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## Invited Presentations and Presentations by Organizations and Societies

### S001. Global Challenges in Prevention and Treatment of Preterm Birth

J. Howse<sup>1</sup>, M. Temmerman<sup>2</sup>, L. Greenslade<sup>1</sup>, L. Rand<sup>1</sup>,  
W. Holzgreve<sup>3</sup>. <sup>1</sup>United States of America; <sup>2</sup>Switzerland; <sup>3</sup>Germany

In 2014, the World Health Organization declared preterm birth and its complications to be the leading worldwide cause of death in children 0–5 years of age. This expert panel will address the many challenges of preterm birth and explore potential approaches and solutions for addressing this complex problem including:

- The growing recognition of the global burden of preterm birth, WHO's normative and research work on addressing preterm birth in lower-income countries, and WHO's priorities in maternal and newborn health, including quality of care, within the post-2015 Sustainable Development Goals (SDGs) framework. (M. Temmerman)
- A dynamic new approach for partnership in the highest burden countries, put forward by the UN Development Fund and emphasizing prevention through improved preconception care and changes in lifestyle, exposure to infections, nutrition, and contraception availability (LINC). (L. Greenslade)
- Promising new models and metrics for improving preterm birth risk detection and improving maternal and newborn health care and treatment in Low Income Countries using new interventions such as “digital medicine”. (L. Rand)
- A case example of how the German Society of Obstetrics and Gynecology successfully translated lessons from obstetric practices in its High Income Countries to improve maternal care and lower preterm birth in a Low Income Country in East Africa. (W. Holzgreve)

Following the presentations, time will be allotted for questions.

### S002. Hysterectomy in 2015

#### S002.1 WHICH HYSTERECTOMY WHEN?

S. Sheth. India

Since hysterectomy can be done via different routes by different techniques, it is essential for us to know which hysterectomy be performed – when?

As regards “which”, science is very clear on the basis of the Cochrane database review of evidence-based hysterectomy, ACOG's Guideline for laparoscopic assisted vaginal hysterectomy (LAVH), comments from giver of Laparoscopic Hysterectomy (LH) – Harry Reich and esteemed Editorial comments. They conclude, if all three can be done on a given uterus, the ideal choice in the best interest of patient is the vaginal route. When the vaginal route is not possible, the laparoscope comes to the rescue and when laparoscopic technique is contraindicated OR becomes risky, opening the abdomen is the way to under-

take hysterectomy. The limits and contraindications for each technique are presented. The evidence-based pathway proceeds from the vaginal to the laparoscopic and finally to the abdominal route.

If the pathology is benign, it is not the disease that matters, but “which route” is dependent on the pelvic findings like uterine size, uterine mobility, scarred or unscarred uterus, adnexal normalcy, normal physiological cervical descent, available space and the operator's “will” to do so. A Uterus with a fibroid, less than 12 weeks size, 16 to 18 weeks size and more will require a different route and/or technique and therefore, which route of hysterectomy when? No doubt, as experience grows, contraindications whither.

In all this however, the commercial angle must be kept away and only the interests of the patient must be considered.

#### S002.2 LAPAROSCOPIC HYSTERECTOMY IN DIFFICULT SITUATIONS

Y.-F. Fong. Singapore

Since the first description of laparoscopic hysterectomy by Harry Reich in 1989, the procedure has been widely accepted and incorporated as part of standard practice. The rate of laparoscopic hysterectomy however, can vary from less than 10 percent to over 80 percent of all hysterectomies performed, depending on the gynaecological unit. A lower rate of acceptance could perhaps be an indication of the association with and/or fear of complications. Even though the benefits of minimally invasive surgery is well known, there are specific issues related to laparoscopic hysterectomy in difficult situations which may deter many from pushing the limits of minimally invasive surgery, such as: obesity, uterine size, endometriosis, adenomyosis, previous caesareans leading to a plastered bladder, distorted anatomy secondary to multiple fibroids, repeated laparotomies etc. This talk focuses on each of these difficult scenarios and practices adopted to overcome these factors, as well as situations whereby consideration for conversion to laparotomy should be considered.

#### S002.3 ROBOTIC ASSISTED GYNECOLOGICAL SURGERY FOR HYSTERECTOMY

L. Mettler. University Hospitals Schleswig-Holstein, Kiel, Germany

Through a better site recognition, 3 D- stable view as well as magnification of the operation field with improved ergonomics using the Da Vinci robot or other robots in development it is possible not only to learn and to teach laparoscopic surgical anatomy in a fascinating direct way, but also to perform advanced laparoscopic operations, as hysterectomies, to a much larger extend in benign and oncological situations which are being performed even in the 21st century quite frequently with open abdominal surgery.

Being aware that, of course, only if robotic technology set up's are available, the following advises should be considered carefully.

- Patient positioning: After general anaesthesia is achieved the

patient is placed in low dorsal lithotomy position. Thighs and legs are gently flexed, ankles and feet evenly supported, hips are minimally abducted and the buttocks are seated at the edge of the table, but not overhanging. Arms are positioned alongside the table, palms facing the thighs and fingers extended, nerve compression should be avoided.

- Trocar placement: With the DaVinci robot as well as with other systems as TeleLap Alf-X there is always the placement of the optical trocar (umbilicus or higher at midline), the assistants port and 2–3 ports for the robotic arms (required distance at least 12–14 cm to the right and left of the optic trocar. To prevent robotic arm collision during the procedure this correct trocar placement is essential.
- Robotic column location and instrumentation: The robotic column(s) should be placed for hysterectomies clearly to the right or the left of the patient.  
The most commonly used instruments are the PK dissecting forceps, monopolar scissors or spatula and the meganeedle holder, which is not permitted to be used in Europe. The monopolar instruments are used with the right arm and a bipolar PK dissecting forceps is used with the left arm for a right handed surgeon.
- Use of assistants: The assistant helps with suction-irrigation, vessel sealing, tissue retraction, specimen retrieval, introduction and removal of sutures and needles and controlling of malfunction of robotic arms.
- Twelve hysterectomy steps for a robotic procedure:
  1. Introduce a uterine manipulator with a cervical cup to facilitate bladder dissection and identification of the cervico-vaginal junction.
  2. After grasping the uterus by one of the round ligaments pull it towards the patient's contra lateral side and help with the uterine manipulator. Make a peritoneal incision parallel to the infundibulopelvic ligament, open the retroperitoneal space and identify the ureter.
  3. Create a window in the medial leaf of the broad ligament, grasp and divide the infundibulo pelvic ligament with a sealing device.
  4. Open the peritoneum over the external iliac vessels towards the end of the round ligaments and open the lateral pelvic peritoneum with a monopolar energy device towards the insertion of the utero sacral ligaments.
  5. Transect the round ligaments and incise the anterior leaf of the broad ligament towards the vesico-uterine fold.
  6. With monopolar energy dissect the retroperitoneal tissue in the broad ligament till the uterine vessels appear and divide the upper cardinal ligament adjacent to the lateral cervical wall.
  7. Repetition of all 6 steps on the contralateral side.
  8. Bladder dissection always from the left or right side at least 1 cm below the cervico-vaginal junction.
  9. With a vessel sealing device or bipolar instrument the lower cardinal ligaments adjacent to the cervix bilaterally are now divided.
  10. Colpotomy on the cervico vaginal junction which is well identified by pushing up the cup of the uterine manipulator with a monopolar instrument or ultracision and removal of the uterus.
  11. Exchange the monopolar instrument with a needle holder, introduction of suture and needle and closure of vaginal cuff incorporation the uterosacral ligaments at the vaginal angles into the suture to prevent douglascele formation. Be careful to maintain a distance between the cuff closure and the ureters.
  12. Check for haemostasis, undock the robotic arms from the trocars and release the gas. For wound closure use a delayed absorbable suture for the fascia in all incision above 10 mm and close the skin.

- The Da Vinci robotic system in its present form is highly appreciated, however, we have to be open for further technical developments of Intuitive Surgery now the Da Vinci Xi as well as many new upcoming robotic systems and instruments, 3D- camera developments and the addition of "force feedback", articulated instruments and wonderful medical technology.

If we do not use it we cannot judge it. Therefore, give it a chance in 2015 even if it is not available for everyone.

### **S003. Gestational Diabetes and its Impact in Latin America**

E. Castelazo Morales, S. Fajardo Duenas, R. Zamora, F. Bernardez. Mexico

Latin America has multiple problems; unequal distribution of wealth, infrastructure, and technology among others. It is the region with more ethnic groups. As globalization progresses, different ways of living appear. LA has an obesity epidemic with malnutrition associated. Mexico is the leading country with overweight and obesity. This rate rise seen in overweight and obesity is parallel to the introduction of fast food, migration to cities, diminution of physical activity, and so on, and also a consequent rise in diabetes type II. There is an association between DMG and T II DM, with a 10% annual risk of DM T II debut after the first complicated pregnancy. The variable reported prevalence of DMG is due to unequal diagnostic criteria.

The world knew glycosuria, but until 1954 it was related to obstetric risk. In 1979 DMG was recognized. The screening test begun with attempts to identify women who would develop DM T II back in 60's. Three basic methodologies are currently approved for screening, 2 steps, (ACOG), 1 step (WHO, ADA, HAPO). Today we recognize the benefits of an early identification and treatment of those women with risk and overt DMG. Although ideally a universal screening test is desired, the economic, geographic and educational barriers appear. It is proven a reduction in the morbimortality perinatal rate. As well a reduction in the offsprings and adult morbidity: hypertension, diabetes, overweight, obesity and quality of life.

### **S008. Abortion Fundamentals**

#### **S008.1**

#### **STATUS OF INDUCED ABORTION IN EUROPE**

*G. Sedgh, Guttmacher, United States of America*

Understanding the sociodemographic profiles of women who have abortions and when women have abortions, and who these profiles have changed over time, can inform efforts to improve and refine relevant services.

We examine data on characteristics of women who obtain legal abortions in Europe. We also examine information for North America as a point of comparison. We compute the percentage distributions of abortions, and abortion rates where possible, by women's age, marital status and parity, and by the gestational age of the pregnancy. We examine trends since the 1990s where possible. Since the adolescent years are a particularly vulnerable period for many females, we also highlight adolescent abortion rates across countries.

In general across Europe and North America, abortion rates are higher among 20–24 year olds than any other age group. In some Eastern European countries, rates among 25–34 year-olds are comparable to the rates in 20–24 year-olds. In most countries with reliable evidence, married women obtain a larger proportion of abortions than unmarried women. More than half of abortions are obtained by women with at least one child. The proportion of abortions obtained by older women and nulliparous women has increased over time. The vast majority of abortions are obtained early during the pregnancy, and abortions are obtained even earlier in gestation now than in the past.

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