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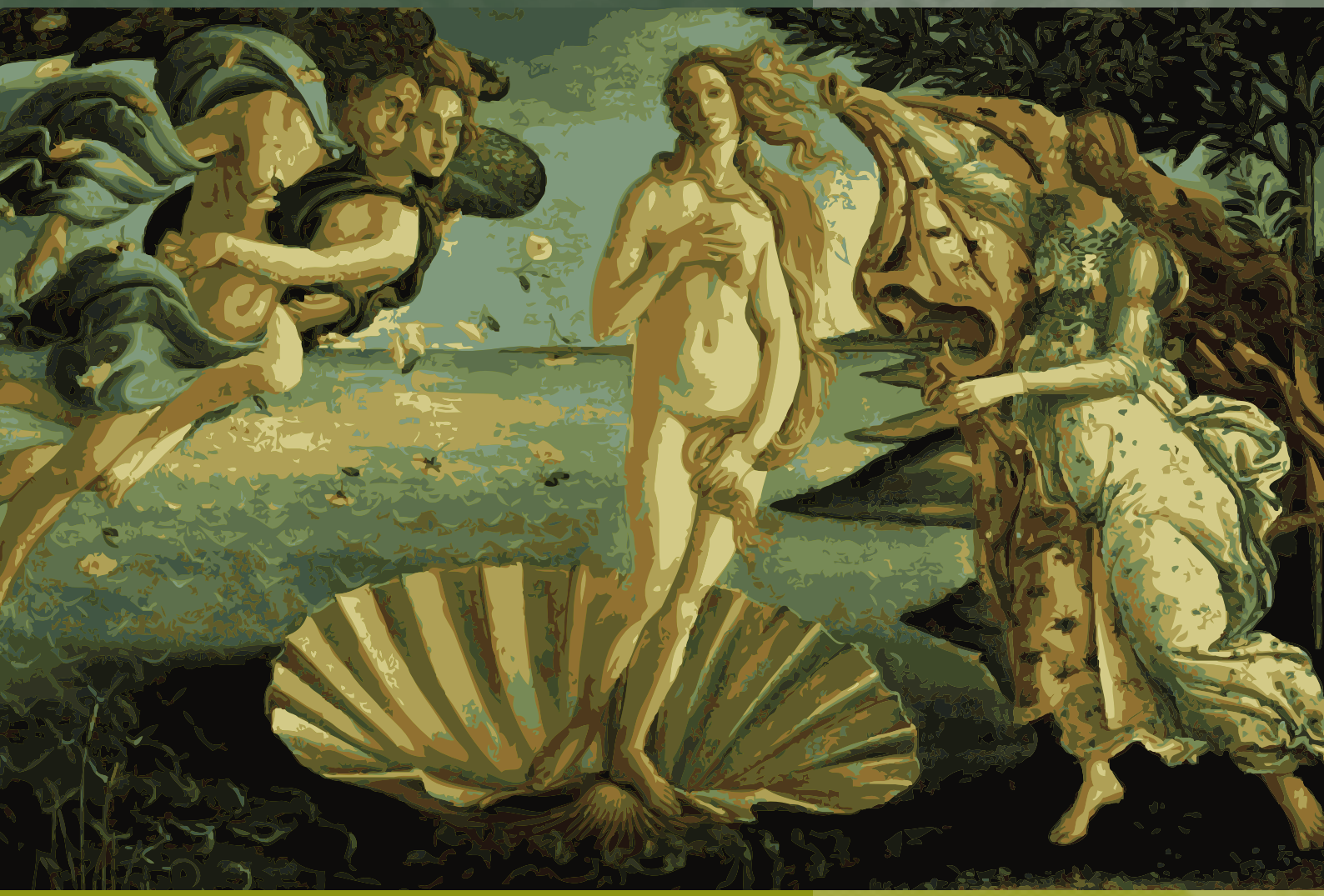

# AGES Focus Meeting 2010

13 – 14 AUGUST 2010
DARWIN CONVENTION CENTRE, AUSTRALIA

# Program & Abstracts

## The Ovary & the Gynaecologist

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## REGISTRATION FEE INCLUSIONS

- Attendance at all Conference Sessions
- Conference satchel and all Conference publications
- Conference meals including lunch, morning and afternoon teas on Friday 13 August and morning tea on Saturday 14 August

# Contents



## PR&CRM and CPD POINTS

This meeting has been approved as a RANZCOG Approved O&G Meeting with an associated Practice Review and Clinical Risk Management (PR&CRM) activity and eligible Fellows of this College will earn CPD and PR&CRM points for attendance as follows:

| | |
|---|---|
| Full attendance | 10 Meeting points and 2 PR&CRM points |
| Attendance 13 August | 8 Meeting points |
| Attendance 14 August | 2 Meeting points and 2 PR&CRM points |

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

Fellows of this College who attend the Meeting and complete the 'Clinical Risk Management Activity Reflection Worksheet' in accordance with the instructions thereon can claim for an additional 5 PR&CRM points. For further information, please contact RANZCOG.

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| Dr Clare Boothroyd | QLD |
| Prof. Michael Chapman | NSW |
| Asoc. Prof. George Condous | NSW |
| Dr Elizabeth Farrell | VIC |
| Dr Robert Ford | NSW |
| Dr Nader Gad | NT |
| Asoc. Prof. Alan Lam | NSW |
| Dr Fiona Langdon | WA |
| Dr Stephen Lyons | NSW |
| Dr Alastair Morris | NSW |
| Prof. Andreas Obermair | QLD |
| Dr Frank Quinn | NSW |
| Dr Stuart Salfinger | WA |
| Dr Jim Tsaltas | VIC |
| Dr Susan Valmadre | NSW |
| Dr Tamara Walters | WA |
| Asoc. Prof. Anusch Yazdani | QLD |

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Membership application forms are available from the AGES website or from the AGES Secretatiat.

### AGES Secretariat

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# Welcome

## Dear Colleagues

It is a great pleasure to welcome you to Darwin, for this Focus meeting on the ovary.

We are delighted that so many experts in various aspects of ovarian physiology, function and pathology have made themselves available to be here, and would like to thank them for giving up their valuable time to travel to Australia's north.

We would like this meeting to be as interactive as possible, and would encourage all of you to engage in questions and discussions with our expert speakers over the next two days.

The Board of AGES is keen to expand our meetings beyond the major Australian capital cities, and see the annual Focus meeting as a way to achieve this.

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Meetings of this type are contemplated for Tasmania, the ACT, New Zealand and Asia, in keeping with our belief that AGES is a truly Australasian society. We are therefore very pleased that we've been able to bring this meeting to the Northern Territory, a unique and important part of Australia.

We are confident that you will enjoy the social program that has been prepared for your stay in multicultural Darwin, and hope that this meeting will give you the opportunity to explore the fantastic tourist destinations that abound in this part of Australia's north.

Welcome.

**Robert Ford**
Conference Chair
Director AGES

**Alan Lam**
President AGES

# Program

## Friday 13 August 2010

Darwin Convention Centre
Waterfront Rooms 1 and 2

0730-0800 Conference Registration
Level 2 Pre-function Area

0800-0810 Conference Opening and Welcome R Ford, A Lam

**0810-0945 SESSION I Developmental and Adolescent Gynaecology and Fertility**
*Sponsored by Stryker*

Chairs: A Lam, A Yazdani

0810-0835 Sugar and spice and all things nice - that's what little girls are made of M Chapman

0835-0900 Adolescent gynaecology – precocious and delayed puberty T Walters

0900-0925 Oocytes and fertility F Quinn

0925-0945 Discussion

**0945-1015 Morning Tea and Trade Exhibition**

**1015-1145 SESSION II Endocrinology**
*Sponsored by Johnson & Johnson Medical*

Chairs: K Jansen, A Morris

1015-1040 PCOS and insulin resistance update C Boothroyd

1040-1105 History and evidence for surgical treatment of PCOS A Yazdani

1105-1115 Premature menopause and oopause E Farrell

1115-1145 Discussion and questions

**1145-1245 Lunch and Trade Exhibition**

**1245-1445 SESSION III Laparoscopy**
*Sponsored by Johnson & Johnson Medical*

Chairs: M McEvoy, R Wulf

1245-1310 Laparoscopic ovarian cystectomy - Tips and Tricks A Morris

1310-1335 Laparoscopic management of ovarian torsion S Lyons

1335-1400 Management of endometriomas J Tsaltas

1400-1425 Ovarian torsion in childhood N Gad

1425-1445 Discussion

**1445-1515 Afternoon Tea and Trade exhibition**

**1515-1700 SESSION IV Oncology**
*Sponsored by Karl Storz Endoscopy*

Chairs: J Tsaltas, N Gad

1515-1530 Screening for ovarian cancer S Salfinger

1530-1545 New developments in surgery for ovarian cancer S Valmadre

1545-1600 Borderline ovarian tumours A Obermair

1600-1615 Triage of ovarian masses I F Langdon

1615-1630 Triage of ovarian masses II A Obermair

1630-1700 CGO's, generalists and RANZCOG
Panel discussion and questions

1700 Close

**1900 for 1930 Gala Dinner**

On the lawn of
Pee Wee's at the Point
*Complimentary coach transport provided from the Medina/Vibe. Please assemble in the hotel lobby at 1830.*

# Program

## Saturday 14 August 2010

Darwin Convention Centre
Waterfront Rooms 1 & 2

**0800-0945 SESSION V Ultrasound**
*Sponsored by Insight*

Chairs: J Tsaltas, K Jansen

| | | |
|---|---|---|
| 0800-0840 | What really is a complex ovarian mass? Can Ultrasound differentiate between benign and malignant ovarian masses. New practical guidelines for classifying ovarian masses, the IOTA (International Ovarian Tumour Analysis) Classification | G Condous, T Bignardi |
| 0840-0945 | PR&CRM Workshop: Interactive session - Ultrasound appearances of ovarian pathology. Application of the new IOTA Classification | |

**0945-1015 Morning Tea and Trade Exhibition**

**1015-1220 SESSION VI Oophrectomy**
*Sponsored by Stryker*

Chairs: S Salfinger, M McEvoy

| | | |
|---|---|---|
| 1015-1030 | The postmenopausal ovary | E Farrell |
| 1030-1045 | Familial ovarian cancer | S Salfinger |
| 1045-1105 | Laparoscopic oophrectomy - anatomy and technique | R Ford |
| 1105-1135 | Tiger country: management of residual ovary syndrome | A Lam |
| 1135-1210 | Discussion and questions | |
| 1210-1220 | AGES Board and meeting update | A Lam |
| 1220 | Close meeting | |

# Darwin 'The Top End'

Darwin's cultural diversity is the result of more than 50 nationalities which comprise its 100,000 population, including the area's traditional landowners, the Larrakia Aboriginal people. The cultural and culinary benefits of such a melting pot are best experienced at Darwin's weekly markets, variety of restaurants and the Darwin Arts Festival which starts on 12 August.

Dining in Darwin is an attraction in itself, with a diversity of culinary choices. Exotic cuisine from all over the world along with authentic Northern Territory fare like mud crabs, barramundi, kangaroo and crocodile are on offer. Downtown Darwin is brimming with restaurants, cafés and pubs, some with live entertainmen. Outside the city centre, dining waterside in Fannie Bay or Cullen Bay means indulging in seafood, from local specialties to fish and chips.

For a gastronomic expedition, visit Darwin's famous markets. The food stalls of Mindil, Parap and Nightcliff provide a globe-trotting experience loved by locals and visitors alike.

Darwin Harbour's booming population of barramundi and other tropical fish make it a world-class fishing destination and its turquoise waters set the scene for the more relaxed option of a sunset cruise.

The Darwin Festival is on from August 12 to 29. Food events include market-to-table shows from Darwin's fabled markets to its best restaurants. Consider extending your stay!

Darwin is an excellent base to explore the natural attractions of World Heritage listed Kakadu National Park, Litchfield and Nitmiluk National Parks, the Tiwi Islands and Arnhem Land.

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# Abstracts - Friday 13 August

## ‘Sugar and Spice and all things nice – that’s what little girls are made of’

Friday 13 August / Session I / 0810-0835

*Chapman M*

Sexual differentiation is a complex process. From intuitive detective work based around the rare abnormalities that occur in sexual differentiation, clinicians before the era of molecular biology had worked out quite remarkably what was going to be involved in the control of the development of the genital system. Subsequent advances in genetics and molecular biology confirmed their views. Genes have now been identified, in particular on the Y chromosome that lead it to differentiation of the male. The female can be viewed as a default where the development of the female internal and external genitalia will occur if there is no overriding active production of specific genes or proteins. This presentation will summarise the genetic, chromosomal and hormonal events that lead to normal sexual development at an anatomical level. It will also cover the various aberrations that occur in the process, primarily due to gene defects as we now understand them. It will also cover a basic approach to clinical problems associated with abnormalities of the development of the female genital organs.

AUTHOR AFFILIATION: Professor Michael Chapman; St George Hospital, Women’s & Children’s Health Service, Level 2, Prichard Wing Gray Street, Kogarah, NSW, Australia

## Adolescent gynaecology – precocious and delayed puberty

Friday 13 August / Session I / 0835-0900

*Walters T*

The mechanism for signaling the onset of puberty is still not completely understood. Although there is a wide variation in the age at which the changes begin, there is usually a well defined progress of the changes from their onset until the child reaches the capability for reproduction. Puberty and menarche have begun at a progressively younger age almost certainly because of better nutrition and the current trend towards obesity in children may see this decrease continue.

True precocious puberty, onset before the age of 8 in girls, is usually idiopathic. However there are both central and peripheral causes which need to be considered. Several factors must be taken into account before deciding which management is appropriate for each case.

Delayed puberty, onset after the age of 13, may be normal in many girls and treatment will not be necessary. There are however, some important causes that will require treatment. The physical and social concerns associated with mistimed puberty onset are substantial and should figure prominently in the discussion of management of these children.

## Oocytes and fertility

Friday 13 August / Session I / 0900-0925

*Quinn F*

In recent years, there has been a trend towards females delaying their child bearing with the median age for women having their first child now entering the early 30s. In addition to females starting their families at an older age, more women are surviving childhood cancers and consequently fertility preservation is now becoming an increasing issue among women during their reproductive years. It is estimated that in 2010, 1:250 women are survivors of cancer treatment.

Interest in fertility preservation strategies is an expanding area of reproductive medicine. Ovarian transposition still remains a standard of care for women undergoing a pelvic radiation, though it has been suggested that it may be combined with ovarian tissue cryopreservation. For patients about to receive chemotherapy or whole body radiation, in-vitro fertilisation (IVF) with embryo cryopreservation is a well-established treatment with a good success rate. However, it requires delaying cancer treatment for two to four weeks and a partner. When these criteria cannot be met, other options include oocyte cryopreservation for later IVF and ovarian tissue cryopreservation. The tissue may be autotransplanted back into the pelvis when the patient is in remission to attempt spontaneous conception or placed subcutaneously for easy access of follicle aspiration for IVF. Alternatively, it may be xenografted into immuno-compromised mice to induce follicle maturation in preparation for retrieval for IVF. Whilst these treatments have seen a significant improvement in pregnancy rates in recent years, the overall success still remain low.

IVF with donor oocytes remains an established option with a very high success rate for those who fail to conceive with the above measures or who elect not to avail themselves to experimental procedures.

AUTHOR AFFILIATION: Dr Frank Quinn; IVF Australia, Northshore, Greenwich, NSW, Australia

# Abstracts - Friday 13 August

## Laparoscopic management of ovarian torsion

Friday 13 August / Session III / 1310-1335

*Lyons S*

Ovarian torsion refers to the twisting of the ovary on its ligamentous supports. It is the fifth most common gynaecologic emergency and affects females of all ages. Concomitant with ovarian torsion, blockade of venous and/or lymphatic blockade, with persistent arterial inflow, results in engorgement and swelling of the ovary. Eventually, if undiagnosed and untreated, arterial stasis may lead to hemorrhagic infarction and necrosis of the ovarian stroma.

The treatment of adnexal torsion has traditionally involved salpingo-oophorectomy via laparotomy. More recently, the management of adnexal torsion is increasingly performed via a laparoscopic approach although laparotomy remains predominant. Despite numerous animal and clinical studies over the last decade, which indicate that the characteristic blackened and engorged torted ovary may remain viable for up to 36 hours after the onset of torsion, however, surgical management infrequently involves conservation of the ovary.

The diagnosis of ovarian torsion is challenging because the symptoms are relatively non-specific, and because transvaginal ultrasound only successfully predicts torsion in ~50% of cases. With a high level of clinical suspicion and prompt action, however, it is possible to preserve ovarian function and/or tubal function.

This presentation focuses on the conservative management of ovarian torsion. The recent literature will be reviewed. Controversies in the management of ovarian torsion will be highlighted by review of practices at several Sydney public hospitals.

Pros and cons for the various aspects of the management of ovarian torsion will also be presented: laparoscopy vs. laparotomy; de-torsion and ovarian conservation vs. salpingo-oophorectomy; ovarian mass decompression vs. expectant mass management; and attenuation of the ovarian ligament (oophoropexy) vs. no attenuation. The optimal management of ovarian torsion should be based on and will include different combinations of the aforementioned options.

AUTHOR AFFILIATION: Dr Stephen Lyons; The Mater Clinic, Sydney, Australia

## Ovarian torsion in childhood

Friday 13 August / Session III / 1400-1425

*Gad N*

Ovarian torsion (OT) in children is rare event. Its diagnosis is often uncertain and delay in surgical intervention may cause necrosis of the ovary. Malignancy is rare in torsed ovaries in paediatric population.

During surgery the gynaecologist is usually faced with the dilemma of should he/she remove the apparently infarcted ovary or should he/she salvaged the ovary by detorsion.

High index of suspicious is needed to diagnose OT in early stage. Although historically OT has been managed by oophorectomy, conservative management by detorsion is feasible in most cases and ovarian function has been shown to recover in most ovaries after detorsion, even in apparently black-bluish non-viable ovaries. If an ovarian cyst or mass is found, then detorsion is performed followed by cystectomy or resection of the mass, oophoropexy is not necessary. Idiopathic ovarian torsion should be managed by detorsion and oophoropexy. Oophorectomy is generally reserved for when there is concern for malignancy or in the presence of large masses that do not resolve with time such as mature teratoma and there is apparent lack of normal ovarian remnant.

Further studies are needed to assess the outcome of delayed resection of neoplasms (benign/malignant).

## New developments in surgery for ovarian cancer

Friday 13 August / Session IV / 1530-1545

*Valmadre S*

Survival from ovarian cancer has been clearly shown to be related to how successfully the tumour can be "debulked."

Over time the surgical approach has tended to become more aggressive in order to ideally achieve no macroscopic disease at the completion of the ovarian cancer surgery. Such an approach may involve resection of the diaphragmatic peritoneum, partial hepatectomy, splenectomy and distal pancreatectomy.

The various surgical techniques as well as the place of intraperitoneal and dose dense chemotherapy and

novel therapeutic agents in modern ovarian cancer treatment will be discussed.

AUTHOR AFFILIATION: Dr Sue Valmadre; Gynaeoncology VMO at Mater, Northshore Private and Royal Northshore Hospitals, Sydney, NSW, Australia

## Borderline ovarian tumours

Friday 13 August / Session IV / 1545-1600

*Obermair A*

Ovarian Borderline Tumours demonstrate histological atypia on a cytological level but do not breach the base membrane and therefore fall short of the criteria for invasive cancer. Their five and ten-year survival is extremely good but recurrences may develop many years after diagnosis and treatment. Laparoscopy is increasingly used by gynaecologists for the investigation of adnexal masses. Uncertainty exists whether ovarian tumours of low malignant potential can effectively be treated by laparoscopy, whether staging bears a benefit for all patients, whether port-site metastases are a problem and how long patients need to be followed up after surgery. My presentation will review the evidence to address these important questions.

AUTHOR AFFILIATION: Professor Andreas Obermair, Brisbane, Queensland, Australia

## The triage of ovarian masses I - by regional gynaecologists

Friday 13 August / Session IV / 1600-1615

*Langdon F, Cottee T, Salfinger S*

INTRODUCTION: It has long been described that women with malignant ovarian masses have a better prognosis if their initial surgical management is performed by a gynaecology-oncologist surgeon.

1 As a definitive diagnosis of the malignant nature of an ovarian mass can usually not be confirmed until the mass is removed, a risk assessment tool must be employed. The Risk of Malignancy Index (RMI) is a method regularly used to triage women, with those patients with an RMI over 200 being referred to a gynaecology-oncologist, and those below 200 being treated by a general gynaecologist.

2 The RMI triage system is not absolute and a further evaluation of women with RMI below 200 must be undertaken by general gynaecologists before initiating management. By reviewing the records of patients referred to the general gynaecology service at Bunbury Regional Hospital with an operative ovarian mass, an analysis of the local gynaecologists' risk assessment of patient's with an RMI below 200 was possible.

MATERIALS/METHOD: A retrospective review of patients' records referred to the gynaecology service at Bunbury Regional Hospital with an ovarian mass between January 2008 and December 2009 was conducted. Patients were identified through the Genie computer program at South-West Gynaecology and through the Western Australia Tumour Board database. Patients were either operated on by the general gynaecologists in Bunbury or referred to the gynaecology-oncologists at King Edward Memorial Hospital. The initial Ca-125, imaging, menopausal status, personal and family history, operation report and final histology and cytology of all patients were reviewed.

RESULTS: Fifty-eight patients were initially assessed to have an operative ovarian mass by the general gynaecologists, all with an RMI below 200. Forty-nine of these patients underwent surgery under the care of a general gynaecologist and nine patients were referred to the gynaecology-oncology service at King Edward Memorial Hospital due to concerning features particularly on imaging or in their history. All of the 49 patients operated on in Bunbury had benign pathology. Of the 9 patients referred to and operated on by the gynaecology-oncologists, 3 had malignant disease. The sensitivity of the regional gynaecologists detection of likely ovarian malignancy was 100% with a specificity of 33%.

CONCLUSIONS: Despite patients having an RMI below 200, the general gynaecologists at Bunbury Regional Hospital referred nine patients to gynaecology-oncologists because of significant concerns raised during their assessment. This approach proved successful in detecting 100% of cases with malignant disease.

REFERENCES:

1. Kehoe S. et al. The influence of the operating surgeon's specialization on patient survival in ovarian carcinoma. Br J Cancer 1994; 70; 1014-1017

2. Jacobs I et al. A risk of malignancy index incorporating CA 125, ultrasound and menopausal status for the accurate pre-operative diagnosis of ovarian cancer. Br J Obstet Gynaecol 1990; 97: 922-929

## Triage of ovarian masses II

Friday 13 August / Session IV / 1615-1630

*Obermair A*

Well established evidence suggests that the best outcomes for women with ovarian cancer can be achieved when patients are treated by a multidisciplinary team that includes a Gynaecological Oncologist. Surgery is the cornerstone of all ovarian cancer treatment. For patients with early ovarian cancer careful and accurate surgical staging will determine the need for further treatment. For patients with advanced

# Abstracts - Friday 13 August

ovarian cancer, optimal survival benefits can be achieved if no residual tumour is left after surgery. Triage of women is therefore important to facilitate appropriate referral. While no risk assessment system is fail-proof, factors associated with the risk of malignancy include age, ultrasound features and levels of serum CA125. Algorithms have been developed to establish referral guidelines for patients with pelvic masses. Serum CA125 is most consistently elevated in patients with epithelial ovarian cancer but can also be expressed in a number of gynaecologic and non gynaecologic cancers. In addition, CA125 can also be elevated in a number of benign conditions, including endometriosis. In patients with Stage 1 ovarian cancer CA125 is negative in approximately 50% of all patients. New tumour markers such as HE4 and OvPlex try to overcome this weakness and will be discussed in the presentation.

AUTHOR AFFILIATION: Professor Andreas Obermair, Brisbane, Queensland, Australia

# Abstracts - Saturday 14 August

## Laparoscopic oopherectomy: anatomy and technique

Saturday 14 August / Session VI / 1045-1105

*Ford R*

The reasons why ovaries should, and should not, be removed have been reviewed by other speakers at this conference.

Laparoscopy is the method of choice for performing oopherectomy when this is required, and RANZCOG Trainees need to become proficient in performing this procedure prior to commencement of Specialist practice. It is an operation that should be familiar to all Generalist Gynaecologists.

Nonetheless, it is well described as being associated with complications.

This presentation will review the anatomy of the pelvic sidewall and present techniques which can assist in the safe and efficient removal of the ovary laparoscopically.

## Management of residual ovarian syndrome

Saturday 14 August / Session VI / 1105-1135

*Lam A*

OBJECTIVES OF PRESENTATION

1. Definition
2. Risk factors
3. Pathology
4. Clinical presentation
5. Diagnosis
6. Treatment options
7. Surgical principles

DEFINITION

- Ovarian Remnant Syndrome (ORS) and Residual ovarian syndrome (ROS) are often used interchangeably in clinical practice but the two conditions are pathologically different entities
  - ORS–ovarian tissue unintentionally left in place in women who have had bilateral salpingo-oophorectomy with or without hysterectomy
  - ROS - an ovary (whole or part) intentionally left in place during gynaecologic surgery
- Residual ovarian tissue subsequently causes pelvic pain and / or pelvic mass

RISK FACTORS
= conditions associated with adhesions and difficult pelvic dissections

- Endometriosis
- PID
- Pelvic adhesions
- Multiple past surgeries

PATHOLOGY

- Residual ovarian tissue may remain viable
- De-vascularised ovarian tissue may become re-vascularised
- Residual functional ovarian tissue subsequently may result in pain in premenopausal women or mass in post-menopausal women

CLINICAL PRESENTATION

- Pain syndromes
  - chronic, constant
  - dyspareunia
  - cyclical pelvic pain
  - dysuria
  - defecation pain
- mass - asymptomatic or symptomatic
- rarely ureteric obstruction, hypertension
- Hormonal status
  - Frequently pre-menopausal – FSH < 30 IU/dl, Oestradiol > 3 pg/ml
  - Post-menopausal status – less common but does not exclude diagnosis of ORS

DIAGNOSIS

- History
- Examination
- Imaging – US, CT scan, MRI – over 90% visible mass often with complex features
- Stimulation test – Clomiphene
- Suppressive test – GnRH analogues
- Exclude potential malignancy – tumour markers , US, +/- oncological opinion

TREATMENT OPTIONS

- Medical suppression
- Radiation ablation
- Surgery

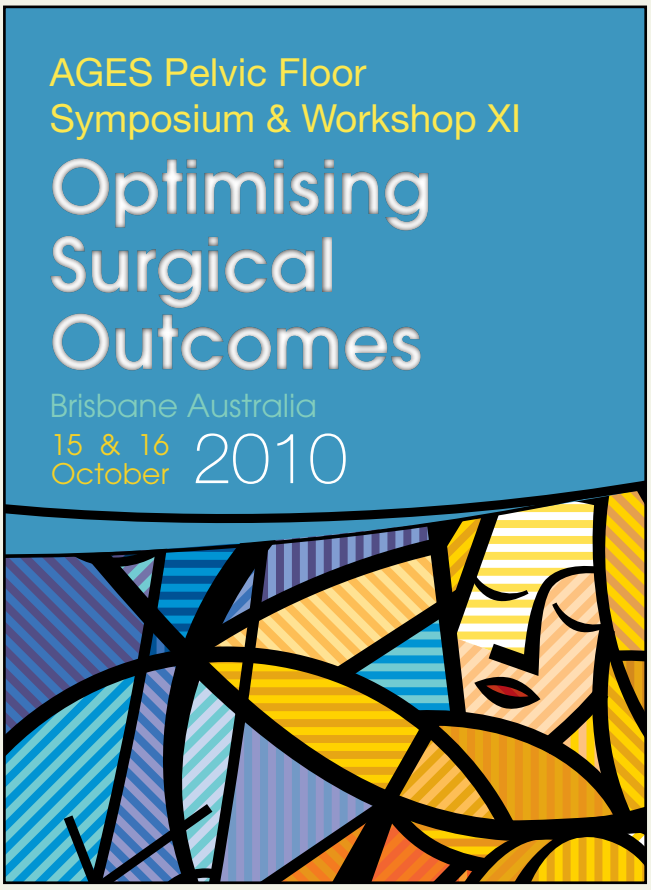
SURGICAL PRINCIPLES

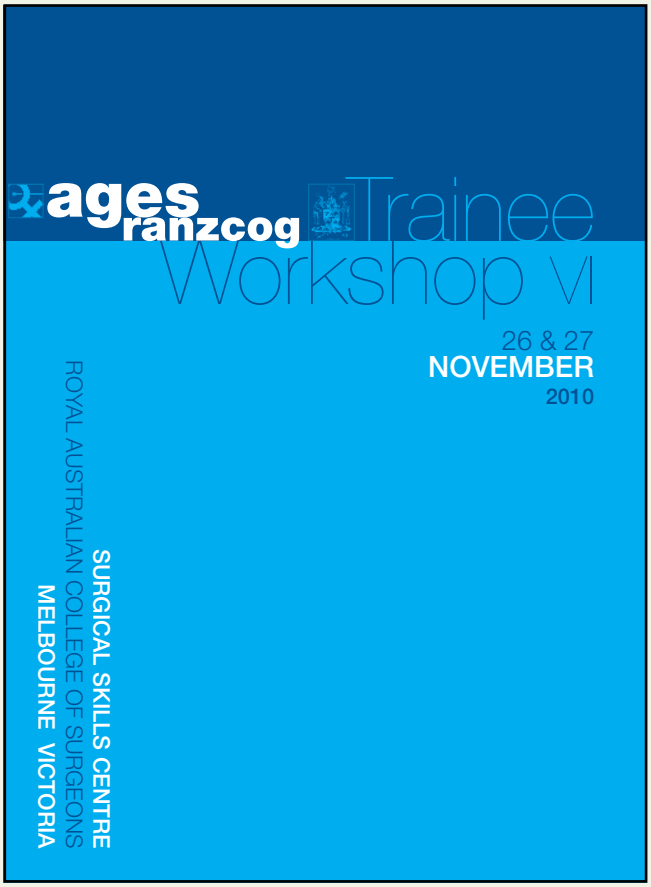
- Mobilisation of bowel adhesions
- Retroperitoneal dissection
- Identification and ligation of infundibulo-pelvic ligament
- Identification of ureter(s) and ureterolysis

- Ligation of  anterior division of internal iliac artery or uterine artery
- Mobilisation of bladder +/- cystotomy as required
- Mobilisation of mass off vaginal vault +/- colpotomy if required
- Mobilisation of mass off recto-sigmoid adhesions +/- bowel resection if required
- Removal of ovarian remnant tissue
- Cystoscopy to check bladder and ureters
- Rectal integrity test
- Assessment of haemostasis +/- pelvic drain
- Antibiotic cover

AUTHOR AFFILIATION: Assoc. Profesor Alan Lam; Centre for Advanced Reproductive Endosurgery, Royal North Shore Hospital Sydney Medical School, NSW, Australia

# *Future* AGES MEETINGS

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- Single Meeting Registrations: the Conference cancellation policy allows a cancellation fee of AU$250.00 of registration fees for cancellations received up to 8 weeks prior to the first day of the Conference, and of 50% of registration fees for cancellations up to 4 weeks prior to the first day of the Conference. 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.

The Conference Organisers reserve the right to cancel any workshop or course if there are insufficient registrations. Also, at any time, without notice and without giving reasons, the Conference Organisers may cancel or postpone the Conference, change the venue or any published timetables, activities, presenters or particulars without being liable for any loss, damage or expense incurred or suffered by any person.

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Registration fees do not include insurance of any kind. It is strongly recommended that at the time you register for the Conference and book your travel you take out an insurance policy of your choice. The policy should include loss of fees/deposit through cancellation of your participation in the Conference, or through cancellation of the Conference, loss of international/domestic air fares through cancellation for any reason, loss of tour monies through cancellation for any reason including airline or related services strikes within and/or outside Australia, failure to utilise tours or pre-booked arrangements due to airline delay, force majeure or any other reason, medical expenses (including sickness and accident cover), loss or damage to personal property, additional expenses and repatriation should travel arrangements have to be altered. The Conference Organisers cannot take any responsibility for any participant failing to arrange his/her own insurance. This insurance is to be purchased in your country of origin.

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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 date 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 reason 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.

Conference 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:**
The Conference Organisers 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 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:**
The Conference Organisers 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.

The Conference Organisers 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 add prices quoted are subject to change without notice.

**PRIVACY:**
Collection, maintenance and disclosure of certain personal information are governed by Australian legislation. Please note that your details may be disclosed to the parties mentioned in this brochure and your details may be included in the list of delegates.

**ENTRY TO AUSTRALIA:**
All participants from countries outside Australia are responsible for complying with Australian visa and entry requirements and re-entry permits to their own countries. Letters to support visa applications will be sent upon request, but only after receipt of registration forms and fees.

**CONFERENCE BADGES:**
Official name badges must be worn or produced on demand at all times during the Conference to obtain entry to all Conference sessions and to social functions. Proof of identity will be required for the issue of replacement badges.

**THE CONFERENCE ORGANISERS:**
References to "the Conference Organisers" in the above Conference Information and Conditions mean Australasian Gynaecological Endoscopy and Surgery Society Limited ACN 075 573 367 and Michele Bender Pty Limited ACN 003 402 328 trading as Conference Connection, and if the context requires, each of them severally.