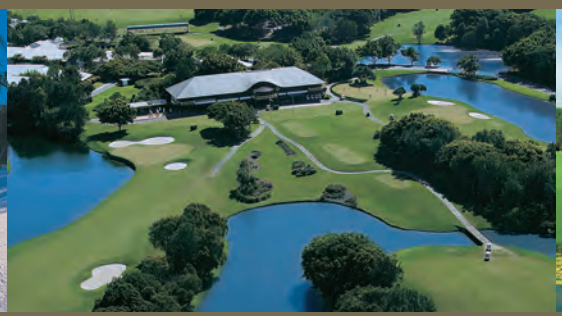
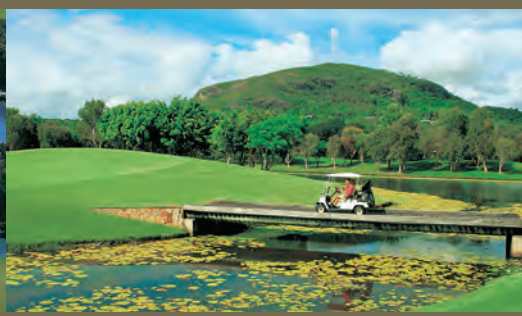
Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES FOCUS MEETING 2009

30 & 31 October 2009

SURGICAL TECHNIQUES – BASED ON FACT OR FICTION?

Hyatt Regency, Coolum
Queensland Australia

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REGISTRATION FEES INCLUDE:

- Attendance at all Conference sessions at Hyatt Regency, Coolum
- Conference satchel and all Conference publications
- Conference lunches, morning and afternoon teas on Friday 30 October
- Morning tea and lunch on Saturday 31 October

ORGANISING COMMITTEE

Assoc. Professor Harry Merkur	Conference Chair
Dr Jim Tsaltas	Co-Chair

AGES AWARD

A prize will be awarded for the best free communication presentation at the Conference. The prize will be presented in the final session on Saturday 31 October. Judging will be by an impartial panel comprising senior members of AGES. The judges' decisions are final. No correspondence will be considered.

AGES SECRETARIAT

Conference Connection
282 Edinburgh Road Castlecrag
Sydney NSW 2068
Australia
T +61 2 9967 2928
F +61 2 9967 2627
secretariat@ages.com.au

WELCOME

Dear Delegate,

AGES' Focus meeting for 2009 is a return to grass roots.
Our meeting is entitled:
Surgical Techniques – Based on Fact or Fiction

This meeting to be held in the resort venue of Coolum, Queensland promises much in terms of elucidation of some of the most common procedures in endoscopic and gynaecological surgery. Prominent Australian surgeons have been specifically chosen to present procedures where their strengths lie. The intricacies and nuances of their techniques and of course the use of currently available technology will be presented. Evidence for the reasons behind particular surgical strategies will be presented, if they exist! The levels of evidence and substantiation for the various surgical procedures will no doubt stimulate vigorous debate.

The speakers have been encouraged to have as much visual content as possible, in order to truly focus on teaching their preferred method of operating. Critical parts of procedures will be emphasized and anecdotal tips from experts will be put forward for discussion. EBM is alive and well, but so are tricks of the trade and experience. Our speakers have been encouraged to put forward their own theories, not necessarily substantiated by the prevailing literature. Anecdotal experience still has a place in medicine, and where surgical technique is concerned, the "art of medicine" continues to command respect.

We warmly welcome you to a meeting which promises education, controversy and camaraderie amongst like-minded practitioners. Of course the social and leisure aspects of Coolum will enhance the whole ambiance of the meeting.

Harry Merkur
Conference Chair

Jim Tsaltas
Co-Chair

Alan Lam
AGES President

DAY 1
FRIDAY 30TH OCTOBER
HYATT REGENCY COOLUM
THE PAVILION

0730-0800 Registration

0800-0810 Welcome H Merkur, J Tsaltas

PR&CRM Points – Pre-Questionnaire
K Jansen

Session 1 Sponsored by Stryker

Laparoscopic Hysterectomy
Chairs: J Tsaltas, H Merkur

0810-0830 Laparoscopic hysterectomy – the critical steps K Karthigasu

0830-0850 Vascular control – what is the evidence? M Wilson

0850-0910 The retroperitoneal space – go there or steer clear! D Molloy

0910-0930 Teaching laparoscopic hysterectomy H Merkur

0930-0950 Evidence for learning and retention of skills A Yazdani

0950-1010 Discussion

1010-1040 Morning Tea and Trade Exhibition

Session 2 Sponsored by Stryker

Disaster Management Chairs: M McEvoy, R Ford

1040-1105 Massive obstetric haemorrhage – who ya gonna call? J Pardey

1105-1130 Significant haemorrhage at gynaecologic endoscopy procedures – management J Nicklin

1130-1200 Trouble shooting in medical practice A Yazdani

1200-1230 Discussion

1230- 1330 Lunch and Trade Exhibition

Session 3 Sponsored by Johnson & Johnson Medical

Pelvic Floor Surgery Chairs: A Rosamilia, K Jansen

1330-1355 Laparoscopic paravaginal repair D Chou

1355-1420 Laparoscopic sacrocolpopexy C Maher

1420-1445 Vaginal Mesh procedure vs native tissue repair A Rane

1445-1500 Discussion

1500-1530 Afternoon Tea and Trade Exhibition

1530-1700 **Session 4** Sponsored by Stryker

Free Communications Session
Chairs: J Abbott, P Maher

Video afternoon – Pearls of Wisdom, Tricks of the Trade and OMG!

1530-1540 Bladder dissection in hysterectomy patients with previous caesarean section at the Sydney West Advanced Pelvic Surgery unit (Video Presentation) Anpalagan A, Merkur H

1540-1550 The case of the missing ovarian cyst wall Bradford S, Saraswat A, Ratnapala M

1550-1600 Laparoscopic retraction - hands free and without additional ports Chetty N

1600-1610 Laparoscopic removal of cornual pregnancy in a woman with previous ipsilateral salpingectomy : A video presentation Wang L, Najjar H

1610-1620 Posterior colpotomy in Pouch of Douglas endometriosis – SWAPS technique Anpalagan A, Merkur H

1620-1630 Dermoid causing doctor distress Faber-Swensson A

1630 -1640 Heuristics and laparoscopic gynaecological surgery Jacobson T

1640 -1650 A video snapshot - what would you do if? Rane A

1930-2300 Gala Dinner
Eliza's Restaurant, Hyatt Regency Coolum

CONFERENCE PROGRAM

SURGICAL TECHNIQUES – BASED ON FACT OR FICTION?

DAY 2
SATURDAY 31ST OCTOBER
HYATT REGENCY COOLUM
THE PAVILION

Session 5 Sponsored by Johnson & Johnson Medical

Surgery for Endometriosis
Chairs: K Karthigasu, S Salfinger

0800-0820	Staging laparoscopy	P Maher
0820-0840	Stage I-II disease	J Tsaltas
0840-0900	Stage III-IV disease	J Abbott
0900-0920	Safe dissection of the ureter in the presence of endometriosis	D Molloy
0920-0940	Avoiding injury to the bowel – what to do if the wall is breached	R Woods
0940-1000	Discussion	
1000-1030	**Morning Tea and Trade Exhibition**	

Session 6 Sponsored by Karl Storz Endoscopy

Hysteroscopic Surgery Chairs: H Merkur, D Molloy

1030-1100	What procedures are obsolete?	J Abbott
1100-1130	Submucous fibroids – how big a lesion can you resect?	J Pardey
1130-1200	Mullerian tract anomaly surgery	M Cooper
1200-1220	Discussion	
1220-1250	The Big Picture – the AMA and the future of Obstetrics and Gynaecology in Australia	A Pesce
1250-1300	Close	
1300-1400	**Lunch and Trade Exhibition**	

PR&CRM/CPD POINTS

Attendance and completion of the Pre- and Post-Questionnaires: 5 PR&CRM points

The Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) approved Pre- and Post-Questionnaires are comprised of a number of multiple choice questions from lectures given on Friday 30 October and on Saturday 31 October.

The Pre-Questionnaire is to be handed in at the registration area at morning tea on Friday 30 October.

The Post-Questionnaire is to be handed in at the close of the meeting on Saturday 31 October.

No exceptions can be made to these deadlines.

This meeting has been approved as a RANZCOG Approved O&G Meeting and eligible Fellows of this College will earn CPD points for attendance as follows:

Full attendance 12 CPD points
Attendance – 30 October 7 CPD points
Attendance – 31 October 5 CPD points

Attendance by eligible RANZCOG Members will only be acknowledged following signature of the attendance roll each morning of the Conference.

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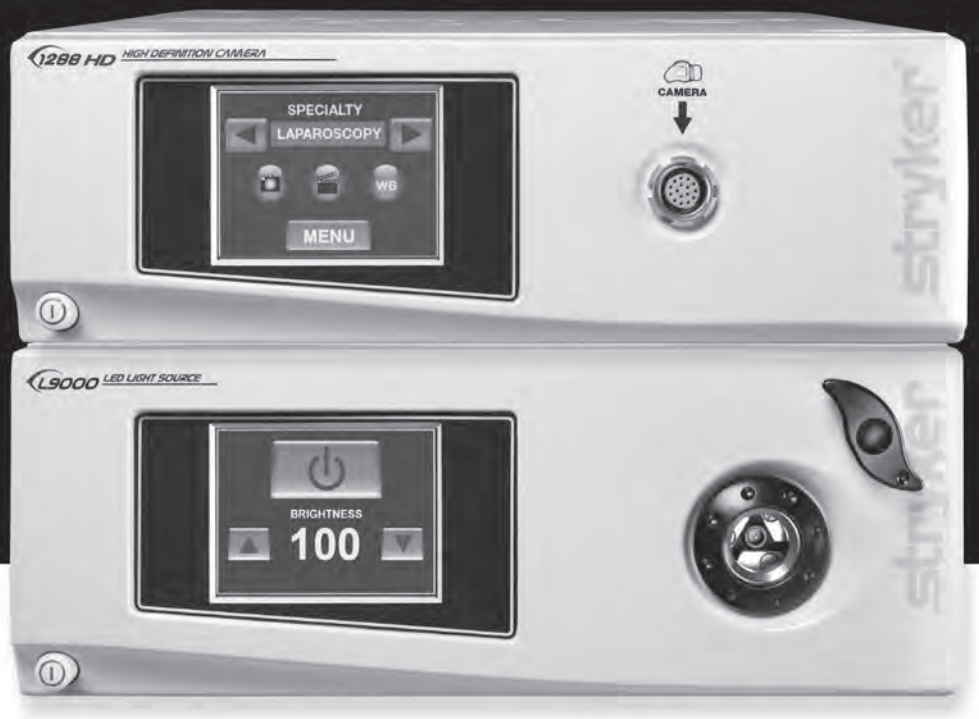

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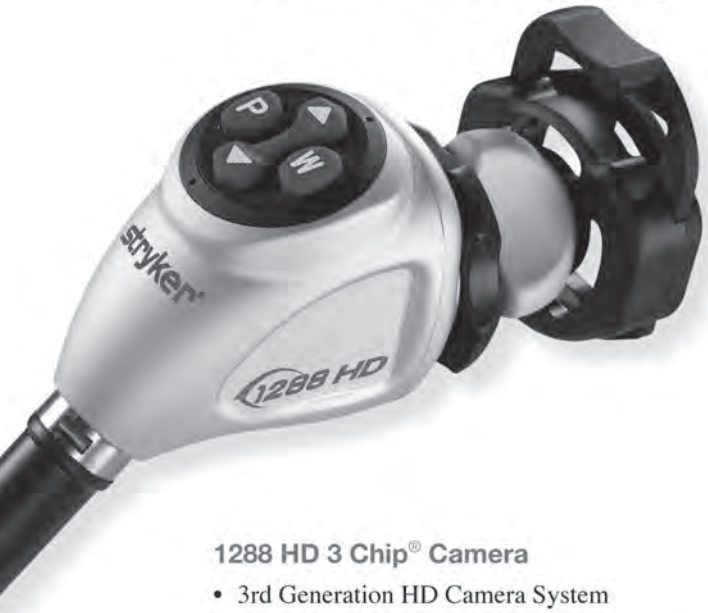

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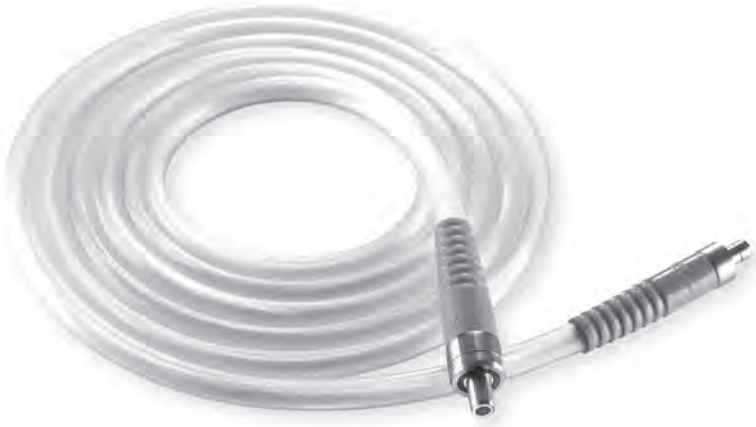

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ABSTRACTS

FRIDAY 30 OCTOBER

Laparoscopic hysterectomy – the critical steps

Friday 30 October / Session 1 / 0810 - 0830

Karthigasu K

Total Laparoscopic Hysterectomy (TLH) has been in regular use since 1989 when Harry Reich first published about the procedure. Now 20 years later it still only accounts for 15-20% of all the hysterectomies performed, with the open abdominal route still the majority for many. Reasons of why this is so is varied, including a perception that it is a riskier procedure, through to lack of facilities. However the major inhibiting factor is the technical skills in laparoscopic surgery required to be comfortable with this form of hysterectomy.

The aim of this presentation is to discuss pre-operative factors in selecting patients suitable for TLH, critical steps in performing a TLH and, via information derived from the Anatomy of Complications Workshops, provide advice regarding avoiding complications and management of intra-operative complications involved in performing a TLH.

Vascular control – what is the evidence?

Friday 30 October / Session 1 / 0830 - 0850

Wilson M

Bleeding is the second commonest complication at laparoscopic hysterectomy. There is an increasing array of new technologies being applied in laparoscopic hysterectomy to secure haemostasis, particularly at the uterine artery. Many units across Australia will use combinations of bipolar sealing devices [LigaSure V (LS) and Gyrus PK (GP)], an ultrasonic device [HarmonicScalpel ACE (HS)] and a novel device using nanotechnology [EnSeal PTC (ES)].

What is the evidence we can examine to decide which modality to use? Is there a best device for this procedure or should a surgeon rely on personal preference and their own experience. Do different devices have particular disadvantages and side-effects? Should a new method be vigorously studied before becoming part of common practice.

References:

1. Gregory R. Lamberton, M.D., Ryan S. Hsi, Daniel H. Jin, Tekisha U. Lindler, M.D., Forrest C. Jellison, M.D., and D. Duane Baldwin, M.D. Prospective Comparison of Four Laparoscopic Vessel Ligation Devices. Journal Of Endourology Volume 22, Number 10, October 2008 © Mary Ann Liebert, Inc.Pp. 2307–2312
2. Hruby GW, Marruffo FC, Durak E, et al.: Evaluation of surgical energy devices for vessel sealing and peripheral energy spread in a porcine model. J Urol 2007;178(6): 2689–2693
3. Harold KL, Pollinger H, Matthews BD, Kercher KW, Sing RF, Heniford BT: Comparison of ultrasonic energy, bipolar thermal energy, and vascular clips for the hemostasis of small-, medium-, and large-sized arteries. Surg Endosc 2003;17(8):1228–1230.

Suggested Reading:

1. *National Institute for Health and Clinical Excellence* - Laparoscopic techniques for hysterectomy Issue date: November 2007.

Dissection of the retro-peritoneal space

Friday 30 October / Session 1 / 0850 - 0910

Molloy D

Advanced laparoscopic surgery requires confidence in using the extra peritoneal or retro- peritoneal spaces as the point of primary surgical approach.

Severe intraperitoneal disease can confidently be handled by approaching the uterus and the adnexal organs through the extra peritoneal space. Most of the dangers of either open or laparoscopic surgery lie in the extra peritoneal space. The extra peritoneal space is the site of major blood vessels, nerves and the uterer. Safe exposure of these structures prevents damage.

In laparoscopic hysterectomy exposure of the extra-peritoneal space and the uterine blood supply enables devascularisation of the uterus. This means that large sized uteri can be managed with proactive devascularisation and safe dissection of the ureter. The management of major endometriosis cases similarly involves exposing the vascular supply and safe dissection of the utera, sometimes all the way to the bladder through the ureteric tunnel.

This lecture will focus on discussing the dissection of the extra-peritoneal space, its anatomy and various compartments.

Author affiliation: Dr David Molloy; Queensland Fertility Group, Brisbane Australia.

Teaching laparoscopic hysterectomy

Friday 30 October / Session 1 / 0910 - 0930

Merkur H

Teaching laparoscopic hysterectomy(LH) will be explored along the following lines:

1) How is LH being taught now?

2) Are these effective models?

3) What methods are being introduced for the future?[1]

4) By what criteria are these teaching methods assessed?

5) Who should learn to perform LH?

6) Is there enough emphasis on the teachers?

Despite the very considerable efforts of societies like AGES and AAGL that promote LH, the overall uptake continues to be disappointingly low[2]. Specifically focused Fellowship jobs are few and far between, and registrars completing their training may not be confident to perform LH at an advanced level[3].

Measures to overcome these deficiencies in training are afoot, including a proposition by AGES to plan for a national curriculum for fellowships in advanced endoscopic surgery. This will require collaboration at multiple levels: AGES, RANZCOG, Public and Private hospitals, accredited surgeons, ITP registrars and approved fellowship positions.

References:

1. Fialkow MF, Goff BA. Training the next Generation of Minimally Invasive surgeons. J Minim Invasive Gynecol 2009; 16(2): 136-141.
2. Miller CE. Presidential Address. Training in Minimally Invasive surgery – You Say You Want a Revolution. J Minim Invasive Gynecol 2009; 16(2): 113-120.
3. Obermair A, Tang A, Charters D, Weaver E, Hammond I. Survey of surgical skills of RANZCOG trainees. Aust NZ J Obstet Gynaecol 2009; 49: 84-92.

Suggested Reading

Editors: Rogers RG, Rayburn WF. Teaching and Evaluating Surgical Skills. Obstet Gynecol Clin North Am 2006: 33 (2).

Author Affiliation: Assoc Prof O&G University Western Sydney, New South Wales, Australia.

Management of haemorrhage at gynaecologic laparoscopic surgery

Friday 30 October / Session 2 / 1105 - 1130

Nicklin J

Major complications occur in 0.1 -10% of cases of gynaecologic laparoscopic surgery in the world literature. Over 50% of complications occur at entry and most of these are vascular injuries. Up to 25% of injuries are not recognized until the post-operative period. Of 629 major trochar injuries reported to the FDA, 408 were major vessel injuries and 182 were visceral injuries. Of the 31 deaths, 81% were due to vascular injury and 19% were due to visceral injury. This emphasizes the importance of safe techniques in pneumoperitoneum and peritoneal entry. Prevention is a vital part of the management of vascular injury. This often entails development of the pelvic retroperitoneal spaces, identification and avoidance of vascular and other structures.

The management paradigm in managing laparoscopic vascular injury is similar to open surgery but adapted for the minimal access situation. These measures include: initial control grasping a bleeder or applying pressure; exposure with retraction and suction; definitive measures with pressure, diathermy, procoagulants, suture, staples, Endoloop etc; and other measures including liaising with nursing and anesthetic staff and optimizing surgical facilities. Consideration should be given to extra ports, extra instruments, extra equipment and extra personnel. Finally, timely recourse to laparotomy is not a failure, but rather an important and safe treatment option.

Multiple videos will be shown to illustrate the points outlined above.

Suggested reading:

1. Stovall TG *et al* Complications of gynecologic laparoscopic surgery *UpToDate* online.
2. Magrina JF *Clin Obstet Gynecol*. 2002 Jun;45(2):469-80
3. Bhoyrul S et al *J Am Coll Surg*. 2001 Jun;192(6):677-83.
4. Ahmad G, Duffy JMN, Phillips K, Watson A. Laparoscopic Entry Techniques. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD006583

Author affiliation: Associate Professor Jim Nicklin; Royal Brisbane and Women's Hospital, and Wesley Hospital, Brisbane, Queensland, Australia.

Laparoscopic sacral colpopexy

Friday 30 October / Session 3 / 1355 - 1420

Maher C

Objective: To present the surgical technique of the laparoscopic sacral colpopexy. We will share our clinical experience gained during a randomised trial comparing the LSC and total vaginal mesh (TVM) for the management of vaginal vault prolapse. The abstract data for the trial is included below.

Methods: Women with symptomatic Stage 2 or greater (POP-q) vaginal vault prolapse were eligible for inclusion. Exclusion criteria included those <18 years of age, inability to comprehend questionnaires, failure to give informed consent or able to return for review: vault prolapse < stage 2, unable to undergo general anaesthesia, BMI>35, ≥5 laparotomies, prior sacral colpopexy or TVM or vaginal length less than 6cm. Prior to surgery women were examined (POP-Q), completed validated pelvic floor and quality of life questionnaires (QLD Pelvic Floor Questionnaire QPFQ and Kings college Pelvic Organ Prolapse P-QOL) and underwent urodynamics with and without prolapse reduction. Randomisation was by computer generated list stratified for urodynamic stress incontinence. with allocation concealment. Reviews were conducted by blinded co-authors, at 6 weeks, and the pre- surgical evaluation was repeated at 6 months. Thereafter annual examination and questionnaires were completed with outcomes reported at 2 and 5 years. Given a 76% objective success rate for any prolapse site sacral colpopexy2 and 92% with Vaginal mesh Prolift3, the sample size required to detect a 20% difference in success rates with a power of 80% and alpha=0.05 is 74. One hundred women were recruited to allow lost to review of 20%. Written consent and ethics committee approval was obtained.

Results: Table 1 describes patient flow in this study. There were no differences in the two groups regarding age, BMI, parity, menopausal status, number with or number of prior continence or prolapse surgery, educational status or household income. Peri-operative complications in LSC include 1 cystotomy, 1 enterotomy and 1 transfusion: TVM group, 1 transfusion and 1 re-admission infected haematoma. The LSC had a longer operating time, reduced blood loss, inpatient days and quicker return to activities of daily living as compared to TVM (Table 1). At mean 2.0 year reviews the patient satisfaction and objective success rate (POP-q stage 0 &1) at Aa, Ba, Ap, Bp individually and all sites combined was superior following the LSC. There was no difference between the two groups at POP-q site C and TVL was longer in LSC group (Table 2). Pelvic floor dysfunction and quality of life (QPFQ, PQOL) improved significantly in both groups post surgery but no difference was seen between the groups. Post operative SUI was detected in 16% LSC and 33% of the TVM (p=0.08) with similar rates of OAB and voiding dysfunction in both groups. Further surgery in the LSC group (n=4) included trocar hernia, TVT-0, 1 mesh erosion, 1 nephrectomy (non-functioning kidney detected in original surgery) and in the vaginal mesh group (n=13) 5 mesh erosions (3 surgery), 4 mesh excisions for mesh contractions, 3 TVTs, 2 LSC and 1 bowel resection for diverticulitis.

Conclusion: At 2 years the LSC had a higher satisfaction rate and objective success rate than the TVM with a lower blood loss, shorter hospital stay, quicker return to activities of daily living and lower reoperation rate. The LSC took longer to perform and no difference was seen between the groups in QPFD and P-QOL questionnaires. Further evaluation is required.

Refer tables next page:

Table 1. Study flow diagram describing recruitment, randomisation and analysis with time.

Eligible n=142	
	12 excluded, 22 refused
Randomised n= 108	
LSC n=53	TVM n=55
Completed 6 months n=53	Completed 6 months n=54
Completed 12 months n=49	Completed 12 months n=48
Completed 30 months n=42	Completed 30 months n=43
1 unwell, 1 lost to review	1 overseas, 2 lost to review
Analysis n=53 2 yr mean review	Analysis n=54 2yr mean review

Table 2. Peri-operative details. Categorical variables were compared using Fisher's exact test and medians were compared using Wilcoxon's exact rank-sum test.

	Laparoscopic (n=53)		Vaginal (n=55)		P value
	median	[range]	median	[range]	
Operating time (mins)	97	[36, 280]	50	[30, 96]	<0.001
Blood loss (ml)	100	[25, 300]	150	[25, 500]	0.004
In patient (days)	2	[2, 6]	3	[2, 6]	0.006
Catheter (days)	1	[1, 42]	2	[1, 21]	0.11
Pain score 1month (0-10)	0	[0, 80]	0	[0, 50]	0.10
Return ADL (days)	21	[7, 50]	21	[5, 63]	<0.001

Table 3. Objective success (stage0&1) at mean 2.0 years for the two treatment groups.

	LSC (n=53)	TVM (n=54)	
Review	n(%)	n (%)	p value
Aa	47(89)	37 (69)	0.02
Ap	49(92)	37 (69)	0.003
C	51(96)	51 (94)	0.99
Ba	50(94)	38 (70)	0.002
Bp	50(94)	39 (72)	0.004
All sites	41(77)	23 (43)	0.001
TVL(cm)(sd)	8.8(0.5)	7.8 (1.4)	<0.001
Satisfaction(sd)	87(21)	70 (20)	0.002

This study supported by AGES Research grant 2006 & 2007

Author affiliation: Associate Professor Christopher Maher; Brisbane Queensland, Australia.

Mesh vs traditional repair

Friday 30 October / Session 3 / 1420 - 1445

Rane A

This abstract deals with issues emerging out of mesh usage in the treatment of genital prolapse. There are certainly more complications now being reported with mesh usage than just success rates in current meetings like IUGA. The general trend for these complications seem to come from low volume usage units. This has obvious implications with training and understanding of the technical nuances of these techniques.

- Mesh usage seems to all be lumped together. However there are currently distinct entities emerging with mesh usage - these include mesh overlay techniques and mesh replacement techniques using various kits. Add to this the usage of biologic meshes, hybrid meshes, and mesh overlays with suture anchorage and vaginal support devices postoperatively!!!!

It becomes very difficult therefore to tease out all these techniques unless each confounding variable is subjected to a randomised controlled trial which is virtually impossible. NICE and FDA has issued 'warnings' on ' mesh' usage. It seems ' those who see - can - those who don't - can't'!!!

Certainly as far as our personal experience goes, our mesh usage could be considered moderate to high volume.

Our pearls for mesh usage are from extensive experience and not necessarily totally evidence based.

These include

- EVERY KIT IS DIFFERENT - one must get familiarised with the nuances of each kit - since needles and trocars can go in extremely dangerous places.

- FULL THICKNESS VAGINAL DISSECTION - vaginal skinning leads to a much more superficial placement and increases risk of erosion and dyspareunia. Learn how to identify the plane between the viscous and the vagina -tension free vaginal mesh placement - avoid pulling on tensioning arms - rather replace the vagina with fingers and spread mesh cranially- this prevents 'ridging' at the level of the arms and subsequent pain

- VISUALLY PLEASING SURGERY - native tissue repair looks visually pleasing immediately post

operatively. Mesh surgery should NOT look visually pleasing - this avoids a tendency to 'over correct' and subsequent pain and dyspareunia.

- AVOID SACROSPINOUS LIGAMENT FIXATION - in our unit we avoid using the SSL as an anchoring point to avoid distortion of the vaginal axis

- AMOUNT OF MESH - mesh is like medicine -tailor the dose per case!

- NO MESH for level 2 posterior defects - we have done three studies to show in the long term it makes no difference provided native tissue repair is not done using the levators.

- NO MESH - for cystocoeles that are symptomatic Grade 2 or less

- SEPARATE COLPOTOMY INCISONS - for each compartment - viz - vaginal hysterectomy, anterior repair, posterior repair

- USE OF VAGINAL ESTROGEN - we recommend pre operative tissue preparation with topical estrogen

- NO VAGINAL TRIMMING - we do not routinely trim vaginal tissue during our repairs.

- CERVICAL AMPUTATION – in cases where uterus preserving surgery with mesh is being performed

- PRECISE UNDERSTANDING - of the anatomy of the obturator, lateral pelvic wall and ischio rectal fossa is necessary to optimise usage of kits or mesh

- ABILITY to identify and manage complications - it is not about being just able to operate but anticipate and handle complications!!

Our 5 year Perigee data is one of the longest data with 350 data units. It certainly has been to shown to have a low complication rate, low recurrence rate and a high day surgery discharge rate - those who see - can - those who don't - cant!!!!!

Author affiliation: Professor Ajay Rane MBBS MSc MD FRCOG FRCS FRANZCOG CU. Consultant Urogynaecologist, Chair and Head, Dept. of Ob-Gyn, James Cook University, Townsville, Queensland, Australia.

Staging laparoscopy in endometriosis

Saturday 31 October / Session 5 / 0800 - 0820

Maher PJ

Pain, dysmenorrhoea, dyspareunia and abnormal uterine bleeding with or without infertility are all well- known symptoms of pelvic endometriosis. Many or all of these symptoms may be present with other diseases of the pelvis. There is no history that is so typical of endometriosis to justify diagnosis on the basis of symptoms alone.

In a disease with such a wide variation in distribution it is not surprising that the symptoms and signs are quite variable. In the past, the finding of adherent adnexae in a patient of reproductive years, in whom TB, gonococcal infection or post-abortal or puerperal infection could be excluded with reasonable certainty, the diagnosis of endometriosis would be considered. Today with these other disease entities almost non-existent in first world countries, together with the availability of laparoscopy, the means to diagnose endometriosis is readily accessible. The most effective diagnosis of endometriosis involves laparoscopy combined with biopsy of suspicious lesions to confirm the presence of ectopic endometrial tissue.

This presentation will be confined to techniques used in the planning to remove endometriotic tissue as it affects the peritoneum, underlying ureter, ovary and to a lesser extent the rectum and the bladder.

Endometriosis or at least pain due to this disease is the most frequent reason for laparoscopy in Australia in women of reproductive years. TeLinde and Scott as early as 1952 described complete excision and fulguration of all obvious endometriotic tissues as the end point of surgical management. The advantages of laparoscopic access to endometriosis surgery include magnification, particularly where the ureter and its associated structures are concerned and easier intra-operative access to bladder and rectal lesions except where resection of a rectal segment becomes necessary. The well known advocated advantages of laparoscopy must also be remembered; same day treatment, less pain, early return to normal duties following a quick recovery.

It is now accepted that laparoscopic results of treatment for mild to moderate endometriosis are equal to those achieved by laparotomy.

Modern operating theatres have a wide range of “up to date” laparoscopic equipment. High flow insufflators, adequate suction irrigation, and a first class video camera setup are the foundations upon which we can confidently approach the resection of endometriosis. Today adequate vision can be achieved using a 5mm 0° telescope and I personally prefer four abdominal wall ports for easy access surgery. As with all laparoscopic procedures it is important to minimize the number of blind needle/port insertions made. It is therefore imperative that once the intra- umbilical port is safely sited, all accessory ports; left iliac fossa, right iliac fossa and a supra pubic port (in line with the other two for ergonomic ease) are placed under direct vision from the primary site. Always remember even though vascular injury during laparoscopic surgery is relatively uncommon (4-6 per 10,000 cases) that after the insertion of the Veress needle and primary port, the right common iliac vessels are the second most common site of injury.

Trendelenberg position (up to 30° with the consent of the anaesthetist) should not be adopted until the primary intra umbilical port is placed. Today shoulder restraints are contra-indicated, thus avoiding the possibility of brachial plexus neuropraxia – a situation probably indefensible in the law courts if they are used.

The power source used to excise endometriosis is really the surgeon’s choice. I personally have always used electrosurgery but other sources such as ultrasound shears, cold knife (scissors) and laser (in one of its many forms) are available. The important principle is to become familiar

with one particular type of power and understand the principles of use and its capabilities. In my institution laser has never been popular but reports in the literature state that laser and electrosurgery have equivalent results in the relief of pain in-patient being treated for endometriosis.

Due to the wide variation in complexity of surgery for endometriosis careful planning is essential. Another important consideration is the optimal use of precious operating time. Simple peritoneal endometriosis is probably the most common finding at primary laparoscopy.

The preferred method of management of side wall endometriosis affected peritoneum is excision. This policy is based on the belief that vaporization or burning of lesions often fails s to completely eradicate endometriotic lesions – the diagnosis of endometriosis needs to be histological not visual. This is impossible if vaporization is the treatment of choice.

Biopsy studies show that at least 7% of lesions are missed and the extent of the disease is underestimated in 50% of cases. Histology frequently shows disease at the border of tissue when excision was thought to be complete. It is important to be sure that the patient is given the correct diagnosis. The diagnosis of endometriosis does precipitate anxiety in many women and once labeled with this diagnosis any exacerbation of pain will often result in further unnecessary laparoscopies or unnecessary drug therapy. Excision biopsy with adequate borders is the preferred method of treatment. Surgeons should avoid biopsy then fulguration as the resultant granuloma scar tissue can mimic further or recurrent endometriosis at future operations. Without doubt proper surgical treatment favours excision. Whilst in a considerable percentage of cases of endometriosis the disease is not penetrating, a significant number of women with persistent disease did have lesions, which infiltrate beyond 5mm. The reasons for the persistence or “recurrence” is most likely the use of thermal ablation where the depth of ablation may be limited because of either a false assumption that the lesions are superficial and deeper treatment is not necessary or more importantly that the persistent application of thermal energy may damage adjacent structures, in particular the ureter on the side wall of the pelvis as it course from the pelvic brim down adjacent often to the uterine artery into the ureteric tunnel. Endometriosis has been found in 13% of normal looking peritoneum next to the endometriotic lesions. This finding together with incomplete excision in up to 50% of cases in another reported series suggested that a 1-2cm margin of normal looking tissue beyond the visible lesion should be considered. In an uncontrolled series there was a lower recurrence rate of endometriosis after a three year follow up when excisional surgery was used compared with thermal ablation of endometriosis deposits on the lateral pelvic wall.

The presentation will address the pre-operative considerations ,simple pelvic sidewall excision and address the more serious surgical considerations associated with deep infiltrating endometriosis.

Author affiliation: Peter J. Maher, Director, Department of Endosurgery, Mercy Hospital for Women ,Melbourne, Australia.

Surgery for endometriosis: stage I-II disease

Saturday 31 October / Session 5 / 0820 - 0840

Tsaltas J

Endometriosis is an enigmatic disease which affects between 4-11% of the female population in the reproductive age group. The classical symptoms of endometriosis are severe dysmenorrhoea, deep dyspareunia, pain with ovulation, infertility, pain when voiding or defecating during the menstrual cycle. As the disease progresses many women often describe that where they initially had pre menstrual and severe menstrual pain, that the same pain now occurred almost through the entire cycle and became significantly during the time of menses.

Traditionally we have all been taught that the severity of symptoms does not correlate with the severity of the disease. Indeed we all have patients who have minimal endometriosis and have quite severe dysmenorrhoea and other patients who have stage four to five endometriosis and have very few if any symptoms. This indeed is the case for some women. However I would like to put it to you that there are a significant number of women whose symptoms do correlate well with a degree of their disease. As their disease progresses their symptoms also progress.

When I was a medical student and also when I was a young trainee I was taught (as I am sure many of you were) that if you found minimal to mild disease that it probably could be left alone. You may be able to cauterise a bit of the disease but also how accurate was the diagnose just staring down the eye piece of a laparoscope compared to modern video laparoscopy with magnification of 40-50 times. Over the last twenty years we have certainly seen a major change in the way that endometriosis is managed. The gold standard of management is to make a diagnosis at laparoscopy and to excise the disease that is present in the pelvis. The question that has been put to me by the organising committee for my talk is whether we should be removing stage I-II disease of endometriosis when it is diagnosed at laparoscopy.

I believe that endometriosis is a progressive disease. Certainly the rate of progression does vary from individual to individual. I am sure that there are immunological and genetic factors which influence how rapidly and how aggressively endometriosis progresses in different individuals. As these factors are yet to be quantified then I would recommend that when a patient is found to have stage I-II disease, and obviously if it is safe to do so, that it should be excised at the time of the laparoscopy. During my presentation I will present some surgical videos on my technique for excising stage I-II disease. I believe that if the disease is found at this time it is often less invasive but, as we all know, what we see on the surface of the peritoneum does not necessarily correlate with how deep the disease into the surrounding structures. An understanding of the anatomy of the pelvic region is important. An appreciation of safe dissection, particularly of the ureter and avoidance of injury to the ureter and the rectum as well as to the vascular supply to the uterus, is of paramount importance.

The other advantage of removing the disease is that it can be sent for histological diagnosis to confirm the presence of endometriosis. Also if the patient's symptomatology continues despite complete excision of the disease then other modalities can be used to help deal with the patient's symptoms.

The other reason that I would advocate excision of the disease is that in my Practice I see many women who had stage III-IV endometriosis and significant problems with their fertility and I am sure that their disease started as minimal, moving through to mild before going to moderate and severe. If the disease was identified early then you may be possibly able to improve fertility outcomes for many of these women.

Author affiliation: Dr Jim Tsaltas, Head of Gynaecological Endoscopy MonashMedical Centre Southern Health, Victoria, Australia.

Laparoscopic excision of stage III-IV endometriosis

Saturday 31 October / Session 5 / 0840 - 0900

Abbott J, Kingston A

In removing moderate-severe endometriosis from the pelvis, surgical technique can be simplified into a series of steps which can be followed, no matter where the disease is. The importance of these steps is to ensure that there is safe removal of disease, which should be completely removed where possible. The tools for performing these steps vary (monopolar, bipolar, harmonic scalpel), and should be based on availability and surgeon's knowledge of the technology and comfort with the tool, however the steps remain the same.

Important in the assessment is the ability to teach the surgical technique to trainees or demonstrate to colleagues. The following describes simple series of steps and what needs to be achieved in each.

Part 1: Assessing the abdomen and pelvis – defining the areas of disease from the diaphragm to the pelvic floor. A non-traumatic approach is essential to determine what is disease and preventing artefact.

Part 2: Making a plan – ensure a methodical approach to removal of disease and list by site or by structure. A written plan may be helpful when first starting this surgical technique (whiteboard in OT)

Part 3: Defining the structures – critical to safe surgery is defining the ureters, vessels, and bowel. The gynaecological organs should be assessed for involvement. Defining the structures before removal of disease will assist confidence and ensure a more complete removal.

Part 4: Removing disease – the modality to do this varies, excising deep disease imperative and ensuring that normal tissue remains.

Part 5: What to do with the ovaries – stripping/vapourisation/mobilisation/adhesiolysis/adhesion prevention/lifting to keep out of the field/suspending post-operatively. All discussed.

Part 6: Additional surgeries – hysterectomy, bowel surgery, urological surgery, removal of ovaries, tubal studies

Part 7: Testing the pelvis – integrity tests for bladder and bowel, ureter examination/cystoscopy. Considering barriers for adhesions, IVF access.

Part 8: Instruments and the future – the technique that we have now may well change with improved instrumentation, although the steps are likely to remain the same. A discussion of the new tools that are available now including their advantages and disadvantages.

Author affiliation: Jason Abbott, Ashley Kingston, School of Women's and Children's Health University of New South Wales, Sydney, New South Wales, Australia.

Safe dissection of the ureter in a patient with endometriosis.

Saturday 31 October / Session 5 / 0900 - 0920

Molloy D

It seems almost axiomatic that where there is endometriosis there is also the ureter. Removal of the lateral pelvic side wall for the management of endometriosis requires safe visualization and dissection of the ureter. This will be discussed and displayed as part of this talk.

For more advanced cases of endometriosis, parametrial endometriosis is common. There may be evidence of infiltrating parametrial endometriosis and fibrosis or even a large lump of endometriosis which may extend from the fornix of the vagina out to the uterine arteries and encase the ureter. In this situation the surgeon needs to confident about opening the ureteric tunnel and dissection of the ureter out of the endometriotic mass. This will also be discussed.

Inevitably where the ureter is attached to endometriosis there will be some risk of ureteric damage. Management of damaged ureters by the gynaecologist is also to be presented.

Author affiliation: Dr David Molloy; Queensland Fertility Group, Brisbane Australia.

Avoiding injury to the bowel – what to do if the wall is breached

Saturday 31 October / Session 5 / 0920 – 0940

Woods R

Bowel injuries can have significant consequences when performing laparoscopic surgery for endometriosis. They can occur irrespective of the severity of endometriosis. With good attention to preoperative assessment and a safe sound technique bowel injury can be minimised, timely recognition made intraoperatively if it does occur and injuries dealt with resulting in minimal morbidity.

Bowel injury can lead to septic complications, increased adhesions, reduced fertility, stomas and of course medico-legal issues. Injuries can result from direct trauma, burns and traction injuries. They may occur at abdominal entry, direct trauma from instruments, dissection in pathological areas, unrecognised burns and traction when holding the bowel. Using sound standard abdominal entry techniques for simple cases and modifying for more complex cases will reduce entry injuries. Adhesions near port sites should be taken down. Careful insertion of instruments is crucial. Intraoperative identification and repair of any defects or potential defects eg. partial thickness injuries is important. Identification requires a high index of suspicion and in the rectum testing with Betadine. Simple defects not involving endometriosis can be closed with simple suture closure or if it is a rectal defect a stapler can be used.

In severe pelvic disease particularly when involving the Pouch of Douglas the rectum is at risk. It is important to identify patients that will need the presence of a Colorectal surgeon. Ideally this should be done preoperatively but certainly prior to any significant dissection of the POD. Normal tissue planes need to be developed and vital structure such as the ureter dissected free to isolate the diseased area. This will help to identify

the anatomy, to determine whether the bowel is involved and to define where to dissect. If there is an inadvertent injury it will also be easier to repair. The rectal and vaginal anatomy can be better seen with the help of rectal and vaginal probes. If a rectal injury occurs during this phase soilage needs to be controlled and repair can involve simple suture repair or even rectal resection if the disease is extensive enough. After dissection of the rectum a Betadine pressure test is mandatory.

Author affiliation: Rod Woods; St Vincent's Hospital, Melbourne, Victoria, Australia.

Hysteroscopic surgery – what procedures are obsolete?

Saturday 31 October / Session 6 / 1030 - 1100

Abbott J, Rao A

Hysteroscopy has evolved from its use as a purely diagnostic procedure to a modality used to treat a wide range of benign gynaecological conditions, ranging from menorrhagia to infertility. The evolution of equipment available has changed the procedures that can be performed, their efficacy, as well as the skill required to perform procedures hysteroscopically.

Medicare Benefits Schedule (MBS) data has been reviewed to gain an overview of the pattern of procedures being performed currently, and trends over time. This review demonstrates that in the 10 year period from 1998 to 2008 the total number of operative hysteroscopic procedures in Australia dramatically increased from 6804 in 1998 to 16 186 in 2008. Compared with this increase of 138%, the number of diagnostic procedures increased by only 6% over the same time period.

The single greatest contributor to operative hysteroscopic procedures in Australia is hysteroscopy in association with adhesiolysis, polypectomy, tubal catheterisation or removal of intrauterine device, accounting for 71% of these procedures in 2008. However, of the more advanced hysteroscopic procedures, a number of interesting trends have emerged. For example, since the introduction of microwave, thermal balloon and radiofrequency generation endometrial ablation techniques in 2001, the number of these procedures has increased from 628 in 2001 to 2329 in 2008. Over the same period of time, the number endometrial ablations by laser or diathermy has decreased from 1873 to 1326.

The various trends in procedures being performed, reasons for these trends, and implications for training and hysteroscopic surgical skills will be outlined.

Author affiliation: Dr Jason Abbott, Dr Archana Rao; School of Women's and Children's Health, University of New South Wales, Sydney, Australia. Royal Hospital for Women, Randwick, Australia.

Mullerian tract anomaly surgery

Saturday 31 October / Session 6 / 1130 - 1200

Cooper M

In this presentation I will refer to the American Fertility Society Classification of Mullerian anomalies and utilise this classification to display a number of different anomalies and surgical methods of coping with this. These conditions are rare and each case management needs to be individualized.

Author affiliation: Dr Michael Cooper; Clinical Senior Lecturer, Sydney University, Head of Gynaecology Royal Prince Alfred Hospital, Sydney, New South Wales, Australia.

FREE COMMUNICATIONS
ABSTRACTS

Bladder dissection in hysterectomy patients with previous caesarean section at the Sydney West Advanced Pelvic Surgery unit (Video Presentation)

Free Communications / Session 4 / 1530 - 1540

Anpalagan A, Merkur H

About 20% of our hysterectomy group would have had at least one previous caesarean section. The instruments that we use for the hysterectomy includes Biswas uterine manipulator, monopolar scissors and bipolar forceps. We aim to dissect the bladder with the peritoneum and the pre-cervical fascia over the edge of the Biswas colpotomiser. The dissection is started from lateral – along the broad ligament – to medial. This enables the anterior colpotomy.

The risk of having inadvertent cystotomy in our unit is 1.4%. We have also noticed that, as the number of previous caesarean section increases, the risk of cystotomy rise. The rate of cystotomy clearly decreases over the years. This could be multi factorial, including the increasing skill level, better equipments and refined technique. Here we are presenting our technique of dissection.

Author affiliation: A. Anpalagan, H. Merkur; Sydney West Advanced Pelvic Surgery (SWAPS) Western Sydney NSW Australia.

The case of the missing ovarian cyst wall

Free Communications / Session 4 / 1540 - 1550

Bradford S, Saraswat A, Ratnapala M

This is a case presentation of a unique complication during the laparoscopic removal of a large tubo-ovarian cyst. A 20 year old nulligravida presented with a large simple cyst arising from the pelvis. The cyst was palpable to 4 cm above the umbilicus. Ultrasound reported a large unilocular cyst and subsequently all tumor markers were normal (histology later confirmed a mucinous cystadenoma). The patient gave consent for surgical removal via laparoscopy/ laparotomy. The cyst was initially deflated under direct vision via the umbilical port site, and further fluid was removed via a 5 mm port under scope vision. The ovary, oviduct and cyst were dissected enbloc at the pedicle with the harmonic scalpel. Due to the specimen's size it was cut into 3 sections measuring around 20cm by 20cm each. The specimen was removed via the 10mm umbilical port incision negating the need for a mini-laporotomy. The third piece of the specimen was not found upon re-entry with the scope and instruments. Despite extensive inspection of the pelvis and abdomen we were unable to recover the last part of the specimen. The presentation will show edited video of the procedure and a discussion of this approach to the operation. Further we will discuss how the patient was told of this complication in full open disclosure.

Author affiliation: S. Bradford, A. Saraswat, M. Ratnapala; Caboolture Hospital, Wooloowin, Brisbane, Queensland, Australia.

Laparoscopic retraction - hands free and without additional ports

Free Communications / Session 4 / 1550 - 1600

Chetty N

Laparoscopic surgery poses unique challenges for retraction.

Invariably an assistant is required to retract structures. This manoeuvre is inefficient, restrictive, and poor retraction can be dangerous. In addition it reduces the number of instruments available to perform a task.

Therefore we propose a technique of retraction that is simple, easily learnt, relatively cheap, uses readily available material and eliminates the need of an assistant to retract. It allows for the mode of retraction to be brought extra-corporal at any chosen location without the need of an additional port- allowing for the degree and angle of traction to be controlled.

This technique, first introduced by us at the AAGL meeting in Las Vegas-2008, has been expanded to allow for traction of the uterus, as well as for retraction to the large bowel.

Traction on the round ligaments aids uterine manipulation when use of a uterine manipulator into the uterine cavity is contraindicated, not possible due to a shortened cervix or the presence of a McCartney tube or if access to the vagina is difficult, as in a robotic surgery.

While retraction on the appendices epiploicae allows the sigmoid colon to be drawn out of the pelvic.

With the aid of this technique the operation is more efficient, as intra-corporal instruments no longer need to be used for retraction.

Effective retraction also leads to a safer operation.

In short this procedure increases the number of 'hands' available to do a laparoscopic operation, without the need for additional ports or assistances.

We look forward to sharing our technique with the AGES audience.

The Technique-

- A pre-made vicryl or PDS loop passed via a port into abdomen.
- Structure requiring traction is looped
- If traction in the plane of the ports is adequate the plastic sheath can be removed and the loop passed adjacent to the port.
- When a different angle of traction is required the entire loop into the abdomen.
- Choose an appropriate site on the abdomen that would allow the best angle of retraction.
- Inspect the inner aspect of the abdominal wall to confirm the absence of vital structures - 14G IV cannular is inserted through the abdominal wall until the peritoneum is reached, then trocar removed.
- A piece of 3/0 prolene is then bent in half and passed down the cannular until it appears in the abdomen.
- The free end of the endoloop is passed through the prolene loop.
- Retraction of the prolene loop retrieves the free end of the endoloop via the cannular.
- Cannular removed- endoloop now extra-corporal, without the need for another port.
- When the appropriate retraction is obtained, a clamp is placed at the level of the skin, thereby allowing for an operation with all available instruments.
- Once complete, the loop is cut and removed.

Author affiliation: N. Chetty; Royal Brisbane and Womens Hospital, Hawthorne, Queensland, Australia. With thanks to staff at – Endogynae Unit, RHW, Randwick, NSW; Queensland Centre for Gynaecological Oncology, Royal Brisbane and Women's Hospital, Hawthorne, Queensland, Australia.

Laparoscopic removal of cornual pregnancy in a woman with previous ipsilateral salpingectomy: A video presentation

Free Communications / Session 4 / 1600 - 1610

Wang L, Najjar H

Monash Endosurgery Unit, Monash Medical Centre, Melbourne, VIC, Australia

Cornual pregnancies constitute 2% of all ectopic pregnancies, and is associated with maternal mortality of 2-2.5% even with improved management. Traditionally, treatment of this involves laparotomy with cornual resection or possibly hysterectomy in cases of extensive haemorrhage. In more recent times, cornual ectopic have been treated successfully with medical therapy. Cases of hysteroscopic removal of cornual pregnancy have been reported.

We present a case of a 39 year old woman, with history of laparoscopic left salpingectomy for ampullary tubal pregnancy. A 3cm left tubal pregnancy was detected on ultrasound after 7 weeks amenorrhoea, and was though to be tubal pregnancy in tubal stump. At laparoscopy, the mass was found to be in the cornua. The ectopic pregnancy was removed laparoscopically using bipolar and monopolar diathermy.

Author affiliation: L Wang, H Najjar; Monash Endosurgery Unit, Monash Medical Centre, Melbourne, Victoria, Australia.

FREE COMMUNICATIONS ABSTRACTS

Posterior colpotomy in Pouch of Douglas endometriosis – SWAPS technique

Free Communications / Session 4 / 1610 – 1620

Anpalagan A, Merkur H

Posterior colpotomy is one of the important steps in laparoscopic hysterectomy. We usually do anterior followed by posterior colpotomy before taking the uterine artery pedicle. Posterior colpotomy is generally easier than the anterior colpotomy as the rectum doesn't need to be dissected off the colpotomiser. However, in cases of endometriosis in the posterior pouch it can be difficult, where the rectum is adherent to the cervix. Even after the rectum is dissected off the cervix, the colpotomiser may not be identified clearly to do the posterior colpotomy.

We have developed a different approach for these cases. Uterine artery pedicle is done after the anterior colpotomy and the lateral fornices entered bilaterally. We then connect these lateral fornices along the posterior fornix to complete the hysterectomy.

Author affiliation: A. Anpalagan, H. Merkur; Sydney West Advanced Pelvic Surgery (SWAPS) Western Sydney NSW Australia.

Dermoid causing doctor distress

Free Communications / Session 4 / 1620 – 1630

Faber-Swensson A

This is a case presentation of a curious histological finding and its consequences following laparoscopic removal of a dermoid ovarian cyst. The patient was a previously well 27 year old mulitparous woman with a right ovarian mass resembling a dermoid cyst diagnosed as an incidental finding on ultrasound. Her tumour markers were normal apart from a CA 19.9 of 55. Consent for a laparoscopic right ovarian cystectomy was obtained. The surgery was uncomplicated, with the cyst attached to a mobile right ovary without adhesions to neighbouring structures. The cyst was removed with largely blunt dissection and sent for histology. The patient was admitted overnight for observation, and recovered well. To the horror of the operating team, the pathologist called the next day as a segment of ureteric tissue was embedded in what was confirmed to be a dermoid cyst. After a review of the procedure it was clear that there had been no surgery performed near the normal path of the right ovary, but it was decided to inform the patient of the finding and to perform suitable imaging to ensure that the right ureter had not been injured. An intravenous urogram demonstrated no evidence of ureteric injury. The final pathology report confirmed the initial finding of tissue resembling ureter lying 2mm deep to the squamous lining of the cyst. Apart from the additional imaging, the histological findings in this case probably caused more discomfort for the operating team than the patient.

Author affiliation: A Faber-Swensson; Caboolture Hospital, QueenslandHealth, Albion, Queensland, Australia.

Heuristics and Laparoscopic Gynaecological Surgery

Free Communications / Session 4 / 1630 - 1640

Jacobson T

Heuristic (from the Greek for "find" or "discover") is an adjective for experience-based techniques that help in problem solving, learning and discovery. A heuristic method is particularly used to rapidly come to a solution that is hoped to be close to the best possible answer, or 'optimal solution'. Heuristics are "rules of thumb", educated guesses, intuitive judgments or simply common sense. Heuristics is a growing area of research in surgery that aims to explore how we learn and teach and actually operate in the real world.

In this presentation I will present my own perspective of heuristic methods that can be useful in laparoscopic surgery. Some of this will be supported by very short video segments. I intend to cover the benefits of Palmer's point entry, ipsilateral port sites, temporary ovarian suspension, use of a lateral port 5mm scope, laparoscopic suturing, how to get things out and the importance of teamwork. Many of these "Pearls of Wisdom and Tricks of the Trade" are well known and none are particularly difficult, but flexibility is essential to keep you out of trouble in difficult situations. Having a few alternative strategies up your sleeve can turn an "OMG" into a straightforward procedure.

Author affiliation: Dr Tal Jacobson, Senior Lecturer and Consultant, University of Auckland, Middlemore Hospital, Private Bag 93311, Auckland, New Zealand.

Video snapshot talk ‘what would you do if’

Free Communications / Session 4 / 1640 – 1650

Rane A

- you see needle thro bladder
- you see sling thro’ bladder
- you see sling very close to bladder
- you see your patient is NOT voiding post op
- prolapse and fistula

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