Inclusion, Healing & Recovery in 2022

Hybrid Meeting

3rd & 4th June 2022
Adelaide Convention Centre

AGES XXII Pelvic Floor Symposium

www.ages.com.au

FRIDAY 3RD JUNE 2022

0700 - 0800	Conference Registration	
0800 - 0945	**SESSION ONE: BRINGING US BACK TO BASICS**	
	Session Chairs: Fariba Behnia-Willison & Emma Readman	Hall K
	Welcome	
	Prediction and primary prevention of pelvic floor trauma - **Jay Iyer**	
	Obstetrics and urogynaecology, are they mortal enemies? - **Ajay Rane OAM**	
	Cystoscopy and urodynamics, still useful? - **Bernard Haylen**	
	Value of point D - what's the point? - **Johnny Yi**	
	Panel discussion	
0945 - 1015	MORNING TEA, TRADE EXHIBITION	Hall J
1015 - 1215	**SESSION TWO: LET'S TALK ABOUT MESH, BABY**	
	Session Chairs: Rachel Green & Tran Nguyen	Hall K
	Bring back Burch?! - **Christopher Maher**	
	Resuscitate the sling, the mesh victim! - **Johnny Yi**	
	Laparoscopic mesh - the ABC of putting it in and where are we now? - **Alison Bryant-Smith**	
	The mesh centres - have the 'meshed' found a home? - **Elvis Šeman**	
	Mesh credentialing for the general gynaecologist and urogynaecologist - **Emmanuel Karantanis**	
	To scan or not to scan - **Ka Lai Shek**	
	Recurrent vaginal prolapse and no mesh, what can we do? **- Jennifer King OAM**	
	Panel discussion	
1215 - 1335	LUNCH, TRADE EXHIBITION & DIGITAL COMMUNICATIONS	Hall J
1335 - 1435	**SESSION THREE: FREE COMMUNICATIONS**	
	Session Chairs: Helen Green & Emma Readman	Hall K
	Onobotulinum toxin for the management of chronic pelvic pain: a systematic review and meta-analysis - **Blake Knapman**	
	The changing trend and clinical implications of the use of mid-urethral sling in the management of stress urinary incontinence - **Charlotte Rook**	
	Management of premalignant changes in ovarian endometriosis - **Kiran Vanza**	
	Robotic intrafascial colpotomy, edge to edge vaginal cuff closure plus peritoneal graft (IFC E2E + PG) for concurrent hysterectomy with sacrocolpopexy to minimise vaginal vault mesh erosion - **Assem Kalantan**	
	Indocyanine green for intraoperative visualisation of bladder and ureters in laparoscopic gynaecological surgery for benign conditions: video presentation - **Reema Kohli**	
	Laparoscopic removal of a 40cm mucinous cystadenoma - **Laarnie LP Pe Benito**	
1435 - 1515	AFTERNOON TEA & TRADE EXHIBITION	Hall J
1515 - 1700	**SESSION FOUR: LONG CLINICAL SCENARIO AND SPEED UPDATING**	
	What a life! From the cradle onwards: the patient journey	
	Session Chairs: Bassem Gerges & Dean Conrad	Hall K
	The young woman: Evidenced based management of recurrent UTI's - **Nevine te West**	

	The pregnant woman: "Doctor, should I have a caesar?" Analysing prelabour risk factors for pelvic floor dysfunction - **Lucy Bates**	
	The post-partum woman: "I have stress incontinence/prolapse/3rd degree tear - how should I have my next baby? - **Jerome Melon**	
	The 50-year-old woman: Consenting the different surgical options for stress incontinence in 2022 - **James Alexander**	
	The 70-year-old: "I have a prolapse – is having a pessary just putting off surgery?" - **Gil Burton**	
	Central Sensitisation: understanding the sensitive nervous system's role in your patient's recovery **- Carolyn Vandyken**	
1700	**CLOSE OF DAY ONE**	
1900 - 2300	**CONFERENCE DINNER & AWARDS NIGHT**	The Conservatory - Ayers House

SATURDAY 4TH JUNE 2022

0800 - 0830	Conference Registration	
0830 - 1005	**SESSION FIVE: THE VAGINA AND SEXUALITY**	
	Session Chairs: Kirsten Connan & Stephen Lyons	Hall K
	PRP: yes, no, maybe? **- Fariba Behnia-Willison**	
	Sexual function disorders - we can make a difference - **Anita Elias**	
	Pelvic congestion syndrome - not a myth! - **John Rophael**	
	Testosterone in gynaecology, has it a place? - **Stephen Birrell**	
	Introduction of new technology in gynaecology; lessons learned - **Alan Lam**	
	Panel discussion	
1005 - 1035	MORNING TEA & TRADE EXHIBITION	Hall J
1035 - 1235	**SESSION SIX: GLOBAL PERSPECTIVES**	
	Session Chairs: Fariba Behnia-Willison & Robert O'Shea	Hall K
	The challenges of mother and child health in Democratic Republic of Congo - **Luc Mulimbalimba**	
	Central sensitisation - the pain control centre - **Carolyn Vandyken**	
	Looking to testosterone in pelvic pain and endometriosis - **Susan Evans**	
	Fistulas - we can find them, we can fix them - **Judith Goh AO**	
	Central sensitisation - I challenge you to make a difference - **Carolyn Vandyken**	
	Panel discussion	
1235 - 1335	LUNCH & TRADE EXHIBITION	Hall J
1335 - 1500	**SESSION SEVEN: PLANNING PELVIC FLOOR SURGERY: MITIGATING RISKS**	
	Session Chairs: George Condous & Martin Ritossa	Hall K
	Patient education - a team effort - **Stephen Lyons**	
	Modern pre-evaluation for prolapse surgery - **Ellen Yeung**	
	Pelvic pain and prolapse repair - a bidirectional relationship - **Jason Chow**	
	Surgery and voiding dysfunction - a bidirectional relationship - **Rebecca Young**	
	Panel discussion	
1500 - 1530	AFTERNOON TEA & TRADE EXHIBITION	Hall J

1530 - 1645	**SESSION EIGHT: PELVIC FLOOR REPAIR - HYSTERECTOMY, UTERINE PRESERVATION AND THE OVERACTIVE BLADDER** *Session Chairs: Kate Martin & Kate Walsh*	Hall K
	Robotic VS laparoscopic pelvic floor repair - **Marcus Carey**	
	Vaginal endoscopic utero-sacral ligament suspension - **Mark Ruff**	
	Overactive bladder - please calm it down! - **Todd Ladanchuk**	
	Apical suspension at hysterectomy - **Anna Rosamilia**	
	Panel discussion	
1645	**CLOSE OF DAY TWO**	

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

DIGITAL FREE COMMUNICATIONS

Lunch - 12.45pm - 1.25pm, *Friday 3rd June 2022*

Laparoscopic management of Tubo-ovarian abscess of a rare organism: Achromobacter xylosoxidans - **Rola Akra**

The feasibility of a new technique for sacral neuromodulation for Bladder Pain Syndrome; An assessment by Pelvic Pain Impact Questionnaire (PPIQ) scores - **Anne O'Connor**

Intrafascial Hysterectomy - **Nancy Peters**

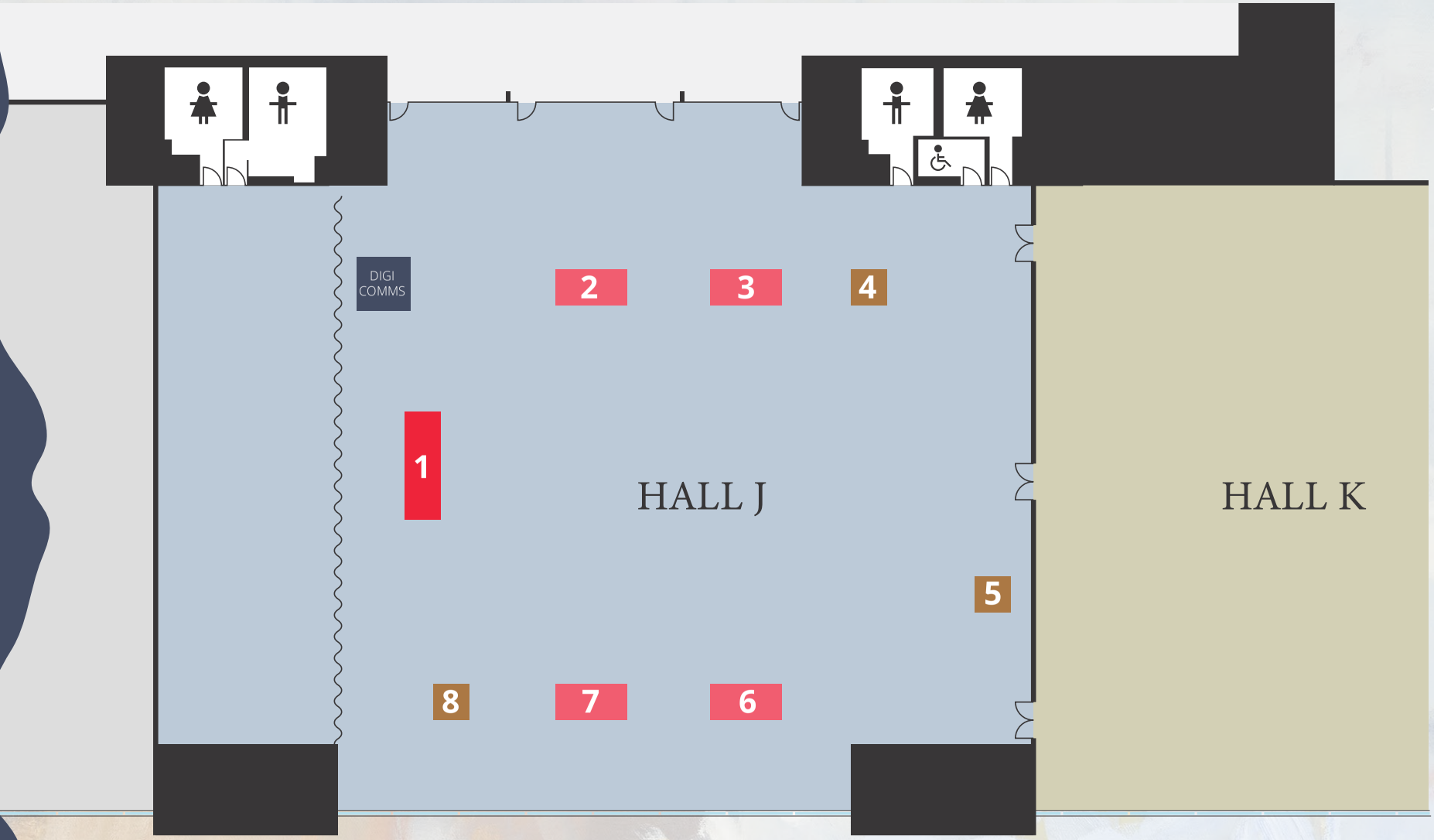
Vascular injury post transvaginal oocyte retrieval - **Nina Reza Pour**

Docking in 60 seconds - is this the death of laparoscopic surgery? - **Jessica A Robertson**

Laparoscopic Sacrocolpopexy using a Biologic Graft - **Charlotte Rook**

Sexual Function after laparoscopic/ robotic sacrocolpopexy – a marker for mesh related complications - **Mikhail Sarofim**

AGES XXII Pelvic Floor Symposium



1 Medtronic
2 Endotherapeutics
3 LifeHealthcare
4 Hologic
5 Applied Medical
6 Avant
7 Device Technologies
8 Medical Devices

PROGRAM ABSTRACTS

FRIDAY, 3RD JUNE 2022

SESSION ONE: BRINGING US BACK TO BASICS / 0800 - 0945

Hall K

Prediction and primary prevention of pelvic floor trauma

Jay Iyer

The relatively small human birth canal is an evolutionary trade-off between different mechanical requirements for locomotion, childbirth, and thermoregulation. Imaging studies have shown that levator avulsion failure seen in a third of vaginally primiparous women is significantly associated with pelvic organ prolapse and the need for treatment. Although several risk factors for levator avulsion have been identified, their predictive role remains unclear as most risk factors are unmodifiable. A holistic prediction tool would significantly advance our ability to counsel women before and after delivery, encourage collaboration with labouring women and identify women for future prevention studies.

Obstetrics and urogynaecology, are they mortal enemies?

Ajay Rane

Despite a growing body of evidence, the maternal urogynaecological outcomes of childbirth remain poorly scrutinized. While episiotomy, induction and caesarean section rates all get a high priority as maternal 'measurements', the same cannot be said for urogynaecological sequalae. Do we look for pelvic floor trauma immediately after birth in EVERY case? How do we do it? Beyond prolapse and incontinence, topics like sexual dysfunction, reduced genital confidence, PTSD post childbirth remain poorly studied. While obstetrics and urogynaecology have the same goal in providing holistic care to women, our paths need to synchronize towards better long-term care.

Cystoscopy and urodynamics, still useful?

Bernard Haylen

There are six main diagnoses in female pelvic floor dysfunction (PFD - relative frequency in women with lower urinary tract symptoms): Urodynamic stress incontinence (USI: 72%); Pelvic organ prolapse (POP: 61%); Detrusor Overactivity (DO: 15-40%); Voiding Dysfunction (VD: 14-39%); Bladder Oversensitivity (BO: 10-13%); Recurrent UTI (11%).

An assessment based on symptoms alone is unsatisfactory - the bladder is an "unreliable witness". For USI, only 2.4% have SI as a sole symptom, i.e. no symptoms to suggest other PFDs. Comprehensive history and clinical examination, ultrasound (vaginal or perineal), voiding and cystometric assessments, all with clinician present, are required for an accurate diagnosis.

Cystoscopy should be, as indicated only, for recurrent UTI, voiding dysfunction, oversensitive or painful bladder and microscopic haematuria. Routine cystoscopy is hard to justify.

Value of point D - what's the point?

Johnny Yi

This talk will discuss the specific utility of Point D for surgeons related to not only prolapse surgery but also vaginal hysterectomy. Point D references the posterior fornix and uterosacral ligament insertion. Understanding how this impacts the success of apical suspension surgery can help the surgeon thoughtfully choose the right surgery for the right patient. Further cervical length measurement can be estimated using Point D. This can be helpful in mental preparation for an upcoming hysterectomy.

SESSION TWO: LET'S TALK ABOUT MESH, BABY / 1015 - 1215

Hall K

Bring back Burch?!

Christopher Maher

Abstract not yet received.

Resuscitate the sling, the mesh victim!

Johnny Yi

Midurethral slings have been in practice for 30 years. Due to the scrutiny of all mesh materials, excellent surgical procedures like midurethral slings and sacrocolpopexies have fallen victim. This may lead to patients undergoing less effective or more invasive surgeries. While new innovation is clearly needed, current evidence supports the continued use of midurethral slings in patients with stress urinary incontinence. This talk will review current evidence, and review the risks associated with midurethral sling. Surgeons should counsel patients thoroughly with any mesh placement but understand that midurethral slings are still the most effective, while least invasive option.

Laparoscopic mesh - the ABC of putting it in and where are we now?

Alison Bryant-Smith

Laparoscopic sacrocolpopexy (LSC) is considered gold standard management of post-hysterectomy vault prolapse. However, LSC is a complex operation, entailing a steep learning curve, advanced laparoscopic suturing, and meticulous anatomical navigation. There is no standardised technical approach to LSC in the literature, with wide variations in nearly every methodological aspect described.

This presentation will outline the guiding principles and key surgical steps of LSC, interspersed with laparoscopic footage of one possible approach. The limited mesh/graft options available to surgeons in the current medico-legal environment will be discussed.

The mesh centres - have the 'meshed' found a home?

Elvis Šeman

Introduction

In the late 2010's, pelvic mesh centres were established in Australia to deal with complications of urogynaecological mesh. At the time, their setting up was very much politicised and publicised. Since then, generalist O & G's have received little feedback about mesh centres. Two centres proposed for New Zealand are yet to be formalised.

Aim

To update AGES members on what is known about mesh centres – what they are, what happens in them, and whether they have fulfilled their brief.

Methodology

A review of available professional web-based information, eg UGSA and RANZCOG, published mesh clinic data (Aust and NZ) and, to fill in any gaps, telephone interview of some mesh clinic medical leads and a consumer representative.

Results

Australia has 16 multidisciplinary mesh centres for 13 million women. Some are funded state-wide, eg QLD & SA, some clinics receive individual funding (eg RPA), but most are operated from existing O & G funding. With the exception of SA, all clinics have subspecialist urogynaecologists involved. Many centres have presented audit data at national and international scientific meetings, and the Queensland service has published important information on the process of its establishment and results of the first 100 mesh excisions, including patient satisfaction.Findings relevant to the aims are presented.

Conclusion

Pelvic mesh centres are offering multidisciplinary-based care to women with pelvic mesh complications, and, on the basis of limited published data, some are fulfilling their brief. My response to the question posed is a 'partial yes.'

Mesh credentialing for the general gynaecologist and urogynaecologist

Emmanuel Karantanis

Abstract not yet received.

To scan or not to scan

Ka Lai Shek

Abstract not yet received.

Recurrent vaginal prolapse and no mesh, what can we do?

Jennifer King OAM

Abstract not yet received.

SESSION THREE: FREE COMMUNICATIONS / 1315 - 1445

Hall K

SESSION FOUR: LONG CLINICAL SCENARIO AND SPEED UPDATING /1515-1700

Hall K

The young woman: Evidenced based management of recurrent UTI's

Nevine te West

Abstract not yet received.

The pregnant woman: "Doctor, should I have a caesar?" Analysing prelabour risk factors for pelvic floor dysfunction

Lucy Bates

Abstract not yet received.

The post-partum woman: "I have stress incontinence/prolapse/3rd degree tear - how should I have my next baby?

Jerome Melon

Pelvic floor dysfunction in the post-partum woman, whether it be stress urinary incontinence, prolapse, or anal incontinence, is common. Patients will often have concerns over the impact of a subsequent vaginal birth on their pelvic floor symptoms. We explore this issue, despite the fact that there is a lack of high-level evidence with which to guide the counselling of our patients. An individualised approach is necessary, based on the concerns and expectations of the woman.

The 50-year-old woman: Consenting the different surgical options for stress incontinence in 2022

James Alexander

The process of obtaining informed consent prior to providing surgical treatment of stress urinary incontinence (SUI) is one of the more difficult discussions to have with patients in light of the mesh controversy. More than ever there exists the need to provide patients with information they are able to understand and so participate in shared decision making

This presentation compares the evidence for the different surgical options for SUI with a focus on meta-analysis and recent evidence. Evidence regarding the material risks related to mesh and non-mesh alternatives will be covered, and product information available for patients will be illuminated.

The 70-year-old: "I have a prolapse – is having a pessary just putting off surgery?"

Gil Burton

This is a common clinical scenario. Data on the longevity of successful pessaries shows a decline in the first year but then stable after that. The risk factors for pessaries eventually not working are multiparity, BMI, the type and size of the prolapse, tolerance of pessary changes and other risk factors such as constipation and chronic cough. Careful history, examination, and assessment of short- and long-term surgical risk can guide decision making. Often a good approach is to run the pessary as a trial and allow the patient to come to a decision.

Central Sensitisation: understanding the sensitive nervous system's role in your patient's recovery

Carolyn Vandyken

Abstract not yet received.

SATURDAY, 4TH JUNE 2022

SESSION FIVE: THE VAGINA AND SEXUALITY / 0830 - 1005

Hall K

PRP: yes, no, maybe?

Fariba Behnia-Willison

Abstract not yet received.

Sexual function disorders - we can make a difference

Anita Elias

Having sexual difficulties is extremely common in the general population, and significantly increased with having Gynaecological and Pelvic disorders. However, research shows that both patients and health care providers are reluctant to bring up the problem, leaving it to be suffered in silence, with negative repercussions on physical, mental, and emotional health, as well as relationships.

This presentation will look at why it's so important to raise the topic, and simple ways that all health care providers can make a difference to cis women's (and people of all genders) sexual, and therefore general, health.

Pelvic congestion syndrome - not a myth!

John Rophael

Chronic pelvic pain (CPP) accounts for 10-20% of gynaecologic consultations – 60% of whom never receive a definitive diagnosis. Pelvic congestions syndrome (PCS) results in CPP secondary to pelvic venous insufficiency. PCS is prevalent in up to 24% of women aged 18-50 years of age. The diagnosis of PCS requires a high index of clinical suspicion.

Ovarian vein embolisation is a minimally invasive procedure which provides effective treatment for patients with PCS. Co-ordination between the GP, Gynaecologist and Vascular Surgeon is critical to achieve good outcomes in the management of patients with PCS.

Testosterone in gynaecology, has it a place?

Stephen Birrell

Androgens in female reproductive health are critical in at multiple stages of life but are essential in the genesis of the breast and regulation of breast involution with age. The critical nature of androgen endocrine function in the breast has extensive overlap in other reproductive functions. This presentation will give a broad overview of androgen action in both endogenous activity and the utility of androgen therapy in women's health.

Introduction of new technology in gynaecology; lessons learned

Alan Lam

During recent history, the practice of gynaecology has evolved at a rapid rate due to the steady introduction of new technology, the provider's eagerness to be at the cutting edge, and the consumer's expectation that 'new things are always better than old things. However, unlike new medications, the adoption of new technology has remained largely unregulated, often not subjected to the same rigorous scientific assessment and regulatory oversight, and at times spruiked by inventors who may also be key opinion leaders and manufacturers, with vested commercial interests. In this context, it is essential to recognise that neither healthcare providers nor consumers may fully appreciate the benefits and risks of new therapeutic options. Nonetheless, consumer safety remains the ethical and legal responsibility of the provider; hence, when embracing new technology, gynaecologists should be astute in differentiating between beneficial technological changes, and those that may cause harm.

In this presentation, we will clarify the definition of 'new technology' and identify key considerations when deciding whether and when to introduce a new technology into clinical practice; how to obtain informed consent around the proposed treatment; the potential benefits, material risks and consequences without adequate supporting evidence; and what should be done after adoption to ensure patient safety.

SESSION SIX: GLOBAL PERSPECTIVES / 1035 - 1235

Hall K

The challenges of mother and child health in Democratic Republic of Congo

Luc Mulimbalimba

Abstract not yet received.

Central sensitisation - the pain control centre

Carolyn Vandyken

Abstract not yet received.

Looking to testosterone in pelvic pain and endometriosis

Susan Evans

Testosterone, the forgotten female hormone.
True, it can reduce fatigue and anxiety. And true, it can increase libido, energy, and confidence.
The wellbeing 'icing on the cake' for your women using HRT.
But there's more. This presentation reviews research comparing testosterone levels and days per month of pelvic pain.
It considers ways to prescribe testosterone for your patients with endometriosis.
And it presents both preclinical and human evidence that endometriosis lesions are a consequence of low testosterone during fetal development.

Fistulas - we can find them; we can fix them

Judith Goh AO

In a 10-year period from 2008-2018, 56 women with iatrogenic fistulas were included in an analysis. For the majority of women, hysterectomy was the antecedent event (including abdominal hysterectomy, laparoscopic assisted and total laparoscopic hysterectomies). Other procedures resulting in fistulas included caesarean section (without hysterectomy), urethral slings, vaginal repair, urethral diverticulum surgery, excision of vaginal mesh complications, cervical cerclage, and construction of neo-vagina.

All women returned to the original surgeon with urinary incontinence. Almost 30% of injuries were recognised at time of initial surgery. Only 50% were referred by their original surgeons. All women returned to original surgeon for routine post-operative review complaining of urinary incontinence. Fifteen of the 56 women had a recognised intraoperative lower urinary tract injury at time of surgery. Women had on average 1.67 (range 1-5) investigations prior to referral for urinary incontinence or diagnosis of fistula. 17 women underwent urodynamic assessment for post-operative urinary incontinence (fistula not previously diagnosed). Other investigations for post-operative urinary incontinence included ultrasound scan of pelvis, MRI pelvis, CT cystourethrogram, CT pelvis and cystoscopy. 63% of these investigations gave a false negative or inconclusive result for fistula. Dye test was 100% accurate. Only 1 patient had 1 investigation prior to referral – the dye test; the other women had more than 1 investigation.

Thus, there is significant delay from initial surgery to referral for definitive management of fistula even in cases of intraoperative injuries. The dye test is a simple, low-cost test that was 100% successful in diagnosing a fistula in our hands.

Central sensitisation - I challenge you to make a difference

Carolyn Vandyken

Abstract not yet received.

SESSION SEVEN: PLANNING PELVIC FLOOR SURGERY: MITIGATING RISKS / 1335 - 1500

Hall K

Patient education - a team effort

Stephen Lyons

Abstract not yet received.

Modern pre-evaluation for prolapse surgery

Ellen Yeung

What can clinicians do pre-operatively to improve outcomes after prolapse surgery? This talk focuses on the evidence behind optimising several patient factors prior to prolapse surgery. It will also discuss the latest research on pre-operative vaginal oestrogen and summarise current guidelines for management of patient medications.

Pelvic pain and prolapse repair - a bidirectional relationship

Jason Chow

Abstract not yet received.

Surgery and voiding dysfunction - a bidirectional relationship

Rebecca Young

We will explore the factors to consider preoperatively; along with how to prevent and manage postoperative voiding dysfunction. Practical tips to optimise patient outcomes and cases will be discussed.

SESSION EIGHT: PELVIC FLOOR REPAIR - HYSTERECTOMY, UTERINE PRESERVATION AND THE OVERACTIVE BLADDER / 1530 - 1645

Hall K

Robotic VS laparoscopic pelvic floor repair

Marcus Carey

Abstract not yet received.

Vaginal endoscopic utero-sacral ligament suspension

Mark Ruff

Adjunct procedures for support of the vaginal vault at the time of hysterectomy may be employed to treat an existing apical prolapse or to reduce the risk of future prolapse. Both vaginal and abdominal approaches can be employed for this, including uterosacral ligament fixation, sacrospinous ligament fixation and sacral colpopexy. In this talk we will discuss a novel technique for uterosacral ligament fixation at the time of hysterectomy using a vaginal endoscopic approach. This approach allows suture placement high on the uterosacral ligaments with good visualisation of the ureters.

Anticholinergics - does it mess with the brain long term?

Tran Nguyen

Abstract not yet received.

Overactive bladder - please calm it down!

Todd Ladanchuk

Abstract not yet received.

Apical suspension at hysterectomy

Anna Rosamilia

Abstract not yet received.

Medtronic
Engineering the extraordinary

Better for Women

Bringing choice, control, and confidence to women's health.

It's time we work together to do better for women by providing the healthcare they deserve; to ensure there's no place for compromise. Talk to us today about how we're bringing choice, control and confidence to women's healthcare.

TruClear™
Tissue Removal System

LigaSure™
Retractable L-hook Device

V-loc™
Wound Closure Device

Sonicision™ Curved Jaw
Cordless Ultrasonic Dissection System

SurgiSleeve™ Wound protector with retractable ring

Valleylab™
FT10 Energy Platform

Please scan the code to register for one of our training courses or to be contacted by your local Medtronic Representative:

Medtronic Australasia Pty Ltd, 2 Alma Road, Macquarie Park NSW 2113
ANZ11087-032022