AAGL 3RD INTERNATIONAL CONGRESS ON MINIMALLY INVASIVE GYNECOLOGY

in conjunction with

AUSTRALIAN GYNAECOLOGICAL ENDOSCOPY SOCIETY
XIX ANNUAL SCIENTIFIC MEETING

Sex, Surgery & Gynaecology

PROGRAM & ABSTRACTS

21–23 May 2009
Brisbane Australia

Alan Lam Congress Chair, AGES President
Anusch Yazdani Congress Co-Chair, AGES Treasurer
Chris Maher Congress Scientific Chair, AGES Secretary
Jim Tsaltas AGES Vice President

Resad Pasic AAGL President
Errico Zupi AAGL International Vice President
C Y Liu AAGL Vice President
Franklin Loffer AAGL Executive Vice President

Invited Faculty
A/Professor Dorothy Kammerer-Doak, USA
A/Professor Leah Millheiser, USA
Professor Susan Davis, Australia

20 May 2009
Pre-Congress Workshop
Brisbane Australia

Major Sponsor of AGES

Johnson & Johnson MED CAI

Platinum Sponsor of AGES

stryker

Sex, Surgery & Gynaecology

SPONSORSHIP AND TRADE EXHIBITION

AGES gratefully acknowledges the following companies which have supported the Congress:

stryker®

Platinum Sponsor of AGES

Johnson & Johnson MEDICAL

STORZ KARL STORZ — ENDOSKOPE

Major Sponsors of the Congress

Queensland Government
Queensland Health

Royal Brisbane & Women's Hospital sponsor of the Pre-Congress Workshop

Exhibitors

Baxter Healthcare
B Braun Australia
Covidien
Hologic
Olympus

Invivo Medical Indemnity
Sponsor of Session 8
'Training, Complications and Risk Management'

American Medical Systems
Applied Medical
ConMed Linvatec
Cook Medical Australia
Device Technologies
Fertility Focus
Fisher & Paykel
Gate Healthcare
Genzyme Australasia
Gytech
Hospira
Insightec
InSight Oceania
Investic Experien
Medchem Surgical
Medfin Australia
Medtronic Australasia
N Stenning & Co
Scanmedics
Sonologic
Sydmed

AAGL 3RD INTERNATIONAL CONGRESS ON MINIMALLY INVASIVE GYNECOLOGY

in conjunction with

AUSTRALIAN GYNAECOLOGICAL ENDOSCOPY SOCIETY XIX ANNUAL SCIENTIFIC MEETING

Sex, Surgery & Gynaecology

21–23 May 2009 Brisbane Australia

CONTENTS

Sex, Surgery & Gynaecology

AGES BOARD

Alan Lam	President
Jim Tsaltas	Vice President
Christopher Maher	Secretary
Anusch Yazdani	Treasurer
Fariba Behnia-Willison	
Robert Ford	
David Healy	
Krishnan Karthigasu	
Michael McEvoy	
Harry Merkur	
Michele Bender	Executive Director

AAGL BOARD OF TRUSTEES

Resad P Pasic	USA	President
C Y Liu	USA	Vice President
Linda Bradley	USA	Secretary/Treasurer
Charles E Miller	USA	Immediate Past President
Errico Zupi	Italy	International Vice President
Linda Michels	USA	Executive Director
Franklin D Loffer	USA	Executive Vice President & Medical Director
Arnold P Advincula	USA	
Ted L Anderson	USA	
Viviane F Connor	USA	
Emilio O Fernandez	Chile	
Rosanne M Kho	USA	
Chyi-Long Lee	Taiwan ROC	
Ceana H Nezhat	USA	
Eugenio Solima	Italy	

ORGANISING COMMITTEE

Alan Lam	Australia	Congress Chair
Anusch Yazdani	Australia	Congress Co-Chair
Christopher Maher	Australia	Scientific Program Chair
Errico Zupi	Italy	
David Baartz	Australia	
Akram Khalil	Australia	
Andreas Obermair	Australia	
Michael Wynn-Williams	Australia	

INVITED FACULTY

Dorothy Kammerer-Doak	USA
Leah Millheiser	USA
Susan Davis	VIC
Jason Abbott	NSW
Arnold Advincula	USA
David Baartz	QLD
Melissa Buttini	QLD
Jonathan Carter	NSW
David Healy	VIC
Neil Johnson	NZ
Ian Jones	QLD
Krishnan Karthigasu	WA
Benjamin Kraal	QLD
Alan Lam	NSW
Christopher Maher	QLD
Peter Maher	VIC
Michael McEvoy	QLD
Harry Merkur	NSW
Charles E Miller	USA
Steve Mokrzecki	QLD
David Molloy	QLD
Les Nathanson	QLD
Ceana Nezhat	USA
Andreas Obermair	QLD
Oseka Onuma	SA
Nicholas O'Rourke	QLD
Robert O'Shea	SA
Ossie Petrucco	SA
Alexandr Popov	Russia
Shailesh Puntambekar	India
Anna Rosamilia	VIC
Stuart Salfinger	WA
Eugenio Solima	Italy
Jim Tsaltas	VIC
Michael Wynn-Williams	QLD
Anusch Yazdani	QLD

PR&CRM/CPD POINTS

THE CONGRESS 21 – 23 MAY 2009

Completion of the Pre and Post Questionnaires: 5 PR&CRM Points

The Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) approved Pre- and Post-Questionnaires are comprised of a number of multiple choice questions from lectures given on Thursday 21 May, Friday 22 May and Saturday 23 May.

The Pre-Questionnaire is to be handed in at the registration area at morning tea on Thursday 21 May.

The Post-Questionnaire is to be handed in at the close of the Congress on Saturday 23 May. No exceptions can be made to these deadlines.

This meeting has been approved as a RANZCOG Approved O&G Meeting and eligible

Fellows of this College will earn CPD points for attendance as follows:

Full Attendance 19 CPD Points

Attendance – 21 May 8 CPD points

Attendance - 22 May 8 CPD points

Attendance – 23 May 4 CPD points

The attendance roll must be signed each day for points to be awarded.

THE PRE-CONGRESS WORKSHOP 20 MAY 2009

The Pre-Congress Workshop has been approved as a RANZCOG Approved O&G Meeting and eligible Fellows of the College will earn points as follows:

Attendance – Wednesday 20 May 7 CPD points

The Pre-Congress Workshop attendance roll must be signed for points to be awarded..

BREAKFAST SESSION 22 MAY 2009

The Breakfast Session has been approved as a RANZCOG Approved O&G Meeting and eligible Fellows of the College will earn points as follows:

Attendance – Friday 22 May 1 CPD point

The breakfast session attendance roll must be signed for points to be awarded.

WELCOME

Dear Colleagues

It gives us great pleasure to welcome you to Brisbane, Australia, for the AAGL 3rd International Congress on Minimally Invasive Gynecology in conjunction with the AGES XIX Annual Scientific Meeting.

In 2009, we have decided on a unique approach to this congress, entitled: ***Sex, Surgery and Gynaecology***. While great advances have been made in gynaecology, particularly in minimally invasive techniques and technology, too little emphasis is placed on the sexual function of our patients. We are privileged to highlight this topic in our scientific meeting.

The 2009 AAGL – AGES Congress offers participants an exciting program, including a pre-congress workshop in minimally invasive surgery and basic sciences. Through our focus on gynaecological surgery, the Congress will explore issues pertaining to sexual and reproductive medicine, pelvic pain, endometriosis, prolapse and cancer surgery. We offer new insights into normal sexual function, hormone replacement, cosmetic and 'rejuvenating' gynaecology.

The AAGL represents the world's largest professional association of gynaecologists, representing over 30 international societies associated with its name and almost 4000 worldwide members who specialise in the use of minimally invasive procedures for diagnosing and treating disorders of the female reproductive system.

AGES is a premier gynaecological surgical association representing the majority of practicing gynaecologists in Australia and New Zealand. With over 550 active members, the society is amongst the largest and most active of all surgical bodies in the southern hemisphere.

AGES' mission is to promote the safest and highest standards of clinical and minimally invasive surgical care for women through education, surgical training and clinical research. AGES is proud to host this conjoint meeting with the AAGL in 2009.

We trust you will enjoy Queensland - the Great Barrier Reef, the beaches, the rainforests, the outback, and most importantly, the metropolitan centre of our Congress: Brisbane.

This promises to be a most informative, unique and memorable AAGL and AGES Congress.

Alan Lam
Congress Chair

Anusch Yazdani
Congress Co-Chair

Chris Maher
Scientific Program Chair

Resad Pasic
AAGL President

Sex, Surgery & Gynaecology PROGRAM

Wednesday 20 May (optional)

Sofitel Brisbane • Ballroom le Grand
Live transmission from the Royal Brisbane & Women's Hospital and Greenslopes Private Hospital

PRE-CONGRESS WORKSHOP

0830-0900	Registration	
0900-0915	Welcome	A Yazdani
0915-1000	Anatomy	M Wynn-Williams, R Pasic
1000-1200	**Live Surgery**	Moderators: A Lam , R Pasic
	Laparosopic hysterectomy	A Obermair
	Robotic hysterectomy	A Advincula
1200-1300	Lunch	
1300-1500	**Live Surgery**	Moderators: A Yazdani, K Karthigasu
	Laparoscopic myomectomy	M Wynn-Williams
	Robotic myomectomy	A Advincula
1500-1520	Afternoon Tea	
1520-1700	Complications Workshop	
	Chair: A Obermair	
1520-1530	Overview	A Obermair
1530-1550	Critical care update	A Obermair
1550-1610	Assessment and management of urological injuries	C Maher, A Lam
1610-1630	Assessment and management of gastrointestinal injuries	M Wynn-Williams, K Karthigasu
1630-1650	Assessment and management of of vascular injuries	A Obermair, A Yazdani
1650-1700	Discussion	
1700	Close	

FACULTY:
A Advincula, D Baartz, G Coghlin, K Karthigasu, A Khalil, A Lam, C Maher, A Obermair, R Pasic, M Wynn-Williams, A Yazdani

Thursday 21 May

0700-0800 Registration

Sofitel Brisbane
Ballroom le Grand 1 & 2

0800-0815 Welcome — A Lam, R Pasic, F Loffer

0815-1030 SESSION 1 sponsored by Stryker
Sex, Surgery and Gynaecology
Chairs: A Yazdani, F Loffer

0815-0835 Where, when and with whom? Defining normal sexual function — L Millheiser
0835-0855 Talking about sex… Defining sexual dysfunction — D Kammerer-Doak
0855-0915 Congenital and developmental abnormalities — D Baartz
0915-0935 Sex and the teenager — L Millheiser
0935-1000 Discussion

1000-1030 Morning Tea and Trade Exhibition

1030-1230 SESSION 2 sponsored by Stryker
Early Reproductive Years: Endometriosis and Sexuality
Chairs: J Tsaltas, R Pasic

1030-1050 Endometriosis in the 21st century — D Healy
1050-1110 Adolescent endometriosis - a management dilemma — K Karthigasu
1110-1130 Nerve-sparing surgery for endometriosis — A Lam
1130-1150 Infertility and endometriosis - surgery or IVF? — A Yazdani
1150-1210 Impact of endometriosis and treatments on sexual function and quality of life — J Abbott
1210-1230 Expert panel discussion and video case reviews

1230-1330 Lunch and Trade Exhibition

1330-1500 SESSION 3
Free Communications 1 - Video Presentations
Chairs: D Baartz, C Miller, R Ford
Ballroom le Grand 1

1330-1340 Laparoscopic uterine artery ligation (LUAL): Laparoscopic myomectomy of a 12cm fibroid
Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Kwik M

1340-1350 Laparoscopic uterine artery ligation (LUAL): Laparoscopic Assisted Myomectomy (LAM) for a 23x16x9cm multiple fibroid uterus
Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Maroun P

1350-1400 Laparoscopic Uterine Artery Ligation (LUAL): Laparoscopic total hysterectomy for a 2,500gm uterus
Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Cook J

1400-1410 Lumbosacral spondylodiscitis as a complication of Ls Sacrocolpopexya
Popov AA, Manannikova TN, Shaginian GG, Ramazanov MR, Chechneva MA, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodianiouk BA, Abramyan KN, Zemskov YV

1410-1420 Vaginal hysterectomy with bicoagulation clamps «Marclamp» application
Popov AA, Shaginian GG, Manannikova TN, Ramazanov MR, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Zemskov YV, Slobodianiouk BA

1420-1430 Outpatient hysteroscopy points in technique: Traditional approach versus the vaginoscopic approach
McIlwaine K, Readman E, Cameron M, Maher P

1430-1440 Temporary uterine artery clipping as an adjunct for the resection of large leiomyomata
Kroon B,Wynn-Williams M

1440-1450 Combined laparoscopic ultra-low rectal resection and right hemicolectomy for endometriosis (video)
Lam A, Khong S-Y, Evans J

1450-1500 The conservative treatment and follow-up in borderline ovarian tumors
Sobiczewski P, Bidzinski M

Free Communications 2 - Pelvic Surgery I
Chairs: H Merkur, T Anderson, K Karthigasu
Ballroom le Grand 2

1330-1340 Can we avoid laparoscopy in most ectopic pregnancies? The experience of our Early Pregnancy Unit
Bignardi T, Alhamdan D, Condous G

1340-1350 The value of pre-operative ultrasound in triaging women with adnexal pathology for advanced laparoscopic surgery
Alhamdan D, Bignardi T, Condous G

1350-1400 Analysis of laparotomy conversions of planned laparoscopic hysterectomies at Sydney West Advanced Pelvic Surgery (SWAPS) unit from January 2001 to December 2008
Anpalagan A, Merkur H

1400-1410 Pregnancy outcomes after laparoscopic myomectomy with blunt tipped stainless pole for fibroids penetrating the uterine cavity
Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

1410-1420 Laparoscopic Entry Technique – a preferred option with optical trocars
Tang L, Wong F

1420-1430 The effect of heated, humidified carbon dioxide on postoperative pain, core temperature, and recovery times in patients having laparoscopic surgery
Manwaring J, Readman E

1430-1440 Laparoscopic Uterine Artery Ligation (LUAL): The anterior approach
Chou D, Cario G, Rosen D, Carlton M, O'Neill A

1440-1450 Operative laparoscopy complications in an advanced gynaecological endoscopy unit (SWEC) in 2008
Cario G, Chou D, Rosen D, Carlton M, O'Neill A

1450-1500 Long-term results of laparoscopic sacrocolpopexy
Popov AA, Manannikova TN, Shaginian GG, Chechneva MA, Ramazanov MR, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodyanyuk BA, Abramyn KN

Free Communications 3 - Reproduction I
Chairs: F Behnia-Willison, E Solima, A Khalil
Bastille Room

1330-1340 Outpatient hysteroscopy: factors influencing post-procedure acceptability in patients attending a tertiary referral centre.
McIlwaine K, Readman E, Cameron M, Dimovski E, Maher P

1340-1350 Laparoscopy for all: A team approach
Georgiou C, Tait N, Bagia S

1350-1400 Bleeding disorders amongst women with endometriosis
Heynemann S, Grover S, Cameron M, Dauer R, Smith C, Barnes C, Johnson E

1400-1410 Haemoperitoneum and ectopic pregnancy does not equal laparoscopy
Bignardi T, Alhamdan D, Condous G

1410-1420 Bleeding disorders in adult women with heavy menstrual bleeding
Johnson E, Grover S, Dauer R, Cameron M, Smith C, Barnes C, Heynemann S

1420-1430 Chlamydia trachomatis in fallopian tubes of women undergoing laparoscopy for ectopic pregnancy
Bignardi T, Branley J, Alhamdan D, Condous G

1430-1440 The Laparoscopic Management of Placenta Accreta – A Case Presentation
Hodge W, Wagaarachchi P

1440-1450 Transrectal ultrasound guided surgical evacuation of caesarean scar ectopic pregnancy: a new technique
Bignardi T, Alhamdan D, Reid G, Condous G

1450-1500 Immediate successful primary repair of ureteroureterostomy in 5~7 days later LAVH
Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

1500-1530 Afternoon Tea and Trade Exhibition

1530-1700 SESSION 4 sponsored by Karl Storz Endoscopy
Ballroom le Grand 1 & 2
New Horizons in Minimally Invasive Surgery
Chairs: H Merkur, D Baartz

1530-1545 Robotic surgery: The way forward? A Advincula
1545-1600 NOTES (Natural Orifice Transluminal Endosopic Surgery) N O'Rourke
1600-1615 Microsurgery, laparoscopic to robotic surgery - are we back where it all began? O Petrucco
1615-1630 Advances in laparoscopic management of gynaecological cancer S Puntambekar

1630-1700 KEYNOTE LECTURE
Surgery for sex I Jones

1700 **Close**

1730 to 1930 **Welcome Cocktail Reception**
Sofitel Brisbane
Trade Exhibition Area

AGES PRIZES & AWARDS

Several substantial prizes will be awarded for the best oral and poster presentations at the Congress. Prizes will be presented in the final session of the Congress on Saturday 23 May. Judging will be by an impartial panel comprising senior members of AGES and AAGL. The judges' decisions are final. No correspondence will be considered.

AGES AWARDS IN 2009

John Kerin Award for Best Free Communication $500 sponsored by **Covidien**

Best Video Presentation $500 sponsored by **B Braun**

Best Registrar Presentation $500 sponsored by **Johnson & Johnson Medical**

Best Poster Presentation $500 Sponsored by AGES

The AGES Awards will be presented during the final session on Saturday 23 May

AGES TRAVELLING FELLOWSHIP IN 2009

The AGES/Covidien Travelling Fellowship for 2009 will also be presented during the final session on Saturday 23 May.

Friday 22 May

0700-0750 OPTIONAL BREAKFAST SESSION
Sponsored By Karl Storz Endoscopy
Odeon Room – lower lobby level
The Importance of Mechanical Morcellation in Myomectomy, Total and Sub-Total Hysterectomy

0700-0720	Myomectomy	C Miller
0725-0745	Hysterectomy	C Nezhat

(numbers limited - bookings at registration desk essential)

Sofitel Brisbane
Ballroom le Grand 1 & 2

0800-1030 SESSION 5 sponsored by Johnson & Johnson Medical
Late Reproductive Years: Hysterectomy
Chairs: R Ford, F Loffer

0800-0815	Hysterectomy in the 21st Century	P Maher
0815-0845	Debate: Please let me keep my cervix: Total or subtotal hysterectomy	D Molloy vs N Johnson
0845-0905	Alternatives to hysterectomy	R Pasic
0905-0920	Pitfalls and challenges in hysterectomy	R O'Shea
0920-0940	Sexual function following hysterectomy	S Davis
0940-1000	Menorrhagia is ruining my sex life – what are my options? Panel chair: F Loffer Panel discussion: M Buttini, S Davis, N Johnson, P Maher, D Molloy, R O'Shea, R Pasic	

1000- 1030 Morning Tea and Trade Exhibition

1030-1230 SESSION 6 sponsored by Karl Storz Endoscopy
Fertility
Chairs: A Yazdani, L Lo

1030-1050	Fibroids – fertility implications and management options	C Miller
1050-1110	Pitfalls and challenges in fibroid surgery	C Nezhat
1110-1130	Tubal surgery in the age of IVF	J Tsaltas
1130-1230	Presidential debate: Sex is for the young	J Abbott, P Maher, D Millheiser vs S Davis, N Johnson, D Kammerer-Doak Adjudicator: M McEvoy

1230- 1330 Lunch and Trade Exhibition

1330-1500 SESSION 7
Free Communications 4 - Miscellaneous
Chairs: H Merkur, A Khalil, M Wynne-Williams
Ballroom le Grand 1

1330-1340 How we can avoid the blood loss and time loss and ureteral injury during laparoscopic hysterectomy in difficult cases
Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

1340-1350 Short term results of Magnetic Resonance Imaging-guided Focused Ultrasound Surgery for adenomyosis patients indicate symptomatic relief and pain reduction
Yoon SW

1350-1400 Videolaparoscopic staging operation for mullerian adenosarcoma of the uterine corpus
Koh LW, Koh PR, Wong CN, Huang MH

1400-1410 Fibroma in ectopic ovarian tissue
Georgiou C, Rosen D

1410-1420 The role of the gynaecological oncologist in a tertiary hospital
Graham J, Salfinger S

1420-1430 Magnetic Resonance Imaging-guided Focused Ultrasound Surgery for symptomatic uterine fibroids. Results in clinical improvement observed throughout the first year
Yoon S-W

1430-1440 Postoperative uterine perfusion following uterine artery clipping at laparoscopic myomectomy
Rosen DMB

1440-1450 Travelling fellowship award winner 2006 - report
Najjar H

1450-1500 Travelling fellowship award winner 2007 - report
Salfinger S

Free Communications 5 - Pelvic Surgery II
Chairs:J Tsaltas, A Advincula, A Obermair
Ballroom le Grand 2

1330-1340 Safety of the optical access trocar in gynecologic laparoscopic surgery
Lee S-H, Ku C-H

1340-1350 Complications of laparoscopic hysterectomy after a decade: A follow-up of the Monash experience
Tan J, Tsaltas J, Lawrence A, Najjar H, Hengrasmee P

1350-1400 Laparoscopic drainage of haematocolpos
Dennie J, Pillay S, Grover S

1400-1410 Combined laparoscopic resection of bladder and rectal endometriosis
Ford R, Khong S-Y, Lam A, Justin J, Vass J, Cario G, David Rosen D, Chou D, O' Neill A

1410-1420 Does entry technique influence intra-abdominal adhesion development?
Cario G, Rosen D, Chou D, O' Neill A

1420-1430 Efficiency, complications and functional outcome of Prolift System(™) in treatment of pelvic organ prolpase
Krasnopolsky VI, Popov AA, Manannikova TN, Shaginian GG, Ramazanov MR, Chechneva MA, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodyanyuk BA, Zemskov YV, Abramyan KN, Fomenko OU

1430-1440 Narrow Band Imaging (NBI): a new technique for detecting endometriosis at laparoscopy
Bignardi T, Alhamdan D, Condous G

1440-1450 A novel use for Seprafilm laparoscopically
Barabash ID, Matthews LH, Ang WC.

1450-1500 Application of Seprafilm - video
Barabash ID, Matthews LH, Ang WC.

Free Communications 6 - Reproduction II
Chairs: M McEvoy, E Solima, D Baartz
Bastille Room

1330-1340 The effects of heated, humidified carbon dioxide in prolonged gynaecological laparoscopy: a randomized, controlled trial
Cameron M, McIlwaine K, Manwaring J, Maher P

1340-1350 Sexual Function and Outcomes in Women with Vaginal Agenesis
Kimberley N, Hutson J, Southwell B, Grover S

1350-1400 Spontaneous Postoperative Conception in IVF Resistant Severe Endometriosis
Kroon B, Yazdani A

1400-1410 Surgical management of recurrent ureteric endometriosis causing recurrent hypertension in a postmenopausal patient
Khong S-Y, Lam A, Coombs G

1410-1420 Uterus didelphys with obstructed hemivagina: a case series
Cameron M, Moore P, Jayasinghe Y, Grover S

1420-1430 What is the value of history taking in predicting the presence of bowel endometriosis?
Khong S-Y, Lam A, Markey J, LuscombeG

1430-1440 Evaluation of the Australian version of the 30-item Endometriosis Health Profile (EHP-30) and its results
Markey J, KhongJS-Y, Luscombe G, Lam A, Ford R

1440-1450 Obturator nerve injury
Lam A, Khong S-Y

1450-1500 Pregnancy outcomes of salpingosalpingostomy in tubal pregnancy
Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A;

1500-1530 Afternoon Tea and Trade Exhibition

1530-1630 SESSION 8
Sponsored by Invivo Medical Indemnity
Ballroom le Grand 1 & 2
Training, Complications and Risk Management
Chairs: C Maher, R Pasic

1530-1630 Video vignettes with expert panel review
A Advincula, F Loffer, H Merkur, L Millheiser, C Nezhat, R O'Shea, M Wynn-Williams, A Yazdani

1630-1730 AGES ANNUAL GENERAL MEETING
Ballroom le Grand 1 & 2

1900-2300 **GALA CONGRESS DINNER**
KOOKABURRA QUEEN BRISBANE RIVER CRUISE
Eagle Street Pier, Cnr Charlotte and Eagle Streets, Brisbane

1845 Complimentary coach transfers from the Sofitel

1930 The Kookaburra Queen departs

Saturday 23 May

Sofitel Brisbane
Ballroom le Grand 1 & 2

0800-1030 SESSION 9 sponsored by Johnson & Johnson Medical
Middle Years and Beyond: Oncology
Chair: A Obermair, E Solima

0800-0815	Expect the unexpected: Inadvertant finding of gynaecological cancer	S Salfinger
0815-0835	Discussion: Gynaecological cancer management outside the big centre	J Carter, S Mokrzecki
0835-0850	Human centred designs - What the experts' performance looks like	B Kraal
0850-0900	Surgical performance documentation	A Obermair
0900-0920	Nerve-sparing radical hysterectomy for cervical cancer	E Solima
0920-0940	Robotic surgery in gynaecological oncology - marketing or patient value?	A Advincula
0940 -1000	Discussion	

1000- 1030 Morning Tea and Trade Exhibition

1030-1230 SESSION 10 sponsored by Stryker
Pelvic Floor and Sexual Function
Chairs: C Maher, K Bajzak

1030-1055	Sex and pelvic floor	D Kammerer-Doak
1055-1110	Dyspareunia	C Maher
1110-1125	Is mesh-associated pain re-igniting interest in laparoscopic surgery?	A Popov
1125-1155	Designer vagina: The debate A Rosamilia vs O Onuma	
1155-1210	Video cases to challenge the expert panel	
1210-1220	**Awards presentation**	A Lam, F Loffer
1220-1230	**Close**	C Maher

SOCIAL PROGRAM

WELCOME COCKTAIL RECEPTION

Thursday 21 May 2009
1730 to 1930
Sofitel Brisbane
Trade Exhibition Area

GALA CONGRESS DINNER

KOOKABURRA QUEEN BRISBANE RIVER CRUISE
Friday 22 May 2009
1900 to 2300
Eagle Street Pier
Cnr Charlotte and Eagle Streets
Brisbane QLD 7000

1845	Complimentary coach transfers to Eagle Street Pier from the Sofitel
1930 sharp	The Kookaburra Queen departs
2230 - 2300	Complimentary return coach transfers to the Sofitel

We will take a leisurely cruise of the Brisbane River in true Queensland style, on the stately Kookaburra River Queen.

Enjoy world-famous Queensland hospitality, jazz entertainment, fine wines and a sumptuous meal.

Complimentary return coach transfers from Eagle Street Pier to the Sofitel.

stryker®

South Pacific

Revolutionary
HD Technology

Unparalleled
Resolution and Clarity

1288 HD 3 Chip® Camera

- 3rd Generation HD Camera System
- 1920 x 1080p HDTV Resolution
- Fully Programmable Camera Head Buttons with Light Source Control

Light
Unlike Ever Before

L9000 LED Light Source

- Cooler Light Emission via LED Light
- Safelight™ Cable Technology puts L9000 on Standby when Scope is Detached
- No Bulbs to Replace, Reduced Lifetime Ownership Cost

Sex, Surgery & Gynaecology PROGRAM ABSTRACTS

Thursday 21 May

DEFINING SEXUAL DYSFUNCTION

THURSDAY 21 MAY / SESSION 1 / 0835-0855

Kammerer-Doak D

OBJECTIVES: To identify models of sexual function, to list common sexual dysfunctions, and to identify therapeutic modalities for patients with sexual dysfunction.

SUMMARY: Female Sexual Function: The traditional, linear model of sexual function described by Masters and Johnson in 1966 with 4 phases of human sexual response, excitement, plateau, orgasm, and resolution, may not be completely applicable to female sexual function. A more contemporary, intimacy-based, female-specific model of sexual response has been proposed that is not linear, but rather circular. The "Sexual Response Circle" described by Basson in 2001 describes a more circular relationship between satisfaction and sexuality and includes other aspects such as sexual desire, emotional intimacy, and emotional and physical satisfaction, recognizing that these aspects are known to be important for overall female sexual satisfaction. Unlike the male sexual response which focuses on the ability to achieve and maintain an erection, the female sexual response is more complex involving social, psychologic, neurologic, vascular and hormonal processes and includes complex interaction of sexual stimulation, the central nervous system, the peripheral neurovascular system, and hormonal influences.

Female Sexual Dysfunction (FSD): is therefore a complex problem with neurovascular, psychosocial, and endocrine etiologies. Sexual dysfunction is recognized as a widespread problem, but data are scare as to the prevalence, which ranges from 25-63% of women depending on the source as well as the definition used. The definition of FSD is problematic, and may be better defined by what it is not, rather than what it is. Media attention and progress in the pharmaceutical treatment of male erectile dysfunction have focused attention on female sexuality. This scrutiny may have artificially created a standard of expected female sexual function that if not attained is labeled a dysfunction. A "less than perfect" sex life becomes FSD when it causes personal distress as determined by the affected women, and not necessarily her partner. The diagnosis of FSD requires that the symptom be persistent, pervasive, and cause personal distress to the woman. Female sexual dysfunction has been classified into 4 areas by an international consensus conference: problems with arousal, orgasm, desire and pain.

Assessment and Treatment of FSD: Management of FSD involves assessment of the level of dysfunction, education of average sexual practices, ways to improve intimacy, treatment of pain, evaluation for psychotherapy depending on current and past relationships and life stressors including history of sexual abuse, and medical management when indicated. Hormone replacement therapy, including testosterone, may be used in the postmenopausal woman, but the role of androgens in premenopausal women with sexual dysfunction is still under investigation.

REFERENCES:
1. Kammerer-Doak D, Rogers RG. Female Sexual Function and Dysfunction Obstet Gynecol Clin North Am. 2008 Jun;35(2):169-83
2. Basson R, Berman J, Burnett A, Derogatis L, Ferguson D, et al. Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications. J Urol 2000;163:888-893
3. Laumann EO, Paik A, Rosen R. Sexual Dysfunction in the United States: Prevalence and Predictors. JAMA 1999;281:537-44
4. Gierhart BS. When Does a "Less Than Perfect" Sex Life Become Female Sexual Dysfunction? Obstet Gynecol 2006;107:750-1

ENDOMETRIOSIS IN THE 21ST CENTURY

THURSDAY 21 MAY / SESSION 2 / 1030-1050

Healy DL

The 2008 World Congress on Endometriosis listed 25 priorities for endometriosis research. For a disease with an estimated annual cost in the USA of 22 billion (2002 figures), endometriosis research is underfunded with a high healthcare burden: this may be due to the difficulties of developing competitive research proposals on a complex and poorly understood disease which affects only women.[1] Surgery is often considered the best treatment for women with symptomatic endometriosis. However, weakness in design of randomised clinical trials damage high quality surgical skill by commonly failing to reach powerful conclusions. Thus, for example, pain recurrence and re-

operation rates after surgery for symptomatic endometriosis are poorly reported compared with other areas of gynaecology, obstetrics and general medicine. Non surgical treatments for endometriosis suffer these same weaknesses. Although meta-analyses indicate that treatment with GNRH analogues prior to IVF cycles, for 3-6 months, improve the odds of clinical pregnancy in women with endometriosis, these studies are small by comparison with other trials in clinical medicine. Nonetheless, data suggests that the eutopic endometrium in patients with endometriosis is abnormal. When these patient conceive, there appears to be direct obstetric consequences such as increased rates of preterm birth and an increased likelihood of having a small for gestational age baby. This seems especially so for infertility patients with ovarian endometriomata who require IVF/ART.

REFERENCES:
1. Rogers PA, D'Hooghe TM, Fazleabas A, Gargett CE, Giudice LC, Montgomery GW, Rombauts L, Salamonsen LA, Zondervan KT. Priorities for endometriosis research: recommendations from an international consensus workshop. 2009. Reprod Sci 16;4:335-346.

SUGGESTED READING: Endometriosis 2008. Edited by Luk Rombauts, Jim Tsaltas, Peter Maher and David Healy. Blackwell Publishing.

AUTHOR AFFILIATION: Professor David Healy. Head of Dept of Obstetrics and Gynaecology, Monash University Monash Medical Centre, Clayton, Victoria, Australia.

NERVE-SPARING EXCISION OF ENDOMETRIOSIS

THURSDAY 21 MAY / SESSION 2 / 1110-1130

Lam A

Endometriosis is a chronic disease which can cause debilitating pain and infertility and consequently severely impact the quality of life of patients. There has been a call for 'aggressive excisional surgery in any patient who wishes to retain fertility and who has pain that has not responded well to previous medical or surgical therapy' (Redwine 2001). This is supported by mounting evidence suggesting that complete excision of endometriosis is effective in producing good long-term pain relief and improving fertility outcomes.

And so, in dealing with deeply infiltrative endometriosis involving the uterosacral ligaments, obliterating the pouch of Douglas with or without involvement of the recto-sigmoid, endometriosis surgeons have adopted almost the same 'radical philosophy' as the way oncologists have treated pelvic cancer.

Such aggressive surgical approach, not surprisingly, may cause possible significant effects on bladder, bowel and sexual function. Indeed, it is because of these concerns that surgeons have adopted nerve-sparing techniques in radical surgery for cervical, bladder and rectal malignancies in the last decade.

There is almost certainly gross under-appreciation and hence under-reporting of complications related to this topic. There is limited data from a small number of non-randomized studies raising concerns about possible damage to the pelvic autonomic nerves and hence pelvic organ dysfunction from radical pelvic surgery. Most, if not all of the evidence, have examined different surgical techniques and used unvalidated questionnaires.

Nevertheless, as we become more radical in our surgical approach to advanced endometriosis, it is imperative that we should have detailed knowledge of pelvic anatomy and pelvic autonomic innervations. We should examine our current surgical techniques. We should be aware that aggressive excisional surgery of endometriosis may result in significant morbidity thus far not yet evaluated on bladder, bowel and sexual function.

REFERENCES:
1. Redwine DB and Wright JT (2001) Laparoscopic treatment of complete obliteration of the cul-de-sac associated with endometriosis: long-term follow-up of en bloc resection. Fertil Steril 76,358–365
2. Ercoli A, Delmas V, Gadonneix P, Fanfani F, Villet R, Paparella P, Mancuso S and Scambia G (2003) Classical and nerve-sparing radical hysterectomy: an evaluation of the risk of injury to the autonomous pelvic nerves. Surg Radiol Anat 25,200–206
3. Ford J, English J, Miles WA and Giannopoulos T (2004) Pain, quality of life and complications following the radical resection of rectovaginal endometriosis. Br J Obstet Gynecol 111,353–356
4. Hoeckel M, konerding MA and Heubel CP (1998) Liposuction-assisted nervesparing extended redical hysterectomy: oncologic rationale, surgical anatomy, and feasibility study. Am J Obstet Gynecol 178,971–976
5. Darai E, Thomassin I, Barranger E, Detchev R, Cortez A, Houry S and Bazot M (2005) Feasibility and clinical outcome of laparoscopic colorectal resection for endometriosis. Am J Obstet Gynecol 192,394–400
6. Landi S et al. (2006) Laparoscopic nerve-sparing complete excision of deep endometriosis: is it feasible? Human Reproduction .21,. 774–781.
7. Raina R et al. Female sexual dysfunction: classification , pathophysiology and management. Fertil Steril 2007;88:1273–84

AUTHOR AFFILIATION: Associate Professor Alan Lam. Centre for Advanced Reproductive Endosurgery, Royal North Shore and Mater Hospitals, Sydney, NSW, Australia.

INFERTILITY AND ENDOMETRIOSIS - SURGERY OR IVF?

THURSDAY 21 MAY / SESSION 2 / 1130-1150

Yazdani A

In 2008, Fertility and Sterility, the official publication of the American Society for Reproductive Medicine, ran an editorial entitled "Infertility surgery is dead' (1), reflecting the increasing focus on assisted reproduction and in particular, in vitro fertilization (IVF). The argument proposed that assisted reproduction was more effective than any surgical intervention and, ultimately, the latter should be abandoned. This argument is particularly poignant in relation to endometriosis.

Endometriosis has been demonstrated to affect ovarian response, oocyte quality, fertilization, embryo quality and implantation. Unfortunately, while excellent evidence supports the role of surgery in the management of endometriosis associated infertility, surgery has increasingly become an intervention of last resort. Furthermore, the failure to operate on their disease robs these women of an opportunity to address their pain and restore an appropriate quality of life, in addition to their infertility.

Unlike IVF, advanced endometriosis surgery has a steep learning curve, requires additional training and is restricted to few centres. In contrast, IVF is readily accessible, widely applicable and ultimately, better remunerated.

Finally, the fundamental premise of the argument for and against surgery presupposes that a child conceived naturally is identical to a child conceived by IVF.

Unfortunately, IVF is only in its infancy. The rapid development and deployment of this technology has resulted in its adoption before the long term effects have been fully understood. As such, children conceived through IVF may have a higher congenital anomaly rate, though the absolute incidence is small (4-5%). Furthermore, while there is no documented increase in genetic abnormalities, there may be epigenetic changes with long term consequences, including second generation effects, that are as yet poorly defined.

Surgery must therefore remain a cornerstone in the management of endometriosis related infertility.

REFERENCES:
1. Feinberg EC et al. Fertil Steril. 2008 Jul;90(1):242-3

ENDOMETRIOSIS AND ITS IMPACT ON SEXUAL FUNCTION

THURSDAY 21 MAY / SESSION 2 / 1150-1210

Abbott J, Maley P

Women with endometriosis frequently describe dyspareunia, defined as genital or pelvic pain experienced immediately before, during or after sexual intercourse. Dyspareunia is experienced by 60-80% of women undergoing surgery for endometriosis, and 50-90% of women using medical therapy, with more than 50% of women diagnosed with endometriosis claiming to have suffered from dyspareunia. In turn, dyspareunia has a significant effect on sexual function specifically and quality of life generally. Due to the presence of sensory and sensory-motor neurones in the uterosacral ligaments, a strong relationship exists between dyspareunia and deep endometriotic lesions in this area with women describing a greater intensity of pain during intercourse than those with lesions elsewhere. Mechanical stretching of these inflamed ligaments contributes to this pain.

The effects of dyspareunia on sexual function includes associations with negative attitudes toward sexuality, anxiety and avoidance of intercourse and low levels of desire, arousal and reduced orgasm. An Italian study compares sexual function in women with endometriosis suffering dyspareunia allocated by site of disease compared with controls. This determined that women with posterior compartment disease including uterosacrals were the most affected but women with disease elsewhere in the pelvis also had reduced sexual function. Women with endometriosis reported significantly increased pain scores as recorded on visual analogue scale (VAS); less satisfying orgasms than those without uterosacral involvement and control groups; a negative approach to sexuality, and anxiety and avoidance of intercourse.

Medical treatments aimed at reducing the inflammatory effects of deeply invasive lesions appear to be mildly effective, with side effect profiles from the oral contraceptive pill and progesterone clearly better than GnRHa and Danazol where tolerability is significantly less and return of dyspareunia high. Surgical treatments have demonstrated that excision of deeply invasive nodules will benefit long term reduction in dyspareunia and improvement in quality of life, although recurrence following surgery remains one of the greatest problems. The longest term data (to 5 years) demonstrates a sustained significant reduction of dyspareunia compared to baseline. Current medical treatments under investigation such as aromotase inhibitors are similarly likely to be limited by duration of use and side effects for this chronic disease.

AUTHOR AFFILIATION: Jason Abbott and Peta Maley. University of New South Wales and Royal Hospital for Women, Sydney, NSW, Australia.

ROBOTIC SURGERY: THE WAY FORWARD?

THURSDAY 21 MAY / SESSION 4 / 1530-1545

Advincula A

Technical advancements such as improved hand instrumentation and electrosurgical devices have clearly brought about improvements to modern day laparoscopy. This technology has continued to grow by leaps and bounds in the area of minimally invasive gynecologic surgery. Studies have clearly shown that laparoscopic surgery allows faster recovery with shorter hospitalization, improved cosmesis, decreased blood loss and less postoperative pain. Despite these technological advancements and proven benefits, more complex procedures such as the management of advanced endometriosis, and procedures that require extensive suturing such as myomectomy and sacrocolpopexy are typically still managed by laparotomy.

One major obstacle to the more widespread acceptance and application of minimally invasive surgical techniques to advanced gynecologic surgery has been the steep learning curve for surgeons. Other limitations encountered with conventional laparoscopy include counter-intuitive hand movement, two-dimensional visualization,

and limited degrees of instrument motion within the body as well as ergonomic difficulty and tremor amplification. In an attempt to overcome these obstacles, robotics has been incorporated into the gynecologic armamentarium. The advantages obtained with robot-assisted laparoscopy may be the way forward in terms of improving surgical outcomes and increasing minimally invasive surgical options as evidenced by the growing number of gynecologic applications and data to support its use.

NOTES – NATURAL ORIFICE TRANSLUMINAL ENDOSOPIC SURGERY

THURSDAY 21 MAY / SESSION 4 / 1545-1600

O'Rourke N

NOTES (Natural Orifices Transluminal Endoscopic Surgery) is blossoming in the general surgical literature. Although using natural orifices for quite advanced surgery has been practiced by gynaecologists and urologists for sometime, it was the incendiary report by Rao from Hydrabad of a wholy trans gastric endoscopic appendicectomy which fired the current enthusiasm amongst general surgeons.

Since then there has been a surge in animal and occasional human reports on pure or modified N.O.T.E.S.

The limitations of closure devices in the stomach and rectum have changed the focus to trans vaginal approaches. A report from New York City in 2007 of a gallbladder removed through the vagina received international media attention.

Things have evolved quickly with the concept of using the umbilicus (embryonic N.O.T.E.S. or E N.O.T.E.S.) considered as a step up to "hybrid N.O.T.E.S."

Keeping up with the terminology and acronyms is difficult! We now have N.O.S.E. (Natural Orifice Specimen Extraction); S.I.L.S (Single Incision Laparoscopic Surgery).and E.N.O.T.E.S.

Undoubtedly, a lot of the hype is associated with marketing and the "me first" mentality. The exciting thing, however, is the development of new instrumentation which will hopefully have broad spin offs for all surgeons interested in advanced laparoscopic surgery.

This presentation will focus on the current state of the art.

AUTHOR AFFILIATION: Dr Nicholas O'Rourke. M.B.,B.S.(Qld) F.R.A.C.S. Laparoscopic, Hepatobiliary& Bariatric Surgeon, Wesley Medical Centre, Auchenflower, Qld, Australia.

MICROSURGERY, LAPAROSCOPIC TO ROBOTIC SURGERY – ARE WE BACK TO WHERE IT ALL BEGAN?

THURSDAY 21 MAY / SESSION 4 / 1600-1615

Petrucco O

Tubal pathology remains a significant cause of infertility and in the past was treated by open or laparoscopic microsurgery. Since the early 90's rapidly improving IVF techniques have become the accepted management of tubal related infertility. As a corollary investigation of the infertile female is often limited to hysterosalpingography and pelvic ultrasound. Treatable pelvic pathology either causing infertility or of significance to the patient may be totally missed. Diagnostic endoscopy and tubal reconstructive surgery should still be considered in view of successful long term outcomes, clinical / cost effectiveness, avoidance of IVF for ethical and or religious reasons and for teaching and maintenance of endoscopic and microsurgical skills for future reproductive surgeons.

New techniques including transvaginal laparoscopy, laparoscopic microsuturing, adhesion prevention, day surgery reversal of sterilization, ovarian transplantation and robotic surgery are expanding the horizons of future reproductive surgeons making this field both a challenge and useful adjunct to our reproductive armamentarium. Reproductive centres of the future should consider providing complementary strategies for patients with compromised tubo / ovarian function including microsurgery concomitantly with in-vitro fertilisation. The choice of initial treatment will be dependant on expertise and available funding for the full range of reproductive programs.

REFERENCES:
1. First and subsequent pregnancies after tubal microsurgery: evaluation of the fertility index. Gillett WR, Clarke RH, Herbison GP. Fertil Steril 1997;68:1033-42
2. Consider Surgery Before IVF. Ledger W. BMJ 2007 335 (7610):66 14July
3. Hydrosalpinx – functional surgery or salpingectomy? Puttemans P, Campo R, Gordts S, Brosens I. Human Reproduction vol. 15 no.7 pp.1427-1430, 2000
4. Prevention of Adhesion Formation Should Combine Local Treatment with Peritoneal Cavity Conditioning. Binda MM & Koninckx P.R. (VIII PAX Meeting on postoperative adhesions – Clemont Ferrand France Sep 2008)
5. Live birth following day surgery reversal of female sterilisation in women older than 40 years: a realistic option in Australia? Petrucco OM, Silber SJ, Chamberlain SL, Warnes GM, Davies M. MJA 03SEP07 Volume 187 Number 5
6. The role of tubal reconstructive surgery in the era of assisted reproductive technologies. The Practice Committee of the American Society for Reproductive Medicine. Fertil Steril 2008;90:S250-3
7. Fertility: assessment and treatment for people with fertility problems. Tubal and uterine surgery. Chapter 8. RCOG Clinical Guideline, February 2004

AUTHOR AFFILIATION: A/Prof Ossie Petrucco. The Robinson Institute, The University of Adelaide.

ADVANCES IN LAPAROSCOPIC MANAGEMENT OF GYNAECOLOGICAL CANCER

THURSDAY 21 MAY / SESSION 9 / 0900-0920

Puntambekar S

When compared with laparotomy, laparoscopy provides a similar outcome with a shorter hospitalization, an earlier recovery, and an improved quality of life for the treatment of advanced gynaecological cancers. One of the challenges for the development of laparoscopic surgery is the difficulty for physicians of acquiring advanced laparoscopic surgical skills. Laparoscopy entered the field of gynaecology in the mid-1950s, but the technique was slow to evolve until the beginning of the 1990s, when it became more widely applied in gynecological oncology. Although few trials have looked at the safety of laparoscopy in oncology, it is now widely used for most gynaecological malignancies.

CERVICAL CANCERS: In advanced cervical cancer patients post CT/RT or patients with recto/ vesico vaginal fistula exentration is the preferred treatment. Exenteration is supposedly a very extensive procedure but it has a definite role in the treatment of cancer cervix. It gives a distinct chance (20%) of cure to the patient. Its offers excellent palliation. Exentration in itself is a major procedure but laparoscopy is feasible and reduces morbidity. We at our centre perform anterior exentration, posterior exentration and total pelvic exentration laparoscopically.

We performed laparoscopic total pelvic exenteration in 7 patients of advanced cervical cancer at Galaxy Laparoscopy Institute from August 2005 to December 2008. All patients underwent a diagnostic laparoscopy for assessment of resectibility of the tumor followed by pelvic exenteration in the same operative procedure.

Eight patients with advanced cervical cancer, involving the rectum and no metastatic spread were considered for this procedure. All the patients underwent Laparoscopic posterior exenteration with either colorectal anastomosis or permanent colostomy.

Forty patients have undergone laparoscopic anterior exentration laparoscopically with ureterosigmoidostomy/ mainz II pouch/ ileal conduit as diversion.

OVARIAN CANCER: Ovarian cancer is the leading cause of death from gynaecological malignancies; it is diagnosed at an advanced stage in approximately 75% of patients. The current standard treatment for ovarian cancer consists of maximum cytoreductive surgery to reduce tumor residuum to a minimum, followed by platin-based chemotherapy. Stage III C the disease already spread, with peritoneal deposits. Hence CO2 insufflation does not add to further transcoelomic spread. So if optimal debulking can be achieved with minimal residual disease laparoscopically, then early early adjuvant chemotherapy can be given. Tumours are removed vaginally to prevent port-site recurrence. Retroperitoneal and para-aortic nodal dissection: Laparoscopy is the best and minimally invasive method for para-aortic nodal dissection in post-chemotherapy patients with node positive status

SUMMARY: The feasibility and safety of laparoscopy for most of the surgical procedures that are used for gynaecological malignancies are now established. The absence of large phase III studies needs to be balanced by the relatively low incidence of advanced cervical and ovarian cancer. Although laparoscopy is very promising and probably oncologically safe, and although there are few published prospective trials, the technique demands satisfactory additional training and, in the setting of gynaecological cancers, should be reserved for trained subspecialists.

SURGERY FOR SEX

THURSDAY 21 MAY / SESSION 4 / 1630-1700

Jones I

Surgery to assist coitus or to reassign gender may be performed by surgeons from many different subspecialties. Gynaecologists perform procedures which can enlarge or tighten the vagina, correct genital prolapse or create a neovagina when congenitally absent. General surgeons, plastic surgeons and urologists perform various operations on the penis to overcome phimosis, penile chordee and insert penile and testicular implants. Various subspecialty surgeons perform sexual reassignment surgery. Breast surgeons either remove or implant breasts for those at an earlier stage of gender reassignment.

This lecture concentrates on the surgical management of those patients who have gender dysphoria and progress to sexual reassignment surgery, more commonly known as sex change surgery.

The theories of causation, the principles of management and the various surgical options available for patients requiring sexual reassignment surgery are presented. Practical problems and the surgical challenges are considered.

The need for strict selection criteria is stressed. The aim of care is always to help the patient. However, there are surgical, anatomical, physiological and psychological realities that must be faced by the patient, the partner, relatives and the treating team if the best, realistic results are to be achieved.

AUTHOR AFFILIATION: Professor Ian Jones, Professor of Obstetrics and Gynaecology, University of Queensland and Executive Director, Women's and Newborn Services, Royal Brisbane and Women's Hospital.

ABSTRACTS

Friday 22 May

HYSTERECTOMY IN THE 21ST CENTURY

FRIDAY 22 MAY / SESSION 5 / 0800-0815

Maher PJ

Despite an increase in the number of treatments including both medical and surgical ,for the management of abnormal bleeding, and in particular, menorrhagia, hysterectomy is still the definitive treatment and has been shown to be associated with greater improvement in general health particularly when compared to endometrial destruction techniques.

Hysterectomy has the obvious advantage over all other treatments in that it provides permanent relief from the symptoms of abnormal bleeding.

The procedure of removal of the uterus goes back many hundreds of years with vague reports of it after the birth of Christ. Abdominal hysterectomy was first performed by Clay (USA) in 1843 although the first successful procedure is credited to Burnham(UK) in 1853 as the patient survived.

In the early part of the twentieth century the operation remained virtually unchanged influenced mainly by blood transfusion, antibiotics, antisepsis and anaesthesia. The concept of total hysterectomy was introduced by Richardson in the 1930s and then nothing un til the advent of endoscopy and the publication of the first laparoscopic hysterectomy by Reich in 1988.

Over the previous 10 years the less invasive endometrial resection/ ablation was being heralded as the "laser hysterectomy" despite most surgeons avoiding the laser and the uterus not being removed. It became increasingly popular as it also allowed removal of small intra-cavity fibroids as well as a minimally invasive treatment for dysfunctional bleeding.

Unfortunately due to a steep learning curve interest in the hysteroscopic approach wained. Industry soon discovered that a simpler approach was needed so the second generation of ablation devices were born-the so-called global ablation systems. These provided better outcomes with less surgical expertise required. Some proved to be better than others with higher rates of amenorrhea.

Newer techniques such as UAE , although first reported as early as 1994 were slow to catch on..these techniques have shown a resurgence in the 21st century. Fibroid treatment with other modalities to be discussed may see a further reduction in hysterectomy for this condition.

The Mirena® intra-uterine device has had an impact not only on the hysterectomy rate but also the ablation rate.

When gynaecologists ,embrace the robotic technology like their urological colleagues have over the last 8 years we may see a reverse of the trend of decline in hysterectomy rates in the next part of the 21st. Century.

AUTHOR AFFILIATION: Peter J. Maher, Melbourne, Australia

DEBATE: PLEASE LET ME KEEP MY CERVIX: TOTAL OR SUBTOTAL HYSTERECTOMY

FRIDAY 22 MAY / SESSION 5 / 0815-0845

Johnson N

Subtotal hysterectomy has been a much under-used operation. The update of the Cochrane systematic review (now six randomised controlled trials, including 1,071 women, a considerable level 1 evidence base) suggests that there are no significant outcome differences between subtotal and total hysterectomy in most aspects of sexual function, bowel dysfunction, most aspects or urinary dysfunction, quality of life, return to normal activities, alleviation of symptoms and hospital readmission rate. Subtotal hysterectomy may offer advantages that include improved body image at 12 months, lower volume blood-loss, less chance of postoperative pyrexia and shorter operating time; but possible disadvantages include a small percentage of ongoing cyclical vaginal bleeding and an increase in the rate of perceived urinary incontinence at 12 months.

SEXUAL FUNCTION FOLLOWING HYSTERECTOMY

FRIDAY 22 MAY / SESSION 5 / 0920-0940

Davis S

Most studies indicate that hysterectomy without bilateral oophorectomy in women treated for benign causes does not in itself adversely affect sexual function. Indeed some studies report improvements in interest, frequency and enjoyment of sexual activity following hysterectomy. Hysterectomy in women at midlife may result in a small but clinically not meaningful reduction in androgen production with the dominating effect, in terms of androgen availability, being the age related decline in adrenal and ovarian androgen production. Thus from a clinical perspective, women

who have undergone hysterectomy with ovarian presentation for benign conditions should be considered in the same manner as non hysterectomised pre-and postmenopausal women.

In general, postmenopausal women experience less sexual desire than premenopausal women and are more likely to report that this is of considerable concern to them constituting hypo-active sexual desire disorder (HSDD). There is no approved therapy for this condition, although transdermal testosterone patches (TTP) have been approved in Europe for the treatment of surgically postmenopausal women who have HSDD despite adequate systemic oestrogen replacement. TTP therapy has been shown to be significantly more effective than placebo therapy for the treatment of HSDD in women who have experienced either natural or surgical menopause, with and without concomitant estrogen therapy(1-3). Transdermal testosterone has also been found to be efficacious for the treatment of HSDD experienced by women in their late reproductive years (4, 5). In contrast, other systemic hormonal therapies, such as DHEA, has not been shown to be beneficial.

Of the other treatments potentially available for the treatment of female sexual dysfunction, PDE5 inhibitor therapy may be useful for the treatment of genital arousal disorder, particularly in association with antidepressants (6).

Earlier all women presenting with sexual concerns should be comprehensively assessed, with attention to their emotional well-being, relationship and partner's health, as well as their gynaecological health.

REFERENCES:
1. Shifren J, Davis SR, Moreau M, et al. Testosterone patch for the treatment of hypoactive sexual desire disorder in naturally menopausal women: results from the INTIMATE NM1 study. Menopause. 2006;13(5):770-779.
2. Simon J, Braunstein G, Nachtigall L, et al. Testosterone patch increases sexual activity and desire in surgically menopausal women with hypoactive sexual desire disorder. J Clin Endocrinol Metab. 2005;90(9):5226-33.
3. Davis SR, Moreau M, Kroll R, et al. Testosterone for Low Libido in Menopausal Women Not Taking Estrogen Therapy. N Eng J Med. 2008;359:2005-17.
4. Davis SR, Papalia MA, Norman RJ, et al. Safety and Efficacy of a Testosterone Metered-Dose Transdermal Spray for treatment of decreased sexual satisfaction in Premenopausal Women: A Placebo-Controlled Randomized, Dose-Ranging Study. . Annals Internal Med. 2008;148:569-577.
5. Goldstat R, Briganti E, Tran J, Wolfe R, Davis S. Transdermal testosterone improves mood, well being and sexual function in premenopausal women. Menopause. 2003;10(5):390-8.
6. Nurnberg HG, Hensley PL, Heiman JR, Croft HA, Debattista C, Paine S. Sildenafil treatment of women with antidepressant-associated sexual dysfunction: a randomized controlled trial. Jama. 2008;300(4):395-404.

AUTHOR AFFILIATION: S Davis, MB, BS, FRACP, Women's Health Program, Dept Medicine, Alfred Hospital, Commercial Rd Prahran, VIC, 3181, Australia

FIBROIDS – FERTILITY IMPLICATIONS AND MANAGEMENT OPTIONS

FRIDAY 22 MAY / SESSION 6 / 1030-1050

Miller C

Dependent on location, fibroids can impact the ability to achieve pregnancy. Currently, there are multiple medical, radiologic and surgical options for the treatment of uterine fibroids. However, the number of treatment regimens is much more limited in patients interested in future fertility. This discussion will focus on the impact of fibroids on fertility as well as the evaluation of treatment options for those patients interested in pregnancy. Special attention, utilizing evidence based medicine will be directed toward patient profiles, benefits, risks and limitations of these various treatment regimens. Moreover, future treatment options will also be presented.

AUTHOR AFFILIATION: Charles E. Miller, MD FACOG . Clinical Associate Professor, Department of OB/GYN University of Chicago, Chicago, IL USA and University of Illinois at Chicago, Chicago, IL USA. Director of Minimally Invasive Gynecologic Surgery, Lutheran General Hospital, Park Ridge, IL USA.

PITFALLS AND CHALLENGES IN FIBROID SURGERY

FRIDAY 22 MAY / SESSION 6 / 1050-1110

Nezhat C

While laparoscopic and robotic assisted myomectomy offer the many advantages of minimally invasive surgery to women undergoing fibroid surgery, they also present specific challenges and potential pitfalls unique to minimally invasive surgery. Because tactile feedback is limited, many argue that laparoscopic myomectomy may result in incomplete resection of myomas, or missing deep intramural fibroids because the surgeon cannot palpate them. Similarly, there is concern that the hystertomy repair may be inadequate compared to repairs done by laparotomy, and thus may lead to an increasing frequency of such rare events as the development of utero-peritoneal fistula or muscle wall weakness and uterine rupture. Additionally, removal of the myomata presents its own challenges. Though more powerful and sophisticated morcellators continue to be developed, the process can be cumbersome, time-consuming, risky to surrounding organs, and may be the cause of iatrogenic creation of parasitic myomas, as well as seeding the abdominal cavity with adenomyosis, endometriosis, and potentially cancer.

TUBAL SURGERY IN THE AGE OF IVF

FRIDAY 22 MAY / SESSION 6 / 1110-1130

Tsaltas J

There has been much debate in the world literature recently as to whether tubal surgery has any place in modern gynaecological practice with increasing success rates of IVF. Indeed tubal disease was one of the early indications for IVF. Indications for IVF have certainly expanded well beyond this classical indication. There are many advocates now who suggest that couples with infertility do not need to have a laparoscopy as part of their infertility work up. I believe that there still is a significant place for laparoscopy in the management of the infertile couple.

Tubal surgery has a place both prior to and during IVF treatment. It is necessary in the correction of tubal anatomy in patients who have significant endometriosis. The normalisation and correction of pelvic anatomy in patients with severe endometriosis offers patients the opportunity to conceive spontaneously and may indeed improve IVF outcomes.

Patients with adhesions from pelvic inflammatory disease can be offered laparoscopic surgery for division of the adhesions and normalisation of their anatomy. The place of neosalpingostomy will be discussed during this presentation. Patients who are already undergoing IVF and have hydrosalpinx present should have the hydrosalpinx removed to improve both their chances of pregnancy on IVF and reduce the slight increased incidence of miscarriage in patients with a chronic hydrosalpinx. These issues will be discussed in detail.

AUTHOR AFFILIATION: J Tsaltas. Head of Gynaecological Endoscopy. Monash Medical Centre, Melbourne, Australia

PRESIDENTIAL DEBATE: SEX IS FOR THE YOUNG

FRIDAY 22 MAY / SESSION 6 / 1130-1230

Johnson N

Analysis of male and female sexual dysfunctions will reveal exactly what age sex is for...

Saturday 23 May

EXPECT THE UNEXPECTED – UNDIAGNOSED GYNAECOLOGIC MALIGNANCY

SATURDAY 23 MAY / SESSION 9 / 0800-0815

Salfinger S

Cervical malignancy. Patients undergoing hysterectomy should all have normal pre-operative pap smear. Colposcopy should be performed on all patients with abnormal smears and relevant assessment/treatment to exclude cervical malignancy pre-operatively. If discovered intra-operatively - consult with Gynae Oncologist. Simple hysterectomy is generally not adequate. If disseminated cervical malignancy is identified at operation the hysterectomy should be abandoned.

Endometrial Malignancy. Patients should have assessment of endometrium prior to hysterectomy. If suspicious findings intra-operatively do frozen section to assess and consult with Gynae oncologist. Most units have protocols for incompletely staged endometrial carcinoma. Treatment depends on uterine risk factors. Options include Restaging, Use of adjuvant treatment. May alter choice of optimal adjuvant treatment or make ineligible for clinical trials.

Ovarian Carcinoma. Triage based on RMI/unit protocols. Will still get unexpected malignancy – the *peek and shriek*. If suspicious lesions are identified take washings and biopsy/oophorectomy, try to avoid spillage as will upstage. Intra-operative consult with Gynae-oncologist. Especially if laparoscopic approach can always abandon procedure and allow formal staging at a later date. Laparoscopic staging has up to 30% chance of under staging. There is an increased rate of optimal debulking with surgery by Gynae oncologist.

SUMMARY: *Expect the unexpected* and use appropriate workup to minimize chance of undiagnosed malignancy. Intra-operative diagnosis cannot be avoided. Remember to "*Phone a Friend*". Less can be more – *he who learns to run away lives to fight another day.*

AUTHOR AFFILIATION: Stuart Salfinger MBBS, FRANZCOG, CGO, Gynaecologic Oncologist. Western Australian Gynaecologic Cancer Service

HUMAN CENTRED DESIGNS – WHAT THE EXERTS' PERFORMANCE LOOKS LIKE

SATURDAY 23 MAY / SESSION 9 / 0835-0850

Kraal B

Research shows that experts work differently to non-experts. This brief presentation will describe recent research on expertise in medical contexts from the perspective of Design Research. Design Research is a field concerned with understanding how people and systems interact in order to design better tools and systems.

AUTHOR AFFILIATION: Dr Ben Kraal. Research Fellow, People + Systems Lab, Queensland University of Technology, Brisbane, Qld, Australia.

SURGICAL PERFORMANCE DOCUMENTATION

SATURDAY 23 MAY / SESSION 9 / 0850-0900

Obermair A

Every surgical procedure poses risks and quality assurance mechanisms should be in place to maintain and improve standards in surgical care. Data collected need to include demographics, preoperative factors, operating theatre factors and clinical outcomes. Clinical audits may be a first step to review case series and also to agree on outcome variables and confounders. Audits can reflect on qualitative and quantitative outcomes.

The aim of Cumulative Summation (Cusum) techniques is to determine whether a variation in surgical performance is due to chance or greater than expected and a reason for concern. Internet-based systems for the self-audit of surgical performance allow benchmarking in regards to surgical adverse events.

SEXUAL FUNCTION AND PELVIC FLOOR DISORDERS

SATURDAY 23 MAY / SESSION 10 / 1030-1055

Kammerer-Doak D

OBJECTIVE: to review sexual function questionnaires used in urogynecology, the impact of pelvic floor dysfunction (PFD) on sexual function, and the impact of surgical treatment of PFD on sexual function, with a focus on the experience and publications of validated sexual function questionnaires in the urogynecologic literature.

SUMMARY: validated questionnaires assure data that are reliable, quantifiable, and reproducible. Quality of life questionnaires, such as The King's Health Questionnaire and the Incontinence Impact Questionnaire, have a few questions addressing sexual function, but really deal with the overall impact of incontinence and/or prolapse on the patient's QOL/ well being and do not focus on sexual function. General questionnaires focused on sexual function include the Female Sexual Function Index (FSFI) and the Sexual History Form-12, and were designed to evaluate sexual function and underwent validation and reliability testing in a general population. General questionnaires are not condition specific, and may not be sensitive enough to detect differences due to PFD. The Pelvic Organ Prolapse Urinary Incontinence Sexual Questionnaire (PISQ) is a condition specific questionnaire focused on sexual function for use in women with PFD and has undergone rigorous validation and reliability testing. Many recent publications examining the impact of urinary incontinence (UI), fecal incontinence (FI) and pelvic organ prolapse (POP) using validated generalized and disease specific questionnaires have reported

poorer sexual function in women with PFD. The PISQ has been used most commonly to evaluate sexual function after surgery for PFD, with increased PISQ scores in about 70%. Significant improvement is noted for sexual function related to physical and partner-related factors, with no changes for orgasm, desire or arousal after surgical repair of PFD. Studies which used generalized sexual function questionnaires mostly found no change in sexual function following surgical treatment of POP and/or UI.

CONCLUSIONS: using validated questionnaires, PFD is associated with a negative impact on sexual function. Surgical correction of POP and/or UI improves sexual function in about 70%, although some studies show no change with the use of non-condition specific questionnaires.

REFERENCES:
1. Rogers RG, Kammerer-Doak DN, Villarreal A, Coates K, Qualls C. A New Instrument to Measure Sexual Function in Women with Urinary Incontinence or Pelvic Organ Prolapse. Am J Obstet Gynecol 2001;184:552-8
2. Kammerer-Doak D. Assessment of Sexual Function In Women with Pelvic Floor Dysfunction. Int Urogynecol J 2009 In Press
3. Rogers RG, Villarreal A, Kammerer-Doak D, Qualls C. Sexual Function in Women with and without Urinary Incontinence and/or Pelvic Organ Prolapse. Int Urogynecol J 2001;12:361-5
4. Pauls RN, Silva WA, Rooney CM, Siddighi S, Kleeman SD, Dryfhout V, Karram MM. Sexual Function After Vaginal Surgery for Pelvic Organ Prolapse and Urinary Incontinence. Am J Obstet Gynecol 2008;197:e1-622.e7
5. Rogers RG, Kammerer-Doak DN, Darrow A, Murray K, Barber M, Olsen A. Sexual Function after Surgery for Stress Urinary Incontinence and/or Pelvic Organ Prolapse: A Multi-Center Prospective Study. Am J Obstet Gynecol 2006;195:e1-4

DYSPAREUNIA

SATURDAY 23 MAY / SESSION 10 / 1055-1110

Maher C

Prolonged and severe dyspareunia is experienced by 10% of women aged between 20-60 years and it is estimated to be a problem in 40% of Gynaecology referrals. Yet this is a topic that is rarely spoken on as a single talk. The epidemiology of dyspareunia will be discussed and many may be surprised by the high incidence of dyspareunia and the long duration of symptoms prior to treatment. I will proceed during the talk to illustrate the wide variety of pathology that can cause dyspareunia and highlight the importance for the Gynaecologist in attaining the correct diagnosis prior to treatment. Care during examination is not only essential to establishes patient's confidence but is critical to establishing the correct diagnosis.

The presentation will deal with choices Gynaecology surgeon can make when deciding which pelvic floor surgery should be performed based upon the impact the intervention can have on the dyspareunia. It is clear that in the posterior vaginal compartment that fascial plication is not only associated with high success rates but also associated with low rate of dyspareunia as compared to site-specific repair, levator ani plication and biological grafts. Polypropylene mesh in the posterior compartment has been associated with unacceptable rates of de-novo dyspareunia in 1/3 of women. In vault suspending procedures the Cochrane review has demonstrated the sacral colpopexy not only to be superior to the vaginal sacrospinous colpopexy but to be associated with a lower rate of dyspareunia. The talk will conclude with practical ways of dealing with vaginal narrowing, constrictions and narrowing that cause dyspareunia.

AUTHOR AFFILIATION: Associate Professor Christopher Maher, Brisbane, Qld, Australia, www.urogyaecology.com.au .

IS MESH ASSOCIATED PAIN RE-IGNITING INTEREST IN LAPAROSCOPIC SURGERY?

SATURDAY 23 MAY / SESSION 10 / 1110-1125

Popov A

Since 1994 MESH technique treatment of genital prolapse has been widely applied by laparoscopic and vaginal approaches. Now laparoscopic sacrocolpopexy and transvaginal MESH (Prolift®) are the two methods we have found the most successful.

In order to come conclusion on effectiveness of the treatment 450 laparoscopic sacrocolpopexy and 550 Prolift cases in 5 different Clinics have been analyzed.

The criteria of effectiveness were the following:
- Frequency of complications, associated and non-associated with the MESH
- The long-term results of prolapse treatment
- The influence of the both kinds of treatment on quality of live
- Universality and accessibility of training

THE RESULTS:
- Frequency of the complications associated both with the MESH and surgical technique appears more often in vaginal approach than laparoscopic. Typical complications for transvaginal MESH were inflammation, erosions and pelvic pain while such complications were rare for laparoscopic approach.
- The long-term results were identical for both methods and were 90% successful cases. However recurrence of cystocele has been appeared more often in patients with laparoscopic approach.
- Dispareunya, pelvic pain, dysfunction of bladder and rectum have been observed more often in transvaginal MESH. There was one case of spondylodiscitis after laparoscopic sacrocolpopexy.
- Relative counter-indication for laparoscopic sacrocolpopexy are serious cardio-vascular and/or lung pathology (because the long time of operation), morbid obesity and previous open surgery.

THE CONCLUSION: In our practice we prefer laparoscopic approach to transvaginal MESH in sexually active patients. But if there are any counter-indication for laparoscopic sacrocolpopexy the transvaginal MESH is the method of choice.

AUTHOR AFFILIATION: Dr., Prof. A. Popov. Dp. Endoscopy Moscow Institute O/G, Moscow, Russia.

Sex, Surgery & Gynaecology

FREE COMMUNICATIONS ABSTRACTS

LAPAROSCOPIC UTERINE ARTERY LIGATION (LUAL): LAPAROSCOPIC MYOMECTOMY OF A 12CM FIBROID

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1330-1340

Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Kwik M

INTRODUCTION: Laparoscopic myomectomy is one of the more technically demanding advanced laparoscopic procedures. It requires identification of the correct cleavage plane, enucleation of the fibroid, suturing the myoma bed and morcellation of the fibroid for extraction. The most daunting challenge is haemostatic control, and it is often haemostasis that mandates conversion to laparotomy, need for transfusion, need to curtail the procedure for fear of coagulopathy and possible need for hysterectomy. Uterine artery ligation provides strategic control of uterine blood supply. We present a surgical video of laparoscopic myomectomy of a 12 cm fibroid with pre-emptive LUAL.

CASE PRESENTATION: The case involves a 36 years old multiparous lady with an enlarging 12cm fibroid (680gm) reaching 4cm above the umbilicus. The procedure commences with ligation of uterine arteries at the base of broad ligament via an anterior broad ligament approach, followed by infiltration of a vasoconstricting agent. The markedly improved haemostatic control permits this difficult laparoscopic procedure to be performed with minimal blood loss of 20ml. The video is edited with segments at "fast forward" speed to give more complete footage of the entire procedure.

DISCUSSION: Pre-emptive uterine artery ligation significantly reduces the operative blood loss during laparoscopic myomectomy, allowing for a more controlled procedure and minimising a wide range of blood-loss related complications.

AUTHOR AFFILIATION: D Chou, G Cario, D Rosen, M Carlton, A O'Neill, M Kwik; Sydney Women's Endosurgery Centre (SWEC), St George Private Hospital, Kogarah, New South Wales, Sydney, Australia

LAPAROSCOPIC UTERINE ARTERY LIGATION (LUAL): LAPAROSCOPIC ASSISTED MYOMECTOMY (LAM) FOR A 23X16X9CM MULTIPLE FIBROID UTERUS.

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1340-1350

Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Maroun P

INTRODUCTION: LAM is a hybrid technique combining laparoscopic and minilaparotomy techniques allowing different steps of the procedure to be performed via the more convenient approach. This technique is particularly suited for larger and more difficult fibroid uterus where a sizeable midline incision would otherwise be required. Typically, steps that are best performed laparoscopically include: Initial inspection, mapping of the fibroid and planning of myomectomy, infiltration of vasoconstricting agent, choosing and making of myomectomy incision, partial enucleation with or without partial debulking. At this stage or earlier, minilaparotomy, often no more than 5cm is made and the remaining steps including, completion of enucleation of the base of fibroid (often the more vascular part), closure of myoma bed and fibroid extraction. Laparoscopic inspection, lavage, placement of adhesion prevention barrier and insertion of a drain complete the procedure. We would like to present a case of LAM with incorporation of LUAL, which allows minimization of intraoperative blood loss.

CASE PRESENTATION: The case involves a 41 years old nulliparous petite Asian lady with enlarging 23x16x9cm fibroid uterus. In order to decrease the size of the fibroid, she had 3 x monthly Zoladex implants. This resulted in mild reduction of uterine size with reduced uterine length from 23cm to 18cm. The video presentation include techniques mentioned above plus the use of Alexis wound retractor and "helical incision" debulking of fibroid through the minilaparotomy.

DISCUSSION: LUAL complements LAM well with markedly improved haemostatic control.

AUTHOR AFFILIATION: D Chou, G Cario, D Rosen, M Carlton, A O'Neill, P Maroun; Sydney Women's Endosurgery Centre (SWEC), St George Private Hospital, Kogarah, New South Wales, Sydney, Australia.

LAPAROSCOPIC UTERINE ARTERY LIGATION (LUAL): LAPAROSCOPIC TOTAL HYSTERECTOMY FOR A 2,500GM UTERUS

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1350-1400

Chou D, Cario G, Rosen D, Carlton M, O'Neill A, Cook J

INTRODUCTION: Total Laparoscopic Hysterectomy (TLH) continues to be popularised as both laparoscopic skill level and available instrumentation evolve. Laparoscopic removal of enlarged uteri poses a number of challenges which ultimately prolong operating time. These include limited access and view of the operative field, haemostasis and tissue extraction. A video presentation of a TLH for a 2.5 kg uterus will be presented and will highlight techniques that can be employed in overcoming these challenges.

CASE REPORT: A 45 yo petite Asian lady with a progressively enlarging abdomen had a CT scan that demonstrated a 25 x 18 x 12 cm fibroid uterus "occupying the entire abdomen". The uterus extended to the superior renal pole and there was evidence of mild right ureteral dilatation and delayed excretion.
The techniques demonstrated in this video include: retroperitoneal uterine artery ligation through anterior broad ligament approach, use of both bipolar and LigaSure devices to secure haemostasis, uterine amputation with a laparoscopic sheathed scalpel (LSS), colpotomy with a Harmonic scalpel and morcellation with the LSS and 15 mm electrical morcellator. The benefits of using different laparoscopes from different ports will also be demonstrated. The video is edited with segments at "fast forward" speed to present more footage of the operative procedure.

CONCLUSION: TLH for the very large uterus is safely performed by experienced and motivated surgeons. This is achieved using the techniques demonstrated and sound anatomical knowledge. The extraction of the uterus and prolonged operating time remain major challenges.

AUTHOR AFFILIATION: D Chou, G Cario, D Rosen, M Carlton, A O'Neill, J Cook; Sydney Women's Endosurgery Centre (SWEC), St George Private Hospital, Kogarah, New South Wales, Sydney, Australia.

LUMBOSACRAL SPONDYLODISCITIS AS A COMPLICATION OF LS SACROCOLPOPEXYA

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1400-1410

Popov AA, Manannikova TN, Shaginian GG, Ramazanov MR, Chechneva MA, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodianiouk BA, Abramyan KN, Zemskov YV

Patient K., 31 years old was operated in our clinic. She has Pelvic Organ Prolapse Stage: II «C» (POP-Q). She has 2 pregnancies with 1 vaginal delivery. At March 2008 operation was done: cervix amputation, posterior colporraphya, LS mesh sacrocolpopexia, Burch procedure, paravaginal deffect repear.

At 21 day after surgery patient admire: extensive pain with irradiation to dorsal parts of the legs, walking difficulties, hyperthermia.
Antibacterial, antiinflammatory, symptomatic therapy was started.
On the tomographic image Lumbosacral spondylodiscitis L5-S1 was detected.

At 65 days after operation we had to remove MESH from the promontorium.

Neurosurgical – operative treatment (discectomy, osteosynthesis?) was recognized to be unreasonable.

Therapeutist, conservative treatment for 9 months was realized.

After 7 months after surgery patient become more active, without extensive pain demanded analgetics.

AUTHOR AFFILIATION: A A Popov, T N Manannikova, G G Shaginian, M R Ramazanov, M A Chechneva, A A Fedorov, I V Krasnopolskaya, O V Machanskite, B A Slobodianiouk, K N Abramyan, Y V Zemskov; Moscow region research institute of obstetrics and gynaecology, Moscow, Russia.

VAGINAL HYSTERECTOMY WITH BICOAGULATION CLAMPS «MARCLAMP» APPLICATION.

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1410-1420

Popov AA, Shaginian GG, Manannikova TN, Ramazanov MR, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Zemskov YV, Slobodianiouk BA

The most popular method of surgical treatment of non-malignant diseases of uterus is hysterectomy. Frequency of this procedure is varying from 25% in the UK to 38% in Sweden and Russia. Laparotomic and laparoscopic technique of hysterectomy has a high frequency of postoperative complications: damage of the bladder and ureter (0,5-0,8%), bowel injury (0,3%). Other disadvantages are: pelvic pain, haematoma of parametrium, long period of rehabilitation. The aim of the study is to assess the results of vaginal hysterectomy using of bipolar coagulation clamps "MarClump".

MATERIALS AND METHODS: Vaginal hysterectomy with bipolar coagulation clamps "MarClump" performed in our clinic in 56 cases with submucous myoma, recurrence of endometrial hyperplasia with contraindications or failure of hormonotherapy. In 47 cases only vaginal hysterectomy was done; in 9 cases hysterectomy was combined with pelvic floor reconstructive surgery. The mean age of the patients was 45,7±4,2 years. Bipolar current is producing by high frequency electrosurgical block and following cross bipolar clamp. The using of bipolar coagulation clamps provides fast and safe operation, allows reducing the cost of suture material. Operation length is about 15-30 minutes. The application of new method allows excluding the retrograde bleeding due to block of the arterial and venous blood stream. The operation wound remains dry and bloodless. The difficulties of vaginal hysterectomy in patients with extreme weight are a well known fact, due to the depth of pelvis and difficulties of stitches of vessels and ligaments. The technique of vaginal hysterectomy using of bipolar coagulation is free of these disadvantages.

RESULTS: The follow advantages of the vaginal hysterectomy using bipolar coagulation clamps "MarClump" in comparison with classical methods were discovered. The time of operation and the blood loss are decrease. Intraoperative and late postoperative complications are absent. The using of this method allows decreasing the duration postoperative period (from 2 or 3 days maximum). Advantage of this method is particularly important among extreme overweight patients, due to difficulties of stitches of vessels and pedicles. This operation is preferable method among somatically compromised patients, because this method significantly reduce the time of operation compared with conventional vaginal/ laparoscopic and laparotomic hysterectomies.

AUTHOR AFFILIATION: A A Popov, G G Shaginian, T N Manannikova, M R Ramazanov, A A Fedorov, I V Krasnopolskaya, O V Machanskite, Y V Zemskov, B A Slobodianiouk; Moscow Regional Research Institute of Obstetrics and Gynecology, Moscow, Russia

OUTPATIENT HYSTEROSCOPY POINTS IN TECHNIQUE: TRADITIONAL APPROACH VERSUS THE VAGINOSCOPIC APPROACH

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1420-1430

McIlwaine K, Readman E, Cameron M, Maher P

The outpatient hysteroscopy service commenced at the Mercy Hospital for Women in 2000. It provides women with the opportunity to have the cause of abnormal uterine bleeding diagnosed in an outpatient setting. The technique employed for the outpatient hysteroscopy procedure in our unit traditionally involves insertion of a bivalve speculum followed by application of 0.1% lignocaine spray to the anterior cervical lip before applying a tenaculum to the cervix and inserting the hysteroscope through the cervical canal. An intracervical, paracervical or intrauterine block may be used if required. A prospective audit of all women attending the outpatient hysteroscopy clinic between May 2003 and February 2008 demonstrated an acceptability rate of 89% which is consistent with that reported in the literature (83 – 99%) (1). Pain was a significant determinant of procedure acceptability and the acceptability rate was not influenced by analgesia or type of anaesthetic administered.

It has been demonstrated that the vaginoscopic approach to outpatient hysteroscopy is easy to perform, significantly reduces patient discomfort and eliminates the need for analgesia or anaesthesia (2), (3). Since mid 2008 we have moved to using the vaginoscopic approach for all outpatient hysteroscopy procedures. This video presentation compares and contrasts the two techniques for outpatient hysteroscopy.

REFERENCES:
1. Readman E, Maher P: Pain Relief and Outpatient Hysteroscopy: A Literature Review. J Am Assoc Gynecol Laparosc 2004, 11: 315 – 319
2. Bettocchi S, Selvaggi L: A vaginoscopic approach to reduce the pain of office hysteroscopy. J Am Assoc Gynecol Laparosc 1997, 4: 255-258
3. Bettocchi S, Nappi L, Oronzo C, Selvaggi L: Office Hysteroscopy. Obstet Gynecol Clin N Am 2004, 31: 641 - 654

AUTHOR AFFILIATION: Dr Kate McIlwaine, E Readman M Cameron P Maher. Endosurgery Fellow, Department of Endosurgery, Mercy Hospital for Women, Heidelberg, Victoria, Australia.

TEMPORARY UTERINE ARTERY CLIPPING AS AN ADJUNCT FOR THE RESECTION OF LARGE LEIOMYOMATA

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1430-1440

Kroon B,Wynn-Williams M

Fibroids are a common gynaecological pathology implicated in menstrual dysfunction, infertility and pelvic pain. The laparoscopic resection of large leiomyomata represents a particular technical challenge, particularly with respect to haemostasis. We present a video study of the use of temporary endoscopic vascular clamps (Aeskulap, Tuttlingen) placed on the uterine artery prior to removal of leiomyoma. This technique minimises intra-operative blood loss and permits the safe removal of large leiomyomata by the laparoscopic route.

AUTHOR AFFILIATION: B Kroon, M Wynn-Williams; Queensland Fertility Group and Eve Gynaecology, Brisbane, Australia

COMBINED LAPAROSCOPIC ULTRA-LOW RECTAL RESECTION AND RIGHT HEMICOLECTOMY FOR ENDOMETRIOSIS (VIDEO)

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1440-1450

Lam A, Khong S-Y, Evans J

Mrs. B, a 36 year old lady, first presented to our unit in July 2007 with secondary infertility, dysmenorrhoea, midcycle pain, and dyschezia. She had previously been diagnosed with severe endometriosis by laparoscopy in December 2006. She had undergone a myomectomy in 2003 and a Caesarean section in 2005.

In September 2007, laparoscopy revealed severe widespread pelvic endometriosis with the presence of nodular disease found in the rectum, ileum and appendix. Pelvic endoemetriosis was excised but bowel surgery was not performed at this time. She was subsequently managed conservatively by ourselves and a colorectal surgeon as she continued to try for another pregnancy.

She returned five months later with worsening dysmenorrhoea, menorrhagia, increasing abdominal bloating and diarrhoea associated with menstruation. As she had failed to conceive naturally, a trial of clomiphene was commenced. She was reviewed in June 2008. Unfortunately, she continued to suffer from dysmenorrhoea, midcycle and premenstrual pain, menstrual diarrhoea with recurrence of dyschesia. Decision was made to proceed with laparoscopic excision of bowel endometriosis which involved an ultra-low rectal resection and a right hemicolectomy with primary reanastamosis. (see video and operation images)

Histology confirmed presence of extensive subserosal and intramural endometriosis involving the rectum, terminal ileum and appendix. (see pathology slides)

Postoperatively recovery was uneventful. She was asymptomatic at her follow up at 3 months. She was restarted on clomiphene as she continued to try for a pregnancy. She decided not to have any IVF treatment.

AUTHOR AFFILIATION: A Lam, S-Y Khong, J Evans; Centre for Advanced Reproductive Endosurgery, St Leonard's NSW, Australia

THE CONSERVATIVE TREATMENT AND FOLLOW-UP IN BORDERLINE OVARIAN TUMORS

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 1 / VIDEO / 1450-1500

Sobiczewski P, Bidzinski M

Borderline ovarian tumors in 80% are diagnosed in stage I according to FIGO classification and in more than 50% the patients are young women in reproductive age. The treatment in such cases should be conservative, if possible, in order to preserve the fertility potential.

MATERIAL AND METHODS: One hundred forty eight patients with borderline tumors were treated in Maria Sklodowska-Curie Memorial Cancer Center from 1996 to 2005 . In 40% conservative treatment was applied with subset of patients managed by laparoscopy. The recurrences occurred in 11,7%, with 7,5% local relapses. The overall survival (OS) and disease free survival (DFS) was calculated using Kaplan –Meier method .Five years OS and DFS in the entire group was 0,98 and 0,87 respectively. The tumor capsule rupture had no influence on prognosis ($p>0,1$).

CONCLUSION: Patients treated by conservative manner needs close follow-up due to the possible risk of relapse in remaining ovary. We used to perform gynecologic examination with transvaginal ultrasound and ca 125 blood sampling every 3 moths until 2 years of follow-up and afterwards every 6 moths .3 D imaging ultrasound may be useful in the diagnostic of small recurrent ovarian cysts with endovegetations which sometimes are difficult to visualize with conventional sonography. Laparoscopy is recommended for diagnostic of relapse and the treatment of recurrent tumors. After finishing the childbearing the radical surgery may be proposed as an option.
The video presents echographic images of borderline tumors and the technique of laparoscopic treatment.

AUTHOR AFFILIATION: P Sobiczewski, M Bidzinski. The Maria Sklodowska Curie Memorial Cancer Center ,Warsaw ,Poland.

CAN WE AVOID LAPAROSCOPY IN MOST ECTOPIC PREGNANCIES? THE EXPERIENCE OF OUR EARLY PREGNANCY UNIT

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1330-1340

Bignardi T, Alhamdan D, Condous G

BACKGROUND: Ectopic pregnancy (EP) remains the leading cause of death in the first trimester of pregnancy. Today, serial serum hCG measurements and high-resolution transvaginal ultrasound (TVS) can provide early diagnosis of most EPs allowing more conservative options, like medical treatment with Methotrexate (MTX) or expectant management. We aimed to review the experience of our Early Pregnancy Unit (EPU) in the diagnosis and treatment of tubal EPs, and to assess the rate of conservative and surgical treatments.

METHODS: We performed a review of all women who presented to the EPU at Nepean Hospital, Sydney between Nov 2006 and Feb 2009, with a TVS diagnosis of tubal EP. In the EPU EPs are managed in accordance to a strict protocol which includes a full evaluation of clinical, sonographic and biochemical (hCG) data. Laparoscopic salpingectomy is performed only if: clinical presentation suggests rupture (severe pain, significant hemoperitoneum on scan, haemodynamycal instability), non-compliance or failure of conservative treatment (MTX or expectant). In all other patients the serum hCG ratio (hCG at 48hrs/hCG at presentation) is determined: if > 1.0 (evolving EP) women are treated with MTX in a single-dose i.m. protocol, if < 1.0 (failing EP) women are offered expectant management with weekly serum hCG. Success was defined as an uneventful decline of the hCG to pre-pregnancy levels with the primary intervention.

RESULTS: During the study period 60 tubal EP were managed. Median age (years) was 30 (IQR 24-35), median gestational age (days) at diagnosis was 47 (IQR 40-54), and median serum hCG level (IU/L) at presentation was 907 (IQR 317-2217). 25 (42%) were treated surgically from the onset, 13 (22%) were treated with MTX, 22 (36%) were managed expectantly. Two women had laparoscopy as a failure of MTX and expectant management respectively. Success rates of MTX and expectant management were 92% and 95%, respectively.

CONCLUSIONS: Today most EPs can and should be managed non-surgically. An early diagnosis, together with a strict protocol incorporating a full clinical, sonographical and biochemical evaluation allow the avoidance of laparoscopy in most cases, and can optimize success rates of MTX and expectant management.

AUTHOR AFFILIATION: T Bignardi, D Alhamdan, G Condous. Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney, Nepean Hospital, Penrith, NSW, Australia

THE VALUE OF PRE-OPERATIVE ULTRASOUND IN TRIAGING WOMEN WITH ADNEXAL PATHOLOGY FOR ADVANCED LAPAROSCOPIC SURGERY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1340-1350

Alhamdan D, Bignardi T, Condous G

OBJECTIVE: We aim to establish the benefit of pre-operative transvaginal ultrasound (TVS) in predicting the feasibility of advanced laparoscopic adnexal surgery.

Methods and design: This is a prospective ongoing study (July 2006 and March 2009). All women who attended the outpatient One-Stop Gynecology clinic with a clinical or ultrasound diagnosis of an adnexal cyst were offered a detailed TVS in order to assess the feasibility of advanced laparoscopic adnexal surgery. The adnexal lesions were classified as benign or malignant according to the IOTA pattern recognition method. The size, echogenicity and papillary structures of the mass were noted. An initial ultrasound classification of the mass was made; all benign and borderline lesions were booked for a laparoscopic approach and all malignant lesions were referred to Gynaecological Oncology for staging laparotomy. Ovarian cysts of any size were included.

RESULTS: 41 women (with 48 adnexal masses) to date have been included in the study, 31 premenopausal and 10 postmenopausal. On histological examination, 83.3% (n=40) of adnexal cysts were benign, 8.5% (n=4) were diagnosed to have borderline malignancy, 6.3% (n=3) primary malignancy and 2.0% (n=1) secondary malignancy. The advanced laparoscopic surgery was successfully completed in 32/33 cases. One had a 34 week ovarian mass with adhesiolysis (previous ileostomy for necrotizing enterocolitis as a neonate) which histologically was confirmed to be a hemorrhagic corpus luteal cyst. This case was done laparoscopically but mini-laparotomy was performed for delivery of the massive ovarian cyst. Four women had primary laparotomy; one presented with an acute abdomen and a 20 week ovarian mass thought to have torted. Histology demonstrated secondary ovarian malignancy from the colon. The other three were referred to Gynaecology Oncology for a staging laparotomy with total abdominal hysterectomy and bilateral salpingo-oophrectomy for primary ovarian cancer. The pre-operative TVS assessment predicted the successful outcome of advanced laparoscopic surgery with a sensitivity of 100%, specificity of 80%, PPV 97% and NPV 100%.

CONCLUSION: Although the numbers are very small, a detailed pre-operative TVS is useful in predicting the feasibility of advanced high-level laparoscopic adnexal surgery. Pattern recognition of ovarian cysts is an essential part of the pre-operative work-up in women planned for laparoscopic adnexal surgery.

AUTHOR AFFILIATION: D Alhamdan, T Bignardi, G Condous; Nepean Clinical School, University of Sydney, Kingswood, NSW, Australia.

ANALYSIS OF LAPAROTOMY CONVERSIONS OF PLANNED LAPAROSCOPIC HYSTERECTOMIES AT SYDNEY WEST ADVANCED PELVIC SURGERY (SWAPS) UNIT FROM JANUARY 2001 TO DECEMBER 2008

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1350-1400

Anpalagan A, Merkur H

AIM: Conversion to laparotomy at laparoscopic hysterectomy has a multiplicity of causes; it may be due to disease/patient related factors, operator related factors and equipment/facility related factors. The aim of this study is to determine the reasons for conversion to laparotomy and its impact on patient care.

METHODS: Hysterectomy data were prospectively collected from January 2001 until December 2008. There were five different hospitals (2 public and 3 private) and 8 laparoscopic gynecologic surgeons involved in the surgical procedures during this study period.

RESULTS: There were 1102 hysterectomies performed during this time. Of these 902 (81.85%) were laparoscopically performed hysterectomies, 115(10.44%) were vaginal and 85(7.71%) were abdominal hysterectomies. There were 63(6.98%) intended laparoscopic hysterectomies which were converted to abdominal hysterectomy. The main reason for conversion was the presence of adhesions [n=37(58.73%] followed by large uteri [n=13 (20.63%). A smaller group was due to other causes including intra-operative complications that could not be dealt with laparoscopically. Average length of operation was 135 minutes and average length of stay was 4.7 days in conversion cases.

CONCLUSION: Conversion to laparotomy during laparoscopic hysterectomy is an accepted occurrence when difficulties arise. This strategy by the surgeon is usually made in the interests of safety for the patient. Conversion to laparotomy at laparoscopic hysterectomy should not be considered a complication but rather a surgical solution to problems encountered. Apart from slightly increased operating time and length of stay, there were no major sequelae reported directly due to the conversion.

AUTHOR AFFILIATION: A Anpalagan, H Merkur. Sydney West Advanced Pelvic Surgery Unit (SWAPS). Sydney West Area Health Service, NSW, Australia.

PREGNANCY OUTCOMES AFTER LAPAROSCOPIC MYOMECTOMY WITH BLUNT TIPPED STAINLESS POLE FOR FIBROIDS PENETRATING THE UTERINE CAVITY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1400-1410

Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

OBJECTIVE: To evaluate pregnancy outcomes in women with fibroids penetrating the uterinal cavity that were enucleated with blunt tipped stainless pole and sutured 3~4 layers

DESIGN: Post operative sheets reviews prospectively

SETTING: Eun's gynecologic laparoscopic hospital, South Korea

PATIENTS: 47 women attempting pregnancy with leiomyomatas penetrating the uterine cavity

INTERVENTION : After 1:200 vasopressin infiltration, the enucleation of myoma was done with blunt tipped stainless pole without myoma screw or electrocoagulator or scissors completely, and suturing was done at the endometrial layer and myometrium in 2~3 layers continuosly

MEASUREMENT AND MAIN RESULTS: The mean operative time was 85(SD39) minutes; the mean reduction in haemoglobin was 0.7±0.3 g/dl. 42 women easily achieved 63 pregnancies (5 women were not married) and 40 women were delivered at or near term by cesarean section. 2 women delivered vaginally twice. 1 uterine rupture occurred during emergent c-section at 34 weeks, and mother and baby were healthy after c-section, in all c-section cases, shallow groove were checked on myomectomy site of the contracted uterus.

CONCLUSION: To achieve the healthy endometrial cavity and good pregnancy outcome, the atraumatic enucleation of myoma must be essential.

REFERENCES:
1. Nelson H. Stringer, et al : Pregnancy outcomes after laparoscopic myomectomy with ultrasonic energy and laparoscopic suturing of the endometrial cavity. Journal of AAGL, Vol.8.,pp129-136,2001
2. P.Seinera, et al : Laparoscopic myomectomy and subsequent pregnancy : results in 54 patients, Human Reproduction, Vol.15, pp1993-1996, 2000
3. R.Seracchioli, et al : Laparoscopic myomectomy for fibroids penetrating the uterine cavity : is it a safe procedure?, International Journal of Obstetrics and Gynaecology, Vol.110, pp236-240, 2003

AUTHOR AFFILIATION: D-S Eun[1], K-Sik Shin[2], Y-S Choi[2],J Choi[2], J-AHa[2]; 1.Korean Society of Obstetrics and Gynecology, Gwang-ju, South Korea. 2.Eun's hospital.

LAPAROSCOPIC ENTRY TECHNIQUE – A PREFERRED OPTION WITH OPTICAL TROCARS

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1410-1420

Tang L, Wong F

INTRODUCTION: A wide variety of opinions exist regarding the safety and effectiveness of laparoscopic entry methods. In general, the techniques commonly used are open laparoscopy, veress needle entry, and direct entry method. Visual entry systems with optical trocar were introduced in the 90s. The visual entry systems may represent an advantage over the traditional cannulas, as it allows clear entry under direct vision. However, this has not been fully evaluated. One of the authors (FW) adopted a disposable visual entry system (Xcel bladeless trocar by Ethicon) since 2006. This presentation is to illustrate his preferred option of laparoscopic entry technique and to share his experience.

MATERIALS AND METHODS: A retrospective study of all patients under the care of FW had been analysed in term of patients' characteristics, types of laparoscopic surgery, and complications to evaluate the outcome of this entry technique.

RESULTS: The study showed no major injuries including bowel, vascular and visceral injuries due to the entry technique. However, there was a bowel injury that was not related to the portal entry by trocar. The result of this study will be presented.

CONCLUSION: There are 2 different types of visual entry systems. 1) Disposable system e.g. endopath optiview optical system by Ethicon (J & J), Visiport optical trocar (Coviden). 2) Reusable system e.g. Endotip visual cannula system by Karl Storz. Optically guided entry system is safe. It allows better understanding of port dynamics, error recognition, and may exert less axial force. While the safer method of laparoscopic entry remains controversial, the endoscopic surgeons need to be versatile and competent with more than one entry technique. This presentation will discuss the pros and cons of all commonly used entry portal device and illustrate the safety and cost effectiveness of this optical guided system.

AUTHOR AFFILIATION: L Tang, F Wong. Department of Obstetrics and Gynaecology, UNSW, Liverpool Hospital, Liverpool NSW, Australia.

THE EFFECT OF HEATED, HUMIDIFIED CARBON DIOXIDE ON POSTOPERATIVE PAIN, CORE TEMPERATURE, AND RECOVERY TIMES IN PATIENTS HAVING LAPAROSCOPIC SURGERY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1420-1430

Manwaring J, Readman E

A literature review regarding the benefit of using heated humidifed carbon dioxide as laparoscopic insufflation gas reveals conflicting results, with only a few randomised controlled trials specific to gynaecologic surgery. A randomised controlled trial involving 60 women undergoing gynaecologic laparoscopy between 30 and 90 minutes duration was designed to determine whether the use of heated, humidified carbon dioxide as insufflation gas has any benefit to pain and recovery time. Patients were randomised into either receiving heated humidified carbon dioxide (study group) or standard cold dry gas (control group). Intraoperative and postoperative core temperature, total analgesic use and recovery room time were recorded, with postoperative pain intensity assessed using a visual analog scale. Statistical analysis revealed no significant difference between groups with regard to postoperative pain, analgesic requirements or recovery room time. The control group had less postoperative hypothermia.

This study demonstrated that the use of heated humidified carbon dioxide insufflation for short-duration gynaecologic laparoscopy up to 90 minutes duration did not convey benefit to postoperative pain, hypothermia or recovery room stay.

AUTHOR AFFILIATION: J Manwaring, E Readman. Mercy Hospital for Women Heidelberg, Victoria, Australia

LAPAROSCOPIC UTERINE ARTERY LIGATION (LUAL): THE ANTERIOR APPROACH

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1430-1440

Chou D, Cario G, Rosen D, Carlton M, O'Neill A.

Uterine artery is the main blood supply to the uterus and thus ligation of uterine artery assures a good haemostatic control during urine surgery. Whilst uterine artery ligation is an inevitable step in any form of hysterectomy, it can also be performed (permanently or temporarily) during laparoscopic myomectomy as a measure to reduce operative blood loss. Being able to ligate the uterine artery at the outset will give the additional benefit of reducing operator's stress level.

Uterine artery ligation can be performed through a variety of approach, including through posterior broad ligament (Posterior approach, lateral pararectal space), anterior broad ligament (Anterior approach, paravesical space) and in between (Lateral approach). We have been exploring the technique of uterine artery ligation for approximately 5 years. We started with posterior approach but over time we have found that anterior approach is often more universally applicable. This is mainly because the large fibroid uterus often fills the Pouch of Douglas, making the posterior broad ligament inaccessible, whereas the uterovesical is almost always exposable with adequate uterine elevation. We now often incorporate LUAL as the initial step for large and difficult total laparoscopic hysterectomy (TLH) and difficult laparoscopic myomectomy.

We would like to share our leaning on this technique through this PowerPoint presentation. The relevant anatomical landmarks, structures, space and their variations will be shown. The evolution of technique will be highlighted and various manoeuvres and helpful tips and tricks will be demonstrated.

AUTHOR AFFILIATION: D Chou, G Cario, D Rosen, M Carlton, A O'Neill; Sydney Women's Endosurgery Centre (SWEC), St George Private Hospital, Kogarah, New South Wales, Sydney, Australia.

OPERATIVE LAPAROSCOPY COMPLICATIONS IN AN ADVANCED GYNAECOLOGICAL ENDOSCOPY UNIT (SWEC) IN 2008

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1440-1450

Cario G, Chou D, Rosen D, Carlton M, O' Neill A

We reviewed the total number of surgeries performed in 2008 in a single endoscopic center, and report on the incidence of associated complications.

METHODS: A multi-center chart review to identify surgeries performed by 5 advanced laparoscopic surgeons from the Sydney Womens Endosurgery Centre (SWEC) from January to December 2008. A total of 1183 cases were performed, and reviewed as we have done annually for the last 4 years.

RESULTS: A total of 1183 cases were performed, 961 (82%) of those were major gynecologic laparoscopic cases and 222 (18%) of those were minor laparoscopic and hysteroscopic cases. The total 961 major laparoscopic cases were comprised of the following: 290 (30%) hysterectomies including 77 (8%) with technically demanding fibroids, 230 (24%) pelvic floor repairs and Burch colposuspensions,33 (4%) lap mesh sacrocolpopexies and 45 (5%) myomectomies, There were 284 (30%) excisions of grade I-IV endometriosis, 131 (14%) adnexal surgeries, 40 (4%) adhesiolysis, and 19 (2%) miscellaneous surgeries. Of the total 1183 surgeries, 3 major complications occurred, which yields a complication rate of 0.026%. There were no ureteric injuries, 2 bladder injuries, and 1 large bowel injury. There were no major vessel injuries and only 2 patients required transfusion. There were 2 laparotomies to handle a complication and 3 conversions to laparotomy for technical reasons..There were also 2 unintended returns to theatre. There were no episodes of thromboembolism and only 4 significant readmissions

CONCLUSIONS: Despite the large number of major procedures performed laparoscopically at our centre and the increasing complexity of the operations, the complication rates remain very low.

AUTHOR AFFILIATION: G Cario, D Chou, D Rosen, M Carlton, A O' Neill; Sydney Women's Endosurgery Centre(SWEC), Sydney, Australia.

LONG-TERM RESULTS OF LAPAROSCOPIC SACROCOLPOPEXY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 2 / PELVIC SURGERY I / 1450-1500

Popov AA, Manannikova TN, Shaginian GG, Chechneva MA, Ramazanov MR, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodyanyuk BA, Abramyn KN.

INTRODUCTION: In this report we present long-term results (1-12 years) laparoscopic sacrocolpopexy for treatment of pelvic organ prolapse.

MATERIALS AND METHODS: in our clinic one of the most popular procedures in treatment of genital prolapse are laparoscopic sacrocolpopexy (Ls SCP). Since 1996 year, we performed 302 Ls SCP in patients with genital prolaps III – IV degree. Last 5 years we apply meshes with index «Soft» and standardized technique of sacrocolpopexy with Y-form of prosthesis.

We combine SCP with hysterectomy in 263 (87%), correction of paravaginal defects in 24 (9%) cases, with posterior colporraphy - in 199 (76%) cases. In case of stress urinary incontinence we used to do Burch procedure, but now we almost always perform TVT obturator, because of the risk recurrence of incontinence is high.

RESULTS: This type of treatment has proved to be efficient in 96% of patients. 205 patients note improvement of sexual function among 241 sexual activity women (85%). It should be noted complications we met: erosions - in 3 (1%) cases, hematoma of perineum – 1(0.5%), ureteral obstruction – 1(0.5%), spondilodiscitis – 1(0,5%), no foreign body reaction.

CONCLUSION: The most important advantages of Ls SCP in comparison with other methods are: low risk of infection, due to minimal vaginal incision; no dispareunya, because of creating physiological direction of

vaginal axis. The disadvantages are: long operation time (> 2 hours); high risk of complications in obese patients with cardio-vascular problems and women with previous laparotomy. We prefer to perform Ls SCP to young patients with long history of active life including sex.

AUTHOR AFFILIATION: A A Popov, T N Manannikova, Shaginian G G, Chechneva M A, M R Ramazanov, A A Fedorov, I V Krasnopolskaya, O V Machanskite, B A Slobodyanyuk, K N Abramyn. Moscow region reserch institute of obstetrics and gynaecology, Moscow, Russia.

OUTPATIENT HYSTEROSCOPY: FACTORS INFLUENCING POST-PROCEDURE ACCEPTABILITY IN PATIENTS ATTENDING A TERTIARY REFERRAL CENTRE.

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1330-1340

McIlwaine K, Readman E, Cameron M, Dimovski E, Maher P

Ambulatory hysteroscopy is a safe, reliable and cost effective alternative to hysteroscopy under a general anaesthetic for the diagnosis of abnormal uterine bleeding (1). The objective of this study was to assess which factors influenced patients' willingness to attend for future outpatient hysteroscopy. A prospective audit was conducted of 283 women attending for outpatient hysteroscopy at the Mercy Hospital for Women over a 5-year period.

Of the women audited, 88.7% stated that they would accept the procedure in future, whilst 11.3% would not. There was a significant difference between the two groups with respect to their mean VAS pain scores during the procedure (3.43 vs 6.03 $p < 0.001$) and also with respect to the change in mean VAS score from anticipated to experienced pain (0.39 vs 2.84 $p = 0.001$). There was also a significantly higher rate of unsuccessful procedures (40.6% versus 0.8% $p < 0.05$) in women who stated that they would not attend the procedure in future as well as a higher rate of clinical vasovagal episodes (25% versus 5.2% $p = 0.01$). Pre-procedure analgesia and type of anaesthetic administered during the procedure did not seem to influence whether women would attend for future outpatient hysteroscopy.

REFERENCE:
1. Readman E, Maher P: Pain Relief and Outpatient Hysteroscopy: A Literature Review. J Am Assoc Gynecol Laparosc 2004, 11: 315 - 319

AUTHOR AFFILIATION: K McIlwaine, E Readman, M Cameron, E Dimovski, P Maher; Department of Endosurgery, Mercy Hospital for Women, Heidelberg, Victoria, Australia.

LAPAROSCOPY FOR ALL: A TEAM APPROACH

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1340-1350

Georgiou C, Tait N, Bagia S

In the Public sector the training of Surgical and Gynaecology Registrars to perform basic laparoscopic operations safely is challenging. The philosophy of see-one, do-one, teach-one is no longer acceptable in modern training. However, a combination of short rotations, reduced working hours and ongoing service commitments has slowly resulted in fewer Trainees having the opportunity to learn basic laparoscopic skills. This is particularly evident in hospitals outside major cities.

At the Wollongong Hospital, in addition to the laparoscopic instruction received by the Registrars with their respective Consultants, we have developed a multifaceted training programme. This teaches basic laparoscopic principles to Registrars in Surgery and Gynaecology and also focuses on the training of theatre Nurses involved in laparoscopic surgery. The emphasis is on the development of a "Team" approach to basic laparoscopic surgery.

The components of the programme include:

- Registrars attending fortnightly "tutorial/ interactive" sessions in a functional operating theatre. The topics range from patient selection and theatre dynamics to specimen retrieval and port closure. They comprise of a combination of theoretical and practical hands-on teaching.
- Registrars are allocated specific topics such as "The Harmonic scalpel" or "The anatomy of a laparoscopic cholecystectomy/ salpingectomy". They then present these to the rest of the group including theatre nurses.
- Various company representatives attend to demonstrate the specific products that are actually used in the hospital.
- The development of a "Laparoscopy for theatre nurses" course addresses the specific issues that enable laparoscopic procedures to be efficient and safe. The course provides "trouble shooting" and involves "role playing" to facilitate this.
- Journal Clubs involving Surgery and Gynaecology allow discussion on related papers such as, laparoscopic guidelines for the pregnant patient and common errors/ complications that occur during laparoscopic surgery.
- Using DVD recordings of laparoscopic cases a joint "show and tell" video evening allows us to discuss as "laparoscopic surgeons" the potential pitfalls and benefits that we may have learned from our collective experiences.

We believe that this multifaceted, multi-discipline approach with gynaecological, surgical and nursing contributions together with input from anaesthetists, other theatre staff and product specialists would

help us develop safe laparoscopic surgery for all, in the Public sector.
AUTHOR AFFILIATION: C Georgiou[1], N Tait[2], S Bagia[3]; 1.Graduate School of Medicine, University of Wollongong, Wollongong Hospital, Illawarra, Australia. 2.Graduate School of Medicine, University of Wollongong, Illawarra, Australia. 3.Wollongong Hospital, Illawarra, Australia

BLEEDING DISORDERS AMONGST WOMEN WITH ENDOMETRIOSIS

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 / REPRODUCTION I / 1350-1400

Heynemann S, Grover S, Cameron M, Dauer R, Smith C, Barnes C, Johnson E

BACKGROUND: It is known that women with endometriosis are more likely to experience menses that are heavier or of longer duration than those without endometriosis. Furthermore a higher prevalence of bleeding disorders exists amongst women who experience heavy menstrual bleeding – 17% reported compared to 1% in the general population[1]. Therefore it is possible that women with endometriosis may have a higher prevalence of bleeding disorders compared with the general population. No investigation to date has focussed on determining whether an association exists between endometriosis and bleeding disorders.

AIM: To establish the prevalence of bleeding disorders amongst women with endometriosis, and investigate predictive history features of a bleeding disorder. To investigate whether an association exists between severity of endometriosis, bleeding history and presence of a bleeding disorder.

METHODS: Women with histopathologic confirmation of endometriosis were recruited from the gynaecology clinics of Mercy Hospital for Women, and private rooms of clinicians involved.

General bleeding tendency was evaluated via a standardised questionnaire previously validated for screening for Type 1 von Willebrand Disease [2] and modified to include factors recently shown to be highly predictive of bleeding disorders, and a bleeding score was calculated. Menstrual bleeding tendency was evaluated by obtaining current and 'worst' episode menses profiles via the Pictorial Blood loss Assessment Chart (PBAC) [3].

Subjects who scored highly on the questionnaire underwent initial blood tests for detection of a bleeding disorder. Evaluation of several aspects of haemostasis was undertaken, including PT, APTT, Platelet Function Analyser-100® and Factor 8 studies. Subjects with abnormal results on initial screening were referred for specialist haematological investigation.

RESULTS: The preliminary data on 54 women reveal 26/54 (48.1%) of the subjects had a sufficiently high bleeding score to warrant blood testing. 45/54 (83.3%) of subjects had either normal blood test results or a low bleeding score which did not demonstrate sufficient bleeding tendency to warrant testing. 4/54 (7.4%) had abnormal von Willebrand Factor tests and 8/54 (14.8%) had abnormal platelet function tests. This and further final data will be presented.

CONCLUSIONS: Prevalence of abnormal bleeding tests in women with endometriosis on preliminary testing, particularly vWF, has been lower than expected, and prevalence of bleeding disorders diagnosed following specialist evaluation is expected to be lower again.

REFERENCES:
1. Kadir, R.A., et al., Frequency of inherited bleeding disorders in women with menorrhagia. The Lancet, 1998. 351(9101): p. 485-489.
2. Rodeghiero, F., et al., The discriminant power of bleeding history for the diagnosis of type 1 von Willebrand disease: an international, multicenter study, in Journal of Thrombosis & Haemostasis. 2005, Blackwell Publishing Limited. p. 2619-2626.
3. Higham, J.M., P.M.S. O'Brien, and R.W. Shaw, Assessment of menstrual blood loss using a pictorial chart. British Journal of Obstetrics and Gynaecology, 1990. 97(8): p. 734-738.

AUTHOR AFFILIATION: S Heynemann [1,4], S Grover[1,2,4], M Cameron[1,2], R Dauer[3], C Smith[3], C Barnes[2], E Johnson[1,4]. 1.Mercy Hospital for Women, Heidelberg, Vic. Australia. 2.Royal Childrens' Hospital, Melbourne, Vic. Australia. 3.Austin Hospital, Heidelberg, Vic. Australia. 4.The University of Melbourne, Parkville, Vic. Australia.

HAEMOPERITONEUM AND ECTOPIC PREGNANCY DOES NOT EQUAL LAPAROSCOPY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1400-1410

Bignardi T, Alhamdan D, Condous G

BACKGROUND: The presence of haemoperitoneum is accepted to be an indication for surgery in women with tubal ectopic pregnancy (EP). The aim of this ongoing study is to evaluate the feasibility of managing such women non-surgically.

METHODS: Prospective observational study. Women with tubal EP and hemoperitoneum on transvaginal ultrasound (TVS) were managed expectantly or with methotrexate (MTX) as an inpatient. Inclusion criteria for conservative management were: compliance, clinical stability, absence of acute abdomen, stable hemoglobin level on two measurements (0 and 12 – 24 hour (h) apart), serum hCG < 5000 IU/L, absence of fetal cardiac activity on TVS and absence of significant hemoperitoneum, defined as blood above the level of uterine fundus and/or in Morison's pouch (hepato-renal space). Subsequent management was based upon hCG ratio at 48h. All women were managed as an inpatient until the abdominal pain settled and the serum hCG levels were falling.

RESULTS: 41 tubal EP presented in the study period. 8/41 (20%) women fulfilled entry criteria. Median gestational age at diagnosis was

53 days (interquartile range, IQR 49-61). All women presented with lower abdominal pain/ right iliac fossa (RIF) or left iliac fossa (LIF) pain. Hemoglobin ranged from 11.2 to 14.2 g/dL at presentation and from 12.0 to 14.8 g/dL after 12 – 24 h. 6/8 (75%) women were managed expectantly; 2/8 (25%) received MTX. All women had resolution of EP within 3 weeks with no complications.

CONCLUSIONS: this pilot study suggests that hemoperitoneum on scan may not be an absolute contraindication to conservative management of tubal EP. We believe that the clinical state of the woman together with a qualitative assessment of the haemoperitoneum with ultrasound are more important in deciding whether to perform surgery.

AUTHOR AFFILIATION: T Bignardi, D Alhamdan, G Condous; Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney, Nepean Hospital, Penrith, NSW, Australia

BLEEDING DISORDERS IN ADULT WOMEN WITH HEAVY MENSTRUAL BLEEDING

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1410-1420

Johnson E, Grover S, Dauer R, Cameron M, Smith C, Barnes C, Heynemann S

BACKGROUND: Bleeding disorders are present in approximately 10% of teenage girls with heavy menstrual bleeding1. However, bleeding disorders are often not considered in the differential diagnosis of heavy menstrual bleeding for adult women despite the reported prevalence being 17%2. A U.K. study showed that only 2% of gynaecologists would consider testing for a bleeding disorder in an adult woman with heavy menstrual bleeding and therefore this diagnosis may often be missed3.

AIMS: To establish the prevalence of bleeding disorders in adult women with heavy menses in Melbourne. To investigate which bleeding symptoms (epistaxis, postpartum haemorrhage, bleeding after surgery, family history, etc) are the most predictive of a bleeding disorder and whether a high Pictorial Blood Loss Assessment chart (PBAC) score is helpful in predicting a bleeding disorder.

METHODS: Women with heavy menstrual bleeding or a history of heavy menstrual bleeding underwent a standardized bleeding questionnaire to determine their risk for a bleeding disorder. A PBAC was also completed for each patient. Those with a significant score on the standardized questionnaire underwent blood tests for detection of a bleeding disorder. These included von Willebrand factor tests, platelet function tests (PFA-100®) and APTT/PT. Those with any abnormal blood tests were referred to a haematologist for repeat and more extensive testing.

RESULTS: Preliminary results on 74 subjects are available. The average age of these subjects was 40.5 years. The prevalence of abnormal platelet tests was 18.9% (14/74) and the prevalence of abnormal von Willebrand factor tests was 5.4% (4/74). The combined prevalence of abnormal tests was 20.3% (15/74). The true prevalence of confirmed bleeding disorders is likely to be lower following haematology review. This and further final data will be presented.

CONCLUSIONS: Although these results are similar to the earlier reports of 17% rate of bleeding disorders in women with heavy menses, the final rate from this study is likely to be lower when further careful assessment is undertaken by the haematologists. Further data including the usefulness of bleeding symptoms and PBAC will also be presented.

REFERENCES:
1. Jayasinghe, Y., P. Moore, et al. (2005). "Bleeding disorders in teenagers presenting with menorrhagia." Australian & New Zealand Journal of Obstetrics & Gynaecology 45(5): 439.
2. Kadir, R. A., D. L. Economides, et al. (1998). "Frequency of inherited bleeding disorders in women with menorrhagia." The Lancet 351(9101): 485-489.
3. Chi, C., N. Shiltagh, et al. (2006). "Identification and management of women with inherited bleeding disorders: a survey of obstetricians and gynaecologists in the United Kingdom." Haemophilia 12(4): 405-412.

AUTHOR AFFILIATION: E Johnson[1,2], S Grover[1,2,3], R Dauer[3], M Cameron[2], C Smith[3], C Barnes[4], S Heynemann[1,2]; 1.University of Melbourne, Vic. Australia. 2.Mercy Hospital for Women, Vic. Australia. 3.Austin Hospital, Vic. Australia. 4.Royal Children's Hospital, Vic. Australia.

CHLAMYDIA TRACHOMATIS IN FALLOPIAN TUBES OF WOMEN UNDERGOING LAPAROSCOPY FOR ECTOPIC PREGNANCY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 / REPRODUCTION I / 1420-1430

Bignardi T, Branley J, Alhamdan D, Condous G

BACKGROUND: Chlamydia trachomatis is common among young and sexually active people. Most often infections are asymptomatic but have potential long-term consequences for the reproductive health. The pathogenesis of tubal ectopic pregnancy (EP) in the context of Chlamydia trachomatis infection is poorly understood. We aimed to study whether Chlamydia trachomatis is absent or persists in a latent state in the fallopian tube at the time of laparoscopy for tubal EP.

METHODS: We examined tissue of the fallopian tubes for the presence of Chlamydia trachomatis from women who underwent laparoscopic salpingectomy for EP.
RESULTS: Fresh tubal tissue from 16 women with histological confirmation of EP were examined in a hospital setting for the presence of Chlamydia trachomatis. The presence of Chlamydia trachomatis DNA

was confirmed by polymerase chain reaction (PCR) using a commercial test (BD ProbeTec™ ET System) and a real-time enhanced PCR able to detect few copies of the organism. Chlamydial DNA was detected in 0 of the 15 tubal specimens. In 1 case the PCR analysis was not possible for presence of inhibitors.

CONCLUSIONS: We did not find any evidence of latent infection of Chlamydia trachomatis in the fallopian tube at the time of laparoscopy for EP in our study. This suggests that EP can be considered a late complication of the tubal damage resulted from a previous acute Chlamydia infection, and that EP may not be related to a latent persistence of Chlamydia in the fallopian tube.

AUTHOR AFFILIATION: T Bignardi[1], J Branley[2], D Alhamdan[1], G Condous[1]; 1.Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney, NSW Australia. 2.Department of Microbiology, Nepean Hospital, Penrith, Sydney, NSW Australia.

THE LAPAROSCOPIC MANAGEMENT OF PLACENTA ACCRETA – A CASE PRESENTATION

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 / REPRODUCTION I / 1430-1440

Hodge W, Wagaarachchi P

Abnormal placental penetration into the uterine wall is a major cause of maternal morbidity and mortality. The known association with prior caesarean section has enhanced the early diagnosis of this condition, and provides the obstetrician with the ability to optimise management at the time of delivery, focusing on minimisation of haemorrhage and preservation of fertility.

In women with no history of predisposing uterine surgery the diagnosis is usually made at the time of delivery when there is no evidence of placental separation and no plane of cleavage at the time of manual removal of the placenta. The benefits and risks of conservative management must be weighed against those of immediate surgical management, and the degree of postpartum haemorrhage often determines the treatment pathway.

This case presentation documents the management of a placenta accreta within the left horn of a presumed septate uterus following vaginal delivery at 34 weeks. Conservative management was instigated but due to the tyranny of distance and time an alternative approach to management was utilised with the successful laparoscopic removal of the placenta several weeks following delivery. Potential reproductive capability was maintained with conservation of the uterus.

AUTHOR AFFILIATION: W Hodge,P Wagaarachchi; Women's and Children's Hospital, North Adelaide, SA, Australia

TRANSRECTAL ULTRASOUND GUIDED SURGICAL EVACUATION OF CAESAREAN SCAR ECTOPIC PREGNANCY: A NEW TECHNIQUE

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1440-1450

Bignardi T, Alhamdan D, Reid G, Condous G

OBJECTIVES: We aimed to describe a new technique for the management of caesarean scar ectopic pregnancy (CSEP): transrectal ultrasound guided surgical evacuation.

MATERIALS AND METHODS: All women who presented to the Early Pregnancy Unit between November 2006 to July 2008 underwent a transvaginal ultrasound (TVS). CSEP was diagnosed if following criteria were met: absence of an intra-uterine pregnancy and empty endocervical canal; presence of a gestational sac implanted within the lower anterior segment of the uterine corpus, with or without evidence of myometrial dehiscence. Women were offered transrectal ultrasound-guided surgical evacuation under general anaesthesia. Successful treatment was defined as complete primary evacuation of the myometrial POC. The need to perform emergency cervical cerclage, insertion of Foley's balloon catheter in order to create tamponade and blood transfusion were recorded.

RESULTS: 987 consecutive women presented to the EPU. 7/987 were diagnosed with a CSEP. 3/7 (43%) were viable at the time of diagnosis. 2/7 (29%) followed IVF; 6/7 (86%) women had a single caesarean section. One woman had a previous tubal ectopic pregnancy, and one a previous CSEP. 3/7 (43%) women were asymptomatic. 6/7 (86%) women were treated with transrectal ultrasound-guided surgical evacuation as the primary treatment, whilst 1/7 (14%) was given systemic MTX. No major complications (i.e. profuse intra-operative bleeding, transfusions) were observed.

CONCLUSION: In our hands, transrectal ultrasound-guided surgical evacuation was the treatment of choice to manage CSEPs, with a 100% success if used as primary treatment.

Figure 1. Mid-sagittal transvaginal scan of a CSEP (case 3). The ectopic sac with visible fetal pole (solid arrow) is within the myometrial defect at the site of the previous caesarean section.

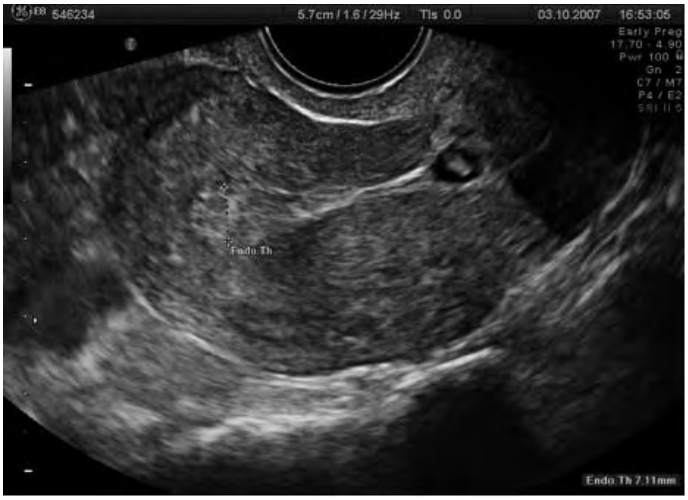


Figure 2. Viability of the same case of CSEP of figure 1, demonstrated with color Doppler ultrasound.

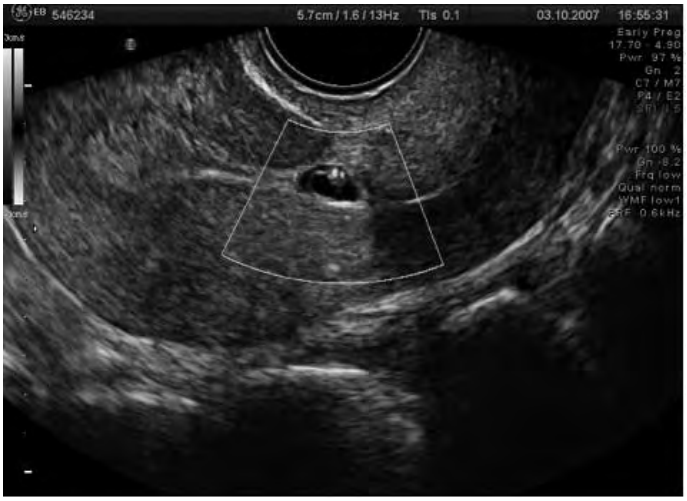


Figure 3. Severe myometrial dehiscence (solid arrow) after treatment of CSEP with systemic Methotrexate (case 2). The woman underwen t laparoscopic surgical repair of the myometrial defect; see Figure 4. (CVX = cervix).

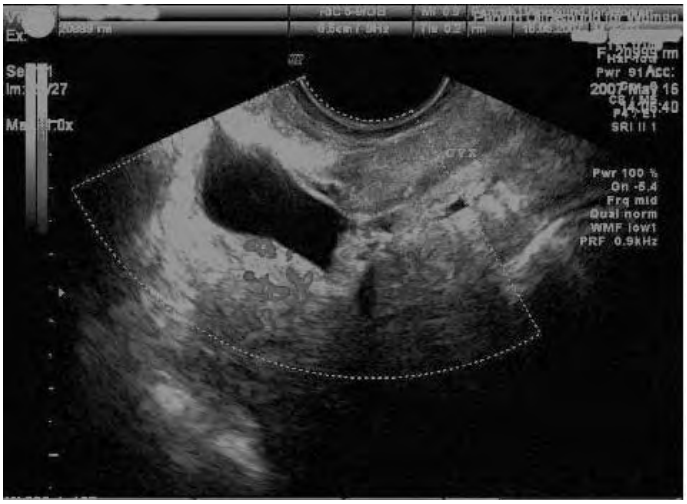
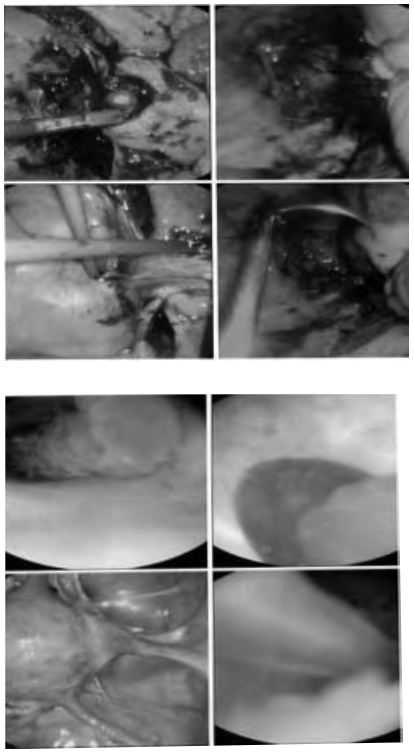


Figure 4. The woman whose ultrasound is featured in Figure 3, underwent laparoscopic surgical repair of the myometrial defect post methotrexate treatment.



AUTHOR AFFILIATION: T Bignardi[1], D Alhamdan[1], G Reid[2], G Condous[1].1.Early Pregnancy and Advanced Endosurgery Unit, Nepean Centre for Perinatal Care, Nepean Clinical School, University of Sydney, Nepean Hospital, Penrith, Sydney, Australia.2.Gynaecological Endoscopy Unit at Liverpool Hospital, Liverpool, Sydney, Australia

PREGNANCY OUTCOMES OF SALPINGOSALPINGOSTOMY IN TUBAL PREGNANCY

THURSDAY 21 MAY / SESSION 3 – FREE COMMUNICATIONS 3 /REPRODUCTION I / 1450-1500

Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

OBJECTIVE: to detect the safe methods to preserve the healthy salpinx.

DESIGN: Post operative sheets reviews prospectively

SETTINGS: Eun's gynecological laparoscopic hospital, South Korea

PATIENTS: 90 women with salpingosalpingostomy due to tubal pregnancy.

INTERVENTION: After 1:200 vasopressin infiltration into mesosalpinx around gestational sac, just only salpinx with G.sac was removed by scissors without electrocoagulation. The tubal artery and mesosalpinx were sutured with 3.0 vicryl. The clean proximal and distal portion of salpinx were sutured with 4.0 vicryl.

MEASUREMENT AND RESULTS: on postop 3 ms later HSG was done, mean age : 27(SD8)yrs, parity;1.6, Hb loss ; 0.5 g/dL, Tubal patency ; 73 patients had completely salpinx. 62 patients were pregnant.

CONCLUSION: The salpingosalpingostomy may be another good method in tubal pregnancy.

REFERENCES:

1. Dubuisson JB, Chapron C, Morice P, et al. Laparoscopica salpingostomy : fertility results according to the tubal mucosal appearance. Hum Reprod 1994;9:334
2. Dubuisoon JB, Chapron C. Single suture laparoscopic tubal reanastomosis. Curr Opin Obstet Gynecol 1998;10:307

AUTHOR AFFILIATION: D-S Eun[1], K-S Shin[2], Y-S Choi[2], J Choi[2], J-A Ha[2]; 1.Korean Society of Obstetrics and Gynecology, Gwang-ju, South Korea. 2.Eun's hospital, , South Korea.

HOW WE CAN AVOID THE BLOOD LOSS AND TIME LOSS AND URETERAL INJURY DURING LAPAROSCOPIC HYSTERECTOMY IN DIFFICULT CASES

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 / MISCELLANEOUS / 1330-1340

Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A

OBJECTIVE: to detect the adequate technique of laparoscopic hysterectomy in case by case.

DESIGN: postoperative chart reviews retrospectively.

SETTINGS: Eun's gynecological laparoscopic hospital, South Korea

PATIENTS: 3777 laparoscopic hysterectomy patients

INTERVENTION: In 2427 cases with adenomyosis with endometriosis, huge myoma uteri ≥ 400gm, dense pelvic adhesion, cervical cancer. The direct suturing the uterine artery and/or vein without dissecting the ureter was done after round ligament coagulation and cutting. In 1350 cases with stage 1 endometrial or ovarian cancers, benign pathology such as adnexal masses, small myoma < 400 gm, prolapse uteri, abnormal uterine bleeding. The uterine artery was coagulated or looped laparoscopically and then cut vaginally.

MEASUREMENT AND RESULTS: in 2427 cases mean op time is 93(SD44) mins, emergent conversion to laparotomy is none, emergent conversion to minilaparotomy is 7 cases(0.27%), ureteral injury is 8(0.33%), bladder laceration is 13(0.54%), colon laceration is 3(0.12%), reoperation due to ureteral injury is 7(0.29%), Hb change 1g/dl.

CONCLUSION: The laparoscopically direct suturing of uterine a&v without ureter dissection is efficient to the difficult cases of LAVH.

REFERENCES:
1. Hwang JL, Seow KM, Tsai YL., et al. Comparative study of vaginal, laparoscopically assisted vaginal and abdominal hysterectomies for uterine myoma lager than 6cm in dimeter or uterus weighting at least 450g : a prospective randomized study. Acta Obstet Gynecol Scand 2002 ; 81 : 1132
2. Reich H. DeCaprio J, McGlynn F. Laparoscopic hysterectomy. J Gynecol Surg 1989; 5 : 213
3. Seracchioli R, Venturoli S, Vianello F, et al. Total laparoscopic hysterectomy compared with abdominal hysterectomy in the presence of a large uterus. J Am Assoc Gynecol Laparosc 2002 ; 9:333

AUTHOR AFFILIATION: D-S Eun[1]; K-S Shin[2] Y-S Choi[2], J Choi[2], J-A Ha[2]; 1.Korean Society of Obstetrics and Gynecology, Gwang-ju, South Korea. 2.Eun's Hosptial, South Korea.

SHORT TERM RESULTS OF MAGNETIC RESONANCE IMAGING-GUIDED FOCUSED ULTRASOUND SURGERY FOR ADENOMYOSIS PATIENTS INDICATE SYMPTOMATIC RELIEF AND PAIN REDUCTION

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 / MISCELLANEOUS / 1340-1350

Yoon SW

PURPOSE: To evaluate the degree of symptomatic relief obtained following the treatment of magnetic resonance imaging-guided focused ultrasound surgery (MRgFUS) on patients with adenomyosis, and to report on the safety of these treatments.

METHODS AND MATERIALS: 17 consecutive patients, who were diagnosed as suffering from symptomatic adenomyosis, were treated with MRgFUS. MR analysis has determined focal adenomyosis for nine patients, while the remaining eight were identified as having diffuse adenomyosis. Treatment efficacy was measured by tracking the level of menstrual pain as well as the symptom severity score (SSS) from the Uterine Fibroids Symptoms Quality of Life (UFS-QOL) questionnaire over the period of 6 months.

RESULTS: The degree of menstrual pain, as reported by the treated patients, was reduced from a mean of 8.1 ± 2.4, at baseline, to 4.6 ± 2.4 by the 6 months follow-up ($P<0.001$). In addition, the level of symptoms (bleeding and pressure) as measured by the SSS has also decreased from a mean baseline score of 49 ± 15 to 26 ± 14 over those 6 months ($P<0.001$). No significant difference was observed between the patients with focal adenomyosis to those with a diffuse lesion. No serious complications were recorded during the treatments or the follow-up period.

CONCLUSION: Short-term clinical improvement (as measured by the decrease of symptoms) for symptomatic adenomyosis treated with MRgFUS has been shown in this study. The treatment modality allows safe treatments. Longer follow-up is required in order to verify the sustainability of this treatment option.

REFERENCES:
1. Elizabeth A. Stewart, Bobbie Gostout, Jaron Rabinovici, Hyun S. Kim, Lesley Regan, Clare M. C. Tempany, Sustained Relief of Leiomyoma Symptoms by Using Focused Ultrasound Surgery Obstetrics & Gynecology, 2007 Aug; 110(2 Pt 1):279-87
2. J.Rabinovici et al. Pregnancy and live birth after focused ultrasound surgery for symptomatic focal adenomyosis: a case report. Hum. Reprod. 2006 May;21(5):1255-9.

AUTHOR AFFILIATION: S-W Yoon; Bundang CHA Hospital, Diagnostic Radiology Department Gyunggi-do, South Korea.

VIDEOLAPAROSCOPIC STAGING OPERATION FOR MULLERIAN ADENOSARCOMA OF THE UTERINE CORPUS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 / MISCELLANEOUS / 1350-1400

Koh LW, Koh PR, Wong CN, Huang MH

The Mullerian adenosarcoma was first noted in 1974 by Clement and Scully. It is a mixed, biphasic neoplasia in which the mesenchymal component is malignant and the epithelial component benign. A best approach for management of uterine adenosarcoma was yet to be defined; surgery, chemotherapy, radiotherapy and follow-up have all been elucidated. We here present a case of 28-year-old, unmarried, sexually active, obese (BMI 38.3 kg/m2) young girl with irregular vaginal bleeding and polypoid mass protruded from cervical introitus noticed for 2 months after amenorrhea for 5 years.Histology reported to be low grade Mullerian adenosarcoma.Laparoscopic staging operation was done. The footage of vediolaparoscopic surgery will be presented.

AUTHOR AFFILIATION: L W Koh[1], P R Koh[2], C N Wong[1], M H Huang[1].
1. Show Chwan Memorial Hospital,Changhua,Taiwan. 2. Prince of Wales Hospital, Sydney, NSW, Australia.

FIBROMA IN ECTOPIC OVARIAN TISSUE

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 / MISCELLANEOUS / 1400-1410

Georgiou C, Rosen D

During the course of an elective laparoscopic hysterectomy and bilateral salpingoophrectomy an omental mass measuring 5cm in diameter was noted in the vicinity of the left ovary.

This mass was pearl white in colouration with an irregular surface and a peripheral blood supply from the surrounding omentum and lateral abdomino-pelvic sidewall.

Careful dissection by shelling out the mass from the peritoneal coverings demonstrated a narrow torted connection with the superior distal portion of the left fallopian tube. The left ovary was inferior to this structure and totally separate.

There was no evidence of a right fallopian tube or right ovary. There was no evidence of any previous surgery or adhesions in the vicinity of the right adnexa. The uterus appeared normal in macroscopic appearance.

Histology reported this omental mass as dense hyalinised fibrous tissue with evidence of central infarction. A small portion of compressed, probable ovarian cortical tissue was seen at the edge of the tumour. The overall appearances favoured a partially infarcted benign ovarian fibroma.

The endometrium demonstrated evidence of persisting oestrogenic stimulus. Sections through the left fallopian tube and ovary showed no significant abnormality.

The past surgical history of this 79yr old woman included a midline laparotomy for an appendectomy at 18yrs old and three normal vaginal deliveries. She did not experience any ectopic pregnancies and there was no history of any adnexal surgery.

Although the literature reports the presence of dermoids (both mature and immature), cystadenomas and normal (supernumerary) ovaries, this appears to be the first report of a fibroma present in ectopic ovarian tissue. A literature review is included.

AUTHOR AFFILIATION: C Georgiou[1], D Rosen[2]; 1.Senior Lecturer Graduate School of Medicine, University of Wollongong, Consultant Obstetrics and Gynaecology, Wollongong Hospital, Illawarra, Australia. 2.Sydney Women's Endosurgery Centre, St George Private Hospital, Kogarah, Sydney, Australia.

THE ROLE OF THE GYNAECOLOGICAL ONCOLOGIST IN A TERTIARY HOSPITAL

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 /MISCELLANEOUS / 1410-1420

Graham J, Salfinger S

INTRODUCTION: Whilst the prime role of a gynaecological oncologist is the comprehensive management of women with a gynaecologic cancer, increasingly their surgical skills are often utilised for general gynaecological and obstetric surgery. Within tertiary centres there is increasing provision of support, for both emergency cases and booked complicated cases. This study aims to investigate and define the growing role of the gynaecological oncologist within obstetrics and gynaecology and ascertain how it can be best utilised.

METHOD: A retrospective study was conducted, involving all non gynaecological oncology unit cases over the last three years that required the presence of a gynaecological oncologist in theatre. The preoperative diagnosis, surgical procedures, reason for requiring assistance, complications, outcomes and whether the cases were booked or emergency were noted.

RESULTS: A wide variety of surgical situations that required the involvement of a gynaecological oncologist were identified. These ranged from complications such as bowel injuries and haemorrhage, to gynaecological surgeries in complicated patients, and obstetric procedure in high risk women such as placenta acreta and intra-operative diagnosis of unexpected malignancy. The results included both emergency and booked procedures.

CONCLUSION: The role of the gynaecological oncologist within a tertiary centre is expanding to include the provision of support to general gynaecologist and obstetricians. There is increasing utilisation of these services whereby their assistance in pre-arranged prior to the surgery, however emergency cases requiring assistance is not uncommon. Discussing possible high risk or complicated cases with the gynaecological oncology team prior to operation can improve outcomes.

AUTHOR AFFILIATION: J Graham, S Salfinger. King Edward Memorial Hospital, Subiaco. WA, Australia.

MAGNETIC RESONANCE IMAGING-GUIDED FOCUSED ULTRASOUND SURGERY FOR SYMPTOMATIC UTERINE FIBROIDS. RESULTS IN CLINICAL IMPROVEMENT OBSERVED THROUGHOUT THE FIRST YEAR

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 / MISCELLANEOUS / 1420-1430

Yoon S-W

PURPOSE: To evaluate the effect of large treatment volumes on the level of symptom improvement and the degree of fibroid reduction throughout the first 12 months after non-invasive magnetic resonance imaging-guided focused ultrasound surgery (MRgFUS).

METHODS AND MATERIALS: 60 consecutive patients, who were diagnosed as suffering from symptomatic uterine fibroids, were treated with MRgFUS. The immediate measure of treatment outcome has been determined by analyzing the degree of non-perfused volume (NPV). Over the period of 12 months, treatment efficacy was measured by tracking the level of the symptom severity score (SSS) from the Uterine Fibroids Symptoms Quality of Life questionnaire. During this period, the amount of volume reduction has been measured and compared with the original value.

RESULTS: The mean NPV ratio, immediately after treatment, was 40% ± 20%. The degree of symptoms as measured by the SSS, has decreased from a mean baseline score of 50 ± 22 to 28 ± 13 ($P<0.001$) after 6 months. An additional significant decrease was seen at the 12 months follow-up (to 19 ± 12, $P<0.001$). The percentage of patients who experienced considerable symptom reduction (more than 10 points) has increased from 66% after 6 months to 88% after 12 months. The total fibroid volume decreased by 32% ± 27% from baseline, 12 months after treatment.

No serious complications were recorded during the course of the study.

CONCLUSION: Large treatment volumes, as measured by NPV percentages, result in continuous clinical improvement throughout the first 12 months after an MRgFUS treatment.

REFERENCES:
1. Stewart EA, Rabinovici J, Tempany CM, Inbar Y, Regan L, Gostout B, et al. Clinical outcomes of focused ultrasound surgery for the treatment of uterine fibroids. Fertil Steril 2006; 85: 22 2.
2. Fennessy FM, Tempany CM, McDannold NJ, So MJ, Hesley G, Gostout B, et al. Uterine Leiomyomas: MR Imaging-guided Focused Ultrasound Surgery-Results of Different Treatment Protocols. Radiology 2007; 243: 885-93.
3. Funaki K, Fukunishi H, Funaki T, Sawada K, Kaji Y, Maruo T. Magnetic resonance-guided focused ultrasound surgery for uterine fibroids: relationship between the therapeutic effects and signal intensity of preexisting T2-weighted MR images. Am J Obstet Gynecol 2007; 196: 184.e1-6.

AUTHOR AFFILILIATION: Bundang S-W Yoon S-W; CHA Hospital, Diagnostic Radiology Department, Gyunggi-do, South Kore

POSTOPERATIVE UTERINE PERFUSION FOLLOWING UTERINE ARTERY CLIPPING AT LAPAROSCOPIC MYOMECTOMY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 4 - MISCELLANEOUS / 1430-1440

Rosen DMB

Advances in laparoscopic surgery have made operations once requiring laparotomy incisions possible via minimally invasive techniques. Laparoscopic myomectomy however, was complicated by the real risk of major intraoperative haemorrhage requiring transfusion or conversion to laparotomy as well as the problems of morcellating the specimen for removal. By clipping the uterine blood supply and reversibly ligating the ovarian blood supply medial to the ovaries prior to myomectomy, blood loss has been able to be kept to a bare minimum.

What is the effect of these clips on long-term uterine perfusion, especially for those women desiring the preservation of fertility. This presentation details the technique of uterine artery ligation and the postoperative effect on uterine perfusion.

AUTHOR AFFILIATION: D M B Rosen. Sydney Women's Endosurgery Centre, St George Private Hospital, Kogarah, NSW, Australia.

SAFETY OF THE OPTICAL ACCESS TROCAR IN GYNECOLOGIC LAPAROSCOPIC SURGERY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 / PELVIC SURGERY II / 1330-1340

Lee S-H, Ku C-H

OBJECTIVE: Despite continued evolution of both laparoscopic instruments and techniques, trocar related complication still remains a common, yet potentially avoidable complication of laparoscopy. The

purpose of this study is to determine whether the optical access trocar can be used to establish a safe entry during gynecologic laparoscopic surgery.

MATERIALS AND METHODS: We retrospectively assessed the safety of the XCEL (Ethicon Endo-Surgery) 12mm in 350 women.

RESULTS: The mean age of the patients was 41.0±9.3 years. The mean height was 158.4±5.3 cm and the mean body weight was 57.4±8.8 kg. The mean BMI was 22.9±3.4. 116 patients (33.1%) had a history of abdominal surgery. Among these 116 patients, 35patients had undergone 2 more abdominal surgeries. The laparoscopic surgical procedures (Table 1) included LAVH (172 cases), LAVH with adnexal surgery (35 cases), TLH (4 cases), TLH with adnexal surgery (1 cases), adnexal surgery (126 cases) and myomectomy (12 cases) Complications are as follows(Table 2); ureteral serosal injury (1 case), readmission due to gastroenteritis (2 cases), readmission due to fever (1 case), readmission due to bleeding at vaginal stump (1 case) But, there were no complications associated with the XCEL trocar. There were no viscus or vascular injuries associated with insertion of the XCEL trocar. No clinical detectable abdominal wall hernias observed at the XCEL trocar site.

CONCLUSION: Trocar related complications associated with use of the XCEL trocar are rare. The XCEL trocar can be safely used even in patients with prior abdominal surgery and the increased risk of intraabdominal adhesions.

AUTHOR AFFILIATION: S-H Lee, C-H Ku; Gachon University Gil Hospital, Incheon, South Korea.

COMPLICATIONS OF LAPAROSCOPIC HYSTERECTOMY AFTER A DECADE: A FOLLOW-UP OF THE MONASH EXPERIENCE

FRIDAY 22 MAY / FREE COMMUNICATIONS 5 / PELVIC SURGERY II / 1340-1350

Tan J, Tsaltas J, Lawrence A, Najjar H, Hengrasmee P

A retrospective review of medical records was performed to assess the incidence and types of significant complications encountered during laparoscopic hysterectomy which would affect the use of a laparoscopic

approach versus other routes of hysterectomy. A total of 526 consecutive patients' medical data between January 1994 and August 2007 were reviewed. Two hundred and thirty-two laparoscopic assisted vaginal hysterectomies (LAVH) and 294 total laparoscopic hysterectomies (TLH) were performed at Monash Medical Centre, a Melbourne tertiary public hospital, and three Melbourne private hospitals, by or under the supervision of three surgeons. Sixteen significant complications occurred. There were two cases of ureteric fistula, two bladder injuries, two bowel obstructions, four postoperative haematomas, one case of a bladder fistula, four conversions to laparotomy and one superficial epigastric artery injury. In-patient stay ranged from two to six days.

Our complication and in-patient stay rates are consistent with the previously reported rates, although there has been a reduction of incidence of visceral injuries with experience and introduction of new equipment. We discuss the factors which we feel have contributed to the reduction of major complications over time.

AUTHOR AFFILIATION: J Tan1, J Tsaltas2, A Lawrence3, H Najjar3, P Hengrasmee4;
1.Mater Medical Centre, Brisbane, Australia. 2.Monash Endosurgery, Melbourne, Australia. 3.Monash Medical Centre, VIC, Australia.4.Siriraj Hospital, Mahidol University, Bangkok, Thailand.

LAPAROSCOPIC DRAINAGE OF HAEMATOCOLPOS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1350-1400

Dennie J, Pillay S, Grover S

BACKGROUND: Transverse vaginal septae are relatively rare anomalies, occurring in about 1 in 70,0001. They usually present with cyclic abdominal pain and amenorrhea, or more acutely with urinary retention. Surgical correction must be planned carefully to decrease the risk of vaginal stenosis post operatively. Percutaneous drainage of the haematocolpos has been described2, but carries a substantial risk of infection. Laparoscopic drainage of the haematocolpos (as described by Dr. Sunil Pillay), colloquially referred to as laparoscopically assisted menstruation or a LAM procedure, offers a novel way of relieving the obstructive symptoms without significant risk of infection and without compromising the definitive surgical treatment. We present two cases of laparoscopic drainage of haematocolpos in two girls who could not undergo definitive treatment at diagnosis.

CASES:
Case 1 is an 11.5 year old girl who presented with acute onset RIF pain and suspected appendicitis. At laparoscopy, the appendix was normal. The uterus and vagina were distended. Examination of the perineum revealed a low transverse septum of unknown thickness, visible above the hymen. A LAM procedure was performed by making a 5mm incision in the anterior vagina, above the reflection of bladder. She was placed on continuous oral contraceptive to suppress her menses and allow for further planning of definitive surgery.

Case 2 is a 17 year old girl with mosaic Turner Syndrome. After 18 months of low dose oestrogen therapy, she reported worsening abdominal pain but remained amenorrheic. A pelvic ultrasound demonstrated a haematocolpos associated with a 2.5cm distal vaginal obstruction. To alleviate her acute pain, a LAM procedure was undertaken and continuous low dose oral contraceptive was started. The patient has been instructed to use vaginal dilators to thin the septum before corrective surgery is performed.

COMMENTS: Definitive management of a transverse vaginal septum can be difficult - the thickness of the septum may be unknown or too large, the patient may not be ready to use vaginal dilators pre operatively to thin the septum or post operatively to prevent stenosis or the surgeon may not be adequately trained. Expectant management of a transverse vaginal septum has been described3 and is feasible as long as the patient remains asymptomatic. However, in cases where pain or urinary retention occurs, acute management is required. Laparoscopic drainage should be considered in these situations to alleviate the obstructive symptoms and to plan for definitive corrective surgery.

REFERENCES
1. Banerjee R, Laufer D. Reproductive disorders associated with pelvic pain. Semin Pediatr Surg, 1998;7:52.
2. Hurst BS, Rock JA. Preoperative dilatation to facilitate repair of the high transverse vaginal septum. Fertility & Sterility 1992;57(6):1351-3.
3. Beyth Y, Klein Z, Weinstein S, Tepper R. Thick transverse vaginal septum: Expectant management followed by surgery. J Pediatr Adolesc Gynaecol 2004;17:379-81.

AUTHOR AFFILIATION: J Dennie[1], S Pillay[2], S Grover[1]; 1.Royal Children's Hospital, Centre for Adolescent Health Parkville, VIC, Australia. 2.National Women's Hospital Auckland, New Zealand

COMBINED LAPAROSCOPIC RESECTION OF BLADDER AND RECTAL ENDOMETRIOSIS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1400-1410

Ford R, Khong S-Y, Lam A, Justin J, Vass J

We would like to present an interesting case where a combined laparoscopic resection of bladder and rectal endometriosis procedure was performed with the help of colorectal and urology colleagues. .

Miss A, a 28year old nulliparous lady, presented with a long history of severe dysmenorrhoea associated with bilateral iliac pain and low back pain. In the last 18 months, she had developed intermittent dyspareunia, micturition pain, and painful bowel movements with diarrhoea during menstruation. She had regular cycle with no history of haematuria, abnormal vaginal or rectal bleeding. She had been on combined oral contraceptives since the age of 16 for contraception and facial acne. She stopped taking COCP 3 months ago.

An ultrasonography in December 2007 showed a bladder mass. Cystoscopy with guided biopsy confirmed bladder endometriosis. Laparoscopy performed by her gynaecologist in September 2008 confirmed severe pelvic endometriosis with complete obliteration of Pouch of Douglas by bowel adhesions. The bladder was also noted to be densely adherent to the anterior uterine surface.

Miss A, was referred to our unit for assessment in October 2008. Vaginal examination revealed a tender uterus, with palpable rectovaginal nodules. Transvaginal scan showed a large complex cyst in the Pouch of Douglas consistent with an endometrioma and a small bladder wall nodule.
She was subsequently referred for colorectal and urology opinions.

AUTHOR AFFILIATION: R Ford[1], S-Y Khong[2], A Lam[2], J Evans[2], J Vass[2]; 1.North Shore Private Hospital, St Leonard's, NSW, Australia. 2.Centre for Advanced Reproductive Endosurgery, Sydney, NSW, Australia.

DO ENTRY TECHNIQUE INFLUENCE INTRA-ABDOMINAL ADHESION DEVELOPMENT?

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1410-1420

Cario G, Rosen D, Chou D, O' Neill A

Intra-peritoneal adhesions can occur after peritoneal surgery in 80 – 85% of cases, and they can result in a range of serious post-operative morbidities, from intestinal obstruction to chronic abdominal or pelvic pain and infertility. It is thought that laparoscopic surgery is associated with less risk of post-operative adhesions. Theoretically, it would seem to make sense that smaller abdominal incisions, presumed reduction in peritoneal drying, more precise adhesiolysis, minimal handling of the bowel and less tissue trauma and haemorrhage all combine to minimise adhesion formation. As reducing peritoneal adhesions is an important objective in gynaecological surgery, we decided to examine whether entry technique at operative laparoscopy influences the development of intra-abdominal adhesions.

This retrospective study was conducted which compared the presence of adhesions at second look laparoscopy in a group of 100 women who underwent Hasson entry technique (open laparoscopy) to a group of 300 women who underwent Veress needle entry at original laparoscopy. The study's objective was to examine whether either entry technique was associated with a higher risk of intra-abdominal adhesions and whether a larger port site incision confers a greater risk of adhesion formation. We also evaluated whether the newer sheath-splitting abdominal trocars lead to a reduced risk of adhesions, as the rectus sheath is not sutured at the end of the surgery.

AUTHOR AFFILIATION: G Cario, D Rosen, D Chou, A O' Neill; Sydney Women's Endosurgery Centre (SWEC), Sydney, Australia.

EFFICIENCY, COMPLICATIONS AND FUNCTIONAL OUTCOME OF PROLIFT SYSTEM(™) IN TREATMENT OF PELVIC ORGAN PROLPASE

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1420-1430

Krasnopolsky VI, Popov AA, Manannikova TN, Shaginian GG, Ramazanov MR, Chechneva MA, Fedorov AA, Krasnopolskaya IV, Machanskite OV, Slobodyanyuk BA, Zemskov YV, Abramyan KN, Fomenko OU

BACKGROUND: POP is a common condition in women. UI, voiding difficulties, constipation, and AI are all could reduce HRQoL.

METHODS: We try to assess anatomical and functional outcome of different mesh augmented repairs of severe forms of POP using all variant of PROLIFT system. All operations performed a standardized technique in one center by senior surgeon.

RESULTS: Almost in 4 year period from March 2005, 204 symptomatic patients with 2-4 degree of POP underwent surgery. PROLIFT anterior (85[42%]), posterior (35[17%]), total (29[14%]), anterior and posterior (55[27%]) were used for this purpose. Mean age 62.3 (37-86). We use standard examination, POP-Q, vaginal ultrasonography to assess pelvic floor, anorectal manometry, electromyography of EAS, m.Puborectalis and evacuation proctography if necessary. As QoL assessment tools we use PISC-12, PFDI-20 and PFIQ-7. In case of AI and anterior anal sphincter defects we use sphincteroplasty combined with levatoroplication (6[5.2%]). If there is flatal incontinence with no sphincter defect detected, all surgical intervention combined with levatoroplication (62[30%]). In case of SUI we use TVT-O (88[43%]). VH performed in 81(40%) cases. In case of cervical elongation we perform amputation in 42(20,5%). Mean operation time was 83±19min, hospital stay – 3(2-10). Intraoperatively in 9(4.4%) cases diagnosed and sutured bladder injury with no consequences. In 3(2.6%) cases massive bleeding in excess of 500ml from pudendal artery and paraurethral venous plexus, which requires laparotomy and remove prosthesis for adequate haemostasis in 1 case. Mean follow-up was 16(2-35) month. 23(11%) hematomas detected by vaginal ultrasonography and 14 erosion (7%), most of them was non-symptomatic we had to remove the MESH in 2(1%) cases only due to erosion. 1 patient (0.5%) has recurrence in Prolift total group due to incorrect operative technique. Two patients (1%) have recurrence of prolapse from IV to II degree. There are statistically significant decrease score PFDI-20 and PFIQ-7 ($p>0,05$) before and 1 year after surgery. Among 94 sexually active women there was improvement in 43 cases (45,8%), 45(47,9%) report no difference, 6(6,3%) worsening symptoms according to PISC-12 due to dyspareunia.

CONCLUSION: TVM operations are very effective in treatment of severe and recurrent POP, especially in obese and old patients. We believe that preservation of the uterus can diminish erosions rate. A future RCT with long-term results is needed.

AUTHOR AFFILIATION: V I Krasnopolsky, A A Popov, T N Manannikova, G G Shaginian M R, Ramazanov, M A Chechneva., A A Fedorov, I V Krasnopolskaya, O V Machanskite, B A Slobodyanyuk, Y V Zemskov, K N Abramyan, O U Fomenko. Moscow region reserch institute of obstetrics and gynaecology Moscow Russia

NARROW BAND IMAGING (NBI): A NEW TECHNIQUE FOR DETECTING ENDOMETRIOSIS AT LAPAROSCOPY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1430-1440

Bignardi T, Alhamdan D, Condous G

BACKGROUND: Laparoscopy is regarded as the gold standard for the diagnosis of endometriosis. However laparoscopy may fail to visualize small and subtle endometriotic superficial lesions. Narrow band imaging (NBI) is a technique, mostly used in gastrointestinal endoscopy, which uses a specific narrow wavelength of light to improve the endoscopic imaging of mucosal surfaces and vasculature. Methods: We aimed to report a case in which the use of NBI has improved the laparoscopic detection of endometriosis. A 29 y/o woman presented with dysmenorrhoea and pelvic pain. She was booked for laparoscopy +/- excision of possible endometriosis. Laparoscopy was performed using the visible white light source first, then the same operator switched on the NBI light source (415 and 540 nm filters) and performed another visual inspection of the pelvis. All lesions were excised using the harmonic scalpel and sent for histology. Results: A total of 5 biopsies were taken, 3 (80%) were positive for endometriosis. Two subtle superficial lesions were not visualised with the visible light and they were identified only with NBI. Conclusions: In our case, NBI has improved the detection of subtle endometriotic lesions at laparoscopy. Further studies are needed to prove if NBI can actually improve the performance of laparoscopy for the diagnosis of endometriosis.

AUTHOR AFFILIATIONS:T Bignardi, D Alhamdan,G Condous; Early Pregnancy and Advanced Endosurgery Unit, Nepean Clinical School, University of Sydney Nepean Hospital, Penrith, NSW, Australia.

A NOVEL USE FOR SEPRAFILM LAPAROSCOPICALLY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1440-1450

Barabash ID, Matthews LH, Ang WC.

Seprafilm™ (Genzyme) has been available in Australia since 2006. It comes in a clear sheet which is easy to use at laparotomy. However, it is brittle and can be difficult to apply during laparoscopy. We outline a novel approach to facilitate its usage.

The sheets of Seprafilm™ are pestled into a "slurry" and combined with normal saline in the following ratio - 3 sheets Seprafilm™: 60 ml 0.9% NaCl. This mélange is then administered via a feeding tube passed through a lateral port site to the target area.

We report on a group of twenty women aged between 18 and 58 who underwent operative laparoscopy between September 2007 and March 2009. The majority had had previous abdominal surgery. They were operated on for endometriosis, ovarian pathology, adhesiolysis and laparoscopic hysterectomy. None of the patients had any major complications (peritonitis, pelvic organ trauma, blood transfusion, and return to theatre).

To date, one patient has undergone repeat laparoscopy. This demonstrated no repeat adhesion formation in the areas where Seprafilm™ had been applied. A significant disadvantage is an increased expense in using multiple sheets. Whilst this is an offline use of the product, we have found that this technique has been safe and easy to use in our small series of patients. It is ideal for targeted adhesion prevention.

AUTHOR AFFILIATION: I D Barabash[1], L H Matthews[1], W C Ang[2]; 1.Masad Private Hospital east St Kilda, Victoria, Australia. 2.Royal Women's Hospital, Parkville, Victoria, Australia.

APPLICATION OF SEPRAFILM - VIDEO

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 5 - PELVIC SURGERY II / 1440-1450

Barabash ID, Matthews LH, Ang WC

This video presentation outlines the application of Seprafilm at laparocopy using a simple and novel technique.

Seprafilm™ (Genzyme) has been available in Australia for since 2006. It comes in a clear sheet which is easy to use at laparotomy. However, it is brittle and can be difficult to apply during laparoscopy.

To simplify its application, the sheets of Seprafilm™ are pestled into a "slurry" and combined with normal saline in the following ratio - 3 sheets Seprafilm™: 60 ml 0.9% NaCl. This combination has been modified for best application through a small-calibre tube. The mixture is then administered via a syringe attached to a 14G or 16G feeding tube that is passed through a lateral port site. Applying the syringe whilst a laparoscopic grasper directs the feeding tube to the pelvis allows ideal targeted application of the Seprafilm.

This method has now been applied to more than 20 patients. Nursing staff can easily be taught to prepare the mixture. The anti-adhesion barrier can now be easily targeted to specific at-risk areas of the pelvis. To our knowledge, this technique has not previously been published in medical literature.

AUTHOR AFFILIATION: I D Barabash[1], L H Matthews[1], W C Ang[2]; 1.Masad Private Hospital east St Kilda, Victoria, Australia. 2.Royal Women's Hospital, Parkville, Victoria, Australia.

THE EFFECTS OF HEATED, HUMIDIFIED CARBON DIOXIDE IN PROLONGED GYNAECOLOGICAL LAPAROSCOPY: A RANDOMIZED, CONTROLLED TRIAL

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1330-1340

Cameron M, McIlwaine K, Manwaring J, Maher P

INTRODUCTION: Laparoscopy with standard cold, dry carbon dioxide (CO2) results in peritoneal drying and cooling with subsequent inflammation, cell damage and death. This results in post-operative pain, and is a likely aetiological factor in the development of adhesions. Heated and humidified carbon dioxide maintains the physiological state and thereby may reduce these operative effects.

Several studies have looked at the effect of heating and humidifying CO2 on post-operative pain and hypothermia. Results have been mixed. A recent RCT suggested little difference between standard and heated, humidified CO2 with respect to post-operative pain and temperature. There was a trend, however, to an improvement in pain scores in patients whose surgery lasted for greater than 90 minutes. This study aims to clarify this difference.

OBJECTIVE: To determine the effect of heated, humidified carbon dioxide on post-operative pain and recovery times in patients undergoing gynaecological laparoscopic surgery lasting for greater than 90 minutes.

METHODS: Patients were randomized to receive either heated, humidified carbon dioxide or standard cold, dry CO2 for insufflation for the entirety of the laparoscopic procedure. Humidification was achieved using the Fisher and Paykel laparoscopic humidification system. Data regarding body temperature, pain, analgesia requirements and time in hospital was collected. Additional post op pain measurements and a questionnaire detailing return to normal function were completed.

RESULTS: Results will be presented outlining a trend to reduced pain and analgesia requirements, and increased temperature in the group receiving humidified CO2. With regards return to normal function, there was no significant differences between the two groups.

AUTHOR AFFILIATION: M Cameron, K McIlwaine, J Manwaring, P Maher, Endosurgery Unit, Mercy Hospital for Women, Heidelberg, VIC, Australia

SEXUAL FUNCTION AND OUTCOMES IN WOMEN WITH VAGINAL AGENESIS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1340-1350

Kimberley N, Hutson J, Southwell B, Grover S

BACKGROUND: Vaginal agenesis is an uncommon condition occurring in approximately 1 in 4-5000 females, in which there is complete or partial absence of the vagina and usually absent uterus. Little has been published regarding sexual function post-treatment in women with congenital absence of the vagina. Standardised sexual satisfaction questionnaires have previously only been used to assess women treated surgically for the condition[1], and never in women who have created a vagina using non-surgical methods.

METHODS: The aim of this study was to determine quality of life and sexual function in a population of women treated for vaginal agenesis. Patients with vaginal agenesis from the Royal Children's Hospital and Mercy Hospital for Women, Melbourne, treated surgically and/or non-surgically and who were sexually active, were administered the Golombok Rust Inventory of Sexual Satisfaction (GRISS) questionnaire. The GRISS is a standardised comprehensive questionnaire comprising 28 questions regarding sexual function; it produces an overall score for level of sexual satisfaction, as well as subscale scores covering 7 domains: infrequency, non-communication, dissatisfaction, avoidance, non-sensuality, vaginismus and anorgasmia. Additionally the WHO Quality of Life questionnaire was also administered to assess general wellbeing.

RESULTS: Of the 20 women participating in the study, 4 had had surgical creation of a vagina and 16 had created a vagina using dilators and/or sexual intercourse. The median age was 23, ranging from 16 to 71 years. The average overall transformed GRISS score was 3.1, with a standard deviation=1.9. 75% of women reported satisfactory sexual function, and 3/20 women reported being dissatisfied. No significant difference was found between overall GRISS scores of women treated surgically versus non-surgically. Women who had been diagnosed more than 5 years ago scored significantly better on the GRISS than those that had been diagnosed within the last 5 years ($p<0.05$). Patients who had had poor experiences previously with medical professionals displayed poorer overall GRISS scores on average than those who did not. Quality of life scores were comparable to that of the normal Australian population. Completed data on the full set of respondents will be presented.

CONCLUSION: Preliminary results suggest that sexual satisfaction and wellbeing in women with vaginal agenesis is generally good. Detailed assessment of sexual satisfaction is necessary to clearly elicit sexual difficulties as demonstrated by the poorer scores on vaginismus and anorgasmia. Duration of time since diagnosis influenced sexual satisfaction, whereas there was little difference between the scores of surgically and non-surgically treated patients.

REFERENCE:
1. Lucco., B., Psychosexual and Functional Outcomes After Creation of a Neovagina Via Laparoscopic Davydov in Patients with Vaginal Agenesis. 2008.

AUTHOR AFFILIATION: N Kimberley1, J Hutson2, B Southwell3, S Grover2; 1.University of Melbourne. 2.The Royal Children's Hospital, Melbourne. 3.Murdoch Children's Research Institute

SPONTANEOUS POSTOPERATIVE CONCEPTION IN IVF RESISTANT SEVERE ENDOMETRIOSIS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1350-1400

Kroon B, Yazdani A

AIM: To assess the conception rate following the resection of severe endometriosis in infertile patients who have failed IVF.

METHOD: A multicentre, multisurgeon retrospective case note review was undertaken. Women were eligible for entry if they had one or more cycles of failed IVF and had undergone laparoscopic resection of severe endometriosis (defined as the presence of endometrioma >4cm and/or Pouch of Douglas obliteration). Outcome measures were spontaneous and assisted pregnancies and complications of the surgical intervention.

AUTHOR AFFILIATION: B Kroon, A Yazdani; Queensland Fertility Group and Eve Gynaecology, Brisbane, Australia.

SURGICAL MANAGEMENT OF RECURRENT URETERIC ENDOMETRIOSIS CAUSING RECURRENT HYPERTENSION IN A POSTMENOPAUSAL PATIENT

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1400-1410

Khong S-Y, Lam A, Coombs G

INTRODUCTION:Ureteral endometriosis is a rare but serious condition. Due to the subtle clinical presentations, and limitations of imaging modalities, the diagnosis is frequently delayed or missed with serious consequences including hypertension, hydronephrosis and loss of kidney function[1].

OBJECTIVE: An unusual case of recurrent ureteral endometriosis in a postmenopausal woman causing recurrent hypertension is presented. Lessons from the case in terms of diagnosis, surgical management (see video) and outcomes (intraoperative blood pressure monitoring and histology results) will be discussed.

The main goals in the management of patients with ureteral endometriosis are to relieve symptoms and prevent recurrence, to relieve any urinary tract obstruction and to preserve renal function[2]. Factors such as patient age, fertility desire, extent of disease, severity of urinary tract and gynaecological symptoms, presence of other pelvic disease determine the choice of treatment[2].
Ureteral endometriosis can be managed surgically and medically. Limitations of both methods will be discussed, including the challenges clinicians face to screen for ureteral endometriosis and to monitor for disease progression and recurrence. As the patient may be asymptomatic or have vague symptoms, clinicians should always maintain a high index of suspicion for this condition.

REFERENCES:
1. Paraiso MF, Gustilo-Ashby AM. Treatment of urinary tract endometriosis. J Minim Invasive Gynecol. 2006; 13: 559–565
2. Yohannes P. Ureteral endometriosis. J Urol. 2003; 170,:20–25

AUTHOR AFFILIATION: S-Y Khong, A Lam, G Coombs: Centre for Advanced Reproductive Endosurgery, Sydney NSW Australia.

UTERUS DIDELPHYS WITH OBSTRUCTED HEMIVAGINA: A CASE SERIES

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1410-1420

Cameron M, Moore P, Jayasinghe Y, Grover S

INTRODUCTION: Uterus didelphys with obstructed hemivagina is a rare Mullerian duct abnormality, occurring in around 0.1% of young women. Patients most commonly present after menarche with an acute abdomen, an abdominal mass or progressively worsening dysmenorrhoea secondary to haematometrocolpos. Misdiagnosis is common and imaging techniques such as ultrasound are not always reliable. It virtually always occurs in conjunction with an absent ipsilateral kidney. Management involves surgical excision of the obstructed septum and drainage of the haematometrocolpos. Several techniques have been described. Prompt diagnosis and appropriate surgical management usually results in an excellent outcome and hysterectomy is rarely required.

We present a series of 16 such patients presenting to the Gynaecology Unit, Royal Children's Hospital, Melbourne between 1999 and 2008.

AUTHOR AFFILIATION: M Cameron, P Moore, Y Jayasinghe, S Grover. Department of Gynaecology, Royal Childrens Hospital, Melbourne, Australia

WHAT IS THE VALUE OF HISTORY TAKING IN PREDICTING THE PRESENCE OF BOWEL ENDOMETRIOSIS?

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1420-1430

Khong S-Y, Lam A, Markey J, LuscombeG

OBJECTIVE: To assess predictive value of individual bowel symptoms for bowel endometriosis

DESIGN: a prospective study

SETTING: university-affiliated tertiary referral centre for endometriosis

METHOD: Data was prospectively collected from 440 consecutive women who underwent laparoscopic surgery for treatment of pelvic pain and/ or infertility-associated endometriosis between December 2004 and September 2008. All patients completed a thorough history including a systematic check of bowel symptoms (dyschezia, constipation, diarrheoa, cyclical bowel frequency, rectal blood, abdominal pain). Logistic regression analyses were performed to investigate the predictive utility of these symptoms in regards to bowel endometriosis.

RESULTS: The overall prevalence of bowel endometriosis identified during laparoscopy was 33.9% (n=149/440). 71.1% of these women who had bowel endometriosis proceeded to have bowel surgery (rectal+/- sigmoid shaving, disc excision or segmental resection and reanastomosis, appendicectomy, ileal resection +/- right hemicolectomy) during the primary laparoscopic procedure. The remaining 16.8% of women underwent bowel adhesiolysis without bowel surgery, 9.4% had biopsies taken from the bowels and 2.7% did not have any surgery related to the bowel.

Women with bowel endometriosis were more likely to have bowel symptoms such as dyschezia (p value<0.001) and rectal bleeding (p value <0.044) when compared to patients without bowel endometriosis. There were significant associations between the presence of dyschezia and all the other symptoms of interest, with the exception of lower abdominal pain. Lower abdominal pain was not significantly associated with any of the symptoms of interest.

The regression analyses indicate that dyschezia and rectal bleeding are the only significant predictors of bowel endometriosis. The relative risk of bowel endometriosis with the presence of dyschezia is 2.16 (95% CI: 1.60 - 2.90) and rectal bleeding is 2.69 (95% CI: 1.10 - 6.53).

CONCLUSION: It is important to enquire about bowel symptoms when taking a clinical history from a patient with suspected endometriosis. In the presence of significant bowel symptoms such as dyschezia and rectal bleeding, coupled with clinical findings suggestive of rectovaginal

disease, referral to a colorectal surgeon should be considered so that any joint surgery can be planned. This also gives the clinician an opportunity to adequately counsel these patients regarding the possibility of requiring bowel surgery.

AUTHOR AFFILIATION: S-Y Khong, A Lam, J Markey, G Luscombe. Centre for Advanced Reproductive Endosurgery, St Leonard's, NSW, Australia

EVALUATION OF THE AUSTRALIAN VERSION OF THE 30-ITEM ENDOMETRIOSIS HEALTH PROFILE (EHP-30) AND ITS RESULTS

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1430-1440

Markey J, Khong S-Y, Luscombe G, Lam A, Ford R

OBJECTIVES: Endometriosis Health Profile-30 (EHP-30) questionnaire has been found to be a suitable instrument to measure health related quality of life of women with endometriosis in the UK and USA population. This study was to evaluate the suitability of the EHP30 questionnaire to be used in the Australian population.

METHODS: Prospective data were obtained from patients seen in a gynaecological tertiary centre between August 2006 and August 2008 for pelvic pain. Questionnaires were self-completed by patients during their first clinic visits.

RESULTS: The Australian sample consisted of n = 195 women, average age 34.6 years (SD 7.6). On average, it had been 9.8 years since onset of symptoms (SD 8.5; range 0 to 38.7 years; n = 145), with the average age at symptom onset being 24.2 years (SD 8.2; range 7.7 to 46.0 years; n = 145). Average time from symptom onset to diagnosis was 4.5 years (SD 6.3; range 0 to 30.2 years; n = 111).

The majority (99.5%, n=195/196) of patients returned completed questionnaires, with 94.4% (184/195) completing all of the items on the EHP 30 questionnaire. Missing response rates for each item in the core and modular sections ranged from 0.5% to 1.0% and 0.6% to 3.8% respectively. There were significant differences between scores in the UK study and the Australian group for all EHP core and modular domains except for pain. Scores were also significantly different between the Australian and USA studies. Current age and age of symptom onset were negatively correlated with several subscales. For example, pain was rated to have a greater negative impact on quality of life by younger than older patients. Younger patients were also more concerned regarding their fertility and ability to work.

There was a significant positive correlation between duration of symptoms and self image, meaning that self image worsened with increased exposure to symptoms.

CONCLUSIONS: This study demonstrates that the EHP 30 questionnaire is a useful and highly acceptable tool to be used in endometriosis related research in the Australian population. The negative impact of endometriosis on quality of life is more pronounced in younger patients, with self image deteriorating as the disease progresses with time.

AUTHOR AFFILIATION: J Markey, S-Y Khong, G Luscombe, A Lam, R Ford. Centre for Advanced Reproductive Endosurgery, St Leonard's, NSW, Australia

OBTURATOR NERVE INJURY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1440-1450

Lam A, Khong S-Y

Neuropathy is an uncommon but known complication of major pelvic surgery, with its incidence quoted to be as high as 1.9% 1. In gynaecology, obturator nerve injury has been reported in cases involving oncology and advanced endometriosis as well as retropubic sling procedures for urinary incontinence. The obturator nerve is particularly susceptible to damage, accounting for 39% 1 of all neuropathies associated with major pelvic surgery. This may be due to its small caliber, its vulnerable site where dissection occurs during pelvic lymphadenectomy and the occasional presence of an accessory branch. This oral and video presentation demonstrates how a transected obturator nerve can be successfully repaired via the laparoscopic route. It will also include:

1. Anatomy illustrating the route of the obturator nerve and its relation to surrounding structures
2. Mechanism of injury (direct trauma via cutting, ligation, clamping) or indirect trauma from electrocautery [2]
3. Signs and symptoms of obturator nerve injury [3]
4. Investigations [3]
5. Management
   a. if recognized intraoperatively, best to perform nerve repair immediately recognition (illustrated by this case) [4]
   b. if recognized postoperatively, various options include physiotherapy, pharmacological methods such as nerve block using local anaesthetic or surgery [3]

REFERENCES:
1. Cardosi R, Cox C, Hoffman M. Postoperative neuropathies after major pelvic surgery. Obstet Gynecol 2002; 100(2): 240-244
2. Fishman J, Moran M, Carey R. Obturator neuropathy after laparoscopic pelvic lymphadenectomy. Urology 1993;42(2):198-200
3. Vasilev S. Obturator nerve injury: a review of management options. Gynecol Oncol. 1994; 53: 152-155
4. Benes J. Immediate Grafting of the Damaged Obturator Nerve by Gynaecological Surgery. Acta Neurochir (Wien) 1999; 141: 435-436 thigh.

AUTHOR AFFILIATION: A Lam, S-Y Khong; Centre for Advanced Reproductive Endosurgery, St Leonard's, NSW, Australia

PREGNANCY OUTCOMES OF SALPINGOSALPINGOSTOMY IN TUBAL PREGNANCY

FRIDAY 22 MAY / SESSION 7 – FREE COMMUNICATIONS 6 - REPRODUCTION II / 1450-1500

Eun D-S, Shin K-S, Choi Y-S, Choi J, Ha J-A;

OBJECTIVE: to detect the safe methods to preserve the healthy salpinx.

DESIGN: Post operative sheets reviews prospectively.

SETTINGS: Eun's gynecological laparoscopic hospital, South Korea.

PATIENTS: 90 women with salpingosalpingostomy due to tubal pregnancy.

INTERVENTION: after 1:200 vasopressin infiltration into mesosalpinx around gestational sac, just only salpinx with G.sac was removed by scissors without electrocoagulation. The tubal artery and mesosalpinx were sutured with 3.0 vicryl. The clean proximal and distal portion of salpinx were sutured with 4.0 vicryl.

MEASUREMENT AND RESULTS: on postop 3 ms later HSG was done, mean age : 27(SD8)yrs, parity;1.6, Hb loss ; 0.5 g/dL, Tubal patency ; 73 patients had completely salpinx. 62 patients were pregnant.

CONCLUSION: The salpingosalpingostomy may be another good method in tubal pregnancy.

REFERENCES :

1. Dubuisson JB, Chapron C, Morice P, et al. Laparoscopica salpingostomy : fertility results according to the tubal mucosal appearance. Hum Reprod 1994;9:334
2. Dubuisoon JB, Chapron C. Single suture laparoscopic tubal reanastomosis. Curr Opin Obstet Gynecol 1998;10:307

AUTHOR AFFILIATION: D-S Eun[1], K-Sik Shin[2], Y-S Choi[2],J Choi[2], J-AHa2; 1.Korean Society of Obstetrics and Gynecology, Gwang-ju, South Korea. 2.Eun's hospital.

TOTAL LAPAROSCOPY HYSTERECTOMY: A THREE YEAR EXPERIENCE INSTITUTO NACIONAL DE PERINATOLOGIA. ISIDRO ESPINOZA DE LOS REYES.

FREE COMMUNICATIONS / POSTERS

Bustos Lopez HH

OBJECTIVE: This retrospective review examine the characteristics of the presented cases, evaluating the age, parity, Body Mass Index (BMI), operating time, estimated blood loss and complications.

METHODS: The study realizes a revision of the patients underwent laparoscopic hysterectomy between January 1st, 2006 and December 31, 2008, excluding those in which were realized supracervical Hysterectomy (SCH).

RESULTS: There were realized 149 laparoscopic hysterectomy in the institution in the period mentioned above, excluding 29 (SCH). Of the 120 analized cases the 83.3% (100) were Total Laparoscopic Hystectomies the rest (20) were submitted to Laparoscopically Assisted Vaginal Hysterectomy (LAVH). The mean age was 42.9 years (in a range of 27-72). These 120 patients were stratified into 2 subgroups according to the BMI $<29.9m^2$ CS (81) with an average of 25.4 (19.6 – 29.5) and $>30m^2$CS (39) with an average of 32.7 (30-41). Observing a median minor blood loss in the non-obese group with an average of 206 ml (in a range of 20- 850 ml) versus 239.7 ml (50-900 ml). There were no difference in the operating time taking a media of 167.4 min (85-465) for the $<29.9m^2$CS BMI group versus 171.6 minutes (85-300) to the second subgroup.

The most common pathology according to the hystopatologic report was leiomiomata en 54.1%, adenomiosis in 19.1%, and both pathologies in 8.3%.

The complications observed were 2 vesical lesions, 1reacto-vaginal fistula, 1 accute abdomen, 2 ileums and neuropathy in the non-obese group (7.4%). In the obese group was observed a intestinal lesion (2.5%).

CONCLUSIONS: The Laparoscopic Histerectomy is a procedure that has become important in the Gynecologic medical practice and the indications to precise, recommending uterine weight above 350gr in order to observe the real benefit of the procedure. It is a minimal invasive procedure, minor recuperation time. Founding similar morbility rates compared to another open procedures according to the bibliography.

KEY WORDS: Laparoscopic hysterectomy, Body Mass Index (BMI), complications.

AUTHOR AFFILIATION: H H Bustos Lopez; Instituto Nacional de Perinatologia Mexico DF, Mexico.

DETRUSOR OVERACTIVITY INCIDENCE IN WOMEN SUBMIT SUBTOTAL AND TOTAL LAPAROSCOPIC HYSTERECTOMY

FREE COMMUNICATIONS / POSTERS

Bustos Lopez HH

INTRODUCTION: De novo detrusor overactive occur in 5-20% of cases after surgery. In Some cases it may be transitory but it could be necessary treat if the condition no disappear spontaneously. The Urogenital Distress Inventory (UDI) was developed to assess the degree to which symptoms associated with incontinence are troubling, covering 3 domains: symptoms related to stress urinary incontinence, detrusor overactivity and bladder outlet obstruction.

OBJECTIVE: Identify detrusor overactivity incidence in patients submit subtotal and total laparoscopic hysterectomy using the Urogenital distress inventory (UDI-6)

STUDY DESIGN: We performed a descriptive and prospective study, were reviewed patients file underwent subtotal and total laparoscopic hysterectomy from January to December 2006 who were administered UDI-6 and we analyses : age frequency, surgery indications, urinary sympstoms and impact.

RESULTS: 35 laparoscopic hysterectomy was performed in this period in patients with benign uterine pathology. Were excluded 18 patients who no were contacted due to changes in directions and phone number and 1 patient who present detrusor overactivity symptoms before surgery. We analyze 16 patients, 68.7% were total laparoscopic hysterectomy, 18.7% subtotal and 12.5% vaginal hysterectomy assisted by laparoscopic. They answered the questions by phone call and we found that 38% expressed no incontinence symptoms, 25% symptoms of stress urinary incontinence, 19% symptoms of mixed incontinence, 12% symptoms of detrusor overactivity and 6% voiding dysfunction symptoms.
Patients who presents a significant negative impact on quality of life were referred to department of Urogynecology for an adequate management and at the rest of the patients were treated with kegel exercise and behavioral therapies.

CONCLUSIONS: Although the literature report that 5 to 20% of patients may present De novo detrusor overactivity after surgery, we found that the majority of the women present symptom of stress urinary incontinence (25%) and De novo detrusor overactivity in 12% of women.

KEY WORDS: De novo detrusor overactivity, laparoscopic hysterectomy, UDI-6, incidence, urinary symptoms

AUTHOR AFFILIATION: H H Bustos Lopez; Instituto Nacional de Perinatologia Mexico DF, Mexico.

COMPLICATIONS AFTER CLASSICAL INTRAFASCIAL SEMM HYSTERECTOMY(CISH)

FREE COMMUNICATIONS / POSTERS

Ki K-D, Lee K-B, Park S-H, Huh C-Y

OBJECTIVE : To evaluate intraoperative and postoperative complications of Classical Intrafascial SEMM Hystercctomy(CISH).

PATIENTS AND METHODS: We analyzed retrospectively, a total of 845 women(range of ages 27~70 yrs., mean age 44.3±6.2) who requested hysterectomy for benign gynecologic disease, mainly uterine myoma(58.6%) and adenomyosis(41.2%), and subsequently underwent CISH operation, during the period of April, 2002 ~ April, 2008, Department of Obstetrics and Gynecology, Kyung Hee Univ. hospital, Seoul, Korea.

RESULTS: The mean operative time was 128.9±39.1 minutes. The mean blood loss(Hb change) was 1.2±1.3 gm/dl. The mean hospital day was 5.4±2.1 days. The overall incidence of complication were 7.7% (66 out of 845 cases). The most common complication was postoperative transient bladder dysfunction. The risk of major hemorrhage requiring transfusion was 1.8%. The intraoperative complication rate was 0.5%, including ureteral injury. The rate of postoperative complications was 7.2%, and soon recovered.

CONCLUSION: CISH procedure appears to be feasible with minimal invasiveness, less postoperative pain, faster recovery, reduced morbidity, no mortality, and more patient's satisfaction without major and severe complications, and therefore may be considered a useful therapeutic option for patient with benign gynecologic disease.

AUTHOR AFFILIATION: K-D Ki[1], K-B Lee[2], S-H Park[3], C-Y Huh[1]; 1.East-West Neo Medical Center, Kyung-Hee University, Seoul, South Korea. 2. Gil Medical Center, Gachon University, Incheon, South Korea. 3 Kangnam Sacred Heart Hospital, Hallym University, Gangwon-do, South Korea.

HYSTEROSCOPIC MANAGEMENT OF ECTOPIC PREGNANCY; CASES OF CORNUAL AND CESAREAN SCAR PREGNANCIES

FREE COMMUNICATIONS / POSTERS

Ki K-D, Lee K-B, Park S-H

OBJECTIVE: The aim of this study was to present our clinical experience with cases of unusual ectopic implantation in the uterine scar from previous cesarean section and uterine cornus to provide information for the management of uncommon ectopic pregnancies

DESIGN: Two cases report

RESULTS: This report describes two cases of a viable ectopic pregnancy successfully treated with hysteroscopic management.

Case 1. A 38-year-old woman who had experienced two of cesarean section was admitted at our hospital due to vaginal hemorrhage 7 weeks after her last menstrual period. Clinical examination and ultrasound findings were consistent with ectopic cervical pregnancy. Transarterial embolization of bilateral uterine arteries was performed to prevent intraoperative hemorrhage and then the gestation was removed by operative hysteroscopy and suction curettage without complications.

Case 2. A 36-year-old woman presented with a history of amenorrhea for 6 weeks and a positive pregnancy test. A transvaginal ultrasound revealed a right cornual pregnancy. The patient was treated with systemic methotrexate therapy, but the gestational sac persisted. Through the operative hysteroscopy, the sac was ruptured, and the conceptional tissue was removed from the right cornus. Two weeks later, she was normal in pelvic examination and had negative pregnancy test and normal ultrasound findings.

CONCLUSION: Surgical treatment with hysteroscopic approach, if validated, could be considered a conservative option for the treatment of unusual ectopic pregnancy in some patients. This technique preserves the uterus and greatly reduces morbidity.

AUTHOR AFFILIATION: K-D Ki[1], K-B Lee[2], S-H Park[3]; 1.East-West Neo Medical Center, Kyung-Hee University, Seoul, South Korea. 2. Gil Medical Center, Gachon University, Incheon, South Korea. 3 Kangnam Sacred Heart Hospital, Hallym University, Gangwon-do, South Korea.

VIDEO-ASSISTED THORACOSCOPIC SURGERY (VATS) FOR RECURRENT OVARIAN CANCER WITH METASTATIC MEDIASTINAL MASS

FREE COMMUNICATIONS / POSTERS

Ki-K-D, Lee K-B, Park S-H, Lee J-M

OBJECTIVE: The aim of this study was to present our clinical experience with case of recurrent ovarian cancer with solitary mediastinal metastasis and introduce video-assisted thoracoscopic surgery (VATS) perfomed at the time of secondary cytoreduction

DESIGN: Case report

RESULTS: This case describes an interesting surgical management of recurrent ovarian cancer metastatic to mediastinum. A 29-year-old woman visited our hospital due to a suspicion of recurrent ovarian cancer. Four years ago, she was first diagnosed with an ovarian papillary serous adenocarcinoma stage IIIc after primary debulking surgery and then administered six cycles of adjuvant chemotherapy consisting

of paclitaxel (175mg/m2) and carboplatin (AUC=5). On physical examination, palpable inguinal mass and multiple enlarged pelvic lymph nodes were detected. In addition, a mediastinal mass with well-defined margin was seen in the CT scan of chest. We had successfully performed video-assisted thoracoscopic surgery (VATS) at the time of secondary cytoreduction for recurrent ovarian cancer patient with solitary mediastinal metastasis. At 14 months of follow-up, she is alive without evidence of disease.

CONCLUSION: VATS may be attempted as a part of secondary cytoreductive surgery for optimal debulking of macroscopic disease and considered an interesting chance for treatment of recurrent ovarian cancer with mediastinal metastasis.

AUTHOR AFFILIATION: K-D Ki[1], K-B Lee[2], S-H Park[3], J-M Lee[1]; 1.East-West Neo Medical Center, Kyung-Hee University Seoul, South Korea 2.Gil Medical Center, Gachon University South Korea 3.Kangnam Sacred Heart Hospital, Hallym University, South Korea

EVALUATION OF HPV DNA TYPING IN SENTINEL LYMPH NODE AND PRIMARY LESION OF CERVIX IN PATIENTS WITH CERVICAL CANCER

FREE COMMUNICATIONS / POSTERS

Rhim CC

OBJECTIVES: The aim of this study was to analyze the HPV DNA types in both sentinel lymph node (SLN) and primary lesion of cervix in patients with cervical cancer.

METHODS: Between March 2001 and December 2008, the 84 patients who underwent radical hysterectomy and pelvic lymphadenectomy with cervical cancer were enrolled in this prospective study. SLN and primary lesion of cervix were evaluated with microscopic pathologic examination as well as HPV DNA typing using HPV oligonucleotide microarray.

RESULTS: HPV DNA types were successfully identified in all the 84 patients studied. The clinical stages were as follows : Ia1 in 4, Ia2 in 10, Ib1 in 27, Ib2 in 14, IIa in 7, and IIb in 22. The cell types were squamous cell carcinoma in 72, adenocarcinoma in 9 and adenosquamous cell carcinoma in 3. The average age of the patients was 48.5 years and multiple infection including HPV 16 were prevalent in age-group of 45 below, whereas single infection was dominent in that of 45 above. It is a distinguishable characteristics that HPV 16 was all detected in primary lesion of cervix, regardless of their age and clinical stage. Sentinel node detection and frozen biopsy were performed on all 84 subjects. There were 64 benign and 20 malignant cases on frozen biopsy. On permanent histopathological specimen, there were 60 benign and 24 malignant cases. In 60 out of 64 cases determined to be benign on the sentinel node frozen biopsy, there were no pelvic lymph node metastasis on the permanent pathology. In only 4 cases found to be benign on the sentinel node frozen biopsy, there were pelvic lymph node metastasis on the permanent histopathology. These results are statistically significant($p<0.0001$).

CONCLUSIONS: HPV 16 was detected in primary lesion of cervix up to 100% as a pattern of single or multiple infection. There was no case that newly detected HPV DNA types in SLN in case of the absent types in primary lesion of cervix. HPV DNA typing as well as microscopic examination of SLN and primary lesion of cervix can be an important biological marker for recurrence , 2 or 5 year disease free survival rate in the near future.

AUTHOR AFFILIATION: C C Rhim. Hallym University Medical College, Anyang City, Kyeonggi-do, South Korea.

METHYLENE BLUE AS AN AID FOR DIAGNOSING ENDOMETRIOSIS AT LAPAROSCOPY: A CASE REPORT

FREE COMMUNICATIONS / POSTERS

Lewis T, Lessey B

ABSTRACT: Diagnostic laparoscopy for chronic pelvic pain is negative up to 30% of time, presenting gynecologists with a therapeutic dilemma when pain is persistent in such women. We used methylene blue at the time of diagnostic laparoscopy as an aid in illuminating affected peritoneum in an effort to visualize otherwise “invisible” endometriosis on initial inspection of the pelvis. We report here two cases in which areas of peritoneum were marked by the dye at the site of pain, with improvement in symptoms observed following resection. Further investigation should be performed regarding the use of methylene blue as an aid in identifying endometriosis at the time of diagnostic laparoscopy.

INTRODUCTION: Chronic pelvic pain (CPP) is a problem that carries significant morbidity and which accounts for 10% of gynecologic office visits (1). One important component in diagnosing a particular etiology for CPP is laparoscopy. Forty percent of all gynecologic laparoscopies are performed for CPP (1). At the time of diagnostic laparoscopy, endometriosis and adhesions are each identified 1/3 of the time. During the remaining 1/3 of laparoscopies no pathology is identified. (2). in a majority of women with negative laparoscopies, pain does persist (2, 3), and for those with no other treatable somatic pathology (myofascial syndrome, gastrointestinal disease, etc) is found, the prognosis is worse (4). Such women are often dismissed, or simply referred to psychiatry (1). Previous prospective reports have suggested that endometriosis can be present but non-visualized using conventional laparoscopy (5). In an effort to increase the diagnostic accuracy for endometriosis at laparoscopy, several adjunctive diagnostic aids have been studied, including peritoneal blood painting (6), spectral analysis (7), and scanning electron microscopy (8). Here we report a technique using methylene blue dye as an aid to potentially illuminate such atypical or subtle endometriosis at the time of laparoscopy.

CASE REPORTS: Patient A is a 31-year-old woman (gravida 0, para 0) with a known history of infertility as well as stage II endometriosis previously diagnosed and treated at the time of diagnostic laparoscopy, by her primary gynecologist in the previous year. She returned 8 months later complaining of increasing pelvic pain, particularly in her left lower quadrant, and was referred to us for management.

At her initial visit with us, she described the pain as severe (10 out of 10) and interfering with her lifestyle and ability to work. An ultrasound was performed that failed to show any pathology, including endometriomas or hydrosalpinges. Due to her history of endometriosis and the debilitating nature of her pain she consented to a repeat laparoscopy.

At the time of diagnostic laparoscopy, no visual evidence of disease was noted. After coating the pelvis was with methylene blue, two areas of peritoneum in the pelvis strongly retained the blue dye. Specifically, there was staining observed to be present in the anterior cul-de-sac and on the left pelvic sidewall (see figure 1). The blue-stained area in the anterior cul-de-sac was desiccated with bipolar cautery, and the peritoneum on the left pelvic sidewall was resected in its entirety and sent to pathology. Pathology demonstrated fragments of benign mesothelial invested soft tissue with benign vascular structures present within the stroma. On deeper sections, there was a minute focus of chronic inflammatory cells adjacent to reactive mesothelium. Other areas also showed interstitial hemorrhage.

At her post-operative visit, two weeks later, she stated that she had complete resolution of her pelvic pain, and more specifically, that she no longer had any pain on her left side.

Patient B is a 31 year-old G0P0 as well, who was self-referred with a chief complaint of 15 months of unexplained infertility and chronic pelvic pain. She had laboratory testing including FSH, prolactin, and TSH, all of which were normal, a semen analysis was normal and she had documented regular, ovulatory cycles. At the time of laparoscopy she was found to have no visible endometriosis with the exception of a thin adhesion between the ovary and pelvic sidewall. After chromopertubation with methylene blue due was performed, and the dye was taken up strongly by one area on the left pelvic sidewall that included the point of attachment for the adhesion on closer inspection diffuse endometriosis was suspected based on the appearance of the stained surface (see Figure 1). Resection of peritoneum and carbon dioxide laser vaporization of subtle implants along the left pelvic sidewall up to the ovary was performed that included the entire area that had taken up the Methylene blue dye.

The pathology showed fibrous connective tissue with focal mesothelial cells identified. No definitive endometrial type glands or stroma, and no hemosiderin deposits were identified. However, her left-sided pelvic pain did resolve, and she conceived in the cycle immediately following her surgery, before her next menstrual period started. An ultrasound detected fetal cardiac activity in a singleton pregnancy with no abnormalities with an ongoing pregnancy now at 12 weeks gestation.

COMMENT: Controversy exists about the role of subtle endometriosis in both chronic pelvic pain and infertility. Different types of endometriosis have been described, including very subtle or invisible endometriosis (5). While scanning electron microscopy has been used in the past to document “invisible” endometriosis (8), the expense and lack of availability for this technology in most offices precludes its routine use.

In this report, we used a vital dye, Methylene Blue, to stain the peritoneum and found that in two cases, areas of uptake were observed. Although the methylene blue-stained peritoneum we identified was not definitively diagnosed as “endometriosis” by the pathologist in either case, we had favorable outcomes in terms of both infertility and pelvic pain in both cases.

It is possible that these patients had microscopic endometriotic implants, which after resection, resulted in the resolution of their pain, and may have also restored fertility. Atypical, invisible endometriosis in a patient with severe and classic symptomatology who has had a negative laparoscopy should not be discounted as rare and clinically unimportant. Based on these findings, further investigation should be performed regarding the use of methylene blue as a diagnostic aid in the evaluation of endometriosis at the time of diagnostic laparoscopy, particularly when initial inspection of the pelvis is negative. Future studies will attempt to document the presence of endometriosis on peritoneum that takes up Methylene blue stain. Understanding why the peritoneum specifically takes up the stain will also be of interest in future investigations.

REFERENCES:

1. Howard FM. The role of laparoscopy in the evaluation of chronic pelvic pain: pitfalls with a negative laparoscopy. J Am Assoc Gynecol Laparosc; 4(1):85-94; 1996.
2. Yasmin H, Bombieri L, Hollingworth J. What happens to women with chronic pelvic pain after a negative [normal] laparoscopy? J Obstet Gynaecol; 25(3):283-5, 2005.
3. Doyle DF, Li TC, Richmond MN. The prevalence of continuing chronic pelvic pain following a negative laparoscopy. J Obstet Gynaecol; 18(3):252-5, 1998.
4. Reiter RC, Gambone JC. Nongynecologic somatic pathology in women with chronic pelvic pain and negative laparoscopy. J Reprod Med; 36(4):253-9, 1991.
5. Balasch J, Creus M, Fabregues F, Carmona F, Ordi J, Martinez-Roman S, Vanrell JA. Visible ad non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain: a prospective study. Hum Reprod; 11(2):387-91, 1996.
6. Redwine, DB. Peritoneal blood painting: an aid in the diagnosis of endometriosis. Am J Obstet Gynecol; 161:865-6, 1989.
7. Demco, L. Laparoscopic spectral analysis of endometriosis. J Am Assoc Gynecol Laparosc; 11(2):219-22, 2004.
8. Murphy AA, Green WR, Bobbie D, dela Cruz ZC, Rock JA. Unsuspected Endometriosis documented by scanning electron microscopy in visually normal peritoneum. Fertil Steril; 46(3):522-24, 1986.

AUTHOR AFFILIATION: T Lewis, B Lessey. Greenville Memorial Hospital University Medical Center, Greenville, SC, USA.

THE COMPARISON OF TOTAL LAPAROSCOPIC, TOTAL ABDOMINAL AND VAGINAL TOTAL HYSTERECTOMY FOR BENIGN GYNECOLOGIC CONDITIONS

FREE COMMUNICATIONS / POSTERS

Park S-H

OBJECTIVE: To compare total laparoscopic hysterectomy(TLH), Total abdominal hysterectomy
(TAH), Vaginal total hysterectomy (VTH) for women with benign disease, with respect to operative time, postoperative complications , recovery from surgery .

METHODS: 127 cases of TLH, 49 cases of TAH and 135 cases of VTH who were operated for benign gynecological disease from January 2007 and December 2008 at the department of Obstetrics and Gynecology, College of Medicine, Hallym University. Medical records of the patients were reviewed. For the comparison between three groups, we used ANOVA test.

A p-value of <0.05 was regarded as significant.

RESULTS: The baselines characteristics of groups were similar. The mean operative time was 87.75, 89.99, 94.32 minutes in the VTH, TAH and TLH group respectively. There was no significant difference between VTH and TAH group but significant difference with TLH group. The mean hemoglobin drop for was 1.51g/dL, 2.72 g/dL and 2.35 g/dL in VTH, TAH and TLH group respectively. There was no significant difference between TAH and TLH group. But there was significantly smaller change in the VTH group. The mean length of hospitalization was 6.31, 7.12 and 5.85 days in VTH, TAH and TLH group respectively. TLH group showed the most shortest hospital stay. The complication rate was higher in the TAH group followed by TLH group (3.6% vs 2.4%) and VTH group showed the lowest complication rate(0.9%).

CONCLUSIONS: VTH is safest and most useful method for benign gynecologic condition. And TLH may be the second choice with less complication and faster recovery when VTH is impossible.

AUTHOR AFFILIATION: S-H Park. Department of Obstetrics & Gynecology, College of Medicine, Hallym University, Seoul, Korea

CAN UTERINE WEIGHT DETERMINE THE COMPLICATIONS AND MORBIDITY OF TOTAL LAPAROSCOPIC HYSTERECTOMY?

FREE COMMUNICATIONS / POSTERS

Lim S, Park H, Lee G-B

OBJECTIVE: To determine if an uterine weight is associated with an increased rate of intraoperative and postoperative complications and morbidity after total laparoscopic hysterectomy (TLH).

MATERIALS AND METHODS: Women who underwent TLH were stratified, according to uterine weight, into 3 groups: group 1, uterine weight < 200 g; group 2, 201-500 g; and group 3, > 500 g. Indications included uterine leiomyomas, chronic pelvic pain, benign ovarian cysts, endometriosis and adenomyosis, dysfunctional uterine bleeding and cervical intraepithelial neoplasia. Statistical analysis compared risks of intraoperative and postoperative morbidity and prolonged hospital stay. RESULTS: There was a significant association between postoperative major complications and uterine size ($p < or = 0.001$). Mean estimated blood loss (EBL) also increased with uterine weight > 500 g ($p = 0.004$). Smaller uterus was associated with fewer postoperative complications, shorter LOS and reduced EBL ($p < or = 0.001$).

CONCLUSION: Average length of stay and risk of blood loss, blood transfusion and other postoperative complications after hysterectomy for benign disease increased with increasing uterine weight. Physicians should consider surgical methods according to uterine weight before operation.

AUTHOR AFFILIATION: S Lim, H Park, G-B Lee. Incheon, South Korea.

THE METRECTOMY (MYOMETRIAL REDUCTION) FOR SEVERE ADENOMYOSIS TO PRESERVE OF UTERUS AND FERTILITY

FREE COMMUNICATIONS / POSTERS

Cha MS, Choi IJ

INTRODUCTION: Adenomyosis is defined as the presence of heterotopic endometrial glands and stroma in the myometrium with adjacent smooth muscle hyperplasia. The common presenting symptoms are menorrhagia, dysmenorrhea. Hysterectomy or use of the levonorgesterel intrauterine system (LNG-IUS) is main treatment of adenomyosis.

LNG-IUS is a alternative method of conservative treatment, but side effects of irregular uterine bleeding and vaginal discharge, ovarian cyst formation, self expulsion are problems. Radiofrequency myolysis is also reported as a effective treatment method, but in virgin and nulliparous

patients, endometrial thermal damage and long-term failure rate are problems. The conservative treatment for Adenomyosis avoiding hysterectomy and retaining fertility is difficult.

Recently, myometrial excision procedures known as metrectomy, zenomectomy, myometrial reduction, and adenomyomectomy were reported as a conservative operation for severe adenomyosis. This study was performed to evaluate the effect of the metrectomy (myometrial reduction) for patients with adenomyosis to preservation of uterus and fertility.

MATERIAL AND METHOD: We performed metrectomy (myometrial reduction) for 24 patients with severe adenomyosis to preservation of uterus and fertility from 2007. January. to 2008. December. Our procedure was started with coronal incision and myometrial reduction by electrocautery on the fundus. The adenomyotic tissue was identified by its rough, dense irregularly fasciculated myometrium, as much as possible. A pediatric Foley catheter inserted within the uterine cavity transvaginally prior to surgery. After removal of adenomyotic tissue, the uterus was closed with interrupted Dexon 1 and 2 and uterine shape refashioned. For prevention of adhesion, we used the antiadhesion material. (Interceed or the Guardix solution.)

CONCLUSION: Metrectomy (myometrial reduction) for patients with severe adenomyosis led to reduction in pain and abnormal bleeding. Despite small patients and short-term follow-up in this study, metrectomy was useful for patients with severe adenomyosis to preservation of uterus and fertility and pain relief.

AUTHOR AFFILIATION: M S Cha, M.D., I J Choi. Department of Obstetrics and Gynecology, Dong-A University, College of Medicine, Busan, Korea.

SPONSOR LIST

When Dr. Homer Stryker, an orthopaedic surgeon from Kalamazoo, Michigan, USA found that certain medical products were not meeting his patients' needs, he invented new ones. As interest in these products grew, Dr. Stryker started a company in 1941 to produce them. The company's goal was to help patients lead healthier, more active lives through products and services that make surgery and recovery simpler, faster and more effective.

At present, Stryker Corporation is one of the world's leading medical technology companies with a broadly based range of products in many medical specialties. Our 15,000 employees work with respected medical professionals in over 120 countries to help people lead more active and satisfying lives. The Company's products include implants used in joint replacement, trauma, craniomaxillofacial and spinal surgeries; biologics; surgical, neurologic, ear, nose & throat and interventional pain equipment; endoscopic, surgical navigation, communications and digital imaging systems; as well as patient handling and emergency medical equipment.

Members of AGES are probably most familiar with Stryker because of our range of visualisation products for endoscopic surgery. Stryker was the first company to introduce a fully soakable camera for endoscopic surgery and the first company to introduce a 3-chip endoscopic camera. Today, Stryker is able to provide unparalleled endoscopic video via our 3rd generation HD camera, the 1288 HD 3-Chip® Camera.

Stryker South Pacific
Contact: Bryan Olson
8 Herbert Street, St Leonards NSW 2065
Tel: +61 2 9467 1000
Fax: +61 2 9467 1010
Email: bryan.olson@stryker.com
Website: www.stryker.com

SPONSOR LIST

Johnson & Johnson through its operating companies, is the world's most comprehensive and broadly based manufacturer of health care products, as well as a provider of related services for the consumer, pharmaceutical, and medical devices diagnostic markets.

The fundamental objective of Johnson & Johnson is to provide scientifically sound, high quality products and services to help heal, cure disease and improve quality of life. This is a goal that began with the company's founding in 1886.

Johnson & Johnson Medical Australia and New Zealand has a long commitment to the Gynaecological community with its Ethicon Endo-Surgery and Women's Health & Urology companies. Our investment in minimally invasive surgery began in Australia in the early 1990's and has been responsible for bringing the following products to market:

- Harmonic ACE
- Endopath XCEL Bladeless Trocars
- GYNECARE TVT and TVT-O
- GYNECARE ProLift
- GYNECARE Morcellex

In 2009, we will proudly launch ENSEAL, a new tissue-sealing device. Please come and visit us at the Johnson & Johnson Medical booth for a preview of this exciting new product.

Johnson & Johnson Medical
1-5 Khartoum Road
North Ryde NSW 2113
Tel: 02 9878 9000/9111

KARL STORZ — ENDOSKOPE

Since its beginnings in 1945, KARL STORZ has established itself worldwide as an international and highly regarded company in the production and sale of medical instruments and devices. KARL STORZ are leaders in matters that count: creativity, versatility and competence.

The range of endoscopic equipment for human medicine now encompasses over 8,000 products. New developments such as the OR1™ fully integrated operating room supplement the comprehensive range of endoscopic equipment. The aim of KARL STORZ OR1™ is to provide the ideal operating room layout for performing minimally invasive procedures. KARL STORZ sets new standards for safety, ergonomics and efficiency in the OR. In times when planning is becoming increasingly constrained by tight financial resources, greater emphasis is being placed on preserving the value of existing instruments and planning future investments efficiently. The EndoProtect1™ Service Programme is the ideal solution for maintaining the quality of your endoscopic equipment.

KARL STORZ will maintain and extend even further its leading position in technological development. The family-owned company applies tradition and experience to think about tomorrow, today. The future has tradition, but tradition too has a future!

KARL STORZ Endoscopy Australia Pty Ltd
15 Orion Road
Lane Cove West NSW 2066
Tel: (02) 9490 6700 Fax: (02) 9420 0695
Website: www.karlstorz.com

GENERAL CONGRESS INFORMATION

Climate: Sub-tropical Brisbane has a pleasant mild climate in May. Temperatures generally range between 15° and 25°C or 60° and 79°F. For more information see www.bom.gov.au. Brisbane has more sunny days than Florida and warmer winter days than the Bahamas.

Currency: Australia's currency is the Australian dollar. All major credit cards are widely accepted in Australia. Current exchange rates are available at www.xe.com

Language: English is spoken throughout Australia and is the official language for the Congress.

Time: Local Brisbane time is Greenwich Mean Time plus 10 hours. There is no Daylight Saving in Queensland. There are several time zones in Australia. The West Coast is two hours behind the East Coast.

Banks: Banks in Australia are generally open from 0930 to 1600 Monday to Thursday and 0930 to 1700 on Fridays. Some banks are also open on Saturdays. Exchange facilities are available airports and major hotels. Automatic teller machines (ATMs) are widely available.

Shopping: In Brisbane, the majority of shops are open Monday to Thursday and Saturday and Sunday from 0900 to 1730, Friday from 0900 to 2100.

Travel and Health Insurance: We strongly recommend that you take out insurance policies to cover medical and travel expenses. Your travel agent or airline will be able to assist.

Wheelchair access or other mobility disability access during the Congress: At the time of registration please notify the Secretariat of any mobility disabilities you have. For more information about getting around Brisbane, please see www.brisbane.qld.gov.au/BCC:BASE::pc=PC_331

Electricity: The electricity supply in Australia is 240 volts, 50Hz. The connection for appliances is a flat 3-pin plug of unique design. Most hotels provide 110 outlets for shavers.

Taxes: A Goods and Services Tax (GST) of 10% applies to all consumer goods and is included in retail prices. You can claim a refund of the goods and services tax (GST) and wine equalisation tax (WET) that you pay on goods you buy in Australia. The refund only applies to goods you take with you as hand luggage, or wear onto the aircraft or ship when you leave the country. You can obtain more information at: www.customs.com.au

Tipping: Service charges are not added to accounts by hotels or restaurants. You may tip hotel porters and food and drink waiters in restaurants if you wish (up to around 10% of the bill). At all times tipping is your choice.

Dress Code: Smart casual attire is recommended for all Congress sessions.

Mobile Phones: Australia operates on a digital network.

Transport from the Airport: There are a number of taxi companies in Brisbane that service the Brisbane Airport so taxis are available at all times. Fare to Brisbane CBD from Airport: Approximately AU$33 plus a AU$3 fee for departing taxis only to Brisbane City / CBD Hotels

Coachtrans operates services every 30 minutes to the door of your hotel, AU$12.00 per person. Phone: Coachtrans +617 3238 4700 or book directly on-line www.coachtrans.com.au.

There is a train service from the Brisbane Domestic Terminal with connection to International Terminal. It is a 22 minute trip. One-way single adult ticket is just AU$13 (6.00am to 7.59pm - 7 days a week). www.bne.com.au/content/standard_v4.asp?name=PublicTransport#30

The Appropriate Visa for Delegates: All visitors to Australia who are not Australian citizens (other than citizens of New Zealand travelling on a New Zealand passport) require a valid visa or Electronic Travel Authority (ETA) to enter Australia. It is essential that you seek further information from your airline, travel agent or the Australian Consulate in your country, as immigration laws are very strict. Please visit for more information www.immi.gov.au

Invitation letter and Visa: If you require an invitation letter for visa purposes, please indicate this on your registration form or contact the Congress Secretariat.

Please note that an invitation letter is simply intended to assist participants who require a visa or permission to attend the AAGL 3RD International Congress on Minimally Invasive Gynecology/AGES XIX Annual Scientific Meeting 2009. It does not represent an official invitation covering fees or other expenses, nor does it imply any financial support for attendance at the Congress.

CONGRESS INFORMATION AND CONDITIONS

DEPOSITS AND FINAL PAYMENTS:
All costs are payable in advance. If, for any reason, your entire payment has not been received by the due date, we reserve the right to treat your booking fee as cancelled and will apply the appropriate cancellation fee.

CANCELLATION POLICY:
Should you or a member of your party be forced to cancel, you should advise the Congress Organisers in writing. Single Meeting Registrations: The cancellation policy for AAGL International Congress / AGES Annual Scientific Meeting allows a cancellation fee of AU$250.00 of registration fees for cancellations received up to 8 weeks' prior to the first day of the Meeting, and of 50% of registration fees for cancellations up to 4 weeks' prior to the Meeting. No refund will be made after this time. Multiple meeting registrants: No refunds apply.

Hotels and other suppliers of services, depending on date of cancellation, may also impose cancellation charges. Accommodation payments will be forfeited if the room is not occupied on the requested check-in date. Please note that a claim for reimbursement of cancellation charges may fall within the terms of travel insurance you effect. AGES reserves the right to cancel any workshop or course if there are insufficient registrations.

INSURANCE:
Registration fees do not include insurance of any kind. Insurance is strongly recommended to cover: loss of payments as a result of cancellation of your participation in the Congress, or through cancellation of the Congress itself, loss of airfares for any reason, loss or damage to personal property, additional expenses and repatriation should travel arrangements need to be altered, medical expenses, or any other related losses.

PRICING POLICY:
It is impossible to predict increases to cost elements such as government taxes and other service provider tariffs. In the event of such fluctuations or increases affecting the price of the Congress , we reserve the right to adjust our prices as may be necessary at any time up to and including the first day of the Congress, even though the balance payment may have been made. If we are forced to change your booking or any part of it for any reasons beyond our control, for instance, if an airline changes its schedule - we reserve the right to vary your itinerary and will give you, or cause to be given to you, prompt notice thereof.

COSTS DO NOT INCLUDE:
Insurance, telephone calls, laundry, food and beverage except as itemised in the brochure, and items of a personal nature.

TRAVEL AND ACCOMMODATION:
AGES, AAGL and Conference Connection are not themselves carriers or hoteliers nor do we own aircraft, hotels, or coaches. The flights, coach journeys, other travel and hotel accommodation herein are provided by reputable carriers and hoteliers on their own conditions. It is important to note, therefore, that all bookings with the Congress Organisers are subject to the terms and conditions and limitations of liability imposed by hoteliers and other service providers whose services we utilise, some of which limit or exclude liability in respect of death, personal injury, delay and loss or damage to baggage.

OUR RESPONSIBILITY:
AGES, AAGL and Conference Connection cannot accept any liability of whatever nature for the acts, omissions or default, whether negligent or otherwise of those airlines, coach operators, shipping companies, hoteliers, or other persons providing services in connection with the Congress pursuant to a contract between themselves and yourself (which may be evidenced in writing by the issue of a ticket, voucher, coupon or the like) and over whom we have no direct and exclusive control.

AGES, AAGL and Conference Connection do not accept any liability in contract or in tort (actionable wrong) for any injury, damage, loss, delay, additional expense or inconvenience caused directly or indirectly by force majeure or other events which are beyond our control, or which are not preventable by reasonable diligence on our part including but not limited to war, civil disturbance, fire, floods, unusually severe weather, acts of God, act of Government or any authorities, accidents to or failure of machinery or equipment or industrial action (whether or not involving our employees and even though such action may be settled by acceding to the demands of a labour group). Please note that the Prices quoted are subject to change without notice.

PRIVACY ACT 1988, Corporations Act 2001:
Collection, maintenance and disclosure of certain personal information are governed by legislation included in these Acts. Please note that your details may be disclosed to the parties mentioned in this brochure.