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Research Article

# THE POSSIBILITY AND VIABILITY OF LAPAROSCOPIC THE BOARD OF CONFUSIONS WITHOUT TRANSFORMATION TO LAPAROTOMY IN GYNECOLOGIC LAPAROSCOPIC SURGERY

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**Abstract:**

**Aim:** To assess the possibility and viability of laparoscopic the board of confusions without transformation to laparotomy in gynecologic laparoscopic surgery.

**Methods:** We examined significant intricacies during gynecologic laparoscopic medical procedure. In view of patients' clinical records, we detailed sorts of laparoscopic medical procedure, kinds of entanglement, early acknowledgment of inconveniences, furthermore, treatment strategy for complexities. Our current research was conducted at Mayo Hospital, Lahore from May 2019 to April 2020.

**Results:** Overall, 34 (2.25%) mix-ups occurred in this survey. There were 18 (0.67%) bladder injuries, 6 (0.22%) significant vessel injuries, 4 (0.13%) interior injuries, 3 (0.11%) ureteral injuries, 2 (0.07%) diaphragmatic injuries, and 1 (0.06%) unfamiliar intravesical body. In total, 32 of the 6 injuries were effectively repaired by laparoscopy. In one case, the rectal hole occurred on the third day after the medical procedure; Hartmann's activity followed by colostomy inversion was performed.

**Conclusion:** Laparoscopic the board of intricacies in gynecologic laparoscopic medical procedure is achievable and productive.

**Keywords:** viability of laparoscopic, transformation to laparotomy, gynecologic laparoscopic surgery.

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**INTRODUCTION:**

Thanks to the experience gained and the improvement of instruments, laparoscopic strategies are currently applied in most gynecological medical procedures, including gynecological risks, which were previously considered contraindicated [1]. The overall frequency of complexities identified in a laparoscopic medical procedure has decreased with advances in laparoscopic instruments and the accumulation of careful experience [2]. Nevertheless, the strategies progressively implemented, for example the gynecological threat by laparoscopy, fundamentally potentiate the danger of difficulties [3]. The danger of major complexities, e.g. bladder, ureter, bowel and major vessel injuries has increased; some injuries can be fatal. This is why it is important to recognize difficulties early and manage them safely and productively. Some examinations have revealed complexities during a medical procedure by laparoscopy and the performance of complexities by laparotomy [4]. However, there are not many examinations that focus on the difficulties of laparoscopic management. The reason for this study was to evaluate the accessibility and viability of laparoscopic frames for complexities during a gynecologic medical procedure by laparoscopy [5].

**METHODOLOGY:**

All activities were performed by a group of similarly attentive laparoscopic masters. Preoperative bowel preparation with Fleet Phospho-pop was performed most of the time. Bladder catheterization before

pneumoperitoneum with direct addition of trocar was performed. Our current research was conducted at Mayo Hospital, Lahore from May 2019 to April 2020. The framework of the port was based on a 4 trocar technique [9]. Between 2 and 4 trocars were used during the laparoscopic medical procedure as indicated by the type or unpredictability of the medical procedure. At the time when the inconvenience occurred, 4 trocars were used in addition in one case; for this exceptional case where a lesion of the left regular iliac vein occurred due to the coordinated addition of trocars, 7 trocars were used. This review explored the significant inconveniences that occurred during the laparoscopic medical procedure by examining the clinical records. Among these, significant complexities requiring repair were analyzed with respect to the type of medical procedure, type of entanglement, early recognition of complexity, and treatment strategy for complexity. As indicated by the type of laparoscopic technique, the medical procedures were characterized in 4 groups: symptomatic laparoscopy (n 5 12), minor laparoscopic medical procedure (n 5 25), major laparoscopic medical procedure (n 5 983) and progressive laparoscopic medical procedure. The danger of difficulty was assessed by the gathering. Estimated values were entered as a middle (range) and all measurements were dissected using programming. The precise Fisher test was used for the measurable investigations. The results were considered to be huge with an estimate of less than 0.06.

**Table 1:**

	Complication (%)	No complication (%)
Prior history of laparotomy	5.4	94.6
No prior history	2.6	97.3

$p = 0.31$  (95% confidence interval:  $-0.01$ – $+0.07$ )

**RESULTS:**

During this 60-month period, 2,668 laparoscopic gynecological medical procedures were performed. The average patient age was 41 years (range 11 to 90 years). In this survey, 97.9% of the patients had a place with major or progressive laparoscopic gatherings. In general, (33/2669, 1.25%) major tangles occurred.

Laparoscopically assisted vaginal hysterectomy was the best known strategy (1178/2668, 45.17%). All confusions occurred at major laparoscopic gatherings or again progressively. Nineteen (58.59%) of the 36 complications occurred in patients who had undergone medical intervention in the stomach, including cesarean section, myomectomy, bowel resection, tubal

anastomosis, appendectomy and, in addition, salpingectomy. Table 1 shows the recurrence of discomfort according to the type of laparoscopic medical procedure. In particular, among patients who underwent a laparoscopic medical procedure for gynecological injury, the rate of complexity was 9.69% (13 out of 150), which was essentially higher than the rate of general entanglement ( $p, .002$ ). Of these 33 complexities, 31 cases were seen intraoperatively and treated immediately without laparotomy. In any case, 3 cases were not seen during a medical procedure: a ureterovaginal fistula, an

intravesical foreign body and a bowel injury. Table 2 shows the rate of inconvenience by type of difficulty. Bladder injuries were the most commonly known entanglements. Bladder injuries occurred in 18 cases (0.67%): fifteen in the case of LAVH and three in the case of a revolutionary laparoscopic vaginal hysterectomy. Of the patients with bladder injuries, 10 (56.57%) had a history of Caesarean section and indicated verified attachments between the bladder and the lower uterus. All bladder wounds were detected promptly during the medical procedure.

**Table 2:**

2003–2005	853 (29.2)
2006–2008	750 (26)
2009–2012	669 (23.2)
Level of technical difficulty [n (%)]	
Simple	1074 (37.20)
Tubal ligation	887 (30.70)
Diagnostic laparoscopy	157 (5.40)
Laparoscopy and biopsy	16 (0.60)
Coagulation	14 (0.50)
Moderate	1564 (54.20)
Unilateral adnexectomy	298 (10.30)
Bilateral adnexectomy	151 (5.20)
Salpingectomy	294 (10.20)
Cystectomy	754 (26.10)
Tubal plasty	6 (0.20)
Adhesiolysis	41 (1.40)
Ovarian drilling	5 (0.20)
IUD <sup>a</sup> removal	15 (0.50)

### DISCUSSION:

As the points of interest, for example, decreased agony, elegant impact, and faster contrast recovery and laparotomy are generally perceived, laparoscopy is currently used in diseases generally gynecological, including the threat [6]. Nevertheless, despite increasing improvements in laparoscopic instruments and strategies, laparoscopic complexities are still encountered. This is due, to a limited extent, to the fact that the unpredictability of the systems to be used by laparoscopy has developed [7]. Hence, interest in administration and the fight against difficulties is growing. The rate of complexity of the laparoscopic medical procedure varies from 0.4% to 10.4%. The extraordinary variety of confusion rates associated with laparoscopic techniques may be the result of the distinction between the multifaceted nature of the operations and the experience of the specialists, both of which are known to be a critical factor in the rate of

difficulty [8]. One survey revealed that the rate of complexity was significantly higher in advanced laparoscopic methods. In this review, 32 inconveniences occurred in advanced laparoscopic methodology [9]. The difficulty rate was generally 1.26%, and the confusion rate reached 7.69% in cases of threatening gynecological diseases, confirming that the difficulty rate is essentially higher in more advanced laparoscopic systems. In addition, the mastery and encounters of the specialist influence the rate of complexity and the outcome of complexities [10].

### CONCLUSION:

Thanks to the involvement of all stakeholders in the laparoscopic medical procedure, complexities can be fixed safely and viably by laparoscopy without changing the laparotomy. Laparoscopic specialists must practice laparoscopic skills and gain experience

that incorporates laparoscopic suturing methods; in addition, they must understand conservative living structures.

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