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OCTOBER
13&14

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SINGAPORE

Australasian
Gynaecological
Endoscopy & Surgery
Society Limited

FOCUS
MEETING

PROGRAM AND ABSTRACTS

Obstetrical & Gynaecological
Society of Singapore

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This meeting is a RANZCOG approved O&G meeting. Fellows of this college can claim 12PD Points for full attendance.

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The AGES membership application form is available online from the AGES website or from the AGES Secretariat. For further details visit the AGES website at www.ages.com.au or to join click the following link https://yrd.currinda.com/register/organisation/43

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WELCOME TO THE AGES FOCUS MEETING

Dear Colleagues,

On behalf of AGES, we would like to welcome you to Singapore. This is a landmark event for our society, our first SE Asian meeting. We have listened to you, our members, and have taken this meeting to the Lion City, and we hope you will enjoy this truly diverse sovereign city state. From the bustling hawker centres and night markets to the tranquillity of the Gardens by the Bay, Singapore has much more to offer than simply a stopover destination.

The two day program has been developed with similar diversity to appeal to the generalist and advanced laparoscopist alike. We will cover topics such as self-preservation and managing stress, to modern day issues affecting fertility and pelvic floor function. Our speakers are a range of local Australian talent as well as some names from Singapore - we are sure they will inspire and educate all.

The social highlight of this meeting will be a bumboat trip down the river to La Brasserie at the landmark Fullerton Hotel. Here we will enjoy an evening of wining and dining in this spectacular river city in a fashion that AGES has become renowned for. Our conference will conclude with the President's Reception, before we return to our home towns.

Once again, we welcome you to Singapore to Preserve, Protect, Promote.

Dr Rachel Green
Board Member, AGES
Conference Chair
On behalf of the Organising Committee

FRIDAY OCTOBER 13

0715 - 0815	**Conference Registration**	*Conference Room One & Two Foyer, Level 2*
0815 - 1000	**SESSION ONE: PRESERVATION OF THE UTERUS** In this opening session we will consider the gynaecologists territory of the uterus. With worldwide hysterectomy rates falling and new technologies emerging, what are the options for the women of today? How does this influence us in our obstetric practice and how does modern practice affect our women? CHAIRS: JASON ABBOTT & RACHEL GREEN	*William Pickering Ballroom, Level 2*
	Welcome ***Rachel Green & Jason Abbott***	
	"I Only Want to see Polyps, Hyperplasia or Cancer": The Role of Primary Care Assessment in AUB ***Jennifer Pontre***	
	Big Fast Bleeding needs Big Fast Response ***Stuart Salfinger***	
	Motherhood after Mullerian Melodramas ***Asha Short***	
	Balancing all the Options for the Myomatous Uterus ***Bernard Chern***	
	Adenomyosis in the Woman Wanting to Conceive ***Timothy Chang***	
	Panel Discussion	
1000 - 1030	**Morning Tea & Trade Exhibition**	*Conference Room One & Two, Level 2*
1030 - 1215	**SESSION TWO: PRESERVATION OF FERTILITY** With ever advancing maternal age and medical co-morbidities, this session will examine options for women. In this session we will look at recent advances in infertility management and what measures we can take to preserve fertility for the demands of modern life? CHAIRS: BERNARD CHERN & STUART SALFINGER	*William Pickering Ballroom, Level 2*
	Cancer Diagnosis and Fertility – A Match Made in Hell? ***Rachael Rodgers***	
	Oocyte Options for the Older Woman ***Ben Kroon***	
	Intra and Extra Pelvic Endometriosis and its Impact on Fertility ***Amani Harris***	
	The Fit and Thin of Fertility – How Can Over Exercise and Under Eating Impact Fertility ***Anusch Yazdani***	
	I Made a Mistake – Now Make My Tubes Work ***Tan Heng Hao***	
	Modern Management of Ectopic Pregnancy: "Saving the Tube" ***Kim Dobromilsky***	
	Panel Discussion	
1215 - 1315	**Lunch & Trade Exhibition**	*Conference Room One & Two, Level 2*
1315 - 1500	**SESSION THREE: PRESERVATION OF SEXUAL FUNCTION** In this session we will examine ways to improve sexual function. What options are available to improve this basic need? Is there a role for plastic surgery? What are the implications of prolapse and pain on sexual function? CHAIRS: EMMA READMAN & PHILIP HALL	*William Pickering Ballroom, Level 2*
	Plastic Surgery of the Vagina ***Fariba Behnia-Willison***	
	Dyspareunia and Pelvic Pain ***Catarina Ang***	
	Prolapse Management and Changes in Sexual Function ***Salwan Al-Salihi***	
	Can Your Smart Phone Improve Your Sex Life? ***Amani Harris***	
	Trans-cendence ***Jason Abbott***	
	Obstetric Trauma: Mental Impact of Traumatic Birth *Theresa Lee*	
	Panel Discussion	
1500 - 1530	**Afternoon Tea & Trade Exhibition**	*Conference Room One & Two, Level 2*

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

FRIDAY OCTOBER 13 (CONT.)

1530 - 1700	**SESSION FOUR: PRESERVATION OF OURSELVES** What can we do to improve our working lives? How can we better manage stress? What is the future of our profession? What happens when we have to manage adverse outcomes? This session will end with a frank presentation and discussion of cases with adverse outcomes. CHAIRS: STEPHEN LYONS & HUGO FERNANDES	*William Pickering Ballroom, Level 2*
	Work Life Balance: How do we Get it Right? ***Rachel Green***	
	Preserving our Muscles ***Michael Wynn-Williams***	
	Cognition in Decision Making ***Krish Karthigasu***	
	There is no "I" in Teamwork ***Yee Leung***	
	Case Presentation: A Challenge For Clinicians. ***Kim Dobromilsky, Fong Yoke Fai, Ben Kroon, Stephen Lyons, Jennifer Pontre & Stuart Salfinger***	
	Panel Discussion	
1900 - 2300	Conference Dinner - La Brasserie, Fullerton Bay Hotel	*Conference Room One & Two Foyer, Level 2*

SATURDAY OCTOBER 14

0800 - 0830	Conference Registration	
0830 - 1015	**SESSION FIVE: PRESERVATION OF PELVIC FLOOR** What can we do to preserve the function of the pelvic floor? What are the real causes of pelvic floor dysfunction? Should generalists be performing pelvic floor repairs or is this now purely the domain of the urogynaecologist? CHAIRS: KRISH KARTHIGASU & MICHAEL WYNN-WILLIAMS	*William Pickering Ballroom, Level 2*
	Pelvic Floor Damage – What are the Real Causes? ***Salwan Al-Salihi***	
	Strategies to Reduce Pelvic Floor Damage ***Bassem Gerges***	
	How do we Repair Defects now Mesh is so Last Year? ***Vinay Rane***	
	Is Examination Enough? Detecting Damage in the New Era ***Erin Nesbitt-Hawes***	
	Who Should Repair the Pelvic Floor? Does the Generalist Have a Role? ***Ajay Rane***	
	What's New in Incontinence ***Philip Hall***	
	Panel Discussion	
1015 - 1045	Morning Tea & Trade Exhibition	*Conference Room One & Two, Level 2*
1045 - 1300	**SESSION SIX: PRESERVATION OF TECHNIQUES** Has our hunger for technology taken over from old fashioned skills? Should we all be trained in robotics? In this session we will look at outcomes of new technologies. We will consider skill acquisition as well as skill preservation. CHAIRS: BASSEM GERGES	*William Pickering Ballroom, Level 2*
	Forget Traditional Training – Just Use a Robot ***Suresh Nair***	
	"Open the Harmonic Scalpel" - I Don't Need to Know How to Suture ***Hugo Fernandes***	
	From Idea to Reality ***Fong Yoke Fai***	
	Do we Really Need to Know That Much Surgery? ***Emma Readman***	
	Techniques to Improve Skill Acquisition ***Bernadette McElhinney***	
	How Much Exposure are our Trainees Really Getting? ***Jade Acton***	
	Old School Obstetrics – Twins and Breech Deliveries ***Stephen Lyons***	
	Family Feud	
1300	Close of Meeting	
1300 - 1330	Lunch	*Conference Room One & Two Foyer, Level 2*
1730 - 1830	President's Reception - LIME BAR, PARKROYAL on Pickering	

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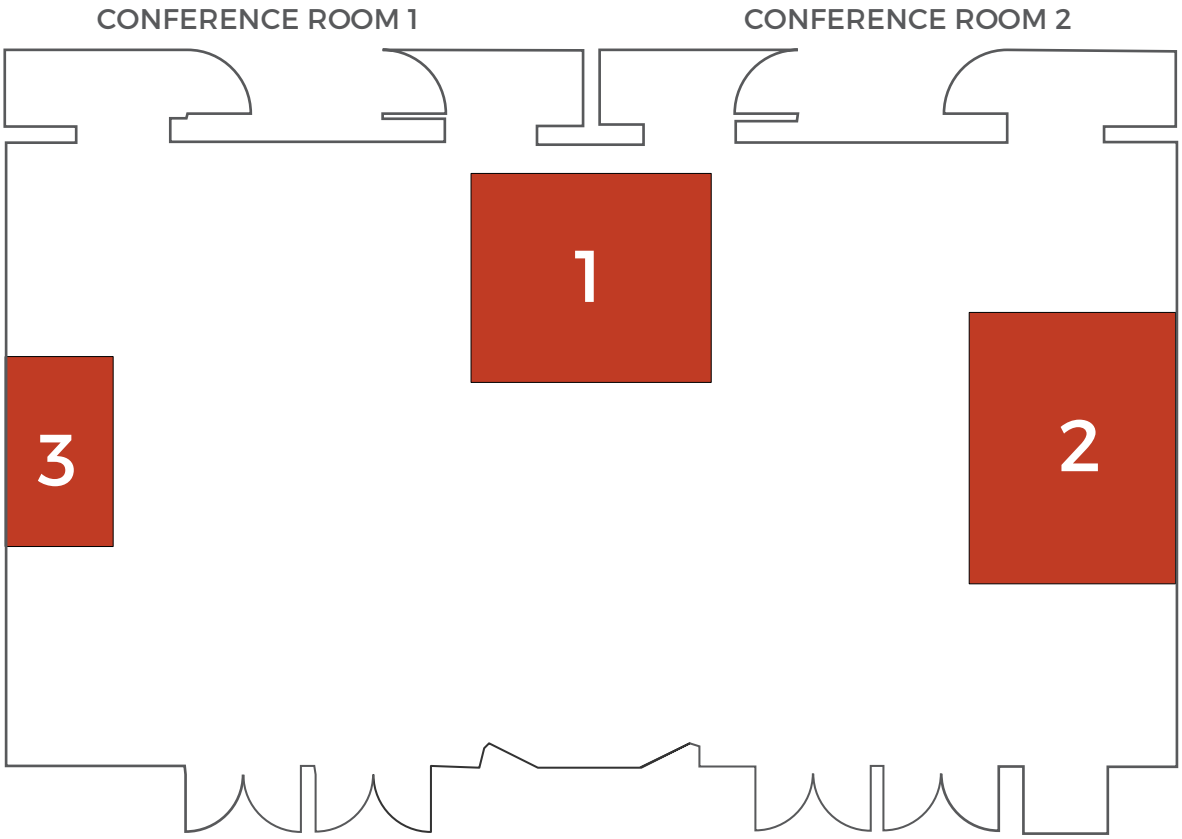
EXHIBITION FLOOR PLAN



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AGES
SOCIETY ART PRIZE

AGES is pleased to announce the inaugural AGES Society Art Prize is once again open for submissions.

Submissions for a $10,000 cash prize will be considered by the AGES Society Board of Directors for three (3) commissioned artworks, to be the covers of our three annual meeting brochures. The three works will further be auctioned at the AGES XXIX ASM 2019, with all proceeds going to a charity of the AGES Board's choice.

The previous winners, Fiona Omeenyo's (2016/2017) and Carrie Pitcher (2017/2018), artworks have been used to promote our meetings, are on the AGES website, and have been seen by more than 700 doctors and surgeons. The artwork will be distributed through various print media to a circulation of more than 6,000 doctors, surgeons, and healthcare professionals.

Carrie Pitchers works will be auctioned at the upcoming AGES XXVIII Annual Scientific Meeting 2018, which will be held in Melbourne from the 8th – 10th March 2018.

PROGRAM ABSTRACTS

FRIDAY OCTOBER 13

SESSION ONE: PRESERVATION OF THE UTERUS / 0815-1000

In this opening session we will consider the gynaecologists territory of the uterus. With worldwide hysterectomy rates falling and new technologies emerging, what are the options for the women of today? How does this influence us in our obstetric practice and how does modern practice affect our women?

"I Only Want to see Polyps, Hyperplasia or Cancer": The Role of Primary Care Assessment in AUB

Jennifer Pontre[1]

1. King Edward Memorial Hospital, Subiaco, Western Australia, Australia

Heavy menstrual bleeding is common, affecting up to 25% of women of reproductive age. It is also an important issue, given the potential to disrupt a womans life with impact on health, wellbeing, their wider roles across the community, within their families, and at work. In the wake of the 2011 new FIGO classification for heavy menstrual bleeding, comes the release of the Australian Clinical Care Standard for heavy menstrual bleeding.

This lecture will review the new clinical standards, the evidence for the medical and surgical range of options for treatment of heavy menstrual bleeding, and the role of the primary care physician in the management of heavy menstrual bleeding – including how we can help to improve perceived issues in this area.

Big Fast Bleeding needs Big Fast Response

Stuart Salfinger

Abstract not yet received.

Motherhood after Müllerian Melodramas

Asha Short[1]

1. Royal Hospital for Women, Randwick, NSW, Australia

Müllerian anomalies affect 4-7% of women and encompass a wide variety of uterine, cervical and vaginal anomalies. Multiple classification systems exist to divide these anomalies into subgroups based on anatomy. Advances in diagnostic imaging has allowed for improved diagnosis of anomalies while minimising the number of invasive procedures required.

The impact of müllerian anomalies on fertility is variable and dependent on the type of anomaly. Potential complications include infertility, miscarriage (first or second trimester), preterm birth, abnormal presentation and caesarean section.

Management strategies are tailored to the specific type of anomaly and the patient's specific fertility or symptomatic goals. Evidence exists for hysteroscopic resection of uterine septums (in specific cases) and laparoscopic excision of a rudimentary uterine horn. While uterine metroplasty and prophylactic cervical cerclage remain controversial and uterine transplantation is still classed as experimental.

Balancing all the Options for the Myomatous Uterus

Bernard Chern[1]

1. KK Women's and Children's Hospital, Singapore

In the current modern society, fibroids are highly relevant and represent a high health burden. Uterine fibroids are the most frequent gynecological tumours in women. Approximately 20-40% of women with fibroids are symptomatic. Clinical symptoms include menorrhagia, abnormal uterine bleeding, anaemia, pelvic pressure, abdominal pain, urinary frequency, constipation, subfertility and preterm labour. However, the majority of women with fibroids are asymptomatic and do not require treatment.

There is an increasing range of options for their management. Treatment should be tailored to the individual woman. Management options are affected by the women's symptoms, age, desire to conceive and local resources. They can be divided into expectant, medical, surgical and minimally invasive modalities. Watchful waiting with serial ultrasound pelvis is an option especially if the patient is asymptomatic and if the fibroid is slow-growing. The use of pharmacological agents to reduce menstrual blood loss and fibroid size may be effective in alleviating symptoms and improving women's quality of life. It is well-documented that interventional radiology procedures such as uterine artery embolisation and magnetic resonance imaging-guided focused ultrasonography may prevent the need for hysterectomy in selected cases. Both conventional surgical procedures and minimal access surgery play important roles in the management of fibroids.

In this interesting lecture, the various management options in treating a myomatous uterus will be discussed. Of note, risk of leiomyosarcoma is generally low, however, patient selection and detailed counselling is key in the decision-making for morcellation. In Singapore, the recently introduced Esmya is a good alternative in patients requesting for fertility preservation.

Adenomyosis in the Woman Wanting to Conceive

Timothy Chang[1]

1. Nureva Womens specialist health, Campbelltown, NSW, Australia

Adenomyosis is a condition whereby the endometrial glands grow into the myometrium. Historically it is diagnosed at hysterectomy and typically presents as heavy menstrual bleeding and dysmenorrhoea in a parous woman in her forties. With the improved diagnostic accuracy of non-invasive methods and increasing trend for older women pursuing fertility, adenomyosis is gaining importance as a condition that may be encountered in women wanting to conceive and may contribute to infertility.

The lecture will review the current literature on the association between adenomyosis and infertility as well as outline current management options: medical, non-surgical as well as surgical treatments, for women wanting to preserve their fertility and non-hysterectomy treatment options.

SESSION TWO: PRESERVATION OF FERTILITY / 1030-1215

With ever advancing maternal age and medical co-morbidities, this session will examine options for women. In this session we will look at recent advances in infertility Management and what measures we can take to preserve fertility for the demands of modern life?

Cancer Diagnosis and Fertility – A Match Made in Hell?

Rachael Rodgers[1]

1. Royal Hospital for Women, Breakfast Point, NSW, Australia

Whereas cancer was once a death sentence, substantial improvements in cancer treatment now mean that many young women diagnosed with cancer can expect to live long and fulfilling lives. However successful cancer treatment has frequently been at the expense of fertility, and this is a cause for considerable distress

among young women diagnosed with cancer. Fortunately, a variety of fertility preservation strategies are now available. Surgical options include oophoropexy prior to the use of pelvic radiotherapy, or the removal and cryopreservation of cortical ovarian tissue prior to the commencement of chemotherapy, with subsequent re-implantation after successful cancer treatment. Non-surgical options include the preservation of oocytes or embryos prior to cancer treatment, in vitro maturation of immature oocytes and the use of ovarian protection agents during chemotherapy.

Oocyte Options for the Older Woman

Ben Kroon[1]
1. Eve Health, Spring Hill, QLD, Australia

Women are increasingly delaying childbearing, a trend which impacts on their ability to conceive and the risks encountered in those pregnancies. In situations where oocyte quality and quantity is severely impacted, oocyte donation is a very realistic option for successful procreation. Unfortunately there are often practical, legal, financial and personal barriers to this type of third party procreation. For those who wish to avoid ever finding themselves in this situation, elective oocyte cryopreservation now offers the chance for preserving one's fertility many years before conception is intended.

Intra and Extra Pelvic Endometriosis and its Impact on Fertility

Haider Najjar[1]
1. Monash Health, Mount Waverley, VIC, Australia

The incidence of endometriosis in women of reproductive age ranges between 2-10% with a higher incidence of up to 50% in women with infertility. Extra pelvic endometriosis is uncommon with an estimated prevalence of 9-12% of all cases of endometriosis. The most commonly affected sites include the urinary tract, bowel, perineum, umbilicus and thoracic cavity. Pelvic endometriosis is commonly associated with extra genital endometriosis occurring in 50-84% of patients with thoracic endometriosis. The clinical presentation of extra pelvic endometriosis is atypical and variable, making it difficult to recognize, diagnose and treat. Medical treatment is often used as a diagnostic tool and first line therapy for symptom alleviation. However, the definitive treatment remains surgical excision of the lesion, which requires a multi-disciplinary approach.

Endometriosis –associated infertility is multifactorial with many underlying pathological processes. The role of surgery in women with infertility and peritoneal endometriosis is well established and supported by multiple international societies. However, the direct link between bowel endometriosis and infertility remains controversial as it is challenging to isolate it from other forms of endometriosis that also negatively impact fertility. Surgery for extra pelvic endometriosis including the bowel is technically demanding as it exposes women to major complications and should be reserved for experienced surgeons.

The Fit and Thin of Fertility – How Can Over Exercise and Under Eating Impact Fertility

Anusch Yazdani

Abstract not yet received.

I Made a Mistake – Now Make My Tubes Work

Tan Heng Hao[1]
1. KK Women's and Children's Hospital, Singapore

Abstract not yet received.

Modern Management of Ectopic Pregnancy: "Saving the Tube"

Kim Dobromilsky[1]
1. Fertility Tasmania, Hobart, TAS, Australia

Abstract not yet received.

SESSION THREE: PRESERVATION OF SEXUAL FUNCTION / 1315-1500

In this session we will examine ways to improve sexual function. What options are available to improve this basic need? Is there a role for plastic surgery? What are the implications of prolapse and pain on sexual function?

Plastic Surgery of the Vagina

Fariba Behnia-Willison

Abstract not yet received.

Dyspareunia and Pelvic Pain

Catarina Ang

Dyspareunia is a poorly understood condition that occurs chronically in perhaps 15% of women. It defined as recurrent genital pain connected with sexual intercourse and is a symptom of diverse disorders, with elements of both organic and psychiatric conditions.

Historically thought to be considered psychogenic, it has been demonstrated that there are strong biological factors and physiopathological rationale as to how it relates to pelvic pain syndrome, rather than sexual dysfunction or "just in your head".

Mention will be made of progress in physical therapies and use of botulinum toxin amongst other novel therapies for this debilitating condition.

Prolapse Management and Changes in Sexual Function

Salwan Al-Salihi[1]
1. The Royal Women's Hospital, Canterbury, VIC, Australia

Abstract not yet received.

Can Your Smart Phone Improve Your Sex Life

Amani Harris[1]
1. Monash, South Yarra, VIC, Australia

It is estimated that 2.6 billion people (25% of the world's population) currently have a smart phone. There are currently more than 10,000 smart phone health (mHealth) applications available on the market, many of which focus on women's sexual function. These include pelvic floor biofeedback apps, cycle tracking apps for pregnancy prevention and fertility planning apps. Mobile phone apps have been shown to contribute to a range of positive health outcomes, specifically in patients with chronic conditions. However, with new technologies come new challenges. Currently, with over 1000 smartphone apps developed for tracking women's cycles, an alarming number of women misuse the apps resulting in undesired events. With an increasing number of our patients utilizing these apps, it is crucial to familiarize ourselves with the science and evidence behind the technology so that we may counsel patients about their choices, appropriate app use and answer their questions.

Trans-cendence

Jason Abbott

Abstract not yet received.

Obstetric Trauma: Mental Impact of Traumatic Birth

Theresa Lee[1]
1. KK Women's and Children's Hospital, Singapore

Birth is usually seen as a time of joy yet about 25-48% of women report their birth experience as traumatic and 1.7-9% develop post-traumatic stress disorder (PTSD). This is significant as it can lead to negative outcomes like maternal mental health problems and difficulty in bonding with their infants which can affect the child's development. A traumatic birth experience is subjective, described as the individual's perception that her life or that of her baby is threatened or in danger. Studies have shown that the risk factors include women with pre-existing mental health condition, obstetric emergencies, neonatal complications and poor Quality of the Provider Interactions (QPI) Women with interpersonal difficulties with their care providers, especially during labour and birth, reported feeling ignored, unsupported or abandoned, resulting in higher levels of anger and conflict and symptoms of PTSD.

Risk factors for birth trauma need to be addressed prior to birth and the interactions with care providers and patients can be improved. Interventions such education of the care providers, midwife-led early identification of risk factors and postnatal counselling have shown benefits. Reducing the risks for women experiencing childbirth as a traumatic event should be the priority for maternity care providers.

SESSION FOUR: PRESERVATION OF OURSELVES / 1530-1700

What can we do to improve our working lives? How can we better manage stress? What is the future of our profession? What happens when we have to manage adverse outcomes? This session will end with a frank presentation and discussion of cases with adverse outcomes.

Work Life Balance: How do we Get it Right?

Rachel Green[1]
1. R Green Medical, Ipswich, QLD, Australia

Almost 50% of US physicians report burnout. This can lead to depression and even suicide. Over the last 10 years there has been a steady increase in burnout and a decrease in work satisfaction. The ever-increasing rate of suicide in the medical profession has raised media scrutiny, and the same US survey found 6% of respondents to have expressed suicidal thoughts.

How do we protect ourselves in the demanding role we have chosen? What practical steps can be taken to improve the quality of our working life? Is RU OK day enough?

Preserving our Muscles

Michael Wynn-Williams[1]
1. Eve Health, Spring Hill, QLD, Australia

As specialists in Obstetrics and Gynaecology we are practitioners of the art and science of caring for women and their offspring through all the stages of their lives. It's a profession that bestows many gifts on its practitioners, but equally it can reap chaos on family life, emotional, mental and physical health. Preserving and maintaining our health to continue our endeavours could be argued as being equally important as the time we spend improving our clinical knowledge or surgical skills at meetings such as this. Despite its

importance, we often neglect our own health, increasing the risk of work related injuries and eventual burnout.

Work related injuries in obstetrics and gynaecology and similar specialty groups will be reviewed. Discussion will focus around a number of evidence based and some "not so evidence based" interventions that you can implement in your own practice to reduce injuries and as a result -preserve your muscles

Cognition in Decision Making

Krishnan Karthigasu

A review of how decision making is made in surgery and factors influencing them.

There is no "I" in Teamwork

Yee Leung[1]
1. The University of Western Australia, Subiaco, WA, Australia

This presentation will explore the evidence on how effective teamwork in surgery is better for patient outcomes and staff satisfaction.

Case Presentation: A Challenge for Clinicians

Panel: Kim Dobromilsky, Fong Yoke Fai, Ben Kroon, Stephen Lyons, Jennifer Pontre & Stuart Salfinger

As clinicians, we come across dilemmas in patient management on a regular basis. This lecture will involve the presentation of various complicated cases, along with a panel discussion on management issues and strategies.

SATURDAY OCTOBER 14

SESSION FIVE: PRESERVAION OF PELVIC FLOOR / 0830-1015

What can we do to preserve the function of the pelvic floor? What are the real causes of pelvic floor dysfunction? Should generalists be performing pelvic floor repairs or is this now purely the domain of the urogynaecologist?

Pelvic Floor Damage – What are the Real Causes?

Salwan Al-Salihi[1]
1. The Royal Women's Hospital, Canterbury, VIC, Australia

Abstract not yet received.

Strategies to Reduce Pelvic Floor Damage

Bassem Gerges[1]
1. Sydney West Advanced Pelvic Surgery (SWAPS), Carlingford, NSW, Australia

Over the past few years there has been increasing public interest on the consequences of modes of delivery with regards to pelvic floor dysfunction. Childbirth is the single-most significant risk factor for pelvic floor dysfunction. The evidence surrounding the impact of caesarean section, vaginal and instrumental delivery, as well as other potentially protective methods during labour will be discussed. Knowledge of this should hopefully equip both obstetricians and gynaecologists with the armamentarium to provide women with informed consent with the potential subsequent sequelae.

How do we Repair Defects now Mesh is so Last Year??

Vinay Rane[1]
1. Royal Brisbane Hospital, Toowong, QLD, Australia

Abstract not yet received.

Is Examination Enough? Detecting Damage in the New Era

Erin Nesbitt-Hawes[1]
1. Royal Hospital for Women, Randwick, NSW, Australia

Women are receiving more information prior to delivery about the possible after-effects of the mode of delivery on their pelvic floor. In this climate of change, this presentation will focus on examining women to assess pelvic floor damage and the adjuncts to physical examination that can be used. What is the evidence around pelvic floor assessment and how does this help decision-making about the optima management of different types of pelvic floor injury?

Who Should Repair the Pelvic Floor? Does the Generalist Have a Role?

Ajay Rane

As more and more scrutiny is placed on the use of mesh transvaginally, the barrel of the gun has moved to the use of slings then will move to abdominal mesh and then who knows perhaps back to native tissue repairs!

Who should repair the pelvic floor? In this talk, we will discuss a number of surgeries being performed, complexities of surgeries being performed and discuss the role of a 'modularised' generalist in the care of pelvic floor disorders.

Who should repair the pelvic floor? Someone who CARES. Someone who really UNDERSTANDS. Someone who AUDITS, TRAINS, IMPROVES, INNOVATES!

What's New in Incontinence

Philip Hall[1]
1. The Pelvic Medicine Centre, Spring Hill, QLD, Australia

Abstract not yet received.

SESSION SIX: PRESERVATION OF TECHNIQUES / 1045-1300

Has our hunger for technology taken over from old fashioned skills? Should we all be trained in robotics? In this session we will look at outcomes of new technologies. We will consider skill acquisition as well as skill preservation.

Forget Traditional Training – Just Use a Robot

Suresh Nair

First of all it is too expensive to do away with traditional laparoscopic surgery especially in simple benign gynaecological surgery which forms the bulk of our daily work load. In gynaecology, robotic laparoscopy is not absolutely essential. Whereas in disciplines like urology, there are hardly any simple procedures that lends itself to basic laparoscopic surgery and the only procedure that is common place is nerve-sparing radical prostatectomy which, although can be done laparoscopically, is exceedingly difficult, even for experienced advanced laparoscopic surgeons. Hence, the robotic Da Vinci system was the bridging gap between open surgery and minimally invasive laparoscopic/ robotic surgery. It is no wonder therefore that robotic surgery had a strong foot hold in urology for this particular procedure. In fact, other procedures like laparoscopic adrenalectomy and pyeloplasty continue to be done laparoscopically by urologists. However, in urological units where a large number of robotic prostatectomies are done, the cost of using this new technology can be amortized over a larger number of cases hence making robotic adrenalectomy and pyeloplasty as competitively priced as the laparoscopic approach. Furthermore it can be more easily done because of all the beneficial characteristics of robotic surgery ie. 7 degrees of freedom of movement of wristed articulating instrumentation, 3 dimensional visualization and high precision through motion scaling and tremor filtration features. Especially when working with obese patients, the resistance from the abdominal wall thickness and the fulcrum effect there of is negated as robotic surgery is intuitive and "powered" as the surgeon's finger engagement of the robotic manipulator translates electronically into mechanical movement of the robotic instruments.

If, however cost containment is a significant factor as is always the case, then we must endevour to continue so as to have good, comprehensive laparoscopic surgery training programmes from as early as residency programmes through to fellowships, and ongoing continuing surgical upgrading as new technology in laparoscopic surgery is developed. Competency, proficiency and continued training in laparoscopic surgery has to continue to equip gynecologists with the ability to function in all settings ie. low cost and in hospitals when access to medical care is rudimentary. This makes the gynecological surgeon more resilient and when called upon to do a surgery, they can easily embark on the laparoscopic or laparotomy approach without elaborate setups like the robotic systems.

A systematic review and meta-analysis (1) compnsmg operative outcomes between standard and robotic laparoscopic surgery for endometrial cancer showed that there is a number of studies where a higher proportion of women were having the laparoscopic approach instead of open surgery when a robot is available (2,3). Randomized controlled trials support the use of laparoscopic techniques over open surgery for endometrial cancer (4) but it becomes exceedingly difficult to perform due to co-mobidities such as obesity (5). Only in these instances should robotic surgery be embraced to provide this cohort of patients the minimal access approach. Thus in most other circumstances, we must endeavor to be better laparoscopic surgeons and not succumb to the hype of robotic surgery.

(1.) Ind TE, Marshall C, Alex L, Nobbenhuis M. A comparison of operative outcomes between standard and robotic laparoscopic surgery for endometrial cancer: A systematic review and meta analysis Int J Med Robotics Comput Assist Surg. 2017;e1851. https://doi.org/10.1002/rcs.1851

(2.)Ind TE, Marshall C, Hacking M, et al. Introducing robotic surgery into an endometrial cancer service a prospective evaluation of clinical and economic outcomes in a UK institution. Int J Med Robot + Comput Assist Surg: MRCAS.2016; 12(1): 137-144. https://doi.org/10.1002/rcs.1651 (published Online First: Epub Date)

(3.)Lau S,Vaknin Z,Ramana-Kumar AV, Halliday D, Franco EL, Gotlieb WH. Outcomes and cost comparisons after introducing a robotics program for endometrial cancer surgery. Obstet Gynecol.2012; 119:717-724

(4.)Galaal K, Bryant A, Fisher AD, Al-Khaduri M, Kew F, Lopes AD. Laparoscopy versus laparotomy for the management of early stage endometrial cancer.Cochrane Database of Systematic Reviews .2012;(9) https://doi.org/10.1002/14651858.CD006655.pub2 (published Online First: Epub Date)

(5.)Willis SF, Barton D, Ind TE. Laparoscopic hysterectomy with or without pelvic lymphadenectomy or sampling in a high-risk series of patients with endometrial cancer. Int Seminars Surg Oneal: ISSO. 2006;3:28.https://doi.org/10.1186/1477-7800-3-28 (published Online First:Epub Date)

"Open the Harmonic Scalpel". I Don't Need to Know How to Suture

Hugo Fernandes[1]

1. Epworth Richmond, East Melbourne, VIC, Australia

Abstract not yet received.

From Idea to Reality

Fong Yoke Fai

Abstract not yet received.

Do we Really Need to Know That Much Surgery?

Emma Readman[1]

1. Mercy Hospital for Women, Clifton Hill, VIC, Australia

There are constantly shifting demographics in Australian gynaecological surgical practice. This talk seeks to outline the changing landscape of Gynaecological surgery, looking at statistics of rates of change of surgical procedures over time, changes in the training and practice numbers of Gynaecologists in Australia and factors that may be impacting on these changes.

There has been a marked decline in some surgical procedures, notably abdominal hysterectomy, vaginal hysterectomy and tubal ligation. Some have increased in numbers and frequency, notably laparoscopic hysterectomy and global ablation systems. The rise in MIRENA dispensing has played a major part in the changing surgical patterns.

Other factors in the changing gynaecological landscape will be explored, including physiotherapy, US and other diagnostic procedures, and the rise of the HPV vaccine.

Techniques to Improve Skill Acquisition

Bernadette McElhinney[1]
1. KEMH/SJOG, Subiaco, WA, Australia

Abstract not yet received.

How Much Exposure are our Trainees Really Getting?

Jade Acton[1]
1. SJOG Subiaco, Subiaco, WA, Australia

In the modern era of surgical training, several factors necessitate reflection on the system of the traditional apprenticeship model and whether it continues to be adequate for training competent surgeons. Reduced working hours, increased numbers of trainees and reduced surgical exposure all make time spent in the operating theatre ever more precious and effective intraoperative teaching essential. It is well accepted that surgical educators must alter this master-apprentice system, integrating education theory principles and seeking alternatives to clinical exposure such as simulation to maximize trainee's educational experience.

Just how much experience are trainees getting? How do they feel about it? How do the trainers feel about it? What can RANZCOG, the surgeon and trainees do to maximise their learning? Are patients going to suffer? All of these questions and more will be pondered....

Old School Obstetrics – Twins and Breech Deliveries

Stephen Lyons[1]
1. North Shore Obstetrics & Gynaecology, North Sydney, NSW, Australia

Abstract not yet received.

AGES Family Feud

Quiz Master: Ajay Rane

Team Jason: Jade Acton, Vinay Rane & Michael Wynn-Williams

Team Anusch: Fariba Behnia-Willison, Hugo Fernandes & Emma Readman

FUTURE AGES EVENTS

Australasian Gynaecological Endoscopy & Surgery
CADAVERIC WORKSHOP

AGES CADAVERIC WORKSHOPS
MERF QUT, BRISBANE
DISSECTION WORKSHOPS: 2ND DECEMBER 2017, 27TH MAY 2018 & 1ST DECEMBER 2018
DEMONSTRATION WORKSHOP: 26TH MAY 2018

AGES TRAINING

AGES/RANZCOG TRAINEE WORKSHOP 2018
KOLLING INSTITURE, SYDNEY
23RD & 24TH JUNE 2018

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SOFITEL BRISBANE
3RD & 4TH AUGUST 2018

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2ND & 3RD NOVEMBER 2018

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