AGES XXIX ANNUAL
SCIENTIFIC MEETING 2019

Perfection, Professionalism & Problems

7th – 9th March 2019
Crown Towers, Perth

PROGRAM BOOKLET

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Prof Johannes Evers	NLD
Dr Marcello Ceccaroni	ITA

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Dr Judith Thompson	WA
Dr Pamela Thompson	WA
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A/Prof David Watson	WA
Dr Anthony Williams	WA
Dr Michael Winlo	WA
Dr Michael Wynn-Williams	QLD
A/Prof Anusch Yazdani	QLD
Dr Jessica Yin	WA

CPD POINTS

This meeting is a RANZCOG approved O&G meeting. Fellows of this college can claim 17PD points for full attendance.

MEMBERSHIP OF AGES

Membership application forms are available from the AGES website or from the AGES Secretariat.
https://ages.com.au/membership-application/

AGES CONFERENCE ORGANISERS

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This brochure and online registration are available on the AGES website **www.ages.com.au**

WELCOME LETTER

Dear Colleagues,

Welcome to Perth, Australia's sunniest capital city. Situated on the Swan River, Perth boasts beautiful sandy beaches, one of the world's largest inner city parks - Kings Park, and the Botanic Gardens, which offer a sweeping view of the city from Mount Eliza.

As you will experience over the next three days, the scientific committee has developed a core program that covers three key principles – Professionalism, Perfection & Problems. As always, we continuously strive for perfection in our surgery and patient care and also in teaching and education. We use professionalism in managing this journey and overcoming the many problems that we face as we travel our pathway.

We have a stellar team of international keynote speakers who have joined us for the meeting including Associate Professor Sawsan (Suzie) As-Sanie from the University of Michigan. Suzie is the Director of minimally invasive surgery at the University of Michigan, and is a world-renowned expert in the field of endometriosis and pain. We also have Professor Johannes (Hans) Evers of Maastricht University and Editor in Chief of Human Reproduction that will strengthen the scientific focus of the meeting and look at the scientific evidence basis of fertility management. For the radicals, Dr Marcello Ceccaroni from the International School of Surgical Anatomy in Verona has joined us (previously called the Che Guevara of Surgery). Marcello will give you a view of pelvic anatomy and dissection techniques beyond the realm of normal, including an exciting "Live" surgery session.

We are also lucky to be joined by Professor Jubliee Brown the Vice President of AAGL and Director Gynaecologic Oncology from Levin Cancer Institute in North Carolina as well as Professor Mark Emanuel, renowned hysteroscopic surgeon from the University of Amsterdam.

Along with this amazing international faculty, we have the local and Australasian faculty who have further complemented this team.

The social program will also be a highlight culminating in the Black Tie Dinner at new Optus Stadium on International Women's Day.

We hope you enjoy the coming days and enjoy everything Perth has to offer.

Stuart Salfinger
AGES Vice President
Chair AGES ASM 2019

INVITED INTERNATIONAL FACULTY

A/Prof Sawsan As-Sanie
Director of the Minimally Invasive Gynecologic Surgery Program and Fellowship, and Director of the Endometriosis and Chronic Pelvic Pain Center. University of Michigan, Michigan, USA

Prof Johannes Evers
Professor Emeritus of Obstetrics and Gynaecology. Maastricht University, Maastricht, The Netherlands

Dr Marcello Ceccaroni
Head of the Department of Obstetrics and Gynecology, Gynecologic Oncology and Minimally-Invasive Pelvic Surgery, Sacro Cuore - Don Calabria Hospital Negrar - Verona, Italy

WEDNESDAY 6TH MARCH 2019

Time	Event	Location
0800 - 1700	AGES Advanced Trainee Workshop (Invitation Only)	*Botanical Rooms 1, 2 & 3*
0800 - 1700	Pre-Conference Hysteroscopy Workshop - Sponsored by Medtronic *For more information, please visit the AGES website*	*CTEC, UWA Perth*

THURSDAY 7TH MARCH 2019

Time	Event	Location
0700 - 0800	Conference Registration	*Crown Ballroom Foyer*
0800 - 1000	**SESSION 1: PROFESSIONALISM, PERFECTION AND PROBLEMS** *Session Chairs: Jason Abbott & Stuart Salfinger*	*Crown Ballroom 1*
	Welcome	
	KEYNOTE: Comparing and Contrasting Nerve Sparing Surgical Techniques in Oncological and Endometriosis Surgery - **Marcello Ceccaroni**	
	KEYNOTE: Hysterectomy and Opioids: A Match Made in Hell - **Sawsan As-Sanie**	
	KEYNOTE: Clinical Trials... Is it True, Is it New and Do I Care? - **Johannes Evers**	
	Panel Discussion	
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	

Time	Session 2A	Session 2B
1030 - 1230	**SESSION 2A: THE PROBLEMS OF PAIN** *Session Chairs: Michael Wynn-Williams & Jade Acton* *Crown Ballroom 1*	**SESSION 2B: PERFECTING FERTILITY MANAGEMENT** *Session Chairs: Anusch Yazdani & Rachel Green* *Botanical 2 & 3*
	The Mystery of Pain in Endometriosis - **Sawsan As-Sanie**	Pituitary Pathways and Pregnancy - **Tamara Hunter**
	Peaky Pain and Persistent Problems - **Susan Evans**	Paediatric Problems - **Jennifer Beale**
	To Chop or Not to Chop? What is the Evidence? - **Jason Abbott**	Protecting and Preserving the Ovary - **Kate Stern**
	The P's of Endometriosis - Puberty to Perimenopause - **Erin Nesbitt-Hawes**	Cutting Edge Science... Receptive and Rejective Endometrium - **Jemma Evans**
	Pain and Poo - **Jacinta Cover**	Perfecting PCOS - **Roger Hart**
	Perfection for the Patient - Outpatient Hysteroscopy in Action - **Mark Emanuel**	Fertility's 5 in 5 in 25 - **Johannes Evers**
	Panel Discussion	Panel Discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS *Room: Crown Ballroom 2 & 3*	1300 - 1400 INTERACTIVE HUBS 1 *Crown Ballroom 2 & 3*
1330 - 1500	**SESSION 3A: FREE COMMUNICATIONS** *Session Chairs: Emma Readman & Todd Ladanchuk* *Crown Ballroom 1*	**SESSION 3B: FREE COMMUNICATIONS** *Session Chairs: Krish Karthigasu & Bernadette McElhinney* *Botanical 2 & 3*

Time	Event	Location
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Crown Ballroom 2 & 3*
1530 - 1700	**SESSION 4: THE PERFECT PICTURE - ANATOMY & RADICAL SURGERY** *Session Chairs: Danny Chou & Jennifer Pontre*	*Crown Ballroom 1*
	Surgical Neuroanatomy of Visceral and Somatic System of the Female Pelvis for Nerve-Sparing Surgery - **Marcello Ceccaroni**	
	ABC - Anatomy Before Cutting - **Helen Green**	
	Contempory Anatomy Teaching - **Ruth Blackham**	
	How Do I Upskill in Anatomy Knowledge - **Michael Wynn-Williams**	
	Does Size Matter? Simplifying Surgery for Large Fibroids - Hysterectomy and Myomectomy - **Haider Najjar**	
1700 - 1730	**DAN O'CONNOR LECTURE SESSION** *Session Chair: Stuart Salfinger* Dan O'Connor Lecture - **Roger Hart**	*Crown Ballroom 1*
1730	CLOSE OF DAY ONE	
1730 - 1830	**WELCOME RECEPTION**	*Crown Ballroom 2 & 3*

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

FRIDAY 8TH MARCH 2019

Time	Session	Location
0700 - 0800	Conference Registration	*Crown Ballroom Foyer*
0800 - 1000	**SESSION 5: FEAR THE LIVE DEAD SURGERY** SESSION THEME: LIVE SURGERY *Session Chairs: Stuart Salfinger & Jim Tsaltas*	*Crown Ballroom 1*
0745 - 0845	INTERACTIVE HUBS 2	
0900 - 1000	INTERACTIVE HUBS 3	*Crown Ballroom 2 & 3*
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Crown Ballroom 2 & 3*

1030 - 1230

SESSION 6A: PROGRESSING ENDOMETRIOSIS *Session Chairs: Ajay Rane & Emma Readman* *Crown Ballroom 1*	SESSION 6B: PRACTICAL PROBLEMS *Session Chairs: Bassem Gerges & Jennifer Pontre* *Botanical 2 & 3*
KEYNOTE: Endometriosis Enigmas - **Sawsan As-Sanie**	Bowel Prep, Bowel Adhesions and Bowel Repair - Is this the Gynaecologists Nightmare? - **Stephanie Chetrit**
	P's & Q's - Letters from a Urologist to a Gynaecologist - **Trent Barrett**
I Don't Want Drugs, Is There Something Natural I Can Do? - **Tracy Gaibisso**	Pulsations, Piercings and Puddles - **Marek Garbowski**
Picture Perfect - **Glen Lo**	The Plastics Perspective - **Anthony Williams**
MDT for Endometriosis - **Nicola English**	Professionally Managing Poor Outcomes - **David Watson**
Perfecting the Pit Stop - **Stephen Lyons**	Personal Risk Reduction Surgery - **Ai Ling Tan**
Panel Discussion	Pop it in a Bag - Protecting Your Patient and Their Specimen - **Danny Chou**
	Panel Discussion

Time	Session	Location
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Crown Ballroom 2 & 3*
1250 - 1350	INTERACTIVE HUBS 4	*Crown Ballroom 2 & 3*
1330 - 1500	**SESSION 7: CHAIRMAN'S CHOICE** *Session Chairs: Krish Karthigasu & Jade Acton*	*Crown Ballroom 1*
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Crown Ballroom 2 & 3*

1530 - 1630

SESSION 8A: PECHAKUCHA'S *Session Chairs: Haider Najjar & Rachel Green* *Crown Ballroom 1*	SESSION 8B: PECHAKUCHA'S *Session Chairs: Simon Edmonds & Helen Green* *Botanical 2 & 3*
New Therapeutic Advances in Endometriosis, SERM, AI and Others - **Bernadette McElhinney**	Eggs on Ice - (Pimp my Ovary) - **Raelia Lew**
Personality and Pain - **Robert Schütze**	Strategies for Preserving Ovarian Function During Surgery for Endometriosis - **Anusch Yazdani**
Patient Resources - What and How and Do They Work? - **Katya Fleming**	Fibroids, Fertility and Pregnancy - What Does the Data Show? - **Krish Karthigasu**
When to Re-scope - My Pain is No Better - **Emma Readman**	Genetics for Idiots - **Tristan Hardy**
Physio for Pelvic Pain - **Judith Thompson**	Pain in my Perineum - **Robyn Leake**
Problematic Post-op Pain - **Philip Kriel**	Itchy Scratchy - **Bernadette Ricciardo**
Oestrogen - What Type Given, How and When? - **Jennifer Pontre**	Vaginal Organisms: Friend or Foe - Management of RVVC - **Sally Murray**

Time	Session	Location
1630 - 1650	Challenges and Accomplishments in the Conduct of Modern MIS Trials - **Jubilee Brown**	*Crown Ballroom 1*
1650	CLOSE OF DAY TWO	*Crown Ballroom 1*
1650 - 1725	AGES Annual General Meeting	*Crown Ballroom 1*
1810 - 2300	**AGES ANNUAL BLACK TIE GALA DINNER, AWARDS & CHARITY AUCTION** (Buses depart at 6.10pm for a 6.30pm arrival for pre-dinner drinks)	*Optus Stadium*

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SATURDAY 9TH MARCH 2019

Time	Session	Location
0700 - 0745	Women in Surgery Breakfast - **Anna Nowak**	*The Studio*
0730 - 0800	Conference Registration	*Crown Ballroom Foyer*

Time	Session 9A	Session 9B
0800 - 1000	**SESSION 9A: WAKEY WAKEY - OBSTETRICS & UROGYN** *Session Chairs: Stephen Lyons & Melissa O'Neil* *Crown Ballroom 1*	**SESSION 9B: TECHNOLOGY, BREAST DISEASE & MENOPAUSE** *Session Chairs: Tamara Hunter & Supuni Kapurubandara* *Botanical 2 & 3*
	Obstetrics Has ARRIVED - Induction for All - **Richard Murphy**	The Virtual Shared Medical Record - **Joseph Sgroi**
	Please Don't Mess with My Biome - Does Caesarean Section Really Affect the Neonate? - **Lisa Stinson**	Gadget Geek Live - **Mark Ruff**
	Planning for Perfection in the Imperfect World - How to Combat Placental Invasion - **Mathais Epee-Bekima**	Big Data Collection for the Future - **Michael Winlo**
	Preventing Coagulopathy as the Patient Bleeds - **Roger Browning**	Patient Experience and Modern Technology - **Marcus Tan**
	Proper Perfusion at Placental Invasion - an Anaesthetic Perspecive - **Nolan McDonnell**	Who Needs to See a Geneticist - **Nicholas Pachter**
	Problems With My Pee After Surgery - **Todd Ladanchuk**	Practical Breast Disease - **Pamela Thompson**
	Pondering Urodynamics - Are They Really that Helpful? - **Nicolas Tsokos**	High Risk Breast Patients - Managemnent in the MDT - **Christobel Saunders**
	The Perfect Mesh in the Current Climate - **Jessica Yin**	Managing Menopausal Symptoms after Breast Cancer - **Paul Cohen**

Time	Session	Location
1000 - 1030	MORNING TEA & TRADE EXHIBITION	*Crown Ballroom 2 & 3*
1030 - 1305	**SESSION 10: PROFESSIONALISM IN PRACTICE** *Session Chairs: Stuart Salfinger & Kirsten Connan*	*Crown Ballroom 1*
	BULLSHIFT: Get More Openness, Honesty and Straight Talk at Work - **Andrew Horabin**	
	Panel Discussion	
	Professionalism in Practice - **Paul McGurgan**	
	What Makes a Good Team in Theatre? - **Joseph Carpini**	
	Montgomery Decision - **Saul Holt QC**	
	It's All in My Head - **Jade Acton**	
	Management Versus Leadership - Apples and Oranges - **Aleksandra Luksyte**	
	Elite Teams - Playing Field to Practice - **Ashleigh Nelson**	
	Panel Discussion	
1305	CLOSE OF DAY THREE & LUNCH ON THE GO	*Crown Ballroom Foyer*

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SOCIAL MEDIA

Follow us on social media!!

Facebook - *https://www.facebook.com/agessociety/*

Instagram - *https://www.instagram.com/ages_society/* or *@ages_society*

LinkedIn - *https://www.linkedin.com/company/ages---australasian-gynaecological-endoscopy-and-surgery-society-limited*

WOMEN IN SURGERY BREAKFAST

SATURDAY 9TH MARCH, 7.00AM - 7.45AM
ROOM: THE STUDIO
Pre-registration essential – limited spots available – please see the registration desk for more information and to register

SOCIAL PROGRAM

PRE-REGISTRATION ESSENTIAL

Welcome Reception
Crown Ballroom 2 & 3,
Crown Perth Convention Centre
Thursday 7th March 2019
5.30pm – 6.30pm

AGES Annual Black Tie Gala Dinner, Awards & Charity Auction
Optus Stadium
Friday, 8th March 2019
6.10pm - late
Ticket cost: $145.00

AGES INTERACTIVE HUBS

AGES is proud to once again present our Interactive Hubs, delivered in conjunction with our Industry Partners. The Interactive Hub is the AGES Society's response to the changing needs of our members and industry partners. The Hub experience is a Members only experience, and places may still be available!!

Interactive Hub sessions will be held during the ASM on Thursday, 7th March at 1.00pm, Friday 8th March at 7.45am, 9.00am and 12.50pm.

Please visit the conference website to see more information on the industry sponsors hubs.

Stryker | Medtronic |Applied Medical | Device Technologies |Ethicon | Hologic | Karl Storz | Olympus

FEAR THE LIVE DEAD SURGERY

Friday 8th March broadcasted live from CTEC, Perth!

Dr Marcello Ceccaroni | Dr Michael Wynn-Williams | Dr Danny Chou

PRIZES & AWARDS

Best Free Communication Presentation
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Outstanding New Presenter
Sponsored by Ethicon

Outstanding Video Presentation
Sponsored by Device Technologies

Outstanding Trainee Presentation
The Platinum Laparoscope Award
Sponsored by Stryker & AGES

Best Digital Communications Presentation
Sponsored by AGES

AGES Travelling Fellowship 2019
Sponsored by Medtronic

AGES-AAGL Exchange Lecture
Sponsored by AGES

Prizes & Awards will be presented at the AGES Annual Black Tie Gala Dinner, Awards & Charity Auction

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AGES MEMBERSHIP
JOIN FOR 2019 MEMBER BENEFITS:

- Attend all three AGES Meetings in 2019 for only $1,500.00, saving of up to 50% per meeting. Only applicable for 3+ year members (closed 31st January 2019).
- Savings of up to 15% on member registration fees for AGES meetings.
- Exclusive access to the new "AGES Video Library – Members only".
- Eligibility to register for the AGES LAP-D Laparoscopic Pelvic Anatomy Dissection & Demonstration Workshops
- Eligibility to register for the AGES Interactive Hubs.
- Eligibility to apply for AGES Research Grants.
- Complimentary subscription to SurgicalPerformance self-auditing Software and AGES/SurgicalPerformance webinars.
- Complimentary subscription to the Journal of Minimally Invasive Gynaecology (formerly AAGL Journal).
- Option to subscribe to the International Urogynaecology Journal instead of JMIG for an additional fee.
- AGES electronic-newsletter, eScope, published four times annually.
- Eligibility to register for the "Who do you want to be when you grow up" Seminars.
- Member access to AGES website and resources.
- Downloadable "AGES Member Icon" available for use in signature blocks and websites.
- Listing on the Membership Directory of the AGES website.
- Eligibility to apply for a position in the AGES Training Program in Gynaecological Endoscopy

AGES ART PRIZE & CHARITY AUCTION

AGES is pleased to announce Shannon Hamilton as the 2018/2019 AGES Society Art Prize winner.

Shannon Hamilton creates appealing, familiar and exciting contemporary artwork which has found popularity throughout Australia and overseas. Having loved art from a young age, Shannon developed her unique self-taught style during her career as an occupational therapist. Giving away occupational therapy in 2000 to explore her own potential, Shannon has gone on to achieve outstanding success. Her paintings feature strong, bold strokes of colour, tastefully capturing the sensuality of the human form in the warmth of Australian sunlight. Her world travels have enabled Shannon to draw inspiration from African and Asian cultures with a focus on warmth of human relationships, especially that of mother and child.

Shannon is becoming increasingly known for her soulful works depicting such universal human moments whilst remaining characteristically Australian. Most of Shannon's works are now sold studio direct, with buyers enjoying the experience of connecting directly with the artist. Her artistic flair is also sought by those looking to find artwork to fit a particular space in homes, offices and newly developed buildings. Shannon's works include the use of chalk pastels, oils on canvas/board and mixed media.

The artworks will be auctioned at the AGES Annual Black Tie Charity Auction & Awards Gala Dinner on Friday 8th March 2019 at Optus Stadium. The proceeds of the Charity Auction will be donated to a charity of the Board's choice.

We do hope you are able to join us on this vibrant and fun-filled night. To enquire about a ticket to Black Tie Gala Dinner, please visit the registration desk.

For more information please visit the website – **www.ages.com.au**

AGES Events 2019/2020

AGES LAP-D Workshop
MERF QUT, Brisbane

Dissection Workshop:
25th & 26th May 2019
30th November 2019

MAY 26 | MAY 25 | NOVEMBER 30

Demonstration Workshop:
17th August 2019

AUGUST 17

AGES SEMINAR

AGES "Who do you want to be when you grow up?" Seminars 2019
Dates and locations coming soon.

Please check the website for more information

AGES/RANZCOG Trainee Workshop 2019
Brisbane
22nd & 23rd June 2019

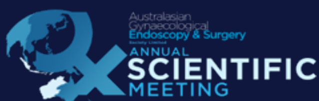
JUNE 22 | JUNE 23

AGES Focus Meeting 2019
in conjunction with The World Endometriosis Society
Grand Hyatt, Melbourne
2nd & 3rd August 2019

AUGUST 2 | AUGUST 3

AGES Pelvic Floor Symposium 2019
Sheraton on the Park, Sydney
1st & 2nd November 2019

NOVEMBER 1 | NOVEMBER 2

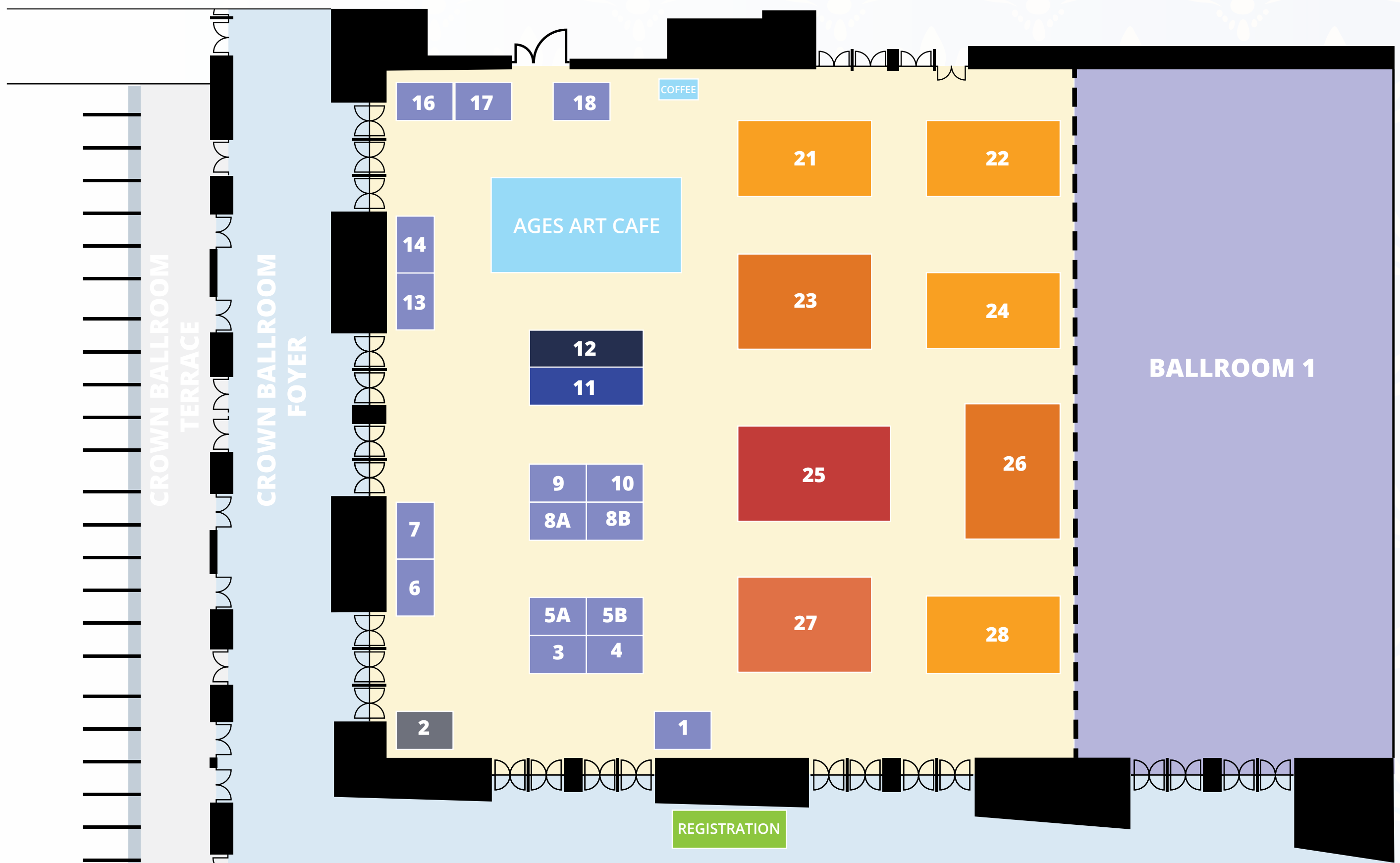


AGES XXX Annual Scientific Meeting 2020
Hyatt Regency, Sydney
5th - 7th March 2020

MARCH 5 | MARCH 6 | MARCH 7

https://ages.com.au/ages-events/

FLOORPLAN



1 Western Diagnostic Pathology
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4 ConMed
5A Baxter
5B Clinipath Pathology
6 Endotherapeutics
7 LifeHealthcare
8A rural LAP
8B The O.R. Company
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10 High Tech Medical
11 Videra
12 Avant
13 Medical Devices
14 Cook Medical
16 Medical Developments International
17 Lumenis
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21 Ethicon
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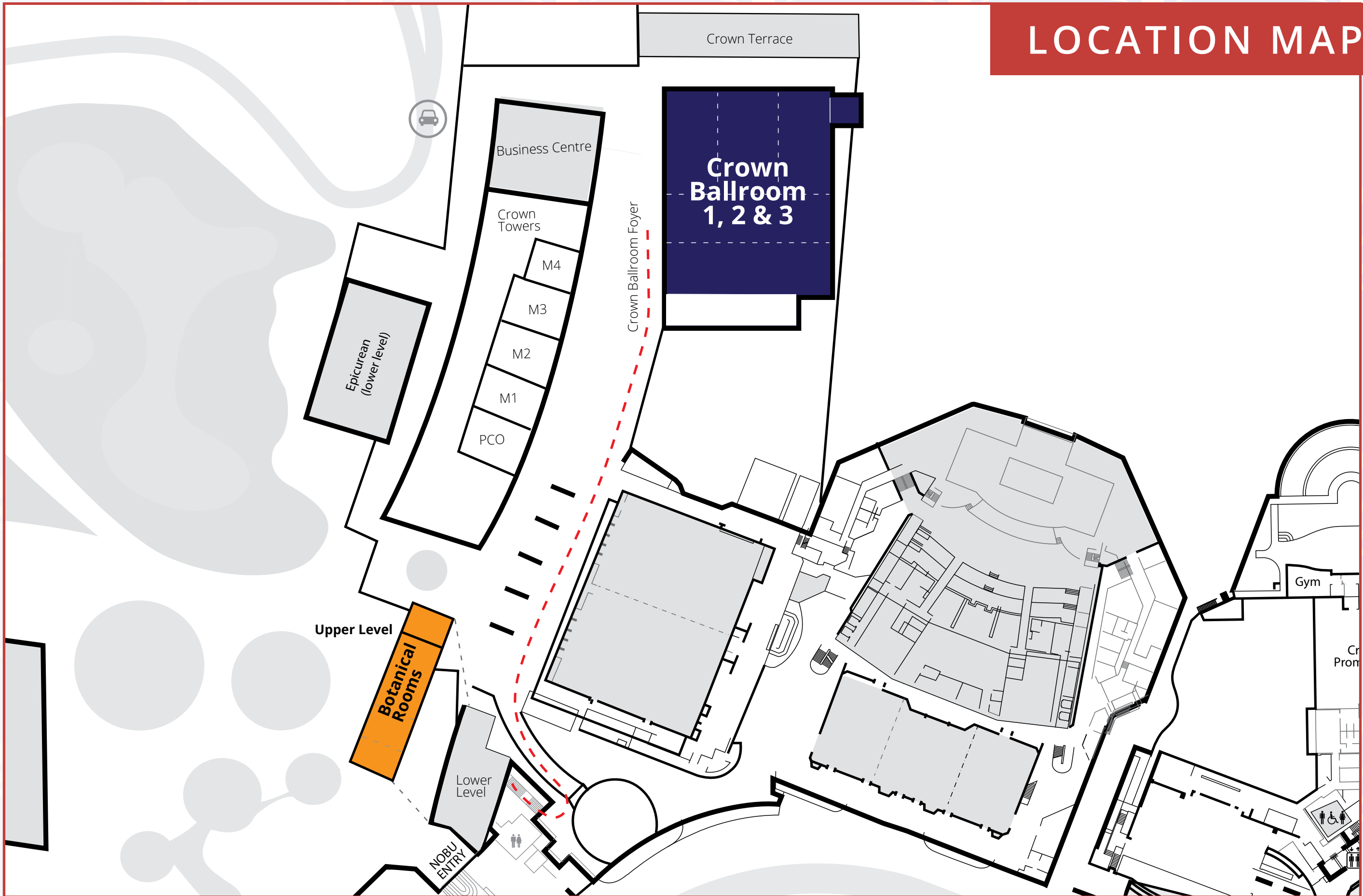
23 Device Technologies
24 Olympus
25 Stryker
26 Applied Medical
27 Medtronic
28 Karl Storz

LOCATION MAP



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STRYKER

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MEDTRONIC

As a global leader in medical technology, services and solutions, Medtronic improves the health and lives of millions of people each year. We believe our deep clinical, therapeutic and economic expertise can help address the complex challenges — such as rising costs, aging populations, and the burden of chronic disease — faced by families and healthcare systems today. But, we can't do it alone. That's why we're committed to partnering in new ways and developing powerful solutions that deliver better patient outcomes.

Founded in 1949 as a medical repair company, we're now among the world's largest medical technology, services and solutions companies, employing more than 85,000 people worldwide, serving physicians, hospitals and patients in more than 160 countries. Join us in our commitment to take healthcare Further, Together. Learn more at Medtronic.com.au.

APPLIED MEDICAL

Applied Medical is a global medical device company based in Southern California. Applied Medical designs, develops and manufactures innovative technologies that advance minimally invasive surgery and enhance patient outcomes.

A high level of vertical integration, along with unparalleled investment in research, development and world-leading manufacturing processes, allows Applied Medical to respond quickly to surgeon feedback and meet evolving clinical needs. This is exemplified by the rapid evolution of the Voyant® intelligent energy system.

Applied Medical's long-standing commitment to clinical training, surgical education programs and symposia places special emphasis on enhancing minimally invasive skills and improving clinical outcomes.

As a new generation medical device company, Applied Medical is equally committed to improving the accessibility and affordability of high-quality healthcare globally.

DEVICE TECHNOLOGIES

For over 25 years, Device Technologies has been pioneering possibility in the Australasian healthcare landscape – seeking out and bringing to market, some of the world's most advanced healthcare products. From high-quality consumables to advanced theatre equipment and robotics, Device Technologies is Australasia's largest independent provider of medical solutions and technologies. Partnering with the world's most innovative medical companies, we offer a comprehensive range of supplies with client care at the core of our values. Our dedicated team of over 650 highly skilled healthcare specialists and support staff, is committed to providing superior outcomes for healthcare professionals and their patients across the entire healthcare community.

ETHICON

Johnson & Johnson Medical Devices produces a range of innovative products and solutions used primarily by healthcare professionals in the fields of gynaecology, orthopaedics, neurovascular, surgery, vision care, diabetes care, infection prevention, cardiovascular disease, sports medicine, oncology and aesthetics.

Johnson & Johnson Medical Devices believes that innovation is critical to our mission of caring and saving lives. We are uniquely positioned to lead the advancement of health care delivery by developing customer-focused solutions and collaborating to bring innovation to life. Locally, we embrace innovation through local partnerships and programs that help shape the medical technology industry.

KARL STORZ

Since its beginnings in 1945, KARL STORZ has established itself globally as a world leader in the production and distribution of endoscopes, medical devices, and cameras. KARL STORZ Endoscopy Australia is a wholly owned affiliate of KARL STORZ SE & Co. KG and the parent company remains owned by the STORZ family. The majority of manufacturing is carried out in Tuttlingen, Germany where the art of instrument making is alive and well.

We will be proudly exhibiting the KARL STORZ range of instruments which will include the latest in Operative Hysteroscopy, Virtual Reality Trainers, Laparoscopic Instrumentation plus Endoscopic Camera Systems including 4K and 3D technology.

HOLOGIC

We enable healthier lives everywhere, every day. As global champions of women's health, we bring The Science of Sure® to life by helping healthcare professionals minimise doubt and maximise the confidence in their decisions and diagnoses.

OLYMPUS

Since its inception in 1919, Olympus has continuously innovated and evolved to become one of the world's leading medical technology manufacturers. With products spanning multiple medical specialties, Olympus has been able to help transform the endoscopy and surgical landscape by providing technology to enable safer, faster and more accurate procedures.

AVANT MUTUAL

Avant Mutual – by doctors for doctors

Avant has a proud heritage of protecting the Australian medical profession that spans over 120 years. Established by a small group of doctors as a mutual in 1893, Avant is now Australia's leading medical defence organisation, representing over 75,000 healthcare practitioners and students across every state and territory.

PROGRAM ABSTRACTS

THURSDAY 7TH MARCH 2019

SESSION ONE: PROFESSIONALISM, PERFECTION AND PROBLEMS / 0800 -1000

CROWN BALLROOM 1

KEYNOTE: Comparing and Contrasting Nerve Sparing Surgical Techniques in Oncological and Endometriosis Surgery

Marcello Ceccaroni[1]

1. Department of Obstetrics and Gynaecology, Gynaecologic Oncology and Minimally-Invasive Pelvic Surgery, Sacro Cuore – Don Calabria Hospital Negrar, Verona, Italy

Abstract not provided.

KETNOTE: Hysterectomy and opioids: A match made in hell

Sawsan As-Sanie[1]

1. University of Michigan, Michigan, United States

Abstract not provided

KEYNOTE: Clinical trials… Is it true, is it new and do I care?

Johannes Evers[1]

1. Maastricht University, Maastricht, Netherlands

Abstract not provided

Challenges and Accomplishments in the Conduct of Modern MIS Trials

Jubilee Brown[1]

1. AAGL, Charlotte, United States

Abstract not available

SESSION TWO A: THE PROBLEMS OF PAIN / 1030-1230

CROWN BALLROOM 1

The Mystery of Pain in Endometriosis

Sawsan As-Sanie[1]
1. University of Michigan, Michigan, United States

Abstract not provided

Peaky Pain and Persistent Problems

Susan Evans[1]
1. Pelvic Pain SA, Norwood, SA, Australia

What to do???

Your surgery was beautiful, but she's having a flare of pelvic pain, and life is hard: for both of you.

Practical information on how to prevent, understand, and manage flares of pelvic pain in your surgical patients.

Then everyone's happy!

To Chop or Not to Chop? What is the Evidence?

Jason Abbott[1]
1. University of New South Wales, Sydney

Abstract not provided

The P's of endometriosis - Puberty to perimenopause

Erin Nesbitt-Hawes[1]
1. Royal Hospital for Women, Randwick, NSW

Endometriosis affects women across all reproductive ages, from puberty to perimenopause. This presentation will outline different clinical presentations and treatment options across these years. Topics covered include the evaluation of women with pain throughout their reproductive life, when to be clinically suspicious of pain in young women, as well as when to laparoscope.

Pain and poo

Jacinta Cover[1]
1. WA, Australia

A discussion on functional bowel disorders and defecation and how to appropriately investigate and manage.

Perfection for the patient - Outpatient hysteroscopy in action

Mark Emanuel[1]
1. University Medical Centre, Utrecht, The Netherlands

With the advances in minituarization of instruments office hysteroscopy is becoming more and more the standard to explore and treat intrauterine pathology. Patients usually appreciate an efficient 'see and treat' procedure, however a cornerstone of this approach is that the patient's experience is acceptable and preferably at the lowest level of pain. A review of current range of opinions and evidence on which the optimal approach is based is offered.

SESSION TWO B: PERFECTING FERTILITY MANAGEMENT / 1030-1230

BOTANICAL 2 & 3

Pituitary Pathways and Pregnancy

Tamara Hunter[1]
1. Dr Tamara Hunter Gynaecologist and Fertility Expert, Perth, WA, Australia

Abstract not yet received

Paediatric Problems

Jennifer Beale[1]
1. King Edward Memorial Hospital, Perth, Western Australia

Müllerian anomalies may first present in the paediatric and adolescent population. This presentation will cover various Müllerian anomalies, discuss how to diagnose them, and review safe management and treatment options.

Protecting and preserving the ovary

Kate Stern[1]
1. Melbourne IVF, East Melbourne, VIC, Australia

Ovarian tissue cryopreservation and grafting is no longer considered experimental. Although most of the grafts function with ovarian hormone production, obtaining good quality oocytes that make good quality embryos is still challenging. Once embryos are transferred, clinical pregnancy rates are acceptable. This form of fertility preservation can potentially provide a large supply of gametes and is the only preservation option for prepubertal girls. Livebirths have now been reported from tissue taken from prepubertal girls. An additional challenge is attempting to "(re)activate" ovarian activity in young women with evidence of premature ovarian insufficiency.

Cutting edge science...Receptive and rejective endometrium

Jemma Evans[1]
1. The Hudson Institute of Medical Research, Clayton, VIC, Australia

As fertile soil is needed for a seed to grow, so too is a receptive endometrium needed for an embryo to implant and develop. Optimal receptivity is achieved during the mid-secretory phase of menstrual cycles, termed the 'window of implantation'. However, this window may be absent or shifted in IVF cycles or in women with infertility and can be accessed via the endometrial receptivity array (ERA). Receptivity is a term used to describe the state of uterine 'readiness' to accept an embryo encompassing the tissue itself, the uterine secretions and the uterine response to embryonic signals. In infertile women, the endometrium may be refractory to implantation, such that implantation never occurs, or super-receptive, allowing implantation of sub-optimal embryos that result in early miscarriage due to an absence of appropriate 'quality

control' mechanisms. Similar to Goldilocks and her porridge, the endometrium must be 'just right' in terms of receptivity and stringency.

Perfecting PCOS

Roger Hart[1]

1. University of Western Australia & Fertility Specialists of WA, Subiaco, WA, Australia

This short lecture will cover the new International Guidelines for the management of women with the polycystic ovary syndrome with particular emphasis on the infertility management of women with PCOS. It will also offer an insight into challenges of weight management, psychological consequences of the condition, and the longer-term health outcomes for women with PCOS

Fertility's 5 in 5 in 25

Johannes Evers[1]

1. Maastricht University, Maastricht, Netherlands

Abstract not yet provided

SESSION THREE A: FREE COMMUNICATIONS / 1330-1500

CROWN BALLROOM 1

Contained Power Morcellation: a multicentre Australian experience

Dean Conrad[1], Tal D Saar[1], Mansour Al-Shamari[1], Samuel Daniels[1], Praveen De Silva[1], Sarah Choi[1], David MB Rosen[1], Michael Wynn-Williams[2], Danny Chou[1], Gregory M Cario[1]

1. St George Private Hospital, Sydney Women's Endosurgery Centre (SWEC), Kogarah, NSW, Australia

2. Eve Health, Brisbane, QLD, Australia

Publish consent withheld

Are we ready for surgery?

Aaron Budden[1, 2], Sophia Song[2], Jason Abbott[1, 2]

1. Royal hospital for women, Randwick, NSW, Australia

2. University of New South Wales, Sydney, Australia

Background: Physician burnout may affect 12-58% of physicians, with surgeons and gynaecologists more likely affected than other physicians (1, 2). Job stress is an important factor associated with physician burnout (1), with stressors defined as events posing a threat in the context of dispositional and environmental factors. Perceived stress stimulates physiological changes impacting cardiovascular and immune systems, with evidence that excessive stress has a deleterious effect on performance (3). We aim to understand if surgeons are prepared for the stress of the surgery they undertake.

Methods: A prospective cohort study involving gynaecological specialists and trainees performing elective laparoscopic hysterectomy, laparoscopic excision of rASRM stage III/IV endometriosis, and hysteroscopic resection of leiomyoma. Participants completed the State-Trait Anxiety Inventory (STAI) and visual analogue scale (VAS) of perceived stress prior to and immediately after completion of the procedure. Relationships between Trait anxiety and State anxiety prior to procedure, changes in State anxiety score, and the correlation between VAS and State anxiety were examined.

Results: Participants were 6 specialists and 10 trainees with trainees starting as primary surgeon in 65 cases (72.2%) with completion by the specialist required in 30 (46.2%) cases. Mean Trait score was 34 with trainees displaying higher scores

than specialists (40.1 vs. 28.5, $p < 0.001$) and mean state score pre-procedure was 33.6 with higher scores in trainees (39.2 vs. 28.5, $p < 0.01$). Specialist State scores were significantly higher when supervising trainees compared to being the primary surgeon (37.2 vs. 29.1, $p < 0.01$). State anxiety scores increased by 3.8 (-24 to 36) with no differences identified when stratified by trainee or specialist (4.3 vs. 3.4, $p = 0.49$) or when the trainee began the operation compared to the specialist (4.6 vs. 1.7, $p = 0.078$). Intervention by the specialist was related to significantly elevated State score (7.9 vs. 1.6, $p < 0.001$) with trainee score changes (8.3 vs. 1.3, $p < 0.001$) affected compared to specialists (7.1 vs 1.7, $p = 0.101$). Pre-procedure State score and VAS were highly correlated ($r=0.682$, $p < 0.01$) as was the changes in State score and VAS ($r=0.53$, $p < 0.01$).

Conclusion: Trainees demonstrate higher trait and state anxiety scores that may contribute towards surgical performance, with increased scores following specialist intervention in the procedure. Further research into the identification of when trainees transition from adaptive stress to maladaptive stress would benefit surgical education programs.

1. Cass I, Duska LR, Blank SV, Cheng G, DuPont N, Frederick PJ, et al. Stress and burnout among gynecologic oncologists: a society of gynecologic oncology evidence-based review and recommendations. Gynecologic Oncology. 2016;143:421-7.
2. Dimou FM, Eckelbarger D, Riall TS. Surgeon burnout: a systematic review. J Am Coll Surg. 2016;222(6):1230-9.
3. Glaser R, Kiecolt-Claser JK. Sterss-induced immune dysfunction: implications for health. Nature. 2005;5:243-51.

Neuropelveology – topographic, surgical and functional anatomy of autonomic and somatic pelvic nerve systems and its clinical applications in gynaecologic pelvic surgery.

Sarah Choi[1], Dean Conrad[1], Tal Saar[1], Mansour Alshamari[1], Gregory Cario[1], Danny Chou[1], David Rosen[1]

1. Sydney Women's Endosurgery Centre, Sydney, NSW

This video presentation demonstrates the functional and surgical anatomy of pelvic nerve systems as described in the newly emerging specialty Neuropelveology pioneered by Professor Marc Possover.(1) With the use of anatomical diagrams and video footages from live surgeries and cadaveric dissection of the authors, topographic anatomy and laparoscopic surgical anatomy of individual pelvic nerves, nerve plexuses and nerve roots are illustrated. The clinical applications of neuropelveology in gynaecology and pelvic surgery, such as nerve-sparing endometriotic surgery(2), chronic pain diagnosis and management, somatic neuropathy and management of surgical complications, are discussed.

1. Neuropelveology: An Emerging Discipline for the Management of Chronic Pelvic Pain. Marc Possover, Karl-Erik Andersson, Axel Forman. Int Neurourol J. 2017 Dec; 21(4): 243–246. 2. Nerve-sparing laparoscopic eradication of deep endometriosis with segmental rectal and parametrial resection: the Negrar method. A single-center, prospective, clinical trial. Ceccaroni M1, Clarizia R, Bruni F, D'Urso E, Gagliardi ML, Roviglione G, Minelli L, Ruffo G. Surg Endosc. 2012 Jul;26(7):2029-45.

Neuropelveology: Why do we need to know about pelvic nerves?

Danny Chou[1], Sarah Choi[1], Dean Conrad[1], Tal Saar[1], Mansour Alshamari[1], Michael Wynn-Williams[2], David Rosen[1], Greg Cario[1]

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

2. Eve Health, Brisbane, QLD

Gynaecological surgery is constantly evolving and continually refined, examples of which, include the use of da Vinci robotic platform, contained in-bag morcellation and concept of nerve sparing pelvic surgery, just to name a few. With our extended surgical ability, we are increasingly dealing with more complex pathologies that may extend or lie beyond our traditional anatomical boundaries, where unfamiliar structures could be encountered, including pelvic nerves. Pelvic neuroanatomy has traditionally been poorly understood not only by our own specialty and detrimental neuro-ablative procedures have been unknowingly performed such as presacral neurectomy. The newly founded discipline of Neuropelveology fills this void thanks to the pioneering work of Prof Marc Possover.

Neuropelveology is a new surgical discipline with focus on nervous systems in and around the pelvis. Comprehensive knowledge of surgical and functional pelvic neuro-anatomy minimizes harm to the pelvic nerves facilitating the concept of nerve sparing approach that has been expanded to benign gynaecological surgeries including that of deeply infiltrative endometriosis and pelvic organ prolapse surgery such as mesh sacrocolpopexy.

Neuropelveological assessment adapts clinical neurological approach to aid diagnosis and treatment of conditions that can affects pelvic nerves such as deeply infiltrating endometriosis, vascular entrapment, surgical complications, neuropathic pain and rarely pelvic tumors. More advance application of Neuropelveology include implantation of stimulating electrodes for both chronic pain management and aiding in ambulation in patients with spinal cord injury.

This presentation will outline the pelvic nerves; highlight the scope of clinical application of Neuropelveology with emphasis on practical and clinically useful pelvic neuroanatomical knowledge.

Neuropelveology online course can be accessed on http://www.theison.org

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Removing the large Uterus WITHOUT morcellation – The Colpo-V incision for specimen extraction at Hysterectomy

Dean H Conrad[1], **Tal D Saar** [1], **Mansour Al-Shamari** [1], **Samuel Daniels** [1], **Praveen De Silva** [1], **Sarah Choi** [1], **Danny Chou** [1], **Gregory M Cario** [1], **David MB Rosen** [1]

1. St George Private Hospital, Sydney Women's Endosurgery Centre (SWEC), Kogarah, NSW, Australia

The benefits of avoiding laparotomy for benign gynaecological disease are well documented (1). However, removing large masses from the abdomen without enlarging laparoscopic incisions has proved challenging. Laparoscopic power morcellators overcame this problem until the highly publicised case of a disseminated uterine sarcoma lead to the 2014 FDA statement discouraging their use (2). The RANZCOG position statement further highlights the potential risks of morcellation, including disseminating benign disease (endometriosis and parasitic fibroids) and the potential risks of inadvertent patient injuries during the morcellation process (3). Although contained morcellation techniques have shown promise in avoiding these risks, the large volumes of small dissociated fragments with the loss of anatomical relationships associated with morcellation continue to cause diagnostic challenges for pathologists (3).

An alternative to performing a laparotomy is to enlarge the colpotomy utilising a technique we refer to as the colop-V. A posterior vertical incision expands the size of the vaginal opening, allowing larger uteri to be removed intact. The colpo-V avoids the need for morcellation while maintaining the benefits of the minimally invasive approach.

The colpo-V was performed in 14 patients undergoing minimally invasive hysterectomies for benign disease between December 2017 and November 2018 by a single surgeon in a private hospital setting. Demographic, intraoperative and 6 week post-operative data was retrospectively collected. Patients' mean age was 50 years with and a mean BMI of 26. Specimen weight ranged from 181 grams to 940 grams, with a mean weight of 373 grams. There were no intra or post-operative complications associated with the colpo-V incision.

In conclusion, the colpo-V is a safe and simple technique to remove larger uterine specimens without the need for morcellation or laparotomy.

1. Nieboer TE, Johnson N, Lethaby A, et al. Surgical approach to hysterectomy for benign gynaecological disease. Cochrane Database System Rev. 2009;3.
2. RANZCOG position statement. Tissue Extraction at Minimally Invasive Procedures (C-Gyn 33). March 2017
3. Laparoscopic Uterine Power Morcellation in Hysterectomy and Myomectomy: FDA Safety Communication. April 2014

Single Versus Double Layer Closure in Total Laparoscopic Hysterectomy

Sanjna Gangakhedkar[1], **Lakshmi Ravikanti**[2], **Ved Prakash Singh**[2], **Pip Walker**[2]

1. University of New England, Armidale , NSW, Australia

2. Anglesea Gynaecology , Hamilton, North Island, New Zealand

Background:

The use of double-layer sutures in laparoscopic hysterectomy has become a common practice among gynaecologic surgeons. Neither approach has shown to be more superior over the other. The purpose of this study is to compare the clinical outcomes of single-layer versus double- layer vault closure, following a total laparoscopic hysterectomy.

Aims:

Our primary outcome was to compare rate of vault dehiscence in patients who had a one-layer closure versus patients who had a two -layer closure. Secondary outcomes included evaluation of other post-operative complications; any complaint of vaginal bleeding and/or the formation of granulation tissue.

Materials and Methods:

A retrospective study was conducted on 114 patients who underwent a total laparoscopic hysterectomy (TLH) and bilateral salpingectomy at Anglesea Gynaecology and Anglesea Private Hospital between May 2014 and September 2016. Patients with cancer and those that required pelvic floor repair were excluded. All cases were performed by the same two surgeons. Patient information regarding complications of vault dehiscence, vaginal bleeding and/or granulation tissue was obtained from their 2 and 8-week follow-up post-appointment visits.

Results:

Fifty-four patients had a continuous single-layer closure and 60 patients had a double-layer continuous suture closure. In all patients 2.0 polydioxanone (PDS) V-LOC suture was used. Patient demographics were similar between both groups. The primary outcome of vault dehiscence was only seen in one patient from the single-layer suture group (1.85%), thus no inference can be drawn due to the limited sample size (n = 114). The incidence of post-operative vault tissue granulation was higher in the single layer closure group than the double-layer group (9.26%) and (1.67%) respectively, (NNT 13.2, OR 5.6,). There were 8 cases of post-operative vaginal bleeding in the single layer closure group (14.81%) and none in the double layer closure group.

Conclusion:

There were no significant differences observed in primary outcomes between single- or double-layer vault closure suturing techniques. However, double-layer closure of the vaginal vault was associated with fewer instances of granulation tissue and bleeding when compared to single-layer closure. These outcomes can be investigated further with a greater sample size.

1. Shen CC, Hsu TY, Huang FJ, Roan CJ, Weng HH, Chang HW, et al. Comparison of one- and two-layer vaginal cuff closure and open vaginal cuff during laparoscopic-assisted vaginal hysterectomy. The Journal of the American Association of Gynecologic Laparoscopists. 2002;9(4):474-80.
2. Yildirim D, Ozyurek SE, Kiyak H, Han A, Koroglu N, Bestel A, et al. Single-layer versus double-layer closure of the vaginal cuff with barbed sutures in laparoscopic hysterectomy. Ginekologia Polska. 2018;89(5):229-34.

Mater Laparoscopic Box-Trainer Update: Motivating Our Trainees

Albert Jung[1], Sarah Janssens[1], Erin Wilson[1]

1. Mater Mothers' Hospital, South Brisbane, QUEENSLAND, Australia

Introduction:

Laparoscopic simulation training through the use of a box-trainer has been demonstrated to improve hand-eye coordination, laparoscopic proficiency and safety.[1] Fortunately this is being adopted by many departments on both a formal and informal basis. However, getting gynaecology trainees to adopt these training resources has been more challenging. [2,3]

Methods:

This project reviews the evolution of an existing take home laparoscopic box-trainer project. All gynaecology trainees in 2018 were offered a laparoscopic box-trainer at the beginning of the year with instruments and a supported curriculum. Following a review of interviews with previous program participants exploring barriers and enablers of training, the 2018 program has been revised to include elements aimed at improving engagement. These changes include: An introductory session with an emphasis on modification of the home environment to allow for opportunistic training, personalized learning contracts where trainees determine when and how many of the tasks they complete, an online Yammer group to encourage discussion and promote social interaction in a digital medium, monthly "lap legend" awards to recognize active and successful trainees, complimentary in hospital laparoscopic training sessions. All trainees were allocated a consultant to whom they were expected to send videos of task to for feedback. A structured feedback form was developed to standardize the feedback given by mentors. Trainees kept track of time spent on their box-trainers through a logbook and skill improvement is objectively measured using completion times of a simple task (thread transfer). All trainees will complete an exit survey in order to better understand what aspects worked well and what barriers still remain.

Results:

Sixteen trainees are currently participating in the box-trainer project. In January 2019, all gynaecology trainees with complete an exit task and a survey describing the impact they felt the interventions had on their use of the box-trainer, the results of which will be presented.

Conclusion:

Simulation training in laparoscopy using box-trainers improves gynaecology trainees' skills in basic laparoscopic tasks. However in the past, uptake of laparoscopic simulation training was poor despite attempts to encourage participation. We examine if changes implemented to provide more autonomy, encourage social interaction and positively reward use of the box-trainer have a positive effect. We acknowledge that simulation training has great value. However, we wonder if a program that is more structured and with mandated skills assessments with potential punitive implications for poor participation are the unfortunately the only way to increase trainee participation.

1. Motola I, Devine LA, Chung HS, et al. Simulation in healthcare education: A best evidence practical guide. AMEE Guide No. 82. Med. Teach. 2013; 35: e1511-e30.
2. Wilson E, Janssens S, Hewett DG, et al. Simulation training in obstetrics and gynaecology: What's happening on the frontline? Aust N Z J Obstet Gynaecol. 2016. 3. Blackhall
3. Blackhall, V.I., Cleland, J., Wilson, P. et al. Surg Endosc (2018). https://doi.org/10.1007/s00464-018-6599-9

Credentialing for Robotic Assisted Gynaecological Surgery in Australia

Chantelle Ruoss[1], Cherynne Johansson[1], Felix Chan[1]

1. Gynaecology, SSWLHD, Sydney, NSW, Australia

Abstract:

As robotic assisted surgery is gaining popularity in Gynaecologic surgery, more gynaecologists are seeking privilege to practice in hospitals providing access to this technology. Privileging and credentialing requirements are determined by medical staff leadership at the hospital level to ensure clinicians provide safe healthcare services. No standardised guidelines exist for gynaecological surgery in Australia.

Study Objective:

To examine the variability of the criteria used to grant surgical privileges and credentials for gynaecologic procedures at high volume academic, private and public hospital systems in Australia.

Design:

We conducted a cross section study (Canadian Task Force classification III).

Setting:

Data was obtained from geographically diverse hospital systems around Australia.

Interventions:

We examined criteria for designating core gynaecologic privileges, credentialing, and other training requirements as well as minimum and annual case number requirements for both initial granting and maintenance of surgical privileges. Participants completed an online questionnaire regarding credentialing policies and practices.

Measurements and Main Results:

Major inconsistencies in privileging were found across the surveyed institutions. Hospitals varied widely in procedures designated as core versus those requiring advanced training. Institutions greatly contrasted in the case number and temporal factors used to define experience. Of particular note was absent privileging criteria of minor procedures, endoscopic procedures and major procedures. Initial and maintenance privileging requirements for special procedures (i.e. robotic –assisted surgery) were likewise discrepant, annual case numbers are also highly variable.

Conclusion:

Considerable variability exists in the criteria used by hospitals for granting and maintaining surgical privileges for gynaecological procedures. Standardisation will likely require efforts at a national leadership level.

One Year Experience in a Tertiary Multidisciplinary Pelvic Mesh Clinic

Victoria Buckley[1], **Milorose Felipe**[1], **Vivian Yang**[1], **Chris Benness**[1]

1. Royal Prince Alfred Hospital, Surry Hills, NSW, Australia

Aim:

To describe the experience of a multidisciplinary tertiary referral clinic for women having undergone pelvic surgery involving a mesh implant.

Method:

In its first year of service (September 2017 to September 2018) a retrospective analysis was performed of a tertiary Pelvic Mesh Clinic in metropolitan Sydney. Information collected included patient demographics, referral source, mesh procedure performed, year procedure performed, level of training of surgeon performing procedure, complications experienced, timing of symptom onset, symptoms experienced, examination findings, investigations and management instituted by the mesh clinic.

Results:

During the first year of service, seventeen patients were referred to the clinic. The majority of these referrals were made within 5 years of the initial surgery. Of those referred, only eleven ever attended an appointment. Referral sources included general practitioners (n=7), general gynaecologists (n=5), the emergency department (n=1) and the Health Department (n=1). The mean age of women referred was 61.6 ±11.4 years. The number of visits attended was overall low with 63.6% of women only ever attending one appointment and none attending more than two visits. The majority of women seen are continuing to engage in clinic follow-up (n=8, 72.7%).

The specific mesh implant used was difficult to ascertain in most cases, but there was an equal referral for vaginal mesh (n=7) and mid-urethral slings (n=8). Two women were referred with abdominal mesh from sacrocolpopexy. The majority of surgeries were performed by a general gynaecologist (n=9), followed by a urogynaecologist (n=4), and urologists (n=2). There was no reliable data on the patient's experience with the consent process. The timing of symptom onset varied, but the majority (81.8%) reported their symptoms began within 6 months of surgery. The range of symptoms varied, but all patients seen had some form of urinary complaint. These included any or all of retention, stress incontinence, urge incontinence, dysuria, frequency and altered stream. Physical examination found mesh exposure in half of women. Of concern, 73% of attendees had mental health complaints with one previous suicide attempt. Nine of the seventeen women referred are known to be involved in medicolegal action, however there is no correlation with treatment response or continued follow up in clinic.

Conclusion:

Despite widespread attention from media outlets and consumer groups, the absolute number of women presenting with vaginal mesh complications in our experience is low. In addition, half of women referred had a mid-urethral sling rather than vaginal mesh for pelvic organ prolapse.

SESSION THREE B: FREE COMMUNICATIONS /1330-1500

BOTANICAL 2 & 3

Concurrent Painful Disorders in Women Diagnosed with Endometriosis

Angamuthu S Arunkalaivanan[1], **Hervinder Kaur**[1]

1. Waikiki Specialist Centre, Waikiki, WA, Australia

Objective:

Chronic pelvic pain (CPP) is pain of apparent pelvic origin that has been present most of the time for the past six months and is severe enough to cause functional disability and require medical or surgical treatment. CPP is a common problem in the women of reproductive age and the reported prevalence rate is as upto 27%, a rate comparable to asthma and back pain(1). The management of CPP is challenging due to the numerous causes. The complicating factor is that these women may have more than one disorder causing pelvic pain.

Endometriosis, the most common painful cause of CPP, is estimated to affect 7-10% of women in the reproductive age group. Women with endometriosis may have other painful conditions(2, 3). The aim of this study is to identify the prevalence of the concurrent painful disorders in women diagnosed with endometriosis on laparoscopy.

Methods:

We performed a chart review of women diagnosed with endometriosis between October 2015 and November 2018. The demographic features, clinical findings and the operative findings were analysed.

Results:

49 women in the age group between 19 and 44 were included in this study. The demographic features are Mean age 33.04±9.25; Median parity 0; BMI-25.29±4.25; VAS pain score 8.2±1.1; Duration of pain/symptoms 22.9±14.5 months; 47 (95.9%) were Caucasians.

Clinical features: Dysmenorrhoea 40(81.6%); Dyspareunia 46(93.9%), pain on filling bladder12(24.5%); Overactive Bladder 35(71.4%); Voiding dysfunction 20(40.8%); Dysuria 37(75.5%); Recurrent UTI 31(63.3%); Tenderness on Speculum examination 49(100%), Anterior Fornix 48(98%), and other fornices 49(100%).

Operative findings: 49(100%) was diagnosed with endometriosis on laparoscopy; 47(95.9%) underwent cystoscopy of which glomerulations were present in 43(87.8%); bladder wall biopsy was performed in 43(87.8%); Bladder Pain syndrome(BPS) was confirmed in 47(97.9%) on the basis of ESSIC criteria and confirmed as interstitial cystitis - mild 19(38.8%), moderate 12(24.5%), severe 4(8.2%) based upon the mast cell count on pathological analysis.

Pudendal Neuralgia was diagnosed based upon Nantes' criteria in 12(24.4%); Provoked vestibulodynia was present in 7(14.2%); Fibromyalgia and migraine were present in 3(6%).

Conclusion:

Although endometriosis is the most common cause of pelvic pain, endometriosis is not solely responsible for pelvic pain. Our study indicates that there are concomitant conditions such as BPS being the most common, pudendal neuralgia and provoked vestibulodynia occur in this cohort of women. Hence it would be wise to perform both cystoscopy and laparoscopy in order to avoid delay in the diagnosis of BPS in women suspected with endometriosis.

1. Ahangari A. Prevalence of chronic pelvic pain among women: an updated review. Pain Physician. 2014;17(2):E141-7.
2. Cervigni M, Natale F. Gynecological disorders in bladder pain syndrome/interstitial cystitis patients. Int J Urol. 2014;21 Suppl 1:85-8.
3. Chung MK, Chung RR, Gordon D, Jennings C. The evil twins of chronic pelvic pain syndrome: endometriosis and interstitial cystitis. JSLS. 2002;6(4):311-4.

Goserelin: A Novel Standardised PrescribingPprotocol.

Rawan Bajis[1], Jenni Pontre[1], Claire Kendrick [2], Monica Sajogo[2], Krishnan Karthigasu[1], Bernie McElhinney[1]

1. Gynaecology/Endoscopy, King Edward Memorial Hospital, Perth, WESTERN AUSTRALIA, Australia

2. Pharmacy , King Edward Memorial Hospital, Perth, Western Australia, Australia

Introduction:

Goserelin is a gonadotrophin releasing hormone analogue used in the treatment of hormone dependent gynaecological diseases such as endometriosis and uterine leiomyoma. The duration of recommended Goserelin therapy is guided by the adverse side effect profile, high cost and lack of long-term high quality data regarding safety and efficacy. Currently, the Pharmaceutical Benefit Scheme (PBS) authorises short term (6 month) use of the 3.6mg Goserelin implant in cases of visually proven endometriosis only. There is a requirement for greater governance and standardization over the prescription of this high cost medication with the ultimate aim of reducing harm and ensuring adequate use of finite resources.

We present a single gynaecological centres' long-term experience and the development of a standardised prescribing protocol.

Aim and objective:

Twofold: To review the Goserelin prescribing practice at a single, major tertiary gynaecology referral centre of all patients prescribed Goserelin for 6 months or more, and to implement a novel prescribing protocol to standardise management for safe and effective long-term use.

Method:

A retrospective analysis of patients prescribed Goserelin for six months or more at King Edward Memorial Hospital between June 2010 and July 2016.

Results:

During our study period, 412 patients were prescribed Goserelin. Sixty-nine patients (16.75%) received Goserelin for more than 6 months cumulatively. Data was obtained from 56 (13.5%). Over 32 patients (57%) were treated with Goserelin for over 12 months duration. The indications for use included endometriosis in 42 patients (75%) and for prior surgical failure in 35 patients (63%). The 10.8mg, non-PBS listed implant was prescribed solely in 40 patients (71%).

Patients' attitudes and responses to Goserelin were generally positive, however negative attitudes existed. The majority of these related to adverse effects such as hot flushes in 22 patients (39%). Further analysis is ongoing.

Conclusion:

In our unit, Goserelin was largely prescribed for situations with proven patient benefit and adverse side effects were managed appropriately. However, prolonged courses of Goserelin were prescribed which exceeded national recommendations and, at times, before other therapies were trialled.

A novel standardised prescribing protocol was developed which has been implemented at our institution providing clinicians with a safe and effective approach in the utilisation of this costly medication. This will be included in the final poster presentation. A repeat audit of the prescribing practice will be completed in 12 months' time.

"My Devil Womb" – Patient Perspectives and Their Understanding of Endometriosis

Nadine Chilton[1], Sarah van Rheede van Oudtshoorn[1], Jennifer Pontre[1], Bernadette McElhinney[1], Krishnan Karthigasu[1], Marian Kember[1]

1. King Edward Memorial Hospital, Greenwood, WA, Australia

Background:

Current literature reports that patients with endometriosis, who lack information, are more likely to have emotional distress and increased uncertainty regarding their condition (1). This lack of education and knowledge about endometriosis may also contribute to the delay in diagnosis of the condition, which at times can be significant (2).

Aim:

1. To explore patients' knowledge and understanding regarding endometriosis.
2. To investigate the sources utilised by patients in self education on endometriosis
3. To quantify pre-existing expectations of patients who are undergoing medical and/or surgical management.

Methods:

A prospective cohort study of patients who attended the specialist Endoscopy Clinic at KEMH was performed over a 1 year period from October 2017 to October 2018. Patients with a diagnosis or symptoms suggestive of endometriosis were invited to enrol. Questionnaires were used to collect quantitative and qualitative data. Amongst other things, patients were asked to explain their perspectives on causes of endometriosis and available treatment options

Results:

Fifty-six questionnaires were collected. 48% of patients (n=27) were satisfied with their knowledge about endometriosis. The internet (e.g. google) was the most utilized source of information for patients, followed by their gynaecologists, then GPs. Women who had surgery previously for endometriosis (n=34) had only slightly higher satisfaction rates in their own knowledge about the disease at 50% (n=17).

Regarding expectations, 36% of women (n=20) believed that surgery would be the best treatment option. 86% (n=48) of women believed that surgery would improve their symptoms while, comparatively, 79% (n=44) believed that medical treatment could improve their symptoms.

Conclusion:

In this study, 43% (n=24) of patients were not satisfied with their understanding of endometriosis, which can be a source of stress. Patients are most likely to utilize the internet to gain information.

By reviewing patient knowledge of endometriosis, we should be able to equip health professionals with an insight into how patients think and identify the gaps in their knowledge. In turn we hope that this will help health care professionals advise patients about their condition and guide management options.

Vault Closure During Total Laparoscopic Hysterectomy with FlexDex System: First Australian Series

Sam Daniels[1], Praveen De Silva[1], Dean Conrad[1], Tal Saar[1], Mansour Al-Shamari[1], Sarah Choi[1], Greg Cario[1], David Rosen[1], Michael Wynn-Williams[2], Danny Chou[1]

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

2. Eve Health, Brisbane, QLD, Australia

Minimally invasive surgery has continued to grow since its inception, prompting the development of new innovative technologies. Despite substantial advancements in vessel sealing devices, camera optics, trochar technology and specimen retrieval methods, standard laparoscopic tools have undergone little design changes and fail to optimize mobility in limited spaces. The conventional laparoscopic straight stick has four degrees of freedom, making knot tying, dissection and suturing in tight areas challenging. Advancements in robotics have attempted to address this, allowing for increasing degrees of freedom and articulation of instruments. Despite this, the robotic platform has proven to be cumbersome with questionable cost-effectiveness that is yet to translate to improved outcomes in the realms of benign gynaecology.(1,2) Various attempts at promoting articulating laparoscopic instruments have failed to be globally accepted. This is likely secondary to their poor functionality and steep learning curve. The FlexDex laparoscopic needle driver is a novel instrument designed to model the seven degrees of motion achieved by robotic systems, whilst maintaining traditional laparoscopic advantages and a reduced cost.(3) In 2018, Sydney Women's Endosurgery Centre (SWEC) performed, for the first time in Australia, a total laparoscopic hysterectomy (TLH) using the FlexDex articulating needle driver for the vault closure.

Closure of the vaginal cuff at the time of TLH can be achieved utilising many different surgical techniques, however surgical training in this area is often lacking. Closure of the colpotomy laparoscopically is most commonly the rate limiting step of a TLH. It is often the deterrent and catalyst for the surgeon to either suture vaginally or book an alternative approach (i.e. vaginal, abdominal or robotic). It is well established that the learning curve for laparoscopy is steeper than for robotic surgery and instruments like the FlexDex may help to bridge this gap. This instrument may provide an alternative to the surgeon that is both more intuitive to use than traditional laparoscopy and more cost effective then robotic surgery and can function as an improved solution to the closure of the vaginal vault. (2)

This video demonstrates the use of the FlexDex system based on our experience in patients undergoing TLH for benign disease since October 2018.

1. Nicklin J. The future of robotic-assisted laparoscopic gynaecologic surgery in Australia–A time and a place for everything. Aust N Z J Obstet Gynaecol [Internet]. 2017; Available from: https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/ajo.12688
2. Tedesco G, Faggiano FC, Leo E, Derrico P, Ritrovato M. A comparative cost analysis of robotic-assisted surgery versus laparoscopic surgery and open surgery: the necessity of investing knowledgeably. Surg Endosc. 2016 Nov;30(11):5044–51.
3. Vigneswaran H. FlexDexTM: A Novel Articulated Laparoscopic Instrument to Perform Renorrhaphy. ETUN [Internet]. 2017 Nov 13;1(2). Available from: http://crimsonpublishers.com/etun/fulltext/ETUN.000506.php

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The Preferred Method of Treatment For a Recurrent Ectopic Pregnancy

Shmuel Dr. Herzberg[1], Gilad Dr. Karavani[1], Einat Dr Gutman-Ido[1], Adiel Cohen[1], Uri Dior[1]

1. Hadassah-Hebrew University Medical Center, Jerusalem, Israel, Jerusalem, ISARAEL, Israel

Background:

Ectopic pregnancy (EP) is a common gynaecologic condition, estimated to occur in more than 1% of all pregnancies. The incidence of recurrence after one episode of EP is estimated between 8% to 15% (1). The current standard management options are conservative (clinical, laboratory and sonographic follow-up), methotrexate therapy and surgical treatment, usually with minimally invasive laparoscopic approach. Previous studies that compared rates of recurrent EP after medical vs surgical management have shown similar rates of a second EP (2). However, it is now known if outcome of the next pregnancy is influenced by the method of treatment of the second ectopic pregnancy.

Objective:

To compare the rate of a third EP amongst three treatment modalities of a second EP.

Methods:

A retrospective study was conducted. Included were women who were treated for a second EP in a tertiary medical centre. Demographic, obstetric, gynaecologic and data of the second EP was collected. The outcome of the following pregnancy was compared between the following groups: (1) conservative management; (2) medical management with methotrexate and (3) surgical management.

Results:

One hundred twenty-five patients with two ectopic pregnancies and a consecutive pregnancy following the second EP were included in the study. Twenty-seven patients were managed conservatively in their second EP, 52 patients received intra-muscular methotrexate and 47 underwent laparoscopic salpingectomy. Whereas third EP rate in the conservative management group was 29.6% (n=8/27), the rates of a third EP in the methotrexate and laparoscopic salpingectomy groups were 9.6% (n=5/52) and 10.6% (n=5/47), respectively (p=0.036). While a further analysis comparing the outcome of symptomatic patients only has shown similar rates of EPs amongst the three groups (conservative management: 22.2%, methotrexate: 8.1% and laparoscopic salpingectomy: 5.7%), this did not reach statistical significance.

Conclusion: Recurrent ectopic pregnancies pose a challenge for the treating gynaecologist. Our results suggest that active management of recurrent EP, by either methotrexate or minimally invasive surgical approach, may result in lower rates of recurrent EP as compared to non-interventional management.

1. Yao, Mylene, and Togas Tulandi. "Current status of surgical and nonsurgical management of ectopic pregnancy." *Fertility and sterility* 67.3 (1997): 421-433.
2. Olofsson, Jan I., et al. "Clinical and pregnancy outcome following ectopic pregnancy; a prospective study comparing expectancy, surgery and systemic methotrexate treatment." *Acta obstetricia et gynecologica Scandinavica* 80.8 (2001): 744-749.

Laparoscopic Approach to a Symptomatic Uterine Wall Caesar Scar Dehiscence in the Setting of Stage Four Endometriosis.

Lulusha Jayawardena[1], Shamitha Kathurusinghe[1], Caterina Ang[1]

1. The Royal Women's Hospital, Parkville, VICTORIA, Australia

Caesarean section is the most common obstetric surgery and its incidence is rising. Caesarean scar dehiscence can result in serious maternal and perinatal morbidity, even mortality, due to uterine rupture in subsequent pregnancies. Predisposing factors for this condition may include preterm delivery, failure to progress in the first stage of labour, lower parity and higher number of previous caesarean deliveries[1].

Currently, when caesar scar dehiscence is identified, counselling of patients often focuses on future pregnancy risks including uterine scar rupture and associated perinatal risks. There is little guidance on management options especially in the setting of a symptomatic uterine wall scar dehiscence contributing to pelvic pain or abnormal vaginal bleeding.

We present a laparoscopic approach to the management of a patient with pelvic pain, vaginal bleeding and secondary infertility in the setting of stage four endometriosis; with an endometrial nodule overlying a two centimetre lower segment uterine wall Caesar scar dehiscence. Following careful patient counselling, decision to proceed to surgical management was made due to the severity of patient's symptoms. Furthermore, an intra operative diagnosis of a duplex collecting system added to the surgical complexity.

During the procedure, extensive adhesiolysis and ureterolysis was performed with identification of four ureters. Excision of stage four endometriosis was then carried out in usual fashion. Hysteroscopy was used to confirm lower segment defect by transilluminating the lower segment. The bladder was reflected off defect. The scar tissue at site of defect including the endometriotic nodule was excised and the defect repaired with a continuous closure. There were no intra operative complications and the patient was discharged home the following day with improvement of symptoms noted at follow up.

Laparoscopic repair of uterine wall caesar scar dehiscence may be a safe and feasible management option to reduce symptoms of pelvic pain, vaginal bleeding and may reduce risk of future scar rupture in those desiring future pregnancy.

1. Klemm P. et al, Laparoscopic and vaginal repair of uterine scar dehiscence following cesarean section as detected by ultrasound, J Perinat Med. 2005

How to Master the Complex Task of Laparoscopic Suturing and Intra-Corporeal Knot Tying Using the Novel Clock Face Logic

Alan Lam[1], Jessica Lowe[1]

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

Background: Laparoscopic suturing and intra-corporeal knot-tying are essential skills which every endoscopic surgeon aspires to be proficient at performing. Yet, despite many hours of watching and practising, these skill sets still seem haphazard at best and mystical at worst to many who wish to perfect these necessary endoscopic skills.

Objective: Using diagrams and high-quality video clips from the skills lab and live surgeries, the objective of this presentation is to demonstrate how we use the novel clock face to simplify the complex task of laparoscopic suturing and intra-corporeal knot tying into a series of reproducible and logically sequenced steps. The aim is to assist surgeons who traditionally struggle with laparoscopic suturing transform this complex task into one that is efficient, ergonomic and enjoyable.

Transvaginal Mesh Support Line: A South Australian Experience

Ellen J Raghoudi[1], Martin Ritossa[2], Julie Tucker[3, 4]

1. Obstetrics & Gynaecology Registrar, Women's and Children's Division, Northern Adelaide Local Health Network, Adelaide, SA, Australia

2. Divisional Director, Women's and Children's Division, Northern Adelaide Local Health Network, Adelaide, South Australia, Australia

3. RN RM, Nurse/Midwife Consultant Continence PhD Candidate, Women's and Children's Division, Northern Adelaide Local Health Network, Adelaide, SA, Australia

4. Robinson Research Institute, School of Medicine, University of Adelaide, Adelaide, SA, Australia

There has been significant public interest in the use of transvaginal mesh (TVM) for treatment of pelvic organ prolapse (POP) and stress urinary incontinence (SUI) due to the negative impact it has had on some women's wellbeing resulting in a class action. In Australia, this lead to an Australian Senate Committee Inquiry, that in March 2018, recommended each State and Territory establish information and helplines to support women who have received TVM implants, as well as specialist multi-disciplinary units for assessment and management of TVM complications.

In response, SA Health established the SA Pelvic Mesh Consumer Support Line and the SA Health Transvaginal Mesh Executive Advisory Group. The phone support line is run by the Continence Nursing Services team at the Lyell McEwin Hospital, a tertiary hospital in outer-metropolitan Adelaide. Data is being prospectively collected via this support line regarding the type of mesh used and to identify the facility where the procedure occurred. Consumer concerns, along with a visual analogue scale (VAS) score for each of their concerns is ascertained. Information regarding current care and support for their concerns is also documented. Finally, the length of each call is recorded.

We are presenting data gathered from consumers contacting this support line since its establishment in May 2018. The support line has received calls from 94 consumers who have undergone TVM procedures. To date, 41 callers had SUI implants, 40 POP implants, 11 have had both, and the remaining 2 callers were unsure of their procedure. Of those that recalled the location of their surgery, 60% occurred in the private sector and 17% occurred in rural/regional centres. The concerns raised by consumers can be grouped into physical concerns such as pain, altered bladder or bowel function, negative impact on emotional wellbeing, financial concerns and impact on quality of life. The average VAS score was 8.6 (range 0 – 10).

This data will be utilised to better understand the needs of consumers with TVM-related concerns to guide the establishment of clinical referral pathways and a dedicated TVM clinic for women in South Australia who have or are experiencing concerns.

1. Number of women in Australia who have had transvaginal mesh implants and related matters. Report by the Senate Community Affairs Secretariat, March 2018.

SESSION FOUR: THE PERFECT PICTURE – ANATOMY & RADICAL SURGERY / 1530-1700

CROWN BALLROOM 1

Surgical Neuroanatomy of Visceral and Somatic System of the Female Pelvis for Nerve-Sparing Surgery

Marcello Ceccaroni[1]

1. Department of Obstetrics and Gynecology, Gynecologic Oncology and Minimally-Invasive Pelvic Surgery, Sacro Cuore - Don Calabria Hospital Negrar, Verona, Italy

Abstract not provided

ABC - Anatomy Before Cutting

Helen Green[1]

1. Gold Coast University Hospital, Southport, QLD, Australia

Abstract to be provided

Contemporary Anatomy Teaching

Ruth Blackham[1]

1. Western Surgical Health, Nedlands, WA, Australia

Abstract not provided

How Do I Upskill in Anatomy Knowledge?

Michael Wynn-Williams[1]

1. Eve Health, Spring Hill, QLD, Australia

Abstract to be provided

Does Size Matter, Simplifying Surgery for Large Fibroids - Hysterectomy and Myomectomy

Haider Najjar[1]

1. Monash Health, Mount Waverley, VIC, Australia

This lecture is dedicated to describing the procedures of myomectomy and hysterectomy when dealing with large uterine myomas with significant pelvic anatomical distortion. There is a special emphasis on the importance of anatomical orientation and rectifying the anatomy during the procedure. The lecture also covers other approaches and techniques to reduce blood loss including medical management pre and intra operatively. The controversial issue of specimen retrieval and the different approaches currently used, and the supporting evidence will also be discussed. Thorough training to enhance surgical skills is paramount to performing this complex surgery.

FRIDAY 8TH MARCH 2019

SESSION FIVE: FEAR THE LIVE DEAD SURGERY / 0800-1000

CROWN BALLROOM 1

Live Surgery

SESSION SIX A: PROGRESSING ENDOMETRIOSIS / 1030-1230

CROWN BALLROOM 1

KETNOTE: Endometriosis Enigmas

Sawsan As-Sanie[1]

1. University of Michigan, Michigan, United States

Abstract not provided

I Don't Want Drugs, is there Something Natural I Can Do?

Tracy Gaibisso[1]

1. WA, Australia

Tracy will highlight the basic aims of a natural therapist when managing endometriosis patients. She will discuss some key clinical strategies, primarily focusing on supporting pain and inflammation reduction utilising herbal medicine, nutrients and dietary interventions.

She will include considerations for gynaecologists around these therapies and surgery and will offer suggestions for effective collaboration between the gynaecologist and the naturopath

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Picture Perfect

Glen Lo[1]

1. Sir Charles Gairdner Hospital, Nedlands, WA, Australia

The gold standard for diagnosis of endometriosis is laparoscopy, however, imaging modalities can certainly help with pre-operative planning. I will describe the diagnostic signs to be seen on MRI in endometriosis and adenomyosis and explain how they can help to make the diagnosis.

MDT for Endometriosis

Nicola English

Abstract not provided

Perfecting the Pit Stop

Stephan Lyons

Abstract not provided

SESSION SIX B: PRACTICAL PROBLEMS / 1030-1230

BOTANICAL 2 & 3

Bowel Prep, Bowel Adhesions and Bowel Repair – Is This the Gynaecologists Nightmare?

Stephanie Chetrit

Abstract not provided

P's & Q's – Letters from a Urologist to a Gynaecologist

Trent Barrett

Abstract not provided

Pulsations, Piercings and Puddles

Marek Garbowski

Abstract not provided

The Plastics Perspective

Anthony Williams

Abstract not provided

Professionally Managing Poor Outcomes

David Watson AM[1]

1. St John of God, Perth, Western Australia

Adverse outcomes are inevitable in all spheres of medical practice. Whilst there are ways of reducing the risk, it is the management of any adverse outcome that becomes one of the great challenges of practice.

In this paper is offered some tips for busy practitioners that hopefully will generate discussion and comment.

There are no hard-and-fast rules other than avoidance is not possible!

The commentary is based on over 30 years of medical indemnity practice, 50 years of clinical practice and two stints as medical directors of St. John of God hospitals in Perth.

Personal Risk Reduction Surgery

Ai Ling Tan[1]

1. Auckland District Health Board, Mt Eden, AUCKLAND, New Zealand

Women with genetic mutations that increase their risk of gynaecological cancers face difficult decisions about risk reducing surgery. The two main areas we will focus on will be the women at high risk of ovarian and endometrial cancers – the BRCA story and Lynch syndrome. BRCA1/2 carriers do not have any effective surveillance for ovarian cancer, but surgery significantly reduces the risk of ovarian and breast cancer. For medical professionals, the management is clear but for women there are many factors that need to be considered including psychosexual sequalae, menopause symptoms, lifetime cancer risk, timing and complications of surgery. It is imperative that these women are supported through this pathway with a multidisciplinary team including genetic counselors, psychologists, menopause specialists, gynaecological oncologist and gynaecologists.

Pop It In a Bag - Protecting Your Patient and Their Specimen

Danny Chou[1]

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

The title of this presentation is befitting as by *popping* the *specimen in a bag* for contained morcellation is likely to *protect our patient* from the potential harms of uncontained morcellation, which will be the main focus of this presentation. But it also aptly reminds us that at times, their *specimen* can benefit from being *protected* from morcellation, such as in cases of malignancies, as an extensively morcellated specimen can hinder accurate pathological diagnosis necessary for precisely tailoring the treatment. However, whilst there is evidence that the prognosis of certain uterine malignancies, such as endometrial adenocarcinoma, may not be significantly adversely affected by perhaps vaginal morcellation, ideally carried out in-bag, where it is possible to have pertinent anatomical regions such as cervix, uterine cavity, tubes and ovaries keep relatively intact; but when it comes to uterine **sarcomas** evidence suggest any form of morcellation (abdominal, vaginal or even hysteroscopic morcellation) would be of detriment, thus **power morcellation**, bagging or no bagging **is absolutely contraindicated**. The standard care for a patient with proven or with suspicion of uterine sarcoma is an open, full surgical staging procedure without any form of morcellation.

The U.S. Food and Drug Administration (FDA) warnings in 2014 against the use of power morcellator for fear of dissemination of occult sarcomas has significantly changed our way of managing surgical patients with large uterine fibroids. It highlighted our need to raise patient awareness of the possibility of occult leiomyosarcoma and the likelihood of worsened prognosis in case of morcellation of occult sarcomas. It has also taught us to be extra vigilant for the possibility of leiomyosarcoma but with no signs, symptoms nor diagnostic tests that can reliably diagnose leiomyosarcoma preoperatively, much of the efforts have naturally been directed towards mitigating the risks of tissue dissemination by performing morcellation within the confine of a bag.

The practice of contained morcellation was quickly adopted in America following the widespread withdrawal of power morcellator. This practice will no doubt remain and become the norm as we become more efficient with technical evolution and development of innovative devices. Even if a reliable preoperative diagnostic test for LMS does become available in the near future, contained morcellation is likely to continue for its benefit of containing benign tissue fragments.

Various forms of contained morcellation have been tried which can be divided based on the instrument used, either manually with the use of a scalpel or with power morcellator. Manual morcellation can be performed vaginally or abdominally. Contained power morcellator can be in the form of a single port configuration or multiport configuration. Contained power morcellation is slightly more involved than manual morcellation as following bagging of the specimen, a pseudo-pneumoperitoneum is created by insufflation of the bag and morcellation taking placed in a similar fashion to open power morcellation within it.

There are currently 5 containment devices available, with only two having FDA approval for power morcellation, namely Alexis Containment Extraction System (Alexis CES) by Applied Medical and the Olympus Contained Tissue Extraction (CTE) System, Pneumoliner, with Alexis CES being only approved for manual morcellation and Pneumoliner only approved for single port power morcellation. There are 3 dual opening containment devices namely MoreSafe, More-Cell-Safe and Espiner Morcellation Containment System, with Espiner being the only system with Rip-Stop Nylon material.

Much has been tried and published in the literature, well beyond the initial feasibility studies and even including comparative studies of different techniques both in an animal model and in clinical settings. Bags have been tested for leakage with use of dye and looking for spindle myometrial cells in peritoneal washing at the completion of procedures. One of the latest recommendations in laparoscopic myomectomy is ample washing of the peritoneal cavity to reduce the number of cells remaining in the peritoneal cavity.

This presentation will summarise available literature on different techniques and containment systems with their merits and shortcomings as well as showing video demonstrations of various techniques highlighting tips and tricks to facilitate the procedures.

SESSION SEVEN: CHAIRMAN'S CHOICE / 1330-1500

CROWN BALLROOM 1

Comparison of Surgical Outcomes Using Gyrus PK and LigaSure in Total Laparoscopic Hysterectomy: A Randomized Controlled Trial

Clare Wong[1, 2], Amy Goh[3, 2], Harry Merkur[1, 2]

1. Blacktown Hospital, Blacktown, NSW, Australia

2. Sydney West Advanced Pelvic Surgery Unit, Sydney, NSW, Austalia

3. Westmead Hospital, Westmead, NSW, Australia

Introduction:
Advanced vessel sealing devices are widely used in laparoscopic surgery. Evidence has suggested benefits of these devices when compared with conventional bipolar electrosurgery including decreased blood loss and shorter operative times.[1,2] Laboratory and animal assessments of mean burst pressure, mean vessel sealing time, thermal spread and smoke generation have been well-documented with advanced vessel sealing devices, and the studies that have directly compared LigaSure and Gyrus PK have suggested that LigaSure performs better in all aspects3. There remains however, a lack of adequately powered trials comparing laparoscopic energy sources and devices in the clinical setting, especially in gynaecology. This randomized controlled trial aims to compare the outcomes of total laparoscopic hysterectomy (TLH) using Gyrus PK LYONS dissecting forceps and LigaSure™ Maryland jaw vessel sealer/dividers.

Methods:
Women were recruited into the study if they were at least 35 years of age and required a TLH for non-malignant indications. They were randomized to having surgeries performed using either Gyrus PK or LigaSure. Mean operating time (from initial skin incision to detachment of the uterus with secured haemostasis) was the primary outcome; a difference of at least 25 minutes was considered clinically significant. Secondary outcomes measured were mean blood loss, complications, conversions, post-operative analgesia use to the end of Day 1, and length of stay.

Results:
69 women were recruited to the study; 5 were excluded as they did not meet criteria, and 64 were included – 33 Gyrus PK, and 31 LigaSure.

Surgeries performed by LigaSure had statistically significantly shorter mean operating times compared to Gyrus PK at 64min vs 74min, p=0.026, There were no statistically significant differences in mean blood loss using either Gyrus PK or LigaSure (70.6ml vs 106.5ml, $p=0.229$), mean total opioid equivalence dose used (121mg vs 116mg, p=0.764), mean diclofenac usage (142mg vs 148mg, p=0.574), and hospital length of stay (2.94 days vs 2.74 days, p=0.362). 2 patients in

the Gyrus PK group had intra-operative complications and nil in the LigaSure group. There were no conversions to laparotomy in either group.

Conclusion:

This randomised controlled trial shows that TLHs performed using LigaSure have a statistically significantly shorter mean operating time than compared when Gyrus PK is used. It does not suggest, however, any clinically significant benefit of the LigaSure device over Gyrus PK as the difference is only 10 minutes. No significant difference was calculated in any of the secondary outcomes measured.

1. Janssen PF et al. Perioperative outcomes using LigaSure compared with conventional bipolar instruments in laparoscopic hysterectomy: a randomised controlled trial. BJOG, 2011,118:1568-1575
2. Ou CS et al. Total laparoscopic hysterectomy using multifunction grasping, coagulating, and cutting forceps. J Laparoendosc Adv Surg Tech, 2004, 14(2):67-71
3. Law KSK, Lyons SD. Comparative studies of energy sources in gynecologic laparoscopy. JMIG, 2013, 20:308-318

Oral Riboflavin to Assess Ureteral Patency During Cystoscopy: A Randomized Controlled Clinical Trial

Keryn Harlow[1], Michael L Stitely[2], Elliot MacKenzie[3]

1. Canterbury District Health Board, Christchurch, CANTERBURY, New Zealand

2. University of Otago, Dunedin School of Medicine, Dunedin, New Zealand

3. Obstetrics and Gynaecology, Southern District Health Board, Dunedin, New Zealand

Introduction

Ureteric injury has an incidence of 0.2-1.0% during any abdominal or pelvic surgery[1]. Intraoperative cystoscopy during prolapse repair has been shown to have a high positive predictive value (99.3%) for identifying ureteral obstruction[2]. Traditionally, intravenous indigo carmine was administered to assist in identifying ureteric jets during cystoscopy. The lack of commercial availability of indigo carmine has prompted investigations to identify suitable alternative agents.

Vitamin B complex (Riboflavin), has been anecdotally noted to colour the urine bright yellow. An observational study published in 2011 noted that Vitamin B complex given pre-operatively coloured the ureteric jets bright yellow, making identification at cystoscopy easier[3]. We conducted a randomized controlled trial aiming to demonstrate whether oral riboflavin can be used as a marker of ureteric patency at cystoscopy and thereby reduce the need for intravenous urinary colouring agents intraoperatively.

Methods

Patients scheduled for gynaecological surgery where cystoscopy was a planned component of the procedure were randomized to receive riboflavin 400 mg or placebo orally the night before surgery. During cystoscopy the operating surgeon visualised ureteric jets and video-recorded the cystoscopy procedure. The primary outcome was to determine if orally administered riboflavin produced stronger yellow colour of urine seen on cystoscopy than placebo on a three-point scale.

Secondary outcomes were to assess if riboflavin administration improved ease of identifying ureteric jets (five-point scale) and if a greater proportion of subjects had both ureteric jets visualized with riboflavin compared to placebo. A sample size of 33 per arm was planned.

Results

From 28 June 2017 - 19 February 2018, 72 women were screened and 66 were randomized with 33 subjects in each study group. The groups were similar in age, weight, BMI and ethnicity. The subjects in the riboflavin group had significant increase of yellow coloured urine as rated by the operating surgeon with median 2 vs 1 on 3- point scale ($p<0.0001$). The ureteral jets were more easily visualised in the riboflavin arm as rated by the operating surgeon, with median of 5 versus 4 on a 5 point scale ($p<0.0130$). Bilateral ureteral patency was confirmed in 30/33 (91%) in the riboflavin group and in 28/33 (85%) in the placebo group. This difference was not statistically significant ($p=0.7085$). At six weeks follow-up, no urinary tract injuries occurred in either group.

Conclusions

The administration of riboflavin prior to gynaecological surgery improves the ease of visualising the ureteric jets by inducing yellow colouration of the urine.

1. Jha S, Coomarasamy A, Chan K, Ureteric Injury in Obstetric and Gynaecological Surgery, The Obstetrician and Gynaecologist 2004;6:203-208
2. Gustilo-Ashby, AM Jelovsek JE, Barber MD et al. The incidence of ureteral obstruction and the value of intraoperative cystoscopy during vaginal surgery for pelvic organ prolapse. Am J Obstet Gynecol 2006; 194(5): 1478-1485.
3. Fernando S, Dowling C, Rosamilia A, The role of preoperative oral vitamin B in the cystoscopic assessment of ureteric patency, Int Urogynecol J (2011) 22:947-951

"We Live in a Virtual World": *Implementing Virtual Reality Systems in Gynecological Laparoscopic Training – Challenges and Successes in Designing a Curriculum*

Shagun Narula[1, 2], Samantha Mooney[1], Lenore Ellett[1], Emma Readman[1]

1. Mercy Hospital, Mercy Hospital for Women, Heidelberg, VIC, Australia

2. Austin Health, Heidelberg, Melbourne, VIC

Structured laparoscopic training curriculums with virtual reality systems (VRS) improve operator learning curves, theatre times and trainee confidence.(1,2) In spite of this, laparoscopic training is inconsistent across gynaecology centres, with no centralized curriculum, and varied access to supervision and simulator equipment. This is detrimental for trainees, who face the burden of competing obstetric and non-clinical demands, and evolving medical management that reduces the number of and access to operative gynaecology lists.(3)

We performed a prospective cohort study to assess the performance of our integrated VRS training curriculum for novice/near-novice and more experienced trainees. In order to supplement live-operating experience, we have enrolled a total of 32 junior and senior trainees to complete a six-month study assessing the effect of a VRS curriculum in improving operative skill and confidence. As a part of this study, we have evaluated pre-existing laparoscopic experience, as well as what program requirements are requested by trainees, before identifying core challenges that prevent trainee engagement in a successful curriculum. The following reports on the baseline and 3-month descriptive data from the study, highlighting curriculum structure, barriers to effective gynaecological training, and trainee desires with regards to laparoscopic education.

Our baseline data revealed over three-quarters of trainees had never attended a dedicated laparoscopy workshop, with more than 50% of junior trainees yet to assist in more than five laparoscopic cases, and only 36% having ever performed a laparoscopic salpingectomy. Trainees identified infrequent opportunities, high obstetric case burden, along with insufficient baseline skills and a lack of consistent supervision as barriers to operating. Trainees were highly supportive of VRS utilisation, and desired a curriculum that taught and assessed basic skills, provided individualized feedback and supervision, and afforded increasing complexity through instructed cases, using realistic equipment and three-dimensional optics.

After three months of regular VRS practice and a laparoscopic skills workshop, trainees reported high approval marking of the curriculum (mean 8.2/10) with subjective improvement detected in specific laparoscopic skills, dexterity/ergonomic movements, visuospatial awareness and overall maintenance of skills. Sadly, over 90% of trainees identified that they were unable to meet the weekly practice aim of 30-60minutes due to rostering commitments, lack of protected teaching time, logistics, and fatigue. The majority of documented use of the VRS occurred outside of hours, and relied heavily on trainee self-direction.

Our data confirms a significant gap in basic training for laparoscopy, with strong support from trainees for additional learning opportunities and integration of VRS.

1. Nagendran M, Gurusamy KS, Aggarwal R, Loizidou M, Davidson BR. Virtual reality training for surgical trainees in laparoscopic surgery. Cochrane Database Syst Rev. 2013(8):CD006575.

2. Shore EM, Grantcharov TP, Husslein H, Shirreff L, Dedy NJ, McDermott CD, et al. Validating a standardized laparoscopy curriculum for gynecology residents: a randomized controlled trial. Am J Obstet Gynecol. 2016;215(2):204 e1- e11.
3. Abbott J. Surgical simulation stimulation. Aust N Z J Obstet Gynaecol. 2015;55(4):301-2.

Four-Dimensional Ultrasound Biometric Changes Following Botulinum Toxin Type A Injection to the Pelvic Floor

Erin M Nesbitt-Hawes[1, 2], **Hans Peter Dietz**[3, 4], **Jason A Abbott**[1, 2]
1. University of New South Wales, Sydney, NSW
2. Royal Hospital for Women, Randwick, NSW
3. Nepean Hospital, Nepean, NSW, Australia
4. Sydney University, Camperdown, NSW

Objectives:
The objective of this study was to provide follow-up data on four-dimensional ultrasound (4DUS) morphometry for women having botulinum toxin A (BoNT-A) treatment of pelvic pain related to pelvic floor muscle over-contraction.

Methods:
A prospective study was performed between October 2013 - June 2018, recruiting women scheduled for BoNT-A injection in the pelvic floor musculature. Translabial 4DUS, vaginal perineometry and pain visual analogue scales (VAS) were performed on all women prior to injection and again at 4, 12 and 26 weeks. The BoNT-A injection was performed under 4DUS guidance.

Results:
29 women had 44 injections over the course of the study. There were no significant differences in ultrasound biometry at either rest, Valsalva, or on contraction when comparing post-injection measurements at 4, 12 and 26 weeks with pre-injection baseline. VAS scores were significantly lower at 4 and 12 but not 26 weeks for reported dysmenorrhoea (respectively 35, 40, 73 vs. 78 pre-injection, p=0.004, p=0.02, p=0.919) and non-menstrual pelvic pain (14, 20, 63 vs. 62 pre-injection, p=0.006, p=0.011, p=0.007), with a significant improvement in dyspareunia at all follow up intervals (36, 19, 25 vs. 75 pre-injection, p=0.002, p=0.001, p=0.002). Similarly, vaginal pressure readings at rest demonstrated a significant improvement throughout the 4, 12 and 26 week follow up (32, 28, 34 vs. 37 cm of H_2O pre-injection, p=0.009, p=<0.001, p=0.038), with a reduction in ability to perform a maximal contraction at 4 and 12 but not 26 weeks (17, 19, 32 vs. 25 cm of H_2O pre-injection, p=<0.001, p=0.006, p=0.865).

Conclusions:
This study demonstrates that 4DUS biometry of the pelvic floor does not correlate with clinical pain and vaginal pressure outcomes for BoNT-A injection in the context of pelvic pain. Although ultrasound has not proven to be beneficial in tracking response or follow up of this treatment, injection under 4DUS guidance remains useful for operator safety and accurately targeting the affected musculature for treatment.

Understanding Anatomy and Restoring the faith!

Emma C Paterson[1], **Michael Wynn-Williams**[1], **Thea Bowler**[1], **Tal Jacobson**[1], **Luke Mclindon**[1]
1. Mater Mother's Hospital, Brisbane , QLD, Australia

When was the last time you studied anatomy? I mean *really* studied anatomy, using text books, prosected specimens and hands-on dissection? If the answer to this is Medical School - then you are not alone! As Gynaecologists we tend to lag behind our surgical counterparts in terms of the emphasis placed on anatomical understanding. We are infrequently examined on it, both in written and oral examinations, and of the consultant and trainee Gynaecologists we surveyed two-thirds felt they had only superficial anatomical knowledge and exposure. In fact, the further along our respondents

were in their career, the more remote their last hands-on anatomy experience. A detailed working knowledge of anatomy means the difference between a mediocre and a great surgeon. More importantly, it is what keeps our patients safe!

How do we improve anatomical knowledge and exposure within our specialty and restore faith in our knowledge?

One solution is observed and hands-on dissection workshops. The Australian Gynaecological Endoscopy Society has been running these workshops at the Medical Engineering and Research Facility, Queensland university of Technology, in Brisbane, since March 2016. To date a total of 171 consultant and trainee Gynaecologists have participated in 9 observational and hands-on Laparoscopic Pelvic Anatomy Workshops. In an effort to better understand participants background anatomical knowledge and deficiencies we conducted pre- and post-workshop surveys. These included questions about past anatomical learning and experience, areas and structures in the pelvis that cause the most "surgical anxiety" and the primary goal of attending the workshop. Participants also completed a six-month follow-up survey. The survey results prove that both direct and observational dissection enhances participants knowledge and confidence, with the added benefit of fine-tuning surgical dissection techniques. Six-month follow-up also demonstrated that attending the workshop translated into improved confidence and anatomical understanding in the operating theatre. This oral presentation will present the results of these surveys.

1. Barton DJP, Davies DC, Mahadevan V, Dennis L, Satvinder TA. Dissection of soft-preserved cadavers in the traisning of gynaecology oncologists: report of the first UK workshop. Gynaecologists oncology 113(3), 352-356, 2009

Skin Preparation for Surgical-Site Antisepsis in Gynaecological Laparoscopic Surgeries: A Double Blinded Randomised Controlled Trial

<u>Charlotte Reddington</u>[1], Uri P Dior[1], Shamitha Kathurusinghe[1], Claudia Cheng[1, 2], Catarina Ang[1, 2], Martin Healey[1, 2]

1. The Royal Women's Hospital, Parkville, VIC, Australia

2. Obstetrics and Gynaecology, The University of Melbourne, Parkville, Victoria, Australia

Background:
Surgical site infections (SSI) comprising superficial or deep skin infection and organ/space infection [1] are an important complication of surgery [2]. They are a leading cause of re-admission, need for antibiotic treatment and general discomfort to patients and substantially increase the cost of care. To date no prospective studies have assessed rates of SSI after gynaecological laparoscopies nor the impact different pre-operative skin preparation solutions have on the rates of SSI.

Objective:
To prospectively assess and compare the rates of SSI in gynaecological laparoscopies among three methods of skin preparation.

Methods:

A double blinded randomized controlled trial of patients aged 18 years or above undergoing an elective operative gynaecological laparoscopy was carried out. Participants were randomized to three groups of skin preparation: (Group 1) Abdominal preparation with Alcohol-based Chlorhexidine solution and vaginal/vulvar preparation with Aqueous-based Chlorexidine solution; (Group 2) Abdominal and vaginal/vulvar preparation with Aqueous-based Poviodine-Iodine solution; (Group 3) Abdominal preparation with Alcohol-based Poviodine-Iodine solution and vaginal/vulvar preparation with Aqueous-based Poviodine-Iodine solution. A standardised protocol of antibiotic treatment was applied. Patients were followed up by a doctor 1 and 4 weeks after surgery and evidence of infection according to the Centres for Disease Control and Prevention (CDC) criteria was documented. The patient's General Practitioners were asked to fill and return follow up forms if infection was diagnosed between the two follow up visits. The patient and the doctor performing the follow up were blinded to method of skin preparation.

Results:

613 participants were included. 94% of participants attended the one-week follow up, 93% attended the four-week follow up and 91% attended both hospital follow ups. The most common procedure performed was laparoscopic treatment of endometriosis. The overall rate of SSI was 17.0%. The rate of skin infection was 11.5% and the rate of organ/space infection was 6.5%. There was no significant difference between the three different skin preparation groups in rates of infections (Group 1: 19.8% vs Group 2: 15.9% vs Group 3: 15.4%, p=NS). The average Body Mass Index (BMI) was significantly higher in those who had a SSI (29.3) compared to those who did not have a SSI (26.3), p<0.001.

Conclusions:

SSI is a common complication after gynaecological laparoscopy, with an overall rate of 17% in this population. The type of skin preparation solution does not have a significant impact on rate of SSI. BMI is significantly higher in those experiencing SSI than those without SSI.

1. [1] Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR. Guideline for Prevention of Surgical Site Infection, 1999. Centers for Disease Control and Prevention (CDC) Hospital Infection Control Practices Advisory Committee. Am J Infect Control. 1999 Apr;27(2):97-132.

2. [2] Haley RW, Culver DH, Morgan WM, White JW, Emori TG, Hooton TM. Identifying patients at high risk of surgical wound infection: a simple multivariate index of patient susceptibility and wound contamination. Am J Epidemiol. 1985;121:206-215.

Sexual Function After Laparoscopic Surgery for Deep Infiltrating Endometriosis: Interim Results of a Prospective Study.

Charlotte Reddington[1], Uri P Dior[1], Claudia Cheng[1, 2], Lucy Richards[1], Martin Healey[1, 2]

1. The Royal Women's Hospital, Parkville, VIC, Australia

2. Obstetrics and Gynaecology, The University of Melbourne, Parkville, Victoria, Australia

Background:
Deep Infiltrative Endometriosis (DIE), where solid endometriotic mass is situated more than 5mm deep to the peritoneum, is an important type of endometriosis often managed surgically. Surgery for DIE may be challenging and is associated with surgical morbidity. To date there is scarce data to report long term sexual function in women undergoing surgical management of DIE.

Objective:
To prospectively evaluate long term sexual function after surgery for DIE.

Methods:
A prospective observational study in women aged 18-50 years undergoing laparoscopic surgery for treatment of suspected DIE in a tertiary pelvic pain gynaecological unit was carried out. The Female Sexual Function Index (FSFI) [1], a validated tool [2,3] assessing domains of sexual function including arousal, orgasm, satisfaction and pain, was completed by participants pre-operatively. Overall sexual function scores range from 2.0 – 36.0. Those with confirmed DIE intraoperatively were followed up and completed the FSFI questionnaire at six weeks, six months and twelve months postoperatively.

Results:
117 participants have been recruited to date with 97 confirmed to have an intraoperative diagnosis of DIE. Seventy-eight, 68 and 34 women have completed the six week, six month and twelve month questionnaires respectively. Overall sexual function scores are significantly improved from preoperative baseline; +2.9 points (p=0.004) at 6 months and +2.5 points (p=0.001) at 12 months. Pain with sex scores improve significantly from baseline at 6 weeks (+0.86, p = 0.002) and 6 months (+0.6, p=0.03). Desire scores are also significantly improved from baseline at 6 weeks (+0.65, p=0.003) and 6 months (+0.4, p=0.003).

Conclusion:
Surgical management of DIE seems to result in ongoing improvement over time in overall sexual function.

1. Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabsigh R, Ferguson D, D'Agostino R Jr. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. J Sex Martial Ther. 2000 Apr-Jun;26(2):191-208.
2. Meston CM. Validation of the Female Sexual Function Index (FSFI) in women with female orgasmic disorder and in women with hypoactive sexual desire disorder. J Sex Marital Ther. 2003 Jan-Feb;29(1):39-46
3. Weigel M, Meston C, Rosen R. The female sexual function index (FSFI): cross validation and development of clinical cutoff scores. J Sex Marital Ther. 2005 Jan-Feb;31(1):1-20

POMMS: Pre-Operative Misoprostol in Myomectomy Surgery – A Pilot Study

Lima Wetherell[1], Shamitha Kathurusinghe [1], Uri Dior[2], Rebecca Szabo[1], Alex Polyakov[1], Swee Wong[3], Christine Gilmartin[3], Martin Healey[2], W. Catarina Ang[1]

1. Gynaecology 1 Unit , Royal Women's Hospital , Parkville, Victoria , Australia

2. Gynaecology 2 Unit , Royal Women's Hospital , Parkville, Victoria, Australia

3. Pharmacy, Royal Women's Hospital , Parkville, Victoria, Australia

Background
Uterine fibroids are the most common benign tumours in women. Fibroid containing uteri have increased aterio-venous blood supply thus myomectomy can result in significant blood loss requiring transfusion. Misoprostol, a synthetic analogue of naturally occurring prostaglandin E1, is used commonly in obstetric medicine to induce uterine contraction causing vasoconstriction of myometrial veins and uterine arteries. Pre-operative misoprostol is not standard practice preceding myomectomy but a few studies suggest its use may decrease intra-operative blood loss (1, 2).

Objective
The primary outcome of this study is test the hypothesis that pre-operative administration of SL misoprostol decreases intra-operative blood loss during open or laparoscopic myomectomy.

Methods
Our study design was a single centre double-blinded randomised control trial (RCT). Patients >18 years of age considered for elective myomectomy (open or laparoscopic) that met inclusion criteria were eligible. Computer generated randomisation of participants into either treatment group (misoprostol 400mcg SL tablets) or placebo (two analogous SL tablets) was then performed. All patients and treating medical staff were blinded to group allocation. Prospective data was collected of primary and secondary outcome measures, including estimated blood loss (EBL), pre- and post-op haemoglobin (Hb), operative time, post-operative complications (Clavien-Dindo) and use of adjuvant medication (i.e. tranexamic acid). Long-term this study is powered to recruit 76 participants (36 in each arm with 1:1 recruitment ratio) over 3 years.

Results
To date 26 patients have been recruited into the POMMS trial. Treatment group allocation remained blinded for this preliminary analysis, but groups were comparably matched for mean age (35.5 vs. 36.5 years), body mass index (BMI) (25.0 vs. 25.8), maximum diameter of fibroid (87.5 vs. 107.6 mm) and number of fibroids removed (2.83 vs. 2.53) ($p > 0.05$). Overall 57.7% of myomectomies were via open abdominal approach and 42.3% laparoscopic. Two patients (7.7%) were converted from laparoscopic to open. All study recruits received SL treatment or placebo within the optimal timeframe (> 30 minutes). EBL was comparable between groups at 281.7mls vs. 260.5mls ($p > 0.05$). In this preliminary analysis there was no significant difference in any other outcome measures between the two groups.

Conclusions
The trial design for POMMS study is adequate to address the hypothesis outlined, although in this preliminary data no conclusions can be drawn regarding efficacy of misoprostol in reducing blood loss in myomectomy. Treatment administration via sublingual route is well tolerated and administered within optimal time to observe a clinical effect.

1. Niroomand N, Hajiha S, Tabrizi NM, Ghajarzadeh M. A single dose of misoprostol for reducing hemorrhage during myomectomy: a randomized clinical trial. Archives of Gynecology and Obstetrics. 2015;292(1):155-8.
2. Abdel-Hafeez M, Elnaggar A, Ali M, Ismail AM, Yacoub M. Rectal misoprostol for myomectomy: A randomised placebo-controlled study. Aust N Z J Obstet Gynaecol. 2015;55(4):363-8.

Not Enough Time, Not Enough Operating... and Other Reasons Why Trainees Don't Use Simulation (plus some solutions)

Erin Wilson[1, 2], Brian Jolly[3], Michael Beckmann[4, 1], Sarah Janssens[1, 5], David G Hewett[2], Shelley Wilkinson[1]

1. Mater Health, Brisbane, Queensland, Australia

2. University of Queensland Faculty of Medicine, Brisbane

3. School of Medicine and Public Health, University of Newcastle, Newcastle, NSW

4. Mater Research, Auchenflower, QLD, Australia

5. Mater Education, Brisbane

Background:
With the goal of improving access to simulation training for gynaecology trainees, each trainee at a tertiary hospital in Brisbane was provided with a "take-home" portable laparoscopic trainer and a curriculum of tasks. Whilst trainees demonstrated some improvements in simulated laparoscopic skills, their engagement with the program was poor. This was despite the program being designed to overcome the known barriers to training. A subsequent study was therefore performed with an aim to more deeply understand the factors influencing the use of such laparoscopic simulators and make suggestions to optimise engagement in future programs.

Design:
A detailed qualitative analysis was performed of interview transcripts from gynaecology trainees who participated in a take-home laparoscopic box trainer simulation program. Transcripts were analysed and emerging themes were sorted using a framework that allowed the formulation of targeted intervention strategies based on behavior-change research.

Results:
Ten of the 16 participants in the program were interviewed. Trainees appeared to have positive attitudes towards the concept of simulation training. However, they experienced numerous barriers to training, many of which were previously under-recognised. Trainees identify as busy doctors, with their professional duties, additional training activities and competing life priorities limiting their time to train. Trainees experienced feelings of inertia and trained less often than even they anticipated. A lack of real operating, perceived poor relationship of training tasks to surgery and difficulties with equipment set up reduced their motivation to practice. Those who trained were motivated by supervision, recognizing their own skill development, belief in the role of simulation training, self-directed training to goals and task deadlines. These findings enabled the development of a range of strategies to improve trainee engagement with laparoscopic simulation, which will be discussed in more detail.

Conclusion:
Despite research demonstrating improved laparoscopic skills following simulation training, trainees did not use their simulators as much as they expected. They believed in the role of simulation, but experienced a wide range of barriers to engagement with this training. A theory driven analysis enabled the development of targeted, evidence-based interventions, which may be incorporated into future versions of the program. This information may guide other centers wishing to establish laparoscopic simulation training programs.

1. Wilson, E. , Janssens, S. , McLindon, L. A., Hewett, D. G., Jolly, B. and Beckmann, M. (2018), Improved laparoscopic skills in gynaecology trainees following a simulation-training program using take-home box trainers. Aust N Z J Obstet Gynaecol. . doi:10.1111/ajo.12802

SESSION EIGHT A: PK'S / 1530-1630

CROWN BALLROOM 1

New Therapeutic Advances in Endometriosis, SERM, & Others

Bernadette McElhinney

Abstract not provided

Personality & Pain

Robert Schutze

Abstract not provided

Patient Resources – What and How and Do They Work?

Katya Fleming

Abstract not provided

When To Re-Scope – My Pain is No Better

Emma Readman

Abstract not provided

Physiotherapy for Pelvic Pain

Judith Thompso [1]

1. WA, Australia

The treatment of the person with persistent pelvic pain (PPP) is complex and clinicians are challenged by the need to translate and integrate emerging pain science research into an evidence-based coordinated multidisciplinary team approach to this condition. The role of physiotherapy in the assessment and management of pelvic pain and pelvic floor muscle pain conditions, including education, manual therapy, and individualized exercise programs will be discussed within the context of a bio-psychosocial approach.

Problematic Post Op Pain

Phil Kriel[1]

1. WA, Australia

Complex pain after surgery can significantly impact patients' bio-psycho-socially. Management may start pre-operatively for at risk patients, and before incision, during the procedure, as well as for varying durations afterwards for all patients as guided by surgical and patient factors. Pre-op and surgical factors, as well as an overview of multidisciplinary and advanced pharmacological management will be presented.

Oestrogen – What Type Given, How and When?

Jennifer Pontre

Abstract not provided

SESSION EIGHT B: PK'S / 1530-1630

BOTANICAL 2 & 3

Eggs on Ice – (Pimp My Ovary)

Raella Lew

Abstract not provided

Strategies for Preserving Ovarian Function During Surgery for Endometriosis

Anusch Yazadni

Abstract not provided

Fibroids, Fertility and Pregnancy – What Does the Data Show?

Krish Karthigasu

Abstract not provided

Genetics for Idiots

Tristan Hardy

Abstract not provided

Pain in My Perineum

Robyn Leake

Abstract not provided

Itchy Scratchy

Bernadette Ricciardo[1]

1. Fiona Stanley Hospital, WA, Australia

Itch is the most common presenting complaint of a vulval skin problem. It may be due to a large number of heterogenous conditions, including inflammatory dermatoses, infections, hypersensitivity reactions, genodermatoses, and neoplasia. In this talk, a clinical approach to diagnosing pruritic vulval skin disorders will be presented.

Vaginal Organisms: Friend or Foe – Management of RVVC

Sally Murray

Abstract not provided

SATURDAY 9TH MARCH 2019

SESSION NINE A: WAKEY WAKEY – OBSTETRICS & UROGYN / 0800-1000

CROWN BALLROOM 1

Obstetrics Has ARRIVED - Induction for All

Richard Murphy[1]

1. Perth, Western Australia

Richard Murphy will discuss the literature on induction of labour, focusing on the recent NEJM RCT. He will finish with his practice experience with induction.

Please Don't Mess with My Biome- Does Caesarean Section Really Affect the Neonate?

Lisa Stinson[1]

1. University of Western Australia, Subiaco, WA, Australia

There is a wealth of epidemiological evidence to suggest that infants delivered by caesarean section are at a greater risk of non-communicable diseases than their vaginally-delivered counterparts. Mode of delivery has also been associated with differences in the infant microbiome. It has been suggested that these differences are attributable to the “bacterial baptism” of vaginal birth, which is bypassed in caesarean deliveries. This has led to the increasingly popular practice of “vaginal seeding”: the iatrogenic transfer of vaginal microbiota to the neonate to promote establishment of a ‘normal’ infant microbiome. However, the “bacteria baptism” hypothesis does not make sense in light of the ecology and

trajectory of the caesarean-delivered infant microbiome. While caesarean delivery is certainly associated with transient alterations in the infant microbiome, the lack of exposure to vaginal microbiota is unlikely to be a major contributing factor. Instead, it is likely that intrapartum antibiotic administration, absence of labour, differences in breastfeeding behaviours, maternal obesity, and gestational age are major drivers of the caesarean delivery microbial phenotype. The rationale for "vaginal seeding" is, therefore, not justified.

Planning for Perfection in the Imperfect World - How to Combat Placental Invasion

Mathais Epee-Bekima

Abstract not provided

Preventing Coagulopathy as the Patient Bleeds

Roger Browning[1]

1. King Edward Memorial Hospital for Women and Fremantle Hospital, Subiaco, WA, Australia

The use of ROTEM to guide blood product administration during surgery for abnormally invasive placentation.

Proper Perfusion at Placental Invasion – An Aesthetic Perspective

Nolan McDonnell

Abstract not provided

Problems With My Pee After Surgery

Todd Ladanchuk

Abstract not provided

Pondering Urodynamics - Are They Really That Helpful?

Nicolas Tsokos[1]

1. St John of God Health Care, Perth

Urodynamics have been vital in fostering our increased understanding of bladder function. This has helped refine patient's assessment and enabled improvements in management. They are expensive, time consuming and a challenge for some. Evidence exists that with careful patient selection they can in some cases be avoided. However to successfully manage patients they continue to be vital in the management of the complex and to foster our knowledge of bladder physiology.

The Perfect Mesh in the Current Climate

Jessica Yin[1]
1. Hollywood Private Hospital , Nedlands, WA

Transvaginal mesh has been the subject of international attention and ongoing controversy. This presentation will touch on the history of mesh insertion in Australia, the recent Senate enquiry and the recommendations from the Australian Commission for Quality and Safety in Health Care. It is recommended that those practitioners continuing to operate with TV mesh be aware of the recommendations in this era of litigation.

SESSION NINE B: TECHNOLOGY, BREST DISEASE & MENOPAUSE / 0800-1000

BOTANICAL 2 & 3

The Virtual Shared Medical Record

Joseph Sgrol

Abstract not provided

Gadget Geek Live

Mark Ruff [1]
1. Mona Vale Hospital, Roseville, NSW, Australia

Mark will talk about interesting gadgets and cutting edge technologies.

Big Data Collection for the Future

Michael Winlo

Abstract not provided

Patient Experience and Modern Technology

Marcus Tan

Abstract not provided

WHO Needs to See a Geneticist

Nicholas Pachter

Abstract not provided

Practical Breast Disease

Pamela Thompson[1]

1. Fiona Stanley Hospital, ACT, Australia

In Practical breast disease, the presentation will cover common breast symptoms including breast lumps, pain, nipple discharge and breast inflammation in the pregnant and non-pregnant woman. The focus will be on practical assessment and management principles including the triple test and when to refer.

High Risk Breast Patients – Management in the MDT

Christobel Saunders

Abstract not provided

Managing Menopausal Symptoms After Breast Cancer

Paul Cohen[1]

1. St John of God Subiaco Hospital, West Leederville, WA, Australia

More than 6 million women worldwide are living with a diagnosis of breast cancer. Menopausal symptoms affect most breast cancer survivors and may significantly impair quality of life. These symptoms may be more severe than those experienced by women after natural menopause leading to decreased compliance with adjuvant hormonal therapy and worse survival. Managing the consequences of treatment, particularly menopausal symptoms, is a priority in supportive cancer care. This presentation will cover the non-hormonal treatments that are available to treat vasomotor symptoms after breast cancer, the role of the multidisciplinary 'menopause after cancer' clinic and the use of topical vaginal oestrogen. The management of surgical menopause in women at high risk for ovarian cancer, without a personal history of breast cancer, will also be discussed.

SESSION TEN: PROFESSIONALISM IN PRACTICE / 1030-1305

CROWN BALLROOM 1

Bullshift: Get More Openness, Honesty and Straight Talk at Work

Andrew Horabin

Abstract not provided

Professionalism in Practice

Paul McGurgan[1]

1. The University of Western Australia, ., WA, Australia

Medical professionalism is a complex, social construct. It can be viewed as a trait, a process (identity formation and development) or a mixture of both depending on the context.

The speaker will use audience participation to illustrate the good, the bad and the difficult aspects of what it means to be a medical 'professional' in the 21st century, and use these as reference points to explore if we have problems with aspects of professionalism and how we can address these.

What Makes a Good Team in Theatre?

Joseph Carpini

Abstract not provided

Montgomery Decision

Saul Holt QC

Abstract not provided

Its all in My Head

Jade Action

Abstract not provided

Management Versus Leadership – Apples and Oranges

Aleksandra Luksyte

Abstract not provided

Elite Teams – Playing Field to Practice

Ashleigh Nelson

Abstract not provided

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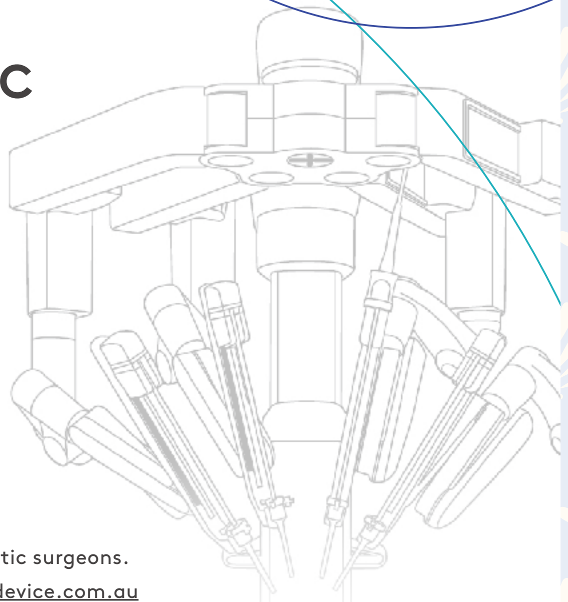

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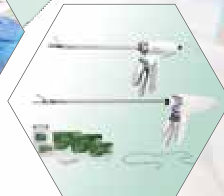
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