

# Difficulties of laparoscopic myomectomy and ways to overcome them.

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Our report summarizes the experience of the author in 2141 laparoscopic myomectomy, which have been make in 21 years. The comparative evaluation of multiply criteria of results of operations, which has been performed in different periods of work - 1996-2006 yy (620 patients) and 2007-2016 (1521 patients). These two periods are fundamentally different in approaches of conserving surgery for patients with uterine myoma.

Laparoscopic myomectomy has a number of advantages, but implementation of this operation is associated with technical difficulties, especially in case of multiple fibroids, large scale or "awkward" location nodes. Myomectomy may be accompanies with severe intraoperative blood loss, blood transfusion, and a high probability of conversion to laparotomy, consequently, an increase in the length of stay in hospital and frequency postoperative complications. When bleeding from the bed assembly, in a limited surgical field and reducing degrees of freedom of movement of tools, it reduces the quality of suturing of the myometrium; you must often perform coagulation of tissue, which can lead to the formation of an insolvent uterine scar. All of these factors in combination lead to the rejection of the present laparoscopic intervention towards laparotomy.

Thus, rejection of the use of standard laparoscopic myomectomy when caused by uncertainty in the process of operation and reliability of the seam on the wall of the uterus.

To eliminate these shortcomings and conservation of benefits of minimally invasive access, we began to use a number of techniques:

- A thorough examination and selection of patients before surgery;
- The use of adequate uterine manipulator for correct exposure of the surgical field;
- Implementation of the methodology temporary occlusion of the internal iliac artery (RF patent for invention №2407467);
- Improvement of manual suture and use of synthetic absorbable suture material;
- The use of BARRIER;
- The introduction of an accelerated rehabilitation protocol ERAS patients.

Using the new algorithm of organ-saving treatment of patients with hysteromyoma, comprising a number of the above techniques for laparoscopic myomectomy, allowed to increase the number of patients with "difficult nodes" from 12 to 67%, with multiple nodes from 40 to 85%. It was possible to reduce the amount of blood loss with  $240 \pm 135$  ml to  $80 \pm 35$  ml, duration of operation from  $85 \pm 22$  to  $42 \pm 13$  minutes (vascular phase of  $7 \pm 3$  minutes), duration of stay decreased from 3.7 to 2.9 days.

Our report examined in details intra- and postoperative complications in two groups of patients and recommendations for their prevention.

In our opinion, the basis for a significant improvement of results in laparoscopic myomectomy was the introduction of a technique of temporary occlusion of internal iliac arteries. During the period from 2007 to 2016, laparoscopic myomectomy with temporary occlusion of the internal iliac arteries was perform in 1262 patients aged from 21 to 48 years old.

In preparation for pregnancy, for all patients we conduct the control office hysteroscopy to rule out intrauterine adhesions after surgery.

Keywords : laparoscopic myomectomy, occlusion of internal iliac arteries

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