Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Bria Johnson: Nothing to disclose; Ciara Sanchez: Nothing to disclose; Kate Woodburn: Nothing to disclose; Cheryl Iglesia: Nothing to disclose.

65 Technique for cost effective cystoscopy following laparoscopic hysterectomy

A. B. McClurg, D. Goodwin, J. Wong, E. Carey
Minimally Invasive Surgery, University of North Carolina, Durham, NC

OBJECTIVE: The objectives of this video are (1) review the incidence of lower urinary tract injury (2) summarize the evidence of cost effectiveness of cystoscopy following hysterectomy and (3) demonstrate a technique for cystoscopy following laparoscopic hysterectomy utilizing only instruments using during hysterectomy without use of a cystoscopy tray.

DESCRIPTION: We demonstrate a technique for post hysterectomy cystoscopy utilizing the 5mm 30-degree laparoscope, suction irrigator, and foley without the use of a cystoscopy tray.

CONCLUSION: The demonstrated technique allows for efficient use of time and resources thereby allowing a cost-effective approach to universal cystoscopy.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Asha B. McClurg: Nothing to disclose; Diamond Goodwin: Nothing to disclose; Jacqueline Wong: Nothing to disclose; Erin Carey: Med IQ, Speaker, Honorarium; Legal Work, Medical Expert Witness Testimony, Honorarium.

66 Laparoscopic cornuostomy for interstitial ectopic pregnancy: a case series and step-by-step demonstration

Y. Youssef[1], H. Warda[2], M. Mamik[3], m. Ahsraf[1], M. Abuzeid[1]
[1]Division of reproductive endocrinology, Department of OBGYN, Hurley Medical Center/Michigan State University, Flint, MI, [2]Division of Female pelvic Medicine and reconstructive surgery, Department of OBGYN, University of California Davis, Sacramento, CA, [3]OBGYN, Mount Sinai School of Medicine, New York, NY

OBJECTIVE: Presenting a case series of IEP managed surgically through laparoscopic cornuostomy, illustration of the technique modification with successful treatment at various gestational age, reviewing the outcomes and the advantages of this surgical technique for IEP.

DESCRIPTION: After appropriate diagnosis using diagnostic ultrasound criteria for interstital ectopic pregnancy, Laparoscopy was performed confirming the diagnosis of IEP lateral to the insertion of the round ligament. Two stay sutures were placed under the ectopic in the first case due to the high risk of hemorrhage. In the following three cases, diluted vasopressin (20 IU diluted in 100 ml of normal saline) was injected circumferentially at the uterotubal junction with no stay sutures required. A linear incision was performed over the most prominent area of the IEP. Hydro-dissection was utilized followed by using a laparoscopic grasper to remove the products of conception. Argon beam coagulation was used to secure hemostasis in the myometrial bed. The Cornuostomy was closed using horizontal mattress sutures followed by continuous running sutures.

The post-operative course was uncomplicated. All patients were discharged on the following day of surgery. The B-hcg levels were followed to non-pregnant levels in all cases. There were no cases of persistent interstitial ectopic pregnancy requiring additional medical methotrexate. Three patients (number 1, 2, 4) had successful subsequent pregnancies and deliveries without any complication. Patient number 3 was lost for follow up.

CONCLUSION: In the presence of an experienced laparoscopic surgeon, laparoscopic cornuostomy is safe and effective in treating IEP even in cases with advanced gestational age.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Youssef Youssef: Nothing to disclose; Hussein Warda: Nothing to disclose; Mamta Mamik: Nothing to disclose; mohamed Ahsraf: Nothing to disclose; Mostafa Abuzeid: Nothing to disclose.

67 Non-communicating rudimentary uterine horn: overview and surgical excision technique

K. A. DelToro[2], J. Cruz[1], M. Stuparich[1], S. Nahas[1], S. Behbehani[1]
[1]Obstetric and Gynecology, University of California-Riverside, Riverside, CA, [2]School of Medicine, University of California-Riverside, Riverside, CA

OBJECTIVE: To present principles and techniques for safe and efficient laparoscopic excision of a rudimentary non-communicating rudimentary horn.

DESCRIPTION: Laparoscopic surgery of a non-communicating rudimentary uterine horn is effective in treating patients with this anomaly. This video will give an overview of a rudimentary uterine horn and review fundamental principles for safe and effective surgical removal of the defect.

A 34-year-old female presents with a history of pelvic pain and endometriosis. She was previously diagnosed with a unicornuate uterus with a non-communicating rudimentary horn. The fundamental principles for safe and effective excision of a non-communicating rudimentary horn include: Accurate diagnosis of rudimentary horn via imaging, hysteroscopy, and laparoscopy. Understanding that Mullerian anomalies have a propensity for pelvic pain and endometriosis, therefore a pelvic survey should be completed. Methylene blue can be helpful to surgeons during rudimentary horn excision because it guides surgeons during the surgery and can notify the surgeon when the uterine cavity has been entered. Methylene blue also helps assess the anatomy and functionality of the fallopian tubes during a Mullerian horn resection. Vasopressin should be considered during uterine horn resection to help minimize blood loss. Identifying the location of the uterine vessels in relation to the uterine horn dissection is essential. Preservation of the uterine vessels is optimal, when possible, especially in women who desire future fertility. Reapproximation of anatomy should be attempted to stabilize anatomy and reduce the risk of ovarian torsion.

CONCLUSION: When performing an excision of a rudimentary horn, a surgeon should remember these operative techniques for a safe and efficient procedure. A rudimentary horn is a lateral fusion defect and can be safely excised if one understands the surgical methods.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Kimberly A. DelToro: Nothing to disclose; Janet Cruz: Nothing to disclose; Mallory Stuparich: Nothing to disclose; Samar Nahas: Medtronic, Speaker, Honorarium; Sadikah Behbehani: Nothing to disclose.

68 Preoperative counseling regarding COVID-19 vaccination

S. Gebrezghi, T. Muffly, C. Schultz, N. Larrea
Department of Obstetrics and Gynecology, Denver Health and Hospital Authority, Denver, CO

OBJECTIVE: The objective of this video is to provide a tool to guide gynecologists in counseling patients about the COVID-19 vaccine. The COVID-19 pandemic has continued to overwhelm health care systems as infection rates rise in the United States as of September 2021. The pandemic reached an inflection point in June 2021 as the Delta variant, a new and more contagious COVID-19 variant, spread while vaccination rates slowed.

DESCRIPTION: In this video, we describe how to use motivational interviewing to address vaccine hesitancy during a preoperative visit. The preoperative visit is an excellent time to review a patient's concerns related to the COVID-19 vaccine. A positive COVID-19 test will delay elective surgery, while COVID-19 infection at the time of surgery increases the risk of postoperative complications, intensive care unit admissions, and mortality. This video demonstrates the use of motivational interviewing during a brief interaction between a physician and a vaccine-hesitant preoperative patient.

CONCLUSION: We both describe and model the techniques outlined by the Centers for Disease Control and Prevention to address a patient's vaccine hesitancy.4 We strongly recommend that all providers counsel their unvaccinated patients about the COVID-19 vaccine during both preoperative and routine gynecologic visits.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Sarah Gebrezghi: Nothing to disclose; Tyler Muffly: Nothing to disclose; Claire Schultz: Nothing to disclose; Nicole Larrea: Nothing to disclose.

69 Laparoscopic myomectomy of a lateral cervical fibroid with temporary uterine artery occlusion

K. McEntee, M. Dahlman
Minimally Invasive Gynecologic Surgery, Virginia Mason Franciscan Health, Seattle, WA

OBJECTIVE: To demonstrate a safe approach to minimally invasive myomectomy near the uterine vessels utilizing temporary uterine artery occlusion

DESCRIPTION: We present the case of a 34 year old P2 female with pelvic pressure, dyspareunia and urinary frequency who was found to have a 5cm left broad ligament fibroid encircling the left uterine isthmus on ultrasound imaging. She desired fertility sparing surgical management given symptoms refractory to hormonal management. Upon laparoscopic survey, the fibroid was at the level of the cervix and isthmus, and the uterine artery was coursing across the anterior surface of fibroid until it turned cephalad and then coursed medially along the fibroid. Given the concern for potential blood loss with inadvertent injury to the vessel, the decision was made for temporary uterine artery occlusion. The pararectal and paravesical spaces were developed. The uterine arteries were isolated at their origin off the hypogastric artery and temporary clips were placed for the duration of the case. The myomectomy was then completed by carefully retracting the uterine vessels and peeling it out of its capsule. There was no significant myometrial defect. After the clips were removed, there was no significant bleeding. The fibroid capsule bed was packed with hemostatic cellulose based product. The fibroid was morcellated in a bag. Estimated blood loss for the case was 100 mL. The patient did well post-operatively and had resolution of her symptoms.

CONCLUSION: Knowledge of retroperitoneal anatomy and skill in retroperitoneal dissection including temporary occlusion of the uterine arteries at their origin can enable safe removal of fibroids located in close proximity to the uterine vessels.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Kelli McEntee: Nothing to disclose; Marisa Dahlman: Nothing to disclose.

70 No endo left behind: a complete excision of endometriosis in the pelvis

P. Katebi Kashi[1,2], E. Welch[3], K. L. Dengler[3]
[1]Gynecology and Obstetrics, Johns Hopkins University School of Medicine, Baltimore, MD, [2]Obstetrics and Gynecology, Inova Fairfax Women's Hospital, Falls Church, VA, [3]Obstetrics and Gynecology, Walter Reed National Military Medical Center, Bethesda, MD

OBJECTIVE: Pelvic endometriosis, a common and sometimes debilitating disease, can be classified into three categories: peritoneal endometriosis, ovarian cyst or endometrioma, and deep endometriosis. We demonstrate advanced surgical techniques for excision of varying presentations of endometriosis.

DESCRIPTION: Peritoneal endometriosis infiltrates the parietal peritoneum but does not erode into underlying tissue. The extent of excision is determined by lesion number, size, location, and degree of infiltration. We utilize an endometriotic surgical approach, also known as a medial-to-lateral approach, with entry into the retroperitoneum medial to the infundibulopelvic (IP) ligament for safe and complete excision of the endometriosis without injury to pelvic sidewall structures. Factors to be considered with endometrioma excision include the number and size of cysts, ovarian tissue involvement, and patient age and fertility desires. We highlight traction-countertraction techniques with and without cyst rupture facilitating complete excision of cyst components, which is critical to decrease reformation. Deep endometriosis is defined as endometriotic infiltration greater than 5 millimeters in depth. Common surgical findings include fibrosis, adhesions, distortion of anatomic structures, and reduced tissue elasticity. We utilize an oncologic, or lateral-to-medial approach, gaining access to the retroperitoneum lateral to the IP ligament. Identification of the external iliac vessels and ureter allows for safe access to the retroperitoneum and endometriosis excision without injury to the bowel or bladder. We also demonstrate excision of endometriosis infiltrating the sigmoid colon with a linear stapler.

CONCLUSION: Surgical excision of endometriosis can be challenging for even the experienced surgeon. Utilizing both endometriotic and oncologic surgical approaches ensures safe, efficient, and reproducible techniques, with no endo left behind.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Payam Katebi Kashi: Nothing to disclose; Eva Welch: Nothing to disclose; Katherine L. Dengler: Nothing to disclose.

71 Multidisciplinary minimally-invasive approach to complex vesicovaginal fistula repair

J. K. Beausang[1], R. Gor[2], S. T. Mama[1]
[1]Obstetrics and Gynecology, Cooper University Hospital, Glenside, PA, [2]Urology, Cooper University Hospital, Camden, NJ

OBJECTIVE: This video's objectives are to demonstrate the techniques and decision process used in the approach to a complex vesicovaginal fistula resulting from obstetric injury, after previous attempts at repair had failed.

DESCRIPTION: Our patient was referred from an outside institution to us. At emergent cesarean delivery at 24 weeks, hemoperitoneum, uterine rupture, and placenta percreta were found. During hysterectomy, the right ureter was ligated and the posterior wall of the bladder sustained large cystotomies. Urology repaired the injury,