ent multiparous or nulliparous with a desire to become pregnant later on. Uterine descensus or prolapsus in nulliparous young/middle aged woman is extremely rare.

The same situation in multiparous women is more common but the frequency is still less than 1 %, so it cannot be considered an everyday problem. In these cases, of course, there are anatomical and connective tissue anomalies, but I would insist on the importance of delivery under well equipped circumstances and responsible (specialized) staff.

In multiparous patients, the descensus/prolapsus of the uterus, in most cases, is connected with vaginal wall elongation – so the ventrofixation itself is an insufficient technique to solve the problem via laparoscopy or laparotomy. In these cases, we prefer vaginal wall repair with partial amputation of the cervix.

In the case of prolapsus/ descensus in nulliparous patients with a desire for future children (which is very, very rare), laparoscopic ventrofixation may solve the problem for a short time, but a personally individualised technique via laparotomy is safer for the patient and the surgeon.

Prof. Attila Pál (Szeged)

If the patient is really very keen to preserve her uterus the laparoscopic ventrosuspension is one of the possible options. I would prefer ventrosuspension of the round ligament, although potential complications of this procedure include avulsion of round ligament secondary to an inadequate fascial incision and undue tension or positioning the round ligaments with a full peritoneum. In case of serious uterine descend ventrosuspension does not give a final solution. If she plans to be pregnant in the near future or suffering from deep dyspareunia, chronic pelvic pain in mine opinion the procedure is indicated. But one should keep it mine that the effect of suspension is questionable.

I. Announcement!

We notify cordially in endoscopy interested domestic and foreign colleagues, that in the year 2001,

the **Annual Meeting**

of *Hungarian Society for Gynecologic Endoscopy*

will be held in Békéscsaba.

The staff memebers of our Department in the Réthy Pál Hospital at Békéscsaba hope that the participiants of the meeting will enjoy the scientific programme as well as the other events planned.

We look forward to seeing you in Békéscsaba.

Árpád Rucz *Zsolt Szeberényi*

MAGYAR NŐGYÓGYÁSZOK ENDOSZKÓPOS TÁRSASÁGA
Alapítva: 1993

NEWSLETTER FROM HUNGARY

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BUDAPEST WELCOMES YOU:

Laparo-Vaginal Surgery in the 21st Century

ISGE 2000. REGIONAL MEETING

Dear Participants,

On behalf of the Hungarian Society of Gynaecological Endoscopits we cordially welcome you to our Regional Meeting of ISGE at the Hotel Hyatt Budapest.
In the program our aim was to provide a forum in which opinions of traditional and laparoscopic surgery can be discussed. The Meeting will cover several aspects of laparoscopic and vaginal surgery as well as new trends in the combination of these techniques.
We invite you to enjoy the scientific deliberations of the congress and the collegiality of all participants in attendance.
We urge you to take full advantage of the social program and the scenic, cultural and gastronomic delights of Budapest.
Welcome to Budapest !

Prof. István Szabó
Congress Chairman

Prof. István Rákóczi
Chairman of Organizing Committee

The Millennium Memorial on the square of heroes

THE EDITORS' VOICE

Dear Colleagues,

Our Newsletter, regularly published in Hungarian language, this time appears in English. We decided this in honour of the participants from abroad arriving to the ISGE Meeting.

The aim of this issue was to give more information from the activity of our Society, discipline and country to our guests. It is to mention that there are returning coloumns in the newsletter, e.g. "Society news", "Hospital introduction", "A question to all", "Important information about instruments", etc. However, this time we compiled this issue with special regard to our foreigner guests, and – therefore – we prepared materials, like the Homage to J. Veres as well as an interview with his widow, and a short story of the Hungarian Society of Gynaecological Endoscopists (HSGE).

This might remember you, when returning home, to the role and achievements of medicine in Hungary. We wish you a useful and pleasant stay in our country.

INFORMATIONS ABOUT

The Department of Obstetrics & Gynaecology of the "Elisabeth" City Hospital in Jászberény

The Jászság is a part of the Great Hungarian Plain, situated in the west from the River Tisza, bordered by the River Zagyva, Tarna and Ágó. The capital city of the province is Jászberény, a town with a pleasant atmosphere rich in cultural heritage. The famous Jász Museum is the home of the legendary relic, the Lehel's horn. (Lehel was a famous figure of the early Hungarian history).

The first medical institution of the town was founded in 1755 as an infirmary. In 1872 fourhundred and fifty four patients were already treated there. A separate obstetrical department was organised in 1927, and later modernised in 1935. The department moved to a newly constructed one-story building in 1963, which has been functioning ever since with a 50-bed capacity.

The obgyn department of the district, and later of the municipal hospital provides primary care for the 92.000 population of the territory. Contrary to the national tendencies the birth rate has not decreased in this region. In the year 1999, 2236 in-patients were treated with an average hospital stay of 5,07 days, there were 17172 patients treated in outpatient department and the number of births reached 757. Six physicians and twenty-one nurses work in the department, which is a rather low number compared to national standards.

The laparoscopic procedure was first introduced in 1995. The necessary skills were acquired on training courses organised by the leading gynaecological departments. Diagnostic laparoscopies and sterilizations were mainly the interventions. Today the management of pelvic adhesions, benign adnexal masses and extrauterine gravidity have became daily procedures. In the near future we are planning to perform the first laparoscopic hysterectomy in some chosen cases.

Between 1st of January 1995 and 30th of July 1999 we performed 327 laparoscopic operations. 221 of them were sterilizations. In the case of 80 patients indication of diagnostic laparoscopy was chronic pelvic pain, in 49 cases adhesiolysis was performed. Cystectomy, oophorectomy, salpingectomy, adnexectomy and salpingotomy were made in 26 cases of benign adnexal changes and ectopic pregnancy, without any serious complications. The laparoscopic procedure has become a routine intervention in the last few years. Despite the financial difficulties we are planning to add hysteroscopic techniques to our endoscopic procedures.

We are convinced that the wider use of the endoscopic procedures are for the greatest benefit of our patients. This progress can not be stopped even by the unfavourable financing system.

Lajos Bördős

The Lehel's horn

The surgical block of the hospital

Jászberény is the capital city of the province Jászság

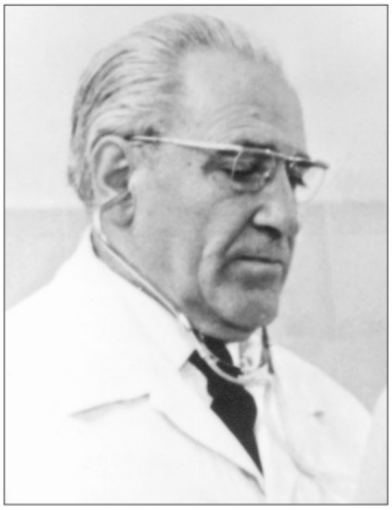
A needle puncture that helped to change the world of surgery

Homage to János Veres

The creation of pneumoperitoneum is the first step that offers space for us to see and work inside the abdominal cavity. Thus all over the world surgeons and gynaecologists every day say to nurses: "the Veres-needle, please." There are only few who know who was the inge-nious inventor of the pneumoperi-toneum-needle and the reason he used this device for originally.

János Veres was born at the beginning of the past century, in 1903 in Hungary, Kismajtény, where his father was the stationmaster of the Royal Hungarian Railways Company. He started to study medicine at the University Medical School of Debrecen, where he got his M.D. degree in 1927. After a year spent at the Department of Forensic Medicine of the same University, he moved to Szombathely in the western part of Hungary. While working at the department of internal medicine in the county hospital, he gained the title of Specialist in Internal Medicine in 1932. In the same year, he was appointed to the head of the Department of Internal Medicine at the hospital in Kapuvár.

At this time there were a lot patients suffering from tuberculosis in Hungary (the disease was often called as "Morbus Hungaricus"), and a special and useful treatment was the pneumothorax creation. To prevent injuries of the lung while getting through the thoracic wall, but none of them was safe. Veres used his own special, spring-loaded needle to create an artifical pneumothorax even in 1932, and after 950 successful interventions he reported his experiences first in 1936 in Hungarian language (3). He had to bear those critical remarks that are the characteristics of important inventions. Immediately after his original report there was a comment



Surgeons and gynaecologists every day say to nurses: "the Veres-needle, please." There are only few who know who was the ingenious inventor of the pneumoperitoneum-needle

published by another Hungarian internist who claimed the priority for himself as the inventor of this needle and at the same time he declared his opinion: this needle was not suitable for everyday practice. Veres explained in his answer why his needle was an original one and emphasized its usefulness based on his own experience. The international medical world got acquainted with the Veres-needle in 1938 through his article written in German.

In 1955, Veres moved to Budapest for family reasons. After the death of his wife he married again and his daughter Andrea is still working today as a psychiatrist in Budapest.

In Budapest, Dr.Veres was working at different medical departments. Meanwhile he got his Ph.D. in 1958 for his study entitled "Clinical course and therapy of tularaemia."

During the years in Budapest he continued his pioneer work in the field of carbondioxide snow (cardice) treatment of patients with peripheral occlusion and other circulatory disorders.

In different scientific papers, he wrote his name some-times with a double "s". Other times he used only a single "s" so today if we cite him we can use both variations.

The question is, who used for the first time the Veres-needle, not to get through the chest wall, but to puncture the abdominal cavity. "We have further evidence in 1952 that he published a case reported a "successful treatment of severe hiccup by performing pneumoperitoneum" (5).

His patient had pleural fluid collection because of pleuritis and the fluid was suctioned. Shortly after treatment severe hiccup started which didn't stop for 11 days. The patient couldn't eat and sleep in spite of sedatives, morphium, atropin, etc., medication even local anesthesia of the phrenic nerve was ineffective. Pneumoperitoneum was performed and the hiccup immediately ceased and didnt come back again. The success was probably due to the elevation of the diaphragm as a consequence of pneumoperitoneum.

For laparoscopic surgery, probably R. Wittmoser, R. Palmer or K. Semm was the first doctor who introduced the Veres-needle (1). Frequen-cy of injuries and complications during laparoscopic surgical proce-dure caused by this needle is ex-tremely low provided it is used in the proper way. Although there are some who prefer open laparoscopic surgery or in gasless procedure - the importance and usefulness of the Veres-needle is obvious. There are a lot of variations and modifications of the needle, but its original idea and technique remain.

Talking with the widow of János Veres

Márta Csörgey, an internist in pension is still living in the same flat, they lived in together. This is an old house in the hilly Buda part of the capital. It is Saturday morning and Andrea Veres, his daughter, a psychiatrist and mother of two daughters at present, joined us. We have no time schedule, we have plenty of time. I took a tape recorder with, but did not begin to use it. The conversation progresses slowly. They want me to understand – and record – the life of a special person, whose life was full with struggle, work, beauty and result. It took me some hours, until I get involved into the family centred atmosphere and seems to me that I caught the characteristics of a unique human being. The ladies remember the head of the family with much love.

- I am glad to have the opportunity to speak about my husband. We learnt to know each other in 1962, during our work at the St. Janos Municipal Hospital at Budapest. Being in his late 50's, he pre-

Married in 1963

tended to be much younger. Our daughter, Andrea then became his third child. We hade a lovely life together, and always shared difficulties.

First I ask about the years at Kapuvar (a small town in the countryside near the western border of Hungary), where his famous and important invention was born. Not too much is remembered from these years:

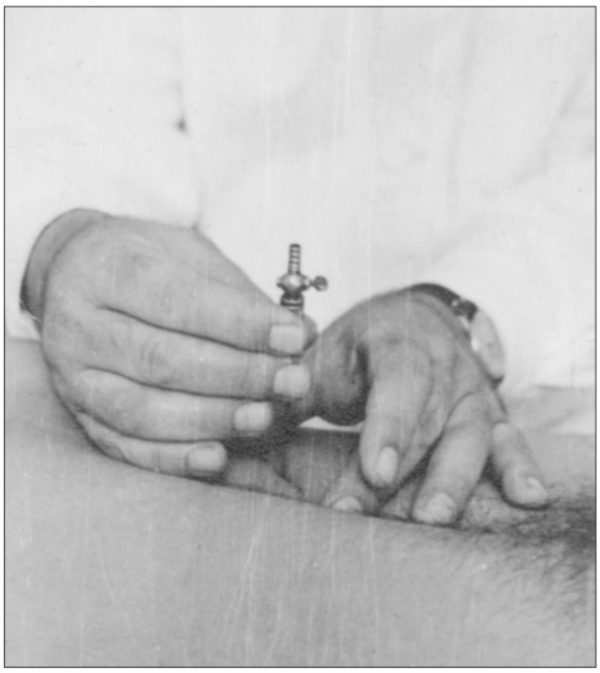
- He was the head of both departments of internal and lung diseases (his third speciality degree was infectious diseases). His first wife died at a young age. There were two sons from this first marriage. The older's name is János Lóránt Veres, he was born in 1934, became also a physician, nowadays lives in Germany. The younger son is Miklós Veres, born in 1937, he is an artist, he is restoring paintings (he lives in the same house we are sitting in). János Veres loved all his children very much and did his best for the sake of his both families. He gave up the Kapuvar-carrier because of family reasons and moved to Budapest to give a better future for his sons.

Mrs Veres recalls his husband's younger years and hobbies:

- In his youth he had been a sportsman who showed up good results in athletics (high-jump). Here is a piece of an old newspaper in which the journalist congratulates him for his activity in the field of sport. He was many-sided: enthusiastic about different kinds of music, later on, too. We regularly went to the opera, he played the piano, preferably Hungarian popular songs. However, one of the main hobby was art, drawing (his own work "Autopsy" illustrates these coloumnes). As far as I know, originally he wan-ted to be an artist. Then, finishing university, unsuccessfully tried to became a gynaecologist. My husband had a good command of many foreign languages, e.g. German, English and Russian, too.

He liked to have evening with our family friends, especially at Balatongyörök, in the family's resort house at the lake Balaton, which was enlarged by the time passed. Winegrowing there was one of his favou-

Pencil drawing by János Veres entitled "Autopsy"



The famous needle in his own hands

More research was done in internal medicine

rite engagements. He was a gourmet, and neither was too bad in the kitchen. He was natural and flexible person.

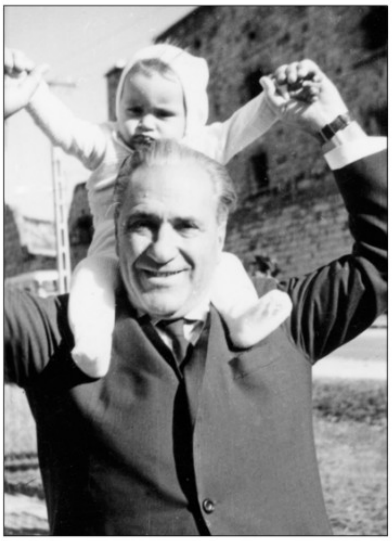
Then Márta takes out family photos in a heap from the drawer. Written documents, like his birth certificate, a wholly hand written curriculum vitae from 1973. After the visible picture-evidences of his inventions a small paper box turns up full with original, but differently developed Veres-needles!!!

Youthful portrait

- I show you here in his birth certificate, that his name was written as "Veres" with a singular "s" at the end. This is often questioned. In fact, it sometimes really was written with double "ss". In family circle we stick to the single "s" version and my daughter's name is also Andrea Veres. Had I have the change, I would suggest everyone to use the single "s" form.

- The family and the patients were equally important to him – this is the unanimous opinion of mother and daughter – he was a beloved father and husband as well as a doctor for his patients at the same time. He was able to make a balance between family and community tasks.

- He was a very creative man, with a colourful, witty personality. – Andrea adds, and goes on – I remember him organising tea-parties for me and my friends. I considered the situation to be natural that he was a man and a physician at a time.



A happy father with his daughter

I was 15 years old when he died. I missed him very much. He was and remained my rolemodel in my life.

At this point we stopped but did not finish the conversation. Márta and Andrea, thank you.

György Gerő

(The conversation originally occurred in Hungarian on the 19th August 2000)

History of Gynaecological Endoscopy and its Society in Hungary

Endoscopy - first of all – laparoscopy has more than three decades long history in Hungary. The first diagnostic laparoscopy was done by Mórocz at the 2nd Department of Obstetrics and Gynaecology of the Semmelweis Medical University. However, we may find the name of Hungarian doctors who contributed significantly to the world-wide spreading of endoscopy. Veress developed in 1938, the insufflation needle later bearing his name that made more secure the penetration into the abdominal cavity. Laparoscopic tests were being done at the beginning of the seventies only in a few departments, then from the middle of the decade in most of the University Departments and some other major hospitals.

However, due to lack of funds, endoscopy began to be applied widely only in the last ten years. From the second half of the eighties and following authorisation of performance of sterilization operations, the use of endoscopy in gynaecology has augmented.

Laparoscopy and hysteroscopy need a new technical and surgical approach. Thus, the arrival of a new generation of gynaecologists was necessary to ensure the proper spread of the technique in Hungary.

Following the initiative of Prof. I. Rákóczi with the support of the Hungarian Gynaecological Society, an organising committee was set up with the task of gathering doctors and surgeon assistants involved or interested in endoscopy. The first meeting was held in April 1992, in the Szent György (Saint George) Hospital of Székesfehérvár. Following conclusion of the scientific programme, the participants decided to found the Endoscopy Section of the Hungarian Gynaecological Society.

After its establishment, the Section organised many symposia. The first of these was organized in 1992 and the title was "Modern Gynaecological Operative Endoscopy". The event was highlighted by lectures delivered by such well known specialist from abroad as: A. Magos (UK), B. G. Molnár (UK), A. Pasternak (USA), B. McLucas (USA).

The next meeting was held in the same year in the city of Győr and the title was "Operative laparoscopy". This meeting was honoured by the participation of Head Physician B. Rudelsdorfer (Hallein, Austria).

The last meeting of the same year was organized on the Department of Obstetrics and Gynaecology University Medical School of Pécs. The main topic of this meeting were diagnostic and operative hysteroscopy.

The international results of diagnostic and operative hysteroscopy was the subject of the next symposium held in Budapest in April 1993, with the participation of Prof. Hamou (France).

The Section organised its first scientific conference in June 1993 in Kaposvár. On this occasion the works and results of Hungarian endoscopic centres were presented and some prominent specialists from abroad also participated. We enumerate among these: A. Magos (UK), T. Pokoly (USA), B. Rudelsdorfer (Austria) and I. Stenzl (Slovakia).

After conclusion of the scientific programme the participants voted and accepted the suggestion of turning the Section into an independent society, named "**ENDOSCOPIC SOCIETY OF HUNGARIAN GYNAECOLOGISTS**". The participants voted on the bylaws of the Society and elected the Board through secret ballot. The officers of the society were elected as follows: *President* – Prof. I. Rákóczi, *General secretary*: P. Sziller, *Members*: G. Bacskó, J. Bódis, T. Fülöp, Prof. J. Gellén, G. Gerő, F. Lintner, G.B. Molnár, A. Nemes, T.F. Prievara, S. Szmodics, Prof. I. Szabó, L. Szabó and F.Zs. Tóth. The mandate of the Board is for three years. The Society holds a General Assembly every year, concurrently with the Annual Congress.

The aim of the Society is the development of general principles and guidance of Hungarian gynaecological endoscopic activities and evaluation of the results obtained. Further aims of the Society are as follows: support of scientific activities of members, development international relationships, organisation at a high level of the university and postgraduate training in the field of endoscopy.

The Society helps the promotion of the results of international scientific research, whenever necessary takes a stance in the ethical issues that may arise in this field, and finally actively participates in the sharping of public opinion as to the minimally invasive surgical interventions.

Since its foundation, Society endeavoured to establish links with numerous domestic and foreign organizations involved in similar activities. In co-operation with the companion professions from Hungary, the Society organized several symposia, workshops and refreshment courses (Endoscopic Section of the Hungarian Surgical Society, Endoscopic Section of the Hungarian Urology Society, Institute of Experimental Surgery of the Debrecen Medical University).

The Society has taken up link with the following societies from abroad:

The Society of Laparoendoscopic Surgeons,
European Socitey for Gynaecological Endoscopy,
The International Society for Gynaecological Endoscopy,

The American Association of Gynaecological Endoscopists,
Endoscopic Surgery Centre Bratislava,
Polish Endoscopic Section of PGS,
Jugoslav Association for Endoscopic Surgery

Since 1995 the Socitey publishes a quarterly "Newsletter". This informs the members about activities of the society, endoscopy courses available in Hungary, endoscopy events abroad, various offers/contests and timing of congresses. Special space is developed to the brief description of new procedures, techniques as well as presentation of new instruments and tools.

In 1997 the Board has compiled the laparoscopy and hysteroscopy training programme of the Society. This has been finalized following consultation with the membership. The nation-wide programme defines the level of theoretical and practical training required for endoscopic activity. Depending on the level (base, middle and advanced), a defined number of endoscopic interventions should be performed alone or with assistance, in the various endoscopic centres of the country. Naturally this may come only following a proper and unified theoretical training. Those who attend the courses receive a certificate featuring the outcome of the surgery and the results of the examination.

In 1997 the Society established the VERESS Memorial Medal. This medal is conferred to domestic and foreign practitioners, for outstanding achievements in the practice, development and teaching of gynaecological endoscopy.

Congresses:
1993 – Kaposvár
1994 – Siófok
1995 – Debrecen
1996 – Pécs
(On this Congress the officers of Society were elected for the next three years: *President*: Prof. I. Rákóczi, *General Secretary*: P. Sziller, *Elected President*: Prof. I. Szabó)
1997 – Budapest
1998 – Szeged
1999 – Kistarcsa

On the last congress held in Kistarcsa the Board and the officers of the Society were elected through secret ballot:
President: Prof. I. Szabó (Pécs)
Past-President: Prof. I. Rákóczi (Bp)
Elected-President: Gy. Gerő (Kistarcsa)
General Secretary: J. Bódis (Pécs)
Members: Gy. Bacskó (Debrecen)
I. Drozgyik (Pécs)
V. Forgács (Budapest)
T. Fülöp (Budapest)
Prof. J. Gellén (Szeged)
J. Inovay (Budapest)
F. Lintner (Budapest)
B.G. Molnár (Szeged)
A. Nemes (Kecskemét)
P. Sziller (Budapest)
I. Veszelovszky (Szentes).

József Bódis

The Veres memorial medal

The Veres medal was established by our Society in order to acknowledge the activity of gynaecological endoscopists who achieved outstanding results in this field and also to serve as a courier of the results and successes of Hungarian medical discipline.
Some distinguished experts already have been awarded by this medal.

Jubilee scientific meeting at the Kaposi Mór County Hospital in Kaposvár

A jubilee scientific meeting has been held at the Kaposi Mór County Hospital in Kaposvár on the 10th anniversary of the beginning of endoscopic and minimally invasive procedures at the Obgyn Department.

Tibor Prievara - the head of the Department - in his greeting message described the events of the last ten years, including the foundation of the MNET at the 1993 congress at Kaposvár.

Prof. István Szabó gave an excellent report on the present place of gynaecological hysteroscopy in our country.

Lajos Németh followed, with the review of the endoscopical activity of the department. The most important statistical figures of the last 10 years were:

- 2745 laparoscopies (510 diagnostic, 2235 operative),
- 74 diagnostic hysteroscopies,
- 118 mini-laparatomies (performed with a Jacoscop).

The nice facade of the Department of Obstetrics and Gynaecology in the hospital

Zoltán Bencze finished with an instructive case-report of an abdominal vessel injury.

With his concluding words the head of the department pointed out that with its 450 laparoscopic interventions the department of Kaposvár stood in second place only preceded by the POTE University Hospital (according to 1998 statistics). Two-thirds of the extrauterine pregnancies have been managed by a laparoscopy. The main task of the coming years will be the wider spread of operational hysteroscopic procedures, which needs the enlargement and modernising of endoscopical instrumental resources.

Ferenc Tibor Prievara

INSTRUMENTS IN FOCUS

Bipolar devices

Many of our colleagues have acquainted with bipolar instrumentation developed for laparoscopy, and their use is without any complication in most cases. However, this rate can be further improved if we are aware of the possible consequences and gynaecologists learn the basic principles of the process occurring during the use of the mentioned devises.

In monopolar electrosurgery, the electrical current passes through the main part of the patients body, while the bipolar electrical current passes between two closely spaced electrodes, coagulating only the grasped tissue clearly within the surgeons view. The use of monopolar energy can lead to injury anywhere along the currents path, with the following mechanisms:

- Capacitive coupling: the use of monopolar energy creates an electric field surrounding the instrument. Stray current from this fields may affect nearby metal instruments resulting in alternate site burns, usually outside the view of the laparoscope.
- Insulation failure: any breakdown in the insulation on the shaft of a monopolar electrosurgical device can cause unwanted current flow.
- Direct coupling: current may pass from a monopolar device in contact with other metal instruments. This may cause unintented tissue damage outside the view of the laparoscope.

The use of bipolar instruments virtually eliminates this phenomenon. A few years ago the so-called "crocodile" forceps was the only widely used bipolar instrument in our country. Today several companies have developed bipolar technology and new instruments have been brought to the market.

The so-called Kleppinger forceps with its gracile, symmetrically formed, smooth pair of jaws is ideal for coagulating smaller and medium arteries. The appearance of bipolar scissors provides the ability to cut and coagulate with bipolar safety. The current passes between the metal blades which are insulated. Bipolar dissecting forcepses have been newly developed. Their design combines secure grasping, precise dissection and bipolar coagulation. Multifunctional use is the main advantage of these new devises, which favours their wider spreading. Although bipolar instruments are more expensive than the older monopolar devices their advantages clearly justify their obtaining.

Tamás Vámosi

WHAT'S YOUR OPINION ABOUT

Laparoscopic ventrofixation for descensus/prolapsus uteri

Dear Colleagues,

The last question was a follows,

"A young/middle aged woman is suffering from descensus/prolapsus uteri. She insists on preserving her womb. Would you select a ventrofixation of the uterus via laparoscopy to treat this patient? Under what circumstanses? Why?"

A few characteristic answers by prominent gynaecologists are – unaltered, as at other times – reported here.

The editors

József Bódis (Pécs)

For this reason we have developed a combined, minimally invasive procedure, which consists of the modified Gittes's bladder neck suspension[1] and laparoscopic uterine suspension.

In 1987 Gittes and Loughlin[1] published their very simple and effective pubovaginal needle suspension technique for stress incontinence. During the procedure the anterior vaginal wall is suspended from the rectus fascia with two heavy nonabsorbeable monofilament mattress sutures on the both side of the urethra. The sutures pass down through and back up through the full thickness of the vaginal wall, and are tied suprapubically to bury the knot into the fat in the suprapubic puncture site. This original method was modified by us as follows: One arm of the suture is crossed over the fascia layer and knotted to one arm of the suture on the other side. The procedure is repeated similarly with the remaining arms of the sutures. During the "suture arm-crossing procedure" the monofilament sutures are driven through the rectus fascia. We believe that the modification makes it possible to achieve a stronger and more durable colposuspension in comparison with the original method.

The ventrosuspension of the uterus is performed laparoscopically. The first trocar is inserted in the midline in the lower part of the umbilicus (at 6 o'clock position) after a ventricle scalpel cut which penetrated as far as the fascia. Through this inserted trocar we insufflate the abdominal cavity with carbon-dioxide gas creating an intraabdominal pressure between 20-30 mmHg. Afterwards the telescope is introduced through the trocar sleeve. The second and third incision site is suprapubical about 4.0 cm above the symphysis, 2.0-3.0 cm to the right and to the left from the midline. The grasping forceps is introduced through the trocar sleeve by visual control to grasp the round ligament at the 1/3-2/3 point close to the uterus. The overpressure in the abdominal cavity is stopped by desufflation. The grasped round ligament is placed very gently above the fascia and sutured by flax stitching to the fascia. After this, we create pneumoperitoneum again under laparoscopic control, than the same procedure is performed on the left side. After the desufflation and trocar removal, the puncture wound edges are closed by sutures, which will be removed 5 days after operation.

The combined operative technique was performed under general anaesthesia in 12 women with III or IV grade pelvic organ prolapse. Preoperatively each patient underwent a complete physical examination and a standardized urogynecologic interview with questionnaire. Other routine procedures include urinanalysis and urine culture, a stress test, as well as measurement of the residual urine. Prolapse was evaluated and staged preoperatively similarly as described by Bump et al.[2]. All patients had suprapubic catheter drainage postoperatively. There have been no significant intraoperative or postoperative complications. During the three years of postoperative period all patients had normal urinary control without any sign or complain of prolapse.

Among various operations for urinary stress incontinence, the modified Gittes's needle colposuspension method complemented with the laparoscopic ventrosuspension of the uterus allowed us a successful and minimally invasive treatment of urinary stress incontinence caused by hypermobility of proximal urethra and the utherovesical junction associated with stage III or IV pelvic organ prolapse.

References

1. Gittes RF, Loughlin KR. No-incision pubovaginal suspension for stress incontinence. J Urol 1987; 138:568-70.
2. Bump RC, Hurt WG, Theofrastous JP, Addison WA, Fantl JA, Wyman JF, McClish DK and the Continence Program for Women Research Group. Randomized propective comparison fo needle colposuspension versus endopelvic fascia plication for potential stress incontinence prophylaxis in women undergoing vaginal reconstruction for stage III or IV pelvic organ prolapse. Am J Obstet Gynecol 1996;175:326-35.

Prof. Zoltán Papp (Budapest)

I would select ventrofixation of the uterus via laparoscopy in very rare cases. In this situation I prefer laparotomy.

WHY?

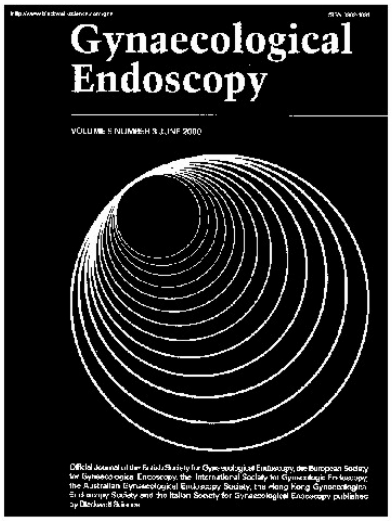
The question is this is the pati-

LITERATURE REVIEW

New trends and methods reported in Gynaecological Endoscopy

Allahbadia *et al.* report on a new hysteroscopic re-canalisation technique of the blocked Fallopian tubes under laparoscopic guidance. In this procedure a flexible Labotect guide canulla and a Terumo hydrophilic guide wire are used for cannulation of the tubal ostia. In a prospective study, a total of 17 patients with proven bilateral cornual blockage of the tubes underwent the re-canalisation attempt. Successful on-table atraumatic re-canalisation of the blocked tubes was documented by laparoscopic chromopertubation. Hysteroscopic cannulation could be attempted in 30 tubal ostia and was successfully accomplished in 15 cases. In all cases, failure of cannulation resulted from lack of visualisation of ostia due to thick endometrium. Overall, 4(24%) of 17 patients undergoing re-canalisation conceived, and delivered at term in the follow-up period. In cases of thick endometrium, use of a depot gonadotrophin agonist, 10-15 days before attempting the procedure is recommended for easy visualisation and access to the internal tubal ostia. Hysteroscopic cannulation of the Fallopian tube is a safe diagnostic procedure that can be used to identify those patients with true proximal occlusion, and may also serve as a therapeutic procedure in some of these patients.
(Allahbadia, G.N. *et al.* Hysteroscopic fallopian tube re-canalization using a flexible guide cannula and hydrophilic guide wire. *Gynaecological Endoscopy* 2000;9:31-35.)

Anaf *et al.* from the Free University of Brussels report on their experiences on the laparoscopically assisted segmental sigmoid resection (LASSR) among patients with



The cover age of the journal

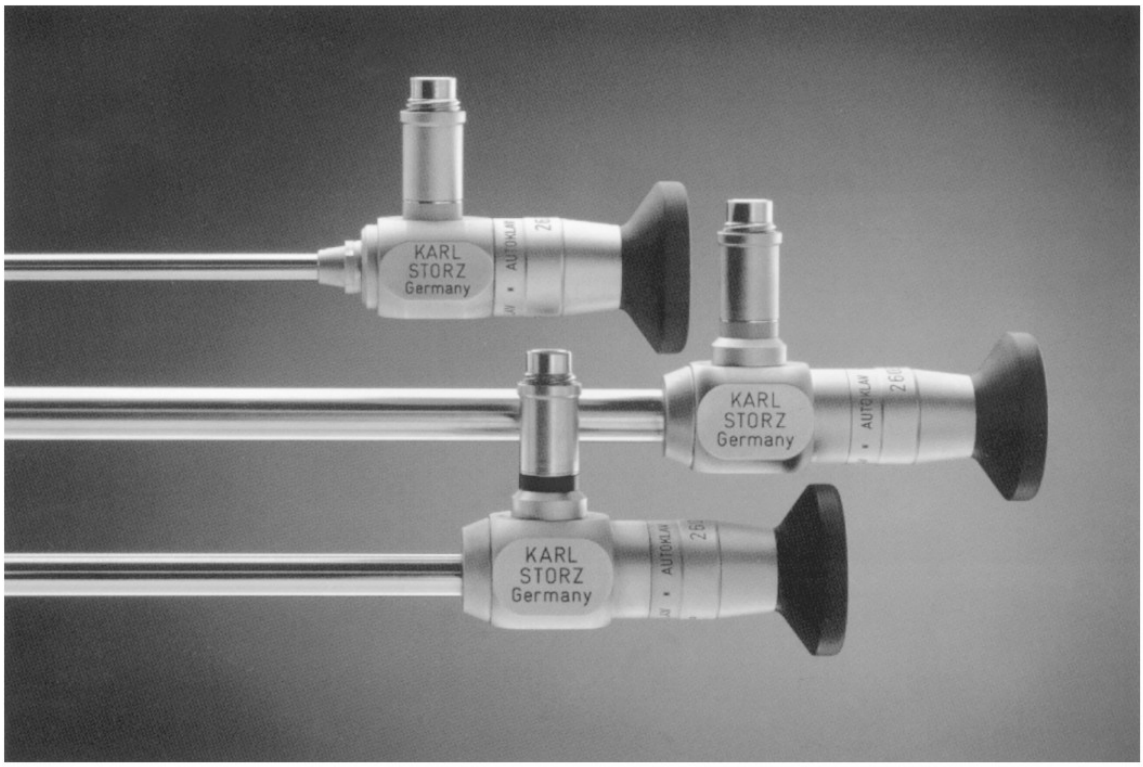
sigmoid endometriosis. Endometriosis of the intestinal tract represents 30% of all extragenital site diseases, the most frequent bowel localtion being that of the sigmoid (40%). In a two-year period, a total of five patients with proven sigmoid endometriosis underwent this laparoscopic operation. The operative intervention was as follows: laparoscopic dissection of the left large bowel from its adherent neighbouring structures, incision of the lateral and medial peritoneal reflections of the mesosigmoid, incision of the left paracolic gutter, identification of the left ovarian vessels, and left urether, extracorporeal resection of the sigmoid and latero-terminal handsewn anastomosis, and laparoscopic treatment of concomitant pelvic endometriosis. No intra- or postoperative complications were documented. The mean operating time was 210 min. Postoperative ileus lasted less than 72 hrs in all cases, and the mean postoperative stay was 6 days. No recurrence of the sigmoid endometriosis symptoms were noted in the 15 months follow-up period. Overall, LASSR was found to be a feasible and safe technique indicated for symptomatic sigmoid endometriosis. Reduced postoperative pain and shortened postoperative ileus represent presumed advantages of LASSR compared with open surgery.
(Anaf, V. *et al.* Laparoscopically assisted segmental sigmoid resection (LASSR) for sigmoid endometriosis. *Gynaecological Endoscopy*, 2000; 9:5-101.)

Paraskevaidis *et al.* report on two cases of patients presenting with cervical cancer who developed metastasis on the surgucal wound or a laparoscopy trocar insertion site. The appearance of cervical cancer metastases on the abdominal wall is unusual and almost always indicates an extremly poor prognosis. The study presents two cases and a literature review is also presented. Metastasis on the surgical wound is not always associated with laparoscopy. Careful haemostasis, avoidance of haematoma formation, careful handling of tissues especiallyin laparoscopy and the extension of radiotherapy fields to include the wound or trocar sites might prevent the development of metastasis. Alertness on the part of surgeons is advised, in order to ensure immediate diagnosis and wide excision of these metastases, as they are often the only site of relapse.
(Paraskevaidis, E. *et al.* Cervical cancer metastasis on the surgical wound: not a new feature and not specific to laparoscopy. Report of two cases and a review of th literature. *Gynaecological Endoscopy*, 2000;9: 175-179)

Péter Sziller

GOLD STANDARD

HOPKINS optika az endoszkópos sebészethez



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