

VALTCHEV[®] UTERINE MODEL VUM - 6 MOBILIZER

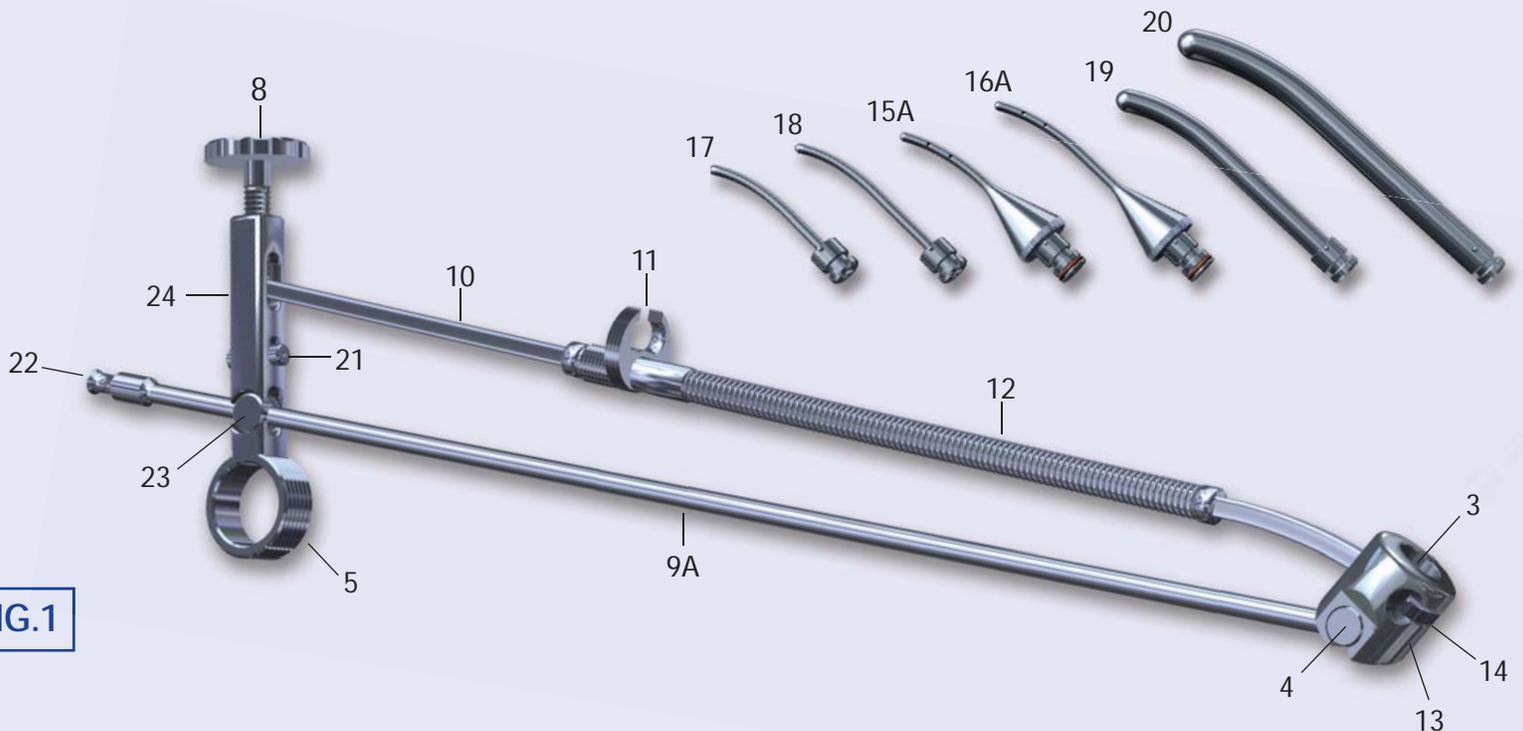


FIG.1

INSTRUCTIONS FOR USE OF THE VALTCHEV[®] UTERINE MOBILIZER, MODEL VUM-6

THE VALTCHEV[®] UTERINE MOBILIZER, MODEL VUM-6 (Fig.1) consists of a body and interchangeable obturators and cannulas.

The body consists of a metal bar (10) and a metal tube (9 A) which pivot the head (13). One end of the tube is attached to a piston (4) and the opposite end is attached to a Luer syringe connector (22). The locking wheel (23) is also attached to the tube. The locking wheel is held in place by a lock (21). The arm space bar (24) permits manipulation of the head. By means of a locking screw (8) on the upper end of the arm space bar (24) the Mobilizer can be locked in the desired position. The finger ring (5) is located at the lower end of the arm spacer bar. The head accommodates, in its cavity (3), an obturator or a cannula locking in place by a lock (14). The four uterine obturators, which are of different lengths and thicknesses are used as follows: No.17 and No.18 are for mobilization of a smaller uterus, No.19 and No.20 are for mobilization of larger uterus.

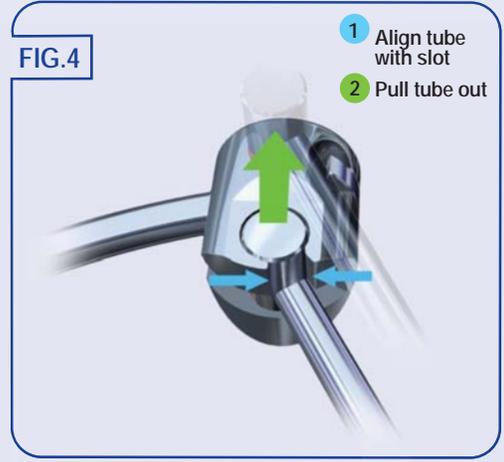
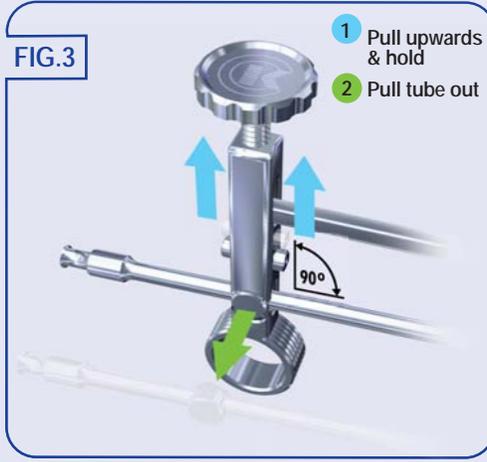
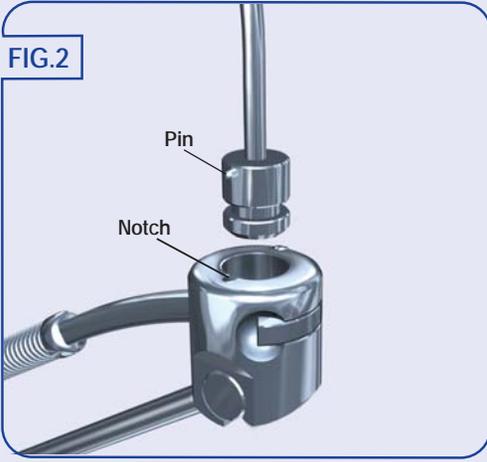
The cannulas: (15A) and (16A) are used for injection of either dye or an X-ray contrast medium. The syringe for injection is attached to the Luer syringe connector (22). The Mobilizer is held in place by a Valtchev[®] tenaculum, supported by a tenaculum holder (11) and held taut by a spring (12).

TECHNIQUE

After the patient has been anaesthetized and prepped, a sterile towel is placed below the buttocks and on the abdomen and the patient is catheterized. A vaginal examination is done to establish the size, position and mobility of the uterus. The surgeon's gloves are changed. A vaginal speculum (with a side opening, which allows removal of the Uterine Mobilizer) is introduced into the vagina. The anterior lip of the cervix is grasped by a Valtchev[®] tenaculum in the horizontal plane with the curved end pointing downward. The uterine cavity is sounded and

measured, and the appropriate uterine obturator or cannula is selected. The selected obturator or cannula is inserted into the cavity of the head (Fig 2). The pin on the obturator or cannula must slip into the notch of the head (Fig 2). This locks the cannula or obturator in place. Then the arm spacer bar is turned forward and the axis of the head is aligned with the bar. The Mobilizer is then locked into position by tightening the locking screw (8).

The surgeon inserts the obturator or cannula carefully into the uterine cavity following the direction of the cervical canal and the uterine cavity. If the uterus is retroverted the Valtchev[®] Mobilizer is rotated around its longitudinal axis to 180 degrees, so that the curve of the uterine obturator or cannula is directed posteriorly. The uterine obturator or cannula is inserted following the cervical canal posteriorly. After the insertion is completed the instrument is gently rotated to its previous position.



With the Uterine Mobilizer held in one hand, the index finger and the thumb of the other hand push the tenaculum holder forward, until it reaches the narrowest part of the tenaculum, and the latter is embraced and held between the hooks of the tenaculum holder. The tenaculum holder is then released; the spring pushes the tenaculum holder back and it holds the tenaculum firmly. The vaginal speculum is removed. The patient is draped. The outside end of the Mobilizer is lifted and kept at or above the level of the symphysis by joining from below the two sterile sheets covering the legs and fastening them with a towel clip. With the Mobilizer in this position, the uterus and adnexa are kept deep in the pelvic cavity reducing the possibility of puncture by the Veres needle or trocar. Then the usual technique for CO2 insufflation is followed.

Once the laparoscope is introduced into the peritoneal cavity the instrument is unlocked by the locking screw (8). Under direct visual control, the surgeon mobilizes the uterus by rotating the arm spacer bar backward and advancing the Mobilizer deeper into the vagina and slightly downward so that the head of the instrument lies in the posterior fornix of the vagina with the uterus in anteversion. The desired angle of the rotation can be maintained by locking the instrument by the locking screw. When the uterus is anteverted, looking through the laparoscope, there is a bulge at the pouch of Douglas. This is due to the pressure exerted by the head of the Mobilizer on the vaginal wall and should not be mistaken for a tumor. Either adnexae can be visualized by turning the Mobilizer to the left or to the right around its longitudinal axis. The uterus can be lifted, pulled, pushed or rotated in any direction in which the uterus can naturally be displaced.

When testing the patency of the fallopian tubes, cannula (15A) or (16A) should be used, depending upon the length of the uterine cavity. To ensure leak proof application of the cannula during the injection of dye, the instrument should be kept in one of two positions. In the first position, the cannula should be straight, parallel to the axis of the instrument. Lock the Mobilizer in this position. The finger rings of the tenaculum should be held with one hand and the Mobilizer gently pushed forward, so that the cone of the cannula is pushed against the external os of the cervix, ensuring a leak proof application. If in this position of the uterus, the tubes cannot be well visualized, the second option is to antevert the uterus to about 90 degrees. Lock the Mobilizer in

this position and release the tenaculum from the tenaculum holder BUT NOT FROM THE CERVIX. Hold the Mobilizer in one hand and lift the Mobilizer up, keeping it in a horizontal position, which again ensures a leak proof application.

When the laparoscopic procedure has been completed, the locking screw has to be released and the instrument should be rotated, so that, the axis of the obturator or cannula can be aligned with the axis of the Mobilizer. The tenaculum has to be released from the tenaculum holder. Then the instrument can be removed from the uterus and the vagina, followed by the removal of the Valtchev® tenaculum. The Valtchev® Uterine Mobilizer is well balanced to facilitate excellent mobilization and make it easier to operate without an assistant.

CARE OF THE MOBILIZER

Immediately after use, remove the obturator or if a cannula was used keep it attached to the instrument. Flush the instrument with warm soapy water. Then flush again with clear warm water. Afterwards the cannula should be detached by releasing the lock (14) Fig1 and the Mobilizer flushed again with clear water. The tube (9A) must also be dismantled and removed from the space bar (24) and from the head (13) Fig.1. This is done in the following way: Release the lock (21), by pulling it away from the tube, and turn the tube so it is at 90° angle with the space bar (24) Fig.3, and lift the tube up. To disengage the tube from the head, rotate the tube toward the head until it is parallel to the slot of the head Fig.4 and pull out the piston from the head. The piston as well as the head can now be easily cleaned with a brush and soapy water and the tube irrigated using a syringe. The whole instrument can be cleaned with a nylon brush and soap, then rinsed thoroughly and dried with a soft cloth. The Mobilizer can be sterilized or autoclaved by following the instructions for each respective method. Sterilization of the Valtchev® Uterine Mobilizer with tray has been certified by Microtest Labs, Procedure MTL 07-05642.

The performance of the Mobilizer will not be affected if a few drops of dye leak out. However, if the leaking is significant, the "O" rings have to be replaced. This can be done by Conkin Surgical Instruments.

PRECAUTIONS

1. The uterine cavity must always be measured and an appropriately sized uterine obturator or cannula selected. If the obturator or cannula is longer than the

uterine cavity, or inserted in the wrong direction, there is danger of uterine perforation.

2. The outside end of the Uterine Mobilizer must be kept at, or above, the level of the symphysis pubis during insertion of the Veres needle and trocar, otherwise the uterus and adnexa can be brought close to the abdominal wall and thus get damaged.

3. Do not attempt uterine mobilization with the Mobilizer without visual control, if the uterus is fixed by adhesions, it may be damaged.

4. If the uterus is retroverted, insert the obturator or cannula with the curve directed posteriorly, following the direction of the cervical canal and uterine cavity. After the insertion is completed, gently rotate the Mobilizer around its longitudinal axis to 180° to bring it to its normal position, and then attach the tenaculum to the Mobilizer.

5. If the obturator (or cannula) is not well locked it can drop out and remain in the vagina or partially in the uterus. It is important to be certain that the cannula or obturator is still attached to the Mobilizer when it is removed from the vagina.

6. The Uterine Mobilizer should be used cautiously, Do not use excessive force in any attempt to correct an abnormal position of the uterus.

SPECIFICATIONS

Base Instrument	length 360mm
Cannula No.15A	length 72mm Shaft thickness 3mm
Cannula No.16A	length 83 mm Shaft thickness 3mm
Obturator No.17	length 45 mm Shaft thickness 3mm
Obturator No.18	length 55mm Shaft thickness 3mm
Obturator No.19	length 80mm Shaft thickness 8mm
Obturator No.20	length 100 mm Shaft thickness 10mm



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