Study design: We studied 347 patients with endometrial cancer treated in a single institution: 71 patients were operated by robotics, 84 by conventional laparoscopy and 192 by laparotomy. All patients underwent total hysterectomy, bilateral salpingoophorectomy and pelvic and para-aortic lymphadenectomy depending on the pathological features.

Results: Operative time was longer in the laparoscopy group as compared to robotics and laparotomy (218.2 min, 189.2 min, and 157.4 min respectively, p = 0.000). The estimated blood loss was lower in the robotic group relative to the other groups (99.4 ml in robotic, 190.0 ml in laparoscopy and 231.5 ml in laparotomy, p = 0.000). Similar findings were observed for the pre- and post-operative mean hemoglobin levels (-1.3 g/dl, -2.3 g/dl and -2.5 g/dl respectively, p = 0.000), and transfusion rate (4.2%, 7.1% and 14.1% respectively, p = 0.036). The length of hospital stay was higher in the laparotomy group compared to robotics and laparoscopy (8.1, 3.5 and 4.6 days respectively; p = 0.000). The conversion rate to laparotomy was lower for robotics (2.4% for robotics and 8.1% for laparoscopy, p = 0.181). Overall complications were similar for robotics and laparoscopy (21.1%, 28.5%) (p = 0.079). Robotic complications were significantly lower as compared to laparotomy (21.2 vs 34.9% (p = 0.036). No differences were found relative to disease-free or overall survival among the three groups. The global costs were similar for the three approaches (p = 0.566).

Conclusion: Robotics is a safe alternative to laparoscopy and laparotomy for endometrial cancer patients, offering improved perioperative outcomes and similar cost as compared to the other two surgical approaches. (C) 2012 Elsevier Ireland Ltd. All rights reserved.

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NR 31

TC 92

Z9 99

U1 0

U2 8

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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ER

PT J

AU Hibner, M

Marianowski, P

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Marianowski, Piotr

Szymusik, Iwona

Wielgos, Miroslaw

TI Robotic surgery in gynecology

SO GINEKOLOGIA POLSKA

LA Polish

DT Article

DE medical robotics; Da Vinci robot; Da Vinci instruments; conventional

surgery

AB Introduction of robotic surgery in the first decade of the 21 century was one of the biggest breakthroughs in surgery since the introduction of anesthesia, For the first time in history the surgeon was placed remotely from the patient and was able to operate with the device that has more degrees of freedom than human hand. Initially developed for the US Military in order to allow surgeons to be removed from the battlefield, surgical robots quickly made a leap to the mainstream medicine. One of the first surgical uses for the robot was cardiac surgery but it is urology and prostate surgery that gave it a widespread popularity.

Gynecologic surgeons caught on very quickly and it is estimated that 31% of hysterectomies done in the United States in 2012 will be done robotically. With over half a million hysterectomies done each year in the US alone, gynecologic surgery is one of the main driving forces behind the growth of robotic surgery Other applications in gynecology include myomectomy, oophorectomy and ovarian cystectomy, resection of endometriosis and lymphadenectomy. Advantages of the surgical robot are clearly seen in myomectomy. The wrist motion allows for better, more precise suturing than conventional "straight stick" laparoscopy. The strength of the arms allow for better pulling of the suture and the third arm for holding the suture on tension. Other advantage of the robot is scaling of the movements when big movement on the outside translates to very fine movement on the inside. This enables much more precise surgery and may be important in the procedures like tubal anastomosis and implantation of the ureter Three-dimensional vision provides excellent depth of field perception. It is important for surgeons who are switching from open surgeries and preliminary evidence shows that it may allow for better identification of lesions like endometriosis. Another big advantage of robotics is that the surgeon sits comfortably with his/her arms and head supported. This results in much less fatigue and therefore increases precision and potentially may decrease the number of medical errors. The eyes of the surgeon are directed at where the hands should be, which is more natural, allows for a more natural body position and mimics open surgery Robot also enables better teaching, especially when two consoles are used. The surgeon and the student may be either sharing the instruments with two consoles or switching between one another In a situation where the student operates, the surgeon can use the telestation to teach. Robotic simulator attached to one of the consoles allows students to practice after hours.

In summary surgical robot is a great tool, especially in gynecology but also in urology cardiac surgery general surgery and laryngology The device will evolve and most likely with time will eliminate laparoscopy

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PT J

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Bossmar, T

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Imboden, Sara

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Borgfeldt, Christer

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TI Reproducibility and accuracy of robot-assisted laparoscopic fertility

sparing radical trachelectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robot; Trachelectomy; Reproducibility; Accuracy

ID CERVICAL-CARCINOMA; CANCER; LYMPHADENECTOMY; HYSTERECTOMY; PREGNANCY;

PRESERVE; SURGERY; WOMEN

AB Objective. To assess the accuracy and reproducibility of robot-assisted laparoscopic abdominal fertility sparing radical trachelectomy in women with early stage cervical cancer.

Methods. Relevant prospective clinical data from 13 consecutive women planned for robotic radical trachelectomy between 2007 and 2012 were compared with retrospective data from 12 consecutive women planned for vaginal radical trachelectomy between 2000 and 2007. The first follow up on all women included a similar vaginal ultrasonographic measurement of the remaining cervical length and the position of the cerclage, enabling a direct comparison. Peri- and postoperative clinical data were evaluated.

Results. The remaining cervical length was equal between the robotic and vaginal procedures (mean 11 mm, range 8-13 mm; mean 11 mm, range 5-19 mm respectively, p = 0.92). The distance from the cerclage to the inner cervical os was significantly shorter and less variable in the robot group (robot mean 2 mm, range of 1-4 mm, vaginal mean 4 mm, range 2-7 mm, p = 0.003). Rejection of the cerclage (n = 3) and/or cervical stenosis (n = 3) was diagnosed in four women, all of whom in the vaginal group, between one and 13 months after surgery.

Conclusions. Robotic trachelectomy is equally reproducible and accurate as the vaginal trachelectomy in terms of the remaining cervical length and results in a significantly more precise placement of the cerclage. (C) 2012 Elsevier Inc. All rights reserved.

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Cohen, SL

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TI Utility of Cystoscopy During Hysterectomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID URINARY-TRACT INJURY; UNIVERSAL CYSTOSCOPY; URETERAL INJURY; SURGERY

AB OBJECTIVE: To estimate the incidence of cystoscopy use at time of hysterectomy and its use to detect urinary tract injury.

METHODS: This was a retrospective cohort study in a tertiary care academic center of 1982 patients who underwent a hysterectomy for any indication (excluding obstetric) between January 2009 and December 2010. Medical records were reviewed for baseline and perioperative characteristics, cystoscopy use, and information about bladder or ureteral injury related to hysterectomy.

RESULTS: Two hundred fifty-one women (12.66%, 95% confidence interval [CI] 11.23-14.21%) underwent a cystoscopy at the time of hysterectomy with no reported complications resulting from the cystoscopy procedure. Cystoscopy was most frequently used by low-volume surgeons and in cases involving prolapse or vaginal mode of access. Fourteen patients (0.71%, 95% CI 0.39-1.19%) experienced bladder injury and five patients (0.25%, 95% CI 0.08-0.58%) sustained ureteral injury. None of these complications were detected by cystoscopy; cystoscopy was either normal at the time of hysterectomy or was omitted. The presence of adhesions was significantly associated with bladder injury at the time of hysterectomy (P=.006). Low-volume surgeon and laparoscopic or robotic mode of access were both significantly associated with ureteral injury (P=.023 and P=.042, respectively).

CONCLUSIONS: Our data support selective rather than universal cystoscopy at the time of hysterectomy. (Obstet Gynecol 2012;120:1363-70) DOI: http://10.1097/AOG.0b013e318272393b

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PT J

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TI Informed Consent for Sacrocolpopexy: Is Counseling Effective in

Achieving Patient Comprehension?

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE Comprehension; informed consent; prolapse; sacrocolpopexy

AB Objectives: The purpose of the informed consent process is to reinforce a patient's understanding of her condition and treatment alternatives and to thoroughly review the chosen procedure with its risks and benefits. We aimed to evaluate how well women who consented to undergo sacrocolpopexy understood their planned procedure.

Study Design: We prospectively studied women who had undergone detailed informed consent in preparation for laparoscopic or robotic sacrocolpopexy. A 15-item questionnaire was developed and administered before surgery to assess the patients' comprehension of preoperative counseling.

Results: Fifty women were enrolled. The mean knowledge score was 69.7%. Sixty-four percent of the patients did not recall that they could have a prolapse repair without mesh, 44% did not understand the location of mesh attachment, and 34% believed there was no risk of recurrent prolapse. Women who completed the questionnaire within 3 weeks of signing the surgical consent had a higher mean score (78.5%) than women for whom 3 or more weeks elapsed (66.3%; P=0.02).

Conclusion: Despite detailed preoperative discussion, women had deficiencies in their understanding of sacrocolpopexy. New methods to improve patient education and comprehension should be considered.

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PT J

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Reeves, K

Snyder, M

Fletcher, SG

AF Choi, Judy M.

Vian Nguyen

Khavari, Rose

Reeves, Keith

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Fletcher, Sophie G.

TI Complex Rectovaginal Fistulas After Pelvic Organ Prolapse Repair With

Synthetic Mesh: A Multidisciplinary Approach to Evaluation and

Management

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE rectovaginal fistula; pelvic organ prolapse; posterior repair;

rectocele; transvaginal mesh

ID RANDOMIZED-TRIAL; VAGINAL REPAIR; COLPORRHAPHY; RECTOCELE; WOMEN

AB Objectives: The use of synthetic mesh for transvaginal pelvic organ prolapse (POP) repair is associated with the rare complication of mesh erosion into hollow viscera. This study presents a single-institution series of complex rectovaginal fistulas (RVFs) after synthetic mesh-augmented POP repair, as well as strategies for identification and management.

Methods: Institutional review board approval was obtained for this retrospective study. Data were collected and analyzed on all female patients undergoing RVF repair from 2000 to 2011 at our institution.

Results: Thirty-seven patients underwent RVF repair at our multidisciplinary center for restorative pelvic medicine. Of these, 10 (27.0%) were associated with POP repairs using mesh. The POP repairs resulting in RVF were transvaginal repair with mesh (n = 8), laparoscopic sacrocolpopexy with concomitant traditional posterior repair (n = 1), and robotic-assisted laparoscopic sacrocolpopexy (n = 1). Time to presentation was an average of 7.1 months after POP repair. Patients underwent a mean of 4.4 surgeries for definitive RVF repair, with 40% of patients requiring a bowel diversion (3 temporary ileostomies and 1 long-term colostomy). Mean follow-up time after last surgery was 9.2 months. On follow-up, 1 patient has a persistent fistula with vaginal mesh extrusion. One patient has persistent pelvic pain.

Conclusions: This series highlights the significant impact of synthetic mesh complications in the posterior compartment. These complications should be cautionary for synthetic graft use by those with limited experience, particularly when an alternate choice of traditional repair is available. When symptoms of RVF are present, collaboration with a colon and rectal specialist should be initiated as soon as possible for evaluation and definitive repair.

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ER

PT J

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TI Accuracy of sentinel lymph node detection following intra-operative

cervical injection for endometrial cancer: A prospective study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Sentinel lymph node; Lymphatic mapping; Endometrial cancer; Robotic

surgery; Lymphadenectomy

ID BIOPSY

AB Objective. The objective of this study is to evaluate the detection rate and diagnostic accuracy of sentinel lymph node (SLN) mapping using intra-operative cervical injection of filtered 99mTc-sulfur colloid (99mTc-SC) and patent blue in patients with endometrial cancer.

Methods. Prospective evaluation of the first 100 endometrial cancer patients undergoing SLN mapping using cervical injection of patent blue combined with filtered 99mTc-SC in the operating room was done. Patients underwent robotic-assisted lymphatic mapping with frozen section, hysterectomy, BSO, and completion bilateral lymphadenectomy (including para-aortic nodes in grade 2 and 3 tumors).

Results. At least one SLN was detected in 92% of patients: in 66 of these (72%) bilateral SLN were detected, and in 15 cases the SLN was in the para-aortic area. Eleven percent of all patients had lymph node metastases, and 4 of which had pre-operative grade 1 tumor. The SLN was the only positive node in 44% of the cases with positive nodes. Sensitivity was 89% with 1 false negative result, yielding a negative predictive value of 99% (95% Cl 93-100). Specificity was 100% (95% Cl 94-100), and positive predictive value was 100% (95% Cl 60-100). No complications or anaphylactic reactions were noted.

Conclusions. Intra-operative SLN biopsy, using cervical injection of patent blue and filtered 99mTc-SC in endometrial cancer patients is feasible and yields adequate detection rates. (C) 2012 Elsevier Inc. All rights reserved.

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PT J

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TI Cost Analysis of Open Versus Robotic-Assisted Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sacrocolpopexy; robotic-assisted sacrocolpopexy; length of stay;

prolapse; surgical costs

AB Objective: This study aimed to report on the costs, operative times, and length of stay for robotic and open sacrocolpopexy.

Study Design: This retrospective study compares consecutive open and robotic sacrocolpopexies that were performed beyond the surgical learning curve. Hospital direct costs, operative times, and length of stay were compared for the 2 groups. Robot cost and maintenance were included. Statistical significance was considered at P < 0.05.

Results: The study comprised 91 open and 73 robotic sacrocolpopexies. Both groups were similar clinically. Median operative times for open and robotic approaches were 166 and 212 minutes (P < 0.001), respectively, and length of stay was 3 versus 2 days (P < 0.001). Of the women in the robotic group, 48% had length of stay less than 24 hours versus 1% in the open group. Median robotic and open procedure direct costs were $ 6668 and $ 7804 (P = 0.002), respectively. Readmission rates at 30 days postoperatively were similar.

Conclusions: Robotic sacrocolpopexy costs less but takes slightly longer to perform than the open procedure.

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NR 10

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Z9 30

U1 0

U2 2

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PT J

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TI Apical Vaginal Prolapse Surgery: Practice Patterns and Factors Guiding

Route of Repair

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE mesh; sacrocolpopexy; native tissue; surgeon survey; practice patterns

AB Objectives: Describe current trends for repair of primary and recurrent apical vaginal prolapse using 4 different approaches, namely, transvaginal native (TVN) tissue, transvaginal using graft, laparotomy, or laparoscopic/robotic, and to determine which factors influence decision for favored approach.

Methods: A 15-item survey was distributed to attendees of the 2011 Society of Gynecologic Surgeons meeting. Demographic data and percentages of routes of repair were collected. Twenty factors were graded on the importance for influencing surgical approach.

Results: Transvaginal native tissue was the preferred route for primary repair (mean, 53.0%), and laparoscopic/robotic for recurrent repair (33.8%). Surgeons in academic practices, without formal postresidency training, and with lower surgical volumes were more likely to elect TVN for primary repair than alternatives. Important factors in selection of surgical approach included patient age and severity of medical comorbidities.

Conclusions: Among the Society of Gynecologic Surgeons meeting attendees, TVN is the preferred primary route for apical prolapse repair. Laparoscopic-assisted repairs are more common for recurrent prolapse.

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NR 13

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Z9 8

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PT J

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TI Robot-Assisted Excision of a Huge Pararectal Dermoid Cyst Via a Totally

Transabdominal Route

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Dermoid cyst; Pararectal tumor; Robotic surgery

ID ADULTS; TUMORS

AB Herein is reported the case of a 17-year-old adolescent with a huge cystic mass located between the vagina and the rectum, with extension into the gluteal region. The lesion caused compression and dislocation of the bladder, uterus, adnexae, and rectum. The patient underwent robot-assisted surgical excision of the mass via a totally transabdominal route. Postoperative recovery was uneventful, with excellent functional and cosmetic results. To our knowledge, this is the first case of a huge pelvic pararectal cyst reaching up to the gluteus and excised via a totally transabdominal approach with the aid of robotic assistance. Robot-assisted surgery seems to be appropriate for therapeutic management of huge pararectal tumors, the major advantages being minimum damage to contiguous structures, rapid postoperative recovery, and excellent cosmetic results. Journal of Minimally Invasive Gynecology (2012) 19, 772-774 (C) 2012 AAGL. All rights reserved.

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OI Palmeri, Matteo/0000-0002-9343-278X; Morelli, Luca/0000-0002-7742-9556

NR 9

TC 3

Z9 3

U1 0

U2 3

PU ELSEVIER SCIENCE INC

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

PD NOV-DEC

PY 2012

VL 19

IS 6

BP 772

EP 774

DI 10.1016/j.jmig.2012.06.008

PG 3

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 031PB

UT WOS:000310653300020

PM 23084685

DA 2024-01-18

ER

PT J

AU Mourik, SL

Martens, JE

Aktas, M

AF Mourik, Sarah L.

Martens, Jolise E.

Aktas, Mustafa

TI Uterine preservation in pelvic organ prolapse using robot assisted

laparoscopic sacrohysteropexy: quality of life and technique

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Uterine prolapse; Quality of life; Robotic surgery; Sacrohysteropexy

ID SHORT-TERM OUTCOMES; ABDOMINAL SACROCOLPOPEXY; SURGERY; MANAGEMENT;

REPAIR; WOMEN

AB Objective: Measuring quality of life of women with disorders of the pelvic floor is crucial when evaluating a therapy. The aim of this study is to profile health related quality of life of women with pelvic organ prolapse who are treated with robot assisted laparoscopic sacrohysteropexy (RALS). We also compare the operative characteristics and learning curve in this study with the current literature and describe the surgical technique.

Study design: A prospective cohort study in a teaching hospital in The Netherlands. Fifty women with uterovaginal prolapse were treated with RALS. This study presents the largest cohort in Europe treated by RALS to date. Quality of life was assessed pre- and post-operatively using the UDI/IIQ validated self-questionnaire designed for Dutch-speaking patients. Clinical and operative data were prospectively collected up to 29 months. RALS was performed with preservation of the uterus. Statistical analysis of categorical data was performed with the paired T-test. Descriptive statistics were computed with the use of standard methods for means, median and proportions.

Results: Before operation, overall wellbeing was scored at 67.7% and after surgery this improved to 82.1% (p = 0.03). Feelings of nervousness, frustration and embarrassment reduced significantly. Sexual functioning improved, but not significantly. The mean operative time was 223(103-340) min. Operative time decreased significantly with gained experience and became comparable to the operative time for abdominal sacrocolpopexy and classic laparoscopy. Average blood loss was less than 50 ml and patients had a mean hospital stay of 2 days. Of all women, 95.2% were very satisfied with the result after RALS.

Conclusion: Health related quality of life improves significantly after RALS. There are high rates of patient satisfaction. RALS proves to be a safe and effective treatment of pelvic organ prolapse. Operative time is comparable to abdominal sacrocolpopexy and classic laparoscopy in the current literature. (C) 2012 Elsevier Ireland Ltd. All rights reserved.

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NR 26

TC 28

Z9 29

U1 0

U2 6

PU ELSEVIER

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EI 1872-7654

J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

PD NOV

PY 2012

VL 165

IS 1

BP 122

EP 127

DI 10.1016/j.ejogrb.2012.07.025

PG 6

WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA 046KB

UT WOS:000311762800022

PM 22897838

DA 2024-01-18

ER

PT J

AU Siedhoff, MT

Carey, ET

Findley, AD

Riggins, LE

Garrett, JM

Steege, JF

AF Siedhoff, Matthew T.

Carey, Erin T.

Findley, Austin D.

Riggins, Lauren E.

Garrett, Joanne M.

Steege, John F.

TI Effect of Extreme Obesity on Outcomes in Laparoscopic Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Hysterectomy; Obesity; Body mass index; Outcomes;

Complications; Surgery time

ID BODY-MASS-INDEX; CLAVIEN-DINDO CLASSIFICATION; ENDOMETRIAL CANCER;

SURGICAL COMPLICATIONS; WOMEN; NONOBESE; IMPACT; CARCINOMA; RISK; FAT

AB Study Objective: To estimate the effect of body mass index (BMI) on several outcomes in laparoscopic hysterectomy, in particular in the extremes of obesity.

Design: Retrospective cohort study (Canadian Task Force classification II-3).

Setting: Tertiary-care university-based teaching hospital.

Patients: Eight hundred thirty-four patients who underwent laparoscopic hysterectomy from January 2007 to October 2011.

Intervention: Laparoscopic hysterectomy for benign indications.

Measurements and Main Results: Demographic, operative, and postoperative data were abstracted from medical records. The primary outcome was a composite index score that took into account operative time, nonsurgical operating room time, estimated blood loss, length of hospital stay, number of complications, and severity of complications according to the Dindo-Clavien classification. We individually examined elements of the composite index as a secondary outcome. Models were developed to assess the association of BM I with the composite index score and the components of the index, controlling for age, presence of diabetes, tobacco use, surgeon, type of hysterectomy (total vs supracervical), use of robotics, uterine weight, number of additional procedures performed, presence of adhesions requiring lysis, and deeply infiltrating endometriosis as potential confounders. Mean (SD) BMI was 31.4 (8.1). Mean (SD) uterine weight was 345 (388) g. Mean operative time was 150 (61) minutes. Increasing BMI was associated with a worse composite score (p < .01); longer operative time (p = .03), nonsurgical operating room time (p = .02), and total operating room time (p < .01); greater estimated blood loss (p < .01); and complication severity (p = .01).

Conclusion: These data suggest that there is a significant association of BMI with surgical outcomes in laparoscopic hysterectomy, and the effect is most pronounced in the morbidly obese. These patients may stand to gain the greatest differential benefit from a laparoscopic approach to surgery. However, they should be properly counseled about the challenge that obesity poses to the operation. Journal of Minimally Invasive Gynecology (2012) 19, 701-707 (C) 2012 AAGL. All rights reserved.

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NR 36

TC 56

Z9 61

U1 0

U2 3

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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IS 6

BP 701

EP 707

DI 10.1016/j.jmig.2012.07.005

PG 7

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 031PB

UT WOS:000310653300008

PM 23084673

DA 2024-01-18

ER

PT J

AU Moore, ES

Foster, TL

McHugh, K

Addleman, RN

Sumners, JE

AF Moore, E. S.

Foster, T. L.

McHugh, K.

Addleman, R. N.

Sumners, J. E.

TI Robotic-assisted transabdominal cerclage (RoboTAC) in the non-pregnant

patient

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Article

DE Cervical insufficiency; pregnancy; robotic surgery; surgical

complications; transabdominal cervical cerclage

ID FAILED TRANSVAGINAL CERCLAGE; CERVICAL CERCLAGE; CERVICOISTHMIC

CERCLAGE; GYNECOLOGIC SURGERY; CONTROVERSIES; INCOMPETENCE

AB The use of cerclage, either through vaginal or abdominal routes, to assist in delaying pre-term delivery among select women with cervical insufficiency may be beneficial, but can also carry significant morbidity. Robotic-assisted transabdominal cervical cerclage (RoboTAC) in the non-pregnant patient has the ability to not only reduce associated morbidity, but also off er the same benefits as the more traditional laparotomy and laparoscopic approaches, while removing the risk to an in situ fetus. We report the use of robotic-assisted transabdominal cervical cerclage in 24 non-pregnant women. Feasibility of the procedure is discussed along with a description of the technical surgical details. In addition, limited pregnancy outcomes are presented. Our results suggest that RoboTAC is a safe alternative to the traditional laparotomy procedure with quicker recovery time

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NR 32

TC 15

Z9 15

U1 0

U2 1

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J9 J OBSTET GYNAECOL

JI J. Obstet. Gynaecol.

PD OCT

PY 2012

VL 32

IS 7

BP 643

EP 647

DI 10.3109/01443615.2012.698666

PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 000EH

UT WOS:000308368800008

PM 22943709

DA 2024-01-18

ER

PT J

AU Rakowski, JA

Tran, TAN

Ahmad, S

James, JA

Brudie, LA

Pernicone, PJ

Radi, MJ

Holloway, RW

AF Rakowski, Joseph A.

Tran, Tien Anh N.

Ahmad, Sarfraz

James, Jeffrey A.

Brudie, Lorna A.

Pernicone, Peter J.

Radi, Michael J.

Holloway, Robert W.

TI Does a uterine manipulator affect cervical cancer pathology or

identification of lymphovascular space involvement?

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 42nd Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncology (SGO)

CY MAR 06-09, 2011

CL Orlando, FL

SP Soc Gynecol Oncol (SGO)

DE Cervical cancer; Uterine manipulator; Robotic radical hysterectomy;

Laparotomy; Lymphovascular space involvement; Pathology

ID LAPAROSCOPIC HYSTERECTOMY SPECIMENS; GYNECOLOGIC-ONCOLOGY-GROUP; RADICAL

HYSTERECTOMY; ENDOMETRIAL CANCER; CARCINOMA; LYMPHADENECTOMY;

LAPAROTOMY; ARTIFACT; SURGERY; STAGE

AB Objective. Uterine manipulators are a useful adjunct for robotic-assisted radical hysterectomy (RARH), but some surgeons avoid their use for fear of altering pathology or interpretation of lymphovascular space involvement (LVSI). We retrospectively compared clinico-pathological data and tumor pathology from patients with cervical cancer operated by laparotomy vs. RARH.

Methods. Charts from cervical cancer patients who underwent radical hysterectomy from January-1997 to June-2010 were reviewed for tumor histology, grade, FIGO stage, lymph node status, LVSI, depth of invasion, and tumor size. A ConMed V-Care (R) uterine manipulator was used in all robotic cases. H&E stained slides from 20 robotic and 24 open stage IB1 cases with LVSI reported in the original pathology were re-reviewed by a blinded pathologist for analysis of tissue artifacts and LVSI.

Results. Two-hundred-thirty-six cases (185 open, 51 robotic) with stages IA2, IB1 and IB2 cervical cancer were reviewed. No significant differences in histology (squamous cell carcinoma, 65% vs. 51%; p = 0.1), 1131 lesion size (<= 2 cm, 62% vs. 61%, p>0.1), LVSI (34% vs. 39%, p>0.1), and depth of stromal invasion (p> 0.1) was found between open and robotic groups. Histologic examination of all 181 cervical carcinomas revealed a higher degree of surface disruption [45% (9/20) vs. 12.6% (3/24), p = 0.038] and artifactual "parametrial carryover" [65% (13/20) vs. 29% (7/24), p = 0.037] in robotic vs. open groups, respectively, but no significant differences in the rate of LVSI.

Conclusion. RARH cases that utilized a uterine manipulator did not show any clinico-pathological differences in depth of invasion, LVSI, or parametrial involvement compared to open cases. (C) 2012 Elsevier Inc. All rights reserved.

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NR 14

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Z9 37

U1 0

U2 7

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

PD OCT

PY 2012

VL 127

IS 1

BP 98

EP 101

DI 10.1016/j.ygyno.2012.07.094

PG 4

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Conference Proceedings Citation Index - Science (CPCI-S)

SC Oncology; Obstetrics & Gynecology

GA 005XQ

UT WOS:000308783800019

PM 22800652

DA 2024-01-18

ER

PT J

AU Turnbull, H

Burbos, N

Abu-Freij, M

Duncan, TJ

Nieto, JJ

AF Turnbull, Hilary

Burbos, Nikolaos

Abu-Freij, Mazen

Duncan, Timothy J.

Nieto, Joaquin J.

TI A novel approach to postoperative bladder care in women after radical

hysterectomy

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Radical hysterectomy; Urinary catheter removal; Bladder dysfunction

ID CERVICAL-CANCER; ABDOMINAL HYSTERECTOMY; ROBOTIC SURGERY; DYSFUNCTION

AB Currently, controversy exists with regard to the duration of bladder drainage and choice of catheter used in women who undergo radical hysterectomy. In this manuscript, we propose a novel approach to improving postoperative bladder care in women who undergo radical hysterectomy.

This is a retrospective study of women who underwent Type 3 Piver radical hysterectomy in a gynaecological oncology centre in the United Kingdom from January 2009 to September 2011. We report the outcomes of removal of urinary catheter 48-72 h following radical hysterectomy.

Over a 32-month period, 30 women underwent radical hysterectomy. 19 (63.3 %) women underwent surgery for treatment of cervical cancer, 5 (16.7 %) women for management of endometrial cancer, 6 (20 %) women for other conditions. One patient underwent partial cystectomy at the time of radical hysterectomy and was not included in the analysis. Of the 29 patients, only five (17.2 %) were found to have urinary residuals greater than 100 ml following the removal of the indwelling catheter on the second postoperative day and required recatheterisation. 82.8 % of the patients had the catheter removed within 48-72 h postoperatively. None of these patients required re-admission with urinary retention.

Removal of urinary catheter on the second postoperative day following radical hysterectomy is feasible and not associated with increased morbidity. This approach may be particularly useful to complement the introduction of laparoscopic and robotic surgical approaches for surgical management of cervical cancer.

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NR 17

TC 11

Z9 15

U1 0

U2 13

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

PD OCT

PY 2012

VL 286

IS 4

BP 1007

EP 1010

DI 10.1007/s00404-012-2393-4

PG 4

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 003YL

UT WOS:000308647200028

PM 22648448

DA 2024-01-18

ER

PT J

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Herzog, TJ

Neugut, AI

Burke, WM

Lu, YS

Lewin, SN

Hershman, DL

AF Wright, Jason D.

Herzog, Thomas J.

Neugut, Alfred I.

Burke, William M.

Lu, Yu-Shiang

Lewin, Sharyn N.

Hershman, Dawn L.

TI Comparative effectiveness of minimally invasive and abdominal radical

hysterectomy for cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Radical hysterectomy; Robotic hysterectomy; Robotic radical

hysterectomy; Laparoscopic hysterectomy; Cervical cancer; Cervical

carcinoma

ID PELVIC LYMPHADENECTOMY; GYNECOLOGIC-ONCOLOGISTS; TREATMENT FAILURE;

ROBOTIC SURGERY; MORTALITY; VOLUME; CARE; LAPAROSCOPY; MORBIDITY;

DIFFUSION

AB Objective. We analyzed the uptake, morbidity, and cost of laparoscopic and robotic radical hysterectomies for cervical cancer.

Methods. We identified women recorded in the Perspective database with cervical cancer who underwent radical hysterectomy (abdominal, laparoscopic, robotic) from 2006 to 2010. The associations between patient, surgeon, and hospital characteristic and use of minimally invasive hysterectomy as well as complications and cost were estimated using multivariable logistic regression models.

Results. We identified 1894 patients including 1610 (85.0%) who underwent abdominal, 217 (11.5%) who underwent laparoscopic, and 67 (3.5%) who underwent robotic radical hysterectomy were analyzed. In 2006, 98% of the procedures were abdominal and 2% laparoscopic; by 2010 abdominal radical hysterectomy decreased to 67%, while laparoscopic increased to 23% and robotic radical hysterectomy was performed in 10% of women (p<0.0001). Patients treated at large hospitals were more likely to undergo a minimally invasive procedure (OR = 4.80; 95% CI, 1.28-18.01) while those with more medical comorbidities (OR = 0.60; 95% CI, 0.41-0.87) were less likely to undergo a minimally invasive surgery. Perioperative complications were noted in 15.8% of patients who underwent abdominal surgery, 9.2% who underwent laparoscopy, and 13.4% who had a robotic procedure (p = 0.04). Both laparoscopic and robotic radical hysterectomies were associated with lower transfusion requirements and shorter hospital stays than abdominal hysterectomy (p<0.05). Median costs were $9618 for abdominal, $11,774 for laparoscopic, and $10,176 for robotic radical hysterectomy (p<0.0001).

Conclusion. Uptake of minimally invasive radical hysterectomy for cervical cancer has been slow. Both laparoscopic and robotic radical hysterectomies are associated with favorable morbidity profiles. (C) 2012 Elsevier Inc. All rights reserved.

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TC 95

Z9 105

U1 0

U2 9

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

PD OCT

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VL 127

IS 1

BP 11

EP 17

DI 10.1016/j.ygyno.2012.06.031

PG 7

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA 005XQ

UT WOS:000308783800003

PM 22735788

DA 2024-01-18

ER

PT J

AU Carroll, AW

Lamb, E

Hill, AJ

Gill, EJ

Matthews, CA

AF Carroll, Ashley W.

Lamb, Elizabeth

Hill, Audra Jo

Gill, Edward J.

Matthews, Catherine A.

TI Surgical management of apical pelvic support defects: the impact of

robotic technology

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Pelvic organ prolapse; Robotic sacrocolpopexy uterosacral suspension

ID SACROCOLPOPEXY

AB Our aim was to determine what effect access to robotic technology had on our approach to managing apical pelvic support defects.

This was a retrospective chart review of 187 pelvic floor reconstructive surgeries performed for the 18 months prior to (time period 1: January 2007 to July 2008) and following (time period 2: July 2009 to December 2009) the introduction of the robot. Chi-square was used to compare percentages, and analysis of variance (ANOVA) was used to compare demographic data among groups.

Overall, 187 procedures were performed for apical prolapse during the study period: 61 in time period 1 and 126 in time period 2. Following the introduction of robotic technology, a significant change from vaginal to abdominal reconstruction occurred. Uterosacral ligament suspension declined from 67 % to 22 % (p < 0.0001), whereas sacrocolpopexy increased from 25 % (15/61) to 66 % (83/126) (p < 0.0001). The rate of abdominal sacrocolpopexy, however, declined from 25 % (15/61) to 2 % (2/126) over the two time periods (p < 0.0001).

The introduction of robotic technology significantly affected the surgical procedure and mode of surgical access for repair of apical pelvic support defects.

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NR 13

TC 15

Z9 15

U1 0

U2 3

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EI 1433-3023

J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

PD SEP

PY 2012

VL 23

IS 9

BP 1183

EP 1186

DI 10.1007/s00192-012-1749-4

PG 4

WC Obstetrics & Gynecology; Urology & Nephrology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Urology & Nephrology

GA 991MN

UT WOS:000307705500008

PM 22527548

DA 2024-01-18

ER

PT J

AU Erickson, BK

Gleason, JL

Huh, WK

Richter, HE

AF Erickson, Britt K.

Gleason, Jonathan L.

Huh, Warner K.

Richter, Holly E.

TI Survey of Robotic Surgery Credentialing Requirements for Physicians

Completing OB/GYN Residency

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT CREOG/APGO Annual Clinical Meeting

CY MAR 09-12, 2011

CL San Antonio, TX

DE Robotic surgery; Credentialing; Resident education

ID ASSISTED SURGERY

AB Study Objective: To describe credentialing requirements for newly graduated resident physicians for robotic-assisted gynecologic surgery in Alabama.

Design: Cross-sectional study (Canadian Task Force classification III).

Setting: Hospitals in the state of Alabama in the United States.

Participants: Credentialing authorities at hospitals in Alabama that currently use robotic surgery in the field of gynecology.

Interventions: Participants completed an online questionnaire about credentialing policies.

Measurements and Main Results: Fifteen of 16 hospitals (94%) in Alabama that use robotic technology for gynecologic surgery participated in this survey. All hospitals had a credentialing policy for robotic surgery; however, only 9 of the 15 hospitals (60%) had a separate pathway for physicians with recent residency training. This pathway consisted of an attestation letter from a residency program director in all of the 9 hospitals, a robotic case list in 3 (33%), and proctored cases after residency in 2 (22%). Five hospitals (55%) required a certain number of hysterectomy procedures (median, 5; range, 2-10).

Conclusion: Robotic surgery credentialing requirements in Alabama vary. Validation of requirements in best practices for robotic surgery by graduating resident physicians is needed. Journal of Minimally Invasive Gynecology (2012) 19, 589-592 (c) 2012 AAGL. All rights reserved.

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PG 4

WC Obstetrics & Gynecology

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ER

PT J

AU Franasiak, J

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Kidd, J

Secord, AA

Bell, M

Boggess, JF

Gehrig, PA

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Boggess, John F.

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TI Physical strain and urgent need for ergonomic training among gynecologic

oncologists who perform minimally invasive surgery

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT SGO Winter Meeting

CY FEB 09-11, 2012

CL Olympic Valley, CA

SP SGO

DE Minimally invasive surgery; Ergonomics; Occupational strain

ID LAPAROSCOPIC SURGERY; PREVALENCE

AB Objectives. There is limited data regarding physical strain and minimally invasive gynecologic surgery (MIS). We sought to evaluate ergonomic strain among gynecologic oncologists.

Methods. An online survey was sent to all physician members of the Society of Gynecologic Oncology in North America in 2010. The survey contained 42 questions and data was analyzed using univariate and bivariate analyses with summary statistics, t-tests, and chi-squared test.

Results. There were 260 respondents (31.2%) to the survey. Case mix was 26% benign and 64% oncologic surgery. Over 52% of respondents had been in practice for greater than 11 years and 52% practice in an academic setting. Physical discomfort related to MIS was reported in 88% (216/244) of surgeons with 52% reporting persistent pain. Increased pain symptoms were associated with surgeon's height, glove size, age and female gender. Patient body mass index (BMI) was associated with pain symptoms in surgeons performing conventional laparoscopic surgery, but not robotic surgery. To decrease pain, surgeons changed positions (78%), limited the number of cases per day (14%), spread cases throughout the week (6%), or limited the total number of cases (3%). Only 29% had received treatment at any time for pain symptoms. Treatment included physical therapy (59%), medical management (28%), surgery (13%), and time off (1%). Only 16% of those with pain symptoms had received formal ergonomic training.

Conclusion. Physical strain rates of 88% are far greater than previously reported. Such prevalent occupational strain presents a growing problem in the face of increasing demand for MIS. (C) 2012 Elsevier Inc. All rights reserved.

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ER

PT J

AU Muhlstein, J

Monceau, E

Lamy, C

Tran, N

Marchal, F

Judlin, P

Malartic, C

Morel, O

AF Muhlstein, J.

Monceau, E.

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Malartic, C.

Morel, O.

TI Contribution of robot-assisted surgery in the management of female

infertility

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Article

DE Robot-assisted; laparoscopy; Infertility; Tubal anastomosis

ID LAPAROSCOPIC TUBAL ANASTOMOSIS; LEARNING-CURVE; LYMPHADENECTOMY;

REANASTOMOSIS; FEASIBILITY; MYOMECTOMY; SKILLS

AB Although considerable progresses were made in the field of medically assisted procreation, surgery keeps its place in the therapeutic armamentarium of female infertility. Indeed, its results are very interesting, both in its tubal, myometrial and endometriosis indications. Laparotomy is the first step in the development of any surgical technique. Laparoscopy brings benefits concerning recovery, but also in terms of fertility because of the reduction of postoperative adhesions. Nevertheless, comfort of the surgeon, so the ease of skills, are often altered, especially for complex operations such as those implicated in infertility treatment. Robot-assistance takes here all its interest. It allows indeed a quality in the realization of precise and complex skills, and results at least as interesting as standard laparoscopy can be provided. An overview of robot-assistance in surgery of female infertility is here presented. A review of world literature furnished multiple studies evaluating the tubal robotic surgery, and demonstrating its interesting results. Other indications could, according to us, emerge and be evaluated in this area, such as myomectomy and endometriosis surgery. (c) 2012 Elsevier Masson SAS. All rights reserved.

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NR 57

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Z9 3

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U2 3

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WC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

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O'Reilly, BA

AF O'Sullivan, O. E.

O'Reilly, B. A.

TI Robot-assisted surgery:-impact on gynaecological and pelvic floor

reconstructive surgery

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Robot-assisted surgery; da Vinci Surgical System; Urogynaecology

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; ORGAN PROLAPSE SURGERY; ENDOMETRIAL

CANCER; VESICOVAGINAL FISTULA; SUTURE HYSTEROPEXY; SURGICAL OUTCOMES;

CERVICAL-CANCER; LEARNING-CURVE; SACROCOLPOPEXY; COST

AB The da VinciA (R) Surgical System dominates robotic surgery, as the only robotic device to have FDA approval in gynaecology. The benefits of robot-assisted surgery include decreased length of stay, decreased blood loss and analgesic requirements. Ergonomic improvements allow the surgeon to operate with less risk of neck and back injury. Unfortunately the initial economic impact of purchasing and maintaining a robot are great but must be balanced with the potential savings from reduced length of stay and earlier return to normal activity. This review looks at the uses for the robot in both gynaecology and urogynaecology, assessing the efficacy of this modality compared to both straight stick (laparoscopy) and open procedures. We assess the benefits to both patient and surgeon from the available literature. Within the current economic environment we appraise the costs associated with the robot.

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FU Cork University Maternity Hospital

FX The Cork University Maternity Hospital is an Intuitive recognized

epicentre for Robotic surgical training. All funds received form this

are placed in the departments research fund.

NR 97

TC 16

Z9 18

U1 2

U2 10

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JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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ER

PT J

AU Ranisavljevic, N

Mercier, G

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De Tayrac, R

Triopon, G

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Mercier, G.

Masia, F.

Mares, P.

De Tayrac, R.

Triopon, G.

TI Robot-assisted laparoscopic myomectomy: Comparison with abdominal

myomectomy

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Article

DE Fibroids; Myomectomy; Laparoscopy; Fertility; Sterility; Robotic

surgery; Morbidity

ID MYOMAS; EXPERIENCE; MANAGEMENT; SURGERY

AB Objective. - To compare morbidity of robot-assisted laparoscopic myomectomy versus those performed by laparotomy.

Patients and methods. - It reports a monocentric retrospective case matched analysis enrolling 22 patients (six laparotomic and 16 robot-assisted laparoscopic myomectomies), needing a surgical treatment for at least one myoma oversizing 6 cm.

Results. - Both patient groups were comparable regarding their age, their weight and myoma's size. There were more complications in the laparotomy group in comparison with the robotic group (66.7%, versus 0%; P=0.002). Average intraoperative blood tosses were respectively 397 +/- 377 mL versus 387 +/- 349 mL (P=0.71) and length of stay 7.2 +/- 0.8 days versus 3.9 +/- 2.8 days (P < 0.001). None of the robot-assisted laparoscopic myomectomy needed any conversion to laparotomy.

Conclusion. - Robot-assisted laparoscopic myomectomy seems to be feasible for heavy fibroids, with a lower morbidity in comparison with laparotomy. These results must be confirmed by several wider prospective studies. (C) 2012 Elsevier Masson SAS. All rights reserved.

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U2 1

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WC Obstetrics & Gynecology

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ER

PT J

AU Sarlos, D

Kots, L

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Sch盲r, G

AF Sarlos, Dimitri

Kots, LaVonne

Stevanovic, Nebojsa

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Schaer, Gabriel

TI Robotic Compared With Conventional Laparoscopic Hysterectomy <i>A

Randomized Controlled Trial</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ASSISTED VAGINAL HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; CURRENT STATE;

OUTCOMES; SURGERY

AB OBJECTIVE: To compare surgical outcome and quality of life of robot-assisted laparoscopic hysterectomy with conventional laparoscopic hysterectomy.

METHODS: For this controlled clinical trial, patients with benign indications for hysterectomy were randomized to receive either a robotic (robotic group) or conventional laparoscopic hysterectomy (conventional group). The primary end point was total operating time; secondary end points were perioperative outcome, blood loss, and the change in quality of life.

RESULTS: Ninety-five patients out of 100 randomized patients completed the study. Patient age, body mass index, and uterus weight showed no significant differences between both groups. All results are given as mean (+/- standard deviation; median). Total operating time for the robotic group was significantly higher with 106 (+/- 29; 103) compared with 75 (+/- 21; 74) (conventional group) minutes. Blood loss, complications, analgesics use, and return to activity for both groups were comparable. The change in preoperative to postoperative quality-of-life index (quality of life measured on a linear scale from 0 to 100) was significantly higher in the robotic group, with 13 (+/- 10; 13) compared with 5 (+/- 14; 5) (conventional group).

CONCLUSION: Robot-assisted laparoscopic hysterectomy and conventional laparoscopy compare well in most surgical aspects, but the robotic procedure is associated with longer operating times. Postoperative quality-of-life index was better; however, long-term, there was no difference. However, subjective postoperative parameters such as analgesic use and return to activity showed no significant difference between both groups.

CLINICAL TRIAL REGISTRATION: ClinicalTrials.gov, www.clinicaltrials.gov, NCT00683293. (Obstet Gynecol 2012; 120: 604-11) DOI: http://10.1097/AOG.0b013e318265b61a

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Z9 152

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U2 19

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ER

PT J

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Herzog, Thomas J.

Wright, Jason D.

TI The commercialization of robotic surgery: unsubstantiated marketing of

gynecologic surgery by hospitals

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE da Vinci; marketing; robot; robotic surgery; Web

ID ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; INTERNET; INFORMATION;

RESOURCES; WEB; QUALITY

AB OBJECTIVE: We analyzed the content, quality, and accuracy of information provided on hospital web sites about robotic gynecologic surgery.

STUDY DESIGN: An analysis of hospitals with more than 200 beds from a selection of states was performed. Hospital web sites were analyzed for the content and quality of data regarding robotic-assisted surgery.

RESULTS: Among 432 hospitals, the web sites of 192 (44.4%) contained marketing for robotic gynecologic surgery. Stock images (64.1%) and text (24.0%) derived from the robot manufacturer were frequent. Although most sites reported improved perioperative outcomes, limitations of robotics including cost, complications, and operative time were discussed only 3.7%, 1.6%, and 3.7% of the time, respectively. Only 47.9% of the web sites described a comparison group.

CONCLUSION: Marketing of robotic gynecologic surgery is widespread. Much of the content is not based on high-quality data, fails to present alternative procedures, and relies on stock text and images.

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Z9 25

U1 0

U2 8

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ER

PT J

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Krivak, TC

Scott, EM

Rauh-Hain, JA

Sukumvanich, P

Olawaiye, AB

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Krivak, Thomas C.

Scott, Eirwen M.

Rauh-Hain, Jose Alejandro

Sukumvanich, Paniti

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TI Dual-console robotic surgery compared to laparoscopic surgery with

respect to surgical outcomes in a gynecologic oncology fellowship

program

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Dual-console robotic surgery; Laparoscopic surgery; Gynecologic

oncology; Fellowship training program

ID ASSISTED HYSTERECTOMY; RADICAL HYSTERECTOMY; LEARNING-CURVE;

ENDOMETRIAL; LYMPHADENECTOMY; LAPAROTOMY; COST

AB Objective. Minimally invasive surgical techniques decrease surgical morbidity and recovery time. Studies demonstrate similar surgical outcomes comparing robotic to laparoscopic surgery. These studies have not accounted for the incorporation of fellow education. With the dual-console da Vinci Si Surgical System, a two surgeon approach could be performed. We sought to compare surgical outcomes at a gynecologic oncology fellowship program of traditional laparoscopic to robotic,surgeries using the dual-console system.

Methods. We identified patients who underwent laparoscopic or robotic surgery performed by a gynecologic oncologist from November 2009-November 2010. Robotic surgeries were conducted using the dual-console, utilizing a two surgeon approach. Surgeries involved a staff physician with a gynecologic oncology fellow. Statistical analysis was performed using student t-test and chi-squared analysis.

Results. A total of 222 cases were identified. Cases were analyzed in groups: all cases identified, all cancer cases, and endometrial cancer cases only. When analyzing all cases, no statistical difference was noted in total operating room time (172 vs. 175 min; p = 0.6), pelvic lymph nodes removed (10.1 vs. 9.6; p = 0.69), para-aortic lymph nodes dissected (3.7. vs. 3.8; p=0.91), or length of stay (1.5 vs. 1.3 days; p = 0.3). There was a significant difference in total surgical time (131 vs.110 min; p<0.0001) and EBL (157 vs.94 ml; p<0.0001), favoring robotic surgery. When analyzing all cancer cases, the advantage in total surgical time for robotic surgery was lost. Complications were similar between cohorts.

Conclusion. Incorporating fellow education into robotic surgery does not adversely affect outcomes when compared to traditional laparoscopic surgery. (C) 2012 Elsevier Inc. All rights reserved.

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NR 22

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AU Smorgick, N

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As-Sanie, S

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TI Risk Factors for Postoperative Urinary Retention After Laparoscopic and

Robotic Hysterectomy for Benign Indications

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 39th Global Congress of Minimally Invasive Gynecology of the

American-Association-of-Gynecologic-Laparoscopists (AAGL)

CY NOV 08-12, 2010

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists (AAGL)

ID VAGINAL HYSTERECTOMY; TRIAL; IMMEDIATE; OUTCOMES; REMOVAL

AB OBJECTIVE: To estimate the occurrence of postoperative urinary retention after traditional laparoscopic and robotic hysterectomy.

METHODS: We performed a chart review of all patients who underwent total or supracervical hysterectomy using a laparoscopic (n = 253) or robotic approach (n = 281) from March 2001 until June 2010 for benign indications at the division for minimally invasive surgery. Urinary retention was defined as the inability to spontaneously void or as incomplete voiding requiring either self-catheterization or Foley catheter replacement in the first postoperative week.

RESULTS: Urinary retention occurred in 7.3% (95% confidence interval [CI] 5.2-9.8%) of women and was more than twice as common among women who underwent robotic hysterectomy compared with laparoscopic hysterectomy (10.3%, 95% CI 7.0-14.5% compared with 4.0%, 95% CI 1.9-7.1%, P = .005). No statistically significant differences in those with and without urinary retention were seen in age, body mass index, smoking status, number of prior cesarean deliveries, operative time, presence of severe adhesions, or findings of endometriosis. In a multivariable logistic regression analysis, only the robotic approach relative to traditional laparoscopic approach was found to be significantly associated with urinary retention (odds ratio 2.6, 95% CI 1.2-5.6). Postoperative urinary retention was associated with a higher incidence of lower urinary tract infection, occurring in 15.4% (95% CI 5.9-30.5%) of cases compared with 4.0% (95% CI 2.5-6.2%) of those without urinary retention (P = .008).

CONCLUSION: Transient urinary retention is relatively more common after robotic hysterectomy when compared with laparoscopic hysterectomy. We postulate that more aggressive bladder dissection performed with robot assistance may be associated with an increased risk of urinary retention. (Obstet Gynecol 2012; 120: 581-6) DOI: http://10.1097/AOG.0b013e3182638c3a

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NR 13

TC 38

Z9 42

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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PY 2012

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Conference Proceedings Citation Index - Science (CPCI-S)

SC Obstetrics & Gynecology

GA 999EX

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DA 2024-01-18

ER

PT J

AU Cormier, B

Nezhat, F

Sternchos, J

Sonoda, Y

Leitao, MM

AF Cormier, Beatrice

Nezhat, Farr

Sternchos, Jason

Sonoda, Yukio

Leitao, Mario M., Jr.

TI Electrocautery-Associated Vascular Injury During Robotic-Assisted

Surgery

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

AB BACKGROUND: The robotic surgical platform is increasingly used in gynecology and, similar to laparoscopy, it has risks of electrocautery-associated injury.

CASE: We present three cases of injury caused by failures of the monopolar scissors' insulating sheath while coagulation and cutting currents were set at 35 W. In case 1, an external iliac vein injury required blood transfusion and emergent laparotomy. In case 2, a full-thickness external iliac artery injury was repaired robotically. In case 3, a partial-thickness external iliac artery injury also was repaired robotically.

CONCLUSION: Unintended electrosurgical arcs can occur from monopolar instruments. Insulation failure is a common finding in this type of injury. Surgeons should avoid excessive instrument collisions and should change the monopolar scissors' insulating sheath if there are any concerns of a defect in its integrity. (Obstet Gynecol 2012;120:491-3) DOI: 10.1097/AOG.0b013e31825a6f60

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NR 6

TC 17

Z9 22

U1 0

U2 5

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

PD AUG

PY 2012

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IS 2

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EP 493

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PN 2

PG 3

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DA 2024-01-18

ER

PT J

AU Fader, AN

Seamon, LG

Escobar, PF

Frasure, HE

Havrilesky, LA

Zanotti, KM

Secord, AA

Boggess, JF

Cohn, DE

Fowler, JM

Skafianos, G

Rossi, E

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Gehrig, Paola A.

TI Minimally invasive surgery versus laparotomy in women with high grade

endometrial cancer: A multi-site study performed at high volume cancer

centers

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Type II endometrial cancer; Minimally invasive

surgery; Laparoscopy; Robotics

ID PAPILLARY SEROUS CARCINOMA; STAGE-I PATIENTS; LAPAROSCOPIC HYSTERECTOMY;

ABDOMINAL HYSTERECTOMY; SURVIVAL OUTCOMES; CHEMOTHERAPY; RECURRENCE;

THERAPY

AB Objective. The study aim was to compare outcomes in women with high-grade endometrial cancer (EC) who underwent surgical staging via minimally invasive surgery (MIS) versus laparotomy.

Methods. This is a retrospective, multi-institutional cohort study of patients with high-grade EC who were comprehensively surgically staged by either MIS or laparotomy. Demographic, surgical variables, complications, and survival were analyzed.

Results. Three hundred and eighty-three patients met criteria: 191 underwent laparotomy and 192 MIS (65% robotic, 35% laparoscopy). Subgroups were well matched by age (mean 66 years), stage, body mass index, histology and adjuvant therapies. Median operative time was longer in the MIS group (191 vs. 135 min; p<.001). However, the MIS cohort had a higher mean lymph node count (39.0 vs. 34.0; p=.03), shorter hospital stay (1 vs. 4 days) and significantly fewer complications (8.4% vs. 31.3%; p<.001). There was no significant difference in lymph node count with laparoscopic versus robotic staging. With a median follow-up time of 44 months, progression-free (PFS) and overall survival were not significantly different between the surgical cohorts. On multivariable analysis, stage, treatment were associated with PFS.

Conclusions. Women with high grade endometrial cancers staged by minimally invasive techniques experienced fewer complications and similar survival outcomes compared to those staged by laparotomy. As this population is elderly and most will receive adjuvant therapies, minimization of surgical morbidity is of interest. When managed by expert laparoscopists or robotic surgeons, a high-risk histologic subtype is not a contraindication to minimally invasive surgery in women with apparent early-stage disease. (C) 2012 Elsevier Inc. All rights reserved.

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Z9 82

U1 0

U2 8

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J9 GYNECOL ONCOL

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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PM 22555102

DA 2024-01-18

ER

PT J

AU 脰nol, FF

脰nol, SY

AF Onol, Fikret Fatih

Onol, Sinasi Yavuz

TI Review of extraperitoneal sacrocolpopexy as a technique for advanced

uterine and vault prolapse

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE complications; minimally invasive techniques; sacrocolpopexy; vault

prolapse

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; PELVIC ORGAN PROLAPSE; SACRAL

COLPOPEXY; ABDOMINAL SACROCOLPOPEXY; ROBOTIC SACROCOLPOPEXY; OUTCOMES;

REPAIR; MANAGEMENT; BURCH

AB Purpose of review

This review is aimed to provide an update on the surgical techniques and complications of sacrocolpopexy procedures, and determine the role of minimally invasive techniques based on the most recent evidence.

Recent findings

The minimally invasive laparoscopic and robot-assisted alternatives to open abdominal sacrocolpopexy offer faster recovery, less complications and better cosmesis. However, this is suggested predominantly by retrospective comparative studies and no high-level evidence is available to date. Robot-assisted sacrocolpopexy (RASC) has enabled surgeons to overcome the steep learning curve associated with laparoscopic sacrocolpopexy at the expense of a higher cost. Recent data, testing its potential advantages of reduced operative time and postoperative pain, have revealed contradictory results. A novel, totally retroperitoneal sacrocolpopexy procedure aimed to eliminate complications associated with transperitoneal access may become an option in patients unsuitable for minimally invasive techniques, but warrants further investigation.

Summary

The benefits of RASC must be weighed against the lack of current evidence to prove its superiority over conventional procedures in terms of faster recovery and cost-effectiveness. There is a need for better reporting of complications associated with these novel techniques and for long-term, randomized comparative data.

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TC 2

Z9 2

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U2 2

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 970GC

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ER

PT J

AU Zapardiel, I

Zanagnolo, V

Kho, RM

Magrina, JF

Magtibay, PM

AF Zapardiel, Ignacio

Zanagnolo, Vanna

Kho, Rosanne M.

Magrina, Javier F.

Magtibay, Paul M.

TI Ovarian remnant syndrome: comparison of laparotomy, laparoscopy and

robotic surgery

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Ovarian remnant syndrome; laparoscopy; robotic surgery; pelvic pain;

remnant ovary

ID MANAGEMENT

AB Objective. To compare laparotomy, laparoscopy and robotic surgery in the management of ovarian remnant syndrome. Design. Retrospective comparative study. Setting. Mayo Clinic Arizona and Mayo Clinic Rochester, USA. Population. Women who underwent surgical treatment for ovarian remnant syndrome. Methods. The clinical records of 223 patients with histologically documented residual cortical ovarian tissue excised at Mayo Clinic by laparotomy, laparoscopy or a robotic approach, from January 1985 through February 2009, were reviewed. Data collected included the patient's age, body mass index, previous medical and surgical history, symptoms, prior management of ovarian remnant syndrome, preoperative imaging study, intraoperative details, postoperative course, complications and follow-up data. Main outcome measures. Intraoperative and postoperative outcomes. Results. One hundred and eighty-seven patients (83.9%) were operated by laparotomy, 19 (8.5%) by laparoscopy and 17 (7.6%) by a robotic approach. Estimated blood loss and length of stay were significantly lower in the robotic and laparoscopic groups compared with laparotomy (p < 0.01). After a mean follow-up of 21.1 +/- 32.4 months, the rate of pain improvement was 93.1, 94.4 and 71.4% for the laparotomy, laparoscopy and robotic surgery group, respectively. Conclusions. Robotic and laparoscopic surgery for the treatment of ovarian remnant syndrome offer advantages over laparotomy in terms of reduced blood loss, lower postoperative complications and shorter length of stay.

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NR 16

TC 14

Z9 15

U1 0

U2 3

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

PD AUG

PY 2012

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PG 5

WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

AU Acholonu, UC

Chang-Jackson, SCR

Radjabi, AR

Nezhat, FR

AF Acholonu, Uchenna C., Jr.

Chang-Jackson, Shao-Chun R.

Radjabi, A. Reza

Nezhat, Farr R.

TI Laparoscopy for the Management of Early-Stage Endometrial Cancer: From

Experimental to Standard of Care

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Endometrial cancer; Robotic surgery; Standard of care

ID ABDOMINAL HYSTERECTOMY; VAGINAL HYSTERECTOMY; SURGERY; COST; RECURRENCE;

LAPAROTOMY; WOMEN; LYMPHADENECTOMY; SURVIVAL; OUTCOMES

AB We performed a search of PUBMED and MEDLINE for articles concerning surgical management of early stage endometrial cancer from 1950 to 2011. From the articles collected we extracted data such as estimated blood loss, operating room time, complications, conversion to laparotomy, and length of hospital stay. Forty-seven relevant sources were analyzed. The patients in the laparoscopy group had less blood loss, fewer complications, longer operating room times, and a shorter length of stay. Lymph node count was similar in both groups. Although obesity is not a contraindication to laparoscopy, it does lead to a higher conversion rate. Route of surgical treatment had no impact on recurrence or survival. Robotic surgery has significant advantages over laparotomy, but advantages over laparoscopy are not as distinct. Laparoscopic hysterectomy offers several advantages over laparotomy. These advantages relate to improvements in patient care with comparable clinical outcome. After careful analysis we believe laparoscopy should be the standard of care for surgical management of early stage endometrial cancer. Journal of Minimally Invasive Gynecology (2012) 19, 434 142 (C) 2012 AAGL. All rights reserved.

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TC 20

Z9 21

U1 0

U2 1

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Chavan, NR

Einarsson, JI

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Chavan, Niraj R.

Einarsson, Jon I.

TI Trendelenburg Position in Gynecologic Robotic-Assisted Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Gynecology; Robotic surgery; Trendelenburg

ID LAPAROSCOPIC HYSTERECTOMY; SURGICAL TECHNIQUE; PNEUMOPERITONEUM;

OUTCOMES

AB Objective: To estimate the necessity of routine patient positioning in steep Trendelenburg in robotic-assisted gynecologic surgery performed for benign indications.

Design: Descriptive study (Canadian Task Force classification II-2).

Setting: University-affiliated community hospital.

Patients: Twenty women undergoing robotic-assisted gynecologic surgery for benign indications.

Intervention: Robotic-assisted total hysterectomy, supracervical hysterectomy, myomectomy, and sacrocolpopexy.

Measurements and Main Results: Demographic data and perioperative variables were recorded including age, body mass index, procedure type, console time, perioperative complications, estimated blood loss, hospital length of stay, and degree of Trendelenburg position. The degree of Trendelenburg position was measured at the end of each procedure using an electronic level. The surgeons were blinded to the degree of Trendelenburg used. All procedures were performed successfully without conversion to laparotomy. All patients were discharged to home within 24 hours. No perioperative complications were noted. The mean (SD; 95% Cl) Trendelenburg position used in this cohort was 16.4 (4.1; 14.4-18.3) degrees. Patient body mass index was 28.5 (5.3; 26.1-31.1). Median console time was 87.5 (27-112) minutes.

Conclusion: Robotic-assisted benign gynecologic surgery can be effectively performed without use of the steep Trendelenburg position. The practice of routine adherence to steep Trendelenburg positioning in benign gynecologic robotic surgery should be questioned. Journal of Minimally Invasive Gynecology (2012) 19, 485-489 (C) 2012 AAGL. All rights reserved.

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Z9 44

U1 6

U2 22

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DI 10.1016/j.jmig.2012.03.019

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WC Obstetrics & Gynecology

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ER

PT J

AU Gould, C

Cull, T

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Osmundsen, B

AF Gould, Claire

Cull, Thomas

Wu, Ying Xing

Osmundsen, Blake

TI Blinded Measure of Trendelenburg Angle in Pelvic Robotic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Trendelenburg angle; Robotic surgery; Pelvic surgery; Anesthesia

complications

ID RADICAL PROSTATECTOMY; ASSISTED HYSTERECTOMY; LAPAROSCOPIC SURGERY;

POSITION; PNEUMOPERITONEUM; ANESTHESIA; OUTCOMES

AB Study Objective: To estimate the Trendelenburg angle needed to perform robotic gynecologic surgical procedures.

Design: Cross-sectional study (Canadian Task Force classification III).

Setting: Community hospital.

Patients: All women undergoing gynecologic pelvic surgery using the da Vinci surgical robot at a single institution between December 2010 and April 2011.

Interventions: The primary surgeon determined the Trendelenburg angle needed for adequate visualization to perform surgery defined as small bowel and sigmoid colon displaced out of the surgical field.

Measurements and Main Results: The primary outcome, measured in blinded fashion, was the degree of Trendelenburg positioning needed to complete the surgical procedure robotically. Secondary data collected included body mass index, type of surgery performed, maximum end-tidal CO2, and maximum peak inspiratory pressure. Sixteen surgeons performed a total of 104 robotic gynecologic pelvic surgeries during the study. Data were available for 86 cases. The mean Trendelenburg angle used was 28.0 degrees (95% confidence interval, 26.9-29.1). This was significantly less than the 40 degrees (p < .001) commonly recommended. The Trendelenburg angle used did not correlate with body mass index (r = -0.2; p = .13) or type of surgery performed (p = .41). Neither the maximum end-tidal CO2 or maximum peak inspiratory pressure was influenced by the Trendelenburg angle used when adjusted for age and body mass index.

Conclusions: A mean Trendelenburg angle of 28.0 degrees was adequate to complete most gynecologic robotic surgical procedures when compared with historical control angle of 40 degrees. Journal of Minimally Invasive Gynecology (2012) 19, 465-468 (C) 2012 AAGL. All rights reserved.

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FX Supported by grant 111080520 from the American Association of

Gynecologic Laparoscopists.

NR 15

TC 20

Z9 21

U1 1

U2 8

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JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Jeppson, Corinne N.

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TI Detection of sentinel lymph nodes in patients with endometrial cancer

undergoing robotic-assisted staging: A comparison of colorimetric and

fluorescence imaging

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 43rd Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncology (SGO)

CY MAR 23-27, 2012

CL Austin, TX

SP Soc Gynecol Oncol

DE Uterine/endometrial cancers; Sentinel lymph node; Robotic-assisted

staging; Fluorescence imaging; Peri-operative outcomes

ID BREAST-CANCER; SURGERY; LYMPHADENECTOMY; DISSECTION; CARCINOMA;

RESECTION; BIOPSY; TRIAL

AB Objective. To retrospectively compare results from lymphatic mapping of pelvic sentinel lymph nodes (SLN) using fluorescence near-infrared (NIR) imaging of indocyanine green (ICG) and colorimetric imaging of isosulfan blue (ISB) dyes in women with endometrial cancer (EC) undergoing robotic-assisted lymphadenectomy (RAL). A secondary aim was to investigate the ability of SLN biopsies to increase the detection of metastatic disease.

Methods. Thirty-five patients underwent RAL with hysterectomy. One mL ISB was injected submucosally in four quadrants of the cervix, followed by 0.5 mL ICG [1.25 mg/mL] immediately prior to placement of a uterine manipulator. Retroperitoneal spaces were dissected for colorimetric detection of lymphatic pathways. The da Vinci (R) camera was switched to fluorescence imaging and results recorded. SLN were removed for permanent analysis with ultra-sectioning, H&E, and IHC staining. Hysterectomy with RAL was completed.

Results. Twenty-seven (77%) and 34 (97%) of patients had bilateral pelvic or aortic SLN detected by colorimetric and fluorescence, respectively (p = 0.03). Considering each hemi-pelvis separately, 15/70 (21.4%) had "weak" uptake of ISB in SLN confirmed positive with fluorescence imaging. Using both methods, bilateral detection was 100%. Ten (28.6%) patients had lymph node (LN) metastasis, and 9 of these had SLN metastasis (90% sensitivity, one false negative SLN biopsy). Seven of nine (78%) SLN metastases were ISB positive and 100% were ICG positive. Twenty-five had normal LN, all with negative SLN biopsies (100% specificity). Four (40%) with LN metastasis were detected only by IHC and ultra-sectioning of SLN.

Conclusions. Fluorescence imaging with ICG detected bilateral SLN and SLN metastasis more often than ISB, and the combination resulted in 100% bilateral detection of SLN. Ultra-sectioning/IHC of SLN increased the detection of lymph node metastasis. (c) 2012 Elsevier Inc. All rights reserved.

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NR 32

TC 128

Z9 134

U1 1

U2 19

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J9 GYNECOL ONCOL

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PG 5

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Conference Proceedings Citation Index - Science (CPCI-S)

SC Oncology; Obstetrics & Gynecology

GA 967AL

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PM 22507531

DA 2024-01-18

ER

PT J

AU Siddiqui, NY

Fulton, RG

Kuchibhatla, M

Wu, JM

AF Siddiqui, Nazema Y.

Fulton, Rebekah G.

Kuchibhatla, Maragatha

Wu, Jennifer M.

TI Sexual Function After Vaginal Versus Nonvaginal Prolapse Surgery

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE sexual function; prolapse; vaginal surgery; robotic surgery

ID PELVIC FLOOR DISORDERS; URINARY-INCONTINENCE; BODY-IMAGE; ORGAN

PROLAPSE; WOMEN; ANATOMY; IMPACT

AB Objectives: To compare sexual function based on the Pelvic Organ Prolapse/Urinary Incontinence Sexual Function Questionnaire (PISQ) in women who underwent vaginal versus nonvaginal surgery for prolapse.

Methods: This was a prospective cohort study of women who underwent vaginal versus nonvaginal (abdominal or robotic) surgery for stage II to stage IV pelvic organ prolapse. We compared 2 groups: those who received vaginal prolapse surgery (defined as any surgical procedure for prolapse requiring incisions in the vaginal wall) and those who received nonvaginal (ie, exclusively abdominal or robotic) prolapse surgery. Women completed the PISQ and additional pelvic floor symptom questionnaires at baseline and 6 months after surgery. Our primary outcome was change in PISQ score from baseline to 6 months.

Results: Of the 80 women in our study population, 58 participants completed 6-month follow-up. Baseline PISQ and pelvic floor symptom questionnaire scores were similar between the vaginal and nonvaginal surgery groups. There were significant overall improvements in sexual function based on the PISQ but no differences in scores between vaginal and nonvaginal surgery groups (mean PISQ change score 6.4 +/- 9.2 vs 6.1 +/- 14.8; P = 0.92). In a linear regression model adjusting for potential confounders, there were still no differences in 6-month PISQ scores between the groups.

Conclusions: In women with prolapse, sexual function is likely to improve after reconstructive surgery, regardless of the route.

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FU Charles Hammond Research Fund; Department of Obstetrics and Gynecology;

Duke University Medical Center; Josiah Charles Trent Memorial

Foundation; Durham, NC

FX This study was funded by Charles Hammond Research Fund, Department of

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NR 22

TC 10

Z9 10

U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

PD JUL-AUG

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VL 18

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PG 4

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Backes, FJ

Brudie, LA

Farrell, MR

Ahmad, S

Finkler, NJ

Bigsby, GE

O'Malley, D

Cohn, DE

Holloway, RW

Fowler, JM

AF Backes, Floor J.

Brudie, Lorna A.

Farrell, M. Ryan

Ahmad, Sarfraz

Finkler, Neil J.

Bigsby, Glenn E.

O'Malley, David

Cohn, David E.

Holloway, Robert W.

Fowler, Jeffrey M.

TI Short- and long-term morbidity and outcomes after robotic surgery for

comprehensive endometrial cancer staging

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Complications; Morbidity;

Comprehensive surgical staging

ID VAGINAL CUFF DEHISCENCE; LYMPHADENECTOMY; HYSTERECTOMY; EXPERIENCE

AB Objective. Although intra-operative and immediate postoperative complications of robotic surgery are relatively low, little is known about long-term morbidity. We set out to assess both short- and long-term morbidities after robotic surgery for endometrial cancer staging.

Methods. All patients who underwent robotic staging for EMCA between 2006 and 2009 from two institutions were identified. Patient charts were retrospectively reviewed for surgical complications and postoperative morbidities.

Results. Five hundred three patients were identified. No differences in complication rates were found between 2006-2007 and 2008-2009, even though the median BMI increased from 29.9 (range 19-52) to 32 (range 17-70) (p=0.03). 6.4% of cases were converted to laparotomy. Median length of stay was one day (range 1-46). No cystotomies, two enterotomies, one ureteric injury, and five vessel injuries occurred (1.6% intra-operative complications). Thirty-eight (7.6%) patients developed major postoperative complications, 11(2.2%) had wound infections, and 15 (3%) required a transfusion in the 30-day pen-operative period. The total venous thromboembolism (VIE) rate for robotic cases was 1.7%. Partial cuff dehiscence managed conservatively occurred in 5 (1%) and complete dehiscence requiring closure in 7 (1.4%) patients; Sixty-three (13.4%) patients who had robotic staging developed lymphedema, with 40 (8%) requiring physical therapy.

Conclusions. This study provides one of the largest cohorts of patients with robotic-assisted hysterectomy and lymphadenectomy (in 92.6%) with an assessment of morbidity. Our data demonstrates that robotic surgical staging can be safely performed with a low risk of short-term complications and lymphedema is the most frequent long-term morbidity. (C) 2012 Elsevier Inc. All rights reserved.

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NR 26

TC 48

Z9 50

U1 0

U2 5

PU ACADEMIC PRESS INC ELSEVIER SCIENCE

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

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PG 6

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Fagotti, A

Gagliardi, ML

Fanfani, F

Salerno, MG

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Turco, LC

Escobar, P

Scambia, G

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Fanfani, Francesco

Salerno, Maria Giovanna

Ercoli, Alfredo

D'Asta, Marco

Tortorella, Lucia

Turco, Luigi Carlo

Escobar, Pedro

Scambia, Giovanni

TI Perioperative outcomes of total laparoendoscopic single-site

hysterectomy versus total robotic hysterectomy in endometrial cancer

patients: A multicentre study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparo-endoscopic single-site hysterectomy; Robotic hysterectomy;

Endometrial cancer; Single port surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; SURGICAL OUTCOMES; LEARNING-CURVE;

SURGERY LESS; LYMPHADENECTOMY; OBESE

AB Objective. To compare the pen-operative outcomes between total laparo-endoscopic single-site (LESS) and robotic approaches for the staging and treatment of early stage endometrial cancer patients.

Methods. A multicentre retrospective study involving three Italian gynaecological groups and one American centre. The pen-operative outcomes of LESS and robotic approach were compared in similar groups of patients, with regard to surgical outcomes and intra- and post-operative parameters and complications.

Results. During the study period, 75 patients submitted to a total LESS hysterectomy and 75 patients received a total robotic hysterectomy. The median operative time - 122 versus 175 min (p = 0.0001) - and the estimated blood loss - 50 versus 80 mL (p = 0.03) - were slightly more favourable in the LESS group. The intra-operative complications were equally distributed (p = 0.99); in the robotic group there were 4 (5.3%) post-operative grade IIIb complications versus 1(1.3%) in the LESS group (p = 0.172).

Conclusions. The LESS and robotic approaches both appear reasonable and each may have benefits and limitations depending upon the patient population. Further studies are needed to validate these preliminary conclusions. (C) 2012 Elsevier Inc. All rights reserved.

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Z9 27

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U2 4

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WC Oncology; Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Farache, C

Alonso, S

Marsollier, CF

Masia, F

de Tayrac, R

Triopon, G

AF Farache, C.

Alonso, S.

Marsollier, C. Ferrer

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Triopon, G.

TI Robotic surgery in gynecologic oncology: Retrospective and comparative

study with laparotomy and laparoscopy

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Article

DE Robotic surgery; Laparoscopy; Hysterectomy; Cervical cancer; Endometrial

cancer

ID RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; RADIATION-THERAPY;

LYMPHADENECTOMY; CARCINOMA; OUTCOMES; MEMBERS; OBESE

AB Objectives. - To compare robot-assisted laparoscopy with conventional laparoscopy and laparotomy in gynecologic oncology.

Patients and methods. - This is a monocentric retrospective study enrolling 92 patients who underwent a standard or radical hysterectomy (with parametrectomy) with or without pelvic lymphadenectomy between January 2008 and December 2010. All patients were diagnosed for a cervical or endometrial cancer. Laparotomy was performed for 33 patients, conventional laparoscopy for 20 patients, and robot-assisted laparoscopy for 39 patients. The main parameter was the length of hospital stay in the three groups.

Results. - Length of hospital stay significantly decreased in the robotic group in comparison with the laparotomic group (median 5 and 8 days respectively, P<0.0001), but no differences were found between the robotic and laparoscopic groups (P=0.77). Intraoperative blood loss was lower in the robotic group. Intraoperative complications and lymph nodes removed were equal in the three groups. Regarding the data recorded, there were no significant differences between conventional and robotic laparoscopy. Hysterectomies performed after pelvic radiation, which were all made by laparotomy before the robot's arrival, were all performed with robotic laparoscopy since its arrival.

Conclusion. - Robotic surgery allows a reduced length of hospital stay and a lower blood loss in comparison with laparotomy, without any worse oncologic results. Robotic surgery changed our practice, especially hysterectomy after pelvic radiation, performed by laparotomy before. (C) 2012 Elsevier Masson SAS. All rights reserved.

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NR 27

TC 6

Z9 7

U1 1

U2 6

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J9 J GYNECOL OBST BIO R

JI J. Gynecol. Obstet. Biol. Reprod.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PM 22542372

DA 2024-01-18

ER

PT J

AU Mok, ZW

Yong, EL

Low, JJH

Ng, JSY

AF Mok, Zhun Wei

Yong, Eu Leong

Low, Jeffrey Jen Hui

Ng, Joseph Soon Yau

TI Clinical Outcomes in Endometrial Cancer Care When the Standard of Care

Shifts From Open Surgery to Robotics

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotics; Endometrial cancer; Laparoscopic naive; Open surgery

ID ASSISTED HYSTERECTOMY; LYMPHADENECTOMY; LAPAROSCOPY; LAPAROTOMY

AB Introduction: In Singapore, the standard of care for endometrial cancer staging remains laparotomy.(1) Since the introduction of gynecologic robotic surgery, there have been more data comparing robotic surgery to laparoscopy in the management of endometrial cancer. This study reviewed clinical outcomes in endometrial cancer in a program that moved from laparotomy to robotic surgery.

Methods: A retrospective review was performed on 124 consecutive endometrial cancer patients. Preoperative data and postoperative outcomes of 34 patients undergoing robotic surgical staging were compared with 90 patients who underwent open endometrial cancer staging during the same period and in the year before the introduction of robotics.

Results: There were no significant differences in the mean age, body mass index, rates of diabetes, hypertension, previous surgery, parity, medical conditions, size of specimens, histologic type, or stage of cancer between the robotic and the open surgery groups. The first 20 robotic-assisted cases had a mean (SD) operative time of 196 (60) minutes, and the next 14 cases had a mean time of 124 (64) minutes comparable to that for open surgery. The mean number of lymph nodes retrieved during robot-assisted staging was smaller than open laparotomy in the first 20 cases but not significantly different for the subsequent 14 cases. Robot-assisted surgery was associated with lower intraoperative blood loss (110 [24] vs 250 [83] mL, P < 0.05), a lower rate of postoperative complications (8.8% vs 26.8%, P = 0.032), a lower wound complication rate (0% vs 9.9%, P = 0.044), a decreased requirement for postoperative parenteral analgesia (5.9% vs 51.1, P < 0.001), and shorter length of hospitalization (2.0 [1.1] vs 6.0 [4.5] days, P < 0.001) compared to patients in the open laparotomy group.

Conclusions: Our series shows that outcomes traditionally associated with laparoscopic endometrial cancer staging are achievable by laparoscopy-naive gynecologic cancer surgeons moving from laparotomy to robot-assisted endometrial cancer staging after a relatively small number of cases.

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NR 21

TC 17

Z9 18

U1 0

U2 3

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JI Int. J. Gynecol. Cancer

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PG 7

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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PM 22561178

DA 2024-01-18

ER

PT J

AU Rutledge, TL

AF Rutledge, Teresa L.

TI Advances in Surgical Care

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Gynecology; Gynecologic oncology; Malignancy; Surgical management

ID ROBOTIC RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; GYNECOLOGIC-ONCOLOGY;

ASSISTED SURGERY; NODE DISSECTION; LAPAROSCOPY; LAPAROTOMY; SURVIVAL;

OUTCOMES; LYMPHADENECTOMY

AB The surgical management of gynecologic malignancy is the cornerstone of the subspecialty. As technology advances, surgical care is changing rapidly. New devices, surgical instruments, and understandings of the disease process have all improved the surgical management of gynecologic malignancies. This article summarizes some of the recent advances in the surgical management of gynecologic malignancies.

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TC 2

Z9 2

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JI Obstet. Gynecol. Clin. N. Am.

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PG 21

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

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PM 22640708

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ER

PT J

AU Tang, KY

Gardiner, SK

Gould, C

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Collins, M

Winter, WE

AF Tang, Karen Y.

Gardiner, Stuart K.

Gould, Claire

Osmundsen, Blake

Collins, Michael

Winter, William E., III

TI Robotic surgical staging for obese patients with endometrial cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 78th Annual Meeting of the

Pacific-Coast-Obstetric-and-Gynecologic-Society

CY SEP 14-18, 2011

CL OR

SP Pacific Coast Obstet & Gynecol Soc

DE endometrial cancer; obesity; robotic surgery

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; TOTAL ABDOMINAL HYSTERECTOMY;

VAGINAL CUFF DEHISCENCE; WOMEN; LAPAROTOMY; OUTCOMES; RISK;

LYMPHADENECTOMY; EXPERIENCE

AB OBJECTIVE: To compare surgical outcomes for robotic vs laparotomy staging in obese endometrial cancer patients.

STUDY DESIGN: This was a retrospective cohort study of patients with body mass index >= 30 kg/m(2) staged in a community gynecologic oncology practice. Patients undergoing robotic staging were compared with historic laparotomy controls.

RESULTS: One hundred twenty-nine patients underwent robotic staging, compared with 110 laparotomy patients. The robotic cohort had fewer abdominal wound complications (13.9% vs 32.7%, P < .001), but more vaginal cuff complications (4.7% vs 0%, P = .032). Blood loss was lower in the robotic group (P < .001), as was length of stay (P < .001). Surgical times were longer in the robotic group (P < .001). There was no difference in terms of percentage of patients undergoing pelvic or paraaortic lymph node dissection.

CONCLUSION: Robotic staging for endometrial cancer is feasible in obese women, with fewer abdominal wound complications, but more vaginal cuff complications.

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TC 36

Z9 39

U1 0

U2 3

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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PG 6

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 947PV

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PM 22409959

DA 2024-01-18

ER

PT J

AU Tsao, KJ

Lally, KP

AF Tsao, KuoJen

Lally, Kevin P.

TI Innovations in the Surgical Management of Congenital Diaphragmatic

Hernia

SO CLINICS IN PERINATOLOGY

LA English

DT Article

DE Congenital diaphragmatic hernia; Minimally invasive surgery; Tissue

engineering; Diaphragmatic patch

ID REVERSE LATISSIMUS-DORSI; WALL MUSCLE FLAP; MINIMALLY INVASIVE REPAIR;

RANDOMIZED PILOT TRIAL; INDUCED LUNG GROWTH; THORACOSCOPIC REPAIR;

RECURRENCE RATE; ROBOTIC REPAIR; CARBON-DIOXIDE; PATCH REPAIR

AB Surgical management of congenital diaphragmatic hernia (CDH) remains a challenge for all clinicians. While the treatment strategies for CDH have evolved from emergent surgical intervention to initial hemodynamic stabilization with delayed surgical repair, surgical innovations have remained limited in the last 20 years. Advances in surgical approaches, such as minimally invasive surgery and alternatives to diaphragmatic replacement, have focused on improvements in surgical morbidity.

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NR 77

TC 12

Z9 12

U1 0

U2 10

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J9 CLIN PERINATOL

JI Clin. Perinatol.

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WC Obstetrics & Gynecology; Pediatrics

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SC Obstetrics & Gynecology; Pediatrics

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ER

PT J

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Bensaid, C

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Bats, A. -S.

Bensaid, C.

Bady, J.

Lecuru, F.

TI Robotic surgery in endometrial cancer: A review

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Review

DE Endometrial cancer; Robotic surgery; Laparoscopy; Complications

ID ABDOMINAL HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY; LYMPHADENECTOMY;

LAPAROTOMY; WOMEN; EXPERIENCE; STANDARD; OUTCOMES; OBESE; TIME

AB Robotic surgery had spread for a few years. This access is now important in urologic surgery, especially for prostatic procedures. Development of robotic surgery in gynecology is more recent. Gynecologic oncology is probably one of the most interesting fields of development of this access. Robotic surgery is frequently used in endometrial cancer. As no randomized study is available, it seems to be interesting to make a review of retrospective studies. Feasibility seems to be high and the learning curve is short (around 20 cases). Operative lengths are longer when compared to laparotomy, but are similar or shorter than laparoscopy. Robot setting increases the global length of the procedure, but decreases with experience. Operative blood loss, as well as transfusion rate are decreased when compared to laparotomy, but are similar to those of laparoscopy. The overall morbidity rate seems lower than with other approaches. Postoperative pain, hospital stay and time to recovery are decreased when compared to laparotomy as well as to laparoscopy for some authors. The main limit to the diffusion of robotic surgery is accessibility because of its important cost. Other limits are pointed out by the most trained teams. (C) 2012 Published by Elsevier Masson SAS.

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WC Obstetrics & Gynecology

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ER

PT J

AU Collins, SA

Tulikangas, PK

O'Sullivan, DM

AF Collins, Sarah A.

Tulikangas, Paul K.

O'Sullivan, David M.

TI Effect of surgical approach on physical activity and pain control after

sacral colpopexy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE accelerometer; postoperative pain control; postoperative recovery; Short

Form-36

ID SURGERY

AB OBJECTIVE: We sought to compare recovery of activity and pain control after robotic (ROB) vs abdominal (ABD) sacral colpopexy.

STUDY DESIGN: Women undergoing ROB and ABD sacral colpopexy wore accelerometers for 7 days preoperatively and the first 10 days postoperatively. They completed postoperative pain diaries and Short Form-36 questionnaires before and after surgery.

RESULTS: At 5 days postoperatively, none of the 14 subjects in the ABD group and 4 of 28 (14.3%) in the ROB group achieved 50% total baseline activity counts (P = .283). At 10 days, 5 of 14 (35.7%) in the ABD group and 8 of 26 (30.8%) in the ROB group (P = .972) achieved 50%. Postoperative pain was similar in both groups. Short Form-36 vitality scores were lower (P = .017) after surgery in the ABD group, but not in the ROB group.

CONCLUSION: Women undergoing ROB vs ABD sacral colpopexy do not recover physical activity faster, and pain control is not improved.

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FU Astellas Pharma US Inc; Hartford Hospital [SG-129512]

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ER

PT J

AU Lee, YL

Kilic, G

Phelps, JY

AF Lee, Yu L.

Kilic, Gokhan

Phelps, John Y.

TI Liability Exposure for Surgical Robotics Instructors

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Instructors; Liability; Proctors; Robotic surgery

AB Surgical robotics instructors provide an essential service in improving the competency of novice gynecologic surgeons learning robotic surgery and advancing surgical skills on behalf of patients. However, despite best intentions, robotics instructors and the gynecologists who use their services expose themselves to liability. The fear of litigation in the event of a surgical complication may reduce the availability and utility of robotics instructors. A better understanding of the principles of duty of care and the physician-patient relationship, and their potential applicability in a court of law likely will help to dismantle some concerns and uncertainties about liability. This commentary is not meant to discourage current and future surgical instructors but to raise awareness of liability issues among robotics instructors and their students and to recommend certain preventive measures to curb potential liability risks. Journal of Minimally Invasive Gynecology (2012) 19, 376-379 Published by Elsevier Inc. on behalf of AAGL.

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ER

PT J

AU Leitao, MM

Briscoe, G

Santos, K

Winder, A

Jewell, EL

Hoskins, WJ

Chi, DS

Abu-Rustum, NR

Sonoda, Y

Brown, CL

Levine, DA

Barakat, RR

Gardner, GJ

AF Leitao, Mario M., Jr.

Briscoe, Gabriel

Santos, Kevin

Winder, Abigail

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Chi, Dennis S.

Abu-Rustum, Nadeem R.

Sonoda, Yukio

Brown, Carol L.

Levine, Douglas A.

Barakat, Richard R.

Gardner, Ginger J.

TI Introduction of a computer-based surgical platform in the surgical care

of patients with newly diagnosed uterine cancer: Outcomes and impact on

approach

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Computer-based surgery; Uterine cancer; Robotic surgery; Laparotomy

ID VAGINAL CUFF DEHISCENCE; LAPAROSCOPIC HYSTERECTOMY; ENDOMETRIAL CANCER

AB Objective. To assess the introduction of computer-based surgery (ie, robotic surgery [RBI]) in the treatment of patients with newly diagnosed uterine cancer.

Methods. We identified all patients who presented to our institution for initial surgical care of newly diagnosed uterine cancer from 5/1/07-12/31/10. Perioperative outcomes of laparotomy cases were compared to those of laparoscopic (LSC) or RBT cases. Complications within 30 days of surgery were graded.

Results. Of 752 patients, the planned approach was laparotomy in 103 (14%), LSC in 302 (40%), and RBT in 347 (46%). The rate of laparotomy for any reason (planned or converted) was 39% in 2007 compared to 18% in 2010 (P<0.001). Preoperative characteristics for LSC and RBT cases were similar, except 10% versus 15%, respectively, were morbidly obese (P=0.049). The extent of procedure, total nodal counts, and overall complications were similar between the LSC and RBT cases. The median length of stay was shorter for RBT cases (P<0.001). The median total room and operative times were longer for RBT cases (P<0.001), mainly due to cases in which the surgeon had less than similar to 40 RBT cases of experience.

Conclusions. Robotics can be efficiently introduced into the surgical care of patients with newly diagnosed uterine cancers. RBT cases require the same operative times as LSC cases after accounting for the 40-case learning curve. Both approaches result in similar excellent patient outcomes and remain reasonable approaches for this disease. The introduction of robotics may lead to further reduction in the rate of laparotomy. (C) 2012 Elsevier Inc. All rights reserved.

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ER

PT J

AU McCullough, M

Downes, JVK

Hoyte, L

AF McCullough, Mona

Downes, Jessica Valceus Katheryne

Hoyte, Lennox

TI The Ureter as a Landmark for Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE CT; robotic surgery; sacral promontory; sacrocolpopexy; ureter

AB Objective: The objective of this study was to report on the location of the ureters in relation to the sacral promontory at the level of the pelvic brim.

Methods: Female patients undergoing indicated computed tomographic (CT) urograms were selected for this study. Charts and images from a defined 3-year study period were reviewed. The GE Centricity software was used to evaluate multiplanar CT views and measure the distance from the bilateral ureters to the midpoint of the distal sacral promontory for each subject.

Results: Sixty-three women underwent CT urography during the study period. Of these, 38 met the criteria for inclusion. Among these, the left ureter was 35.9 +/- 4.9 mm lateral to the midsacral promontory. The right ureter was 29.7 +/- 6.2 mm lateral to the sacral promontory.

Conclusions: On average, the sacral promontory is located 29.7 mm medial to the right ureter at the level of the pelvic brim. This represents a landmark that may prove clinically useful, along with other visual cues, in choosing the proper location for careful dissection toward the anterior longitudinal ligament during robotic sacrocolpopexy.

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Z9 6

U1 0

U2 0

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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ER

PT J

AU Siddiqui, NY

Geller, EJ

Visco, AG

AF Siddiqui, Nazema Y.

Geller, Elizabeth J.

Visco, Anthony G.

TI Symptomatic and anatomic 1-year outcomes after robotic and abdominal

sacrocolpopexy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE abdominal sacrocolpopexy; pelvic organ prolapse; robotic sacrocolpopexy;

surgical outcome

ID LAPAROSCOPIC SACROCOLPOPEXY; TERM OUTCOMES; QUALITY; WOMEN;

INCONTINENCE; SURGERY

AB OBJECTIVE: The purpose of this study was to compare symptomatic and anatomic outcomes 1 year after robotic vs abdominal sacrocolpopexy.

STUDY DESIGN: Our retrospective cohort study compared women who underwent robotic sacrocolpopexy (RSC) with 1 surgeon to those who underwent abdominal sacrocolpopexy (ASC) as part of the Colpopexy and Urinary Reduction Efforts trial. Our primary outcome was a composite measure of vaginal bulge symptoms or repeat surgery for prolapse.

RESULTS: We studied 447 women (125 with RSC and 322 with ASC). Baseline characteristics were similar. There were no significant differ-ences in surgical failures 1 year after surgery based on our primary composite outcome (7/86 [8%] vs 12/304 [4%]; P = .16). When we considered anatomic failure, there were also no significant differences between RSC and ASC (4/70 [6%] vs 16/289 [6%]; P = .57).

CONCLUSION: One year after sacrocolpopexy, women who underwent RSC have similar symptomatic and anatomic success compared with those women who underwent ASC.

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RI Geller, Elizabeth/AAE-9010-2020

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FX Funded by the Charles B Hammond Research Fund, Duke University.

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ER

PT J

AU Lau, S

Vaknin, Z

Ramana-Kumar, AV

Halliday, D

Franco, EL

Gotlieb, WH

AF Lau, Susie

Vaknin, Zvi

Ramana-Kumar, Agnihotram V.

Halliday, Darron

Franco, Eduardo L.

Gotlieb, Walter H.

TI Outcomes and Cost Comparisons After Introducing a Robotics Program for

Endometrial Cancer Surgery

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID OF-GYNECOLOGIC-ONCOLOGISTS; LYMPHADENECTOMY; HYSTERECTOMY; CARCINOMA;

MEMBERS

AB OBJECTIVE: To evaluate the effect of introducing a robotic program on cost and patient outcome.

METHODS: This was a prospective evaluation of clinical outcome and cost after introducing a robotics program for the treatment of endometrial cancer and a retrospective comparison to the entire historical cohort.

RESULTS: Consecutive patients with endometrial cancer who underwent robotic surgery (n = 143) were compared with all consecutive patients who underwent surgery (n = 160) before robotics. The rate of minimally invasive surgery increased from 17% performed by laparoscopy to 98% performed by robotics in 2 years. The patient characteristics were comparable in both eras, except for a higher body mass index in the robotics era (median 29.8 compared with 27.6; P<.005). Patients undergoing robotics had longer operating times (233 compared with 206 minutes), but fewer adverse events (13% compared with 42%; P<.001), lower estimated median blood loss (50 compared with 200 mL; P<.001), and shorter median hospital stay (1 compared with 5 days; P<.001). The overall hospital costs were significantly lower for robotics compared with the historical group (Can$7,644 compared with Can$10,368 [Canadian dollars]; P<.001) even when acquisition and maintenance cost were included (Can$8,370 compared with Can$10,368; P=.001). Within 2 years after surgery, the short-term recurrence rate appeared lower in the robotics group compared with the historic cohort (11 recurrences compared with 19 recurrences; P<.001).

CONCLUSION: Introduction of robotics for endometrial cancer surgery increased the proportion of patients benefitting from minimally invasive surgery, improved short-term outcomes, and resulted in lower hospital costs. (Obstet Gynecol 2012;119:717-24) DOI: 10.1097/AOG.0b013e31824c0956

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FU Intuitive Surgical Inc.; Israel Cancer Research Foundation; Week-end to

end Women Cancers, Gloria's girls, Turqwise; Greenbaum fund; Dr. Hoffman

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FX Dr. Gotlieb has proctored robotics in Canada, China, India, and Israel,

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PT J

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AF Venkat, Pavithra

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TI An economic analysis of robotic versus laparoscopic surgery for

endometrial cancer: Costs, charges and reimbursements to hospitals and

professionals

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Laparoscopy; Endometrial cancer; Cost; Economic

analysis

ID HYSTERECTOMY; LAPAROTOMY

AB Objective. To determine the actual costs, charges, and reimbursements associated with robotic vs. laparoscopic surgery for endometrial cancer.

Methods. Data were collected from hospital billing records, MD professional group billing records, tumor registry, and medical records on operations performed by a single surgeon from one institution between 2008 and 2010. For comparison, surgical groups were matched based on age, histology, and stage of disease over the same time period.

Results. Of 54 patients, 27 underwent robotic surgery (RS) and 27 had laparoscopic surgery (LS). The median age was 57 years. There were no statistically significant differences between the groups based on age, stage, and histology. The hospital charges for RS were higher at $64,266 vs. $55,130 for LS (p=0.036). However, the reimbursement to the hospital was not statistically different at $13,003 for RS and $10,245 for LS (p=0.29). Operating suite, room and board, anesthesia, post anesthesia care unit, and pathology accounted for over 90% of hospital charges. The surgeon charges for RS and LS were $6824 and $6327, respectively (p = 0.033) and the anesthesiologist charges were $4049 and $2985, respectively (p=0.001). However, there were no differences in reimbursement to the surgeon (p=0.74) and anesthesiologist (p=0.84) between the two operative approaches.

Conclusions. Our data showed that the direct costs and charges associated with robotic surgery were higher compared to laparoscopic surgery. However, actual reimbursements to the hospital, surgeon, and anesthesiologist were not significantly different between the two surgical approaches. (C) 2011 Elsevier Inc. All rights reserved.

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WC Oncology; Obstetrics & Gynecology

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PT J

AU Ercoli, A

D'asta, M

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Baldazzi, G

Salerno, MG

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Baldazzi, G.

Salerno, M. G.

Scambia, G.

TI Robotic treatment of colorectal endometriosis: technique, feasibility

and short-term results

SO HUMAN REPRODUCTION

LA English

DT Article

DE deep endometriosis; colorectal endometriosis; robotic-assisted

laparoscopy

ID DEEP INFILTRATING ENDOMETRIOSIS; RESECTION; MANAGEMENT; SURGERY

AB Deep infiltrating endometriosis (DIE) is a complex disease that impairs the quality of life and the fertility of women. Since a medical approach is often insufficient, a minimally invasive approach is considered the gold standard for complete disease excision. Robotic-assisted surgery is a revolutionary approach, with several advantages compared with traditional laparoscopic surgery.

From March 2010 to May 2011, we performed 22 consecutive robotic-assisted complete laparoscopic excisions of DIE endometriosis with colorectal involvement. All clinical data were collected by our team and all patients were interviewed preoperatively and 3 and 6 months post-operatively and yearly thereafter regarding endometriosis-related symptoms. Dysmenorrhoea, dyschezia, dyspareunia and dysuria were evaluated with a 10-point analog rating scale.

There were 12 patients, with a median larger endometriotic nodule of 35 mm, who underwent segmental resection, and 10 patients, with a median larger endometriotic nodule of 30 mm, who underwent complete nodule debulking by colorectal wall-shaving technique. No laparotomic conversions were performed, nor was any blood transfusion necessary. No intra-operative complications were observed and, in particular, there were no inadvertent rectal perforations in any of the cases treated by the shaving technique. None of the patients had ileostomy or colostomy. No major post-operative complications were observed, except one small bowel occlusion 14 days post-surgery that was resolved in 3 days with medical treatment. Post-operatively, a statistically significant improvement of patient symptoms was shown for all the investigated parameters.

To our knowledge, this is the first study reporting the feasibility and short-term results and complications of laparoscopic robotic-assisted treatment of DIE with colorectal involvement. We demonstrate that this approach is feasible and safe, without conversion to laparotomy.

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PT J

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TI Robotic-assisted sacrocolpopexy/sacrocervicopexy repair of pelvic organ

prolapse: initial experience

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic assisted sacrocolpopexy; Sacrocervicopexy; Pelvic organ prolapse

ID VAGINAL VAULT PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; SURGERY; OUTCOMES

AB To present the short-term surgical outcomes of robotic-assisted sacrocolpopexy and sacrocervicopexy.

Between January 2009 and September 2010, 12 patients underwent robotic-assisted pelvic organ prolapse repair including six sacrocolpopexy and six sacrocervicopexy. Patients' demographics, surgical procedures, operative and postoperative complications, hospital stay, conversion to laparotomy, time data including all operative times and estimated blood loss (EBL) were recorded.

All surgeries were completed robotically with no conversion to laparotomy. The average operative time for the robotic-assisted sacrocolpopexy (RASCP) was 150.5 +/- A 29.6 min (range 114-189) and the mean console time was calculated as 123.6 +/- A 34.2 min (range 84-166). The averages of the dissection and the suturation time were 34.8 +/- A 24.3 min (range 13-72) and 63.3 +/- A 21.8 min (range 28-95), respectively. The mean length of hospitalization was 2.8 +/- A 0.7 days (range 2-4) and the mean EBL was calculated as 12.5 +/- A 4.1 ml (range 10-20). There was one intraoperative complication. The mean age and body mass index of the patients underwent robotic-assisted sacrocervicopexy were 38.1 +/- A 6.5 years (29-47) and 28.4 +/- A 5.8 kg/m(2) (18.6-34.4), respectively. The mean operating times were calculated as follows: set-up time was 25.6 +/- A 4.0 min, docking time was 3 +/- A 0.8 min, dissection time was 28.6 +/- 7.7 min, suturation time was 70.8 +/- A 10.9 min and console time was 123.1 +/- A 23.6 min. There were no recurrences during the follow-up period (12 months) in both groups of the patients.

The use of the robotic system during pelvic organ prolapse repair is feasible, safe and may support the surgeon during dissection and suturing at the level of sacral promontory.

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NR 15

TC 10

Z9 10

U1 0

U2 2

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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ER

PT J

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TI Bowel Function After Minimally Invasive Urogynecologic Surgery: A

Prospective Randomized Controlled Trial

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE bowel function; constipation; defecatory; gynecologic surgery

AB Objectives: The goals of this study were to assess the effect of a standardized postoperative bowel regimen of over-the-counter medications on (1) time to first bowel movement (BM) and (2) pain level associated with first BM in subjects undergoing minimally invasive urogynecologic surgery.

Methods: Eligible patients scheduled to undergo minimally invasive urogynecologic surgery were offered participation. Enrolled subjects were randomized by computerized schedule. Demographic and perioperative data were collected. Subjects completed a validated questionnaire preoperatively and postoperatively assessing preexisting constipation, frequency and consistency of bowel movements, use of pain medications, mean daily pain level (using visual analog scale), stool consistency, and pain associated with first postoperative bowel movement. The control group was instructed to take docusate sodium twice daily postoperatively. The treatment group took docusate sodium plus Miralax, fiber wafers, and bisacodyl suppositories as directed by protocol. Wilcoxon or t testing was used to compare continuous variables; chi(2) testing was used for categorical relationships, and backward-elimination multiple regression was used to assess independent effects.

Results: Seventy-two subjects were enrolled and randomized. Twelve subjects withdrew, leaving 60 (30 per group) completing the study. There were no statistically significant differences between groups in baseline characteristics. Mean (SD) age was 63 (9) years for the control group and 58 (10) for the study group (P = 0.06). Mean pelvic organ prolapse stage was III in each group. The mean (SD) operating room time was 198 (65) minutes for the controls and 216 (74) for the study subjects. Sixty-five percent underwent robot-assisted surgery (50% hysterectomy and 63% sacrocolpopexy). Ninety-eight percent of surgeries were performed under general anesthesia.

Before adjustment, the mean (SD) time to first BM was 77 (24) hours in controls versus 64 (21) in the study patients (P = 0.03). Using multiple regression, baseline frequency of defecation (1-2 BMs/wk) was directly associated with the time to first BM (added 25.2 hours; P = 0.009) and being in the study group was inversely associated (first BM, 11.7 hours sooner; P = 0.04). No other variables were retained.

There was no difference in pain associated with first postoperative BM (visual analog scale, 3.6 (3.2) vs 3.7 (2.8); P = 0.98), but those with prior complaints of vaginal or rectal splinting had higher pain scores (1.9 and 2.8 points higher, respectively; P = 0.04 for both). There was a trend toward higher pain scores with higher postoperative daily narcotic intake (P = 0.06). No other variables were retained.

There was a significant difference in recorded compliance between control versus study regimens (94% vs 81%, respectively; P = 0.002).

Conclusions: Mean time to first postoperative BM after minimally invasive urogynecologic surgery is more than 3.5 days with use of docusate sodium alone and is only slightly shorter when combination therapy is used. First BM after surgery is considered to be painful de-spite the use of medications. Future studies targeting postoperative discomfort/pain with defecation could target preoperative bowel regimens or more aggressive postoperative interventions. Regimens should remain simple to increase compliance.

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TC 16

Z9 17

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U2 4

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ER

PT J

AU Nezhat, CR

AF Nezhat, Camran R.

TI When Will Video-assisted and Robotic-assisted Endoscopy Replace Almost

All Open Surgeries?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endoscopy; Keyhole surgery; Laparoscopy; Laparotomy; Laser surgery;

Minimally invasive surgery; Robotic surgery; Robotic-assisted

laparoscopy; Video-assisted endoscopy; Video-assisted laparoscopy

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; RANDOMIZED CONTROLLED-TRIAL;

SMALL-BOWEL OBSTRUCTION; TERM-FOLLOW-UP; OPERATIVE LAPAROSCOPY;

POSTOPERATIVE ADHESIONS; PULMONARY COMPLICATIONS; INCISIONAL HERNIA;

VAGINAL DELIVERY; ADNEXAL MASSES

AB This article traces the development of laparoscopy, and establishment resistance to its emergence as the technique to replace almost all laparotomies. Journal of Minimally Invasive Gynecology (2012) 19, 238-243 (C) 2012 AAGL. All rights reserved.

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PT J

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TI Mesh Erosion in Robotic Sacrocolpopexy

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE robotic; sacrocolpopexy; mesh; erosion; hysterectomy

ID VAGINAL CUFF DEHISCENCE; COMPLICATIONS; OUTCOMES

AB Objective: This study aimed to compare the incidence of mesh erosion after robotic sacrocolpopexy between women undergoing total and those undergoing supracervical hysterectomy (SH).

Methods: This is a retrospective cohort study of women who underwent sacrocolpopexy and concomitant hysterectomy using the DaVinci surgical robot between May 2007 and December 2010 at 2 sites. Baseline data were gathered before surgery. The primary outcome was mesh erosion identified during 3 months of follow-up.

Results: A total of 102 women underwent sacrocolpopexy, of whom 45 were with concomitant SH and 57 were with total hysterectomy (TH). Their mean age was 58 years, mean body mass index was 26.8 kg/m(2), 98% were white, 6% smoked, and 25% were on systemic hormone replacement therapy. Mean preoperative Ba = +1.4, C = -2.2. These were not different between the 2 groups or by site. Within 3 months of surgery, mesh erosion was diagnosed in 8 women, all of whom had TH. No mesh erosions occurred in the SH group (14% vs 0%). Total hysterectomy mesh erosion rate at site 1 was 3% compared with 37% at site 2. Mesh type was the only identifiable difference between sites: self-cut polypropylene at site 1, precut polypropylene at site 2. Two women in the SH had abnormal uterine pathology: 1 endometrial adenocarcinoma and 1 focus of hyperplasia with atypia.

Conclusions: No mesh erosions were associated with SH within the first 3 months. In TH, the graft material used may be a modifiable factor needing further investigation. Unexpected abnormal uterine pathologic diagnosis remains a possibility with SH. Longer-term follow-up and a randomized trial are warranted to answer these questions.

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ER

PT J

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TI Minimally Invasive Apical Sacropexy: A Retrospective Review of

Laparoscopic and Robotic Operating Room Experiences

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE minimally invasive surgery; sacral colpopexy; learning curve; robotic

colpopexy; laparoscopic colpopexy

ID ABDOMINAL SACROCOLPOPEXY; ASSISTED HYSTERECTOMY; ORGAN PROLAPSE;

SURGERY; OUTCOMES

AB Objectives: Minimally invasive apical sacropexies (MI-APSC) can be performed using robotics or laparoscopy. We hypothesized that operative characteristics of MI-APSC, laparoscopic (LSC) and robotic (RSC), were similar. The objective of our study was to compare operative characteristics, objective prolapse outcomes, and robotic learning curve.

Methods: Ninety-two women planning MI-APSC for treatment of apical pelvic organ prolapse from 2006 to 2010 were included in the study. The primary outcome was operative time. The secondary outcomes included estimated blood loss, rate of conversion, intraoperative complications, hospital stay, and objective prolapse outcome. We also analyzed the robotic learning curve. Statistical analysis included independent samples t test, Wilcoxon rank sum test, chi(2), and multiple logistic regressions; significance was set at P < 0.05. Learning curve was graphed with moving average and analyzed with moving block technique.

Results: Forty-eight RSCs and 43 LSCs were analyzed. Mean operative times were LSC, 238 +/- 59 minutes; and RSC, 242 +/- 54 minutes. Robotic MI-APSC setup was longer (P = 0.02). Complications, conversions, estimated blood loss and hospital stay were low and similar between groups. Patients' characteristics were similar. Concomitant procedures produced longer operative times.

Conclusions: Operating room experiences with laparoscopic- and robotic-assisted approaches to MI-APSC were similar, but setup time is longer for the robotic-assisted approach. The robotic learning curve is short for surgeons who have experience with LSC.

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PT J

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Fu, Pei-Te

Liu, Yung-Liang

Sun, Cheng-Chian

Chang, Cheng-Chang

Yu, Mu-Hsien

Lai, Hung-Cheng

TI Robotic surgery in complicated gynecologic diseases: Experience of

Tri-Service General Hospital in Taiwan

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE adhesions; hysterectomy; myomectomy; robotic staging; subtotal

hysterectomy

ID LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; RISK-FACTORS;

OUTCOMES; CONVERSION; LAPAROTOMY; OBESE

AB Objective: Minimally invasive surgery has been the trend in various specialties and continues to evolve as new technology develops. The development of robotic surgery in gynecology remains in its infancy. The present study reports the first descriptive series of robotic surgery in complicated gynecologic diseases in Taiwan.

Materials and Methods: From March 2009 to February 2011, the records of patients undergoing robotic surgery using the da Vinci Surgical System were reviewed for patient demographics, indications, operative time, hospital stay, conversion to laparotomy, and complications.

Results: Sixty cases were reviewed in the present study. Forty-nine patients had benign gynecologic diseases, and 11 patients had malignancies. These robot-assisted laparoscopic procedures include nine hysterectomy, 15 subtotal hysterectomy, 13 myomectomy, eight staging operation, two radical hysterectomy, five ovarian cystectomy, one bilateral salpingo-oophorectomy and myomectomy, two resections of deep pelvic endometriosis, one pelvic adhesiolysis, three sacrocolpopexy and one tuboplasty. Thirty-three patients had prior pelvic surgery, and one had a history of pelvic radiotherapy. Adhesiolysis was necessary in 38 patients to complete the whole operation. Robotic myomectomy was easily accomplished in patients with huge uterus or multiple myomas. The suturing of myometrium or cervical stump after ligation of the uterine arteries minimized the blood loss. In addition, it was much easier to dissect severe pelvic adhesions. The dissection of para-aortic lymph nodes can be easily accomplished. All these surgeries were performed smoothly without ureteral, bladder or bowel injury.

Conclusion: The present analyses include various complicated gynecologic conditions, which make the estimation of the effectiveness of robotic surgery in each situation individually not appropriate. However, our experiences do show that robotic surgery is feasible and safe for patients with complicated gynecologic diseases. Copyright (c) 2012, Taiwan Association of Obstetrics & Gynecology. Published by Elsevier Taiwan LLC. All rights reserved.

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TC 21

Z9 22

U1 0

U2 9

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JI Taiwan. J. Obstet. Gynecol.

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ER

PT J

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AF van der Wat, Johan

TI When Will Laparoscopy Totally Replace Laparotomy?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Laparotomy; Vaginal hysterectomy; Robotic surgery; MIGS;

Managed care

ID MINILAPAROTOMY; HYSTERECTOMY; COST

AB This clinical opinion explores the current "zeitgeist" of minimally invasive gynaecological surgery (MIGS) as reflected in opinions expressed at the 40th AAGL conference held in Hollywood, Florida. It addresses concerns relating to the introduction of MIGS globally and the current position of robotic surgery in relation to conventional minimally invasive techniques like vaginal hysterectomy and minilaparotomy. It also explores challenges relating to MIGS in the healthcare environment of the 21st century. Journal of Minimally Invasive Gynecology (2012) 19, 236-237 (C) 2012 AAGL. All rights reserved.

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Z9 2

U1 0

U2 0

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ER

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TI Study of surplus cost of robotic assistance for radical hysterectomy,

versus laparotomy and standard laparoscopy

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Gynaecology; Laparoscopy; Robotic assistance; Da Vinci; Cost comparison

ID CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; ENDOMETRIAL CANCER; EXPERIENCE;

OUTCOMES; TECHNOLOGY; CARCINOMA; ECONOMICS; SURGERY; TIME

AB Objectives. - The study purpose was to compare the costs among robotic, laparoscopic and open radical hysterectomy for cervical cancer.

Patients and methods. - Thirty-seven patients underwent robotic radical hysterectomy for cervical cancer. Cases were performed by three surgeons, at two institutions, and were retrospectively reviewed to perform a cost comparison between all three modalities. We included costs for edible materials in anesthesia and surgery, but costs for staff and indirect financial expenses were excluded. Those data are compared to open and laparoscopic radical hysterectomy data.

Results. - The average cost for robotic assistance presented a surplus of 1796 euros compare to laparotomy and 1313 euros compare to standard laparoscopy in 2008, and 1320 and 837 euros respectively.

Discussion and conclusion. - The average cost for radical hysterectomy was highest for robotic, followed by standard laparoscopy, and least for laparotomy. However, over only 2 years of use, this difference tends to decrease. Medico-economic impact is the main restraint for robotic assistance development, and needs to be assessed permanently. (c) 2012 Published by Elsevier Masson SAS.

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ER

PT J

AU ElSahwi, KS

Hooper, C

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Ratner, E

Silasi, DA

Santin, AD

Schwartz, PE

Rutherford, TJ

Azodi, M

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Rutherford, Thomas J.

Azodi, Masoud

TI Comparison between 155 cases of robotic vs. 150 cases of open surgical

staging for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Minimally invasive; Laparoscopic; Robotic; da Vinci;

Surgical staging

ID AORTIC LYMPHADENECTOMY; HYSTERECTOMY; LAPAROSCOPY; LAPAROTOMY

AB Objective. To compare the outcomes of 155 cases of endometrial cancer who had robot-assisted surgical staging to 150 open cases.

Methods. Retrospective chart review of cases of endometrial cancer that underwent staging two different ways by two surgeons at an academic institution.

Results. Mean age was 62.4 years in the robotic arm and 65 (P = 0.04) in the open arm. Mean body mass index was 34.5 Kg/m(2) in the robotic arm and 33 Kg/m(2) in the open arm (P = 0.2). Pelvic and para-aortic lymph node dissection were performed in 94.8% and 67.7% of the robotic cases versus 95.3% and 74% of the open cases, respectively. Mean operative time was 127 min in the robotic arm, and 141 min in the open arm (P = 0.0001). Mean lymph node count was 20.3 in the robotic arm, and 20 in the open arm (P = 0.567). Mean estimated blood loss was 119 ml in the robotic arm and 185 in the open arm (P = 0.015). Mean hospital stay was 1.5 days in the robotic arm, and 4 days in the open arm (P = 0.0001). The incidence of postoperative ileus (0.6% vs. 10.7%, P = 0.0001), infections (5.2% vs. 24%, P = 0.0001), anemia/transfusion (1.3% vs. 7.7%, P = 0.005), and cardiopulmonary complications (3.2% vs. 14.7%, P = 0.003) was significantly lower in the robotic arm vs. the open arm. There was one death in the robotic arm attributed to pre-existing cardiac condition.

Conclusion. Robotic-assisted staging reaps the benefits of minimally invasive surgery without compromising the adequacy of the procedure. Dedication to the technique shortens the operative time. (C) 2011 Elsevier Inc. All rights reserved.

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PT J

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TI Learning experience using the double-console da Vinci surgical system in

gynecology: a prospective cohort study in a University hospital

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic-assisted laparoscopy; Double console da Vinci robot; Learning

curve; Surgical outcomes

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; UNITED-STATES; ROBOTICS; SURGERY;

RATES

AB To report our preliminary experience with robotic-assisted laparoscopy in a variety of gynecological surgeries in a teaching hospital.

A total of 33 patients who underwent robotic-assisted laparoscopic procedures for gynecological diseases were included in the study. All surgeries were performed using the double-console da Vinci surgical system. Patient's demographics, surgical procedures, operative time, perioperative complications, conversion rate, hospital stay and estimated blood loss were prospectively collected.

All procedures were completed robotically except three (9%): two cases were converted to laparotomy and one case was converted to vaginal surgery. The mean age was 47 +/- A 11 and mean BMI was 23 kg/mA(2). Mean time taken for docking the robot was 22 min. Mean operative time was 152 min. Mean anesthesia time was 196 min. Mean hemoglobin drop was 2 g/dL. Four complications occurred: one transitory ischemic attack, one port-site hernia managed through trocar incision, one periumbilical hematoma managed conservatively and one vaginal cuff hematoma who required laparoscopy. The mean hospital stay was 4 days.

With the use of robotic technology, surgeons are able to offer minimally invasive surgery to a larger percentage of patients. Double console system seems a promising tool in surgical education, improving both resident training and participation in surgeries. A shorter adaption to robotics could be expected in teams with previous experience with standard laparoscopy, however, a stepwise start with simpler cases is the key to achieve a safe adaption to robotic surgery.

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U1 0

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J9 ARCH GYNECOL OBSTET

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PT J

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Feinglass, J

Zei, C

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Lewicky-Gaupp, C

Lin, A

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Feinglass, Joe

Zei, Charles

Lu, Guanning

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Lewicky-Gaupp, Christina

Lin, Alexander

TI Robotic-assisted laparoscopic myomectomy versus abdominal myomectomy: a

comparative analysis of surgical outcomes and costs

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Myomectomy; Non-invasive surgery; Robot-assisted laparoscopic myomectomy

ID UTERINE RUPTURE

AB To compare clinical and effectiveness outcomes between robotic-assisted laparoscopic myomectomy (RALM) and abdominal myomectomy (AM).

Records were reviewed for the first 27 RALM procedures at our institution. Age, BMI, insurance status, race, uterine size, and operative indication were used to select comparable patients who had undergone AM. Clinical and efficiency outcomes were compared stratifying for uterine size, specimen weight, and matched propensity scores.

IV hydromorphone use was significantly lower for RALM (P < 0.01), with no significant differences in blood loss or complications. RALM patients had significantly shorter hospital stays; however, total hospital charges were higher (P < 0.0001). This likely reflects longer operating room time (P < 0.0001), which was magnified as specimen size increased (P < 0.0001).

RALM patients require less IV hydromorphone, have shorter hospital stays, and have generally equivalent clinical outcomes compared with AM patients. Additionally, as specimen size increased, the operative efficiency of RALM decreased compared with AM.

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PT J

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TI Robotic-Assisted Laparoscopic Transection and Repair of an Obturator

Nerve During Pelvic Lymphadenectomy for Endometrial Cancer

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

AB BACKGROUND: Obturator nerve injury may occur in gynecologic surgery, particularly in cases in which extensive pelvic sidewall retroperitoneal dissection is performed. The lack of tactile feedback from the robotic surgical system may contribute to obturator nerve injury. If surgical division occurs, microsurgical end-to-end anastomosis of the obturator nerve may be performed.

CASE: A 76-year-old woman with stage IA endometrial adenocarcinoma sustained a left obturator nerve transection during pelvic lymphadenectomy that was recognized immediately. Robotic-assisted laparoscopic repair was performed successfully, with the patient experiencing no residual neuropathy 6 months postoperatively.

CONCLUSION: Robotic-assisted laparoscopic repair is feasible for the treatment of obturator nerve injury. (Obstet Gynecol 2012;119:462-4) DOI: 10.1097/AOG.0b013e31823d0c4f

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NR 10

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Z9 16

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U2 6

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J9 OBSTET GYNECOL

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PT J

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Schmeler, Kathleen M.

Ramirez, Pedro T.

TI Fertility sparing surgery for treatment of early-stage cervical cancer:

Open vs. robotic radical trachelectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Radical trachelectomy

ID PELVIC LYMPHADENECTOMY; WOMEN; LAPAROTOMY; OUTCOMES

AB Objective. To compare the open versus robotic surgical approaches and provide surgical outcome data on patients who have undergone radical trachelectomy (RT).

Methods. We identified patients who underwent open (ORT) or robotic radical trachelectomy (RRT) between September 2005 and June 2011. Tumor characteristics, perioperative, operative and obstetrical outcomes were analyzed.

Results. Thirty-seven patients with early stage cervical cancer that desired future fertility underwent attempted radical trachelectomy, and 32 patients (20 with 1B1, 11 with 1A2, and 5 with 1A1 with LVSI/poorly differentiated histology) had successful completion of RT. Five (1 open/4 robotic) underwent conversion to radical hysterectomy secondary to close (<5 mm) endocervical margin (p = 0.08). The median age at diagnosis was 28.9 years (range; 21.4-37.2), 70% were nulliparous, and 9 had a visible lesion. Twenty-five patients (68%) underwent ORT and 12 (32%) underwent RRT. RRT was associated with less blood loss (62.5 mL vs. 300 mL, p = 0.0001) and decreased length of postoperative stay (1 vs. 4 days, p < 0.001), with no difference in operative time or histopathologic outcomes. Twenty-three patients (62%) had no residual cervical disease on final pathology. Common long-term morbidities were irregular menstrual bleeding or amenorrhea (25%), cerclage erosion (13%), or cervical stenosis (9%). Although there was a higher rate of conversion to hysterectomy in the robotic surgery cohort, rates of serious morbidities among the cohorts were comparable (robotic: 33% vs. open: 24%, p = 0.70). Eleven (36%) patients are actively attempting pregnancy and three have achieved pregnancy. The median time of follow up is 17.0 months (range 0.30-64.9 months). There are no documented recurrences.

Conclusions. RRT results in less blood loss and decreased length of hospital stay with no compromise in histopathologic outcomes. (C) 2011 Elsevier Inc. All rights reserved.

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PT J

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AF Yim, Ga Won

Kim, Young Tae

TI Robotic surgery in gynecologic cancer

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE gynecologic cancer; laparoscopy; robotic surgery

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; BILATERAL PELVIC LYMPHADENECTOMY;

STAGE CERVICAL-CANCER; ENDOMETRIAL CANCER; ASSISTED SURGERY;

TRACHELECTOMY; OUTCOMES; FERTILITY; LAPAROTOMY; MORBIDITY

AB Purpose of review

The development of robotic technology has facilitated the application of minimally invasive techniques for complex operations in gynecologic oncology. The objective of this article is to review the published literature regarding robotic surgery and its application to gynecologic cancer.

Recent findings

To date, 20 articles addressing radical hysterectomy, six articles of radical trachelectomy, seven articles of surgical procedure in advanced or recurrent cervical cancer, 14 articles of endometrial cancer staging, and two articles solely on ovarian cancer all performed robotically are published in the literature. The majority of publications on robotic surgery are still retrospective or descriptive in nature. However, the data for gynecologic cancer show comparable results of robotic surgery compared with laparoscopy or laparotomy in terms of blood loss, length of hospital stay, and complications.

Summary

Computer-enhanced technology with its associated benefits appears to facilitate the surgical approach for technically challenging operations performed to treat selected cases of cervical, endometrial, and ovarian cancer as evidenced by the current literature. Continued research and clinical trials are needed to further elucidate the equivalence or superiority of robot-assisted surgery to conventional methods in terms of oncologic outcome and patients' quality of life.

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TI Cost Analysis of Abdominal, Laparoscopic, and Robotic-Assisted

Myomectomies

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic assisted laparoscopic myomectomy; Costs; Abdominal myomectomy;

Laparoscopic myomectomy; Cost minimization analysis

ID RANDOMIZED-TRIAL; SURGERY; LEIOMYOMATA; OUTCOMES

AB Study Objective: To perform a cost-minimization analysis of abdominal, traditional laparoscopic and robotic-assisted myomectomy.

Design: Cost analysis (Canadian Task Force Classification III).

Setting: Academic medical center.

Patients: Women undergoing myomectomy by various surgical approaches.

Interventions: We developed a decision model to compare the costs ($2009) of different approaches to myomectomy from a healthcare system perspective. The model included operative time, conversion risk, transfusion risk, and length of stay (LOS) for each modality. Baseline estimates and ranges were based on reported values extracted from existing literature. We analyzed two different models: #1) Existing Robot model and #2) Robot Purchase model.

Measurements and Main Results: In the baseline analysis for the Existing Robot model, abdominal myomectomy (AM) was the least expensive at $4937 compared with laparoscopic myomectomy (LM) at $6219 and robotic-assisted laparoscopic myomectomy (RM) at $7299. The abdominal route remained the least expensive when varying all parameters and costs except for two cases in which LM became least expensive: 1) If AM length of stay was greater than 4.6 days, and 2) If the surgeon's fee for AM was greater than $2410. When comparing LM to RM, the cost of RM was consistently higher unless the robotic disposable equipment costs were less than $1400. In the Robot Purchase model, only the RM costs increased while AM and LM costs remained the same.

Conclusion: In this cost-minimization analysis, abdominal myomectomy is the least expensive approach when compared to laparoscopy and robotic-assisted laparoscopy. Journal of Minimally Invasive Gynecology (2012) 19, 52-57 (C) 2012 AAGL. All rights reserved.

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TI Surgical Outcome of Robotic Surgery in Morbidly Obese Patient With

Endometrial Cancer Compared to Laparotomy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Endometrial cancer; Robotic surgery; Morbid obesity

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; IMPACT; WOMEN

AB Introduction: Before the introduction of robotic surgery at our institution, most obese women of class 2 or greater (body mass index [BMI] > 35) underwent a laparotomy for the management of endometrial cancer. Since November 2008, we have performed most of these cases in a robotic fashion. This manuscript presents the outcome of these women in comparison with a historical cohort of women treated with laparotomy.

Methods: Women with clinical stage I or II endometrial cancer and a BMI greater than 35 kg/m(2) treated with robotic surgery at our institution between November 2008 and November 2010 were compared with a historical cohort of similar patients who underwent laparotomy. Patients' characteristics, operating room time, type of surgery, length of hospital stay, and incidence of perioperative complications were compared between the 2 groups.

Results: A total of 86 women were analyzed in this study (robotic surgery, 45; laparotomy, 41). The overall intraoperative complication rate is 5.8%. There is no statistical difference in age, number of comorbidities, BMI, prior abdominal surgery, and operative complications between the women who underwent robotic surgery versus laparotomy. Postoperative complication rates are higher in the laparotomy group (44% vs 17.7%; P = 0.007), and hospital length of stay is also higher in the laparotomy group (4 vs 2 days; P < 0.001). There is no difference in rates of (pelvic) lymph node dissection; however, para-aortic node dissection is more common in the robotic surgery group.

Conclusion: Robotic surgery for the surgical management of the morbidly obese patient is shown to be safe and have less perioperative complications compared with open surgery.

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TI Robotic-assisted surgery in the management of endometrial cancer

SO JOURNAL OF OBSTETRICS AND GYNAECOLOGY RESEARCH

LA English

DT Article

DE cost; endometrial cancer; hysterectomy; lymphadenectomy; obesity;

robotic surgery

ID LAPAROSCOPIC HYSTERECTOMY; SURGICAL OUTCOMES; LYMPHADENECTOMY;

LAPAROTOMY; OBESE; COST

AB Advanced laparoscopic procedures for hysterectomy and staging lymphadenectomy were not widely adopted for management of endometrial cancer despite nearly 20 years of improvements in laparoscopic technology. Many surgeons have recently embraced da Vinci robotic-assisted laparoscopy in preference to traditional laparoscopy because of its technological advantages of wristed instrumentation, high-definition 3-D optics, ergonomics and autonomy of camera control; the majority of women with endometrial cancer in the USA now undergo robotic-assisted surgery. The purpose of this article is to review the robotic surgical techniques for hysterectomy, pelvic and aortic lymphadenectomy procedures, and the current comparative literature discussing perioperative outcomes. Additionally, literature that discusses challenges managing obese patients and robotic surgical costs are reviewed. Future multi-institutional, prospective registration studies comparing perioperative outcomes, complications, pain, recovery time, cost and long-term clinical outcomes with open, laparoscopic and robotic procedures will be necessary to completely appreciate the impact of robotic-assisted technology.

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Z9 30

U1 0

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ER

PT J

AU Schreuder, HWR

Wolswijk, R

Zweemer, RP

Schijven, MP

Verheijen, RHM

AF Schreuder, H. W. R.

Wolswijk, R.

Zweemer, R. P.

Schijven, M. P.

Verheijen, R. H. M.

TI Training and learning robotic surgery, time for a more structured

approach: a systematic review

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Review

DE Curriculum; education; learning; robotic surgery; training

ID ASSISTED LAPAROSCOPIC PROSTATECTOMY; VIRTUAL-REALITY; RADICAL

PROSTATECTOMY; POSTGRADUATE UROLOGISTS; OBJECTIVE EVALUATION; SURGICAL

EDUCATION; SKILL ACQUISITION; OPERATIVE TIME; TERM IMPACT; CURVE

AB Background Robotic assisted laparoscopic surgery is growing rapidly and there is an increasing need for a structured approach to train future robotic surgeons.

Objectives To review the literature on training and learning strategies for robotic assisted laparoscopic surgery.

Search strategy A systematic search of MEDLINE, EMBASE, the Cochrane Library and the Journal of Robotic Surgery was performed.

Selection criteria We included articles concerning training, learning, education and teaching of robotic assisted laparoscopic surgery in any specialism.

Data collection and analysis Two authors independently selected articles to be included. We categorised the included articles into: training modalities, learning curve, training future surgeons, curriculum design and implementation.

Main results We included 114 full text articles. Training modalities such as didactic training, skills training ( dry lab, virtual reality, animal or cadaver models), case observation, bedside assisting, proctoring and the mentoring console can be used for training in robotic assisted laparoscopic surgery. Several training programmes in general and specific programmes designed for residents, fellows and surgeons are described in the literature. We provide guidelines for development of a structured training programme.

Authors' conclusions Robotic surgical training consists of system training and procedural training. System training should be formally organised and should be competence based, instead of time based. Virtual reality training will play an import role in the near future. Procedural training should be organised in a stepwise approach with objective assessment of each step. This review aims to facilitate and improve the implementation of structured robotic surgical training programmes.

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FX Rene Verheijen is a proctor for radical robot-assisted surgery,

sponsored by Intuitive Surgery. For all other authors there is no

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WC Obstetrics & Gynecology

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ER

PT J

AU Boruta, DM

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McCann, CK

Garrett, LA

del Carmen, MG

Goodman, A

Schorge, JO

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Schorge, John O.

TI Evolution of surgical management of early-stage endometrial cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 39th Annual Global Congress of Minimally Invasive Gynecology of the

American-Association-of-Gynecologic-Laparoscopists (AAGL)

CY NOV 08-12, 2010

CL Las Vegas, NV

SP Amer Assoc Gynecol Laparoscopists (AAGL)

DE endometrial cancer; laparoscopy; surgical staging

ID LYMPHADENECTOMY; HYSTERECTOMY; EXPERIENCE; SURGERY; OBESE

AB OBJECTIVE: We sought to examine the evolution of surgical care for early-stage endometrial cancers and factors affecting use of laparoscopy.

STUDY DESIGN: Women with surgically managed early-stage endometrial cancer were divided into 2 groups corresponding to before and after addition of faculty with formal fellowship training in laparoscopic staging and access to a robotic surgery platform.

RESULTS: In all, 502 women were identified. Laparoscopic management increased from 24-69% between time periods (P < .0001). Performance of comprehensive surgical staging, and lymph node counts, increased (P < .0001) despite an increase in median body mass index (P = .001). A traditional "straight stick" technique was performed in 72% of laparoscopic cases during the later period. Laparoscopy patients had lower estimated blood losses and shorter hospital stays (each P < .0001) compared to laparotomy patients.

CONCLUSION: Addition of faculty with formal fellowship training in laparoscopic staging and access to a robotic surgery platform shifted management of early-stage endometrial cancer toward laparoscopy.

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TC 7

Z9 7

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U2 5

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Jauffret, C

Lambaudie, E

Bannier, M

Buttarelli, M

Houvenaeghel, G

AF Jauffret, C.

Lambaudie, E.

Bannier, M.

Buttarelli, M.

Houvenaeghel, G.

TI Robot-assisted laparoscopy in the management of recurrent pelvic cancer

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Robot-assisted laparoscopy; Pelvic cancer; Recurrence

ID CERVICAL-CANCER; EXENTERATION; SURGERY

AB Objectives. - The aim of this study is to establish the feasibility of the management of recurrent pelvic cancers by robot-assisted laparoscopy, and particularly the feasibility of robot-assisted laparoscopy anterior pelvic exenteration, from a single center series of seven patients.

Patients and methods. - From February 2007 to April 2010, all patients cared for recurrent pelvic cancer have been included (n = 7). Five patients have been cared for a cervical cancer recurrence, one patient for recurrent VAIN 3, and one patient for squamous cell carcinoma of the vaginal vault after hysterectomy for cervical carcinoma in situ. All patients were benefited from robot-assisted laparoscopy: two had surgery such as anterior pelvic exenteration with Miami Pouch urinary reconstruction, and five had colpectomy with or without lymph node removal, including one with vaginal preparation first before vaginal cuff resection. Data were collected prospectively identifying treatment history, intraoperative data, immediate outcomes, pathological findings, and long-term outcomes.

Results. - From February 2007 to April 2010, 195 patients underwent robot-assisted laparoscopy at the Institut Paoli-Calmettes. Among them, seven patients had pelvic cancer recurrence. The median age was 53 years (44 to 67). The median BMI was 25 (19.7 to 35.3). The median Karnofsky index was 100 (80100). The median operative time was 210 min (90 to 300) for colpectomy, 480 min for pelvectomy, 240 min (90-480) for the serie. The mean duration of the installation of the robot, all procedures combined, is estimated at 22.5 min (+/- 4.8 min). There was no conversion to laparotomy, the median blood loss was 340 ml (100 to 800). One patient was transfused with two red blood cells. There was a surgical complication (wound of the inferior mesenteric artery). There were no early postoperative complications and the median hospital stay was 6 days (3-24). There was a late postoperative complication: a patient who underwent anterior pelvic exenteration had impaired wound healing, with scarring requiring led by the VAC system. On pathological findings, the average number of nodes removed in the pelvic was 8.5 (+/- 2) on the left, and 4 (+/- 1.4) on the right. Three patients had involved margins; it was an anterior pelvic exenteration and two colpectomy. There was no hospital mortality, neither post-operative mortality at D30 and D90. After a median follow up of 22 months (9-34), the recurrence rate was 71% (5 patients out of 7), and one patient died 10 months after the intervention of a pulmonary embolism.

Discussion and conclusion. - The surgical management of recurrent cervical cancer by laparoscopy-assisted robot is feasible for selected indications, and could be proposed as an alternative to laparotomy. Monitoring data in this series raise the question of the validity of conservative treatment in cases of recurrent pelvic cancer. The possibilities in terms of urinary and vaginal reconstruction remain to be defined. The impact of this surgical approach on oncological data must be confirmed. (C) 2011 Elsevier Masson SAS. All rights reserved.

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ER

PT J

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TI A cost analysis of postoperative management in endometrial cancer

patients treated by robotics versus laparoscopic approach

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic gynecologic surgery; Cost; Postoperative pain

ID RADICAL HYSTERECTOMY; LYMPHADENECTOMY; OUTCOMES

AB Objective. The purpose of this study is to compare postoperative pain management and costs in endometrial cancer patients who had a robotic-assisted or laparoscopic-assisted hysterectomy.

Methods. This is a retrospective cohort study of all endometrial cancer patients from 9/2005 to 6/2010 who had a completed robotic-assisted or laparoscopic-assisted hysterectomy. All surgeries were performed by gynecologic oncologists on the da Vinci S surgical system. Demographic data, patient-recorded pain scores, pain-management interventions, and postoperative pain medication costs were compared. Data was analyzed using Student's t-tests and Pearson's chi(2) tests in SPSS.

Results. Two-hundred fifteen (101 robotic and 114 laparoscopic) patients met the inclusion criteria. There were no significant differences between the groups in age, BMI, clinical stage, comorbidities, lymph nodes retrieved, and the number of narcotic vs. non-narcotic drug interventions administered. Robotic patients had a lower number of initial drug interventions (21 vs. 52; P<.001) and total drug interventions (162 vs. 219; P<.001) than laparoscopic patients. Robotics had a lower initial pain score (2.1 vs. 3.0; P = .012). There was a 50% reduction in the pain medication cost on the day of surgery for robotic patients ($12.24 vs. $24.45; P < .01), and a 56% cost reduction for the rest of their length of stay ($3.63 vs. $8.17; P < .01).

Conclusion. Endometrial cancer patients who have robotic surgery experience less initial postoperative pain and have fewer drug interventions. The cost associated for their pain management represents a savings of greater than 50%. These factors demonstrate the value of robotic surgery in regard to postoperative pain management by delivering higher quality care at a lower cost. (C) 2011 Elsevier Inc. All rights reserved.

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TI Total laparoscopic hysterectomy versus da Vinci robotic hysterectomy: is

using the robot beneficial?

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Total laparoscopic hysterectomy; da Vinci robot; Robotic hysterectomy

ID LAPAROTOMY; OUTCOMES; SURGERY

AB Objective: To compare the outcomes of total laparoscopic to robotic approach for hysterectomy and all indicated procedures after controlling for surgeon and other confounding factors.

Methods: Retrospective chart review of all consecutive cases of total laparoscopic and da Vinci robotic hysterectomies between August 2007 and July 2009 by two gynecologic oncology surgeons. Our primary outcome measure was operative procedure time. Secondary measures included complications, conversion to laparotomy, estimated blood loss and length of hospital stay. A mixed model with a random intercept was applied to control for surgeon and other confounders. Wilcoxon rank-sum, chi-square and Fisher's exact tests were used for the statistical analysis.

Results: The 124 patients included in the study consisted of 77 total laparoscopic hysterectomies and 47 robotic hysterectomies. Both groups had similar baseline characteristics, indications for surgery and additional procedures performed. The difference between the mean operative procedure time for the total laparoscopic hysterectomy group (111.4 minutes) and the robotic hysterectomy group (150.8 minutes) was statistically significant (p=0.0001) despite the fact that the specimens obtained in the total laparoscopic hysterectomy group were significantly larger (125 g vs. 94 g, p=0.002). The robotic hysterectomy group had statistically less estimated blood loss than the total laparoscopic hysterectomy group (131.5 mL vs. 207.7 mL, p=0.0105) however no patients required a blood transfusion in either group. Both groups had a comparable rate of conversion to laparotomy, intraoperative complications, and length of hospital stay.

Conclusion: Total laparoscopic hysterectomy can be performed safely and in less operative time compared to robotic hysterectomy when performed by trained surgeons.

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U2 5

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JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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L枚nnerfors, C

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TI Robot-assisted laparoscopic hysterectomy in obese and morbidly obese

women: surgical technique and comparison with open surgery

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Complications; hysterectomy; laparoscopy; laparotomy; obesity; robotic

surgery

ID BODY-MASS INDEX; ENDOMETRIAL CANCER; OUTCOMES; LAPAROTOMY; COMPLICATIONS

AB Objective. Comparison of surgical results on obese patients undergoing hysterectomy by robot-assisted laparoscopy or laparotomy. Setting. University hospital. Methods. All women (n=114) with a BMI >= 30 kg/m(2) who underwent a simple hysterectomy as the main surgical procedure between November 2005 and November 2009 were identified. Robot-assisted procedures (n=50) were separated into an early (learning phase) and a late (consolidated phase) group; open hysterectomy was considered an established method. Relevant data was retrieved from prospective protocols (robot) or from computerized patient charts (laparotomy) until 12 months after surgery. Complications leading to prolonged hospital stay, readmission/reoperation, intravenous antibiotic treatment or blood transfusion were considered significant. The surgical technique used for morbidly obese patients is described. Results. Women in the late robot group (n=25) had shorter inpatient time (1.6 compared to 3.8 days, p<0.0001), less bleeding (100 compared to 300 mL, p<0.0001) and fewer complications (2/25 compared to 23/64, p=0.006) than women with open surgery (n=64) but a longer operating time (136 compared to 110 minutes, p=0.0004). For women with a BMI >= 35 kg/m(2), surgical time in the late robot group and the laparotomy group was equal (136 compared to 128 minutes, p=0.31). Conclusions. Robot-assisted laparoscopic hysterectomy in a consolidated phase in obese women is associated with shorter hospital stay, less bleeding and fewer complications compared to laparotomy but, apart from women with BMI >= 35, a longer operative time.

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TC 26

Z9 31

U1 0

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WC Obstetrics & Gynecology

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OA Bronze

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ER

PT J

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Lockrow, EG

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Novak, Christopher M.

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TI Survey of Robotic Surgery Training in Obstetrics and Gynecology

Residency

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Resident; Robotic surgery; Robotic training

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; SURGICAL OUTCOMES

AB To examine the status of resident training in robotic surgery in obstetrics and gynecology programs in the United States, an online survey was emailed to residency program directors of 247 accredited programs identified through the Accreditation Council for Graduate Medical Education website. Eighty-three of 247 program directors responded, representing a 34% response rate. Robotic surgical systems for gynecologic procedures were used at 65 (78%) institutions. Robotic surgery training was part of residency curriculum at 48 (58%) residency programs. Half of respondents were undecided on training effectiveness. Most program directors believed the role of robotic surgery would increase and play a more integral role in gynecologic surgery. Robotic surgery was widely reported in residency training hospitals with limited availability of effective resident training. Robotic surgery training in obstetrics and gynecology residency needs further assessment and may benefit from a structured curriculum. Journal of Minimally Invasive Gynecology (2011) 18,755-760 Published by Elsevier Inc. on behalf of AAGL.

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Z9 35

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U2 2

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JI J. Mimim. Invasive Gynecol.

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ER

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AU Gultekin, M

Dursun, P

Vranes, B

Laky, R

Bossart, M

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TI Gynecologic Oncology Training Systems in Europe <i>A Report From the

European Network of Young Gynaecological Oncologists</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE ESGO; ENYGO; Training; Gynecologic oncology; Training systems; European

Network of Young Gynaecological Oncologists

ID OVARIAN-CANCER; SURVIVAL

AB Objective: The objectives of the study were to highlight some of the differences in training systems and opportunities for training in gynecologic oncology across Europe and to draw attention to steps that can be taken to improve training prospects and experiences of European trainees in gynecologic oncology.

Methods: The European Network of Young Gynaecological Oncologists national representatives from 34 countries were asked to review and summarize the training system in their countries of origin and fulfill a mini-questionnaire evaluating different aspects of training. We report analysis of outcomes of the mini-questionnaire and subsequent discussion at the European Network of Young Gynaecological Oncologists national representatives Asian Pacific Organization for Cancer Prevention meeting in Istanbul (April 2010).

Results: Training fellowships in gynecologic oncology are offered by 18 countries (53%). The median duration of training is 2.5 years (interquartile range, 2.0-3.0 years). Chemotherapy administration is part of training in 70.5% (24/34) countries. Most of the countries (26/34) do not have a dedicated national gynecologic-oncology journal. All trainees reported some or good access to training in advanced laparoscopic surgical techniques, whereas 41% indicated no access, and 59% some access to training opportunities in robotic surgery. European countries were grouped into 3 different categories on the basis of available training opportunities in gynecologic oncology: well-structured, moderately structured, and loosely structured training systems.

Conclusions: There is a need for further harmonization and standardization of training programs and structures in gynecologic oncology across Europe. This is of particular relevance for loosely structured countries that lag behind the moderately structured and well-structured ones.

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TI Interest of robot-assisted laparoscopy in the initial surgical training:

Resident survey

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Robotic surgery; Learning; Learning curve; Gynaecologic surgery

ID SKILL ACQUISITION; SURGERY

AB Objective. - This survey evaluated if residents felt a benefit to their participation in robot-assisted procedures and highlights the interest of robot in the initial surgical training.

Patients and methods. - A questionnaire was submitted to 33 residents participating as assistants in robot-assisted surgical procedures in our department and to seven residents of the Chapel Hill hospital, North Carolina, USA. Items rated their experience with the robot, their feeling during the surgical procedures and whether they thought they improved their technical skills.

Results. - The majority of French residents felt passive during the procedures (97%) or bored (75%); most of them found an immediate interest to learn anatomy (72.7%) and surgical procedures (66.7%). Then, a minority of them reported an improvement of their knowledge in anatomy (39.4%), in surgical procedures (24.2%), and conventional laparoscopy (9.1%). Most of French residents are not willing to repeat the experience as an assistant (81.8%), whereas they showed great interest in practicing robot-assisted surgery later. The oldest residents benefited more than younger in learning anatomy and surgical procedures. US resident' ratings concerning the contribution of the robot in their training were generally more positive. They were all convinced they made progress in anatomy, as in surgical techniques and they all wanted to repeat such procedures.

Discussion and conclusion. - This work demonstrates the pedagogical value of using the robot for teaching surgical procedures and anatomy. It also suggests the establishment of training programs dedicated to the learning of robot-assisted surgery in gynaecology, in parallel with training in conventional laparoscopy. (C) 2011 Elsevier Masson SAS. All rights reserved.

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PT J

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TI Laparoscopic Compared With Robotic Sacrocolpopexy for Vaginal Prolapse

<i>A Randomized Controlled Trial</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID PELVIC ORGAN PROLAPSE; ABDOMINAL SACROCOLPOPEXY; SACRAL COLPOPEXY;

COSTS; WOMEN; DIFFERENCE

AB OBJECTIVE: To compare conventional laparoscopic and robotic-assisted laparoscopic sacrocolpopexy for vaginal apex prolapse.

METHODS: This single-center, blinded randomized trial included participants with stage 2-4 posthysterectomy vaginal prolapse. Participants were randomized to laparoscopic or robotic sacrocolpopexy. The primary outcome was total operative time from incision to closure. Secondary outcomes were postoperative pain, functional activity, bowel and bladder symptoms, quality of life, anatomic vaginal support, and cost from a health care system perspective.

RESULTS: A total of 78 patients enrolled and were randomized (laparoscopic n = 38; robotic n = 40). Total operative time was significantly longer in the robotic group compared with the laparoscopic group (+ 67-minute difference; 95% confidence interval [CI] 43-89; P <.001). Anesthesia time, total time in the operating room, total sacrocolpopexy time, and total suturing time were all significantly longer in the robotic group. Participants in the robotic group also had significantly higher pain at rest and with activity during weeks 3 through 5 after surgery and required longer use of nonsteroidal anti-inflammatory drugs (median, 20 compared with 11 days, P <.005). The robotic group incurred greater cost than the laparoscopic group (mean difference +$1,936; 95% CI $417-$3,454; P=.008). Both groups demonstrated significant improvement in vaginal support and functional outcomes 1 year after surgery with no differences between groups.

CONCLUSION: Robotic-assisted sacrocolpopexy results in longer operating time and increased pain and cost compared with the conventional laparoscopic approach. CLINICAL TRIAL REGISTRATION: ClinicalTrials.gov, www.clinicaltrials.gov,NCT00551993. (Obstet Gynecol 2011;118:1005-13) DOI: 10.1097/AOG.0b013e318231537c

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PT J

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TI Radical hysterectomy: A comparison of surgical approaches after adoption

of robotic surgery in gynecologic oncology

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Gynecologic oncology; Radical hysterectomy; Cervical

cancer; Laparoscopy

ID STAGE CERVICAL-CARCINOMA; PELVIC LYMPHADENECTOMY; LAPAROSCOPY

AB Objective. To compare intra-operative, postoperative and pathologic outcomes of three surgical approaches to radical hysterectomy and bilateral pelvic lymph node dissection over a three year time period during which all three approaches were used.

Methods. We reviewed all patients who underwent radical hysterectomy with pelvic lymph node dissection between 1/2007 and 11/2010. Comparison was made between robotic, laparoscopic and open procedures in regard to surgical times, complication rates, and pathologic findings.

Results. A total of 95 radical hysterectomy procedures were performed during the study period: 30 open (RAH), 31 laparoscopic (LRH) and 34 robotic (RRH). There were no differences in age, body mass index or other demographic factors between the groups. Operative time was significantly shorter in the RAH compared, to LRH and RRH (265 vs 338 vs 328 min, p = 0.002). Estimated blood loss was significantly lower in LRH and RRH compared with RAH (100 vs 100 vs 350 mL, p <0.001). Thirteen (24%) of RAH required blood transfusion. Conversion rates were higher in the LRH (16%) compared to RRH (3%) although not significant (p = 0.10). Median length of stay was significantly shorter in RRH (1 day) vs LRH or RAH (2 vs 4 days, p < 0.01). Pathologic findings were similar among all groups.

Conclusion. Minimally invasive surgery has made a significant impact on patients undergoing radical hysterectomy including decrease in blood loss and transfusion rates however; operative times were significantly longer compared to open radical hysterectomy. Our findings suggest that the robotic approach may have the added benefit of even shorter length of stay compared to traditional laparoscopy. (C) 2011 Elsevier Inc. All rights reserved.

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TI Robotic surgery in the management of cervical carcinoma

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Cervical cancer; Robotic surgery; Radical trachelectomy; Radical

hysterectomy; Radical parametrectomy; Pelvic exenteration

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY; PORT-SITE;

TRACHELECTOMY; FERTILITY; CANCER; PARAMETRECTOMY; SERIES; WOMEN

AB To review the published literature concerning robotic surgery and its applications in the management of cervical carcinoma.

We electronically searched the MEDLINE from January 1990 until June 2010. We cross-examined article references to identify relevant articles not detected by the electronic search.

The majority of the reported literature consisted of case series, case reports or retrospective comparisons. Twenty-one articles were included in this review covering the different surgical applications: (5) radical trachelectomy, (12) radical hysterectomy, (3) pelvic exenteration and one parametrectomy.

Robotic surgery enabled more gynaecological oncologists to perform more complex procedures safely while maintaining the minimal access approach.

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PT J

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TI Robotic Surgery in the Obese Gynecologic Patient

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE obesity; robotic surgery; hysterectomy; myomectomy; gynecology;

laparoscopy

ID BODY-MASS INDEX; ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; SURGICAL

OUTCOMES; COMPLICATIONS; IMPACT; WOMEN

AB Despite robust interest in minimally invasive surgery for obese gynecologic patients, widespread use by gynecologic surgeons has been hindered by the technical difficulty of completing these procedures. The use of robotic assistance to overcome these challenges continues to increase. This study discusses the problem of obesity in the United States, provides basic definitions and calculations related to the disease, reviews some of the literature supporting laparoscopic surgery in obese patients, explores the emergence of robotics in this patient population, and offers "surgical pearls" to aid in the successful completion of minimally invasive robotic gynecologic procedures in heavier patients.

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TI Assessing Current Trends in Resident Hysterectomy Training

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE gynecologic training; hysterectomy; robotic surgery; surgical skills

ID VIDEO; STATE

AB Objectives: Our survey assessed the current trends in hysterectomy experience in US obstetrics and gynecology (OG) residency programs and residents' and program directors' perceptions of robotic surgery's effect on surgical training.

Methods: An online survey was e-mailed to program directors and graduating residents of 42 US OG programs.

Results: A total of 21 program directors and 35 graduating residents responded. There was no significant difference between the number of hysterectomies residents and program directors thought should be performed. Only 38.1% of program directors and 27.8% of residents reported graduating residents as being "completely prepared" to perform a vaginal hysterectomy compared with 76.2% and 58.3% for abdominal, 28.6% and 22.2% for laparoscopic, and 0% and 2.8% for robotic hysterectomies. Only 12.1% of graduating residents and 17.7% of program directors reported residents sitting at the console "often" or "always" during robotic surgery. Only 34.3% of residents plan to perform robotic hysterectomy after graduation. Both residents (77.2%) and program directors (71.5%) reported that robotic surgery is having a negative impact on residents' training nationally.

Conclusions: Graduating residents report adequate numbers of vaginal and abdominal hysterectomies. Both residents and program directors report that graduating residents are not prepared to perform all types of hysterectomies. Both residents and program directors express concern that robotic surgery is negatively impacting surgical training. Further efforts are needed to ensure that residents are graduating with surgical proficiency in these basic gynecologic procedures.

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NR 15

TC 56

Z9 59

U1 0

U2 2

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J9 FEMALE PELVIC MED RE

JI Female Pelvic Med. Reconstr. Surg.

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA V35WQ

UT WOS:000209176400002

PM 22453103

DA 2024-01-18

ER

PT J

AU Bush, AJ

Morris, SN

Millham, FH

Isaacson, KB

AF Bush, Amanda J.

Morris, Stephanie N.

Millham, Frederick H.

Isaacson, Keith B.

TI Women's Preferences for Minimally Invasive Incisions

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Incisions; Single-site surgery; Robotics; Surgical

procedures; Minimally invasive; Aesthetics; Survey; Choice behavior;

Adult; Middle aged; Female; Humans

ID HYSTERECTOMY

AB Study Objective: To determine whether traditional, robotic, or single-site laparoscopic incisions are more appealing to women.

Design: Descriptive study using a survey (Canadian Task Force classification III).

Setting: Single-specialty referral-based gynecology practice.

Patients: All patients older than 18 years who came for care to the Newton-Wellesley Hospital Minimally Invasive Gynecological Surgery Center from April 2, 2010, to June 30, 2010.

Interventions: Three identical photos of an unscarred female abdomen were each marked with a black pen to indicate typical incision lengths and locations for robotic, single-site, and traditional laparoscopic surgery. Subjects were then asked to rank these incisions in order of preference. Additional demographic and surgical history questions were included in the survey.

Measurements and Main Results: Two-hundred fifty of 427 patients (58.5%) returned surveys, and of these, 241 completed critical survey elements. Preference for traditional laparoscopic incisions was 56.4% (95% confidence interval [CI], 50.1%-62.7%), for a single incision was 41.1% (95% CI, 34.8%-47.3%), and for robotic surgery was 2.5% (95% CI, 0.5%-4.5%). Two-sample test of proportion (Z test) showed the difference in preference for traditional over the other methods to be significant: p = .007 for a single incision and p <.001 for robotic surgery. Multivariatble analysis for factors influencing choice of single-site incision demonstrated that Latina/Hispanic ethnicity was the only significant factor (p = .02).

Conclusion: Women prefer both single-site and traditional laparoscopic incisions over robotic procedures. Inasmuch as aesthetics are an important consideration for many women and clinical outcomes are similar, during the informed-consent procedure, location and length of incisions should be included in the discussion of risks, benefits, and alternatives. Journal of Minimally Invasive Gynecology (2011) 18, 640 643 (C) 2011 AAGL. All rights reserved.

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NR 8

TC 38

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U1 0

U2 5

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JI J. Minim. Invasive Gynecol.

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GA 823TA

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DA 2024-01-18

ER

PT J

AU Catenacci, M

Flyckt, RL

Falcone, T

AF Catenacci, M.

Flyckt, R. L.

Falcone, T.

TI Robotics in reproductive surgery: Strengths and limitations

SO PLACENTA

LA English

DT Article

DE Robotic surgery; Robotic tubal reanastomosis; Robotic myomectomy

ID MICROSURGICAL TUBAL REANASTOMOSIS; LAPAROSCOPIC MYOMECTOMY; RADICAL

TRACHELECTOMY; ABDOMINAL MYOMECTOMY; SURGICAL OUTCOMES; ANASTOMOSIS;

FERTILITY; EXPERIENCE

AB Minimally invasive surgical techniques are becoming increasingly common in gynecologic surgery. However, traditional laparoscopy can be challenging. A robotic surgical system gives several advantages over traditional laparoscopy and has been incorporated into reproductive gynecological surgeries. The objective of this article is to review recent publications on robotically-assisted laparoscopy for reproductive surgery. Recent clinical research supports robotic surgery as resulting in less post-operative pain, shorter hospital stays, faster return to normal activities, and decreased blood loss. Reproductive outcomes appear similar to alternative approaches. Drawbacks of robotic surgery include longer operating room times, the need for specialized training, and increased cost. Larger prospective studies comparing robotic approaches with laparoscopy and conventional open surgery have been initiated and information regarding long-term outcomes after robotic surgery will be important in determining the ultimate utility of these procedures. (C) 2011 Elsevier Ltd. All rights reserved.

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TC 12

Z9 13

U1 0

U2 4

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J9 PLACENTA

JI Placenta

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WC Developmental Biology; Obstetrics & Gynecology; Reproductive Biology

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SC Developmental Biology; Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

AU Delotte, J

Mialon, O

Bouaziz, S

Frigenza, M

Bongain, A

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Bouaziz, S.

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Bongain, A.

TI Is there a real place for robotics in proximal tubal surgery?

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA English

DT Article

DE Da-Vinci (R); Tubal surgery; Fertility; Robotics

AB Tubal surgery requires a fine gesture. Its complexity, the difficulty of learning, the low recognition at the time of T2A and the success of Assisted Reproductive Technology (ART) could have announced the obituary of this surgery. However, in well-trained hands, tubal surgery avoids unnecessary ARTs and even allows pregnancies when medical technology fails. In this context, it is legitimate to ask whether the contribution of new technologies in the operating theatre, such as robotic surgery, can lead to an easy realization of microsurgery on a particularly complex portion of Fallopian tubes: the proximal segment. (C) 2011 Elsevier Masson SAS. All rights reserved.

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JI Gynecol. Obstet. Fertil.

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DA 2024-01-18

ER

PT J

AU FitzGerald, MP

Mueller, ER

Edelstein, S

AF FitzGerald, Mary P.

Mueller, Elizabeth R.

Edelstein, Steven

TI Severe Acidosis During Laparoscopic Repair of Pelvic Organ Prolapse and

Incontinence

SO FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY

LA English

DT Article

DE acidosis; laparoscopy; robotic-assisted laparoscopy; subcutaneous

emphysema

ID SUBCUTANEOUS EMPHYSEMA

AB The creation and maintenance of a carbon dioxide pneumoperitoneum to allow a laparoscopic approach to surgery for pelvic organ prolapse has been associated with hypercapnea and respiratory acidosis. We present a case report of a 68-year-old patient who developed severe acidosis during a robotic-assisted laparoscopic sacrocolpopexy and discuss a practical approach to surgical and anesthetic decision making.

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FU Allergan

FX Dr Mueller is a research investigator and receives support from

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Z9 2

U1 0

U2 0

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DA 2024-01-18

ER

PT J

AU Gargiulo, AR

AF Gargiulo, Antonio R.

TI Fertility Preservation and the Role of Robotics

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic surgery; robotics; reproductive surgery; fertility preservation;

myomectomy; tubal reanastomosis; ovarian transposition

ID MICROSURGICAL TUBAL REANASTOMOSIS; LAPAROSCOPIC MYOMECTOMY; ABDOMINAL

MYOMECTOMY; ANASTOMOSIS; MULTICENTER; SUTURE; TERM

AB Reproductive surgery employs microsurgical techniques to achieve preservation of natural fertility and enhancement of assisted reproductive technologies. The minimalist approach of this branch of gynecology has made it the natural trailblazer of laparoscopic surgery. Minimally invasive conservative treatment of uterine, tubal, ovarian, and peritoneal pathology has long been the gold standard for women of reproductive age. Advanced laparoscopic surgery provides clear advantages over classic microsurgery, at the cost of significant technical challenges. Robot-assisted laparoscopic surgery is now posed to bridge this technical gap and promises to be the next revolution in the field of reproductive surgery.

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NR 40

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Z9 8

U1 0

U2 4

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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SC Obstetrics & Gynecology

GA 809IK

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DA 2024-01-18

ER

PT J

AU Kho, RM

AF Kho, Rosanne M.

TI Comparison of Robotic-Assisted Laparoscopy Versus Conventional

Laparoscopy on Skill Acquisition and Performance

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotics; laparoscopy; learning curve

ID LEARNING-CURVE; RADICAL HYSTERECTOMY; LYMPHADENECTOMY

AB With an increasing adoption of robotics in gynecologic surgery, training and acquisition of robotic skills become pertinent. The learning curve for the acquisition of robotic skills has been studied using different assessment measurements in both the laboratory and surgical setting. In the laboratory setting, task acquisition and performance is superior with the robotic platform compared with conventional laparoscopy. The 3-dimensional viewing condition provides a perceptive advantage. Learning curve for robotics in the clinical setting is indirectly assessed. Conclusive statements regarding the learning curve comparing robotics with conventional laparoscopy in the surgical setting are difficult to make. To date, clinical studies are limited by lack of standard definitions and objective assessment measurements.

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NR 24

TC 20

Z9 20

U1 0

U2 6

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

PD SEP

PY 2011

VL 54

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WC Obstetrics & Gynecology

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GA 809IK

UT WOS:000294045100002

PM 21857168

DA 2024-01-18

ER

PT J

AU Lenihan, JP

AF Lenihan, John P., Jr.

TI Navigating Credentialing, Privileging, and Learning Curves in Robotics

With an Evidence and Experienced-Based Approach

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotics; credentialing; currency; competency

ID HYSTERECTOMY; VOLUME

AB The rapid growth of robot-assisted surgery has created new challenges for hospitals to establish credentialing guidelines for new surgeons. Developing and maintaining these skills requires frequent practice. Borrowing from the aviation model that requires maintaining currency and demonstrating proficiency, robotic credentialing guidelines are being developed that will enable hospitals to insure patient safety and optimal outcomes. The utilization of computerized robotic simulators will, like flight simulators, also help surgeons to maintain and improve skills.

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Z9 18

U1 0

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JI Clin. Obstet. Gynecol.

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU L枚nnerfors, C

Persson, J

AF Lonnerfors, Celine

Persson, Jan

TI Pregnancy following robot-assisted laparoscopic myomectomy in women with

deep intramural myomas

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Fertility; myomectomy; pregnancy; robotic surgery; fibroids

ID ABDOMINAL MYOMECTOMY; UTERINE MYOMAS; SHORT-TERM; FIBROIDS; FERTILITY;

COMPLICATIONS; OUTCOMES

AB Objective. To describe fecundity after robot-assisted laparoscopic myomectomy for deep intramural myomas. Design. Prospective observational study. Setting. University hospital. Population. Women undergoing robot-assisted laparoscopic myomectomy. Methods. Expanding on a previous prospective feasibility study, 31 consecutive women in whom a robot-assisted laparoscopic myomectomy was performed between April 2006 and July 2010 were included. The women, of whom 14 had known infertility, were selected for having symptomatic, deep intramural myomas with a possible impact on fertility. Using a prospective protocol, relevant peri-operative and follow-up data were retrieved. Main Outcome Measures. Fertility and pregnancy outcome. Results. The 31 women included had a median age of 35years (range 28-42years) and median body mass index of 22.0kg/m(2) (range 20.1-24.7kg/m(2)). Fifteen (68%) of the 22 women with an active wish of conceiving had become pregnant at a median time of 10 months after surgery. A total of 18 pregnancies occurred, resulting in three miscarriages, two terminated pregnancies, 10 successful term deliveries and three ongoing pregnancies. The subgroup of 14 women with a known but otherwise unexplained infertility had a similar pregnancy rate (69%) and of those, 55% conceived naturally. The women who conceived naturally were on average eight years younger than the women becoming pregnant after in vitro fertilization, and all miscarriages occurred in an in vitro fertilization pregnancy. Conclusions. In women with symptomatic, deep intramural myomas and either otherwise unexplained infertility or myomas with a possible effect on conception, the pregnancy rate following robot-assisted laparoscopic myomectomy was 68%.

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NR 30

TC 35

Z9 39

U1 0

U2 6

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Nick, AM

Ramirez, PT

AF Nick, Alpa M.

Ramirez, Pedro T.

TI The impact of robotic surgery on gynecologic oncology

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Gynecologic malignancies; Robotic surgery

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; CERVICAL-CARCINOMA; PELVIC

LYMPHADENECTOMY; ENDOMETRIAL CANCER; FALLOPIAN-TUBE; OVARIAN;

LAPAROTOMY; SURVIVAL

AB The objective of this article was to review the published scientific literature pertaining to robotic surgery and its applications in gynecologic malignancies and to summarize the impact of robotic surgery on the field of gynecologic oncology. Summarizing data from different gynecologic disease-sites, robotic-assisted surgery is safe, feasible, and demonstrates equivalent histopathologic and oncologic outcomes. In general, benefits to robotic surgery include decreased blood loss, fewer perioperative complications and decreased length of hospital stay. Disadvantages include accessibility to robot surgical systems, decreased haptic sensation and fixed cost as well as cost of disposable equipment. As robotic surgery becomes readily available it will be imperative to develop standardized training modalities. Further research is needed to validate the role of robotic surgery in the treatment of gynecologic malignancies.

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TC 7

Z9 7

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Parnell, BA

Matthews, CA

AF Parnell, Brent A.

Matthews, Catherine A.

TI Robot-Assisted Techniques and Outcomes in the Realm of Pelvic

Reconstructive Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic surgery; robotic-assisted surgery; sacrocolpopexy;

sacrocervicopexy; pelvic organ prolapse; prolapse

ID SACROCOLPOPEXY

AB Robotic-assisted surgery for the treatment of pelvic organ prolapse continues to grow in popularity as more surgeons adopt this technology. Encompassing all of the benefits of laparoscopic surgery, robotic-assisted techniques allow more surgeons the ability to perform complex tasks such as meticulous deep pelvic dissection and extensive suturing without having to resort to laparotomy. This chapter reviews the techniques involved in the robotic approach to pelvic reconstructive surgery and discusses the currently available information focusing on the outcomes of this procedure.

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NR 17

TC 12

Z9 12

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U2 1

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DA 2024-01-18

ER

PT J

AU Payne, TN

Pitter, MC

AF Payne, Thomas N.

Pitter, Michael C.

TI Robotic-Assisted Surgery for the Community Gynecologist: Can it Be

Adopted?

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE hysterectomy; myomectomy; sacrocolpopexy; endometriosis; robotic

assistance; community gynecologist

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; SURGICAL OUTCOMES; UNITED-STATES;

ABDOMINAL MYOMECTOMY; SACRAL COLPOPEXY; SACROCOLPOPEXY; EXPERIENCE;

REPAIR; RATES

AB The American College of Obstetricians and Gynecologists and the American Association of Gynecologic Laparoscopists confirm advantages of conventional minimally invasive surgery over laparotomy for benign gynecological procedures; however, adoption remains low for the general gynecologist. A systematic search for gynecology publications was performed using Medline and Scopus. Available data on adoption rates and perioperative outcomes for hysterectomy, myomectomy, sacrocolpopexy, and endometriosis were reviewed. Robotic assistance may provide an improved rate of minimally invasive surgery adoption with equivalent perioperative outcomes to that of conventional techniques. Accessibility and cost remain controversial. Formal training programs are being created to address these issues.

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TC 23

Z9 23

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U2 3

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PT J

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Perez-Benavente, Assumpcio

Xercavins, Jordi

TI Laparoscopic Radical Hysterectomy with Pelvic Lymphadenectomy in Early

Invasive Cervical Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Cervical cancer; Laparoscopic radical hysterectomy; Laparoscopic

surgery; Pelvic lymphadenectomy; Robotic surgery; Surgical morbidity

ID NODE IDENTIFICATION; EXPERIENCE; SURGERY; COMPLICATIONS; CARCINOMA;

MORBIDITY

AB Laparoscopic radical hysterectomy is one surgical procedure currently performed to treat gynecologic cancer. The objective of this review was to update the current knowledge of laparoscopic radical hysterectomy in early invasive cervical cancer. Articles indexed in the MEDLINE database using the key words "Laparoscopic radical hysterectomy" and "Cancer of the cervix" were reviewed. Studies of laparoscopic radical hysterectomy for treatment of early cervical cancer with a minimum study population of 10 patients were selected. The laparoscopic approach was associated with less surgical morbidity (surgical bleeding) and with shorter length of hospital stay, although the duration of the operation may be longer. Laparoscopic radical hysterectomy with endoscopic pelvic lymphadenectomy, and paraaortic lymphadenectomy if needed, is a safe surgical option for treatment and staging of early invasive cervical cancer considering surgical risk, intraoperative bleeding, intraoperative and postoperative complications, and patient recovery. It is important to respect the learning curve. Surgical advances including new laparoscopic instrumentation and, in particular, use of robotics will contribute to reducing the duration of the operation and facilitating learning and teaching of the procedure. Journal of Minimally Invasive Gynecology (2011) 18, 555-568 (C) 2011 AAGL. All rights reserved.

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U2 8

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 823TA

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DA 2024-01-18

ER

PT J

AU Subramaniam, A

Kim, KH

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Zhang, B

Sikes, C

Kimball, KJ

Kilgore, LC

Huh, WK

Straughn, JM

Alvarez, RD

AF Subramaniam, Akila

Kim, Kenneth H.

Bryant, Shannon A.

Zhang, Bin

Sikes, Christa

Kimball, Kristopher J.

Kilgore, Larry C.

Huh, Warner K.

Straughn, John M., Jr.

Alvarez, Ronald D.

TI A cohort study evaluating robotic versus laparotomy surgical outcomes of

obese women with endometrial carcinoma

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial carcinoma; Robotics; Obesity; Laparotomy; Outcomes

ID CANCER

AB Objective. Minimally invasive surgery offers advantages for management of obese patients, but technical difficulty often deters its utilization. Compared to laparotomy, robotic surgery should allow comparable staging and improved surgical outcomes. Therefore, we evaluated outcomes in robotic and laparotomy cohorts of obese women with endometrial cancer at our institution.

Methods. Retrospective robotic and laparotomy cohorts of obese women (BMI >= 30 kg/m(2)) undergoing surgical management of primary endometrial cancer from March 2006 to March 2009 were formulated utilizing a computerized database. Patient demographics, operative statistics, per-operative complications. and pathologic details were collected in an intent to treat analysis. Chi-square Or Fisher's exact test and t-test were used for statistical analysis.

Results. 73 women underwent robotic surgical management. 11% converted to laparotomy. Mean BMI (39.8 vs. 41.9. p = 0.152). number of co-morbidities (2.49 vs. 2.62, p = 0.690), number of previous surgeries (0.97 vs. 0.94, p = 0.841). and lymphadenectomies performed (65.8% vs. 56.7%, p = 0.227) were similar between cohorts. Total lymph nodes obtained were not statistically different between cohorts (8.01 vs. 7.24. p=0.505). Total operative time and room time was significantly longer for robotic surgery: however, estimated blood loss, the percentage of patients receiving transfusion, hospital length of stay, wound complications (4.1% vs. 20.2%. p = 0.002) and other complications (9.6% vs. 29.8%, p = 0.001) were improved for the robotic cohort.

Conclusions. Robotic management of obese women with endometrial cancer yields acceptable staging results and improved surgical outcomes. Although operating time is longer, hospital time is shorter. Robotic surgery may be an ideal approach for these patients. (C) 2011 Elsevier Inc. All rights reserved.

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U2 5

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

PD SEP

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PG 4

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 810TY

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PM 21658752

DA 2024-01-18

ER

PT J

AU Swan, K

Advincula, AP

AF Swan, Kimberly

Advincula, Arnold P.

TI Understanding the Financial Impact of Robotics in Gynecologic Surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic costs; hysterectomy; myomectomy; sacrocolpopexy; laparoscopy;

finances

ID ENDOMETRIAL CANCER; SURGICAL OUTCOMES; TUBAL ANASTOMOSIS; COST;

HYSTERECTOMY

AB As surgical innovation and technological advancements evolve, the associated costs cannot be overlooked. Currently, the United States health care system is undergoing an attempted overhaul with technology such as robotics sitting front and center of the financial debate. As patient demand for less invasive surgical options increases and standards of practice change, patient outcomes must be carefully evaluated to justify the costs increase from traditional, often more invasive treatments. The collection of financial data is quite varied among hospital systems and so is the models used to determine the costs of robotics. Although limited thus far, various cost data have been ascertained in the areas of reproductive surgery, hysterectomy (both benign and oncologic), and pelvic reconstructive surgery.

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NR 18

TC 2

Z9 2

U1 0

U2 1

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

PD SEP

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 809IK

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PM 21857174

DA 2024-01-18

ER

PT J

AU Zechmeister, JR

Levey, KA

AF Zechmeister, J. R.

Levey, K. A.

TI Successful Robotically Assisted Laparoscopic Correction of Chronic

Uterine Inversion

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Postpartum complication; Uterine inversion

ID POSTPARTUM

AB We report a successful robotically assisted repair of a chronic uterine inversion. A modified Spinelli technique was used. The patient was discharged home after an uncomplicated postoperative course. Journal of Minimally Invasive Gynecology (2011) 18, 671-673 (C) 2011 AAGL. All rights reserved.

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Z9 6

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U2 2

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ER

PT J

AU Espada, M

Munoz, R

Noble, BN

Magrina, JF

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Munoz, Raquel

Noble, Brie N.

Magrina, Javier F.

TI Insulation failure in robotic and laparoscopic instrumentation: a

prospective evaluation

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE electricity; insulation failure; robotic instrument; surgery

ID COMPLICATIONS; INJURIES; SURGERY

AB OBJECTIVE: The purpose of this study was to detect the incidence, prevalence, and location of insulation failures (IFs) in laparoscopic and robotic instruments.

STUDY DESIGN: In phase A, a total of 78 robotic and 298 laparoscopic instruments were tested at 20 W and 2.64 kV at Mayo Clinic in Arizona. In phase B, 60 robotic and 308 laparoscopic instruments were tested at 20 W/1 kV and 20 W/4.2 kV, respectively.

RESULTS: In phase A, the robotic group showed a higher prevalence (25/78; 32%) and incidence of IFs after 10 uses (35/44 instruments; 80%) when compared with laparoscopy (prevalence, 39/298 [13%]; incidence, 68/189 [36%]; P < .05). In phase B, IFs were detected in 81.7% of the robotic instruments and in 19.5% of the laparoscopic instruments (P < .005).

CONCLUSION: There is a high incidence and prevalence of IF in endoscopic instrumentation that is more common in the robotic group.

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Z9 25

U1 0

U2 5

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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GA 798ON

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DA 2024-01-18

ER

PT J

AU Sarlos, D

Kots, LA

AF Sarlos, Dimitri

Kots, LaVonne A.

TI Robotic versus laparoscopic hysterectomy: a review of recent comparative

studies

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Review

DE cost of robotic surgery; robotic versus laparoscopic hysterectomy;

surgical outcome of laparoscopic hysterectomy; surgical outcome of

robotics

ID ASSISTED VAGINAL HYSTERECTOMY; BENIGN UTERINE PATHOLOGIES; RANDOMIZED

CLINICAL-TRIAL; QUALITY-OF-LIFE; RADICAL HYSTERECTOMY; CONTINUOUS

SERIES; LEARNING-CURVE; SURGERY; COMPLICATIONS; EXPERIENCE

AB Purpose of review

To illustrate the current stand on robotic versus conventional laparoscopic hysterectomy regarding operating times, clinical outcome and costs.

Recent findings

Only six studies were reviewed, as there are only few recent studies comparing robotic with laparoscopic hysterectomy and most are retrospective. Apart from one multicentre study with over 36 000 patients, 350 institutions and numerous surgeons, most studies were performed with few cases by one or two surgeons at one or two hospitals. Operating times for robotic hysterectomies generally were longer, ranging from 89.9 to 267 min. Surgery time for conventional laparoscopic hysterectomies was between 83 and 206 min. In all studies, clinical outcomes such as blood loss, complications or hospital stay of both the robotic and the conventional laparoscopic procedure were similar. Only two studies compared costs and both came up with very similar findings. Cost for a robot-assisted hysterectomy is approximately 2600 USD higher than that for conventional laparoscopic hysterectomy not including investment and amortization.

Summary

Robotic and conventional laparoscopic hysterectomy are essentially equivalent regarding surgical and clinical outcome. Operating times are slightly higher and costs are significantly higher for the robotic procedure.

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U1 0

U2 6

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

PD AUG

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SC Obstetrics & Gynecology

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UT WOS:000292498100012

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DA 2024-01-18

ER

PT J

AU Walid, MS

Heaton, RL

AF Walid, Mohammad Sami

Heaton, Richard L.

TI The role of laparoscopic myomectomy in the management of uterine

fibroids

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE laparoscopic myomectomy; minimally invasive surgery; uterine fibroids

ID SAFETY

AB Purpose of review

Laparoscopic myomectomy has been described as comparable to open myomectomy in terms of fertility and obstetrical outcome with decreased intraoperative bleeding and postoperative disability. Despite this, laparoscopic myomectomy is not widely used reportedly due to lack of experience. This article presents our technique for laparoscopic myomectomy and assesses the current evidence-based literature for the use of this minimally invasive procedure in benign gynecological practice.

Recent findings

Literature continues to support the safety and feasibility of laparoscopic myomectomy for symptomatic women desiring to preserve their fertility. Alternatively, laparoscopically assisted myomectomy has been suggested when wider access is needed to perform the procedure. This variant of the technique allows palpating the uterus and does not require laparoscopic suturing skills. Robotic-assisted laparoscopic myomectomy currently has limited advantage over conventional laparoscopy due to longer operative time, loss of tactile sensation necessary to detect intramural myomas and high cost. Single-port surgery is a new promising approach, but still requires extensive investigation to determine whether it has significant benefits over conventional techniques.

Summary

Laparoscopic myomectomy cases are mostly doable, but may become difficult if bleeding problems occur. Extended operative times may be required for morcellation and extensive laparoscopic suturing. Gynecologists need to improve their laparoscopic skills, as minimally invasive surgery is becoming the sine qua non of a modern surgeon.

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Z9 48

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U2 3

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JI Curr. Opin. Obstet. Gynecol.

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ER

PT J

AU Wells, T

Plante, M

McAlpine, JN

AF Wells, Tiffany

Plante, Marie

McAlpine, Jessica N.

CA Soc Gynecologic Oncologists Canada

TI Preoperative Bowel Preparation in Gynecologic Oncology <i>A Review of

Practice Patterns and an Impetus to Change</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Preoperative mechanical bowel preparation; Survey; Practice patterns;

Surgery; Literature review

ID ELECTIVE COLORECTAL SURGERY; BLINDED-RANDOMIZED-TRIAL; INFECTIONS

POSTCOLORECTAL RESECTIONS; PRIMARY INTRAPERITONEAL ANASTOMOSIS;

EMERGENCY SUBTOTAL/TOTAL COLECTOMY; EPITHELIAL OVARIAN-CANCER;

UNPREPARED LEFT COLON; RECTAL SURGERY; SODIUM-PHOSPHATE; CLINICAL-TRIAL

AB Objectives: Preoperative mechanical bowel preparation (MBP) is commonly used in gynecologic oncology (GO). We wished to assess the practice patterns and beliefs within the Society of Gynecologic Oncologists of Canada (GOC), review the literature on MBP as applicable to GO surgeries, and construct recommendations specific to our subspecialty.

Methods: A 23-question, 10-minute Internet survey was sent to 110 GOC members regarding their use, rationale, and understanding of the literature pertaining to MBP for GO surgeries. The historical justifications for using MBP before pelvic and abdominal surgery were identified through literature review.

Results: Half of respondents (48%) routinely order MBP despite acknowledgment in 77% that there was no good evidence to support its use. Use encompassed all cancer sites (53% ovary, 32% endometrial, 27% cervical, and 8% vulvar) and approaches (43% laparotomy and 29% laparoscopy/robotics). The most common reasons cited for ordering MBP were to decrease risk of anastomotic leak and improve visualization. In the last 5 years, use of MBP has decreased in most (77%) GOC respondents. Of all respondents, 71% felt that formal recommendations specific to the field of GO would be helpful. None of the arguments for using MBP could be justified in the literature. In contrast, common and often serious sequelae from MBP are frequently described. Admitted use of bowel preparation in other surgical specialties was even higher (53%-99%) than within the GOC.

Conclusions: There is no literature to support the routine use of MBP in GO. Published recommendations (herein) should support and guide change in practice.

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Z9 22

U1 0

U2 3

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J9 INT J GYNECOL CANCER

JI Int. J. Gynecol. Cancer

PD AUG

PY 2011

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BP 1135

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Bot-Robin, V

Rubod, C

Zini, L

Collinet, P

AF Bot-Robin, V.

Rubod, C.

Zini, L.

Collinet, P.

TI Early evaluation of the feasibility of robot-assisted laparoscopy in the

surgical treatment of deep infiltrating endometriosis

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Endometriosis; Deep infiltrating endometriosis; Bladder andometriosis;

Robot-assisted surgery

ID EPIDEMIOLOGY; SURGERY

AB Background. - Preliminary study of the feasibility of robot-assisted laparoscopy for deep pelvic endometriosis nodule resection.

Patients and methods. - Between May 2009 and February 2010, we collected medical and surgical data about deep infiltrating endometriosis resections performed in our institution, using robot-assisted laparoscopy (DA VINCI Intuitive Surgical System (R)).

Results. - Six patients were included: four partial bladder and two uterosacral ligament resections. The median age was 29.5 years (24-48). All patients reported chronic pelvic pain, associated with urinary tract symptoms in case of bladder endometriosis. Before surgery, lesion mapping was performed using magnetic resonance imaging for all, and mechanical bowel preparation or double-j stenting were prescribed, depending on the endometriosis location. Surgical procedures median time was 173 minutes (156-244), and median length of stay was 3 days (2-5). Complete resection was possible in all cases. There was no conversion in classical laparoscopy or laparotomy, and no intraoperative complication. Pathology diagnosis of surgical pieces concluded to endometriosis lesion in all cases.

Conclusion. - This study shows the feasibility of the robot-assisted laparoscopy in the resection of deep pelvic endometriosis, without increasing of surgical timing, blood loss or intraoperative complications. (C) 2011 Elsevier Masson SAS. All rights reserved.

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JI Gynecol. Obstet. Fertil.

PD JUL-AUG

PY 2011

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 804SN

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ER

PT J

AU Lee, YL

Kilic, GS

Phelps, JY

AF Lee, Yu L.

Kilic, Gokhan S.

Phelps, John Y.

TI Medicolegal Review of Liability Risks for Gynecologists Stemming from

Lack of Training in Robot-Assisted Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Informed consent; Insufficient training; Lawsuit; Negligent

credentialing; Robotic surgery

AB The advances in robot-assisted surgery in gynecology evolved after most practicing gynecologists had already completed residency training. Postgraduate training in new technology for gynecologists in practice is limited. Therefore, gynecologists with insufficient training who perform robot-assisted surgery may potentially be at risk for liability. In addition to the traditional medical negligence claims, plaintiff attorneys are seeking causes of actions for lack of informed consent and negligent credentialing. Thus, it is essential that gynecologists be aware of these potential liability claims that arise in a robot-assisted malpractice suit. This commentary provides an overview of the current medicolegal liability risks originating from lack of training in robotic surgery and seeks to raise awareness of the implications involved in these claims. A better understanding of the doctrine of informed consent and seeking assistance of proctors or experienced co-surgeons early in robotics training are likely to reduce the liability risks for gynecologic surgeons. Journal of Minimally Invasive Gynecology (2011) 18, 512-515 (C) 2011 AAGL. All rights reserved.

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Soliman, Pamela T.

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TI Rate of Port-Site Metastasis Is Uncommon in Patients Undergoing Robotic

Surgery for Gynecological Malignancies

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotic; Laparoscopy; Port-site metastasis/recurrence; Ovarian cancer;

Cervical cancer; Uterine cancer

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; ABDOMINAL-WALL; TUMOR IMPLANTATION;

WOMEN; CARCINOMA; CANCER; CERVIX; TROCAR

AB Objective: To describe the rate of port-site metastasis in patients who underwent robotic surgery for suspected gynecological malignancy.

Methods: Using a prospective database, we identified all patients who underwent robotic surgery performed by the Gynecologic Oncology service at 1 institution between December 2006 and March 2010. Records of patients with confirmed malignancy were reviewed for clinicopathological data and information about port-site metastasis.

Results: One hundred eighty-one patients met the inclusion criteria. The median age was 55.4 years (range, 19-82 years), and the median body mass index was 29.6 kg/m(2) (range, 17.9-70.7 kg/m(2)). Port-site metastases were detected in 2 patients (1.1%) at 3 weeks (patient 1) and 11 months (patient 2) after surgery. Patient 1 underwent surgery for an adnexal mass, and pathological examination revealed gallbladder adenocarcinoma metastatic to the ovary. She had a recurrence in the right lateral abdominal wall robotic trocar site with concurrent metastases in the gallbladder fossa and liver. Patient 2 was diagnosed with adenocarcinoma of unclear (cervical vs endometrial) origin. Imaging showed metastases in pelvic and para-aortic lymph nodes. She underwent laparoscopy and was found intraoperatively to have gross disease on the right ovary. The patient underwent right salpingo-oophorectomy and chemoradiation. She had residual disease in the cervix and subsequently underwent robotic hysterectomy and left salpingo-oophorectomy. Pathological examination revealed endometrial cancer. She had a recurrence at the transumbilical trocar site concurrent with retroperitoneal lymphadenopathy and carcinomatosis. There were no cases of isolated port-site metastasis.

Conclusions: The rate of port-site metastasis after robotic surgery in women with gynecological cancer is low and similar to the rate for laparoscopic procedures.

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TI Minimally Invasive Surgical Approaches for Patients With Endometrial

Cancer

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE endometrial cancer; robotics; minimally invasive; laparoscopy;

hysterectomy; lymphadenectomy

ID ROBOTIC-ASSISTED HYSTERECTOMY; LAPAROSCOPY; LAPAROTOMY; LYMPHADENECTOMY;

OUTCOMES; SURGERY

AB Over the past 10 years, multiple studies have shown that minimally invasive surgical approaches for the treatment of endometrial cancer reduce blood loss, length of hospital stay, and the incidence and severity of surgical complications compared with laparotomy. In addition, minimally invasive approaches result in better cosmesis and short-term patient quality of life. Although data from prospective studies have yet to mature, laparoscopic and open surgeries seem to be equivalent oncologically. In this article, we will review the current literature on traditional laparoscopy, robotically assisted laparoscopy, and single-port laparoscopy as surgical approaches for the treatment of endometrial cancer.

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TI Robotic nerve-sparing radical hysterectomy: Feasibility and technique

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic; Nerve-sparing; Radical hysterectomy

ID INVASIVE CERVICAL-CANCER; ANATOMIC IDENTIFICATION; IIA

AB Objective. To describe the anatomy of pelvic autonomic nerves as it applies to nerve-sparing radical hysterectomy, and the technique, feasibility, and results of robotic nerve-sparing radical hysterectomy.

Methods. Prospective evaluation of 6 patients undergoing robotic nerve-sparing radical hysterectomy (type C1) for cervical cancer Stage IB (1B1 in 3 and 1B2 in 3 patients). Pelvic lymphadenectomy was performed in 3 patients and pelvic and aortic in the remaining 3 patients.

Results. The operation was completed in all patients. The mean age of the patients was 51.0 (range 33-73) and mean BMI 27.8 (range 23.2-35.1). The mean operating time was 238.6 min (range 207-256), mean blood loss 135 ml (range 100-150), mean number of lymph nodes was 23.6 (range 19-29), mean hospital stay was 2 days (range 1-4). There were no intraoperative complications. Postoperative complications occurred in 1 patient with an ileus who required an extended hospital stay. One patient did not regain normal urinary voidings until the fourth week after surgery. All patients remain free of disease.

Conclusion. Robotic nerve-sparing radical hysterectomy is safe and feasible. Urinary dysfunction may occur. (C) 2011 Elsevier Inc. All rights reserved.

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Kim, Young Tae

TI Robotic single-port transumbilical total hysterectomy: a pilot study

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Single-port; Laparoscopic; Hysterectomy; Gynecology

ID RADICAL HYSTERECTOMY; SURGERY; SITE

AB Objective: To evaluate the feasibility of robotic single-port transumbilical total hysterectomy using a home-made surgical glove port system.

Methods: We retrospectively reviewed the medical records of patients who underwent robotic single-port transumbilical total hysterectomy between January 2010 and July 2010. All surgical procedures were performed through a single 3-4-cm umbilical incision, with a multi-channel system consisting of a wound retractor, a surgical glove, and two 10/12-mm and two 8 mm trocars.

Results: Seven patients were treated with robotic single-port transumbilical total hysterectomy. Procedures included total hysterectomy due to benign gynecological disease (n=5), extra-fascial hysterectomy due to carcinoma in situ of the cervix (n=1), and radical hysterectomy due to cervical cancer IB1 (n=1). The median total operative time was 109 minutes (range, 105 to 311 minutes), the median blood loss was 100 mL (range, 10 to 750 mL), and the median weight of the resected uteri was 200 g (range, 40 to 310 g). One benign case was converted to 3-port robotic surgery due to severe pelvic adhesions, and no post-operative complications occurred.

Conclusion: Robotic single-port transumbilical total hysterectomy is technically feasible in selected patients with gynecological disease. Robotics may enhance surgical skills during single-port transumbilical hysterectomy, especially in patients with gynecologic cancers.

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TI Surgical outcomes in gynecologic oncology in the era of robotics:

analysis of first 1000 cases

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 77th Annual Meeting of the

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CL Kohala, HI

SP Pacific Coast Obstet & Gynecol Soc

DE endometrial carcinoma; robotic surgery; surgical morbidity

ID ENDOMETRIAL CANCER; LAPAROSCOPIC HYSTERECTOMY; OBESE

AB OBJECTIVE: We sought to examine outcomes in an expanding robotic surgery (RS) program.

STUDY DESIGN: In all, 1000 women underwent RS from May 2006 through December 2009. We analyzed patient characteristics and outcomes. A total of 377 women undergoing RS for endometrial cancer staging (ECS) were compared with the historical data of 131 undergoing open ECS.

RESULTS: For the entire RS cohort of 1000, the conversion rate was 2.9%. Body mass index increased over 3 time intervals: T1 = 26.2, T2 = 29.5, T3 = 30.1 (T1:T2, P = .01; T1:T3, P = .0001; T2:T3, P = .037). Increasing body mass index was not associated with increased major complications: T1 = 8.7%, T2 = 4.3%, T3 = 5.7%. In the ECS cohort, as compared with open ECS, women undergoing RS had lower blood loss (46.9 vs 197.6 mL, P = .0001), shorter hospitalization (1.4 vs 5.3 days, P =.0001), fewer major complications (6.4% vs 20.6%, P =.0001), with higher lymph node counts (15.5 vs 13.1, P = .007).

CONCLUSION: RS is associated with favorable morbidity and conversion rates in an unselected cohort. Compared to laparotomy, robotic ECS results in improved outcomes.

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TI Robot-assisted laparoscopic radical hysterectomy: Comparison with total

laparoscopic hysterectomy and abdominal radical hysterectomy: one

surgeon's experience at the Norwegian Radium Hospital

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical carcinoma; Robot-assisted laparoscopic radical hysterectomy;

Minimal invasive surgery; Total laparoscopic radical hysterectomy;

Abdominal radical hysterectomy; Recurrences

ID PELVIC LYMPHADENECTOMY; CERVICAL-CANCER; NODE DISSECTION; CARCINOMA;

MORBIDITY

AB Objectives. The purpose of this study was to investigate the 3 years follow-up results regarding the recurrence pattern of robot-assisted laparoscopic radical hysterectomies and pelvic lymphadenectomies in the early stage cervical carcinoma patients and compare the results with both total laparoscopic radical hysterectomy and abdominal radical hysterectomy groups.

Methods. A total of 68 patients underwent radical hysterectomy and pelvic lymphadenectomy for early stage cervical carcinoma management. All cases (35 robot-assisted, 7 cases laparoscopy and 26 with laparotomy) were operated by the same surgeon at the Norwegian Radium Hospital. All cases were retrospectively reviewed to compare demographics, pen-operative variables such as mean operative time, estimated blood loss, lymph node counts, complications and follow-up results.

Results. The mean operating times (skin-to-skin) for patients undergoing robot-assisted laparoscopic radical hysterectomy (RALRH), total laparoscopic radical hysterectomy (TLRH) or abdominal radical hysterectomy (ARH) were 263 +/- 70, 364 +/- 57 and 163 +/- 26 min respectively. Patients receiving laparotomy had shortest operative time, followed by those undergoing RALRH and then laparoscopy (p < 0.0001 for both). Estimated blood loss was significantly reduced in robot-assisted surgeries compared to surgeries involving laparoscopy and laparotomy (82 +/- 74 ml vs. 164 +/- 131 ml (p < 0.0001) and 595 +/- 284 ml (p = 0.023), respectively). The mean follow-up times were 36 +/- 14.4, 56.4 +/- 14 and 70 +/- 21 months in patients who underwent RALRH, TLRH and ARH respectively. Until now there have been 5 recurrences and one cervical cancer related death in the robot-assisted group and no recurrences in both the laparoscopy and the laparotomy group.

One patient died due to primary lung cancer in the laparoscopic group and other patient died due to primary pancreatic cancer in the laparotomy group.

Conclusions. Robot-assisted laparoscopic radical hysterectomy and pelvic lymph node dissection is feasible and more precise because the instruments provide better flexibility and 3-D vision. We must proceed cautiously, however, if a new treatment modality appears to present an increased recurrence rate. Therefore, patients submitted to robot-assisted laparoscopic radical hysterectomy should be followed carefully and RALRH would be encouraged as protocol setting until the long-term oncological outcome data are available. (C) 2011 Elsevier Inc. All rights reserved.

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PT J

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TI Pelvic Floor Function Before and After Robotic Sacrocolpopexy: One-Year

Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic sacrocolpopexy; Pelvic organ prolapse; Pelvic floor function

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; ORGAN PROLAPSE; REPAIR

AB Study objective: Estimate pelvic floor function and support 1 year after robotic sacrocolpopexy.

Design: Prospective cohort analysis of women undergoing robotic sacrocolpopexy for correction of advanced pelvic organ prolapse (Canadian Task Force Classification III). Primary outcome was pelvic floor function. Secondary outcomes included anatomic support and long-term surgical failures and complications.

Setting: One university hospital in the southeastern United States.

Patients: Primarily postmenopausal women (mean age 60) with advanced pelvic organ prolapse.

Interventions: All subjects underwent robotic sacrocolpopexy during the study period. Subjects then underwent 1-year postoperative assessment of pelvic floor function via validated condition-specific quality of life questionnaires and assessment of pelvic floor support, long-term surgical failures, and complications via physical examination.

Measurements and main results: From November 2007 to April 2009, there were 28 subjects, 25 of whom (89.3%) were evaluated. Mean time since surgery was 14.8 months. Pelvic floor function remained significantly improved over preoperative baseline: PFDI-20 (117 vs 38, p < .001), PFIQ-7 (60 vs 10, p = .001), with stable high sexual function: PISQ-12 (34 vs. 36, p = .17), and improved pelvic support on POP-Q: Ba (+3 vs 2, p = .001), Bp (+0.5 vs 1, p = .092), C (+2.25 vs 8, p = .001). Anatomic cure for vault prolapse was 100% at 1 year. There were two mesh exposures and two subsequent prolapse surgeries.

Conclusion: Robotic sacrocolpopexy demonstrates durable improvement in pelvic floor function and support, with high sexual function and reasonable failure and complication rates 1 year after surgery. Journal of Minimally Invasive Gynecology (2011) 18, 322-327 (c) 2011 AAGL. All rights reserved.

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TI Relationship Between Body Mass Index and Robotic Surgery Outcomes of

Women Diagnosed With Endometrial Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotics; Endometrial cancer; Obesity; Complications; Quality of life

ID OBESITY; IMPACT; AGE

AB Objective: This is a prospective evaluation of the outcome of minimal invasive surgery using robotics in function of the body mass index (BMI) of patients.

Methods: This is a prospective cohort study of consecutive women undergoing surgery for endometrial cancer at a tertiary care facility since the initiation of a robotic program in December 2007. Surgical and personal outcome variables as well as quality of life and postoperative recovery were assessed using a combination of objective and subjective/self-report questionnaires. Women were divided into 3 groups based on their BMI. Comparative analyses among nonobese (n = 52), obese (n = 33) and morbidly obese (n = 23) women were performed on the outcome measures after surgery.

Results: The mean BMI and the range in each of the BMI categories was 25 kg/m(2) (18.7-29.4 kg/m(2)), 34 kg/m(2) (30.1-38.4 kg/m(2)), and 46 kg/m(2) (40.0-58.8 kg/m(2)). Women with higher BMI tended to be more frequently affected with comorbidities such as diabetes (15.4%, 26.0%, and 27.3%, respectively; P = 0.32) and hypertension (55.8%, 69.6%, and 69.7%, respectively; P = 0.19). Despite these differences, surgical console time (P = 0.20), major postoperative complications (P = 0.52), overall wound complications (P = 0.18), and median length of hospitalization in days (P = 0.17) were not statistically different among the 3 groups. Only 5.6% of women needed a mini laparotomy all of which were performed for the removal of their enlarged uterus, which could not be delivered safely via the vagina, at the end of the surgical procedure. There was no increased conversion to laparotomy due to increased BMI. Women in all 3 groups reported rapid resumption of hygiene regimens and chores, little need for narcotic analgesia, and high satisfaction with the procedure.

Conclusions: Obese and morbidly obese patients with endometrial cancer are also good candidates for robotic surgery. These women benefit considerably from minimal invasive surgery and have little perioperative complications.

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PT J

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TI Effect of Body Mass Index on Robotic-Assisted Total Laparoscopic

Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Body mass index; Obesity; Laparoscopic hysterectomy; Robotic assisted

laparoscopy

ID SURGICAL OUTCOMES; UNITED-STATES; OBESITY; RATES

AB Study Objective: To estimate the impact of body mass index (BMI) on the surgical outcomes of patients undergoing robotic-assisted total laparoscopic hysterectomy.

Design: Retrospective cohort study.

Setting: Henry Ford Health System academic medical center (Henry Ford and Henry Ford West Bloomfield Hospitals)

Patients: A total of 135 patients who underwent scheduled robotic-assisted total laparoscopic hysterectomy for benign indications, without concomitant urogynecologic procedures between January 2008 and June 2010.

Interventions: Patients underwent robotic-assisted total laparoscopic hysterectomy as the intention to treat. Two cases were converted to laparotomy.

Measurements & Main Results: Electronic medical records of all patients that underwent robotic-assisted total laparoscopic hysterectomy at Henry Ford Health System were reviewed. Data on demographics, BMI (kg/m(2)), estimated blood loss, perioperative hemoglobin change, procedure duration, hospital length of stay, specimen weight, pathology, and postoperative complications were obtained. The women's median age was 45 years (range 30-68), 61.5% were black, and BMI ranged from 14.8-56.2 kg/m2; 23.4% of women were normal weight or less (BMI < 25, n = 31), 52.7% of women were obese (BMI > 30, n = 70) and 36 of these patients (27.1%) were morbidly obese (BMI >= 35). BMI did not correlate with procedure duration (Spearman r = .12, p = .16), length of stay (Spearman r = .10, p = .24), or estimated blood loss (Spearman r = .12, p = 18). Our analysis did not identify any meaningful associations between BMI and absolute change in hemoglobin. In addition BMI was not associated with an increase in major or minor complications.

Conclusion: BMI is not associated with blood loss, duration of surgery, length of stay, or complication rates in patients undergoing robotic-assisted total laparoscopic hysterectomy. Robotic assistance may help surgeons overcome adverse outcomes sometimes found in obese patients. Journal of Minimally Invasive Gynecology (2011) 18, 328-332 (c) 2011 AAGL. All rights reserved.

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ER

PT J

AU Stitely, ML

Hashmi, M

Jain, P

Hochberg, C

AF Stitely, Michael L.

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TI Use of a Yankauer Suction Tip Combined with the Colpo-Pneumo Occluder

Balloon to Suction the Surgical Field at the Vaginal Cuff During Robotic

Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Colpo-Pneumo Occluder balloon; Obesity; Robotic hysterectomy; Yankauer

suction

AB A 39-year-old patient with complex endometrial hyperplasia without atypia underwent robotic total laparoscopic hysterectomy with bilateral salpingo-oophorectomy. The procedure was technically challenging because of the patient's obesity (body mass index 50 kg/m(2)). Concomitant suction of pooled blood and retraction of bowel and omentum were necessary to close the vaginal cuff. An endoscopic retractor was used through the assistant's port, and a Yankauer suction tip was placed through an inflated Colpo-Pneumo Occluder balloon in the vagina to provide directed suction to the vagina cuff. This technique enabled efficient closure of the vaginal cuff. Journal of Minimally Invasive Gynecology (2011) 18, 362-363 (c) 2011 AAGL. All rights reserved.

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ER

PT J

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Mertz, HL

AF Yalcinkaya, Tamer M.

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TI Robotic-Assisted Laparoscopic Repair of Symptomatic Cesarean Scar Defect

<i>A Report of Two Cases</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE cesarean scar defect; cesarean section; robotic-assisted laparoscopic

repair

ID SECTION SCAR; UTERINE SCAR; PERIPARTUM HYSTERECTOMY; TRANSVAGINAL

ULTRASOUND; BLEEDING SECONDARY; 2-LAYER CLOSURE; DELIVERY SCAR;

DEHISCENCE; PREGNANCY; PREVALENCE

AB BACKGROUND: Symptomatic cesarean scar defect is one of the commonly reported long-term complications of cesarean section.

CASES: We present two cases of symptomatic cesarean scar defect treated conservatively by robotic-assisted laparoscopy at our institution. Both patients presented with hematocele, pelvic discomfort and secondary infertility. Transvaginal ultrasound revealed hematocele measuring 3.7x1.9x3.8 cm and 3.0x2.0x1.6 cm in the lower uterine segments, respectively. After surgery normal menses resumed in both patients, and their childbearing potential was preserved. The patients conceived 3 and 11. months after surgery, respectively.

CONCLUSION: Recognition of cesarean scar defect is important in the explanation of certain menstrual disorders since surgical intervention can result in improvement of symptoms and prevent the related secondary obstetric and gynecologic complications. Robotic-assisted laparoscopic approach is a good minimally invasive alternative for the repair of cesarean scar defect. (J Reprod Med 2011;56:265-270)

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ER

PT J

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Ponce, J

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Garc铆a-Tejedor, A

de Castillo, LF

Gin茅, L

AF Jesus Pla, Ma

Ponce, Jordi

Marti, Lola

Garcia-Tejedor, Amparo

Fernandez de Castillo, Luis

Gine, Luis

TI Robotic surgery in endometriosis

SO GINECOLOGIA Y OBSTETRICIA CLINICA

LA Spanish

DT Article

DE Endometriosis; Robotic- assisted laparoscopic surgery; Minimally

invasive surgery

ID LAPAROSCOPIC PRESACRAL NEURECTOMY

AB The advent of robotic technology represents the most important advance in minimally invasive surgery in the last ten years. The adventages of robotic assistance include: the use of three dimensional imaging and more dextrous and precise instruments.

Current studies clearly demonstrate the feasibility and safety of applying robotics to surgery of endometriosis.

The value of robotics lies in severe endometriosis and in allowing robotic laparoscopies in cases that had been indications of laparotomies. This is the role of robotics in endometriosis; to convert laparotomies in laparoscopies by means of robotic assistance.

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Z9 0

U1 1

U2 1

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J9 GINECOL OBSTET CLIN

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ER

PT J

AU Magrina, JF

Zanagnolo, V

Noble, BN

Kho, RM

Magtibay, P

AF Magrina, Javier F.

Zanagnolo, Vanna

Noble, Brie N.

Kho, Rosanne M.

Magtibay, Paul

TI Robotic approach for ovarian cancer: Perioperative and survival results

and comparison with laparoscopy and laparotomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Ovarian cancer; Robotics; Laparoscopy; Cytoreduction

ID ENDOMETRIAL CANCER; ABDOMINAL HYSTERECTOMY; RADICAL HYSTERECTOMY;

OUTCOMES; LYMPHADENECTOMY

AB Objective. Comparison of perioperative outcomes and survival of patients undergoing primary surgical treatment for epithelial ovarian cancer (EOC) by a robotic, laparoscopy, or laparotomy approach.

Methods. Retrospective case-control analysis of 25 patients with EOC undergoing robotic surgical treatment between March 2004 and December 2008. Comparison was made with similar patients treated by laparoscopy and laparotomy and matched by age, body mass index (BMI), and type of procedures between January 1999 and December 2006.

Results. The mean operating times were 314.8, 253.8 and 260.7 min for robotic, laparoscopy and laparotomy patients, respectively (p < 0.05); the mean blood loss was 164.0, 266.7, and 1307.0 ml, respectively (p = 0.001); the mean length of hospital stay was 4.2, 3.2, and 9.4 days, respectively (p = 0.001). The overall survival (OS) for robotics, laparoscopy and laparotomy patients was 67.1%, 75.6% and 66.0%, respectively (p = 0.08). Patients were subdivided and compared according to the extent of surgery by the type and number of major procedures. Type I and II debulking patients operated by robotics and laparoscopy had improved perioperative outcomes as compared to laparotomy. For patients undergoing a type III debulking, robotic outcomes were not improved over laparotomy.

Conclusion. Laparoscopy and robotics are preferable to laparotomy for patients with ovarian cancer requiring primary tumor excision alone or with one additional major procedure. Laparotomy is preferable for patients requiring two or more additional major procedures. Survival is not affected by the type of surgical approach. (C) 2010 Published by Elsevier Inc.

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FU Mayo Foundation for Medical Education and Research

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ER

PT J

AU Oehler, MK

AF Oehler, Martin K.

TI Robotic surgery in gynaecology and gynaecological oncology: Program

initiation and operative outcomes at the Royal Adelaide Hospital

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Article

DE gynaecological oncology; gynaecology; hysterectomy; laparoscopy; minimal

invasive surgery; robotic surgery

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; ASSISTED HYSTERECTOMY; ENDOMETRIAL

CANCER; SURGICAL OUTCOMES; MORBIDITY

AB Background: Robotic surgery has become an integral part of gynaecological surgery in the USA. In Australia, however, robotic surgery has only been established in urologic and cardiac surgery. In 2008, the Royal Adelaide Hospital (RAH) was the first public hospital to initiate a robotic surgery program in gynaecology and gynaecological oncology in Australia.

Aims: To evaluate the feasibility and outcome of the robotic surgery program in gynaecology and gynaecological oncology at the RAH.

Methods: A prospective case series analysis of the first 71 patients operated by robotic surgery from August 2008 to May 2010 was performed.

Results: All patients underwent a total or radical robotic hysterectomy with or without staging for gynaecological cancer, benign disease or genetic risk. No conversions to laparotomy were required. Sixty-seven patients (95%) were discharged the morning after surgery. Four patients (5%) required hospital stays of up to 3 days because of pre-existing medical conditions or logistical reasons. The only major postoperative complication was one vault dehiscence. Minor short-term problems in four patients were vaginal cuff cellulitis, vaginal vault granulation tissue and infected port sites.

Conclusion: The RAH experience is that robotic surgery in gynaecology and gynaecological oncology is safe and feasible. Patient recovery is excellent, and the hospital stay is reduced. Robotic surgery has the potential to significantly expand the minimally invasive surgical options for women undergoing surgery for benign and malignant gynaecological disease in Australia.

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U1 0

U2 2

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ER

PT J

AU Escobar, PF

Kebria, M

Falcone, T

AF Escobar, Pedro F.

Kebria, Mehdi

Falcone, Tommaso

TI Evaluation of a novel single-port robotic platform in the cadaver model

for the performance of various procedures in gynecologic oncology

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Single port robotic; Single port laparoscopy; LESS

ID SITE SURGERY; LYMPHADENECTOMY; HYSTERECTOMY; CANCER

AB Objectives. The purpose of this protocol was to evaluate the feasibility and reproducibility of a dedicated da Vinci (R) single-port robotic platform in cadavers for the performance of various gynecologic oncology procedures.

Methods. Three fresh frozen female cadavers were used to evaluate the feasibility, reproducibility, and to develop the correct docking of the robotic column and trocars. Procedures performed in this training protocol included (hysterectomy, bilateral salpingo-oophorectomy, modified radical hysterectomy, six pelvic lymph node dissections, and one para-aortic node dissection). A data set was collected for each procedure, operative times were compared between cases and procedures by use of Wilcoxon rank sum test, a p-value <0.05 was considered significant.

Results. All the procedures were technically successful with no need of additional ports or conversions to a standard laparoscopy. The median time of port insertion and BMI was 6 min range (4-10) and 33 min range (25-56) respectively. The median time for a left and right pelvic lymph node dissection was 22 min range (22-23) and 28 min range (26-38) respectively. There was significant difference in operating times for symmetrical procedures (pelvic lymphadenectomy), p = 0.049.

Conclusion. This preliminary data demonstrates that the performance of various oncology procedures using the new da Vinci single-site robotic platform is feasible, and more importantly, reproducible in the cadaver model. (C) 2010 Elsevier Inc. All rights reserved.

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PT J

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Slomovitz, BM

Holcomb, KM

AF Frey, Melissa K.

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TI Minimally Invasive Staging of Endometrial Cancer Is Feasible and Safe in

Elderly Women

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Elderly; Endometrial cancer; Hysterectomy; Laparoscopy

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; MANAGEMENT; SURVIVAL; SURGERY

AB Study Objective: To compare the surgical outcome of elderly and younger patients undergoing laparoscopic or robotic surgical staging of endometrial cancer.

Design: Retrospective analysis (Canadian Task Force classification II-2).

Setting: University-affiliated hospital.

Patients: One hundred twenty-nine patients comprised the study group. Sixty patients were aged 65 years or older (elderly group), and 69 patients were younger than 65 years (younger group).

Intervention: Abdominal, laparoscopic, or robotic hysterectomy.

Measurements and Main Results: Among the 109 patients who underwent laparoscopic or robotic staging, there were no differences in estimated blood loss, lymph node count, surgical time, complications, rate of blood transfusion, conversion to laparotomy, and mean postoperative stay between elderly and younger patients.

Conclusion: Minimally invasive surgical staging for endometrial cancer is both feasible and safe in the elderly population and offers similar outcomes as in younger patients. Journal of Minimally Invasive Gynecology (2011) 18, 200-204 (C) 2011 AAGL. All rights reserved.

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PT J

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Nezhat, C

AF Gargiulo, Antonio R.

Nezhat, Ceana

TI Robot-Assisted Laparoscopy, Natural Orifice Transluminal Endoscopy, and

Single-Site Laparoscopy in Reproductive Surgery

SO SEMINARS IN REPRODUCTIVE MEDICINE

LA English

DT Article

DE Robotic surgery; robotics; natural orifice transluminal endoscopic

surgery; NOTES; single-incision laparoscopic surgery; SILS; laparoscopic

single-site surgery; LESS; reproductive surgery

ID FLEXIBLE TRANSGASTRIC PERITONEOSCOPY; ABDOMINAL MYOMECTOMY; TUBAL

ANASTOMOSIS; CHOLECYSTECTOMY; ENDOMETRIOSIS; FEASIBILITY; MULTICENTER;

EXPERIENCE; SUTURE; SILS

AB Minimally invasive gynecologic surgery is continuously pushing its limits by embracing ever more sophisticated technology. This is also true for reproductive surgery, arguably the birthplace of gynecologic endoscopy, where minimally invasive treatment of uterine, tubal, ovarian, and peritoneal pathology has long become the gold standard. This article describes in some detail three novel minimally invasive surgery approaches that have seen the light during the past decade: robot-assisted laparoscopic surgery, natural orifice transluminal endoscopic surgery, and single-incision laparoscopic surgery. These fascinating technologies, far from being widely adopted, are sure to generate scientific controversy for years to come. Nonetheless, they follow in the footsteps of the tradition of innovation that is a defining aspect of our specialty and hold the promise to potentially revolutionize the field of reproductive surgery.

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WC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

AU Geller, EJ

Schuler, KM

Boggess, JF

AF Geller, Elizabeth J.

Schuler, Kevin M.

Boggess, John F.

TI Robotic Surgical Training Program in Gynecology: How to Train Residents

and Fellows

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic training; Robotic surgery; Surgical training

ID OUTCOMES

AB A protocol was established to standardize surgical training using the da Vinci Surgical System. Third- and fourth-year residents and first-year fellows in obstetrics and gynecology participated. The protocol includes online instruction and 2 hands-on modules: platform set-up and surgical skills. Platform set-up provides orientation to the console, visual platform, surgical cart ("robot"), camera set-up, port placement, and instrument insertion and removal. Surgical skills includes specific drills using rubber models that simulate human tissue: manipulation, dissection, and simple and advanced suturing. Performance times were recorded for each trainee, as well as previous robotic experience. Times were compared with goals established by Intuitive Surgical, Inc., to assess feasibility of this protocol and baseline robotic surgical aptitude. All trainees (n = 17) completed the training protocol. Performance times met goals for docking and dissection. These times also varied according to level of training. Performance times for manipulation and simple and advanced suturing were prolonged across all groups. Overall pass rates were 100% for docking, 90% for dissection, 11.8% for manipulation, and 0% for simple and advanced suturing. Dissection pass rates varied according to level of training. Performance times and pass rates were not improved with higher level of training or previous robotic experience. Resident and fellow instruction in new surgical technology is an important part of training in obstetrics and gynecology. Herein is reported a method to accomplish robotic training that standardizes instruction and assessment of skills. Journal of Minimally Invasive Gynecology (2011) 18, 224-229 (C) 2011 AAGL. All rights reserved.

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ER

PT J

AU Holloway, RW

Brudie, LA

Rakowski, JA

Ahmad, S

AF Holloway, Robert W.

Brudie, Lorna A.

Rakowski, Joseph A.

Ahmad, Sarfraz

TI Robotic-assisted resection of liver and diaphragm recurrent ovarian

carcinoma: Description of technique

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 2nd European Symposium on Robotic Gynecological Surgery

CY SEP 09-11, 2010

CL Lund, SWEDEN

DE Robotic surgery; Liver resection; Diaphragm resection; Ovarian cancer;

Technique description

ID CYTOREDUCTIVE SURGERY; CANCER; SURVIVAL; IMPROVES

AB Goals. To describe port placement and operative technique for resection of right hepatic and full-thickness diaphragm metastatic ovarian carcinoma in a patient with recurrent disease using the da Vinci (R) Surgical System.

Case. A 60-year-old female with recurrent platinum sensitive ovarian cancer presented with disease confined to the liver by PET-CT scan. The lesion measured 3.4 cm on the dome of the right hepatic lobe. After two attempts at intra-hepatic arterial chemo-embolization the lesion remained stable. She subsequently agreed to robotic-assisted resection of the right lobe liver mass after refusing laparotomy for 9 months.

Procedure. Pnuemoperitoneum was established in the left upper quadrant by directly inserting a 5-mm laparoscope. There were no midline adhesions. The 12-mm camera port was placed in the midclavicular line on the right 10 cm off the costal margin with the right and left operative arms 10 cm from the camera near the costal margin, and the third arm in the right flank. The robot was docked from the right shoulder. Resection was accomplished with a monopolar spatula in the right, fenestrated bipolar grasper in the left, and double fenestrated grasper in the third operative arm. Adhesions between diaphragm and liver were separated, the liver lesion was excised, the diaphragm lesion was resected full thickness, and diaphragm was closed with running prolene. Surgicel (R) was placed on the liver for hemostasis. Console time was 82 min and the patient discharged on day-5 after drainage of a cytology negative pleural effusion day-4.

Conclusions. Robotic resection of liver and full-thickness diaphragm lesions is possible. The port placement used in this patient was efficient and without operative arm collisions. Patients with isolated upper-abdominal recurrence are candidates for robotic secondary cytoreduction. (C) 2010 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Robot-assisted versus total laparoscopic radical hysterectomy in early

cervical cancer, a review

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Robot; Laparoscopy; Radical hysterectomy; Review

ID PELVIC LYMPHADENECTOMY; MULTIINSTITUTIONAL EXPERIENCE; NODE

IDENTIFICATION; PUNE TECHNIQUE; MORBIDITY; COMPLICATIONS; METAANALYSIS;

FEASIBILITY; SURGERY; SAFETY

AB Objective. The aim of this study was to review current literature on total laparoscopic (TLRH) and robot-assisted radical hysterectomy (RRH) with pelvic lymphadenectomy in the treatment of early stage cervical cancer by analyzing data published in individual case series in order to compare surgical and oncological outcomes.

Methods. Up to January 2010,27 studies were identified that met the inclusion criteria, together with our own unpublished data of patients, accounted for 342 RRH patients and 914 TLRH patients.

Results. There was no statistical difference between the methods in terms of age, BMI or prior abdominal surgery. Estimated mean operative time, blood loss and number of lymph nodes retrieved did not statistically differ between the RRH and TLRH method. Less blood transfusions were needed in patients treated by RRH (5.4%) versus TLRH (9.7%, p<0.05). Both methods were similar in respect to adjuvant chemo- or (chemo) radiation and recurrence rate. When complications were prioritized to severity, major post-operative complications where more frequent in RRH patients (9.6%) than in TLRH patients (5.5%, p<0.05). The length of hospital stay was significantly shorter in RRH compared to TLRH treatment (3.3 versus 6.2 days respectively; p:0.04).

Conclusions. Robot-assisted and total laparoscopic radical hysterectomy appears to be equally adequate and feasible. RRH studies had small patient populations and further experience beyond the learning curve phase may improve operative time and complication rate. Both minimal invasive techniques should be investigated in a randomized manner. (C) 2010 Elsevier Inc. All rights reserved.

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PT J

AU Lim, PC

Kang, E

Park, DH

AF Lim, Peter C.

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TI A comparative detail analysis of the learning curve and surgical outcome

for robotic hysterectomy with lymphadenectomy versus laparoscopic

hysterectomy with lymphadenectomy in treatment of endometrial cancer: A

case-matched controlled study of the first one hundred twenty two

patients

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Learning curve; Robotic; Laparoscopic surgery; Endometrial cancer

ID SURGERY; WOMEN

AB Goal. To determine the learning curve and surgical outcome for the first one hundred twenty-two robotic hysterectomy with lymphadenectomy patients in comparison to the first one hundred twenty-two patients who underwent the same procedure laparoscopically.

Materials and methods. An analysis of the first 122 patients who underwent a robotic assisted hysterectomy with lymphadenectomy (RHBPPALND) was compared to the first 122 patients who underwent a total laparoscopic hysterectomy with lymphadenectomy (LHBPPALND). The learning curve of the surgical procedure was determined by measuring operative time with respect to chronological order of each patient who had undergone their respective procedure. Number of lymph nodes, estimated blood loss, days of hospitalization, and complications of all patients were also analyzed and compared.

Results. The learning curve of the surgical procedure was determined by measuring operative time with respect to chronological order of each patient who had undergone their respective procedure. Data were analyzed for mean age, body mass index, operative time, estimated blood loss, lymph node retrieval and complications for both surgical procedures. The mean operative time was 147.2 +/- 48.2 and 186.8 +/- 59.8 for RHBPPALND and LHBPPALND respectively. The mean EBL was statistically significant at 81.1 +/- 45.9 and 207.4 +/- 109.4 for RHBPPALND and LHBPPALND respectively. The total number of pelvic and aortic lymph nodes was 25.1 +/- 12.7 for RHBPPALND and 43.1 +/- 17.8 for LHBPPALND. The number of pelvic lymph node was 19.2 +/- 9.0 and 24.7 +/- 11.9 for RHBPPALND and LHBPPALND. The days of hospitalization of RHBPPALND and LHBPPALND were 1.5 +/- 0.9 and 3.2 +/- 2.3. The number of intraoperative complications for RHBPPALND, and LHBPPALND was 1 and 7, respectively.

Conclusion. Robotic hysterectomy with lymphadenectomy has a faster learning curve in comparison to laparoscopic hysterectomy with lymphadenectomy. The adequacy of surgical staging was comparable between the two surgical methods. RHBPPALND is associated with shorter hospitalization, less blood loss and less intraoperative and major complications, and lower rate of conversion to open procedure. (C) 2010 Elsevier Inc. All rights reserved.

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PT J

AU Soto, E

Soto, C

Nezhat, FR

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Gretz, Herbert F.

Chuang, Linus

TI Chylous ascites following robotic lymph node dissection on a patient

with metastatic cervical carcinoma

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Chylous ascites; Robotic surgery; Cervical carcinoma

ID TOTAL PARENTERAL-NUTRITION; LAPAROSCOPIC MANAGEMENT; SOMATOSTATIN;

DIAGNOSIS

AB Chylous ascites is an uncommon postoperative complication of gynecological surgery. We report a case of chylous ascites following a robotic lymph node dissection for a cervical carcinoma. A 38-year-old woman with IB2 cervical adenocarcinoma with a palpable 3 cm left external iliac lymph node was taken to the operating room for robotic-assisted laparoscopic pelvic and para-aortic lymph node dissection. Patient was discharged on postoperative day 2 after an apparent uncomplicated procedure. The patient was readmitted the hospital on postoperative day 9 with abdominal distention and a CT-scan revealed free fluid in the abdomen and pelvis. A paracentesis demonstrated milky-fluid with an elevated concentration of triglycerides, confirming the diagnosis of chylous ascites. She recovered well with conservative measures. The risk of postoperative chylous ascites following lymph node dissection is still present despite the utilization of new technologies such as the da Vinci robot.

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TC 3

Z9 3

U1 0

U2 2

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

PD MAR

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AU Hong, DG

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Chong, GO

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AF Hong, Dae Gy

Lee, Yoon Soon

Park, Nae Yoon

Chong, Gun Oh

Park, Il Soo

Cho, Young Lae

TI Robotic Uterine Artery Preservation and Nerve-Sparing Radical

Trachelectomy With Bilateral Pelvic Lymphadenectomy in Early-Stage

Cervical Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Cervical carcinoma; Robotic surgery; Trachelectomy

ID FERTILITY; CONSERVATION; HYSTERECTOMY; CARCINOMA; SERIES

AB Objective: The aim of the study was to evaluate the safety and feasibility of robotic uterine artery preservation and nerve-sparing radical trachelectomy with pelvic lymphadenectomy using the da Vinci surgical system.

Methods: Three patients who were diagnosed with early-stage cervical cancer underwent robotic uterine artery preservation and nerve-sparing radical trachelectomy with bilateral lymphadenectomy from January 2010 to March 2010. The data were compared with those of 4 cases of total laparoscopic nerve-sparing radical trachelectomy that were performed from July 2004 to May 2005 and were previously reported.

Results: In the robotic group, the mean console time was 275 minutes (range, 240-305 minutes). The mean postoperative hemoglobin change was 0.4 g/dL (range, 0.2-0.6 g/dL). The mean estimated blood loss was 23 mL (range, 15-40 mL), which is less than that of the laparoscopic group. There were no metastases detected in any of the cases, and the resection margins were negative in both groups.

Conclusions: The robotic uterine artery preservation and nerve-sparing radical trachelectomy with pelvic lymphadenectomy were efficient in reducing blood loss and feasible methods such as other approaches.

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TC 30

Z9 34

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U2 8

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PT J

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Einstein, MH

Perry, L

Hartenbach, EM

Kushner, DM

AF Al-Niaimi, Ahmed N.

Einstein, Margaret H.

Perry, LaToya

Hartenbach, Ellen M.

Kushner, David M.

TI Uterine artery sparing robotic radical trachelectomy (AS-RRT) for early

cancer of the cervix

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE AS-RRT; Early cervical cancer; Robotic surgery; Surgical technique;

Trachelectomy

ID OF-THE-LITERATURE; ABDOMINAL TRACHELECTOMY; PATHOLOGICAL OUTCOMES;

CARCINOMA; MANAGEMENT; SURGERY; UPDATE

AB Objective: To describe the surgical technique of uterine artery sparing robotic assisted radical trachelectomy (AS-RRT) for early stage cervical cancer. Methods: We used our experience with AS-RRT performed at the University of Wisconsin-Carbone Comprehensive Cancer Center, USA, to present a detailed description of the surgical technique. Results: The report details, step-by-step, our innovative surgical technique, supported by photos and illustrations. We also discuss potential difficulties with the surgical technique and offer solutions. Conclusion: Technically, the surgery is feasible and could be performed by any gynecologic oncologist who is skilled in radical pelvic surgery and the robotic system. The long-term obstetric and oncologic outcome of this technique would be expected to match the outcome of the other radical trachelectomy techniques in the published literature, but is yet to be fully elucidated. (C) 2010 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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U1 0

U2 3

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JI Int. J. Gynecol. Obstet.

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PY 2011

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Bing-Shu, L

Li, H

Qin, W

Min, H

Yan-Xiang, C

AF Bing-shu, L.

Li, H.

Qin, W.

Min, H.

Yan-xiang, C.

TI Clinical effects of transvaginal vesicovaginal fistula repair surgery

mediated by the Foley catheter (64 cases)

SO CLINICAL AND EXPERIMENTAL OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE Vesicovaginal; Urinary fistula; Foley catheter

ID LAPAROSCOPIC REPAIR; ROBOTIC RECONSTRUCTION

AB Objective: To investigate the clinical effects and superiority of transvaginal vesicovaginal fistula (VVF) repair surgery mediated by the Foley catheter. Patients and Methods: We retrospectively reviewed the case notes of 129 patients with vesicovaginal fistulas who received surgery in our hospital; 68 patients received VVF repair surgery mediated by the Foley catheter (modified group), and 61 patients received traditional transvaginal VVF repair surgery (traditional group). Results: The success rate of the primary operation, mean operation time, mean intraoperative blood loss, mean postoperative hospitalization time, and rate of patients with postoperative urine leakage were significantly different between the modified group and traditional group. However, the mean bladder capacity, postoperative recovery time of self-miction, and postoperative wound infection rate were not significantly different between the groups. Conclusions: Transvaginal VVF repair surgery mediated by the Foley catheter had a higher success rate, shorter operation time, less blood loss and sooner recovery time postoperatively. Therefore, it should be applied in clinics generally.

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NR 16

TC 1

Z9 1

U1 0

U2 0

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JI Clin. Exp. Obstet. Gynecol.

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PT J

AU Geisler, JP

Orr, C

Manahan, KJ

AF Geisler, J. P.

Orr, C.

Manahan, K. J.

TI Robotically-assisted laparoscopic radical parametrectomy and radical

vaginectomy

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Radical parametrectomy; Laparoscopic; Cervical cancer; Robotics

ID SIMPLE HYSTERECTOMY; SURGICAL-TREATMENT; CANCER; WOMEN; LYMPHADENECTOMY;

GYNECOLOGY

AB Background: Radical parametrectomy is a technically challenging operation used for women found to have occult cervix cancer after a hysterectomy for benign reasons. A similar operation, radical vaginectomy, is rarely performed because of the its technical difficulty in getting adequate margins without an attached uterus. Case Reports: A 41-year-old woman was found to have a presumed surgical Stage IB1 squamous cell carcinoma of the cervix at time of surgery for uterine prolapse. The patient was offered multiple options of surgery and chemoradiation. A second case, a 55-year-old woman, was found to have I cm vaginal cancer nine years after a total vaginal hysterectomy for carcinoma in situ of the cervix. She was also offered chemoradiation versus surgery. For the robotically-assisted laparoscopic radical parametrectomy operating time was 186 minutes with an estimated blood loss of 250 ml. For the robotically-assisted laparoscopic radical vaginectomy operating time was 154 minutes with an estimated blood loss of 150 ml. Neither patient had a hospitalization over 24 hours. There were no intraoperative or postoperative complications. Conclusions: Robotically-assisted laparoscopic radical paremetrectomy and vaginectomy are both technically feasible procedures.

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NR 18

TC 2

Z9 2

U1 0

U2 1

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J9 EUR J GYNAECOL ONCOL

JI Eur. J. Gynaecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

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PM 22335034

DA 2024-01-18

ER

PT J

AU Magrina, JF

Zanagnolo, V

Giles, D

Noble, BN

Kho, RMC

Magtibay, PM

AF Magrina, J. F.

Zanagnolo, V.

Giles, D.

Noble, B. N.

Kho, R. M. C.

Magtibay, P. M.

TI Robotic surgery for endometrial cancer: comparison of perioperative

outcomes and recurrence with laparoscopy, vaginal/laparoscopy and

laparotomy

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotics; Laparoscopy

ID RADICAL HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; SURGICAL ROBOTICS;

LYMPHADENECTOMY; WOMEN

AB Introduction: Comparison of perioperative outcomes and recurrence in patients undergoing primary surgical treatment for endometrial cancer by robotics, laparoscopy, vaginal/laparoscopy, or laparotomy approaches. Methods: Prospective analysis of 67 patients undergoing robotic surgery for endometrial cancer between March 2004 and December 2007. Comparison was made with similar patients operated between November 1999 and December 2006 by laparoscopy (37 cases), laparotomy (99 cases) and vaginal/laparoscopy approach (vaginal hysterectomy, bilateral adnexectomy/laparoscopic lymphadenectomy) (47 cases) and matched by age, body mass index (BMI), histological type and International Federation of Gynecologists and Obstetricians (FIGO) staging. Results: Mean operating times for patients undergoing robotic, laparoscopy, vaginal/laparoscopy or laparotomy approach were 181.9, 189.5, 202.7 and 162.7 min, respectively (p = 0.006); mean blood loss was 141.4, 300.8, 300.0 and 472.6 ml, respectively (p < 0.001); mean number of nodes was 24.7, 27.1, 28.6, and 30.9, respectively (p = 0.008); mean length of hospital stay was 1.9, 3.4, 3.5 and 5.6 days, respectively (p < 0.001). There were no significant differences in intra- or postoperative complications among the four groups. The conversion rate was 2.9% for robotics and 10.8% for the laparoscopy group (0.001). There were no differences relative to recurrence rates among the four groups: 9%, 14%, 11% and 15% for robotics, laparoscopy, vaginal/laparoscopy, and laparotomy, respectively. Conclusion: Robotics, laparoscopy and vaginal/laparoscopy techniques are preferable to laparotomy for suitable patients with endometrial cancer. Robotics is preferable to laparoscopy due to a shorter hospital stay and lower conversion rate and preferable to vaginal/laparoscopy due to a reduced hospitalization.

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NR 24

TC 46

Z9 46

U1 1

U2 4

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J9 EUR J GYNAECOL ONCOL

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PG 5

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SC Oncology; Obstetrics & Gynecology

GA 830PI

UT WOS:000295668500002

PM 22053656

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ER

PT J

AU Stark, M

Gidaro, S

Morales, ER

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Gidaro, Stefano

Morales, Emilio Ruiz

TI The future of gynaecological surgery - telesugery with haptic sensation

SO GINECO RO

LA English

DT Article

DE telesurgery; haptic sensation; cystectomy; endotracheal intubation

ID LAPAROSCOPIC HYSTERECTOMY; ROBOT; NEPHRECTOMY; SURVIVAL

AB The 19th century will be remembered as the era of open surgery. The history of gynaecological surgery started in 1807 in Kentucky, Missoury, when Ephraim McDowell performed the first successful cystectomy using a longitudinal abdominal incision. Throughout the 19th century, longitudinal incisions were routinely used in all gynaecological operations. In 1897, however, Johannes Pfannenstiel introduced the transverse incision, which showed to have benefits over the longitudinal one, such as less wound dehiscence(1). At the beginning of the 20th century, experimental endoscopy was introduced by Georg Kelling in Germany(2). Due to the development of light sources, insufflators, and endotracheal intubation, more and more gynaecological operations, such as the laparoscopy-assisted vaginal hysterectomy, were done endoscopically(3). At the beginning of the 21st century, telesurgical systems are emerging for gynaecological procedures, both for benign and malignant indications. It seems that in the course of this century this new technology will replace many of the conventional endoscopic techniques.

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NR 17

TC 2

Z9 2

U1 0

U2 1

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J9 GINECO RO

JI Gineco ro

PY 2011

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WC Obstetrics & Gynecology

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ER

PT J

AU Tchartchian, G

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Dietzel, Joanna

Bojahr, Bernd

Hackethal, Andreas

De Wilde, Rudy

TI Decreasing strain on the surgeon in gynecologic minimally invasive

surgery by using semi-active robotics

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE Laparoscopy; LapMan; Minimally invasive gynecologic surgery; Robotic

assistance; Robotic laparoscope holder

ID LAPAROSCOPIC SURGERY

AB Objective: To assess the advantages of a surgeon-controlled robotic endoscope holder in gynecologic minimally invasive solo-surgery as compared with conventional assistance with a second surgeon. Methods: One hundred gynecologic laparoscopies were consecutively allocated to surgery with either a robot as the surgical assistant or a conventional assistant surgeon. Total operation time, image stability, and frequency of corrective maneuvers of the camera, in addition to the surgeon's satisfaction regarding the ergonomics of the intervention, were recorded. All interventions were performed by the same surgeon. All laparoscopic surgery was classified as either easy or advanced surgery. Results: The image stability score was significantly higher (10 vs 7; P<0.001) and fewer corrective maneuvers of the robotic endoscope were necessary (1 vs 5; P<0.001) with the robotic laparoscope holder; in addition, the surgeon recorded a significantly higher satisfaction score for the ergonomics of the semi-active robot (10 vs 7; P<0.001). Conclusion: The robot does not prolong total operation time and increases the surgeon's comfort by improving image stability and laparoscope handling. It could provide major benefit, especially in complex gynecologic laparoscopic surgery. (C) 2010 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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NR 8

TC 10

Z9 10

U1 0

U2 4

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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PY 2011

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BP 72

EP 75

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GA 710UO

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ER

PT J

AU Uppal, S

Frumovitz, M

Escobar, P

Ramirez, PT

AF Uppal, Shitanshu

Frumovitz, Michael

Escobar, Pedro

Ramirez, Pedro T.

TI Laparoendoscopic Single-Site Surgery in Gynecology: Review of Literature

and Available Technology

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE E-NOTES; Laparoendoscopic single-site surgery; Laparoscopy; LESS; Single

port; Single scar; SILS; SPA; TUES

ID LAPAROSCOPIC SUPRACERVICAL HYSTERECTOMY; RETROPERITONEOSCOPIC

ADRENALECTOMY SARA; PORT ACCESS; PELVIC LYMPHADENECTOMY;

CHOLECYSTECTOMY; INCISION; APPENDECTOMY; NEPHRECTOMY; EXPERIENCE;

ONCOLOGY

AB The objective of this article was to review the published literature on laparoendoscopic single-site surgery (LESS) in gynecology and to present current advances in instruments used in LESS surgery. Inasmuch as LESS surgery is relatively new, the current literature on use of this technique in gynecology is somewhat limited. Sixteen articles were available for the literature review: 10 case series, 2 comparative studies, 3 case reports, and 1 surgical technique demonstration. In recent years, however, improvements in traditional laparoscopic techniques and availability of more advanced instruments has made single-incision laparoscopy more feasible and safer for the patient. There is increasing interest in LESS surgery both as an alternative to traditional laparoscopy and as an adjunct to robotic surgery when performing complicated procedures through a single incision. Although LESS surgery provides another option in the arena of minimally invasive gynecologic surgery, the ultimate role of this approach remains to be determined. Journal of Minimally Invasive Gynecology (2011) 18, 12-23 (C) 2010 AAGL. All rights reserved.

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FU NCI NIH HHS [P30 CA016672] Funding Source: Medline

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TC 67

Z9 69

U1 0

U2 7

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JI J. Minim. Invasive Gynecol.

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PY 2011

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BP 12

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WC Obstetrics & Gynecology

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PT J

AU Yim, GW

Kim, SW

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Kim, YT

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Kim, Sang Wun

Nam, Eun Ji

Kim, Young Tae

TI Role of Robot-Assisted Surgery in Cervical Cancer

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Review

DE Cervical cancer; Robotic surgery; da Vinci surgical system

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC NODE DISSECTION;

LYMPHADENECTOMY; TRACHELECTOMY; FERTILITY; CARCINOMA; EXPERIENCE;

PRESERVATION; LAPAROTOMY

AB Background: The development of robotic technology has facilitated the application of minimally invasive techniques for complex operations in gynecologic oncology.

Objectives: The objective of the study was to assess and summarize the current literature on the role of robot-assisted surgery in cervical cancer in terms of its utility and outcome.

Methods: Literature review concerning the use of robot-assisted technology in the management of cervical cancer, including radical hysterectomy, trachelectomy, parametrectomy, pelvic and aortic lymphadenectomy, and pelvic exenteration, was performed.

Results: To date, 12 articles addressing radical hysterectomy, 5 articles of radical trachelectomy, and 6 articles of surgical procedure in advanced or recurrent cervical cancer, all performed robotically, are published in the literature. The advantages of the robotic system include 3-dimensional vision, tremor reduction, motion downscaling, improved ergonomics, and greater dexterity with instrument articulation. Because of these benefits, the robotic technology seems to facilitate the surgical approach for technically challenging operations performed to treat primary, early or advanced, and recurrent cervical cancer as evidenced by the current literature.

Conclusions: Surgical management of cervical cancer may be one of the gynecologic oncology surgeries that can take full advantage of robotic assistance in a minimally invasive manner. Continued research and clinical trials are needed to further elucidate the equivalence or superiority of robot-assisted surgery to conventional methods in terms of oncological outcome and patient's quality of life.

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FU Korean Government [2009-0071158]

FX This study was supported by the Brain Korea (BK) 21 Project for Medical

Sciences of Yonsei University and a National Research Foundation of

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NR 30

TC 15

Z9 17

U1 1

U2 4

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J9 INT J GYNECOL CANCER

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PD JAN

PY 2011

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SC Oncology; Obstetrics & Gynecology

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PM 21178577

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ER

PT J

AU Zapardiel, I

Zanagnolo, V

Magrina, JF

Magtibay, PM

AF Zapardiel, Ignacio

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TI Robotic Radical Parametrectomy in Cervical Cancer

SO GYNECOLOGIC AND OBSTETRIC INVESTIGATION

LA English

DT Article

DE Radical parametrectomy; Robotic surgery; Minimally invasive surgery

AB Radical parametrectomy is indicated in cases of undiagnosed early-stage invasive cervical carcinoma discovered after simple hysterectomy performed for a presumed benign disease process. This radical surgical procedure is rarely performed for benign disease; however, there are some benign conditions such as endometriosis or ovarian remnant syndrome which may require wide excision, including parametria. Traditionally, radical parametrectomy has been performed via laparotomy; however, a minimally invasive approach via laparoscopy has been reported to be feasible and safe. Here we describe the robotic surgical approach to radical parametrectomy. Copyright (C) 2011 S. Karger AG, Basel

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NR 5

TC 8

Z9 8

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U2 2

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J9 GYNECOL OBSTET INVES

JI Gynecol.Obstet.Invest.

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WC Obstetrics & Gynecology

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ER

PT J

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Holloway, RW

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Ahmad, S

Di Silverio, E

Spinillo, A

AF Gaia, Giorgia

Holloway, Robert W.

Santoro, Luigi

Ahmad, Sarfraz

Di Silverio, Elena

Spinillo, Arsenio

TI Robotic-Assisted Hysterectomy for Endometrial Cancer Compared With

Traditional Laparoscopic and Laparotomy Approaches <i>A Systematic

Review</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Review

ID TOTAL ABDOMINAL HYSTERECTOMY; LYMPHADENECTOMY; METAANALYSIS; OUTCOMES;

OBESE

AB OBJECTIVE: To summarize comparative studies describing clinical outcomes of robotic-assisted surgeries compared with traditional laparoscopic or laparotomy techniques for the treatment of endometrial cancer.

DATA SOURCES: Using search words "robotic hysterectomy" and "endometrial cancer," 22 citations were identified from Medline and PubMed (2005 to February 2010).

METHODS OF STUDY SELECTION: We selected English language studies reporting at least 25 robotic cases compared with laparoscopic or laparotomy cases that also addressed surgical technique, complications, and perioperative outcomes. Patients underwent total hysterectomy, bilateral salpingo-oophorectomy, and lymphadenectomy.

TABULATION, INTEGRATION, AND RESULTS: Eight eligible comparative studies were identified that included 1,591 patients (robotic=589, laparoscopic=396, and laparotomy=606). Pooled means of the resected aortic lymph nodes for robotic hysterectomy and laparoscopy were 10.3 and 7.8 (P=.15),and robotic hysterectomy and laparotomy were 9.4 and 5.7 (P=.28). Pooled means of pelvic lymph nodes for robotic and laparoscopic hysterectomy were 18.5 and 17.8 (P=.95) and 18.0 compared with 14.5 (P=.11) for robotic hysterectomy compared with laparotomy. Estimated blood loss was reduced in robotic hysterectomy compared with laparotomy (P<.005) and laparoscopy (P=.001). Length of stay was shorter for both robotic and laparoscopic cases compared with laparotomy (P<.01). Operative time for robotic hysterectomy was similar to laparoscopic cases but was greater than laparotomy (P<.005). Conversion to laparotomy for laparoscopic hysterectomy was 9.9% compared with 4.9% for robotic cases (P=.06). Vascular, bowel, and bladder injuries; cuff dehiscence; and thromboembolic complications were similar for each surgical method. Transfusions for robotic hysterectomy compared with laparotomy was 1.7% and 7.2% (P=.06) and robotic hysterectomy compared were laparoscopy was 2.6% and 5.0% (P=.22).

CONCLUSION: Perioperative clinical outcomes for robotic and laparoscopic hysterectomy appear similar with the exception of less blood loss for robotic cases and longer operative times for robotic and laparoscopy cases. (Obstet Gynecol 2010;116:1422-31)

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NR 29

TC 127

Z9 132

U1 0

U2 8

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

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Wu, Kai-Yun

Wang, Chin-Jung

Yen, Chih-Feng

TI ROBOT-ASSISTED LAPAROSCOPIC STAGING SURGERY FOR ENDOMETRIAL CANCER-A

PRELIMINARY REPORT

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE endometrial cancer; laparoscopic staging surgery; robotic surgery;

surgical outcomes

ID TOTAL ABDOMINAL HYSTERECTOMY; LYMPHADENECTOMY; LAPAROTOMY; SURVIVAL;

PATIENT

AB Objective: The robotic surgical system is reported to overcome some technical difficulties in traditional laparoscopic hysterectomy. This study aimed to evaluate the feasibility and surgical outcomes of a robotic surgery program for endometrial cancer.

Materials and Methods: Patients with endometrial cancer with the intention to receive treatment using robot-assisted laparoscopic staging surgery were recruited in a university hospital from July 2007 to August 2008. All of these surgeries were performed with the da Vinci system.

Results: Six patients (mean age, 47.5 +/- 1.4 years; mean body mass index, 26.2 +/- 3.5 kg/m(2)) were enrolled and completed robot-assisted laparoscopic staging surgery. The robot docking time was 45.0 +/- 13.6 minutes and the robot-assisted operation time was 200.3 +/- 30.0 minutes. The mean estimated blood loss was 180.0 +/- 147.6 mL. The mean number of lymph nodes retrieved was 23.2 +/- 7.4. No laparoconversion and no intraoperative or postoperative complications occurred. All patients were alive and free of disease up to the date of this report, at a median follow-up of 6.5 months (range, 5-17 months).

Conclusion: Robot-assisted laparoscopic staging surgery is a feasible treatment and helps overcome the technical limitations in conventional laparoscopy for endometrial cancer. [Taiwan J Obstet Gynecol 2010;49(4):401-406]

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FU Chang Gung Memorial Hospital [CMRPG361661, CMRPG370241]

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U1 0

U2 3

PU ELSEVIER TAIWAN

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 704FI

UT WOS:000286036100002

PM 21199739

OA gold

DA 2024-01-18

ER

PT J

AU Muff, TM

Diwadkar, GB

Paraiso, MFR

AF Muff, Tyler M.

Diwadkar, Gouri B.

Paraiso, Marie Fidela R.

TI Lumbosacral osteomyelitis after robot-assisted total laparoscopic

hysterectomy and sacral colpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Osteomyelitis; Post-operative complications; Surgical procedures;

Minimally invasive; Robotics; Uterine prolapse

ID PROLAPSE

AB We report on the transabdominal resection of infected lumbosacral bone, synthetic mesh, and sinus tract following sacral colpopexy. A 45-year-old nulliparous patient who had undergone transvaginal mesh followed by robot-assisted sacral colpopexy presented with increasing back pain and foul-smelling vaginal drainage. An epidural abscess required surgical intervention, including diskectomy, sacral debridement, and mesh removal to drain the abscess and vaginal sinus tract. Recognized complications of open prolapse procedures also manifest following minimally invasive approaches. Osteomyelitis of the sacral promontory following sacral colpopexy may require gynecologic and neurosurgical management.

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NR 4

TC 32

Z9 33

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

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PY 2010

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WC Obstetrics & Gynecology; Urology & Nephrology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Urology & Nephrology

GA 690SH

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ER

PT J

AU Nezhat, C

Lewis, M

Kotikela, S

Veeraswamy, A

Saadat, L

Hajhosseini, B

Nezhat, C

AF Nezhat, Camran

Lewis, Michael

Kotikela, Sumathi

Veeraswamy, Arathi

Saadat, Lily

Hajhosseini, Babak

Nezhat, Ceana

TI Robotic versus standard laparoscopy for the treatment of endometriosis

SO FERTILITY AND STERILITY

LA English

DT Article

DE Endometriosis; robotic surgery; laparoscopy; robotic-assisted

laparoscopy; minimally invasive surgery; keyhole surgery

ID MICROSURGICAL TUBAL ANASTOMOSIS; GYNECOLOGIC ONCOLOGY; SURGERY;

EXPERIENCE; HYSTERECTOMY

AB Objective: To compare robot assisted laparoscopic platform to standard laparoscopy for the treatment of endometriosis.

Design: A retrospective cohort controlled study.

Setting: Tertiary referral center.

Patient(s): Seventy-eight reproductive aged women.

Intervention(s): Robot assisted or standard laparoscopy for the treatment of endometriosis between January 2008 and January 2009.

Main Outcome Measure(s): Operative time, estimated blood loss, hospitalization time, intraoperative and postoperative complications.

Result(s): Seventy-eight patients underwent treatment of endometriosis, 40 by robot assisted laparoscopy and 38 by standard laparoscopy. The two groups were matched for age, body mass index (BMI), stage of endometriosis, and previous abdominal surgery. Mean operative time with the robot was 191 minutes (range 135-295 minutes) compared with 159 minutes (range 85-320 minutes) during standard laparoscopy. There were no significant differences in blood loss, hospitalization, intraoperative or postoperative complications. There were no conversions to laparotomy.

Conclusion(s): Both robot assisted laparoscopic and standard laparoscopic treatment of endometriosis have excellent outcomes. The robotic technique required significantly longer surgical and anesthesia time, as well as larger trocars. (Fertil Steril (R) 2010; 94:2758-60. (C) 2010 by American Society for Reproductive Medicine.)

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TC 94

Z9 97

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U2 10

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA 684TV

UT WOS:000284573700053

PM 20537632

OA hybrid

DA 2024-01-18

ER

PT J

AU Piver, MS

Ghomi, A

AF Piver, M. Steven

Ghomi, Ali

TI The twenty-first century role of Piver-Rutledge type III radical

hysterectomy and FIGO stage IA, IB1, and IB2 cervical cancer in the era

of robotic surgery: a personal perspective

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Cervix cancer; Type III radical hysterectomy; Robotic surgey

ID PELVIC NODE DISSECTION; RADIATION-THERAPY; CARCINOMA; LYMPHADENECTOMY;

WOMEN

AB Type III radical hysterectomy reported in 1974 by Fiver, Rutledge, and Smith is considered worldwide by many as the standard surgical therapy for invasive cervical carcinoma stage IB and IIA. With the increasing number of robotic surgeries being performed for early stage cervical cancer worldwide, the purpose of the paper is to present our personal perspective of the 21st century role of Piver-Rutledge type III radical hysterectomy for stage IB cervical cancer in the era of robotic surgery using the da Vinci robot.

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NR 31

TC 11

Z9 11

U1 0

U2 1

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J9 J GYNECOL ONCOL

JI J. Gynecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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AU G枚莽men, A

Sanlikan, F

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AF Gocmen, Ahmet

Sanlikan, Fatih

Ucar, Mustafa Gazi

TI Comparison of robotic-assisted surgery outcomes with laparotomy for

endometrial cancer staging in Turkey

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic surgery; Endometrial cancer; da Vinci

ID LAPAROSCOPIC HYSTERECTOMY; EXPERIENCE; LYMPHADENECTOMY; COST

AB To compare the results of patients on whom staging was applied by robotic-assisted laparoscopic surgery and laparotomy for endometrial cancer.

The study included 10 patients who had undergone robotic-assisted endometrial staging (group 1) and 12 patients staged by open surgery (group 2). Demographical characteristics and operative outcomes of all patients were compared. Body mass index, age, previous abdominal surgeries, histopathologic characteristics, performed operative procedure, operation time, complications, hospitalization duration, estimated blood loss and number of resected lymph nodes were recorded for all patients.

Mean age of the patients in the robotic surgery group was 55.7 years (37-66) and in the laparotomy group 56.4 years (47-75). Body mass index was calculated as 32.7 kg/m(2) (24.5-40.3) in group 1 and 30.3 kg/m(2) (25.9-35.8) in group 2. Total duration of operation was 234.6 min (137-300) and 168.5 min (102-232) in group 1 and 2, respectively. Mean duration of hospitalization in group 1 was 2.8 days (2-5) and in group 2 was 8.8 days (6-13). Estimates of blood loss were 95 ml (20-210 ml) in the robotic surgery group and 255 ml (80-420) in the other group. The mean number of resected lymph nodes was 42 (13-86) and 46.5 (26-107) in the robotic-assisted surgery group and laparotomy group, respectively. None of the cases in the robotic-assisted endometrial staging group required transition to laparotomy.

Robotic surgery may be preferred over laparotomy with respect to the advantages observed in the duration of hospitalization, estimated amount of blood loss and complications. There was no significant difference between the two methods in terms of number of resected lymph nodes. Despite the limited number of patients in this study, these results are important as they represent the first data on robotic surgery in Turkey.

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NR 26

TC 12

Z9 13

U1 0

U2 1

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EI 1432-0711

J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 659SW

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ER

PT J

AU Lim, PC

Kang, E

Park, DH

AF Lim, Peter C.

Kang, Elizabeth

Park, Do Hwan

TI Learning Curve and Surgical Outcome for Robotic-Assisted Hysterectomy

with Lymphadenectomy: Case-Matched Controlled Comparison with

Laparoscopy and Laparotomy for Treatment of Endometrial Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Laparoscopy; Laparotomy; Learning curve;

Lymphadenectomy; Robotic; Staging

ID SURGERY; WOMEN

AB Study Objective: To determine the learning curve for robotic-assisted hysterectomy with lymphadenectomy for surgical treatment of endometrial cancer.

Design: An analysis of robotic-assisted hysterectomy with lymphadenectomy vs total laparoscopic hysterectomy with lymphadenectomy and laparotomy with total abdominal hysterectomy with lymphadenectomy (Canadian Task Force classification II-1).

Setting: Solo, experienced, minimally invasive gynecologic oncology practice in a tertiary hospital.

Patients: One hundred forty-eight patients including 56 patients who underwent robotic-assisted hysterectomy with bilateral pelvic and paraaortic lymph node dissection, 56 patients who underwent total laparoscopic hysterectomy with bilateral pelvic and paraaortic lymph node dissection, and 36 patients who underwent traditional total abdominal hysterectomy with bilateral pelvic and paraaortic lymph node dissection performed by the same surgeon for treatment of endometrial cancer.

Interventions: Robotic-assisted hysterectomy with bilateral lymphadenectomy, total laparoscopic hysterectomy with bilateral lymphadenectomy, and traditional total abdominal hysterectomy with bilateral lymphadenectomy were performed. Data were categorized by chronologic order of cases into groups of 20 patients each. The learning curve of the surgical procedure was estimated by measuring operative time with respect to chronologic order of each patient who had undergone the respective procedure.

Measurements and Main Results: For the 3 surgical procedures, data analyzed included mean age, body mass index, operative time, blood loss, lymph node retrieval, and complications. Mean (SD); 95% confidence interval [CI]) operative time for the 3 procedures was statistically significant: 162.5 (53) minutes (95% CI, 148.6-176.4]), 192.3 (55.5) minutes (95% CI, 177.6-207.0), and 136.9 (32.3) minutes (95% CI, 126.3-147.5), respectively. Analysis of operative time for robotic-assisted hysterectomy with bilateral lymph node dissection with respect to chronologic order of each group of 20 cases demonstrated a decrease in operative time: 183.2 (69) minutes (95% CI; 153.0-213.4) for cases 1 to 20, 152.7 (39.8) minutes (95% CI, 135.3-170.1) for cases 21 to 40, and 148.8 (36.7) minutes (95% CI, 130.8-166.8) for cases 41 to 56. For the groups with laparoscopic hysterectomy with lymphadenectomy and traditional total abdominal hysterectomy with lymphadenectomy, there was no difference in operative time with respect to chronologic group order of cases. There was a difference between the number of lymph nodes retrieved between robotic-assisted hysterectomy with bilateral lymphadenectomy (26.7 [12.8]; 95% CI, 23.3-30.1) compared with laparoscopic hysterectomy with bilateral lymphadenectomy (45.1 [20.9]; 95% CI, 39.6-50.6) and traditional total abdominal hysterectomy with lymphadenectomy (55.8 [23.4]; 95% CI, 48.2-63.4). The rate of intraoperative complications for laparoscopic hysterectomy with bilateral lymphadenectomy was 12.5% (7 of 56) compared with 0 % for robotic-assisted hysterectomy with bilateral lymphadenectomy. The rate of postoperative complications was 14.3% (8 of 56), 21.4% (12 of 56), and 19.4% (7 of 36), respectively, for the 3 groups. There was less blood loss with robotic-assisted hysterectomy with bilateral lymphadenectomy (89.3 [45.4]; 95% CI, 77.4-101.2) compared with laparoscopic hysterectomy with bilateral lymphadenectomy (209.1 [91.8]; 95% CI, 185.1-233.1) and traditional total abdominal hysterectomy with lymphadenectomy (266.0 [145.1]; 95% CI, 218.6-313.4). Duration of hospitalization was shorter in the group with robotic-assisted hysterectomy with bilateral lymphadenectomy (1.6 [0.7]; 95% CI, 1.4-1.8) compared with the groups who underwent laparoscopic hysterectomy with bilateral lymphadenectomy (2.6 [0.9]; 95% CI, 2.4-2.8) or traditional total abdominal hysterectomy with lymphadenectomy (4.9 [1.9]; 95% CI, (4.3-5.5).

Conclusion: The learning curve for robotic-assisted hysterectomy with lymph node dissection seems to be easier compared with that for laparoscopic hysterectomy with lymph node dissection for surgical management of endometrial cancer. Journal of Minimally Invasive Gynecology (2010) 17, 739-748 (C) 2010 AAGL. All rights reserved.

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U2 3

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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ER

PT J

AU Pasic, RP

Rizzo, JA

Fang, H

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Moore, M

Gunnarsson, C

AF Pasic, Resad P.

Rizzo, John A.

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Gunnarsson, Candace

TI Comparing Robot-Assisted with Conventional Laparoscopic Hysterectomy:

Impact on Cost and Clinical Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Hysterectomy; Robot assisted; Laparoscopic

ID SURGICAL OUTCOMES; UNITED-STATES; SURGERY; RATES

AB Objective: To compare clinical and economic outcomes (hospital costs) in women undergoing laparoscopic hysterectomy performed with and without robotic assistance in inpatient and outpatient settings.

Methods: Using the Premier hospital database, we identified women >18 years of age with a record of minimally invasive hysterectomy performed in 2007 to 2008. Univariable and multivariable analyses examined the association between robot-assisted hysterectomy and adverse events, hospital costs, surgery time, and length of stay.

Results: Of 36 188 patient records analyzed from 358 hospitals, 95% (n = 34 527) of laparoscopic hysterectomies were performed without robotic assistance. Inpatient and outpatient settings did not differ substantively in frequency of adverse events. For cardiac, neurologic, wound, and vascular complications, frequencies were <1% for robot and non-robot procedures. In inpatient and outpatient settings alike, use of robotic assistance was consistently associated with statistically significant, higher per-patient average hospital costs. Inpatient procedures with and without robotic assistance cost $9640 (95% confidence interval [CI] = $9621, $9659) versus $6973 (95% CI = $6959, $6987), respectively. Outpatient procedures with and without robotic assistance cost $7920 (95% CI = $7898, $7942) versus $5949 (95% CI = $5932, $5966), respectively. Inpatient surgery times were significantly longer for robot-assisted procedures, 3.22 hours (95% CI = 3.21, 3.23) compared with non-robot procedures at 2.82 hours (95% CI = 2.81, 2.83). Similarly, outpatient surgery times with robot averaged 2.99 hours (95% CI = 2.98, 3.00) versus 2.46 hours (2.45, 2.47) for non-robot procedures.

Conclusion: Our findings reveal little clinical differences in perioperative and postoperative events. This, coupled with the increased per-case hospital cost of the robot, suggests that further investigation is warranted when considering this technology for routine laparoscopic hysterectomies. Journal of Minimally Invasive Gynecology (2010) 17, 730-738 (C) 2010 AAGL. All rights reserved.

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FX This study was funded by Ethicon Endo-Surgery, Inc.

NR 15

TC 118

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U1 0

U2 6

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WC Obstetrics & Gynecology

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PT J

AU Soliman, PT

Frumovitz, M

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Greer, Marilyn J.

Sharma, Sheena

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Ramondetta, Lois M.

TI Lynaphadenectomy during endometrial cancer staging: Practice patterns

among gynecologic oncologists

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Surgery; Staging; Lymphadenectomy; Practice

patterns; Robotic surgery

ID LYMPHADENECTOMY; HYSTERECTOMY; STATISTICS

AB Objectives. Several controversies surround lymphadenectomy for endometrial cancer: surgical approach, who to stage, and the anatomic borders of the lymphadenectomy. The purpose of this study was to identify practice patterns among gynecologic oncologists when performing a lymph node evaluation during staging for endometrial cancer.

Methods. A self-administered survey was sent via email to all SGO members on 3 occasions between 2/09 and 4/09. The survey addressed surgical approach, algorithms used to determine staging, and anatomic landmarks defining lymphadenectomy.

Results. Four hundred and six members (40%) responded. Eighty-two percent completed fellowship and 14% were fellows. Thirty-four percent finished fellowship in 2000 or later. Eighty-five percent educate fellows/residents in either academic (65%) or private practice settings (20%). For a majority of cases 40% prefer laparotomy, 31% perform robotic surgery, and 29% use laparoscopy. Minimally invasive surgery was associated with university-based practice (p = 0.048). Most (53%) never/rarely use frozen section to determine whether or not to perform lymphadenectomy. A majority perform staging on all grade 2 and grade 3 cancers (66% and 90%, respectively). When performing paraaortic lymphadenectomy, 50% of respondents use the IMA as the upper border and 11% take the dissection to the renal vessels. Participants who completed fellowship in 2000 or later were less likely to go to the renal vessels (p = 0.002).

Conclusion. Current controversies in surgical staging for endometrial cancer are reflected in the practice patterns among gynecologic oncologists. At this point it is unclear if standardizing surgical practice patterns will improve outcomes for patients with endometrial cancer. (C) 2010 Elsevier Inc. All rights reserved.

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TI Outcome and Quality of Life in a Prospective Cohort of the First 100

Robotic Surgeries for Endometrial Cancer, With Focus on Elderly Patients

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Robotics; Endometrial cancer; Elderly; Quality of life; Minimal invasive

surgery

ID LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; AGE; MORBIDITY

AB Objective: Evaluation of surgical outcomes, including quality of life, in patients with endometrial cancer in the early phase of implementation of a robotic surgery program, comparing elderly with younger patients.

Methods: Prospective evaluation of perioperative data and a postoperative quality-of-life survey of the first 100 robotic surgeries for endometrial cancer performed in the Division of Gynecologic Oncology at a tertiary cancer center. Women were divided in 2 groups based on age, allowing comparison of outcomes between the elderly (>= 70 years) and younger groups (<70 years).

Results: Of the first 100 patients, 41 were elderly (mean age, 78 years). The elderly group had significantly higher number of comorbidities and more advanced disease when compared with the younger women. Despite this, elderly women had similar mean operative times (252 vs 243 minutes), mean console times (171 vs 175 minutes), and mean blood loss (83 vs 81 mL) as compared with the younger group. Conversion rate to minilaparotomy was 6%, all of which were performed at the end of surgery for the removal of enlarged uteri that could not be delivered vaginally. The overall perioperative complication rates were not statistically different between the age groups. Median hospital stay tended to be longer for the elderly women (2 vs 1 day) but was not statistically significant. The postoperative quality-of-life assessment revealed that patients young and old alike were highly satisfied with the procedure.

Conclusions: Prospective evaluation indicates that even in the early phases of implementation of a robotic surgical program for endometrial cancer, the procedure seems safe and confers an excellent quality of life for elderly patients.

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ER

PT J

AU Delotte, J

Breaud, J

Mialon, O

Verger, S

Bongain, A

AF Delotte, J.

Breaud, J.

Mialon, O.

Verger, S.

Bongain, A.

TI A role of robotic-assisted surgery to preserve female fertility?

Comments about the first paratubal cystectomy performed with the "Da

Vinci S" robotic system in a young girl

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Robot; Surgery; Paratubal cyst; Da Vinci; Laparoscopy; Fertility

ID LAPAROSCOPIC SURGERY; HYSTERECTOMY; ADHESIONS; PROLAPSE; CHILDREN

AB In the field of adnexal surgeries in children, robotic surgery seems to make easier the realization of minimal invasive surgery. It could lead to a decrease of post-surgical adherences and therefore preserve the fertility of young patients. We report the first paratubal cystectomy performed using robotic assistance on a child in order to preserve her future fertility and discuss advantages and disadvantages of this technology (C) 2010 Elsevier Masson SAS. All rights reserved

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PT J

AU Zacharopoulou, C

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Baulon, E

Garbin, O

Wattiez, A

AF Zacharopoulou, C.

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Baulon, E.

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TI Robotic gynecologic surgery: State of the art. Review of the literature

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Review

DE Gynaecology; Laparoscopy; Telesurgery; Robot; Da Vinci

ID VAGINAL VAULT PROLAPSE; ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; DA-VINCI

SYSTEM; RADICAL PROSTATECTOMY; ABDOMINAL MYOMECTOMY; TUBAL ANASTOMOSIS;

LEARNING-CURVE; SURGICAL OUTCOMES; HYSTERECTOMY; EXPERIENCE

AB Tele-operating robots, that have been developing for 10 years, are a revolution in the field of minimally invasive gynaecology. Indeed, by restoring three-dimensional view and the surgeon's hand freedom, the robot diminishes the technical difficulties of laparoscopy. The robot brings the surgeon back to open-air movements while preserving the minimally invasive aspect of the procedure and should, therefore, allow an easier transition for laparotomic surgeons to minimally invasive techniques. However, some inconvenients remain: the robot's size, its time-consuming installation, the lack of force feedback and the cost of robotic surgery. To this day, the robot was used in gynaecology for tubal reversal, myomectomies, hysterectomies, promontofixations and the treatment of gynaecological cancers, but the benefits compared to laparoscopic techniques have not yet been demonstrated and will require large scale prospective studies. These benefits will also have to be weighed up to the cost and organizational constraints. (C) 2010 Elsevier Masson SAS. All rights reserved.

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AU Zapardiel, I

Zanagnolo, V

Peiretti, M

Maggioni, A

Bocciolone, L

AF Zapardiel, Ignacio

Zanagnolo, Vanna

Peiretti, Michele

Maggioni, Angelo

Bocciolone, Lucca

TI Avoiding Vaginal Cuff Dehiscence After Robotic Oncological Surgery

<i>Reliable Suturing Technique</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Vaginal cuff dehiscence; Robotic surgery; Oncological surgery; Robotic

hysterectomy

AB Introduction: The rate of vaginal cuff dehiscence seems to have been shown to increase after both robotic and laparoscopic surgeries compared with that after the open approach. The aim of this study was to describe the vaginal cuff dehiscence rate with a novel vaginal suturing technique performed by a robotic approach in the treatment of oncological conditions.

Methods: Medical records of all robotic procedures from January 1, 2009, until August 10, 2009, performed at the European Institute of Oncology of Milan were reviewed. Forty vaginal closures were carried out with a novel technique after extrafascial or radical hysterectomy for an oncological diagnosis. Outcomes were compared with those of 41 parallel vaginal closures performed with other techniques.

Results: Among the 40 patients treated with the novel technique, an endometrial pathological feature was observed in 15 (37.5%); ovarian disease, 13 (32.5%); and cervical malignancies, 12 (30%). No vaginal cuff dehiscences were observed after a median follow-up time of 126 days (range, 36-248 days). On the other group, an endometrial pathological feature was observed in 12 patients (29.6%); ovarian disease, 6 (14.6%); cervical malignancies, 22 (53.6%); and tubal cancer, 1 (2.2%). Three vaginal cuff dehiscences were observed after a median follow-up time of 130 days (range, 39-261 days).

Conclusions: The results of the study suggest that vaginal closure technique may decrease the vaginal cuff dehiscence rate for robotic surgery, although longer follow-up time is needed, and larger studies should be carried out, encouraging gynecologic surgeons to perform it.

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AU Barnett, JC

Judd, JP

Wu, JM

Scales, CD

Myers, ER

Havrilesky, LJ

AF Barnett, Jason C.

Judd, John P.

Wu, Jennifer M.

Scales, Charles D., Jr.

Myers, Evan R.

Havrilesky, Laura J.

TI Cost Comparison Among Robotic, Laparoscopic, and Open Hysterectomy for

Endometrial Cancer

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 41st Annual Meeting on Women's Cancer of the

Society-of-Gynecologic-Oncologists

CY MAR 14-17, 2010

CL San Francisco, CA

SP Soc Gynecol Oncologists

ID ASSISTED VAGINAL HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; OVARIAN-CANCER;

LYMPHADENECTOMY; CHEMOTHERAPY; OBESE; WOMEN

AB OBJECTIVE: To use decision modeling to compare the costs associated with robotic, laparoscopic, and open hysterectomy for the treatment of endometrial cancer.

METHODS: Three separate models were used, each with sensitivity analysis: 1) a societal perspective model, which included inpatient hospital costs, robotic expenses, and lost wages and caregiver costs; 2) a hospital perspective plus robot costs model, which was identical to the societal perspective model but excluded lost wages and caregiver costs; and 3) a hospital perspective without robot costs model, which was identical to the hospital perspective plus robot costs model except that it excluded initial cost of the robot.

RESULTS: The societal perspective model predicted laparoscopy ($10,128) as the least expensive approach followed by robotic and ($11,476) and open hysterectomy ($12,847). Societal perspective model sensitivity analyses predicted robotic hysterectomy to be least expensive when robotic disposable equipment cost less than $1,046 per case (baseline cost $2,394). In the hospital perspective plus robot costs model, laparoscopy was least expensive ($6,581) followed by open ($7,009) and robotic hysterectomy ($8,770); however, if hospital stay after open surgery was less than 2.9 days, open hysterectomy was least expensive. In the hospital perspective without robot costs model, laparoscopy remained least expensive, but robotic surgery became least expensive if the cost of robotic disposable equipment was reduced to less than $1,496 per case.

CONCLUSION: Laparoscopy is the least expensive surgical approach for the treatment of endometrial cancer. Robotic is less costly than abdominal hysterectomy when the societal costs associated with recovery time are accounted for and is most economically attractive if disposable equipment costs can be minimized. (Obstet Gynecol 2010;116:685-93)

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PT J

AU Matthews, CA

Schubert, CM

Woodward, AP

Gill, EJ

AF Matthews, Catherine A.

Schubert, Christine M.

Woodward, Ashley P.

Gill, Edward J.

TI Variance in Abdominal Wall Anatomy and Port Placement in Women

Undergoing Robotic Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Abdominal wall anatomy; Ethnic differences; Port placement; Robotic

surgery

ID AORTIC BIFURCATION; RACIAL-DIFFERENCES; PELVIC FLOOR; UMBILICUS

AB Study Objectives: To estimate whether variability in the size and ratios of the lower and upper abdomen exist in women undergoing robotic gynecologic surgery and whether demographic variables are significantly associated, and to determine the association between abdominal wall dimensions and supraumbilical robotic port placement.

Design: Prospective cohort study (Canadian Task Force classification II).

Setting: University teaching hospital.

Patients: Seventy-eight women undergoing robotic surgery between May 2008 and March 2009.

Intervention: Measurements from the symphysis pubis to the umbilicus (lower abdomen), umbilicus to the xyphoid process (upper abdomen), and distance between the anterior superior iliac crests were obtained at surgery. A multiple linear regression model was created to determine the relationships between abdominal wall measurements, demographic variables, and need for supraumbilical robotic port placement.

Measurements and Main Results: Fifty-six white and 22 black women were enrolled. Mean lower abdominal length was significantly affected by body mass index (BMI) (p <.001) and race (p = .006), with white women having longer measurements (17.1 cm vs 15 cm). Mean lower abdominal width was independent of age (p = .95) or race (p = .98), but was significantly correlated with BMI (p <.001). Mean upper abdominal length correlated with BMI (p <.001) and age (p = .03) but not race (p = .13). Ratios of bottom to top were significantly affected by race (p = .002) and age (p = .008) but not BMI (p = .07). Adjustments to port placement above the umbilicus were made in 44 of the 74 women (59.5%). Those who required supraumbilical port placement had a significantly shorter mean (SD) distance between the symphysis pubis and the umbilicus (14.99 [1.36] vs 18.55 [2.21]; p <.001).

Conclusions: Significant variability in abdominal wall anatomy exists in women undergoing robotic gynecologic surgery, and the need for supraumbilical robotic port placement is common. Journal of Minimally Invasive Gynecology (2010) 17, 583-586 (C) 2010 AAGL. All rights reserved.

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AU Suh, DH

Kim, JW

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Chia, Yin Nin

Wilailak, Sarikapan

Park, Sang Yoon

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Kamura, Toshiharu

Kang, Soon-Beom

TI Asian society of gynecologic oncology workshop 2010

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE ASGO; Workshop; Cervical caner; Endometrial cancer; Ovarian cancer;

Clinical trials

ID EPITHELIAL OVARIAN-CANCER; HUMAN-PAPILLOMAVIRUS HPV; RADICAL ABDOMINAL

TRACHELECTOMY; RANDOMIZED CONTROLLED-TRIAL; ADVANCED CERVICAL-CANCER;

ENDOMETRIAL CANCER; VISUAL INSPECTION; NEOADJUVANT CHEMOTHERAPY;

ANATOMIC IDENTIFICATION; RADIATION-THERAPY

AB This workshop was held on July 31-August 1, 2010 and was organized to promote the academic environment and to enhance the communication among Asian countries prior to the 2nd biennial meeting of Australian Society of Gynaecologic Oncologists (ASGO), which will be held on November 3-5, 2011. We summarized the whole contents presented at the workshop. Regarding cervical cancer screening in Asia, particularly in low resource settings, and an update on human papillomavirus (HPV) vaccination was described for prevention and radical surgery overview, fertility sparing and less radical surgery, nerve sparing radical surgery and primary chemoradiotherapy in locally advanced cervical cancer, were discussed for management. As to surgical techniques, nerve sparing radical hysterectomy, optimal staging in early ovarian cancer, laparoscopic radical hysterectomy, one-port surgery and robotic surgery were introduced. After three topics of endometrial cancer, laparoscopic surgery versus open surgery, role of lymphadenectomy and fertility sparing treatment, there was a special additional time for clinical trials in Asia. Finally, chemotherapy including neo-adjuvant chemotherapy, optimal surgical management, and the basis of targeted therapy in ovarian cancer were presented.

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PT J

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Escobar, PF

Gunderson, C

AF Fader, Amanda Nickles

Cohen, Sarah

Escobar, Pedro F.

Gunderson, Camille

TI Laparoendoscopic single-site surgery in gynecology

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE conventional laparoscopy; laparoendoscopic single-site surgery; single

incision laparoscopic surgery; single port

ID PORT ACCESS; EXPERIENCE

AB Purpose of review

To review the contemporary literature on laparoendoscopic single-site surgery (LESS) advances in gynecology.

Recent findings

Minimally invasive surgery has become a standard of care for the treatment of many benign and malignant gynecologic conditions. Both conventional laparoscopy and robotic assisted surgery have impacted the entire spectrum of gynecologic surgery. Ongoing efforts to improve upon the morbidity and cosmetic sequelae of laparoscopic surgery have led to minimization of size and number of ports required for these procedures. LESS surgery is a recently coined surgical term used to describe various techniques that aim at performing laparoscopic surgery through a single, small skin incision concealed within the umbilicus. LESS surgery is not a new endeavor but recent developments in surgical technology and techniques have resulted in an exponential increase in utilization of LESS across many surgical subspecialties. Recently published outcome data demonstrate feasibility, safety and reproducibility for LESS in gynecology. The contemporary LESS literature, gamut of gynecologic procedures and limitations of current technology will be reviewed in this article.

Summary

LESS represents the latest innovation in minimally invasive surgery but comparative data and prospective trials are required to determine the clinical impact of LESS in treatment of gynecologic conditions.

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JI Curr. Opin. Obstet. Gynecol.

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ER

PT J

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Sanlikan, F

U莽ar, MG

AF Gocmen, Ahmet

Sanlikan, Fatih

Ucar, Mustafa Gazi

TI Turkey's experience of robotic-assisted laparoscopic hysterectomy: a

series of 25 consecutive cases

SO ARCHIVES OF GYNECOLOGY AND OBSTETRICS

LA English

DT Article

DE Robotic-assisted hysterectomy; Da Vinci Surgical System

ID SURGERY; LYMPHADENECTOMY; OUTCOMES; SYSTEM

AB To present the outcomes of the first 25 robotic-assisted hysterectomies from Turkey.

A total of 25 patients who underwent robotic-assisted hysterectomy (RAH) for benign conditions were included in the study. Patients' demographics, surgical procedures, operative and postoperative complications, hospital stay, conversion to laparotomy, time data including all operative times, uterus weight and estimated blood loss (EBL) were recorded. All hysterectomies were American Association of Gynecologic Laparoscopists type IVE.

All hysterectomies were completed robotically with no conversion to laparotomy. The mean and range of the operating time were 104.1 and 47-176 min, respectively. The mean hysterectomy time was 40.5 min (range 14-77). The mean cuff incision time and cuff suturation time were 6.8 min (range 2-18) and 16.4 min (range 7-40), respectively. The mean set-up time was 30.4 min (range 17-41 min). The mean docking time was 4.3 min (range 2-9 min). The mean console time was 74.2 min (range 30-137). The mean and range of the anesthesia time were 133.8 min and 75-210 min, respectively. The averages of EBL and uterus weight were calculated as 38.2 cc and 221.9 g, respectively. Three complications occurred: one postoperative paralytic ileus and the others were peroperative vaginal cuff lacerations during the removal of the specimen through the vagina.

Robotic-assisted hysterectomy (RAH) is feasible and safe for women with benign uterine pathologies, although it has limitations that may be overcome in the future.

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NR 30

TC 9

Z9 11

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U2 0

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J9 ARCH GYNECOL OBSTET

JI Arch. Gynecol. Obstet.

PD AUG

PY 2010

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PG 9

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 620LN

UT WOS:000279501500008

PM 19838722

DA 2024-01-18

ER

PT J

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Kim, YH

Lind, LR

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TI Sacral Osteomyelitis After Robotically Assisted Laparoscopic Sacral

Colpopexy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ABSCESS; ANCHORS

AB BACKGROUND: Osteomyelitis associated with using synthetic mesh for laparoscopic sacral colpopexy is rare.

CASE: We present a patient who developed Staphylococcus sacral osteomyelitis after sacral colpopexy with synthetic mesh and titanium tack fixation to the sacral promontory in the absence of mesh erosion or fistula formation. The patient presented with low back pain 6 weeks postoperatively. Magnetic resonance imaging, bone aspirate, and culture confirmed sacral osteomyelitis and discitis 10 weeks after surgery. The patient underwent 8 weeks of outpatient antibiotic treatment. Six months after surgery, serial laboratory values have demonstrated excellent response to antibiotic treatment, and the patient has clinically improved without the need for mesh removal.

CONCLUSION: We recommend a high index of suspicion for osteomyelitis in patients who present with back pain after sacral colpopexy. Osteomyelitis can occur as a complication of laparoscopic, robotic sacral colpopexy using mesh in the absence of abscess or fistula formation. (Obstet Gynecol 2010;116:513-5)

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NR 8

TC 33

Z9 34

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JI Obstet. Gynecol.

PD AUG

PY 2010

VL 116

IS 2

BP 513

EP 515

DI 10.1097/AOG.0b013e3181e10ea6

PN 2

PG 3

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 630SU

UT WOS:000280295200016

PM 20664437

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ER

PT J

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Magtibay, Paul M.

TI Robotic radical parametrectomy in benign disease: report of two cases

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Robotic surgery; radical parametrectomy; benign diseases

ID CANCER; LYMPHADENECTOMY; CARCINOMA

AB Radical parametrectomy is rarely performed for benign diseases given the considerable risk of complications, however, some benign conditions require wide excision of the pelvic tissue, including parametria. We report on two cases of robotic radical parametrectomy performed for benign diseases. An electronic search was also carried out in PubMed database online to review this subject. Robotic surgery for radical parametrectomy seems safe and feasible and may be the preferred approach in terms of both lower complication rates, and shorter hospital stay compared to laparotomy, with the same results in terms of improvement of symptoms of chronic pelvic pain, although further studies are needed to confirm this observation.

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NR 11

TC 4

Z9 4

U1 0

U2 1

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

PD AUG

PY 2010

VL 89

IS 8

BP 1108

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DI 10.3109/00016349.2010.481016

PG 3

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

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Chernick, M

Dunton, CJ

AF Holtz, David O.

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Chernick, Michael

Dunton, Charles J.

TI Endometrial Cancer Surgery Costs: Robot vs Laparoscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 36th Annual Meeting of the

American-Association-of-Gynecologic-Laparoscopists

CY NOV 13-17, 2007

CL Washington, DC

SP Amer Assoc Gynecol Laparoscopists

DE Cost; Endometrial cancer; Hysterectomy; Laparoscopy; Robotic surgery

ID ABDOMINAL HYSTERECTOMY; ALTERNATIVE TECHNIQUES; VAGINAL HYSTERECTOMY;

LAPAROTOMY; OUTCOMES; CHARGES

AB Study Objective: To compare surgical costs for endometrial cancer staging between robotic-assisted and traditional laparoscopic methods.

Design: Retrospective chart review from November 2005 to July 2006 (Canadian Task Force classification II-3).

Setting: Non-university-affiliated teaching hospital.

Patients: Thirty-three women with diagnosed endometrial cancer undergoing hysterectomy, bilateral salpingo-oophorectomy, and pelvic and paraaortic lymph node resection.

Interventions: Patients underwent either robotic or traditional laparoscopic surgery without randomization.

Measurements and Main Results: Hospital cost data were obtained for operating room time, instrument use, and disposable items from hospital billing records and provided by the finance department. Separate overall hospital stay costs were also obtained. Mean operative costs were higher for robotic procedures ($3323 vs $2029; p < .001), due in part to longer operating room time ($1549 vs $1335; p = .03). The more significant cost difference was due to disposable instrumentation ($1755 vs $672; p < .001). Total hospital costs were also higher for robotic-assisted procedures ($5084 vs $ 3615; p = .002).

Conclusion: Robotic surgery costs were significantly higher than traditional laparoscopy costs for staging of endometrial cancer in this small cohort of patients. Journal of Minimally Invasive Gynecology (2010) 17, 500-503 (c) 2010 AAGL. All rights reserved.

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TC 48

Z9 53

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J9 J MINIM INVAS GYN

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PD JUL-AUG

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BP 500

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DI 10.1016/j.jmig.2010.03.012

PG 4

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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TI Use of Anti-Skid Material and Patient-Positioning To Prevent Patient

Shifting during Robotic-Assisted Gynecologic Procedures

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Antiskid material; Laparoscopy; Robotics; Shoulder braces

ID SHOULDER RESTRAINTS; NERVE INJURIES; ARM ABDUCTION; NEUROPATHIES;

SURGERY

AB Study Objective: To estimate patient shifting with the current practice of use of an antiskid material and patient positioning during robotic procedures in gynecology.

Design: Pilot observational study (Canadian Task Force classification).

Setting: Tertiary referral center.

Patients: Twenty-two women undergoing robotic-assisted gynecologic procedures.

Intervention: Antiskid material (egg-crate pink foam) was placed beneath patients and patient positioning was used during robotic-assisted procedures.

Measurements and Main Results: Patient position was marked before and after surgery. Measurements of shift distance before and after surgery were determined for each patient. Median (range) shift distance was 1.3 (0-7.5) cm. There was no significant association between shift in position and either body mass index or duration of the Trendelenburg position. No shoulder neuropathic injuries were observed during the study.

Conclusion: Minimal patient shifting is observed with the use of an antiskid material and patient positioning described, without the use of shoulder braces and straps. Journal of Minimally Invasive Gynecology (2010) 17, 504-507 (c) 2010 AAGL. All rights reserved.

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TC 35

Z9 40

U1 0

U2 5

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J9 J MINIM INVAS GYN

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PG 4

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PM 20471916

DA 2024-01-18

ER

PT J

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TI Robot-Assisted Laparoscopic Presacral Neurectomy: Feasibility,

Techniques, and Operative Outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Central pelvic pain; da Vinci; Dysmenorrhea; Dyspareunia; Endometriosis;

Presacral neurectomy; Robot

ID PELVIC PAIN; MIDLINE DYSMENORRHEA; ENDOMETRIOSIS; HYSTERECTOMY;

MANAGEMENT; EFFICACY; NERVE

AB Study Objectives: To report the feasibility and description of robot-assisted presacral neurectomy (RPSN) and to compare outcomes with laparoscopic presacral neurectomy (LPSN).

Design: Prospective case series (Canadian Task Force classification III).

Setting: Tertiary care center.

Patients: Eighteen patients with central pelvic pain who underwent RPSN and 12 patients with central pelvic pain who underwent conventional LPSN in a metropolitan hospital between July 1, 2006, and April 30, 2008.

Interventions: The da Vinci Surgical System (Intuitive Surgical, Inc., Sunnyvale, CA) was used for the robotic portion of the procedure. Availability of the robot was the sole determining factor for the procedure chosen. Bipolar, monopolar, and ultrasonic instruments were used for conventional laparoscopy. All patients underwent several additional procedures performed laparoscopically including adhesiolysis, treatment of endometriosis, appendectomy, enterolysis, and salpingo-ovariolysis.

Measurements and Main Results: All presacral neurectomies in both groups were successfully completed by excising the hypogastric nervous plexus within the interiliac triangle. Presence of nerve ganglion and fibers was confirmed at pathologic analysis in all cases. Mean duration of presacral neurectomy, from incision of the posterior peritoneum at the sacral promontory to complete excision of the superior hypogastric nerve plexus at the interiliac triangle (Cotte triangle) was less than 10 minutes in both groups. Mean estimated blood loss was less than 30 mL for the entire surgical procedure (29.4 mL for RPSN, and 28.8 mL for LPSN). Median (range) patient age was 25 (19-44) years in the RPSN group, and 26(18-36) years in the LPSN group; gravidity was 0, and parity was 0. All patients had central pelvic pain, the primary indication for presacral neurectomy. Concomitant indications for surgery included ovarian cysts, endometriosis, and adhesions. There were no intraoperative or postoperative complications. At analysis, follow-up ranged from 13 to 36 months. No short- or long-term complications related to the surgical procedure were reported. All patients reported subjective improvement of pelvic pain.

Conclusion: Robot-assisted laparoscopic presacral neurectomy is feasible and safe, without added risk of short- or long-term complications. It compares favorably to the conventional laparoscopic approach of presacral neurectomy. The surgical robot provides a better angle and 3-dimensional visualization of the operating field, similar to laparotomy, and supplemented with magnification. This combined with elimination of hand tremor enables better surgeon control. Journal of Minimally Invasive Gynecology (2010) 17, 508-512 (c) 2010 AAGL. All rights reserved.

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TC 9

Z9 10

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U2 3

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PG 5

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WE Science Citation Index Expanded (SCI-EXPANDED)

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DA 2024-01-18

ER

PT J

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Aseff, JN

Iglesia, CB

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Aseff, John N.

Iglesia, Cheryl B.

TI Brachial Plexus Injury after Laparoscopic and Robotic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Brachial plexus injury; Laparoscopy; Robotic surgery; Trendelenburg

position

ID DONOR NEPHRECTOMY; NERVE; KIDNEY; PALSY

AB The objective of this article was to review the literature regarding brachial plexus injury (BPI) in laparoscopic and robotic surgery. BPI complicates gynecologic laparoscopic surgery with an estimated incidence of 0.16%. Nevertheless, as the numbers of advanced laparoscopic and robotic procedures increase, the anticipated risk of this complication may rise as well. Robotic surgery often requires steeper Trendelenburg positioning and longer operative times when compared with traditional laparoscopic surgery. In this article we review the anatomy, pathophysiology, diagnosis, and treatment of position-related BPI in the context of laparoscopic and robotic gynecologic surgery. We suggest a multidisciplinary approach to the diagnosis and treatment of BPI. Recommendations for prevention of this complication are also provided. Journal of Minimally Invasive Gynecology (2010) 17, 414-420 (c) 2010 AAGL. All rights reserved.

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TC 51

Z9 53

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U2 6

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PG 7

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ER

PT J

AU Sutton, C

AF Sutton, Chris

TI Past, Present, and Future of Hysterectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Alternatives to hysterectomy; Complications of laparoscopic

hysterectomy; Day-case surgery; Endometrial ablation; History of

hysterectomy; Hysterectomy; Laparoscopic subtotal/total hysterectomy;

Laparoscopic surgery; Levonorgestrel intrauterine system; Oophorectomy

at hysterectomy; Quality of life after hysterectomy; Robotic

hysterectomy; Subtotal hysterectomy; Total abdominal hysterectomy

ID QUALITY-OF-LIFE; SUPRAVAGINAL UTERINE AMPUTATION; TOTAL LAPAROSCOPIC

HYSTERECTOMY; RANDOMIZED CONTROLLED-TRIAL; TOTAL ABDOMINAL HYSTERECTOMY;

ENDOMETRIAL ABLATION; SUPRACERVICAL HYSTERECTOMY; COMPARING

HYSTERECTOMY; SUBTOTAL HYSTERECTOMY; OVARIAN CONSERVATION

AB Until the late 1930s, the standard type of abdominal hysterectomy was subtotal, leaving the cervix behind to decrease the risk of peritonitis with its attendant high mortality. With the discovery of antibiotics, careful attention to antisepsis, and other medical and surgical advances, this method was gradually replaced by total abdominal hysterectomy in the United States and the United Kingdom, although the subtotal approach still remained popular, in particular in Scandinavian countries. With the advent of laparoscopic hysterectomy, many surgeons, wanting a simpler approach and for a variety of other reasons, have returned to performance of subtotal hysterectomy. The objectives of the present article is to review the development of the operation from a historical perspective, and to attempt to answer some of the dilemmas posed when choosing between a total and subtotal procedure, using results from evidence-based research when possible. Journal of Minimally Invasive Gynecology (2010) 17, 421-435 (c) 2010 AAGL. All rights reserved.

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TC 28

Z9 33

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U2 6

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JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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PM 20621006

DA 2024-01-18

ER

PT J

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Randall, TC

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Eun, Daniel

Lee, David

Randall, Thomas C.

TI Robotic-assisted laparoscopic exenteration in recurrent cervical cancer

Robotics improved the surgical experience for 2 women with recurrent

cervical cancer

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cervical cancer; exenteration; robotic-assisted laparoscopy

AB Pelvic exenteration can be used to cure women with a central pelvic recurrence or persistence of gynecologic malignancy after initial definitive therapy. Refinements in patient selection, operative techniques, and surgical instrumentation have significantly improved outcomes over the past 60 years, but the procedure is still associated with significant mortality, morbidity, and recovery time. New technologies have made it possible to approach radical gynecologic surgeries in a minimally invasive fashion. We present 2 patients successfully treated with robotic-assisted anterior pelvic exenteration for treatment of persistent or recurrent cervical cancer after definitive radiotherapy.

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TC 25

Z9 26

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U2 1

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

PD JUN

PY 2010

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PG 1

WC Obstetrics & Gynecology

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PM 20510970

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ER

PT J

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Masback, Anna

Epstein, Elisabeth

Saldeen, Pia

TI Histopathology indicates lymphatic spread of a pelvic retroperitoneal

ectopic pregnancy removed by robot-assisted laparoscopy with temporary

occlusion of the blood supply

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Robot; retroperitoneal ectopic pregnancy; lymphatic spread

ID PREVIOUS BILATERAL SALPINGECTOMY; METHOTREXATE TREATMENT; FERTILIZATION;

PATIENT

AB Retroperitoneal ectopic pregnancies are extremely rare and a diagnostic and therapeutic challenge as an early diagnosis is difficult and all treatments entail a risk for severe bleeding. We present a case of a live completely retroperitoneal ectopic pregnancy in the right obturator fossa. Following 3D color Doppler vaginal ultrasonography to evaluate the relation to larger blood vessels the pregnancy was completely removed by robot-assisted laparoscopic surgery. The hypogastric artery was temporarily occluded by removable vessel clips. Time for surgery was 126 minutes, no bleeding occurred. The postoperative course was uneventful and s-beta hCG normalized in five weeks. Histopathology of the intact specimen showed trophoblast surrounded by lymphatic tissue. We believe robot-assisted laparoscopic surgery is a feasible and safe technique for surgery of retroperitoneal ectopic pregnancies with similar or other locations allowing occlusion of the main supplying artery. Lymphatic spread may explain retroperitoneal ectopic pregnancies.

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TC 15

Z9 22

U1 0

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

PD JUN

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PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 663LS

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OA Bronze

DA 2024-01-18

ER

PT J

AU Agdi, M

Tulandi, T

AF Agdi, Mohammed

Tulandi, Togas

TI Minimally Invasive Approach for Myomectomy

SO SEMINARS IN REPRODUCTIVE MEDICINE

LA English

DT Article

DE Laparoscopy; laparoscopic myomectomy; hysteroscopy; hysteroscopic

myomectomy; robotic-assisted myomectomy

ID PROGESTERONE-RECEPTOR MODULATORS; FOCUSED ULTRASOUND SURGERY; ASSISTED

LAPAROSCOPIC MYOMECTOMY; ABDOMINAL MYOMECTOMY; UTERINE LEIOMYOMATA;

HYSTEROSCOPIC MYOMECTOMY; 2ND-LOOK LAPAROSCOPY; RANDOMIZED-TRIAL;

FOLLOW-UP; FIBROIDS

AB Uterine fibroids are the most common benign tumor of the uterus in women of reproductive age. However, most of them are asymptomatic and do not require any treatment. Menorrhagia and pelvic pain are the most usual symptoms, and some women may present with infertility or pregnancy-related complications. In those with abnormal uterine bleeding, one should exclude other causes of abnormal vaginal bleeding including endometrial cancer. Diagnosis of uterine fibroid is established by pelvic ultrasonography with or without saline infusion hysterosonography. Management options depend on the patient's fertility potential and desire for future pregnancy. Submucous myoma should be treated by a hysteroscopic approach. Intramural and subserous myomas in women who opt for nonsurgical treatment could be treated with uterine artery embolization (UAE), high-intensity focused ultrasound (HIFU), or medical treatment such as selective gonadotropin-releasing hormone agonists, progesterone receptor modulators, or aromatase inhibitors. All interventions aside from hysterectomy provide temporary relief, although myomectomy, UAE, and HIFU provides more durable symptom relief relative to current medical management. Patients wishing to preserve their fertility are best treated by myomectomy, which can be done by laparoscopy. A laparoscopic approach is more advantageous than laparotomy, but laparoscopic suturing is more demanding. This can be overcome by robotic-assisted laparoscopic myomectomy.

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U2 8

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA 587FW

UT WOS:000276976400007

PM 20414845

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ER

PT J

AU Ascher-Walsh, CJ

Capes, TL

AF Ascher-Walsh, Charles J.

Capes, Tracy L.

TI Robot-assisted Laparoscopic Myomectomy Is an Improvement Over Laparotomy

in Women with a Limited Number of Myomas

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 35th Annual Meeting of the Society-of-Gynecologic-Surgeons

CY MAR 30-APR 01, 2009

CL New Orleans, LA

SP Soc Gynecol Surg

DE Robotic assisted laparoscopic myomectomy; Myoma; Minimally invasive

surgery

AB Study Objective: To compare surgical and immediate postoperative results of robot-assisted laparoscopic myomectomy vs myomectomy via laparotomy in patients with 3 myomas or fewer.

Design: Case-control (Canadian Task Force classification II-2).

Setting: University hospital.

Patients: Seventy-five women who had undergone robotic-assisted laparoscopic myomectomy were compared with patients who had undergone myomectomy via laparotomy.

Interventions: Medical records were reviewed for surgical and postoperative variables. Both groups had 3 myomas or fewer confirmed at preoperative magnetic resonance imaging or final pathology report.

Measurements and Main Results: No significant differences were observed between patients insofar as preoperative demographic data. There was a significant increase in mean duration of surgery for robotic-assisted myomectomy. There was a significant decrease in blood loss, change in hematocrit concentration on postoperative day I, length of stay, number of days to regular diet, and febrile morbidity in robotic-assisted myomectomies. There were no significant differences in operative or postoperative complications.

Conclusion: Although robotic-assisted myomectomy took substantially longer, most of the other variables improved in comparison with similar procedures performed via laparotomy. Journal of Minimally Invasive Gynecology (2010) 17, 306-310 (C) 2010 AAGL. All rights reserved.

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NR 11

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Z9 58

U1 0

U2 1

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 597US

UT WOS:000277788200007

PM 20303834

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ER

PT J

AU Cardenas-Goicoechea, J

Adams, S

Bhat, SB

Randall, TC

AF Cardenas-Goicoechea, Joel

Adams, Sarah

Bhat, Suneel B.

Randall, Thomas C.

TI Surgical outcomes of robotic-assisted surgical staging for endometrial

cancer are equivalent to traditional laparoscopic staging at a minimally

invasive surgical center

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Laparoscopy; Uterine cancer; Surgical staging

ID HYSTERECTOMY; SURGERY; LYMPHADENECTOMY

AB Objective. To compare peri- and post-operative complications and outcomes of robotic-assisted surgical staging with traditional laparoscopic surgical staging for women with endometrial cancer.

Methods. A retrospective chart review of cases of women undergoing minimally invasive total hysterectomy and pelvic and para-aortic lymphadenectomy by a robotic-assisted approach or traditional laparoscopic approach was conducted. Major intraoperative complications, including vascular injury, enterotomy, cystotomy, or conversion to laparotomy, were measured. Secondary outcomes including operative time, blood loss, transfusion rate, number of lymph nodes retrieved, and the length of hospitalization were also measured.

Results. 275 cases were identified-102 patients with robotic-assisted staging and 173 patients with traditional laparoscopic staging. There was no significant difference in the rate of major complications between groups (p = 0.13). The mean operative time was longer in cases of robotic-assisted staging (237 min vs. 178 min, p < 0.0001): however, blood loss was significantly lower (109 ml vs. 187 ml, p < 0.0001). The mean number of lymph nodes retrieved were similar between groups (p = 0.32). There were no significant differences in the time to discharge, re-admission, or re-operation rates between the two groups.

Conclusion. Robotic-assisted surgery is an acceptable alternative to laparoscopy for minimally invasive staging of endometrial cancer. In addition to the improved ease of operation, visualization, and range of motion of the robotic instruments, robotic surgery results in a lower mean blood loss, although longer operative time. More data are needed to determine if the rates of urinary tract injuries and other surgical complications can be reduced with the use of robotic surgery. (C) 2010 Elsevier Inc. All rights reserved.

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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PT J

AU Matthews, CA

AF Matthews, Catherine A.

TI Applications of Robotic Surgery in Gynecology

SO JOURNAL OF WOMENS HEALTH

LA English

DT Article

ID ASSISTED LAPAROSCOPIC MYOMECTOMY; VAGINAL VAULT PROLAPSE; ABDOMINAL

MYOMECTOMY; SURGICAL OUTCOMES; HYSTERECTOMY; SACROCOLPOPEXY; EXPERIENCE;

EVALUATE

AB This article reviews the applications of robotic surgery in gynecology and presents a summary of the early studies that have been performed regarding its use for hysterectomy, myomectomy, reproductive surgery, pelvic floor reconstruction, and gynecological cancer staging. Despite significant advances in conventional laparoscopic techniques, the majority of gynecological procedures are still performed through major abdominal incisions, which are associated with higher surgical morbidity. This article addresses the potential that robotic surgery may have in converting more gynecological operations to a minimally invasive approach.

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NR 26

TC 9

Z9 9

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U2 1

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J9 J WOMENS HEALTH

JI J. Womens Health

PD MAY

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WC Public, Environmental & Occupational Health; Medicine, General &

Internal; Obstetrics & Gynecology; Women's Studies

WE Science Citation Index Expanded (SCI-EXPANDED); Social Science Citation Index (SSCI)

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Medicine; Obstetrics & Gynecology; Women's Studies

GA 595HW

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ER

PT J

AU Reynisson, P

Shokri, E

Bendahl, PO

Persson, J

AF Reynisson, Petur

Shokri, Ebi

Bendahl, Par-Ola

Persson, Jan

TI Tensile Strength of Surgical Knots Performed with the da Vinci Surgical

Robot

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Da Vinci System; Knot; Robot; Tensile strength

ID MECHANICAL PERFORMANCE; CONVENTIONAL KNOTS; SURGERY; SECURITY; SUTURES

AB The objective of this study was to estimate the tensile strength of surgical knots made using the da Vinci robot. Four different types of flat square knots (strand-to-strand 4 throw, strand-to-strand 6 throw, loop-to-strand 4 throw, and loop-to-strand 6 throw) were made using the da Vinci-S system by 4 different surgeons, all experienced with the system. For the knots, we used braided polyglactin 910 (Vicryl 2-0). Hand-tied, flat, square, 4-throw strand-to-strand knots were used as reference. The tensile strength was measured for all knots using the Instron 5566 system calibrated to an accuracy of +/-.5% at 4 to 10 newtons (N) and +/-.4% at greater than ION. Compared with reference knots, only 1 of 4 surgeons could make knots as equally strong with the robot. For all surgeons, strand-to-strand knots had a significantly higher tensile strength than loop-to-strand knots when made with the robot. Adding 2 throws to the knot did not increase the knots strength in the robot. It is possible to make equally strong surgical knots with the da Vinci robot as by hand; however, despite previous experience with the robot, only 1 of 4 surgeons managed to do so. Adding 2 throws to R4SS and R4LS knots did not increase the tensile strength significantly for any of the 4 surgeons. It is important to train and tie knots using the da Vinci system with the same care as by hand and to be aware of possible differences in knot-tying technique with the robot and manually. With the robot, strand-to-strand knots were stronger than loop-to-strand knots, and should be preferred. Journal of Minimally Invasive Gynecology (2010) 17, 365-370 (C) 2010 AAGL. All rights reserved.

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TC 5

Z9 6

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U2 7

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

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Stevanovic, N

Schaer, G

AF Sarlos, Dimitri

Kots, LaVonne

Stevanovic, Nebojsa

Schaer, Gabriel

TI Robotic hysterectomy versus conventional laparoscopic hysterectomy:

Outcome and cost analyses of a matched case-control study

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Robotic hysterectomy; Hysterectomy; Robot-assisted; Hysterectomy;

Laparoscopic; Hysterectomy; Robotic versus laparoscopic; Laparoscopy;

Cost analysis

ID QUALITY-OF-LIFE; ASSISTED HYSTERECTOMY

AB Objective: Robotic surgery, with its technical advances, promises to open a new window to minimally invasive surgery in gynaecology. Feasibility and safety of this surgical innovation have been demonstrated in several studies, and now a critical analysis of these new developments regarding outcome and costs is in place. So far only a few studies compare robotic with conventional laparoscopic surgery in gynaecology. Our objective was to evaluate our initial experience performing total robot-assisted hysterectomy with the da Vinci (R) surgical system and compare pen-operative outcome and costs with total laparoscopic hysterectomy.

Study design: For this prospective matched case-control study at our institution, pen-operative data from our first 40 consecutive total robot-assisted hysterectomies for benign indications were recorded and matched 1:1 with total laparoscopic hysterectomies according to age, BMI and uterus weight. Surgical costs were calculated for both procedures. Surgeons' subjective impressions of robotics were evaluated with a self-developed questionnaire.

Results: No conversions to laparotomy or severe pen-operative complications occurred. Mean operating time was 109 (113; 50-170) min for the robotic group and 83 (80; 55-165) min for the conventional laparoscopic group. Mean postoperative hospitalisation for robotic surgery was 3.3(3: 2-6) days versus 3.9 (4; 2-7) days for the conventional laparoscopic group. Average surgical cost of a robot-assisted laparoscopic hysterectomy was (sic)4067 compared to (sic)2151 for the conventional laparoscopic procedure at our institution. For the robotic group wider range of motion of the instruments and better ergonomics were considered to be an advantage, and lack of direct access to the patient was stated as a disadvantage.

Conclusion: Robot-assited hysterectomy is a feasible and interesting new technique with comparable outcome to total laparoscopic hysterectomy. Operating times of total laparoscopic hysterectomy seem to be achieved quickly especially for experienced laparoscopic surgeons. However, costs of robotic surgery are still higher than for conventional laparoscopy. Randomised clinical trials need to be conducted to further evaluate benefits of this new technology for patients and surgeons and analyse its cost-effectiveness in gynaecology. (C) 2010 Elsevier Ireland Ltd. All rights reserved.

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FU Kanton (district government) Aargau; Kantonsspital Aarau

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NR 17

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U1 1

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA 598XM

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PT J

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Manahan, KJ

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Khurshid, Naumann

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Manahan, Kelly J.

TI Robotically Assisted Laparoscopic Radical Hysterectomy Compared With

Open Radical Hysterectomy

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Radical hysterectomy; Laparoscopic; Cervical cancer; Robotics

ID PARAAORTIC LYMPHADENECTOMY; PELVIC LYMPHADENECTOMY; TRACHELECTOMY;

SURGERY; FERTILITY; AGE

AB Background: Radical hysterectomy is a common and effective treatment of early cervical cancer. Modern advances include the use of robotic assistance to perform equivalent minimally invasive procedures. The purpose was to compare surgical and short-term outcomes, as well as margins, between robotic-assisted laparoscopic radical hysterectomy and open radical hysterectomy.

Methods: The first 30 cases of robotically assisted type III radical hysterectomy for cervical cancer were compared with the 30 previous cases of open type III radical hysterectomy. Body mass index, length of operation, nodal yield, margins, estimated blood loss, hospital stay, and complications were all documented and compared.

Results: The 30 patients undergoing robotically assisted laparoscopic radical hysterectomy were similar in body mass index to the women undergoing open radical hysterectomy (34 kg/m(2) robotic, 32 kg/m(2) open, P = 0.22). The mean operating time was 154 minutes compared with 166 minutes in the open arm (P = 0.36). The mean blood loss was 165 mL compared with 323 mL in the open arm (P = 0.001). The mean pelvic nodal yield was 25 nodes compared with 26 nodes in the open group (P = 0.45). The mean parametrial margin size was not significantly different between groups. The mean postoperative length of stay was 1.4 days compared with 2.8 days for the open cases (P < 0.001). Urinary retention was significantly more common in the robotic arm.

Conclusions: Radical surgery for cervical cancer can be accomplished using the da Vinci surgical system (Intuitive Surgical, Sunnyvale, Calif) with acceptable blood loss, operating time, parametrial margins, and nodal yield. Future studies need to address long-term outcomes.

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FU Women's Oncology Research & Development Foundation

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JI Int. J. Gynecol. Cancer

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SC Oncology; Obstetrics & Gynecology

GA 586IJ

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PT J

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Haldar, K

Tozzi, R

AF Martinek, Igor E.

Haldar, Krishnayan

Tozzi, Roberto

TI Laparoscopic surgery for gynaecological cancers in obese women

SO MATURITAS

LA English

DT Review

DE Laparoscopy; Minimal invasive surgery; Obese; Endometrial cancer;

Cervical cancer; Ovarian cancer

ID BODY-MASS-INDEX; TOTAL ABDOMINAL HYSTERECTOMY; MINIMALLY INVASIVE

SURGERY; ENDOMETRIAL CANCER; RADICAL HYSTERECTOMY; PELVIC

LYMPHADENECTOMY; CERVICAL-CANCER; LEARNING-CURVE; MORBIDITY; RISK

AB The use of laparoscopic surgery in the management of gynaecological malignancies has been growing for over a decade. Concomitantly the incidence of obesity has been increasing worldwide. This review summarizes the available studies on minimal invasive surgery in obese women with gynaecological malignancies. We undertook a literature search to identify the differences between traditional open methods and the laparoscopic approach in terms of intra- and postoperative outcome and patient safety. Only eight relevant studies were identified. Six of these focused on endometrial cancer, one study included early stage cervical and ovarian cancers with other benign conditions, while another paper included cervical and endometrial pre-cancers and only a few malignant conditions.

Obesity is generally known to increase the risk of intra- and postoperative complications. However, several studies show that obesity, formerly precluding keyhole surgery, seems now to be an indication for the laparoscopic approach. As compared to laparotomy, laparoscopic surgery has a good postoperative outcome, reduced estimated blood loss (EBL) and pain and in some series an increased lymph node count. Laparoscopy has been shown to be cost effective with a shorter hospital stay and return to normal activity. Survival is reported to be the same with both laparotomy and laparoscopy. The benefits of minimal invasive surgery in gynaecological surgery are starting to be found with robotic surgery. (C) 2009 Elsevier Ireland Ltd. All rights reserved.

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U1 0

U2 4

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JI Maturitas

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EP 324

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WC Geriatrics & Gerontology; Obstetrics & Gynecology

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SC Geriatrics & Gerontology; Obstetrics & Gynecology

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PT J

AU Payne, TN

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Dauterive, Francis R.

Pitter, Michael C.

Giep, Hoang N.

Giep, Bang N.

Grogg, Terry W.

Shanbour, K. Anthony

Goff, Darren W.

Hubert, Helen B.

TI Robotically Assisted Hysterectomy in Patients With Large Uteri

<i>Outcomes in Five Community Practices</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; BENIGN; OUTCOMES

AB OBJECTIVE: To examine outcomes of robotically assisted laparoscopic hysterectomy in patients with benign conditions involving high uterine weight and complex pathology.

METHODS: A multicenter study was undertaken in five community practice settings across the United States. All patients who had minimally invasive laparoscopic hysterectomy with robotic assistance March 2006 through July 2009 and uterine weights of at least 250 g were included. Retrospective chart review identified outcomes including skin-to-skin operative time, conversion to an exploratory laparotomy, blood loss, complications, and hospital duration of stay. The effect of uterine weight on skin-to-skin time and blood loss also was examined.

RESULTS: Data were analyzed for 256 patients with uteri weighing 250 to 3,020 g (median 453 g). Most patients were obese or had a history of pelvic or abdominal surgery. Median operative time was 145 minutes. Duration of surgery in patients with uteri 500 g or greater was significantly longer than in patients with uteri less than 500 g (167 compared with 126 minutes, P<.001). Median estimated blood loss also was greater in women with uteri weighing 500 g or more (100 compared with 50 mL, P<.001). Multivariable linear regression analysis confirmed the independent effect of uterine weight on operative time and blood loss. Median duration of hospital stay was 1 day. The conversion rate was 1.6%, the minor complication rate was 1.6%, and major complications occurred in 2.0% of patients.

CONCLUSION: Women with large uteri may successfully undergo robotically assisted hysterectomy with low morbidity, low blood loss, and minimal risk of conversion to laparotomy. Results were reproducible among general gynecologists from geographically diverse community settings. (Obstet Gynecol 2010;115:535-42)

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NR 17

TC 40

Z9 43

U1 0

U2 0

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 563LA

UT WOS:000275132300009

PM 20177284

DA 2024-01-18

ER

PT J

AU Ramirez, PT

Schmeler, KM

Malpica, A

Soliman, PT

AF Ramirez, Pedro T.

Schmeler, Kathleen M.

Malpica, Anais

Soliman, Pamela T.

TI Safety and feasibility of robotic radical trachelectomy in patients with

early-stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Laparoscopy; Robotic surgery; Radical trachelectomy; Cervical cancer

ID PELVIC LYMPHADENECTOMY; HYSTERECTOMY

AB Objective. This study aimed to determine the safety and feasibility of robotic radical trachelectomy and bilateral pelvic lymphadenectomy. We also describe Our Surgical technique.

Methods. This is a retrospective review of all patients who underwent robotic radical trachelectomy and bilateral pelvic lymphadenectomy from October 2008 to May 2009. We analyzed our data to evaluate the safety and feasibility of this surgery.

Results. This analysis included 4 patients with early-stage squamous cell carcinoma of the cervix. The median body mass index was 27.1 kg/m(2) (range, 22.7 to 39.1). Three patients had stage IA2 adenocarcinoma; I patient had stage IA1 adenocarcinoma with lymph-vascular space invasion. The median operative time was 339.5 min (range, 245 to 416). The median console time was 282.5 min (range, 217 to 338). The median estimated blood loss was 62.5 nil (range, 50 to 75). There were no conversions to laparotomy. There were no intraoperative complications. No patient required blood transfusion. The median length of hospital stay was 1.5 days (range, I to 2). One patient experienced a postoperative complication, transient left lower extremity sensory neuropathy. No patient had residual tumor ill the trachelectomy specimen, and no patient underwent adjuvant therapy. The median number of pelvic lymph nodes removed was 20 (range, 18 to 27). The median time to a successful voiding trial was 8 days (range, 7 to 9). The median follow-up was 105 days (range, 82 to 217). There were no recurrences.

Conclusion. Robotic radical trachelectomy and bilateral pelvic lymphadenectomy is feasible and safe and should be considered for patients desiring fertility-sparing surgery. (C) 2009 Elsevier Inc. All rights reserved.

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NR 13

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Z9 61

U1 0

U2 1

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J9 GYNECOL ONCOL

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 566HF

UT WOS:000275360000044

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DA 2024-01-18

ER

PT J

AU Rivlin, ME

Meeks, GR

May, WL

AF Rivlin, Michel E.

Meeks, G. Rodney

May, Warren L.

TI Incidence of Vaginal Cuff Dehiscence after Open or Laparoscopic

Hysterectomy <i>A Case Report</i>

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE hysterectomy; laparoscopic hysterectomy; laparoscopic surgery; vagina

AB BACKGROUND: The incidence of vaginal incision dehiscence after total hysterectomy has been reported to be higher with laparoscopic than with open surgery, but the data are limited. This report documents a case and reviews the literature in order to further estimate the differences in incidence by route of hysterectomy.

CASE: A 45-year-old woman underwent successful vaginal repair of postcoital cuff dehiscence with small bowel evisceration 67 days after total laparoscopic hysterectomy and bilateral salpingo-oophorectomy for menometrorhagia.

CONCLUSION: Seven observational studies were identified. The comparison of total laparoscopic to robotic hysterectomy was not statistically significant, nor was the comparison of total abdominal to vaginal hysterectomy. However, the incidence of dehiscence for laparoscopic procedures was statistically greater than the incidence for open surgery (p value <0.001). (J Reprod Med 2010;55:171-174)

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Z9 12

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J9 J REPROD MED

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WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 595HC

UT WOS:000277600300017

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DA 2024-01-18

ER

PT J

AU Seamon, LG

Cohn, DE

Richardson, DL

Hurt, JD

Nickerson, EC

Fowler, JM

AF Seamon, Leigh G.

Cohn, David E.

Richardson, Debra L.

Hurt, Jason D.

Nickerson, Edward C.

Fowler, Jeffrey M.

TI Robotic Pelvic and Aortic Lymphadenectomy for Endometrial Cancer: The

Console Surgeon's Perspectives on Surgical Technique and Directing the

Assistant

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Endometrial cancer; Gynecology; Hysterectomy; Lymphadenectomy; Robotic

surgery

ID HYSTERECTOMY; MANAGEMENT; EXPERIENCE; OBESE

AB Objective: Our purpose is to describe and demonstrate basic console dissection techniques in robotic hysterectomy, aortic and pelvic lymphadenectomy for endometrial carcinoma, and efficient methods to direct the assistant.

Methods: The operating room and patient are prepared as previously detailed. Adequate exposure is the key to a successful procedure, and a skilled bedside assistant is essential in developing the dissection. Clear communication between the console surgeon and assistant plays a critical role. In addition, proper use of the robotic fourth arm allows additional retraction and permits smooth case progression.

Results: We have completed more than 120 robotic hysterectomies, pelvic-aortic lymphadenectomies for endometrial cancer with these key steps.

Conclusions: A systematic routine and effective use of the bedside assistant is essential for successfully completing robotic hysterectomy and aortic and pelvic lymphadenectomy. This manuscript and video illustrates our method emphasizing an efficient and comprehensive technique for this procedure. Journal of Minimally Invasive Gynecology (2010) 17, 180-185 (c) 2010 AAGL. All rights reserved.

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NR 21

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Z9 11

U1 0

U2 3

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WC Obstetrics & Gynecology

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ER

PT J

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Batezini, NSS

Pinto, ERS

Skaff, M

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Almeida, FG

AF Zambon, Joao Paulo

Batezini, Nelson S. S.

Pinto, Eduardo R. S.

Skaff, Milton

Girotti, Marcia E.

Almeida, Fernando G.

TI Do we need new surgical techniques to repair vesico-vaginal fistulas?

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

DE Vesicovaginal fistula; Vaginal approach; O' Connor technique

ID VESICOVAGINAL FISTULA; ROBOTIC RECONSTRUCTION; BLADDER

AB The urogenital fistula is a devastating condition for women. Despite advances in medical care, the vesicovaginal fistula continues to be a distressful problem. Complex vesicovaginal fistulae repair may need tissue interposition. It can be achieved by vaginal or abdominal approach and depends on the surgeon's experience and local factors like size, location, and previous radiotherapy. The aim of this study was to demonstrate that using traditional approaches is possible and reasonable to treat any sort of vesicovaginal fistula.

Between January 2004 and August 2007, we treated 23 patients with complex urogenital fistulae. Of those with concomitant ureteral fistula requiring re-implantation or bladder augmentation, the vaginal approach was the first choice in 17 and abdominal approach in six. Patients were clinically evaluated at 1, 4, and 12 weeks postoperatively, then every 3 months in the first year.

Seventeen women were treated by vaginal approach and six patients were treated by abdominal approach. Hysterectomy was the major etiology (73.9%). Ten patients (43.5%) had at least one previous abdominal surgery for fistulae repair without success before. In those patients with abdominal approach, the hospitalization was longer than vaginal approach (80.5+/-6 h versus 48+/-3 h). In both, there were no major intraoperative or postoperative complications; 13% developed urgency and 4% developed stress urinary incontinence. No patients have recurrence of fistulae (success rate 100%).

Complex vesicovaginal fistulas are a big challenge for the urologist, and there is no gold standard surgical approach. The majority of complex vaginal fistula can be successfully managed by vaginal repair. As the vaginal approach is a minimally invasive procedure with low costs, easy learning curve, and high cure rates, new approaches must be carefully evaluated before being suggested as an alternative.

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NR 19

TC 27

Z9 29

U1 0

U2 3

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JI Int. Urogynecol. J.

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WC Obstetrics & Gynecology; Urology & Nephrology

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GA 551ZA

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PM 19949771

DA 2024-01-18

ER

PT J

AU Farghaly, SA

AF Farghaly, S. A.

TI Robotic-assisted laparoscopic anterior pelvic exenteration in patients

with advanced ovarian cancer: Farghaly's technique

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

ID CERVICAL-CANCER

AB The safety and efficacy of the robotic-assisted laparoscopic approach to anterior pelvic exenteration is evaluated in patients with advanced ovarian cancer undergoing anterior pelvic exenteration for involvement of the urinary bladder during primary cytoreduction surgery. All patients undergo preoperative lab work, imaging studies and bowel preparation prior to surgery. The Davinci surgical system is used to perform urinary cystectomy, total hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic adenectomy (including obturator, hypogastic, external iliac, and common iliac lymph nodes). In addition, debulking to less than 1 cm is performed. The anterior pelvic exenteration procedure involves wide perivesical dissection. Then the robot is locked, and ileal conduit is performed via a 6 cm lower midline incision. Operative time can be maintained in 4.6 hours with a mean blood loss of 215 ml and hospital stay of five days. Farghaly's technique of robotic-assisted laparoscopic anterior pelvic exenteration in patients with advanced ovarian cancer is safe, feasible, and cost-effective with acceptable operative, pathological and short- and long-term clinical outcomes. It retains the advantage of minimally invasive surgery.

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NR 5

TC 10

Z9 11

U1 0

U2 2

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J9 EUR J GYNAECOL ONCOL

JI Eur. J. Gynaecol. Oncol.

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EP 363

PG 3

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 632BG

UT WOS:000280394400001

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ER

PT J

AU Magrina, JF

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Giles, DL

Montero, RP

Magtibay, PM

AF Magrina, Javier F.

Long, Jaime B.

Kho, Rosanne M.

Giles, Dobie L.

Montero, Regina P.

Magtibay, Paul M.

TI Robotic Transperitoneal Infrarenal Aortic Lymphadenectomy <i>Technique

and Results</i>

SO INTERNATIONAL JOURNAL OF GYNECOLOGICAL CANCER

LA English

DT Article

DE Aortic lymphadenectomy; Gynecologic neoplasms; Robotic surgery

ID LYMPH-NODE DISSECTION; CERVICAL-CANCER; OVARIAN-CANCER; LAPAROTOMY

AB Introduction: This study was designed to evaluate the feasibility and the results of robotic transperitoneal infrarenal aortic lymphadenectomy.

Methods: Development of a technique of robotic transperitoneal infrarenal aortic lymphadenectomy in female cadavers and review of the results in 33 patients who underwent the newly developed technique as part of the surgical treatment of gynecologic malignancies.

Results: The mean console time was 42 minutes (range, 19-64 minutes). The mean number of nodes was 12.9 (range, 2-27); the mean number of positive nodes was 2.6 (range, 0-8). There was 1 conversion to laparotomy.

Conclusions: Robotic transperitoneal infrarenal aortic lymphadenectomy can be performed adequately and safely with the robotic column at the patient's head. Operating table rotation and additional trocar sites are needed when used in conjunction with robotic pelvic surgery.

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NR 14

TC 38

Z9 39

U1 0

U2 1

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J9 INT J GYNECOL CANCER

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GA 559ZH

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ER

PT J

AU Bedient, CE

Magrina, JF

Noble, BN

Kho, RM

AF Bedient, Carrie E.

Magrina, Javier F.

Noble, Brie N.

Kho, Rosanne M.

TI Comparison of robotic and laparoscopic myomectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE laparoscopy; myomectomy; robot-assisted surgery

ID SURGICAL OUTCOMES; UTERINE MYOMAS; HYSTERECTOMY; GYNECOLOGY; SURGERY

AB OBJECTIVE: To compare surgical outcomes of patients with symptomatic leiomyomas after robot-assisted (" robotic") or laparoscopic myomectomy.

STUDY DESIGN: Retrospective chart review of 81 patients undergoing robotic (n = 40) or laparoscopic (n = 41) myomectomy. Data included fibroid characteristics (number, weight, location, and pathologic findings), operating time, blood loss, complications, and postoperative hospitalization length.

RESULTS: Patients undergoing laparoscopy had a significantly larger mean uterine size, larger mean size of the largest fibroid, and greater number of fibroids. When adjusted for uterine size and fibroid size and number, no significant differences were noted between robotic vs laparoscopic groups for mean operating time (141 vs 166 minutes), mean blood loss (100 vs 250 mL), intraoperative or postoperative complications (2% vs 20% and 11% vs 17%, respectively), hospital stay more than 2 days (12% vs 23%), readmissions, or symptom resolution.

CONCLUSION: Short- term surgical outcomes were similar after robotic and laparoscopic myomectomy; long- term outcomes were not assessed.

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Z9 131

U1 0

U2 5

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

PD DEC

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PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Fastrez, M

Vandromme, J

George, P

Rozenberg, S

Degueldre, M

AF Fastrez, Maxime

Vandromme, Jean

George, Pascale

Rozenberg, Serge

Degueldre, Michel

TI Robot assisted laparoscopic transperitoneal para-aortic lymphadenectomy

in the management of advanced cervical carcinoma

SO EUROPEAN JOURNAL OF OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY

LA English

DT Article

DE Cervical cancer; Staging; Para-aortic lymphadectomy; Laparoscopy; Robot

surgery

ID GYNECOLOGIC ONCOLOGY; RADICAL HYSTERECTOMY; STAGE IB; CANCER;

DISSECTION; EXPERIENCE; BULKY

AB Objectives: Adequate staging of advanced cervical cancer is essential in order to optimally treat the patient. FIGO clinical staging, imaging techniques such as CT scan, MRI and PET sometimes underestimate the extension of tumors. The presence of para-aortic lymph node metastases in advanced cervical cancer identifies patients with poor prognosis who need to be treated aggressively. Laparoscopic para-aortic lymph node dissection is now proposed as a diagnostic tool in many guidelines. We evaluated the feasibility and safety of a robot assisted laparoscopic transperitoneal approach to paraaortic lymph node dissection.

Study design: Eight patients with advanced cervical carcinoma who were eligible for primary pelvic radiotherapy combined with concurrent cisplatin chemotherapy or pelvic exenteration underwent a pre-treatment robot assisted transperitoneal laparoscopic para-aortic lymphadenectomy.

Results: We isolated from 1 to 38 para-aortic nodes per patient and had one para-aortic node positive patient who was treated with extended doses of pelvic radiotherapy. We did not encounter any major complications and post-operative morbidity was low.

Conclusions: Robot assisted transperitoneal laparoscopic para-aortic lymphadenectomy is feasible and provides the surgeon with greater precision than classical laparoscopy. Larger prospective multicentric trials are needed to validate the generalised usefulness of this technique. (C) 2009 Elsevier Ireland Ltd. All rights reserved.

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NR 30

TC 15

Z9 15

U1 1

U2 2

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J9 EUR J OBSTET GYN R B

JI Eur. J. Obstet. Gynecol. Reprod. Biol.

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WC Obstetrics & Gynecology; Reproductive Biology

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ER

PT J

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TI Robotic-assisted laparoscopic hysterectomy and lymphadenectomy for

endometrial cancer: Analysis of surgical performance

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Meeting of the Society-of-Gynecologic-Oncologists

CY FEB 05-08, 2009

CL San Antonio, TX

SP Soc Gynecol Oncol (SGO)

DE Endometrial cancer; Robotic-assisted laparoscopic hysterectomy;

Lymphadenectomy; Clinical-pathological analyses; Complications; Learning

curve

ID ABDOMINAL HYSTERECTOMY; SURGERY; ADENOCARCINOMA; MANAGEMENT; CARCINOMA;

COST

AB Objectives. To provide an objective analysis of surgical performance of robotic-assisted laparoscopic hysterectomy (RALH) with lymphadenectomy for endometrial cancer during the learning phase of the procedure and to assess Opportunities for improvement.

Methods. From July 2006 to March 2008, 100 patients with endometrial cancer underwent RALH with lymphadenectomy using the da Vinci (R) Robotic Surgical System. Data were analyzed for operative time (OT), estimated blood loss (EBL), length of stay (LOS), intra-operative complications, surgical-pathologic factors, and post-operative complications using an intent-to-treat analysis. A comparison of the data on a quartile (Q) basis was performed For the 100 RALH cases and separately for the 65 cases that had a complete pelvic-and-aortic lymphadenectomy (PAL).

Results. Age and body mass index (BMI) did not change significantly during the study. More grade 3 turners were treated in the last 50 cases (22% vs. 10%, p<0.05). Stage HI turners were identified in 18.7% cases in Q2-4 and none in Q1 (p<0.05). The number of patients undergoing complete PAL and the number of aortic lymph nodes (LN) removed per case increased each quarter. There were 4 (4%) conversions to laparotomy. Delayed vaginal cuff healing decreased from 16% in Q1 to 0% in Q3-4. No case required blood transfusion, Comparing first 10 cases to the last 10 cases, the total LN Counts increased from 15 to 21 nodes, the aortic LN Counts increased from 4.7 to 8.0, and the OT decreased from 203 to 160 min. Intra-surgeon analysis revealed an improvement in the total LN yields from first 50 to second 50 cases for each surgeon.

Conclusions. Operative times decreased and aortic dissections improved with increasing LN counts during the first 100 cases of RALH Furthermore, patient safety and improvement in Surgical performance was demonstrated. (C) 2009 Elsevier Inc. All rights reserved.

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NR 26

TC 79

Z9 80

U1 0

U2 2

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WC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Wu, WC

Hsieh, CH

Huang, LC

Chang, YY

Hung, YC

Chang, WC

AF Wu, Wei-Chien

Hsieh, Ching-Hung

Huang, Li-Chia

Chang, Yin-Yi

Hung, Yao-Ching

Chang, Wei-Chun

TI SURGICAL BLOOD LOSS AND LAPAROSCOPIC-ASSISTED VAGINAL HYSTERECTOMY

SO TAIWANESE JOURNAL OF OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE hysterectomy; laparoscopic; operation time; quality indicator; robotic

surgery; surgical blood loss

ID OPERATIVE TIME; SURGERY

AB Objective: This study aimed to elucidate the possible relationship between surgical blood loss (SBL) and medical outcomes of laparoscopic-assisted vaginal hysterectomy (LAVH).

Materials and Methods: Patients who underwent LAVH performed by the same surgeon For benign gynecologic diseases from 2004 to 2006 were analyzed retrospectively. Patients were divided into two groups according to the amount of SBL (< 150 mL or >= 150 mL, 75(th) percentile of mean SBL). Clinical medical outcomes of all women were analyzed to identify the effects of SBL during LAVH.

Results: A total of 133 women with benign gynecologic disease were included. Group 1 (SBL < 150 mL) consisted of 108 patients and Group 2 (SBL >= 150 mL) consisted of 25 patients. The mean operative time for patients with SBL >= 150 mL was 36.1 minutes longer than that for patients with SBL < 150 mL (p < 0.001). Mean hospital stay, mean shift in serum hemoglobin, mean shift in serum hematocrit and mean flatulence relief time were not significantly different between the two groups.

Conclusion: Greater SBL (>= 150 mL) during LAVH was significantly associated with longer operating time, but had no detrimental effect on short-term surgical outcomes. Thus, efforts to minimize intraoperative bleeding and so reduce operative time will be beneficial for women undergoing LAVH. [Taiwan J Obstet Gynecol 2009;48(4):400-402]

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NR 9

TC 4

Z9 5

U1 0

U2 1

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J9 TAIWAN J OBSTET GYNE

JI Taiwan. J. Obstet. Gynecol.

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WC Obstetrics & Gynecology

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OA gold

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ER

PT J

AU Brenot, K

Goyert, GL

AF Brenot, Karen

Goyert, Gregory L.

TI Impact of Robotic Surgery on Obstetric-Gynecologic Resident Training

SO JOURNAL OF REPRODUCTIVE MEDICINE

LA English

DT Article

DE hysterectomy; residents; robotics

AB OBJECTIVE: To compare the volume and type of surgical techniques for hysterectomies performed prior to and after the introduction of robotic surgery at our institution and to assess the potential impact on obstetric-gynecologic resident training.

STUDY DESIGN: A retrospective study examined the number and types of hysterectomies performed at our institution during the 18 months prior to, and the 18 months after, the introduction of a robotic surgical system. Procedures performed during both time periods were compared by number and percentage using the chi(2) or Fisher's exact test for counts, <5.

RESULTS: A total of 903 hysterectomies were performed from July 1, 2005, to July 1, 2008. There were 444 hysterectomies in the prerobotic surgical system group and 459 hysterectomies in the postrobotic surgical system group. There was a statistically significant decrease in the number of laparoscopically assisted vaginal hysterectomies (94 vs. 36; p < 0.001) and total abdominal hysterectomies (249 vs. 203; p < 0.001) performed.

CONCLUSION: This study demonstrated a significant impact on the volume and type of surgical techniques for hysterectomies performed prior to and after the introduction Of robotic surgery at out, institution. This observation may have direct consequences for obstetric-gynecologic resident surgical experience. (J Reprod Med 2009;54:675-677)

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ER

PT J

AU Cho, JE

Nezhat, FR

AF Cho, Jennifer E.

Nezhat, Farr R.

TI Robotics and Gynecologic Oncology: Review of the Literature

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Cervical cancer; Endometrial cancer; Ovarian cancer; Robotic-assisted;

Laparoscopy; Laparotomy

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY;

CERVICAL-CARCINOMA; ABDOMINAL HYSTERECTOMY; SURGERY; EXPERIENCE

AB The objectives of this article were to review the published scientific literature about its application to gynecologic oncology to date and to summarize findings of this advanced computerhanced laparoscopic technique. Relevant sources were identified by a search of PUBMED from January 1950 to January 2009 using the key words Robot or Robotics and Cervical cancer, Endometrial cancer, Gynecologic oncology, and Ovarian cancer. Appropriate case reports, case series, retrospective studies, prospective trials, and review articles were selected. A total of 38 articles were identified on the subject, and 27 were included in the study. The data for gynecologic cancer show comparable results between robotic and laparoscopic surgery for estimated blood loss, operative time, length of hospital stay, and complications. Overall, there were more wound complications with the laparotomy approach compared with laparoscopy and robotic-assisted laparoscopy. There were more lymphocysts, lymphoceles, and lymphedema in the robotic-assisted laparoscopic group compared with the laparoscopy and laparotomy groups in patients with cervical cancer. Infectious and king-related morbidity, postoperative ileus, and bleeding or clot formation were more commonly reported in the laparotomy group compared with the other 2 cohorts in patients with endometrial cancer. Computer-enhanced technology may enable more surgeons to convert laparotomies to laparoscopic surgery with its associated benefits. It seems that in the hands of experienced laparoscopic Surgeons, final outcomes are the same with or without use of the robot. There is good evidence that robotic surgery facilitates laparoscopic Surgery, with equivalent if not better operative time and comparable surgical outcomes, shorter hospital stay, and fewer major complications than with surgeries using the laparotomy approach. Journal of Minimally Invasive Gynecology (2009) 16, 669-681 (C) 2009 AAGL. All rights reserved.

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U1 0

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 521IL

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DA 2024-01-18

ER

PT J

AU George, A

Eisenstein, D

Wegienka, G

AF George, Amy

Eisenstein, David

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TI Analysis of the Impact of Body Mass Index on the Surgical Outcomes after

Robot-Assisted Laparoscopic Myomectomy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic myomectomy; Laparoscopy; Leiomyoma; Obesity

ID ABDOMINAL MYOMECTOMY; HYSTERECTOMY; OBESITY; MULTICENTER; SURGERY

AB Study Objective: To estimate the impact of body mass index (BMI) on surgical outcomes in patients undergoing robotic myomectomy.

Design: A retrospective cohort data analysis (Canadian Task Force classification II-2).

Setting: Community-based reaching hospital.

Patients: A total of 77 consecutive patients from January 2005 through November 2008 with symptomatic leiomyomata.

Intervention: Robotic-assisted laparoscopic myomectomy.

Measurements and Main Results: Body mass index ([BMI] expressed as kg/m(2)) was abstracted from the medical charts of all patients undergoing robotic myomectomy. Data on estimated blood loss, procedure time, length of hospital stay, diameter of the largest fibroid, and specimen weight were also extracted. Overall patient demographics between the groups were similar. Thirty-two patients (41.6%) were obese or morbidly obese (BMI > 30). The parameters analyzed for associations with the continuous measure of BMI included length of postoperative hospital stay (LOS), estimated blood loss (EBL), and procedure duration. Median (range) procedure time among all patients was (195 minutes, 98-653 minutes), estimated blood loss was (100 mL, 10-700 mL), and length of hospital stay was (I day, 1-5 days). No associations were determined between BMI and LOS (r = 0. 14, p = .22), EBL (r = 0.25, p = .03), or procedure duration (r = 0. 16, p = .22) with Spearman correlations. The size of the largest leiomyoma diameter did not affect these associations.

Conclusion: Preoperative obesity is not a risk factor for poor surgical outcome in patients undergoing robotic myomectomy. Journal of Minimally Invasive Gynecology (2009) 16, 730-733 (C) 2009 AAGL. All rights reserved.

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PT J

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Roviglione, Giovanni

Velez, Jorge Ivan

TI Robotic approach for cervical cancer: Comparison with laparotomy A case

control study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Robotic radical hysterectomy; Cervical cancer;

Laparotomic radical hysterectomy

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; PELVIC LYMPHADENECTOMY; VAGINAL

HYSTERECTOMY; ABDOMINAL HYSTERECTOMY; ENDOMETRIAL CANCER; MORBIDITY;

DISSECTION; CARCINOMA

AB Objective. To compare the surgical outcome of robotic radical hysterectomy (RRH) versus abdominal radical hysterectomy (ARH) for the treatment of early stage cervical cancer.

Methods. A prospective collection of data of all RRH for stages IA2-IIA cervical cancer was done. The procedures were performed at the European Institute of Oncology, Milan, Italy, between November 1, 2006 and February 1, 2009.

Results. A total of 40 RRH were analyzed, and compared with 40 historic ARH cases. The groups did not differ significantly in body mass index, stage, histology, or intraoperative complications, but in age (p = 0.035). The mean (SD) operative time was significantly shorter for ARH than RRH, 199.6 (65.6) minutes and 272.27 (42.3) minutes respectively (p = 0.0001). The mean (SD) estimated blood loss (EBL) was 78 ml (94.8) in RRH group and 221.8 ml (132.4) in ARK This difference was statistically significant in favor of RRH group (p<0.0001). Statistically significantly higher number of pelvic lymph nodes was removed by ARH than by RRH, mean (SD) 26.2 (11.7) versus 20.4 (6.9), p<0.05. Mean length of stay was significantly shorter for the RRH group (3.7 versus 5.0 days, p<0.01). There was no significant difference in terms of postoperative complications between groups.

Conclusion. This study shows that RRH is safe and feasible. However, a comparison of oncologic outcomes and cost-benefit analysis is still needed and it has to be carefully evaluated in the future. (C) 2009 Published by Elsevier Inc.

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ER

PT J

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Leblanc, E.

TI Early experience of robotic-assisted laparoscopy for extraperitoneal

para-aortic lymphadenectomy up to the left renal vein

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical carcinoma; Surgery; Para-aortic lymph nodes; Robotic-assisted

laparoscopy

ID CERVICAL-CARCINOMA; DISSECTION

AB Objective. To describe our early experience with robotic-assisted laparoscopy for extraperitoneal para-aortic lymphadenectomy up to the left renal vein, including Da Vinci robot positioning.

Methods. Six patients underwent robotic-assisted laparoscopy using the Da Vinci apparatus. The patients included a man with a pT2 non-seminomatous germ cell turnout of the left testicle treated by chemotherapy with an incomplete response (mature teratoma), four women with locally advanced cervical cancer, and one case of bulky cancer of the vaginal cuff. The procedure was carried out using four port sites: one for the camera, one each for the no. 1 and no. 3 arms of the Da Vinci robot system, and one for the assistant.

Results and conclusion. Robotic-assisted lymphadenectomy carried out using the Da Vinci system was safe and effective with a short learning period for an experienced oncological team. A larger prospective study is now required to evaluate this procedure further. (C) 2009 Elsevier Inc. All rights reserved.

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U2 0

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Cantrell, Leigh

Shafer, Aaron

Mendivil, Alberto

Rossi, Emma

Hanna, Rabbie

TI Perioperative Outcomes of Robotically Assisted Hysterectomy for Benign

Cases With Complex Pathology

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID TOTAL LAPAROSCOPIC HYSTERECTOMY; TOTAL ABDOMINAL HYSTERECTOMY; VAGINAL

HYSTERECTOMY; LEARNING-CURVE; MORBIDITY; AUDIT

AB OBJECTIVE: To report on the perioperative outcomes after robotically assisted total hysterectomy for benign indications in a large patient population with predominantly complex pathology.

METHODS: One hundred fifty-two patients underwent robotic hysterectomy for noncancer indications from May 2005 to May 2008. A systematic chart review of consecutive robotic cases was conducted based on preoperative and perioperative characteristics of each patient. Each case was evaluated for its complexity based on preoperative diagnosis, prior pelvic or abdominal surgery, patient's body mass index, and uterine weight.

RESULTS: The overall operative time was 122.9 minutes, estimated blood loss was 79.0 mL, and there were three (2.1%) intraoperative complications, with no perioperative blood transfusions or conversions. There were five (3.5%) patients with postoperative complications, and length of hospital stay was 1.0 days on average. Of the characteristics indicating complexity, only uterine weight greater than 250 g resulted in significantly increased operative times, attributable to increased morcellation time.

CONCLUSION: Robotically assisted total hysterectomy for benign indications in patients with complex pathology is feasible, with low morbidity and a short hospital stay. This study suggests that robotic assistance facilitates the use of a minimally invasive approach in high-risk patient populations. (Obstet Gynecol 2009;114:585-93)

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SC Obstetrics & Gynecology

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ER

PT J

AU Chen, CCG

Falcone, T

AF Chen, Chi Chiung Grace

Falcone, Tommaso

TI Robotic Gynecologic Surgery: Past, Present, and Future

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE robotic surgery; laparoscopic surgery

ID LAPAROSCOPIC SKILLS; TUBAL ANASTOMOSIS; RADICAL HYSTERECTOMY; SURGICAL

OUTCOMES; LEARNING-CURVE; PERFORMANCE

AB Robotic techniques are increasingly being used to perform gynecologic surgical procedures including hysterectomies, performed for benign and malignant indications, myomectomies, tubal reanastomoses, and sacrocolpopexies. Robotic procedures seem to confer the same benefits as laparoscopic surgery without additional complications. It is unclear, however, whether robotic surgery imparts any additional benefits such its decreased operative times when compared with open or conventional laparoscopic techniques. The advantages to robotic surgery include improved visualization of the operative field with increased dexterity allowing more precise movements. Disadvantages include the learning curve associated with learning a new surgical technique and the equipment and operating costs of the robot and of using the robot.

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PT J

AU Cho, JE

Liu, C

Gossner, G

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AF Cho, Jennifer E.

Liu, Connie

Gossner, Gabrielle

Nezhat, Farr R.

TI Laparoscopy and Gynecologic Oncology

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE laparoscopy; robotics; gynecologic malignancy;

ovarian/endometrial/cervical cancer

ID ROBOTIC RADICAL HYSTERECTOMY; FALLOPIAN-TUBE; PELVIC LYMPHADENECTOMY;

OVARIAN; MANAGEMENT; SURVIVAL; SURGERY; CHEMOTHERAPY; LAPAROTOMY;

CARCINOMA

AB Laparoscopy was used for a second-look assessment in ovarian cancer patients back in the 1970s. However, it is only with the advent of new developments in equipment in the late 1980s and early 1990s along with the vision of pioneers in laparoscopic surgery that has made operative laparoscopy in gynecologic oncology feasible. Laparoscopy has multiple benefits in the cancer patients, including image magnification to visualize metastatic or recurrent disease and improved dissection in challenging areas such its the paravesical and pararectal spaces. There is limited bleeding from small vessels because or the pressure from pneumoperitoneum, decreased hospital stay, and rapid recovery. Postoperative chemotherapy or radiation can be initiated earlier, and radiation complications from bowel adhesions are minimized. Significant progress has been made in the last 2 decades in gynecologic malignancy. In this study, the application of laparoscopy in cervical, endometrial, and ovarian cancer will be presented.

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NR 30

TC 27

Z9 30

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TI Robotic-Assisted Laparoendoscopic Single-Site Surgery in Gynecology:

Initial Report and Technique

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Single port surgery; Robotic surgery; Laparo Endoscopic Single Site;

gynecology

AB Robotic surgery has greatly improved surgeon dexterity and ergonomics but has substantially increased the number and size of ports required. The typical robotic surgical procedure will use three 8-mm ports and two 12-mm ports. Single-port laparoscopy, also known as Laparo-Endoscopic Single Site (LESS) surgery, is an attempt to further enhance cosmetic benefits and reduce morbidity of minimally invasive surgery. We present our initial clinical experience and technique with robotic-assisted single-port surgery in gynecology. Journal of Minimally Invasive Gynecology (2009) 16, 589-591 (C) 2009 AAGL. All rights reserved.

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ER

PT J

AU Jung, YW

Kim, SW

Kim, YT

AF Jung, Yong Wook

Kim, Sang Wun

Kim, Young Tae

TI Recent advances of robotic surgery and single port laparoscopy in

gynecologic oncology

SO JOURNAL OF GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Minimal surgical procedure; Endometrial neoplasm; Cervical neoplasm;

Laparoscopic surgery

ID RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; MULTIINSTITUTIONAL EXPERIENCE;

PELVIC LYMPHADENECTOMY; ABDOMINAL HYSTERECTOMY; CERVICAL-CANCER; FUTURE;

OBESE

AB Two innovative approaches in minimally invasive surgery that have been introduced recently are the da Vinci robotic platform and single port laparoscopic surgery (SPLS). Robotic surgery has many advantages such as 3-dimensional view, the wrist like motion of the robotic arm and ergonomically comfortable position for the surgeon. Numerous literatures have demonstrated the feasibility of robotic surgery in gynecologic oncology. However, further research should be performed to demonstrate the superiority of robotic surgery compared to conventional laparoscopy. Additionally, cost reduction of robotic surgery is needed to adopt robotic surgery into gynecologic oncology worldwide. SPL.S has several possible benefits including reduced operative complications, reduced postoperative pain, and better cosmetic results compared to conventional laparoscopy. Although several authors have indicated that SPLS is a feasible approach for gynecologic surgery, there have been few reports demonstrating the potential advantages over conventional laparoscopy. Moreover, technical difficulties of SPLS still exist. Therefore, the advantages of a single port approach compared to conventional laparoscope should be evaluated with comparative study, and further technologic development for SPLS is also needed. These two progressive technologies take the lead in the development of MIS and further studies should be performed to evaluate the benefits of robot surgery and SPLS.

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Z9 37

U1 0

U2 5

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J9 J GYNECOL ONCOL

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PT J

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Noble, Brie N.

Kho, Rosanne M. C.

TI Robotic Adnexectomy Compared With Laparoscopy for Adnexal Mass

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID SALPINGO-OOPHORECTOMY; HYSTERECTOMY; SURGERY

AB OBJECTIVE: To evaluate whether the application of robotic technology in the performance of adnexectomy resulted in benefits for the patient when compared with patients operated by laparoscopy.

METHODS: Evaluation of 85 patients undergoing robotic adnexectomy and comparison with a group of 91 patients operated on by laparoscopy during the same period of time and by the same surgeons. Patients were compared by age, body mass index (BMI), American Society of Anesthesiologists (ASA) physical status classification, indications, unilateral compared with bilateral adnexectomy, adhesions, size or weight or both of the adnexal mass, and previous abdominal or pelvic surgery. Univariate and multivariate analysis was used to determine factors favorable to each technique. Comparison between the groups was evaluated using the Fisher exact test from a one-way analysis of variance.

RESULTS: The robotic group had an increased number of obese (BMI 30 or more) and higher anesthetic risk (ASA classification 2 and 3) patients as compared with laparoscopy patients. The mean operating time was 12 minutes longer in the robotic group (P=.01). The mean blood loss (80 mL robotic, 71 mL laparoscopic), length of hospital stay (0.15 days robotic, 0.28 days laparoscopic), intraoperative complications (1% robotic, 21% laparoscopic), and postoperative complications (12% robotic, 11% laparoscopic) were similar in both groups.

CONCLUSION: Laparoscopy and robotics provided similar results for the performance of adnexectomy, with similar blood loss, intraoperative and postoperative complications, and length of hospital stay. Robotics mean operating time was 12 minutes longer. (Obstet Gynecol 2009;114:581-4)

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PG 4

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ER

PT J

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Hale, DS

AF McDermott, Colleen D.

Hale, Douglass S.

TI Abdominal, Laparoscopic, and Robotic Surgery for Pelvic Organ Prolapse

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

DE Pelvic organ prolapse; Uterosacral; Sacral colpopexy; Sacral

colpoperineopexy; Paravaginal; Laparoscopic; Robotic

ID STRESS URINARY-INCONTINENCE; VAGINAL VAULT PROLAPSE; PARAVAGINAL DEFECT

REPAIR; TERM FOLLOW-UP; SACRAL COLPOPEXY; UTEROSACRAL LIGAMENT; UTERINE

SUSPENSION; SURGICAL-MANAGEMENT; SYNTHETIC MESH; UTEROVAGINAL PROLAPSE

AB Abdominal correction of pelvic organ prolapse remains a viable option for patients and surgeons. The transition from open procedures to less invasive laparoscopic and robotic-assisted surgeries is evident in the literature. This article reviews the surgical options available for pelvic organ prolapse repair and their reported outcomes. Procedures reviewed include apical support (sacral, uterosacral, and others), and abdominal anterior and posterior vaginal wall support. Long-term follow-up and appropriately designed studies will further help direct surgeons in deciding which approach to incorporate into their practice.

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TC 25

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U2 6

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ER

PT J

AU Zanagnolo, V

Magrina, JF

AF Zanagnolo, Vanna

Magrina, Javier F.

TI Robotic Radical Trachelectomy after Supracervical Hysterectomy for

Cut-Through Endometrial Adenocarcinoma Stage IIB: A Case Report

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Cut-through; Endometrial cancer; Robotic radical trachelectomy;

Supracervical hysterectomy

ID SURGERY

AB We report on a patient with a cut-through endometrial malignancy after supracervical hysterectomy treated by radical trachelectomy and staging via a robotic approach.

A 58-year-old patient with incidental finding of it stage IIB G1 endometrial adenocarcinoma after a supracervical hysterectomy underwent robotic radical trachelectomy, bilateral pelvic lymphadenectomy, and ileal resection with anastomosis. The operative time was 360 minutes, and blood loss was 100 mL. The pathology report revealed no evidence of residual disease. The patient remains disease-free 18 months after her robotic procedure. Robotic radical trachelectomy and pelvic lymphadenectomy appear to be feasible and safe for the treatment of endometrial malignancy discovered after supracervical hysterectomy. We Suggest use of the terms partial radical trachelectomy, for fertility preservation procedures and radical trachelectomy after subtotal hysterectomy for the complete radical removal of the cervix. Journal of Minimally Invasive Gynecology (2009) 16, 655-657 (C) 2009 AAGL. All rights reserved.

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ER

PT J

AU Fader, AN

Escobar, PF

AF Fader, Amanda Nickles

Escobar, Pedro F.

TI Laparoendoscopic single-site surgery (LESS) in gynecologic oncology:

Technique and initial report

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Single-port laparoscopy; Robotic surgery; Gynecologic oncology

ID ENDOMETRIAL CANCER; CHOLECYSTECTOMY; LAPAROSCOPY; OBESE

AB Objectives. Recent reports Suggest that laparoendoscopic single-site surgery (LESS), also known as single-port surgery, is technically feasible in treating a variety of disease processes. The purpose Of this Study was to assess the feasibility of LESS for the surgical treatment of various gynecologic cancers or precancerous conditions through both laparoscopic and robotic-assisted approaches.

Methods. A single institution retrospective review of patients treated with LESS on the gynecologic oncology service in 2009 was performed. Patients underwent surgery through a single 2-3 cm umbilical incision with a multi-channel SILS (TM) port for laparoscopic cases or a single-channel Gelport (R) for robotic cases on the daVinci (R) Surgical System.

Results. Thirteen patients had LESS surgery performed, nine done laparoscopically and four robotically. Procedures included endometrial cancer Staging (n = 1), ovarian cancer Staging (n = 1), retroperitoneal pelvic lymph node dissection (n = 1), risk-reducing extrafascial hysterectomy/bilateral salpingo-oophorectomy (BSO, n = 2) and BSO alone (n 5), and an ovarian cystectomy (n = 1) and BSO (n = 2) for complex adnexal masses. Median patient age and BMI were 47 years and 28, respectively. Median operating time was 65 min. All procedures were successfully performed via a single incision and no post-operative complications Occurred. The majority of patients required no narcotics post-operatively.

Conclusion. We present the first series of laparoendoscopic single-site surgery for the treatment of various gynecologic oncology conditions. LESS is feasible in select patients by laparoscopic or robotic-assisted techniques. Further studies are needed to better define the ideal gynecologic procedures for single-site surgery and to assess the benefits of LESS compared with more conventional minimally invasive approaches. (C) 2009 Elsevier Inc. All rights reserved.

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ER

PT J

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Buttin, Barbara M.

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Lowe, M. Patrick.

TI Robotic surgery in gynecologic oncology: Impact on fellowship training

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Endometrial; Cervical; Fellowship; Training

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; PELVIC

LYMPHADENECTOMY; ABDOMINAL HYSTERECTOMY; LAPAROTOMY; COST

AB Objectives. To report the impact of a new robotic surgery program on the surgical training of gynecologic oncology fellows over a 12 month period of time.

Methods. A robotic Surgery program was introduced into the gynecologic oncology fellowship program at Northwestern University Feinberg School of Medicine in June 2007. A database of patients undergoing surgical management of endometrial and cervical cancer between July 2007 and July 2008 was collected and analyzed. Changes in fellow surgical training were measured and analyzed.

Results. Fellow surgical training for endometrial and cervical cancer underwent a dramatic transition in 12 months. The proportion of patients undergoing minimally invasive surgery increased from 3.3% (4/110 patients) to 43.5% (47/108 patients). Fellow training transitioned from primarily an open approach (94.4%) to a minimally invasive approach (11% laparoscopic, 49% robotic, 40% open) for endometrial cancer stagings, and from an open approach (100%) to an open (50%) and robotic (50%) approach for radical hysterectomies. Fellow participation in robotic procedures increased from 45% in the first 3 months to 72% within 6 months, and 92% by 12 months. The role of the fellow in robotic cases transitioned from bedside assistant to console operator within 3 months.

Conclusions. Fellow surgical training underwent a dramatic change with the introduction of a robotic surgery program. The management of endometrial and cervical cancer was impacted the most by robotics. Robotic surgery broadened fellowship surgical training, but balanced surgical training and standardized fellow training modules remain challenges for fellowship programs. (C) 2009 Elsevier Inc. All rights reserved.

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ER

PT J

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TI Incidence and Characteristics of Patients With Vaginal Cuff Dehiscence

After Robotic Procedures

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 34th Annual Meeting of the Society-of-Gynecological-Surgeons

CY APR 14-16, 2008

CL Savannah, GA

SP Soc Gynecol Surg

ID HYSTERECTOMY RATES; UNITED-STATES; LAPAROSCOPY; OUTCOMES

AB OBJECTIVE: To estimate the incidence and characteristics of patients with vaginal cuff dehiscence after robotic cuff closure.

METHODS: We reviewed medical records from March 2004 to December 2008 of all patients with vaginal cuff dehiscence after a robotic simple and radical hysterectomy, trachelectomy, and upper vaginectomy using the robotic da Vinci Surgical System.

RESULTS: Twenty-one of 510 patients were identified with vaginal cuff dehiscence (incidence 4.1%, 95% confidence interval 2.3-5.8%). In nine patients, the robotic procedure was performed for a gynecologic malignancy. Coitus was the triggering event in 10 patients. Patients most commonly presented with vaginal bleeding and sudden gush of watery vaginal discharge. Bowel evisceration was associated in six patients. Median time to presentation was 43 days or 6.1 weeks. Nineteen cases were repaired through a vaginal approach and one combined vaginal and laparoscopic. Three of 21 patients experienced a repeat dehiscence and required a second repair.

CONCLUSION: Vaginal cuff dehiscence should be considered in patients with vaginal bleeding and sudden watery discharge after robotic cuff closure. The incidence is similar as previously reported for laparoscopic procedures. Contributing factors remain unknown but thermal effect and vaginal closure technique probably play major roles. (Obstet Gynecol 2009;114:231-5)

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ER

PT J

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Kamelle, Scott A.

Kumar, Saurabh

Chamberlain, Donald H.

Tillmanns, Todd D.

TI A Multiinstitutional Experience With Robotic-Assisted Hysterectomy With

Staging for Endometrial Cancer

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Meeting on Women's Cancer

CY FEB 05-08, 2009

CL San Antonio, TX

ID LAPAROSCOPIC HYSTERECTOMY; OUTCOMES; LYMPHADENECTOMY; LAPAROTOMY;

MANAGEMENT; SURVIVAL; SURGERY; COST

AB OBJECTIVE: To report perioperative outcomes and learning curve characteristics from a multiinstitutional experience with robotic-assisted surgical staging for endometrial cancer.

METHODS: A multiinstitutional robotic surgical consortium was created to evaluate the usefulness of robotics for gynecologic oncology surgery. An analysis of a multiinstitutional database of all patients who underwent robotic surgery for endometrial carcinoma between April 2003 and January 2009 was performed. Records were reviewed for demographic data and perioperative outcomes. Individual surgeon outcomes were analyzed as well in an attempt to evaluate characteristics of learning with incorporation of robotic technology.

RESULTS: Four hundred five patients were identified who underwent robotic surgery for endometrial cancer. Mean age was 62.2 years and mean body mass index was 32.4. Fifty-five percent of patients reported a prior abdominal surgery. Final pathologic analysis demonstrated that 89.6% of all patients had stage I and 11 disease. Mean operative time was 170.5 minutes. Mean estimated blood loss was 87.5 mL. Mean lymph node count was 15.5. Mean hospital stay was 1.8 days. Intraoperative complications occurred in 3.5% of the patients and conversion to laparotomy occurred in 6.7%. Postoperative complications were reported in 14.6% of the patients. For the group, fewer than 10 cases were required to achieve proficiency with the procedure.

CONCLUSION: Robotic technology may level the playing field between the novice and expert laparoscopist for endometrial cancer staging. Prospective trials should be undertaken to compare robotic and laparoscopic approaches to treat endometrial cancer. (Obstet Gynecol 2009;114:236-43)

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U2 2

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PT J

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Boggess, JF

AF Mendivil, Alberto

Holloway, Robert W.

Boggess, John F.

TI Emergence of robotic assisted surgery in gynecologic oncology: American

perspective

SO GYNECOLOGIC ONCOLOGY

LA English

DT Review

DE Robotics; Endometrial cancer; Cervical cancer; da Vinci

ID LAPAROSCOPIC RADICAL PROSTATECTOMY; ENDOMETRIAL CANCER;

CERVICAL-CARCINOMA; CLINICAL PATHWAY; HYSTERECTOMY; EXPERIENCE;

LAPAROTOMY; OUTCOMES; FUTURE; SYSTEM

AB Objectives. To discuss the emergence of robotic Surgery in gynecologic oncology and describe the growth of robotic surgery in a university medical center and a community based practice.

Methods. In addition to the historical evolution of the robotic assisted surgery medicine, a survey of robotic cases was performed on two robotic programs since the inception of the programs. A review of the current literature on the use of the da Vinci robot in gynecologic oncology was also performed.

Results. The robotic surgery programs at UNC Hospital and Florida Hospital are growing steadily since the inception of the programs in 2005 and 2006, respectively. Since 2005 there have also been numerous publications detailing the effectiveness, safety, and efficiency of the robot.

Conclusions. Robotic surgery is gaining acceptance and is rapidly growing as evidenced by an increased number of publications on the topic; these publications demonstrate the safety, efficacy, and improved outcomes compared to Open Surgery and conventional laparoscopy. (C) 2009 Published by Elsevier Inc.

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WC Oncology; Obstetrics & Gynecology

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PT J

AU Seamon, LG

Fowler, JM

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AF Seamon, Leigh G.

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Valmadre, Sue

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Cohn, David E.

TI A detailed analysis of the learning curve: Robotic hysterectomy and

pelvic-aortic lymphadenectomy for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Meeting of the Society-of-Gynecologic-Oncologists

CY FEB 05-08, 2009

CL San Antonio, TX

SP Soc Gynecol Oncol (SGO)

DE Robotics; Laparoscopy; Endometrial cancer; Lymphadenectomy; Learning

curve

ID LAPAROSCOPIC SURGERY; WOMEN; PROSTATECTOMY; EXPERIENCE

AB Objective. To define the learning curve for robotic hysterectomy and pelvic-aortic lymphadenectomy for endometrial carcinoma.

Methods. Patient demographics and segmental operative times on all patients at one institution who underwent robotic comprehensive surgical staging (hysterectomy, pelvic and aortic lymphadenectomy) for endometrial cancer were prospectively collected. Patients were arranged in order based on surgery date and outcomes were compared between quartiles (cases 1-20, 21-40, 41-60, and 61-79). Proficiency was defined as the point at which the slope of the curve becomes less steep for operative times. Efficiency was defined as the point at which the slope is zero. ANOVA or Fisher's exact test was used to compare the procedure times. Locally weighted regression generated smoothed lines that represent operative time over the sequence of the operations.

Results. 79 patients were comprehensively staged robotically. While age, the percentage of patients with >= 2 co-morbidities, number of patients with previous laparotomy, EBL, LOS and lymph node counts do not differ between groups, the first 20 patients had a lower BMI compared to the next 20 (27 vs. 34 kg/m(2), P=0.009). Operative times decreased from the first 20 cases to next 20, but was not significantly changed over the next three quartiles. Each component of the procedure has a separate learning curve.

Conclusions. Proficiency for robotic hysterectomy with pelvic-aortic lymphadenectomy for endometrial cancer is achieved after 20 cases; however, the number of procedures to gain efficiency varies for each portion of the case and continues to improve over time. (C) 2009 Elsevier Inc. All rights reserved.

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Z9 128

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GA 470JQ

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PT J

AU Peiretti, M

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Sanguineti, F

Maggioni, A

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Colombo, Nicoletta

Minig, Lucas

Sanguineti, Fabio

Maggioni, Angelo

TI Robotic Surgery: Changing the Surgical Approach for Endometrial Cancer

in a Referral Cancer Center

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic surgery; Endometrial cancer

ID ASSISTED VAGINAL HYSTERECTOMY; LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL

HYSTERECTOMY; LYMPHADENECTOMY; EXPERIENCE

AB Study Objective: To study the effect of robotic surgery on the surgical approach to endometrial cancer in a gynecologic oncology center over a short time.

Design: Prospective analysis of patients with early-stage endometrial cancer who underwent robotic surgery.

Setting: Teaching hospital. Patients: Eighty patients who underwent robotic surgery.

Interventions: Between November 2006 and October 2008, 80 consecutive patients with an initial diagnosis of endometrial cancer consented to undergo robotic surgery at the European Institute of Oncology, Milan, Italy.

Measurements and Main Results: We collected all patient data for demographics, operating time, estimated blood loss, histologic findings. lymphnode count. analgesic-free postoperative day, length of stay, and intraoperative and early postoperative complications. Mean (SD) patient age was 58.3 (11.5) years (95% confidence interval [CI], 55.7-60.9). Body mass index was 25.2 (6.1) kg/m(2) (95%, CI, 23.6-26.7). in 3 patients (3.7%), conversion to conventional laparotomy was required. Mean operative time was 181.1 (63.1) minutes (95% CI, 166.7-195.5). Mean docking time was 4.5 (1.1) minutes (95% CI, 2.2-2.7). Mean hospital stay was 2.5 (1.1) days (95% CI, 2.2-2.7), and 93% of patients were analgesic-free on postoperative clay 2.

Conclusions: Over a relatively short time using the da Vinci surgical system, we observed a substantial change in our surgical activity. For endometrial cancer, open surgical procedures decreased from 78% to 35%. Moreover, our preliminary data confirm that surgical robotic staging for early-stage endometrial cancer is feasible and safe. Age, obesity, and previous surgery do not seem to be contraindications. Journal of Minimally Invasive Gynecology (2009) 16, 427-431 (C) 2009 AAGL. All rights reserved.

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TC 43

Z9 45

U1 0

U2 1

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J9 J MINIM INVAS GYN

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 473KD

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ER

PT J

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Rheaume, Patrick S.

Kimball, Kristopher J.

Huh, Warner K.

Fowler, Jeffrey M.

Phillips, Gay S.

Cohn, David E.

TI Comprehensive Surgical Staging for Endometrial Cancer in Obese Patients

<i>Comparing Robotics and Laparotomy</i>

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 40th Annual Meeting of the Society-of-Gynecologic-Oncologists

CY FEB 05-08, 2009

CL San Antonio, TX

SP Soc Gynecol Oncol (SGO)

ID LAPAROSCOPY; LYMPHADENECTOMY; MANAGEMENT; OUTCOMES; WOMEN

AB OBJECTIVE: To compare adequacy and outcomes of surgical staging for endometrial cancer in obese women by robotics or laparotomy.

METHODS: Clinical stage I or occult stage II endometrial cancer patients with body mass indexes (BMIs) of at least 30 (BMI is calculated as weight (kg)/[height (m)](2)) were identified undergoing robotic staging and matched 1:2 with laparotomy patients. Patient characteristics, operative times, complications, and pathologic factors were collected. An adequate lymphadenectomy was defined arbitrarily as at least 10 total nodes removed, and adequate pelvic and paraaortic lymphadenectomy was defined as at least six and at least four nodes removed, respectively.

RESULTS: A total of 109 patients underwent surgery with the intent of robotic staging and were matched to 191 laparotomy patients. The mean BMI was 40 for each group. The robotic conversion rate was 15.6% (95% confidence interval [CI] 9.5-24.2%). Ninety-two completed robotic patients were compared with 162 matched laparotomy patients. The two groups were comparable regarding total lymph node count (25 +/- 13 compared with 24 +/- 12, P=.45) and the percentage of patients undergoing adequate lymphadenectomy (85% compared with 91%, P=.16) and adequate pelvic (90% compared with 95%, P=.16) and aortic lymphadenectomy (76% compared with 79%, P=.70) for robotic and laparotomy patients, respectively, but there was limited power to detect this difference. The blood transfusion rate (2% compared with 9%, odds ratio [OR] 0.22, 95% CI 0.05-0.97, P=.046), the number of nights in the hospital 0 compared with 3, P<.001), complications (11% compared with 27%, OR 0.29, 95% CI 0.13-0.65 P=.003), and wound problems (2% compared with 17%, OR 0.10, 95% CI 0.02-0.43, P=.002) were reduced for robotic surgery.

CONCLUSION: In obese women with endometrial cancer, robotic comprehensive surgical staging is feasible. Importantly, obesity may not compromise the ability to adequately stage patients robotically. (Obstet Gynecol 2009;114:16-21)

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NR 21

TC 98

Z9 104

U1 0

U2 4

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SC Obstetrics & Gynecology

GA 463BX

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ER

PT J

AU Estape, R

Lambrou, N

Diaz, R

Estape, E

Dunkin, N

Rivera, A

AF Estape, Ricardo

Lambrou, Nicholas

Diaz, Robert

Estape, Eric

Dunkin, Natalie

Rivera, Angel

TI A case matched analysis of robotic radical hysterectomy with

lymphadenectomy compared with laparoscopy and laparotomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; daVinci Surgical System; Laparoscopic; Radical

hysterectomy; Robotic

ID SURGICAL ROBOTICS; EXPERIENCE; SURGERY; CANCER

AB Objective. To compare robotic radical hysterectomy to laparoscopic and radical abdominal hysterectomy in the treatment of cervical cancer.

Methods. Prospective analyses of thirty-two consecutive patients undergoing robotic radical hysterectomy were compared to 17 patients undergoing laparoscopic radical hysterectomy and 14 patients undergoing radical abdominal hysterectomy.

Results. Operative time for the robotic group was 2.4 h +/- 0.8 and not significantly different from the laparoscopic group at 2.2 h +/- 0.7, nor the laparotomy group (1.9 h +/- 0.6. p = 0.05). The estimated blood loss for patients undergoing robotic hysterectomy was 130 cm(3) +/- 119.4. This was significantly less than the laparotomy group (621.4 mL +/- 294.0, p < 0.0001), but not the laparoscopic group (209.4 mL +/- 169.9. p = 0.09). The robotic group had an average of 32.4 total nodes retrieved, as compared to 18.6 and 25.7 nodes retrieved in the laparoscopy and laparotomy cohorts, respectively. All differences were significant (p < 0.0001 and p < 0.05). Mean length of hospital stay was 2.6, 2.3 and 4.0 days in the robotic. laparoscopic, and laparotomy cohorts respectively. The incidence of postoperative complications was less in the robotic cohort (18.8%) as compared to the laparoscopic (23.5%), and laparotomy cohorts (28.6%).

Conclusions. Robotic total laparoscopic radical hysterectomy with pelvic and para-aortic lymphadenectomy is feasible and may be preferable over laparoscopic or radical abdominal hysterectomy. (C) 2009 Elsevier Inc. All rights reserved.

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

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ER

PT J

AU Nezhat, C

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Nezhat, F

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Lavie, Ofer

Lemyre, Madeleine

Unal, Ebru

Nezhat, Ceana H.

Nezhat, Farr

TI Robot-assisted laparoscopic surgery in gynecology: scientific dream or

reality?

SO FERTILITY AND STERILITY

LA English

DT Article

DE Robotic-assisted laparoscopy; gynecologic surgery; da Vinci robot

ID MICROSURGICAL TUBAL ANASTOMOSIS; EXPERIENCE; HYSTERECTOMY; UROLOGY

AB Objective: To analyze the feasibility, safety, advantages, and disadvantages of using robotic technology for gynecologic surgeries in a large group of patients.

Design: Retrospective study (Canadian Task Force classification II-3).

Setting: Tertiary endoscopic referral centers.

Patient(s): Eighty-seven patients requiring laparoscopic treatments for benign gynecologic conditions.

Intervention(s): Charts reviewed from robotic-assisted gynecologic operative laparoscopies.

Main Outcome Measure(s): Length of surgery, time for robot assembly and disassembly, rate of conversion to laparotomies, and complications.

Result(s): Between January 2006 and August 2007, 137 robotically assisted gynecologic procedures were performed in 87 patients. The da Vinci Surgical System was used. The average length of the surgeries was 205 minutes (60-420 ninutes). Assembly of the robot lasted 16 minutes (10-27 minutes) when disassembly took 2.5 minutes (2-6 minutes). There were no conversions to laparotomy. There were three complications.

Conclusion(s): Robotic-assisted technology, in its present state, is enabling more surgeons to perform endoscopic surgery. Its advantages are 3D Vision and a faster learning curve for suturing and operating while sitting. It's an exciting enabling technology with a great future. (Fertil Steril (R) 2009;91:2620-2. (C)2009 by American Society for Reproductive Medicine.)

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TC 53

Z9 57

U1 0

U2 6

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J9 FERTIL STERIL

JI Fertil. Steril.

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WC Obstetrics & Gynecology; Reproductive Biology

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DA 2024-01-18

ER

PT J

AU Advincula, AP

Wang, KR

AF Advincula, Arnold P.

Wang, Karen

TI Evolving Role and Current State of Robotics in Minimally Invasive

Gynecologic Surgery

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Robotics; Laparoscopy; Computer-assisted surgery

ID ASSISTED LAPAROSCOPIC SACROCOLPOPEXY; VAGINAL VAULT PROLAPSE; RADICAL

HYSTERECTOMY; ABDOMINAL MYOMECTOMY; TUBAL ANASTOMOSIS; LEARNING-CURVE;

SURGICAL OUTCOMES; RANDOMIZED-TRIAL; CERVICAL-CANCER; UNITED-STATES

AB Advancements in conventional laparoscopy afford gynecologists the ability to treat disease with minimally invasive interventions. Procedures such as hysterectomy are still performed predominantly via laparotomy. Instrumentation, complex disease. and steep learning curves are often cited as obstacles to minimally invasive surgery. The advent of robotic technology may provide a means to overcome the limitations of conventional laparoscopy through the use of 3-dimensional imaging and more dextrous and precise instruments, Current studies clearly demonstrate the feasibility and safety of applying robotics to the entire spectrum of gynecologic procedures. Rigorous scientific studies and long-term data are needed to determine the appropriate applications of robotics in gynecology. Numerous questions still exist pertaining to costs, credentialing and privileging, and training. Journal of Minimally Invasive Gynecology (2009) 16, 291-301 (c) 2009 AAGL All rights reserved.

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U1 0

U2 4

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PG 11

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 448HI

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ER

PT J

AU Herman, B

Duy, KT

Dehez, B

Polet, R

Raucent, B

Dombre, E

Donnez, J

AF Herman, Benoit

Duy, Khanh Tran

Dehez, Bruno

Polet, Roland

Raucent, Benoit

Dombre, Etienne

Donnez, Jacques

TI Development and First In Vivo Trial of EvoLap, an Active Laparoscope

Positioner

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Compact laparoscope manipulator; Ergonomic control interface; Robotic

assistant

ID MINIMALLY INVASIVE SURGERY; SYSTEM; CAMERA; HOLDERS

AB To determine essential specifications for ail active endoscope holder. a survey of laparoscopic procedures was conducted. A review of the literature highlighted the advantages and limitations of existing scope-holding systems. From this analysis, basic requirements were listed for Such devices. Pursuant to this, ail ergonomic and user-friendly laparoscope manipulator was designed to assist the surgeon. A first in vivo procedure demonstrated feasibility of the device and its Value in clinical practice, enabling surgeons to work more comfortably. Journal of Minimally Invasive Gynecology Gynecology (2009)16, 344-9 (c) 2009 AAGL. All rights reserved.

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Z9 7

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U2 11

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ER

PT J

AU Lowe, MP

Chamberlain, DH

Kamelle, SA

Johnson, PR

Tillmanns, TD

AF Lowe, M. Patrick

Chamberlain, Donald H.

Kamelle, Scott A.

Johnson, Peter R.

Tillmanns, Todd D.

TI A multi-institutional experience with robotic-assisted radical

hysterectomy for early stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotics; Cervical cancer; Radical hysterectomy; da Vinci; Minimally

invasive surgery; Robotic radical hysterectomy

ID OF-GYNECOLOGIC-ONCOLOGISTS; EARLY ENDOMETRIAL CANCER; LAPAROSCOPIC

HYSTERECTOMY; PELVIC LYMPHADENECTOMY; CARCINOMA; LAPAROTOMY; OUTCOMES;

SURGERY; MEMBERS

AB Objective. The purpose of the study is to report a multi-institutional experience with robotic-assisted radical hysterectomy to treat patients with early stage cervical cancer with respect to perioperative outcomes.

Methods. A multi-institutional robotic surgical consortium consisting of five board-certified gynecologist oncologist in distinct geographical regions of the United States was created to evaluate the utility of robotics for gynecologic surgery (benign and malignant). Between April 2003 and August 2008, a total of 835 patients underwent robotic surgery for benign gynecologic disorders and/or gynecologic malignancies by a surgeon in the consortium. IRB approval was obtained and data was collected in a prospective fashion at each institution. For the purposes of the study, a multi-institutional HIPPA compliant database was then created for all patients that underwent robotic-assisted surgery between the April 2003 and August 2008. This database was queried for all patients who underwent a robotic-assisted type II or II radical hysterectomy for Stage IA1 (+ vsi)-IB2 cervical carcinoma. Forty-two patients were identified. Records were then reviewed for demographic data. medical conditions, prior abdominal or pelvic surgeries, and follow-up. The perioperative outcomes analyzed included: operative time (skin-skin), estimated blood loss (EBL), length of hospital stay, total lymph node count, conversion to laparotomy, and operative complications.

Results. From a database of 835 patients who underwent robotic surgery by a gynecologic oncologist, a total of 42 patients who underwent a robotic-assisted type II (n = 10) or type III (n = 32) radical hysterectomy for early stage cervical cancer were identified. Demographic data demonstrated a median age of 41 and a median BMI of 25.1. With regard to stage, seven patients (17%) were Stage IA2, twenty-eight patients (67%) were Stage IB1 and six patients (14%) were Stage IB2. There was a single patient with Stage IA1 cervical cancer with vascular space invasion who underwent a type II radical hysterectomy. The overall median operative time was 215 min. The overall median estimated blood loss was 50 cc. No patient received a blood transfusion. The median lymph node Count was 25. The median hospital stay was 1 day. Positive lymph nodes were detected in 12% of the patients. Pelvic radiotherapy or chemo-radiation was given to 14% of the patients based on final surgical pathology. Intraoperative complications Occurred in 4.8% of the patients and included one conversion to laparotomy (2.4%) and one ureteral injury (2.4%). Postoperative complications were reported in 12% of the patients and included a DVT (2.4%), infection (7.2%), and bladder/ urinary tract complication (2.4%) The conversion Fate to laparotomy was 2.4%.

Conclusions. Robotic-assisted radical hysterectomy is associated with minimal blood loss, a shortened hospital stay, and few operative complications. Operative time and lymph node yields are acceptable. This data suggests that robotic-assisted radical hysterectomy may offer an alternative to traditional radical hysterectomy. This series contributes to the growing literature on robotic-assisted radical hysterectomy and prospective comparisons with traditional radical hysterectomy are needed. (C) 2009 Elsevier Inc. All rights reserved.

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Vinatier, D

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Leblanc, E.

Vinatier, D.

TI Robotic assistance in gynaecological surgery: State-of-the-art

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Review

DE Gynaecology; Laparoscopy; Telesurgery; Robotic assistance; Da Vinci

ID VAGINAL VAULT PROLAPSE; LAPAROSCOPIC RADICAL HYSTERECTOMY; MICROSURGICAL

TUBAL ANASTOMOSIS; INITIAL CLINICAL-EXPERIENCE; MINIMALLY INVASIVE

SURGERY; PELVIC ORGAN PROLAPSE; SACRAL COLPOPEXY; ABDOMINAL MYOMECTOMY;

CERVICAL-CARCINOMA; SURGICAL TECHNIQUE

AB From the Automated Endoscopic System for Optimal Positioning (AESOP), a robotic arm which operates the laparoscope, to the robots Zeus and da Vinci, robotic assistance in gynaecological endoscopic surgery has continuously evolved for the last fifteen years or so. It has brought about new technical advancements: the last generation robots offer a steady three-dimensional image, improved instrument dexterity and precision, higher ergonomics and comfort for the Surgeon. The da Vinci robotic system has been used without evincing my specific morbidity in various cases, notably for tubal reanastomosis, myomectomy, hysterectomy, pelvic and para-aortic lymphadenectomy or sacrocolpopexy amongst others. Robotic assistance in gynaecology is thus feasible. Like conventional laparoscopic surgery, it allows decreased blood loss and morbidity as well as shorter hospital stay, as compared to laparotomy. It might indeed allow many surgical teams to perform minimally invasive surgical procedures which they were not used to performing by laparoscopy. Randomized prospective studies are needed to define its indications more precisely. Besides, its medico-financial impact should be evaluated too. (C) 2009 Elsevier Masson SAS. All rights reserved.

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PT J

AU Persson, J

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Kannisto, Paivi

Lindahl, Bengt

Bossmar, Thomas

TI Robot assisted laparoscopic radical hysterectomy and pelvic

lymphadenectomy with short and long term morbidity data

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Cervical cancer; Robotic surgery; Radical hysterectomy

ID CERVICAL-CARCINOMA; EXPERIENCE; SURGERY

AB Objective. To evaluate feasibility and morbidity of robot assisted laparoscopic radical hysterectomy. Methods. From December 2005 to September 2008 robot assisted laparoscopic radical hysterectomy and pelvic lymphadenectomy was performed on 80 women. Using a prospective protocol, and an active investigation policy for defined adverse events, perioperative, short and long term data were obtained.

Results. Time for Surgery (skin to skin) reached 176 and 132 min after 9 and 34 procedures respectively. All tumours were radically removed. Median number of retrieved lymph nodes was 26 (range 15-55). All women had an early follow up (1-3 months) and 43 of eligible 46 women (93%) had a long term follow up (>= 12 months). In 33 of 80 women (41%) the peri/postoperative period was uneventful. The remainder had one or more mainly mild adverse events, most commonly from the vaginal cuff (n = 17, 21%) or the lymphatic system (n = 16, 20%). The proportion of uneventful cases increased significantly over time. Five women were resutured for dehiscence of the vaginal cuff, two women were reoperated for trocar site hernias and one woman had a ureter Stricture that resolved following stent treatment. Eight women (14%) needed 60 days or more to resume spontaneous voiding. One 72-year old woman with disseminated endometrial cancer on autopsy died of pulmonary embolism 31 days after surgery.

Conclusions. Robot assisted laparoscopic radical hysterectomy is a feasible alternative to conventional laparoscopy and open surgery. Effort should be made to ensure proper closure of the vaginal cuff, trocar sites and to develop nerve sparing techniques. (C) 2009 Elsevier Inc. All rights reserved.

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Z9 83

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U2 7

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PT J

AU Oehler, MK

AF Oehler, Martin K.

TI Robot-assisted surgery in gynaecology

SO AUSTRALIAN & NEW ZEALAND JOURNAL OF OBSTETRICS & GYNAECOLOGY

LA English

DT Review

DE gynaecological oncology; gynaecology; laparoscopy; minimal invasive

surgery; robot-assisted laparoscopic surgery; robotic surgery

ID VAGINAL VAULT PROLAPSE; LAPAROSCOPIC HYSTERECTOMY; VESICOVAGINAL

FISTULA; RADICAL HYSTERECTOMY; EXPERIENCE; REPAIR; LYMPHADENECTOMY;

FEASIBILITY; MYOMECTOMY; CARCINOMA

AB Robotic surgery is the latest development in minimal invasive surgery. It provides superior visualisation and dexterity and therefore allows the surgeon to perform complex tasks that would exceed his/her abilities with conventional laparoscopy and would be associated with an increased morbidity if performed by laparotomy. Current evidence demonstrates the feasibility and safety of this technology in gynaecology. The costs of robotic surgery remain one of the main sources of controversy but are expected to come down with further developments of the technology. If evidence-based long-term outcome evaluations show the superiority of robotic surgery in comparison to conventional laparoscopic and open surgery, this technology will have a major impact on gynaecological surgery.

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PT J

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Carlson, MJ

Phillips, GS

Fowler, JM

AF Seamon, Leigh G.

Cohn, David E.

Henretta, Melissa S.

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Carlson, Matthew J.

Phillips, Gary S.

Fowler, Jeffrey M.

TI Minimally invasive comprehensive surgical staging for endometrial

cancer: Robotics or laparoscopy?

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 39th Annual Meeting of the Society-of-Gynecologic-Oncologists

CY MAR 09-12, 2008

CL Tampa, FL

SP Soc Gynecol Oncol

DE Robotic surgery; Laparoscopy; Hysterectomy; Lymph node dissection;

Endometrial cancer; Gynecology

ID ASSISTED VAGINAL HYSTERECTOMY; ADJUVANT RADIATION-THERAPY;

MORBID-OBESITY; LYMPHADENECTOMY; MANAGEMENT; SURVIVAL; SURGERY;

LAPAROTOMY; WOMEN; EXPERIENCE

AB Objective. To compare outcomes between robotic versus laparoscopic hysterectomy and lymphadenectomy in patients with endometrial cancer.

Methods. A cohort study was performed by prospectively identifying all patients with clinical stage I or occult stage 11 endometrial cancer who underwent robotic hysterectomy and lymphadenectomy from 20062008 and retrospectively comparing data using the same surgeons' laparoscopic hysterectomy and lymphadenectomy cases from 1998-2005, prior to our robotic experience. Patient demographics, operative times, complications, conversion rates, pathologic results, and length of stay were analyzed.

Results. 181 patients (105 robotic and 76 laparoscopic) met inclusion criteria. There was no significant difference between the two groups in median age, uterine weight, bilateral pelvic or aortic lymph node counts, or complication rates in patients whose surgeries were completed minimally invasively. Despite a higher BMI (34 vs. 29, P<0.001), the estimated blood loss (100 vs. 250 ml, P<0.001), transfusion rate (3% vs. 18%, RR 0.18, 95%CI 0.05-0.64, P=0.002), laparotomy conversion rate (12% vs. 26%, RR 0.47, 95%CI 0.25-0.89, P=0.017), and length of stay (median: I vs. 2 nights, P<0.001) were lower in the robotic patients compared to the laparoscopic cohort. The odds ratio of conversion to laparotomy based on BMI for robotics compared to laparoscopy is 0.20 (95% CI 0.08-0.56, P=0.002). The mean skin to skin time (242 vs. 287 min, P<0.001) and total room time (305 vs. 336 min, P<0.001) was shorter for the robotic cohort.

Conclusion. Robotic hysterectomy and lymphadenectomy for endometrial carcinoma can be accomplished in heavier patients and results in shorter operating times and hospital length of stay, a lower transfusion rate, and less frequent conversion to laparotomy when compared to laparoscopic hysterectomy and lymphadenectomy. (C) 2008 Elsevier Inc. All rights reserved.

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PT J

AU Leblanc, E

Narducci, F

Lefebvre, D

Villers, A

AF Leblanc, E.

Narducci, F.

Lefebvre, D.

Villers, A.

TI How I do ... to define circumstances of an immediate conversion into a

laparotomy, during a laparoscopic or a robotically-assisted laparoscopic

surgery

SO GYNECOLOGIE OBSTETRIQUE & FERTILITE

LA French

DT Article

DE Laparoscopy; Da Vinci robot; Conversion; Hypocarbia

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ER

PT J

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Soliman, PT

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Sharma, Sheena

Schmeler, Kathleen M.

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Ramirez, Pedro T.

TI Trends in laparoscopic and robotic surgery among gynecologic

oncologists: A survey update

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Gynecologic oncology; Laparoscopy; Evaluation

ID RADICAL HYSTERECTOMY; ENDOMETRIAL CANCER; PELVIC LYMPHADENECTOMY;

CERVICAL-CANCER; ABDOMINAL HYSTERECTOMY; 10-YEAR EXPERIENCE;

OVARIAN-CANCER; LAPAROTOMY; MANAGEMENT; SAFETY

AB Objectives. To assess the use of traditional and robotic assisted laparoscopy by Society of Gynecologic Oncology (SGO) members and to compare the results With those Of Our published Survey in 2004.

Methods. Surveys were mailed to SGO members, and anonymous responses were collected by mail or through a web site. Data were analyzed and compared with those of our previous survey. In addition. we gathered information on the effect of robotic assisted Surgery on the management of gynecologic malignancies.

Results. Three hundred eighty-eight (46%) of 850 SGO members responded to the Survey. Three hundred fifty-two (91%) indicated that they performed laparoscopic surgery in their practice (compared with 84% in the 2004 Survey). The three most common laparoscopic procedures were laparoscopic hysterectomy and staging for uterine cancer (43%), diagnostic laparoscopy for adnexal masses (39%), and prophylactic bilateral oophorectomy for high-risk women (11%), Although 76% of respondents had received either limited or no laparoscopic training during their fellowship, 78% now believe that maximum or much emphasis should be placed on laparoscopic training (55% in the 2004 survey). Twenty-four percent of respondents indicated that they performed robotic assisted Surgery, with 66% indicating that they planned to increase their use of the procedure in the next year.

Conclusions. We found an overall increase in the use of and perceived indications for minimally invasive surgery in gynecologic oncology among SGO members. Endometrial cancer staging has become an accepted indication for laparoscopy. In addition, most respondents were planning on increasing their use of robotic assisted surgery in the next year. (C) 2008 Elsevier Inc. All rights reserved.

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PT J

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TI Robotic surgery in gynecologic oncology

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE cervical cancer; endometrial cancer; gynecologic oncology; ovarian

cancer; robotic surgery

ID LAPAROSCOPIC RADICAL HYSTERECTOMY; CERVICAL-CARCINOMA; PARAAORTIC

LYMPHADENECTOMY; PELVIC LYMPHADENECTOMY; ENDOMETRIAL CANCER

AB Purpose of review

Robotic surgery is rapidly taking the place of laparoscopy in many gynecologic oncology practices. Numerous practitioners have published their experience with this new technology. A review of their findings is timely and relevant.

Recent findings

The majority of case series of robotic surgery for hysterectomy and lymphadenectomy show that the procedure is feasible and at least comparable to laparoscopic surgery. Similarly, case series of robotic radical hysterectomy for cervical cancer also compare favorably to laparoscopic surgery. Less common procedures such as robotic trachelectomy, parametrectomy, and retroperitoneal lymphadenectomy have also been described. Numerous patient and practitioner advantages are discussed in this review.

Summary

Robotic surgery is a minimally invasive alternative to laparoscopy for the surgical treatment of endometrial cancer and cervical cancer. Its role in ovarian cancer is just starting to be explored. Keywords

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U2 2

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AU Nezhat, C

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Lemyre, M

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Barnett, Ofra

Lemyre, Madeleine

TI Robotic-assisted laparoscopic myomectomy compared with standard

laparoscopic myomectomy-a retrospective matched control study

SO FERTILITY AND STERILITY

LA English

DT Article

DE Robotic-assisted myomectomy; laparoscopic myomectomy; da Vinci robotics;

minimally invasive surgery

ID MICROSURGICAL TUBAL ANASTOMOSIS; ABDOMINAL MYOMECTOMY; SURGERY;

EXPERIENCE; GYNECOLOGY; UROLOGY

AB Objective: Compare robotic-assisted laparoscopic myomectomy (RALM) to a matched control standard laparoscopic myomectomy (LM).

Design: A retrospective matched control study.

Setting: Private practice setting.

Patient(s): Premenopausal and postmenopausal women who underwent either robotic-assisted or standard laparoscopic myomectomy.

Intervention(s): None.

Main Outcome Measure(S): Retrospective chart review was performed. Cases of laparoscopic robotic-assisted myomectomies were compared with a matched control group of standard LM. Comparisons were based on Fisher's exact, Mann-Whitney, and exact chi-square tests.

Result(S): Between January 2006 and August 2007, 15 consecutive RALMs were performed at our institution, compared with 35 matched control standard LMs. The two groups were matched by age, body mass index, parity, previous abdominopelvic surgery, size, number, and location of myomas. Mean surgical time for the RALM was 234 minutes (range 140-445) compared with 203 minutes (range 95-330) for standard LMs. Blood loss, hospitalization time, and postoperative complications were not significantly different.

Conclusion(S): The RALM required a significant prolonged surgical time over LM. It appears that in the hands of a skilled laparoscopic surgeon, the RALM does not offer any major advantage. This technology, however, offers exciting potential applications while learning endoscopic surgery. Further studies are warranted to asses the utility of RALM for general gynecologic surgeons. (Fertil Steril(R) 2009;91:556-9. (C)2009 by American Society for Reproductive Medicine.)

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NR 24

TC 132

Z9 147

U1 1

U2 8

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J9 FERTIL STERIL

JI Fertil. Steril.

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VL 91

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PG 4

WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA 408OW

UT WOS:000263445300034

PM 18377901

OA hybrid

DA 2024-01-18

ER

PT J

AU Patel, M

O'Sullivan, D

Tulikangas, P

AF Patel, Minita

O'Sullivan, David

Tulikangas, Paul K.

TI A comparison of costs for abdominal, laparoscopic, and robot-assisted

sacral colpopexy

SO INTERNATIONAL UROGYNECOLOGY JOURNAL

LA English

DT Article

CT 29th Annual Meeting of the American-Urogynecologic-Society

CY SEP 04-06, 2008

CL Chicago, IL

SP Amer Urogynecol Soc

DE Estimated hospital charges; Estimated hospital costs; Sacral colpopexy

ID PELVIC ORGAN PROLAPSE; SURGERY

AB The aim of this study was to compare the short-term estimated hospital costs and charges for open, laparoscopic, and robot-assisted sacral colpopexy. The null hypothesis was that there would be no difference in costs and charges. Fifteen comparable cases were reviewed for demographics, surgical information, and estimated hospital charges and costs and then compared with analysis of variance. There were no differences in demographics and surgical variables among the three groups. For estimated hospital charges, minimally invasive sacral colpopexy was most expensive; open was the least expensive approach. The estimated direct costs were significantly higher for robot-assisted compared with open sacral colpopexy, but not different between robot-assisted and laparoscopic sacral colpopexy. Robot-assisted sacral colpopexy produces the highest estimated hospital charges and is more expensive than open sacral colpopexy. The least expensive surgical approach from the hospital costs perspective is open abdominal sacral colpopexy.

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NR 10

TC 56

Z9 58

U1 0

U2 1

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J9 INT UROGYNECOL J

JI Int. Urogynecol. J.

PD FEB

PY 2009

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BP 223

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PG 6

WC Obstetrics & Gynecology; Urology & Nephrology

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SC Obstetrics & Gynecology; Urology & Nephrology

GA 393YQ

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PM 18923803

DA 2024-01-18

ER

PT J

AU Schneider, A

K枚hler, C

Erdemoglu, E

AF Schneider, Achim

Koehler, Christhardt

Erdemoglu, Evrim

TI Current developments for pelvic exenteration in gynecologic oncology

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE indications; laparoscopy; pelvic exenteration; urinary diversion

ID DIVERSION ROME POUCH; CERVICAL-CANCER; URINARY-DIVERSION; LAPAROSCOPY

PRIOR; FECAL DIVERSION; PORCINE MODEL; RECONSTRUCTION; ANASTOMOSES;

ACCURACY; SURGERY

AB Purpose of review

The present review aims to update new techniques of pelvic exenteration including minimal invasive surgery, and discuss other aspects of this radical surgery, including worldwide differences.

Recent findings

Major advances are made since the first description of pelvic exenteration and the operation is still under evolution. Explorative laparoscopy prior to exenteration is a valuable alternative to laparotomy to elect candidates for pelvic exenteration. There are considerable differences with respect to indications, contraindications, preoperative staging and adjuvant therapy after exenteration in different countries. Advances in laparoscopic instruments also led to the laparoscopic exenteration. The main limiting step of the operation is urinary diversion. New techniques of laparoscopic-assisted and robotic-assisted techniques of urinary diversion have been reported that decrease the operation time. Vascularized muscle flaps are preferred by many surgeons to fill the empty pelvis and provide an acceptable vaginal reconstruction. J-pouch seems to be a safer technique than end-to-end coloanal anastomosis for bowel reconstruction. Developments in the bioengineering tissue for pelvic reconstruction are required.

Summary

Laparoscopy has the advantages of decreased blood loss, improved convalescence, lower incidence of wound infection and incisional hernia, short recovery periods, rapid return of bowel function, better pain control and improved cosmetics compared with laparotomy for pelvic exenteration. Magnification and improved visualization permits enbloc dissection of tumor and good anastomosis technique. New techniques of urinary diversion, orthotopic neobladder and coloanal are promising.

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NR 29

TC 21

Z9 23

U1 0

U2 1

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

PD FEB

PY 2009

VL 21

IS 1

BP 4

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 403QA

UT WOS:000263095900003

PM 19124997

DA 2024-01-18

ER

PT J

AU L枚nnerfors, C

Persson, J

AF Lonnerfors, Celine

Persson, Jan

TI Robot-assisted laparoscopic myomectomy; a feasible technique for removal

of unfavorably localized myomas

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE Uterine myomas; robot-assisted laparoscopic surgery

ID ABDOMINAL MYOMECTOMY; UTERINE FIBROIDS; COMPLICATIONS; EMBOLIZATION;

MANAGEMENT; PREGNANCY; FERTILITY; LEIOMYOMA; OUTCOMES

AB Objective. To describe the feasibility of robot-assisted laparoscopic myomectomy for unfavorably localized myomas using the da Vinci surgical system. Design. Prospective observational. Setting. University hospital. Method. Between April 2006 and March 2008, a robot-assisted laparoscopic myomectomy was performed on 13 women selected for having deep intramural myomas with probable impact on fertility and/or later pregnancy. The alternative surgical approach for all 13 was myomectomy via laparotomy. A transvaginal ultrasonography (TVUS) mapping of the myomas was performed to enable an optimal approach during surgery. Using a prospective protocol, relevant times at the operating theater as well as postoperative and follow-up data, were obtained. Results. Median time for surgery was 132 minutes (range 94-209 minutes). Median blood loss was 50 ml (range 25-200 ml). No significant complication occurred during or after surgery. Median postoperative hospital stay was one day (range 1-3 days). At follow-up, including TVUS, no unexpected residual myomas larger than 5 mm were identified. Of eight women with an active wish for conception, six have become pregnant a median time of 15 months after surgery. All additional symptoms associated with the myomas were alleviated. Conclusion. Robot-assisted laparoscopic myomectomy is a feasible technique for removal of deep intramural myomas unfavorably localized for traditional laparoscopy. The properties of the da Vinci robot facilitate dissection and suturing comprising the major surgical parts of myomectomy.

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NR 24

TC 35

Z9 36

U1 0

U2 1

PU WILEY

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J9 ACTA OBSTET GYN SCAN

JI Acta Obstet. Gynecol. Scand.

PY 2009

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 485BH

UT WOS:000269094900008

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OA Bronze

DA 2024-01-18

ER

PT J

AU McLean, K

Dillman, JR

McCarthy, JD

Strouse, PJ

Quint, EH

Advincula, AP

AF McLean, Karen

Dillman, Jonathan R.

McCarthy, Jenifer D.

Strouse, Peter J.

Quint, Elisabeth H.

Advincula, Arnold P.

TI Delayed Iliac Artery Thrombosis after Blunt Trauma during Operative

Laparoscopy

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Laparoscopy; Vascular injury; Trocar; Thrombus

ID MAJOR VASCULAR INJURY; RECOGNITION; ANOMALIES; ACCESS

AB Major vascular injury during laparoscopic surgery is an uncommon but serious complication. A small number of earlier case reports describe delayed diagnosis of vascular lacerations. Herein we report a unique case of a robot-assisted laparoscopic resection of an obstructed uterine horn, complicated by delayed postoperative presentation of a common iliac artery thrombus without extravascular hemorrhage. The injury was likely caused by blunt trauma to the exterior of the vessel with damage to the vascular intima and subsequent dissection. Meticulous surgical technique, accurate diagnosis, and subsequent treatment are essential to decrease morbidity from such major vascular injuries at the time of laparoscopy. Journal of Minimally Invasive Gynecology (2009) 16, 102-105 (C) 2009 AAGL. All rights reserved.

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TC 3

Z9 3

U1 0

U2 0

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J9 J MINIM INVAS GYN

JI J. Minim. Invasive Gynecol.

PD JAN-FEB

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 393VW

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PM 19110192

DA 2024-01-18

ER

PT J

AU Schreuder, HWR

Verheijen, RHM

AF Schreuder, H. W. R.

Verheijen, R. H. M.

TI Robotic surgery

SO BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY

LA English

DT Review

DE Gynaecology; laparoscopy; robotics; robotic surgery; training

ID ASSISTED LAPAROSCOPIC SURGERY; VATTIKUTI-INSTITUTE PROSTATECTOMY;

MICROSURGICAL TUBAL ANASTOMOSIS; INITIAL CLINICAL-EXPERIENCE; VINCI

SURGICAL SYSTEM; RADICAL CYSTECTOMY; LEARNING-CURVE; VIRTUAL-REALITY;

CERVICAL-CARCINOMA; VESICOVAGINAL FISTULA

AB Over the past decade, there has been an exponential growth of robot-assisted procedures and of publications concerning robotic-assisted laparoscopic surgery. From a review of the available literature, it becomes apparent that this technology is safe and allows more complex procedures in many fields of surgery, be it at relatively high costs. Although randomised controlled trials in gynaecology are lacking, available evidence suggests that particularly in gynaecology robotic surgery might not only reduce morbidity but also be cost effective if performed in high-volume centres. Training in robotic surgery and programs for safe and effective implementation are necessary.

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NR 209

TC 71

Z9 79

U1 5

U2 37

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J9 BJOG-INT J OBSTET GY

JI BJOG

PD JAN

PY 2009

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BP 198

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DI 10.1111/j.1471-0528.2008.02038.x

PG 16

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 382WC

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OA Bronze

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ER

PT J

AU Delotte, J

Karimdjee, B

Bouaziz, J

Trastour, C

Bernard, JL

Benchimol, D

Bongain, A

AF Delotte, J.

Karimdjee, B.

Bouaziz, J.

Trastour, C.

Bernard, J. -L.

Benchimol, D.

Bongain, A.

TI Feasibility and preliminary experiment of a routine use of Da-Vinci S庐

in fertility surgery

SO JOURNAL DE GYNECOLOGIE OBSTETRIQUE ET BIOLOGIE DE LA REPRODUCTION

LA French

DT Article

DE Robotic surgery; Fertility; Da-vinci (R)

ID LAPAROSCOPIC SURGERY

AB Objectives.- The goat of our study is to evaluate the use of Da-Vinci S (R) in the field of fertility laparoscopic surgery.

Materials and methods.-Ten successive patients were included for a laparoscopic fertility surgery using the Da-Vinci S (R). Surgical feasibility, operating time, length of hospital stay and postoperative complications have been analyzed.

Results.- All. procedures have been completed using Da-Vinci S (R).

Conclusion.- In our preliminary surgical experience, the Da-Vinci S (R) can be technically used in the field of fertility surgery. (c) 2008 Elsevier Masson SAS. Tous droits reserves.

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NR 9

TC 5

Z9 5

U1 0

U2 2

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J9 J GYNECOL OBST BIO R

JI J. Gynecol. Obstet. Biol. Reprod.

PD DEC

PY 2008

VL 37

IS 8

BP 753

EP 757

DI 10.1016/j.jgyn.2008.09.004

PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 388KI

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ER

PT J

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Holloway, RW

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Bigsby, Glenn E.

Pikaart, Dirk P.

Ahmad, Sarfraz

Finkler, Neil J.

TI Robotically assisted laparoscopic hysterectomy versus total abdominal

hysterectomy and lymphadenectomy for endometrial cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Endometrial cancer; Robotic-assisted laparoscopic hysterectomy;

Lymphadenectomy; Clinical-pathologic analyses; Post-operative;

Complications

ID UTERINE-CANCER; EXPERIENCE; SURGERY

AB Objective. To compare surgical morbidity and clinical-pathologic factors for patients with endometrial cancer (EC) undergoing robotic-assisted laparoscopic hysterectomy (RALH) versus total abdominal hysterectomy (TAH) with aortic and/or pelvic lymphadenectomy (LA).

Methods. During the first 14 months of a robotics surgical program. 56 patients with EC were scheduled to undergo RALH with LA. Cases were analyzed for operative (op) time, estimated blood loss (EBL), transfusion, intra- and post-op complications, surgical-pathologic data, patient demographics and length of stay (LOS). Data was compared to 106 serially treated patients with EC Who underwent TAH with LA immediately prior to initiation Of Our robotics program.

Results. Three robotic cases (5.4%) were converted to TAH secondary to intra-op factors. FIGO stages for RALH vs. TAH were: stage 1 (82 vs. 69%,), stage II (7 vs. 7.5%) and stage III (11 vs. 21.5%). Patients' mean age was 59 +/- 10 vs. 63 +/- 11 years (p=0.05) and body mass index (BMI) was 29 +/- 6.5 vs. 34 +/- 9 kg/m(2) (p=0.0001) for the robotic and open groups, respectively. Severe medical co-morbidities affected 5.4% of robotic patients compared to 8.5% of open cases (p>0.05). Comparing RALH and TAH, mean op time was 177 +/- 55 vs. 79 +/- 17 min (p=0.0001) EBL was 105 +/- 77 vs, 241 +/- 115 ml (p<0.0001), transfusion was 0 vs. 8.5% (p=0.005), and LOS was 1.0 +/- 0.5 vs. 3.2 +/- 1.0 days (p<0.0001). Robotic patients incurred a 3.6% major peri-operative complication rate while women undergoing open procedures had an incidence of 20.8% (p=0.007). Total lymph node Count was 19 +/- 13 nodes for robotic cases vs. 18 +/- 10 nodes obtained from open hysterectomy patients.

Conclusions. Patients with EC who underwent RALH with LA during the first year of our robotics program were younger, thinner and had less cardio-pulmonary illness than patients previously treated with TAH and LA. LOS, EBL and peri-op complication rates were significantly lower for the robotic cohort. (C) 2008 Elsevier Inc. All rights reserved.

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Z9 146

U1 0

U2 4

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J9 GYNECOL ONCOL

JI Gynecol. Oncol.

PD DEC

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IS 3

BP 412

EP 417

DI 10.1016/j.ygyno.2008.08.025

PG 6

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Oncology; Obstetrics & Gynecology

GA 384PZ

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DA 2024-01-18

ER

PT J

AU Geller, EJ

Siddiqui, NY

Wu, JM

Visco, AG

AF Geller, Elizabeth J.

Siddiqui, Nazenza Y.

Wu, Jennifer M.

Visco, Anthony G.

TI Short-Term Outcomes of Robotic Sacrocolpopexy Compared With Abdominal

Sacrocolpopexy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 29th Annual Meeting of the American-Urogynecologic-Society

CY SEP 04-06, 2008

CL Chicago, IL

SP Amer Urogynecol Soc

ID PELVIC ORGAN PROLAPSE; LAPAROSCOPIC SACROCOLPOPEXY; HYSTERECTOMY;

MANAGEMENT; SURGERY; REPAIR

AB OBJECTIVE: To compare short-term Outcomes of robotic sacrocolpopexy with abdominal sacrocolpopexy for vaginal vault prolapse.

METHODS: We conducted a retrospective cohort study comparing robotic to abdominal sacrocolpopexy with placement of permanent mesh. The primary Outcome was vaginal vault Support on 6-week postoperative pelvic organ prolapse quantification (POP-Q) system examination. Secondary outcomes included blood loss, operative time, length of stay, blood transfusion, pulmonary embolus, gastrointestinal or genitourinary tract injury, ileus, bowel obstruction, postoperative fever, pneumonia, wound infection, and urinary retention.

RESULTS: The analysis included 178 patients (73 robotic and 105 abdominal sacrocolpopexy). There were no differences in age, race, or body mass index. Robotic sacrocolpopexy showed slight improvement on POP-Q "C" point (-9 compared with -8, P=.008) when compared with abdominal sacrocolpopexy and was associated with less blood loss (103 +/- 96 mL compared with 255 +/- 155 mL, P <.001), longer total operative time (328 +/- 55 minutes compared with 225 +/- 61 minutes, P <.001), shorter length of stay (1.3 +/- 0.8 days compared with 2.7 +/- 1.4 days, P <.001), and a higher incidence of postoperative fever (4.1% compared with 0.0%, P=.04). There were no differences in other secondary outcomes. Operative time remained significantly greater in the robotic group (P <.001), and estimated blood loss remained lower (P <.001) when controlling for possible confounders.

CONCLUSION: Robotic sacrocolpopexy demonstrated similar short-term vaginal vault support compared with abdominal sacrocolpopexy, with longer operative time, less blood loss, and shorter length of stay. Long-term data are needed to assess the durability of this new minimally invasive procedure.

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NR 18

TC 206

Z9 214

U1 0

U2 5

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

PD DEC

PY 2008

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IS 6

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PG 6

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Conference Proceedings Citation Index - Science (CPCI-S)

SC Obstetrics & Gynecology

GA 378JE

UT WOS:000261316200003

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ER

PT J

AU Ko, EM

Muto, MG

Berkowitz, RS

Feltmate, CM

AF Ko, Emily M.

Muto, Michael G.

Berkowitz, Ross S.

Feltmate, Colleen M.

TI Robotic versus open radical hysterectomy: A comparative study at a

single institution

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic radical hysterectomy; Open radical hysterectomy; Cervical

cancer; Minimally invasive surgery; Early stage cervical cancer;

Surgical factors

ID PERIOPERATIVE BLOOD-TRANSFUSION; VAGINAL HYSTERECTOMY; ENDOMETRIAL

CANCER; PELVIC LYMPHADENECTOMY; GYNECOLOGIC-ONCOLOGY; CERVICAL-CANCER;

LAPAROTOMY; SURGERY; EXPERIENCE; RECURRENCE

AB Objective. To compare the short-term surgical outcome of patients undergoing robotic radical hysterectomy (RRH) versus open radical hysterectomy (ORH) for the treatment of early stage cervical cancer.

Methods. IRB approval was obtained for a retrospective chart review of all radical hysterectomies (RHs) for Stage I and II cervical cancer performed at Brigham and Women's Hospital between August 1, 2004 and August 1, 2007. Prior to August 1, 2006 all procedures were ORHs. After this date, all procedures were RRHs. Demographic data, operative data and short-term outcomes were compared. Statistical analysis using t-tests and Fisher's Exact test were performed with SAS software.

Results. A total of 48 RHs were identified, including 16 RRHs and 32 ORHs. The groups did not differ significantly in age, body mass index, stage, or histology. Mean operative time was significantly longer for RRH than ORH (4:50 vs 3:39 h, p=0.0002). The mean estimated blood loss was significantly less for RRH than ORH (81.9 vs 665.6 mL, p<0.0001). The mean number of lymph nodes resected did not differ between RRHs and ORHs (15.6 vs 17.1, p=0.532). There were no intra-operative complications in the RRH group and one ureteral transection in the ORH group. Three RRH patients (18.8%) suffered post-operative complications which included a vaginal cuff inflected hematoma, a transient ureterovaginal fistula, and a pelvic lymphocele, in comparison to seven in the ORH group (21.9%) which included 3 wound infections, two patients with pulmonary emboli, a partial small bowel obstruction with a mesenteric abscess, and a post-operative ileus (p=0.999). Mean length of stay was significantly shorter for the RRH group (1.7 vs. 4.9 days, p<0.0001). 1

Conclusion. RRH results in lower blood loss and shorter length of stay, compared to ORH. Intra-operative and post-operative complication rates are comparable. RRH is a promising new Surgical technique that deserves further study. (C) 2008 Elsevier Inc. All rights reserved,

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FX Allison Vitonis is acknowledged for statistical support.

NR 31

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Z9 93

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U2 2

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WC Oncology; Obstetrics & Gynecology

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GA 384PZ

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ER

PT J

AU Persson, J

Kannisto, P

Bossmar, T

AF Persson, J.

Kannisto, P.

Bossmar, T.

TI Robot-assisted abdominal laparoscopic radical trachelectomy

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic surgery; Cervical cancer; Trachelectomy

ID CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; CARCINOMA; HYSTERECTOMY

AB Background. Radical trachelectomy in conjunction with pelvic lymphadenectomy is an established method to preserve fertility in early cases of cervical cancer. The radical trachelectomy is usually performed vaginally despite the initial use of laparoscopy for the lymphadenectomy. The complexity of a laparoscopic abdominal trachelectomy may explain this dual approach. Here we describe the surgical technique of a robot-assisted laparoscopic radical trachelectomy with lymphatic mapping using a radiotracer and without a vaginal approach.

Cases and surgical technique. Two nulliparous women with early cervical cancer Underwent a laparoscopic radical trachelectomy and pelvic lymphadenectomy with the assistance of the da Vinci robot (Intuitive Surgical Inc, Sunnyvale, CA). After the sentinel lymph nodes were found negative on frozen section, the parametria, paracolpia and sacrouterine ligaments were dissected sparing the main branches of the uterine arteries. Following ligation of the descending branches of the uterine arteries the cervix and the vagina were transsected Using monopolar diathermia and the vagina was sutured to the remaining cervix. Finally, a permanent cerclage was placed. Time for surgery was 387 and 358 min respectively. No perioperative complications were noted and the postoperative period was Uneventful in both cases.

Conclusions. Robot-assisted laparoscopic abdominal trachelectomy is a feasible alternative to a combined laparoscopic and vaginal approach. (C) 2008 Elsevier Inc. All rights reserved.

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NR 13

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U1 1

U2 6

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PT J

AU Seamon, LG

Cohn, DE

Richardson, DL

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AF Seamon, Leigh G.

Cohn, David E.

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Valmadre, Sue

Carlson, Malthew J.

Phillips, Gary S.

Fowler, Jeffrey M.

TI Robotic Hysterectomy and Pelvic-Aortic Lymphadenectomy for Endometrial

Cancer

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ASSISTED VAGINAL HYSTERECTOMY; GYNECOLOGIC-ONCOLOGY; LAPAROSCOPIC

HYSTERECTOMY; LEARNING-CURVE; SURGERY; EXPERIENCE; CARCINOMA; SURVIVAL;

MANAGEMENT; MORBIDITY

AB OBJECTIVE: To report the learning curve and outcomes after Our first 105 patients underwent robotic hysterectomy and pelvic-aortic lymphadenectomy for the comprehensive staging of endometrial cancer.

METHODS: We prospectively collected patient demographics, operative times, complications, pathologic results, and length of stay on all patients who underwent robotic hysterectomy pelvic-aortic lymphadenectomy for clinical stage I or occult stage II endometrial carcinoma.

RESULTS: One hundred five patients at The Ohio State University between March 2006 and April 2008 underwent exploration with the intent of robotic hysterectomy pelvic-aortic lymphadenectomy. Ninety-two (87.6%) were completed robotically and 13 (12.4%) were converted. The probability of conversion was 15% (95% confidence interval [CI] 8.4-25.7), 24%, (95%, CI 12.4-39.9), 35% (95% CI 15.9-59.6), and 48% (95% CI 19.1-77.8) for a body mass index of 40, 45, 50, and 55 kg/m(2), respectively. The median body mass index was 34 kg/m(2) (range 19-58). In patients who underwent a robotic hysterectomy pelvic-aortic lymphadenectomy (n=79, 75%) or a robotic hysterectomy-pelvic lymphadenectomy (n=6, 5.7%), the average operating time from skin opening to Closure was 242 minutes (+/- 50 minutes). The median estimated blood loss was 99 mL (+/- 83 mL). The median number of lymph nodes recovered was 29 (range 9-56), 21 (range 5-40) pelvic nodes and 9 (range 2-21) aortic nodes. The median length of stay was 1 night. After analysis of the data, we determined approximately 20 cases are needed to gain proficiency.

CONCLUSION: Early experience demonstrates that robotic hysterectomy pelvic-aortic lymphadenectomy for endometrial cancer is feasible, with approximately 20 procedures needed to gain proficiency.

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Z9 92

U1 0

U2 1

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ER

PT J

AU Visco, AG

Advincula, AP

AF Visco, Anthony G.

Advincula, Arnold P.

TI Robotic Gynecologic Surgery

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; VAGINAL VAULT PROLAPSE; TUBAL

ANASTOMOSIS; RADICAL HYSTERECTOMY; ABDOMINAL MYOMECTOMY; SURGICAL

OUTCOMES; SACRAL COLPOPEXY; RANDOMIZED-TRIAL; EXPERIENCE; SACROCOLPOPEXY

AB The objective of this article is to review the recent adoption, experience, and applications of robot-assisted laparoscopy in gynecologic surgery. The use of robotics in gynecologic surgery is increasing in the United States. Robotic-assisted laparoscopic surgeries in gynecology include benign hysterectomy, myomectomy, tubal reanastomoses, radical hysterectomy, lymph node dissections, and sacrocolpopexies. The majority of the current literature includes case series of various robotic surgeries. Recently, comparative retrospective and prospective studies have demonstrated the feasibility of this particular type of surgery. Although individual studies vary, robot-assisted gynecologic surgery is often associated with longer operating room time but generally similar clinical outcomes, decreased blood loss, and shorter hospital stay. Robot-assisted gynecologic Surgery will likely continue to develop as more gynecologic surgeons are trained and more patients seek minimally invasive surgical options. Well-designed, prospective studies with well-defined clinical, long-term outcomes, including complications, cost, pain, return to normal activity, and quality of life, are needed to fully assess the value of this new technology.

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NR 63

TC 145

Z9 158

U1 0

U2 14

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ER

PT J

AU Chuang, LT

Lerner, DL

Liu, CS

Nezhat, FR

AF Chuang, Linus T.

Lerner, Dimitry L.

Liu, Connie S.

Nezhat, Farr R.

TI Fertility-sparing Robotic-assisted Radical Trachelectomy and Bilateral

Pelvic Lymphadenectomy in Early-stage Cervical Cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Robotic-assisted; Trachelectomy; Fertility preservation; Radical

trachelectomy

ID OF-THE-LITERATURE; VAGINAL TRACHELECTOMY; INITIAL-EXPERIENCE;

HYSTERECTOMY; CARCINOMA; PRESERVATION; SURGERY; SERIES

AB A combined pelvic lymphadenectomy with radical vaginal trachelectomy is an alternative to radical hysterectomy in the treatment of young women with cervical cancer desiring fertility preservation. This technique requires advanced vaginal surgery skills not commonly acquired. In an attempt to simplify the procedure we preformed what we believe to be the first case of robotic-assisted radical trachelectomy. A 30-year-old woman, gravida 1, para 1, desiring fertility preservation was given the diagnosis of invasive adenocarcinoma on cervical cone excision. The patient was treated with robotic-assisted pelvic lymphadenectomy and radical trachelectomy. We hope robotic-assisted radical trachelectomy will become an option for select women with early-stage cervical cancer who desire fertility preservation. Journal of Minimally Invasive Gynecology (2008) 15, 767770 (C) 2008 AAGL. All rights reserved.

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U1 0

U2 6

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ER

PT J

AU Liu, C

Peresic, D

Samadi, D

Nezhat, F

AF Liu, Connie

Peresic, Dusan

Samadi, David

Nezhat, Farr

TI Robotic-assisted Laparoscopic Partial Bladder Resection for the

Treatment of Infiltrating Endometriosis

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE Vesical endometriosis; Robotic; Bladder resection

ID URINARY-TRACT

AB This article reveals our surgical approach for treatment of a patient with severe pelvic and infiltrative bladder endometriosis with mucosal involvement using robotic-assisted laparoscopic excision and cystotomy repair. To out-knowledge, this is the first case of total robotic-assisted laparoscopic partial bladder resection for the treatment of endometriosis. This article also discusses the pros and cons of robotic-assisted surgery and the current literature on infiltrative bladder endometriosis. Journal of Minimally Invasive Gynecology (2008) 15, 745-748 (C) 2008 AAGL. All rights reserved.

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Z9 41

U1 0

U2 1

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ER

PT J

AU Nezhat, F

AF Nezhat, Farr

TI Minimally invasive surgery in gynecologic oncology: Laparoscopy versus

robotics

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Minimally invasive surgery; Laparoscopy; Robotic-assisted surgery

AB The role of laparoscopy has evolved from a diagnostic tool to all integral approach to management of gynecologic malignancies. This surgical approach has afforded patients the benefits of shorter hospitalizations, more rapid recoveries, smaller incisions, less need for analgesics, and fewer complications. Additionally, specific to gynecologic malignancies, improved visualization and shorter intervals to postoperative treatments are advantages to minimally invasive surgery. However, laparoscopy is limited by its long learning curve, counterintuitive motions, and two-dimensional views. To overcome these challenges of laparoscopy, technology has expanded to include computer-enhanced technology in the form of robotics. Robotic-assisted surgery provides three-dimensional views, intuitive motions, less operator fatigue, tremor filtration facilitating more precise movements, and possesses a shorter learning curve. Robotic-assisted surgery has also paved a pathway to telesurgery and telementoring. This may expand the availability of advanced minimally invasive surgeries throughout the globe. However, robotic-assisted procedures are not Without limitations-cost, bulky size, lack of haptic feedback, limited instrumentation, and larger required incisions. Published by Elsevier Inc.

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U2 3

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DA 2024-01-18

ER

PT J

AU Pareja, R

Ramirez, PT

AF Pareja, Rene

Ramirez, Pedro T.

TI Robotic Radical Hysterectomy in the Management of Gynecologic

Malignancies

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Review

DE Robotic; Laparoscopy; Radical hysterectomy; Laparotomy

ID PELVIC LYMPHADENECTOMY; CERVICAL-CARCINOMA; SURGERY; CANCER

AB Robotic Surgery is being used with increasing frequency in gynecologic oncology. To date, 44 cases were reported in the literature of radical hysterectomy performed with robotic surgery. When comparing robotic surgery with laparoscopy or laparotomy in performing a radical hysterectomy, the literature shows that robotic surgery offers an advantage over the other 2 surgical approaches with regard to operative time, blood loss, and length of hospitalization. Future Studies are needed to further elucidate the equivalence or superiority of robotic Surgery to laparoscopy or laparotomy in performing a radical hysterectomy. Journal of Minimally Invasive Gynecology (2008) 15, 673-676 (C) 2008 AAGL All rights reserved.

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RI Pareja, Rene/AEQ-4268-2022

FU International Federation of Gynecology and Obstetrics (FIGO);

International Gynecologic Cancer Society (IGCS)

FX Dr. Ramirez is on the speaker's bureau for Intuitive Surgery (Sunnyvale,

CA). This project was funded through an award granted to Dr. Pareja from

the International Federation of Gynecology and Obstetrics

(FIGO)/International Gynecologic Cancer Society (IGCS).

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Z9 7

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U2 0

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DA 2024-01-18

ER

PT J

AU Shafer, A

Boggess, JF

AF Shafer, Aaron

Boggess, John F.

TI Robotic-assisted endometrial cancer staging and radical hysterectomy

with the da Vinci庐 surgical system

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE Robotic-assisted surgery; Radical hysterectomy; Endometrial cancer;

Staging; Minimally invasive surgery

ID PELVIC LYMPHADENECTOMY; LAPAROSCOPIC HYSTERECTOMY; CERVICAL-CANCER;

FOLLOW-UP; EXPERIENCE; SURGERY

AB Robotic-assisted surgery leverages the advantages of standard laparoscopy while restoring three-dimensional vision, ergonomic, intuitive controls, and wristed instruments that approximate the motion of the human hand. Robotic-assisted surgery has already shown feasibility and in many cases superiority to standard laparoscopy in urology and general and cardiothoracic surgery. The applications of robotic-assisted surgery are rapidly being incorporated into the field of gynecologic oncology. (C) 2008 Elsevier Inc. All rights reserved.

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U2 2

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ER

PT J

AU Wolfe, L

DePasquale, S

Adair, CD

Torres, C

Stallings, S

Briery, C

Pearce, C

AF Wolfe, Lynlee

DePasquale, Stephen

Adair, C. David

Torres, Carlos

Stallings, Shawn

Briery, Christian

Pearce, Christy

TI Robotic-Assisted Laparoscopic Placement of Transabdominal Cerclage

During Pregnancy

SO AMERICAN JOURNAL OF PERINATOLOGY

LA English

DT Article

DE Abdominal cerclage; cervical incompetence; da Vinci robot (R)

ID ABDOMINAL CERCLAGE

AB Cervical incompetence treated with transabdominal cerclage can carry significant morbidity with the need for sequential laparotomies and necessitating prolonged postoperative recovery. Laparoscopic transabdominal cerclage placement has been described but has significant limitations with only two-dimensional depth perception and limited dexterity. Robotic-assisted laparoscopic surgery (RALS) is rapidly gaining acceptance in gynecologic surgery. RALS has reportedly been used for placement of an interval transabdominal cerclage. We report the first two cases where the da Vinci (R) robot was used during pregnancy for placement of abdominal cerclage. Two women were successfully treated with robotic-assisted laparoscopic placement of transabdominal cerclage in pregnancy. Robotic-assisted laparoscopic transabdominal cerclage placement is less invasive and is effective not only as an interval procedure but also during pregnancy, offering the patient an alternative to the traditional laparotomy with quicker recovery time.

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Science Center; University of Tennessee System; University of Tennessee

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NR 7

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Z9 32

U1 0

U2 1

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JI Am. J. Perinatol.

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PG 3

WC Obstetrics & Gynecology; Pediatrics

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PT J

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Gehrig, PA

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Shafer, A

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Skinner, EN

Fowler, WC

AF Boggess, John F.

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Cantrell, Leigh

Shafer, Aaron

Ridgway, Mildred

Skinner, Elizabeth N.

Fowler, Wesley C.

TI A case-control study of robot-assisted type III radical hysterectomy

with pelvic lymph node dissection compared with open radical

hysterectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE cervical cancer; da Vinci Surgical System; laparoscopy; radical

hysterectomy; robotic technology

ID CERVICAL-CANCER; VAGINAL HYSTERECTOMY; ABDOMINAL HYSTERECTOMY;

LYMPHADENECTOMY; EXPERIENCE; CARCINOMA; MORBIDITY

AB OBJECTIVE: The purpose of this study was to compare robotically assisted hysterectomy (RAH) with open (ORH) type III radical hysterectomy in the treatment of early-stage cervical cancer.

STUDY DESIGN: The outcomes of 51 consecutive patients who underwent RAH were compared with the outcomes of 49 patients who underwent ORH.

RESULTS: There were no differences with regard to patient demographics. There were significant differences between the groups with regard to operative blood loss (P < .0001), operative time (P = .0002), and lymph node retrieval (P = .0003), all of which were in favor of the RAH cohort. All patients with RAH were discharged on postoperative day 1, compared with a 3.2-day average hospitalization for the cohort with ORH. The incidence of postoperative complications was 7.8% and 16.3% for the RAH and ORH cohorts, respectively (P = .35).

CONCLUSION: Robotic type III radical hysterectomy with pelvic node dissection is feasible and may be preferable over open radical hysterectomy in patients with early-stage cervical cancer. Further study will determine procedure generalizability and long-term oncologic outcomes.

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NR 25

TC 252

Z9 267

U1 0

U2 3

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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PY 2008

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PG 7

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 360GJ

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DA 2024-01-18

ER

PT J

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Abaid, LN

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Boggess, JF

AF Gehrig, Paola A.

Cantrell, Leigh A.

Shafer, Aaron

Abaid, Lisa N.

Mendivil, Alberto

Boggess, John F.

TI What is the optimal minimally invasive surgical procedure for

endometrial cancer staging in the obese and morbidly obese woman?

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE robotic surgery; endometrial cancer; obesity

ID LAPAROSCOPIC SURGERY; VAGINAL HYSTERECTOMY; CERVICAL-CARCINOMA; WOMEN;

OVERWEIGHT; LAPAROTOMY; OUTCOMES

AB Objective. Thirty-three percent of U.S, women are either obese or morbidly obese. This is associated with an increased risk of death from all causes and is also associated with an increased risk of endometrial carcinoma. We sought to compare minimally invasive surgical techniques for staging the obese and morbidly obese woman with endometrial cancer.

Material and methods. Consecutive robotic endometrial cancer staging procedures were collected from 2005-2007 and were compared to consecutive laparoscopic cases (2000-2004). Demographics including age, weight, body mass index (BMI), operative time, estimated blood loss, lymph node retrieval, hospital stay and complications were collected and compared.

Results. During the study period, there were 36 obese and 13 morbidly obese women who underwent surgery with the DaVinci (R) robotic system and 25 obese and 7 morbidly obese women who underwent traditional laparoscopy. For both the obese and morbidly obese patient, robotic surgery was associated with shorter operative time (p=0.0004), less blood loss (p<0.0001), increased lymph node retrieval (p=0.004) and shorter hospital stay (p=0.0119).

Conclusions. Robotic surgery is a useful minimally invasive tool for the comprehensive surgical staging of the obese and morbidly obese woman with endometrial cancer. As this patient population is at increased risk of death from all causes, including post-operative complications, all efforts should be made to improve their outcomes and minimally invasive surgery provides a useful platform by which this can occur. (C) 2008 Elsevier Inc. All rights reserved.

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NR 26

TC 202

Z9 215

U1 0

U2 6

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PG 5

WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 358DF

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PM 18694588

DA 2024-01-18

ER

PT J

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Whitten, SJ

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Steinkampf, Michael P.

Whitten, Scott J.

Malizia, Beth A.

TI Robotic tubal anastomosis: surgical technique and cost effectiveness

SO FERTILITY AND STERILITY

LA English

DT Article

DE tubal anastomosis; robotic-assisted surgery; tubal surgery;

cost-effectiveness

ID MICROSURGICAL REVERSAL; SURGERY; STERILIZATION; LAPAROTOMY; PREGNANCY

AB Objective: To evaluate the feasibility of robotic microsurgical tubal anastomosis and compare the results and cost effectiveness with the same procedure performed by laparotomy.

Design: Prospective cohort study.

Setting: University hospital.

Patient(s): Patients with a history of bilateral tubal ligation who desired reversal for future fertility.

Intervention(s): Tuba anastomoses through either a robotic approach or through a laparotomy.

Main Outcome Measure(s): Operative times, hospitalization, complications, postoperative patency, clinical outcomes, and the cost per live birth.

Result(s): The mean operative time for robotic anastomoses was statistically significantly greater than open anastomoses, (ROBOT 201 minutes; OPEN 155.3 minutes), although hospitalization times were statistically significantly shorter (ROBOT 4 hours; OPEN 34.7 hours). The return to instrumental activities of daily living was accelerated in the patients who had undergone a robotic anastomosis (ROBOT 11.1 days; OPEN 28.1 days). Although this was a small series, the pregnancy rates were comparable between groups (ROBOT 62.5%; OPEN 50%), yet the rate of abnormal pregnancy was higher in the robotic group (ectopic: ROBOT 4, OPEN 1; spontaneous pregnancy loss: ROBOT 2, OPEN 1). The cost per delivery was similar between the groups (ROBOT $92,488.00, OPEN $92,205.90).

Conclusion(s): Robotically assisted laparoscopic microsurgical tubal anastomosis is feasible and cost effective with results that are comparable with the traditional open approach.

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NR 25

TC 69

Z9 70

U1 0

U2 2

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J9 FERTIL STERIL

JI Fertil. Steril.

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PG 5

WC Obstetrics & Gynecology; Reproductive Biology

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SC Obstetrics & Gynecology; Reproductive Biology

GA 358UQ

UT WOS:000259943400036

PM 18054354

OA hybrid

DA 2024-01-18

ER

PT J

AU Ramirez, PT

Schmeler, KM

Wolf, JK

Brown, J

Soliman, PT

AF Ramirez, Pedro T.

Schmeler, Kathleen M.

Wolf, Judith K.

Brown, Jubilee

Soliman, Pamela T.

TI Robotic radical parametrectomy and pelvic lymphadenectomy in patients

with invasive cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE laparoscopy; robotic surgery; radical parametrectomy; cervical cancer

ID CARCINOMA; VAGINECTOMY; MANAGEMENT; SURGERY; WOMEN

AB Objective. We describe a series of patients diagnosed with invasive cervical cancer after undergoing simple hysterectomy who subsequently underwent robotic radical parametrectomy and bilateral pelvic lymphadenectomy. The goal of this Study is to report on the safety and feasibility of robotic radical parametrectomy.

Methods. A retrospective review was performed of all patients who underwent robotic radical parametrectomy and bilateral pelvic lymphadenectomy at Our institution during the period December 2006 to February 2008. We analyzed our data to evaluate the safety and feasibility of performing robotic radical parametrectomy.

Results. This analysis included 5 patients with invasive squamous cell carcinoma of the cervix. The median body mass index was 23.8 kg/m(2) (range, 17.7 to 26.5). The median operative time was 365 min (range, 331 to 430). The median estimated blood loss was 100 mL (range, 50 to 175). There were no conversions to laparotomy. There was 1 intraoperative complication - cystotomy. No patient required blood transfusion. The median length of hospital stay was 1 day (range, 1 to 2). One patient experienced two postoperative complications, a vesicovaginal fistula and a lymphocyst. No patient had residual tumor in the parametrectomy specimen, and no patient underwent adjuvant therapy. The median number of pelvic lymph nodes removed was 14 (range, 6 to 16). The median follow-up for all patients was 7.5 months (range, 1.3 to 13.8). There were no recurrences.

Conclusion. Robotic radical parametrectomy and bilateral pelvic lymphadenectomy is feasible and safe and can be performed with an acceptable complication rate. (C) 2008 Elsevier Inc. All rights reserved.

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NR 11

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Z9 31

U1 1

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SC Oncology; Obstetrics & Gynecology

GA 358DF

UT WOS:000259896200006

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DA 2024-01-18

ER

PT J

AU Lenihan, JP

Kovanda, C

Seshadri-Kreaden, U

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Kovanda, Carol

Seshadri-Kreaden, Usha

TI What is the learning curve for robotic assisted gynecologic surgery?

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE robotic surgery; laparoscopy; hysterectomy; da Vinci; learning curves

ID LAPAROSCOPIC HYSTERECTOMY; EXPERIENCE; PROSTATECTOMY; OUTCOMES

AB Study Objective: The purpose of this study was to estimate the learning curve when using the da Vinci Surgical System (Intuitive Surgical Inc., Sunnyvale, CA) in benign gynecologic cases by a team of 2 gynecologic laparoscopists. Design: Retrospective case series (Canadian Task Force classification II-1). Setting: A private practice obstetrics/gynecology clinic. Patients: Patients requiring major benign gynecologic surgery who were candidates for a laparoscopic approach. Intervention: All patients who would have otherwise been offered a transabdominal or conventional laparoscopic procedure were offered the option of having their procedure performed laparoscopically with robotic assistance. Data that were collected included robot set-up times by the operative room staff, operative times for use of robot, total operative times, and perioperative outcome. We analyzed the learning curve defined as the number of cases required to stabilize operative time to perform the various procedures. Measurements and Main Results: One hundred thirteen patients were treated over a 22-month period with the da Vinci Surgical System. Most procedures were hysterectomies, whereas other gynecologic procedures included supracervical hysterectomy, laparoscopic vaginal assisted hysterectomy, myomectomy, sacrocolpopexy, and oophorectomy. Total operative times for hysterectomies studied sequentially stabilized at approximately 95 minutes after 50 cases. The decrease in robotic time did not depend on uterine size. The mean length of hospital stay was 24 hours, and return to normal activities averaged 2.8 weeks. Conclusions: Robotic assisted surgery is an enabling technology that allows gynecologic surgeons the ability to offer laparoscopic procedures to most of their patients. In the hands of surgeons with advanced laparoscopic skills, the learning curve to stabilize operative times for the various surgical procedures in women requiring benign gynecolologic interventions is 50 cases.

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Z9 197

U1 0

U2 12

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EI 1553-4669

J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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PG 6

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 347HR

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ER

PT J

AU Obermair, A

Gebski, V

Frumovitz, M

Soliman, PT

Schmeler, KM

Levenback, C

Ramirez, PT

AF Obermair, Andreas

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Frumovitz, Michael

Soliman, Pamela T.

Schmeler, Kathleen M.

Levenback, Charles

Ramirez, Pedro T.

TI A phase III randomized clinical trial comparing laparoscopic or robotic

radical hysterectomy with abdominal radical hysterectomy in patients

with early stage cervical cancer

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE cervical cancer; laparoscopic surgery; radical hysterectomy; robotic

surgery; phase III clinical trial; quality of life; body image; pain;

health care cost

ID PELVIC LYMPHADENECTOMY; CARCINOMA; THERAPY

AB Study Objective: Cervical cancer is a significant health problem in countries of the developing world. Although case series suggest advantages of total laparoscopic radical hysterectomy (TLRH) compared with total abdominal radical hysterectomy (TARH), no randomized controlled trial is currently available to establish TLRH as the new standard treatment. In this study, TLRH or total robotic radical hysterectomy (TRRH) will be performed without a vaginally assisted portion of the procedure. Design: A biphasic randomized controlled trial was designed to test feasibility of recruitment and equivalence in regard to disease-free survival (Canadian Task Force classification 1). Setting: Tertiary referral hospital. Patients: Patients with histologically confirmed invasive squamous cell carcinoma or adenocarcinoma of the cervix, stage IA1 (with lymphovascular space invasion), IA2, and IB1 are eligible. Interventions: During the first phase, 100 patients will be randomized (1: 1) to receive either TLRH/TRRH or TARH, with the primary end point being the rate of enrollment. During the second phase, recruitment will be extended by another 640 patients in a 1: 1 TLRH/TRRH:TARH allocation, to determine equivalence with respect to disease-free survival with 80% power and alpha = 0.05. Measurements and Main Results: Equivalence will be assumed if the difference in disease-free survival does not exceed 7% at 4 years. Secondary outcomes include treatment-related morbidity, costs and cost effectiveness, patterns of recurrence, quality of life, pelvic floor function, feasibility of intraoperative sentinel node sampling, and overall survival. All data from this multicenter study will be entered using online electronic case report forms, allowing real-time assessment of data completeness and patient follow-up. Conclusion: This prospective trial aims to show the equivalence of a TLRH/TRRH versus TARH approach for patients with early stage cervical cancer following a 2-phase protocol. This trial was developed and designed with the input and approval of the members of the Gynecologic Oncology Committee from the American Association of Gynecologic Laparoscopists.

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NR 16

TC 122

Z9 130

U1 0

U2 17

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 347HR

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ER

PT J

AU Ramirez, PT

Soliman, PT

Schmeler, KM

dos Reis, R

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Schmeler, Kathleen M.

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Frumovitz, Michael

TI Laparoscopic and robotic techniques for radical hysterectomy in patients

with early-stage cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article; Proceedings Paper

CT 1st International Symposium on Cervical Cancer - Challenging Cervical

Cancer

CY FEB 21-22, 2008

CL Madrid, SPAIN

DE laparoscopic surgery; robotic surgery; radical hysterectomy; cervical

cancer

ID PELVIC NODE DISSECTION; LYMPHADENECTOMY; LAPAROTOMY; EXPERIENCE;

CARCINOMA

AB Objectives. The goal of this review is to Summarize the latest literature on the subject of laparoscopic and robotic approaches for radical hysterectomy in patients with early-stage cervical cancer.

Methods. We analyzed the published literature in search of all articles addressing Surgical techniques, intraoperative and perioperative Outcomes in patient undergoing radical hysterectomy by the minimally invasive approach.

Results. Recurrence and overall survival rates in patients with early-stage cervical cancer are equivalent in patients who undergo laparoscopic radical hysterectomy and those who undergo surgery performed by laparotomy. There is growing evidence highlighting the benefits of robotic Surgery in management of gynecologic malignancies. The advantages of the robotic system include three-dimensional vision, tremor reduction, seven degrees of intra-abdominal articulation, and motion scaling. Recent studies comparing radical hysterectomy performed through the open, laparoscopic, or robotics approach showed that there were no significant differences in intra- or postoperative complications among the three groups and no conversion in the robotic or laparoscopic groups.

Conclusions. Total laparoscopic radical hysterectomy is a feasible and safe procedure that is associated with fewer intraoperative and postoperative complications than abdominal radical hysterectomy. We await results from additional series of radical hysterectomy performed by robotic surgery. (C) 2008 Elsevier Inc. All rights reserved.

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NR 17

TC 41

Z9 47

U1 0

U2 0

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J9 GYNECOL ONCOL

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PY 2008

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BP S21

EP S24

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PG 4

WC Oncology; Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED); Conference Proceedings Citation Index - Science (CPCI-S)

SC Oncology; Obstetrics & Gynecology

GA 350ZH

UT WOS:000259392000008

PM 18486966

DA 2024-01-18

ER

PT J

AU Seamon, LG

Backes, F

Resnick, K

Cohn, DE

AF Seamon, Leigh G.

Backes, Floor

Resnick, Kimberly

Cohn, David E.

TI Robotic trocar site small bowel evisceration after gynecologic cancer

surgery

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID INCISIONAL HERNIAS; LAPAROSCOPY; ACCESS; PREVENTION; SYSTEMS; CANNULA

AB BACKGROUND: Trocar site hernia is a known, rare complication after laparoscopic surgery. We describe a case of bowel herniation, evisceration, and bowel obstruction through an 8-mm robotic port site.

CASE: A 67-year-old patient with endometrial cancer underwent an uncomplicated robotic hysterectomy, bilateral salpingo-oophorectomy, and pelvic and aortic lymphadenectomy. Four days later, she presented with symptoms of a small bowel obstruction and was found to have evisceration through a laterally placed 8-mm robotic port site. The bowel was reduced locally and the fascial defect repaired without midline laparotomy or bowel resection.

CONCLUSION: Bowel herniation can occur through the fascial defect after placement of an 8-mm robotic port. Continued reporting is needed to accurately gauge the occurrence of this complication.

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NR 16

TC 28

Z9 28

U1 0

U2 0

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J9 OBSTET GYNECOL

JI Obstet. Gynecol.

PD AUG

PY 2008

VL 112

IS 2

BP 462

EP 464

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PN 2

PG 3

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 334QV

UT WOS:000258237200019

PM 18669765

DA 2024-01-18

ER

PT J

AU Fanning, J

Fenton, B

Purohit, M

AF Fanning, James

Fenton, Bradford

Purohit, Manisha

TI Robotic radical hysterectomy

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article

DE radical hysterectomy; robotic surgery

ID SURGICAL STAPLING TECHNIQUE; PELVIC LYMPHADENECTOMY; CERVICAL-CANCER;

LAPAROTOMY

AB OBJECTIVE: Advanced laparoscopic procedures are increasing being used in gynecologic surgery. The da Vinci robotic system (Intuitive Surgical Corporation, Sunnyvale, CA) can further augment laparoscopic surgery. We describe our initial experience using the da Vinci robotic system to perform radical hysterectomy.

STUDY DESIGN: Twenty consecutive patients with primary stage IB-IIA cervical carcinoma underwent class 3 radical hysterectomy with the use of the da Vinci robotic system. Median age was 44 years, median weight was 69.9 kg, 65% of patients had medical comorbidity, and 40% had prior abdominal surgery.

RESULTS: All 20 patients successfully underwent robotic radical hysterectomy. Median operative time was 6.5 hours (3.5-8.5 hours) and median blood loss was 300 mL. All patients were discharged on the first day after surgery. At median follow-up of 2 years (0.6-3 years), 90% of patients are alive and disease free.

CONCLUSION: We report the first series of robotic radical hysterectomy for early stage cervical cancer. All cases were successfully performed robotically with minimal complications and all patients were discharged on postoperative day 1.

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NR 13

TC 97

Z9 102

U1 0

U2 0

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J9 AM J OBSTET GYNECOL

JI Am. J. Obstet. Gynecol.

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PG 4

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

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GA 309FM

UT WOS:000256446100014

PM 18538146

DA 2024-01-18

ER

PT J

AU Veljovich, DS

Paley, PJ

Drescher, CW

Everett, EN

Shah, C

Peters, WA

AF Veljovich, Dan S.

Paley, Pamela J.

Drescher, Charles W.

Everett, Elise N.

Shah, Chirag

Peters, William A., III

TI Robotic surgery in gynecologic oncology: program initiation and outcomes

after the first year with comparison with laparotomy for endometrial

cancer staging

SO AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY

LA English

DT Article; Proceedings Paper

CT 74th Annual Meeting of the

Pacific-Coast-Obstetrical-and-Gynecological-Society

CY OCT 10-14, 2007

CL Henderson, NV

SP Pacific Coast Obstet & Gynecol Soc

DE endometrial carcinoma; laparoscopy; lymphadenectomy; robotic surgery

AB OBJECTIVE: The objective of the study was to evaluate outcomes during the first year of a robotic surgery program in gynecologic oncology.

STUDY DESIGN: We studied the initiation of a robotic surgery program with prospective data collection, including intraoperative times, estimated blood loss (EBL), length of stay (LOS), lymph node yields, and complications. Patients were compared with historical and contemporary open staging surgery for endometrial cancer.

RESULTS: One hundred eighteen patients underwent robotic surgery ( mean age 52.5 years, body mass index of 26.3 kg/m(2), hospital stay of 32.4 hours), with 8 major and 13 minor complications. Compared with open endometrial staging (n = 131), the robotic procedure ( n = 25) was longer ( 283 vs 139 minutes, P < .0001), had less blood loss (66.6 vs 197.6 mL, P < .0001), and had shorter length of stay (40.3 vs 127 hours, P < .0001) with comparable node yields (17.5 vs 13.1, P = .1109).

CONCLUSION: Robotic surgery is feasible in gynecologic oncology and facilitated a dramatic expansion in our minimally invasive surgical practice. Despite longer operative times, EBL and LOS are reduced and lymph node yields are comparable.

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NR 2

TC 126

Z9 133

U1 0

U2 0

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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ER

PT J

AU Kim, YT

Kim, SW

Hyung, WJ

Lee, SJ

Nam, EJ

Lee, WJ

AF Kim, Young Tae

Kim, Sang Wun

Hyung, Woo Jin

Lee, Soo Jin

Nam, Eun Ji

Lee, Woo Jung

TI Robotic radical hysterectomy with pelvic lymphadenectomy for cervical

carcinoma: A pilot study

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE robotics; hysterectomy; lymphadenectomy; cervix cancer

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; EXPERIENCE; SURGERY

AB Objectives. The purpose of this study was to evaluate the feasibility and surgical outcome of robotic radical hysterectomy with pelvic lymphadenectomy for stage I cervical carcinoma using the da Vinci surgical system.

Methods. A retrospective clinical review was performed of ten patients with FIGO stage IA2-IB1 cervical carcinoma who underwent a total robotic approach for definitive surgical treatment. Patient status was estimated in terms of operative morbidity, length of surgery, docking time, estimated blood loss, yield of pelvic lymph node and hospital stay.

Results. All operations were completed robotically with no conversions to laparotomy. Mean operative time was 207 min (range 120 to 240 min). Mean docking time was 26 min (range 10 to 45 min). Mean estimated blood loss was 355 mL. The average number of pelvic lymph nodes resected was 27.6 (range 12 to 52). There were no ureteral injuries or fistula complications.

Conclusions. Robotic radical hysterectomy with pelvic lymphadenectomy for selected patients with stage IB1 cervical cancer is feasible, promising and related with a low morbidity in this pilot study. Only prospective randomized trials will permit the evaluation of potential benefits associated with this surgical technique. (C) 2007 Elsevier Inc. All rights reserved.

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Z9 95

U1 1

U2 4

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ER

PT J

AU Zakashansky, K

Bradley, WH

Nezhat, FR

AF Zakashansky, Konstantin

Bradley, William H.

Nezhat, Farr R.

TI New techniques in radical hysterectomy

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE cervical cancer; laparoscopy; radical hysterectomy; robotic surgery

ID INVASIVE CERVICAL-CANCER; PELVIC LYMPHADENECTOMY; ABDOMINAL

HYSTERECTOMY; VAGINAL HYSTERECTOMY; WESTERN PATIENTS; NODE DISSECTION;

FOLLOW-UP; SURGERY; FEASIBILITY; EXPERIENCE

AB Purpose of review

To review the recent literature regarding modifications of abdominal radical hysterectomy as well as development of new approaches including laparoscopic, vaginal, and robotic radical hysterectomy.

Recent findings

Nerve-sparing radical hysterectomy technique allows for significant reduction in postoperative bladder morbidity. Radical vaginal hysterectomy with laparoscopic lymph node dissection is a well-recognized technique that offers excellent cure rates with absence of abdominal entry as well as reduced postoperative febrile and gastrointestinal morbidity. Total laparoscopic radical hysterectomy is a minimally invasive alternative to a traditional abdominal radical hysterectomy approach that yields comparable safety profile with a significant reduction in blood loss and hospital stay. Robotic surgery is becoming more widely accepted in the management of gynecologic cancers and larger series describing successful treatment of cervical cancer with robotic radical hysterectomy are soon to be published.

Summary

There are a number of approaches to performing radical hysterectomy. The feasibility and safety of these techniques have been well established. Preliminary oncologic outcome data are encouraging. The decision to utilize newer techniques depends on the patient and type of practice, as well as the surgeon's comfort level with laparoscopy, robotics, or vaginal surgery.

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NR 49

TC 21

Z9 22

U1 0

U2 3

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WC Obstetrics & Gynecology

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ER

PT J

AU Vergote, I

Pouseele, B

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Amant, Frederic

TI Robotic retroperitoneal lower para-aortic lymphadenectomy in cervical

carcinoma: First report on the technique used in 5 patients

SO ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA

LA English

DT Article

DE cervical neoplasms; robotic; endoscopy; lymphadenectomy; paraaortic

ID HYSTERECTOMY; EXPERIENCE; DISSECTION

AB Objective. Retroperitoneal para-aortic laparoscopic lymphadenectomy is a technically challenging operation. The robotic Da Vinci system might be valuable in this operation due to a steady three-dimensional visualization, instrumentation with articulating tips, and an adaptive downscaling of the surgeons movements (without tremor). To the best of our knowledge, this is the first report on robotic retroperitoneal para-aortic lymphadenectomy in patients with gynecologic cancer. Method and results. We report on the technique and operative results of the robotic retroperitoneal lower para-aortic lymphadenectomy using the Da Vinci Surgical System. Five patients with cervical carcinoma stage IIb-IIb were included. Technically the procedure was easier to perform than with the classical retroperitoneal laparoscopic approach. However using the Da Vinci Surgical System it is important to tilt the patient slightly to the left to avoid collision between the left arm of the patient and the robotic arms, and to place the endoscopic robotic arm between the 2 arms used for dissection. Finally, we experienced that using a 30 scope is advantageous for the dissection of the paracaval nodes. None of the patients had evidence of para-aortic metastases on preoperatively staging, including Positron Emission Tomography - Computed Tomography (PET-CT). One of the patients had positive para-aortic lymph nodes. Conclusion. Here we report on the surgical technique used in our first 5 patients undergoing retroperitoneal para-aortic lymphadenectomy using the robotic Da Vinci system. It is important to adapt the surgical technique using the Da Vinci Surgical System compared with the classical laparoscopic technique.

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OA Bronze

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PT J

AU H枚ckel, M

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Dornhoefer, N.

TI New techniques in the surgical treatment of cervical carcinoma:: A

systematic review

SO GEBURTSHILFE UND FRAUENHEILKUNDE

LA German

DT Review

DE cervical cancer; minimally invasive surgery; preservation of fertility;

autonomic nerve preservation; compartment resection

ID SPARING RADICAL HYSTERECTOMY; SENTINEL LYMPH-NODES; OF-THE-LITERATURE;

LAPAROSCOPIC PELVIC LYMPHADENECTOMY; EXTENDED ENDOPELVIC RESECTION;

POSTSURGICAL BLADDER FUNCTION; POSITRON-EMISSION-TOMOGRAPHY;

FERTILITY-PRESERVING OPTION; GYNECOLOGIC-ONCOLOGY-GROUP; BLUE-DYE

INJECTION

AB Abdominal radical hysterectomy (the "Wertheim operation") combined with pelvic and periaortic lymph node dissection is still regarded as the standard surgical therapy for cervical carcinoma, FIGO stages IB - IIA. In Germany and Austria, this procedure is also carried out in selected patients with FIGO stage IIB cancer. Postoperative adjuvant (chemo-)radiation is recommended for all patients with histopathologically high risk factors detected in the surgical specimens - generally about 50% of cases. This conventional surgical approach is obviously associated with a higher treatment-related morbidity compared to primary radiation as the therapeutic alternative, without achieving better tumor control. In consequence, various new surgical techniques have recently been developed with the aim of improving the therapeutic index of surgery for cervical cancer. The new surgical spectrum includes minimally invasive/robotic techniques, supraradical procedures as well as techniques which preserve fertility and the autonomic nerves. Compartment resection, a new excisional approach based on embryologically defined surgical pelvic anatomy, makes it possible to dispense with adjuvant radiation. Although none of the new procedures has been compared with the current standard in prospective randomized trials significant progress in the surgical therapy of cervical cancer can be expected from the results published to date. This systematic review examines and analyzes the new developments based on literature from the Medline and Cochrane databases with particular reference to the patient and tumor-related conditions which must be met to obtain (potential) benefits compared to the standard therapy. New surgical options for the treatment of microcarcinomas (FIGO stage IA) and locoregionally advanced and recurrent disease are reviewed as well.

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TC 1

Z9 1

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U2 1

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JI Geburtshilfe Frauenheilkd.

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PT J

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TI Clinical-pathologic and morbidity analyses of types 2 and 3 abdominal

radical hysterectomy for cervical cancer

SO GYNECOLOGIC ONCOLOGY

LA English

DT Article

DE cervical cancer; radical hysterectomy; clinical-pathologic analyses;

postoperative; complications

ID PELVIC LYMPHADENECTOMY; VAGINAL HYSTERECTOMY; STAGE; CARCINOMA;

EXPERIENCE

AB Objective. To provide representative data analyses of surgical morbidity and clinical-pathologic factors for Types 2 and 3 abdominal radical hysterectomies (ARE) with pelvic aortic node dissection performed in a private practice with a fellowship-training program.

Methods. From 1997 to 2005, 329 cervical cancer patients underwent ARE with lymphadenectorny. Two hundred and one cases performed at our primary institution were analyzed for operative time, blood loss, intra-operative complications, surgical-pathologic data, recurrence of disease and adjuvant therapy.

Results. We evaluated 201 surgical patients who underwent Type 2 (n = 45) or Type 3 (n = 156) ARH with node dissection. The FIGO stages were: IB1=64%, IB2=6.5%, IA=28.4%, and IIA=1%. Aortic node dissection was performed in 64% of Type 3 cases and none of Type 2 cases. Pfannenstiel incision was used in 80% (Type 2) and 76% (Type 3) cases. A suprapubic catheter was placed in 9% of Type 2 and 81% of Type 3 cases. Median age and weight were 47 +/- 13 years and 149 +/- 35 lb. Positive nodes were identified in 12% of Type 3 and 2.2% of Type 2 cases. No positive aortic nodes were found. For Types 2 and 3 ARH, median operative time was 80 +/- 90 vs. 99 +/- 23 min (p < 0.00 1) and blood loss was 250 +/- 134 vs. 300 +/- 234 ml (p < 0.001). The transfusion rate was 3%. Intra-operative complications included: 3 ureteral injuries and I colotomy. Tumor histology was 60% squamous, 37% adenocarcinoma, 1% adenosquamous, and 2% others.

Conclusions. ARH with pelvic lymphadenectomy in modem practice is an efficient, safe procedure with low transfusion rate and shorter hospital stay than previously reported. Data will be useful as comparison when scrutinizing novel approaches to radical hysterectomy including robotic-assisted and laparoscopic techniques. (c) 2007 Elsevier Inc. All rights reserved.

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NR 24

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ER

PT J

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Song, Arleen

TI The role of robotic surgery in gynecology

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE gynecologic surgical procedures; laparoscopy; robotics

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; ABDOMINAL MYOMECTOMY; EXPERIENCE;

FEASIBILITY; LAPAROTOMY; BENIGN

AB Purpose of review

To discuss the recent experience and feasibility of integrating robot-assisted technology into minimally invasive gynecologic surgery. Current applications in gynecology and their associated outcomes will be analyzed.

Recent findings

Since the late 1990s, the use of computer-assisted or robotic technology in minimally invasive gynecologic surgery has increased. Much of this experience revolves around the da Vinci surgical system, which was approved by the Food and Drug Administration for gynecologic applications in April 2005. The largest body of experience exists with robot-assisted laparoscopic hysterectomy, particularly those classified as American Association of Gynecologic Laparoscopists type IVE or Laparoscopic Supracervical Hysterectomy III. Other notable applications are in the areas of myomectomy, tuba[ reanastomosis, sacrocolpopexy, and cancer staging. Advantages of the robotic approach are the improved dexterity and precision of the instruments coupled with three-dimensional imaging. Limitations include the absence of haptic (tactile) feedback, bulkiness of the system, lack of vaginal access, and cost.

Summary

Current evidence demonstrates the safety-and feasibility of the robotic approach for gynecologic surgery. Experience is still in its infancy, however, and prospective trials are needed to compare the,efficacy against conventional laparoscopy and to help determine not only who should be doing robotic-assisted surgery but also for which applications.

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TC 133

Z9 145

U1 0

U2 5

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J9 CURR OPIN OBSTET GYN

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WC Obstetrics & Gynecology

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ER

PT J

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Oehninger, S

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Stadtmauer, Laurel

Oehninger, Sergio

TI Current status of robotically assisted laparoscopic surgery in

reproductive medicine and gynaecology

SO REPRODUCTIVE BIOMEDICINE ONLINE

LA English

DT Review

DE gynaecological laparoscopy; reproductive medicine; robotic surgery

ID MICROSURGICAL TUBAL ANASTOMOSIS; SPONTANEOUS UTERINE RUPTURE;

VESICOVAGINAL FISTULA; VAGINAL HYSTERECTOMY; ADHESION FORMATION;

MYOMECTOMY; PREGNANCY; MANAGEMENT; TRIAL; LEIOMYOMATA

AB Laparoscopic techniques have revolutionized the concept of minimally invasive surgery. Robotically assisted surgery is one of the latest innovations in this field and many operative laparoscopic procedures have been performed in urology, cardiac and general surgery. More recently, the use of robotically assisted techniques have been introduced in gynaecology, and most available studies have shown it to be a safe and effective alternative to conventional laparoscopic surgery. However, whether or not to approach the management of certain gynaecological pathologies with a laparotomy or laparoscopy (conventional or with robotic aid) continues to be a point of debate. This article reviews recent developments in the endoscopic management of reproductive (tubal reanastomosis and myomectomies) and other gynaecological surgical conditions (hysterectomies, pelvic organ prolapse, repair of vesicovaginal fistulas and staging for gynaecological malignancies). Ongoing controversies associated with this technology, such as cost, learning curve, conversion rate to laparotomy, post-surgical fertility and complications, are briefly addressed. Long-term analysis of outcomes is ongoing.

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Z9 14

U1 0

U2 1

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ER

PT J

AU Rodgers, AK

Goldberg, JM

Hammel, JP

Falcone, T

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TI Tubal anastomosis by robotic compared with outpatient Minilaparotomy

SO OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID STERILIZATION REVERSAL; SURGERY; EXPERIENCE; PREGNANCY

AB Objective: To compare tubal anastomosis by robotic system compared with outpatient minilaparotomy.

Methods: In this retrospective case-control study, women were identified by current procedural terminology code for tubal anastomosis. We included all cases of tubal anastomosis for reversal of a prior tubal ligation by either outpatient minilaparotomy or robotic system technique. Cases performed by laparoscopy without aid of the robot were excluded. Comparisons were based on Fisher's exact, chi(2), and Wilcoxon rank sum tests.

Results: There were 26 cases of tubal anastomosis performed with the robot and 41 cases performed by outpatient minilaparotomy. The two groups were comparable in age, body mass index, and parity. Anesthesia time for the robotic technique (median with interquartile range) was 283 (267-290) minutes compared with 205 (170-230) minutes with outpatient minilaparotomy (P<.001). Surgical times for the robot and minilaparotomy were 229 (205-252) minutes and 181 (154-202) minutes respectively (P=.001). Hospitalization times, pregnancy, and. ectopic pregnancy rates were not significantly different. The robotic technique was more costly. The median difference in costs of the procedures was $1,446 (95% confidence interval $1,1121,812) (P<.001). The time to return to work was significantly shorter in the robotic system group by approximately 1 week (P=.013).

Conclusion: Robotic surgery for tubal anastomosis was successfully accomplished without conversion to laparotomy. The robotic technique for tubal anastomosis required significantly prolonged surgical and anesthesia times over outpatient minilaparotomy (P <=.001). Costs were higher with the robotic technique. Return to normal activity was shorter with the robotic technique.

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NR 21

TC 81

Z9 88

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U2 1

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WC Obstetrics & Gynecology

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ER

PT J

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Magrina, Javier F.

Magtibay, Paul M.

TI Pathologic findings and outcomes of a minimally invasive approach to

ovarian remnant syndrome

SO FERTILITY AND STERILITY

LA English

DT Article; Proceedings Paper

CT 32nd Annual Meeting of the Society-of-Gynecologic-Surgeons

CY APR 03-05, 2006

CL Tucson, AZ

DE laparoscopy; malignancy; minimally invasive surgery; ovarian remnant

syndrome; surgery; robot-assisted surgery

ID ADENOCARCINOMA; DIAGNOSIS; CANCER; FROZEN

AB Objective: To review outcomes and pathologic findings of a primarily minimally invasive approach to ovarian remnant syndrome.

Design: Data were abstracted from medical records documenting bilateral salpingo-oophorectomy and subsequent treatment between 1996 and 2006 for pathologically confirmed ovarian remnant tissue. Follow-up was by mailed questionnaires and telephone interviews.

Setting: Tertiary care academic medical institution.

Patient(s): Twenty patients (mean age, 48 years) receiving treatment for ovarian remnant tissue after prior bilateral salpingo-oophorectomy.

Intervention(s): Primarily minimally invasive approach (conventional laparoscopy and robot-assisted laparoscopy) for removal of ovarian remnant tissue.

Main Outcome Measure(s): Postoperative complications and recurrence.

Result(s): The 20 patients had a mean follow-up of 30 months. Indications were endometriosis in 8 and ovarian neoplasm in 6. Eighteen patients presented with pain, and 2 presented with a pelvic mass. Nineteen had laparoscopy (14 conventional; 5 robotic), and I had laparotomy. Remnant ovarian tissue was associated with endometriosis in 5 and corpus luteurn in 3. Two patients had malignancy in remnant ovarian tissue. Postoperative complications included pneumonia (1 case). Follow-up identified no recurrence.

Conclusion(s): Ovarian remnant syndrome can be managed safely and successfully with minimally invasive surgery. Risk of carcinoma mandates surgical resection.

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NR 14

TC 24

Z9 24

U1 0

U2 3

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J9 FERTIL STERIL

JI Fertil. Steril.

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PG 5

WC Obstetrics & Gynecology; Reproductive Biology

WE Conference Proceedings Citation Index - Science (CPCI-S); Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

GA 169HP

UT WOS:000246583600002

PM 17478171

OA hybrid

DA 2024-01-18

ER

PT J

AU Bocca, S

Stadtmauer, L

Oehninger, S

AF Bocca, Silvina

Stadtmauer, Laurel

Oehninger, Sergio

TI Uncomplicated full term pregnancy after da Vinci-assisted laparoscopic

myomectomy

SO REPRODUCTIVE BIOMEDICINE ONLINE

LA English

DT Article

DE da Vinci robotic system; laparoscopy; myomectomy; pregnancy

ID ROBOT

AB Laparoscopic surgery with the assistance of the da Vinci robotic system has been recently introduced in gynaecology, as this new technology provides three-dimensional vision and easier suture capability. This study reports, for the first time, the case of an uncomplicated full term pregnancy after laparoscopic myomectomy with the assistance of the da Vinci robotic system. The patient was a 35-year-old woman presenting with secondary infertility and a single 3 cm, predominantly intramural, fundal myoma. Following surgery, she conceived with minimal intervention therapy and delivered a healthy term infant by Caesarean section. The successful outcome suggests that this advancement can restore reproductive capacity with improved suturing capability of the uterine wall. More studies are needed to establish indications and outcome of the technique according to the number, size and location of fibroids.

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NR 8

TC 20

Z9 26

U1 0

U2 0

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J9 REPROD BIOMED ONLINE

JI Reprod. Biomed. Online

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PG 4

WC Obstetrics & Gynecology; Reproductive Biology

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GA 137IU

UT WOS:000244287100018

PM 17298730

OA Bronze

DA 2024-01-18

ER

PT J

AU Magrina, JF

AF Magrina, J. F.

TI Robotic surgery in gynecology

SO EUROPEAN JOURNAL OF GYNAECOLOGICAL ONCOLOGY

LA English

DT Article

DE robotics; gynecology; hysterectomy

ID ASSISTED LAPAROSCOPIC HYSTERECTOMY; INITIAL CLINICAL-EXPERIENCE;

VESICOVAGINAL FISTULA; SURGICAL ROBOTICS; LEARNING-CURVE; UNITED-STATES;

PERFORMANCE; TELESURGERY; ANASTOMOSIS; REPAIR

AB Robotic technology is nothing more than an enhancement along the continuum of laparoscopic technological advances and represents only the beginning of numerous more forthcoming advances. It constitutes a major improvement in the efficiency, accuracy, ease, and comfort associated with the performance of laparoscopic operations.

Instrument articulation, downscaling of movements, absence of tremor, 3-D image, and comfort for the surgeon, assistant and scrub nurse are all new to the practice of laparoscopy. In our hands, robotic operative times for simple and radical hysterectomy are shorter than those obtained by conventional laparoscopy. Robotic technology is preferable to conventional laparoscopic instrumentation for the surgical treatment of gynecologic malignancies and most operations for benign disease of certain complexity such as hysterectomy myomectomy, and invasive pelvic endometriosis.

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NR 23

TC 49

Z9 53

U1 0

U2 4

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J9 EUR J GYNAECOL ONCOL

JI Eur. J. Gynaecol. Oncol.

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WC Oncology; Obstetrics & Gynecology

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SC Oncology; Obstetrics & Gynecology

GA 152NX

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DA 2024-01-18

ER

PT J

AU Mourtzinos, A

Raz, S

AF Mourtzinos, Arthur

Raz, Shlorno

TI Repair of vaginal vault prolapse and pelvic floor relaxation using

polypropylene mesh

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE mesh; pelvic floor relaxation; perineal body descent; rectocele; vault

prolapse

ID ABDOMINAL SACRAL COLPOPEXY; ILIOCOCCYGEUS FASCIA; ORGAN PROLAPSE;

SACROCOLPOPEXY; ENTEROCELE; SUSPENSION; FIXATION; SURGERY; SUPPORT;

SUCCESS

AB Purpose of review Innumerable techniques have been described for vaginal vault prolapse and enterocele repair including abdominal (open, laparoscopic, and robotic) and vaginal techniques. Recently, the use of surgical mesh in pelvic floor surgery has become increasingly popular due to the high incidence of recurrence with primary repairs and no surrogate material. The increasing variety of available materials and techniques, combined with a lack of well conducted clinical trials, make the choice of repair to use difficult.

Recent findings This article provides an update review on the different procedures available to the urogynecologist and female urologist for repair of vault prolapse. We will also discuss a new surgical technique for the repair of vault prolapse, which recreates the sacrouterine-cardinal ligament complex and reconstructs the pelvic floor with mesh.

Summary The best approach to vaginal vault prolapse remains unknown. Surgeon comfort and preference as well as proper patient selection remain critical. The use of graft materials in pelvic floor reconstruction should have limited use in a carefully selected patient population. There is a need for well powered, controlled, long-term, randomized studies with patient generated quality-of-life questionnaires comparing the short and long-term outcomes of these techniques.

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NR 27

TC 9

Z9 13

U1 0

U2 1

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

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BP 555

EP 559

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PG 5

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 086DJ

UT WOS:000240653000013

PM 16932052

DA 2024-01-18

ER

PT J

AU Dickens, BM

Cook, RJ

AF Dickens, B. M.

Cook, R. J.

TI Legal and ethical issues in telemedicine and robotics

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE telemedicine; robotic surgery; cross-border treatment; legal liability

across borders; licensure across borders; conflict of laws; legal

harmonization; ethics across borders

ID RADIOLOGY

AB Modern medical concerns with telemedicine and robotics practiced across national or other jurisdictional boundaries engage the historical, complex area of taw called conflict of taws. An initial concern is whether a practitioner licensed only in jurisdiction A who treats a patient in jurisdiction B violates B's laws. Further concerns are whether a practitioner in A who violates a contract or treats a patient in B negligently incurs liability in B, A, or both, and, if treatment lawful in A is unlawful in B, whether the practitioner commits a crime. Judicial procedures are set by courts in which proceedings are initiated, but courts may decline jurisdiction due to inconvenience to parties. If courts accept jurisdiction, they may apply their own substantive legal rules, but may find that the rules of a conflicting jurisdiction should apply. Cross-border care should not change usual medical ethics, for instance on confidentiality, but may mitigate or aggravate migration of specialists. (c) 2006 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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NR 15

TC 33

Z9 34

U1 0

U2 19

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EI 1879-3479

J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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IS 1

BP 73

EP 78

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WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 066JZ

UT WOS:000239226900021

PM 16777109

DA 2024-01-18

ER

PT J

AU Gardiner, HM

AF Gardiner, Helena M.

TI Keeping abreast of advances in fetal cardiology

SO EARLY HUMAN DEVELOPMENT

LA English

DT Article

DE fetal screening; cardiac function; echocardiography; fetal

electrocardiography; arrhythmia; cardiac surgery

ID CONGENITAL HEART-DISEASE; ECHOCARDIOGRAPHY; INTERVENTION; PREVENTION;

STENOSIS

AB Advances in genetics and computing have contributed to a better understanding of the mechanisms underlying cardiovascular development, its programming and possible therapeutic manipulation. Pre-conceptual folate can reduce the prevalence of cardiac malformations and improvements in imaging allow us to detect congenital heart disease and assess function at earlier gestations. Three- and four-dimensional imaging may improve the surgeons' understanding of complex vascular malformations as well as permitting remote diagnosis. Treatment of fetal arrhythmias may be rationalised by fetal electrocardiography and magnetocardiography and by further defining the natural history of complete heart block and mechanisms of tachyarrhythmia. Tissue engineering and robotics may improve the surgical outcome for children by creating conduits with growth potential thus reducing the need for multiple surgical procedures. These technologies may permit successful fetal surgical procedures. Cross discipline collaboration has been key in enabling these advances which have changed the face of fetal cardiology. (c) 2005 Elsevier Ireland Ltd. All rights reserved.

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TC 9

Z9 9

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U2 0

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J9 EARLY HUM DEV

JI Early Hum. Dev.

PD JUN

PY 2006

VL 82

IS 6

BP 415

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DI 10.1016/j.earlhumdev.2005.10.014

PG 5

WC Obstetrics & Gynecology; Pediatrics

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Pediatrics

GA 059SQ

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ER

PT J

AU Fiorentino, RP

Zepeda, MA

Goldstein, BH

John, CR

Rettenmaier, MA

AF Fiorentino, RP

Zepeda, MA

Goldstein, BH

John, CR

Rettenmaier, MA

TI Pilot study assessing robotic laparoscopic hysterectomy and patient

outcomes

SO JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

LA English

DT Article

DE robotic surgery; laparoscopy; hysterectomy

ID EXPERIENCE; SURGERY

AB STUDY OBJECTIVE: To examine the operative variables and complications associated with robotic-assisted total laparoscopic hysterectomy.

DESIGN: Canadian Task Force classification II-1.

SETTING: Gynecology service affiliated with a major cancer center in Southern California.

PATIENTS: Twenty women with a benign gynecologic condition.

INTERVENTION: Robotic-assisted total laparoscopic hysterectomy. Patient status was evaluated in terms of operative morbidity, length of surgery, anesthesia time, estimated blood loss, and hospital stay.

MEASUREMENTS AND MAIN RESULTS: Mean operative time was 3.2 hours, and anesthesia time was 4 hours. Mean estimated blood loss was 81 mL, and patient postoperative hospital stay was 2 days. The complication rate in this study was low. The surgical procedure was converted to a laparotomy and abdominal hysterectomy in two patients because of poor visualization during robotic-assisted surgery.

CONCLUSIONS: While the number of patients and nonrandomized nature of this single-institution experience are insufficient to draw any definitive conclusions regarding potential treatment efficacy, the patient postoperative stay and low complication rates suggest that this procedure is feasible and promising. Additional study comparing the efficacy and cost of robotic laparoscopic hysterectomy with standard laparoscopic hysterectomy with a larger patient population is warranted. (C) 2006 AAGL. All rights reserved.

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NR 11

TC 65

Z9 73

U1 0

U2 1

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J9 J MINIM INVAS GYN

JI J. Mimim. Invasive Gynecol.

PD JAN-FEB

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IS 1

BP 60

EP 63

DI 10.1016/j.jmig.2005.11.001

PG 4

WC Obstetrics & Gynecology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology

GA 010HR

UT WOS:000235178900012

PM 16431325

DA 2024-01-18

ER

PT J

AU Senapati, S

Advincula, AP

AF Senapati, S

Advincula, AP

TI Telemedicine and robotics: Paving the way to the globalization of

surgery

SO INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS

LA English

DT Article

DE robotics; telesurgery; gynecologic surgery; laparoscopy

ID UNITED-STATES; HYSTERECTOMY; EXPERIENCE

AB The concept of delivering health services at a distance, or telemedicine is becoming an emerging tool for the field of surgery. For the surgical services, telepresence surgery through robotics is gradually being incorporated into health care practices. This article will provide a brief overview of the principles surrounding telemedicine and telepresence surgery as they specifically relate to robotics. Where limitations have been reached in laparoscopy, robotics has allowed further steps forward. The development of robotics in medicine has been a progression from passive to immersive technology. In gynecology, the utilization of robotics has evolved from the use of Aesop((R)), a robotic arm for camera manipulation, to full robotic systems such as Zeus((R)), and the daVinci((R)) surgical system. These systems have not only been used directly for a variety of procedures but have also become a useful tool for conferencing and the mentoring of surgeons from afar. As this mode of technology becomes assimilated into the culture of surgery and medicine globally, caution must be taken to carefully navigate the economic, legal and ethical implications of telemedicine. Despite the challenges faced, telepresence surgery holds promise for more widespread applications. (c) 2005 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.

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TC 25

Z9 25

U1 0

U2 10

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J9 INT J GYNECOL OBSTET

JI Int. J. Gynecol. Obstet.

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PG 7

WC Obstetrics & Gynecology

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PT J

AU Gadonneix, P

Ercoli, A

Scambia, G

Villet, R

AF Gadonneix, P

Ercoli, A

Scambia, G

Villet, R

TI The use of laparoscopic sacrocolpopexy in the management of pelvic organ

prolapse

SO CURRENT OPINION IN OBSTETRICS & GYNECOLOGY

LA English

DT Article

DE laparoscopic pelvic floor surgery; laparoscopic sacrocolpopexy; mesh;

pelvic organ prolapse

ID VAGINAL VAULT PROLAPSE; SACRAL COLPOPEXY; POSTERIOR

AB Purpose of review This paper aims to review and comment on the developments in laparoscopic sacrocolpopexy published during the last year.

Recent findings We classified the findings reported recently in the literature for laparoscopic sacrocolpopexy as technical or tactical findings. Technical findings concern the material of the mesh, the methods of mesh fixation, the use of adapted vaginal retractors and the interest in robotic assistance. Tactical findings consist of specific modifications to the standard surgical procedure aimed at reducing the side effects and complications and ameliorating the effectiveness of this intervention. These modifications include the possibility of avoiding the placement of a posterior mesh and the fixation of the posterior mesh to the puborectal muscles or the perineal body instead of the posterior vaginal wall. A specific section has been dedicated to reviewing and commenting on those interventions associated routinely with laparoscopic sacrocolpopexy.

Summary Laparoscopic sacrocolpopexy is a safe surgical procedure in constant evolution which allows excellent results in the treatment of utero-vaginal prolapse. Large prospective, randomized studies comparing the different technical and tactical modifications recently introduced are needed in order to further enhance the effectiveness of this intervention.

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NR 11

TC 50

Z9 51

U1 0

U2 3

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J9 CURR OPIN OBSTET GYN

JI Curr. Opin. Obstet. Gynecol.

PD AUG

PY 2005

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EP 380

DI 10.1097/01.gco.0000175355.48802.7b

PG 5

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

GA 949CK

UT WOS:000230762300010

PM 15976543

DA 2024-01-18

ER

PT J

AU Dharia, SP

Falcone, T

AF Dharia, SP

Falcone, T

TI Robotics in reproductive medicine

SO FERTILITY AND STERILITY

LA English

DT Review

DE robotics; reproductive surgery; telepresence surgery; minimally invasive

surgery

ID MICROSURGICAL TUBAL ANASTOMOSIS; ASSISTED LAPAROSCOPIC SURGERY; SURGICAL

EDUCATION; VIRTUAL-REALITY; LEARNING-CURVE; PERFORMANCE; KIDNEY; REPAIR;

SKILLS; HYSTERECTOMY

AB Objective: To review the history, development, current applications, and future of robotic technology.

Design: The MEDLINE database was reviewed for all publications on robotic technology in medicine, surgery, reproductive endocrinology, its role in surgical education, and telepresence surgery.

Setting: University medical center.

Conclusion(S): Robotic-assisted surgery is an emerging technology, which provides an alternative to traditional surgical techniques in reproductive medicine and may have a role in surgical education and telepresence surgery. (c) 2005 by American Society for Reproductive Medicine.

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Z9 38

U1 0

U2 7

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J9 FERTIL STERIL

JI Fertil. Steril.

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PY 2005

VL 84

IS 1

BP 1

EP 11

DI 10.1016/j.fertnstert.2005.02.015

PG 11

WC Obstetrics & Gynecology; Reproductive Biology

WE Science Citation Index Expanded (SCI-EXPANDED)

SC Obstetrics & Gynecology; Reproductive Biology

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PM 16009146

OA hybrid

DA 2024-01-18

ER

PT J

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TI Laparoscopic robotic gynecologic surgery

SO OBSTETRICS AND GYNECOLOGY CLINICS OF NORTH AMERICA

LA English

DT Article

ID MICROSURGICAL TUBAL ANASTOMOSIS; HYSTERECTOMY; ASSISTANCE

AB The first gynecologic procedure performed with a robot was a tubal anastomosis. This was performed in 1998 with the Zeus robot. Over the past several years other gynecologic procedures have been performed with other robots. Current robotic technology may not be universally applicable to many gynecologists' clinical practice. The field of surgical robotics is evolving at an ever-increasing pace, however, and gynecologists need to participate in its development.

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TC 18

Z9 22

U1 0

U2 2

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J9 OBSTET GYN CLIN N AM

JI Obstet. Gynecol. Clin. N. Am.

PD SEP

PY 2004

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IS 3

BP 599

EP +

DI 10.1016/j.ogc.2004.05.004

PG 13

WC Obstetrics & Gynecology

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DA 2024-01-18

ER

PT J

AU Falcone, T

Goldberg, JM

AF Falcone, T

Goldberg, JM

TI Robotic surgery

SO CLINICAL OBSTETRICS AND GYNECOLOGY

LA English

DT Article

ID TELESURGERY; EXPERIENCE

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TC 11

Z9 46

U1 0

U2 6

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J9 CLIN OBSTET GYNECOL

JI Clin. Obstet. Gynecol.

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PG 7

WC Obstetrics & Gynecology

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SC Obstetrics & Gynecology

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PM 12686893

DA 2024-01-18

ER

PT J

AU Goldberg, JM

Falcone, T

AF Goldberg, JM

Falcone, T

TI Laparoscopic microsurgical tubal anastomosis with and without robotic

assistance

SO HUMAN REPRODUCTION

LA English

DT Article; Proceedings Paper

CT 56th Annual Meeting of the American-Society-for-Reproductive-Medicine

CY OCT 21-26, 2000

CL SAN DIEGO, CALIFORNIA

SP Amer Soc Reprod Med

DE laparoscopy; robotic surgery; tubal anastomosis

ID FERTILITY

AB BACKGROUND: We previously reported our results with laparoscopic microsurgical tubal anastomosis with robotic assistance. The purpose of this study was to compare the duration of the procedure and hospitalization, blood loss and clinical outcomes for laparoscopic microsurgical tubal anastomosis performed with and without robotic assistance. METHODS: This was a retrospective comparative case study in an academic tertiary referral centre. Laparoscopic microsurgical tubal anastomosis was performed on 10 women with robotic assistance and the subsequent 15 patients underwent the procedure without the robot. The length of the procedure, estimated blood loss (EBL), time until hospital discharge, tubal patency and clinical pregnancy rates were compared. RESULTS: The operative times were 2 h longer with robotic assistance (P < 0.001). The increased EBL with the use of the robot (70 +/- 68 ml versus 20 +/- 16 ml) was statistically but not clinically significant. The robot provided no benefit in patient recovery. Tubal patency and clinical pregnancy rates were not significantly different. CONCLUSIONS: Robotic assistance increases operative times of laparoscopic tubal anastomosis without an appreciable improvement in patient recovery or clinical outcomes.

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NR 8

TC 65

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U1 0

U2 2

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SC Obstetrics & Gynecology; Reproductive Biology

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PM 12525456

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ER

PT J

AU Falcone, T

Goldberg, JM

Margossian, H

Stevens, L

AF Falcone, T

Goldberg, JM

Margossian, H

Stevens, L

TI Robotic-assisted laparoscopic microsurgical tubal anastomosis: a human

pilot study

SO FERTILITY AND STERILITY

LA English

DT Article

DE robotics; tubal surgery; laparoscopy

ID SURGERY

AB Objective: To evaluate the feasibility and safety of a robotic device to perform a laparoscopic tubal anastomosis.

Design: Prospective pilot study.

Setting: Tertiary care medical center.

Patient(s): Ten patients with previous tubal ligations underwent laparoscopic tubal ligation reversal using a robotic suturing device.

Intervention(s): Tubal surgery was performed with a robotic system. A two-layered closure was used for all tubes. Four stitches of 8-0 polygalactin sutures were used for each layer.

Main Outcome Measure(s): Tubal patency; secondary measures were pregnancy rates, complications, and operative time.

Result(s): The procedure was completed successfully in all 10 patients. No patient required conversion to an open procedure. The mean time (+/-SD) required to complete the anastomosis of both tubes was 159 +/- 33.8 minutes. Chromotubation at the end of the procedure showed patency in all tubes anastomosed. A postoperative hysterosalpingogram 6 weeks after surgery demonstrated patency in 17 of the 19 (89%) tubes anastomosed. There have been five pregnancies so far. There were no complications.

Conclusion(s): Robotic technology can be used safely to create laparoscopic microsurgical anastomoses with adequate patency rates. Robotic technology has the potential to make laparoscopic microsuturing easier. (Fertil Steril(R) 2000;73:1040-2. (C) 2000 by American Society for Reproductive Medicine).

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NR 4

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U1 0

U2 3

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JI Fertil. Steril.

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SC Obstetrics & Gynecology; Reproductive Biology

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UT WOS:000086879200024

PM 10785235

OA Green Submitted, hybrid

DA 2024-01-18

ER

PT J

AU Mettler, L

Ibrahim, M

Jonat, W

AF Mettler, L

Ibrahim, M

Jonat, W

TI One year of experience working with the aid of a robotic assistant (the

voice-controlled optic holder AESOP) in gynaecological endoscopic

surgery

SO HUMAN REPRODUCTION

LA English

DT Article

DE gynaecological endoscopic surgery; robotic assistance

AB The aim of the study was a comparison of robotic versus human laparoscopic camera control. Utilizing robotic technology a robot has been designed specifically for the purpose of holding and manoeuvring the laparoscope under the direct control of the surgeon. We tested AESOP (auto; mated endoscopic system for optimal positioning) in 50 patients undergoing routine gynaecological endoscopic surgical procedures, The elimination of the camera holder allows two doctors to perform complex laparoscopic surgery faster than without the robotic arm. The timing of surgical procedures performed by surgeons using the voice control was compared to the timing of similar operations using the foot or hand control. The voice-controlled AESOP works more efficiently and faster than the hand or foot control.

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RI Jonat, Walter/E-3024-2010

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JI Hum. Reprod.

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DI 10.1093/humrep/13.10.2748

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OA Bronze

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ER

PT J

AU Margossian, H

Garcia-Ruiz, A

Falcone, T

Goldberg, JM

Attaran, M

Gagner, M

AF Margossian, H

Garcia-Ruiz, A

Falcone, T

Goldberg, JM

Attaran, M

Gagner, M

TI Robotically assisted laparoscopic microsurgical uterine horn anastomosis

SO FERTILITY AND STERILITY

LA English

DT Article

DE animal; uterine horns; microsurgery; sterilization reversal; surgery;

laparoscopic; robotics

ID TUBAL ANASTOMOSIS

AB Objective: To evaluate the feasibility, safety, and sterility issues with regard to the use of a robotic device to perform uterine horn anastomosis in a live porcine model.

Design: Prospective animal study.

Setting: Landrace-Yorkshire pigs in a conventional laboratory setting.

Intervention(s): Six female pigs underwent laparoscopic bipolar electrocoagulation of the distal uterine horns. Two weeks later, the uterine horns were reanastomosed laparoscopically with use of a robotic system for microsuturing. Necropsy was performed 4 weeks later to assess postoperative adhesions and anastomosis patency.

Main Outcome Measure(s): Tubal patency; secondary measures were operative time, complications, and surgeon fatigue.

Result(s): The mean(+/- SD) total operative time per animal was 170 +/- 34 minutes including setting up and dismantling the robotic arms. The robot functioned well with only minor technical problems. All pigs survived both surgeries with no perioperative complications related to the use of the robot. Patency was confirmed after completing each anastomosis (12 anastomoses: 100% patency). Four weeks later, necropsy showed that eight anastomoses were still patent (67%). Only one pig had bilateral occlusion. Surgeon's fatigue was mild for each animal study.

Conclusion(s): Robotic technology can be used safely in creating laparoscopic microsurgical anastomoses. The robot functioned properly in a sterile operating room environment. Adequate patency rates were achieved during the acute phase and at 4-week follow-up. Robotic technology has the potential to make laparoscopic microsuturing easier. (Fertil Steril(R) 1998;70:530-4. (C) 1998 by American Society for Reproductive Medicine.).

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RI Gagner, Michel/AFK-7360-2022

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U1 0

U2 2

PU AMER SOC REPRODUCTIVE MEDICINE

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J9 FERTIL STERIL

JI Fertil. Steril.

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DI 10.1016/S0015-0282(98)00196-4

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