Australasian Gynaecological Endoscopy & Surgery Society Limited

WORLD ENDOMETRIOSIS SOCIETY
leading the way in endometriosis

The Limits and Limitations of Surgery and Endometriosis

Grand Hyatt, Melbourne, 2nd & 3rd August 2019

PROGRAM BOOKLET

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FOCUS MEETING

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A certificate of attendance will be emailed post-conference detailing the number of lecture hours. This can be used to claim RANZCOG CPD points.

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WELCOME TO THE AGES/WES FOCUS MEETING

Dear Colleagues,

It is our pleasure to welcome you to the AGES/WES Focus Meeting 2019, "The Limits and Limitations of Surgery and Endometriosis".

Our program over the next 2 days will cover a broad range of topics including bowel, urological, diaphragmatic and chest disease in endometriosis, along with fertility and ovarian surgery. There are sessions on techniques and evidence, as well as the complex areas of pain management before, after, and instead of surgery. We will also take a look at the limits of our treatment options and what to do when surgery and pharmacologic treatments fail the women.

We have a record number of registrations for this combined meeting and it's not the first time that AGES and WES have collaborated. In 2008 we also joined together and delivered the extremely successful 10th World Congress on Endometriosis – which was also held in Melbourne. This meeting has a strong clinical focus around surgery and examines the risks and opportunities for endometriosis surgeons and clinicians in our region.

We have an exceptional international faculty including Horace Roman from France, Sun-Wei Guo from China and Moamar Al-Jefout from Jordan/UAE, as well as highly regarded Australasian surgeons and scientists.

We hope you enjoy the coming days in Melbourne as we explore 'The Limits and Limitations of Surgery and Endometriosis'.

Thank you.

Sincerely,

Stuart Salfinger
President, AGES

Prof Neil Johnson
President, WES

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FRIDAY 2ND AUGUST 2019

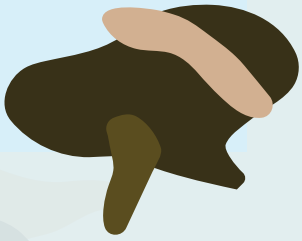
0700 - 0755	Conference Registration	
0755 - 1000	**SESSION ONE - THE EVOLUTION OF ENDOMETRIOSIS**	
	Session Chairs: Rachel Green & Sun-Wei Guo	*Mayfair Ballroom*
	Welcome - **Stuart Salfinger & Neil Johnson**	
	Endometriosis 2019 - **Jason Abbott**	
	Forget Sampson's theory, genetics are a theory with science - **Grant Montgomery**	
	Stem cells and their role in endometriosis: from diagnosis to treatment - **Caroline Gargett**	
	Epidemiology of endometriosis - **Gita Mishra**	
	Everything old is new again: hormone treatment in endometriosis - **Anusch Yazdani**	
	Panel Discussion	
1000 - 1030	MORNING TEA & TRADE EXHIBITION	*Savoy Ballroom*
1030 - 1230	**SESSION TWO - DOES RADICAL SURGERY HAVE A LIMIT?**	
	Session Chairs: Stephen Lyons & Helen Green	*Mayfair Ballroom*
	To the diaphragm and beyond: Management of the upper abdomen and the place of radical surgery - **Pip Walker**	
	KEYNOTE: Management of the lower bowel lesions, disc segmental or anterior resection - **Horace Roman**	
	What is the limit of radical excision of urologic disease - **Anita Clarke**	
	New understanding of the pathogenesis and pathophysiology of adenomyosis - **Sun-Wei Guo**	
	Limits and limitations of treatment for adenomyosis - **Luke McLindon**	
	Panel Discussion	
1230 - 1330	LUNCH & TRADE EXHIBITION	*Savoy Ballroom*
1330 - 1500	**SESSION THREE - THE LIMITS: OF THE SURGEON - WHO SHOULD AND WHO SHOULDN'T BE DOING SURGERY**	
	Session Chairs: Anusch Yazdani & Fiona Connel	*Mayfair Ballroom*
	If I knew then what I know now - **Donna Ciccia**	
	What constitutes a centre of expertise? - **Lone Hummelshoj**	
	Endometriosis: unmet need in patient centred care - **Deborah Bush**	
	How cognitive bias limits the surgeon - **Luk Rombauts**	
	Panel Discussion: 50-50 or phone a friend: what's your lifeline, Eddie?	
1500 - 1530	AFTERNOON TEA & TRADE EXHIBITION	*Savoy Ballroom*
1530 - 1700	**SESSION FOUR - THE LIMITATIONS: USING PAIN MANAGEMENT BEFORE, AFTER AND INSTEAD OF SURGERY**	
	Session Chairs: Catherine Allaire & Moamar Al-Jefout	*Mayfair Ballroom*
	Thinking outside the box: endometriosis co-morbidities - **Susan Evans**	
	Tuning in: neuromodulation and chronic pelvic pain - **Bruce Mitchell**	
	The complex plan for the complex patient: how the physio can keep things under control and the patient out of the ED - **Shan Morrison**	
	Cannabis and the Endocannabinoid system for endometriosis associated pain - **Justin Sinclair**	
	When, how and why to use a psychologist - **Jacqui Standford**	
	Panel Discussion	
1700	CLOSE OF DAY ONE	
1915 - 2230	**CONFERENCE DINNER** (COACHES DEPART GRAND HYATT AT 1845)	*Pure South Dining*

SATURDAY 3RD AUGUST 2019

0730 - 0800	Conference Registration	
0800 - 0930	**SESSION FIVE - THE LIMITS: FERTILITY AND OVARIAN SURGERY**	
	Session Chair: Luk Rombauts & Fariba Behnia-Willison	*Mayfair Ballroom*
	Similarities and differences in endometrium and endometriosis - **Peter Rogers**	
	Fertility preservation before ovarian surgery - **Jim Tsaltas**	
	Should women who want a pregnancy ever have surgery for endometriosis? - **Martin Healey**	
	When other options are preferable to surgery: Lipiodol and ART - **Neil Johnson**	
	Panel Discussion	
0930 - 1000	MORNING TEA & TRADE EXHIBITION	*Savoy Ballroom*
1000 - 1200	**SESSION SIX - THE LIMITS: TECHNIQUES AND EVIDENCE**	
	Session Chairs: Horace Roman & Catarina Ang	*Mayfair Ballroom*
	KEYNOTE: The interdisciplinary endometriosis pain clinic - **Catherine Allaire**	
	Evidence for nerve sparing surgery and endometriosis - **Dean Conrad**	
	The practical anatomy of nerve sparing surgery - **Danny Chou**	
	Endometriosis and neurological disease: nerves, the brain and more - **Jason Chow**	
	MRI for investigation of endometrosis - **Natalie Yang**	
	Panel Discussion	
1200 - 1300	LUNCH & TRADE EXHIBITION	*Savoy Ballroom*
1300 - 1500	**SESSION SEVEN - THE EVIDENCE IN PRACTICE: DOING SURGERY IN THE ENDOMETRIOSIS PATIENT**	
	Session Chairs: Kirsten Connan & Deborah Bush	*Mayfair Ballroom*
	Subtle endometriosis: a disease requiring intervention by surgery or a natural phenomenon? - **Moamar Al-Jefout**	
	Techniques for advanced disease - **Krish Karthigasu**	
	Treating the endometrioma: which surgical technique should I choose? - **Jade Acton**	
	Entering spaces, approaching dangerous places - **Michael Wynn-Williams**	
	Non-technical skills in the operating theatre: the key to multidisciplinary team working - **Joy Marriott**	
	Surgical volume and training: why should you be my doctor? - **Stuart Salfinger**	
	Panel Discussion: What are your limits? The worst case of endometriosis I have ever seen!	
1500	CLOSE OF DAY TWO AND CONFERENCE	

SOCIAL PROGRAM

Venue: Pure South Dining
Friday, 2nd August 2019
7.15pm
Ticket cost: $145.00
(Subject to availability)



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

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We remain a mutual organisation, serving our members, not shareholders, ensuring our members will always be at the heart of everything we do.

www.avant.org.au

AGES wishes to thank our major sponsors for their continued support. Without their contributions we could not deliver meetings of this standard.

Australasian Gynaecological Endoscopy & Surgery Society Limited

XX PELVIC FLOOR SYMPOSIUM 2019

DARE TO BE *Different*

ABSTRACT SUBMISSIONS CLOSE
FRIDAY, 30TH AUGUST 2019

EARLYBIRD REGISTRATIONS CLOSE
FRIDAY, 6TH SEPTEMBER 2019

REGISTRATION OPEN

1st & 2nd November 2019
Sheraton Grand
Sydney Hyde Park

To register visit the AGES website
www.ages.com.au

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^at an additional fee.

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Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

XX AGES Pelvic Floor Symposium 2019
Sheraton Grand Sydney Hyde Park
1st & 2nd November 2019

NOVEMBER 1 | NOVEMBER 2

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

AGES XXX
Annual Scientific Meeting 2020
Hyatt Regency, Sydney
5th - 7th March 2020

MARCH 5 | MARCH 6 | MARCH 7

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES/AAGL Focus Meeting 2020
The Kerry Hotel, Hong Kong
17th & 18th July 2020

JULY 17 | JULY 18

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

AGES XXI Pelvic Floor Symposium 2020
Adelaide Convention Centre
30th & 31st October 2020

OCTOBER 30 | OCTOBER 31

https://ages.com.au/ages-events/

Australasian Gynaecological Endoscopy & Surgery Society Limited
LAP-D WORKSHOP

AGES LAP-D Workshops
MERF QUT, Brisbane

2019
Demonstration Workshop:
17th August 2019

Dissection Workshop:
30th November 2019

AUGUST 17 | NOVEMBER 30

2020
Dissection Workshop:
4th April 2020
28th November 2020

Advanced Dissection Workshop:
5th April 2020

Demonstration Workshop:
29th August 2020

APRIL 4 | APRIL 5 | AUGUST 29 | NOVEMBER 28

AGES CLINICAL RESEARCH GRANTS 2020

The AGES Research Fund was conceived some 16 years ago, with the specific aim of targeting surgical research in gynaecology. The first awards for funding were granted in 2003 and since that time, more than 87 different projects have been funded or part-funded with more than 1.25 million dollars in grants allocated. Multiple large-scale randomised controlled trials, prospective cohort studies and retrospective reviews have received funding and had results published in national and international Journals.

Applications opened 1st June 2019

Applications close 31st August 2019

For further details https://ages.com.au/research/

Professor Rodger Hart
Chair, 2020 Research Grant Committee

PROGRAM ABSTRACTS

FRIDAY 2ND AUGUST 2019

SESSION ONE: THE EVOLUTION OF ENDOMETIOSIS / 0755 - 1000

MAYFAIR ROOM

ENDOMETRIOSIS 2019

Jason Abbott[1]

1. Alana Healthcare for Women, RANDWICK, NSW, Australia

With an estimated prevalence of 10% in reproductive life, some 730,000 Australian women have endometriosis with 176,000,000 worldwide having the disease. Healthcare and productivity loss due to endometriosis-associated pain symptoms costs in excess of $7billion annually in Australia and until recently it has been underestimated as a serious burden of illness to Society. An increase in awareness brought about through collaborations between patients and healthcare providers and driven by advocacy groups, has resulted in bipartisan agreement to tackle the problem. In 2017, the word endometriosis was first spoken in the Australian parliament and an official apology to women given by the Minister of Health, Greg Hunt. In 2018 after a rapid and combined effort from patients, scientists, clinicians, policymakers and parliamentarians, the first National Action Plan for any disease was launched for endometriosis. Initial funding of $4.5million for education and the establishment of the National Endometriosis Clinical and Scientific Trials (NECST) Network, has been further boosted by a $10million for endometriosis specific research funding and a national electronic platform to host an awareness and education hub. These changes provide the initial steps in a truly collaborative program for large-scale research and educational projects that are needed to continue the progress in the field of endometriosis care. Aligning clinical and scientific priorities with the needs of patients and participatory action from clinicians and scientists will see Australia at the forefront of endometriosis research and health-care policy in the next 10 years.

Forget Sampson's theory, genetics are a theory with science

Grant Montgomery[1]

1. University of Queensland, Brisbane, QLD, Australia

The aetiology of endometriosis has long been the subject of debate. The complexity of endometriosis is beginning to be revealed, and like many diseases, it is not straight forward. Genetic and genomic studies show genetic factors contribute to 50% of the variation in risk for endometriosis made up from many genetic risk factors with small effects. Genomic locations of over 40 genetic risk factors have been mapped, and the functional consequences underlying increased disease risk in some genomic regions are actively being pursued. The other 50% of risk is likely due to environmental factors. Recently, sequencing of endometriosis lesions identified a high burden of somatic (acquired) mutations in lesion including known cancer driver mutations. Somatic mutations appear specific to the epithelial cell compartment and are also seen in the eutopic endometrium. This suggests the possibility that abnormal epithelial progenitor cells in the eutopic endometrium can give rise to ectopic disease providing support for Sampson's theory. It is likely that disease risk is the result of the combined additive effects of the germline variants and somatic mutations working together to influence survival of critical cells during retrograde menstruation leading to initiation and progression of lesions. Understanding the spectrum of somatic mutations in endometriosis and the functional consequences of genetic risk factors is expected to lead to new diagnostic, therapeutic and preventive strategies.

Stem cells and their role in endometriosis: from diagnosis to treatment

Caroline Gargett[1]
1. The Ritchie Centre, Hudson Institute of Medical Research, Clayton, VIC, Australia

Human endometrium regenerates on a cyclical basis each month, likely mediated by endometrial stem/progenitor cells. Several types of endometrial stem/progenitor cells have been identified; $CD140b^{+}CD146^{+}$ or $SUSD2^{+}$ mesenchymal stem cells (eMSC), N-$cadherin^{+}$ epithelial progenitor cells and Side Population cells, a heterogeneous population predominantly comprising endothelial cells. eMSCs reside in a perivascular niche and may mediate angiogenesis and stromal regeneration. Human endometrial epithelial progenitor cells are located in the bases of glands in the basalis and may be more primitive than $SSEA\text{-}1^{+}$ basalis epithelial cells. Endometrial stem/progenitor cells may contribute to the pathogenesis of endometriosis by their retrograde shedding into the pelvic cavity, either after menarche or as a result of neonatal uterine bleeding. Clonogenic eMSCs have been identified in ectopic endometriotic lesions. eMSCs may have a role in the generation of progesterone resistant phenotype of endometrial stromal fibroblasts in endometriosis. Bone marrow derived cells may contribute to endometriosis lesion development, but the identity of these cells is currently unknown. In future clinical practice, menstrual fluid may be assessed as a potential relatively non-invasive diagnostic for endometriosis if endometrial stem/progenitor cell concentrations or their gene profiles are sufficiently different between women with and without endometriosis. eMSC have immunomodulatory and anti-inflammatory properties that could be harnessed as potential therapeutic agents for treating endometriosis.

Epidemiology of endometriosis

Gita Mishra[1]

1. *University of Queensland, St Lucia, QLD, Australia*

It is estimated that about 10% of women have endometriosis, however in the absence of a non-invasive diagnostic test, these data are debated. The Australian Longitudinal Study on Women's Health provides important information on the prevalence of the disease by age and linked data are providing new insights into the epidemiology of endometriosis. This presentation will highlight some of these new findings.

Everything old is new again: hormone treatment in endometriosis

Anusch Yazdani[1]

1. *Eve Health, Brisbane, QLD, Australia*

Abstract not yet received.

SESSION TWO: DOES RADICAL SURGERY HAVE A LIMIT? / 1030 – 1230

MAYFAIR ROOM

To the diaphragm and beyond: Management of the upper abdomen and the place of radical surgery

Pip Walker[1]

1. *Obstetrics and Gynaecology, Waikato District Health Board, Hamilton, Waikato, New Zealand*

Endometriosis of the upper abdomen and thoracic cavity is a rare and serious disorder. Although the exact prevalence of extrapelvic endometriosis is unknown, diaphragmatic endometriosis is the most frequent extrapelvic site. The finding of endometrial implants in the airways, pleura, pericardium, and/or lung parenchyma is known as thoracic endometriosis syndrome (TES). Chest pain is one of the most common symptoms and is typically catamenial. The right chest is affected in 95% of patients, most patients will also have concomitant pelvic endometriosis, and up to 60% will have infertility.

Aetiology has not yet been completely elucidated. Menstrual fluid which travels from the peritoneal cavity to the sub diaphragmatic area passes through diaphragmatic fenestrations which serve as entry portals for peritoneal fluid containing endometrial tissue to access the pleural space.

Due to its rarity, there are no guidelines and little evidence to guide best practice of endometriotic lesions in the upper abdomen or thoracic cavity. Expectant management is the preferred approach in asymptomatic patients. Hormonal suppressive therapy may be tried in those with symptoms. Surgical excision offers definitive management. A multidisciplinary team approach, that is, support from a general surgeon and/or cardiothoracic surgeon is crucial to the management of this disease in order to facilitate a safe and complete excision. Optimal patient positioning and comprehensive disease mapping will help avoid leaving behind residual disease. Simultaneous laparoscopy and thoracoscopy can be considered for those with diaphragmatic lesions. There is risk of recurrence after excision and post-operative hormonal suppression is recommended in those not planning for immediate pregnancy.

Management of the lower bowel lesions, disc segmental or anterior resection

Horace Roman[1]

1. WES, France

Deep intestinal endometriosis (DIE) is the most frequent among the most severe forms of endometriosis. Medical treatment for DIE can reduce the symptoms but does not cure the disease. Surgical removal of the lesion is required when lesions are symptomatic, impairing bowel, urinary, sexual and reproductive functions. Although several surgical techniques such as laparoscopic bowel resection, disc excision or rectal shaving have been described, there is no consensus regarding the choice of technique or the timing of surgery. Various reviews of publications reporting the results and complications of surgery for DIE nodules revealed higher complication rate after bowel resection when compared to shaving and disc excision, especially for rectovaginal fistulas, anastomotic leakage, delayed hemorrhage and long-term bladder catheterization. Data in the literature show that conservative surgery is feasible even in advanced disease. The risk of immediate complications after conservative surgery is probably lower than after colorectal resection, allowing for functional outcomes at least as good as colorectal resection. The risk of postoperative bowel stenosis is higher after colorectal resection. The presumed higher risk of recurrence related to conservative surgery has not been demonstrated during the first 5 years after the surgery. Although the risk of low anterior rectal resection syndrome is well known after low colorectal resection, the unique randomized trail comparing conservative surgery and colorectal resection did not reveal significant differences in terms of postoperative digestive function. Postoperative pregnancy rates after surgery of colorectal endometriosis are high, at least as high as those observed after first line IVF. Furthermore, there is a high probability of postoperative spontaneous conception. For these reasons, surgeons should consider rectal shaving for the first-line surgical treatment of rectal endometriosis, any time this technique completely removes bowel infiltration; when the result of rectal shaving is unsatisfactory, disc excision may be performed either exclusively by laparoscopy or by using transanal staplers. Segmental resection may ultimately be reserved for advanced lesions responsible for major stenosis or for multiple nodules infiltrating the rectosigmoid. Disc excision and short segmental resection may be associated, instead of long/low “en block” colorectal resection, in patients with multiple rectosigmoid nodules when the distance between two consecutive nodule exceeds 5-7 cm. The main goal of surgical strategy should focus on the best conservation of pelvic organs and the improvement of the quality of life.

What is the limit of radical excision of urologic disease

Anita Clarke[1]

1. *WA Cancer & Palliative Care Network, Perth, WA, Australia*

Approximately 5% of women with established endometriosis have involvement of the urinary tract. Accurate diagnosis and confirmation of the extent of the disease involving the urinary tract is a vital part of directing appropriate treatment options. Deep infiltrating endometriosis generally requires surgical removal and the principles of treatment are based on complete surgical excision whilst minimizing the impact on the structure and function of the urinary tract. Diagnostic techniques and surgical principles in managing endometriosis of both the ureter and the bladder will be discussed and the principles of reconstruction will be reviewed.

New understanding of the pathogenesis and pathophysiology of adenomyosis

Sun-Wei Guo[1]

1. *WES, China*

Adenomyosis is a common gynecological disorder affecting about 20% of women of reproductive age. It is responsible for pelvic pain, heavy uterine bleeding and infertility. Both of its pathogenesis and pathophysiology are poorly understood and frequently viewed as enigmatic. In the last few years, accumulating data indicate that adenomyotic lesions are wounds undergoing repeated tissue injury and repair (ReTIAR), just like endometriotic lesions. In this talk, I should show data to demonstrate that adenomyotic lesions undergo ReTIAR and ultimately become highly fibrotic lesions, in conjunction with enlarged uterus size. This essentially depicts the natural history of adenomyotic lesions, which can be capitalized to devise novel diagnostic procedures. I shall also show how adenomyosis can be artificially induced in mouse, which sheds new light on the pathogenesis of adenomyosis.

Limits and limitations of treatment for adenomyosis

Luke McLindon[1]

1. *Mater Health, Brisbane, Queensland, Australia*

Adenomyosis is a disease known to contribute to pelvic pain, abnormal bleeding and adverse reproductive outcomes. If we consider it a medical or surgical disease – management is often absolute in the loss of fertility. Is there a place for a conservative approach and do the outcomes justify the risks?

SESSION THREE: THE LIMITS OF THE RADICAL SURGEON – WHO SHOULD AND WHO SHOULDN'T BE DOING SURGERY / 1330 - 1500

MAYFAIR ROOM

If I knew then what I know now

Donna Ciccia[1]

1. *Endometriosis Australia, ., NSW, Australia*

You've learnt a lot on this endometriosis journey. Sometimes we feel we could write a book on it, but what would be the one thing you would tell your 16-year-old self?

This question was posed to Endometriosis Australia's 51+K social media followers and here is what we all had to say.

What constitutes a centre of expertise?

Lone Hummelshoj[1]

1. *World Endometriosis Society, London, England, United Kingdom*

The establishment of centres of expertise has been acknowledged for over a decade as a sensible and responsible way forward to ensure that those with endometriosis receive optimal management of their life altering condition. As an example, referral centres of expertise are already well established in oncology. Without specialist care there is a high risk of "hit and miss" treatmenta with a consequent impact on women's symptoms – and lives. There is no evidence that demonstrates that specialist care and centres of expertise make a difference in the outcomes of the treatment of endometriosis – because no studies have been undertaken to evaluate this. Yet centralised care was established in Denmark in 2001 by the national institute of health (Sundhedsstyrelsen), and models of specialist care have since emerged in Germany and the UK, though structured and managed differently with differing criteria. Is it possible to establish a broad consensus on what constitutes the optimal, specialised, care for those with endometriosis - and should such care be contained within a centre of expertise?

Endometriosis: unmet need in patient centred care

Deborah Bush[1]

1. *WES, Vancouver*

Endometriosis has significant impacts on the physical, psychological, financial, social and mental well-being of affected individuals due to ongoing chronic symptoms, diagnostic delays and uncertainty associated with treatment and disease recurrence. Additionally, endometriosis places considerable economic burden on the individual and society. Given the effect endometriosis has on so many aspects of life, we can presume that women with this disease have considerable unmet need.

This presentation will examine how we can best meet those unmet needs through a patient-centred, multi-disciplinary approach to care, given there is currently little evidence to quantify the unmet need. Studies from other persistent and painful conditions show that good education and knowledge of disease and good physical functioning is positively associated with patient involvement in their care and satisfaction with their care. Above all – we need to assess and determine who cares!

How cognitive bias limits the surgeon

Luk Rombauts[1]

1. *Monash University, Richmond, VIC, Australia*

Abstract not yet received.

SESSION FOUR: THE LIMITATIONS: USING PAIN MANAGEMENT BEFORE, AFTER AND INSTEAD OF SURGERY / 1530 - 1700

MAYFAIR ROOM

Thinking outside the box: endometriosis co-morbidities

Susan Evans[1]

1. *Pelvic Pain SA, Norwood, SA, Australia*

When we think of Endo, we think of period pain and lesions. However, women with endometriosis have a wide range of clustered co-morbid conditions, and women with dysmenorrhea based pelvic pain don't always have Endo. A study of 168 consecutive women presenting to a gynaecologist with pelvic pain that included dysmenorrhea found an average of 8 symptoms per woman.

This presentation looks at the basis for understanding her pain and provides a rational approach to treating each woman's full pain experience.

It considers the symptom profile in women with and without Endo, the neuroanatomy underlying her symptoms, the language she uses to describe her pain, and the effect of the immune system on pain. It describes practical methods to address these symptoms in everyday practice.

Tuning in: neuromodulation and chronic pelvic pain

Bruce Mitchell[1]

1. *Monash Clinical Research, Clayton*

Pelvic pain can be generated from the structures within the pelvis or be referred from the pelvic girdle or spine.

Most data on the outcomes of sacral nerve stimulation have been based on single leadsd placed (usually) at S3 or via the Posterior Tibial nerve. These have been limited further by the lack of stimulation parameters and power available. Some recent studies have looked at outcomes from repurposed Spinal Cord Stimulation systems being placed via the sacral hiatus. More recent advances in technology have allowed 4 foraminal leads with advanced stimulation options to be placed on the sacral DRG's. Also, for 2 sacral octrode leads and 2 pudendal octrode leads to be placed together as well as combination of sacral/pudendal stimulation with conus stimulation.

Outcome data on a prospective case series of sacral hiatus stimulation to treat pelvic and low back pain will be presented.

The complex plan for the complex patient: how the physio can keep things under control and the patient out of the ED

Shan Morrison[1]

1. *Specialist Women's, Men's & Pelvic Health Physiotherapist, Camberwell, VIC, Australia*

Chronic pelvic pain (CPP) in women, especially those with endometriosis, is associated with significant morbidity and financial burden to the individual, as well as their partners, families and the wider community. It involves a complex interplay of biological, behavioural, environmental and societal factors, compounded by intricate neurogenic innervation of closely related visceral and somatic structures, the intimate nature of the pelvis, and the impact on personal relationships and sexuality.

Despite optimal gynaecological treatment, many women with endometriosis experience ongoing bladder, bowel and sexual dysfunction. One contributing factor to this is dysfunction in the internal and external pelvic musculature. Increased tension and myalgia in the pelvic floor, abdominal, hip and external pelvic muscles are commonly associated with endometriosis and CPP severity and is an emerging reason for referral to pelvic health physiotherapists. Reduced flexibility, dyssynergia, altered motor control with a habitual holding pattern and reduced capacity to relax these muscles may be present both in voluntary and functional scenarios. Commonly these muscles contract involuntarily in response to threat, occurring without conscious awareness.

There is also growing appreciation that CPP in women with endometriosis may be the manifestation of central sensitisation, regardless of the endometriosis-specific factors. Amplification, viscero-visceral, and viscero-somatic convergence explains the link between gynaecological pain and other visceral (ie bladder) or somatic (ie pelvic floor muscle) structures. Both peripheral and central abnormalities have been implicated in endometriosis, indicating central hypersensitivity, and therefore an inherent need to address central nervous system dysfunction. There is strong evidence for a biopsychosocial approach to management of endometriosis-related pelvic pain, due to the high prevalence of contributing psychological variables.

Based on this rationale, physiotherapy management, applying an individualised biopsychosocial model with the application of explaining pain neuroscience, is widely advocated. Addressing the complexity of the pain experience physiotherapeutically means assessing and managing local tissue issues, within a broader context of sensitised protective mechanisms resulting from central nervous system sensitivity.

Treatment seeks to build self-efficacy and reduce catastrophising, which has been associated with pelvic pain severity. Physiotherapy management commonly involves education, techniques to relax the muscles ('down training'), internal manual therapy techniques, biofeedback, and home exercise with vaginal trainers. Neuroscience-based pain education is a crucial component of treatment and is an effective treatment in itself. This may include education and reassurance around normal laparoscopy findings which can contribute positively to pain resolution. Bladder and bowel function also need to be assessed, as overactive bladder or irritable bowel with diarrhea may be contributing to the upregulation of the pelvic floor muscles by having to "hold on". The current evidence for various aspects of the pelvic health physiotherapy approach will be explored.

Cannabis and the Endocannabinoid system for endometriosis associated pain

Justin Sinclair

Abstract not yet received.

When, how and why to use a psychologist

Jacqui Standford[1]

1. *EmpowerRehab, Rosanna, VIC, Australia*

When working with clients with chronic pelvic pain, it is important to identify both the psychosocial factors and any psychological disorders that may exist.

Psychosocial factors include factors such as concern, uncertainty, and relationship changes. The psychosocial factors need to be considered by all people involved in the treatment team, and sometimes psychological treatment will be needed. Psychological disorders may pre-exist or develop subsequent to the pain. Common disorders include anxiety, depression and trauma.

Pain management and psychological treatment needs to be integrated. Acceptance and Commitment Therapy and Cognitive Behavioural Therapy are both effective interventions for both the psychosocial factors and psychological disorders.

In order to achieve optimal outcomes, treatment needs to be collaborative. It is up to each of us to contribute, initiate and support multidisciplinary, and hopefully interdisciplinary treatment.

SATURDAY 3RD AUGUST 2019

SESSION FIVE: THE LIMITS: FERTILITY AND OVARIAN SURGERY / 0800 - 0930

MAYFAIR ROOM

Similarities and differences in endometrium and endometriosis

Peter Rogers[1]

1. *University of melbourne, Parkville, VIC, Australia*

Although endometriotic lesions are the primary pathology at the centre of endometriosis, relatively little attention has been focussed on them compared to eutopic endometrium. There is a poor correlation between lesion appearance and disease symptoms, and limited understanding of their origin or life cycle. Retrogradely shed endometrium is most commonly thought to be the primary source of tissue that goes on to form endometriotic lesions, although other potential mechanisms exist. While considerable work has been undertaken on many different aspects of eutopic endometrial biology, the same is not true for lesions. The clinical definition of endometriosis requires pathological confirmation that surgically excised tissues contain endometrial-like stroma and glands, although they are seldom of a normal endometrial appearance. Under pathological examination, lesions are highly heterogeneous, and can include significant inflammatory elements and invading nerve fibres; features not typically found in eutopic endometrium. At a functional level there is a view that lesions do not respond to progesterone or are progesterone resistant. Experimental data on hormonal response of lesions in humans is also very limited.

Fertility preservation before ovarian surgery

Jim Tsaltas[1]

1. *Freemasons Medical Centre, East Melbourne, VIC, Australia*

In this lecture I would like to focus on the evidence on the impact of endometriosis and endometriomas on ovarian reserve. There is certainly data to suggest the damage to ovarian reserve occurs prior to any surgical intervention. If there is a significant concern about ovarian reserve, then strategies need to be implemented for fertility preservation. I will outline the place of ovarian tissue freezing, CoQ10 to improve ovarian reserve, egg and embryo freezing. I will also discuss the place of two step endometrioma surgery depending on size of endometrioma and AMH levels. I will not discuss surgical approach for endometriomas as this will be covered in a lecture later in programme.

Should women who want a pregnancy ever have surgery for endometriosis?

Martin Healey[1]

1. *Monash IVF Victoria; Royal Womens Hospital Victoria, Malvern East, VIC, Australia*

Does endometriosis cause infertility? Does treatment of endometriosis improve success of natural conception or IVF success? These two questions are at the core of a longstanding debate on the role of surgical management of endometriosis for infertility. This presentation will explore the effect of surgical treatment of endometriosis on natural conception and IVF, as well as exploring the specific areas of management of endometriomas and hydrosalpinges.

When other options are preferable to surgery: Lipiodol and ART

Neil Johnson[1]

1. *WES, New Zealand*

Robinson Research Institute, University of Adelaide; University of Auckland, New Zealand; Auckland Gynaecology Group and Repromed Auckland, 105 Remuera Road, Auckland, NZ; President, World Endometriosis Society.

None of us can be overly confident about the effectiveness of laparoscopic removal of endometriosis for improving fertility for women with endometriosis-related infertility. Best estimates of the benefit of laparoscopic removal are modest, with a 95% confidence intervals that includes the possibility of no benefit. There are circumstances in which surgery can be harmful to fertility, particularly if young women undergo repeated removal of ovarian endometriomas, such repeated surgery having a potentially damaging effect on ovarian reserve.

Results of a systematic review and network meta-analysis will be presented that endeavours to compare all fertility treatment options for women with endometriosis, including surgery. It will surprise no-one to learn that new good randomised studies are needed to compare the effectiveness of in vitro fertilisation (IVF), intrauterine insemination (IUI), lipiodol (which appears to be uniquely beneficial for the fertility of women with endometriosis) and laparoscopic surgery. However other results might be considered surprising.

SESSION SIX: THE LIMITS: TECHNIQUES AND EVIDENCE / 1000 - 1200

MAYFAIR ROOM

The interdisciplinary endometriosis pain clinic

Catherine Allaire[1]

1. *UBC Department of Obstetrics and Gynaecology, Vancouver, BC, Canada*

This session will discuss our current understanding of endometriosis-associated persistent pelvic pain, highlight useful tools in the assessment of this problem, review the evidence supporting an interdisciplinary approach and explore how this can be adapted to the general gynecologist's practice.

Evidence for nerve sparing surgery and endometriosis

Dean Conrad[1]

1. *SWEC, Sydney*

Abstract not yet received.

The practical anatomy of nerve sparing surgery

Danny Chou[1]

1. *Sydney Women's Endosurgery Centre, Kogarah, NSW, Australia*

Abstract not yet received.

Endometriosis and neurological disease: nerves, the brain and more

Jason Chow[1]

1. *Operative Gynaecologist and Pain Physician, Sydney*

The pain of endometriosis is often attributed to endometriotic lesions and the changes to peripheral and visceral nerves. This reinforces a Cartesian paradigm to understanding endometriosis related pain. The neurobiology of endometriosis related pain and its effects on pain mechanisms is not a part of usual gynaecology curricula but is important to understand and helps direct management. This presentation will focus on the clinical implications of understanding pain neurobiology and why it matters to the gynaecological surgeon.

MRI for investigation of endometriosis

Natalie Yang[1]

1. *Department of Radiology, Austin Health, Melbourne*

Although ultrasound remains the first line imaging modality for endometriosis, Magnetic Resonance Imaging (MRI) is increasingly being performed when the ultrasound examination is incomplete/limited (often due to patient pain), when cases are complex, for surgical planning or as a potential problem-solving tool. According to the European Society of Urogenital Radiology (ESUR)1, there is no current international consensus regarding patient preparation, MRI protocols or reporting criterion. At Austin Health, (10 years' experience in performing pelvic MRI for endometriosis in a multidisciplinary team (MDT) setting) pelvic MRI for assessment of endometriosis is performed at 1.5 Tesla, with a phase array, surface coil. IV buscopan is administered at the commencement of the scan, but there is no specific bowel preparation, no vaginal gel and no gadolinium (contrast agent) except if there is concern regarding an ovarian lesion. Our imaging protocols include the Coronal T2 SPACE (with multiplanar reformats), sagittal T2 high resolution small FOV through the rectum, axial T1 non-fat saturated through the pelvis and 3 plane T1 fat saturated sequences. The talk will review key pelvic MRI anatomy, as well as the classic MRI appearances of endometriosis.

SESSION SEVEN: THE EVIDENCE IN PRACTICE: DOING SURGERY IN THE ENDOMETRIOSIS PATIENT / 1300 - 1500

MAYFAIR ROOM

Subtle endometriosis: a disease requiring intervention by surgery or a natural phenomenon?

Moamar Al-Jefout[1]

1. *WES, Jordan/UAE*

Abstract not yet received.

Techniques for advanced disease

Krish Karthigasu[1]

1. *Hollywood Medical Centre, NEDLANDS, WA, Australia*

Abstract not yet received.

Treating the endometrioma: which surgical technique should I choose?

Jade Acton[1]

1. *SJOG Subiaco, Subiaco, WA, Australia*

Ovarian endometrioma can be found in up to 17-44% of women with endometriosis and are often associated with the severe form of the disease. They are thought to occur during invagination of endometriosis tissue/cells through the ovarian serosa, for example during remodelling of the ovarian cortex after ovulation.

Endometrioma can present a clinical dilemma – should they be treated if asymptomatic and how are they best treated to reduce the risk of recurrence with minimal damage to the underlying normal ovarian tissue?

This presentation will discuss the evidence and expert opinions behind the techniques for the surgical management of endometriomas, including cystectomy, ablation, plasma energy ablation and electrocautery. The importance of the underlying clinical factors in making the decision in which approach to take will be explored and finally fertility preserving surgery and techniques for minimal tissue damage will also be discussed.

Entering spaces, approaching dangerous places

Michael Wynn-Williams[1]

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

Abstract not yet received.

Non-technical skills in the operating theatre: the key to multidisciplinary team working

Joy Marriott[1]

1. *Auckland DHB, Auckland, NEW ZEALAND, New Zealand*

NTS are an essential prerequisite for surgical competency and safe patient care in the operating theatre. Given the complexity of endometriosis surgery and the potential for the involvement of various surgeons from different specialties, the importance of NTS for the endometriosis surgeon is axiomatic.

I will summarise the literature regarding the role of NTS in surgery and outline tools for the assessment of NTS in the operating theatre, presenting data on the reliability and validity of the NOTSS tool, a workplace-based assessment tool used by various Colleges of Surgery internationally.

I will explore the current assessment of NTS for AGES trainees and the potential value of NTS training in the AGES programme.

Surgical volume and training: why should you be my doctor?

Stuart Salfinger[1]

1. *St. John of God Hospital, Perth*

Abstract not yet received.

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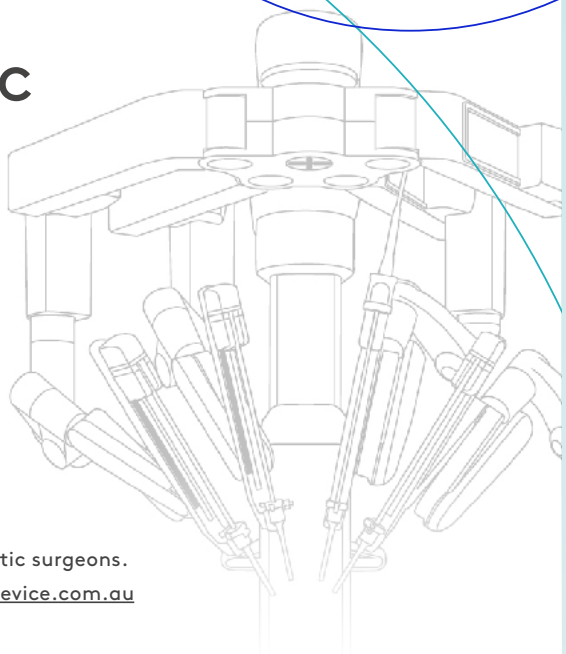

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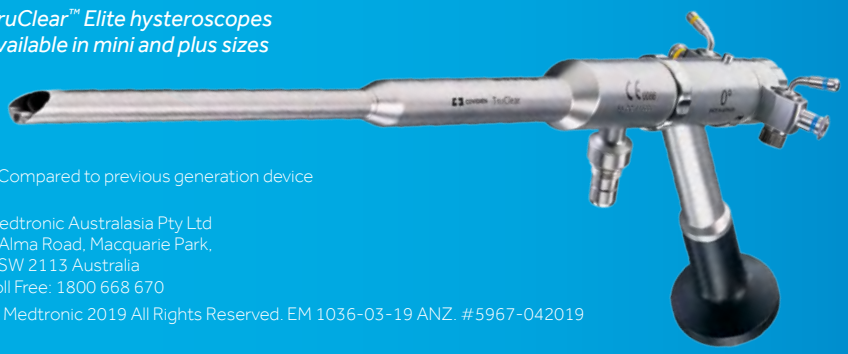

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