AGES SILVER ANNIVERSARY
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AN AGES
FOCUS
MEETING 2015

TAKING CONTROL

ABSTRACT BOOKLET

NOVEMBER 6 AND 7

HOTEL GRAND CHANCELLOR
HOBART, AUSTRALIA

Australasian Gynaecological Endoscopy & Surgery Society Limited

stryker®

DAY 1 FRIDAY 6 NOVEMBER

7.45am - 8.45am **Conference Registration**

7.45am - 8.45am Welcome / **Arrival tea and coffee**

Session 1

8.45am - 11.00am **Taking Control of Obstetric Surgery**
Chairs: Emily Hooper & Warren Kennedy

Managing Ovarian Cysts in Pregnancy
Penny Blomfield

Surgical Management of Recurrent Mid-trimester Pregnancy Loss
Alex Ades

The Difficult Caesarean
Frank Clark

Our Obsession with the Caesarean Section Rate and its Effect on Women and their Babies
Hans Peter Dietz

11.00am - 11.30am **Morning Tea & Trade Exhibition**

Session 2

11.30am – 1.00pm **Taking Control of Conception: Periconceptual Gynaecology and Assessment**
Chairs: Haider Najjar & Irena Nikakis

Modern Infertility Assessment and the Specialist
Ben Kroon

Prenatal Screening – What Should We Test For?
David Amor

First Trimester Screening – Taking Control of Your Choices
Lindsay Edwards

1.00pm - 2.00pm **Lunch & Trade Exhibition**

Session 3

2.00pm -2.40pm **Taking Control of Justice**
Chairs: Jason Abbott & Stephen Bradford

The Medicolegal Consequences of Adverse Events
Ms Sophie Pennington & Dr Michael McEvoy

2.40pm - 3.10pm **Afternoon Tea & Trade Exhibition**

Session 4

3.10pm - 4.50pm **Taking Control of Gynaecological Surgery (Interactive Session)**
Chairs: Frank Clark & Anusch Yazdani

Panel: Salwan Al-Salihi, Stephen Brough, Michael Bunting, Hans Peter Dietz, Kim Dobromilsky, Rachel Green, David Lloyd, Emma Readman

An interactive transponder session with responses/questions from floor

4.50pm **Close of Day One**

5.20pm Gather in Hotel Grand Chancellor Hobart foyer to walk to Gala Dinner Ferry (8 minute walk)

5.40pm Ferry departing at 5.40pm **sharp**

6.15pm **Gala Dinner and private viewing MONA**

DAY 2 SATURDAY 7 NOVEMBER

7.30am – 8.30am **Conference Registration**

7.30am – 8.30am **Arrival tea and coffee**

Session 5

8.30am - 10.30am **Taking Control of Your Imaging**
Chairs: Kim Dobromilsky & Krish Karthigasu

Imaging Endometriosis: Ultrasound (COGU)
Sofie Piessens

Gynaecological Imaging: When Ultrasound is Not Enough
Bridget Sutton

Dopplers - What Can We Measure? What Does it Mean?
Lynne Brothers

Intrapartum Ultrasound
Oshri Barel

10.30am - 11.00am **Morning Tea & Trade Exhibition**

Session 6

11.00am-12.30pm **Taking Control of Your Practice**
Chairs: Emma Readman & Adele Zito

What Does the GP Want From Their Specialist, What Would Make Me Refer to You?
Marita Long

Pitfalls of Staff Management
Rebecca Kroon

Facebook, Twitter and Websites - Trending to make Patients Come to You!
Georgi Wicks & Ned Worledge

12.30pm-1.30pm **Lunch & Trade Exhibition**

Session 7

1:30pm - 3.30pm **The Generalist VS The Sub-Specialist Let The Battle Begin!**
Chairs: Frank Clark & Anusch Yazdani

CREI
Amanda Dennis VS Luk Rombauts

CGO
Warren Kennedy VS Michael Bunting

CU
Sue Keating VS Salwan Al-Salihi

COGU
Sofie Piessens VS Rupert Sherwood

3.30pm **Close of Day Two**

Program correct at time of printing and subject to change without notice. Updates available on the AGES website.

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Program Abstracts

Friday 6 November 2015

Session 1 / 0845 - 1100

Taking Control of Obstetric Surgery

Managing ovarian cysts in pregnancy

Penny Blomfield

Abstract not yet received.

Surgical management of recurrent mid-trimester pregnancy loss

Alex Ades [1]

1. *Royal Women's Hospital, Melbourne*

Cervical cerclage has been used for the treatment of cervical insufficiency for over 60 years. Transabdominal cerclage is indicated for cervical insufficiency not amenable to a transvaginal procedure. The most common reasons are previous failed vaginal cerclage and/or previous cervical surgery where large portions of the cervix were removed.

More recently, a laparoscopic approach to transabdominal cerclage has been used with the aim of reducing the morbidity associated with laparotomy.

We present the obstetric outcomes after laparoscopic transabdominal cerclage in a group of consecutive women who had the procedure between 2007 and 2015.

All eligible women were enrolled in a prospective observational study.

The primary outcome was neonatal survival. Secondary outcome was delivery of an infant at ≥34 weeks gestation. Surgical morbidity and complications were also evaluated.

150 women underwent laparoscopic transabdominal cerclage during the study period. In 15 women the cerclage was inserted during the first trimester of pregnancy; in the remaining 135 the cerclage was inserted pre-pregnancy as an interval procedure. In the pre-pregnancy group, there is an expected lag between cerclage placement and pregnancy. 101 pregnancies which have gone beyond 12 weeks have been documented to date. 18 patients are currently pregnant. 83 were evaluated for obstetric outcome. The perinatal survival rate was 98.8 % with a mean gestational age at delivery of 36.1 weeks. 81 % of women delivered at ≥34 weeks gestation. In pregnancies before the transabdominal cerclage, in the same group, perinatal survival rate was 29%, mean gestational age 25.1 weeks.

Conclusion: Laparoscopic transabdominal cerclage is a safe and effective procedure resulting in favourable obstetric outcomes in women with a poor obstetric history. Success rates compare favourably to the laparotomy approach.

1. Laparoscopic transabdominal cervical cerclage: a 6-year experience. Aust N Z J Obstet Gynaecol. 2014 Apr;54(2):117-20. doi: 10.1111/ajo.12156. Epub 2013 Dec 23. Ades A, May J, Cade TJ, Umstad MP.
2. Transabdominal Cervical Cerclage: Laparoscopy Versus Laparotomy. J Minim Invasive Gynecol. 2015 Sep-Oct;22(6):968-73. doi: 10.1016/j.jmig.2015.04.019. Epub 2015 Apr 28. Ades A, Dobromilsky KC, Cheung KT, Umstad MP.

The difficult caesarean

Frank Clark

1. *Launceston General Hospital, Prospect, TAS, Australia*

Caesarean section is arguably the most common operation done by general obstetricians and gynaecologists.

Paradoxically it can be the easiest of operations or the most challenging and difficult.

At a time when trainee surgical experience is decreasing, the likelihood of being involved with a difficult caesarean is increasing.

Caesarean section can be difficult for many reasons. This presentation will aim to describe and discuss some of those difficulties and to provide some advice for dealing with them.

Our obsession with the Caesarean Section rate and its effect on women and their babies

Hans Peter Dietz

1. *Sydney Medical School Nepean, Penrith, NSW, Australia*

Caesarean Section rates have become a political issue, coming to the attention of governments and health bureaucrats. The result are guidelines and policy directives designed to increase the likelihood of vaginal delivery, sometimes with limited input from clinicians. In the UK, pressure exerted on clinicians to reduce Caesarean Section rates has had publicly debated negative consequences, and recent medicolegal developments are likely to have a major impact on this issue.

In this talk I will try to examine the likely implications of policies attempting to lower Caesarean Section rates in the light of recent maternity statistics, judicial decisions and clinical research, both for obstetric clinical practice and maternal morbidity. The result of such policies are longer second stages, an emphasis on VBAC, greater reliance on Forceps (even Forceps at higher stations and rotational procedures), a bias against effective pain relief and against C/S on maternal request, and a particularly pernicious influence on obstetric research. A recent UK Supreme Court decision will lead to substantial changes in antenatal and intrapartum informed consent. Negative impacts on patient outcomes are now becoming measurable and will result in very substantial additional medicolegal liability in the near future, revealing the danger of a single- minded focus on C/S rates for patients and obstetricians alike.

Session 2 / **11.30am – 1.10pm**

Taking Control of Conception: Periconceptual Gynaecology and Assessment

Modern infertility assessment and the specialist

Ben Kroon

1. *Eve Health, Spring Hill, QLD, Australia*

The initial assessment of the infertile couple is fundamental to the timely diagnosis and management of reproductive pathology. The initial evaluation should be comprehensive, time-efficient and cost-effective. This talk will provide a suggested framework for the appropriate initial investigation of the infertile couple.

Prenatal screening – what should we test for?

David Amor

Abstract not yet received.

First Trimester Screening – Taking Control of Your Choices

Lindsay Edwards [1]

1. *Mercy Hospital for Women, Northcote, VIC, Australia*

Prenatal aneuploidy screening is an established component of antenatal care and there are now several options available for couples when it comes to screening for chromosomal abnormalities, such as trisomy 21. Maternal serum screening using multiple analytes first became available in the 1980s, and improvements were made with the addition of the nuchal translucency ultrasound to maternal biochemistry in the 1990s for the First Trimester Combined Screening (FTCS) test. The FTCS has until recently been the gold standard for screening for trisomy 21, along with the other less common trisomies, 18 and 13. With the incorporation of the nasal bone in the mid-2000s, the performance of the FTCS has improved, and detection rates in excess of 90% are expected, with a false positive rate of 3-5%. Limitations of the test have been widely recognised and in the event of an increased risk result (> 1:300), invasive testing with either chorionic villus sampling (CVS) or amniocentesis is offered. The FTCS has also been proposed as a screen for other adverse pregnancy outcomes, such as preeclampsia and intrauterine growth restriction, using the pregnancy-associated plasma protein-A (PAPP-A) level, though the specificity of the test for this indication remains poor.

Since the discovery of cell-free DNA (cfDNA) of fetal origin in the maternal circulation in 1997, technologies have advanced rapidly so that it is now possible to screen for trisomy 21 and other aneuploidies on a maternal blood sample using several different DNA sequencing approaches. With a sensitivity and specificity of around 99% for trisomy 21 in high risk populations, non-invasive prenatal testing (NIPT) has surpassed the FTCS as the preferred screening test, and while its performance has been validated in low risk women, the positive predictive value of an abnormal result in this setting may be lower. NIPT was introduced in 2011 in the USA and China, and into Australia in early 2013. At that time the technology, which was only available in international laboratories, came at a significant cost and this was a prohibitive factor for a number of couples. From early 2015 however, with the advent of on-shore processing, both the turn-around time and the cost of the test decreased dramatically, making NIPT more widely available. It must be remembered however, that NIPT remains a screening test, and though significantly lower than the traditional FTCS, false positives, and negatives still occur. As such invasive testing remains the final pathway for those couples with an increased risk result seeking a definitive diagnosis.

It can be challenging counselling couples as to which test is right for them, and knowledge of the expected performance and limitations of each screening modality is essential to provide the appropriate advice. In an effort to highlight the difference between the options for first trimester screening, case-based discussion will be undertaken.

Session 3 / **2.00pm – 2.40pm**

Taking Control of Justice

The Medicolegal Consequences of Adverse Events

Ms Sophie Pennington & Dr Michael McEvoy

Abstract not yet received.

Session 4 / **3.10pm – 4.50pm**

Taking Control of Gynaecological Surgery (Interactive Session)

Panel: Salwan Al-Salihi, Stephen Brough, Michael Bunting, Hans Peter Dietz, Kim Dobromilsky, Rachel Green, David Lloyd, Emma Readman

An interactive transponder session with responses/questions from floor

Saturday 7 November 2015

Session 5 / 0830 - 1030

Taking Control of your Imaging

Imaging Endometriosis: Ultrasound (COGU)

Sofie Piessens [1]

1. *Monash Health, Glen Iris, VIC, Australia*

Surgical treatment of deep infiltrating endometriosis is complex, particularly when pouch of Douglas obliteration or bowel nodules are present. Over the last 10 years literature increasingly suggests that transvaginal ultrasound allows accurate assessment of bowel or bladder involvement, vaginal nodules or pouch of Douglas obliteration. Patient care is improved by identifying the subgroup of patients who would benefit from referral to an endometriosis expert and/or bowel surgeon. This presentation gives an overview of what the referring clinician can expect with regard to the preoperative transvaginal ultrasound diagnosis of deep infiltrating endometriosis involving the bowel, the bladder and the uterosacral ligaments.

Pelvic Imaging: CT & MRI - Why bother?

Bridget Sutton [1]

1. *SOGI SCAN, South Bank, QLD, Australia*

Transvaginal ultrasound is well established as the first line of imaging investigation for pelvic pain, infertility and early pregnancy. In this lecture we discuss the shortcomings of TVS and explore additional imaging techniques such as Hysterosalpingography (HyCoSy) and Hysterosalpingography (HSG) and pelvic MRI as adjuncts to TVU.

Pelvic MRI is considered by women's imaging specialists to be the "problem solver", often reserved for the non -specific adnexal mass or the indistinct endometrium in patients with post- menopausal bleeding. There are however a number of indications for which MRI should be routinely considered such as fibroid mapping, accurate classification of congenital uterine anomalies and disorders of sex development, staging of pelvic malignancy and pre-surgical workup of deep infiltrating endometriosis.

While TVU remains the most important initial imaging technique for gynaecology and infertility patients, when the report leaves us with more questions than answers, we are no longer limited to CT scan in order to obtain more diagnostic information.

Dopplers - What can we measure? What does it mean?

Lynne Brothers

We are familiar with the cascade of Doppler changes in the early growth restricted fetus in the umbilical artery, middle cerebral artery and the ductus venosus. But Doppler parameters from these and other vessels are increasingly reported through out pregnancy in a variety of diagnostic and screening situations.A discussion on the use of ductus venosus in the first trimester, uterine artery in the first, second and third trimesters and the CPR will form the basis of this presentation.We will discuss how these measurements should be obtained, what to look for in the images and whether you can believe them.The choice of Doppler measurement parameters S/D, RI or PI Is this confusing and is it time to choose?

Intrapartum ultrasound

Oshri Barel

Abstract not yet received.

Session 6 / 1100 - 1230

Taking Control of Your Practice

What does the GP want from their specialist, what would make me refer to you?

Marita Long

The role of the GP has been described as one in which the doctor diagnoses and treats what they can and then refers everything else off to the specialist. The actual role of a GP however is much broader than this. GPs are the providers of comprehensive and continuous patient centred care that incorporates both primary and preventative health care and is largely based in the community.

As GP's we are expected to have a good working knowledge of 187 conditions, but we can't know everything. We rely heavily on our specialist colleagues for their knowledge and skills making the referral process an essential part of patient care. We are now seeing patients with more chronic and complex disease than we have in the past and this, combined with limited resources, means the need for collaboration has never been greater.

Hopefully through inviting you into the world of general practice you will better understand what it is we need from you, the specialist, and what influences our referral pathways.

1. Pitterman, L and Koritsas, S. General practitioner- specialist relationship. Part 1. Internal Medicine Journal 2005;35: 430-434
2. Pitterman ,L and Koristas , S. General practitioner- specialist relationship. Part 2. Internal Medicine Journal 2005; 35: 491-496

Pitfalls of staff management

Rebecca Kroon [1]

1. *DibbsBarker, Paddington, QLD, Australia*

A strong employment relationship is the foundation for a successful business. Effective management of this relationship is essential for maintaining long-term business performance and prosperity. Therefore, it is important to have the right tools in place to support good staff management practices.

Implementing proactive measures, such as contracts of employment and workplace policies, is one way for employers to ensure they are best equipped to manage the employment relationship, in particular employee performance or conduct.

Managing poor performance or conduct can be a challenging task for many managers and business owners, and can be easily overlooked when working in a busy work environment. Legal claims that can arise as a result of poor management practices, such as unfair dismissal, discrimination or workers' compensation, can be extremely damaging in terms of a business's reputation, financial position and work environment. Consequently, it is critical that managers and business owners have an understanding of the reactive measures that can be taken in response to performance issues to reduce the risks associated with poor performance.

This session will cover some of the most effective strategies for minimising or avoiding the pitfalls of staff management, particularly in a busy fast-paced working environment such as healthcare. In particular, this session will outline some of the fundamental processes that any workplace should have in place for the performance management and dismissal of employees.

Facebook, Twitter and Websites - Trending to make patients come to you!

Georgi Wicks & Ned Worledge

1. *Font Public Relations, Battery Point, TAS, Australia*

Font has been a leader in social media studies in Tasmania for a number of years. Since 2011 Font has conducted the Font Social Media Index, detailing the key figures and findings of social media use in Tasmania. Through collecting this data, we can get an understanding into the ways in which Tasmanian's are engaging on social media, including the percentages of people in Tasmania using social media, the demographics of who is using social media and the psychographics, such as the key reasons for using social media. All these findings are shared with participant to help them make informed decisions around their social media strategy.

The presentation will highlight the power of social media in spreading and dictating news, revealing how your organisation can be the leader of important discussions relating to your field. The session also provides an overview of how advertising can be used on social media, with insights and examples of content that works how to reach your target market and the pitfalls of advertising on social media. Participants will be shown the key to engaging with people on social media, including how you can generate discussion, produce engaging content and create calls to action as well as providing participants the opportunity to gain an understanding of how search engine optimisation can help attract people to your practice.

Session 7 / 1.30 – 3.30pm
The Generalist VS The Sub-Specialist – let the battle begin!

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