Patient with endometrial cancer suffered rupture and bleeding of inferior vena cava during renal vascular level para-aortic lymphadenectomy. After surgery, low molecular weight heparin was given to patient for five days and she recovered fully.
Great vessels injures in laparoscopies can be repaired laparoscopically.

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Congenital Absence of the Utero-Ovarian Ligament: A Clinical Dilemma

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An elongated utero-ovarian ligament is associated with an increased risk for ovarian torsion. Our review of literature revealed no published studies on absent utero-ovarian ligament and its management. To present a unique case of congenital absence of the utero-ovarian ligament and the clinical dilemma associated with it. A 37-year-old G6P1 female presented to us with recurrent pregnant loss. She had regular periods with dysmenorrhea and no dyspareunia. The patient underwent diagnostic laparoscopy, which revealed congenital absence of the left utero-ovarian ligament. The left ovarian was adhered to the right utero-sacral ligament secondary to endometriosis. It was a clinical dilemma as to whether we should free the ovary from its current position and reattach it to the posterior surface of the uterus near the normal insertion of the utero-ovarian ligament. We decided to leave the ovary.

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Caput Medusae

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In this video we are presenting a 28-year-old female with late onset congenital adrenal hyperplasia and liver cirrhosis with portal hypertension.
Clinically was hyperandrogenic with clitoromegaly and hairsutism.
Started on Dexamethasone July 2011.
DHEAS decreased but testosterone remained high.
Ovaries had no focal lesion but looked polycystic on ultrasound.
Admitted for laparoscopy to evaluate the source of high androgen + ovarian drilling on 25/6/13.
Operative findings:
This patient did not show any superficial blood vessels dilatation and no evidence of any Porto-systemic collateral circulation.
At the umbilical port a tortuous tubular structure was identified extending from the umbilicus to the liver, later identified as the falciform ligament, that was significantly dilated and needed suturing for hemostasis.
Now we recognize this possibility and we advise consideration of other Primary access points like Left upper quadrant (LUQ, Palmer's) point access.

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Laparoscopic Extraperitoneal Inframesenteric and Infrarenal Aortic Lymphadenectomy

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A technique for laparoscopic extraperitoneal comprehensive aortic lymphadenectomy, from the bifurcation of the common iliac vessels to the renal vessels, is demonstrated in detail. The technique for extraperitoneal approach yields more nodes in high-BMI women and does not have a significant learning curve. Comprehensive staging can reveal unexpected metastases in as many as one third of patients, potentially improving survival probability by signaling enhanced post-operative therapy.

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Use of D50 as Distension Medium in Diagnostic Cystoscopy

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Due to the scarcity of indigo carmine dye which was routinely utilized in diagnostic cystoscopy, different methods of evaluating ureteric patency have been devised. This video demonstrates the use of 50% dextrose (D50) as distension medium in diagnostic cystoscopy. This novel, low-cost technique enables one to visualize ureteric jets with ease.

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Approach to Minimizing Bleeding at Multiple Myometcomy

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There are many approaches that may help minimize bleeding in multiple myomectomy. This submission showcases a video where we present pre-operative and intraoperative approaches that effectively minimized bleeding in a patient undergoing multiple myomectomy surgery. Our patient is a 37 year-old female with multiple fibroids, anemia, and history of sickle cell trait. Preoperatively, she was prescribed oral iron therapy to correct anemia, selective progesterone receptor modulator therapy for bleeding control, and tranexemic acid IV just prior to the surgery. Intra-operatively, penrose bands and bulldog clamps were used to secure uterine and utero-ovarian blood supply, respectively. Dilute vasopressin was injected along the incision lines as needed. In total, 24 fibroids were successfully removed with an estimated blood loss of 100cc. Blood transfusions were not required.

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Minimally Invasive Non-Laparoscopic Ovarian Cystectomy: A Unique Way to Approach Large Ovarian Cysts

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We present a minimally invasive technique for the removal of large ovarian cysts with low suspicion for malignancy in a manner that safely contains the cyst contents. Our technique involves a 2-3 cm incision in the abdomen and use of surgical glue to affix an isolation bag onto the cyst wall. We place sutures through the bag and cyst after it is glued then incise the cyst and safely drain its contents. The cyst wall can then be lifted out of the pelvis by the sutures for cystectomy. To date all pathology in our series has been benign. Further studies are needed to validate this as a safe alternative to large laparotomy especially when there is unexpected malignant pathology.

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In-Bag Morcellation in LESS Surgery Using a XXL LapBag®

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To introduce a secure way of using power morcellator to remove intracorporeal mass by creating an isolated space in abdomino-pelvic cavity with a XXL size LapBag® (Sejong Medical Co., Ltd., Seoul, Korea). A 31-year-old woman came to the clinic because of a palpable abdominal mass as a chief complaint. Gynecologic vaginal sonography was done and it revealed 5.7 x 5.2 cm sized subserosal myoma on the fundus of her uterus. She underwent laparoendoscpic single site myomectomy surgery in February 27, 2015. The specimen, the fundal myoma, was removed with a power morcellator by 'In-bag morcellation' technique.

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Successful Uterine Isthmo-Vagina Anastomosis With Barbed Suture in Robotic Radical Trachelectomy

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This video clip is to show a technique of uterine isthmo-vagina anastomosis with barbed suture in robotic radical trachelectomy. Trachelectomy could be