A-071

# Am I pregnant or am I having cancer? Confusion between pregnancy, miscarriage, cervical cancer & endometrial cancer in the same patient

**Ahmad Shuib Yahaya[1,2], Anuradha Suberamaniam[1], Subashini Selvaratnam[1], Ain Nur Waheeda Abdul Aziz[1], Vigneswaran Ramakrishnan[1]**

[1]Department of Obstetrics & Gynaecology, Hospital Tengku Ampuan Rahimah, Klang, [2]Faculty of Medicine & Health Sciences, Universiti Putra Malaysia

**ABSTRACT**

**Introduction:** Diagnosis of a gynaecological malignancy can be challenging, and sometimes multiple other diagnosis preceded the definitive one. **Case Description:** A 36-year-old nulliparous lady, suspected to be pregnant after incidental finding of "intrauterine gestational sac" during ultrasound of renal system done to investigate for the cause of hypertension. Pregnancy test was not done. She was known to have PCOS and has been having oligomenorrhoea for the past one year. Ultrasound revealed a rounded hypoechoic fluid-echogenicity inside the uterine cavity sized 4 x 3 cm with small elongated hyperechoic mass at the bottom, which was measured as CRL of 11 mm. No "fetal heart activity" was observed, so she was diagnosed with missed miscarriage & subjected to suction & curettage. However, during the procedure, it was found that she has bulky cervix, with growth towards the centre and the cervical os was not identified. The impression was changed to cervical cancer and biopsy was done, revealed adenocarcinoma with positive Vimentin and negative for P16 on immunohistochemistry. Patient was then subjected for dilatation & curettage by a gynae-oncologist and it was performed under ultrasound guidance. "POC" and endometrial tissue histopathological examination confirmed there was no POC and the tissue favour endometrioid adenocarcinoma. CT scan showed enlarged pelvic nodes apart from intrauterine tumour with cervical involvement and the current diagnosis is endometrioid adenocarcinoma of endometrium, stage 3c. She is currently undergoing neoadjuvant chemotherapy, carboplatin & paclitaxel 3-weekly regime while waiting for debulking surgery. **Discussion:** Thorough clinical history and examination with complement of radiological and pathological assessment is important to reach the final diagnosis.

A-072

# Laparoscopy sacrocolpopexy: Step-by-step

**Suriani binti idris[1], Bahiyah Abdullah[1], Ida Lilywati Md Latar[2]**

[1]Department of Obstetrics & Gynaecology, Faculty of Medicine, University Technology MARA, Sungai Buloh, Selangor, Malaysia, [2]Department of Obstetrics & Gynaecology, Pantai Hospital Cheras, Cheras, Selangor, Malaysia

**ABSTRACT**

**Introduction:** Laparoscopy sacrocolpopexy (LSC) is currently a gold-standard surgery for vaginal vault prolapse. Although this surgery is established worldwide, it remains relatively new in Malaysia. Benefits of LSC include a remarkably lesser recurrence rate than native tissue repair surgeries. The laparoscopic approach is also associated with lesser intraoperative blood loss, shorter hospital stays, and faster recovery than an open technique. **Objectives:** To demonstrate the surgical procedure of LSC step-by-step to simplify a complex surgery. **Methods:** This video presentation demonstrates the surgical steps during LSC. The patient is positioned in a supine Trendelenburg position. Then, introduce the primary and secondary ports, and ensure a good exposure of the surgical field. Subsequently, the steps of LSC are as the following: 1) Dissect the sacral promontory to expose the anterior longitudinal ligament, 2) open the retroperitoneal space and dissect both pararectal space, 3) subtotal hysterectomy (in a patient with uterus in-situ), 4) posterior dissection to expose bilateral levator ani muscle (LAM), 5) suturing the posterior mesh onto the LAM, 6) dissect the bladder away from the anterior vaginal wall, 7) suturing the anterior mesh, 8) unification of both meshes and attach it on the cervical stump, 9) close the pelvic peritoneum, and 10) suturing the cephalic end of the mesh onto the anterior longitudinal ligament. Finally, close the peritoneum to ensure all part of the mesh is covered completely to avoid contact with the bowel. **Conclusions:** Understanding a complex surgery is easier by breaking the whole process into a step-by-step approach.