

AGES Focus Meeting

ENDOSCOPY FOR FERTILITY

20 & 21 November 2008

Sheraton Perth Hotel
Western Australia



Ovum II by Ana Duncan

AGES Workshop

**ROBOTIC
SURGERY**

19 November 2008

St John of God Hospital
Subiaco, Perth
Western Australia

International Faculty

Professor Togas Tulandi, Canada
Assoc Professor John Boggess, USA

ABSTRACTS & PROGRAM

Platinum Sponsor of AGES

stryker[®]

Major Sponsor of AGES

Johnson & Johnson
MEDICAL



AUSTRALIAN
GYNAECOLOGICAL
ENDOSCOPY
SOCIETY LTD

SPONSORS & EXHIBITORS

AGES gratefully acknowledges the following companies:

stryker[®]

Platinum Sponsor of AGES

Johnson & Johnson
MEDICAL

Major Sponsor of AGES

SPONSORS

Baxter Biosurgery

Covidien

Fisher & Paykel Healthcare

EXHIBITORS

Cytec

B Braun Aesculap

Colocap Pharmaceuticals

ConMed Linvatec

Cook Australia

Experien

Gyrus ACMI

InSight Oceania

Intervent

Merck Serono

Olympus Australia



CONTENTS

SPONSORS AND EXHIBITORS	inside cover
FACULTY, AGES BOARD AND COMMITTEE MEMBERS	2
WELCOME MESSAGE	3
OPTIONAL WORKSHOP PROGRAM	5
CONFERENCE PROGRAM	6
ABSTRACTS	8
THURSDAY 20 NOVEMBER	8
FRIDAY 21 NOVEMBER	14
FUTURE AGES MEETINGS	20
CONFERENCE INFORMATION & CONDITIONS	inside back cover



Ovum II by Ana Duncan

AGES BOARD

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

ORGANISING COMMITTEE

Dr Krishnan Karthigasu	Chair
Professor Tony McCartney	Co-Chair
Assoc Professor Roger Hart	Scientific Chair
Dr Bernadette McElhinney	
Dr Stuart Salfinger	
Dr Iris Menninger	

INTERNATIONAL FACULTY

Professor Togas Tulandi	Canada
Assoc Professor John Boggess	USA

AGES SECRETARIAT

Phone: +61 2 9967 2928 Fax: +61 2 9967 2627
 Email: conferences@ages.com.au
 Address: 282 Edinburgh Road,
 Castlecrag NSW 2068, AUSTRALIA

AUSTRALIAN FACULTY

Dr Jason Abbott	NSW
Dr Fariba Behnia-Willison	SA
Mr Harsha Chandraratna	WA
Dr Michael Cooper	NSW
Dr Phil Daborn	WA
Dr Robert Ford	NSW
Assoc Professor Roger Hart	WA
Dr Krishnan Karthigasu	WA
Assoc Professor Alan Lam	NSW
Dr Robyn Leake	WA
Assoc Professor Chris Maher	QLD
Professor Tony McCartney	WA
Dr Bernadette McElhinney	WA
Dr Iris Menninger	WA
Assoc Professor Harry Merkur	NSW
Dr Sanjay Nadkarni	WA
Dr Jay Natalwalla	WA
Dr Rob O'Shea	SA
Mr Richard Pemberton	WA
Dr Stuart Salfinger	WA
Dr Graeme Thompson	WA
Dr Jim Tsaltas	VIC
Dr Simon Turner	WA
Dr Michael Wynn-Williams	QLD
Dr Anusch Yazdani	QLD

MEMBERSHIP OF AGES

Membership application forms are available from the AGES website or from the AGES Secretariat, 282 Edinburgh Road, CASTLECrag NSW 2068 AUSTRALIA

PR&CRM AND CPD POINTS

The AGES Focus Meeting 2008, 'Endoscopy for Fertility' has been approved as a RANZCOG Approved O&G Meeting and eligible Fellows of the College will earn points as follows:

ATTENDANCE: Full: 18 CPD points in the Meetings category
 Thursday 20 November: 9 CPD points.
 Friday 21 November: 8 CPD points
 Breakfast Session Friday 21 November: 1 CPD point

Attendance rolls must be signed each day and at the breakfast session for points to be awarded.
 Completion of the Pre and Post Questionnaires: 5 PR&CRM points

The college approved Pre- and Post-Questionnaires are comprised of 25 multiple choice questions from lectures given on Thursday 20 November and Friday 21 November 2008.

The Pre-Questionnaire must be handed in at Morning Tea on Thursday 20 November. The Post-Questionnaire must be handed in at the close of the meeting on Friday 21 November. No exceptions can be made to these deadlines.



WELCOME

Dear Colleagues,

The AGES Board is delighted to welcome you to Perth, Western Australia for the AGES Focus Meeting entitled 'Endoscopy for Fertility'.

Prior to the commencement of the meeting we are holding an AGES workshop in robotic surgery at St John of God Hospital, Subiaco, facilitated by experts from the USA, Assoc Professor John Boggess designed to:

- examine the role of the robot in gynaecology surgery
- provide one to one practical interaction with the robot, and
- demonstrate a case of live gynaecological robotic surgery.

Approximately 10-15% of couples will require some form of assistance in achieving a pregnancy, and this figure may be higher in certain groups of patients.

Endoscopic surgery has provided not only improved means of diagnosis of problems, but also surgical options to treat conditions where improved fertility outcomes are needed.

The meeting in Perth aims to show the current and future role of endoscopic surgery in sub-fertile couples, with national and international experts in the area.

Topics to be discussed include management of uterine anomalies, training in minimal access surgery for fertility specialists, hysteroscopic surgery, management of pelvic and adnexal diseases, management of tubal disease, fertility preserving cancer surgery, interactive sessions involving complications of surgery in those wishing to conserve fertility and new techniques for fertility surgery and robotic surgery.

We aim to explore the breadth and depth of Endoscopy in this field of gynaecology, so those attending the meeting will have a greater practical and theoretical knowledge of the area to apply in practice.

We are privileged to have a number of international experts at this meeting. Professor Togas Tulandi is well known in the field of endoscopic surgery and fertility with countless publications and books written on this topic, and most involved with fertility work with are aware of his reputation. A/Professor John Boggess is a leader in the burgeoning world of robotic surgery, with Assoc Professor Boggess lecturing and operating internationally on robotic surgery.

The Gala Dinner will be held at the award winning Matilda Bay Restaurant overlooking the Swan River and the City.

We also encourage you to explore Perth and surrounding areas during your stay. It is the perfect time of year to visit the wineries and sites in the south-west of Western Australia, and to enjoy the beaches and restaurants of Perth.

We trust you will enjoy the AGES Focus Meeting 2008 in our beautiful city.

Krishnan Karthigasu
Conference Chair

Tony McCartney
Co-Chair

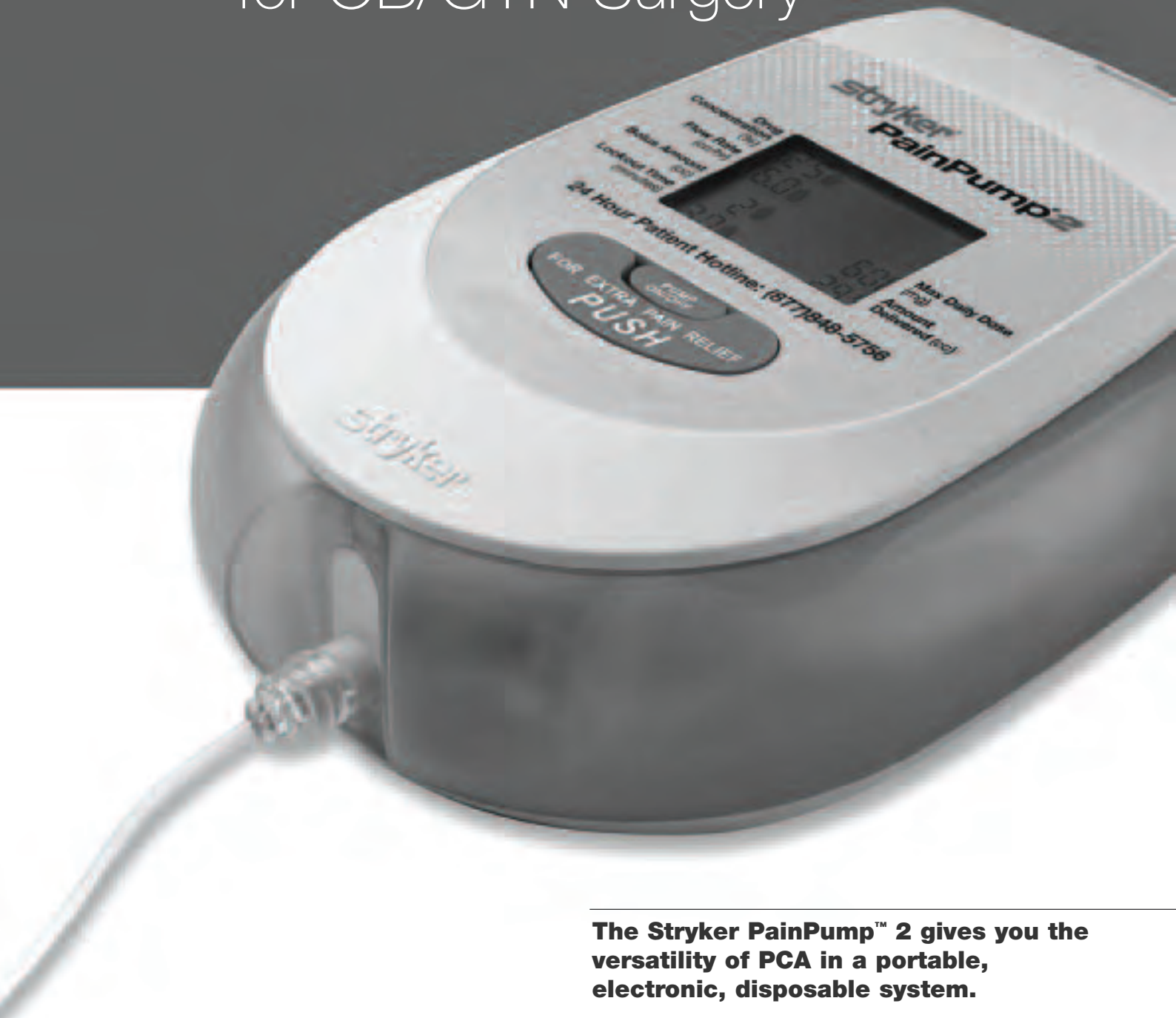
Roger Hart
Scientific Chair

Alan Lam
AGES President



PainPump™ 2

Pain Management
for OB/GYN Surgery



The Stryker PainPump™ 2 gives you the versatility of PCA in a portable, electronic, disposable system.

Perfect for use in continuous peripheral nerve blocks and in site-specific postoperative infusion

OPTIONAL WORKSHOP PROGRAM

WEDNESDAY 19 NOVEMBER 2008

AGES Workshop

ROBOTIC SURGERY

St John of God Hospital, 12 Savado Road, Subiaco WA

ORGANISING COMMITTEE

Professor Tony McCartney	WA
Dr Krishnan Karthigasu	WA
Assoc Professor Roger Hart	WA
Dr Bernadette McElhinney	WA
Dr Stuart Salfinger	WA
Dr Iris Menninger	WA

INTERNATIONAL FACULTY

Assoc Professor John Boggess	USA
------------------------------	-----

AUSTRALIAN FACULTY

Dr Tom Manolitsas	VIC
Dr Justin Vivian	WA

'Come See and Play with the Robot'

AGES would like to welcome you to Perth and one of the first Gynaecology Robotic Surgery Workshops in Australia.

AGES has always been at the forefront of innovation in gynaecological surgery and is considered a leader in the field.

In recent years one of the major advances in surgery has been the use of robotic technology. At this moment in time it is in its infancy in Australia, but is being used on a regular basis in the USA.

We are privileged to have one of the world experts in gynaecologic robotic surgery from USA – Assoc Professor John Boggess – in Perth to demonstrate and to perform live surgery using the robot. These the first cases of robotic gynaecological surgery in Western Australia will be performed at St John of God Hospital, Subiaco.

This workshop aims to not only discuss the theory and uses of the robot, but also to get a "hands on" experience with the robot and see live surgery using the robot.

This workshop will be of use to anyone interested in the future of gynaecological surgery.

We hope you will gain valuable knowledge at this AGES Workshop.

Tony McCartney **Krishnan Karthigasu**

MORNING SESSION

0800	Introduction	A McCartney, K Karthigasu
0815	Evolution of robotic surgery	T Manolitsas
0830	Robotic surgery in Western Australia so far	J Vivian

0900	Anatomy overview and port placement	J Boggess
------	--	-----------

1000 MORNING TEA

1030	Practical 'hands on' with the robot	
1130	Robotic surgery in gynaecological oncology	J Boggess
1230	Robotic surgery in general gynaecology – is there a future?	T Manolitsas

1300 LUNCH AND DISCUSSION WITH THE EXPERTS

AFTERNOON SESSION

1400	Live robotic surgery – Total laparoscopic hysterectomy	A McCartney, J Boggess
------	---	------------------------

Commentary: T Manolitsas

1530 AFTERNOON TEA

1600	'Hands on with the robot'	
1700	Closing comments	A McCartney

The AGES Robotic Workshop has been approved as a RANZCOG Approved O&G Meeting and eligible Fellows of the College will earn points as follows:
Attendance Wednesday 19 November 8 CPD points.
Attendance roll must be signed for points to be awarded.



CONFERENCE PROGRAM

THURSDAY 20 NOVEMBER 2008

AGES Focus Meeting

ENDOSCOPY FOR FERTILITY

Golden Ballroom, Sheraton Perth

0800 Welcome A Lam
K Karthigasu

0815 PR&CRM Points – Pre-Questionnaire R Ford

0830 SESSION 1

Sponsored by Stryker

TRAINING IN ENDOSCOPIC SURGERY

Chairs: A Lam, R O'Shea

0830 Training tools for laparoscopic surgery
K Karthigasu

0855 Endoscopic training for CREI A Yazdani

0920 Setting up a training program in
laparoscopic surgery I Menninger
B McElhinney

0935 Hysteroscopic training J Abbott

1000 MORNING TEA AND TRADE EXHIBITION

1030 KEYNOTE LECTURE

Introduction K Karthigasu

Management of uterine myoma 2008 T Tulandi

1100 SESSION 2

Sponsored by Johnson & Johnson Medical

HYSTEROSCOPIC SURGERY FOR FERTILITY

Chairs: J Abbott, I Menninger

1100 Hysteroscopic treatment of fibroids R Hart

1115 Ashermann's Syndrome J Abbott

1130 Hysteroscopic surgery for uterine anomalies
T Tulandi

1150 Laparoscopic creation of neo-vagina M Cooper

1210 Questions

1215 LUNCH AND TRADE EXHIBITION

1315 SESSION 3

HIGHLIGHTS FROM THE AGES/WES 10TH WORLD CONGRESS ON ENDOMETRIOSIS

Chairs: H Merkur, B McElhinney

1315 Highlights from the scientific program J Tsaltas

1345 Highlights from the clinical program J Tsaltas

1415 SESSION 4

FIBROIDS AND FERTILITY

Chair: M Cooper

1415 Evidence for fibroids and infertility R Hart

1435 Surgery for fibroids – practical tips in
operating on fibroids for fertility
M Wynn-Williams

1455 Radiological treatment of fibroids S Nadkarni

1515 Case discussion and questions I Menninger

Panel discussion

Panel: R Hart, M Wynn-Williams, S Nadkarni,
J Tsaltas, K Karthigasu

1530 AFTERNOON TEA AND TRADE EXHIBITION

1600 SESSION 5

Sponsored by Stryker

ROBOTICS

Chairs: A McCartney, K Karthigasu

1600 KEYNOTE LECTURE

Introduction A McCartney

Robotics and gynaecology in 2008 J Boggess

1630 Robotic use in WA – a urology view R Pemberton

1700 Practical use of the robot in USA / video
presentations J Boggess

1730 Close

1900 FOR 1930 GALA DINNER

MATILDA BAY RESTAURANT

Complimentary coach transfers will depart from
the Sheraton Perth Hotel at 1830



FRIDAY 21 NOVEMBER 2008

AGES Focus Meeting

ENDOSCOPY FOR FERTILITY

Goldsworth Room Sheraton Perth

0730 OPTIONAL BREAKFAST SESSION

Sponsored By Baxter Biosurgery

A Simple Solution to Reduce Adhesions

Speakers: GH Trew & AA Luciano

(numbers limited - bookings at registration desk essential)

Golden Ballroom, Sheraton Perth

0830 **Housekeeping** K Karthigasu

0845 SESSION 6

Sponsored by Johnson & Johnson Medical

TUBAL SURGERY AND MANAGEMENT OF THE YOUNG WOMAN WITH ENDOMETRIOSIS

Chairs: R Ford, S Salfinger

0845 **Ectopic pregnancy – current management to retain fertility** G Thompson

0915 **Laparoscopic tubal surgery in the IVF era** T Tulandi

0945 **The young woman with endometriosis – long term management** K Karthigasu

1015 MORNING TEA AND TRADE EXHIBITION

1045 SESSION 7

OBESITY AND FERTILITY

Chairs: A Yazdani, S Turner

1045 **Effects of obesity on fertility** R Hart

1105 **Minimally invasive surgical options for treatment of obesity** H Chandraratna

1125 SESSION 8

IVF

Chair: J Tsaltas, G Thompson

1125 **Endoscopic surgery prior to IVF: who, when & how?** A Yazdani

1145 **Single woman in her mid 30s, what are the options?** S Turner

1205 Case presentations – dilemmas for IVF – panel discussion

Panel: R Hart, S Turner, T Tulandi, A Yazdani, J Natalwalla, M Cooper

1230 LUNCH AND TRADE EXHIBITION

1330 SESSION 9

FERTILITY PRESERVING CANCER SURGERY

Chairs: A Lam, C Maher

1330 **Cervix/endometrial issues – hyperplasia/neoplasia** T McCartney

1350 **Ovarian masses, early ovarian cancer/borderline tumors** S Salfinger

1410 **CIN treatment and fertility** B McElhinney

1430 SESSION 10

FERTILITY PRESERVING PROLAPSE SURGERY

Chairs: F Behnia-Willison, R Leake

1430 **Vaginal approach to fertility preserving prolapse surgery** C Maher

1450 **Laparoscopic approach to uterine preserving prolapse surgery** A Lam

1510 **Can we use mesh safely in fertility preserving prolapse surgery? Benefits and pitfalls** P Daborn

1530 AFTERNOON TEA AND TRADE EXHIBITION

1600 SESSION 11

Sponsored by Stryker

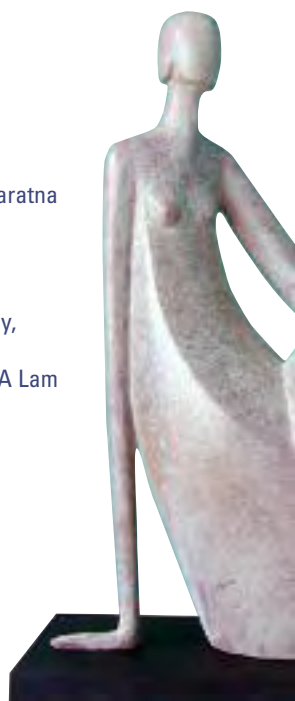
ANATOMY OF COMPLICATIONS IN FERTILITY PATIENTS

Chairs: P Daborn, R Leake

1600 **Tiseal and Flowseal treatment for haemorrhage** H Chandraratna

1630 **Interactive sessions – Complications**
Chairs: P Daborn, R Leake
Panel: T Tulandi, J Abbott, A Lam, T McCartney,

1730 **Close – Final remarks** A Lam



ABSTRACTS

THURSDAY 20 NOVEMBER 2008

TRAINING TOOLS FOR LAPAROSCOPIC SURGERY

Thursday 20 November / Session 1 / 0830-0855

Karthigasu K

In recent years training in surgery has come under greater scrutiny by both the public as well as the specialist colleges. The previous system of mentorship is presently increasingly difficult to implement with the increase in trainee numbers, reduced working hours, reduced number of surgical cases plus its inherent subjectiveness. Laparoscopic surgery requires additional skills to conduct advanced surgery. In this presentation I will discuss the various training tools available to acquire skills in surgery, particularly laparoscopic surgery and some evidence of their effectiveness.

Author Affiliation: Dr K Karthigasu. King Edward Memorial Hospital for Women, Subiaco WA, Australia.

SETTING UP A TRAINING PROGRAM IN LAPAROSCOPIC SURGERY

Thursday 20 November / Session 1 / 0920-0935

McElhinney B, Menninger I

Endoscopic gynaecological procedures were introduced more than twenty years ago. The number of endoscopic procedures performed and their diversity has increased over the years. As early as 1981 surgical societies and hospitals worldwide introduced guidelines regarding laparoscopic surgery. Endoscopic operations are an integral part of our daily work and require a structured training programme.

New modalities by which doctors in training are taught are required to avoid medical error, teach more complex surgical techniques and make up for less exposure to hands on surgical training of junior doctors requires.

At King Edward Memorial Hospital for Women we have developed a comprehensive endoscopic training program for junior doctors to acquire basic and advanced laparoscopic skills.

The aim is for the trainees to improve their surgical safety, operative confidence and efficiency. The course focuses on the techniques necessary to safely carry out endoscopic

procedures. The different modalities used to acquire basic laparoscopic skills include lectures and box training simulators to improve hand-eye coordination and depth perception and get acquainted with different entry techniques, trochar placements and instruments. Animal and cadaver practice sessions as well as life surgery are used to teach advanced laparoscopic skills like dissection, cutting, coagulation, suturing and knot-tying. The training is objectively assessed using multiple choice questions before and after the training module. Endoscopic skills are also assessed by an experienced trainer in the operating room.

Good clinical training and supervision can be considered an essential part of a junior doctors' training. It would be desirable if national/international training programs for endoscopic surgery could be developed overseen by the individual surgical colleges.

Author Affiliation: Dr B McElhinney, Dr I Menninger. King Edward Memorial Hospital for Women, Subiaco, WA, Australia.

MANAGEMENT OF UTERINE MYOMA 2008

Thursday 20 November / Session 2 / 1030-1100

Tulandi T

Leiomyoma or fibroid is the most common benign tumor occurring in the uterus and in the female pelvis. Fibroids are the primary indication for hysterectomies and they represent over 30% of the total number of hysterectomies. There are other treatments of uterine fibroids including expectant management, medical treatment, conservative surgical treatment, uterine artery embolization (UAE), and MR guided focused ultrasound (MRgFUS).

For women in reproductive age, myomectomy is an option and in selected cases it can be done by laparoscopy. However, it is essential that the surgeon has an expertise in laparoscopic suturing. Submucous myoma should be treated by hysteroscopic approach. To date, there is a lack of a prospective trial concerning the effect of intramural fibroids on fertility compared to women with no fibroids. Although, UFE has been associated with premature ovarian failure in <1% of women, it appears that it might reduce ovarian reserve affecting future fertility.



Contrary to UAE, MRgFUS is myoma-specific treatment. In theory, it should not affect the ovarian blood supply and ovarian reserve. It is associated with myoma shrinkage of up to 25%. Newer treatments include temporary uterine occlusion with Doppler-guided transvaginal clamp, and intrauterine-ultrasound guided radiofrequency ablation of fibroids. These treatments are still in the investigational phase.

Myolysis is associated with adhesion formation that might further decrease fertility. For women who have completed their family, hysterectomy is a viable option.

References:

1. Agdi M, Valenti D, Tulandi T. Intra-abdominal Adhesions after Uterine Artery Embolization. Am J Obstet Gynecol (In Press).
2. Alessandri F, Lijoi D, Mistrangelo E, Ferrero S, Ragbi N. Randomized study of laparoscopic versus minilaparotomic myomectomy for uterine myomas. J Min Invasive Gynecol 2006;13:92-7.
3. Goldberg J & Pereira L. Pregnancy outcomes following treatment for fibroids: uterine fibroid embolization versus laparoscopic myomectomy. Curr Opin Obstet Gynecol.2006; 18: 402-406.
4. Goodwin SC, Bradley LD, Lipman JC, Stewart EA, Noshier JL, Sterling KM, Barth MH, Siskin GP & Shlansky-Goldberg RD. Uterine artery embolization versus myomectomy: a multicenter comparative study. Fertil Steril. 2006; 85: 14-21.
5. Pritts EA. Fibroids and infertility: a systematic review of the evidence. Obstet Gynecol Surv 2001;56: 483-491
6. Seracchioli R, Manuzzi L, Vianello F, Gualerzi B, Savelli L, Paradisi R, Venturoli S. Obstetrics and delivery outcome of pregnancies achieved after laparoscopic myomectomy. Fertil Steril 2006;86:159-65
7. Spies JB, Bruno J, Czeyda-Pommersheim F, Magee ST, Ascher SA & Jha RC. Long-term outcome of uterine artery embolization of leiomyomata. Obstet Gynecol. 2005; 106: 933-935.
8. Stewart EA, Rabinovici J, Tempany CMC, Inbar Y, Regan L, Gastout B, Hesley G, Kim HS, Hengst S & Gedroye WM. Clinical outcomes of focused ultrasound surgery for the treatment of uterine fibroids. Fertil Steril. 2006; 85 : 22-29.

9. Tulandi T. Treatment of uterine myomas. Is surgery obsolete? NEJM 2007;356:411-3.

Author Affiliation: Togas Tulandi MD, MHCM, FRCSC, FACOG. Professor of Obstetrics and Gynecology, Milton Leong Chair in Reproductive Medicine, McGill University, Montreal, Quebec, Canada.

HYSTEROSCOPIC TREATMENT OF FIBROIDS

Thursday 20 November / Session 2 / 1100-1115

Hart R

This review will focus on the procedure of hysteroscopic resection of fibroids and will include a discussion on patient selection, the procedure, the risks of hysteroscopic surgery and the success of the procedure. The discussion will also include a brief mention of alternative techniques.

Author Affiliation: R Hart, Associate Professor Reproductive Medicine, School of Women's and Infants Health, the University of Western Australia. King Edward Memorial Hospital, Subiaco, WA, Australia.

HYSTEROSCOPIC SURGERY FOR UTERINE ANOMALY

Thursday 20 November / Session 2 / 1130-1150

Tulandi T

Besides septate uterus, most uterine anomalies do not require correction. Septate uterus has the highest rate of recurrent pregnancy losses and poor obstetrical outcome. Treatment is performed by hysteroscopic approach. The term delivery rates after hysteroscopic metroplasty are approximately 80% with a miscarriage rate of approximately 15%.

It is paramount to establish the diagnosis preoperatively. The best non-surgical technique for diagnosing and differentiating different types of uterine anomalies is magnetic resonance imaging. It is particularly useful to differentiate septate, bicornuate or didelphys uterus.

The septum is avascular. Bleeding usually occurs when the incision reaches the level of the myometrium at the fundus. The procedure is terminated at this point. Reproductive outcome is favorable with a residual septum of <1cm.

Further septum resection is not recommended. A complete septum involves the cervix. Some surgeons believe that resection of the cervical portion is associated with cervical incompetence. However, leaving the cervical portion of the septum might cause dystocia preventing vaginal delivery. Our practice is to resect the cervical septum.

References:

1. Atlas of Laparoscopy and Hysteroscopy Technique, 3rd edition (Ed. T. Tulandi), Informa, London, 2007.
2. Homer HA, Li TC, Cooke ID. The septate uterus: a review of management and reproductive outcome. *Fertil Steril* 2000;73(1):1-14
3. Pabuccu R, Gomel V. Reproductive outcome after hysteroscopic metroplasty in women with septate uterus and otherwise unexplained infertility. *Fertil Steril* 2004;81(6):1675-8

Author Affiliation: Togas Tulandi MD, MHCM. Professor of Obstetrics and Gynecology & Milton Leong Chair in Reproductive Medicine McGill University, Montreal, Quebec, Canada.

LAPAROSCOPIC CREATION OF NEO-VAGINA

THE VECCHIETTI PROCEDURE

Thursday 20 November / Session 2 / 1150-1210

Cooper M

Mayer-Von Rokitansky-Kuster-Hauser (MRKH) Syndrome is a rare congenital abnormality characterised by normal secondary sexual characteristics, vaginal aplasia, normal ovaries and a rudimentary uterus. The prevalence of this anomaly is one case per 4-5,000 live female births. To produce a functioning neovagina in affected subjects, management relies on one of several approaches; non-surgical i.e. Frank technique (1), a split-thickness skin graft i.e. McIndoes technique (2), sigmoid colon grafts (3,4) or a combination of surgical and non-surgical (Vecchietti technique). Numerous variations of these techniques have also been described.

Giuseppe Vecchietti first described his technique for creating a neovagina in subjects with Mayer-Von Rokitansky-Kuster-Hauser Syndrome (MRKH) in 1965 (5). The initial description was of an open abdominal procedure involving a Pfannenstiel incision, dissection of the vesico-rectal space and placement transabdominally of two sutures passing from the anterior abdominal wall through the vaginal groove and into an external 'dilation olive'. Post-operatively the 'olive' is progressively drawn into the vaginal groove by continuous and increasing

tension on the abdominal sutures wound. A neovagina is thus formed and is maintained patent by subsequent dilator use. This procedure has been used for subjects with vaginal aplasia secondary to Mayer-Von Rokitansky-Kuster-Hauser and Morris syndrome (6) but also in subjects with a shortened vagina secondary to surgery or radiotherapy (7). The open procedure has been seen to be highly effective in producing an anatomical and functional neovagina in more than 600 cases. The laparoscopic approach was first described in 1992 (8,9) and has been shown to have similar outcomes to the open procedure (10). Vecchietti procedures have been predominantly performed in Europe with only one case being reported in the Australasian literature to date (11).

The authors experience will be described during the presentation.

References:

1. Frank, R. T. The formation of an artificial vagina without operation. *Amer. J Obst Gynec* 1938; 35: 1053.
2. McIndoe, A. The treatment of congenital absence and obliterative conditions of the vagina. *Brit J Plast Surg* 1950; 2: 254.
3. Wesley, J. R. and Coran, A. G.: Intestinal vaginoplasty for congenital absence of the vagina. *J Ped Surg* 1992;27: 885.
4. Hendren, W. H. and Atala, A.: Use of bowel for vaginal reconstruction. *J Urol* 1994; 152: 752.
5. Vecchietti G. [Creation of an artificial vagina in Rokitansky-Kuster-Hauser syndrome]. *Attual Ostetric Ginecol.* 1965; 11(2): 131-47, Mar-Apr.
6. Marzetti L. Veneziano M. Boni T. Pecorini F. Framarino dei Malatesta MF. Giobbe M. Fabiani C. [The creation of a neovagina with laparoscopic technique]. *Chirurg Ital* 1999; 51(3): 253-8.
7. Veronikis DK. McClure GB. Nichols DH. The Vecchietti operation for constructing a neovagina: indications, instrumentation, and techniques. *Obstet Gynecol* 1997; 90(2): 301-4.
8. Gauwerky JF. Wallwiener D. Bastert G. An endoscopically assisted technique for construction of a neovagina. *Arch Gynecol Obstet* 1992; 252(2): 59-63.
9. Popp LW. Ghirardini G. Creation of a neovagina by pelviscopy. *J Laparoendosc Surg* 1992; 2(3): 165-73.
10. Borruto F. Chasen ST. Chervenak FA. Fedele L. The Vecchietti procedure for surgical treatment of vaginal agenesis: comparison of laparoscopy and laparotomy. *Intl J Gynaecol Obstet* 1999; 64(2): 153-8.
11. Cooper MJ. Fleming S. Murray J. Laparoscopic assisted Vecchietti procedure for the creation of a



neovagina. J Obstet Gynaecol Res 1996; 22(4): 385-8.

12. Fedele L. Bianchi S. Zanconato G. Raffaelli R. Laparoscopic creation of a neovagina in patients with Rokitansky syndrome: analysis of 52 cases. Fertil Steril 2000; 74(2): 384-9.
13. Bartos P. [Congenital vaginal aplasia: laparoscopic reconstruction of a neovagina using the Vecchietti technique in the Mayer-von Rokitansky-Kuester-Hauser syndrome]. Ceska Gynekol. 2000; 65(1): 45-7.
14. Rechberger T. Kotarski J. Tarkowski R. Jakowicki JA. [Laparoscopic modification of Vecchietti operation in the treatment of congenital vaginal aplasia]. Ginekol Pol 1999; 70(5): 279-83.
15. Khater E. Fathy H. Laparoscopic Vecchietti vaginoplasty. J Am Assoc Gynecol laparoscop 1999; 6(2): 179-82.
16. Chatwani A. Nyirjesy P. Harmanli OH. Grody MH. Creation of neovagina by laparoscopic Vecchietti operation. J Laparoendoscop Adv Surg Techn. Part A. 1999; 9(5): 425-7.
17. Weijnenborg PT. ter Kuile MM. The effect of a group programme on women with the Mayer-Rokitansky-Kuster-Hauser syndrome. Br J Obst Gynaecol 2000; 107(3): 365-8.

Author Affiliation: Dr Michael Cooper, Clinical Senior Lecturer, Department of Obstetrics and Gynaecology, Sydney Univeristy.

EVIDENCE FOR FIBROIDS AND INFERTILITY

Thursday 20 November / Session 4 / 1415-1435

Hart R

This presentation will focus on the origins of fibroids, their association with subfertility and the treatment strategies currently available. The evidence for the effect of submucosal, intramural and subserosal fibroids on conception will be discussed and the evidence for and against surgical intervention will be described.

Author Affiliation: R Hart, Associate Professor Reproductive Medicine, School of Women's and Infants Health, the University of Western Australia. King Edward Memorial Hospital, Subiaco, WA, Australia.

SURGERY FOR FIBROIDS – PRACTICAL TIPS FOR OPERATING ON FIBROIDS FOR FERTILITY

Thursday 20 November / Session 4 / 1435-1455

Wynn-Williams M

The surgical management of uterine fibroids for the fertility can present many challenges to the gynaecological surgeon. Firstly the decision to perform surgery and improve the fertility must be balanced against the risks of surgery and the potential risks to a future pregnancy. Ultrasound and MRI may be used to map the size and position of fibroids to carefully plan the surgical approach and inform the patient of the potential risks.

Laparoscopic and laparoscopic assisted myomectomy are both effective techniques for managing intramural, subserosal and pedunculated fibroids. The size and position of the fibroid can limit the ease with which the procedure can be performed. Open myomectomy has traditionally been used for numerous and larger fibroids. Temporary uterine artery occlusion at laparoscopic myomectomy is a novel method of performing laparoscopic myomectomy on larger fibroids.

At completion of the procedure, removal of myomata from the abdominal cavity can be a time-consuming. A number of techniques including the use of a laparoscopic knife, mechanical morcelation and kevlar retrieval bags have been used to expedite the process. Adhesions following myomectomy are unfortunately common. Anti-adhesion barriers such as Adept and Seprafilm could be of benefit for future fertility by reducing adhesions.

Author Affiliation: Dr Michael Wynn-Williams – Eve Gynaecology, Brisbane, Australia.

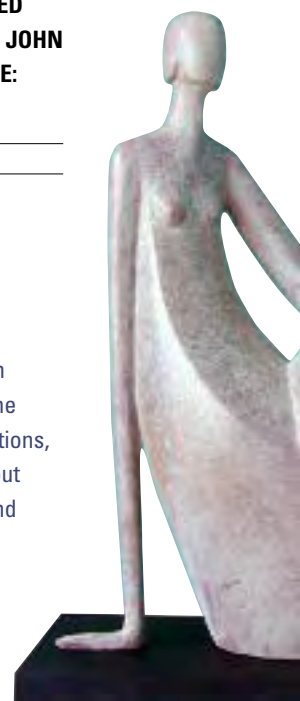
THE FOLLOWING ABSTRACTS ARE FROM PUBLISHED ARTICLES SUBMITTED BY ASSOCIATE PROFESSOR JOHN F BOGGESS IN SUPPORT OF THE PLENARY LECTURE: ROBOTICS AND GYNAECOLOGY IN 2008

Thursday 20 November / Session 5 / 1600-1630

ROBOTIC SURGERY IN GYNECOLOGIC ONCOLOGY: EVOLUTION OF A NEW SURGICAL PARADIGM

Boggess JF

Robotic surgical platforms were first developed with telesurgery in mind. Conceptualized by NASA and the military to provide surgical expertise to remote locations, some telesurgical success has been documented, but progress has been held back by communication band



width limitations. Telepresence surgery, where the surgeon is in proximity to the patient but is provided with an ergonomic console equipped with three-dimensional vision and autonomous control of wristed laparoscopic surgical instruments and energy sources, has shown efficacy first in cardiac and then urologic cancer surgery. Interest is currently focused on the application of this technology in the field of gynecology, with techniques being described to perform simple hysterectomy, myomectomy, tubal anastomosis, and pelvic reconstruction procedures. This article will review the application of robotic- and computer-assisted surgery in the specialty of gynecologic oncology.

Author Affiliation: John F. Boggess, Department of Gynecologic Oncology, University of North Carolina at Chapel Hill, 4014 Old Clinic Building, Chapel Hill, NC27599-7570, USA.

Cite this article as: Boggess J F. Robotic surgery in gynecologic oncology: Evolution of a new surgical paradigm. *J Robotic Surg* DOI 10.1007/s 11701-007-0011-4

ROBOTIC-ASSISTED ENDOMETRIAL CANCER STAGING AND RADICAL HYSTERECTOMY WITH THE DA VINCI® SURGICAL SYSTEM

Shafer A, Boggess JF

Robotic-assisted surgery leverages the advantages of standard laparoscopy while restoring three-dimensional vision, ergonomic, intuitive controls, and wristed instruments that approximate the motion of the human hand. Robotic-assisted surgery has already shown feasibility and in many cases superiority to standard laparoscopy in urology and general and cardiothoracic surgery. The applications of robotic-assisted surgery are rapidly being incorporated into the field of gynecologic oncology.

Author Affiliation: Aaron Shafer, John F. Boggess, Division of Gynecologic Oncology, The University of North Carolina at Chapel Hill, Chapel Hill, NC, USA.

Cite this article as: Shafer A, Boggess J F. Robotic-assisted endometrial cancer staging and radical hysterectomy with the da Vinci® surgical system. *Gynecol Oncol* (2008), doi:10.1016/j.ygyno.2008.07.023

A COMPARATIVE STUDY OF 3 SURGICAL METHODS FOR HYSTERECTOMY WITH STAGING FOR ENDOMETRIAL CANCER: ROBOTIC ASSISTANCE, LAPAROSCOPY, LAPAROTOMY

Boggess JF, Gehrig PA, Cantrell L, Shafer A, Ridgway M, Skinner EN, Fowler WC

Objective: The purpose of this study was to compare outcomes in women who underwent endometrial cancer staging by different surgical techniques.

Study Design: Three hundred twenty-two women underwent endometrial cancer staging: 138 by laparotomy (TAH); 81 by laparoscopy (TLH) and 103 by robotic technique (TRH).

Results: The TRH cohort had a higher body mass index than the TLH cohort ($P=0.008$). Lymph node yield was highest for TRH ($P<0.0001$); hospital stay ($P<0.0001$) and estimated blood loss ($P<0.0001$) were lowest for this cohort. Operative time was longest for TLH (213.4 minutes) followed by TRH (191.2 minutes) and TAH (146.5 minutes); $P<0.0001$. Postoperative complication rates were lower for TRH, compared with TAH (5.9% vs 29.7%; $P<0.0001$). Conversion rates for the robotic and laparoscopic groups were similar.

Conclusion: TRH with staging is feasible and preferable over TAH and may be preferable over TLH in women with endometrial cancer. Further study is necessary to determine long-term oncologic outcomes.

Author Affiliation: John F. Boggess, MD; Paola A. Gehrig, MD; Leigh Cantrell, MD; Aaron Shafer, MD; Mildred Ridgway, MD; Elizabeth N. Skinner, MD; Wesley C. Fowler, MD. Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC.

Cite this article as: Boggess J F, Gehrig P A, Cantrell L, et al. A comparative study of 3 surgical methods for hysterectomy with staging for endometrial cancer: robotic assistance, laparoscopy, laparotomy. *Am J Obstet Gynecol* 2008; 199: 360. e1-360.e9

A CASE-CONTROL STUDY OF ROBOT-ASSISTED TYPE III RADICAL HYSTERECTOMY WITH PELVIC LYMPH NODE DISSECTION COMPARED WITH OPEN RADICAL HYSTERECTOMY

Boggess JF, Gehrig PA, Cantrell L, Shafer A, Ridgway M, Skinner EN, Fowler WC

Objective: The purpose of this study was to compare robotically assisted hysterectomy (RAH) with open (ORH)



type III radical hysterectomy in the treatment of early-stage cervical cancer.

Study Design: The outcomes of 51 consecutive patients who underwent RAH were compared with the outcomes of 49 patients who underwent ORH.

Results: There were no differences with regard to patient demographics. There were significant differences between the groups with regard to operative blood loss ($P<.0001$), operative time ($P=.0002$), and lymph node retrieval ($P=.0003$), all of which were in favor of the RAH cohort. All patients with RAH were discharged on post operative day 1, compared with a 3.2-day average hospitalization for the cohort with ORH. The incidence of post operative complications was 7.8% and 16.3% for the RAH and ORH cohorts, respectively ($P=.35$).

Conclusion: Robotic type III radical hysterectomy with pelvic node dissection is feasible and may be preferable over open radical hysterectomy in patients with early-stage cervical cancer. Further study will determine procedure generalizability and long-term oncologic outcomes.

Author Affiliation: John F. Boggess, MD; Paola A. Gehrig, MD; Leigh Cantrell, MD; Aaron Shafer, MD; Mildred Ridgway, MD; Elizabeth N. Skinner, MD; Wesley C. Fowler, MD. Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, NC.

Cite this article as: Boggess J F, Gehrig P A, Cantrell L, et al. A case-control study of robot-assisted type III radical hysterectomy with pelvic lymph node dissection compared with open radical hysterectomy. *Am J Obstet Gynecol* 2008; 199: 357. e1-357.e7

WHAT IS THE OPTIMAL MINIMALLY INVASIVE SURGICAL PROCEDURE FOR ENDOMETRIAL CANCER STAGING IN THE OBESE AND MORBIDLY OBESE WOMAN?

Gehrig PA, Cantrell LA, Shafer A, Abaid LN, Mendivil A, Boggess JF

Objective: Thirty-three percent of U.S. women are either obese or morbidly obese. This is associated with an increased risk of death from all causes and is also associated with an increased risk of endometrial carcinoma. We sought to compare minimally invasive surgical techniques for staging the obese and morbidly obese woman with endometrial cancer.

Materials and methods: Consecutive robotic endometrial

cancer staging procedures were collected from 2005–2007 and were compared to consecutive laparoscopic cases (2000–2004). Demographics including age, weight, body mass index (BMI), operative time, estimated blood loss, lymph node retrieval, hospital stay and complications were collected and compared.

Results: During the study period, there were 36 obese and 13 morbidly obese women who underwent surgery with the Da Vinci® robotic system and 25 obese and 7 morbidly obese women who underwent traditional laparoscopy. For both the obese and morbidly obese patient, robotic surgery was associated with shorter operative time ($p=0.0004$), less blood loss ($p=0.0001$), increased lymph node retrieval ($p=0.004$) and shorter hospital stay ($p=0.0119$).

Conclusions: Robotic surgery is a useful minimally invasive tool for the comprehensive surgical staging of the obese and morbidly obese woman with endometrial cancer. As this patient population is at increased risk of death from all causes, including post-operative complications, all efforts should be made to improve their outcomes and minimally invasive surgery provides a useful platform by which this can occur.

Author affiliation: Paola A. Gehrig, Leigh A. Cantrell, Aaron Shafer, Lisa N. Abaid, Alberto Mendivil, John F. Boggess. Division of Gynecologic Oncology, University of North Carolina at Chapel Hill, Chapel Hill, NC27599, USA

Cite this article: Gehrig P A, Cantrell L A, Shafer A, Abaid L N, Mendivil A, Boggess J F. What is the optimal minimally invasive surgical procedure for endometrial cancer staging in the obese and morbidly obese woman? *GynecologicOncology*111(2008)41–45

ROBOTIC SURGERY IN PERTH AUSTRALIA – A UROLOGICAL PERSPECTIVE

Thursday 20 November / Session 5 / 1630-1700

Pemberton R

Minimally invasive Radical Prostatectomy was first described in 1992. It heralded benefits with reduced blood loss, earlier discharge and return to normal activities while maintaining cancer control when compared with open surgery.

The first robotic assisted radical prostatectomy was performed in the US in 1999. It was not until 2003 that Australia followed. SJOG Subiaco in Perth became the fifth DaVinci Robotic system to be operational in Australia commencing in December 2007.



ABSTRACTS

FRIDAY 21 NOVEMBER 2008

This presentation will focus specifically on the establishment of the Robotic programme in Perth solely by urologists performing radical prostatectomy prior to this meeting.

Results from large single centre studies report potential advantages of this approach and include reduced hospital stay and recovery, earlier catheter removal, improved potency rates with equivalent cancer control.

The transition from pure laparoscopic radical prostatectomy will be discussed and early results from prospective data collection presented from the programme's inception.

ECTOPIC PREGNANCY - CURRENT MANAGEMENT TO RETAIN FERTILITY

(OLD IS THE NEW NEW)

Friday 21 November / Session 6 / 0845-0915

Thompson GR

Objective: To present a balanced, objective approach to the management of ectopic pregnancy (EP) with regard to the future fertility of the patient.

Methods: Literature search (both historical and contemporary) and presentation of previously published data from our group and others.

Application of deductive reasoning to the problem.

Conclusions: Even with the availability of assisted reproductive technology, it is difficult to make a case for radical treatment of ectopic pregnancy. Conservative management is feasible and has proven efficacy.

References:

- 1 Tait R.L. Five cases of extrauterine pregnancy operated upon at the time of pregnancy. *Br Med J* 1884 1 1250
- 2 Stromme W.B. Salpingotomy for tubal pregnancy. *Obstet Gynecol* 1 472 1953
- 3 Bruhat M.A. et al. Treatment of ectopic pregnancy by means of laparoscopy. *Fertil Steril* 33 411 1980
- 4 Meyer W.R. De Cherney A.H. Diamond M.P. Tubal ectopic pregnancy: Contemporary diagnosis, treatment and reproductive potential. *J Gynecol Surg* 5 343 1989

- 5 Fernandez E. et al. Spontaneous resolution of ectopic pregnancy. *Obstet Gynecol* 71 2 1988
- 6 Tanaka T. et al. Treatment of interstitial ectopic pregnancy with methotrexate, report of a successful case. *Fertil Steril* 1982. 37 851-852
- 7 Ory S.J. et al. Conservative management of ectopic pregnancy with methotrexate. *Am J Obstet Gynecol* 1986.154 1299-1306
- 8 Feichtinger W. Kemeter P. Conservative treatment of ectopic pregnancy by transvaginal aspiration under sonographic control and methotrexate injection. *Lancet* 1 381 1987
- 9 Leeton J. Davison G. Nonsurgical management of unruptured tubal pregnancy with intraamniotic methotrexate, preliminary report of two cases. *Fertile Steril* 1988 50 167 – 169
- 10 Thompson G.R. O'Shea R.T. Seman E. Methotrexate injection of tubal ectopic pregnancy. A logical evolution? *Med J Aust* 1991 154: 469 – 471
- 11 Thompson G.R. O'Shea R.T. Harding A. Beta hCG levels after conservative treatment of ectopic pregnancy; is a plateau normal *Aust NZ J Obstet Gynaecol* 1994 34
- 12 Stovall T.G. Ling F.W. Single dose methotrexate for the treatment of ectopic pregnancy. *Obstet Gynecol* 1991 77 754 – 755
- 13 Pouly J.L. Conservative laparoscopic treatment of 321 ectopic pregnancies. *Fertil Steril* 46 1093 1986
- 14 Tulandi T. Reproductive performance of women after two ectopic pregnancies. *Fertil Steril* 1983 40 289
- 15 Dubuisson J.B. et al. Reproductive outcome after laparoscopic salpingectomy for tubal pregnancy. *Fertil Steril* 53 6 1990
- 16 Pansky M. et al. Reproductive outcome after laparoscopic local methotrexate injection for tubal pregnancy. *Fertil Steril* 60 1 1993
- 17 Stovall T.G. Ling F.W. Buster J.E. Reproductive performance after methotrexate treatment of ectopic pregnancy. *Am J Obstet Gynecol* 1990 162 1620 – 1624
- 18 Murray H. Baakdah H. Bardell T. Tulandi T. Diagnosis and treatment of ectopic pregnancy. *CMAJ* 2005 Oct 11 905 – 912

Author Affiliation: G.R. Thompson. Concept Fertility Centre & Clinical Lecturer University of Western Australia, Perth, WA, Australia.



LAPAROSCOPIC TUBAL SURGERY IN THE IVF ERA

Friday 21 November / Session 6 / 0915-0945

Tulandi T

Due to availability of assisted reproductive technologies, the need for reproductive surgery in infertile women has declined over the past decades. However, it still has a place in the management of infertile women. For example, young women with a history of pelvic inflammatory disease might have pelvic adhesions or blocked Fallopian tubes that impair their fertility; and they will benefit from early surgical intervention. On the other hand, women over the age of 35 with a long history of infertility or those who require a laparotomy for correction of their disorders are better treated with in-vitro fertilization.

The radiologic findings of proximal tubal occlusion (PTO) have to be interpreted with caution. Indeed, we found that false diagnosis was 26.5%. In those with true cornual occlusion, selective tubal catheterization should be done. It leads to an overall pregnancy rate of 31.9%. The value of diagnostic laparoscopy is low. We perform laparoscopy only in young women with a history of pelvic inflammatory disease, or with ovarian endometrioma.

Due to the generally poor results of reconstructive surgery of distal tubal occlusion (hydrosalpinx), the patients are better treated with IVF. Salpingectomy is first performed to enhance the IVF pregnancy rate. The fluid in the hydrosalpinx decreases the implantation rate. Laparoscopic tubal anastomosis leads to a good pregnancy rate. In addition, it might lead to more than one pregnancy.

The increasing use of IVF for infertile women is associated with increasing rate of ectopic pregnancy. Most ectopic pregnancies however could be treated medically. Those who have contraindication to medical treatment can be treated by laparoscopy.

The concept of fertility management has changed. We perform reduced number of tubal surgery and instead of laparotomy, we repair the fallopian tube with laparoscopy approach. As Christina Baldwin once said, "Change is the constant, the signal for rebirth, the egg of the phoenix."

References:

1 Al-Fadhli R, Tulandi T. Tubal disease in relation to

infertility. In: Clinical Reproductive Medicine and Surgery. Ed. T. Falcone and W. W. Hurd, Mosby, 2007.

2 Al-Jaroudi D, Herba MJ, Tulandi T. Reproductive performance after selective tubal catheterization. *J Min Inv Gynecol.* 2005;12:150-2

3 Hurst BS, Tucker KE, Schlaff WD. Hydrosalpinx treated with extended doxycycline does not compromise the success of in vitro fertilization. *Fertil Steril.* 2001;75:1017-9.

4 Johnson NP, Mak W, Sowter MC. Surgical treatment for tubal disease. In: Surgical treatment for tubal disease in women due to undergoing in vitro fertilisation. The Cochrane Database of Systematic Reviews 2004, Issue 3. Art. No.: CD002125.pub2

5 Sacks G, Trew G. Reconstruction, destruction and IVF: dilemmas in the art of tubal surgery. *BJOG* 2004; 111:1174-81.

6 Zeyneloglu HB, Arici A, Olive DL. Adverse effects of hydrosalpinx on pregnancy rates after in vitro fertilization-embryo transfer. *Fertil Steril.* 1998;70:492-9.

Author Affiliation: Togas Tulandi MD, MHCM. Professor of Obstetrics and Gynecology & Milton Leong Chair in Reproductive Medicine McGill University, Montreal, Quebec, Canada.

YOUNG WOMEN WITH ENDOMETRIOSIS - LONG TERM MANAGEMENT

Friday 21 November / Session 6 / 0945-1015

Karthigasu K

The diagnosis of endometriosis in adolescents and young women is not uncommon, however the longer term management to provide symptom relief and retain optimal fertility can be variable amongst gynaecologists. In recent years more data has become available about the effectiveness of both surgical management and medical management of endometriosis. In this presentation, via the use of case presentations, I aim to have an interactive session to explore options of treatment available to young women diagnosed with endometriosis and discuss the relevant data available for the treatment options.

Author Affiliation: Dr K Karthigasu. King Edward Memorial Hospital for Women, Subiaco, WA, Australia.



EFFECT OF OBESITY ON FERTILITY

Friday 21 November / Session 7 / 1045-1105

Hart R

This presentation will describe the adverse influence of being overweight on the chance of natural conception, the effect of obesity upon the success of assisted reproduction, its influence on the chance of miscarriage and a brief mention of the adverse pregnancy outcomes related to obesity.

Author Affiliation: R Hart, Associate Professor Reproductive Medicine, School of Women's and Infants Health, the University of Western Australia. King Edward Memorial Hospital, Subiaco, WA, Australia.

MINIMALLY INVASIVE SURGICAL OPTIONS FOR THE TREATMENT OF OBESITY

Friday 21 November / Session 7 / 1105-1125

Chandraratna H

Obesity is the plague of the 21st Century. It's true causes largely unknown, it's promoters obvious and despite a wide array of treatments it persists. It's secondary effects spill over into every field of medicine and it is a rapidly increasing cause of infertility. Because of this every doctor today needs to be familiar with it's associated morbidities and have an understanding of the treatments available. Surgical management has been shown to be the only reliable sustained method of weight loss, but the operations performed subtly change physiology and doctors need to account for this when managing patients peri-operatively.

In this talk we will cover the causes and surgical treatment options available for obesity, and how non obesity surgeons should manage patients who are obese and also those who have had a surgical intervention. We will also cover the relationship between obesity and infertility and management options to achieve a successful pregnancy.

Author Affiliation: Dr H Chandraratna. University of Notre Dame, Freemantle, WA, Australia.

EARLY OVARIAN CANCER AND BORDERLINE TUMORS

Friday 21 November / Session 9 / 1350-1410

Salfinger S

Requests for preservation of fertility are most common in young women with ovarian tumors of low malignant potential or nonepithelial ovarian cancers. Fertility preservation is also an option for women with stage IA EOC.

It should be remembered that this treatment should be regarded non standard and limited data is available to base advice upon. Conservative surgery such as USO should be accompanied by full surgical staging including washings, omentectomy, appendicectomy and possibly node biopsies. Thorough laparotomy with exploration and biopsy of any suspicious areas is also required and endometrial sampling should be performed. A review of studies of women with early stage epithelial ovarian carcinoma who underwent conservative treatment included 282 women and 113 deliveries. There were 33 relapses and 16 disease-related deaths. Studies of women having fertility conserving surgery for gynaecologic cancer have shown that only 50% even attempt to become pregnant.

Low malignant potential or borderline tumours have an excellent prognosis. USO or even cystectomy may be considered. Any visible disease should be removed. Some trials have shown an increased incidence of cyst rupture with laparoscopic surgery but the implications on recurrence rate is unclear; there are no RCT's assessing this. The appendix should always be removed in patients with mucinous tumours. Frozen section diagnosis may often be altered on final complete histopathological analysis.

Recurrence rates vary from 5-30% with Cystectomy having a significantly higher recurrence rate than oophorectomy. Recurrences are most commonly borderline tumours (90%) with recurrence as malignant tumour similar to the incidence of ovarian carcinoma in the general population, one of the largest series showing only a 2% risk of recurrence as malignancy. Progression to invasive cancer may represent true transformation, de novo development of an ovarian cancer, or a primary peritoneal cancer.

Currently there is no evidence that women who have had fertility sparing surgery are at increased risk of mortality from disease progression if they become pregnant. Ovulation induction and other fertility treatments appear safe.

Author Affiliation: Dr Stuart Salfinger, Gynaecologic Oncologist.



CIN TREATMENT AND FERTILITY

Friday 21 November / Session 9 / 1410-1430

McElhinney B

Detection and treatment of CIN greatly decreases the risk of cervical cancer. The peak incidence of severe dysplasia occurs in women aged 25-29, a time when many women are considering pregnancy. Therefore the impact of CIN treatment on fertility is of great importance.

Historically, hysterectomy or cold knife conisation was the standard of care. Since the 1980's, more conservative out-patient excisional treatments of the transformation zone have become popular.

Currently LLETZ is the treatment of choice worldwide. The procedure is easy, inexpensive, effective as earlier/alternative methods and provides a surgical specimen. However, excisional treatment of any kind may affect the mechanical support of the cervix with implications for future pregnancies.

Absolute indications for cold knife conisation include suspicion of an early invasive cancer, significant glandular abnormality and incompletely seen lesions in the presence of a high grade squamous abnormality.

Early case series and retrospective cohort studies describe the impact of cold knife conisation on preterm birth. However, the studies were small & inadequately powered with variable composition of comparative groups; few undertook multivariate analyses to adjust for potential confounders. Total number of cases was 558 and the relative risk of preterm births was 2.9.

There are ten cohort studies published in the English Language peer reviewed literature on the effect of LLETZ on preterm birth. The largest and most recent studies both show a significant association between LLETZ and spontaneous preterm birth and with pPROM.

In summary it is probable that excisional therapies increase the risk of spontaneous preterm birth. However, the data regarding the amount of tissue removed are imprecise. Further research is needed to confirm the likely effect of excisional treatments on the subsequent risk of spontaneous preterm birth.

Author Affiliation: Dr Bernadette McElhinney, King Edward Memorial Hospital for Women, Subiaco, WA, Australia.

UTERINE PRESERVATION. VAGINAL APPROACH

Friday 21 November / Session 10 / 1430-1450

Maher C

Uterine preservation at prolapse surgery is increasingly being considered by women due to a delay in childbearing to a later age, a belief that the uterus plays a role in sexual satisfaction and successful conservative treatments for the control of menorrhagia. In women wishing uterine preservation a variety of surgical options are available including the Manchester repair and sacrospinous hysteropexy vaginally, and uterosacral hysteropexy and sacral hysteropexy abdominally.

The Manchester repair has largely been abandoned due to recurrence of prolapse in excess of 20% in the first few months, decrease in fertility, pregnancy wastage as high as 50% and future sampling of the cervix and the endometrium can be difficult due to vaginal re-epithelialization or cervical stenosis.

The sacrospinous hysteropexy is a safe and effective procedure as compared to vaginal hysterectomy and sacrospinous colpopexy for uterine prolapse. Two comparative studies involving 165 women with at least a mean 2-year review are available and demonstrate the operating time, blood loss and complications are reduced in the hysteropexy group with success rates of 90% being reported in both groups^{1,2}. Only limited data is available on pregnancy outcome following sacrospinous hysteropexy as Hefni et al who contributed 109 women to the literature only reported in women over 60 years. Seven pregnancies have been reported with 2 (29%) undergoing further prolapse surgery, one each following vaginal and caesarian delivery^{1,3}.

Anterior compartment prolapse has been problematic following sacrospinous hysteropexy. Also recent RCTS have demonstrated at 1 year that the use of polypropylene mesh significantly reduces the rate of recurrent prolapse at 1 year as compared to anterior colporrhaphy⁴⁻⁶. Finally vaginal hysterectomy has been associated with 5x higher rate of mesh erosions as compared to mesh repairs with no hysterectomy⁷. These three factors have encouraged us to perform vaginal uterine preservation and anterior mesh for the management of uterovaginal prolapse. Information on our outcomes for sacrospinous hysteropexy, anterior mesh and posterior repair will be reported.

Several authors have reported objective success rates of over 90% with sacral hysteropexy^{8,9} where mesh secures the cervix to the sacrum. Rover's et al in a



randomized control trial compared sacral hysteropexy and vaginal hysterectomy and repair¹⁰ reported a significantly higher re-operation rate for prolapse in the hysteropexy group at 2 and 5 years.

The literature demonstrates that the vaginal approach is superior to abdominal approach in the management of uterovaginal prolapse in those requesting uterine preservation.

References:

- 1 Maher CF, Cary MP, Slack MC, Murray CJ, Milligan M, Schluter P. Uterine preservation or hysterectomy at sacrospinous colpopexy for uterovaginal prolapse? *Int Urogynecol J Pelvic Floor Dysfunct* 2001;12(6):381-4.
- 2 Hefni M, El Toukhy T, Bhaumik J, Katsimanis E. Sacrospinous cervicocolpopexy with uterine conservation for uterovaginal prolapse in elderly women: an evolving concept. *Am J Obstet Gynecol* 2003;188(3):645-50.
- 3 Kovac SR, Cruikshank SH. Successful pregnancies and vaginal deliveries after sacrospinous uterosacral fixation in five of nineteen patients. *Am J Obstet Gynecol* 1993;168(6 Pt 1):1778-83.
- 4 Hiltunen R, Nieminen K, Takala T, et al. Low-weight polypropylene mesh for anterior vaginal wall prolapse: a randomized controlled trial. *Obstetrics And Gynecology* 2007;110(2 Pt 2):455-462.
- 5 Nguyen JN, Burchette RJ. Outcome after anterior vaginal prolapse repair: a randomized controlled trial. *Obstet Gynecol* 2008;111(4):891-8.
- 6 Sivaslioglu A, Unlubilgen E, Dolen I. A randomised comparison of polypropylene mesh surgery with site-specific surgery in treatment of cystocele. *International Urogynecology Journal And Pelvic Floor Dysfunction* 2007; published online (DOI 10.1007/s00192-007-0465-y).
- 7 Belot F, Collinet P, Debodinance P, Ha Duc E, Lucot JP, Cosson M. [Risk factors for prosthesis exposure in treatment of genital prolapse via the vaginal approach]. *Gynécologie, Obstétrique & Fertilité* 2005;33(12):970-974.
- 8 Leron E, Stanton SL. Sacrohysteropexy with synthetic mesh for the management of uterovaginal prolapse. *BJOG* 2001;108(6):629-33.
- 9 Barranger E, Fritel X, Pigne A. Abdominal sacrohysteropexy in young women with uterovaginal prolapse: long-term follow-up. *Am J Obstet Gynecol* 2003;189(5):1245-50.
- 10 Roovers JP, van der Vaart CH, van der Bom JG, van Leeuwen JH, Scholten PC, Heintz AP. A randomised

controlled trial comparing abdominal and vaginal prolapse surgery: effects on urogenital function. *BJOG* 2004;111(1):50-6.

Author Affiliation: Associate Professor Christopher Maher, Brisbane, Qld, Australia.

LAPAROSCOPIC APPROACH TO UTERINE PRESERVING PROLAPSE SURGERY

Friday 21 November / Session 10 / 1450-1510

Lam A

Traditional approach to significant utero-vaginal prolapse, defined as \geq stage 2 POP-Q prolapse, often involves vaginal hysterectomy and vaginal repair. Increasingly more and more women are interested in uterine-preserving prolapse surgery. The variety of reasons which may influence women in seeking this line of surgical management includes:

- Fertility-preserving option – nulliparous or multiparous women
- Fear of loss of femininity
- Cultural factor
- Psychological factor
- Potential de-novo bladder or bowel dysfunction
- Potential impact on sexual function
- Anatomical considerations – loss of vaginal length, loss of central support leading to possible subsequent vault prolapse
- Morbidity associated with hysterectomy
- Hysterectomy may not necessarily reduce the risk of long-term prolapse recurrence

Anatomical considerations: Uterine prolapse occurs as a result of damage to Delancey level I support i.e. the utero-sacral cardinal complex.

Uterine prolapse may occur in isolation or as part of a multi-level, multi-compartment pelvic floor damage. Uterine prolapse may therefore occur along with level II anterior and/or posterior compartment defects, and level III defects.

Women who have uterine prolapse may also have cervical elongation which can result in the leading edge of the prolapse, namely the cervix (point C of POP-Q) presenting outside while vaginal posterior fornix (point D) remaining above the hymenal remnant.

Management options: Frequently, most women with significant utero-vaginal prolapse are advised



conservative management if they wish to preserve fertility. The conservative measures include pelvic floor exercise with or without the use of vaginal pessary. Surgery is often delayed until childbearing is complete because of:

- The risk of recurrence of prolapse with further childbirth which in turn may necessitate repeat surgery
- Possible impact on fertility from cervical surgery (shortening, amputation)
- Possible development of cervical incompetence resulting necessitating cervical cerclage
- Possibility of cervical stenosis and hematometra
- Hysterectomy is frequently considered an inevitable component of surgery for significant utero-vaginal prolapse

Laparoscopic approach: Laparoscopic approach offers women who are symptomatic of their prolapse the choice of uterine preserving surgery. This can be achieved by

- Suture repair – level I hysteropexy uterosacral suspension +/- level II anterior and posterior para-vaginal attachment and level III repair
- Mesh repair – in cases where the quality of uterosacral ligaments is inadequate:
 - o sacro-cervicopexy with mesh
 - o sacro-hysteropexy with mesh attachment to both the anterior and posterior cervix.
 - o sacro-hystero-colpopexy with mesh attachment to both the anterior and posterior vaginal wall and the cervix

It is important to assess the length of the cervix. In general, women wishing to preserve fertility should avoid cervical repair. Where necessary, only the removal of the hypertrophic, elongated infra-vaginal portion of the cervix maintaining a minimum of 2 cm of endocervical canal to the internal os to minimise the risk of cervical incompetence.

Results: There are a number of case series in the literature reporting on open or laparoscopic approach to uterine-preserving prolapse surgery. In this presentation we will examine the literature as well as present our own techniques and experience to date.

Conclusion: Laparoscopic approach to uterine preserving prolapse surgery is a feasible and effective surgical option which can be offered to women wishing to preserve fertility or those without significant uterine pathology wishing to avoid hysterectomy.

Author Affiliation: Associate Professor Alan Lam; CARE, Royal North Shore Hospital, Northern Clinical School, University of Sydney, NSW, Australia.

CAN WE USE MESH SAFELY IN FERTILITY PRESERVING PROLAPSE SURGERY?

Friday 21 November / Session 10 / 1510-1530

Daborn P

This interactive session will review the limited available literature for the use of mesh in fertility preserving prolapse surgery. In particular the options of Sacrohysteropexy and vaginal placement of mesh including the new mesh kit systems will be covered. Pertinent clinical issues will be discussed in the setting of a case presentation highlighting the “pros and cons” of mesh graft augmentation.

Author Affiliation: Dr J Phillippe Daborn. King Edward Memorial Hospital for Women, Subiaco, WA, Australia.

CONTROLLING INTRA-OPERATIVE HAEMORRHAGE

Friday 21 November / Session 11 / 1600-1630

Chandraratna H

Hemorrhage can come in many shapes and forms, from a minor annoying ooze to life threatening bleeding that can terminate a life in minutes. The modern surgeons needs to know an array of maneuvers and have an understanding of the modern tools available to them to get out of unexpected (and expected) events safely and succinctly. This may involve not only intra-operative techniques but also the need to give advice to anesthetists who may not be familiar with catastrophic events.

In this talk we will cover preoperative preparation. Emergency surgical maneuvers, advanced techniques of local control, simple vascular reconstruction techniques, stabilizing measures as well as correcting coagulopathy.

Author Affiliation: Dr H Chandraratna. University of Notre Dame, Fremantle, WA, Australia.





Australian
Gynaecological
Endoscopy
Society Ltd

Upcoming AGES MEETINGS

Leading the way in gynaecological surgery

3RD AAGL INTERNATIONAL CONGRESS ON MINIMALLY INVASIVE GYNECOLOGY

in conjunction with the

**AUSTRALIAN GYNAECOLOGICAL
ENDOSCOPY SOCIETY
XIX ANNUAL SCIENTIFIC MEETING
BRISBANE 21-23 MAY 2009**
SEX, SURGERY & GYNAECOLOGY

**AUSTRALIAN GYNAECOLOGICAL
ENDOSCOPY SOCIETY
PELVIC FLOOR SYMPOSIUM &
WORKSHOP X**

**CROWN PROMENADE/
CROWN TOWERS
MELBOURNE 7-8 AUGUST 2009**

**AUSTRALIAN GYNAECOLOGICAL
ENDOSCOPY SOCIETY
FOCUS MEETING 2009
COOLUM, QUEENSLAND
30-31 OCTOBER 2009**

***SURGICAL TECHNIQUES:
BASED ON FACT OR FICTION***

**INTERNATIONAL SOCIETY FOR
GYNECOLOGIC ENDOSCOPY (ISGE)
19TH ANNUAL CONGRESS**

in conjunction with the

**AUSTRALIAN GYNAECOLOGICAL
ENDOSCOPY SOCIETY
XX ANNUAL SCIENTIFIC MEETING
SYDNEY 27-29 MAY 2010**



Gynecare[®]
Interceed[®]
Absorbable Adhesion Barrier

**The TRUSTED Choice
for Adhesion Prevention**

Helping Surgeons protect women for OVER 15 YEARS

For more information contact Ethicon Women's Health & Urology
Customer Service 1800 257 944 (Just Toll Free)
9678 0260 (Sydney) Mails 0800 809 988 (NZ Toll Free)

Johnson & Johnson Medical Pty Limited ABN 85 000 860 405
15 Klemmum Road North Ryde NSW Australia 2113
The Cribbaker Pt. Mt. Wellington 02541 Auckland New Zealand

Johnson & Johnson
MEDICAL

GYNECARE INTERCEED is a trademark of Ethicon Inc.

ETHICON
Women's Health & Urology

CONFERENCE INFORMATION & CONDITIONS

DEPOSITS AND FINAL PAYMENTS:

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

CANCELLATION POLICY:

Should you or a member of your party be forced to cancel, you should advise the Conference Organisers in writing. Single Meeting Registrations: The cancellation policy for this AGES Focus Meeting allows a cancellation fee of \$100.00 of registration fees for cancellations received up to 8 weeks' prior to the first day of the Meeting and of 50% of registration fees for cancellations up to 4 weeks' prior to the Meeting. No refund will be made after this time. Multiple meeting registrants: No refunds apply.

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

INSURANCE:

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

PRICING POLICY:

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

COSTS DO NOT INCLUDE:

Insurance, telephone calls, laundry, food and beverage except as itemised in the brochure, and items of a personal nature.

TRAVEL AND ACCOMMODATION:

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

OUR RESPONSIBILITY:

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

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

PRIVACY ACT 1988, CORPORATIONS ACT 2001:

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



