

2022-VA-1035-ESGO **THE CASE OF LAPAROSCOPIC ANTERIOR RECTAL RESECTION AND RETRANSPLANTATION OF THE URETER WITH THE USE OF ICG**

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Introduction/Background Presenting the method of laparoscopic anterior rectal resection and retransplantation of the ureter in the case of deep infiltrating endometriosis (DIE)

Methodology 28-year-old lady with the history of dyschezia 9/10, dysmenorrhoea 9/10, dyspareunia 6/10, dysuria 7/10, infertility, left huge hydronephrosis which were explained by urologist as a consequence of anatomical variation of the vessel. She had the trial of cystoscopic ureteric JJ stent insertion prior to planned surgery with no success. 2 weeks later she had done laparoscopic

Results She had done segmental resection of the anterior rectum with the end-to-end recto-sigmoid colon anastomosis due to 6 cm nodule of the rectum, the intraabdominal insertion of the JJ stent to the left ureter after cutting the wall of ureter 10 cm from the bladder due to impossible JJ cystoscopic stenting with simultaneous retransplantation of the left ureter. All procedure was done in control of vascularity by ICG both the bowel and the ureter. Both anastomosis of the colon and the uretero-bladder were protected by fibrine glue. The bladder was isolated from rectum with the flap of omentum. 5 weeks after surgical procedure the JJ stent was removed from the ureter. Proper function of the bowel and the ureter were proved in control visit – 6 weeks after surgery. In histopathology: endometriotic nodule of the bowel and ureter were diagnosed. The result of the surgery was complete realising from the pain and tailored surgery on colon and ileum due to low grade neoplasia of appendix.

Conclusion Laparoscopy is a perfect method for tailored and radical surgery in DIE and multiorgans surgery with all advantages of the minimally invasive access. Complete realising of the pain was huge success of the surgery.

2022-VA-1036-ESGO **PROTECTED LAPAROSCOPIC LARGE OVARIAN CYST ASPIRATION – A FIVE STEPS ALTERNATIVE TO LAPAROTOMY**

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Introduction/Background In this video, we describe a five-step surgical technique allowing to safely incise and aspirate the content of large ovarian cysts through a single port laparoscopic incision. This allows performing laparoscopic oophorectomies instead of large xypho-pubic laparotomies.

Methodology A Stepwise demonstration of the technique

Results Ovarian masses, especially cysts, are common gynecological conditions. However, depending on their size, large adnexal cysts are usually managed with transverse or midline laparotomies. This is to prevent cyst ruptures and

abdominal contamination and ensure the oncological safety of the procedure. Different leak-proof aspiration techniques were described in the literature allowing for safe large cyst aspiration and adnexectomy through a mini-laparotomy incision or via laparoscopy (2,3,6–10). We describe a five steps surgical technique allowing for closed aspiration of ovarian intracystic fluid and adnexectomy while respecting oncological safety.

Interventions Step 1: Perform diagnostic laparoscopy to rule out peritoneal carcinomatosis contraindicating this procedure then after cyst exposition, thoroughly dry the cyst wall.

Step 1 Bis: Cut the cuff of a sterile glove to prepare a 46 square piece of membrane

Step 2: Place a protective gauze, then apply the surgical glue to the ovarian cyst wall followed by the glove/membrane application. Perform a purse suture through the glove/membrane and the ovarian wall superficially to ensure further adhesion and prevent ovarian fluid spillage.

Step 3: Incise the ovarian wall then introduce the aspiration cannula and tighten the purse suture to aspirate the cystic fluid.

Step 4: After aspiration is complete, tighten the suture and close the glove to guarantee a closed space and prevent abdominal contamination.

Step 5: Perform laparoscopic oophorectomy or cystectomy. Safely remove the specimen in an endoscopic retrieval bag through the trocar incision.

Conclusion This technique allows safe laparoscopic large ovarian cysts resections while respecting oncologic safety and preventing intraabdominal spillage and contamination.

2022-VA-1050-ESGO **LAPAROSCOPY IS A PERFECT METHOD FOR TAILORED AND RADICAL SURGERY IN DIE AND MULTIORGANS SURGERY WITH ALL ADVANTAGES OF THE MINIMALLY INVASIVE ACCESS. COMPLETE REALISING OF THE PAIN WAS HUGE SUCCESS OF THE SURGERY**

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Introduction/Background Presenting the method of laparoscopic anterior rectal resection, partial sigmoid colon resection, right hemicolectomy and extended hysterectomy in the patient with deep infiltrating endometriosis (DIE) diagnosed with coexisting of low grade appendiceal mucinous neoplasm (LAMN).

Methodology 37-year-old lady with the history of multiple laparoscopic and laparotomic intervention due to endometriosis and infertility qualified to laparoscopic intervention.

Results She had done laparoscopic segmental resection of the sigmoid colon and anterior rectum resection with end-to-end anastomosis, total extended hysterectomy, right hemicolectomy with side-to-side anastomosis, cystoscopy with protective JJ stenting of both ureters due to massive adhesiolysis of the ureters. In histopathology: multifocal endometriotic infiltration of the bowel with the big endometriotic nodules on rectum, sigmoid colon and cecum, low grade appendiceal mucinous