MINIMALLY INVASIVE GYNECOLOGIC ENDOSCOPY PLATFORM

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3rd Annual Meeting of the ISON

Neuropelveology and Endometriosis

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May 30-31 2025
ACIBADEM MASLAK HOSPITAL
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INVITATION

Dear Colleagues,

Neuropelveology has redefined our understanding of pelvic nerves, one of the most fundamental aspects of medicine and anatomy. Developed by Prof. Marc Possover, Founder of the International School of Neuropelveology in 2008 and President of the International Society of Neuropelveology (ISON) since 2014, this concept has established quality standards to enhance patients' quality of life, particularly in advanced gynecological surgeries.

Neuropelveology introduces a new perspective to routine surgery. While it may seem like a novel challenge for more junior colleagues, especially as we strive to push the boundaries of minimally invasive gynecology, it embodies the principle of "primum non nocere" by enabling us to improve patients' lives without compromising their well-being.

In addition to offering advanced learning modules, ISON provides a robust network, fostering a specialized community dedicated to reducing patient morbidity. At this year's 3rd International Neuropelveology Congress in Istanbul, you will not only have the opportunity to reassess and refine your surgical expertise but also to join this exclusive community.

Looking forward to seeing you in Istanbul!

Prof. Ercan Başţu

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Friday, May 30, 2025

Moderators: Marc Possover / Mete Güngör

09:00-10:30 Cadaveric Session; Anatomic Spaces and Neuroanatomy - ***Vito Chiantera, Çağatay Taşkıran***

10:30-10:45 Coffee Break

Moderators: Kemal Özerkan / Hale Göksever Çelik

10:45-11:15 Introduction in Clinical Neuropelveology - Guiding the Patient - ***Marc Possover (Zuerich / Switzerland)***
11:15-11:25 Evolution of Diagnosis and Treatment Approaches Over Time - ***Mauricio Abrao (Brazil)***
11:25-11:45 Diagnostic Techniques in Neuropelviology: Clinical Implementations of Pelvic Nerve Mapping - ***Kiper Aslan***
11:45-12:05 "Neuroimnuology" an Innovative, New Way to Look at Disease - ***Andrea Vidali (USA)***
12:05-12:25 Pain Pathways and Management in Pelvic Surgery - ***Onur Topçu***

Moderator: Faruk Buyru

12:25-12:45 Endometrioma and Infertility: What Should We Do? - ***Ercan Baştu***

12:45-13:30 Lunch Break

Moderators: Gürkan Uncu / Erhan Şimşek

13:30-15:00 Live Surgery - ***Vito Chiantera***

15:00-15:20 Coffee Break

Moderators: M. Faruk Köse, Funda Güngör Uğurlucan

15:20-15:40 Chronic Pelvic Pain Syndromes: Diagnosis & Treatment - Q&A - ***Gustavo Leme Fernandes (Sao Paulo /Brazil)***
15:40-16:00 Surgical Techniques in Deep Endometriosis with Pelvic Nerve Preservation - ***Bülent Urman***
16:00-16:20 Pudendal Nerve Entrapment and Its Treatment - ***Üzeyir Kalkan***
16:20-16:40 LION Procedures for Gynecologic Diseases - ***Vito Chiantera (Neaples / Italy)***

16:40-17:20 **Free Video Presentations - Özgüç Takmaz, Engin Çelik**
16:40-16:50 VP-01 Robotic Sentinel Lymph Node Dissection Under Direct Visualization of the Obturator Nerve: Revealing the Hidden Node ***Zeliha Fırat Cüylan***
16:50-17:00 VP-02 Laparoscopic Hysterectomy for Deep Infiltrating Endometriosis: Anterior Colpotomy First Technique ***Nasuh Utku*** Doğan
17:00-17:10 VP-03 Anatomical Video: Describing Deep Pelvic Structures with Robotic Surgery (Patient with Concomitant Chronic Pelvic Pain) ***Doğan Vatansever***
17:10-17:20 VP-04 Fertility-Preserving Multidisciplinary Laparoscopic Management of Deep Infiltrating Endometriosis with Rectosigmoid Involvement - ***Salih Taşkın***
17:20-17:30 VP-05 Laparoscopic Robot-Assisted Neurolysis for Pudendal Neuralgia Occurring After Sacrospinofixation Procedure: a 4-steps Technique - ***Olivier Celhay***

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Saturday, May 31, 2025

Moderators: Hüsnü Çelik / Doğan Vatansever

09:00-10:30 Cadaveric Session; Endometriozis Surgery; Bowel and Urinary Endometriosis Aproach - ***Vito Chiantera, Zeliha Fırat Cüylan***

10:30-10:45 Coffee Break & Networking

Moderators: İlkkan Dünder / Nasuh Utku Doğan

10:45-11:05 Advanced Imaging for Endometriosis and Neuropelvic Disorders - ***Ayşe Seyhan***
11:05-11:25 Sciatic Nerve Endometriosis - ***Marc Possover (Zuerich / Switzerland)***
11:25-11:45 Pelvic Vascular Entrapment - ***Henrique Abrao (Sao Paulo / Brazil)***
11:45-12:15 Pelvic Pain Management Nöromodulation and Ultrasound-Guided Injections - ***Serdar Aydın***

12:15-12:45 **Satellite Symposium**
Moderator: Yaprak Üstün
Speaker: Hale Göksever Çelik
Managing Endometriosis Across the Lifespan: Is Long-Term Control Possible?

Exeltis
Rethinking healthcare

12:45- 13:30 Lunch Break

Moderators: U. Fırat Ortaç / Salih Taşkın / Mauricio Abrao

13:30-15:00 Live Surgery - ***Ercan Bastu***

15:00-15:20 Coffee Break

Moderators: Cihat Ünlü / Hamdullah Sözen

15:20-15:50 The Different Sites of Endometriosis and Their Relationship to Pain - ***Mauricio Abrao (Brazil)***
15:50-16:10 Nerve Sparing Surgery in Gynecologic Oncology - ***Çağatay Taşkıran***
16:10-16:30 Neuropelveological Complications & Managment of Mesh-Prolapse Surgery - ***Nihita Warty (Mumbai / India)***
16:30-16:50 Bioelectronic Medicine - The Future of Neuropelveology - ***Marc Possover (Zuerich / Switzerland)***

16:50- 17:50 **Free Video Presentations - Cenk Yaşa , Serdar Açıkgöz**
16:50-17:00 VP-06 Surgical Management of Vascular Entrapment and Deep Endometriosis in a Young Female with Pelvic Pain and Neurological Symptoms: A Case Report - ***Onur Topçu***
17:00-17:10 VP-07 Laparoscopic Management of Deep Endometriosis, Involving a Large Bladder Nodule - ***Kiper Aslan***
17:10-17:20 VP-08 When Pain Persists: Refractory Unilateral Deep Infiltrating Endometriosis with Ovarian Involvement - ***Ömer Faruk Öz***
17:20-17:30 VP-09 Dorsolateral Parametrectomy and Oophorectomy for Deep Endometriosis with a Suspicious Adnexal Mass ***Kemal Güngördük***
17:30-17:40 VP-10 A Systematic Approach For Pudendal Nerve Endometriosis - ***Çağla Bahar Bülbül***
17:40-17:50 VP-11 Sciatic Nerve Endometriosis on the Left Side: Diagnostic and Surgical Management from a Case Report - ***Bahadır Koşan***

VP-001

Robotic Sentinel Lymph Node Dissection Under Direct Visualization of the Obturator Nerve: Revealing the Hidden Node

Zeliha Firat Cuylan, Gunsu Kimyon Comert, Eda Kayali
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AIM: With this video, we present a demonstration of the surgical technique for robotic sentinel lymph node (SLN) biopsy in the obturator region for endometrial cancer.

METHOD: A 55-year-old patient presented to our center with a complaint of postmenopausal bleeding. An endometrial biopsy revealed endometrioid-type endometrial cancer, Grade 1. Radiological evaluation indicated that the disease was confined to the uterus, with no evidence of metastasis. The patient subsequently underwent robotic hysterectomy and bilateral salpingo-oophorectomy with bilateral SLN biopsy. For SLN mapping, a total of 2 ml of indocyanine green (ICG) dye was injected into the cervical stroma—0.5 ml superficially (1–3 mm deep) and 0.5 ml deeply (1 cm) at the 3 and 9 o'clock positions.

RESULT: After accessing the left retroperitoneal space, the first and second lymph nodes were visualized at the left external iliac region using Firefly mode of the Da Vinci Xi system. Dissection was then continued in the obturator region, where Firefly mode revealed lymphatic channels crossing the left obliterated umbilical artery. These channels were traced to the true SLN in the obturator region. During this step, sentinel lymph node dissection was meticulously performed over the obturator nerve to ensure nerve preservation and complete nodal excision. Final pathology confirmed as FIGO 2023 Stage IA2 endometrioid-type endometrial carcinoma. Results of ultra-staging of the SLN were negative.

CONCLUSION: While performing a SLN biopsy, the first identified lymph node may not always be the true sentinel node. It is essential to continue the dissection of the obturator region to thoroughly assess for additional lymph nodes that may represent the true sentinel node. During this process, sentinel lymph node dissection should be performed under direct visualization of the obturator nerve to ensure both accurate identification and safe excision.

Keywords: obturator nerve, sentinel lymph node, endometrial cancer

VP-002

Laparoscopic hysterectomy for deep infiltrating endometriosis: Anterior colpotomy first technique

Nasuh Utku Dogan[1], Sefa Metehan Ceylan[2], Esra Bagcioglu[2], Selen Dogan[2]
[1]Dogan Gynecology Clinic Antalya
[2]Akdeniz University Department of Gynecology

Background: In symptomatic patients with deep infiltrating endometriosis, when fertility preservation is not a concern, the primary surgical goal is the complete removal of all visible endometriotic lesions. In cases where the Douglas pouch and rectosigmoid colon are involved, a retrograde hysterectomy technique is recommended. This approach involves performing the hysterectomy first, followed by an anterior colpotomy and subsequent posterior dissection of the Douglas pouch. By proceeding in this manner, the hysterectomy becomes more manageable, particularly in the setting of severe adhesions or deep pelvic infiltration.

METHODS: This video article illustrates the laparoscopic retrograde hysterectomy technique in a 44-year-old multiparous woman with a history of previous endometriosis surgeries. The procedure was performed with careful attention to the anatomical distortions caused by endometriotic adhesions.

RESULTS: The surgical intervention included a total hysterectomy with bilateral salpingo-oophorectomy, excision of endometriotic nodules from the uterosacral ligaments, and rectal shaving to remove superficial rectal endometriosis without full-thickness bowel resection. The total operative time was 195 minutes, with an estimated blood loss of 75 milliliters. The patient had an uncomplicated postoperative course and was discharged on the third day after surgery.

CONCLUSION: The retrograde hysterectomy technique, which prioritizes hysterectomy before Douglas pouch dissection, offers a systematic and efficient approach to managing deep infiltrating endometriosis with rectosigmoid involvement. By adhering to this structured sequence, surgeons can achieve optimal visualization, minimize intraoperative challenges, and reduce the risk of complications. This method is particularly advantageous in patients with extensive pelvic adhesions or recurrent disease.

Keywords: deep infiltrating endometriosis, hysterectomy, anterior colpotomy first technique

VP-003

Anatomical video: Describing deep pelvic structures with robotic surgery (patient with concomitant chronic pelvic pain)

Dogan Vatansever, Oytun Turkkan, Burak Giray, Emin Erhan Donmez, Muhterem Melis Canturk, Cagatay Taskiran
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Chronic pelvic pain is a debilitating condition affecting a significant portion of the population, often necessitating advanced surgical interventions to alleviate suffering and improve quality of life. Success in these complex procedures hinges on the surgeon's thorough comprehension of the intricate three-dimensional anatomy of the deep pelvis. This anatomical video provides an in-depth, intra-operative visualization of key anatomical landmarks encountered during robotic surgery for chronic pelvic pain. The video meticulously dissects and presents critical structures, including the lumbosacral plexus and its branches, the sacral nerve roots, hypogastric nervre branches, the pelvic floor musculature and fascia, major vascular bundles (such as the internal iliac vessels and their branches), the course of the ureters within the pelvis, and the spatial relationships of the rectum and sigmoid colon. By offering a clear and dynamic depiction of these structures in their post-surgical context, this video serves as an invaluable educational resource. It aims to enhance anatomical awareness, refine surgical orientation within the deep pelvic space, and ultimately contribute to improved precision, reduced intraoperative risks, and better patient outcomes in chronic pelvic pain.

Keywords: chronic pelvic pain, deep pelvic structures, robotic surgery, hypogastric nerve branches

VP-004

Fertility-Preserving Multidisciplinary Laparoscopic Management of Deep Infiltrating Endometriosis with Rectosigmoid Involvement

Salih Taşkın, Eda Sonel
Department of Gynecologic Oncology, Ankara University, Ankara, Türkiye

OBJECTIVE: To demonstrate the stepwise surgical management of extensive deep infiltrating endometriosis (DIE) with rectosigmoid involvement in a reproductive-age woman, focusing on fertility preservation, multidisciplinary technique, and minimally invasive principles in accordance with current ESGE, ESHRE, AAGL, and ASRM guidelines.

Case Summary: A 35-year-old G1P1 woman with no prior surgical history presented with progressive dysmenorrhea and menometrorrhagia unresponsive to dienogest. She had a history of spontaneous pregnancy and desired future fertility. Hysterosalpingography revealed bilateral tubal occlusion. Preoperative CA-125 was 49 U/mL; AMH was 2.67 ng/mL.

Pelvic MRI identified bilateral kissing ovaries, each adherent to the posterior uterus and to each other, with a 30×21 mm right and a 52×38 mm left endometrioma. Hematosalpinx was noted bilaterally (up to 8 mm). A 78×17 mm deep infiltrative endometriotic lesion extended from the posterior uterine corpus to the anterior wall of the rectosigmoid colon. Colonoscopy was unremarkable.

Preoperative staging revealed r-ASRM Stage IV and ENZIAN A3, B3, C3, O3, T3, P3, consistent with extensive and deeply infiltrative disease.

Surgical Approach: The patient underwent fertility-preserving laparoscopic surgery including bilateral salpingectomy, segmental rectosigmoid resection with primary anastomosis, and extensive adhesiolysis, performed jointly by gynecologic oncology and colorectal surgery teams.

The procedure began with the identification and protection of both ureters following retroperitoneal dissection. The ovaries were mobilized using sharp and blunt dissection. Bilateral round ligament transection allowed safe entry into the retroperitoneum. A 6–7 cm segment of the rectosigmoid colon infiltrated by DIE was identified.

Using a GIA stapler, segmental resection was performed. The specimen was extracted via a 4 cm suprapubic mini-laparotomy. Primary end-to-end colorectal anastomosis was created and confirmed via air-leak testing. Bilateral salpingectomy followed, targeting the tubal occlusion and hematosalpinx. Drains were placed anterior and posterior to the anastomosis. Operative time was 180 minutes with 100 cc blood loss. No intraoperative complications occurred.

Outcomes and Technical Highlights:

This case highlights several critical principles:

• Anatomical restoration and nerve-sparing dissection were prioritized to minimize functional morbidity.
• Segmental bowel resection was selected based on lesion size (>3 cm), transmural involvement, and rectosigmoid segmental fibrosis — in line with ESGE/ESHRE criteria.
• Fertility preservation guided surgical limits: the uterus and ovaries were preserved, and bipolar energy use was minimized to protect ovarian reserve.
• Pre-existing bilateral tubal occlusion with hematosalpinx justified salpingectomy, potentially improving future ART outcomes.

Postoperative recovery was uneventful. The patient is planned for fertility counseling and early IVF referral.

CONCLUSION: This case demonstrates that in extensive deep infiltrating endometriosis with bowel involvement, a multidisciplinary, fertility-conscious laparoscopic approach is both feasible and effective. Segmental resection, when indicated, achieves complete excision, restores anatomy, and may enhance reproductive outcomes when combined with ART.

Adherence to international guideline principles—including individualized surgical planning, use of validated classification systems (r-ASRM, ENZIAN), and expertise-driven operative execution—ensures optimal outcomes. This case underlines the importance of integrating oncologic precision and reproductive strategy in the surgical management of DIE.

Keywords: deep infiltrating endometriosis, rectosigmoid resection, fertility-Preserving Multidisciplinary Laparoscopic Management

VP-005

Laparoscopic robot-assisted neurolysis for pudendal neuralgia occurring after sacrospinofixation procedure: a 4-steps technique

Olivier Celhay
Clinique Tivoli, Bordeaux, France

GOAL: Sacrospinous ligament fixation (SSLF) can cause pudendal neuralgia in approximately 6% of cases, primarily due to trauma or compression of the pudendal nerve, which runs beneath the sacrospinous ligament. Acute neuropathic pain may appear immediately after surgery, requiring urgent revision in cases of direct nerve injury. In other cases, patients may experience progressive neuropathic pain several months postoperatively, often related to fibrotic entrapment secondary to hematoma formation. We demonstrate the feasibility of robot-assisted laparoscopic neurolysis for pudendal neuralgia occurring after SSLF.

METHODS: Between 2021 and 2024, six consecutive patients suffering from pudendal neuralgia following SSLF were treated at our center using a robot-assisted laparoscopic neurolysis approach. Our technique is illustrated through narrated intraoperative video footage.

Findings and RESULTS: We describe the patient installation and our four-step technique:
1. Opening of the peritoneum between the external iliac vessels and the umbilical ligament
2. Dissection of the internal iliac and pudendal arteries up to the pudendal nerve
3. Releasing the pudendal nerve and its branches from surrounding fibrosis
4. Resection of the sacrospinous ligament up to the fixation device (with or without adding a new fixation)

The procedure was successfully completed in all patients, with one minor complication (3 cm parietal hematoma). Pelvic organ prolapse correction was preserved in all cases after 6 months of follow-up.

CONCLUSION: We demonstrate the feasibility and safety of a robot-assisted laparoscopic approach for complete pudendal neurolysis in patients experiencing pudendal neuralgia after SSLF. This technique offers a precise dissection and effective nerve decompression while preserving the anatomic integrity of prolapse repair.

Keywords: neurolysis, pudendal, SSLF, neuralgia, pelvic pain, complication

VP-006

Surgical Management of Vascular Entrapment and Deep Endometriosis in a Young Female with Pelvic Pain and Neurological Symptoms: A Case Report

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[2]Departmenf of Obstetrics & Gynecology, Bilkent City Hospital, Ankara, Turkiye
[3]Department of Obstetrics & Gynecology, Çam and Sakura City Hospital, Istanbul, Turkiye

GOAL: The objective of this study is to present a comprehensive approach to managing a 25-year-old female patient with a combination of deep endometriosis, suspected vascular entrapment, and associated neurological symptoms through a multidisciplinary surgical approach. The focus is on pain relief, restoring quality of life, and improving long-term outcomes post-surgery.

METHODS: A 25-year-old virgin female presented with chronic pelvic pain, left-sided groin discomfort, lower back pain radiating down the left leg to the foot, and urgency without dysuria. Her systemic history was significant for Hashimoto's thyroiditis, and she had no known allergies. On pelvic examination, a nodule was detected beneath the cervix, and pelvic ultrasound revealed a bilobular 5x3 cm endometrioma on the left ovary. The patient's pain was thought to be partially related to a suspected vascular entrapment affecting the sacral nerve and sciatic nerve. After failing medical treatment with Visanne (dienogest), which worsened her quality of life, she underwent a combined surgical approach consisting of:

1. Vascular entrapment release of the sacral and sciatic nerves,
2. Surgical excision of deep left sacrouterine endometriosis,
3. Drainage or cystectomy of the left chocolate cyst.

FINDINGS: Preoperative assessments, including rectal examination and pelvic ultrasound, suggested significant endometriosis involvement with potential nerve compression. The patient experienced chronic pain that worsened during menstruation, with associated dyschezia and left-sided leg pain. Medical therapy with Visanne did not alleviate the symptoms; instead, the patient reported exacerbation of pain and significant psychological distress. The diagnosis of vascular entrapment involving the second sacral and sciatic nerves was considered, and surgical intervention was recommended.

RESULTS: Postoperative Day 7 - The patient experienced complete resolution of menstrual pain (Pain score: 0) and no dyschezia. The urgency persisted, but without associated pain. Left groin pain decreased, and the previously radiating leg pain (which had been severe) improved significantly.

Postoperative Month 6 - The patient's menstrual cycle returned without pain (Pain score: 0). New onset right-sided leg pain developed (Pain score: 6), and mild dyschezia persisted (Pain score: 2), but dysuria was absent. Left groin and leg pain were no longer significant. The patient reported a significant improvement in overall quality of life, with marked reductions in the severity of both pelvic and neurological symptoms.

CONCLUSION: This case demonstrates the efficacy of a combined surgical approach in managing complex pelvic pain associated with deep endometriosis and suspected vascular entrapment. The patient experienced significant improvement in both pain management and quality of life, confirming the value of targeted surgical interventions in young women with similar presentations. Further studies are necessary to explore the long-term outcomes of such combined procedures in managing endometriosis with neurological involvement.

Keywords: Deep Infiltrative Endometriosis, Laparoscopy, Vascular Entrapment

VP-007

Laparoscopic Management of Deep Endometriosis, Involving a Large Bladder Nodule

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Goal: Endometriosis is a common cause of chronic pelvic pain. The pathology is named "deep infiltrative endometriosis" when the peritoneal involvement is more than 5 mm. Urinary tract involvement is relatively common in women with deep infiltrative endometriosis.

This case report involves a rare and complicative case of an endometriotic nodule, invading the complete thickness of the bladder wall. This abstract aims to emphasize that; by performing a partial cystectomy operation a rare incidence of deep infiltrative endometriosis involving bladder can be cured with improved post operative pain scores.

METHODS: A 39 years old patient who had a c-section in 2009 presented to Uludag University School of Medicine Department of Obstetrics and Gynecology with chronic pelvic pain (Vısual Analogue Scale 8/10), cyclic disuria (VAS 9/10), dyspareunia (VAS 7/10). The patient has familial Mediterranean fever and is not on any medications. She does not have a history of abdominal surgery except a c-section. During the physical examination of the patient a painful nodule was palpated on anterıor cervical fornix and bilateral sacro-uterine ligament tension and fibrosis was present. Transvaginal Ultrasound revealed asymmetrical myometrial wall, a normal rectovaginal space and a normal right adexa. However, the left adnexa was adhered to the posterıor corpus of uterus and the pouch of Douglas. The bladder wall was thickened and the mucosal lining had irregularities. Magnetic Resonance Imaging (MRI) was also similar to ultrasound findings. In order to visualize the endometriotic nodule a cystoscopy was performed and a full thickness infiltrative endometriotic nodule was detected. Laparoscopic deep inflatrative endometriosis surgery was indicated.

During the laparoscopic approach to the patient one 10 mm umbilical port and three 5mm ports were used. The inspection of the abdomen has revealed dense adhesions between uterus, bladder and left adnexa. Butterfly ecxision of the peritoneum covering rectovaginal pouch was performed while preserving the neural structures of the pelvis. In the second stage of the surgery bladder was dissected from the uterus by the help of an ultrasonic sclapel system and vesico-vaginal space and Retzius space were developed. A 4 cm endometriotic nodule on the dome of the bladder was then excised with circular incision. Primary suturation was done by a 3.0 barbed suture and a second layer of 3.0 polyglactin 910 suturation was performed to prevent urine leakage. The patient was then discharged from hospital in post operative second day with a urinary catheter. On post operative day 12 the urinary catheter was removed and spontaneous micturition observed.

Discussion: ndometriosis is a common pathology in patients presenting with pelvic pain and most of the time medical therapy may not suffice to relieve the excruciating symptoms of this pathology. Urinary system involvement is another factor complicating the prognosis of the disease adding dysuria to the bigger picture of chronic pelvic pain accompanying dyspareunia and dysmenorrhea. Bladder is the most common anatomic location to find an endometriotic nodule on the urinary tract. In our patient pain scores were very high indicating how crippling the symptoms were to the patient. Dyspareunia 4/10, dysmenorrhea 5/10, dysuria 10/10 was the initial pain scoring of the patient that lead our team to the decision of laparoscopic endometriosis surgery. Using cystoscopy to localize the endometriotic nodule and visualize the possible infiltration to the bladder mucosa is essential in pre-operative planning; due to the fact that in mucosa infiltrated nodules simple shaving would not suffice and partial cystecyomy is indicated. Double J ureteral catheters may be applied in order to prevent any ureteral per-operative injury however in our case such catheterization was not necessary due to the level of experience of the surgeon. Recurrence is rare in partial cyctectomy, in our case during the follow up period of ten months there had been no urinary tract endometriosis recurrence.

Keeping the bladder catheter for seven to ten days is ideal to allow bladder epithelisation. In this case post-operative pain scores were considerably lower: dysmenorrhea 2/10, dysuria 0/10, chronic pelvic pain 0/10; except a slight deterioration of dyspareunia 6/10.

CONCLUSION: In conclusion, bladder endometriosis is a rare but severe presentation of endometriosis that is critical to deal with for the clinicians. Although, hormonal therapy can be useful, there is no gold standard therapy of bladder endometriosis that may lead endometriosis surgeons to prefer surgical approach on bladder endometriosis. Partial cystectomy of a full thickness invasive endometriotic nodule is a safe and effective method of therapy that should be considered in patients with dire urinary system symptoms.

re was notable tenderness and nodularity in the left lateral and posterior fornices. Pelvic MRI revealed a 3.5 cm endometrioma in the left ovary and marked abnormalities in the left uterosacral (sacrouterine) ligament, which appeared shortened and thickened compared to the contralateral side.

Imaging FINDINGS: High-resolution pelvic MRI confirmed the presence of a left-sided ovarian endometrioma with associated fibrosis and infiltration of the left sacrouterine ligament. In contrast, the right uterosacral ligament demonstrated normal length and morphology. These findings are suggestive of unilateral deep infiltrating endometriosis with ligamentous involvement—an uncommon but significant variant that may contribute disproportionately to pain.

Intervention: Given the failure of medical therapy and the extent of disease observed radiologically, the patient underwent laparoscopic excision of endometriotic lesions, including resection of the fibrotic left uterosacral ligament and cystectomy of the left ovarian endometrioma. Surgical findings correlated with imaging, revealing dense adhesions and fibrosis localized to the left side, consistent with the imaging and symptomatology.

Outcome: Postoperative follow-up at 6 months revealed substantial pain relief and improvement in daily functioning. The patient no longer required daily analgesics and reported resumption of normal activities. No complications were reported.

DISCUSSION: This case underscores the importance of correlating imaging findings with clinical symptoms in DIE, especially when symptoms are lateralized and persistent despite standard medical therapy. The involvement of the uterosacral ligaments, particularly in a unilateral pattern, is often under-recognized but can be a key pain generator. MRI proves invaluable in the preoperative assessment of such patients, enabling precise mapping of deep lesions, guiding surgical planning, and ultimately improving patient outcomes.

The presented MR images (Figures 1 and 2) demonstrate the characteristic features of this condition. The thickened and shortened left uterosacral ligament contrasts sharply with the morphologically normal right side. These asymmetrical findings, coupled with ovarian involvement, highlight the heterogeneity of endometriosis presentations and the necessity for individualized treatment strategies.

CONCLUSION: Refractory unilateral deep infiltrating endometriosis involving the ovarian and sacrouterine structures may present with localized, severe pelvic pain unresponsive to hormonal management. In such cases, detailed imaging and timely surgical intervention can provide significant symptom relief. This case highlights the diagnostic and therapeutic relevance of identifying lateralized ligament involvement in DIE, emphasizing a tailored approach to endometriosis management.

Keywords: Deep infiltrating endometriosis, Uterosacral ligament, Ovarian endometrioma, Pelvic MRI, Hormone-resistant pelvic pain

VP-009

Dorsolateral parametrectomy and oophorectomy for deep endometriosis with a suspicious adnexal mass

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BACKGROUND: Performing surgery for parametrial endometriosis poses many challenges due to uncertainties in standardization, radical surgical methods, and clear surgical indications. Tackling deep-seated endometriosis with a parametrectomy may lead to serious complications, such as postoperative pelvic dysfunction. These issues often arise from unintended damage to, or required removal of, the pelvic ortho- and parasympathetic nervous systems, especially when they are affected by parametrial disease. This video illustrates a laparoscopic procedure for dealing with deeply infiltrating endometriosis, focusing on bilateral dorsolateral parametrectomy. Consent from the patient was obtained for this video demonstration, and the authors report no conflicts of interest.

CASE: A 38-year-old woman, gravida 1 para 1, had been experiencing endometriosis for the past decade. She previously underwent two laparoscopic procedures for endometriosis and a cesarean delivery. She was referred to our gynecologic oncology clinic due to a suspected adnexal mass. Her symptoms included pelvic and distal vaginal pain, particularly during menstruation. The patient strongly wished to preserve her fertility. MRI findings showed a 70x60 mm hyperdense lesion with mixed solid and cystic components located in the right adnexal region (ORADS-3). Her CA-125 levels were elevated at 290 u/mL, and her ROMA index was 25. A laparoscopic right salpingo-oophorectomy along with bilateral dorsolateral parametrectomy was planned.

RESULT: The surgery lasted 137 minutes, with a blood loss of 210 mL. The patient was discharged two days post-operation without any complications. Pathological analysis identified atypical ovarian endometriosis and an endometriotic nodule on both dorsolateral parametrium.

CONCLUSION: Laparoscopic surgery can be successfully performed for deep-infiltrating endometriosis in carefully chosen cases. Combining technique with patience, this approach is especially advantageous for cases with severe adhesions.

Keywords: parametrial endometriosis, laparoscopic surgery, adnexal mass

VP-010

A Systematic Approach For Pudendal Nerve Endometriosis

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INTRODUCTION: Pudendal neuralgia is a debilitating condition that often presents with pelvic pain, clitoral discomfort, and pain during voiding. This case report presents the laparoscopic management of a 24-year-old virgin woman who presented with daily left pelvic pain, clitoral pain, and dysuria. Symptoms were partially alleviated by a pudendal block, suggesting pudendal nerve involvement. The patient's preoperative imaging showed normal ovaries and uterus, making this an atypical presentation of pelvic pain. Surgical intervention was considered to explore potential sources of the pain and address any underlying pathology.

Preoperative Assessment: The patient, a 24-year-old virgin with a history of daily left pelvic pain, clitoral pain, and dysuria, underwent preoperative evaluation, which included ultrasonography. Both ovaries and the uterus were normal, excluding common gynecologic causes of pelvic pain. The patient had experienced temporary relief with a pudendal block, indicating the likely involvement of the pudendal nerve. Given these findings, a laparoscopic approach was planned to explore potential pelvic causes of the pain, with a focus on nerve-related pathology and associated structures.

Surgical Procedure: The patient underwent laparoscopic surgery in the lithotomy position under general anesthesia. After sterile preparation and draping, a Foley catheter was inserted, and a 1 cm umbilical incision was made. Insufflation of the abdomen was followed by the placement of a 10 mm trocar. The camera revealed normal liver and bowel appearance. In the Douglas pouch, prominent varicose veins were noted in the sacrouterine ligament region.

Access was obtained through 5 mm trocars in the left inguinal and suprapubic areas, with careful dissection of the peritoneum using bipolar cautery and scissors. The peritoneal flap was secured to the anterior abdominal wall with a No. 1 Vicryl suture to aid in retraction. During the procedure, the obturator nerve, arcus tendineus, and pudendal nerve were identified. The pudendal nerve was found to be encased by an aberrant muscle tissue, which was released through meticulous dissection. Additionally, the Alcock canal was freed, and the sacrospinous ligament was excised.

Throughout the procedure, great care was taken to preserve nerve integrity and control any bleeding. No intraoperative complications occurred, and hemostasis was achieved without issue.

Outcome and CONCLUSION: The patient had an uneventful postoperative recovery and was discharged on the second postoperative day. At follow-up, she reported significant improvement in her pelvic pain, including resolution of clitoral discomfort and dysuria. This case underscores the importance of a thorough exploration in patients with pelvic pain of unclear origin, especially when nerve involvement is suspected. Laparoscopic surgery allowed for successful identification and release of the pudendal nerve compression, which is critical in managing pudendal neuralgia. This approach offers valuable insights into the management of complex cases of pelvic pain and highlights the potential for laparoscopic intervention in alleviating symptoms and improving quality of life.

Keywords: Pelvic Pain, Endometriosis, Laparoscopy

VP-011

Sciatic Nerve Endometriosis on the Left Side: Diagnostic and Surgical Management from a Case Report

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Study OBJECTIVE: To present a rare case of deep infiltrating endometriosis involving the sciatic nerve and to demonstrate the surgical steps undertaken for complete excision and nerve decompression.

Design: This video article illustrates a case study with comprehensive surgical footage and narration, highlighting diagnostic challenges and operative nuances in the management of pelvic and extra-pelvic endometriosis.

Setting: Endometriosis is a chronic, estrogen-dependent, inflammatory condition affecting approximately 10–15% of women of reproductive age, most commonly involving pelvic organs. Deep infiltrating endometriosis (DIE) involving pelvic nerves, particularly the sciatic nerve, represents a rare but clinically significant form of extra-pelvic disease. This case is reported in accordance with CARE guidelines and emphasizes the importance of multidisciplinary surgical planning and detailed anatomical knowledge.

Intervention: We present the case of a 38-year-old woman with a longstanding history of dysmenorrhea, dyspareunia, and progressive catamenial sciatica. She first presented in 2008 with severe dysmenorrhea and was treated with laparoscopic bilateral endometrioma excision, followed by cyclic oral contraceptives. In 2018, she underwent open surgery for deep pelvic endometriosis. Her symptoms recurred and intensified over the last year, necessitating hormonal therapy with oral dienogest. While partially effective, treatment was discontinued due to mood-related side effects. She subsequently developed cyclical left-sided sciatica (VAS 6/10), in addition to severe dysmenorrhea (VAS 9/10) and dyspareunia (VAS 9/10).

On pelvic examination, a firm nodule was palpable in the left uterosacral ligament. Imaging studies revealed a 7 cm left ovarian endometrioma and a 2 cm right ovarian cyst with kissing ovaries in the midline, posterior to the uterus. MRI also showed adhesions and probable infiltration in the sigmoid colon, a 2 cm lesion in the left adnexa, and infiltration around the left obturator nerve. Lumbosacral plexus MRI revealed nodular lesions and altered perineural fat planes suggestive of sciatic nerve involvement.

The patient underwent laparoscopic surgery in the low lithotomy position. Intraoperatively, complete obliteration of the pouch of Douglas and dense adhesions involving the rectum were noted. A stepwise laparoscopic excision of deep pelvic endometriosis was performed, including the left ureter, sigmoid colon shaving, and left ovarian endometrioma excision using the SOSURE technique. Upon completion of pelvic excision, attention was directed to the retroperitoneum. The peritoneum overlying the external iliac artery was incised to expose the genitofemoral nerve, followed by dissection of the iliolumbar space. The obturator nerve and vessels were carefully identified, and the lumbosacral space was accessed to visualize the sciatic nerve at its emergence from the L4–S3 nerve roots. The endometriotic lesion encasing the sciatic nerve was completely excised with meticulous nerve-sparing techniques.

RESULTS: Histopathological evaluation confirmed the diagnosis of sciatic nerve endometriosis. The patient had an uneventful postoperative recovery and was discharged on postoperative day two. At four months follow-up, her cyclical sciatica had resolved, and significant symptom improvement was reported (VAS scores: dysmenorrhea 4/10, dyspareunia 3/10).

CONCLUSION: Sciatic nerve endometriosis is a rare and often underdiagnosed form of extra-pelvic endometriosis. A high index of suspicion is required in women presenting with cyclical sciatica, especially when pain radiates from

the gluteal region to the posterior limb and worsens during menstruation. Neurological symptoms such as sensory loss, muscle weakness, or altered reflexes may also be present in advanced stages.

MRI is the most effective diagnostic imaging modality for detecting nerve-infiltrating lesions and should replace exploratory laparoscopy as the initial step in diagnosis. On MRI, endometriotic lesions typically exhibit high T1-weighted signal intensity and variable T2-weighted characteristics. In the presence of symptoms suggestive of nerve involvement, targeted lumbosacral imaging is essential.

Complete surgical excision of endometriosis and nerve decompression can lead to significant symptom relief, but functional recovery may be limited in chronic cases due to longstanding fibrosis and nerve damage. Knowledge of pelvic neuroanatomy is critical for avoiding iatrogenic injury during dissection. Early diagnosis and timely intervention, followed by long-term physiotherapy, can improve outcomes.

This case underscores the importance of considering sciatic nerve involvement in atypical presentations of pelvic pain and highlights the role of advanced surgical techniques in treating complex cases of deep endometriosis.

Keywords: Sciatic nerve endometriosis, Deep infiltrating endometriosis, Pelvic nerve dissection, Laparoscopic nerve-sparing surgery, Catamenial sciatica, Extrapelvic endometriosis

VP-012

Laparoscopic excision of bilateral uterosacral ligament nodules and ovarian endometrioma

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GOAL: To describe the laparoscopic surgical management and postoperative outcome in a patient with deep infiltrating endometriosis (DIE) involving the uterosacral ligaments and a large ovarian endometrioma.

METHODS: A 41-year-old female with chronic left groin pain underwent comprehensive preoperative assessment. Vaginal examination identified a 1.5 cm posterior vaginal wall nodule, and transvaginal sonography revealed a 10 cm left ovarian endometrioma. A laparoscopic approach was performed. Following pelvic inspection, adhesiolysis and aspiration of the endometrioma the ovary was suspended to the pelvic sidewall using a T-Lift device to optimize visualization. Bilateral uterosacral ligament nodules were dissected from surrounding tissue and excised using bipolar energy and the Thunderbeat device. After identifying the plane of cleavage between the cyst wall and ovarian tissue, bimanual opposite traction was applied to strip the cyst wall from the ovarian cortex. The ureters were identified and preserved throughout the dissection. The ovarian cortex was sutured with a 2/0 V-Loc suture, preserving ovarian reserve.

FINDINGS: Extensive pelvic adhesions and bilateral DIE nodules were noted. The anatomical relationship of the ureters to the nodular tissue required meticulous dissection. The endometrioma was completely resected with ovarian tissue preservation.

RESULTS: Postoperative follow-up demonstrated complete resolution of preoperative pain. No complications occurred.Vaginal intraoperative examination should be taken into consideration to confirm the precise localization of the lesion.

Keywords: pelvic pain, uterosacral ligaments, endometrioma, DIE

VP-014

Primary repair of obturator nerve injury during laparoskopic pelvic lymphadenectomy: keep calm and carry on

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Goal: Obturator nerve injury is a rare complication during pelvic lymph node dissection in laparoscopic oncologic surgery. Depending on the location and nature of the injury, patients may experience paresthesia and sensory loss on the medial aspect of the thigh, as well as loss of motor function in the adductor muscles

Methods: The patient, who had previously undergone laparoscopic hysterectomy and left salpingo-oophorectomy at an external center, was referred to our institution after the final pathology revealed endometrioid-type endometrial adenocarcinoma. The pathology report indicated <50% myometrial invasion, focal lymphovascular space invasion, and grade 2 histology.

Findings: Following evaluation at the gynecologic oncology surgical board, it was decided to perform a laparoscopic bilateral pelvic and para-aortic lymph node dissection along with infracolic omentectomy. During the right pelvic lymph node dissection, a complete transection of the right obturator nerve was identified intraoperatively. After both ends of the nerve were located, a laparoscopic primary end-to-end anastomosis was performed using 4/0 polypropylene sutures. Additionally, the patient received 200 mg of intravenous methylprednisolone. Postoperatively, oral vitamin B12 supplementation was administered twice daily for one month. Methylprednisolone was continued with a tapering dose over three days. On physical examination during the postoperative period, the patient exhibited mild weakness in right thigh adduction. She was discharged on postoperative day four and was referred for physical therapy. The patient's pathology report revealed 17 reactive right pelvic lymph nodes, 14 reactive left pelvic lymph nodes, and 15 reactive para-aortic lymph nodes. No metastasis was detected in the omentum. The patient received adjuvant intracavitary brachytherapy to the vaginal cuff for five days. At the third postoperative month follow-up, the patient had fully recovered muscle strength and had no sensory deficits.

Results: Obturator nerve injury is a rare but significant complication that can occur during pelvic lymphadenectomy. Laparoscopic repair is feasible and safe, and may eliminate the need for laparotomy. Surgical experience and careful attention to anatomical details are crucial to prevent this complication.

Keywords: obturator nerve, pelvic, repair

VP-015

Genitofemoral Nerve Injury During Pelvic Lymphadenectomy: A Case-Based Evaluation on Pelvic Nerve Anatomy and Surgical Awareness

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AIM: The aim of this video presentation is to illustrate pelvic nerve anatomy and emphasize strategies to prevent unintended nerve injury during pelvic lymphadenectomy.

METHOD: A 62-year-old patient presented to our center with a complaint of postmenopausal bleeding. An endometrial biopsy revealed endometrioid-type endometrial cancer, Grade 2. Radiological evaluation indicated that the disease was confined to the uterus, with no evidence of metastasis. The patient subsequently underwent laparoscopic hysterectomy and bilateral salpingo-oophorectomy with bilateral pelvic lymphadenectomy.

RESULT: After entering the left retroperitoneal space, the left psoas muscle and external iliac vessels were clearly visualized. The subcostal, iliohypogastric, ilioinguinal, and lateral femoral cutaneous nerves were identified along the lateral aspect of the psoas muscle. Lymph node dissection was initiated from the distal and lateral portions of the external iliac vessels and proceeded medially into the obturator fossa. The obturator nerve, artery, and vein were carefully exposed during this phase. However, the left genitofemoral nerve could not be visualized at the beginning of the dissection. Upon reviewing the surgical field, it became evident that the genitofemoral nerve had been inadvertently transected during dissection along the psoas muscle. In contrast, on the right side, the genitofemoral nerve was clearly identified and preserved throughout the lymphadenectomy. The procedure was completed successfully, and all lymphatic specimens were submitted for pathological evaluation. Final pathology confirmed FIGO 2023 Stage IA2 endometrioid-type endometrial carcinoma, grade 2.

CONCLUSION: This case underscores the importance of detailed anatomical recognition of pelvic nerves and vigilance during pelvic lymphadenectomy, particularly in areas where critical nerve structures may be obscured.

Keywords: genitofemoral nerve, pelvic lymphadenectomy, endometrial cancer

VP-016

One room, three doors: Anatomical approach to the pelvic floor after deep infiltrative endometriosis surgery

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This video provides a detailed anatomical description of the critical neurovascular structures of the pelvic floor – specifically nerves, ureter, veins, and arteries – in the context of deep infiltrative endometriosis (DIE) surgery. Recognizing the complex anatomical distortions caused by DIE, the video meticulously illustrates the normal anatomy and highlights key landmarks relevant to surgical approaches. The primary aim is to enhance surgeons' understanding of these vital structures and their spatial relationships within the pelvic floor. Through clear visualization and anatomical dissections, the video offers a systematic guide for identifying and potentially protecting these structures. This anatomical focus serves as a foundational resource for surgeons seeking to minimize iatrogenic injury and optimize surgical outcomes in neuropelveology.

Keywords: neuropelveology, deep infiltrating endometriosis, chronic pelvic pain, pelvic floor

VP-017

Is this the limit of pelvic surgery? Ultra-radical surgery with minimal invasive approach

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Background: This video presents a case of laparoscopic total infralevatory pelvic exenteration with Singapore flap reconstruction in a patient with recurrent vulvar cancer.

Methods: Presentation of a video performed in tertiary hospital setting

Results: The patient was a 66-year-old woman with a history of vulvar squamous cell carcinoma. She had previously undergone radical wide deep local excision along with inguinofemoral lymphadenectomy. Following two local recurrences, she was treated with local excision and chemoradiotherapy. Despite these treatments, she presented to our clinic with pain and foul-smelling vaginal discharge. Imaging (pelvic MRI) and clinical evaluation revealed a 3 cm local recurrence that was unresponsive to chemoradiotherapy, with no evidence of distant metastasis. Multidisciplinary tumor board recommended pelvic exenteration.

The surgery was performed in four distinct phases:
1. Laparoscopic phase – preparation and dissection of pelvic organs.
2. Vaginal phase – resection of the vulvar tumor along with the involved pelvic organs.
3. Diversion phase – formation of an ileal conduit and an end colostomy.
4. Reconstruction phase – closure of the vulvar defect using a Singapore flap.

The total operative time was 480 minutes, with an estimated blood loss of 100 cc, primarily during the vaginal phase. The patient was discharged 32 days postoperatively. At the 5-month follow-up, there was no evidence of disease recurrence.

Conclusions Laparoscopic total infralevatory pelvic exenteration, while a complex and ultraradical procedure, is a feasible approach for select patients with recurrent vulvar cancer. However, it carries a significant risk of complications and should be performed in specialized centers.

Keywords: Laparoscopic total pelvic exenteration, infralevatory exenteration, vulvar cancer, ultra radical surgery

VP-018

Safe Protocol for DIE In Frozen Pelvis

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Goal: The goal of this surgical intervention was to address the severe pelvic pain and infertility in a 29-year-old woman with a history of dyspareunia, dyschesia, and one year of infertility. Preoperative assessment indicated the presence of a unilateral endometrioma, a frozen pelvis with extensive adhesions, and significant involvement of the ovaries and fallopian tubes. The primary objective was to relieve pelvic pain, restore pelvic anatomy, and preserve fertility by performing adhesiolysis and removal of the rectal nodule.

METHODS: A laparoscopic approach was chosen for the treatment of this patient's complex endometriosis. The surgery was performed under general anesthesia in the lithotomy position. Plan was to explore the pelvis, identifying the ureters, medializing the disease and liberate the pouch of douglas. Then the rectal nodule excision was planned.

Findings: During the procedure, several key findings were made: a 1 cm endometrioma on the RO and a rectal DIE nodule were observed. The Douglas pouch was obliterated, leading to the diagnosis of a frozen pelvis. The left and right ureters were identified and carefully preserved during dissection. The sacrouterine region on the right side showed a palpable nodule that was excised. The cyst contents were aspirated, and both ovaries were reattached to the peritoneal wall with careful preservation of ovarian reserve.

RESULTS: The surgery was completed without intraoperative complications, and hemostasis was achieved. The patient had an uneventful recovery and was discharged on the second postoperative day. Follow-up visits revealed significant improvement in her symptoms of dyspareunia and dyschesia. The patient expressed satisfaction with the resolution of her pelvic pain. The preservation of ovarian reserve and the relief of adhesions provided hope for improved fertility. No complications were noted during postoperative follow-up, and the patient was scheduled for further fertility assessment and counseling.

Keywords: Endometriosis, laparoscopy, Rectal involvement

VP-019

Surgical Approach of Bilateral Endometriomas with Right Uterosacral Deep Infiltrative Endometriosis (DIE) Excision and Bladder Dissection

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OBJECTIVE: To demonstrate a comprehensive surgical approach for managing bilateral endometriomas complicated by right uterosacral deep infiltrative endometriosis (DIE) and bladder dissection, with a focus on preserving ovarian reserve and preventing postoperative adhesions.

METHODS: The patient underwent oocyte cryopreservation prior to surgery. The surgical intervention was performed to address symptoms including dysmenorrhea, dyschezia, and urinary frequency.Left-sided endometrioma was treated with partial excision and limited bipolar coagulation, while the right-sided endometrioma was managed solely by aspiration, followed by deep infiltrative endometriosis removal from the right uterosacral ligament and bladder dissection. Special attention was given to ovarian reserve preservation. At the conclusion of the procedure, ovaries were sutured to the anterior abdominal wall using delayed absorbable sutures to minimize adhesion formation.

RESULTS: The surgical technique effectively managed the patient's symptoms while preserving ovarian reserve and restoring anatomical functionality. The delayed absorbable suturing method significantly reduced the likelihood of postoperative adhesions.

CONCLUSION: This tailored surgical approach provides a valuable technique for managing complex cases of endometriomas and DIE, ensuring symptom resolution, ovarian reserve preservation, and adhesion prevention.

Keywords: Bilateral Endometriomas, Deep Infiltrative Endometriosis (DIE), Surgical Techniques in Endometriosis, Adhesion Prevention

VP-020

Advanced laparoscopic management of deep infiltrating endometriosis involving the bowel and appendix: surgical video presentation

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OBJECTIVE: To demonstrate a stepwise laparoscopic surgical approach for the treatment of complex deep infiltrating endometriosis (DIE) involving the rectosigmoid colon, bilateral ovaries, uterosacral ligaments and appendix in a patient with a history of infertility.

METHODS: This video demonstrates the laparoscopic management of a 44-year-old patient who presented with infertility and a history of pelvic infection requiring hospitalization following hysterosalpingography, a prior left salpingectomy, and an unsuccessful in vitro fertilization (IVF) attempt. She was diagnosed with bilateral endometriomas, adenomyosis, and deep infiltrating endometriosis involving the bowel. Key steps included comprehensive pelvic exploration, retroperitoneal dissection, bilateral ureterolysis, excision of bilateral uterosacral ligament nodules, extensive adhesiolysis, and resection of endometriotic lesions. The procedure also involved right salpingectomy, right ovarian endometrioma excision, left ovary excision due to abscess formation, ileocecal resection and appendectomy due to appendiceal endometriosis, and resection of the rectosigmoid colon with primary anastomosis due to deep infiltrating endometriotic nodules. The right ovary was temporarily suspended using the T-lift technique to enhance surgical exposure. Anastomotic integrity was confirmed with air and saline leak tests. Hemostasis was achieved, and a pelvic drain was placed at the end of the procedure.

RESULTS: The surgery was completed laparoscopically without intraoperative complications. Pelvic anatomy was restored following the release of dense adhesions and resection of DIE lesions. The postoperative course was uneventful.

CONCLUSION: This video illustrates a structured laparoscopic strategy for the management of complex DIE involving multiple pelvic and gastrointestinal sites. Anatomical restoration through careful dissection and systematic surgical planning is essential for achieving optimal outcomes.

Keywords: deep infiltrating endometriosis, endometrioma, infertility, laparoscopy

VP-021

Transforming Pelvic Surgery with Neuropelveology. Hypogastric Nerve Release Surgery: A Minimally Invasive Approach for Chronic Pelvic Pain

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INTRODUCTION: Endometriosis frequently infiltrates the autonomic and somatic nerves of the pelvis, including the hypogastric nerves. Pelvic function depends on the delicate balance between autonomic and somatic nerves. In neuropelveologic surgery, the preservation and restoration of these nerves are fundamental.

Case summaries/ material: Patients undergoing pelvic surgery for chronic pelvic pain, endometriosis, fibroid uterus commonly involves dissection close to hypogastric nerves leading to iatrogenic pathology such as nerve entrapment in fibrosis, surgical non sparing due to lack of anatomical knowledge or involvement with disease. The video presents detailed anatomical demonstration of MIS techniques for identification, preservation and neurolysis of hypogastric nerves leading to organ function preservation and symptom relief of chronic pain.

DISCUSSION: Neuropelveology represents a paradigm shift in pelvic surgery, moving away from excision-focused approaches toward nerve preservation, neuromodulation, and neurofunctional restoration.

By integrating minimally invasive techniques, advanced diagnostics, and nerve-sparing strategies, neuropelveology ensures that patients receive safer, more effective, and functionally restorative care.

CONCLUSION: For patients suffering from endometriosis, pelvic nerve entrapments, or complex pelvic pain syndromes, neuropelveology offers new hope—providing relief, restoring function, and improving long-term quality of life.

Keywords: Hypogastric nerves, neurolysis, nerve sparing, organ function preservation, Neuropelveology

VP-022

An Atypical Cause of Chronic Pelvic Pain in the Postmenopausal Period: Mega-Hydrosalpinx

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GOAL: In this rare case presentation, we aim to present the diagnosis, treatment, and surgical management of a female patient who presented with postmenopausal bleeding due to an endometrial polyp and chronic pelvic pain due to unilateral mega-hydrosalpinx.

METHODS: A 58-year-old female patient, Gravida 3, Para 3, with a history of three spontaneous vaginal deliveries and no known comorbidities, presented to the gynecology outpatient clinic with complaints of postmenopausal vaginal bleeding and chronic pelvic pain. Her body mass index (BMI) was 28.5 kg/m². On transvaginal ultrasonography, a hyperechoic lesion consistent with an endometrial polyp was observed within the uterine cavity, and the left fallopian tube appeared anechoic and markedly dilated. The findings were confirmed with contrast-enhanced pelvic MRI, which revealed a 15 cm mega-hydrosalpinx in the left fallopian tube. Endometrial sampling was performed to rule out malignancy, and the result was benign. Based on the patient's persistent symptoms and radiological findings, total laparoscopic hysterectomy and bilateral salpingectomy were planned. Intraoperatively, a mega-hydrosalpinx was confirmed in the left tube. The surgery was completed without complications.

FINDINGS: Postoperatively, the patient experienced a hemoglobin drop of 1.9 g/dL; however, hemoglobin and hematocrit levels remained stable, and no complications were observed. She was discharged on the 44th postoperative hour in stable condition. A significant improvement in the patient's symptoms was observed in the postoperative period.

RESULTS: Endometrial polyps are among the common causes of abnormal uterine bleeding in the postmenopausal period, and the risk of malignancy may vary depending on the presence of symptoms. In particular, the risk of malignancy increases in patients who present with postmenopausal bleeding. Therefore, the diagnosis and management of endometrial polyps in symptomatic postmenopausal women are of great clinical importance.

Hydrosalpinx, while typically seen in women of reproductive age, can also lead to chronic pelvic pain in postmenopausal women. This condition is often caused by pelvic inflammatory disease or tubo-ovarian adhesions resulting from previous surgical interventions. Although hydrosalpinx is rare in the postmenopausal period, it should be considered in the differential diagnosis of patients presenting with chronic pelvic pain.

This case demonstrates that conditions such as endometrial polyps and hydrosalpinx, which are rarely seen in the postmenopausal period, can coexist and can be successfully managed with appropriate surgical intervention. A comprehensive evaluation and accurate diagnosis using appropriate imaging techniques are crucial for effective treatment planning in postmenopausal women with complaints of abnormal uterine bleeding and chronic pelvic pain.

Keywords: Postmenopausal bleeding, endometrial polyp, hydrosalpinx, chronic pelvic pain

VP-023

Vnotes hysterectomy with bilateral salpingo-oophorectomy for huge bilateral adnexal masses

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INTRODUCTION: Adnexal masses are a frequent gynecological concern for women across all age groups, with approximately 10% needing adnexal surgery throughout their lives. When addressing benign ovarian tumors, laparoscopic adnexectomy is favored over laparotomy due to its reduced surgical trauma, fewer postoperative complications, lower levels of postoperative pain, and shorter duration of hospitalization. Evaluating the features of an adnexal mass before undergoing surgery is vital. To avoid cyst rupture and abdominal spillage in cases where masses possess a moderate to high malignancy risk (O-RADS 4 or 5), a laparotomy might be required. However, larger adnexal masses presumed to be benign can be effectively extracted through minimally invasive methods.

CASE: A 58-year-old patient with a history of two cesarean deliveries presented with a pelvic mass causing significant daily pain and a mass effect. During the pelvic exam, two soft, non- tender, and movable masses were noted in the midline, extending above the umbilicus. A CT scan revealed simple unilocular cysts originating from both ovaries, measuring 18x12 cm and 7x5 cm, with no nodularity or septations. CA125: 25 U/mL. A vNOTES hysterectomy and BSO were completed successfully. A Frozen Section revealed benign masses on both sides. The surgery was completed without any perioperative complications, and the patient experienced a smooth postoperative recovery. The final pathology report verified the diagnosis of bilateral serous cystadenoma. The procedure is demonstrated in the accompanying video.

RESULT: The patient returned home on the first day after surgery without any noticeable incisions. vNOTES is an innovative minimally invasive technique that can effectively address suitable adnexal conditions. By integrating laparoscopic and vaginal surgical methods, this approach offers several added advantages, such as improved visualization, quicker recovery, and the absence of visible incisions.

Keywords: vNOTES, adnexal mass, hysterectomy

VP-024

Successful Resolution of Chronic Pelvic Pain and Pregnancy After Endometrioma Surgery

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GOAL: To evaluate fertility preservation strategies in women with ovarian endometrioma, with an emphasis on surgical approaches that avoid the use of electrocautery and bipolar energy devices, thereby minimizing ovarian reserve loss.

METHODS: This case was identified through routine surgical practice in a tertiary referral center. The patient, a 39-year-old nulligravida woman with chronic pelvic pain and a known diagnosis of left ovarian endometrioma, was referred for fertility-preserving management. After preoperative counseling and baseline ovarian reserve testing, laparoscopic excision of the endometrioma was performed without the use of electrocautery or bipolar coagulation. A non-thermal dissection technique was applied, and hemostasis was achieved using gentle suturing when necessary. Written and verbal informed consent was obtained from the patient and her husband prior to the procedure, including permission for the scientific use of surgical images and clinical data.

Findings: A 39-year-old nulligravid woman presented with secondary dysmenorrhea, dyschezia, and dyspareunia. She had been married for 6 months and expressed a desire for pregnancy. Imaging studies, including pelvic ultrasound and MRI, revealed a well-defined, thick-walled, homogenous cystic lesion in the left adnexal region, adjacent to the uterus. The lesion exhibited high signal intensity on T2-weighted MRI sequences, consistent with endometrioma. Tumor markers were within normal limits. Her preoperative serum anti-Müllerian hormone (AMH) level was 3.89 ng/mL.

A laparoscopic cystectomy was performed using a fertility-preserving, non-thermal technique. No electrocautery or bipolar devices were used during the dissection or hemostasis. Instead, traction and countertraction with blunt dissection were employed to separate the cyst wall from the ovarian cortex, thereby minimizing damage to healthy ovarian tissue. The procedure was uneventful. At 40 hours postoperatively, the patient showed a 1.6 g/dL drop in hemoglobin but was clinically stable and discharged without complications. Final pathology confirmed the diagnosis of endometrioma.

Postoperative monitoring of ovarian reserve showed an increase in AMH to 4.25 ng/mL at the 4th postoperative month, indicating preserved and potentially enhanced ovarian function. At postoperative month six, the patient conceived spontaneously. As of April 29, 2025, her pregnancy is ongoing and has reached 30 weeks of gestation without complications.

RESULTS: This case highlights the feasibility of endometrioma surgery without electrosurgical devices, demonstrating a fertility-sparing benefit through the preservation of ovarian reserve. Non-thermal techniques can be safely implemented in selected patients, particularly those with high reproductive potential or immediate fertility preservation goals. This approach supports growing evidence that avoiding thermal energy in endometrioma surgery may reduce follicular loss and improve assisted reproductive outcomes.

Keywords: endometrioma, fertility preservation, ovarian reserve, non-thermal surgery, electrocautery-free technique

VP-025

Laparoscopic sentinel lymph node dissection in Endometrial cancer: Current literature, case report

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OBJECTIVE: Endometrial cancer is the most common gynecologic cancer in developed countries. The average age of onset is 63 years. Women have a 2.9% chance of encountering it in their lifetime. Sentinel lymph node mapping in endometrial cancer is a targeted surgical approach with varying degrees of acceptability in clinical practice among gynecologic oncologists. The sentinel lymph node mapping approach should be considered for surgical staging when imaging methods do not detect metastases or when there is no extrauterine disease on exploration. The advantages of this method are the reduced risk of lymphedema and intraoperative complications and the increased rate of positive lymph node detection by ultrastaging. We aimed to present our patient in whom we performed laparoscopic sentinel lymph node dissection for endometrial cancer with a video presentation in light of the current literature.

CASE: A 58-year-old patient underwent endometrial sampling due to abnormal uterine bleeding, and endometrial adenocarcinoma Grade 2 was reported. Magnetic resonance imaging showed a T1-T2 hypointense myoma uteri with a compatible appearance of approximately 2 cm in the posterior part of the uterine corpus. The patient underwent laparoscopy, total hysterectomy, bilateral salpingo-oophorectomy, bilateral sentinel lymph node dissection, and omentectomy. Indocyanine green was used for sentinel lymph node dissection. It was applied to the deep and superficial cervix at 3 and 9 o'clock, 2 ml on each side. Frozen results showed less than 1/2 myometrial invasion and no lower uterine segment involvement. Pathology showed tumor diameter 5.5 cm, endometrioid carcinoma localized in the endometrium, Figo grade 2, myometrial invasion rate <50%, no serosa involvement, lower uterine segment involvement, no cervical stromal involvement, positive lymphovascular invasion. Sentinel lymph node protocol performed on the right and left sentinel lymph nodes showed reactive hyperplasia in 2 lymph nodes on the right and reactive hyperplasia in 6 lymph nodes on the left.

CONCLUSION: Recent studies indicate that laparoscopic sentinel lymph node detection may replace systemic lymphadenectomy in early-stage endometrial cancers. Tanaka et al. included 211 patients in their study, performed laparoscopic surgery in 152 patients, and performed sentinel lymph node biopsy during laparotomy in 59 patients using three types of dyes: 99m-technetium-labeled tin colloid (99m Tc), indigo carmine, and indocyanine green. Side-specific detection rate, sensitivity, and factors related to the false negative rate were analyzed. Patients undergoing laparoscopy with <50% myometrial invasion and low-grade tumors had not only higher detection rates but also lower false negative rates. Compared with systemic lymphadenectomy in women with disease confined to the uterus, sentinel lymph node mapping and ultrastaging increased lymph node metastasis detection rates with low false negatives. Sentinel lymph node dissection safely reduces the morbidity of systemic lymphadenectomy without compromising the detection rate of lymphatic metastases. 2020 ESGO/ESTRO/ESP guidelines support sentinel lymph node biopsy as an alternative to systematic lymphadenectomy to avoid associated morbidity.

Keywords: Laparoscopy, endometrial cancer, indocyanine green, sentinel lymph node.

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Fertility-Sparing Management of Advanced Adolescent Endometriosis Mimicking Ovarian Torsion: A Non-Thermal Laparoscopic Approach

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Goal: Adolescent endometriosis is an underrecognized yet impactful condition, often presenting with non-specific symptoms such as dysmenorrhea, pelvic pain, gastrointestinal disturbances, and even respiratory complaints. Due to the limitations in physical examination and imaging—especially in virginal patients—diagnosis is frequently delayed, leading to disease progression and potential compromise of future fertility. The presence of extra-pelvic lesions, including diaphragmatic implants, further complicates the clinical picture and may be mistaken for unrelated pathologies.

This video article aims to highlight a case of advanced-stage adolescent endometriosis in a 20-year-old virgin female, initially suspected to have ovarian torsion. The surgical management focused on fertility preservation through the avoidance of thermal energy devices during laparoscopic cyst excision. The goal is to emphasize the feasibility and importance of non-thermal techniques in endometriosis surgery for young patients with reproductive potential.

METHODS: This case was identified during routine clinical evaluation at a tertiary center. The patient, a 20-year-old virgin female, presented to the emergency department with acute pelvic pain, nausea/vomiting, and respiratory distress during menses. Her CA-125 level was elevated at 70 U/mL. Initial imaging with pelvic CT and MRI revealed a complex right adnexal mass, raising suspicion for ovarian torsion. Following informed consent, diagnostic laparoscopy was performed for further evaluation and management. During surgery, the cyst was aspirated and excised using non-thermal techniques, without electrocautery or bipolar energy.

Findings: Laparoscopic exploration revealed multiple peritoneal endometrial implants located beneath the right diaphragmatic dome. Dense adhesions were observed between the bowel loops and both lateral pelvic sidewalls. Deep infiltrative lesions were noted involving the bladder dome, anterior and posterior surfaces of the uterus, and both uterosacral ligaments.

A large, cystic lesion was identified in the right adnexal region and was excised using a fertility-preserving surgical approach. To protect the ovarian cortex, no thermal energy was applied. Minimal use of monopolar scissors was necessary for dissection, and hemostasis was achieved with 2/0 barbed sutures instead of bipolar coagulation. The procedure was completed without intraoperative complications.

RESULTS: This case demonstrates the feasibility and clinical benefit of non-thermal laparoscopic management of adolescent endometriosis, even in the setting of extensive pelvic and diaphragmatic disease. Avoiding energy devices minimized damage to ovarian tissue and reduced the risk of ovarian reserve loss. The patient was discharged without complications and referred for follow-up care including hormonal suppression therapy.

This approach reinforces current trends advocating for energy-free dissection techniques in endometriosis surgery, especially in young women with fertility concerns or virgin anatomy where vaginal access is limited. Early surgical intervention and careful technique may support long-term reproductive health.

Keywords: adolescent endometriosis, diagnostic laparoscopy, endometrioma, peritoneal endometriosis

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