

PROGRAM

CHALLENGING TIMES

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AUGUST
04&05

HILTON, ADELAIDE, SOUTH AUSTRALIA



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Gynaecological
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PELVIC FLOOR
SYMPOSIUM XVIII

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CPD POINTS

This meeting is a RANZCOG approved O&G meeting. Fellows of this college can claim 15CPD Points for full attendance.

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Australasian
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PELVIC FLOOR SYMPOSIUM XVIII

AUGUST 04&05

HILTON, ADELAIDE, SOUTH AUSTRALIA

WELCOME

Dear Colleague,

We welcome you once again to the city of churches – Adelaide – where we will present the theme 'Challenging Times'.

With company closures, lawsuits, credentialing issues, rise of laser and non-laser therapies – the future appears challenging to the pelvic surgeon. Our stellar and diverse international speakers are Dr Ty Erickson (USA), Prof Khaled Ismail (UK) and A/Prof Eric Sokol (USA). In this meeting we have challenged our speakers to present their thoughts and evidence on what the future holds, both challenges and solutions alike. We want to challenge them with the questions from you, the audience, and as always we will have virtual surgery and a stump the experts session. We are particularly delighted that Prof Ismail is able to join us this year, he will share with us his knowledge as a global expert on perineal medicine as well as his extensive research in obstetric perineal trauma and management.

Once again, welcome to Adelaide for this exciting meeting. We hope you will enjoy all the city of churches has to offer.

Prof Ajay Rane OAM
CONFERENCE CHAIR

Dr Stuart Salfinger
CONFERENCE CO-CHAIR



INTERNATIONAL FACULTY

DR TY ERICKSON

Ty Erickson is an American Urogynecologist. He is the national principle investigator for the FDA Altis Single Incision Sling 522 trial. He has trained surgeons in

fourteen countries in pelvic surgery. Dr Erickson serves on the board of directors of The Janice Foundation, committed to helping impoverished women worldwide.



PROF KHALED ISMAIL

Professor of Obstetrics and Gynaecology at the University of Birmingham. Hon. Director of eLearning, RCOG. Reproductive health specialty lead for West Midlands CRN.

Professor Ismail runs an active clinical academic programme

in perinatal medicine. His collaborative work in the prediction, recognition and management of childbirth-related perineal trauma and the effect of maternal nutrition on the fetal epigenome has informed global policy and its implementation. Professor Ismail is the Chair of the European Perineal Trauma PEERS group.



A/PROF ERIC SOKOL

Dr. Eric R. Sokol is Co-Chief of Urogynecology and Pelvic Reconstructive Surgery at Stanford University School of Medicine, where he is an Associate Professor of Obstetrics and Gynecology and Urology. His principle area of research is in the

development and testing of novel, minimally invasive treatment modalities for pelvic floor disorders.



THURSDAY AUGUST 03

BOSTON SCIENTIFIC PRE-CONFERENCE WORKSHOP

FRIDAY AUGUST 04

0700-0800	CONFERENCE REGISTRATION	LEVEL 1 GALLERY
0800-1000	SESSION ONE: CHALLENGING TIMES - WHAT IS HAPPENING IN THE WORLD OF SLINGS AND MESHES SESSION CHAIRS: <i>Jason Abbott & Stuart Salfinger</i>	BALLROOM A & B
	WELCOME <i>Jason Abbott & Ajay Rane</i> Surgery for Pelvic Organ Prolapse - Where Do We All Stand? <i>Brendan Miller</i> Industry and Slings and Meshes - Are You Here To Stay? <i>Steve Blum</i> Mesh: "The Good, The Bad, and The Ugly" <i>Ty Erickson</i> Biodesign - How Do We Get It Right? <i>Eric Sokol</i> Challenges In Training and Credentialing <i>IUGA Perspective: Anna Rosamilia Australian Perspective: Liz Gallagher</i> Panel Discussion & Questions	
1000-1030	MORNING TEA & TRADE EXHIBITION	LEVEL 1 GALLERY & BALLROOM C
1030-1230	SESSION TWO: LIVE SURGERY BY VIDEO - I CHALLENGE YOU TO DO IT MY WAY! SESSION CHAIRS: <i>Emma Readman & Greg Cario</i>	BALLROOM A & B
	Anterior Vaginal Reconstruction - Anatomical and Functional Considerations <i>Ty Erickson</i> Perineal Reconstruction - Exploding Perineums - Can We Get It Right This Time? <i>Khaled Ismail</i> Laparoscopic Colposacropexy - The Pitfalls <i>Eric Sokol</i> Slings - The Rise and the Fall and the Transition of Slings <i>Ajay Rane</i> Panel Discussion & Questions	
1230-1330	LUNCH, TRADE EXHIBITION & DIGITAL COMMUNICATIONS	LEVEL 1 GALLERY & BALLROOM C
1330-1500	SESSION THREE: INCONTINENCE - A LIFETIME OF CHALLENGES SESSION CHAIRS: <i>Ajay Rane & Elvis Šeman</i> PANEL: <i>Eric Sokol, Ty Erickson, Khaled Ismail, Salwan Al-Salihi & Ian Tucker</i>	BALLROOM A & B
1500-1530	AFTERNOON TEA & TRADE EXHIBITION	LEVEL 1 GALLERY & BALLROOM C
1530-1640	SESSION FOUR: CHALLENGING FUTURE SESSION CHAIRS: <i>Haider Najjar & Rachel Green</i>	BALLROOM A & B
	Benefits and Limitations of POPQ and Urodynamics <i>Robert O'Shea</i> Fecal Incontinence - Simple Novel Therapies - The US Model <i>Eric Sokol</i> Obstructive Defecation - Myths, Facts and Therapies <i>Ajay Rane</i> Laser, PRP and Stem Cells in Restoration of Pelvic Floor Function <i>Fariba Behnia-Willison</i> Panel Discussion & Questions	

MEETING PROGRAM

FRIDAY AUGUST 04 (Cont.)

1640-1730	SESSION FIVE: CONSUMER PERSPECTIVES TO PELVIC FLOOR DISORDERS SESSION CHAIR: <i>Ajay Rane</i> PANEL: <i>Eric Sokol, Fariba Behnia-Willison, Robert O'Shea & Elvis Šeman</i>	BALLROOM A & B
1730	CLOSE	
1930-2300	GALA DINNER	ADELAIDE TOWN HALL

SATURDAY AUGUST 05

0730-0800	CONFERENCE REGISTRATION	LEVEL 1 GALLERY
0800-0930	SESSION SIX: MANAGING A CASE OF RECURRENT PROLAPSE OVER THE LIFE OF A WOMAN SESSION CHAIRS: <i>Robert O'Shea & Alan Lam</i> PANEL: <i>Eric Sokol, Khaled Ismail, Ty Erickson, Anna Rosamilia, Greg Cario & Jenny King</i>	BALLROOM A & B
0930-1000	MORNING TEA & TRADE EXHIBITION	LEVEL 1 GALLERY & BALLROOM C
1000-1230	SESSION SEVEN: PROLAPSE! WHO GOES THERE? A CHALLENGE ISSUED SESSION CHAIRS: <i>Krish Karthigasu & Bassem Gerges</i>	BALLROOM A & B
	VAULT Trial - Does It Matter? <i>Eric Sokol</i> Challenges In Vaginal Reconstruction - Where To Next? <i>Greg Cario</i> Robot Or Stick - The Challenge And The Justification <i>Salwan Al-Salihi</i> Humanitarian Efforts: Zooming in Closer Than the 30,000 Foot View <i>Ty Erickson</i> What Women Want: 'PROMS' for Perineal Trauma <i>Khaled Ismail</i> Informed Consent In The Current Medicolegal Climate <i>Alan Lam</i> Panel Discussion & Questions	
1230-1330	LUNCH, TRADE EXHIBITION & DIGITAL COMMUNICATIONS	LEVEL 1 GALLERY & BALLROOM C
1330-1500	SESSION EIGHT: FREE COMMUNICATIONS SESSION CHAIRS: <i>Stephen Lyons & Michael Wynn-Williams</i>	BALLROOM A & B
1500-1530	AFTERNOON TEA & TRADE EXHIBITION	LEVEL 1 GALLERY & BALLROOM C
1530-1630	SESSION NINE: OBSTETRICS & UROGYNAECOLOGY - CAN WE DELIVER BETTER? SESSION CHAIR: <i>Fariba Behnia-Willison</i>	BALLROOM A & B
	Birth Trauma - Challenges in Prevention and Management <i>Jenny King</i> Challenges in Managing Pregnancies AFTER Trauma Repair <i>Khaled Ismail</i> Panel Discussion & Questions	
1630-1700	SESSION TEN: CAN WE SURVIVE THE CHALLENGE IN A WORLD OF NO SLINGS, NO MESH? SESSION CHAIRS: <i>Ajay Rane</i> Team 1: <i>Ty Erickson</i> Team 2: <i>Eric Sokol</i>	BALLROOM A & B
1700	CLOSE	

SUNDAY AUGUST 06

COLOPLAST POST-CONFERENCE WORKSHOP

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



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GALA DINNER

Friday 4th August 2017

Adelaide Town Hall

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BOSTON SCIENTIFIC PRE-CONFERENCE WORKSHOP

“PELVIC FLOOR DEFECTS AMID CURRENT GUIDELINES”

Thursday 3rd August 2017

Hilton Adelaide | 1300-1630

- > The evidence on the different approaches to apical suspension
- > The science behind Xenoforn
- > Laparoscopic and robotic approaches to uterine and supracervical suspension, what have we learned so far and where are we heading?
- > The RANZCOG position statement on mid-urethral slings and what it means to you

FACULTY

Dr Salwan Al-Salihi
Dr Philip Hall
Dr Anna Rosamilia
A/Prof Eric Sokol

COLOPLAST POST-CONFERENCE WORKSHOP

WORKSHOP CONVENOR: *Dr Fariba Behnia-Willison*

Sunday 6th August 2017

Hilton Adelaide | 0800-1400

FACULTY

Mr Steve Blum
Dr Ty Erickson
A/Prof Alan Lam
Dr Fariba Behnia-Willison
Prof Khaled Ismail
Prof Ajay Rane

Our faculty will be discussing the key issue of informed consent and how to deal with it in this present climate. There will be small group discussions as well offering plenty of time for interactive Q and A.



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FREE COMMUNICATIONS

SESSION EIGHT- FREE COMMUNICATIONS | SATURDAY 5TH AUGUST | 1330-1500

Four-dimensional ultrasound guidance for pelvic floor
Botulinum toxin A injection in chronic pelvic pain: a novel
technique

Aaron Budden

Laparoscopic Burch colposuspension for stress
incontinence in women: long term follow up.

Dean Conrad

To Mesh or Not to Mesh

Sapna Dilgir

ThermiVa: Does It Work?

Sapna Dilgir

Compartment syndrome related to lithotomy position:
A case report

Sean Heinz-Partington

Laparoscopic hysterectomy with pfannenstiel incision
for specimen retrieval: Surgical technique

Rose McDonnell

Video of Laparoscopic Repair of Vesico-Uterine Fistula

Jerome Melon

MiniArc vs TVT Abbrevio Midurethral Sling in Women
with Stress Urinary Incontinence - an RCT - 6 and
12month follow up

Anna Rosamilia

Native Tissue Repair for Vault Support

Stanley Santiago

DIGITAL FREE COMMUNICATIONS | LUNCH TIME, FRIDAY 4TH AND SATURDAY 5TH AUGUST

FRIDAY 4TH AUGUST

BALLROOM C | 1250-1320

A case of BHCG Negative ectopic pregnancy

Opi Chiram

Is total vaginal length a confounder between cervical
descent and symptoms of pelvic organ prolapse?

Myriam Girgis

Epiploic appendagitis masquerading as ovarian torsion in
a morbidly obese 21 year old

Patrick Harrington

Large Mullerian cyst causing mass effect requiring
laparoscopic excision in a post menopausal woman

Patrick Harrington

Laparoscopic sacrohysteropexy in a prolapsed
adenomyotic uterus: How to discuss and manage

Pattaya Hengrasmee

Vaginectomy with concomitant vaginal hysterectomy: An
effective and economical reconstructive procedure for
advanced stage pelvic organ prolapse

Pattaya Hengrasmee

SATURDAY 5TH AUGUST

BALLROOM C | 1250-1320

Use BRAIN to TAME the PAIN of informed consent in pelvic
floor prolapse repair.

Justin Lam

A challenging case of recurrent vault prolapse managed by
robotic surgery

Justin Lam

*The effect of age on success rates in tension free vaginal
tape (TVT) surgery*

Jia Yi Lee

Video of Laparoscopic Removal of Bladder Suture
complicating Burch Colposuspension

Jerome Melon

Early Pregnancy During Major Surgery: Importance of
Careful Pre-operative Assessment and Advice

Jennifer Pontre

Management of rectal prolapse after sacrocolpopexy with
dorsal rectopexy

Mikhail Sarofim

PROGRAM ABSTRACTS

FRIDAY 4TH AUGUST 2017

SESSION ONE: CHALLENGING TIMES – WHAT IS HAPPENING IN THE WORLD OF SLINGS & MESHES?

0800-1000

BALLROOM A & B

This year the conference kicks off with a discussion of the issues and controversies that surround mesh and slings. In this session we want to discuss the views of generalists, sub specialists, international specialists and industry. There is a lot of concern amongst pelvic surgeons with a lot of conflicting information.

Surgery for Pelvic Organ Prolapse – Where do we all Stand?

Brendan Miller¹, Elvis Seman, Robert O'Shea, Paul Hakendorf

1. St Vincent's, Toowoomba South, QLD, Australia

The Food and Drug Administration (FDA) in the United States of America has issued two mesh warnings in 2008 and 2011. These advised doctors and consumers about an increase in reporting of adverse events related to vaginal mesh for prolapse and incontinence.

In addition to the FDA warnings the Scottish government requested a complete suspension of vaginal mesh products in Scotland in June 2014 pending an independent review. In Australia in February 2017 Derryn Hinch won Senate approval for an inquiry into gynaecological mesh devices.

In 2007 and 2015 RANZCOG members were surveyed regarding how they would manage different types of vaginal prolapse. The 2015 survey closely resembled the 2007 survey. Additional questions were asked in the 2015 survey related to the impact of Ethicon's withdrawal of Prolift and Prosima mesh kits.

This presentation will summarise the change in attitudes among Australian and New Zealand gynaecologists towards the use of mesh between 2007 and 2015. It will also discuss the "Scottish Independent Review of the use, safety and efficacy of transvaginal mesh implants in the treatment of stress urinary incontinence and pelvic organ prolapse in women" as well as the findings of the PROSPECT study.

Industry And Slings And Meshes- Are You Here To Stay?

Steve Blum

Abstract not yet received.

Mesh: "The Good, the Bad, and the Ugly"

Ty Erickson

Augmented surgical repairs are found throughout medicine: orthopedic titanium joints, cardiac stents and valves, ocular lens implants, etc. Urogynecologists also uses graft repairs. We will discuss the Good: reality that in many clinical cases augmented repairs are helpful; the Bad: lack of surgical expertise and certain synthetic materials have created potentially greater harm than benefit, and the Ugly – the legal system in a zeal to "protect patients" has created confusion in the media, courts and amongst patients of the value of grafts being used in urogynecology and may ultimately lead to a lack of surgical options for patients to benefit from.

Biodesign – How Do We Get It Right?

Eric Sokol¹

1. Stanford University School of Medicine, Stanford, CA, United States

We are all aware of the perceived downsides of traditional surgeries for pelvic floor disorders such as prolapse, including invasiveness and high recurrence rates, and the new devices that were developed to try to tackle those problems. Typically, this is how "innovation" happens: we have a solution in mind, and then we think of the

problem we can fix with that solution. Vaginal mesh prolapse kits were developed in this fashion. Surgeons and companies saw a solution (mesh similar to slings) and then thought, "We can fix the problem (prolapse recurrence) with this!" Well, we all know how that is turning out. In a nutshell, this is the WRONG way to go about medtech innovation. But what if there was a better way? There is!

Biodesign is the process of identifying unmet healthcare needs and then designing solutions for those needs. It turns the typical path of medtech innovation on its head. This talk will give an overview of the RIGHT way to go about medtech innovation, through the Biodesign process, which ultimately leads to better solutions for stakeholders including patients, physicians, hospital systems and payers

Challenges in Training and Credentialing - IUGA Perspective

Anna Rosamilia

Abstract not yet received.

Challenges in Training and Credentialing - Australian Perspective

Elizabeth Gallagher

1. Women's Health on Strickland, Deakin, ACT, Australia

For a generalist midcareer, trying to acquire and upskill as techniques evolve is challenging. This presentation will look at what training in O&G is looking like at the moment, where are the subspecialists, and how does the generalist remain skilled and relevant in this changing environment. What does credentialing involve in Australia at the moment, and what is the future likely to hold?

SESSION TWO: 'LIVE SURGERY BY VIDEO' - I CHALLENGE YOU TO DO IT MY WAY!

1030-1230

BALLROOM A & B

In this session our panel of experts will operate with you step by step so feel free to stop them whenever you want to clarify a step but please let them finish their surgery too!

Anterior Vaginal Reconstruction - Anatomical and Functional Considerations

Ty Erickson

Graft augmented anterior reconstruction from the vaginal approach requires a clear understanding of anatomy. Surgical expertise encompasses dissection, precautions to protect surrounding viscera and the correct techniques for implanting the augmented material to maximize safety and efficacy. Each step will be demonstrated within a dialogue of a surgical video presentation.

Perineal Reconstruction - Exploding Perineums: Can we get it right this time?

Khaled Ismail

1. University of Birmingham, Birmingham, United Kingdom

Perineal trauma during childbirth affects millions of women throughout the world and can result in long-term maternal morbidity. In the UK approximately 85% of women will sustain some degree of perineal trauma during vaginal birth and 60% to 70% of these will need suturing, which equates to approximately 1000 women per day. The majority of women experience some short-term discomfort or pain, however, up to 20% will continue to have long-term problems. The video will show a step-by-step demonstration of the evidence based method and materials for perineal repair stressing on some surgical tips to mitigate risk of such long term complications and improve outcomes.

Laparoscopic Colposacropexy - The Pitfalls

Eric Sokol

1. Stanford University School of Medicine, Stanford, CA, United States

Minimally invasive sacrocolpopexy is considered to be a "gold standard" procedure for advanced apical prolapse, but the surgery requires advanced technical skills and can be associated with serious complications. This talk shows video clips of tips and tricks to streamline minimally invasive sacrocolpopexy and avoid common pitfalls associated with the

traditional approach. Video clips showing bowel retraction, dissection techniques, graft tunneling, use of barbed suture, and vaginal mesh attachment techniques will be shown, with time for audience members to comment and ask questions. If time permits, we may even show some clips of novel approaches, such as complete transvaginal sacrocolpopexy.

Slings - The Rise and the Fall and the Transition Of Slings

Ajay Rane

Abstract not yet received.

SESSION THREE: INCONTINENCE - A LIFE TIME OF CHALLENGES

1330-1500

BALLROOM A & B

A session that takes you through a temporal sequence of events, challenges, therapies, surgeries, complications, elations and disappointments dealing with Urinary incontinence. The local team will keep throwing googlies and doosra's for those who understand cricket to our panel of experts- plus of course the audience can hit them all for a six!

Panel: Eric Sokol, Ty Erickson, Khaled Ismail, Salwan Al-Salihi & Ian Tucker

SESSION FOUR: CHALLENGING FUTURE

1530-1640

BALLROOM A & B

This session looks at asking the question - where to from here? Is it time to drastically change our thinking or keep going steady and avoid fixing what is not broken?

Benefits and Limitations of POPQ and Urodynamics

Robert O'Shea

Abstract not yet received.

Fecal Incontinence - Simple Novel Therapies - The US Model

Eric Sokol!

1. Stanford University School of Medicine, Stanford, CA, United States

Fecal incontinence is a common but undertreated health condition, which can adversely affect quality of life. Traditional surgeries such as overlapping sphincteroplasty are invasive, prone to incision breakdown, and may fail in up to 50% of patients by 5 years. Given the shortcomings of typical therapies, there has been a recent push in the US to develop simpler, novel therapies. We will review a few of these newer therapies and discuss some of the evidence (or lack of evidence) behind them.

Obstructive Defecation - Myths, Facts and Therapies

Ajay Rane

Abstract not yet received.

Laser, PRP, Stem Cells in Restoration of Pelvic Floor Function

Fariba Behnia-Willison

Seventy percent of women may experience stress incontinence and prolapse in their lifetime, of whom 30-40% are symptomatic and will require treatment to improve their quality of life. Pelvic floor surgery affects women physically, economically and socially due to possible complications, failures, and prolonged recovery post-op. Pelvic floor surgery has proven to be the most challenging surgery in recent times due to multiple factors such as: well-informed, educated, time-poor modern women who desire minimally invasive surgery with little down-time. In addition, recent

mesh controversies have instigated the need for gynaecologists to seek a more holistic and comprehensive approach to conservative management. Evaluating the literature of other specialities such as plastic & reconstructive surgery, one can conclude that cell therapy, laser, platelet rich plasma (PRP), fillers, and fat-grafting have contributed significantly to tissue revitalisation and reshaping; they contribute in such a way that procedures, such as face-lifts, will be replaced. In this presentation the role of Pelvic Floor Medicine as an alternative to pelvic floor surgery will be discussed.

SESSION FIVE: CONSUMER PERSPECTIVES TO PELVIC FLOOR DISORDERS

1640-1730

BALLROOM A & B

A video based session showing the perspectives of consumers when we look after them.

Panel: Eric Sokol, Fariba Behnia-Willison, Robert O'Shea & Elvis Šeman

SATURDAY 5TH AUGUST 2017

SESSION SIX: MANAGING A CASE OF RECURRENT PROLAPSE OVER THE LIFE OF A WOMAN

0800-0930

BALLROOM A & B

This session will take you through a temporal sequence of events, challenges, therapies, surgeries, complications, elations and disappointments dealing with genital prolapse. The local team will keep throwing the ball in play to our panel of experts who will score own goals, get penalties and even get red carded - plus of course the audience can sin bin them all!

Panel: Eric Sokol, Ty Erickson, Khaled Ismail, Anna Rosamilia, Greg Cario & Jenny King

SESSION SEVEN: PROLAPSE! WHO GOES THERE? A CHALLENGE ISSUED

1000-1230

BALLROOM A & B

In this session we will look at a detailed overview of what is the current status of play in therapy for prolapse - does evidence really matter or is every problem a nail since we hold a hammer?

VAULT trial - does it matter?

Eric Sokol¹

1. Stanford University School of Medicine, Stanford, CA, United States

It is standard to remove the uterus during sacrocolpopexy, but why? In most cases, the uterus is tiny and access to the ligaments that hold the top of the vagina up is possible without hysterectomy. However, there is a relative paucity of data supporting uterine-sparing prolapse surgery - until now! The VAULT trial is a recent multicenter trial comparing outcomes of laparoscopic or robotic-assisted sacrohysteropexy versus vaginal sacrohysteropexy. We will discuss the trial design, outcomes and results. You may be surprised by the conclusion!

Challenges In Vaginal Reconstruction - Where To Next?

Greg Cario¹, Stefan Pacquee¹, Dean Conrad¹, Tal Saar¹

1. Sydney Women's Endosurgery Centre, Sydney, Australia

Patients expectations for a surgical cure for Pelvic Organ Prolapse in 2017 have never been higher. Native tissue repairs which have not changed essentially for 100 years have not delivered these results due to high recurrence rates despite low complications rates. Vaginal mesh repairs which were introduced in 2003 with much optimism based on the success rates for hernia repairs have delivered high success rates but unexpectedly high graft related complications. The backlash has been shattering for patients and surgeons and even our gold standard operations of sacrocolpopexy and TVT are now under threat due to the medico legal and social media storm, This leaves us with little to offer our patients.

One of the challenges that face us is how we define prolapse and interpret data. Should we move away from the objective POPQ and anatomical data and move towards a functional outcome self reported from the patients themselves. In our rooms or in the clinic or over the phone we really only need to know whether they have a new bulge that worries them or whether they have bothersome urinary, bowel or sexual dysfunction and have required further surgery. This changes what we tell patients about the results of surgery significantly and certainly improves the results for non mesh vagina surgery and site specific laparoscopic repairs. Anterior repair is the commonest operation with the highest failure rate. The Cochrane review in 2016 shows recurrent prolapse rates of 12.6% for vaginal mesh compared to 37.9% for native tissue repair. This however is at the expense of complications like repeat surgery for prolapse, SUI and mesh exposure of 9.7% compared to 5.4% for native tissue repairs. Therefore mesh has no place as a first line intervention in the anterior compartment. Apical prolapse is the reverse situation with the gold standard mesh sacrocolpopexy easily the operation of choice compared to any vaginal native tissue operation with recurrence rates of 23.2% compared to an alarming 43.8%. In the posterior compartment the success rates are over 80% for native tissue repairs and similar to mesh kits without the possibility of up to 17% mesh exposure rates. Once again there is no place for mesh.

There is little literature regarding Laparoscopic site specific repair. Anterior paravaginal repair has a success rate of 70-80% with low complication rates and there are similar results for the apex and the posterior compartment. There is no supportive evidence for vaginal rejuvenation as a major treatment entity for prolapse or incontinence. We eagerly await the results of the new ultralight meshes with properly controlled randomized trials. There may still be a very important role for mesh particularly if clinicians are able to identify patients at higher risk of recurrence using ultrasound or MRI assessment of levator avulsion and genital hiatus measurement.

Perhaps we can make an impact on vaginal prolapse itself both surgically by a more thorough knowledge of the surgical anatomy of the pelvic floor nerves and obstetrically as we begin to see the impact of a more active management of labour and higher Caesarean section rates.

What is left for us to honestly offer our patients? Do we perform Laparoscopic or robotic SCP for all patients and for all compartments? Do we give up and insert pessaries for everyone. It is probably the safest option.

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Robot or Stick - The Challenge and the Justification

Salwan Al-Salihi

Abstract not yet received.

Humanitarian Effort: Zooming in Closer Than the 30,000 Foot View

Ty Erickson

The world's humanitarian needs are growing at a rate faster than NGO's and Government Health Care systems can resolve. This open facilitated discussion will review specific geopolitical and economic barriers to facilitating efforts to improve women's access to vital care. Using combined experience of participants, we hope to create a robust dialogue to look at creative prospects for more efficient and detailed methods to bring better health care to women of need. This requires different thinking than the "Band-Aid" typically applied in today's paradigm.

What Women Want: "PROMs" for Perineal Trauma

Khaled Ismail

1. University of Birmingham, Birmingham, United Kingdom

Patient Reported Outcomes (PROs) provide a means of gauging patients' views on their health and assessing the impact that treatments or interventions have on their clinical condition, wellbeing and quality of life. The NHS spent £2.6 billion on maternity care in 2012/13 and more than 700,000 women use different aspects of maternity services in the UK per annum, yet there are no routine PROs in place to assess the actual impact of the health care being delivered to women utilising these services. It is increasingly recognised that understanding the impact of pregnancy and the post-partum period on how women feel, what they can do, and how they live their lives, is an important indicator of the quality and effectiveness of healthcare services. The talk will introduce the importance of PROs in general focusing on their importance in maternity in the context of research, improvement science and governance this will be supported by a practical example of how PROs were developed and utilised in perineal trauma research.

Informed Consent in the Current Medicolegal Climate

Alan Lam

Abstract not yet received.

SESSION EIGHT: FREE COMMUNICATIONS

1330-1500

BALLROOM A & B

Four-dimensional ultrasound guidance for pelvic floor Botulinum toxin A injection in chronic pelvic pain: a novel technique

Erin M Nesbitt-Hawes^{1,2}, Hans Peter Dietz^{3,4}, Aaron Budden¹, Jason Abbott^{1,2}

1. Royal hospital for women, South Coogee, NSW, Australia

2. University of New South Wales, Sydney, Australia

3. University of Sydney, Sydney

4. Napean Hospital, Sydney

Botulinum toxin A (BoNT-A) is used in the treatment of pelvic floor muscle overactivity associated with chronic pelvic pain (CPP) when conservative methods such as physiotherapy are not effective or appropriate. Injection of the pelvic floor musculature using BoNT-A may provide reduced muscle spasm and associated pain with subsequent physiotherapy able to be performed and tolerated. Over the last 10 years, BoNT-A has been recognised as a therapeutic tool for women with CPP and pelvic floor muscle overactivity.

Traditional injection techniques require finger-guided palpation of pelvic floor muscles with concurrent insertion of the needle. This has the associated disadvantages of potential inaccuracy in the injection location as well as a risk to the operator of needle stick injury due to the close confines within the vagina. Three- and four-dimensional ultrasound (3D/4D US) is rapidly developing, particularly in urogynaecology, and allows dynamic and static imaging of the pelvic floor musculature and anal sphincter complex. Given the accuracy of injection is reportedly low in large musculature (for example gastrocnemius), we sought to investigate the feasibility of 4D US guidance for the target area of the pelvic floor to improve accuracy and assess longer-term treatment outcomes.

From October 2013 until January 2016, women with pelvic floor muscle overactivity and pain who were scheduled for BoNT-A were recruited to participate in a study to assess 4D US guidance. A 4D curved array probe with an acquisition angle of at least 70 degrees was used to capture 3D images and dynamic 4D volumes of the pelvic floor. BoNT-A injection was performed under deep sedation anaesthetic with the patient placed in the dorsal lithotomy position with the hips flexed and abducted. The probe was placed on the perineum, and was aligned with the midsagittal view. Once in this plane the ultrasound probe is diverted slightly to the left or right to visualise the pubovisceral muscle on that side for injection.

A total of 31 women underwent the procedure with this new technique. We found all cases were able to be performed using 4D US guidance with correct placement of the needle within the body of muscle possible in all cases. We present a video of the technique described in this study.

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Laparoscopic Burch colposuspension for stress incontinence in women: long term follow up.

Dean Conrad¹, Stefaan Paquee¹, Carly Walsh¹, Tal Saar¹, Danny Chou¹, David Rosen¹, Greg Cario¹

1. SWEC, Sydney

Introduction: The increased media attention on the adverse outcomes associated with vaginal mesh procedures has seen a rise in demand for minimally invasive non-mesh alternatives for treating stress incontinence. The laparoscopic Burch colposuspension, although notoriously difficult to perform, is a suitable alternative to the tension free vaginal tape (TVT) with similar short term outcomes. However, findings in the literature demonstrate significant variability in technique and outcomes, and there is a paucity of data to describe long term results.

Objective: To evaluate the long term outcomes of laparoscopic Burch colposuspension for treatment of stress urinary incontinence (SUI) in women.

Design: This is a retrospective cohort study of cases performed by a single surgeon between January 2010 and January 2016 in two private hospital settings.

Population: Out of 159 women who underwent laparoscopic Burch colpopexy, data was available for 90 at the time of this abstract submission. Of the 90 women analysed (mean age 56.17+/-11.36 years) all presented with either urodynamic proven SUI, positive cough test, or significant symptoms of SUI, with no previous incontinence surgery.

Intervention: Laparoscopic Burch colposuspension was performed using four non-absorbable sutures, two attached lateral to the midurethra and two at the bladder neck, then secured to the ipsilateral Cooper's ligament with gentle tension. This surgery was performed either alone or in combination with other laparoscopic procedures.

Outcomes measured: Primary outcome was successful treatment of SUI, defined as cure or significant improvement of stress incontinence symptoms as reported to their physician, or through standardised telephone interview. Secondary outcomes included new onset or worsened urgency, urge incontinence, voiding dysfunction, rectoenterocele, and re-operation rate.

Results: Mean follow up duration was 37.6 +/- 17 months. 61 patients were followed up with a physician visit and the remaining 29 via telephone interview, with a response rate of 93%. Overall rates of successful treatment of SUI were 96.6%, with 3 cases requiring re-operation with obturator tension free vaginal tape (TVT-O), at 20, 49 and 57 months post operatively. New or worsened urge incontinence was reported by 12.4% of patients, with a further 13.4% experiencing new or worsened symptoms of urgency without incontinence. Symptomatic voiding dysfunction was reported by 5.5%. New or worsened symptomatic rectoenterocele was demonstrated in 15.5%, of which 6 cases underwent surgery.

Conclusion: Laparoscopic Burch colposuspension is an effective long term treatment for urinary stress incontinence, with low failure rates and minimal adverse outcomes.

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2. Jenkins T, Liu C. Laparoscopic Burch colposuspension. Curr Opin Obstet Gynecol 19:314-318. 2007 Lippincott Williams & Wilkins
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To Mesh or Not to Mesh

Sapna Dilgiri

As the hype surrounding mesh complications in genital prolapse surgery heightens it is not surprising that most pharmaceutical companies have withdrawn their transvaginal mesh kits from the market. In 2016 mesh was classified as a "high risk" device by the FDA. The most feared risk of mesh usage being highlighted is mesh exposure ranging from 3 to 18 percent. Other concerns include dyspareunia, voiding difficulties, bleeding and organ perforation. Moreover, treatment failure & need for additional surgery has been reported to be up to 35%. However, the existing evidence continues to suggest that use of mesh in the anterior compartment reduces subjective and objective recurrence of prolapse. Furthermore, though an association between use of mesh in prolapse surgery and complications has been established many denominators remain unanswered. Large randomized trials addressing this issue are sparse. These include type of mesh used, patient factors (prolapse stage, menopausal status, sexual activity etc.) and of extreme importance surgical experience. As a consequence of this dogma urogynaecologists have been left minimal options when it comes to treating advanced or recurrent prolapses. At our unit, we continue to venture on with one of the only available vaginal mesh kits available in a research setting. This product is marketed as a "smart

mesh” which is physiologically compatible, ultra-light weight polypropylene mesh. It is designed to be non-palpable to the patient or the partner. It is available for both anterior or posterior compartment repairs. In a free communication session, I propose to discuss the mesh controversy and demonstrate how to use this mesh in the anterior compartment.

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3. Dias, M. M., de A Castro, R., Bortolini, M. A. T., Delroy, C. A., Martins, P. C. F., Girão, M. J. B. C., & Sartori, M. G. F. (2016). Two-years results of native tissue versus vaginal mesh repair in the treatment of anterior prolapse according to different success criteria: A randomized controlled trial. *Neurourology and Urodynamics*, 35(4), 509-514. <http://doi.org/10.1002/nau.22740>

ThermiVa: Does It Work?

Ajay Rane¹, Jay Iyer¹, Sapna Dilgiri¹, Thomas Currie¹

1. James Cook University, Douglas, QLD, Australia

Introduction: Common to elderly females is a decline in genitourinary health as involution of the reproductive organs, declining oestrogen levels and atrophy of the vaginal mucosa give way to a myriad of symptoms often neglected despite inconvenience and discomfort. Women often persist with vaginal laxity, dryness, decreased sexual satisfaction and urinary symptoms such as stress urinary incontinence. While interventions are available, they largely involve the use of topical oestrogens or invasive sling procedures for the latter. Recently, transcutaneous radiofrequency devices have enjoyed increasing popularity where they are being used to restore tissue elasticity in several cosmetic applications. The proposed mechanism of this device is three-fold: 1) eliciting minor trauma to tissues with the effect of stimulating collagen deposition, 2) heating tissues to stimulate blood flow and 3) encouraging the sensitisation of afferent sensory nerve fibres. Transcutaneous radiofrequency technology is now being targeted for “rejuvenation” of vaginal tissues, claiming to abate the above listed symptoms without the need for further medical or surgical intervention. Popularity of the device among Australian GPs and private gynaecologists continues to increase despite minimal research validating efficacy. As this device offers a potentially safer alternative to restoring the pelvic health of women, further studies are warranted.

Aim: to assess the efficacy of a transcutaneous, monopolar, radiofrequency device in improving vaginal laxity, sexual satisfaction, climax ability, vaginal moisture, urinary stress incontinence, stream control and urinary urge incontinence.

Methods: a prospective cohort of 50 women was identified as having symptoms as outlined. Each candidate was offered a course of transvaginal, monopolar, radiofrequency therapy consisting of three treatments spaced at four-week intervals. A pre-treatment Likert questionnaire was completed prior to each of the three treatments, and four-weeks post-third treatment. Digital photographs were taken throughout to correlate patient evaluation with visible improvement.

Results: Improvements in patient satisfaction were reported for symptoms of vaginal laxity, sexual satisfaction, climax ability, vaginal moisture, urinary stress incontinence and urge urinary incontinence. Digital photography shows improvement of labial tissues in respect to tissue atrophy.

Conclusion: Subjective efficacy of transvaginal radiofrequency therapy has been demonstrated. Further studies are warranted to assess the placebo effect which has not been excluded by the trial.

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2. Magon N, Alinsod R. ThermiVa: The Revolutionary Technology for Vulvovaginal Rejuvenation and Noninvasive Management of Female SUI. *J Obstet Gynaecol India*. 2016;66(4):300-2.
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Compartment syndrome related to lithotomy position: A case report

Sean Heinz-Partington¹, Nishamini SUBRAMANIAM¹, Hans Peter Dietz¹

1. Nepean Hospital, Kurrajong Hills, NSW, Australia

Background: Compartment syndrome of the lower extremities following gynaecological surgery performed in the lithotomy position is a rare, but potentially life-threatening complication. Compartment syndrome occurs as a result of tissue hypoperfusion from prolonged compression of blood vessels with high arterial pressure and reduced venous pressure.⁽¹⁾ Consequent endothelial damage causes proteins and fluid to leak into the interstitial space and further compress blood vessels, perpetuating the cycle. In addition, sudden re-perfusion at the conclusion of the surgery exposes tissues to oxygen free radicals, further damaging the endothelium and resulting in more tissue ischemia. Proposed risk factors include surgical time greater than two hours, Trendelenburg position, intra-operative hypovolemia, epidural anaesthesia, and the use of intermittent pneumatic compression devices.⁽²⁾ Suggested preventative measures comprise the use of newer, more encompassing leg supports that have gel padding, and can be manipulated intra-operatively to minimise tissue ischemia.⁽³⁾

Case: 49 year old JS underwent an uncomplicated vaginal hysterectomy, anterior repair, anterior sacrospinous fixation, bilateral levatoplasty and insertion of a puborectalis sling at a tertiary centre in October of 2016. The procedure involved the patient being positioned in lithotomy (Lloyd-Davis stir-up) position for a total of 320 minutes. Within an hour of the completion of the surgery, the patient complained of severe bilateral hip pain. A subsequent CT aided in diagnosing bilateral quadriceps rhabdomyolysis. Bilateral compartment syndrome was then diagnosed and she was taken back to theatre on day zero for a bilateral thigh fasciotomy and debridement. Two days later she underwent an irrigation, wound debridement and closure of the fasciotomy wounds. Her post-operative course was further complicated three weeks later by an abscess of the right thigh, which required surgical drainage. She has consequently made a full recovery.

Conclusion: Compartment syndrome of the lower limbs following gynaecological surgery in the lithotomy position is an important iatrogenic complication to understand. Significant morbidity and in rare cases, mortality can result from the condition. Preventative measures proposed include the use of newer leg supports and intra-operative lower limb manipulation may help in preventing this condition.

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Laparoscopic hysterectomy with pfannenstiel incision for specimen retrieval: Surgical technique

Rose McDonnell¹, Stuart Salfinger^{1,2}, Paul Cohen², Jade Hollingworth¹

1. KEMH, Perth, WA, Australia

2. St John of God Hospital, Subiaco, WA, Australia

Background

Morcellation of uterine specimens for removal has been a topical subject since the TGA advice regarding power morcellation. When dealing with specimens that are of clinical or imaging concern for sarcomatous lesions; techniques avoiding morcellation need to be employed.

We outline a simple surgical technique, which enables the removal of very large uteri at Total Laparoscopic Hysterectomy (TLH) without the concomitant risks of midline laparotomy or tumour dissemination due to morcellation. It can also be employed for narrow or inadequate vaginal access.

Technique - Key Points

- Routine TLH, 3 x 5mm ports
- Uterus detached from vagina and specimen free in abdominal cavity
- Suture inserted via McCartney tube and vault closed laparoscopically
- Specimen grasped with toothed needle holders
- Small pfannenstiel incision (6-8cm)
- Specimen delivered via incision (in bag if surgeon prefers)
- Sheath closed

Proposed benefits of this technique include:

- No morcellation

- Incision only big enough to deliver specimen (not operate through)
- No retractors (minimises nerve/soft tissue injury)
- Minimal tissue effect
- Low pain
- Quick discharge

Results

Our series consists of 28 cases of TLH with pfannenstiel incision for specimen retrieval.

The average uterine weight was 952g (156-3200g).

Average blood loss=17ml (Range 10-300ml) There were no Intraoperative complications (vascular, bowel, bladder or ureteric injury) There were no blood transfusion and no readmissions required. The average operating time was 101 minutes (71-129 range) The average length of stay was 2.71 days (range 2-6), 13 (46%) of patients went home the morning of day 2 post op. Only 3 (10.7%) stayed more than three nights in hospital.

Conclusion

This technique provides a safe technique for removing concerning uterine specimens at Laparoscopic Hysterectomy without additional morbidity and preserving the benefits of minimally invasive surgery.

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2. American College of Obstetricians and Gynecologists. Power Morcellation and Occult Malignancy in Gynecologic Surgery. May 2014.
3. AAGL Advancing Minimally Invasive Gynecology Worldwide. AAGL Tissue Extraction Task Force Report. May 2014

Video of Laparoscopic Repair of Vesico-Uterine Fistula

Jerome Melon¹, Fay Chao¹, Weng Chan¹, Anna Rosamilia¹

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Background:

Vesico-uterine (VU) fistulas are rare in modern gynaecological practice in Australia. Laparoscopic repair of vesico-uterine fistulas have been described however surgical videos demonstrating techniques are few.

Aims: To demonstrate with a video the surgical techniques involved in laparoscopic repair of a vesico-uterine fistula (Yousseff's syndrome).

Case details: 37 year old para 2, otherwise healthy, presented day 1 following a 2nd vaginal birth after caesarean (VBAC) with haematuria and pink-coloured watery discharge per vaginum. CT urogram demonstrated a 2cm diameter VU fistula with dye spillage from bladder through to lower aspect of uterus. An intra-partum uterine dehiscence of previous caesarean site was suspected. Conservative treatment with antibiotics failed to resolve symptoms with ongoing pink-coloured fluid vaginal losses. Cystoscopy and hysteroscopy confirmed the findings of a well granulated fistulous tract connecting the base of the bladder and anterior uterine wall just above the level of the internal os. She proceeded to a laparoscopic repair of VU fistula as described below 5 months following the delivery of her baby. She was discharged day 2 with indwelling catheter drainage for 2 weeks and has been well post-operatively to date.

Surgical Technique: Cystoscopy with insertion of bilateral ureteric catheters. 4 port laparoscopy with opening of the utero-vesical fold and dissection of bladder from lower uterus. Challenging dissection in midline due to peri-fistula fibrosis. Identification and excision of fistula tract with creation of cystostomy and hysterotomy. Double layer laparoscopic bladder repair using 2.0 delayed absorbable suture and closure of uterine wall with 2.0 vicryl. Bladder integrity checked with methylene blue instillation. Omental flap placed between uterus and bladder. Removal of bilateral ureteric catheters at completion of case and check cystoscopy normal with bilateral ureteric jets seen.

Conclusions: This video demonstrates the laparoscopic surgical techniques involved in repair of a vesico-uterine fistula, an unusual case in modern gynaecological practice in Australia

MiniArc vs TVT Abbrevo Midurethral Sling in Women with Stress Urinary Incontinence – an RCT – 6 and 12month follow up

Joan Melendez Munoz¹, M Braverman¹, **Anna Rosamilia¹**, N Young¹, A Leitch¹, J Lee¹

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Introduction: Single incision slings (SIS) were introduced in an attempt to decrease the complications associated with retropubic and transobturator slings. The TVT Abbrevo is a modification of the TVT-O with a reduced length and less immediate postoperative pain¹. The Miniarc SIS has been shown to be equivalent to outside-in transobturator sling, Monarc at 12 month follow-up².

Objective: To evaluate objective and subjective outcomes of MiniArc SIS and TVT Abbrevo midurethral sling (MUS) in women with stress urinary incontinence

Methods: Female subjects who were assessed and referred for stress urinary incontinence surgery were eligible to participate in this study. Exclusion criteria included women with intrinsic sphincter deficiency previous failed midurethral or fascial sling, untreated detrusor overactivity or significant voiding dysfunction.

Patients' randomisation was performed with computer-generated blocks of 4-8, with concealed allocation. Assuming an objective cure rate of 90% for TVT Abbrevo™ with a power of 80%, a sample size of 79 in each arm was required to detect a clinical difference of 15%, using a one sided α of 0.05.

The target recruitment number was 220 allowing for an attrition rate of 15%. Institution ethics approval was obtained and the trial was registered.

Routine preoperative assessment was conducted for objective data, whilst patient reported outcome tools (PRO) were utilised for subjective outcomes. These include ICIQ UI SF, ICIQ OAB, IIQ7, EQ5D, PISQ12, PGIs & PGII.

TVT Abbrevo™ or Miniarc™ were performed in a standardized fashion, together with any concomitant prolapse surgery. Review was conducted at 6 weeks and at 6 and 12 months.

Objective cure was defined as a negative cough stress test with a comfortably full bladder. Subjective cure was defined as no report of leakage with physical exertion. All Data was collected and outcomes were analysed statistically.

Results: Between 2011 and December 2015, a total of 246 women were randomized to receive MiniArc (121) or TVT Abbrevo (125) with 21 withdrawals over the first 12 months. Baseline characteristics were clinically balanced in both groups.

At the current time-point, 183 women were assessed. There were significant differences in subjective cure at 12 months though no differences were seen in objective cure rates and patient reported outcomes.

Conclusion: There were no significant differences in objective cure rates at 6 and 12months between MiniArc and TVT Abbrevo. Subjective cure rate was significantly higher for TVT Abbrevo compared with MiniArc at 12months but not at 6 months.

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Native Tissue Repair for Vault Support

Stanley Santiago¹, Harry Merkur¹

1. Sydney West Advanced Pelvic Surgery (SWAPS), Blacktown, NSW, Australia

Objective: To demonstrate the incorporation of endopelvic fascia with vaginal cuff closure at laparoscopic hysterectomy.

Patient: 42 year old woman with apical prolapse, cervical protrusion 3-4 cm past the introitus -her obstetric history Para2 with one vaginal delivery and one caesarean section. There were no abnormal urinary or bowel symptoms. Her

medical and surgical history were unremarkable. She was booked for total laparoscopic hysterectomy and bilateral salpingectomy.

Procedure: Uterine length was 12cm. RUMI 2™ manipulator with 10cm tip and 3.5cm Koh Cup™ was inserted. Uterus, tubes and ovaries were normal. The cervix was elongated. PK GyruS™ bipolar and monopolar scissors were used to perform a total laparoscopic hysterectomy and bilateral salpingectomy. Both vaginal cuff angles were sutured to the uterosacral ligaments on either side using 1 Vicryl suture. 2.0 V-Loc™ 180 barbed suture was used to close the vault, incorporating the pubocervical fascia. There was good vaginal vault support noted at the end of the procedure with no cystocele or rectocele evident. Examination at her 6 weeks follow up revealed good vault support with no evidence of prolapse.

Discussion: Hysterectomy is the most common major gynaecological procedure performed. Prolapse is a common indication, however hysterectomy itself can also be the cause of future prolapse if appropriate surgical steps are not taken prophylactically. Surgeons should thoroughly assess continence and prolapse before planning every hysterectomy to reduce future risk.¹ Using native tissue for apical prolapse repairs has long been performed and validated. In 1929, Richardson introduced closure of vault incorporating uterosacral ligament and broad ligament at abdominal hysterectomy. McCall culdoplasty was described in 1957 to re-establish pelvic support.¹ Rahn and colleagues looked at incorporating uterosacral ligaments bilaterally to vault angle and pubocervical fascia at time of abdominal hysterectomy. This improves level 1 support, hence reducing apical vault prolapse and lowers incidence of future prolapse surgery.² Currently, more hysterectomies are being performed laparoscopically and various techniques has been used to incorporate native tissue to correct prolapse and minimize future recurrence. At laparoscopy, the anatomy is well visualized providing the advantage of better incorporation of uterosacral ligaments and pubocervical fascia. This in turn gives better apical support. It also has the advantage of better visualization over vaginal or abdominal hysterectomy of vital structures such as the ureter, and in some cases distorted anatomy and adhesions, therefore, reducing the risk of injury.³ In our case, these technical points were used advantageously with good result.

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3. O'Hanlan KA, Emene PL, Peters A, Sten MS, McCutcheon SP, Struck DM, Hoang JK. Analysis of a Standardized Technique for Laparoscopic Cuff Closure following 1924 Total Laparoscopic Hysterectomies. *Minim Invasive Surg*. 2016; 2016:1372685. Epub 2016 Aug 4.

SESSION NINE: OBSTETRICS & UROGYNAECOLOGY – CAN WE DELIVER BETTER?

1530-1630

BALLROOM A & B

A crowd favourite! This session throws open one question – can we deliver better vaginally? We have challenged our speakers to show you evidence one way or the other about issues of vaginal birth and the pelvic floor.

Birth Trauma – Challenges in Prevention and Management

Jenny King

The protection of the perineum by episiotomy in delivery at term.

Martin DL, *California State Journal of Medicine* 1921.

“Let them not be the usual spontaneous lacerations that follow prolonged pressure, that follow a dangerous degree of stretching, the laceration, the location and the extent of which are entirely beyond our control; but let us make our laceration where we want it, as deep as is necessary in the particular case and let us make it before pressure injury and undue stretching of tissue have occurred.”

Challenges in managing pregnancies after trauma repair

Khaled Ismail¹

1. University of Birmingham, Birmingham, United Kingdom

Trauma to the genital tract is commonly seen with vaginal births. This can be associated with significant morbidity particularly with obstetric anal sphincter injuries (OASIS). Several demographic, antenatal and intrapartum factors

determine an individual's risk for sustaining perineal trauma and long-term pelvic floor disorders. Labour and childbirth is an integrated, multi-faceted process the clinical factors of which will change as the pregnancy progresses. This talk aims to review the current evidence for the contribution of such variables, which include, parity, mode of delivery, birthing position, perineal support programmes and episiotomy to the risk of OASIS and its reduction. The talk will also discuss current recommendations and knowledge gaps in managing pregnancies after trauma repair and the feasibility of developing a prediction model that can facilitate the process of counselling and decision-making.

SESSION TEN: CAN WE SURVIVE THE CHALLENGE IN A WORLD OF NO SLINGS, NO MESH?

1630-1700

BALLROOM A & B

Lucky last - watch this 10 round action packed slug fest as our boxers throw punch after punch and try for a knockout whilst the audience cheers on in a frenzy.

Team 1: Ty Erickson

Team 2: Eric Sokol

FRIDAY 4TH AUGUST 2017

1250-1320

BALLROOM C

A case of BHCG Negative ectopic pregnancy

Opi Chiram¹, Shakeebha Albayati¹

1. Bankstown Hospital, NSW

Introduction: In women of reproductive age group presenting with lower abdominal pain to emergency department ectopic pregnancy is an important differential diagnosis.

We are reporting a case showcasing dilemma in diagnosing ectopic pregnancy.

Case presentation: A 26 year old female presented to Emergency Department with sudden onset sharp lower abdominal pain with nil associated symptoms. She was on oral contraceptive pills. On examination the patient was hypotensive to 90/54 mmHg, PR- 80 bpm. Her abdomen was soft with generalised tenderness in the epigastrium, right lower quadrant and suprapubic region. Investigations-hemoglobin -123, Serum Beta HCG -2 CA-125: 13 CEA-19.9: 73. Bedside ultrasound performed showed free fluid CT abdomen/pelvis-showed left adnexal ovarian cysts/follicles with heterogeneous appearing right adnexal focus that measured approximately 50 mm x 60 mm x 55 mm with a foci of low attenuation, and surrounded by hyperdense material. Also, extensive intraperitoneal haemorrhage noted.

Pelvic ultrasound showed extensive free complex fluid in the pelvis. A complex right adnexal mass lesion with solid/fluid components measuring approximately 8.9 x 5.7 x 5.5 cm was seen. No obvious internal colour flow could be detected within this lesion.

Based on these findings ruptured haemorrhagic ovarian cyst was the first diagnosis.

Patient was taken to operating room for laparoscopy and findings were- 1.Right fallopian tube had hematosalpinx. Left fallopian tube normal. Both the ovaries were normal. Blood and clots in abdomen. She underwent right salpingectomy with drainage of the blood clots. Post operatively patient developed atelectasis with possible aspiration which was treated with iv antibiotics. But rest of the postoperative period was uneventful.

Histopathology -Inflamed fallopian tube and blood clot. Within the blood clot necrotic chorionic tissue seen.

Conclusion: Right tubal ectopic pregnancy and benign paratubal cyst.

Discussion: This case represents a very challenging scenario where both ultrasound and beta HCG was misleading. According to the literature, a negative pregnancy test via urine or low β -hCG in serum of pregnant women is 3.1% and 2.6% respectively in ectopic pregnancies¹⁻². One hypothesized mechanism to account for the low β -hCG values is its reduction or cessation of production of the degenerate trophoblastic tissue and another likely explanation is the existence of low-mass chorionic villi which produce this hormone and their increased clearance from the circulation.³

Our case demonstrates that ectopic pregnancy should always be considered very carefully in all women with lower abdominal pain.

Is total vaginal length a confounder between cervical descent and symptoms of pelvic organ prolapse?

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Introduction: The POP-Q prolapse quantification system was introduced in 1996 to standardise clinical assessment and staging of pelvic organ prolapse (POP) and it is now widely employed for this purpose (1). It requires total vaginal length (tvL) for the staging of central compartment prolapse (2,3). Some clinicians use absolute values for central compartment descent, without reference to vaginal length, which has the potential to simplify the assessment.

Objective: To determine whether tvl is a confounder of the relationship between central compartment descent and POP symptoms.

Methods: This is a retrospective observational study on patients seen in a tertiary urogynaecological unit for POP symptom and/symptoms of lower urinary tract dysfunction between March 2014 and November 2015. All underwent a standardized interview, POP-Q and 4D translabial ultrasound assessment (2). Statistical analysis was carried out using SPSS v20.

Binary logistic regression was performed to determine the association between prolapse symptoms and station of cervix or vaginal vault (i.e. C). Age, BMI, menopausal state, history of previous hysterectomy and/or prolapse and/or incontinence surgery and vaginal parity were tested as potential confounders. Variables that were significant on binary logistic regression ($P < 0.05$) were included in a model for ROC statistical analysis. This was repeated after adding tvl to the model.

Results: During the inclusion period 721 women were seen. Mean age was 56.9 (18.8 – 88.6) years, BMI was 29.2 (15.7-64.4) and 458 (64%) were menopausal. Mean parity was 2.6 (0-8), 646 (90%) were vaginally parous. 275 (38%) had had a previous hysterectomy or incontinence/prolapse procedure. 365 (50.6%) reported prolapse symptoms, i.e. lump/drag. A prolapse of POP-Q \geq stage 2 was found in 548 women (76%). It was a cystocele in 417 (58%), uterine prolapse in 190 (35%), enterocele in 29 (4%) and a clinical rectocele in 360 (50%). Mean Ba was -0.8cm (-3 to +4.5), C -4cm (-11 to +7), Bp -1.2cm (-3 to +6).

On binary logistic regression a highly significant association ($P < 0.001$) was noted between symptoms of prolapse and C, age and menopausal status.

ROC analysis with these variables in the model yielded an area under the curve (AUC) of 0.74. Adding tvl to the model yielded an AUC of 0.749.

Conclusion: Adding tvl marginally improved ROC curves of cervical/ vaginal vault station in predicting prolapse symptoms. However, the difference is small and unlikely to be clinically significant. It seems reasonable to stage central compartment descent in POP assessment without reference to tvl.

1. Dietz HP. Ultrasound imaging of the pelvic floor. Part I: two-dimensional aspects. *Ultrasound Obstet Gynecol.* 2004; 23; 80-92.
2. Bump RC et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol.* 1996; 175; 10-7.
3. Pham T et al. Current use of pelvic organ prolapse quantification by AGUS and ICS members. *Female Pelvic Reconstr Surg.* 2011;17:67-9.

"Epiploic appendagitis masquerading as ovarian torsion in a morbidly obese 21 year old"

Patrick F Harrington¹

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Epiploic appendagitis is an uncommon, usually benign but exquisitely painful inflammation of the adipose appendages that are located on the colon. It can prove to be a diagnostic dilemma and may be mistaken for diverticulitis, appendicitis or indeed in this case ovarian torsion leading to unnecessary admission, administration of antibiotics or surgical procedures. Epiploica are pedunculated protrusions of fatty, serosa covered structures found along the entire course of the colon but more common and generally larger in the transverse and sigmoid colon. Each appendage has its own blood supply and they are greater in size, more abundant and most obvious in patients with increased BMI and in those who have recently lost weight. Acute torsion causes ischemia and infarction with aseptic fat necrosis and spontaneous venous thrombosis. While epiploic appendagitis itself is quite rare the type encountered in this case- that in the descending colon- is the least frequently occurring at 2%. Diagnosis primarily relies on imaging modalities such as CT with the most common finding being mesenteric stranding, fat density ovoid lesions with surrounding inflammation- occasionally there is a high-attenuated dot within the inflamed appendage representing a thrombosed draining vein

I present the case of a morbidly obese nursing student who presented with severe left iliac fossa pain in the setting of a known left ovarian cyst. She was initially thought to have ovarian torsion but at laparoscopy was discovered to have this infrequent and self-limiting non-gynaecological condition. I discuss the clinical manifestations, appropriate diagnostic tools and management of this condition.

1. Sangha S, Soto JA, Becker JM, Farraye FA. Primary epiploic appendagitis: an underappreciated diagnosis. A case series and review of the literature. *Dig Dis Sci* 2004; 49:347.
2. Rao PM, Rhea JT, Wittenberg J, Warshaw AL. Misdiagnosis of primary epiploic appendagitis. *Am J Surg* 1998; 176:81.
3. Rioux M, Langis P. Primary epiploic appendagitis: clinical, US, and CT findings in 14 cases. *Radiology* 1994; 191:523.

Large Mullerian cyst causing mass effect requiring laparoscopic excision in a post menopausal woman

Patrick F Harrington¹

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Vaginal cysts occur in less than 1% of the female population and are most prevalent in women in the third or fourth decade of life. A number of vaginal cysts that have been identified including, squamous epithelial inclusion cysts of the vagina, Gartner duct cysts, urothelial cysts, Bartholin gland cysts and the Mullerian or paramesonephric type. Mullerian cysts are the most common type of vaginal cyst (40%) and are usually small, benign fluid filled vaginal growths that are asymptomatic and rarely cause discomfort. The most common location of a Mullerian cyst is on the anterolateral aspect of the vagina and they are lined by columnar endo-cervical and tubo-endometrial type cells resembling lining of the endo cervix and fallopian tube. Mullerian cysts are known to be caused by displacement of epithelium, secondary to trauma (i.e. surgery) or abnormal congenital distribution. There have been case reports in the literature of malignant transformation.

I present the case of a 58 year old woman who required 2 laparoscopies for pelvic pain and bleeding in the eight years after a vaginal hysterectomy. Her pain was initially attributed to ovarian cysts but only truly improved following removal of a large Mullerian cyst which was causing a mass effect.

1. Benign Cystic Lesions of the Vagina: A Literature Review EILBER, KARYN SCHLUNT et al. *The Journal of Urology* , Volume 170 , Issue 3 , 717 - 722
2. *Gynecologic Oncology* Volume 99, Issue 3, December 2005, Pages 767-769 Kyung Soo Lee et al
3. WHO Classification of Tumours, Volume 6 IARC WHO Classification of Tumours, No 6 Kurman, R.J., Carcangiu, M.L., Herrington, C.S., Young, R.H.

Laparoscopic sacrohysteropexy in a prolapsed adenomyotic uterus: How to discuss and manage

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Background: Laparoscopic sacrohysteropexy is a minimally invasive surgical technique for POP repair, aiming to correct uterine prolapse by re-suspending apical portion to presacral ligament using strip of polypropylene mesh and recreating level I support. Although it carries a very high success rate of 92% with durability, reduced blood loss, direct visualization of ureters, fewer adhesion formations, less wound complications, shorter hospital stay, less postoperative pain and improved QoL, it requires lengthy operative time and advanced laparoscopic skills. Moreover, uterine preservation is contraindicated in pathologic uterus and there is potential difficulty of future pelvic surgery in the presence of pericervical mesh. Careful consideration and intensive counseling are mandatory for women with uterine pathology desiring for future child bearing.

Case report: A 47 year-old, nulliparous, married woman who had never been successful in trying for natural pregnancy presented at Urogynecology Clinic complaining of pelvic pressure and protruding lump through vaginal opening for over a year with coital difficulty and moderate impact on QoL. Additional symptoms of occasional urinary urgency and stress incontinence were also noticed. Pelvic examination revealed a top-normal sized uterus with the cervix protruding slightly beyond hymen and left uterosacral ligament thickening and tenderness. POP-Q examination revealed Aa -2, Ba -2, C +1, D -2, Ap -1, Bp -1, gh 4, pb 5, TVL 10. Due to abnormal PV findings and prolonged history of severe dysmenorrhea with deep dyspareunia, a transvaginal ultrasonography was performed. Anteverted uterus measuring 8.3x4.4x5.3 cm with small leiomyomas and thickened heterogeneous posterior myometrium, suggestive of adenomyosis, were detected.

Discussion: Due to uterine pathology and perimenopause, laparoscopic subtotal hysterectomy and sacrocervicopexy were offered. However, patient insisted on uterine preservation and desire for future pregnancy without ART. Intensive preoperative counseling regarding details of planned procedures, perioperative complications, fertility treatment and hormonal therapy for endometriosis was undertaken. Successful laparoscopic myomectomy and sacrohysteropexy were carried out. Patient returned for 6-week postoperative follow-up still complaining of pelvic pressure and severe dysmenorrhea, but very satisfied with disappearance of bulging symptom. POP-Q examination demonstrated Aa -2, Ba

-2, C -5, D -8, Ap -2, Bp -2, gh 3, pb 3, TVL 9. Mirena was recommended for her persistent pelvic pressure and dysmenorrhea, patient insisted on trying for natural pregnancy.

Conclusion: Laparoscopic sacrohysteropexy is a feasible, effective and minimally invasive reconstructive procedure for uterine sparing prolapse surgery. However, careful consideration and intensive counseling are mandatory for women with uterine pathology desiring for future child bearing.

1. Rahmanou, et al. Laparoscopic hysteropexy: 1- to 4-year follow-up of women postoperatively. *Int Urogynecol J* 2014
2. Nair, et al. Clinical outcomes in women undergoing laparoscopic hysteropexy: A systematic review. *Eur J Obstet Gynecol Reprod Biol* 2017

Vaginectomy with concomitant vaginal hysterectomy: An effective and economical reconstructive procedure for advanced stage pelvic organ prolapse

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Background: Pelvic organ prolapse (POP) is one of the major health problems affecting almost half of women over 50 years of age. Consideration for surgery include location and severity of prolapse, concurrent pelvic pathology, patient's preference, sexual activity, overall health status, and expected outcomes. In healthy elderly patients with severe prolapse who are no longer sexually active, vaginectomy and concomitant vaginal hysterectomy may be preferable procedures due to (1) optimal exposure to cul de sac closure and cysto-rectocele repair, (2) removal of potential danger of a difficult-to-access uterus, (3) patient's preference of the most definitive method, and (4) avoidance of vaginal mesh repair and mesh complications. Furthermore, these are considered effective and economical procedures with good surgical outcomes and low recurrence rates.

Case summary: A 75 year-old, P3, non-sexually active woman presented at Urogynecology Clinic complaining of a bulging lump through vaginal opening for over a year with voiding difficulty, urgency and stress incontinence. POP-Q examination revealed stage III uterovaginal prolapse with point Aa +1, Ba +3, C +5, D +1, Ap +1, Bp +1, gh 5, pb 3, TVL 9. Patient underwent vaginal hysterectomy, vaginectomy and posterior colpoperineorrhaphy. At 6-week postoperative follow-up, patient was very satisfied with the resolution of prolapse and urinary symptoms with POP-Q: Aa -2, Ba -2, C -2, Ap -1, Bp -1, gh 3, pb 2, TVL 3.

Intervention: The VDO demonstrates essential steps in vaginectomy procedure. Vaginectomy was carried out after traditional vaginal hysterectomy by making landmark circumferential incision on vagina approximately 2 cm above hymen, followed by anterior midline incision. With lateral dissection until approaching pubic rami and levator plate, vaginal mucosa was 360-degree separated from underlying pubocervical and rectovaginal fascia. Plication of perivesical, apical, and perirectal fascia with 2-3 consecutive purse-string sutures was performed with additional Kelly plication when indicated. Excess vaginal mucosa was excised. Posterior colpoperineorrhaphy was achieved, followed by closure of vaginal stump.

Conclusion: Vaginectomy and concomitant vaginal hysterectomy are effective and economical procedures with good surgical outcomes, less morbidities, and low recurrence rates, and should be considered as one of the treatment options for advanced stage prolapse in healthy elderly patients who are no longer sexually active.

1. Koski ME et al. Colpocleisis for advanced pelvic organ prolapse. *Urology*. 2012 Sep;80(3):542-6.
2. Wu JM et al. Lifetime risk of stress urinary incontinence or pelvic organ prolapse surgery. *Obstet Gynecol* 2014; 123: 1201-6.

SATURDAY 5TH AUGUST 2017

1250-1320

BALLROOM C

Use BRAIN to TAME the PAIN of informed consent in pelvic floor prolapse repair.

Justin Lam¹

1. Centre for Advanced Reproductive Endosurgery, St. Leonards, NSW, Australia

Objective: to present a logical system in obtaining informed consent for pelvic floor prolapse repair in the current medico-legal climate

Setting: CARE

Design: A case report

Patient: A 72-year-old G3P3 female, referred by her gynaecologist, seeking advice regarding management options for stage 3 recurrent vaginal vault and posterior wall vaginal prolapse.

She had vaginal hysterectomy and native tissue repair in 1987, and (2) rectocele native tissue repair in 2012. Her presenting complaint was a lump protruding on standing which affects her activities of daily living and causes coital discomfort. She otherwise had normal bladder and bowel control. On speculum examination, stage 3 posterior wall vault prolapse and stage 2 vault was diagnosed (POP-Q: Pb 1cm TVL 7, Ap+2, Bp+3, C =0, Ap-2, Bp-2, Gh 4 cm).

Of note, patient was married to a physician and her daughter was an investigative journalist. Both had expressed major reservations and advised her against considering mesh repair due to negative media reports.

Intervention: Use the BRAIN (Benefits, Risks, Alternatives, Indication, Nature) principle, the patient was guided through a thorough discussion including full disclosure of benefits, risks, alternative options, indication and nature of the available treatment options.

In the end, she accepted the recommended treatment of Posterior Directfix sacrospinous colpopexy. terior Directfix repair with sacrospinous colpopexy.

Results: Patient was able to go home the day after surgery and has been able to resume all physical activities including play golf. She further reported feeling well and delighted with the speed of recovery. Her bladder and bowel function remained normal. Speculum examination at follow up showed a healed and well supported vaginal vault and posterior wall anatomy (POP-Q: C-7, Aa-2, Ba -3, C-8, Ap-3, Bp-4, pb 3, Ch 3, TVL 8)

Conclusion: Seeking and obtaining informed consent for pelvic organ prolapse surgery is a time consuming but necessary process. We suggest the use of a logical system using the BRAIN principle to help patients select the option they choose based on full disclosure of benefits, risks, alternatives, indication, and nature of intervention.

A challenging case of recurrent vault prolapse managed by robotic surgery

Justin Lam¹

1. Centre for Advanced Reproductive Endosurgery, St. Leonards, NSW, Australia

Design: a DVD case presentation:

Setting: Centre for Advanced Reproductive Endosurgery, Sydney.

Patient: An interstate 60 years old lady with recurrent stage 4 vault prolapse after 4 unsuccessful surgeries including laparoscopic pelvic floor suture repair, laparoscopic sacrocolpopexy and transvaginal mesh repairs, failed vaginal pessary trial, complicated by vaginal ulceration.

Intervention(s):

- Discussion and review of case history with referring gynaecologist
- Skype consultation with the patient to discuss impact of prolapse on her quality of life and management options
- Interim partial colpocleisis to reduce the prolapse and reduce vaginal ulceration
- Examination under anaesthesia to determine the levels, stage of prolapse, location and extent of vaginal vault ulceration.
- Using Xi robotic platform to dissect bladder off the anterior vaginal vault, rectum off posterior wall, the full extent of vault prolapse was displayed.
- Colpotomy was performed to excise the redundant ulcerated part of vaginal vault, followed by closure in 2 layers.
- Inspection of the presacral area showed previous sacrocolpopexy mesh was still attached to the presacral ligament with caudal end detachment from the vaginal vault
- Restorelle Y-Mesh was attached to the anterior, posterior wall and vault and finally secured to the caudal end of the previous sacrocolpopexy mesh.
- Cystoscopy confirmed bladder integrity and ureteric jet flow equality.

Outcome(s):

- Patient was able to void and mobilise freely the day after surgery
- She was discharged on day 4 and flew home on day 5
- Early follow-up confirmed successful repair with patient reporting improved bladder function

Conclusion: Robotic DaVinci platform is a feasible and safe option for management of recurrent vault prolapse.

The effect of age on success rates in tension free vaginal tape (TVT) surgery

Jia Yi Lee¹, How Chuan Han¹

1. KK Women's & Children's Hospital, Singapore, SINGAPORE

Background: Multiple factors affect a patient's decision for surgical intervention for stress urinary incontinence. Current research data regarding age and poorer surgical outcomes is conflicting. Our objective is to assess if age lowers the cure rates of transvaginal tape surgery in our centre.

Materials and methods: 196 women underwent tension free vaginal tape (TVT) surgery for stress urinary incontinence from January 1999 to December 2004. We conducted 2 reviews, at 6 months and at 1 year post operatively. Patients were interviewed about their symptoms and a bedside cough stress test was done to demonstrate any stress urinary leakage at each review. Reported symptoms of urinary leakage were categorized into 5 age categories. An objective cure was defined as no demonstrable stress urinary incontinence seen, any demonstrable leakage was defined as failure. We compared the cure rates using Fisher's exact t test. Statistical analysis was complete with Graphpad. Informed consent was not required and ethical board approval was obtained.

Results and discussion: The mean age was 51.9 years (95% confidence interval 49.8 to 52.5). Overall, 51 (26%) women were lost to follow up at 6 months, 86 (42%) were lost to follow up at 1 year. We stratified women into 5 age categories. Most patients were at 40-49 years old (36%), and fewest patients were above 70 (3%). Overall cure rates at 6 months were 87%, and 93% at 1 year.

All patients had high cure rates above 75% at both reviews. None were worse off post operatively. The highest cure rate was observed in patients under 40 years old. We compared the cure rates of patients above and below 60 years old, as patients above 60 were found to have the lowest cure rates at 6 months (77%). The difference was not found to be statistically significant ($p = 0.182$). Though failure rates for this group at 6 months were highest, actual patient numbers were low. At 1 year, improved cure rates at 100% was found, however, the small sample size is likely to have had a pronounced effect on the cure rates.

Conclusion: There was no statistically significant drop in cure rates when a patient's age exceeded 60. Lost to follow up and the small sample size may have inflated the percentage cure rates at 1 year. Older patients who are fit for surgery should not be dissuaded should they be otherwise good surgical candidates.

1. Robinson TN, Finlayson E. How to best forecast adverse outcomes following geriatric trauma: An ageless question? JAMA Surg. 2014 Jun 11
2. Thom DH, Brown JS. Reproductive and hormonal risk factors for urinary incontinence in later life: a review of the clinical and epidemiologic literature. J Am Geriatr Soc 1998;46:1411-7

Video of Laparoscopic Removal of Bladder Suture complicating Burch Colposuspension

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Aims: To demonstrate with a video the surgical techniques involved in laparoscopic removal of a bladder suture complicating Burch colposuspension.

Case details: 45 year old para 2, otherwise healthy, with a history of vaginal repair and laparoscopic Burch colposuspension in 2001 presented with a 2 year history of recurrent urinary tract infections. Was found to have a remnant suture in the bladder from previous Burch colposuspension with failed attempted cystoscopic removal by urology. Repeat cystoscopy confirmed Ethibond suture through bladder wall at the left antero-superior quadrant.

Surgical Technique: 4 port laparoscopy with opening of peritoneum above bladder and sharp dissection into the cave of retzius over the left side. Bladder noted to be very adherent to bony pelvis due to previous surgery. Slow dissection laterally but difficulty to identify Ethibond suture outside the bladder. Cystotomy performed in order to identify and grasp suture and maintain it under tension to facilitate localization. Dissection continued externally until suture loosened and cut from bladder with knot intact. Cystotomy closed with 2.0 vicryl and peritoneum closed with 2.0 V-lock.

Conclusions: This video demonstrates the laparoscopic surgical techniques involved in removal of a suture from the bladder complicating Burch colposuspension, another unusual case in modern gynaecological practice in Australia.

Early Pregnancy During Major Surgery: Importance of Careful Pre-operative Assessment and Advice

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2. St. John of God Hospital, Subiaco, Western Australia, Australia

A 26 year old nulliparous patient with a two year history of pelvic pain and unexplained primary infertility was referred for gynaecology review. On bimanual examination the pelvic organs felt immobile with nodularity over the uterosacral ligaments. Pelvic transvaginal ultrasound scan demonstrated deeply infiltrating endometriosis with restricted mobility of the uterus and ovaries, obliteration of the Pouch of Douglas, bilateral uterosacral ligament nodularity and a 14mm nodule within the posterior vaginal fornix overlying a 10mm rectovaginal septum nodule in keeping with the pelvic examination.

The patient underwent radical laparoscopic excision of endometriosis, adhesiolysis and ureterolysis, chromotubation demonstrating bilateral free spill, and hysteroscopy and curettage. The endometrial cavity was of normal and unremarkable appearance. Histopathological analysis of all laparoscopically obtained specimens confirmed endometriosis, and endometrial curettings were reported as good quality and demonstrated a secretory endometrium.

The surgery was performed on day 18 of the menstrual cycle. Pre-operatively, on the day of surgery, the date of the last menstrual period was recorded and the patient was asked if she was pregnant or not, to which she responded 'no'. No urinary or serum human Chorionic Gonadotrophin (hCG) test was performed.

Subsequent menses were delayed; the patient had not been sexually active since her surgery. Pelvic ultrasound scan revealed a single, live intra-uterine pregnancy consistent with 6 weeks plus 1 day size, placing her at 4 days post conception on the day of surgery. She went on to have an uneventful pregnancy and delivered a healthy female baby by spontaneous vaginal delivery at 39 weeks gestation weighing 3210g.

Ongoing pregnancy in patients following inadvertent gynaecological surgery in the early implantation phase is clearly possible(1, 2). This case suggests that the effect of surgery during the implantation phase on the developing embryo may not be as significant as assumed. This is reflected by current literature stating that the 10.5% overall rate of miscarriage in women undergoing any form of surgery in the first trimester is not greater than that of the general obstetric population, and it may not increase rate of birth defects(3). More importantly, this case demonstrates the value of pre-operative advice regarding contraception or avoidance of unprotected sexual intercourse even in the 'sub' fertile population when planning surgery. It also highlights the importance of a day of surgery pregnancy test or serum hCG up to two weeks post conception, even when menses are not yet delayed, to exclude current pregnancy

1. Erenus M, Sezen D. Ongoing pregnancy in a woman who inadvertently underwent office hysteroscopy during early pregnancy. *Fertil Steril.* 2005;83(1):211-2.

2. AL-Mizyen E, Barnick CG, Grudzinskas JG. Early pregnancy is elusive and robust. *Early Pregnancy* (Online) 2001. 144-8 p.
3. Cohen-Kerem R, Railton C, Oren D, Lishner M, Koren G. Pregnancy outcome following non-obstetric surgical intervention. *American journal of surgery*. 2005;190(3):467-73.

Management of rectal prolapse after sacrocolpopexy with dorsal rectopexy

Mikhail Sarofim¹

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Introduction: Defective pelvic floor support may give rise to rectal prolapse (RP). 15-30% of women with RP report associated vaginal prolapse. Laparoscopic ventral rectopexy has been proposed as the ideal approach for RP. However, it can be anatomically challenging secondary to a laparoscopic sacrocolpopexy (LSCP) where mesh is attached to the perineal body and posterior vaginal wall. We describe the technique of a laparoscopic nerve-sparing dorsal rectopexy to manage rectal prolapse after previous LSCP.

Method: We present the case of a multiparous 58-year-old woman who presented with a rectal prolapse six-months after treatment of a cystocele and vaginal vault prolapse with LSCP using a Coloplast™ mesh.

As demonstrated in the video, dorsal rectopexy was performed with a biosynthetic mesh. Dissection through the right mesorectal plane using the hypogastric nerves as landmarks was performed. The biosynthetic mesh was secured to the dorsal aspect of the rectum and to the sacral promontory; thus avoiding mesh-to-mesh interaction in the rectovaginal septum.

Results: Our patient made a full recovery. Postoperative review at six-months showed an anatomically successful repair with no complications. The patient was subjectively satisfied with the anatomical outcome and reported normal bowel and sexual function.

Discussion: Optimal treatment of rectal prolapse is divided: laparoscopic ventral repair vs perineal approaches both have advantages and disadvantages. Moreover, after LSCP either approach increases in complexity and risk of complications. Due to the higher recurrence rate of perineal approaches in a young, healthy patient, we preferred laparoscopic management. Using the dorsal aspect of the rectum while sparing the hypogastric nerve was feasible through careful dissection in order to avoid postoperative constipation, voiding and sexual dysfunction.

The aim of this posterior nerve-sparing technique was to reduce the risk of disrupting the posterior vaginal wall mesh and prevent graft related complications. Dorsal rectopexy avoids contact with the perineum and posterior vaginal wall entirely, thus avoiding interaction with the previous LSCP repair. Literature is limited on management of rectal prolapse after SCP; however, with advances in laparoscopic and robotic surgery the number of SCPs being performed is likely to rise.

Conclusion: Laparoscopic dorsal rectopexy appeared to be effective in managing rectal prolapse in our patient who had undergone a LSCP. In our experience it can be used for minimally invasive treatment of rectal prolapse post LSCP; however longer follow-up and further research is warranted.

1. D'Hoore A, Cadoni R, Penninckx F. Long-term outcome of laparoscopic ventral rectopexy for total rectal prolapse. *Br J Surg*. 2004 Nov; 91(11):1500-5.
2. Samaranayake CB1, Luo C, Plank AW, Merrie AE, Plank LD, Bissett IP. Systematic review on ventral rectopexy for rectal prolapse and intussusception. *Colorectal Dis*. 2010, 12(6) 504-12.
3. Ercoli A, Cosma S, Riboni F, Campagna G, Petruzzelli P, Surico D, Danese S, Scambia G, Benedetto C. Laparoscopic Nerve-Preserving Sacropexy. *Minim Invasive Gynecol*. 2017 Mar 18. pii: S1553-4650(17)30217-0. doi: 10.1016/j.jmig.2017.03.008.

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The Alexis Contained Extraction System enables minimally invasive procedures by creating a contained environment for manual tissue extraction.

Designed as a complete solution for contained tissue extraction, this device is available in several kit configurations to support multi-port, reduced port and single incision techniques.



To learn more, please visit us at www.appliedmedical.com/alexiscs or by calling Australia 1800 666 272 | New Zealand 0800 644 344



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INTRODUCING

Integrated Table Motion for da Vinci Xi



da Vinci Surgery

Integrated Table Motion enables the da Vinci® Xi™ Surgical System to connect to Trumpf Medical's TruSystem™ 7000dV OR Table so that a patient can be dynamically positioned while the surgeon operates. The ability to reposition the operating table allows for optimal exposure and access to the target anatomy. This helps to increase efficiency and better manage the patient during robotic-assisted procedures.

- ✔ **Dynamic Access & Exposure** Use gravity to expose anatomy, maximise reach and deliver tissue at an ideal working angle.
- ✔ **Efficient Workflow for Every Case** Optimally position the patient without compromise to increase autonomy for the surgeon and anesthesiologist or to provide immediate patient relief.
- ✔ **Seamless Integration with Precise Feedback** The da Vinci® Xi™ System and Trumpf Medical TruSystem™ 7000dV OR Table connect wirelessly, then provide feedback on table angles for the OR team.



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FUTURE AGES EVENTS



AGES FOCUS MEETING 2017 – PRESERVATION
PARKROYAL ON PICKERING, SINGAPORE
13TH - 14TH OCTOBER 2017



AGES/RANZCOG
TRAINEE WORKSHOP 2018
23RD & 24TH JUNE 2018



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



AGES
PELVIC FLOOR SYMPOSIUM XIX 2018
BRISBANE, 3RD - 4TH AUGUST 2018



AGES XXVIII ANNUAL SCIENTIFIC MEETING 2018
CROWN PROMENADE, MELBOURNE
8TH - 10TH MARCH 2018



AGES
FOCUS MEETING 2018
CANBERRA, 2ND - 3RD NOVEMBER 2018

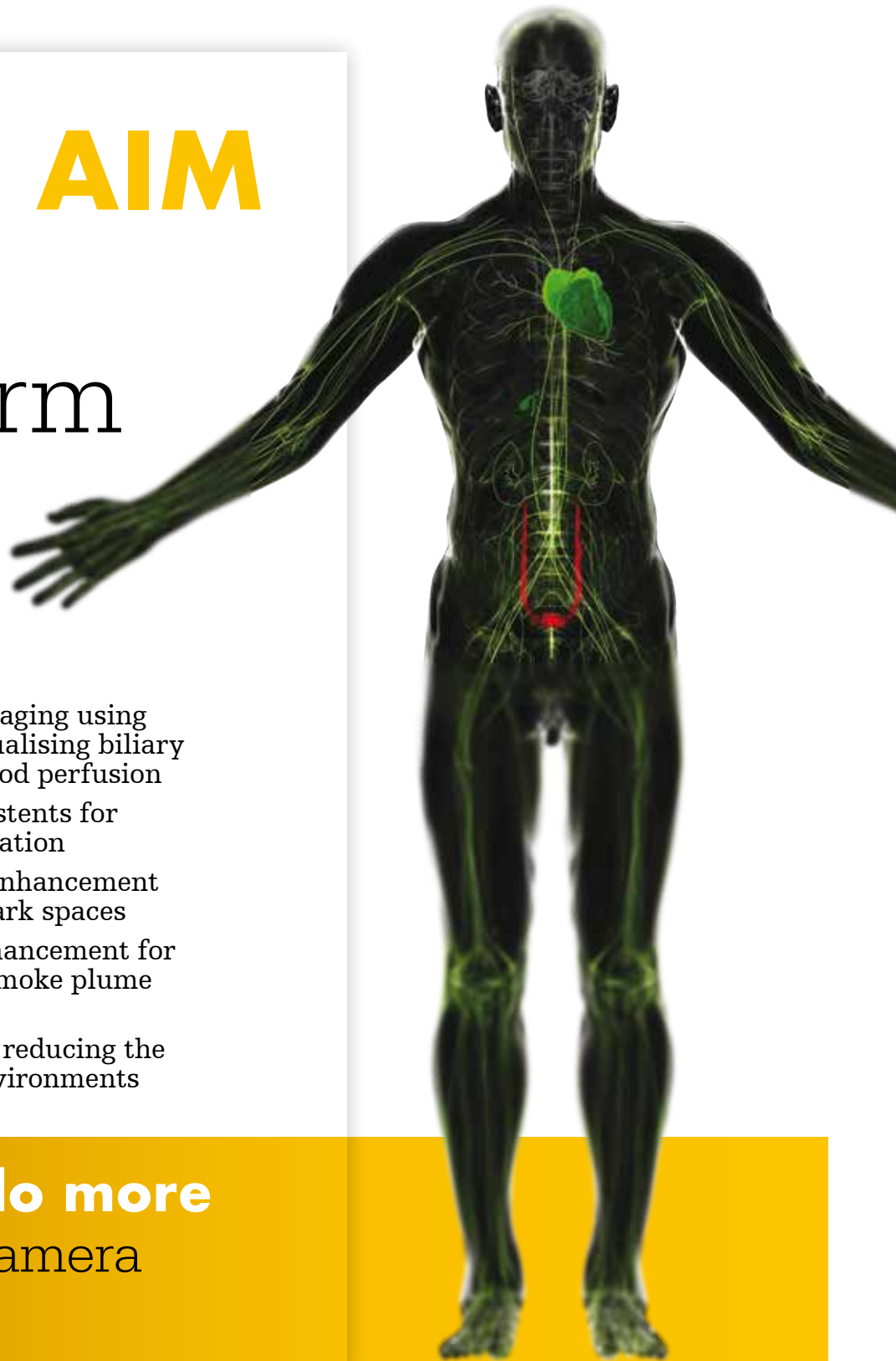
1588 AIM

video platform

5 Advanced Imaging Modalities including:

- Near infrared imaging using ICG dye* for visualising biliary anatomy and blood perfusion
- Infrared lighted stents for ureteral identification
- Dynamic range enhancement for visualising dark spaces
- Clarity video enhancement for seeing through smoke plume and murky fluid
- Desaturation for reducing the red in bloody environments

See and do more
with your camera
system



*The ENV functionality of this product is used in conjunction with an intravenous injection of indocyanine green dye (ICG).
ICG is not included on the ARTG or in the New Zealand Gazette.
Stryker is not a manufacturer or distributor of ICG.

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