

第六届中国西部暨国际妇科内镜
新技术与盆底结构重建论坛



资料汇编



第六届中国西部暨国际妇科内镜新技术与盆底结构重建论坛

资 料 汇 编

第三军医大学西南医院妇产科

“第六届中国西部暨国际妇科内镜新技术与盆底结构 重建论坛” 议程

2008-4-19 星期六

08: 30 - 08: 50	致开幕辞		梁志清教授		
	代表合影				
学术报告					
08: 50 - 09: 20	腹腔镜手术治疗盆底功能障碍性疾病		Alan Lam	主持人: 史常旭教授 张震宇教授	
09: 20 - 09: 50	腹腔镜下子宫切除及盆底重建		Robert O' Shea		
10: 00 - 10: 30	腹腔镜下盆底解剖		Paya Pasic		
10: 30-11: 00	Prolift 手术治疗盆腔脏器脱垂		徐惠成		
手术演示					
11: 10 - 18: 00	1 号手术间		2 号手术间		主持人: 张震宇教授 石 钢教授
	手术名称	手术者	手术名称	手术者	
	腹腔镜下子宫骶骨固定术	Alan Lam	压力性尿失禁的腹腔镜手术治疗	Robert O' Shea	
	TVT、TVT-O 治疗张力性尿失禁	徐惠成	腹腔镜下全子宫切除术	Paya Pasic	
	Prolift 手术治疗盆腔脏器脱垂	徐惠成	腹腔镜下全盆底重建	梁志清	

2008-4-20 星期日

学术报告					
08: 30 - 09: 00	腹腔镜下完全广泛子宫切除术+盆腔淋巴清扫术治疗宫颈癌		Jubilee Brown		主持人: 石 钢教授 张震宇教授
09: 00 - 09: 30	腹腔镜下保留神经广泛子宫切除术、盆腔淋巴结清扫术		William Lin		
09: 40-10: 10	妇科肿瘤的手术新进展		曹泽毅		
10: 10-10: 40	深部子宫内膜异位症的腹腔镜手术技巧		冷金花		
手术演示					
11: 00 - 17: 50	1 号手术间		2 号手术间		主持人: 梁志清教授 张震宇教授
	手术名称	手术者	手术名称	手术者	
	腹腔镜下解剖性广泛子宫切除术	William Lin	腹腔镜下保留神经根治性子 宫切除术	陈 勇	
	腹腔镜下卵巢癌全面分期手术	徐惠成	腹腔镜下次广 泛切除术	Jubilee Brown	
	早期宫颈癌腹腔镜下根治性宫颈切除术	梁志清			
17: 50 - 18: 10	致闭幕词			梁志清教授	

**INTERNATIONAL FORUM ON LAPAROSCOPIC NEW TECHNIQUE IN GYNECOLOGIC ONCOLOGY
AND PELVIC RECONSTRUCTION**

International Lecture Theatre – Southwest Hospital

Friday 18th April 2008

Arrival : Allocation of Accommodation at YuYuan Hotel,

Third Military Medical University, Chongqing.

Saturday 19th April 2008

08: 30 - 08: 50	Welcome and Opening Ceremony		Zhiqing Liang		
	Photography				
Lecture					
08: 50 - 09: 20	Laparoscopic surgery on female pelvic floor dysfunction		Alan Lam	Chairman: Changxu Shi Zhenyu Zhang	
09: 20 - 09: 50	Laparoscopic hysterectomy and pelvic reconstruction		Robert O' Shea		
10: 00 - 10: 30	Pelvic anatomy through the laparoscope		Paya Pasic		
10: 30-11: 00	Prolift Procedure for pelvic floor prolapse		Huicheng Xu		
Live surgery					
11: 10 - 18: 00	Theatre 1		Theatre 2		Chairman: Zhenyu Zhang Gang Shi
	Demonstration	operator	Demonstration	operator	
	Laparoscopic Utero-sacropexy	Alan Lam	Laparoscopic treatment for stress urinary incontinence	Robert O' Shea	
	TVT or TVT-O for urinary stress incontinence	Huicheng Xu	Laparoscopic total Hysterectomy	Paya Pasic	
	Prolift Procedure for pelvic floor prolapse	Huicheng Xu	Laparoscopic Prolift pelvic reconstruction	Zhiqing Liang	

Sunday 20th April 2008

Lecture					
08: 30 - 09: 00	Laparoscopic total radical hysterectomy and lymphadenectomy in cervical cancer		Jubilee Brown	Chairman: Gang Shi Zhenyu Zhang	
09: 00 - 09: 30	Laparoscopic Nerve Sparing Radical hysterectomy in early cervical cancer		William Lin		
09: 40-10: 10	Update on surgical management in gynecologic oncology		Zeyi Cao		
10: 10-10: 40	The Laparoscopic skills on removal of deep endometriosis		Jinhua Leng		
Live surgery					
11: 00 - 17: 50	Theatre 1		Theatre 2		Chairman: Zhiqing Liang Zhenyu Zhang
	Demonstration	operator	Demonstration	operator	
	Laparoscopic anatomic Radical hysterectomy	William Lin	Laparoscopic Nerve Sparing Radical hysterectomy	Yong Chen	
	Laparoscopic overall staging operation in ovarian cancer	Huicheng Xu	Laparoscopic sub-radical hysterectomy in endometrial cancer	Jubilee Brown	
	Laparoscopic radical trachelectomy for early invasive Cervical cancer	Zhiqing Liang			
17: 50 - 18: 10	Closing Ceremony			Zhiqing Liang	

注 意 事 项

- 与会人员凭代表证参加各项活动。
- 会议发言代表请在注册时向会议秘书处提供大会交流幻灯。
- 请按照会议日程表安排活动如不参加会议活动,请提前通知会议秘书处。如日程有变化,以会议临时通知为准。
- 酒店提供 1 份免费早餐,请凭房卡到相应餐厅用餐。会议组委会承担与会代表会议期间用餐费用,其余费用自理。
- 会议秘书处设在瑜园宾馆 401 房间,房间电话:68753900 - 401

Information

- Participants are kindly requested to bear name badges for access to activities.
- Presenters are required to copy their presentations to the secretarial upon registration.
- Participants are kindly requested to arrange activities according to the program. if not, please inform the secretarial in advance, Any changes of program will be notified by the secretariat in advance.
- Room rated are inclusive of one breakfast. meal incurred during the meeting will be covered by the host. Other charges, for example. Laundry, long distance calls ect. are on delegates own expenses.
- Secretarial is at Room 401 yu yuan Hotel:68753900 - 401

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Laparoscopic uteropexy – suture or mesh repair

Alan Lam

Associate Professor Centre for Advanced Reproductive Endosurgery
Royal North Shore Hospital, University of Sydney

Learning Objectives

- * To review the prevalence of pelvic organ prolapse
- * To recall the anatomy of pelvic floor support
- * To have an overview of the available surgical options for pelvic organ prolapse
- * To analyse the role of laparoscopic pelvic floor repair
- * To examine the surgical techniques of laparoscopic uteropexy and sacrocolpopexy
- * To consider the potential benefits and complications of these techniques
- * To examine the author's extensive experience since 1993 to date
- * posterior vaginal wall prolapse

Setting

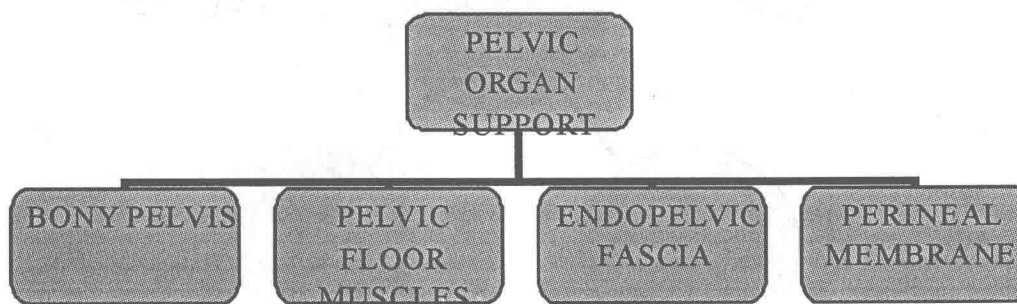
- * Tertiary referral unit
- * Extensive experience of over 1100 cases of laparoscopic and vaginal pelvic floor repairs

Prevalence of pelvic organ prolapse

- * Some 50% (43 – 76%) of women have some degree of Pelvic organ prolapse
- * In a multi – centre study, women between 18 – 83 yrs presenting for routine care (Swift SE et al. Am J Obstet Gynecol 2003) :

Stage 0	Stage I	Stage II	Stage III
24%	38%	35%	2%

Anatomical considerations



- * Three levels of vaginal support and correlation to pelvic floor defects (DeLancey 1992)

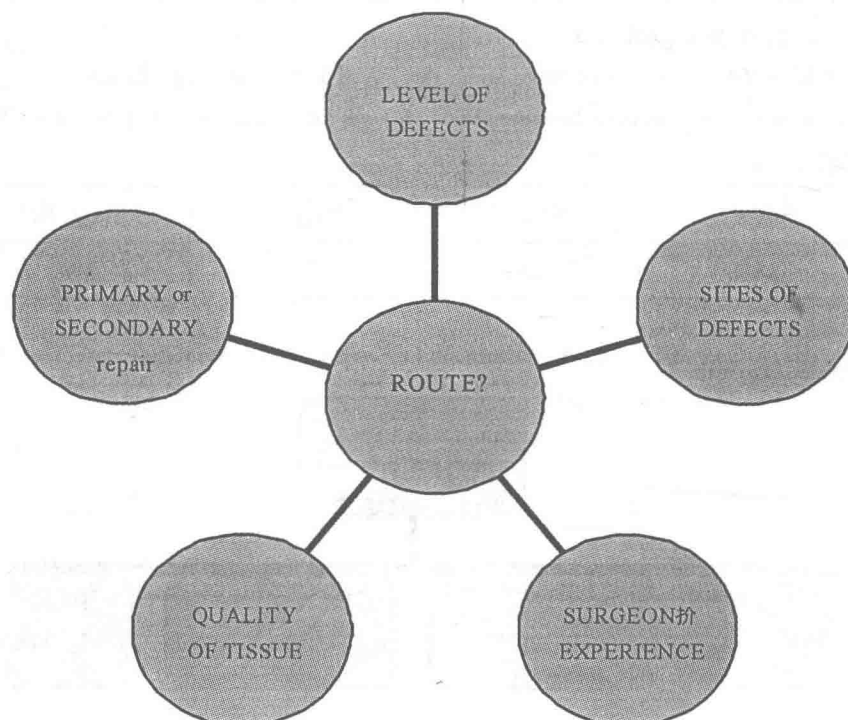
Level	Structure	Function	Effect of damage
Level I Suspension	Upper paraocolpium	Suspends apex to pelvic walls	Prolapse of vaginal apex
Level II Attachment	Lower paraocolpium, Pubocervical fascia	Supports bladder and vesical neck	Cystocele-urethrocele
	Rectovaginal fascia	Prevents anterior expansion of rectum	Rectocele
Level III Fusion	Perineal membrane, perineal body, levatori ani	Fixes vagina to adjacent structures	Urethrocele or deficient perineal body

* Uterine and vaginal vault prolapse occur as a result of fascial defects and damage to the levator muscular support

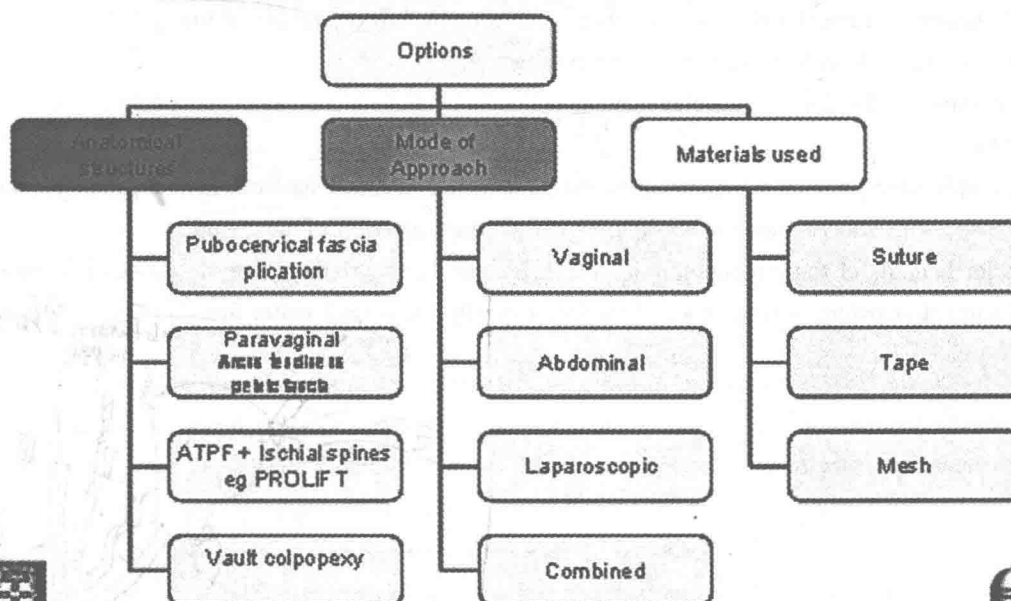
* A combination of fascial defects is commonly found

- with disruption of the uterosacral suspension at level I
- detachment of endopelvic fascia from levator ani fascia at level II
- and disruption to the perineal body at level III

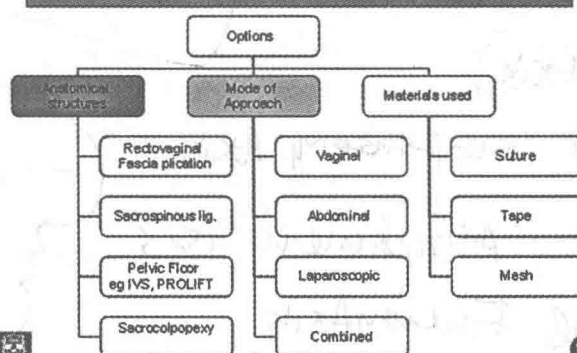
Factors determining the route of surgery for pelvic organ prolapse



Anterior wall prolapse



Posterior wall and Vault prolapse



Surgical video presentation on techniques

1. laparoscopic suture repair of vault prolapse
2. laparoscopic suture uteropexy
3. laparoscopic sacro – colpexy with mesh
4. laparoscopic sacro – uteropexy with mesh

Contraindications to laparoscopic pelvic floor surgery

* contraindications to general anesthesia

- * contraindications to laparoscopy
- * severe intra - abdominal adhesions

Results

- * success rates exceed 90 percent with greater than 12 months follow - up
- * complications - uncommon, one enterotomy, no ureteric injury, no rectal injury
- * suture erosion - 1 to 3 % with Ethibond sutures
- * mesh erosion - 1 - 2% with prolene mesh

Conclusions

- * laparoscopic uteropexy or colpopexy with suture or mesh is a safe and effective surgical option for uterine and vault prolapse, with success rates exceeding 90 percent in long - term follow - up
- * the major benefits of the laparoscopic approach include low morbidity, very low risk of foreign body reaction, reduced vaginal scarring, maintenance of vaginal capacity for normal coital function

L₁-L₂

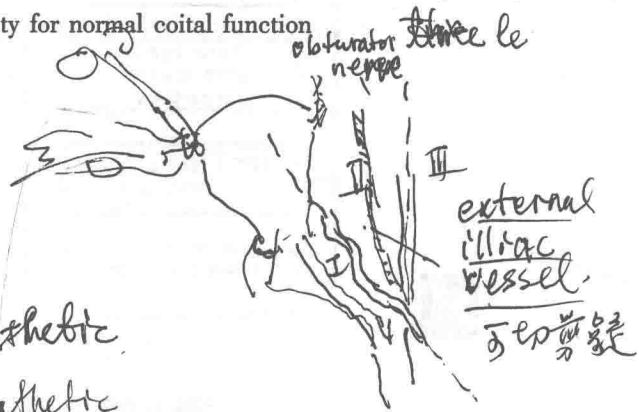
S₂-S₄

T₁₁-T₁₂-L₁

T₉ T₁₀

ovary & tube

Sympathetic
Sympathetic



Three level (Axis)

I. upper vertical suspensory Axis

II Horizontal Attachment Axis

III lower vertical Fusion Axis

present concept of
Visceral Fascia
内脏筋膜概念

Caval plate



www.gynlaparoscopy.com

Laparoscopic Hysterectomy and Pelvic Reconstruction

Dr. Robert T O' Shea

**Head of Unit Flinders Endogynaecology,
Flinders University**

Flinders Medical Centre, Adelaide Australia

Total laparoscopic hysterectomy offers considerable advantages over traditional total abdominal hysterectomy. Laparoscopically assisted vaginal hysterectomy became popular in the early 1990's following the first laparoscopic hysterectomy performed by Dr. Harry Reich. However, LAVH has proved a suboptimal procedure. Progression to total laparoscopic hysterectomy produces improved theatre efficiency, diminished blood loss, improved operative visibility with better appreciation of pelvic anatomy. The concept is using a tube in the vagina to perform a colpotomy with this procedure was initially suggested by Harry Reich and subsequently developed by Dr. Tony McCartney in Perth, Western Australia. Progression from LAVH to total laparoscopic hysterectomy requires equipment, confidence and competence.

The equipment required is not extensive, although a good uterine manipulator, a vaginal tube and laparoscopic suturing equipment is imperative. The procedure however, can be performed using both uni and bipolar diathermy in a low cost setting. Once the uterine arteries are taken laparoscopically, dissection is then continued into the paracervical region. The McCartney tube is then introduced. This has potential advantages such as elevating the uterus, delineating the uterine arteries for ligation if required and presenting the vagina for colpotomy. It also tamponades the vagina and preserves the pericervical ring. The vault is then closed with two mattress figure of eight sutures, using absorbable sutures such as Monocryl or Caprosyn.

A uterosacral colpopexy is performed using non-absorbable suture such as Ethibond, providing excellent suspension of the vaginal vault.

The use of the vaginal tube facilitates progression to total laparoscopic hysterectomy. Suturing skills are required to close the vagina but these can be easily obtained. Our data indicates that total laparoscopic hysterectomy versus LAVH results in diminished blood loss and shorter hospital stay with early return to work.

total laparoscopic hysterectomy should replace total abdominal hysterectomy and not vaginal hysterectomy. This procedure represents elegant anatomical surgery and is without doubt the? connoisseur's operation and is definitely worth the extra time and effort.

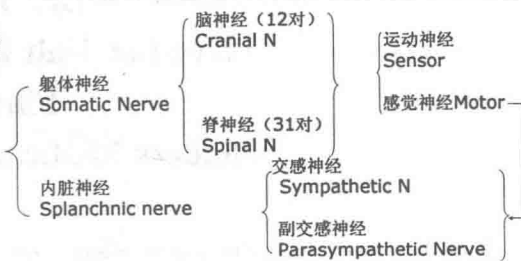
腹腔镜下保留神经的根治性子宫切除术

William lin

腹腔镜神经保留式广泛性子宫切除术

林武周
中国医药大学附属医院, 台湾
台湾妇产科内镜暨微创医学会

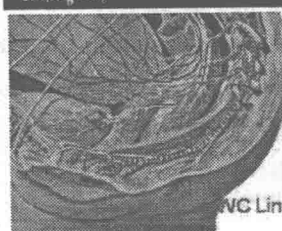
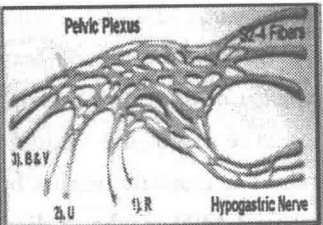
周围神经系统: PERIPHERAL NERVOUS SYSTEM

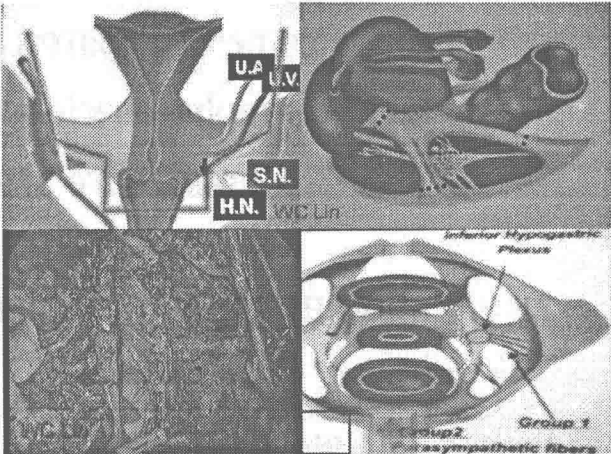
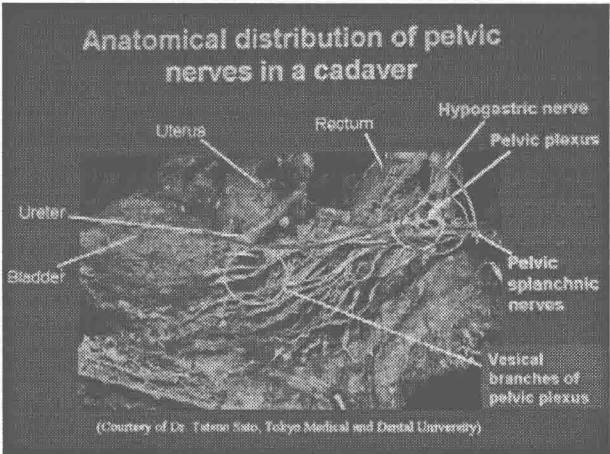


膀胱的神经 子宫、子宫颈的神经

- | | |
|--|---|
| 子宫的神经 <ul style="list-style-type: none">○ 交感神经:<ul style="list-style-type: none">1. 节前神经元: T12-L2侧角2. 节后神经元: 腹下丛神经节和骶交感神经节○ 副交感神经:<ul style="list-style-type: none">1. 节前神经元: S2-4骶副交感核2. 节后神经元: 子宫阴道丛内的子宫颈神经节和壁内节○ 内脏感觉神经<ul style="list-style-type: none">1. 子宫体和宫底的痛觉随交感行2. 子宫颈的痛觉随副交感行 | 膀胱的神经 <ul style="list-style-type: none">○ 交感神经:<ul style="list-style-type: none">1. 节前神经元: L1-2侧角2. 节后神经元: 肠系膜下丛和腹下丛的神经节○ 副交感神经:<ul style="list-style-type: none">1. 节前神经元: S2-4骶副交感核2. 节后神经元: 膀胱丛内和壁内节○ 内脏感觉神经<ul style="list-style-type: none">1. 膀胱体的痛觉随交感行2. 膀胱颈的痛觉和膀胱的牵张觉随副交感行---盆内脏神经 |
|--|---|

- 1) A group of thin fibers directed medially toward the rectum running through the mesorectum (medial efferent bundle)
 - 2) A group of thin fibers directed cranially toward the uterus running through the parametrium (cranial efferent bundle)
 - 3) A group formed by 3-4 main fibers which run through the paraovary directed toward the bladder and vagina (anterior efferent bundle or bladder branches)
- (Cuccaroni et al Inpress, Ercoli et al. Surg Radiol Anat 2003;25:203-206)





STAGE IB1(EARLY): 39P'TS, FROM 2004-08 TO 2007-06				
	P't No.	P-Op days after PVR≤50cc	Contipation (need Laxative)	Complication
LRH	23	28	30% (7/23)	V-V fistula=1
LRH-NS	16	8.5	6.2% (1/16)	L't U-V fistula=1 (D-J tube only) Bladder injury=1 (primary repair)

RH-NS VS BLADDER FUNCTION				
Author	E. Ito (ARH) (Japan 2004)	N. SAKURA-GI (ARH) (Tokyo, Japan 2005)	K. CHAROE-NKWAN (ARH)(2006 Thailand)	WC Lin (LRH) (CMUH Taiwan 2007)
Results				
P't No.	25	20	21	16
P-Op days after PVR=50cc	17.1	NA	10.5	8.5

The Outcome of Laparoscopic Radical Hysterectomy and Lymphadenectomy for Cervical Cancer: a prospective analysis of 295 patients.

Zhiqing Liang, Huicheng XU, Yong Chen, Yuyan LI, Dan Wang, Qiaoyu Zhang.

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Abstract

Objectives: Cervical carcinoma is likely to become one of the most important indications for laparoscopic radical surgery. The laparoscopic technique combines the benefits of minimal invasive approach with established surgical principles. In our institution the laparoscopic radical hysterectomy and trans - peritoneal approach lymphadenectomy have become the standard techniques for invasive cervical cancer. We report the indications, techniques, results and oncological outcome in a single center experience.

Design: Between February 2001 and June 2007 we performed laparoscopic radical hysterectomies for cervical cancer in 295 patients. Their initial techniques, operation data, complications, post - operative course, oncological outcome and survival were evaluated.

Results: 290 procedures out of 295 were successful. Para - aortic lymphadenectomy was performed in 156 (52.9%) patients and pelvic lymphadenectomy was performed in all 295 patients. The median blood loss was 230 ml (range 50 - 1200 ml). The mean operation time was 162 min (range 110 - 350) which included the learning curves of three surgeons. In five cases (1.7%) conversion to open surgery was necessary due to bleeding (3 cases), bowel injury (1 case) and hypercapnia (1 case). Other major intra - operative injuries occurred in 12 (4.1%) of the patients. Positive lymph nodes were detected in 80 cases (27.1%), lymphovascular space invasion in 54 cases (18.3%) and surgical margins were negative for tumor in all patients. The mean hospital stay was 10.3 days. Post - operative complications occurred in 10.8% patients, uretero - vaginal fistula in 5 cases, vesico - vaginal fistula in 4, uretero - stenosis in 3 cases, deep venous thrombosis in 9 cases, lymphocyst in 4 cases, lymphedema in 5 cases 1 case with trocar insertion site metastasis. Other medical problems included 47 (15.9%) cases of bladder dysfunction and 62 (21.0%) cases of rectum dysfunction or constipation. The median follow - up was 36.45 months (range 8 - 76 months). 48 (16.3%) patients had recurrences or metastasis. Of

these patients, 43 (14.6) have died of their disease and 5 (1.7%) are alive with disease. The overall disease-free survival was 95.2% for Ia, 96.2% for Ib, and 84.5% for IIa, 79.4% for IIb, 66.7% for IIIa and 60.0% for IIIb respectively.

Conclusions: Laparoscopic radical hysterectomy is a routine, effective treatment for patients with Ia2 - IIb cervical carcinoma. With more experience it is envisaged that IIb stage patients can be managed safely offering all the benefits of minimal surgery to the patients. Although no long-term follow-up is available our follow-up data for up to 76 months confirm the effectiveness of laparoscopic radical hysterectomy in terms of surgical principles and oncological outcome.

Keywords: Cervical cancer; laparoscopy; radical hysterectomy

1. Introduction

Radical hysterectomy is an established treatment modality for localized cervical cancer. The laparoscopic approach, which has been developed since 1992[1], is now regularly used at several centers. Laparoscopic radical hysterectomy and retro-peritoneal or trans-peritoneal approaches pelvic or para-aortic lymphadenectomy has been developed for gynecological cancer and data have been published by various centers [2, 3 and 4]. The benefits of minimal invasive surgery - less trauma with increased patients comfort, better visualization and preparation, less blood loss, short recovery time with decreased analgesic requirements, shorter hospital stay and convalescence, are obvious. Principally the new technique has to address two points: is the laparoscopic approach a safe procedure and are the oncological results equal to standard surgery? Long-term data in large series are not available as yet because of the relatively short time since laparoscopy has been in use, when compared to the standard open surgical procedures [5]. However, data regarding medium and long-term survival did not prove that significant differences occurred between laparoscopic and open surgical procedures [3, 6 and 7].

In our institution laparoscopic radical hysterectomy with a trans-peritoneal approach lymphadenectomy has become the standard procedure for treatment of cervical cancer. We report on our single center experience with 295 procedures.

2. Patients and methods

2.1. Patients

Between February 2001 and June 2007, 295 laparoscopic hysterectomies and pelvic lymphadenectomy for invasive cervical cancer were performed at our institution, including 156 para-aortic lymphadenectomy for FIGO Stage II cervical cancer. The patients and tumor characteristics are summarized in Table 1. The average age of the population was 43.08 (range 25 - 77y). The weight of the patients varied from 52 to 73 kg, with an average of 58.1 kg. The staging of patients was done according to the FIGO staging system. Of the 295 patients, FIGO stage, Ia2 n = 21, Ib1 n = 27, Ib2 n = 53, IIa n = 71, IIb n = 107, IIIa n = 6, IIIb n = 10.

With more experience the indication for laparoscopy has been extended and at this time the laparoscopic radical hysterectomy has become the standard procedure in our institution. Data regarding the first 295 procedures have been analyzed retrospectively in terms of stage, operative findings, complications and outcome and follow up.

2.2. Surgical Technique

Informed consent was obtained from each patient. All procedures were performed under general endo-tracheal anesthesia. All patients underwent bowel preparation and were administered pre-operative antibiotics. In addition, all patients underwent placement of a urinary Foley catheter. Following induction of general anaesthesia, an orogastric tube was inserted by the anaesthetist to decompress the stomach and this was removed at the end of the