AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-26004

When Benign Turns Complex: Advanced Laparoscopic Strategies for the Unexpected Pelvis

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PG-26004: When Benign Turns Complex: Advanced Laparoscopic Strategies for the Unexpected Pelvis

Chair: Luis F. Garcia Rodriguez
Co-Chair: Fernando Heredia
Faculty: Luis F. Garcia Rodriguez, Fernando Heredia,
Thiers Soares Raymundo, Juan Diego Villegas-Echeverri

Course Description

Benign gynecologic surgery may unexpectedly escalate into highly complex operative scenarios, challenging even experienced laparoscopic surgeons. Pelvic abscesses, frozen pelvis, large benign tumors, complex hysterectomy, and unexpected adnexal findings require advanced anatomical knowledge, refined laparoscopic skills, and real-time surgical judgment. This postgraduate course focuses on advanced laparoscopic strategies to safely manage complex benign gynecologic conditions. Through expert-led, step-by-step video case analysis and structured decision-making frameworks, participants will gain practical tools to navigate high-risk benign surgery, minimize complications, and optimize surgical outcomes.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Recognize intraoperative warning signs that convert benign pathology into complex surgical scenarios; and 2) Navigate high-risk benign surgery, minimize complications, and optimize surgical outcomes.

Course Outline

10:30 am	Welcome, Introduction and Course Overview	L. Garcia Rodriguez
10:35 am	Adnexal Surprises: When Benign Is Not Straightforward	F. Heredia
11:00 am	Frozen Pelvis: Navigating Severe Adhesions and Distorted Anatomy	T. Soares Raymundo
11:25 am	Pelvic Abscesses and Hostile Inflammatory Pelvis	J. Villegas-Echeverri
11:50 am	Large Benign Tumors and Complex Laparoscopic Hysterectomy	L. Garcia Rodriguez
12:15 pm	Discussion Questions & Answers	All faculty
12:30 pm	Adjourn	

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Disclosure of Relevant Financial Relationships

As an ACCME-accredited provider, AAGL is responsible for ensuring that accredited education is fair, balanced, free of commercial bias, and supports safe, effective patient care. AAGL maintains control over all aspects of educational planning, content, faculty selection, delivery, and evaluation.

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Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

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COURSE CHAIR DISCLOSURE

Luis F. Garcia, MD – Speakers Bureau: Johnson & Johnson

COURSE CO-CHAIR DISCLOSURE

Fernando Heredia, MD – Consultant: Johnson & Johnson, Merck & Co./MSD; Speakers Bureau: Johnson & Johnson, AstraZeneca, Merck & Co./MSD, KLS Martin; Travel Expenses: Merck & Co./MSD, KLS Martin, Medtronic

FACULTY DISCLOSURES

The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).

Luis F. Garcia, MD – Speakers Bureau: Johnson & Johnson
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Thiers Soares Raymundo, Dr h, c., MD – Speakers Bureau: Johnson & Johnson, Intuitive Surgical
Juan Diego Villegas-Echeverri, MD, FRCPI, PPSD*

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

Drs. Garcia and Heredia's roles as Course Chair and Co-Chair were limited primarily to course oversight and moderation, rather than development of educational content. Any planning decisions or content under their influence were subject to independent peer review by individuals without relevant financial relationships.

The presentation content for course faculty, Drs. Garcia Rodriguez, Heredia, and Soares Raymundo, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

Adnexal surprises

"when benign is not straightforward"

Fernando Heredia , MD · Universidad de Concepción, CHILE
Full Professor Obstetrics & Gynecology
Vice President Chilean Society Gynecologic Oncology (SCHIGO)
Harvard Medical School SLP Graduate
Co-Chair Education Committee's Surgical Work Group, International Gynecological Cancer Society (IGCS)
AAGL Board member for México, Central and South America 2006-2027

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@drfhernandoheredia

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Disclosures

Consultant: J&J Medtech, Astra Zeneca, MSD.

Speakers Bureau: J&J Medtech, Astra Zeneca, MSD, KLS Martin.

Travel expenses: J&J Medtech, Astra Zeneca, MSD, KLS Martin, Medtronic.

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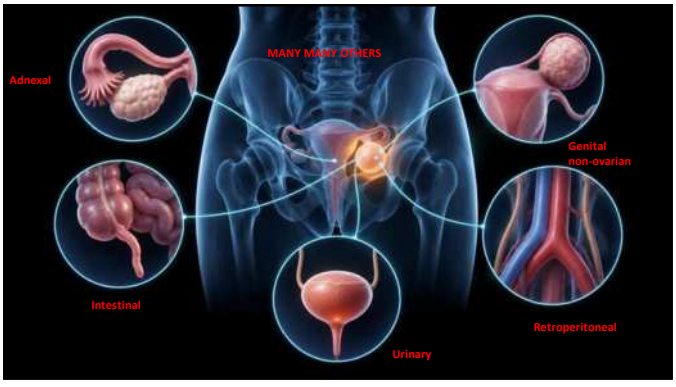
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Where´s the surprise?

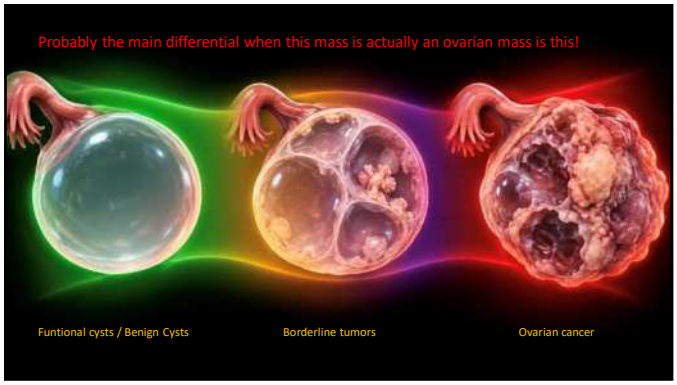
Probably in the **Differentials**



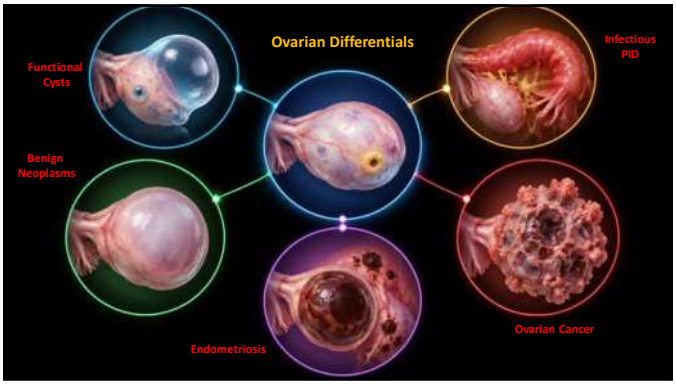
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Probably the main differential when this mass is actually an ovarian mass is this!
Funtional cysts / Benign Cysts
Borderline tumors
Ovarian cancer

7


Ovarian Differentials
Functional Cysts
Benign Neoplasms
Infectious PID
Endometriosis
Ovarian Cancer

8


Is there any chance of surprise nowadays?

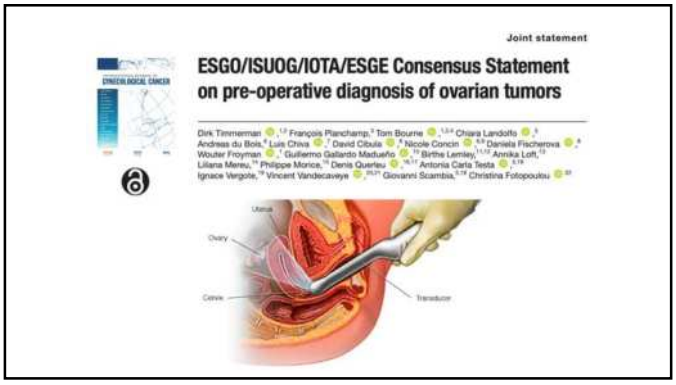
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"Complex adnexal mass"
Laparotomy

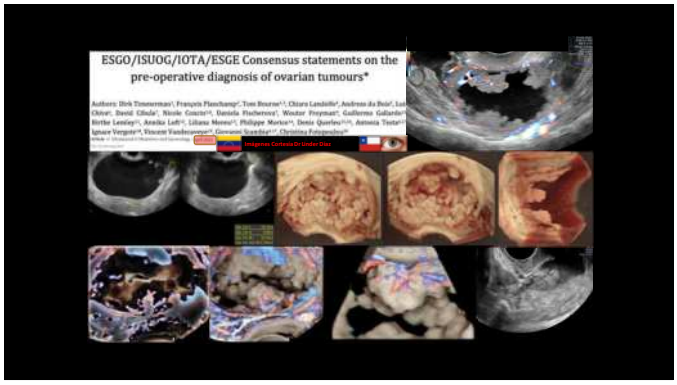
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FLUOROSCOPY
ULTRASOUND
DOPPLER · CT · MRI
IOTA ADNEX O-RADS
ENDOMETRIOSIS MAPPING
AAGL 2021
12%

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Joint statement
ESGO/ISUOG/IOTA/ESGE Consensus Statement on pre-operative diagnosis of ovarian tumors

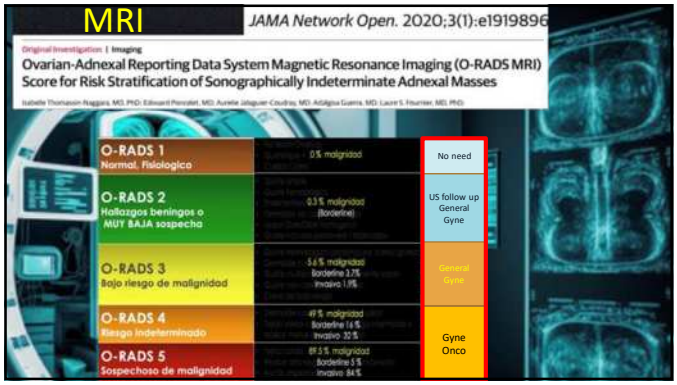
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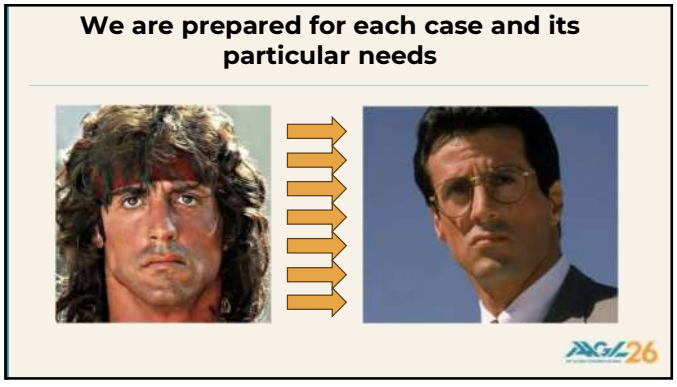
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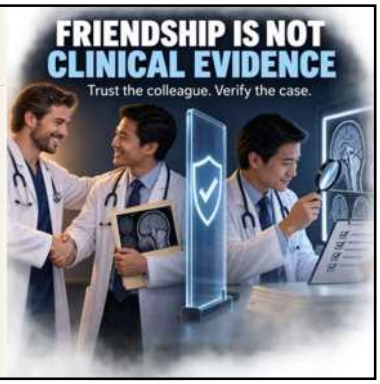


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Case 1

- A dear Colleague asks for surgical help.
- Right ruptured tubal pregnancy.
- Office Ultrasound by the same dear colleague

- "Easy-Peasy case"
- "15- minute –case"



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Interstitial pregnancy

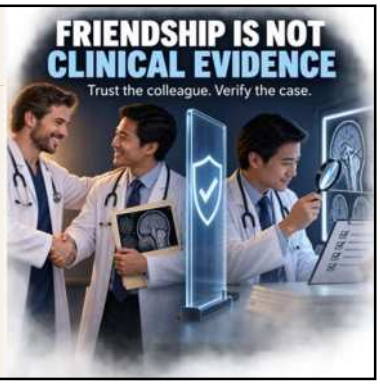
- Undisclosed detail:
- Prior right salpingectomy
- IVF pregnancy

21

Case 2

- **THE SAME** dear Colleague asks for surgical help 2 weeks after.
- Left ruptured tubal pregnancy.
- Office Ultrasound by the same dear colleague

- **NOW ITS TRUE** "Easy-Peasy case"
- "15- minute –case and you are off"



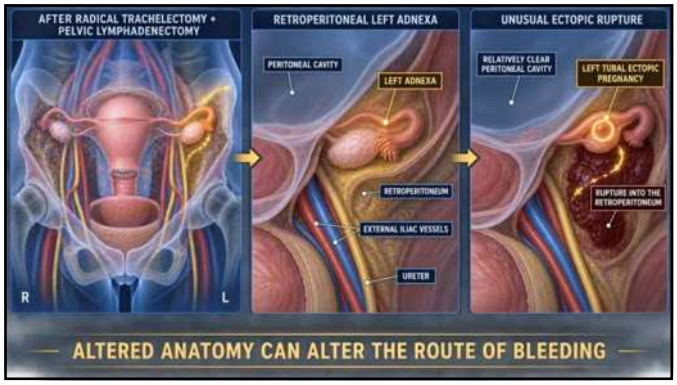
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The undisclosed detail… Open Abdominal Radical Traquelectomy + Pelvic Lymphadenectomy 3 years before…soooo



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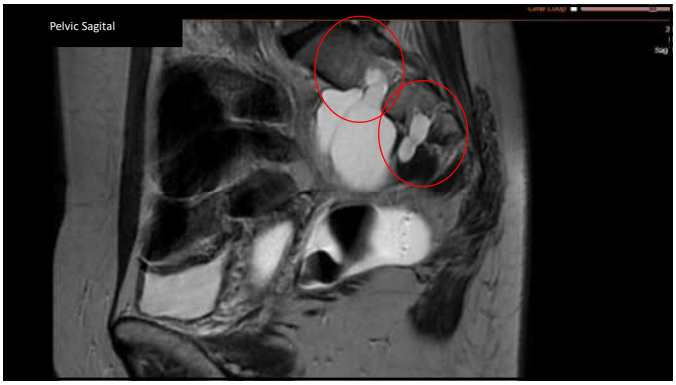
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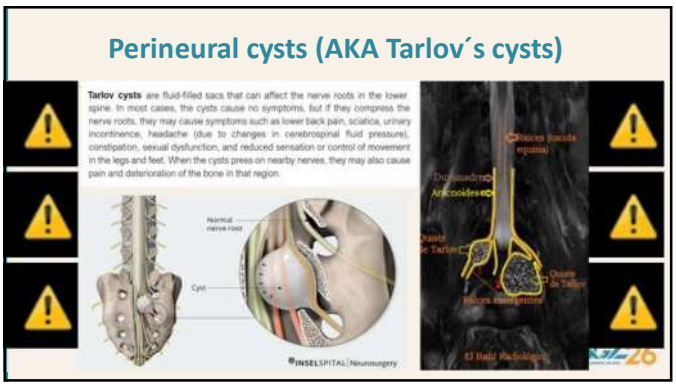
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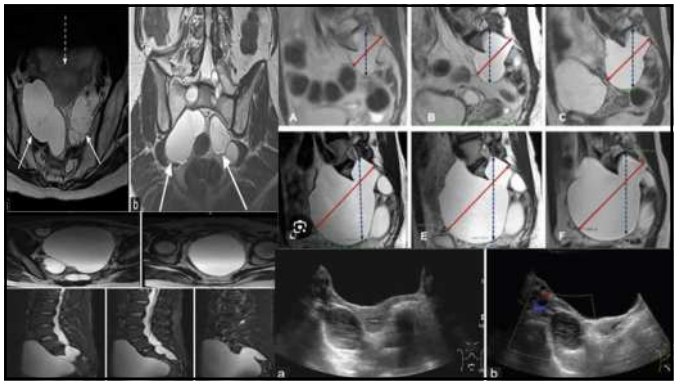
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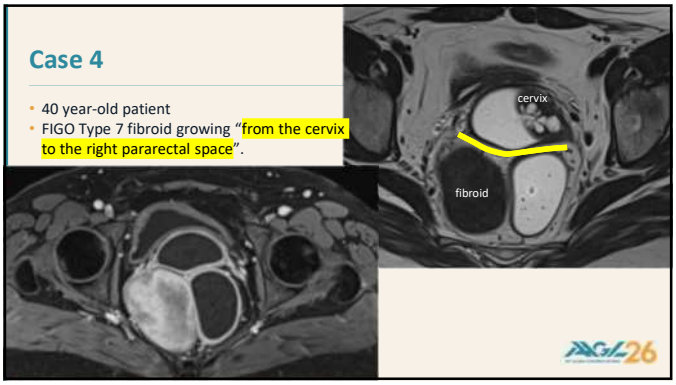
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Case 4

- 40 year-old patient
- FIGO Type 7 fibroid growing "from the cervix to the right pararectal space".



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Case 5

- 50 years of age, postmenopausic.
- CT Scan: Solid right 2 x 3 cm ovarian mass, highly suspicious of Fibroma.
- Serum CA125 / Ca19-9 are normal.
- Anamnestic detail: 2 episodes of lower GI bleeding during the past month associated with abdominal pain.
- What are you thinking of?
  - Meckel´s? concomitant hemorrhoids? Colon cancer?

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GIST (Gastrointestinal Stromal Tumor)

36

Case 6: ¿Teratoma or not teratoma?

- 18 year-old, BMI 36, mild hirsutism.
- TVUS /CT scan depict a Solid-cystic right 10 cm adnexal tumor, no adhesions, probably ovarian teratoma.
- Scheduled for ovarian tumorectomy and I´m consuletd for a second opinion.
- ¿What did I do?
  - Asked for tumor markers (epitelial and germinal/stomal markers)
  - Pelvic MRI / Thorax X ray…its a 10 cm ovarian mass!!!!



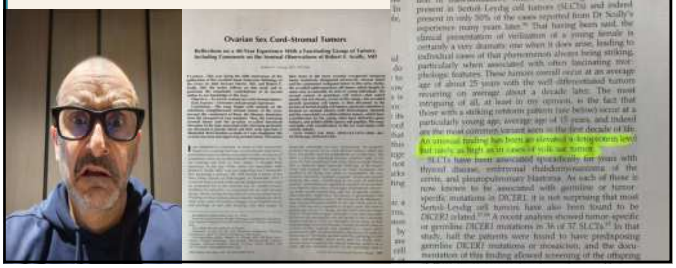
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Tumor markers

- All normal but: Alfafetoprotein 147 ng/ml (10X)
- Diagnosis Check! Done!: Endodermal sinus tumor, highly agressive.
- So, Surgical plan changed to: Right adnexectomy + frozen section.
- Anything else?
  - Chemotherapy catheter instalation since she will need three cycles of adjuvant Chemotherapy (Bleomicin – Etopiside –Cisplatin).

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Biopsy: High grade Sertoli Leydig tumor



SERTOLI-LEYDIG CELL TUMOR

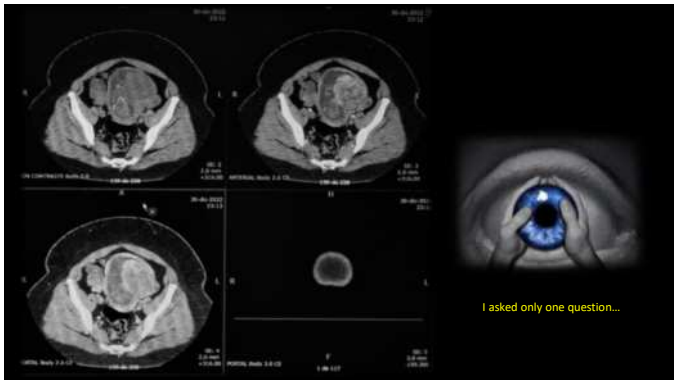
Ovarian Sex Cord-Stromal Tumors

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Case 7 "The Death trap"

- Paciente 31-year-old patient.
- Primary infertility – Chronic Anovulation - Metabolic Syndrome.
- The patient presents on January 3rd , three days after a CT scan due to pelvic pain (New Years Day eve!) which diagnosed a complex ovarian mass.
- Referred for Oncological Study and management.

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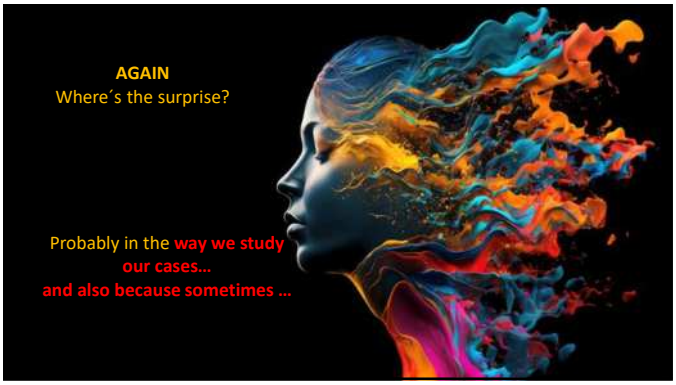
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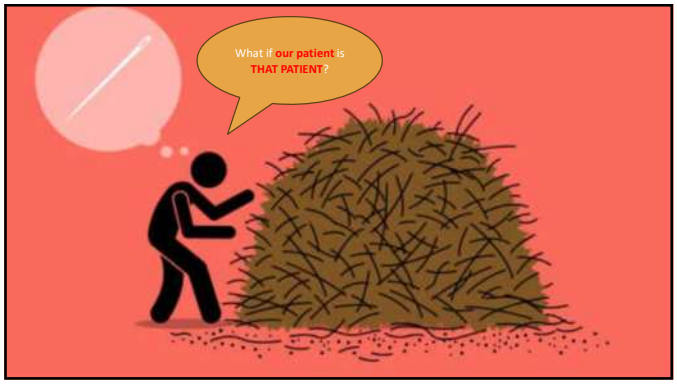
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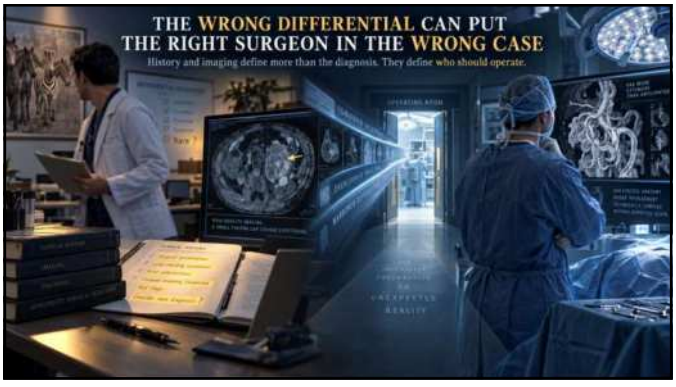
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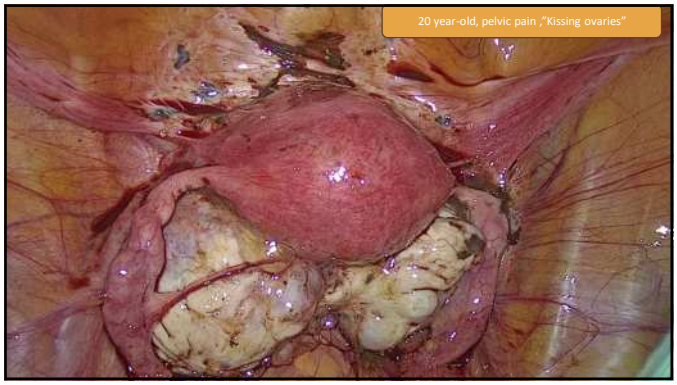
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Final messages

1. The decision to perform surgery on an adnexal mass is the **final element of a comprehensive process** and involves much more than just inserting a tube or placing a surical robot on a patient!
2. It is essential to remember clinical details, conduct lab tests, and obtain quality imaging.
3. We are treating individuals, not just cases.
4. Use **COMMON SENSE.**
5. If you have any doubts, seek assistance.



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Navigating Severe Adhesions and Distorted Anatomy

Thiers Soares, Dr.h.c., MD ·
State University of Rio de Janeiro – UERJ
Cardoso Fontes Hospital

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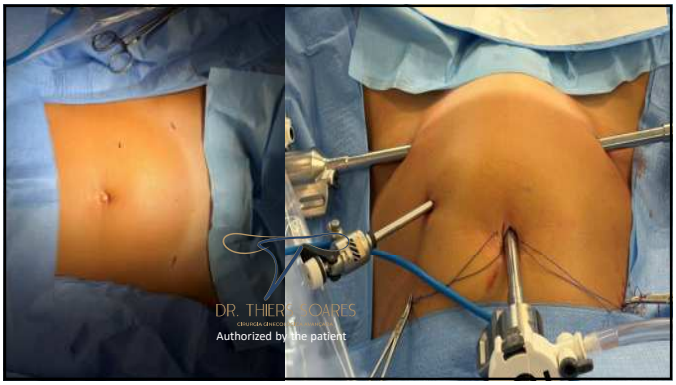
Disclosure

J&J Med Tech

Intuitive

DR. THIERS SOARES
CIRURGIA GINECOLÓGICA AVANÇADA

3



4

JMIG The Journal of Minimally Invasive Gynecology

Systematic Surgical Approach for DIE of the Posterior Compartment

Raymundo TS,[1,2] Panisset KS,[2] de Oliveira MA Pinho,[1] Crispi CP,[2] Oliveira FM.[2] [1]University of the State of Rio de Janeiro, Rio de Janeiro, Brazil; [2]Fernandes Figueira Institute, Rio de Janeiro, Brazil

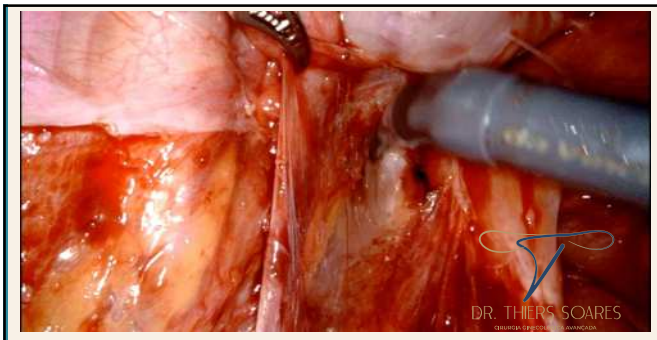
Journal of Minimally Invasive Gynecology 15 (2008) S1e S159

5

Step-by-Step (Posterior/Lateral Compartment)

- Sigmoid Mobilization
- Ureterolysis
- Medial Pararectal Space (Okobayash)
- Hypogastric Nerve
- Lateral Pararectal Space (Latzko)
- Paravesical Space (Yabuki)

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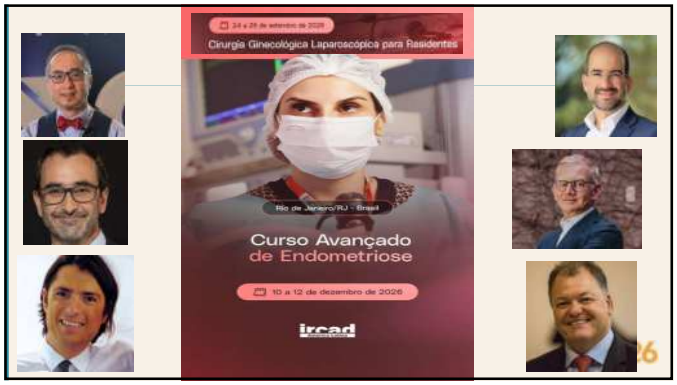


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Take Home Message

- Use preserved anatomical landmarks and retroperitoneal dissection to restore anatomical orientation.
- Apply systematic adhesiolysis techniques to minimize bowel, urinary tract, vascular, and nerve injury.
- Define anatomical and functional limits of dissection and recognize when to modify the surgical strategy or seek additional expertise.
- Recognize intraoperative injuries and outline appropriate management strategies.

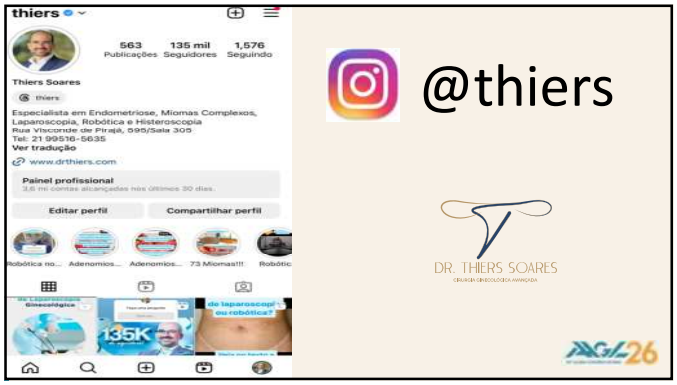
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Cirurgia Ginecológica Laparoscópica para Residentes
Curso Avançado
de Endometriose
ircad

13


Advanced Techniques
in Deeply Infiltrative
Endometriosis Excision Surgery
Nov 18 and 19, 2026
AdventHealth Nicholson Center, Celebration, FL
AdventHealth
This advanced cadaver-based course offers an immersive, hands-on experience focused on the surgical management of deep infiltrating endometriosis (DIE). Participants will engage in guided dissections that emphasize retroperitoneal anatomy, nerve-sparing techniques, and multidisciplinary surgical approaches.
Key components of the course include:
Course Directors:
Aileen Caceres, MD, MPH, FACOG
Thiers Soares, MD
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15



The Hostile Pelvis Playbook:

Expect the Unexpected Before You Scrub In

Juan Diego Villegas-Echeverri, MD, FRCPI, PPSD
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Disclosures

I have no conflict of interest to declare related to this presentation

The best available evidence is evidence is presented

I am part of several BoDs of societies societies related to gynecological surgery and pelvic pain

I am part of a transdisciplinary group group that is dedicated to the diagnosis and management of patients with chronic pelvic pain

Some of the visual resources and graphic aids included in this presentation have been created with the support of generative AI tools

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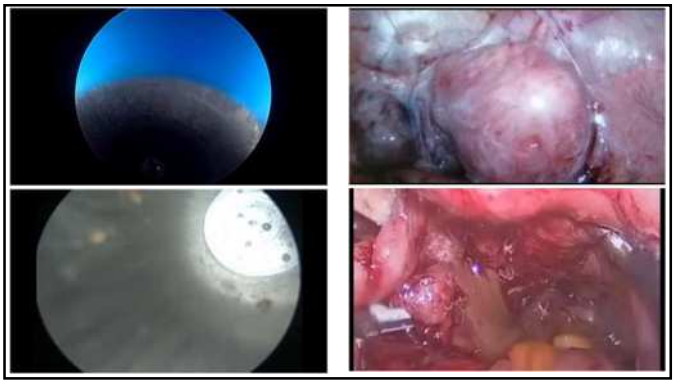


3

How many of you have walked into this without expecting it?

If you didn't suspect it before going in, you failed before you scrubbed.

4



5

The playbook



6

The body count

What happens when you walk in blind

#1

Risk factor for major complications in hysterectomy

ADHESIONS

0.33%

Lower urinary tract injury in benign laparoscopic gynecologic surgery

Rises significantly with adhesions

91%

Of ureteral injuries in gynecologic surgery occur in the distal ureter

. Mooney SS, Gordon H, Karmakar D, Hicks L, Wong A, Harlow K, McNamara HC, Readman E, Ellett L; Mercy MIG Group. What Lies Beneath: Adhesion and Injury Risk in Laparoscopy after Abdominopelvic Surgery. J Minim Invasive Gynecol. 2026 Jul 8:S1553-4650(26)00356-0

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. Luder A, Shvero A, Mashiach R, Dotan ZA, Kleinmann N. Endoscopic management of ureteral injuries arising from gynecologic procedures. BJUI Compass. 2026 Feb 11;7(2):e70160

. Tanaka Y, Otsuka A, Ishii T, Shiki Y. Effect of Endometriosis on Surgical Outcomes of Total Laparoscopic Hysterectomy for Benign Indications: A Propensity Score-Matched Analysis. Asian J Endosc Surg. 2026 Jan-Dec;19(1):e70369

7

Your first surgical instruments

The clipboard and your hands

RED FLAGS — Ask actively

- Prior PID / TOA (treated and forgotten)
- Long-standing IUD without screening
- Prior pelvic surgery (multiple C-sections, appendectomy)
- Known deep endometriosis
- History of peritonitis, diverticulitis, Crohn's
- Chronic pelvic pain



PHYSICAL EXAM

- Fixed uterus on bimanual
- Non-mobile adnexal mass
- Intense cul-de-sac tenderness
- Rectovaginal septum nodularity
- EUA: reduced organ mobility

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8

The sliding sign

Not a luxury — a clinical obligation

Transvaginal sliding bladder sign

Negative sign → adhesions present
Positive sign → severe adhesions unlikely
n = 128 women pre-hysterectomy

Transabdominal sliding sign

Paraumbilical + suprapubic signs
predict dense adhesions accurately
Easy to learn, feasible by non-experts

Multicenter validation (n = 262)

Absent sliding sign significantly associated with confirmed adhesions
p < 0.001 | AUC 0.884
Sensitivity 96% (combined), Specificity 100%

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. Mavibenye M, Buga GAB, Mdaka M, Nanjoh N. Skin scar characteristics in prediction of severe intraperitoneal adhesions in women undergoing repeat caesarean section. S Afr Med J. 2026 Jul 2;116(6):e3175

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9

See it before you cut it

Imaging the hostile pelvis

Dynamic ultrasound

Sliding sign (TV + TA) as covered
Real-time organ mobility assessment
Mapping parietal adhesions before first trocar

Pelvic MRI

Deep endometriosis compartment mapping
Abscess vs. malignancy differentiation
Retrocervical / parametrial extension

CT scan

Acute setting: ruptured TOA, peritonitis
Abscess loculation and accessibility assessment
Guides percutaneous drainage planning

Integration: match modality to clinical question

Adhesion risk → Dynamic US (first line)
Deep extension suspected → MRI
Acute abdomen / drainage planning → CT
Never operate a hostile pelvis without imaging

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10

The best operation might be no operation

Evidence-based management of pelvic abscess in 2026

At a surgery congress, telling you not to operate is provocative.
But the evidence demands it.

65–85%

TOA resolved with IV antibiotics alone

90–100%

Success rate of image-guided drainage

0–3 days

Hospital stay with image-guided drainage

11

Antibiotics first: the boring hero

CDC 2021: Cefoxitin/Cefotetan + Doxycycline ± Metronidazole

TOAST Study — Marshall et al. IJGO 2025

522 admissions for TOA. 86% started on IV antibiotics alone.
Of these, 65% (293/450) resolved successfully without any surgical or radiological intervention.
35% required additional intervention.

81.6%

Success with IV ATB alone
Chan et al. Infect Dis Obstet Gynecol 2019
n = 136, Asian population

~75%

Overall conservative treatment success
SASGOG Clinical Pearl 2025
Failure ~25%

Most TOAs in 2026 will never see an OR — and that's not a failure, that's evidence-based medicine.

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12

Needles beat scalpels

Image-guided drainage as second line

Image-guided drainage

90–100%

0 complications at 6 months
0–3 days hospital stay

Laparoscopic drainage

89–96%

Higher morbidity
5–12 days hospital stay

Antibiotics alone

65–83%

First line — but know when to escalate

95% resolution without salpingo-oophorectomy in PID-related TOA

77–100% success for transvaginal US-guided drainage across literature | PACTOL Trial NCT03819309 (ongoing)

. Goje O, Markwei M, Kollikonda S, Chavan M, Soper DE. Outcomes of Minimally Invasive Management of Tubo-ovarian Abscess: A Systematic Review. J Minim Invasive Gynecol. 2021 Mar;28(3):556-564

13

Who will fail conservative treatment?

An honest answer: we don't really know

Prediction scores — external validation

Fouks Score: AUC 0.63–0.65
(age, WBC, abscess size, bilaterality)

Yongue Score: AUC 0.55
(poor discriminatory ability)

Both perform poorly in external validation

Consistent red flags for ATB failure

- TOA size ≥ 7 cm
- Age > 40 years
- Persistent fever on ATB
- Elevated BMI
- Gardnerella vaginalis infection (OR 6.9)
- Abdominal guarding (OR 3.1)
- Recent abdomino-gyn intervention (OR 5.6)

We cannot reliably predict who will fail. But we CAN identify red flags that raise our vigilance — not our eagerness to operate.

. Marshall A, Wimsett J, Handforth C, Unsworth L, Wilson J, Van Der Merwe AM, Oyston C. The Tubo-ovarian abscess study (TOAST): A single-center retrospective review of predictors of failed medical management. Int J Gynaecol Obstet. 2025 Aug;170(2):927-935
. Baer A, Lia M, Weigerber C, Aktas B, Wolf B. Predicting the Need for Surgery in Tubo-Ovarian Abscess: A Clinical Evaluation and External Validation of Risk Scores. J Minim Invasive Gynecol. 2026 Sep;33(9):1306
. Chan GMF, Fong YF, Ng KL. Tubo-Ovarian Abscesses: Epidemiology and Predictors for Failed Response to Medical Management in an Asian Population. Infect Dis Obstet Gynecol. 2019 Jun 2;2019:4161394
. Fouks Y, Cohen A, Shapira U, Solomon N, Almog B, Levin I. Surgical Intervention in Patients with Tubo-Ovarian Abscess: Clinical Predictors and a Simple Risk Score. J Minim Invasive Gynecol. 2019 Mar-Apr;26(3):535-543
. Yongue G, Mollier J, Anin S, Ibeto L, Ross C, Ayim F, Guha S. Tubo-ovarian abscess: A proposed new scoring system to guide clinical management. Int J Gynaecol Obstet. 2022 Jun;157(3):588-597

14

When surgery becomes non-negotiable

Plan B – you're up!

Ruptured TOA	Diffuse peritonitis, hemodynamic instability — surgical emergency
Failed conservative Tx	No improvement after 48–72h IV antibiotics
Failed image-guided drainage	Persistent or enlarging collection despite drainage
Suspected malignancy	Mandatory differential, especially in postmenopausal patients
Inaccessible anatomy	Multiloculated abscess not amenable to percutaneous/TV drainage

Surgical Indications in the Hostile Inflammatory Pelvis

15

Pick your door

How you enter changes everything

Palmer's point

Left subcostal, midclavicular line
First choice in prior midline/infraumbilical scars
Contraindicated: splenomegaly, upper abd scars

Lee-Huang point

Supraumbilical midline entry
Useful in prior lower abdominal surgery
Requires adequate distance from xiphoid

Open (Hasson) technique

Direct cut-down under vision
Safest in dense periumbilical adhesions
Slower but controlled — no blind step

Optical trocar entry

Visualization of layers during insertion
Requires experience and proper equipment
Not a substitute for adhesion mapping

RULE: Map parietal adhesions with US BEFORE choosing your entry point. Never place the first trocar blind in a hostile pelvis.

16

You don't go to war alone

Building your surgical team

Urology

On standby or scrubbed if ureteral injury risk is high
Ureteral stenting pre- or intra-op if indicated

General surgeon / Colorectal surgery

Essential when bowel adhesions are anticipated
Rectosigmoid involvement in deep endometriosis or TOA

Anesthesiology

Contingency plan: conversion, massive transfusion protocol
Positioning considerations for prolonged cases

Interventional radiology

Preoperative ureteral stenting if planned
Postoperative drainage if needed

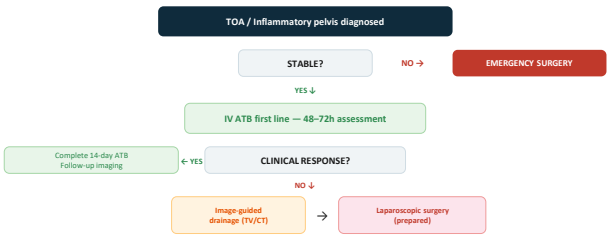
Before you scrub: the briefing

Plan A (primary approach) → Plan B (if anatomy is worse than expected) → Plan C (conversion criteria)
Team briefing is not a luxury — it's a patient safety standard.

17

The decision algorithm

One page, no excuses



18

Navigating the Hostile Pelvis

A Step-by-Step Surgical Framework

01	**ORIENT**	Identify undistorted landmarks: promontory, IP ligament, psoas, iliac vessels
02	**OPEN SPACES**	Develop retroperitoneal avascular spaces: paravesical, pararectal, rectovaginal
03	**FREE URETERS**	Systematic ureterolysis BEFORE central dissection — 91% of injuries are distal
04	**DISSECT SAFELY**	Hydrodissection + blunt dissection. Avoid energy near vital structures until identified
05	**DRAIN & CULTURE**	Controlled drainage, copious lavage, aerobic + anaerobic cultures, check hollow viscera
06	**DECIDE**	Continue? Convert? Drain and re-stage? The best surgeons know when to stop

[VIDEO CASE — Step-by-step surgical narration here]

19

Red flags that change your plan

The cheat sheet you check before you scrub

RED FLAG	ACTION
Prior pelvic surgery	Sliding sign + parietal adhesion mapping + extended surgical planning
Prior PID / TOA	Dynamic preoperative US — assess organ mobility before committing to approach
Known deep endometriosis	Compartment mapping (#ENZIAN) + MRI — anticipate retroperitoneal involvement
Long-standing IUD	High suspicion for subclinical TOA — don't assume sterile field
Age > 40 + TOA	Higher ATB failure risk + rule out malignancy — consider frozen section
TOA ≥ 7 cm	Higher risk of conservative failure — lower threshold for image-guided drainage
Bilateral TOA	Higher risk of conservative failure — plan for potential bilateral salpingo-oophorectomy

FIGO-IPPS "R U MOVVING SOMe" — Chronic pelvic pain post-PID/TOA requires a transdisciplinary approach

. Lamvu G, Villegas-Echeverri JD, Allaire C, As-Sanie S, Carrillo J, Khalil S, Horne AW, Wang A, Munro MG. Developing the FIGO-IPPS "R U MOVVING SOMe" classification system for female chronic pelvic pain. Int J Gynaecol Obstet. 2025 Nov;171(2):550-565

20

The hands and the head

Technical and non-technical competencies
for the hostile pelvis

Your instruments are only as good as the surgeon holding them.
And the surgeon is only as good as the decisions they make under pressure.

21

The hands

Technical skills that keep you out of trouble

Retroperitoneal dissection

The foundation of hostile pelvis surgery. If you can't open the retroperitoneum confidently, you shouldn't be in there.

Ureterolysis

Systematic identification and mobilization. 91% of injuries are distal — know the crossing points and the danger zones.

Energy discipline

No thermal energy near unidentified structures. Cold scissors and blunt dissection until the anatomy is clear. Energy is a privilege, not a default.

Injury recognition & repair

Bladder, ureter, bowel — recognize intraoperatively, not postoperatively. A missed injury at the time of surgery becomes a complication. A recognized one becomes a repair.

These are not advanced skills — they are prerequisite skills. If your training didn't include them, the hostile pelvis is not your learning curve.

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. Fecso AB, Kuzulugil SS, Babaoglu C, Bener AB, Grantcharov TP. Relationship between intraoperative non-technical performance and technical events in bariatric surgery. Br J Surg. 2018 Jul;105(8):1044-1050
. Dick L, Boyle C, Tallentire VR, Norton J, Howie E, Smink DS, Skipworth RJE, Yule S; Surgical Video Grading and Assessment (SVGA) Group. Identifying novel indicators of non-technical skills derived from operative video annotation. Br J Surg. 2026 Mar 4;113(3):znag015.

22

The head

Non-technical skills that actually save lives

Situational awareness

Continuous reassessment of what you see vs. what you expected. When the anatomy doesn't match your mental model, pause — don't push.

Structured communication

Closed-loop communication with the team. Announce critical steps before executing. CRM principles adapted to the OR — not aviation theater, actual safety practice.

Decision-making under pressure

Continue, convert, or stop? The decision must be explicit, verbalized, and documented. Anchoring bias kills — don't commit to finishing just because you started.

Knowing when to stop

Drain and re-stage. Damage control surgery. A planned second-look is not a failure — an unplanned complication from pushing too far is.

The best surgeons are not the ones who can operate through anything.
They are the ones who know when the operation is over before the patient tells them.

. Jung JJ, Borkhoff CM, Jüni P, Grantcharov TP. Non-Technical Skills for Surgeons (NOTSS): Critical appraisal of its measurement properties. Am J Surg. 2018 Nov;216(5):990-997
. Fecso AB, Kuzulugil SS, Babaoglu C, Bener AB, Grantcharov TP. Relationship between intraoperative non-technical performance and technical events in bariatric surgery. Br J Surg. 2018 Jul;105(8):1044-1050
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23

The operation is over.

The case is not.

What you do in the next 72 hours, 14 days, and 6 months
is as important as what you did in the OR.

24

What to watch, when to worry, when to re-intervene

72 hours	14 days	3–6 months
• Clinical response: fever curve, WBC trend, CRP	• Complete IV → oral ATB transition (total 14 days)	• Fertility: AMH, tubal patency if reproductive age
• Drain output if placed — volume, character	• Follow-up imaging: resolution vs. residual collection	• Ovarian function if ovarian surgery performed
• Repeat imaging if no clinical improvement	• Wound assessment if conversion to open	• Recurrence: re-infection, re-accumulation
• Threshold for re-intervention: worsening despite ATB	• Early detection: fistula, ureteral obstruction	• Transition to CPP management if pain persists

When to re-intervene

Persistent/enlarging collection on imaging • New-onset sepsis despite adequate ATB • Suspected ureteral or bowel injury not recognized intra-op • Rising creatinine (ureteral obstruction) • Enteric content in drain (bowel fistula)

. Workowski KA, Bachmann LH, Chan PA, Johnston CM, Muzny CA, Park I, Reno H, Zenilman JM, Bolan GA. Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep. 2021 Jul 23;70(4):1-187

25

Take-home messages

1. The hostile inflammatory pelvis should NEVER be a surprise. History + exam + imaging predict complexity.
2. The sliding sign should be routine preoperative assessment in every patient with adhesion risk factors.
3. Most TOAs in 2026 resolve without surgery. IV antibiotics (65–85%) and image-guided drainage (90–100%) are first and second line.
4. When surgery IS needed: preparation is surgery. Multidisciplinary team planned, not improvised. Entry mapped, not guessed.
5. Retroperitoneal spaces, ureterolysis, energy discipline, Plan A-B-C. Technical competence is prerequisite — knowing when to stop is mastery.
6. The case doesn't end at skin closure. Follow-up is a commitment: fertility, recurrence, chronic pain.
7. **Never walk in without a map.**

26

In the hostile pelvis, the smartest thing
a surgeon can do is not always to operate —
but when you must,
never walk in without a map.

27

Large Benign Tumors and Complex Laparoscopic Hysterectomy

Luis Fernando García MD · TecSalud – Monterrey MX

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

- Speaker for Johnson & Johnson Institute
- CEO & Founder of ProScope Institute

2

How large is too large?



3



4

Defining Large uterus

- **There is no universally accepted definition**
- **≥300 g:** Enlarged uterus
- **≥500 g:** Very enlarged uterus
- **≥1,000 g:** Extremely large uterus
- **Fundus at or above the umbilicus:** Anatomical definition
- **Weight defines size—not necessarily complexity**

Wattiez A, et al. J Am Assoc Gynecol Laparosc. 2002;9:125–130. Uccella S, et al. BJOG. 2021;128:1526–1533.

5

DOES UTERINE SIZE MATTER?

- **Uterine weight increases operative time**
- 235 total laparoscopic hysterectomies
- Median operative time: **140 minutes**
- Positive correlation between uterine weight and operative time
- **r = 0.211; p = 0.002**
- Approximately **2–11 additional minutes per 100 g**
- **The association is significant—but weak**

Flores-Mendoza H, García-Rodríguez LF, Basurt-Díaz D. J Minim Invasive Gynecol. 2015;22(6 Suppl):S88.

6

LARGE VS. NORMAL-SIZE UTERI

Outcome	Uterus ≥500 g	Uterus ≤300 g
Operative time	160 min	108 min
Conversion to laparotomy	0%	0%
Overall complications	14.7%	10.3%
Hospital stay	3.6 days	3.5 days

Uterine size increased operative time—not morbidity

Wattiez A, Soriano D, Fiaccavento A, et al. J Am Assoc Gynecol Laparosc. 2002;9(2):125–130.

7

WHAT ABOUT UTERI >1 KG?

- **Minimally invasive hysterectomy is feasible in selected patients**
- **79** minimally invasive hysterectomies
- Mean uterine weight: **1,522 g**
- Maximum uterine weight: **4,800 g**
- Mean operative time: **201 minutes**
- Conversion to laparotomy: **6.3%**
- Organ injury: **1.2%**
- **Feasibility depends on experience, preparation and patient selection**

Ito TE, Vargas M, Opoku-Anane J, et al. J Minim Invasive Gynecol. 2015

8

> 1 kg: LAPAROSCOPY VS. LAPAROTOMY

Outcome	Laparoscopy	Laparotomy
Operative time	125 min	85 min
Estimated blood loss	150 mL	200 mL
Hospital stay	1 day	3 days
Conversion	7%	—

- 62% discharged within 24 hours
- Comparable complication rates
- 13% required minilaparotomy for specimen extraction

Uccella S, Casarin J, Morosi C, et al. J Minim Invasive Gynecol. 2015

9

Key points to consider

- Uterine size
- Mobility
- US or MRI
- Leiomiosarcoma suspicious
- Equipment
- Port placement
- Strategy for extraction

10

Key points for success

- Diagnosis & surgical plan
- Vascular & bleeding control
- Visualisation & equipment
- Resection & enucleation
- Myometrial reconstruction
- Extraction (myomas or uterus)

Sinha R, Hegde A, Mahajan C, Dubey N, Sundaram M.
Laparoscopic myomectomy: do size, number, and location of the myomas form limiting factors for laparoscopic myomectomy?
J Minim Invasive Gynecol. 2008 May-Jun;15(3):292-30.
Vargas MV, Moawad GN, Sievers C, Opoku-Anane J, Marfori CQ, Tyan P, Robinson JK.
Feasibility, Safety, and Prediction of Complications for Minimally Invasive Myomectomy in Women With Large and Numerous Myomata. J Minim Invasive Gynecol. 2017 Feb;24(2):315-322

11

- OR equipment
  - Optics (0º, 30º)
  - Vessel sealer devices
  - Bleeding prevention
  - Tenaculums
  - Extaction devices
  - Sutures
  - Uterine manipulator
- Pneumoperitoneum & Port placement

12



Poizac, S., Tourette, C., Crochet, P., Sabiani, L., Pivano, A., & Agostini, A. (2019).
Miomectomia laparoscópica. EMC - Ginecología-Obstetricia,
55(1), 1–12. doi:10.1016/s1283-081x(19)41706-2

13



- Wattiez A, Einarsson J, Minimally Invasive Gynecologic Surgery: Evidence-Based Laparoscopic, Hysteroscopic and Robotic Procedures
- Sudhoff Matthew , Chapter 18, Laparoscopic Myomectomy

14

Vascular & bleeding control

- Temporary oclussion of uterine artery
- Vasopressin
- Misoprostol??
- Tranexamic acid
- Others (oxitocine??)

15

- Uterine artery oclussion
- Posterior access



16

- Case 1

- 44 Y, 8 cm fibroid 10 Years before
- Negative past medical or surgical history
- No pregnancy desire
- She accepts definitive treatment

- Last year with heavy menstrual bleeding and noticed a pelvic mass

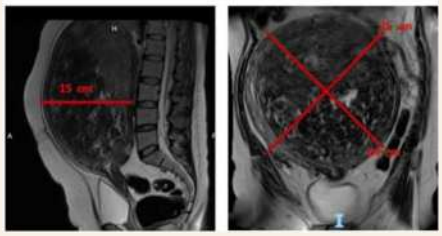
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- Physicall exam
- 30w uterus
- Mobile



18

- MRI: A giant uterine leiomyoma measuring **25 × 24 × 15 cm**, extending into the abdominal cavity, with no evidence of degeneration or suspicious imaging features suggestive of malignancy.



19

What´s your Plan?

- Open hysterectomy
- TLH with contained power morcelation
- TLH with ExCITE



20

- TLH
- Hand Assisted
- Cold Knife morcelation
- MiniLAP



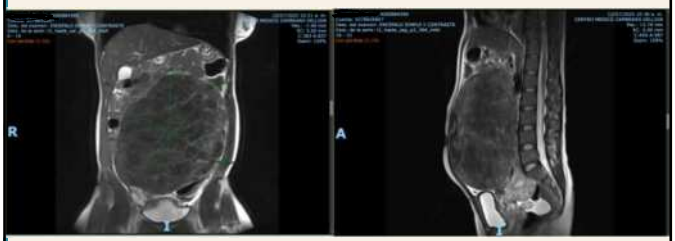
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Applied Medical

22

- 37 Y, G0, abdominal mass, ten years ago



23



24

Case 2

- 47 Y
- G2C2
- Palpable abdomino-pelvic mass, heavy menstrual bleeding
- 2015: fibroid 3.5 cm
- 2023: fibroid 16 x 13 cm

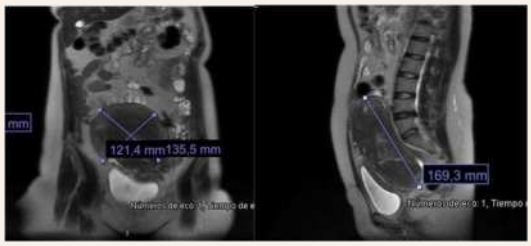
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- 2015



26

- 2023



27

- Plan: ? Open vs MIGS
- Port placement?
- Extraction?

28

- Read the pelvis
- Adapt your routine
- Accesible structures
- Release the fibroid
- Continue as usual



29

- ExCite



30

Case 3

- 42 Y
- G2 P2
- AUB
- 12 cm fibroid

31

- Plan: ? Open vs MIGS
- Port placement?
- Extraction?

32



33

Case 4

- 47 Y
- BMI 22
- G2P2
- 30w uterus
- Heavy menstrual bleeding
- Hgb 7.0 gr
- Negative endomertrial biopsy

34

- Plan: ? Open vs MIGS
- Port placement?
- Extraction?

35

Take home messages…

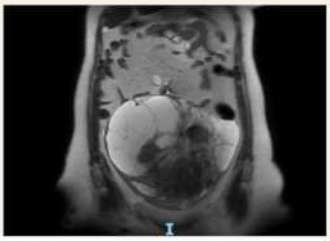
- MIGS in enlarged uterus is feasible
- Surgical plan
- Checklist
- Diagnosis accuracy
- Equipment
- Teamwork
- Informed consent

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#NoalaCirugíaAbierta®



37





Conclusión por imagen:

Extensa masa heterogénea abdominopélvica con volumen aproximado de 2482 mL dependiente del fondo uterino, como primera posibilidad diagnóstica, se considera al leiomioma con degeneración quística/ mixoide, sin embargo no es posible descartar que se trate de un leiomiosarcoma.

38



Save The Date!!!

AAGL + FEMEG
International Congress

September 1 – 4, 2027

Monterrey, México

39

Thank You…



Hospital Zambrano Hellion – TecSalud
Monterrey, México

LUISFGARCIAR

Luis F García MD
TecSalud Professor
FEMEG President 2025-27

40

FMIGS
International
Program

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CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/