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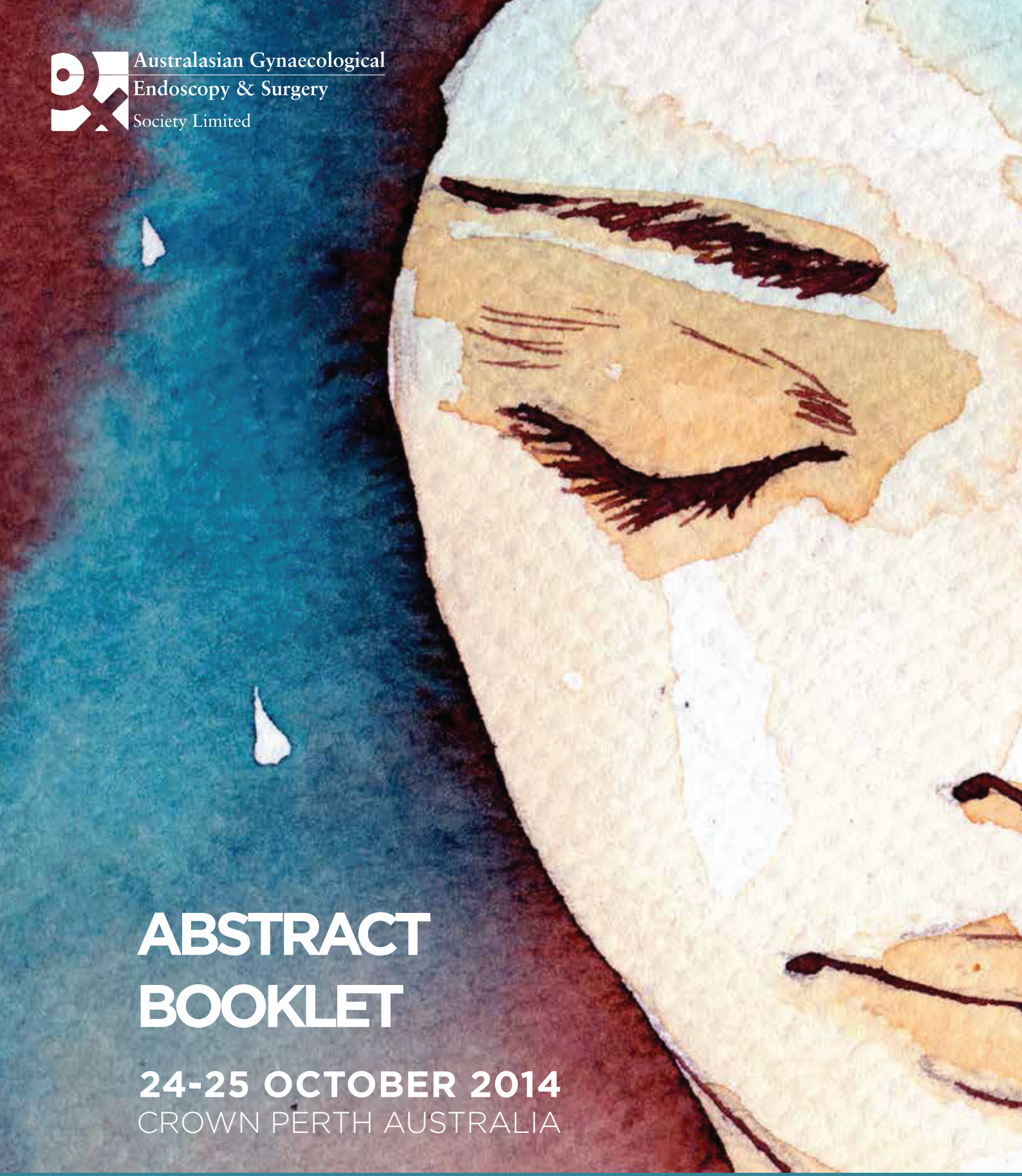

ABSTRACT BOOKLET

24-25 OCTOBER 2014
CROWN PERTH AUSTRALIA

COMPLICATIONS
AN AGES FOCUS MEETING 2014

COMPLICATIONS
AN AGES FOCUS MEETING 2014

CONFERENCE COMMITTEE

Dr Stuart Salfinger	Conference Chair
Dr Jade Acton	Co-Chair
Dr Jason Tan	Members
Dr Krish Karthigasu	
Dr Jim Tsaltas	
Assoc. Prof. Anusch Yazdani	

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Jim Nicklin	QLD	Gynaecologic Oncologist
Jan Dickinson	WA	MFM, Editor ANZJOG
Michael Gannon	WA	O&G, President AMA
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Patrick McIlwaine	WA
Raj Mohan	WA
Haider Naajar	VIC
Martin Ritossa	SA
Stuart Salfinger	WA
Joel Stein	
Jason Tan	WA
Scott White	WA

CPD AND PR&CRM POINTS

This meeting is a RANZCOG Approved O&G Meeting. Eligible Fellows of this college can claim **16 points** for full attendance. If the meeting is used for critical reflection and practice improvement, PR&CRM Points can be claimed by submitting a reflection worksheet to RANZCOG. Visit the Registration

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24-25 OCTOBER 2014
CROWN PERTH AUSTRALIA

WELCOME - CONFERENCE CHAIR

Dear Colleagues

Welcome to Perth for the AGES focus meeting where we plan to take a close look at **Complications**.

Over the next two days, the program will cover a variety of topics of interest to all gynaecologic and obstetric specialists. We will be reviewing investigation and management of urologic, GI and vascular complications related to gynaecology surgery and have urologists and colorectal surgeons who work regularly with gynaecologists and obstetricians.

In addition to this, there is a strong focus on panel discussions, sharing the pain and the learning that comes from the experience of complications. There are special sessions looking at hysteroscopic and anaesthetic complications as well as complications to obstetrics such as the management of cancer, trauma and other surgical procedures in pregnancy.

We will also be focussing on the aspects of training that have become more complicated and the possible pathways for our speciality to follow in negotiating these new challenges to procedural speciality training.

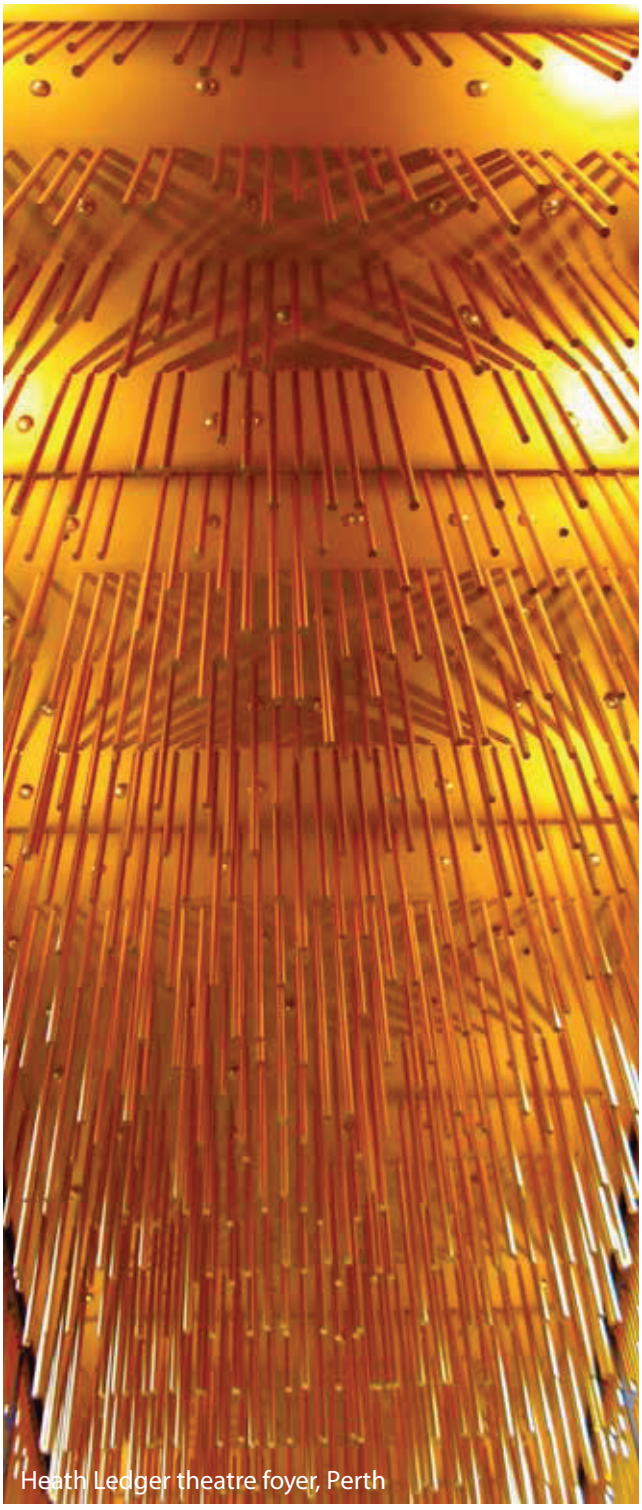
The meeting promises opportunity for all specialist O&G's to expand their knowledge.

The social highlight will be the dinner at Fraser's restaurant complete with fine food, music and dancing.

I look forward to seeing you all over the next few days.

Dr Stuart Salfinger

Conference Chairman
Treasurer, AGES



Heath Ledger theatre foyer, Perth

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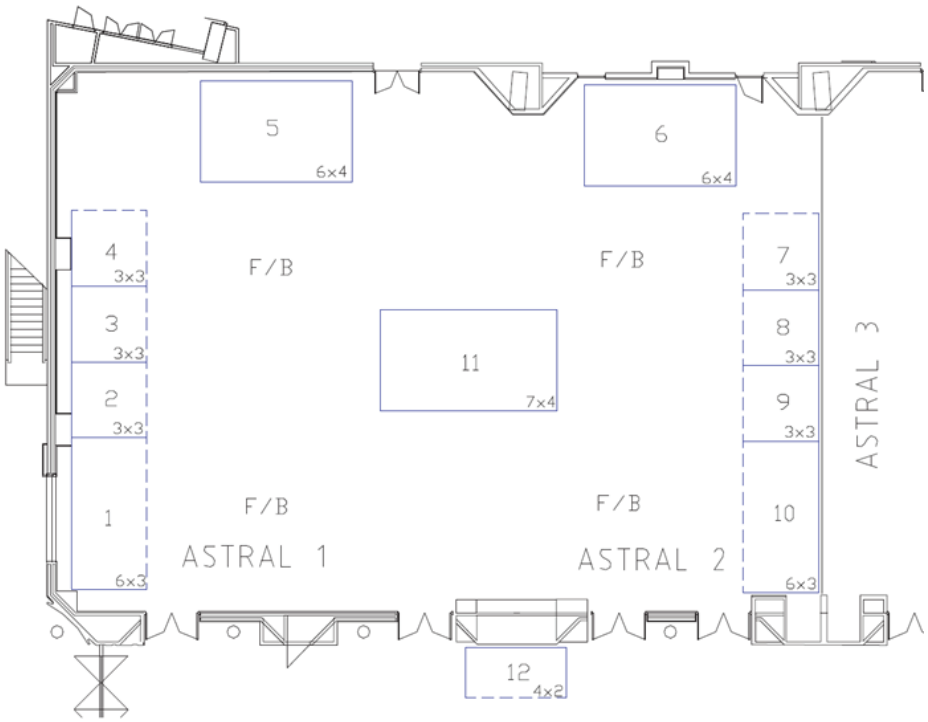

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AGES / RANZCOG
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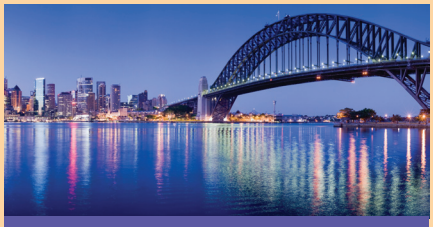

AGES Pelvic Floor
Symposium & Workshop XVI
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7 & 8 August 2015

AGES Focus Meeting
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24-25 OCTOBER 2014
CROWN PERTH AUSTRALIA

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We will proudly be exhibiting the KARL STORZ range of instruments which will include the latest morcellation systems, operative hysteroscopic sheaths and telescopes, laparoscopic instrumentation plus endoscopic camera systems including 3D technology.

COMPLICATIONS
AN AGES FOCUS MEETING 2014

DAY 1
FRIDAY 24 OCTOBER 2014

0730 - 0800 Conference Registration

0800 - 1015 **SESSION 1**
OOPS THAT WAS NOT MEANT TO HAPPEN
Chairs: Martin Ritossa & Anusch Yazdani

0800 - 0815 Welcome
Stuart Salfinger & Jim Tsaltas

0815 - 0845 Management of Bladder and Ureteric Injury — Jessica Yin

0845 - 0915 GI Complications - investigation, intraoperative and delayed managment — Joel Stein

0915 - 0945 Vascular Injury - Identification and Emergency Steps — Marek Garbowski

0945 - 1015 Panel Discussion

1015 - 1045 MORNING TEA

1045 - 1230 **SESSION 2**
NOTHING WORTHWHILE IS EVER WITHOUT COMPLICATIONS
Chairs: Stuart Salfinger & Jason Tan

1045 - 11 15 Anatomy is destiny — Stuart Salfinger

11 15 - 1145 Tricks of the trade — Jim Nicklin

1145 - 1230 Complications Cascade - Presentations and Panel Discussion
Panel: Stuart Salfinger, Jason Tan, Jim Nicklin, Jim Tsaltas, Krish Karthigasu

1230 - 1330 LUNCH

1330 - 1500 **SESSION 3**
FREE COMMUNICATIONS
Chairs: Martin Ritossa & Krish Karthigasu

1330 - 1340 Laparoscopic Morcellation of Large Uteri without a Power Morcellator — JS Singh

1340 - 1350 The complex obstetric patient across two pregnancies — I Nikakis

1350 - 1400 Laparoscopic excision of a retroperitoneal mass in a recurring stage III-C ovarian cancer. — E Coghlan

1400 - 1410 Laparoscopic abdominal cervical cerclages in a patient with uterine didelphys complicated by mid-trimester FDIU: Case report and review of the literature — K Dobromilsky

1410 - 1420 Inferior epigastric artery injury - an unusual location — D Thangavel

1420 - 1430 10 Year Retrospective Review of Leiomyosarcoma Cases and Complications from Surgery for Fibroids — T Ma

1430 - 1440 Team assisted complications — C Georgiou

1440 - 1450 The comparison of surgical outcomes using LigaSure and Gyrus PK in total laparoscopic hysterectomy — CN Wong

1500 - 1530 AFTERNOON TEA

1530 - 1700 **SESSION 4**
IT'S ALL ABOUT PRESSURE
Chairs: Keith Harrison & Harry Merkur

1530 - 1545 Hysteroscopic Complications - Fluid Management — Patrick McIlwaine

1545 - 1600 Hysteroscopic Complications - Perforation — Haider Najjar

1600 - 1620 Complications of Pneumoperitoneum – Pressure down (or up) — Raj Mohan

1620 - 1640 Optimization of surgical operating conditions with neuromuscular blockade: novel techniques and tricks — Nolan McDonnell

1640 - 1700 Surgery with a bit less pressure — Krish Karthigasu

1900 - 2230 GALA DINNER

Dance the night away after the Gala Dinner at Fraser's

Fraser's Function Centre
Fraser Avenue
Kings Park
WEST PERTH WA 6005

Buses depart Crown Perth at 1840.

24-25 OCTOBER 2014
CROWN PERTH AUSTRALIA

DAY 2
SATURDAY 25 OCTOBER 2014

0730 - 0800 Conference Registration

0800 - 0940 **SESSION 5**
COMPLICATED PREGNANCY
Chairs: Harry Merkur & Haider Najjar

0800 - 0820 Pregnancy after Bariatric Surgery
Scott White

0820 - 0840 Obstetric Trauma
Martin Ritossa

0840 - 0900 Cancer in Pregnancy
Jim Nicklin

0900 - 0920 Surgery in Pregnancy
Joel Stein

0920 - 0940 Panel Discussion
Panel: Scott White, Martin Ritossa, Jim Nicklin, Rupert Hodder, Jan Dickinson

1010 - 1200 **SESSION 6**
PREVENTION IS BETTER THAN CURE
Chairs: Jade Acton & Krish Karthigasu

1010 - 1040 Post op Care - The surgeon
Jason Tan

1040 - 1120 The pap is dead! - Review of the National Cervical Screenin program
Ian Hammond

1120 - 1150 Legal Management of complications
MDA National - Nerissa Ferrie and Lisa Watkins

1150 - 1200 Panel Discussion & Questions

1230 - 1330 LUNCH

1300 - 1440 **SESSION 7**
COMPLICATIONS IN TRAINING
Chairs: Stuart Salfinger & Anusch Yazdani

1300 - 1320 Challenges to Training
Jade Acton

1320 - 1340 The blind leading the blind - Anatomy the Trainer and the Trainee
Jason Abbott

1340 - 1400 Follow my lead - RACS surgical training
Jeff Hamdorf

1400 - 1420 Simulation in Surgical Training
Katrina Calvert

1420 - 1440 Discussion
Panel: Jade Acton, Jason Abbott, Jeff Hamdorf, Katrina Calvert

1440 - 1510 AFTERNOON TEA

1510 - 1610 **SESSION 8**
TO "C" OR NOT TO "C" - THAT IS THE QUESTION - THE GREAT DEBATE
Affirmative:
Michael Gannon, Martin Ritossa, Scott White
Negative:
Jan Dickinson, Jason Abbott, Stuart Salfinger

1610 - 1630 Awards and Close
Stuart Salfinger & Jim Tsaltas

24-25 OCTOBER 2014
CROWN PERTH AUSTRALIA

FACULTY BIOGRAPHIES

Jim Nicklin QLD Gynaecologic Oncologist

Dr Jim Nicklin is a graduate of the University of Queensland. He did his internship and residency at the Royal Brisbane and Royal Women's Hospitals. He subsequently went on to do specialty training in obstetrics and gynaecology in Queensland. He then did his sub-specialty training in gynaecologic oncology at the Royal Hospital for Women in Sydney and the Ohio State University, USA. He returned to Queensland and set up practice as a gynaecologic oncologist in late 1995. He is currently a VMO and Director of Gynaecologic Oncology at RBWH, Qld and conducts his private practice based at the Wesley Hospital, Brisbane.

Jan Dickinson WA

Professor Jan Dickinson is a Fellow of the RANZCOG and certified subspecialist in Maternal Fetal Medicine. She is Professor of Maternal Fetal Medicine at the School of Women's' and Infants' Health, The University of Western Australia and Director of the Maternal-Fetal Medicine Service at King Edward Memorial Hospital, Perth, where she is also the Director of Ultrasound services. In 2011 she became the Editor-in-Chief for the Australian and New Zealand Journal of Obstetrics and Gynaecology. She has active research interests in many areas of fetal medicine and has authored >100 peer-reviewed journal publications.

Michael Gannon WA

Dr Michael Gannon is Head of Department of Obstetrics & Gynaecology at St John of God Hospital Subiaco.

Dr Gannon is an Obstetrician & Gynaecologist in public and private practice with an interest in medical problems in pregnancy. He is the Lead Obstetrician of the Perinatal Loss Service at King Edward Memorial Hospital. He also holds appointments at Osborne Park Hospital, The WA Country Health Service and St John of God Hospital Mt Lawley.

Dr Gannon graduated from the University of Western Australia, before training at Royal Perth Hospital, King Edward Memorial Hospital, the Rotunda Hospital in Dublin and St Mary's Hospital in London.

In his spare time Dr Gannon is President of the Australian Medical Association (WA).

Marek Garbowski WA Vascular Surgeon MBBS, FRACS (Vasc)

Mr Marek Garbowski is a consultant vascular and endovascular surgeon at Sir Charles Gairdner, Royal Perth and Osborne Park Hospitals, as well as Joondalup Health Campus. Marek's private practice (Perth Vascular Clinic) is located at St John of God Hospital in Subiaco. After completing his MBBS in 1994 Marek worked in Sydney, Hobart and Melbourne, and completed advanced surgical training in Vascular and Endovascular Surgery in Adelaide as well as New Zealand.

Jeff Hamdorf WA General Surgeon MBBS, PhD, FRACS.

Winthrop Professor of Surgical Education. Director, TEC. Head of School of Surgery, UWA Professor Jeff Hamdorf graduated from The University of Western Australia's Medical School and soon after undertook studies contributory to a Doctor of Philosophy in Surgery. He completed surgical training and was awarded the Fellowship of the Royal Australasian College of Surgeons in 1993. Surgical training was undertaken through Sir Charles Gairdner Hospital, Royal Perth Hospital and Fremantle Hospital. Post Fellowship training in upper gastrointestinal surgery was undertaken at the University of New South Wales with clinical privileges at the Prince of Wales and Prince Henry Hospitals. He was the inaugural Professor of Medical Education, at The University of Western Australia, is the Director of CTEC, a world class skills training centre and is UWA's Winthrop Professor of Surgical Education.

Ian Hammond WA Chair National Cervical Screening Program

Professor Ian Hammond retired in 2012 after 30 years in clinical practice as a Gynaecologic Oncologist in Perth, WA.

In 2000 he developed (with John Taylor and Paul McMenamin) the Anatomy of Complications Workshop, that continues to assist colleagues avoid and manage complications of surgical practice.

He was Chair of the Guidelines Review Group that developed the 2005 NHMRC guidelines for the management of abnormal Pap smears. Since 2011 he has been actively involved in the Renewal of the National Cervical Screening Program that has led to the MSAC recommendations regarding proposed innovative changes to the program.

He was recently appointed as Chair of the Steering Committee for the Renewal Implementation Project that has oversight for bringing the proposed changes into everyday clinical practice. In 2011 he was awarded the President's Medal of the RANZCOG for services to Women's Health.

Rupert Hodder WA Colorectal Surgeon - Cancelled

Mr Rupert Hodder is a general and colorectal surgeon who operates at Royal Perth Hospital and Hollywood Private hospital. He also has a Consultantappointment King Edward Memorial Hospital for Women where is is involved on the management of surgical problems in women with gynaecologic and obstetric problems.

Nolan McDonnell WA Anaesthetist

Clinical Associate Professor Nolan McDonnell is an Anaesthetist that works primarily in the fields of obstetrics and complex gynae-oncology across both the public and private sectors. He has a number of varied research interests and is currently undertaking a three year, Department of Health funded Clinical Research Fellowship. He has a particular interest in neuro-muscular blockade and how the appropriate management of nneuro-muscular blockade can not only optimise surgical operating conditions, but also improve both surgical and anaesthetic related outcomes. His talk aims to highlight the key issues for both the surgeon and the anaesthetist in management of neuro-muscular blockade and how recent pharmaceutical developments can change our traditional approach.

Jessica Yin WA Urologist

Dr Jessica Yin is a urologist with a special interest in Urogynaecologic reconstruction. She has appointments at Sir Charles Gardener hospital, King Edward Memorial Hospital and Hollywood Private Hospital.

Speaker biographies at time of printing.

PROGRAM ABSTRACTS
FRIDAY 24 OCTOBER 2014

SESSION 1 / 0815 – 0845

Management of Bladder and Ureteric Injury

Jessica Yin

Urological Injuries occurring at the time of Gynaecological surgery continue to vex even experienced surgeons. Unexpected urological complications are the major source of litigation proceedings in Obstetrics and Gynaecology even though the reported incidence is low at 1% of all women undergoing pelvic surgery.

Here we present a summary of the topic based an up to date literature review and on the teachings of the Anatomy of Complications workshops that have been developed in Perth as a result of collaboration between Urogynaecologists, Gynae Onc Surgeons and Urologists. We include recommendations for prevention, investigation and management as well as some common pitfalls in diagnosis.

In addition, the topics of after care and counselling of patients is discussed.

SESSION 1/ 0915 - 0945

Vascular Injury - Identification and Emergency Steps

Marek Garbowski

Early recognition of any vascular injuries encountered during laparoscopic surgery leads towards improved patient outcome.
Even initially small vascular injuries can transform to delayed catastrophic complications not infrequently leading to poor outcome.

This presentation will address early recognition of arterial and venous injuries and discuss modern management options including endovascular approach to serious vascular emergencies.

SESSION 2/ 1045 - 1115

Anatomy is destiny

Stuart Salfinger

Well maybe not in the way Freud described but as surgical Gynaecologists it truly does determine not only our but also our patients destiny.

Knowledge of anatomy both normal and abnormal is essential for survival in the surgical field. It determines the limits and boundaries of our operations and our approach. Sound confident knowledge will enable the surgeon to safely navigate the perils of pathology.

The hysterectomy where one “keeps to the middle” because it is perceived to be away from danger is far from the clear identification of important structures and safe dissection to ensure the avoidance of complications.

The surgeons response to complications is also guided by their knowledge of anatomy and where they can safely identify and remedy a complication.

A video presentation will guide you though the anatomy of a hysterectomy and the pelvic sidewall.

PROGRAM ABSTRACTS
FRIDAY 24 OCTOBER 2014

SESSION 2 / 1115 - 1145

Tricks of the trade

Jim Nicklin

Complications in laparoscopic surgery vary with degree of difficulty of the surgery and operator experience, but rates are reported to vary from 0.1 – 10% of cases, in a review of over 1.5 million cases. Over 50% of complications occurred at entry and 20 – 25% were not recognized until the post operative period. Nearly two thirds involve major vessel injury and one third involve visceral injury. Many complications can be anticipated on the basis of body habitus, comorbidities, prior surgery (especially involving mesh) and the pathology to be treated. Anticipation and planning can reduce the incidence of injury, and flexibility and innovation is required for port placement in the execution of the surgical procedure. Identification and management of vessel injury, bowel and bladder injury will be discussed. Post operative identification of complications should be directed by symptoms with a low threshold to "investigate for the complication you fear the most". Many re-operations can be performed via a minimally invasive approach. Complications are inevitable and should be reviewed in a Quality Assurance framework to optimize education, support and ongoing safety.

SESSION 3 / 1330 - 1340

Laparoscopic Morcellation of Large Uteri without a Power Morcellator

JS Singh

Removal of a large uterus following TLH and fibroids after myomectomy has always required some form of debulking procedure.

Power morcellators have been a common tool used by most gynaecologists. Reports of parasitic fibroid remnants and possible leiomyosarcoma spread by the use of power morcellators have resulted in a cautionary statement by the AAGL and FDA regarding their use.

Calls for a complete ban on their use has been advocated by some. Those of us using them have noted the tissue scatter that can occur.

Using a laparoscopic cold knife does not cause tissue scatter and may be a cheap and safer option to morcellate large benign uteri and fibroids. Using the laparoscopic route to morcellate under direct vision may be less challenging and possibly less traumatic than vaginal morcellation.

This video presentation will show the technique when using the 5mm laparoscopy knife to morcellate a large uterus.

SESSION 3 / 1340 - 1350

The complex obstetric patient across two pregnancies

I Nikakis, WH Lim, G Blanchette, J Walsh

A 33 year old G5P2 who was 28 weeks pregnant was transferred to Royal Hobart hospital with antepartum haemorrhage and threatened pre-term labour.

Her obstetric history includes one normal delivery at 35 weeks gestation, followed by a second trimester miscarriage at 20 weeks. Her third pregnancy resulted in a first trimester miscarriage for which she had a surgical evacuation, followed by an emergency Caesarean section at 28 weeks for threatened pre-term delivery. On this pregnancy her cervix was

noticed to be short at 19 weeks, and a cervical cerclage was performed. She is mildly intellectually disabled, presumably due to Dandy Walker malformation for which she had a VP shunt inserted due to chronic headaches. She is also a poorly compliant type 1 diabetic.

During admission, she developed acute abdominal pain consistent with Ogilvie syndrome and was transferred to theatre for a surgical decompression. During induction, she suffered a cardiac arrest and underwent a peri-mortem Caesarean section. She received 2 minutes of cardiopulmonary resuscitation as well as adrenaline. A caecostomy was performed at the same time and she was transferred to intensive care for further monitoring. Her condition slowly improved and she was discharged home after 4 weeks of rehabilitation.

Two years later she fell pregnant again with minimal antenatal care. She was again transferred to our institution at 34 weeks gestation this time with acute pulmonary oedema secondary to worsening cardiomyopathy. An echocardiogram confirmed heart failure with an ejection fraction of 20-25%. She refused to consent for sterilisation, and an application to the guardianship board was initiated on the background of her previous delivery complication as well as her intellectual disability. She remained estranged from her partner, and her 3 children are not in her care. She underwent an elective Caesarean section under a slow infusing epidural anaesthesia. Intra-operatively her placenta was found to be morbidly adherent, and an emergency peripartum hysterectomy was performed. Histopathology confirmed a posterior placenta percreta.

This case illustrates the complex medical, social and legal circumstances surrounding the challenges faced with a high risk obstetric patient across her two pregnancies. The complications would not have been viable without a multidisciplinary team care approach.

SESSION 3 / 1350 - 1400

Laparoscopic excision of a retroperitoneal mass in a recurring stage III-C ovarian cancer. Video presentation.

E Coghlan

Objective

Description of laparoscopic approach for excision of a paraaortic-retropancreatic mass by a gynecologic oncologist

Methods and materials

54 years old lady diagnosed with advanced ovarian cancer, stage III-C received chemotherapy and was under surveillance for 28 months when she complained of a retrosternal discomfort with no other signs or symptoms suggestive of recurrence. Her Ca125 was elevated from a baseline of 20 up to 45. A CT scan suggested a 4X5 cm mass behind the pancreas adjacent to the celiac trunk. No other sites of metastasis.

Laparoscopic excision of a retroperitoneal disease was performed with no immediate or delayed complications

Conclusion

Conventionally a laparotomy incision would be the standard approach to operating in this difficult area. However, by using basic surgical principles and every day ‘tricks and tools’ allowed a laparoscopic approach to be both feasible and practical to debulk ovarian cancer in the upper abdomen.

PROGRAM ABSTRACTS
FRIDAY 24 OCTOBER 2014

SESSION 3 / 1400 - 1410

Laparoscopic abdominal cervical cerclages in a patient with uterine didelphys complicated by mid-trimester FDIU: Case report and review of the literature.

K Dobromilsky, A Ades

We present a case of a 27 year old Tasmanian woman who presented with recurrent mid-trimester pregnancy loss and known uterine didelphys. She also had a history of failed trans-vaginal cervical cerclage. Previous pregnancies were up to 24 weeks in the left side. The patient proceeded to have laparoscopic abdominal cervical cerclages inserted to both cervices in 2013. We illustrate the technique in this unusual case via video.
Following abdominal cerclage the patient fell spontaneously pregnant in the right side. Pregnancy proceeded uneventfully with low risk antenatal screening for aneuploidy. At 21 weeks the patient presented with painful tightenings. On ultrasound examination the pregnant cervix was long and closed. She was admitted and commenced on tocolytics. Two days after admission FDIU was diagnosed.
To avoid hysterotomy the patient was transferred to Melbourne where laparoscopic removal of abdominal cerclage was successfully undertaken. We present a video of our findings and procedure at laparoscopy. The patient delivered a stillbirth vaginally within 24 hours after removal of cerclage.
Case reports of laparoscopic removal of abdominal cerclage has been published previously. In these case reports patients were 171 and 192 weeks gestation. No publications were found for laparoscopic removal of abdominal cerclage beyond 20 weeks.

References:
1. Carter JF, Soper DE. Laparoscopic abdominal cerclage: a case report. JSLS. 2005; 9:491-493.
2. Carter JF, Savage A, Soper DE. Laparoscopic removal of abdominal cerclage at 19 weeks'gestation. JSLS. 2013; 17(1):161-163.

SESSION 3 / 1410 - 1420

Inferior epigastric artery injury - an unusual location

D Thangavel, C Wong

Introduction
Injury to the inferior epigastric artery (IEA) is a well-recognised complication of laparoscopic gynaecological surgery. Although insertion of the umbilical port carries the highest risk of unintentional vascular injury, they are not uncommon during insertion of ancillary ports, even under direct vision. Avoiding vascular injury involves a sound knowledge of surface anatomy and portals are placed in conventionally established locations, however, injuries do occur commonly due to anatomical variation in the course of the IEA. IEA injury has an incidence of about 3 in 1000 and occurs most commonly during the insertion of lateral ports.

Case description
A 20 year old female nulliparous woman underwent a laparoscopic salpingectomy for a left-sided ectopic pregnancy. The umbilical port was inserted with optical entry and all other ports were inserted under direct vision. Surgery was uneventful. There was minimal blood loss and irrigation was used. Sixteen hours after her operation, she had total more than 1500mls drain-output, which appeared as frank blood. Her haemoglobin was falling and she developed a swollen and bruised right labia. She was taken back to theatre and was found to have 600mL of haemoperitoneum. The surgical site was dry, however there was a bleeder from the right IEA at the suprapubic port site, which was 1cm off the midline. It was sutured with Endoclose and patient had an uneventful recovery. It was noted the left IEA was 5cm off the midline.

Discussion
Several methods are currently used to identify the inferior epigastric vessels prior to insertion of ancillary ports and currently direct laparoscopic visualisation is the most commonly used. Cadaver studies of the anatomic variations of the course of IEA show that generally the midline is avascular. Unfortunately, in this case, the right IEA was very close to the midline. Injury to the main trunk of the IEA can be avoided if the trocar is inserted greater than two-thirds the distance of the horizontal line between the ASIS and midline. The lowest part of the abdomen lateral to the artery is the least likely position to encounter branches of the IEA. IEA injury can result in significant haemorrhage and a numbers of methods have been described for surgical repair including sutures, cautery, balloon tamponade, IEA embolisation and mini-laparotomy. Removal of ports under vision can identify abdominal wall vessels injury from the port insertion.

Hurd, W., Amesse, L., Gruber, J., Horowitz, G., Cha, G. and Hurteau, J. (2003). Visualization of the epigastric vessels and bladder before laparoscopic trocar placement. Fertility and Sterility, 80(1), pp.209-212.
Epstein, J., Arora, A. and Ellis, H. (2004). Surface anatomy of the inferior epigastric artery in relation to laparoscopic injury. Clinical Anatomy, 17(5), pp.400--408.
Chatzipapas, I. and Magos, A. (1997). A simple technique of securing inferior epigastric vessels and repairing the rectus sheath at laparoscopic surgery. Obstetrics \& Gynecology, 90(2), pp.304--306.

SESSION 3 / 1420 - 1430

10 Year Retrospective Review of Leiomyosarcoma Cases and Complications from Surgery for Fibroids

T Ma, L Ellett, J Manwaring, K McIlwaine, E Readman, P Maher

Recent events have highlighted the rare but serious risk of unintended spread of undiagnosed uterine cancer, particularly leiomyosarcoma, with the use of intra abdominal morcellators at laparoscopic hysterectomy or myomectomy.

A search of pathology records from 1st July 2004 to 1st July 2014 was performed to identify all cases of leiomyosarcoma. 11 cases were identified and the records reviewed in regards to presentation and management. 4 cases were referred directly to gynae-oncology with tissue diagnosis from uterine currettings. 4 cases had features suspicious for potential malignancy on history or imaging and underwent abdominal hysterectomy. 2 cases were diagnosed after abdominal hysterectomy but had uteri which were not suitable for laparoscopy. 1 case was diagnosed after total laparoscopic hysterectomy and vaginal morcellation. No cases had laparoscopic morcellation of their pathology.

A search of coding records for the same time period was performed to assess how many operations for fibroids occured. A heterogenous group of 1135 open hysterectomies, 236 laparoscopic hysterectomies, 219 vaginal hysterectomies, 207 open myomectomies and 42 laparoscopic myomectomies were identified. Coding for complications among this group were assessed and explored.

When considering uterine surgery, particularly when intrabdominal morcellation may be required,a detailed history, pre operative imaging and tissue sampling may be of help in determining the risk of uterine malignancy and the choice of surgical approach versus the risks of other alternative methods. However, there remains no reliable preoperative diagnostic tools to differentiate malignant mesenchymal tumours of the uterus from their benign counterparts.

PROGRAM ABSTRACTS
FRIDAY 24 OCTOBER 2014

SESSION 3 / 1430 - 1440

Team assisted complications

C Georgiou

Recent events have highlighted the rare but serious risk of unintended spread of undiagnosed uterine cancer, particularly leiomyosarcoma, with the use of intra abdominal morcellators at laparoscopic hysterectomy or myomectomy.

A search of pathology records from 1st July 2004 to 1st July 2014 was performed to identify all cases of leiomyosarcoma. 11 cases were identified and the records reviewed in regards to presentation and management. 4 cases were referred directly to gynae-oncology with tissue diagnosis from uterine currettings. 4 cases had features suspicious for potential malignancy on history or imaging and underwent abdominal hysterectomy. 2 cases were diagnosed after abdominal hysterectomy but had uteri which were not suitable for laparoscopy. 1 case was diagnosed after total laparoscopic hysterectomy and vaginal morcellation. No cases had laparoscopic morcellation of their pathology.

A search of coding records for the same time period was performed to assess how many operations for fibroids occured. A heterogenous group of 1135 open hysterectomies, 236 laparoscopic hysterectomies, 219 vaginal hysterectomies, 207 open myomectomies and 42 laparoscopic myomectomies were identified. Coding for complications among this group were assessed and explored.

When considering uterine surgery, particularly when intrabdominal morcellation may be required,a detailed history, pre operative imaging and tissue sampling may be of help in determining the risk of uterine malignancy and the choice of surgical approach versus the risks of other alternative methods. However, there remains no reliable preoperative diagnostic tools to differentiate malignant mesenchymal tumours of the uterus from their benign counterparts.

SESSION 3 / 1430 - 1440

The comparison of surgical outcomes using LigaSure and Gyrus PK in total laparoscopic

C N Wong, H Merkur

The comparison of surgical outcomes using LigaSure and Gyrus PK in total laparoscopic hysterectomy
Dr. Clare Wong, Prof. Harry Merkur Sydney West Advanced Pelvic Surgery Unit

Background: The development of advanced vessel sealing devices has improved the efficiency and safety of laparoscopic surgical procedures1. The mean burst pressure, mean vessel seal time, thermal spread and smoke/vapour are the four main parameters of laparoscopic blood vessel sealing devices that have been assessed in laboratory based and animal studies. However, there is insufficient clinical evidence to support the use of one device over the other2. In laboratory based studies, Ligasure had the highest mean burst pressure and fastest blood sealing time when compared to other vessel sealing devices such as Enseal, Gyrus PK and Harmonic scalpel3. Currently, clinical studies are needed to further evaluate the claimed advantages provided by LigaSure in laparoscopic gynaecological surgery.

Objective: To compare operative time and blood loss with the use of Ligasure (using 5mm vessel-sealing instrument: LS 1500V) versus Gyrus PK blood vessel sealing device during laparoscopic hysterectomy.
Methods: Randomised controlled trial. Women, who undergo a laparoscopic hysterectomy for benign indications will be randomised to the use of Ligasure or Gyrus PK blood vessel sealing devices.
Main outcome measures: Primary outcome is operating time from initial skin incision till detachment of the uterus with secured haemostasis. Secondary outcome measures are total operating time (from initial skin incision until final skin closure), intra-operative blood loss, major complications, post-operative analgesia usage, conversion rate, ergonomics and costs.

PROGRAM ABSTRACTS
FRIDAY 24 OCTOBER 2014

Inclusion criteria: age>35 years age, scheduled for total laparoscopic hysterectomy for benign pathology with ultrasound confirmation of a uterus <14 weeks size. 14>14>Exclusion criteria: pregnancy or malignancy suspected, or uterus exceeding 14 weeks in size. Power calculation: 57 patients are needed in each arm to have 80% of power to detect a 25 minutes difference in operative time at the two sided 5% significance level.

References:1) Lyons S & Law K, Laparoscopic Vessel Sealing Technologies, JMIG, 2013, 20:301-3072) Law k& Lyons S, Comparative Studies of Energy Sources in Gynaecologic Laparoscopy, JMIG, 2013, 20:308-3183) Lamberton G et al. Prospective Comparison of Four Laparoscopic Vessel Ligation Devices, Journal of Endourology, 2008, 22(10):2307-2312

SESSION 4 / 1530 - 1545

Hysteroscopic Complications – Fluid Management

Patrick McIlwaine

This presentation will give an overview of the different distending media that are used in hysteroscopic surgery. Potential complications of excessive systemic fluid absorption will be discussed and strategies to minimise these risks will be highlighted.

SESSION 4 / 1545 - 1600

Hysteroscopic Complications – Perforation

Haider Najjar

Uterine perforation is one of the major risks of diagnostic and operative hysteroscopy. Resulting morbidity such as haemorrhage or sepsis caused by injury to surrounding blood vessels or viscera can occur. Uterine perforation with resulting incarceration of bowel has been reported. Risk factors for uterine perforation include those that increase the difficulty of access to the endometrial cavity and also those that decrease the strength to the myometrium. Significant factors that lead to uterine perforation will be explored as well as strategies for its prevention and management.

Istre O. Managing bleeding, fluid absorption and uterine perforation at hysteroscopy. Best Pract Res Clin Obstet Gynaecol 2009; 23:619.
Paschopoulos M, Polyzos NP, Lavasidis LG, et al. Safety issues of hysteroscopic surgery. Ann N Y Acad Sci 2006; 1092:229.
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SESSION 4 / 1600 - 1620

Complications of Pneumoperitoneum – Pressure down (or up)

Raj Mohan

An evidence based review and discussion of the complications associated with pneumoperitoneum during laparoscopic surgery. The ideal operating pressure described in the literature ranges between 8 to 12mmHg. Operating with pressures above 15mmHg has significant side effects on the intra abdominal organs especially in patients with significant cardiopulmonary compromise. Preoperative preparation and appropriate intraoperative interventions in these patients can help prevent some of these detrimental side effects.

PROGRAM ABSTRACTS
FRIDAY 25 OCTOBER 2014

SESSION 4 / 1620 - 1640

Optimization of Surgical Operating Conditions with Neuromuscular Blockade: Novel Techniques and Tricks

Nolan McDonnell

The use of muscle relaxants as part of anaesthesia has a long and chequered history. Until comparatively recent times muscle relaxants were considered a routine part of anaesthesia. This changed in response to research that showed, prior to the development of new agents as well as equipment and monitoring, that the use of muscle relaxants was associated with a much higher anaesthesia related mortality. Subsequent to this, anaesthesia has evolved such that many procedures are now performed without significant muscle relaxation. However, most laparoscopic intra-abdominal procedures require some form of muscle relaxation. Appropriate degrees of muscle relaxation in these instances can potentially decrease insufflation pressures, optimise surgical operating conditions and decrease complications. However, obtaining sufficient levels of muscle relaxation, particularly towards the end of a surgical procedure, can result in prolonged anaesthesia times or patients waking up with residual amounts of neuromuscular blockade (which can lead to a variety of complications such as aspiration). This talk will examine the history of muscle relaxation and the potential advantages and disadvantages of muscle relaxation for intra-abdominal surgery. It will then look at relatively recent advances in anaesthetic pharmacology and how this may assist optimising the management of neuromuscular blockade.

SESSION 4 / 1640 - 1700

Surgery with a bit less pressure

Krish Karthigasu

This presentation does not discuss gas pressures with laparoscopic surgery, but rather discusses the psychology of the surgeon in the operating theatre and various theories of the complex processes in the mind and actions of surgeons. It discusses the theory of "automation" and "slowing down" as well as factors influencing the decisions and psychology within the operating surgeons mind, particularly in times of stress. The understanding of the psychology of surgeons and surgeons actions in the operating theatre is an adjunct to the acquisition of technical skills resulting in development of the "expert" surgeon and less pressure in the operating room environment.

PROGRAM ABSTRACTS
SATURDAY 25 OCTOBER 2014

SESSION 5 / 0800 - 0820

Pregnancy after Bariatric Surgery

Scott White

The global obesity pandemic has seen a tidal wave of obesity in pregnancy. In our institution, over 30% of mothers are morbidly obese at the commencement of their pregnancy. The consequent morbidity and economic burden is enormous. Whilst lifestyle interventions are of clear benefit for those individuals who are able to maintain them in the long term, at a population level such interventions have failed to reverse the obesity trend. Bariatric surgery is highly efficacious in producing immediate and sustained weight loss, and the benefits extend to reductions in the adverse metabolic associations of obesity such as hyperglycaemia. It is therefore a promising therapy in women planning future pregnancies, in order to reduce the adverse maternal and fetal outcomes associated with gestational obesity. This benefit does not come without risk however, and serious maternal and fetal complications have been observed in pregnancies following such surgery. This session discusses the perinatal outcomes following bariatric surgery and the implications for practice.

SESSION 5 / 0820 - 0840

Obstetric Trauma

Martin Ritossa

Trauma in pregnancy is an uncommon but potentially catastrophic event. It can have a significant impact on both the mother and the baby. Fortunately in Australia pregnant patients account for less than 1% of trauma admissions. Usually these admissions are due to blunt trauma of a relatively mild nature. The majority of admissions are a result of motor vehicle accidents or falls. Deaths from trauma are rare, accounting for 3-4 deaths per 1 Million deliveries. Of some concern is that between 2003 and 2010, 30% of those deaths were a result of assaults.

Violence against women is a common event and has been reported in as many as 1 in 5 pregnancies. Pregnancy is known to be a period of increase risk, with domestic violence often occurring for the first time during pregnancy. The presentation will provide a summary of the effects of trauma in pregnancy to both mother and child, describe the need and protocols for the correct and rapid response to trauma, as well as discussing the implications of domestic violence in pregnancy.

SESSION 5 / 0840 - 0900

Cancer and pregnancy

Jim Nicklin

Approximately 1 in 1000 – 1500 pregnancies will be complicated by cancer, which is a rare cause for maternal mortality. The health of the mother and the safety of the fetus often lead to therapeutic dilemmas. Ethical, cultural and religious issues need to be considered and an interdisciplinary approach is essential. As a general principle, the malignancy is managed on it's merits and a determination made as to what allowances can be made for the pregnancy and fetus. Ultimately, management comes down to maternal wishes. Gynaecological malignancies, CIN, breast cancer, melanoma, colorectal cancer and myeloproliferative disorders in the pregnant patient, will each be discussed.

PROGRAM ABSTRACTS
SATURDAY 25 OCTOBER 2014

SESSION 6 / 1010 - 1040

Post op Care - The surgeon

Jason Tan

A successful procedure, especially complicated surgeries, consists of 3 phases, which intermingle to produce specific outcomes: pre/intra/post-operative phases.
Often, after an actual surgical procedure is complete us as surgeons let our guard down, and suboptimal post-operative care leads to complications.
As obstetrician gynaecologists, our patients are often young and have a much higher margin to tolerate insult and maintain homeostasis.
This talk will focus on the routine post-operative care of surgically unwell patients. Specific focus will be placed on evidence for anti-coagulation, nutrition, placement of drains, fluid replacement.
What is best post-surgical care?

SESSION 6 / 1040 - 1120

The Pap is Dead! Review of the National Cervical Screening Program

Ian Hammond

Chair, Renewal Steering Committee and Steering Committee for the Renewal Implementation Project, National Cervical Screening Program
Since 1991 the National Cervical Screening Program (NCSP) has offered routine screening with Pap smears every 2 years for women between the ages of 18 and 69 years. Over this time, the incidence and mortality rates for cervical cancer have both decreased by approximately 50 per cent.

The NCSP now operates in a changing environment
- Improved knowledge about the natural history of cervical cancer
- New evidence about the screening age range and interval
- New tests such as Liquid Based Cytology and HPV DNA testing
- The National Human Papilloma Virus (HPV) Vaccination Program commenced in 2007 for girls and 2013 for boys

The aim of the Renewal is to ensure the continuing success of the program and that all Australian women, HPV vaccinated and unvaccinated, have access to a cervical screening program that is based on current evidence and best practice.
The objectives of the Renewal are to
- Assess the evidence for screening pathways: tests, age range, interval
- Determine a cost effective pathway
- Improve national data collection and registers
- Improve safety and quality monitoring
- Access feasibility and acceptability of the new program

After a rigorous and transparent process, the Medical Services Advisory Committee considered the external Evidence and the Economic Modeling reviews and made their recommendations to the Minister on 28th April 2014:

- Five yearly cervical screening using a primary HPV test with partial HPV genotyping and reflex liquid based cytology (LBC) triage, for HPV vaccinated and unvaccinated women 25 to 69 years of age, with exit testing of women up to 74 years of age

- Self collection of an HPV sample, for an under-screened or never-screened woman, which has been facilitated by a medical or nurse practitioner (or on behalf of a medical practitioner) who also offers mainstream cervical screening

- Invitations and reminders to be sent to women 25 to 69 years of age, and exit communications to be sent to women 70 to 74 years of age, to ensure the effectiveness of the program

- Delisting of the existing cervical screening test MBS items over a 6 to 12 month transition period

The Australian Health Ministers Advisory Council (AHMAC) accepted these recommendations in September 2014 and implementation is planned for 2016. The Steering Committee for the Renewal Implementation Project (SCRIP) chaired by Ian Hammond will have oversight of this complex and innovative program, and will employ expert working groups to facilitate the process. The Implementation Project has 5 core activities:

MBS Items: Deletions/Additions and Transition
Registers: develop a National approach to registers
Workforce and Practice Change: Cytologists, Colposcopists, Laboratories
Safety and Quality: monitoring the program
Communication and Information: health professionals and consumers
This presentation will offer insight into the process, outcome and implementation of Renewal and what it means for you and your patients.

Useful documents can be accessed at:
www.msac.gov.au (Application 1276)
www.cervicalscreening.gov.au (Renewal evidence and economic modeling documents including the Executive Summary)

SESSION 6 / 1120 - 1150

Legal management of complications

N Ferrie, L Watkins
MDA National

Knowing how to manage complications is vital to good medical practice. Almost every doctor will face an adverse outcome at some stage in their career. It is important to ensure the process of disclosure is managed appropriately and in accordance with your clinical and legal obligations. What information you should convey, how disclosure should occur, and the implications of poor communication are all relevant to the eventual outcome. This segment will provide a practical and informative view on how to best manage the medico-legal impact of surgical complications.

PROGRAM ABSTRACTS
SATURDAY 25 OCTOBER 2014

SESSION 7 / 1300 - 1320

Challenges to Training

Jade Acton

Surgical education is not just the training of junior doctors. It is the process from undergraduate, through to post-graduate and continuing professional development. The challenges that surgical education will face over the next decade are extensive. Medical education is inextricably tied to the health service system in which it takes place and changes in one impact on the other. Surgical education must be adaptive and remain current and relevant to be effective in the long term. Most challenges relate to the changes within the trainees, changes within the system in which they are trained, technological advances and in better equipping the educators.

Modern trainees have new expectation of their training and desire more flexible surgical training. To continue to produce high quality surgeons, RANZCOG must examine its programs and work in conjunction with training sites to provide more appropriate part-time training opportunities.

Surgical educators must continue to examine the training opportunities presented to the modern trainee and ensure that despite decreasing working hours and surgical exposure, that the trainees receive adequate exposure to meet the desired outcomes.

Surgical education must remain technologically savvy, embracing new opportunities for training and delivery as they become available. Finally, surgical education must develop and deliver educational programs for trainees and surgeons and recognise and reward achievement for those who undertake the additional training.

SESSION 7 / 1320 - 1340

The blind leading the blind: Anatomy, the trainer and the trainee

Jason Abbott

The performance of good gynaecological surgery is dependent on a number of factors. These must include a comprehensive knowledge of anatomy and pathology as well as a wide-ranging skillset to work abdominally, vaginally, hysteroscopically and with a range of instruments and energy forms. Completion of RANZCOG training allows graduates to undertake any surgical procedure they deem appropriate for their skill level. Repeated studies have reported that trainees feel their anatomy knowledge and surgical skill sets to be incomplete at the end of training. This is particularly true of the pelvic side-wall, where complications may be life-threatening and an excellent working knowledge is required.

University teaching programs approach anatomy with a variety of methods and none seems to be superior to any other. Without an entry examination to our specialty, it is possible that surgery may be undertaken with a poor knowledge of anatomy and the consequences of a complication may be profound.

Continued anatomical training is essential after completion of RANZCOG training and teaching of anatomy by Fellows supervising trainees is of variable quality. It requires a persistent review of surgical anatomy, a working knowledge of pathology and instrument handling and educational skills to translate the knowledge from one individual to another. Anatomy outside of the pelvis is essential and includes neuromuscular anatomy of the thigh, the inguinal canal and the upper abdomen.

Specific anatomy revision allows repetition of pre-existing knowledge, courses may reinforce applied anatomy, skill acquisition may stem from cadaveric dissection, simulators and live surgery but needs to be undertaken in conjunction with specific testing and revision for retention. Surgery in the setting of complex pathology requires recognition and a high degree of manual skill. The capacity to teach in such a live surgical setting is a level above this skillset and is difficult to attain and master. Video and audio recording during procedures to check educational skills, anatomical revision through non surgical resources (digital media, courses, dissection and books) and comprehension of the needs of the woman (patient) and the trainee are integral components of learning and teaching the anatomy required to undertake surgery safely and effectively.

PROGRAM ABSTRACTS
SATURDAY 25 OCTOBER 2014

SESSION 7 / 1340 - 1400

Follow my lead - RACS surgical training

Jeff Hamdorf

The Royal Australasian College of Surgeons has undertaken a number of changes over the last 2 decades as it has evolved from an institution primarily involved in assessment to one invested in training. Historically trainees were expected to successfully complete the Part 1 examination in anatomy, pathology and physiology before they would register their interest with the College and were then generally able to fill non-accredited (service) registrar positions.

After a period of "service" registrars were able to apply to regional-based training boards for selection into Advanced Training which involved 4 – 5 years of supervised hospital-based work. Upon achieving an "appropriate standard", generally the completion of the designated training period, Advanced Trainees attempted the Part 2 exam – the FRACS qualification. In 2000 the RACS introduced a more systematised approach to training in which the previously "unrecognised" but nonetheless enthusiastic junior doctors applied for Basic Surgical Training.

Following this the BSTs participated in a number of compulsory skills courses and accessed on line learning modules. They then sat the Part 1 Examination – enjoying a much higher success rate than their predecessors. Defined limits as to the number of attempts at summative assessments were also introduced.

The BST-AST arrangement resulted in a bottleneck which most considered was at too senior a level. In order to address this, Surgical Education and Training (SET) was introduced in 2008. SET was designed to improve the quality and efficiency of surgical education and training through early selection into specialty training and streamlining of the training experience and included a focus on the essential roles of a surgeon include:

Professionalism, Health Advocate, Manager and leader, Collaborator, Communicator, Medical Expertise, Judgement – clinical decision-maker, and Technical expertise.

Initiatives to introduce a competency basis to progression through training via in-training assessment have been set down with variable uptake amongst the various specialties. In most surgical streams Fellowship graduates are expected to pursue post-Fellowship training opportunities prior to application for consultant posts.

SESSION 7 / 1400 - 1440

Simulation in Surgical Training

Katrina Calvert

Training in surgical specialties traditionally comprised an apprenticeship model, with expertise being gained as a function of exposure, to the potential detriment of patients exposed to a trainee in the early part of their learning curve. With the decrease in surgical case load and with a growing awareness of medico-legally robust training practises, simulation has arisen as a training modality which allows the attainment of expertise in clinical skills in a safe environment without the fear of negative patient care outcomes. Simulation training can comprise high tech, high fidelity scenarios, but simulation can also encompass low tech scenarios with minimal cost.

This session will aim to discuss the theoretical underpinnings of simulation based training, to outline the potential application of simulation in gynaecology and to look at the current evidence base behind the use of simulation in gynaecological surgical training.

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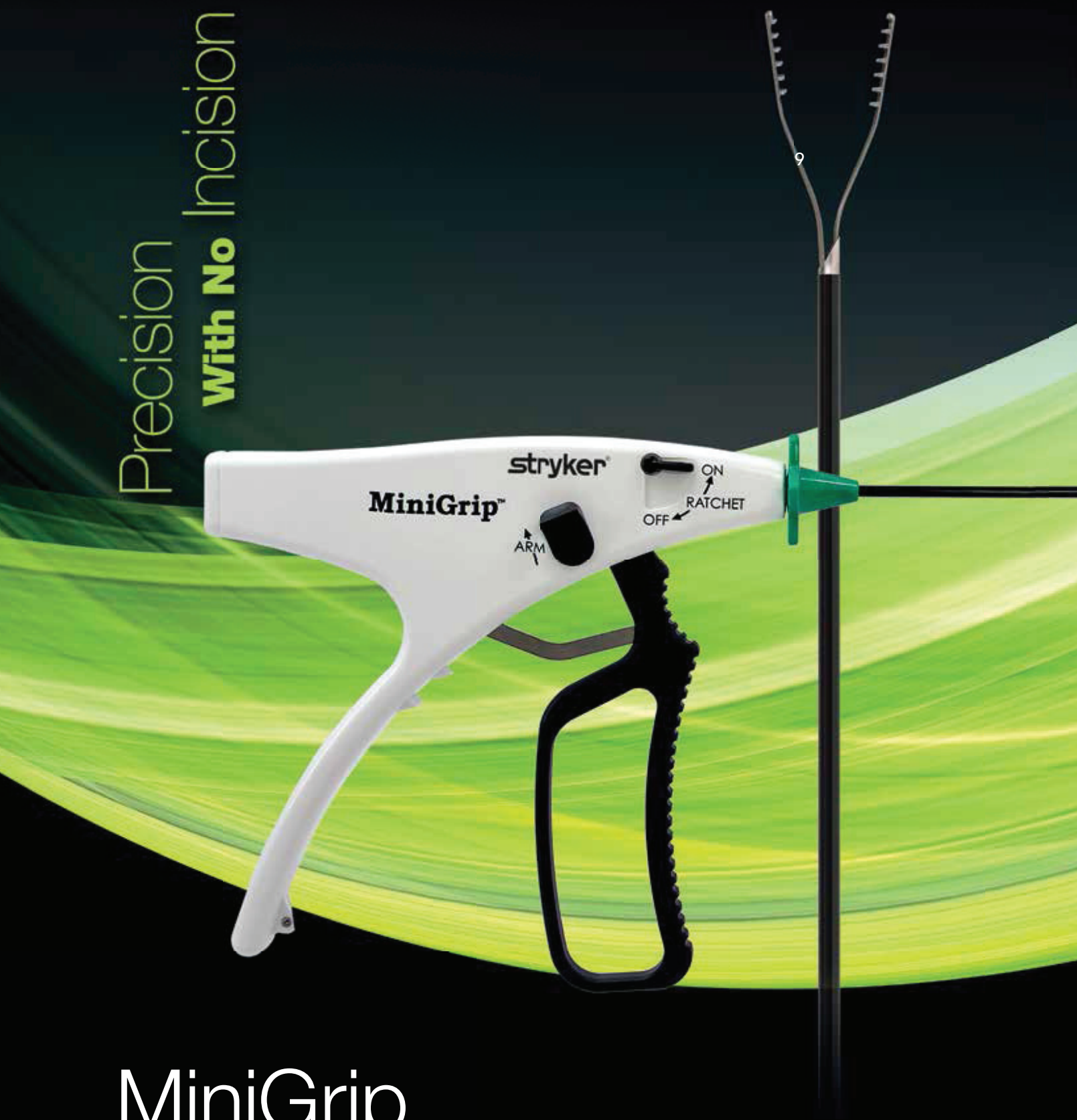

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