

**XXV National Congress of the "Società Polispecialistica Italiana dei Giovani Chirurghi"
13-15 June 2013, Bari, Italy**

UTERINE LEIOMYOMAS: THERAPEUTIC MANAGEMENT AND OPEN QUESTIONS

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Objective: Submucosal myomas induce menorrhagia and pelvic pain, and increase the risk of infertility and obstetrical complications. Submucosal fibroid location and distortion of the endometrial cavity (either submucosal or deeply infiltrating intramural fibroids) are most predictive of impaired fertility and probable benefit of surgical removal, and warrant consideration of hysteroscopic myomectomy in the subfertile patient. The aim of this study was to evaluate the effects of hysteroscopic treatment on reproductive outcome and symptoms resolution in patients with submucosal myomas.

Methods: We evaluated all patients occurred at our institution with ultrasound diagnosis of submucosal myomas, and symptoms such as pelvic pain and menometrorrhagia. All these patients underwent hysteroscopic myomectomy.

Results: We evaluated 50 patients subjected to hysteroscopic myomectomy between 2007 and 2009. Mean age was 35 years and 8 months (range 29-42). Twenty-seven women (54%) suffered from primary infertility, 15 women (30%) had history of abortion. Mean size of the fibroid was 35 mm. Type 1 myomas represented 56% of cases while type 2 10% of cases. The most frequent emplacement of the myoma was the anterior surface of fundus of the uterus (45%). After hysteroscopic treatment, the resection was considered as complete in all patients. Rate of blood loss was significantly greater if multiple myomas. The functional result was good with disappearance of bleeding symptoms in 45 patients (90%) after a mean follow up of 24 months. Thirty-five women (70%) experienced 40 pregnancies after myomectomy.

Conclusions: Treatment of uterine leiomyoma should be tailored to patient symptoms, age and desire for pregnancy. Our results indicate that hysteroscopic myomectomy improves fertility and symptoms. The pregnancy rate in women desirous of offspring after hysteroscopic myomectomy was 70% and the 90% of patients had disappearance of bleeding symptoms. Hysteroscopic resection is a viable and safety alternative to abdominal myomectomy for submucous myomas.

**SUCCESSFUL LAPAROTOMIC MYOMECTOMY OF A LARGE SUBSEROVAL MYOMA
CAUSING HYDRONEPHROSIS AT 16th WEEK OF PREGNANCY: A CASE REPORT**

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A case of laparotomic myomectomy at 16th weeks of pregnancy is presented. A 35 year-old primigravid presented with acute abdominal pain and hydronephrosis (serum creatinine 1,6 mg/dL). Ultrasonography and magnetic resonance imaging demonstrated a large myoma of 17 cm of diameter occupying the pouch of Douglas and compressing bladder, ureters, rectus and gestational chamber. Laparotomic myomectomy was performed successfully. Pregnancy continued uneventfully until 38th when cesarean section was performed. Surgical management of myomas during pregnancy is feasible in selected cases and is indicated when patients are highly symptomatic.

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**WHICH IS THE PRICE OF AN UPPER ABDOMEN OPTIMAL CYTOREDUCTION FOR
ADVANCED OVARIAN CANCER? ANALYSIS AND MANAGEMENT OF COMPLICATIONS**

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Objective: To evaluate the complication rate in patients submitted to extensive upper abdominal surgery for treatment of advanced ovarian cancer.

Methods: From January 2003 to December 2007 all patients undergone upper abdominal surgery during primary, interval or secondary cytoreduction, including diaphragm stripping/resection, splenectomy, distal pancreatectomy, partial gastric resection, partial liver resection and cholecystectomy were considered for the study. Inclusion criteria were: diagnosis of advanced ovarian cancer (FIGO stage IIIC-IV) histologically confirmed, age > 18 and < 80 years, at least a metastasis in the upper abdomen, ECOG Performance status (Oken MM, 1982) ≤ 2. Intra-operative, early and late post-operative complications were evaluated through physical and gynecological examination, laboratory work-up and abdomino-pelvic ultrasonography.

Results: 78 patients affected by IIIC-IV FIGO stage ovarian cancer were included: 35 (44.9%) submitted to primary cytoreduction, 16 (20.5%) to interval debulking surgery and 27 (34.6%) patients to secondary cytoreduction for recurrent disease on upper abdomen. One-hundred and thirty-seven upper-abdomen surgical procedures were performed: 16 (11.7%) diaphragmatic peritonectomies, 28 (20.4%) diaphragmatic resections, 12 (8.8%) glissonian resections, 19 (13.8%) liver resections, 8 (5.8%) gastric resections, 8 (5.8%) partial pancreatectomies, 31 (22.6%) splenectomies and 15 (11.1%) cholecystectomies. Pulmonary, cardiovascular, hematologic, gastrointestinal and infective post-operative early and late complications were reported respectively in 20 (25.7%) and 2 (2.6%), 3 (3.9%) and 2 (2.6%), 2 (2.6%) and 3 (3.9%), 2 (2.6%) and 2 (2.6%), 6 (7.7%) and 2 (2.6%) of patients respectively. The overall grade 1-2, grade 3-4, grade 5 complications rate was respectively 15.5% (12/78), 19.3% (15/78) and 1.3% (1/78). Median follow-up time was 60 months.

Conclusions: Extensive upper abdominal surgery encloses a global post-operative complications rate of 38% but only 20% of patients present grade 3-5 complications. Upper abdomen surgery for treatment of ovarian cancer is feasible and safe with an acceptable complication rate.

VULVAR MALIGNANCY IN TYPE 1 NEUROFIBROMATOSIS SYNDROME

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Type 1 neurofibromatosis (NF1) is a dominantly inherited neurologic disorder that affects primarily the skin, bones, and peripheral nervous system. It may be associated with a variety of clinical manifestations including cafe-au-lait spots, skinfold freckling, Lisch nodules and visceral neurofibromas. Individuals affected by NF1 harbor an increased risk for both benign and malignant tumors. Malignant transformation is usually observed in the form of neurosarcoma. Rarely NF1 affects the genital tract, and isolated vulvar localization is extremely rare. Here is reported a rare case of a solitary neurosarcoma of the vulva in a 43-year-old woman affected by von Recklinghausen syndrome treated with surgical excision. The purpose of this case is to underline the possibility of association between NF1 and genital tract sarcoma and to suggest an accurate evaluation of rapid growth vulvar mass in this setting.

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EFFECTS OF UNILATERAL OVARIECTOMY ON FEMALE FERTILITY OUTCOME

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Objective: To compare the fertility outcome among women subjected to unilateral ovariectomy and other abdominal or non-gynaecologic pelvic surgery.

Methods: One hundred and sixteen fertile women, surgically treated between 1990 and 2001 at Sapienza University of Rome with unilateral ovariectomy (UO), appendectomy (AP) or cholecystectomy (CO) for benign disease, were analysed for long-term post-operative pregnancy and "take home baby" rate. Patients with assessed pre-surgical fertility defects, previous abdominal or pelvic surgeries and post-surgical contraception were not included.

Results: Thirtysix women underwent UO, 39 were subjected to AP and 41 were treated with CO. After a minimum 10-years post-surgical interval, the overall number of successful pregnancies was 97. The rate of women who experienced at least 1 post-operative successful pregnancy was: 50% in UO, 41% in AP and 53.6% in CO ($P > 0.05$; UO vs AP, $P = 0.49$; UO vs CO, $P = 0.82$; AP vs CO, $P = 0.27$). In UO, 18/36 (50%), 5/36 (13.9%) and 2/36 (5.5%) patients carried out 1, 2 and > 2 successful pregnancies, respectively.

Conclusions: No statistical difference in terms of post-operative pregnancy rate and "take home baby" rate between patients subjected to UO, AP or CO was found, thus allowing to suppose that the removal of one ovary does not significantly worsen the female fertility outcome respect to other abdominal or pelvic procedures.

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