Laparoscopic Suturing: Practical Tips for Needle Management, Knot Tying and Suture Use (Simulation Lab)

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Professional Education Information

Target Audience
Educational activities are developed to meet the needs of surgical gynecologists in practice and in training, as well as, other allied healthcare professionals in the field of gynecology.

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Laparoscopic Suturing: Practical Tips for Needle Management, Knot Tying and Suture Use (Simulation Lab)

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Course Description

This workshop provides an overview of laparoscopic suturing and knot tying techniques, which will include both intracorporeal and extracorporeal knots. The course will offer hands-on suturing simulation where experienced faculty will actively guide participants through the training steps. Various applications for different suture materials and technologies utilized in gynecologic laparoscopy will also be reviewed. The course is designed for gynecologists in practice who want to develop or improve their suturing skills for immediate application in their surgical practice.

Course Objectives

At the conclusion of this course, the participant will be able to: 1) Manipulate and load a needle laparoscopically for tissue reapproximation; 2) perform extracorporeal knots; 3) perform intracorporeal knots; 4) outline the advantages, disadvantages, and clinical applications for extracorporeal versus intracorporeal knots; 5) distinguish advantages and disadvantages of various suture materials, including barbed suture; and 6) distinguish advantages and disadvantages of suturing technologies used in laparoscopy.

Course Outline (SAME for AM and PM sessions)

1:30 Welcome, Introductions and Course Overview  A. Cholkeri-Singh
1:35 Port Placement, Needle Loading and Tissue Re-approximation  A. Cholkeri-Singh
1:50 Hands-on Training – Needle Loading and Needle Manipulation  All Faculty
2:30 Extracorporeal Knot Tying  A. Cholkeri-Singh
2:45 Hands-on Training – Extracorporeal Knot Tying  All Faculty
3:15 Questions & Answers  All Faculty
3:25 Break
3:40 Intracorporeal Knot Tying  H.C. Hur
3:55 Hands-on Training – Intracorporeal Knot Tying  All Faculty
4:35  Suture Selection and Technologies Used in Gynecologic Laparoscopy  K.C. Wang
4:50  Hands-on Training – Barbed Suture and Suturing Devices  All Faculty
5:20  Questions & Answers  All Faculty
5:30  Course Evaluation
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
Art Arellano, Professional Education Manager, AAGL*
Viviane F. Connor
Consultant: Conceptus Incorporated
Frank D. Loffer, Executive Vice President/Medical Director, AAGL*
Linda Michels, Executive Director, AAGL*
Jonathan Solnik
Other: Lecturer - Olympus, Lecturer - Karl Storz Endoscopy-America

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The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Larry R. Glazerman
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Mark R. Hoffman*  
Jian Qun (Kathy) Huang  
Speaker’s Bureau: Intuitive Surgical  
Joseph L. Hudgens  
Consultant: Karl Storz Endoscopy-America  
Gretchen E.H. Makai  
Other: Honorarium - Intuitive Surgical  
Nash S. Moawad*  
Angela M. Pratt*  
Sangeeta Senapati*  
Jessica A. Shepherd*  
Matthew T. Siedhoff*  
Karen C. Wang*  

Asterisk (*) denotes no financial relationships to disclose.
Port Placement, Needle Loading, & Tissue Re-approximation

Jay L. Hudgens, M.D.
Center for Women’s Health
Owensboro, KY
Gutta Faculty University of Louisville
Department of Obstetrics, Gynecology, & Women’s Health

Presented by:
Aarathi Cholkeri-Singh, M.D., FACOG

Disclosures
Jay Hudgens, M.D.
Aarathi Cholkeri-Singh, M.D., FACOG
We have no financial relationships to disclose

Objectives
1. Present the different port placements used in laparoscopic suturing
2. Present a system for setting the needle
3. Discuss strategies for tissue re-approximation

System
1. Set the Needle
2. Reapproximate
3. Knot Tying

Ipsilateral
- Ergonomics
- Assistant
- One Sided
Contralateral

- Ideal Triangulation
- Poor Ergonomics?
- No Assistant

Suprapubic

- Gravity
- Ergonomics?
- Two Sided

Needle Holders

- Straight
- Curved
  - For desired needle angles $>135^\circ$
- Self-Righting
- Endo Wrist Articulating
  - Hand-held
  - Da Vinci Robot

Straight Needle Holder

Curved Needle Holder

Self-Righting Needle Holder
Endowrist Needle Holder

System
1. Set the Needle
2. Re-approximate
3. Knot Tying

System
• Set (perpendicular)
• Parallel (tissue)
• Rotate (key)
• Reset

Needle Entry
• Direct-trocar
• Backloaded
• Abdominal Wall

Setting the Needle

Setting the Needle
A-B-C

“A” = 2cm from Swedge
“B” = 1/3 from Point
“C” = 1/3 from Swedge

Laparoscopic
Robotic

Tie Knot
What is the most important factor in reproducible tissue re-approximation?

A. Port placement.
B. Understanding the relationship between the tissue, camera, and ports.
C. Use of mechanical suturing device to improve efficiency and accuracy.
D. The type of suture and needle used.
E. Not applicable to my practice.

References


Disclosures

- I have no financial relationships to disclose.

Objectives

- Review principles of knot security
- Overview of applications of Extracorporeal Knots
- Understand Extracorporeal Knot tying technique
- Extracorporeal knot troubleshooting
- Video demonstrations of extracorporeal knot use in gynecologic surgery

“... an unreliable suture knot can spoil the outcomes of an otherwise beautifully performed surgical procedure.”

- unknown author

Principles of Knot Security

1. Type of Suture
2. Type of Knot
3. Surgical Technique
4. Length of cut end

GOAL = tissue is approximated and secured

Suture Material

- Natural vs. Synthetic
  - Natural i.e. Chromic
    - Tissue fluids alter ability to hold knot
  - Synthetic
    - Multifilament
      - Lay flat more readily secondary to less memory
    - Monofilament
      - Less tissue inflammation
      - Slippage and weaken from surgical instruments

Friction is greater for braided multifilament than monofilament suture
**Suture Length**

- Single-use suture, minimum length of suture should be 27 inches (70 cm) – standard length
- Multiple-use or purse-string suture, recommend length of suture to be minimum 48 inches (122 cm)

---

**Laparoscopic Knots**

  - 1 surgeon, 7 types of knots
  - 140 knots conventional vs. 140 knots laparoscopic
  - 2-0 braided polyester
  - 4-6 throws
  - Knots measured for breaks using tensiometer and knot slips >3mm

---

**Laparoscopic Knots**

<table>
<thead>
<tr>
<th>Type of knot</th>
<th>Intracorporeal</th>
<th>Extracorporeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sliding knot</td>
<td>Coefficient of friction not equally distributed between suture ends</td>
<td>Each end of suture enters and leaves knot in opposite direction</td>
</tr>
<tr>
<td>Sliding knot</td>
<td>One axial strand is held under tension as the other ties around it</td>
<td></td>
</tr>
</tbody>
</table>

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**Laparoscopic Knots**

- Goldenberg et al, *JSLS* 2009
  - 3 surgeons, 100 knots, 2-0 silk, 4 throws measured for knot slips and breaks using tensiometer
  - Extracorporeal square knots vs. Intracorporeal square-square vs. Intracorporeal flat-square
Robot-assisted Laparoscopic Knots

- Larger variability in the strength of the knots made using the robot, which corresponded to higher percentage of unraveling knots.

Extracorporeal Knots

- Decrease operative time
- Easy to perform
- Quicker to tie than intracorporeal knots
- Tensile strength comparable to intracorporeal knots

Applications

- General GYN
  - Ovarian reconstruction
  - Vaginal cuff closure
  - Cervical stump closure
  - Myomectomy
  - In lieu of additional port and grasper
- Repairs
  - Bladder
  - Bowel
  - Uterine Perforation
- UroGyn
  - Sacrococcygeal/Sacroventerotomy
  - Paravaginal defect repair
  - Burch
  - McCall’s Culdoplasty
- REI
  - Cuff tuboplasty
  - Tubal Reanastomosis

Surgical Technique of Extracorporeal Knots

1. Interrupted or purse-string stitch placed in tissue
2. Both ends of suture outside of laparoscopic port
3. Knot formed outside of abdominal cavity
4. Laparoscopic knot pusher mounted adjacent to knot
5. Tension placed on both ends of suture as laparoscopic knot pusher cinches down and secures each knot to tissue
6. Release knot pusher from suture
7. Repeat throws (steps 2-6)

Laparoscopic Knot Pushers
Extracorporeal Knot

Suture Tail
- Cutting tail of knot too short compromises knot integrity as it can easily unravel

Extracorporeal Knot Video

Suture too short
- Needle through 5 mm port
- Suture twisting
- Open knot pusher released early
Laparoscopic Babcock

Applications of Extracorporeal Knots

Vaginal Cuff Repair

Uterosacral Suspension

Ovarian Reconstruction

Oophoropexy
Question

A 34-year-old woman who desires pregnancy has had 18 months without conception. She has been found to have a right hydrosalpinx and is opting to undergo laparoscopic tuboplasty for treatment. Upon insertion of the uterine manipulator, the uterine fundus is perforated and actively bleeding.

What is the best step in maintaining hemostasis at the site of the uterine perforation?

A. Dessicate the area
B. Place surgical hemostatic agent
C. Place an interrupted suture
D. No treatment necessary
E. Not applicable to my area of practice

Correct Answer: C
Intracorporeal Knot Tying

Hye-Chun Hur, MD
Beth Israel Deaconess Medical Center
Director, Minimally Invasive Gynecologic Surgery
Assistant Professor, Harvard Medical School

Objectives

- Indications for intracorporeal knot tying
- Basic equipment
- Technique
  - breakdown of steps
  - helpful tips
  - video demo

Indications

**General:**
- any indication for extracorporeal knot tying can be applied to intracorporeal knot tying
- vaginal cuff closure
- laparoscopic myomectomy
- oophoropexy
- suturing for retraction (e.g. ovary, bowel, uterus)

**Specific:**
- more delicate suturing, tying knots off tension
- bowel repair
- bladder repair
- parietal peritoneal closures (e.g. sacrocolpopexy)

Equipment

- Laparoscopic Needle Driver (curved, locking)
- Laparoscopic Needle Grasper (straight)
- Laparoscopic Scissors
- Suture, cut 6-8 inches (interrupted vs figure of eight sutures)
- 10 mm trocar (direct delivery of needle)
- 5 mm trocar (back load needle)

Disclosures

I have no financial relationships to disclose.
Breakdown of Steps

1. Select appropriate trocar size for needle delivery.
2. Cut suture in advance.
   • Interrupted suture → 6 inches
   • Figure of eight suture → 8 inches
   • Continuous running suture → 12 inches
3. Place suture.
4. Throw 4-6 square knots (opposite direction).
   • Vicryl → 4 throws
   • PDS → 6 throws
5. Cut suture, remove needle under direct visualization.

Important Tips

- Leave free end (tail) short
- Keep heel of needle in-line with needle grasper
- Pull ends so the free end stays short

Tips: Intracorporeal Knot Tying

1. Select appropriate trocar size for needle delivery
2. Cut suture in advance (6-8 inches)
3. Place suture (use locking needle driver)
   TIP: Leave free end (tail) short
4. Throw 4-6 square knots (opposite direction)
   TIP: Keep heel of needle in-line with needle grasper
   TIP: Pull ends so the free end stays short
5. Cut suture and remove needle under direct visualization

Take Home Points

Think ahead
• select appropriate trocar size (10 vs 5mm)
• cut suture in advance (6-8 inches)

Suturing & Intracorporeal Knot Tying
• Leave free end (tail) short
• Keep heel of needle in-line with needle grasper
• Pull ends so the free end stays short
Conclusion

If you can do an instrument tie, you can do intracorporeal knot tying.

Laparoscopic suturing and intracorporeal knot tying is a skill that anyone can learn and master in the dry lab setting.

Questions?

Continuous Running Suture
Alternative Suture and Technologies used in Gynecologic Laparoscopy

Karen C. Wang, MD
Associate Director MIGS, Fellowship Director
Brigham and Women's Hospital
Instructor, Harvard Medical School
AAGL November 6, 2012

Objectives
- Introduce alternative suture material and devices utilized in gynecologic laparoscopic surgery
- Demonstrate utility of these alternatives to facilitate laparoscopic suturing

Laparoscopic suturing
- Technically challenging
- Diminished tactile feedback
- Lack of depth perception
- Tremor amplification
- Limited instrument mobility

Solution?
- Barbed suture
- Automated suturing devices

Barbed Suture
- Quill™
  FDA approved 2004
  Initially used by Plastics
- V Loc™
  FDA approved 2009

Disclosures
- I have no financial relationships to disclose.
**Quill™**
- Angiotech
- Bidirectional
- Helical pattern
- Anchors every 1mm

**V Loc™ 90 and 180**
- Covidien
- Unidirectional barbed suture
- 20 barbs/cm
- Spiral configuration of barbs

**Advantages of Barbed Suture**
- No knot tying required
- Equally distributed tension throughout suture
- Enables continuous suturing without backsliding
- Provides hemostatic closure of myometrium during myomectomy

**V-Loc™ vs continuous suture in lsc myomectomy**
- N = 19
- Solitary intramural fibroids 3-5 cm

<table>
<thead>
<tr>
<th></th>
<th>V-loc 90</th>
<th>Conventional</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBL</td>
<td>113.7 ± 74.1 ml</td>
<td>168.6 ± 75.1 ml</td>
<td>0.0076</td>
</tr>
<tr>
<td>Operative time (total)</td>
<td>51 ± 18.1 min</td>
<td>56 ± 17.8 min</td>
<td>0.0616</td>
</tr>
<tr>
<td>Suturing time</td>
<td>9.9 ± 4.3 min</td>
<td>15.8 ± 4.7 min</td>
<td>0.0004</td>
</tr>
</tbody>
</table>

Alessandri et al. 2010 JMIG
Einarsson et al. 2011. JMIG
Angoli et al. 2012. USGO
### Advantages of Barbed Suture

**Does barbed suture reduce the risk of vaginal cuff dehiscence?**
- Retrospective study N = 387, Jan 2007 - Jan 2010
  - 149 Barbed suture vs. 229 with Vicryl or Endostitch
  - Mean time dehiscence 45 days
  - Two layer closure 0-PDO Quill 14 x 14 cm

<table>
<thead>
<tr>
<th>Suture Type</th>
<th>No. Dehiscence</th>
<th>Length of follow-up (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quill (149)</td>
<td>0</td>
<td>96</td>
</tr>
<tr>
<td>Vicryl or Endostitch</td>
<td>10 (4.2%)</td>
<td>281</td>
</tr>
</tbody>
</table>

*Steele et al. 2011. JMG*

### Downside of Barbed Suture

**Does barbed suture increase the risk of adhesion formation?**
- **Unidirectional barbed suture**
  - 13 canine enterotomy model
    - No significant difference in adhesion scores at 21 days

- **Bidirectional barbed suture**
  - 23 non-pregnant ewes
    - Necropsy at 3 months
    - 12 horns (52.2%) with barbed suture-adhesions
    - 10 horns (43.5%) with Vicryl closure-adhesions

*Einarsson et al. 2011 JMG*

**"His" pareunia**
- Limited data
  - 117 TLH, 82 completed questionnaires
  - 5 reported persistent dyspareunia (6.8%) at 6 months post-op
  - 6 reported "his"pareunia (8.2%)

*Einarsson et al. 2010 JSLS*

### Downside of Barbed Suture

**Case report**
- Bowel obstruction after TLH
  - 0-PDO 14 x 14 cm Quill with Lapra Ty
  - Presented POD #30
  - On laparoscopy-tail of left end of barbed suture (4cm) found as cause of point of volvulus

*Donnellan et al. 2011 JMG*

### Quill™ Suturing Video: Myomectomy Closure

### V-Loc™ Suturing Video: Vaginal Cuff Closure
Automated Suture Devices

- **RD 180™ and TK®**
  - LSI Solutions
  - Single use
  - First used for heart valve surgery
  - Vaginal cuff closure

- **Endostitch™**
  - Covidien
  - Single use
  - Vaginal cuff closure

RD 180™ and TK® Video

- **Endostitch™**
  - Covidien
  - Single use
  - Vaginal cuff closure

Endostitch™ Video

- **Comparative study of pyeloplasties and bladder neck suspension**
  - Automated intracorporeal suturing versus conventional suturing

<table>
<thead>
<tr>
<th></th>
<th>Endostitch</th>
<th>Conventional</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stitch placement</td>
<td>43 ± 27 sec</td>
<td>151 ± 24 sec</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Knot tying</td>
<td>74 ± 50 sec</td>
<td>197 ± 70 sec</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

Adams et al. 1995. Urology
Endostitch™ with Barbed Suture

- 0, 2-0, 3-0 V-Loc
- 10, 15, 20 cm lengths

Suture Comparison

<table>
<thead>
<tr>
<th>Suture Name, Size</th>
<th>Type</th>
<th>Absorption Rate</th>
<th>Tensile Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quill Polydioxanone Monofilament</td>
<td>Complete by 180 days</td>
<td>80% at 14 days</td>
<td>80% at 28 days</td>
</tr>
<tr>
<td>V Loc VLoc™ 90 VLoc™ 180 Monofilament</td>
<td>Complete by 110 days</td>
<td>90% at 14 days</td>
<td>90% at 28 days</td>
</tr>
<tr>
<td>RD 180 Strongsorb 2-0 Monofilament</td>
<td>Complete by 110 days</td>
<td>90% at 21 days</td>
<td>90% at 21 days</td>
</tr>
<tr>
<td>Endostitch Polyorb 3-0</td>
<td>Multifilament</td>
<td>Complete 56-70 days</td>
<td>30% at 21 days</td>
</tr>
</tbody>
</table>

Cost $$$

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quill</td>
<td>$20-60</td>
</tr>
<tr>
<td>V-Loc</td>
<td>V-Loc 90 $20 V-Loc 180 $23</td>
</tr>
<tr>
<td>RD 180 + TK</td>
<td>RD 180 $175 each TK Device $150 each 53&quot; suture $32 each Ti Knot clips $35 pack of 12</td>
</tr>
<tr>
<td>Endostitch</td>
<td>Device $140-150 Suture $20-28 V-Loc Suture $57</td>
</tr>
</tbody>
</table>

References

CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

~

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.