Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES 2013 Focus Meeting
The Surgery of Obstetrics

1 & 2 November 2013
Hilton Auckland New Zealand

AGES Pre-Conference Workshop
31 October 2013
Advanced Laparoscopic Suturing

Program & Abstracts

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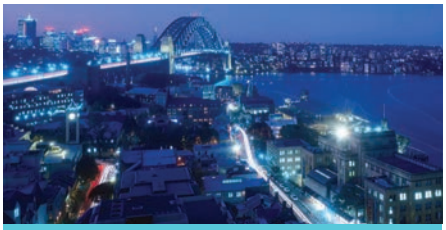

AGES Annual Scientific Meeting XXIV
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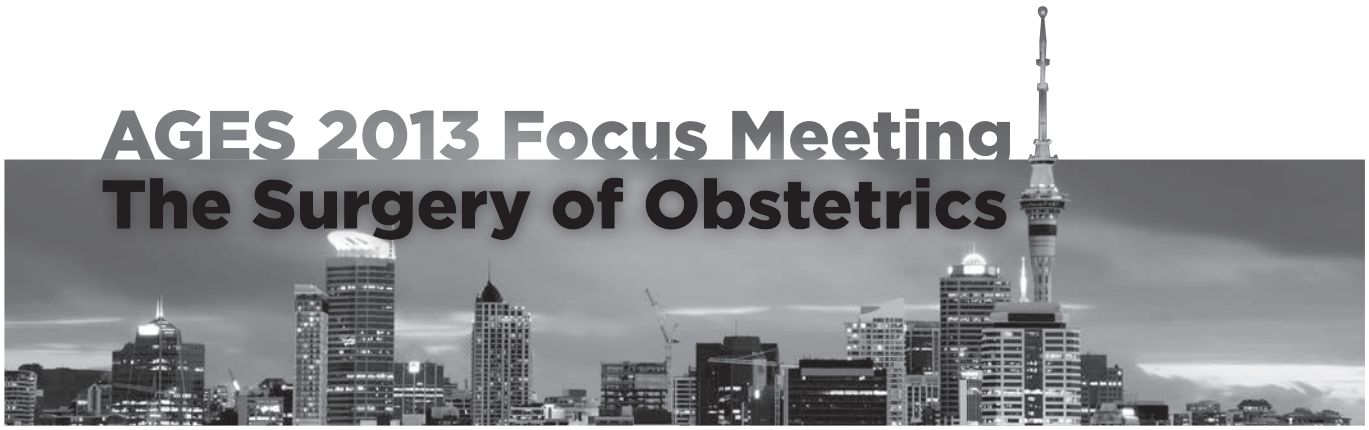
15 & 16 August 2014

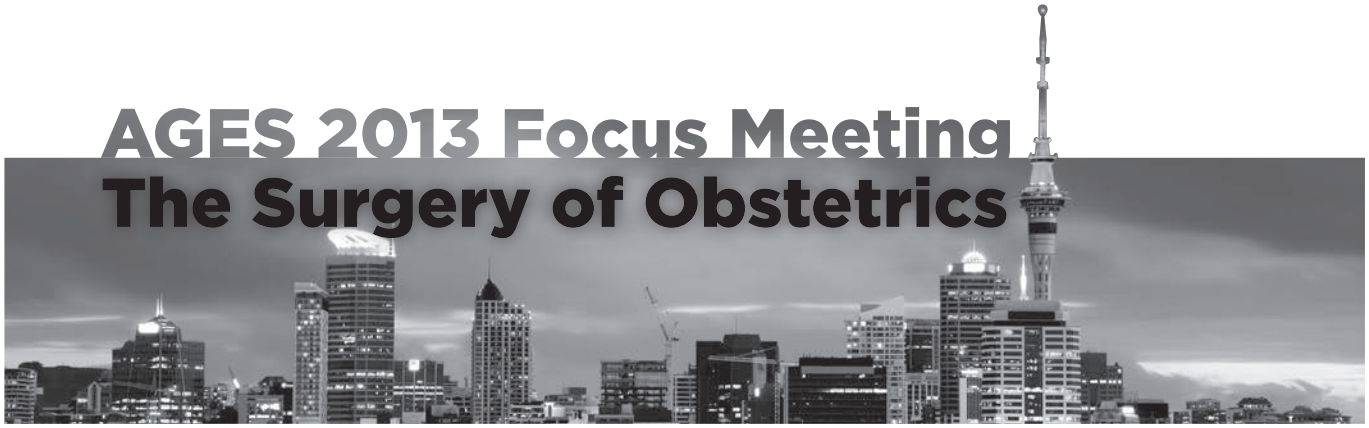
AGES Focus Meeting
Perth
24 & 25 October 2014

AGES 2013 Focus Meeting
The Surgery of Obstetrics



CONTENTS

AGES 2013 Focus Meeting
The Surgery of Obstetrics



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Dr Keith Harrison	*Conference Co-Chair*
Assoc. Prof. Anusch Yazdani	*Committee Members*
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WELCOME

The Australasian Gynaecological Endoscopy & Surgery Society is excited to welcome you to our special interest meeting in Auckland – New Zealand's City of Sails.

AGES has broadened its educative function to include all areas of Obstetric and Gynaecological surgery. As such, the theme for this meeting is *The Surgery of Obstetrics*.

An exciting and comprehensive two day programme will take us through the surgeries of fertility and early pregnancy leading onto the surgeries of vaginal and caesarean births. We will showcase the life threatening calamities that can be thrust suddenly upon us.

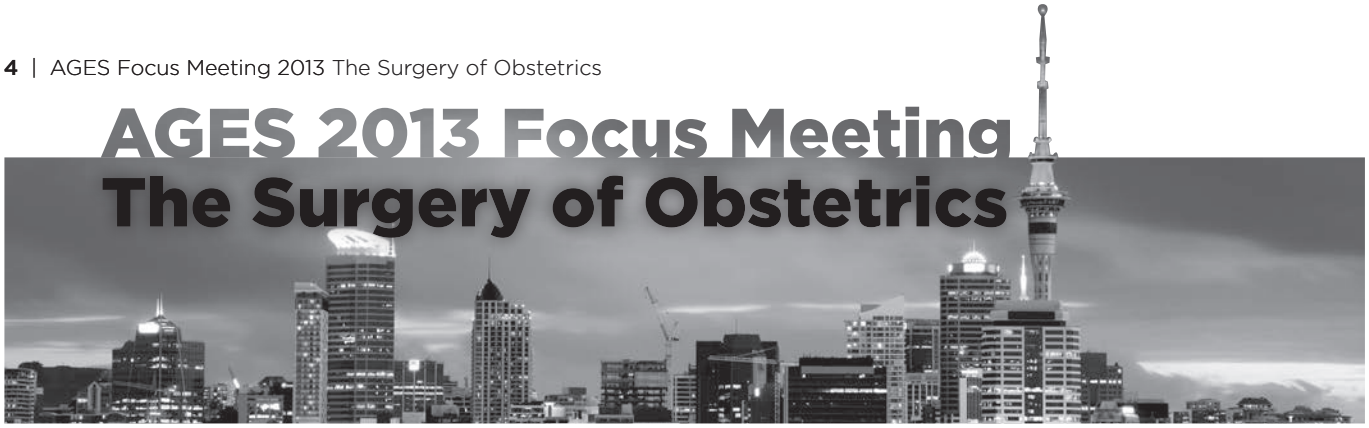
This is the surgery of judgement and courage; the surgery of the quiet and lonely small hours.

We trust you will find the meeting stimulating, thought provoking, and enjoyable.

Dr Jim Tsaltas
President AGES
Conference Co-Chair

Dr Keith Harrison
Director AGES
Conference Co-Chair

AGES 2013 Focus Meeting
The Surgery of Obstetrics



DAY 1

Friday 1 November 2013
Hilton Auckland, Aquamarine Room

0730-0815 **Conference Registration**

0815-0830 **Conference Opening and Welcome** *J Tsaltas, K Harrison*

0830-1030 **SESSION 1 – The Surgery of Fertility**
Sponsored by Stryker
Chairs: *J Tsaltas, K Harrison*

0830-0850 **Ovarian drilling – to drill or not to drill: surgical management of PCOS** *A Yazdani*

0850-0910 **Tubal surgery – reproductive surgery in the age of IVF** *N Johnson*

0910-0930 **Myomectomy for fecundity – improving fertility and reducing miscarriage** *M East*

0930-0950 **Hysteroscopic surgery for fertility – polyps fibroids and septae** *A Murray*

0950-1010 **Endometriosis and ovarian reserve** *J Tsaltas*

1010-1030 **Questions and discussion**

1030-1100 Morning Tea and Trade Exhibition

1100-1230 **SESSION 2 – The Surgery of Pregnancy**
Sponsored by Karl Storz Endoscopy
Chairs: *A Yazdani, N Johnson*

1100-1120 **Cervical cerclage – which technique for which patient?** *K Groom*

1120-1140 **Surgical management of ectopic pregnancy** *N Bedford*

1140-1200 **Ovarian cysts in pregnancy – anxious oncologist vs. expectant obstetrician** *S Edmonds*

1200-1230 **Fetal surgery – the state of the art** *E Parry*

1230-1330 Lunch and Trade Exhibition

1330-1500 **SESSION 3 – The Surgery of Vaginal Birth**
Sponsored by Olympus
Chairs: H Merkur, J Abbott

1330-1350 **Episiotomy – can we do a bad procedure really well?** *A Rane*

1350-1410 **OASIS – best practice in the modern era** *J Smalldridge*

1410-1430 **Delayed repair of lower genital tract injury** *L Hayward*

1430-1450 **Reconstructive vulval and vaginal surgery – restoring function and anatomy** *A Mackintosh*

1450-1500 **Questions and discussion**

1500-1530 Afternoon Tea and Trade Exhibition

1530-1715 **SESSION 4 – Caesarean Section**
Sponsored by Stryker
Chairs: *A Rane, M Ritossa*

1530-1550 **Surgical approach to vaginal and cervical lacerations** *K Jansen*

1550-1610 **C/S – what evidence for which technique?** *D Souter*

1610-1630 **The difficult C/S – obesity, prematurity, multiples and malpresentations** *H Najjar*

1630-1715 **Tips and tricks from the floor**
Delegates are invited to present their own experiences in an interactive session with the panel
Moderator: K Harrison
with invited panel

1930 *for* 2000 **Gala Dinner**
Euro
Princes Wharf
Auckland
Please assemble in the Hilton Auckland foyer at 1910 if you wish to join the group walking to Euro from the Hilton

DAY 2

Saturday 2 November 2013
Hilton Auckland, Aquamarine Room

0825–0830 Welcome

0830-1030 **SESSION 5 – Obstetric Haemorrhage**
Sponsored by Karl Storz Endoscopy
Chairs: *J Tsaltas, C Farquhar*

0830-0900 **KEYNOTE LECTURE**
C/S in abnormal placentation – praevias and accretas *E Wallace*

0900-0920 **Postpartum hysterectomy – obstetrician or oncologist** *D Court*

0920-0950 **KEYNOTE LECTURE**
Management of massive uterine haemorrhage in the gravid patient *E Wallace*

0950-1010 **Interventional radiology in the management of obstetric haemorrhage – facility and techniques** *B Buckley*

1010-1030 **Questions and discussion**

1030-1100 Morning Tea and Trade Exhibition

1100-1230 **SESSION 6 – The Delivery of Gynaecology**
Sponsored by Olympus
Chairs: *H Najjar, S Lyons*

1100-1120 **Laparoscopic hysterectomy – now the standard?** *R O'Shea*

1120-1140 **Complications in laparoscopic surgery** *S McDowell*

1140-1200 **Abdominal hysterectomy – resurrected or laid to rest** *J Abbott*

1200-1220 **Haemorrhage from the non-pregnant uterus – a template for management of abnormal menstrual bleeding** *C Farquhar*

1220-1230 **Questions and discussion**

1230-1330 Lunch and Trade Exhibition

1330-1500 **SESSION 7 – When It All Goes Wrong**
Sponsored by Stryker
Chairs: *J Abbott, K Harrison*

1330-1350 **Peri-mortem caesarean section** *M Ritossa*

1350-1410 **Management of the critically ill obstetric patient – transfusion protocols and intensive care** *A Williams*

1410-1430 **Perinatal death – how do we cope?** *E Wallace*

1430-1445 **Questions, discussion and close** *K Harrison*

1445 **Close** *K Harrison*

CPD AND PR&CRM POINTS

Full attendance

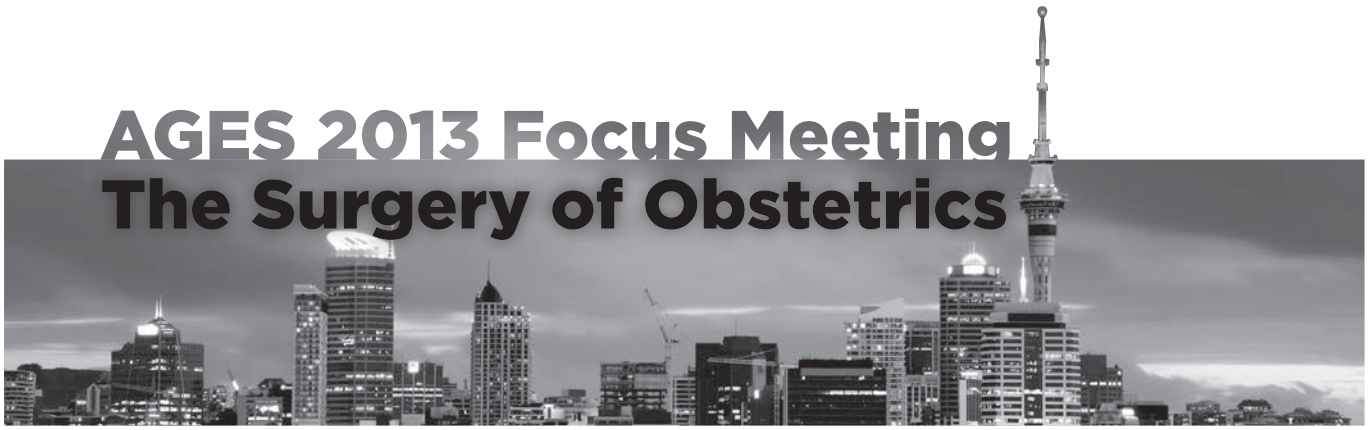
Friday 1 November and Saturday 2 November 2013	12 CPD points
Friday 1 November only	7 CPD points
Saturday 2 November only	5 CPD points

Pre-Conference Workshops 31 October 2013

AGES Laparoscopic Suturing Workshop 1 CPD point, 2 PR&CRM points

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

The **RANZCOG Clinical Risk Management Activity Reflection Worksheet** (provided in the Conference satchel and available from the College at **www.ranzcog.edu.au**) can be used by Fellows who wish to follow up on a meeting or workshop that they have attended to obtain PR&CRM points. This worksheet enables you to demonstrate that you have reflected on and reviewed your practice as a result of attending a particular workshop or meeting. It also provides you with the opportunity to outline any follow-up work undertaken and to comment on plans to re-evaluate any changes made. 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 the Meeting and for the Workshop. For further information, please contact the College.



Abstracts: Friday 1 November 2013

Session 1 / 0850-0910

Tubal surgery – reproductive surgery in the age of IVF

Johnson NP

Has IVF truly rendered tubal surgery obsolete? Can restorative surgery stand up to the challenge of a technology that is better than the gold standard natural process? Is reproductive surgery an important part of the armamentarium of individualised fertility treatment? This presentation will explore the relative success of reproductive surgical approaches versus IVF, surgical approaches as adjuncts to IVF and discuss in what situations surgery might have a place.

AUTHOR AFFILIATIONS: Associate Professor Neil Johnson[1,2]; 1.University of Auckland, Auckland Gynaecology Group and Repromed Auckland, New Zealand. 2.University of Adelaide, South Australia, Australia.

Session 1 / 0930-0950

Hysteroscopic surgery for fertility – polyps, fibroids and septae

Murray A

When should hysteroscopy be performed for fertility? The role of hysteroscopy to enhance fertility will be discussed.

AUTHOR AFFILIATION: Dr Andrew Murray MBChB (Otago) DipObsMedGyn (Auckland) FRANZCOG CREI; Medical Director, Fertility Associates, Wellington, New Zealand.

Session 1 / 0950-1010

Endometriosis and ovarian reserve

Tsaltas J

In my presentation I will aim to discuss the diagnosis and management of endometriomas and the impact of surgery on fertility and pain.

One of the issues that has become more obvious since a wider selection of ovarian function tests have been available, in particular AMH is the impact of surgery on ovarian reserve. This raises new challenges in counselling, treatment options and the approach to surgery.

I will discuss surgical technique, the use of pre and post op ovarian reserve testing and the place of egg freezing in the Australian community in 2013 and into future.

AUTHOR AFFILIATIONS: Dr Jim Tsaltas; Head of Gynaecological Endoscopy and Endometriosis Surgery at Monash Medical Centre and Southern Health, Melbourne, Victoria, Australia. President of AGES.

Session 2 / 1100-1120

Cervical cerclage - which technique for which patient?

Groom KM

Preterm birth is one of the major complications of pregnancy and a leading contributor to perinatal mortality and morbidity which may extend to cause life-long issues for individuals and their families. Drugs, surgical procedures and devices have been developed, investigated and used in an attempt to prevent and treat preterm birth.

Cervical cerclage was initially described in the 1950s as a therapy for inevitable miscarriage. Since that time indications for its use have been extended to include not only emergency or 'rescue' situations but also for women identified to be at high risk of preterm birth due to previous early births/late miscarriage or prior history of cervical surgery and for women who develop a short cervix during pregnancy (ultrasound indicated cerclage).

There are a wide variety of techniques described and employed for cerclage including transvaginal (McDonald, Shirodkar, high, low) and transabdominal (via laparotomy or laparoscopy), with placement in pregnancy and prior to pregnancy. In the published literature evidence of effect is limited, however, in appropriately selected cases cervical cerclage is likely to be highly beneficial and is an essential therapeutic tool for the prevention of preterm birth. Consideration of risk factors, previous therapies and outcomes, risk of adverse events and patient/clinician preference should all be considered when deciding on the appropriateness of cerclage and the technique to be used.

AUTHOR AFFILLIATIONS: Dr Katie M. Groom; Senior Lecturer in Department of Obstetrics and Gynaecology, University of Auckland and Maternal Fetal Medicine Subspecialist National Women's Health, Auckland District Health Board, New Zealand.

Session 2 / 1140-1200

Ovarian cysts in pregnancy: anxious oncologist vs expectant obstetrician

Edmonds S

OBJECTIVES: The aim of this lecture is to give a balanced opinion on the management of ovarian cysts in pregnancy, the majority of which can be managed conservatively until after delivery. Exposing a pregnant woman to the risks of surgery and miscarriage for a benign, asymptomatic cyst, however big, is to be avoided.

METHODS: Appropriate imaging is the most important tool used in planning intervention. We will discuss the role of ultrasound, MRI and CT and their predictive capabilities in identifying malignant lesions, which themselves have a very low incidence in pregnant women. Timing of surgical intervention is also relevant and the evidence for the long held belief of waiting to the 2nd trimester to intervene will be reviewed. This leads on to discussion regarding the approach to surgery, which ideally should be laparoscopic, at a time when the risk of miscarriage is lowest but also the least traumatic and when surgical access is best, which may well be just after 10 weeks gestation.

The initial management of malignant or severely symptomatic cysts should be similar to the non pregnant patient.

CONCLUSIONS: Rather than an anxious oncologist or an expectant obstetrician, ovarian cysts in pregnancy should be managed by a confident gynaecological radiologist with skills in laparoscopic surgery!

SUGGESTED READING:

Spencer, C. P. and Robarts, P. J. (2006), Management of adnexal masses in pregnancy. The Obstetrician & Gynaecologist, 8: 14–19. doi: 10.1576/toag.8.1.014.27203

AUTHOR AFFILIATION: Dr Simon Edmonds; Clinical Lead in Gynaecology, Middlemore Hospital, Auckland, New Zealand.

Session 3 / 1330-1350

Episiotomy - can we do a bad procedure really well?

Rane A

Episiotomy now ranks as one of those 'unnecessary interventions' in obstetrics. The average episiotomy rate in Australia and NZ is 15% well below the 'restricted' episiotomy rate of the 2012 Cochrane review of 27%. What is the evidence that episiotomy in individualised cases is better? What is the evidence for spontaneous tearing being better than an episiotomy? Why is intact perineal skin a 'good' obstetric indicator?

In Australia less and less midwives are suturing episiotomies - does this prevent them from giving episiotomies? The Scandinavian evidence along with some recent evidence locally shows the benefit of giving a timely episiotomy to reduce Obstetric Anal Sphincter Injury. However the episiotomy must be given at a proper angle, with a proper length and adequate depth.

This lecture deals with all these issue.

AUTHOR AFFILIATIONS: Professor Ajay Rane OAM MBBS MSc MD FRCS FRCOG FRANZCOG CU FICOG (Hon) PhD; Professor and Head, Obstetrics and Gynaecology, Consultant Urogynaecologist, James Cook University, Townsville, Queensland, Australia. Vice President, RANZCOG.

Session 3 / 1350-1410

OASIS – best practice in the modern era

Smalldridge J

PREVENTION: There has been increasing interest over the last few years looking at factors that may prevent OASIS. Evidence for the role of episiotomy (angle and length), position at birth, parity, ethnicity, instrumental delivery, hands –on vs hands- off delivery will be presented.

RECOGNITION: The role of education of midwives, trainees and Obstetricians in the increasing rates of OASIS will be discussed with particular attention to changing behaviour in the delivery suite.

REPAIR: The best practice guidelines will be presented for end–to–end vs overlap technique for repair of 3a,3b,3c, and 4th degree tears.

FOLLOW-UP: Latest evidence on which patients to follow up and advice for their next pregnancy will be discussed.

AUTHOR AFFILIATIONS: Dr Jackie Smalldridge MBBS, FRCOG,FRANZCOG; Clinical Senior Lecturer, Department of Obstetrics and Gynaecology, University of Auckland FHS and Counties Manukau District Health Board, New Zealand.

Session 3 / 1410-1430

Delayed repair of lower genital tract injury

Hayward L

Traditional management of wound breakdown following perineal repair has been expectant, with healing by secondary intention. Some argue that this approach delays recovery, results in prolongation of sexual dysfunction and that an early secondary surgical repair is an advantage. I will explore the evidence for both approaches and apply a practical approach for the clinician. Infection is a common cause of wound breakdown; the current best practice guidelines for wound care will be explored.

REFERENCES:

1. Early repair of episiotomy dehiscence.Hankins GD, Hauth JC, Gilstrap LC 3rd, Hammond TL, Yeomans ER, Snyder RRObstet Gynecol. 1990;75(1):48.
2. Dudley LM, Kettle C, Ismail KMK. Secondary suturing compared to non-suturing for broken down perineal wounds following childbirth (Protocol). Cochrane Database of Systematic Reviews 2011, Issue 2. Art. No.: CD008977
3. Early repair of episiotomy dehiscence associated with infection.Ramin SM, Ramus RM, Little BB, Gilstrap LC 3rd Am J Obstet Gynecol. 1992;167(4 Pt 1):1104

AUTHOR AFFILIATIONS: Dr Lynsey. Hayward; Middlemore Hospital, Papatoetoe, New Zealand, Honorary Senior Lecturer University of Auckland, New Zealand, Treasurer of the Australasian Urogynaecology Society, Public Relations Chair of The International Urogynaecology Society, member of the Auckland Pelvic Floor Research Group.

Session 3 / 1430-1450

Reconstructive vulval and vaginal surgery - restoring function and anatomy

Mackintosh AR

The relatively widespread use of mesh is re-evaluated currently by gynaecologists. The use of the patients anatomy and the surgical techniques employed may have become compromised as various mesh products have been marked and popularised. The importance of obtaining adequate vaginal vault and adequate suburethral support remains consistent and the favoured techniques for obtaining this may require synthetic materials.

Congenital variations of the lower genital tract are a significant patient concern and can be helped with surgery.

AUTHOR AFFILIATION: Dr Andrew Mackintosh; FRANZCOG, FRCOG; Ascot Central Women's Clinic, Remuera, Auckland, New Zealand.

Session 4 / 1550-1610

Caesarean section- what evidence for which technique?

Souter D

The surgical objectives of a caesarean section are;

1 to deliver the baby
2 to keep the mother alive and minimise her recovery time
3 to achieve a good cosmetic result
4 to make the next caesarean section as uncomplicated as possible
5 to maintain fertility.

The relative importance of these objectives will vary from patient to patient as will the required speed of the delivery of the baby. One caesarean section technique is not best for all clinical situations.

The Cochrane reviews of surgical technique for caesarean section are reviewed and the advantages and disadvantages of the described techniques are discussed.

The author's experience of performing multiple repeat caesarean sections on the same patients and the resultant changes in his surgical technique and increase in operating times are discussed. Whilst leaving out layers may reduce operating time it may not result in a better operation.

A personal approach to maximising early recovery and making the next caesarean section easy is demonstrated.

A lively discussion is looked forward to!

AUTHOR AFFILIATION: Dr Dereck Souter FRCOG FRANZCOG DDU; National Women's Hospital, Auckland, New Zealand.

Session 4 / 1610-1630

The difficult caesarean section – obesity, prematurity, multiples and malpresentations

Najjar H, Manley T

OUTLINE: Caesarean section delivery to avoid potential fetal harm from a traumatic birth is common practice. The maternal risks of Caesarean section have fallen with the advent of safe regional anaesthesia and antibiotics, making the decision to avoid vaginal birth in situations of multiples and malpresentation less complicated. The practice of performing the caesarean section in these situations however, can be very difficult. With an increasing obese population the decision to avoid vaginal birth in this group of women is not as straightforward because the surgical risk is not only greater for the mother but also the fetus. When performing a difficult caesarean section risk minimization strategies should be in place and consideration given to the perioperative team including neonatal support and onsite available resources should you need them.

CONFLICT OF INTEREST:There is no known conflict of interest.

REFERENCES:

1. Delivery of the Fetus at Caesarean section. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. C-Obs 37. July 2013
2. Obesity in pregnancy. Committee Opinion No. 549. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013:121;213–7

AUTHOR AFFILIATION: Dr Haider Najjar, Dr Tom Manley; Southern Health, Monash Medical Centre, Clayton, Victoria, Australia.

Abstracts: Saturday 2 November 2013

Session 5 / 0830-0900

Caesarean section in abnormal placentation – praevias and accretas

Wallace EM

The incidence of abnormal placentation, both site and invasiveness, has increased greatly over the past 40 years. For example, in the 1970s placenta accreta complicated about 1 in 4000 pregnancies. It now affects more than 1 in 500. Unfortunately, this trend appears to be a direct result of the increased use of caesarean section. Certainly, in women with a placenta praevia, the rate of placenta accreta is directly related to the number of prior caesarean sections.

Why is this important? The presence of a placenta praevia or an accreta greatly increases maternal morbidity and risks of mortality. For example, the average blood loss at delivery in women with a placenta accrete is over 3000mLs and 9 out of 10 women with a placenta accrete require a blood transfusion with nearly half of all such women receiving more than 10 units of red cells. The most common indication for a caesarean hysterectomy today is placenta accreta.

In this session we will discuss all aspects of the management of women with abnormal placentation including the role of ultrasound and MRI in diagnosis, delivery planning, including surgical approaches, contingencies for emergency delivery and, for placenta accreta, conservative management versus hysterectomy. The outcomes from the multidisciplinary surgical approach that underpins the service at Monash Women's, Victoria's largest women's health service, will be presented.

AUTHOR AFFILIATIONS: Professor Euan M. Wallace AM; The Ritchie Centre, Department of Obstetrics and Gynaecology, Monash University and Monash Women's Services, Monash Health, Clayton, Victoria, Australia.

Session 5 / 0900-0920

Postpartum hysterectomy – obstetrician or oncologist

Court D

The incidence of peripartum hysterectomy is increasing; in part because of increased caesarean section rates (morbid placental adherence) and the obesity epidemic (disordered myometrial contractility). Whilst advances in imaging mean that the former can sometimes be predicted and multidisciplinary planning for surgical management can occur, the latter is unpredictable. It is inevitable that generalist obstetricians will on occasions find themselves in the situation of considering peripartum hysterectomy where realities of time and place may mean that little if any experienced (let alone subspecialty) backup is available. The general obstetrician needs to be aware of factors that can influence the likelihood of peripartum haemorrhage leading to hysterectomy (such as "venous hypertension" from excessive crystalloid) and techniques short of hysterectomy for managing peripartum haemorrhage as well as both surgical and adjunctive techniques to be applied during peripartum hysterectomy. These issues will be discussed.

AUTHOR AFFILIATION: Dr Denys Court; Clinical Lead in Acute Care, Women's Health, Auckland District Health Board, New Zealand.

Session 5 / 0920-0950

Management of massive obstetric haemorrhage

Wallace EM

The full term uterus is perfused by about 1200mLs of blood per minute, representing 20% of total cardiac output. On separation of the placenta the uterine vasculature in the placental bed is left bare, requiring rapid contraction of the uterus to compress the vessels externally. The vessels themselves have no intrinsic ability to contract because their muscular tunica media was stripped away in early pregnancy by the invasive trophoblast cells to allow the rapid increase in uterine blood flow required to sustain pregnancy. The scene is well set for massive haemorrhage. No surprise then that obstetric haemorrhage remains the leading cause of maternal mortality worldwide and the most common indication for admission of an obstetric patient to intensive care in Australia.

Thankfully, massive obstetric haemorrhage is not common in resource-rich nations, largely due to the routine administration of uterotonic agents. Nonetheless, a recurrent finding of clinical reviews of maternal mortality or severe morbidity secondary to massive postpartum haemorrhage is that care is often suboptimal. Inexperience, lack of preparedness, of either resource infrastructure and/or personnel, or delayed or inadequate responses often convert an urgent but manageable emergency into one of critical, life-threatening proportions with most profound adverse outcomes.

A systematic approach to the management of massive postpartum haemorrhage will be presented – the "what to do", from escalating medical management to staged surgical interventions, including consideration of longer term outcomes. The importance of adequate staff training, resource preparedness, and proactive management will be discussed, providing some useful tools such as templates for the rapid estimation of blood loss, recommended volume replacement protocols, and massive transfusion protocols. The potential impact of massive blood loss on maternal cardiac function and subsequent outcomes will also be highlighted.

AUTHOR AFFILIATION: Professor Euan M. Wallace AM; The Ritchie Centre, Department of Obstetrics and Gynaecology, Monash University and Monash Women's Services, Monash Health, Clayton, Victoria, Australia.

Session 5 / 0950-1010

Interventional Radiology in the management of obstetric haemorrhage

Buckley B

The role of Interventional Radiology (IR) in the management of obstetric haemorrhage has evolved significantly over the past two decades. IR equipment and techniques have progressed, and access to IR has improved for many obstetric units.

Unfortunately this has not been matched by robust data on the most appropriate algorithms to ensure the best use of IR in obstetric haemorrhage. While a wide variety of protocols for utilizing IR have been published, the talk will discuss the principles of IR in obstetric haemorrhage,

equipment and logistical management including experience from our local prospective study of IR in obstetric haemorrhage.

AUTHOR AFFILIATION: Dr Brendan Buckley BSc MB BCh BAO MRCS FRCR; Consultant Interventional Radiologist at Auckland City Hospital, Auckland, New Zealand.

Session 6 / 1120-1140

Complications in laparoscopic surgery

McDowell S

Surgical complications are unintended, undesirable, and a direct result of our actions. Complications may be inevitable, but with appropriate and timely management an adverse event need not be an adverse outcome.

Why do gynaecologic laparoscopic complications occur? Simply put, this method of surgery is challenging. We operate in a confined area, have limited access, narrow vision and are surrounded by structures deemed another specialties domain. The learning curve is steep and long and the outcomes of complications such as bowel and vascular injury can be profound.

Surgical training is now diluted as a result of decreasing numbers of simple procedures (such as the'standard vaginal hysterectomy'), improvement in medical therapies, and an increase in trainee numbers. It is therefore vital junior consultants and trainees learn from our peers' experiences.

The lecture will utilize actual complications provided by experienced gynaecologists. Complications can shape practice – for good and bad. We will examine what impact such complications may have on practitioner's in both the short and long-term.

AUTHOR AFFILIATIONS: Dr Simon McDowell FRANZCOG, MbCHB, PGdipOMG; Queensland Fertility Group, Eve Health, The Fertility Centre, Royal Brisbane Women's Hospital, University of Queensland, Brisbane, Queensland, Australia.

Session 6 / 1140-1200

Abdominal hysterectomy – laid to rest or resurrected?

Abbott J

Australian MBS data for the last decade confirms a gradual decline in abdominal hysterectomy from 8783 cases in 2002 to 4860 cases in 2012. This represents a halving of the per capita rate of 43/100,000 in 2002 to just 21/100,000 in 2012. During the same time, vaginal hysterectomy rates were 6840 in 2002 and 5011 in 2012 for a per capita change of 33/100,000 to 22/100,000. All forms of laparoscopic hysterectomy have increased from 3003 in 2002 to 4842. This is equal to a per capita change of 15/100,000 to 21/100,000 in 2012. These data appear to confirm that Australia has adopted the recommendations that laparoscopic hysterectomy should be preferred over abdominal hysterectomy where possible, and these two modalities are now on par.

What is also apparent from these data are that abdominal hysterectomy continued to account for 1/3 of all hysterectomies and is still an important surgical modality for many gynaecologists. The reasons for this are likely complex with surgical training and patient factors contributing. Given that more than half of the RANZCOG workforce are currently over the age of 50, the next 10 years are likely to provide information on how hysterectomy will be performed into the future. What is also apparent is that hysterectomy per capita has decreased from 91/100,000 to 64/100,000 in the last decade. There is also a hgher proportion of O&G specialists to population in both Australia and New Zealand. This equates to more specialists with fewer procedures and the issues of confidence and competence for hysterectomy are again drawn into focus.

Given that post-partum haemorrhage resulting in hysterectomy will nearly always be an abdominal approach, there continues to be a need for this modality in our profession. However, who will do the procedure, who will be trained and where these will be undertaken remain serious issues for consideration.

AUTHOR AFFILIATION: Associate Professor Jason Abbott; School of Women's and Children's Health University of New South Wales, Kensington, New South Wales, Australia.

Session 6 / 1200-1220

Haemorrhage from the non-pregnant uterus – a template for management of abnormal menstrual bleeding

Farquhar C

Abnormal uterine bleeding is the most common reason for referral to a gynaecologist. It is also the most common cause of iron deificiency anemia in women during the reproductive years. This presentation will discuss the FIGO nomenclature and classification system and current and new management stategies for management.

AUTHOR AFFILIATIONS: Professor Cindy Farquhar; Fertility Plus, National Women's Hospital, University of Auckland, Auckland, New Zealand.

Session 7 / 1330-1350

Peri-mortem Caesarean section

Ritossa M

Caesarean section procedures date back to 715 BC when the second King of Rome, Numa Pompilius passed a law that no pregnant woman could be buried unless the child has been removed from the womb. It was not until 237 BC that the first reliable report of infant survival from caesarean section was described. The Roman practice of post mortem caesarean section was upheld until 1861 with no expectation of foetal survival.

Today's society desires perfect outcomes. The current expectation at the time of maternal collapse is for survival of both the mother and infant. In the UK 1 in 170 000 deliveries will result in a peri mortem caesarean section. Although statistically an individual obstetrician is unlikely to be faced with this complication it is our responsibility to be prepared for this rare event. This presentation will review the available literature on peri mortem caesarean section, providing an in depth summary as to the most appropriate clinical responses, as well as discussing the realistic expectations for maternal and foetal outcomes.

AUTHOR AFFILIATIONS: Dr Martin Ritossa; Head of Gynaecology, Northern Adelaide Local Area Health Network, Adelaide, South Australia, Australia. Director AGES, Treasurer RANZCOG.

Session 7 / 1410-1430

Perinatal death – how do we cope?

Wallace EM

The perinatal mortality rate in Australia is about 10 per 1000 births. The leading causes of perinatal loss remain extreme prematurity and/or congenital abnormalities. The majority of these were not preventable. However, a significant number of losses, particularly at or near term, remain unexplained and are likely to relate to unrecognized fetal growth restriction. In many of these cases there had been some warning, such as reduced fetal movements. Most stillbirths occur prior to labour onset with only 10% or so occurring during labour.

Consideration of "how do we cope" with perinatal death necessarily includes the parent(s), the care provider(s), and the population. Care of any grieving relative can be challenging and difficult but care of a women or couple, and often of the extended family, who have lost their baby can be particularly hard. Honest and timely open disclosure is central to providing good care, particularly where deficient care may have contributed to the outcome. This can be extremely hard but the Australian Commission on Safety and Quality in Health Care Open Disclosure Framework is an excellent roadmap. Expressions of sorrow and sympathy such as "I am sorry" are not admissions of liability. Patients and families greatly value opportunities for open dialogue so that they can better understand what happened. Implications, if any, for future pregnancies must not be ignored and the patient may require further investigations and/or referral for future planning.

Losing a baby, particularly where there may have been contributory deficiencies in care, can be very traumatic for the attending care providers. It is important that support and assistance be available to attending staff and that, where relevant, there are opportunities to discuss events among those involved. Some institutions hold regular, open, informal de-briefing sessions that are proactive rather than responsive. It is also often useful to ask staff to record their involvement in care so that a contemporaneous record is available in the future. These can be held so that they are non-discoverable. Timely investigation of losses, as a routine process, is also important to staff. It is not uncommon for a perinatal death to be erroneously attributed to events or actions that, when objectively investigated, are proven incorrect. All maternity services, whether private or public, should have a perinatal mortality review process for all deaths, ideally utilizing the PSANZ template.

Last, at a population level it is important that all perinatal deaths are reported and reviewed. In this way emerging causes, such as obesity, can be more readily identified and recommendations for practice developed. Such reviews offer distilled expertise and experiences that no individual clinician or hospital could ever hope to acquire in several lifetimes of practice.

How do we cope? By being open, honest, inquisitive and supportive.

AUTHOR AFFILIATIONS: Professor Euan M. Wallace AM; The Ritchie Centre, Department of Obstetrics and Gynaecology, Monash University and Monash Women's Services, Monash Health, Clayton, Victoria, Australia.

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