THE MODERN WOMAN

Australasian Gynaecological Endoscopy & Surgery Society Limited

XXVI ANNUAL SCIENTIFIC MEETING

ABSTRACT

2-5 MARCH 2016

BCEC, BRISBANE

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MEETING **PROGRAM**

WEDNESDAY **2 MARCH 2016**

1600 – 1830	**Conference Registration**
1830 – 2000	**Opening & Welcome Reception**

THURSDAY **3 MARCH 2016**

0715 – 0815	**Conference Registration**
0815 – 0830	Welcome **Anusch Yazdani**

Session 1
0830 – 0945

THE MODERN WOMAN

Who is the Modern Woman? This session will explore the changes that have shaped the modern woman and provide an overview of modern presentation patterns in women's health.

CHAIRS: Harry Merkur & Robyn Boston

The modern woman: Demystified
Alison Ariotti

The modern woman: Modern expectations
Fariba Behnia-Willison

The modern gynaecologist
Rachel Green

0945 – 1030

Dan O'Connor Perpetual Lecture

CHAIR: Jim Tsaltas

Presented by Judith Goh

1030 – 1100 **Morning Tea & Trade Exhibition**

Session 2
1100 – 1230

THE MODERN PELVIC FLOOR

The faculty will critically appraise current approaches to the management of pelvic floor disorders, with specific reference to 'state of the art' prolapse and continence surgery.

CHAIRS: Vinay Rane & Krish Karthigasu

Conventional vs mini tape: Is less more?
Salwan Al-Salihi

Native tissue repair: The natural way
Stefano Salvatore (sponsored speaker)

The young woman with prolapse: A conundrum
Nahla Merhi (sponsored speaker)

Where are we with prolapse surgery after all the reviews?
Chris Maher

THE MODERN TEENAGER

The session will explore modern surgical approaches to the management of paediatric and adolescent gynaecology, with a special focus on reconstructive surgery.

CHAIRS: Emma Readman & Donald Angstetra

Troubled Teens: Periods, pimples and pain
Amy Mellor

Surgical solutions to congenital abnormalities
Sonia Grover

Paediatric gynaecology: Surgeon, gynaecologist, paediatrician or endocrinologist?
Peta Wright

Consent for those who can't
Lauren Reibelt

1230 – 1330 **Lunch & Digital Free Communications**

Session 3
1330 – 1500

FREE COMMUNICATIONS : CHAIRMAN'S CHOICE

CHAIRS: Rachel Green & Tal Jacobson

1500 – 1530 **Afternoon Tea & Digital Free Communications**

Session 4
1530 – 1700

SEX AND THE MODERN WOMAN

How are sex and sexuality shaped by modern society? Or is sex shaping society?

CHAIRS: Fariba Behnia-Willison & Anna Burrows

Labiaplasty & the pornographic industry
Gemma Sharp

Vaginal rejuvenation: Fact or fiction
Stefano Salvatore (sponsored speaker)

Cosmetic genital surgery
Ajay Rane

Pelvic pain and sexual pain
Jayne Berryman

CLOSE OF DAY ONE

FRIDAY **4 MARCH 2016**

0730 - 0800 **Conference Registration**

Session 5
0800 – 1030

LIVE SURGERY

Live surgical telecast from the Wesley Hospital, Brisbane.

CHAIRS: Stuart Salfinger & Akram Khalil

Michael Wynn-Williams
Felix Chan
Tina Martino

CONFERENCE WORKSHOP AN AGES FIRST: THE MODERN AGES INTERACTIVE HUB

Surgical Skills and Learning Centre
Sponsored by Stryker and Applied Medical
(continued after lunch)

1030 – 1100 Morning Tea & Trade Exhibition

Session 6
1100 – 1230

REPRODUCTION AND THE MODERN WOMAN

The faculty will explore surgical aspects of modern reproductive trends, including the role of tubal surgery and endometriosis.

CHAIRS: Simon Edmonds & David Molloy

Reproductive challenges in the Modern Woman: From surgery to IVF
Ben Kroon

Endometrioma: Modern surgical management
Prashant Mangeshikar

Reproductive microsurgery in modern fertility management: Girls & boys
Derek Lok

Fibroids and the fetus: A match made in hell
Hugo Fernandes

MODERN ONCOLOGY

The session will explore contemporary management of malignant and premalignant disorders and how practices have been shaped by the modern woman.

CHAIRS: Stephen Lyons & Ken Law

Routine salpingectomy for all
Stuart Salfinger

VAIN and VIN: A modern approach to a persistent problem
Andrea Garrett

Complex endometrial hyperplasia in the young woman
Naven Chetty

Endometriosis and cancer
Jim Tsaltas

1230 – 1330 Lunch & Digital Free Communications

Session 7
1330 – 1500

FREE COMMUNICATIONS A
CHAIRS: Emma Readman & Andrew Cary

FREE COMMUNICATIONS B
CHAIRS: Krish Karthigasu & Jospeh Jabbour

AN AGES FIRST: THE MODERN AGES INTERACTIVE HUB
(continued)

1500 – 1530 Afternoon Tea & Trade Exhibition

Session 8
1530 – 1700

THE MODERN PELVIS

From Laser to robotics, contemporary surgical techniques dominate this session.

CHAIRS: Simon McDowell & Anusch Yazdani

Robotics – the future of surgery?
Nahla Merhi (sponsored speaker)

Vaginal surgery: Why reinvent the wheel?
Stefano Salvatore (sponsored speaker)

Day surgery hysterectomy: From concept to reality
Felix Chan

Uterine Transplantation is a reality but who,how and when?
Ash Hanafy

1715 – 1800 **AGES AGM – Members only**

1900 – 2230 AGES XXVI ASM Gala Dinner
Dress Code: Black Tie

Program correct at time of printing and subject to change without notice. Updates available on the AGES website.

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SATURDAY **5 MARCH 2016**

0800 – 0830 **Conference Registration**

Session 9
0830 – 1000

MODERN DILEMMAS
Modern approaches to old problems!

CHAIRS: Alan Lam & Gino Pecoraro

Morcellation madness
Jason Abbott

Taking control of your bladder
Nahla Merhi (sponsored speaker)

Endometriosis, adenomyosis and pain – Where are we now?
Tal Jacobson

Endometrial ablation in the new millennium
Simon Edmonds

1000 – 1030 Morning Tea & Trade Exhibition

Session 10
1030 – 1200

THE MODERN GYNAECOLOGIST
Gynaecological practice now and into the future: expectations and reality. Should we support or report?

CHAIRS: Rachel Green & Melinda Heywood

The Australian perspective of the modern gynaecologist: Surgical training in 2016
Michael Permezel

The modern health consumer: Rights & responsibilities when accessing healthcare
Leon Atkinson-MacEwen

Medicare reform: Purpose or shambles
David Molloy

Support or Report: Concerned about your colleagues?
Vinay Rane

Session 11
1200 – 1230

PRESIDENT'S DEBATE: MODERN WOMAN IS JUST ANCIENT WOMAN WITH A SMART PHONE
A light hearted look at modern society

CHAIRS: Anusch Yazdani & Jason Abbott

FOR	AGAINST
Nahla Merhi (sponsored speaker)	**Emma Readman**
Rachel Green	**Supuni Kapurubandara**

1200 - 1245 CLOSE OF CONFERENCE / PRESENTATION OF AWARDS & CERTIFICATES / 2015 TRAVELLING FELLOWSHIP PRESENTATION BY MARILLA DRUITT

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

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Please use the link below to access the Conference App:

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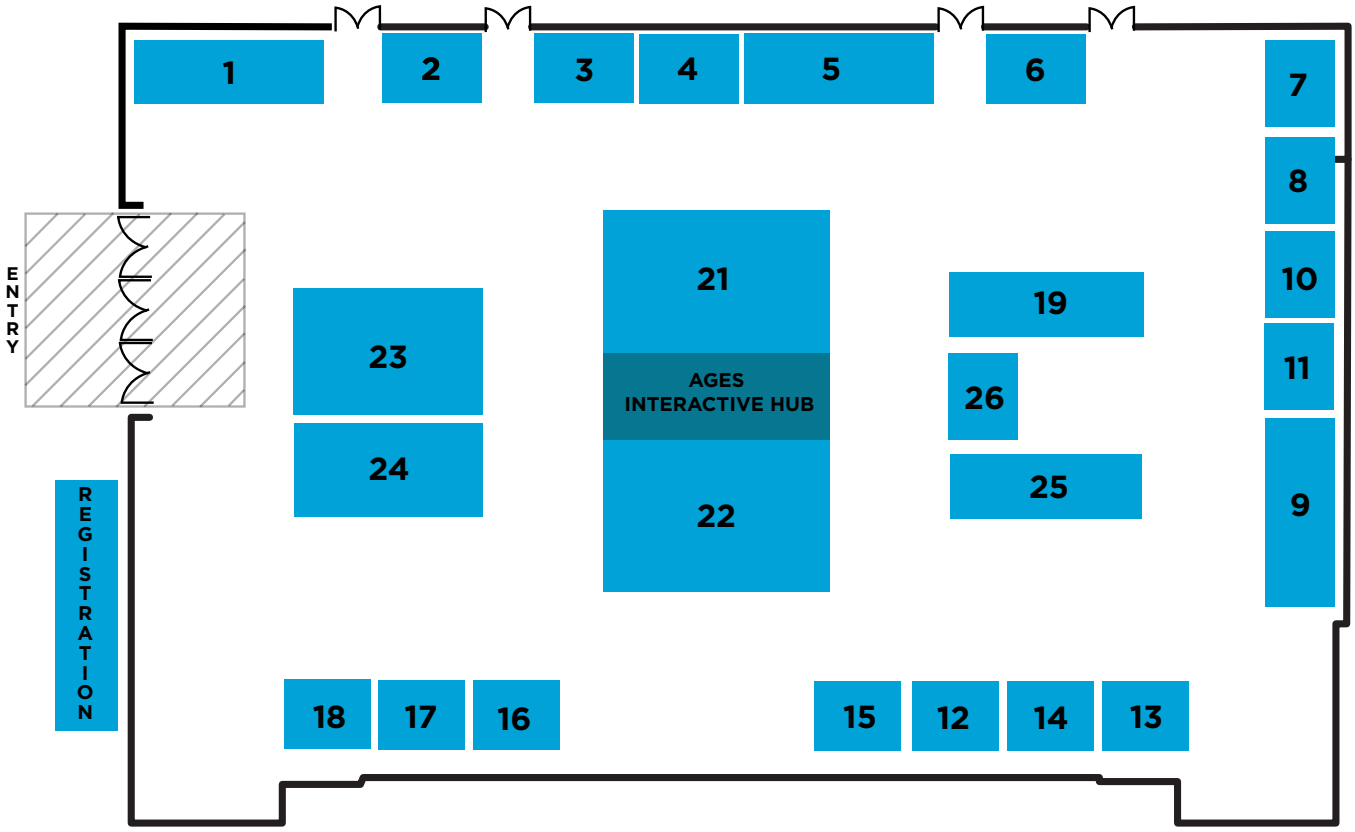
EXHIBITION
FLOORPLAN



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AN AGES FIRST: **THE MODERN AGES INTERACTIVE HUB**

FRIDAY 4 MARCH

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Places strictly limited. Pre-registration essential.

PRE-CONFERENCE
RANZCOG TRAINING SUPERVISOR WORKSHOP
WEDNESDAY 2 MARCH | 0900 – 1630

FACILITATORS
Lyn Johnson (RANZCOG Director of Education & Training) and **Shaun McCarthy** (RANZCOG Training Services Manager)

PRE-CONFERENCE WORKSHOP IN LAPAROSCOPIC CADAVERIC PELVIC ANATOMY
WEDNESDAY 2 MARCH | 0800 – 1730

COURSE CONVENOR
Dr Michael Wynn-Williams MBChB, FRANZCOG

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DA VINCI GYNAECOLOGY ADVANCED COURSE
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POST-CONFERENCE
AGES ASM ADVANCED TRAINEE WORKSHOP
Sponsored by Applied Medical
SUNDAY 6 MARCH | 0900 – 1630
No additional cost. Invite only.

Please refer to the AGES website for more information
www.ages.com.au or ages-asm-2016.w.yrd.currinda.com

SOCIAL **PROGRAM**

CONFERENCE OPENING & WELCOME RECEPTION
Plaza Terrace, BCEC
Wednesday 2 March 2016
1830 - 2030

AGES XXVI ANNUAL SCIENTIFIC MEETING GALA DINNER
Queensland Art Gallery – Watermall
Friday 4 March 2016
1900 - 2230
Ticket Cost: $145

The Queensland Art Gallery | Gallery of Modern Art (QAGOMA) is set in the Cultural Precinct at Brisbane's South Bank. The Gallery's vision is to be the leading institution for the contemporary art of Australia, Asia and the Pacific, and holds a Collection of over 16,000 works of historical, modern and contemporary art.

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FREE COMMUNICATIONS

SESSION 3
FREE COMMUNICATIONS CHAIRMAN'S CHOICE
PLAZA AUDITORIUM

ORAL PRESENTATIONS

Neuropelveology: A new pelvic surgical discipline ranging from nerve sparing surgical approach to implantation of electrodes to aid ambulation in spinal cord injury patients
Danny Chou

Excision of rectovaginal endometriosis: Is there a surgical learning curve?
Sarah Fitzgibbon

3-D transvaginal sonography as pre-operative predictor of the need to morcellate in women undergoing laparoscopic hysterectomy: Pilot study to evaluate the "probability of morcellation index"(PMI)
Bassem Gerges

Successful pregnancies in women seeking fertility enhancement with MRI guided focused ultrasound (MRgFUS) fibroid ablation
Karen Kong

Can narrowband imaging improve the laparoscopic identification of superficial endometriosis?
Tony Ma

Acute abdominal pain and the emergency laparoscopy – a diagnostic dilemma for the surgeon or gynaecologist?
Jess McMicking

Medium to long-term gastrointestinal outcomes following disc resection of the rectum for treatment of endometriosis using a validated scoring questionnaire
Ada Ng

Independent assessment of long-term outcome in a prospective cohort of patients undergoing laparoscopic sacrocolpopexy
Stefaan Pacquée

Laparoscopic management of caesarean scar ectopic pregnancy
Keisuke Tanaka

SESSION 7
FREE COMMUNICATIONS A
PLAZA AUDITORIUM

VIDEO PRESENTATIONS

Prelaparoscopic ultrasound "soft marker" evaluation of ovarian mobility in the normal and endometriotic ovary
Bassem Gerges

My period takes my breath away
Luke McLindon

Robotic application and special surgical techniques to remove multiple fibroids in a culturally challenging context
Valerie To

ORAL PRESENTATIONS

A prospective analysis of hysteroscopic morcellation in the management of intrauterine pathologies
Amy Arnold

Opportunistic bilateral salpingectomy at the time of hysterectomy – An audit of surgical practice
Ushmi Chatterjee

How accurate is ultrasound imaging in the detection of deep infiltrating endometriosis?
Alexandra Gil

Bowel injury at laparoscopic surgery: Mechanism, prevention & management
Amani Harris

Caesarean scar pregnancy: A systematic review of diagnosis and management
Sarah Maheux-Lacroix

A comparitive study of contrasting national training programmes in advanced gynaecological endoscopy
James McLaren

SESSION 7
FREE COMMUNICATIONS B
MEETING ROOMS P6 & P7

ORAL PRESENTATIONS

Prospective validation of the Ultrasound Based Endometriosis Staging System (UBESS)
George Condous

The Take Home Box Trainer (THBT) Project: A novel approach to enhance O&G trainee laparoscopic skills
Sarah Janssens

A comparison of two misoprostol regimens for medical management of first trimester miscarriage
Fiona Langdon

The role of endometriosis specific ultrasound in pre-operative planning
Tony Ma

Complications and outcomes post laparoscopic hysterectomy at King Edward Memorial Hospital, Western Australia
Jennifer Pontre

The effect of salpingectomy on the ovarian reserve
Rachael Rodgers

VIDEO PRESENTATIONS

Vaginal myomectomy for multiple cervical fibroids
Karen Kong

The challenges of an ovarian ectopic
Luke McLindon

Laparoscopic ovarian transposition to preserve ovarian function before pelvic radiation in 2 young patients with rectal cancer, at the level of a secondary institution
Lionel Reyftmann

DIGITAL FREE COMMUNICATIONS
EXHIBITION AREA

Neuropelveology: Isolated sciatic nerve endometriosis, thank God for neuropelveology
Paul Atkinson

Morcellation – a NOTEworthy approach
Thea Bowler

The management of obstetric haemorrhage secondary to abnormal placentation: A prospective cohort study
Prathima Chowdary

Systematic review of self retaining retractors and complications with open abdominal surgery
Prathima Chowdary

The modern management of the paroophoron cyst
Chris Georgiou

Bladder endometriosis: A view from both ends
Hillary Hu

Efficacy of thermal balloon endometrial ablation in menorrhagia and the prognostic factors
Shreekala Kakatkar

Severe Deeply Infiltrative Endometriosis (DIE) requiring laparoscopic left nephrectomy and laparoscopic ultra-low anterior bowel resection with defunctioning Ileostomy
Louise Konaris

Laparoscopic ovarian detorsion and subsequent conservative management in pregnancy
Tal Jacobson

Vaginal vault dehiscence with evisceration of the fallopian tube post Vaginal Hysterectomy in a pre-menopausal woman: A case report and Literature Review
Kent Lin

Keeping up appearances with our 'Modern Woman' – Stumbling across metal hair extensions in the anaesthetic bay.
Jess McMicking

Severe endometriosis with full thickness bladder wall excision and achievement of spontaneous pregnancy - a case report
Angela Model

Feacal matter in a tubo-ovarian mass
Nargis Noori

When haemorrhage raises your BP
Emma Paterson

Use of a Bettocchi hysteroscope and microscissors, in difficult cases of access to the uterine cavity
Lionel Reyftmann

Vaginal birth after cesarean: Does ethnicity matter?
Nina Reza Pour

Total laparoscopic hysterectomy with distorted pelvic anatomy
Mark Ruff

Did AGES training program make a difference? The learning curve for total laparoscopic hysterectomy
Tarek Saleh

An interesting case of a large uterine leiomyoma with possible associated intravenous leiomyomatosis with intracardiac extension
Cheryl Silveira

When a post partum haemorrhage fails medical treatment
Ashleigh Smith

EXTREME GYNAECOLOGY-1 Hybrid umbilical entry: A laparoscopic entry technique for patients with extreme obesity(BMI ≥40 kg/m2).
Hasan Titiz

EXTREME GYNAECOLOGY-3 Tips & Tricks: 3 steps total laparoscopic hysterectomy technique for extremely large uterus (34 weeks size) with Titiz utero-vaginal manipulator
Hasan Titiz

Exploring the benefits of robotic surgery in the management of severe endometriosis
Valerie To

In-bag morcellation: Tips and tricks
Caroline Walsh

Unraveling the mystery behind the Open (Hasson) technique to laparoscopic entry: A video teaching tool for gynaecology trainees
Saima Wani

Program Abstracts

Thursday 3 March 2016

The Modern Woman

Session 1 / 0830 – 1030
Plaza Auditorium

Who is the Modern Woman? This session will explore the changes that have shaped the modern woman and provide an overview of modern presentation patters in women's health.

The modern woman: Demystified

Alison Ariotti

The modern woman has more choices, more opportunities than ever before. Her quest to balance a career, family and personal pursuits is a constant challenge. Life is a juggling act and she fiercely battles to keep all the balls in the air. But is she sacrificing her health and happiness? I will delve into how the modern woman has evolved and what direction she'll take next.

The modern woman: Modern expectations

Fariba Behnia-Willison

12 Million Modern women comprise the better half of Australia's diverse multicultural society. What are some of their uniting characteristics, whether stay-at-home mothers or successful business women?

In the past, women were heavily socially and politically oppressed, triggering waves of feminist activisms leading to the social and political emancipation of women.

Due to the emancipation of women and the consequent expectations from herself, her family work and society, Modern women now have fast-paced lifestyles. Their day comprises dropping off their children to multiple events each day, helping them with homework, managing their own and their children's social media issues, engaging in many face to face events, facing employment or business and travel pressures or, more commonly, a complex mixture of all. These commitments leave her less time to attend to personal health, well-being and relaxation.

Moreover, these fast-paced women want convenience when they consider gynaecological care for health or aesthetic procedures; the modern woman is more aware of ageing due to media and the availability of cosmetic surgery, laser and other surgical and non-surgical options. Due to time constraints her health, sexuality and anti-ageing personal desires and needs are frequently given the lowest priority.

For modern women time offline is the enemy so practitioners need to provide:

Flexible options for the timing of consultations and surgery time

The smallest intervention possible for the maximum gain, to reduce procedural time and recovery time

Efficient after-care that fits with their schedules to ensure she complies with care plans and does not compromise her health for the sake of other pressures.

Clear, efficient and practical communication, kept to the basics to allow for full absorption and follow through

The six S's of Modern Women are therefore:

Safe: They want care that is proactive, preventative and gives them the greatest health

Sexy: Modern women want to look good and feel good

Serene: They need to know that care givers have their best interests at heart and that in times of need they will be fully supported

Small: Modern women want the smallest intervention, given to provide the best health outcome

Short: Want short downtime and maximum uptime

Solutions: Modern women are solutions-oriented, and need to see gynaecologists who are confident, convenient and able to educate them without making them feel vulnerable.

The modern gynaecologist

Rachel Green

Abstract not yet received.

Dan O'Connor Perpetual Lecture

Judith Goh

Who is the modern woman? What constitutes the modern gynaecologist/obstetrician?

One's views would depend on a number of factors including age, experience, lifetime experiences, social/family environment, perceived needs and where one is living/working. As a urogynaecologist in Australia, my understanding of the modern woman here is quite different to my view as a fistula surgeon (for over 20 years) working in low income countries.

We now live in the age with the desire to be 'perfect' in our body-image and instantaneous gratification. This is evident from the boom in cosmetic surgery including the genital area. Dr Google tells us we can get fit and lose weight in 2 weeks without too much effort and there are always 'super' foods to assist us. Dr Google tells us what we should look like. And upgrades are always better.

In terms of pregnancy and childbirth, perfection is now the aim, with a beautiful baby and body after delivery. Young women are now unhappy, that in spite of a normal spontaneous vaginal delivery with a healthy baby, she feels that 'things down below' are not the same and she is unable to attain her pre-pregnancy body shape and weight. In the not so modern world, the woman is expected to rest after delivery (between 30-60 days – depending on the culture e.g. Chinese, Indian, Turkish). In these traditional cultures, she is not expected to return to the gym and do heavy lifting etc. She does not expect to return to her pre-pregnancy body shape and weight within 2 weeks! However, our modern mother often believes she can and has to, with pressure from family/friends and media.

In terms of medical practice around the world, many doctors in low income countries have the perception that what is done in high income countries is always better. This is often done without consideration of what is actually available (or not available) in the local health care system. In many parts of the world, there is no reliable mains electricity, no adequately trained health professionals especially in rural areas, and medical equipment including sutures are suboptimal.

In many parts of Africa, there is now a high cesarean section rate without a corresponding improvement in maternal mortality/morbidity and perinatal outcomes. An instrumental delivery is not performed as it is 'bad' because it 'damages the mother and baby' – Dr Google says so. Even for women with obstetric fistulas, there is a high cesarean section rate – to deliver a stillborn baby low in the maternal pelvis. With pressure necrosis of maternal tissues from the prolonged obstructed labour, an impacted fetal presenting part very low in the maternal pelvis causes significant morbidity and has a significant impact on the woman's future fertility.
In our modern woman/mother, media plays a large role in her perceptions of her desired outcomes. However, the obstetrician/gynaecologist/urogynaecologist is also influencing her views. If we give the impression that something has 'gone wrong' when an instrumental delivery has occurred or the delivery resulted in a perineal tear or haemorrhoids or some pelvic floor dysfunction or levator muscle tear, then we may be not better than the media.

We also often forget that as the 'world is getting smaller' with easier access to communications etc, we need to be more responsible about what we say and do as it does impact on women around the world. Most women around the world do not have access to antenatal care or a trained health care provider to assist her at time of delivery. About 1 in 16 women in sub-Saharan Africa still die from complications in pregnancy and childbirth. In some areas it may be as high as 1 in 6. In Uganda, maternal mortality accounts for 18% of all deaths in women between 15-49 years of age. In many parts of the world, cesarean section causes significant maternal morbidity and mortality with no perinatal benefits.

In other words, we need to be mindful about what we say and do as we are being watched.
As a fistula surgeon working in many low-income countries, my desire for the modern woman in these areas, after a delivery, is for someone to say "mother and baby are well." I hope this is not too old fashioned.

The Modern Pelvic Floor

Session 2 / 1100 – 1230

Plaza Auditorium

The faculty will critically appraise current approaches to the management of pelvic floor disorders, with specific reference to 'state of the art' prolapse and continence surgery.

Conventional vs mini tape: Is less more?

Salwan Al-Salihi[1]

1. *Department of Urogynaecology, The Royal Women's Hospital, Parkville, Victoria, Australia*

Introduction and Background

Obtaining entry into the abdominal cavity is one of the most potentially dangerous steps of laparoscopy3. Multiple examples of injury to major blood vessels and abdominal viscera exist. Several techniques of entry to the abdomen and peritoneal cavity have been described. Recent Cochrane review by Ahmad et al concluded no recommendation for best technique2. The Royal College of Surgeons of England recommends the use of open technique in all instances3. According to survey, the majority of gynaecologists prefer either direct or closed entry techninques3 and as such gynaecology trainees often have limited exposure to open technique.

Open 'Hasson' Technique describes abdominal entry achieved with direct incision to the abdomen under vision, followed by a combination of blunt and sharp dissection. Decreased rates of vascular injury with open technique have been shown1. Some studies have shown decreased rates of visceral injury1. Historically this technique has been reported to be lengthy and more surgically complex compared with other techniques.

We have found at our tertiary institution that specialist gynaecology trainees have limited experience with open entry and are both hesitant and unfamiliar with this technique. Instructional video has been recognized as an important tool to progress development of surgical skills. This video has been specifically created to improve the gynaecology trainees' understanding of open entry techniques including background, risks, benefits and a step-by-step approach to the procedure. Whist this video is not intended to be a substitute for hands on surgical teaching, we aim to enhance and maximize the learning opportunity for the trainee prior to exposure to the hands on surgical experience.

Method

Consent for Surgical video was obtained from two women undergoing routine elective laparoscopic procedures. Video was recorded with Sony NxtCam, and Storz Laparoscopic equipment. Video editing was undertaken. Care has been taken to include footage regarding both setup and procedure.

Conclusion

The technique of open entry as demonstrated in the video is a straightforward and relatively simple technique when learnt and performed correctly. Although there is no evidence forone entry technique over another, what cannot be disputed is that trainee surgeons will be best equipped and most versatile when given the opportunity to add additional skills to their surgical armamentarium

Native tissue repair: The natural way

Stefano Salvatore

Pelvic organ prolapse is a very common condition whose treatment could be conservative or surgical in relation to bothersome and severity experienced by a woman. Prolapse surgery is performed worldwide using different approaches and by different specialists. Success rate varies enormously in literature and mesh surgery has been proposed in the last decades to improve outcome. However due to complications graft procedures have been loosing more and more attractiveness and native tissue repair is returning to be considered the favourite way. In this lecture aspects related to efficacy and safety of native tissue repair in all the vaginal compartments will be covered. A comparison with mesh surgery will also be included.

The young woman with prolapse: A conundrum

Nahla Merhi

We will discuss how to counsel the young woman about the best surgical approach to repair her pelvic organ prolapse;

Apical prolapse:

- Comparing the recurrence rate, durability and effect on sexuality of the different techniques used for apical prolapse repair
- Comparing Pelvic Organ prolapse surgeries With or Without uterine preservation

Anterior & Posterior Colporrhaphy:

- Comparing observation vs surgical repair .. effect on recurrence and sexuality
- Comparing briefly Native tissue vs Site specific vs Graft augmented repair

Where are we with prolapse surgery after all the reviews?
Chris Maher

The Medicines and Healthcare Products Regulatory Agency (MHRA) reported in late 2014 MHRA 2014 after reviewing literature generated from York report in 2012 and commissioning further literature review in 2012, taking submissions from support groups and reviewed adverse events reports made to MHRA, engaging with professional organisations, regulatory bodies in European Union and USA and participated in European Commision (EC) Task Force Group on vagina mesh implants. The full report was extensive and concluded on the data before them that: for the majority of women, the use of vaginal mesh implants is safe and effective the current evidence shows that when these products are used correctly they can help alleviate the very distressing symptoms of SUI and POP and as such the benefits still outweigh the risks.

The Modern Teenager
Session 2 / 1100 – 1230
P6 & P7
The session will explore modern surgical approaches to the management of paediatric and adolescent gynaecology, with a special focus on reconstructive surgery.

Troubled teens: Periods, pimples and pain
Amy Mellor

Periods:
- Heavy menstrual bleeding in the adolescent
- Menstruation in specific populations, eg. adolescents with a disability, the anti-coagulated adolescent

Pimples:
- Polycystic ovarian syndrome in the adolescent
- Other causes of androgen excess in the adolescent

Pain:
- Primary dysmenorrhoea versus endometriosis in the adolescent population

Pluses and perils:
- Adolescence in the modern age.

Surgical solutions to congenital abnormalities
Sonia Grover

Congenital anomalies can be detected at birth but sometimes are uncovered in adolescence. Remembering that the aim of management is to achieve optimal health outcomes for the young woman, and that the care has to take into account her developmental stage is critical for good long term outcomes. Unlike some obstructive problems in other systems, those affecting the Mullerian tract can often be optimally managed with delayed intervention by suppressing menses. Increasingly the potential for maintenance of fertility by early and active involvement of gynaecologists can result in positive outcomes – this applies to conditions such as cervical agenesis. Some of the common anomalies and the principals of surgical care will be outlined in this presentation.

Paediatric gynaecology: Surgeon, gynaecologist, paediatrician or endocrinologist?
Peta Wright

- A role that requires knowledge of all four specialties and crucially understands the value of collaboration.

Understand how and why this sub-specialty arose at the intersection of several well-established disciplines (pediatrics, endocrinology and gynecology), and why a specialized pediatric /adolescent gynecologist is essential for the optimal care of the child or adolescent with a gynecological issue. Who takes the clinical lead with common conditions, and the imperative role of collaboration with the other specialties will be explored.

Consent for those who can't
Lauren Reibelt

The law that governs consent to medical treatment to be provided to a child is complex and varies depending on the nature of the medical procedure to be given or refused. This session will canvass when a child may provide consent, what role the parent will play in providing consent, and the circumstances in which a court may be called upon to intervene.

Free Communications: Chairman's choice
Session 3 / 1.30pm – 3.00pm
Plaza Auditorium

Neuropelveology: A new pelvic surgical discipline ranging from nerve sparing surgical approach to implantation of electrodes to aid ambulation in spinal cord injury patients

Danny Chou[1], Gregory Miles Cario[1], David Rosen[1], Stefaan Pacquée[1], Paul Atkinson[1], Walsh Carly[1]

1. *Sydney Women's Endosurgery Centre, Kogarah, NSW, Australia*

This presentation is a brief introduction of an exciting new pelvic surgical disciple based on detailed understanding of pelvic nerve anatomy and function, established by Prof Marc Possover, founder of the International Society of Neuropelveology. The society's website, www.theison.org has wealth of resources including E-Learning Course "Clinical Neuropelveology" which will have lectures and videos (Available from March 2016) with Certification at the end of completion of online examination.

This new field of pelvic surgery has wide ranging implications to gynaecological surgery. The detailed knowledge and understand of pelvic nerves, particularly the pelvic autonomic nervous system, not only allows us to refine our surgery to be more respectful to the neural structures, it fundamentally changes our approach to the a "nerve sparing approach", this is particularly so in more radical surgery such as in case of extensive deeply infiltrative endometriosis. It's akin to nerve sparing radical hysterectomy approach where the autonomic pelvic nerve are identified and dissected free of harms way prior to excision. In situation where injuries has occur to pelvic nerve one can better understand and diagnose as well potential treat such complications.

Neuropelveology has uncovered uncommon and less well-understood pathologies that involves pelvic nerves including endometriosis in pelvic nerves and vascular entrapments syndromes where with better understanding of pelvic neuroanatomy one becomes better prepared for such conditions.

Perhaps the even more exciting aspect of Neuropelveology lies in the expanded therapeutic roles with the use of implanted stimulating electrodes for the treatment of patients with chronic pelvic pain syndromes, patients with pelvic organ dysfunctions (bladder over-activities, faecal urgency and certain sexual dysfunction) as well as patients with spinal cord injury (SCI) to aid ambulation. In patients with pelvic pain syndromes and pelvic organ dysfunctions, implanted electrode induces electro-modulation similar to the better know Sacral Nerve Stimulation. In patients with SCI, implanted electrodes over major pelvic nerves (Femoral and Sciatic) leads to extension of knees and hips to aid weigh bearing and ambulation.

The presentation will briefly highlight some of the practical aspects of this exciting new field of pelvic surgery, which will no doubt continue to evolve and refine in its wide ranging applications.

Excision of rectovaginal endometriosis: Is there a surgical learning curve?

Sarah Fitzgibbon[1]

1. *Obstetrics and Gynaecology, Counties Manukau District Health Board, Auckland, New Zealand*

Introduction: In 2011 Counties Manukau District Health Board (CMDHB) established an advanced laparoscopic service to enable rectovaginal excisional endometriosis surgery to be offered to women in the public system.

Aim: To assess the performance of this new service and ensure improving surgical outcomes and patient safety over the 4 ½ year period from establishment. Methods: Data was prospectively collected on patients having rectovaginal excisional surgery between July 2011 – December 2015. The service was multidisciplinary including a lead gynaecological surgeon, a gynaecology fellow, a colorectal surgeon that was present in theatre for the first 18 months and on call as required thereafter, and a dedicated anaesthetist. Patients underwent a staging laparoscopy prior to referral to the service. Data was recorded from the hospital clinical information management system "concerto" and included demographic and surgical details including major complications.

Results: A total of 103 patients underwent excision of rectovaginal endometriosis. Overall laparoscopic surgery was performed in 69% of cases and laparotomies in 31%. The unintentional laparoconversion rate was 5.8%. Comparatively in the last year of the study laparoscopic completion rates had increased to 79% and laparotomy rates had decreased to 21%. The rate of unintentional laparoconversion had decreased from 11% in 2011 to 4% in

2015. The need for bowel resection declined from 9% in 2011 to 4% in 2015. Conversely intraoperative repair of minor bowel related defects increased from 0% in 2011 to 4% in 2015. Duration of stay decreased from a median of 3 days (IQR 2.5-4.5) in 2011 to 2.5 days (IQR 2.0-3.3) in 2015. Major complication rates remained low. A total of 6 (5.8%) patients required blood transfusion, 2 (1.9%) a wound infection requiring return to theatre, 4 (3.9%) a pelvic abscess, and 2 (1.9%) an unintentional genitourinary injury. The risk of any major complication decreased from an average of 13.6% to only 3.4% in 2015. Conclusion: Our study shows that the set up of an advanced endometriosis surgical unit is feasible and can be safely established by a lead gynaecologist surgeon with appropriate colorectal support. A learning curve is clearly demonstrated with increased laparoscopy rates, decreased laparoconversions, decreased major complication rates, and decreased length of hospital stay over the study period.

3-D transvaginal sonography as pre-operative predictor of the need to morcellate in women undergoing laparoscopic hysterectomy: Pilot study to evaluate the "probability of morcellation index"(PMI)

Bassem Gerges[1, 2], Max Mongelli[1, 2], Ishwari Casikar[1, 2], Tommaso Bignardi[3], George Condous[1, 2, 4]

1. *Acute Gynaecology, Early Pregnancy and Advanced Endosurgery, Nepean Hospital, Kingswood, NSW, Australia*
2. *Nepean Medical School, University of Sydney, Sydney, NSW, Australia*
3. *Department of Obstetrics and Gynecology, A.O. Niguarda Ca' Granda, Milan, Italy*
4. *Omni Gynaecological Care Centre for Women's Ultrasound and Early Pregnancy, St Leonards, NSW, Australia*

Objective: In light of recent statements from the FDA and AAGL regarding morcellation during laparoscopy, we sought the use of 3-D transvaginal sonography (TVS) using a previously published algorithm to predict the need for morcellation based on estimated uterine volume and parity.

Methods: Prospective observational study performed between October 2008 and November 2011 in a tertiary referral laparoscopic unit. All women scheduled to undergo total laparoscopic hysterectomy (TLH) in the study period were included and underwent detailed transvaginal scan (TVS) at the pre-operative assessment. The 3D uterine volumetric datasets were reviewed using SonoView Pro and uterine volumes were estimated with off-line processing using Virtual organ computer-aided analysis (VOCAL). Age, parity, operating time, estimated blood loss, and final uterine weight at histology were recorded. Outcome measures included sensitivity, specificity, positive and negative predictor values for VOCAL volumes and need to morcellate at different previously calculated predicted probability for morcellation[1]. Uterine volumes calculated using VOCAL have previously been correlated to the corresponding dry uterine weights ($R = 0.97$, $P < 0.001$)[2]. The estimated uterine volumes were then incorporated into a previously published model to predict the need to morcellate. The probability cut-offs were set at thresholds ≥ 0.25, ≥ 0.5, ≥ 0.7 and ≥ 0.9. For the purposes of this study, this is referred to as the "probability of morcellation index" (PMI).

Results: 76 women underwent LH during the study period. Complete data were available in 96% (74/76) of cases. The mean age of the women was 43.7 years and 92% were multiparous. The prediction for morcellation using receiver operating characteristic curve analysis was performed. For VOCAL, the area under the curve (AUC) was 0.90, sensitivity 71% at a false positive rate of 10% and for dry weight, AUC 0.90, sensitivity was also 71% with a false positive rate of 10%. The uterine volumes for nulliparous and multiparous women at PMIs of 0.25, 0.5, 0.7 and 0.9 were 50/160, 120/220, 160/280 and 240/350 milliliters, respectively. The sensitivities, specificities and false negatives for each PMI were 86.4/66.7/3.95, 72.7/89.7/7.89, 68.2/97.4/9.2 and 63.6/97.4/10.5 percent, respectively.

Conclusions: The need to morcellate can be predicted preoperatively using uterine volumes obtained by TVS using VOCAL and parity with a fair degree of accuracy. Furthermore, our results allow surgeons to individualise their own PMIs in accordance with their level of expertise and risk aversion.

1. Condous G, Bignardi T, Alhamdan D, et al. What determines the need to morcellate the uterus during total laparoscopic hysterectomy? J Minim Invasive Gynecol. 2009; 16: 52-5.
2. Casikar I, Mongelli M, Reid S and Condous G. Estimation of uterine volume: a comparison between Viewpoint and 3D ultrasound estimation in women undergoing laparoscopic hysterectomy. Australian Journal of Ultrasound Medicine. 2015; 18: 27-32.

Successful pregnancies in women seeking fertility enhancement with MRI guided focused ultrasound (MRgFUS) fibroid ablation

Karen Kong[1], Emma Pun[2], Amber Moore[3], Lynn Burmeister[4], Mark Petris[5], Gareth Weston[4], Catarina Ang[1], Andrew Dobrotwir[2]

1. *Department of Gynaecology 1 unit, The Royal Women's Hospital, Parkville, VIC, Australia*
2. *Department of Radiology, The Royal Women's Hospital, Parkville, VIC, Australia*
3. *St Vincent's Private Hospital Melbourne, Fitzroy, VIC, Australia*
4. *Monash IVF, Melbourne, VIC, Australia*
5. *Monash Medical Centre, Clayton, VIC, Australia*

Background: The role of fibroids in infertility and the role of fibroid treatment to enhance fertility continue to be controversial and contentious issues. Females in developed countries tend to start a family at an age when natural fertility is in decline and the incidence of fibroids is increasing, this issue is becoming more relevant. Recent publications have attempted to analyze the available data and draw conclusions regarding the significance of fibroids with respect to fertility and pregnancy outcomes. Consensus panels have proposed treatment recommendations for symptomatic fibroids where the patient desires fertility preservation and also for fertility enhancement in the context of fibroid related infertility or failed assisted reproductive techniques (1). MRI guided focused Ultrasound (MRgFUS) have become established in the treatment of symptomatic fibroids, clinicians have expressed concern, initially regarding the safety in future pregnancy and subsequently the efficacy of these treatment modalities in infertility.

As promising data has emerged over time with respect to MRgFUS, favourable pregnancy outcomes and even a role in fertility enhancement, a major limitation has been the lack of published data and limited patient numbers (2,3). We aim to add to this growing body of literature with this report, which is the first to incorporate 16 consecutive successful live births in 14 women following fibroid MRgFUS specifically for fertility enhancement in the setting of primary infertility, secondary infertility, and in increasing the success rates of assisted reproductive techniques.

Objective: To describe a series of 16 consecutive live births in women seeking fertility enhancement with MRI guided focused ultrasound uterine fibroid ablation.

Design: Retrospective report.

Setting: University hospital and Private Centre for MRI guided focused ultrasound treatment.

Patients: Women with uterine fibroids and primary or secondary infertility seeking fertility enhancement with MRgFUS.
Interventions: MRI guided focused ultrasound ablation of uterine fibroids to enhance fertility in patients with primary or secondary infertility.

Main outcome measures: Time from treatment to conception, method of conception, intrapartum complications and Obstetric outcomes including gestational age at delivery, mode of delivery, birth weight, Apgar scores and post-partum complications.

Results: 16 healthy babies were born to 14 women following MRI guided focused ultrasound fibroid ablation to enhance fertility in the setting of primary or secondary infertility.

Conclusions: Women suffering primary or secondary infertility with uterine fibroids seeking fertility enhancement may conceive spontaneously or with assisted reproductive techniques following MRI guided focused ultrasound fibroid ablation, resulting in successful term pregnancies.

1. Kroon B, Johnson N, Chapman M, Yazdani A, Hart R . Fibroids in infertility--consensus statement from accept (australasian crei consensus expert panel on trial evidence). Aust N Z J Obstet Gynaecol 2011; 51: 289-295.
2. Bouwsma EVA, Gorny KR, Hesley GK, Jensen JR, Peterson LG Stewart EA . Magnetic resonance-guided focused ultrasound surgery for leiomyoma-associated infertility. Fertil Steril 2011; 96: e9-e12.
3. Zaher S, Lyons D Regan L . Successful in vitro fertilization pregnancy following magnetic resonance-guided focused ultrasound surgery for uterine fibroids. J Obstet Gynaecol Res 2011; 37: 370-373.

Can narrowband imaging improve the laparoscopic identification of superficial endometriosis?

Tony Ma[1], Lenore Ellett[1], Alex Eskander[1], Kate McIlwaine[1], Janine Manwaring[1], Emma Readman[1], Peter Maher[1]

1. *Endosurgery Unit, Mercy Hospital for Women, Melbourne, VIC, Australia*

Laparoscopy is considered the 'gold standard' diagnostic procedure for the detection of endometriosis. However, the accuracy of laparoscopy is operator dependent and histological confirmation of suspected endometrial biopsies varies from 45-76% depending on the experience of the surgeon (1).

Narrow Band Imaging (NBI) has been proposed as a simple method of increasing the visual diagnosis of superficial peritoneal endometriosis at laparoscopy. NBI uses 415 and 540nm wavelengths of light which are absorbed preferentially by haemoglobin in vessels on the peritoneal surface, making the neovascularization inherent to endometriosis easier to visualise at laparoscopy.

A small pilot study of 20 patients by Barrueto demonstrated NBI after white light laparoscopy detected additional suspicious lesions in 70% of patients of which approximately 50% were positive for endometriosis (2).

A similar but larger prospective cohort study was performed by our unit. 53 eligible patients undergoing laparoscopy for pelvic pain were included. Thirty two (60%) patients had at least one lesion suspicious for endometriosis excised after white light survey of the pelvis. Twenty four (75% of patients biopsied) had endometriosis confirmed on histopathology. NBI survey revealed an additional area of suspicion in 11 patients (20%), of which six (54%) were positive for endometriosis.

The unit's experience was that NBI not only made neovascularization of superficial endometriosis more prominent but the depth of field of the laparoscopy was significantly shortened. This forced the operator to make a very close inspection of the peritoneal surfaces. It was often found that after an area of suspicion was identified with NBI, in retrospect the lesion could also be seen with white light.

Therefore NBI is a simple and non-invasive adjunct to traditional white light laparoscopy that can aid in the diagnosis of superficial endometriosis that may otherwise be missed.

1. Pardanani S, Barbieri R. The gold standard for the surgical diagnosis of endometriosis: visual findings or biopsy results? J Gyecol Techniques. 1998;4:121.
2. Barrueto F, Audlin K. The Use of Narrowband Imaging for Identification of Endometriosis. Journal of Minimally Invasive Gynaecology (2008) 15,636-639.

Acute abdominal pain and the emergency laparoscopy – a diagnostic dilemma for the surgeon or gynaecologist?

Jess McMicking[1], Swati Mahajan

1. *Bankstown Hospital, Bankstown, NSW , Australia*

Background: Acute abdominal pain is a common presenting complaint in reproductive aged females. The differential diagnosis can be complex, including both gynaecological and non-gynaecology pathology such as ruptured ovarian cysts, salpingitis, ectopic pregnancy, appendicitis and other gastrointestinal conditions[1]. Laparoscopy is an important diagnostic tool used to reveal intra-abdominal pathology, as well as valuable modality for treatment[2,3]. The decision to pursue surgery can be difficult as well as challenging in the setting of surgeon versus gynaecologist. Given that surgical complications are associated with a laparoscopy, it is important to have high accuracy rate for predicting the diagnosis and decision for surgery be taken seriously.

Aim: The objective of this study was to evaluate the emergency laparoscopy cases and assess the accuracy in diagnosis prior to surgery.

Methods: This was a retrospective cohort study over a 3 year period that included all reproductive aged women who underwent an emergency laparoscopy at a secondary hospital in Sydney. An emergency laparoscopy was defined as an acute presentation of abdominal pain, with subsequent laparoscopy being performed under emergency conditions within 72 hours. The data collected included the type of primary surgeon, intraoperative and histological findings, presence of further intraoperative consultation, if the pathology had been accurately

predicted preoperatively, if negative findings were found, and any diagnostic investigations undertaken prior to the decision for surgery.

Results: A total of 83 cases were identified. The primary operator was 58% gynaecology team and 42% surgical team. Out of the surgical female patients, only 54% had surgical pathology, 20% required gynaecology intraoperative input and 14% had gynaecology pathology that was handled solely by the surgeons. In comparison, 90% of the gynaecological patients had gynaecology pathology found during surgery. The majority of gynaecology patients also underwent a pelvic ultrasound prior to the decision made for theatre, whereas this was not the case for the surgical patients.

Discussion: This study reinforces that in an acute abdomen setting, both surgical and gynaecological pathology can be responsible. It is acknowledged that the applicability of these findings is limited given the design of the study, however important learning lessons still stand. If a patient undergoes both blood tests and imaging prior to surgery, then there is greater likelihood of is providing an accurate diagnosis for gynaecology pathology. Gynaecologists as well as gynaecology trainees must also be aware of the potential for being called to an intraoperative consultation in the setting of acute abdominal pain.

1. Becker J, Graaff J, Vos C. Torsion of the ovary: a known but frequently missed diagnosis. European Journal of Emergency Medicine. 2009; 16: 124-126.
2. Phillips A, Jones A, Sargen K. Should the Macroscopically Normal Appendix be Removed During Laparoscopy for Acute Right Iliac Fossa Pain when No other explanatory pathology is found? Surgical Laparoscopy Endoscopy and Percutaneous Techniques. 2009; 19: 392-396.
3. Ahmad T et al. Experience of Laparoscopic Management in 100 Patients with Acute Abdomen. Hepato-Gastroenterology. 2001; 48: 733-736.

Medium to long-term gastrointestinal outcomes following disc resection of the rectum for treatment of endometriosis using a validated scoring questionnaire

Ada Ng[1], Phillip Yang[1], Shing Wong[1], Surya Krishnan[2], Thierry Vancaillie[3]

1. *Prince of Wales Hospital Sydney, Fitzroy, VIC, Australia*
2. *Department of Gynaecology, Royal Hospital for Women, Sydney, NSW, Australia*
3. *Clinical Professor, School of Women's and Children , University of New South Wales, Sydney, NSW, Australia*

Objective: To assess the gastrointestinal functional outcomes and symptoms of low anterior resection syndrome after disc resection for deeply infiltrative endometriosis (DIE) using a validated scoring system.

Design: Retrospective study to assess the gastrointestinal functional outcomes after rectal disc resection for deeply infiltrative endometriosis using a validated scoring system.

Setting: University tertiary referral centre.

Patients: Women who underwent disc resection for endometriosis at Royal Hospital for Women and Prince of Wales Private Hospitals between January 2012 and December 2013 were included.

Main Outcome Measure: Low anterior resection syndrome (LARS) score using a validated questionnaire.

Results: Forty-one women met the inclusion criteria. The mean age was 40±10 years (range 22 to 75 years). All procedures were performed laparoscopically. Eleven women (27%) underwent a hysterectomy in addition to rectal disc resection and endometriosis surgery. Mean operative time for the entire cohort was 158±64 minutes and mean length of hospital stay was 5±2 days.
Completed questionnaires were received from 31 women , a response rate of 76%. The mean length of follow up was 17±10 months (range 3 to 34 months). The LARS scores ranged from 0 to 34 (median 15, IQR 0 to 24). Eight women (26%) had a LARS score of 0. Nineteen women (61%) had a LARS score less than 21 (the threshold for low anterior resection syndrome).

Conclusion: Conservative treatment of DIE with rectal disc resection is safe and feasible and is associated with mild gastrointestinal dysfunction in the medium to long term.

1. Emmertsen KJ, Laurberg S. Low anterior resection syndrome score: development and validation of a symptom-based scoring system for bowel dysfunction after low anterior resection for rectal cancer. Ann Surg. 2012;255(5):922-8. Epub 2012/04/17.
2. Roman H, Vassilieff M, Gourcerol G, Savoye G, Leroi AM, Marpeau L, et al. Surgical management of deep infiltrating endometriosis of the rectum: pleading for a symptom-guided approach. Hum Reprod. 2011;26(2):274-81. Epub 2010/12/07.
3. Johnson NP, Hummelshoj L. Consensus on current management of endometriosis. Hum Reprod. 2013;28(6):1552-68. Epub 2013/03/27.

Independent assessment of long-term outcome in a prospective cohort of patients undergoing laparoscopic sacrocolpopexy

Stefaan Pacquée[1, 2], Jan Deprest[1] , Danny Chou[2] , Gregory Miles Cario[2] , David Rosen[2] , Joanne McKenna[2]

1. *UZ Leuven, Leuven, Belgium*
2. *SWEC, Sydney, NSW, Australia*

Objective: To report on a prospective cohort of 331 patients scheduled for laparoscopic sacrocolpopexy (LSC) in a single centre.

Materials and methods: This is a cohort of all patients with symptomatic prolapse(≥stage 2) who underwent LSC with polypropylene mesh, and who were at least one year postoperative. Principle outcome measures were duration of follow up, anatomical outcome, failure rate at the vault(=C ≥ 0 cm) or in any compartment, occurrence and timepoint of complications, re-interventions, subjective measures like Patient Global Impression of Change-score(PGIC) and responses to a standardized interview based on UDI-6, IIQ-7 and PQOL. Patients who could not be physically assessed were interviewed by telephone. An assessor not involved in the surgery or clinical management of the patient performed evaluations. Data are reported as mean (SD), median (IQR), number and %, as appropriate. Student t-test, Chi square Fisher exact and survival analysis were used to compare groups.

Results: 331 patients were contacted, 185 underwent physical re-evaluation and 85 had a telephone interview (n=270: 81.6% follow up rate). Mean age was 72.46±9.93 years, median follow up 90 months (39 -141). Anatomical cure at point C was 91.4%. The presence of anterior (22.1%) and/or posterior compartment (28.6%) prolapse was common. Of those with objective recurrence at the vault (n=16), the majority of patients (n=10) still reported to be improved. At interview (n=270), 60 patients (22.2%) reported reoperations at some stage, of whom 22 (8.1%) for graft related complications (GRC) and 10 (3.7%) for recurrent or de novo prolapse. At study closure, 82.5% felt better, 5.7% (n=16) were as before, 5% (n=14) resp. 6.8% (n=19) were slightly resp. frankly worse according to PGIC. Of those women reporting subjective worsening (n=33), 39% (n=13) had still prolapse symptoms, 75.7% (n=25) reported urinary incontinence and 42.4% (n=14) had defecation problems, of whom 4 fecal incontinence.

Conclusions: We were able to retrieve long-term outcomes in 81.6% of patients at a median of 7.5 years. An independent assessor found an objective cure rate at point C of 91.4%. However 17.5% of the clinically assessed patients reported no improvement: in one third this was because of prolapse, the majority however because of urinary or bowel problems. Of those with objective recurrences at level I the majority still considered themselves improved. There were many patients with objective prolapse in other compartments, though only 3.7% were reoperated for prolapse. The leading cause for reoperation was GRC (8.1%) followed by stress urinary incontinence (7%).

Laparoscopic management of caesarean scar ectopic pregnancy

Keisuke Tanaka[1], Donald Angstetra[1], Tina Fleming[1]

1. Obstetrics and Gynaecology, Gold Coast University Hospital, Southport, QLD, Australia

Caesarean scar ectopic pregnancy (CSEP) is one of the rarest forms of ectopic pregnancies and as yet there is no practical reference standard on the preferred mode of treatment.[1] An increase in the number of reported CSEP cases may be a reflection of the increase in the number of caesarean deliveries worldwide.[2] We describe a case of a haemodynamically stable 38 year old woman who presented to the emergency department with per vaginal spotting, and a history of 2 previous elective lower uterine segment caesarean sections. Her beta-human chorionic gonadotropin (β-hCG) was 140,000 IU/L upon presentation. A pelvic ultrasound scan showed a CSEP with a crown-rump length (CRL) correlating to the gestational age of 7 weeks and 1 day. Fetal heart rate was present at 135 beats per minute. The patient initially opted for medical management comprising of intravenous bolus dose of methotrexate 100mg, followed by 200mg infusion over 12 hours with oral folinic acid rescue.Although the patient remained haemodynamically stable, she developed abdominal pain on day 2 post methotrexate therapy. A repeat ultrasound scan then showed an unchanged CRL but absence of fetal cardiac activity. A repeat β-hCG showed an upward trend at 170,000 IU/L. The patient was subsequently managed surgically using the laparoscopic approach. We present a video demonstration of the laparoscopic technique undertaken where having reflected the bladder, the lower uterine segment was incised and the embryo-

containing gestational sac clearly identified. The product of conception was removed with suction and grasper forceps and the uterus was closed with 0 v-loc suture. The patient had an uncomplicated postoperative course. It is uncertain if medical therapy was going to be successful in this case, however systemic methotrexate as an initial single therapy for CSEP has been reported to be successful in 55% of cases.[1] This is in contrast to the 100% success rate reported in a retrospective study with laparoscopy without converting to laparotomy.[3]

1. S. Bodur, Ö. Özdamar, S. Kılıç, İ. Gün. The efficacy of the systemic methotrexate treatment in caesarean scar ectopic pregnancy: A quantitative review of English literature. J Obstet Gynaecol 2015; 35: 290-296
2. Rotas MC, Haberman S, Levgur M. Cesarean scar ectopic pregnancies: Etiology, diagnosis, and management. Am J Obstet Gynecol 2006; 107: 1373-1381
3. Lee HJ, Kim SH, Cho SH et al. Laparoscopic surgery of ectopic gestational sac implanted in the cesarean section scar. Surg Laparosc Endosc Percutan Tech 2008; 18: 479-482

Sex & The Modern Woman

Session 4 / 3.30pm – 5.00pm

Plaza Auditorium

How are sex and sexuality shaped by modern society? Or is sex shaping society?

Labiaplasty & the pornographic industry

Gemma Sharp

The demand for labiaplasty has grown rapidly in Australia and other Western countries over the last decade. Labiaplasty is performed primarily for aesthetic reasons, but little is known about the social and psychological factors that motivate women to undergo labiaplasty. Our previous research revealed that three factors predicted women's interest in labiaplasty in a general community sample of Australian women: these were media exposure to genital images, peer influence from romantic partners and friends, and romantic relationship quality. Of these factors, media exposure was the strongest influence. We also recently showed that women who are seeking labiaplasty have been exposed to a significantly greater volume of genital images in the media than women who are not, further supporting the influence of the media on women's decisions to undergo labiaplasty. The issue with mainstream media as a primary source of information regarding female genital appearance is that only genitals with non-protruding labia minora are able to be shown owing to the Australian classification guidelines for depictions of nudity. Some women may be concerned that their genital appearance is "abnormal" after seeing these media images (some of which have been digitally altered to remove protruding labial tissue) and think they require labiaplasty to become "normal". We recently showed that a short, freely available video could improve understanding of the wide variation in normal female genital appearance for women in the general Australian community. However, this is yet to be investigated in women who are highly concerned with their genital appearance and are requesting surgery. Nevertheless, such a resource could potentially be useful in preventing the development of genital appearance concerns in younger women.

Vaginal rejuvenation: Fact or fiction

Stefano Salvatore

Vaginal rejuvenation is a term that has reached a great popularity between doctors and women over the last few years. Commonly speaking this is referred to cosmetic procedures aiming to improve the aspects of female genitalia secondary to changes related to age or vaginal deliveries. Many important scientific Societies and Authorities have delivered documents warning about the paucity of evidence in such procedures that should also produce and improvement in quality of life and sexual function. Etymologically, however, vaginal rejuvenation could be part of regenerative medicine including not surgical procedures but medical or outpatient approaches. Tissue remodelling can be nowadays stimulated in a regenerative way in different organs with a great scientific interest in different medical fields. In this lecture all controversies and the most recent knoledeges will be illustrated in relation to vaginal rejuvenation.

Cosmetic genital surgery

Ajay Rane

Cosmetic Genital surgery is definite in the spotlight in modern gynaecology and reconstructive surgery.
In this talk we will discuss the following issues

- Who needs cosmetic genital surgery
- Who should perform cosmetic genital surgery
- Why is there an increase in cosmetic genital surgery
- What does the modern woman thing of cosmetic genital surgery
- What does the modern man think of cosmetic genital
- Will we see more need for cosmetic reconstruction surgery in Australia
- What do our peer bodies say about cosmetic genital surgery

Pelvic pain and sexual pain
Jayne Berryman

"Everything is normal, it's all in your head". And is it?

Sexual pain is an often silent, embarrassing and shameful suffering for many women. This has significant effects on self-esteem, relationships and quality of life. The prevalence in premenopausal women is estimated to be between 10-20%.

During this talk we will delve into the fascinating and fast moving world of our newest specialty: Pain Medicine. What is pain really? What is a 'biopsychosocial' model and why should we care about it? What is 'central sensitisation' and how does it apply to sexual pain? How does a patient's mood and personality apply to their pain state? How could your language alter the outcomes of treatment? What is 'multidisciplinary' pain management and how can it really improve patient's quality of life? What is the role of the Gynaecologist in this team?

I will discuss the commonly used 'Fear Avoidance' model of pain behavior and apply this to sexual pain states.

I will briefly consider the role of current therapies: pharmacotherapy, Mona Lisa Touch, Botox and pelvic floor physiotherapy.

When managing sexual pain, a good functional outcome is rare without a holistic, biospychosocial approach to management.

Friday 4 March 2016

Live Surgery
Session 5 / 8.00am – 10.30am
Plaza Auditorium
Live surgical telecast from the Wesley Hospital, Brisbane.

An AGES First: The Modern Ages Interactive Hub
Session 5 / 8.00am – 10.30am
Exhibition Area – Plaza Terrace Room
By registration only

Reproduction and the modern woman
Session 6 / 11.00am – 12.30pm
Plaza Auditorium
The faculty will explore surgical aspects of modern reproductive trends, including the role of tubal surgery and endometriosis.

Reproductive challenges in the Modern Woman
Ben Kroon

The modern woman is faced with reproductive challenges and opportunities not shared by previous generations. This talk will examine how modern women are choosing to manage their reproductive choices through the uptake of improved oocyte freezing technology, the use of donor gametes and advanced genetic screening technologies.

Endometria: Modern surgical management
Simon McDowell

Abstract not yet received.

Reproductive microsurgery in modern fertility management: Girls & Boys
Derek Lok

Despite improvement in success of IVF, reproductive surgery will remain an important option and complement to assisted reproductive technologies (ART). New surgical technique of testicular microdissection (microTESE) using high-powered operative microscope to avoid blood vessels and identify and selectively remove those seminiferous tubules that contain sperm not only provides better sperm recovery compared to simple or multiple blind testicular biopsies, but minimising damage to or loss of testicular tissue and reducing complications. Such

approach has helped many men with non-obstructive azoospermia to conceive their biological children through ART. Reproductive surgery should be considered as the first-line treatment when the correction of infertility pathologies is simple and a good result is expected once corrected, when the pathology is causing symptoms such as pain or abnormal bleeding or if uncorrected will compromise the results or increase the risks of ART. The success of surgical infertility treatment depends on the optimal selection of cases using appropriate investigative techniques, carefully follow microsurgical principles to conserve normal tissues and avoid adhesion formation, with procedures performed in centres with sufficient expertise. Endoscopic approach has many inherent microsurgical advantages which offers improved results, safety, cost-effectiveness and quicker recovery times. Most of the female reproductive microsurgical procedures that traditionally required laparotomy can now be performed endoscopically on a day surgery basis.

Fibroids and the fetus: A match made in hell
Hugo Fernandes

Fibroids are a benign smooth muscle tumour of the uterus, the management of which is dependent on several factors including symptoms, size, past obstetric history and future plans for children. Whilst most women with fibroids have an uncomplicated pregnancy, the potential for issues is frequently a clinical concern since these tumours are common in reproductive aged women. We will review the impact of fibroids on fertility, the foetus during conception, through pregnancy and labour.

Modern Oncology
Session 6 / 11.00am – 12.30pm
P6 & P7
The session will explore contemporary management of malignant and premalignant disorders and how practices have been shaped by the modern woman.

Routine salpingectomy for all
Stuart Salfinger

Abstract not yet received.

VAIN and VIN: A modern approach to a persistent problem
Andrea Garrett

Abstract not yet received.

Complex endometrial hyperplasia in the young woman
Naven Chetty

Endometrial hyperplasia is rare pathology for young women. It poses unique challenges of managing the hyperplasia in order to minimise risk of cancerous change while attempting to preserve fertility and maintain hormonal status.

Being able to quantify risk of developing a malignancy, or the chance in situ cancer is also vital when counselling patients.

In addition, definitive surgical treatment raises further questions regarding ovarian preservation and pelvic lymphadenectomy should an in situ cancer be discovered.

These issues will be discussed during this presentation.

Endometriosis and cancer
Jim Tsaltas

Background: Endometriosis is a chronic gynaecological disorder affecting approximately 10% of premenopausal women. Although endometriosis is a benign disease, it shares characteristics of malignant cells such as local and distant metastasis and the ability to invade tissue and destroy it. The sequelae of endometriosis being considered a pre-neoplastic disease are grave. They would mandate a reappraisal of the current long-term management of endometriosis.

Methods & Results: A literature review of the current evidence linking endometriosis to cancer was performed. Epidemiological studies; cohort and case-control studies identified are mainly retrospective in nature but link endometriosis to an increased long-term risk of ovarian cancer. Furthermore, molecular-genetic studies have identified a common genetic mutation occurring in both cells of epithelial ovarian cancers and endometriotic cells. The suggestion is that certain types of epithelial ovarian tumours arise through a continuum sequential stage during tumour progression of endometriotic cells.

Conclusion: The evidence in the literature so far highlights a potential link between endometriosis and ovarian epithelial tumours. However, the epidemiological studies are mainly retrospective, incurring potential for bias. As for the bio-molecular evidence presented, it is in its early stages and further studies are needed to determine how the earlier genetic mutations contribute to the transformation from an endometriotic cell to a malignant one. This presentation will endeavor to provide a recommendation as to how to counsel and proceed when your patient enquires about cancer risk.

Free Communications A
Session 7 / 1.30pm – 3.00pm
Plaza Auditorium

Prelaparoscopic ultrasound "soft marker" evaluation of ovarian mobility in the normal and endometriotic ovary

Bassem Gerges[1, 2], Chuan Lu[3], Shannon Reid[1, 2], Batool Nadim[1, 2], George Condous[1, 2, 4]

1. *Acute Gynaecology, Early Pregnancy and Advanced Endosurgery, Nepean Hospital, Kingswood, NSW, Australia*
2. *Nepean Medical School, University of Sydney, Sydney, NSW, Australia*
3. *Department of Computer Sciences, University of Wales, Aberystwyth, United Kingdom*
4. *Omni Gynaecological Care Centre for Women's Ultrasound and Early Pregnancy, St Leonards, NSW, Australia*

Objective: To determine the prevalence of ovarian immobility with endometriomas as well as the diagnostic accuracy of transvaginal sonographic (TVS) ovarian mobility in both the presence and absence of endometriomas.

Methods: Multicenter prospective observational study of women presenting with chronic pelvic pain from January 2009 to March 2015. All women with symptoms of chronic pelvic pain +/- history of endometriosis and a plan for laparoscopic endometriosis surgery underwent a detailed history and specialized TVS in a tertiary referral unit prior to laparoscopy. During TVS, ovarian mobility and the presence of endometriomas were assessed. The relationship between TVS ovarian mobility with or without endometriomas were correlated with surgical gold standard.

Results: 265/274 (97%) women with pre-operative TVS and laparoscopic outcomes were included in the final analysis. Ovarian immobility was significantly associated with endometriomas with a prevalence of 12.2%, 10.8% and 52.7% for fixation of the left, right and bilateral ovaries, respectively, compared with 4.2%, 3.7% and 7.3% of normal ovaries. The sensitivity, specificity, positive and negative predictor values for diagnosing ovarian immobility with endometriomas in the left, right and bilateral ovaries were 50.0/98.5/80.0/94.2 per cent, 44.4/92.3/44.4/92.3 per cent, 74.4/68.6/72.5/70.6 per cent compared with 14.3/92.9/7.1/96.6 per cent, 25.0/87.98.3/96.4 percent and 35.7/97.2/50.0/95.0 percent in left, right and bilateral normal ovaries, respectively ($p < 0.05$ except for normal left and right ovaries with $p = 0.2$ and 0.4, respectively).

Conclusions: There is a significant association of ovarian immobility with the presence of endometriomas compared with normal ovaries. The performance of ovarian immobility as an ultrasound soft marker is better in the presence of endometriomas.

Video Presentation

My period takes my breath away

Luke McLindon[1], Michael Wynn-Williams[2], Shinn Yeung[3], Ben Kroon[2]

1. *Mater Health Services, Brisbane, Queensland, Australia*
2. *Eve Health, Brisbane, Queensland, Australia*
3. *Greenslopes Private Hospital, Brisbane, Queensland, Australia*

Endometriosis has been shown to be present in many different regions and tissues of the body. While pelvic endometriosis is associated with pain and infertility, excisional surgery has been shown to improve both. Diaphragmatic endometriosis is regarded as higher risk surgery and the benefit is not so clear.

However, when the endometriosis is extensive and the catemenial symptoms profound, the excisional surgery of endometriotic nodules on the diaphragm and liver becomes a calculated risk. This must involve a combined

surgical team. This video presents the surgical approach, illustrates a number of techniques and the repair of a pneumothorax.

Video Presentation

Robotic application and special surgical techniques to remove multiple fibroids in a culturally challenging context

Valerie To[1], Alan Lam[1]

1. *Centre for Advanced Reproductive Endosurgery, St Leonards, NSW, Australia*

Introduction: Myomectomies can be challenging when performed by minimally invasive techniques, especially when dealing with larger and lower fibroids extending into the uterine cavity and/or broad ligament.

Materials and methods: This video illustrates a case of a 27 yo G0 Muslim virgin who presented after heavy vaginal bleeding requiring transfusion for a haemoglobin of 63. The patient was found to have multiple fibroids and the MRI showed a fundal fibroid of 6.5cm and a submucosal fibroid of similar size extending to the broad ligament. The patient wanted to have them removed while maintaining reproductive function and virginity.

Results: Via the robotic platform, we successfully performed a myomectomy without the need of a uterine manipulator or use of speculum. The steps of a myomectomy and special tips and tricks were outlined.

Conclusions: Robotic surgery, while following the same surgical principles of traditional laparoscopy, offers special advantages to the surgeon and patient, especially in this culturally sensitive context.

A prospective analysis of hysteroscopic morcellation in the management of intrauterine pathologies

Amy Arnold[1, 2], Ashradha Ketheeswaran[1], Mominah Bhatti[1] , Erin Nesbitt-Hawes[1, 2], Jason Abbott[1]

1. *University of New South Wales, Sydney*
2. *Royal Hospital for Women, Sydney*

Objective: To determine the effectiveness of the MyoSure® intrauterine mechanical morcellator device for removal of intrauterine pathology

Methods: A prospective cohort study was performed at the Royal Hospital for Women and Prince of Wales Private Hospital, Sydney, Australia. All patients undergoing hysteroscopic resection of intrauterine pathology by use of the MyoSure® device between January 2013 and June 2015 were included.

Results: A total of 255 MyoSure® procedures were performed, with 61% performed by trainees. 40% were resections of leiomyomas, 39% resections for polyps, 9% had a combination of pathology, 6% were pregnancy products and 6% were pre-invasive or invasive disease. Complete resection of pathology was achieved in 92% of polyps, 66% of leiomyomas and 87% of pregnancy tissue. Leiomyomas were more likely to be completely resected when surgery was performed by an attending physician or senior resident, however there was no statistically significant difference in clinical outcomes. When leiomyomas were stratified according to size, 87% of leiomyomas ≤ 40mm were completely resected with only 48% of leiomyomas > 40mm completely resected. No intra-operative complications occurred. Post-operative outcomes included symptom resolution in 76%, further surgery (repeat hysteroscopy or hysterectomy) in 10%, pregnancy in 2% and medical/conservative management in 12% of patients.

Conclusion: The MyoSure® device is very effective when used to resect endometrial polyps. Leiomyomas above 40mm in size are unlikely to be completely resected at a single operation with use of the MyoSure®. Similar clinical outcomes were obtained when procedures were performed by trainees compared to senior clinicians.

Opportunistic bilateral salpingectomy at the time of hysterectomy – An audit of surgical practice

Ushmi Chatterjee[1] , Supuni Kapurubandara[1, 2, 3], A/Prof Harry Merkur[3, 4, 5], Apputhurai Anpalagan[1, 3]

1. Department of O&G, Westmead Hospital, Westmead, NSW, Australia
2. University of Sydney, Sydney, NSW, Australia
3. Sydney West Area Pelvic Surgery Unit, Sydney, NSW, Australia
4. Department of O&G, Blacktown Hospital, Blacktown, NSW, Australia
5. Western Sydney University, Sydney, NSW, Australia

Objective: To audit the uptake of opportunistic bilateral salpingectomy (OBS) at the time of hysterectomy for benign gynaecological indication at a tertiary institution.

Background: Ovarian cancer remains the leading cause of death by gynaecological malignancy in the developed world.[1] A new classification of ovarian cancer has identified High-Grade Serous Cancers (HGSC) as the most frequently diagnosed and aggressive form of the disease.[1] This type of ovarian cancers represent the most common subtype with no effective screening test.[1] Evidence over the past decade confirms majority of HGSC derive from the fallopian tubes.[1]

Due to this recognition of malignant potential in the fallopian tubes, there is a shift to adopt OBS at the time of surgery for benign gynaecological indications, to potentially reduce the risk of sporadic ovarian cancer in the general population.[2] This change in surgical paradigm is particularly seen in Canada and The United States of America where OBS is being increasingly considered at the time of hysterectomy and as an alternative to surgical sterilization in a low risk population. While no randomised controlled trials have yet demonstrated the safety and absolute benefit of OBS, the robust epidemiological evidence available suggests there is an associated risk reduction in subsequent ovarian cancer.[3]

The internationally recognised Sectioning and Extensively Examining the FIMbriated End (SEE-FIM) protocol for histological assessment of the fallopian tube specimen has been adopted at Westmead Hospital over the last decade, in order to avoid missing malignant or premalignant lesions. Since the introduction of a survey on OBS was conducted in 2013, we have noticed an increasing uptake of OBS particularly during abdominal and laparoscopic hysterectomies for benign indications at our institution.

Over a three-year period, a total of 214 hysterectomies were performed, 43 in 2013, 40 in 2014 and 130 in 2015. One hundred and twenty six (58%) were performed via laparoscopic approach and 71 (33%) via an abdominal approach. Bilateral salpingo-opherectomy was performed in 44 cases, unilateral salpingo-opherectomy in 5 cases and OBS performed in 85 cases. Of the eligible hysterectomy cases, the rate of OBS was 18.6% (8/43) in 2013, 37.5% (15/40) in 2014 and 47.7% (62/130) in 2015. The pathology of OBS cases revealed 26 (32.5%) with paratubal and parafimbrial cysts, 5 (6.25%) with endometriosis and 5 (6.25%) with salpingitis. A review of the literature and current evidence for opportunistic salpingectomy along with the detailed outcomes of our retrospective audit will be discussed.

1. Tone AA, Salvador S, Finlayson SJ, et al. (2012). The role of the fallopian tube in ovarian cancer. Clinical Advances in Hematololgic Oncology, 10, 296–306.
2. Morelli, M., Venturella, R., Mocciaro, R. et al. (2013). Prophylactic salpingectomy in premenopausal low-risk women for ovarian cancer: Primum non nocere. Gynaecologic Oncoogy, 129, 448-451.
3. Falconer H, Yin L, Gro€nberg H, Altman D. Ovarian cancer risk after salpingectomy: A nationwide population based study. Paper presented at the 15th Biennial meeting of the International Gynecologic Cancer Society; Melbourne; 2014 Nov 8-11.

How accurate is ultrasound imaging in the detection of deep infiltrating endometriosis?

Alexandra Gil[1], Cheryl Phua[1] , Joanne Ludlow[1]

1. *Women and Babies, Royal Prince Alfred Hospital, Sydney, NSW, Australia*

Background: Endometriosis affects 10% of the general population[1]. Of women affected by endometriosis 12-25% have bowel involvement[2] and 10-15% have deep infiltrating endometriosis (DIE)[3]. DIE is defined as endometriosis infiltrating ≥5mm beneath the peritoneum.

Many of these women experience a protracted course of multiple laparoscopies, medication and surgery before a definitive therapeutic laparoscopy is performed. Ultrasound is emerging as a new diagnostic modality for women with DIE. But how accurate is ultrasound in the diagnosis of DIE?

Aims: To investigate the sensitivity, specificity, positive and negative predictive values of ultrasound in the diagnosis of DIE at our institution.

Methods: Observational cohort study comparing the pre-operative ultrasound findings (US) with the surgical findings in women with presumed DIE and/or women who underwent diagnostic laparoscopies for the investigation of pelvic pain or infertility. In particular, we examined pouch of douglas (POD) obliteration, presence of uterosacral disease (USL) and presence of rectal nodules.

Results: A total of 214 women were recruited into the study, of which 159 had suspected DIE on ultrasound findings. 81 of these women underwent surgery. 55 women have not undergone surgical procedures or are awaiting surgery.

The sensitivity of predicting POD obliteration was 82%, USL disease 53% and rectal nodules 93%. The specificity of POD obliteration was 97%, USL disease 78% and rectal nodules 95%.

Conclusion: This cohort has shown that US has a high accuracy for detecting DIE. There is an excellent sensitivity and specificity for the detection of rectal nodules and POD obliteration. USL disease is not as visible at US; however its specificity is good.

These findings should reduce the number of diagnostic laparoscopies being performed prior to definitive surgery. Lack of, or a poor result from, bowel preparation prior to TVUS may possibly affect the accuracy of the detection of DIE.

There may be difficulty in correlating DIE US findings with the surgical findings as the two modalities may be referring to the same anatomical location but using a different classification. We plan to externally validate an existing ultrasound based classification system.

We conclude that it is important to standardise the reporting of findings using a systematic approach. TVUS significantly improves the pre-operative diagnosis of DIE, consequently it enhances the surgical results.

This has significant benefits for the women, health service facility and health economics alike. Integrating the concept of advanced gynaecological imaging in the assessment of endometriosis is consistent with a cost-effective approach.

1. Grasso RF et al. Diagnosis of deep infiltrating endometriosis: accuracy of magnetic resonance imaging and transvaginal 3d ultrasonography. Abdominal imaging 35(6): 716-25 2010.
2. Wills J, Reid GD, Cooper MJ, Morgan M. Fertility and pain outcomes following laparoscopic segmental bowel resection for colorectal endometriosis: a review. Aust N Z J Obstet Gynaecol. 2008: 48(3):292
3. Reid, Bignardi T, Lu C, Lam A. The use of intra-operative saline sonovaginography to define the rectovaginal septum in women with suspected endometriosis: a pilot study. Australasian Journal of Ultrasound Medicine. 2011 14(3): 4-9.

Bowel injury at laparoscopic surgery: Mechanism, prevention & management

Amani Harris[1, 2], Harry Merkur[1]

1. *Gynaecology, Sydney West Advanced Pelvic Surgery, Sydney, New South Wales, Australia*
2. *Gynaecological Endoscopic Surgery Unit, Monash Health, Clayton, Victoria, Australia*

Bowel injury during laparoscopic surgery can have devastating sequelae for the patient and serve as grounds for malpractice claims against surgeons 1. The incidence of bowel injury at laparoscopy is approximately 1.3 per 1000 cases. The literature suggests this is increasing as comfort with laparoscopy is growing, as is the number of technically challenging procedures performed. This is reflected in the timing of injury, which has moved from entry phase of the procedure to the dissection phase and the use of sharp and blunt dissection, along with thermal energy[2]. Approximately, 70% of injuries go unrecognized intra-operatively, half of which are attributed to thermal damage[3].

The morbidity and mortality associated with delayed presentation of bowel injury is decreasing due to increased intra-operative recognition and awareness[1]. The two types of bowel injury occurring at laparoscopy include: thermal and traumatic injuries[4]. The histological features of these injuries differ, with traumatic injury mainly incurring a rapid infiltration of white cells and capillary ingrowth, fibrin deposition and fibroblast proliferation with an overall limited, non-coagulative type cell necrosis. As opposed to thermal injuries that lack white cell and fibroblast proliferation and are characterized by areas of coagulation necrosis[4]. Bowel injury can be either partial or full thickness, with the potential for partial thickness injuries to evolve into full thickness or heal over a variable period of time[5]. The risk of full thickness bowel injury increases dramatically with the number of previous laparotomies[6].

Delayed presentations of bowel injury post laparoscopic procedures occur days or weeks later[5]. A negative immune modulating effect of laparoscopy may contribute to masking clinical and laboratory evidence of peritonitis after laparoscopic bowel injury[7]. Symptoms can be nonspecific and range from unexplained fever, abdominal pain, and general discomfort, signs of peritoneal reaction and nausea or vomiting. A low index of suspicion is recommended, as is a low threshold for re-exploration via laparotomy[5].
This presentation will include a clinical example of inadvertent laparoscopic minor bowel injury, and a review of the current literature surrounding mechanism, prevention and management of bowel injury at laparoscopic surgery.

1. Delayed Manifestations of Laparoscopic Bowel Injury. C.Sebastiano. The American Surgeon.81.5.May 2015
2. Iatrogenic enterotomy in laparoscopic ventral/incisional hernia repair: a single center experience of 2,346 patients over 17 years. Sharma, A; Khullar, R; Soni, V; Baijal, M; Kapahi, A; et al. Hernia 17.5 (Oct 2013): 581-7.
3. Laparoscopic bowel injury: incidence and clinical presentation. J.T. Bishoff, M.E. Allaf, W. Kirkels, et al. J Urol, 161 (1999), p. 887

Caesarean scar pregnancy: A systematic review of diagnosis and management

Sarah Maheux-Lacroix[1], Aaron Budden[1], Rebecca Deans[1], Grace Soon[1], Amy Arnold[1], Erin Nesbitt-Hawes[1], Stephen Lyons[1], Jason Abbott[1]

1. *Royal Hospital for Women, University of New South Wales, Randwick, NSW, Australia*

Background: Caesarean scar pregnancies (CSP) are increasingly common [1]. They occur in about 1/2000 pregnancies [1] and account for 6% of ectopic pregnancies among women with a caesarean scar [2]. Diagnosis can be challenging and lead to catastrophic consequences if delayed. Given the rarity of CSP, evidence mainly relies on observational studies and case reports.

Objective: To review diagnosis and treatment options for CSP.

Methods: A systematic review of studies published before November 2015 and reporting case(s) of CSP was performed. We searched MEDLINE, EMBASE, CENTRAL, and reference lists. Collected data were pooled in frequencies, proportions and means.

Results: Of the 1,257 citations identified, 183 studies were eligible, representing 1,717 cases of CSP. CSP were diagnosed at a mean gestational age of 7 weeks (range 4-39). Most women (76%) had only one previous caesarean section. Symptoms ranged from vaginal bleeding with or without pain to hypovolemic shock. Diagnosis was mainly made by ultrasound while magnetic resonance imaging and hysteroscopy were used in some cases to further evaluate pregnancy location. Expectant management to gain foetal maturity was attempted in 19 cases: 9 obtained a live birth by caesarean hysterectomy (except one), 5 experienced uterine rupture before viability (3 hysterectomies), 4 had a spontaneous abortion, and 1 needed medical therapy. Medical management was attempted in 364 cases and included, systemic methotrexate, local injection of methotrexate or potassium chloride, and combined systemic and local therapy with success rates of 54%, 63%, and 87%, respectively. Surgical management was attempted in 507 cases and included dilatation and curettage (D&C), hysteroscopic resection, and open, laparoscopic or vaginal scar excision with success rates of 59%, 87%, and 95%, respectively. Success rate using combined medical and surgical management (290 cases) was of 79%. In 529 cases, pre-treatment uterine artery embolization (UAE) led to 3% of subsequent haemorrhage, whereas haemorrhage occurred in 7% and 15% of cases with medical and surgical management, respectively. Hysterectomies were infrequent in all options (≤3%) except for D&C (6%). ßhCG resolution took an average of 24 days (range 9-63) with surgical management and 61 days (range 14-247) with medical therapy.

Conclusion: Expectant management of CSP is associated with a high risk of life-threatening haemorrhage and hysterectomy. High success rates were reported with scar excision and combined systemic and local therapy. UAE embolization lead to a low risk of haemorrhage, but its safety has not been established for women wishing to attempt a subsequent pregnancy.

1. Rotas MA, Haberman S, Levgur M. Caesarean scar ectopic pregnancies: etiology, diagnosis, and management. Obstet Gynecol 2006;339:1373-1381.
2. Jurkovic D,Hillaby K,Woelfer B et al. First trimester diagnosis and management of pregnancies implanted into the lower uterine segment caesarean section scar. Ultrasound Obstet Gynecol 2003;21:220–7.

A comparitive study of contrasting national training programmes in advanced gynaecological endoscopy

James McLaren[1], Rasiah Bharathan[2], Thomas Ind[1]

1. *Royal Marsden Hospital, London, United Kingdom*
2. *Royal Surrey County Hospital, Guildford, United Kingdom*

Introduction: Advanced skills in minimal access gynaecology surgery are difficult to obtain in a traditional postgraduate Obstetric & Gynaecology training programme. In collaboration with their respective Colleges, the British Society of Gynaecological Endoscopy (BSGE) and Australasian Gynaecological Endoscopy Society (AGES) have introduced a two-year national specialty programme in advanced laparoscopy. The UK Joint Committee on Surgical Training (JCST) has described quality indicators for surgical training. This is the first study aimed at comparing advanced gynaecology laparoscopic programmes.

Methods: A questionnaire was developed based on JCST quality indicators in three areas of surgical training: Operative Case Volume, Supervision Level, Education & Research. The questionnaire was distributed electronically to AGES (N=18) & BSGE (N=25) advanced laparoscopic fellows.

Results: A total of 21 (49%) fellows completed the questionnaire (12 BSGE, 9 AGES). Both sets of respondents had a median number of 7 years experience in gynaecology. AGES respondents were rostered an average of 40 to 44hrs per week compared with 45 to 49hrs for BSGE respondents, while both groups worked an average of actual hours per week of 50 to 54hrs. AGES respondents had a median of 5.6 theatre sessions and 2.5 clinic sessions allocated per week compared with 4.5 theatre sessions (p=0.313) and 2 clinic sessions (p=0.362) from BSGE respondents. During an average week, AGES respondents completed a median of 5.5 elective & 2 emergency cases as primary surgeon (7 elective & 1 emergency cases as first assistant) vs 6 elective (p=0.92) and 3 emergency cases (p=0.27) as primary surgeon from BSGE respondents (5 elective & 3 emergency cases as first assistant). When performing elective procedures the Consultant was 'always' or 'often' first assistant in 37.5% of AGES respondents and 85.7% (p=0.12) of BSGE respondents. 28.5% of AGES trainees were undertaking higher education i.e. Masters, MD, PhD compared with no BSGE respondents (p=0.46). 85.7% of AGES and 50% of BSGE (p=0.27) respondents had publications accepted or pending from their current fellowship. All respondents felt they would be competent to perform TLH & Stage IV Endometriosis (excluding bowel resection) at the completion of their fellowship.

Conclusions: Due to the small number of advanced laparoscopic trainees, comparative data did not reach significance. AGES trainees, potentially, experience a greater operative case volume with less supervision and are more likely to be undertaking higher education during their training. Despite these apparent differences, trainees appear to reach similar competences at completion of their respective training scheme.

1. Joint Committee on Surgical Training. JCST quality indicators. http://www.jcst.org/quality-assurance/jcst-quality-indicators-andtrainee-survey. Accessed 8th June 2015

Free Communications B

Session 7 / 1.30pm – 3.00pm

P6 & P7

Video Presentation

Laparoscopic ovarian transposition to preserve ovarian function before pelvic radiation in 2 young patients with rectal cancer, at the level of a secondary institution

Lionel Reyftmann[1]

1. *Graduate School of Medicine, University of Wollongong, Wollongong, NSW, Australia*

Ovarian transposition is a surgical maneuver used to protect ovarian function before delivery of gonadotoxic doses of radiation therapy. Ovarian transposition has been performed at laparotomy, and laparoscopically (1) since 1996, in patients whose treatment includes pelvic radiotherapy as a part of management for Hodgkin's disease, sarcoma, cervical cancer and rectal cancer. The technique is well described and studied, and was recommended by the American ASCO guidelines in 2013 (2) but surprisingly not by the Australian COSA (Clinical Oncology Society of Australia) guidelines (3) arguing that the technique was not demonstrated to substantially preserve ovarian function and spontaneous fertility.

Even if the technique is widely diffused at the level of tertiary and cancer care centres, it is probably underused at the level of secondary institutions. Since 2015, we have developed a fertility preservation clinic at the Wollongong hospital, and offer this type of preservation.

In the first case, a 19-year-old was operated concomitantly with the colorectal team as she presented with a perforated rectal cancer complicated of pelvic abscess (T4). A colostomy and the transposition were performed simultaneously. In the second case, laparoscopic ovarian transposition was performed electively on a 31-year-old female with rectal cancer (T4) who subsequently underwent 2 cycles of IVF and was able to freeze her eggs.

This communications will present the clinical context of the 2 cases, the surgical technique with a video, and a review of the literature.

Conclusion: Consideration should be given for ovarian transposition for pelvic malignancies before onset of radiation treatments in patients who desire preservation of ovarian function. Laparoscopic techniques can be used to move the ovaries outside of the radiation portal. This technique shoud be available for the patients ate the level of a secondary institution.

1. Clough KB, Goffinet F, Labib A, Renolleau C, Campana F, de la Rochefordiere A,Durand JC. Laparoscopic unilateral ovarian transposition prior to irradiation: prospective study of 20 cases. Cancer. 1996 Jun 15; 77 (12):2638-45.
2. Loren AW, Mangu PB, Beck LN, Brennan L, Magdalinski AJ, Partridge AH, Quinn G, Wallace WH, Oktay K; American Society of Clinical Oncology. Fertility preservation for patients with cancer: American Society of Clinical Oncology clinical practice guideline update. J Clin Oncol. 2013 Jul 1;31(19):2500-10.
3. AYA cancer fertility preservation guidance working group. Fertility preservation for AYAs diagnosed with cancer: Guidance for health professionals.. Sydney: Cancer Council Australia. [Version URL: http: //wiki. cancer.org.au/australiawiki/index.php?oldid=110662, cited 2016 Jan 31]. Available from:http://wiki.cancer.org. au/ australia/COSA:AYA_cancer_fertility_preservation

Prospective validation of the Ultrasound Based Endometriosis Staging System (UBESS)

Bassem Gerges[1, 2], Shannon Reid[1, 2], Danny Chou[3], Timothy Chang[4, 5], **George Condous[1, 2, 5, 6]**

1. *Acute Gynaecology, Early Pregnancy and Advanced Endosurgery, Nepean Hospital, Kingswood, NSW, Australia*
2. *Nepean Medical School, University of Sydney, Sydney, NSW, Australia*
3. *Sydney Women's Endosurgery Centre (SWEC), Hurstville, NSW, Australia*
4. *Nureva Women's Specialist Health, Campbelltown, NSW, Australia*
5. *Laparoscopic Surgery for General Gynaecologist (LaSGeG), Sydney, NSW, Australia*
6. *Omni Gynaecological Care Centre for Women's Ultrasound and Early Pregnancy, St Leonards, NSW, Australia*

Objective: To prospectively validate the recently developed Ultrasound Based Endometriosis Staging System (UBESS)[1]

Methods: Multicentre study of consecutive women presenting with chronic pelvic pain from July 2013 to December 2015. All women with symptoms of chronic pelvic pain +/- history of endometriosis underwent a detailed specialized transvaginal ultrasound (TVS) in a tertiary referral unit to stage the endometriosis prior to laparoscopy using the three stage UBESS. The findings from UBESS were correlated with surgical gold standard.

Results: 136/141 (96.5%) women with pre-operative TVS and laparoscopic outcomes were included in the final analysis. 48 (34%) of the women had a history of previous endometriosis with the mean age of diagnosis was 25.3 +/- 10.3 years. The accuracy, sensitivity, specificity, positive predictive value and negative predictive value for the performance of UBESS at predicting level 1 laparoscopic surgery were 86.5/86.6/86.5/85.3/87.7 per cent, level 2 were 84.4/67.6/89.7/67.6/89.7 per cent and level 3 were 90.8/82.5/94.1/84.6/93.1 per cent, respectively.

Conclusions: UBESS can be used to pre-operatively stage women to the most appropriate level of laparoscopic endometriosis surgery required. It needs to be externally validated in order to assess its general applicability in other centres.

1. Gerges B, Lu C, Reid S, et al. Development and Validation of a Preoperative Ultrasound Staging System for Predicting Level of Laparoscopic Endometriosis Surgery Required. J Minim Invasive Gynecol. 22: S26-S7.

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The Take Home Box Trainer (THBT) Project: A novel approach to enhance O&G trainee laparoscopic skills

Sarah Janssens[1], Erin Wilson[1], Luke McLindon[1]

1. Mater Health Services, Sherwood, QLD, Australia

The Take home box trainer project. a novel program to enhance O&G trainee laparoscopic skills Background: Accessibility is a commonly cited barrier to laparoscopic simulation training. A project to loan registrars a laparoscopic box trainer and instruments was conceived to enhance surgical training at the Mater Mothers' Hospital. Aim: To describe the process of obtaining funding, creating a research framework, designing a curriculum and implementing the "take home box trainer (THBT)" project. Methods: A research protocol was developed to assess qualitative and quantitative outcomes from the project. The hospital ethics and governance committees provided approval for the project. Funding was applied for through various grant programs, with support ultimately being secured through Mater Education who purchased 17 box trainers for use by our trainees at a cost of approximately $25000. Developing and maintaining a strong relationship between these two departments was instrumental in obtaining funding. The choice of box trainer was based on the accompanying software for instrument tracking and ability to upload videos of performance (eoSim ProTrac). To secure a box trainer, participating trainees provided consent to participate in the project, paid a deposit of $200, completed pre-assessment tasks, and signed an equipment checklist and agreement to return the box at project completion. Box trainers were distributed to trainees over a 2-week period prior to project commencement. Several logistical challenges were encountered during purchase, delivery and distribution of the box trainers. A curriculum was provided comprising of ten box trainer tasks utilising equipment supplied with the box trainer. An orientation video, electronic log book ,links to demonstration videos and study materials were provided to trainees via USB stick. An email account was created for sending reminders and data collection. Trainees were directed to practice one task each week for 10 weeks and log their training time. Pre-training and post-training assessments were performed using a virtual reality simulator and box trainer tasks. Results: The THBT project was implemented in September 2015 and the first cohort of trainees are currently completing their project requirements. Conclusion: The THBT project was implemented through a variety of strategies, including building a strong relationship with Mater Education, embedding the project in a research framework, providing a curriculum for the trainees to follow and using a variety of IT solutions for data collection and communication.

A comparison of two misoprostol regimens for medical management of first trimester miscarriage

Fiona Langdon

Introduction: Misoprostol is an accepted management option for early pregnancy failure. It is a synthetic PGE1 analogue that causes myometrial stimulation of the uterus leading to uterine contractions, cervical dilatation, and uterine emptying. Randomised trials have not identified the optimal dosing of misoprostol in early pregnancy failure.

King Edward Memorial Hospital recently changed their misoprostol regimen for missed miscarriage from 800mcg PV on Day 1, with follow up and if needed repeat dosing on Day 3 and review on Day 10, to 800mcg PV on Day 1 and follow up and repeat dosing if required on Day 8 and review on Day 15.

Aims: Altering the guidelines to misoprostol therapy allowed the two different regimens to be analysed and their efficacy and side-effects documented thus determining if there was any difference in success between the two arms.

Methods: 200 women with a diagnosis of missed miscarriage treated with medical management had their charts reviewed. These women were the last 100 women to receive the old regimen and the first 100 women to receive the new regimen.

The primary endpoint was successful medical management by the second review. Other outcomes reviewed were number of misoprostol doses, number and reason for medical review and need for emergency surgical management.

Results: There was a significant reduction in the number of patients who failed medical management in the new regimen with 56% less patients requiring a D and C. The number of presentations for medical review and the

number of misoprostol doses required was also reduced. This was not associated with an increase in the need for emergency curettes or emergency presentations.

Conclusion: A longer period to first review increased the success rate of misoprostol medical management of first trimester miscarriage as well as reducing the total doses of misoprostol needed and number of medical reviews required.

The role of endometriosis specific ultrasound in pre-operative planning

Tony Ma[1], Madeline Ward[2], Lenore Ellett[1], Kate McIlwaine[1], Janine Manwaring[1], Emma Readman[1], Kate Stone[3], Peter Maher[1]

1. *Endosurgery Unit, Mercy Hospital for Women, Melbourne, VIC, Australia*
2. *Mercy Hospital for Women, Melbourne, VIC, Australia*
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Background: Ultrasound imaging is becoming increasingly accurate in the pre-operative prediction of endometriosis as image resolution and subspecialist expertise improves. It has been published that 'soft' markers (site specific tenderness and lack of ovarian mobility) at ultrasound correlates to positive findings for endometriosis at laparoscopy (1). However, it has also been noted that proficiency at detecting these new markers requires additional training and expertise above those required for routine gynaecologial imaging (2).

Objective: To assess the correlation of isolated 'soft' markers for endometriosis at ultrasound with the presence of endometriosis at laparoscopy before and after additional subspecialist training.

Design: Retrospective audit.

Method: Department records were searched of all ultrasounds performed by the unit's lead ultrasonologist (KS) who has a special interest in ultrasound diagnosis of endometriosis performed from Oct 2010 – Nov 2015. KS received additional subspecialist training in ultrasound pre-operative diagnosis of endometriosis at the Sirio Libanes Hospital, Sao Paolo, Brazil in 2013. The cohort was divided into pre and post training. 2x2 contingency tables were formed and a Fischer exact 2 tailed test performed.

Outcome: Presence or absence of endometriosis at laparoscopy.

Results: Of the 185 ultrasounds performed, 27 were found to have no 'hard' markers for endometriosis (endometrioma, adenomyosis or evidence of deep disease) and also had a laparoscopy.

19 patients were scanned prior to additional training and 8 after.

The Fischer exact 2 tailed tests were p=1.000 (2012/2013- 19 patients) and p=0.1964 (2014/2015- 8 patients). Accuracy improved from 47% to 75%. Sensitivity, specificity and negative predictive value all improved.

Conclusion: Ultrasound can be a valuable tool in the management of women with pelvic pain. Improved identification of those with superficial endometriosis can guide pre-operative counselling and allow appropriate allocation of hospital resources and theatre cases. Sub specialist expertise in endometriosis assessment is required for accurate detection and this should be considered when interpreting reports.

1. Okaro E, Condous G, Khalid A, Timmerman D, Ameye L, Huffel S, Bourne T. The use of ultrasound based 'soft markers' for the prediction of pelvic pathology in women with chronic pelvic pain- can we reduce the need for laparoscopy? BJOG 2006;113:251-256.
2. Reid S, Winder S, Condous G. Sonovaginography: redefining the concept of a normal pelvis on transvaginal ultrasound pre laparoscopic intervntion for suspected endometriosis. Australian Journal of Ultrasound in Medicine. 2011;14:21-24.

Complications and outcomes post laparoscopic hysterectomy at King Edward Memorial Hospital, Western Australia

Jennifer C Pontre[1], Edwina Coghlan[1], Bernadette McElhinney[1]

1. *King Edward Memorial Hospital, Subiaco, Western Australia, Australia*

Introduction: Since the first laparoscopic hysterectomy, innovations in technology and technique have improved the efficiency and safety of this approach. The benefits of minimally invasive surgery are well documented1. When compared to total abdominal hysterectomy, the laparoscopic approach is associated with less blood loss, less analgesic requirement, shorter hospital stay and better cosmetic result, However, an increased risk of major complications has also been reported[1,2].

Previously, a major complication rate of 11.1% and minor complication rate of 23-27% has been reported2. Surgical complications and patient outcomes are determined by patient factors3, as well as level of operator experience. It is generally accepted that the surgical complication rate decreases with increasing surgical experience. With increasing experience, even if surgeons do experience an untoward event, quite often repair can be carried out laparoscopically rather than by conversion to a laparotomy.

There is a possibility that the previously documented complication rate may have been a reflection of the relative newness of the technique and the 'surgical learning curve' and, in fact, the complication rate may not be so high.

Aim: To review experience and outcomes of total laparoscopic hysterectomy (TLH) within a tertiary referral centre. In particular, rates of intra- and post-operative complications will be compared. The overall outcomes of patients undergoing TLH, laparoscopically assisted vaginal hysterectomy (LAVH) or laparoscopic radical hysterectomy (LRH) will be assessed to determine whether or not there is a relationship between grade of primary operator and patient outcome.

Method: Retrospective cohort analysis of consecutive patients in a tertiary referral centre, over a 12 month period (21st January 2014 to 31st December 2014), who underwent TLH, LAVH, or LRH.

Results: Mean patient age and BMI were 50.4 years (range 29 to 82) and 31.9 (range 20 to 49.9) respectively. Intra-operative complications were: major 0%, minor 8.5%. Anaesthetic complication rate was 6.38%. Post operative major complication rate was 2%, and minor complication rate was 8.5%. Intra-operative complications included conversion to laparotomy, bladder injury and pervaginal bleeding. Post operative complications included wound dehiscence, vault haematoma and pervaginal bleeding requiring return to theatre. 2 patients required re-admission.

Conclusion: Preliminary analysis suggests that TLH, LAVH and LRH via laparoscopic approach at KEMH is a safe and efficient procedure, with a favourable complication rate when compared to reported complication rates in current literature

1. Nieboer TE, Johnson N, Lethaby A, Tavender E, Curr E, Garry R, van Voorst S, Mol BW, Kluivers KB. "Surgical approach to hysterectomy for benign gynaecological disease". Cochrane Database Systematic Review. 2009 Jul 8;(3):CD003677. doi: 10.1002/14651858.CD003677.pub4.
2. Garry, R et al. "EVALUATE Hysterectomy Trial: A Multicentre Randomised Trial Comparing Abdominal, Vaginal And Laparoscopic Methods Of Hysterectomy". BMJ, (2004); 328:129.
3. Brummer, THI et al. "FINHYST, A Prospective Study Of 5279 Hysterectomies: Complications And Their Risk Factors". Human Reproduction 26.7 (2011): 1741-1751.

The effect of salpingectomy on the ovarian reserve

Rachael Rodgers[1, 2], Jonathan Carter[2, 3], Geoffrey Reid[4], Joanne Ludlow[2], Michael Cooper[2, 4], Surya Krishnan[2, 5], Jason Abbott[5, 6]

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2. Womens & Babies, Royal Prince Alfred Hospital, Sydney, NSW, Australia
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5. Royal Hospital for Women, Breakfast Point, NSW, Australia
6. Dept of Medicine, University of New South Wales, Sydney, NSW, Australia

Background: Evidence now suggests that a significant proportion of ovarian cancers are arising from the fallopian tubes. This raises the questions of whether the fallopian tubes should be routine removed at the time of hysterectomy, and whether a bilateral salpingectomy (rather than a tubal ligation) should be conducted on women requesting permanent contraception. Before these measures can be implemented, we must first determine whether salpingectomy has any negative impact on the ovary.

Objective: To determine if salpingectomy has an impact on ovarian function due to the proximal location and shared blood supply of the fallopian tube and the ovary.

Design: Prospective cohort study.

Setting: Tertiary referral hospital in Sydney, Australia

Patients: Twenty five patients attending the early pregnancy service or emergency department for surgical management of a tubal ectopic pregnancy.

Interventions: Laparoscopic salpingectomy.

Measurements & Main Results: Anti-mullerian hormone (AMH) is used as a marker of ovarian reserve. AMH was measured pre-operatively and this level was compared to the AMH level taken three months post-operatively.

Results: No significant difference in pre- and post-operative AMH levels was recorded.

Conclusions: Laparoscopic salpingectomy does not have a negative impact on the ovary. It is reasonable to conduct a bilateral salpingectomy at the time of hysterectomy or for permanent contraception.

Video Presentation

Vaginal myomectomy for multiple cervical fibroids

Karen Kong[1], Vadim Mirmilstein[1], Catarina Ang[1]

1. *Department of Gynaecology 1 unit, The Royal Women's Hospital, Parkville, VIC, Australia*

Cervical fibroids are uncommon. It accounts for less than 10% of uterine leiomyomas (1,2).

Patient is a 35 year old nulliparous woman who presented with menorrhagia, irregular PV bleeding, abnormal vaginal discharge and dyspareunia. On examination, a polypoid growth of the cervix was found to be protruding into the vagina. The differential diagnosis for the cervical lesions are prolapsed submucosal uterine fibroids, and rarely, a polypoid form of uterine adenomyosis, carcinoma of the cervix and prolapsed uterine sarcoma.

MRI showed 6 cervical fibroids circumferentially encircling the cervix, exophytically arising from the cervix and prolapsing into the vagina. The larger fibroids measured 5 cm, 4 cm and 3 cm. Three small fibroids measured up to 1.5 cm.

Patient underwent an examination under anesthesia and removal of the fibroids for the purpose of diagnosis and relief of symptoms.

This video serves as a demonstration of removal multiple cervical fibroids (FIGO type 8) via a vaginal approach. The most likely potential complication of vaginal myomectomy is excessive bleeding from the fibroid site. We will demonstrate the techniques of vaginal myomectomy and measures to minimise blood loss.

1. Gompel C, Silverberg SG. The cervix: benign tumors and tumor-like lesions.Pathology in gynecology and obstetrics. 4th ed. Philadelphia, Pa: Lippincott, 1994
2. Tiltman AJ. Leiomyomas of the uterine cervix: a study of frequency. Int J Gynecol Pathol. 1998 Jul;17(3):231-4.

The challenges of an ovarian ectopic

Luke McLindon[1], Michael Wynn-Williams[2], Greg Duncombe[3]

1. *Mater Health Services, Brisbane, Queensland, Australia*
2. *Eve Health, Brisbane, Queensland, Australia*
3. *Queensland Ultrasound for Women, Brisbane, Queensland, Australia*

Ectopic pregnancies complicate approximately 1.5% of pregnancies, of these less than 1% are situated within or on the ovary. If surgery is contemplated, accurate pre-operative diagnosis and planning is paramount. The common outcome for an ovarian ectopic is a unilateral oophorectomy. This decision is made the more difficult in the setting of unilateral ovarian function for a childless woman.

In this video we present the pre-operative diagnosis, the intra-operative approach and the successful final result - the enucleation of an ovarian ectopic pregnancy in a woman with a solitary functional ovary in the infertility setting.

An AGES First: The Modern Ages Interactive Hub

Session 7 / 1.30pm – 3.00pm
Exhibition Area – Plaza Terrace Room
By registration only

The Modern Pelvis

Session 8 / 3.30pm – 5.00pm
Plaza Auditorium
From laser to robotics, contemporary surgical techniques dominate this session.

Robotics – the future of surgery?

Nahla Merhi

Will present:
- the evolution of Gynecology surgery from Open to Laparoscopy to Robotic approach,
- the multiport and single site robotic approach,
- the advantages and disadvantages of robotic approach, where the Gyne Surgery future?

Vaginal surgery: Why reinvent the wheel?

Stefano Salvatore

Reconstructive Pelvic Surgery may include different approaches, such as an open abdominal, a laparoscopic, a robotic and a vaginal one. The general effort in all the surgical disciplines to encourage minimally invasiveness has dramatically reduced laparotmic operations for prolapse with a constant increase in laparoscopic and robotic procedures. Vaginal approach has always been performed by gynaecologists to repair pelvic organ prolapse. Technical changes and new procedure have been proposed secondary to new functional anatomical knowledge. However in many Countries vaginal surgery is not taught anymore and young gynaecologists are loosing this skills in favour of laparoscopy and robotic procedures. This despite the fact that vaginal surgery should be considered, by all means, as the less invasive approach being a natural orifice procedure. In this lecture evolution of vaginal surgery will be reported.

Day surgery hysterectomy: from concept to reality

Felix Chan

Minimally invasive hysterectomy procedures include those completed vaginally (VH), laparoscopically (LH), or via a robot-assisted laparoscopic route. These techniques also can be used in combination, such as laparoscopy-assisted VH.

Minimally invasive hysterectomy offers several benefits, and recent studies of laparoscopic and robotic procedures for benign or malignant indications have documented less pain, less blood loss, fewer complications, shorter hospital stays, faster recovery and return to normal activities, as well as improved cosmesis compared with abdominal hysterectomy.

A personal series of single site robotic assisted laparoscopic hysterectomy will be presented. With a standardised protocol, same day discharge can be carries out with safety. Patient selection with preoperative

education is crucial for success. Preoperative analgesia, intraoperative antiemetic, specific comfort measures and detail postoperative care has made the concept of day surgery hysterectomy a reality.

Uterine Transplantation is a reality but who, how and when?
Ash Hanafy

Absolute uterine factor infertility (AUFI) represents 5% of infertile women and is the only untreatable subgroup of female infertility. It is due to absence of the uterus (congenital or hysterectomy) or the presence of a non-functional uterus. The only two options for a woman with AUFI to become mother today are through a gestational surrogate mother or adoption; both procedures are prohibited in many countries and not without several legal and ethical concerns. Uterus transplantation (UTx) presents a potential future treatment of AUFI. After extensive animal research over the last 15 years, also involving non-human primates, a small number of human UTx cases have recently been performed in Sweden. Here, I summarize our primate UTx experiments that have paved the way for our "nine" human UTx cases, resulting in "five" healthy babies. The estimate number for potential candidates and the ethics around UTx are also addressed.

Saturday 5 March 2016

Modern dilemmas
Session 9 / 8.30am – 10.00am
Plaza Auditorium
Modern approaches to old problems

Morcellation madness
Jason Abbott

Abstract not yet received.

Taking control of your bladder
Nahla Merhi

- For stress urinary incontinence, will discuss slings vs Burch approach
- For Overactive bladder, will discuss newer medications, Botox bladder injection and Interstim Sacral neuromodulation

Endometriosis, adenomyosis and pain – Where are we now?
Tal Jacobson

This presentation will review the current understanding, diagnosis and management of endometriosis and adenomyosis with a focus on pain symptoms.
Current evidence and the role of new and future technologies will be discussed. Uterine sparing treatments for adenomyosis will be reviewed.
Surgical trends in endometriosis management will be presented.

Sacral modulation – role, benefits, limitations
Simon Edmonds

Abstract not yet received.

The Modern Gynaecologist
Session 10 / 10.30am – 12.00pm
Plaza Auditorium
Gynaecological practice now and into the future: expectations and reality. Should we support or report?

The Australian perspective of the modern gynaecologist: Surgical training in 2016
Michael Permezel

Obstetrics and gynaecology is fundamentally a surgical specialty. The end result of surgical training is the product of 'native ability' at the commencement of training and the training itself. How should the College select the most 'gifted' future specialists?

Efforts to improve procedural training remain a key area of activity for the College. All acknowledge the changes in "quantity" of training brought about by influences including 'safe working hours', reduced utilisation

of overseas experience and increasing recourse to medical management of conditions that had previously required surgery. While it is easy to be critical without offering solutions, the College has determined on a number of strategies to improve procedural training.
One such strategy, amongst the many that have the College's focus, will be the increased utilisation of simulation. The e-Portfolio continues to progress with 'electronic' logging of all training procedures planned for the 2016 training year. It is envisaged that, with the availability of detailed information on the specific procedures, their complexity and the quantum available to trainees at any given site, hospital allocation of trainees will be adjusted to capitalise on the best available training opportunities.

The modern health consumer: Right's & responsibilities when accessing healthcare
Leon Atkinson-MacEwen

The Australian Charter of Healthcare Rights, the National Safety and Quality Health Service Standards (patient and consumer-centred care) and Dr Google.

Medicare reform: Purpose or shambles
David Molloy

The concept of universal health cover in Australia is under increasing threat. An aging population and an expansion of services have put pressure on both Federal and State Budgets to deliver effective and affordable health services. Challenges of equity, access and affordability are significant. The Federal government has responded to this by freezing Medicare Benefits recently and inadequate indexation for more than 20 years. Previous attempts at Medicare reform have failed (the Relative Value Study) and new services are slow to be approved through the MSAC process. Various budgetary attempts have been made to cut Medicare services including the introduction of GP Co-payments and more recently legislation that failed trying to limit access by patients to both out traditional Medicare Safety Net and the extended Medicare Safety Net. In 2016 the government is embarking on a Medicare Benefits review process. This process carries mostly threats for the profession and patients and very few benefits. This presentation will attempt to explain the pathways to Medicare reform and the potential effects on private practitioners and their patients.

Support or Report: Concerned about your colleagues?
Vinay Rane

Abstract not yet received.

Presidents Debate
Session 11 / 12.00pm – 12.30pm
Plaza Auditorium
Modern Woman is just ancient woman with a smart phone

FOR:
Nahla Merhi & Rachel Green

AGAINST:
Emma Readman & Supuni Kapurubandara

Digital Free Communications

Neuropelveology: Isolated sciatic nerve endometriosis, thank God for neuropelveology
Danny Chou[1], Gregory Miles Cario[1], David Rosen[1], Stefaan Pacquée[1], **Paul Atkinson[1],** Carly Walsh[1]

1. *Sydney Women's Endosurgery Centre, Kogarah, NSW, Australia*

Neuropelveology is an exciting new surgical pelvic discipline based on in depth understanding of pelvic nervous symptoms, both somatic and autonomic system, founded by Prof Marc Possover. Neuropelveology provides detailed knowledge of the anatomy and function of the pelvic nerves and pathologies that involve such structures which no other traditional disciplines would sufficiently understand. We present a case of a 23 year old young lady with this unusual pathology of Isolated Sciatic Endometriosis, with essentially normal pelvis who presented with menstrual "sciatica". Her MRI demonstrated a 3cm lesion over her right sciatic nerve. The unusual pathology led to multidisciplinary consultations including, neurosurgeon and orthopedic surgeon but of little help. We will present the surgical video of this unusual endometriosis case.

Morcellation – a NOTEworthy approach

Thea Bowler
Luke McLindon[1], Michael Wynn-Williams[2], Tal Jacobson[2]

1. *Mater Health Services, Brisbane, Queensland, Australia*
2. *Eve Health, Brisbane, Queensland, Australia*

Most benign gynaecology surgery is undertaken very successfully by minimal access surgery, with reduced post-op pain, faster recovery and improved patient satisfaction. The enlarged fibroid uterus while technically challenging and surgically satisfying, has the added dimension of potentially seeding previously undiagnosed neoplasm during minimal access surgery. A balance needs to be struck, one that aims to provide minimal access surgery while being cognisant of the small but real risk of harm with laparoscopic uterine, and fibroid, morcellation.

This video demonstrates one such balanced surgical practice.

The enlarged perimenopausal fibroid uterus can be tackled laparoscopically, where vessels are isolated, uterus and cervix surgically excised, then safely and efficiently removed using the Alexis Containment System and a small Alexis Wound Retractor, both used vaginally.

The management of obstetric haemorrhage secondary to abnormal placentation: A prospective cohort study

Prathima Chowdary[1], Brendan Dr Buckley

1. *Auckland City Hospital, Birkenhead, AUCK, New Zealand*

Objective: To examine the effect of prophylactic intra-iliac balloon catheters on bleeding morbidity among women with a prenatal diagnosis of placenta accreta.

Methods: In a prospective trial, women with a prenatal diagnosis of placenta accreta underwent a MDM process and decision was made for internal iliac balloons and caesarean hysterectomy. The primary study outcome was the measurement of blood loss. To detect a difference in the blood loss between the prospective and restrospective group.

Results: Between March 2010 and March 2013, 14 in the prospective group and 26 patients in the retrospective group. Demographic and obstetric characteristics were similar between the groups. All statistical tests were two-sided at a 5% significance level. Demographic and clinical characteristics of all patients were summarised by cohorts. Continuous variables were presented as mean, standard deviation, median and range. For those measured on both cohorts, statistical difference was assessed using the Fisher's exact test on categorical variables, and two sample t-test on continuous variables. Model-estimated difference between the means was tested, with associated 95% confidence interval and p-value.

Conclusion: In women with preoperative suspicion of placenta accreta, preoperative placement of prophylactic balloon catheters did affect the estimated blood loss in association with a multidisciplinary planned approach to the operation.

Systematic review of self retaining retractors and complications with open abdominal surgery

Prathima Chowdary[1], Monika Baumann[2]

1. *Auckland City Hospital, Birkenhead, AUCK, New Zealand*
2. *Surgical Department, Fisher and Paykel, Auckland, New Zealand*

Objectives: A systematic review was undertaken to evaluate the effectiveness of incision retention available to surgeons conducting open abdominal or pelvic surgeries. Both the ability of the retractor to retain the wound and harm to the patient due to the retractor were reviewed.

Methods: A search was conducted using the following databases: EMBASE, PubMed, BIOSIS, Engineering Village, Web of Science, Best practice, Science Direct, CRCnetBASE, Proquest, Wiley Online Library, and Comprehensive Biomaterial.

Results: The articles found were then narrowed down to those which matched the objective of the review. This resulted in ten articles to review. Two reviewers reviewed and summarized the articles. Femoral neuropathy was found to be a common complication due to Retractors. Other outcomes analysed or studied were found to be infected, postoperative pain and exposure provided. Femoral neuropathy can be estimated to occur at a rate between 2.6% and 7.5% in open pelvic and abdominal surgeries. The Alexis O-ring retractor was found to lower the required morphine intake following surgery when compared to the Belfour retractor.

Conclusions: There is a lack of high quality/high levels of evidence studies that have been conducted on Retractors. Femoral neuropathy is the outcome most commonly documented in relation to Retractors. Surgeons need to be aware about the use and implementations of the retractors. Care should be taken in protecting the blades and during long surgery relocating retractors should be considered.

The modern management of the paroophoron cyst

Chris Georgiou[1, 2, 3]

1. *Women and Children, Eastern Health, Melbourne, VIC, Australia*
2. *Eastern Health Clinical School, Monash Health, Melbourne, Victoria, Australia*
3. *Science, Medicine and Health (SMAH) , Illawarra Health and Medical Research Institute (IHMRI), University of Wollongong, Wollongong, NSW, Australia*

A 21yr old woman presented to the Emergency department on a number of occasions with intermittent right-sided abdominal discomfort over a 3-month period. An ultrasound scan prior to her initial presentations reported the presence of a 7cm left-sided simple ovarian cyst with normal blood flow to both ovaries. The woman was diagnosed and treated as a possible urinary tract infection and discharged home on each occasion. The presence of the cyst on the contralateral side of her discomfort was not thought to be a contributing factor.

Due to ongoing discomfort, her GP referred the woman to an outpatient gynaecology service and a diagnostic laparoscopy was arranged. The proposed procedure was that of a right ovarian cystectomy.

At laparoscopy an 8cm left-sided paroophoron cyst was identified that had twisted three times involving the left fallopian tube and ovary. The ovaries were otherwise normal in appearance.

A laparoscopic enucleation and removal of the intact paroophoron cyst was performed preserving the elongated left fallopian tube. Histology demonstrated the presence of a serous cystadenoma.

A video of the procedure is presented together with a review of the literature. The embryological basis for paroophoron cysts is also described.

Bladder endometriosis: A view from both ends

Hillary Hu[1], Emma Inglis[1], Supuni Kapurubandara[1], Yogesh Nikam[1]

1. *Obstetrics and Gynaecology, Westmead Hospital, Westmead*

Bladder endometriosis is an infrequent manifestation of endometriosis. It occurs when endometrial glands and stroma infiltrate the detrusor muscle and has a prevalence of 1-15% [1], occurring more frequently in women with severe pelvic endometriosis. Urinary symptoms occur most commonly and include frequency, dysuria and haematuria. The gold standard for treatment is laparoscopic excision of bladder endometriotic nodules and usually results in significant improvement in symptoms [2].

We present the case of a 25 year old nulliparous woman who presented to our gynaecology outpatient service following a diagnosis of Grade IV endometriosis at diagnostic laparoscopy for acute right iliac fossa pain suspected to be appendicitis. She reported a history of severe dysmenorrhea and menorrhagia, dyspareunia, cyclical haematuria and dysuria since age 14 with symptoms worsening over the past 6-12 months. Ultrasound imaging demonstrated severe bladder endometriosis with a large, full thickness nodule (21x28x22mm) obliterating the retrovesical space and adhering densely to the anterior aspect of the uterus.

A trial of medical management was undertaken which was initially effective but was ceased due to side effects and therefore a plan was made for surgical management. Diagnostic laparoscopy and cystoscopy were performed to plan the surgical approach. Grade IV endometriosis with adhesions to the bladder was seen and cystoscopy showed significant bladder involvement with a full thickness lesion on the posterior wall of the bladder above the trigone.

A bimodal surgical approach was performed with concurrent laparoscopy and cystoscopy. Ureteric catheters were placed. Lysis of adhesions between the bladder and uterus was performed and the bladder mobilised. The endometriotic nodule in the bladder was defined from above with laparoscopy and below with cystoscopy. The nodule was excised using the harmonic scalpel and the cystotomy closed laparoscopically in two layers. This approach allowed delineation of the bladder lesion and conservation of maximal normal bladder tissue and reduced the risk of damage to the trigone during the procedure.

Bladder endometriosis is commonly treated laparoscopically - either by superficial excision of endometriotic lesions, and partial or complete cystotomy. This method of approaching excision of the endometriotic lesion under direct visualisation with laparoscopy and cystoscopy allows complete removal of the lesion whilst preserving as much bladder tissue as possible and minimising damage to the trigone. We will present images and a video illustrating our procedure and discuss current literature.

1. Leone Roberti Maggiore U, Ferrero S, Salvatore S. Urinary incontinence and bladder endometriosis: conservative managment. Int Urogynecol J. 2015;26(1):159-62. doi: 10.1007/s00192-014-2487-6
2. Kjer JJ, Kristensen J, Hartwell D, Jensen MA. Full-thickness endometriosis of the bladder: report of 31 cases. Eur J Obstet Gynecol Reprod Biol. 2014;176:31-3. doi: 10.1016/j.ejogrb2014.02.018

Efficacy of thermal balloon endometrial ablation in menorrhagia and the prognostic factors

Shreekala Kakatkar[1], Sheetal Gujral[1]

1. *Obstetrics and Gynaecology, Mumbai Port Trust Hospital, Mumbai, Maharashtra, India*

Aim and objectives:

1. To evaluate the efficacy and outcome of thermal balloon endometrial ablation in selected women with menorrhagia.
2. To study the predictors of amenorrhoea after the procedure.

Methodology: A hospital based observational study (retrospective and prospective) over a period of 32 months (November 2011 to June 2014) at Mumbai Port Trust Hospital, Mumbai with the approval of Ethical committee.

137 women with menorrhagia and fulfilling the inclusion criteria underwent Thermal Balloon Endometrial Ablation (TBEA) with Gynecare Thermachoice III device.

Patients were studied for age distribution, parity distribution, tubal ligation status, menorrhagia quantification (Pictorial blood loss assessment chart score,PBAC), pre-procedure endometrial thickness, utero-cervical length. The outcome of the procedure in terms of menstrual pattern and improvement in haemoglobin was studied at 3, 6 and 12 months' follow-up.

By studying these variables, predictors of amenorrhoea after the procedure were analysed.

Results:

- 56.9% women had amenorrhoea, 38% women had hypomenorrhoea and 5.1% women were with normal menstrual blood loss at 3 months. Whereas, 80.2% women had amenorrhoea at 1 year follow-up.
- 65% women had improved haemoglobin at 3 months and 91.89% women at 6 months.
- 86% women were with age of 45-49 years. Percentage of women attaining amenorrhoea was more (67.0% at 3 months and 72.16% at 6 months) in the older group than younger women.
- 62.04% women were with PBAC score of more than 200. 86.53% of patients with PBAC less than 200 and 51.76% of patients with PBAC more than 200 attained amenorrhoea at 6 months.
- 78.10% women had utero-cervical length less than 9 cm. Rate of amenorrhoea was more in patients with lesser UCL (86.96%) than in patients with UCL of more than 9 cm (50%).
- 62.17% women had pre-procedure endometrial thickness of more than 4 mm (5-9mm). More percentage of patients from the group with ET less than 4 mm attained amenorrhoea at all the follow-ups.
- There were no major complications during or after the procedure.
- The hysterectomy rate was 2.18%

Conclusion: By observing improved menstrual pattern, nil major complication rate and with review of literature, we could state that TBEA is efficient, safe and technically easy to perform procedure.

We studied certain variables and their correlation with post procedure menstrual pattern. After studying similar data from the literature, we could conclude that advanced age, lower PBAC, utero-cervical length of less than 9cm, and endometrial thickness of less than 4mm predict higher chances of attainment of amenorrhoea.

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Severe Deeply Infiltrative Endometriosis (DIE) requiring laparoscopic left nephrectomy and laparoscopic ultra-low anterior bowel resection with defunctioning Ileostomy

Louise Konaris[1], Reem Alanazy[1], Stefaan Pacquée[1], Lionel Reyftmann[1], David Rosen[1], Gregory Miles Cario[1], Danny Chou[1]

1. *SWEC, Sydney, NSW, Australia*

DIE, in contrast to peritoneal disease, is the more severe form of endometriosis that is associated with infiltration of disease deep into adjacent organs. It is these types of disease that often require a more radical surgical procedure. We present a surgical video of a 32 year old lady with severe disease causing chronic left-sided obstructive Nephropathy, resulting in end-stage hydronephrosis and hydroureter requiring nephrectomy, as well as an obstructive recto-sigmoid lesion requiring Laparoscopic Ultra-Low anterior resection and anastomosis with defunctioning ileostomy. The surigcal video of this complex multidisciplinary procedure highlights the severity of the disease and the challenges faced during its surgical management.

Laparoscopic ovarian detorsion and subsequent conservative management in pregnancy

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2. *Eve Health, Brisbane, QLD, Australia*

A 28 year old woman presented at 11 weeks gestation in her first pregnancy with a history of sudden onset of severe right sided pain. Ovarian torsion was suspected and a pelvic ultrasound showed an enlarged right ovary with no vascular flow. A laparoscopy was performed within 12 hours of onset of pain. The right ovary and tube was torted in a clockwise direction with a full 360° rotation. The ovary was engorged and distended. The ovary contained a 4cm simple cyst. The tube and ovary were detorted and the ovarian cyst was fenestrated and aspirated. The ovary was dusky and dark and was observed for 10 minutes. The ovary subsequently showed evidence of capillary refilling after pressure with a laparoscopic instrument and the decision was made to leave the ovary in situ rather than perform an oophorectomy. Consideration was given to performing an oophropexy but this was not done. Following surgery the patient was counselled about the findings and the small risk of ovarian necrosis or repeat torsion. She was discharged home and made a good recovery. The pregnancy was ongoing at the time of discharge. This case highlights the option of conservative surgical management in ovarian torsion and particularly in the case of early pregnancy allows minimal intervention that may decrease the risk of miscarriage.

Vaginal vault dehiscence with evisceration of the fallopian tube post Vaginal Hysterectomy in a pre-menopausal woman: A case report and Literature Review

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Introduction: Vaginal vault dehiscence (VVD) is a rare complication of hysterectomy with an estimated incidence of 0.31%. Vault dehiscence predisposes to evisceration of small bowel, fallopian tube, appendix or any other intra-peritoneal contents. Risk factors include postmenopausal atrophy, previous vaginal surgery, enterocele, post-hysterectomy wound infection or haematoma, smoking, obesity, and vaginal trauma (eg, intercourse, instrumentation).

Vaginal evisceration in premenopausal women after vaginal hysterectomy is extremely rare and only few cases have been documented in worldwide literature. This is a case report of a 37 years old woman with evisceration of the fallopian tube that was managed by combined laparoscopic-vaginal approach.

Case: A 37 years old woman with a history of 4 normal vaginal deliveries had a vaginal hysterectomy, anterior and posterior colporrhaphy for uterine prolapse, stress urinary incontinence, and digital assistance of defecation for emptying. 3 months post operation, she became sexually active and started to experience dyspareunia, vaginal discharge and constant mild right sided lower abdominal pain.

Management: On speculum examination, vaginal vault evisceration of the fallopian tube was suspected, which was confirmed by examination under anaethesia and diagnostic laparoscopy. Right fallopian tube and surrounding structures were carefully identified to avoid any injury. Laparoscopic adhesiolysis and right salpingectomy were performed without complication. Vault dehiscence was repaired with vaginal approach. Intravenous cephazolin was given for 24 hours post operatively. Pelvic rest for 6 weeks was recommended.

One year follow-up showed the patient made an unremarkable recovery with resolution of her symptoms. Histopathology confirms inflamed distal fallopian tube and no evidence of malignancy.

Discussion: The actual incidence of vaginal vault dehiscence is unknown since the complication is likely underreported. Mode of hysterectomy affects the incidence. The rate of VVD is higher after total laparoscopic hysterectomy (0.64%) compared with abdominal (0.21%) or vaginal (0.13%) approaches. Unique features of laparoscopic surgery that may be responsible for increased rate of VVD are: 1) thermal spread and vault tissue damage from electrosurgery, 2) sutures placement too close to the vaginal vault edge due to laparoscopic magnification of the surgical field, and 3) technique of laparoscopic suturing.

In premenopausal women the most common precipitating factors for VVD are early sexual intercourse and the presence of foreign bodies. In contrast, in postmenopausal women, it can occur spontaneously or with activities that increase intra-abdominal pressure. Topical estrogen replacement could be considered post operatively if vaginal atrophy is present.

1. Uccella S, Ceccaroni M, Cromi A, et al. Vaginal cuff dehiscence in a series of 12,398 hysterectomies: effect of different types of colpotomy and vaginal closure. Obstet Gynecol 2012; 120: 516
2. Gandhi P, Jha S. Vaginal vault evisceration. The Obstetrician & Gynaecologist 2011; 13: 231-237

Keeping up appearances with our 'Modern Woman' – Stumbling across metal hair extensions in the anaesthetic bay.

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Our Modern Woman has come along way in the 21st century, more notably with female cosmetic advancements. The growing popularity of these techniques can poise difficulty on gynaecologists and surgical procedures, given its unfamiliar territory and potentially have a detrimental impact on patients if not addressed appropriately.

This case demonstrates one such cosmetic technique 'micro bead hair extensions' that was only discovered in the anaesthetic bay immediately prior to major abdominal surgery. Much to the unbeknown of the surgical team, micro-beads are a popular new type of hair extension that involves multiple copper rings that are placed against the skull, holding a new hair extension and an original hair strand in place. The dilemma facing both the gynaecology and anaesthetic team was a unique one; proceed with surgery despite the risk of scalp burn from the copper bead, offer to remove all the hair prior to skin incision or perform the operation in a traditional fashion with no diathermy.

This case raised some important learning lessons in a world today where cosmetic procedures are becoming more common. These include basic knowledge of the different cosmetic technologies available to women that can impose on a surgery, the use of electrocautery in surgery versus the conductive properties of these foreign items, and the importance of having a comprehensive peri-operative checklist and consent form.

When encountering the Modern Woman in gynaecological surgery, we as surgeons need to keep up appearances with our modern patient in order to embark on safe surgical operating in the future.

Severe endometriosis with full thickness bladder wall excision and achievement of spontaneous pregnancy - a case report

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This is a case report following a 32 year old woman, who presented with pelvic pain and infertility. She had a laparoscopic resection of severe endometriosis including a full thickness resection of the bladder wall with endometriotic nodule.

A spontaneous pregnancy was achieved within months after her surgery. At this stage she is still pregnant being managed by the obstetric as well as the urology team due to recurrent haematuria, which at times has required admission with a three way catheter. On cystoscopy an area of dilated vessels could be identified, but no recurrence of the endometriosis.

As she will have delivered in February 2016 a full case report will be presented.

Feacal matter in a tubo-ovarian mass

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Tubo-ovarian abscess is one of the more severe complications of pelvic inflammatory disease. It is formed by an inflammatory mass involving the fallopian tube, ovary, and often surrounding structures. There are reports of colonic involvement with perforation in other gynecologic pathologies. This is a case of a previous perforation of rectal diverticulum, developing as acute on chronic tubo-ovarian abscess.

A 35 year old lady presented with left iliac fossa pain in the context of a long standing 6cm left ovarian cyst. She was taken to theatre for a laparoscopic left salpingoopherectomy. Intra-operatively, the left ovarian cyst was densely adherent to the pelvic side wall and rectum. Pyosalpinx of the left fallopian tube was noted. Bowel perforation was suspected, however there was no air leak demonstrated at sigmoidoscopy. The surgery was conducted jointly by the gynaecological and colorectal teams.

Post-operatively, the patient developed sepsis. She was persistently febrile to 39 degrees Celsius with an elevated CRP (219 mg/L H – 346 mg/L H). Her white cell count was within normal range as were other parameters. A CT abdomen pelvis was performed to further investigate the ongoing fevers and excluded any abscess formation or intra-operative bowel injury. The patient was treated with intravenous broad spectrum antibiotics with good effect and was discharged from hospital day seven post-operatively with oral antibiotics and follow up.

Histopathology of the left ovarian cyst and left fallopian tube demonstrated a tubo-ovarian abscess with pyosalpinx. This was complicated by evidence of foreign body granulomas resembling vegetable matter suggesting possibility of diverticulum with perforation into the tubo-ovarian mass in the past. The intra operative rigid sigmoidoscopy and post operative contrast enhanced CT abdomen showed no bowel injury.

When haemorrhage raises your BP

Emma Paterson

Luke McLindon[1] , Michael Wynn-Williams[2] , Tal Jacobson[2]

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In experienced hands, laparoscopic and open surgery is very safe. Nevertheless, major haemorrhage is a recognised adverse event occurring approximately once per thousand cases. Certain complex cases will be more prone to haemorrhage. The surgical principles remain the same, identification of anatomy, control of vascular bed, meticulous surgical technique, avoidance of haemorrhage, minimal tissue damage and optimised post-op recovery. What of the time when it wells up red - right before your and the theatre team's eyes?

This video presents two surgical cases where the principles of controlling major surgical haemorrhage (venous) are illustrated in a stepwise and effective manner. A relived experience!

Use of a Bettocchi hysteroscope and microscissors, in difficult cases of access to the uterine cavity

Lionel Reyftmann

The main reason for failure to successfully perform a hysteroscopy is the inability to access the uterine cavity as a result of cervical stenosis, a common encounter in the postmenopausal population. (1) Factors associated with uterine trauma during hysteroscopy include cervical stenosis (atrophy, cervical surgery, previous caesarean section, nulliparity), a tortuous cervical canal and a deviated uterine cavity (acute flexion, fibroids). Typically in such case, the risks of uterine trauma (lacerations to the cervix or uterine perforation) will increase and is varies from 0.002–1.7% according to the published series. (1)

The British Green Top Guidelines for best practice in office hysteroscopy as well as those from the French National College of Ob-Gyn stressed that the incidence of uterine trauma is lower for diagnostic hysteroscopy performed with small-diameter endoscopes (outer sheath diameter under 5.5 mm) under direct vision, and the accent on vaginoscopy was emphasized (2). In Australia, for various reasons, this equipment is unfortunately not widely available in the public sector.

This communication features 4 clinical vignettes illustrating the usefulness of a Bettochi hysteroscope and microscissors in difficult cases of access to the uterine cavity.

We present 2 cases of Asherman syndrome in premenopausal women (severe cervico isthmic synechia, ASRM class 3), and 2 observations of post menopausal patients diagnosed with increased endometrial thickness referred after 2 previous failed attempts to enter the cavity at a diagnostic hysteroscopy under general anesthesia. In all four cases a 2.9 mm Bettochi telescope with a 30° lens in a 5 mm continuous flow-operative sheath was used with microscissors, using the principles of vaginoscopy. The 2 adhesiolysis were successfully performed under US guidance, and the 2 post menopausal patients had a complete assessment of the cavity demonstrating the presence of a benign polyp easily excised with the microscissors.

Conclusion: The possibility of referring patients to a unit who disposes of such equipment should be advocated in case of previous failed attempts to access the cavity, especially if all the usual recommendations taken in first place have proven unhelpful (ultrasound guidance, cervical priming with prostaglandins). A RANZCOG-AGES guideline would be very helpful.

1. RCOG/BSGE joint Green-top Guideline No. 59 March 2011. Best Practice in Outpatient Hysteroscopy.
2. Deffieux X, Gauthier T, Ménager N, Legendre G, Agostini A, Pierre F. [Prevention of the complications related to hysteroscopy: guidelines for clinical practice]. J Gynecol Obstet Biol Reprod (Paris). 2013 Dec;42(8):1032-49.

Vaginal birth after cesarean: Does ethnicity matter?

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Background: As part of Western Sydney Area Health policy, all eligible women with previous caesarean delivery have the option of repeat elective caesarean section or trial of labour (TOL) based on the approved antenatal agreement between the woman and their obstetrician. Despite the equal opportunities, we suspected that the rate of repeat elective caesarean section and failed TOL is much higher among women from specific ethnic backgrounds. We hypothesise that TOL and vaginal birth after caesarean (VBAC) rates would vary by women's ethnicity.

Aim: To determine factors associated with vaginal birth after caesarean section in women delivering at Westmead Hospital. The key independent variable of interest was maternal ethnicity by country of birth.

Materials and methods: A retrospective study was conducted at Westmead Hospital, a tertiary referral centre in Western Sydney local health district that serves a diverse patient population. Clinical data was used to identify women who gave birth at Westmead Hospital with history of caesarean delivery eligible for TOL between

January 2014 and June 2015. The study was designed to estimate the association between women's ethnicity, age, pariety, BMI, labour induction/augmentation, epidural use and gestational age with TOL and VBAC rates.

Results: Based on our findings the associated characteristics of successful TOL were younger age, lower BMI, history of previous vaginal birth and use of epidural anaesthesia. Although, the higher the parity the more likely a patient is to opt for a virginal birth but it was not associated with increased chance of VBAC. Despite being univarietly significant, the maternal country of birth being India did not affect the overall outcome. It was noted that if a patient was from an Indian ethnic background there was a higher chance of requesting a repeat elective caesarean section rather than opting for a trial of labour.

Conclusions: The impact of this study on our local practice is that ethnicity may affect the decision regarding mode of delivery in future pregnancies and should be considered during antenatal counseling. This information could be used to improve candidate selection for TOL and give more accurate advice when counseling our patients with different personal characteristics and ethnic backgrounds. Also, as epidural anaesthesia is one of the predictors of successful TOL we encourage its use in our trial of labour candidates.

Total laparoscopic hysterectomy with distorted pelvic anatomy

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This is a case report and video presentation of a complicated total laparoscopic hysterectomy, with discussion of techniques employed to manage the challenges encountered.

The patient was a 50 year old G2P2, with a uterus didelphys. Her significant history included a resection of a vaginal septum associated with the uterus didelphys and two caesarean sections. The indication for hysterectomy was menorrhagia and pelvic pain. Preoperative ultrasound showed a right ovarian cyst consistent with an endometrioma and a 3cm fibroid in the left hemiuterus.

Uterus didelphys is a Mullerian tract abnormality arising due to complete failure of fusion of the Mullerian ducts. This results in a double uterus, cervix and upper vagina (longitudinal vaginal septum). Hysterectomy for uterus didelphys has been described in case reports (Erian, 2012).

A number of factors contributed to the difficulty of this operation:

- Abnormal anatomy due to the uterus didelphys. This affected insertion of the uterine manipulator, as it could only enter one uterine cavity and the colpotomiser cone had to surround both cervices. While the right hemi-uterus manipulated well, the left did not, requiring assistance with laparoscopic graspers.
- Previous caesarean sections, with resultant adhesions of the bladder. The bladder was adherent very high on the anterior uterus, reaching the top of the midline raphe between the hemi-uteri. Dissection of the bladder peritoneum commencing laterally where the bladder was less adherent allowed safe planes to be developed.
- Stage 4 endometriosis with obliteration of the pouch of Douglas. The rectum was adherent to the posterior uterus and cervix, both ovaries were adherent to the posterior uterus, with a right endometrioma.
- The fibroid arising from the left hemi-uterus contributed to suboptimal manipulation.

The key to safely completing this laparoscopic hysterectomy was to maintain optimal operative views and restore normal pelvic anatomy, as is demonstrated in the video.

1. Erian J, Lee C, Watkinson S, Alsheikh Ali A, Chaudhari L, Hill N. Laparoscopic subtotal hysterectomy in a case of uterine didelphys. Archives of Gynecology & Obstetrics. 285(1):139-41, 2012 Jan.

Did AGES training program make a difference? The learning curve for total laparoscopic hysterectomy

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Objective: We assessed the learning curve for total laparoscopic hysterectomy performed by the AGES fellow as the primary operator over 24 months period at the Waikato Hospital program.

Methods: This is a retrospective study. We analyzed 40 total laparoscopic hysterectomy procedures performed by the fellow and one of two laparoscopic surgeons between January 2014 and January 2016 to examine whether a learning curve exists as defined by a decrease in operating time and complications. We defined the first 20 laparoscopic hysterectomies as "early" cases and the later 20 cases as "late" cases.

Results: The progress was assessed in the following:

- Mean operating time
- Day one post operative haemoglobin drop and need for blood transfusion
- Intra operative complications (Urinary tract, and major blood vessels injuries)
- Post discharge readmission to the hospital

Conclusion: There is a learning curve for TLH. After gaining experience in performing 20 cases, the operating time is significantly reduced.

No major differences in the intra operative complications between the early and late cases with experienced senior assistant.

An interesting case of a large uterine leiomyoma with possible associated intravenous leiomyomatosis with intracardiac extension

Cheryl Silveira

Leiomyomas are common, histologically benign tumours arising from the smooth muscle of the uterus. (1) Intravenous leiomyomatosis is a rare condition where this benign smooth muscle cell forms a tumour which occupies vascular spaces ascending through the venous circulation from the intrauterine venules via the iliac veins to the inferior vena cava. (1,2,3) The mass can sometimes extend into the right heart and pulmonary arteries to cause intracardiac leiomyomatosis (1,2,3). Intracardiac leiomyomatosis may cause an obstructive effect on the tricuspid orifice and interfere with venous return, which can result in cardiac symptoms (such as exertional dyspnoea), a cardiac murmur, syncopal episodes, pulmonary embolism and even in some cases sudden death. (1,2,3) The pathogenesis is still unclear, with the two main theories being that it either originates from the venous wall or that uterine leiomyomas invade into the uterine veins. (3) Diagnosis can be difficult and often patients have a delayed diagnosis, and can subsequently be improperly treated. (3) Multiple imaging modalities, including computed tomography, magnetic resonance imaging and echocardiography, should be used to make a more accurate diagnosis. (1)

We describe the case of a 53 year old female who presented with worsening heavy vaginal bleeding, on a background of several months of abdominal bloating and swelling. Computed tomography of her abdomen and pelvis showed a large, 31x23x25cm uterine mass. There was also an incidental finding of a large filling defect in the inferior vena cava which appeared to be extending up from at least the level of the renal veins, whilst veins distal to this were collapsed. Further imaging with computed tomography of her chest and cardiac echocardiography demonstrated the caval filling defect extending through the entire length of the inferior vena cava, terminating in the right heart, with a 3cm mobile mass traversing the right atrium into the right ventricle. Multidisciplinary expertise was sought with the gynaecological oncology, cardiothoracic surgery, vascular surgery, interventional radiology and cardiology teams aiding in diagnosis and management of our patient. She underwent a bilateral uterine artery embolisation procedure under fluoroscopic guidance, followed by a total abdominal hysterectomy and bilateral salpingo-oopherectomy. Histopathology confirmed a diagnosis of uterine leiomyoma. Differential diagnoses for her intracardiac mass include intravenous leiomyomatosis with intracardiac extension, thrombosis and atrial myxoma. Cardiothoracic surgery is planned in the near future, to manage the atrial mass before it causes cardiovascular symptoms and to confirm the diagnosis.

When a post partum haemorrhage fails medical treatment

Ashleigh Smith[1], Tapasi Bagchi[1], Emma Ballard

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BACKGROUND: Post Partum Haemorrhage (PPH) is a common obstetric emergency. Stepwise guidelines for PPH management need to be clearer.

AIM: to evaluate the B-lynch suture technique and the Bakri balloon technique, or both ('the uterine sandwich') as second line management strategies for PPH that has failed medical therapy. Outcome is measured by prevention of hysterectomy.

METHODS: A retrospective case study of all women who had a PPH and insertion of either B-lynch suture or Bakri balloon, or both, at The Royal Brisbane and Women's hospital, between January 2009 and December 2013.

RESULTS: During the study period, 97 cases of PPH occurred in which medical therapy alone failed. B-lynch was used in 49.5 % of cases, Bakri in 41.2 %, and a combination of 'both' procedures was required in only 8.2 % of cases. 93.8% of women treated with these interventions avoided hysterectomy. There were 7 emergency hysterectomies (6.2%) performed due to failure of these interventions. There were no mortalities in this study. Four (50%) of the 8 patients treated with 'the uterine sandwich' avoided hysterectomy.

CONCLUSION: The Bakri and B-lynch suture are both highly effective in terminating PPH when medical therapy alone fails. The 'uterine sandwich' appears to be an effective option to trial in an effort to avoid hysterectomy, when B-lynch or Bakri are attempted and fail in isolation. Further studies such as this one, are needed to optimize the stepwise addition of each procedure in heterogeneous patient populations.

EXTREME GYNAECOLOGY-1 Hybrid umbilical entry: A laparoscopic entry technique for patients with extreme obesity(BMI ≥40 kg/m2).

Hasan Titiz

INTRODUCTION

Laparoscopic entry can fail in morbidly obese patients. Failure rate varies from 4% to 29%, depending on which entry technique is used (1).

CHALLENGES OF OPEN AND DIRECT ENTRY

Challenges of conventional umbilical open entry(Hasson technique) in a morbidly obese patient are going through thick fat layer (8-10 cm) before opening fascia, muscle and peritoneum in a small incision (1), putting sutures on the fascia, and gas leakage from entry site.
Challenges of direct optic entry in a morbidly obese patient are to grasp and stabilize abdominal wall. It also requires significant strength and force to push the trocar through fat layers, fascia, muscle and peritoneum (1). Common factors involved in laparoscopic access injuries include inadequate stabilization of the abdominal wall, excessive resistance to trocar insertion, and excessive, misdirected or poorly controlled force along the axis of the trocar (3).

OPEN ENTRY WITH UMBILICAL STALK ELEVATION

Umbilical stalk is a fibrous remnant of umbilical vessels and rarely mentioned in anatomy textbook and literature. This fibrous, white ligament like structure runs from the linea alba to the dermis of the umbilical cicatrix. Peritoneum is fused to the junction between umbilical stalk and linea alba (single layer of fascia). This junction is the thinnest entry point into the abdominal cavity even in morbidly obese patients. Literature review revealed no published article on open umbilical entry technique with elevation of umbilical stalk in gynaecology. But in general surgery this technique was used successfully without any vascular or visceral injury for more than 2000 patients who has no history of midline laparotomy. (2,3).

HYBRID ENTRY

Hybrid entry is the combination of an incision to the junction of umbilical stalk and linea alba with umbilical stalk elevation technique and direct optic entry through fascia incision and peritoneum.

DISCUSSION

This presentation is a combination of power point presentation and a video. It discusses the literature review about open entry with umbilical elevation technique. It also analyses the challenges and failure rate of different laparoscopic entry techniques in morbidly obese patients in gynaecology.
The video shows the followings: 1.Demonstration of umbilical anatomy (including umbilical cicatrix, umbilical stalk, linea alba and peritoneum) and open entry surgical technique with elevation of umbilical stalk in a patient with normal BMI. 2. Demonstration of hybrid entry technique in a patient with BMI of 49.

1. Pasic R et al. Laparoscopy in morbidly obese patients. J Am Assoc Gynecol Laparosc 1999; 6(3): 307-312 2.Antevil JL et al. Safe and rapid laparoscopic access- A new approach World J. Surg. 29, 800–803 (2005) 3.Carbonell AM et al. Umbilical stalk technique for establishing pneumoperitoneum Journal of laparoendoscopic and advanced surgical technique 2002; 12(3):203-206

EXTREME GYNAECOLOGY-3 Tips & Tricks: 3 steps total laparoscopic hysterectomy technique for extremely large uterus (34 weeks size) with Titiz utero-vaginal manipulator

Hasan Titiz

INTRODUCTION

The removal of an extremely large uterus can be challenging task to the surgeon regardless of the surgical approach and technique used. There is no clear guideline about surgical technique of total laparoscopic hysterectomy for extremely large uterus.

An extremely large uterus can obstruct the pelvis and it can be difficult to access the pelvic space around the utero-vaginal junction. It is also difficult to mobilize and manipulate the uterus due to its size. As a result it can be difficult to visualize surrounding anatomical structures. Therefore using a uterine manipulator that can manipulate extremely large uterus and expose utero-vaginal junction is important.

It has been shown that combination of Titiz utero-vaginal manipulator and this surgical technique ("total laparoscopic hysterectomy in 3 steps") has made it possible to complete total laparoscopic hysterectomy for larger uterus (426grams vs 1144 grams)(1).

In the recent case series and review article, there were 133 cases reported in English literature in which laparoscopic hysterectomy is used for uteri weighing ≥1000 grams (2).

CASE

A 44 years old, G0P0, patient with the history of extremely large uterus decided to have definitive surgical treatment after 5 years follow-up. On clinical examination, she had 34 weeks size of uterus. Ultrasound showed multiple fibroids including the one from supra-vaginal part of cervix with the size of 7x5 centimetres. Endometrial biopsy was negative. Abdominal CT did not show any abnormality apart from very large uterus with multiple fibroids. Patient had a total laparoscopic hysterectomy and knife morcellation through mini laparotomy after discussing the treatment options and possibility of sarcoma. Uterus weight was 2320 grams. Histopathology showed benign fibroids. Patient did not have any postoperative complications.

DISCUSSION

This presentation is a combination of power point presentation and a video. It discusses challenges and the literature review about laparoscopic hysterectomy for extremely large uterus. The video demonstrates the surgical technique and the following tips and tricks on how to do total laparoscopic hysterectomy for an extremely large uterus: 1. What needs to be checked during bimanual examination just before operation 2.Where the surgeon and assistant should stand 3.Which entry techniques can be used 4. Number, sizes and locations of trocars 5.How to use operating table throughout the operation. 6. Step by step laparoscopic hysterectomy technique for extremely large uterus with Titiz utero-vaginal manipulator.

1. Raymond S and Titiz H. Total laparoscopic hysterectomy: Single surgeon experience in a regional centre after changing uterine manipulator and surgical technique. AGES, ASM, March 2015, AAGL, ASM, November 2015 2.Uccella S et al. Laparoscopic hysterectomy in case of uteri weighing ≥ 1kilogram: A series of 71 cases and review of the literature J Minim Invasive Gynecol 2014; 21: 460– 465

Exploring the benefits of robotic surgery in the management of severe endometriosis

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Introduction: While the benefits of minimally invasive surgery are well established, the role of robotic surgery versus laparoscopic surgery is continuing to be debated. Even for experienced laparoscopists, robotic surgery can offer advantages when faced with certain pathologies, including severe endometriosis.

Materials and methods: This video illustrates the case of a 41 yo G3P2 with persistent pelvic pain and dyspaneuria despite previous vaginal hysterectomy. Her pelvic ultrasound prior to consultation showed bilateral endometriomas. She underwent a robotic bilateral cystectomy, adhesiolysis with resection of severe and deep endometriosis.

Results: This case serves to remind us that endometriosis is often underdiagnosed. In addition, robotic platform, while abiding to the same surgical principles as traditional laparoscopy, provides many additional benefits that prove to be useful when dealing with advanced endometriosis cases, such as 3D vision and clear high magnification of the operative field.

Conclusion: Robotic surgery is comparable and may be superior to traditional laparoscopy in the surgical management of severe endometriosis.

In-bag morcellation: Tips and tricks

Reem Alanazy[1], **Carly E Walsh[1]**, Stefaan Pacquée[1], Paul Atkinson[1], Gregory Miles M Cario[1], David M Rosen[1], Danny Chou[1]

1. *Sydney Women's Endosurgical Centre, Sydney, Australia*

Since the U.S. Food and Drug Administration (FDA) statement discouraging the use of "power" or electromechanical morcellation for hysterectomy and myomectomy in most women with uterine myoma gynecologists are forced to consider open surgery or morcellation carried out through a wound retractor or vaginally with a scalpel.

While the risk of sarcoma is real and serious the advantages of minimally invasive surgery over open procedures regarding outcomes and complications must be considered.

Our unit developed a technique of in bag morcellation ' The Sydney Contained in Bag Morcellation for Laparoscopic Myomectomy' This allows for specimen retrieval without dissemination to enable patients to continue to have the benefits of minimally invasive surgery.

The AAGL raised concerns about the technical challenges associated with morcellation using a specimen containment approach

This is an instructional presentation including short videos and illustrated slides to teach the technique and tips and tricks to make it achievable.

1. Kanade TT, McKenna JB, Choi S, Tsai BP, Rosen DM, Cario GM, Chou D. Sydney contained in bag morcellation for laparoscopic myomectomy. J Minim Invasive Gynecol. 2014 Nov-Dec;21(6):981
2. McKenna JB, Kanade T, Choi S, Tsai BP, Rosen DM, Cario GM, Chou D. The Sydney Contained In Bag Morcellation technique. J Minim Invasive Gynecol. 2014 Nov-Dec;21(6):984-5
3. AAGL Advancing Minimally Invasive Gynecology Worldwide. AAGL Morcellation during Uterine Tissue Extraction, May 2014

Unraveling the mystery behind the Open (Hasson) technique to laparoscopic entry: A video teaching tool for gynaecology trainees

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Introduction and Background: Obtaining entry into the abdominal cavity is one of the most potentially dangerous steps of laparoscopy3. Multiple examples of injury to major blood vessels and abdominal viscera exist. Several techniques of entry to the abdomen and peritoneal cavity have been described. Recent Cochrane review by Ahmad et al concluded no recommendation for best technique2. The Royal College of Surgeons of England recommends the use of open technique in all instances3. According to survey, the majority of gynaecologists prefer either direct or closed entry techninques3 and as such gynaecology trainees often have limited exposure to open technique.

Open 'Hasson' Technique describes abdominal entry achieved with direct incision to the abdomen under vision, followed by a combination of blunt and sharp dissection. Decreased rates of vascular injury with open technique

have been shown1. Some studies have shown decreased rates of visceral injury1. Historically this technique has been reported to be lengthy and more surgically complex compared with other techniques.

We have found at our tertiary institution that specialist gynaecology trainees have limited experience with open entry and are both hesitant and unfamiliar with this technique. Instructional video has been recognized as an important tool to progress development of surgical skills. This video has been specifically created to improve the gynaecology trainees' understanding of open entry techniques including background, risks, benefits and a step-by-step approach to the procedure. Whist this video is not intended to be a substitute for hands on surgical teaching, we aim to enhance and maximize the learning opportunity for the trainee prior to exposure to the hands on surgical experience.

Method: Consent for Surgical video was obtained from two women undergoing routine elective laparoscopic procedures. Video was recorded with Sony NxtCam, and Storz Laparoscopic equipment. Video editing was undertaken. Care has been taken to include footage regarding both setup and procedure.

Conclusion: The technique of open entry as demonstrated in the video is a straightforward and relatively simple technique when learnt and performed correctly. Although there is no evidence forone entry technique over another, what cannot be disputed is that trainee surgeons will be best equipped and most versatile when given the opportunity to add additional skills to their surgical armamentarium.

1. Laparoscopic Entry: A Review of Techniques, Technologies, and Complications. George A. Vilos, MD, FRCSC Artin Ternamian, MD, FRCSC Jeffrey Dempster, MD, FRCSC Philippe Y. Laberge, MD, FRCSC, SOGC CLINICAL PRACTICE GUIDELINE, No. 193, May 2007, Reviewed in June 2013 2.Cochrane Review – Laparoscopic entry techniques 2015. Ahmad G1, O'Flynn H, Duffy JM, Phillips K, Watson A.doi: 10.1002/14651858.CD006583.pub4 3. RCOG/BSGE – Green top guideline number 49 – 2008 http://bsge.org.uk/userfiles/file/GtG%20no%2049%20Laparoscopic%20Injury%202008.pdf

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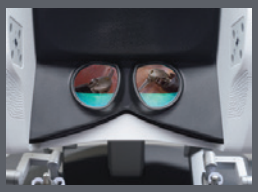

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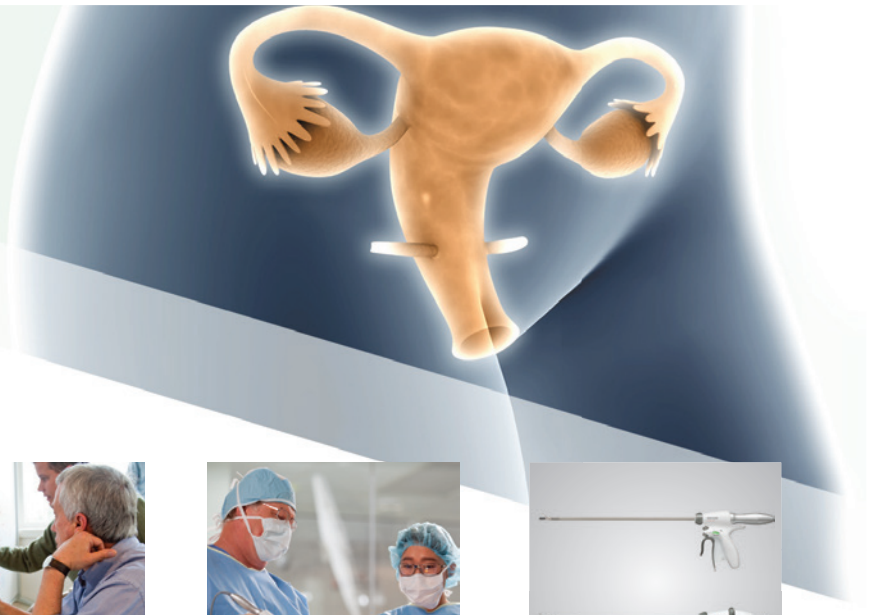

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