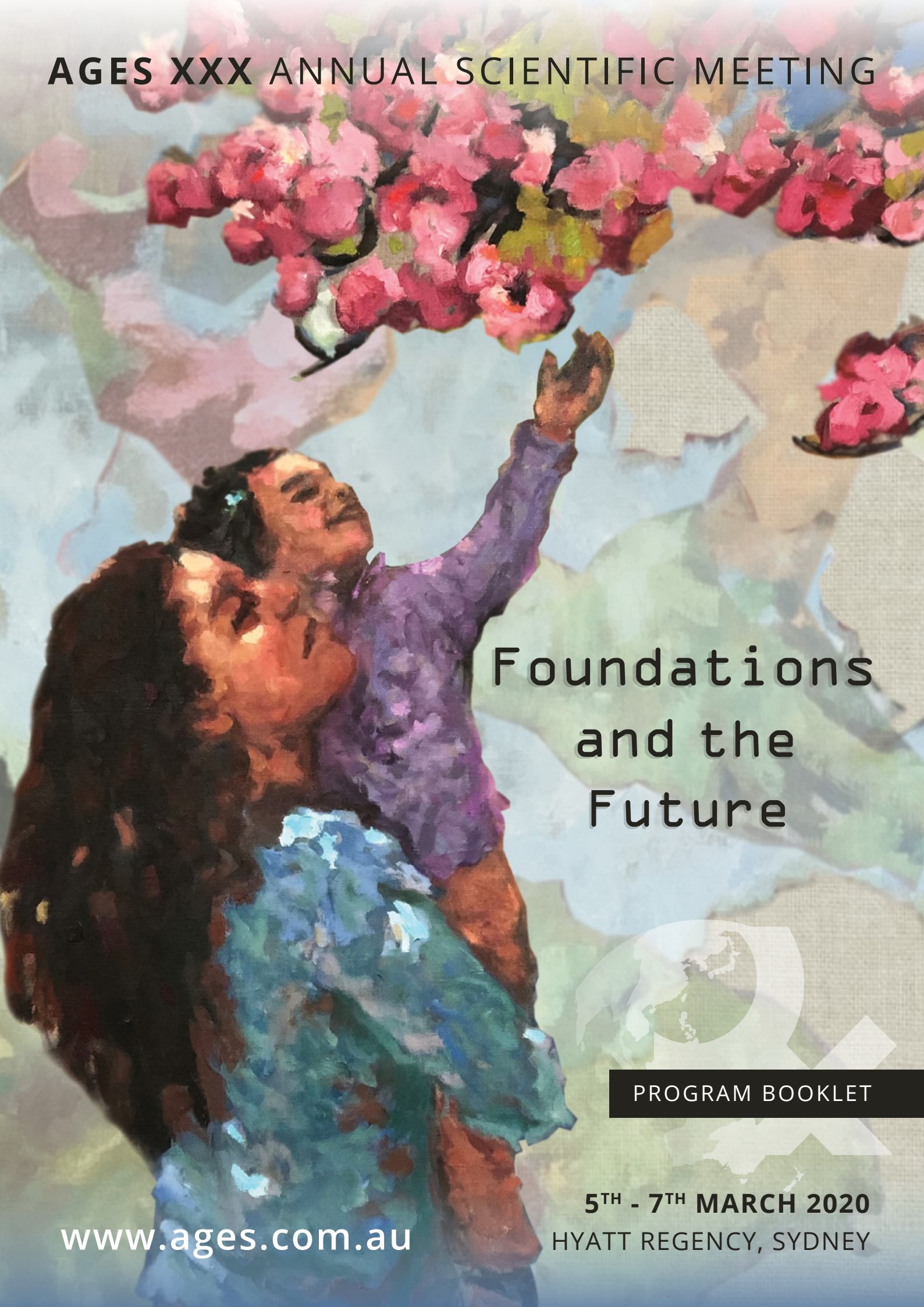
AGES XXX ANNUAL SCIENTIFIC MEETING



Foundations and the Future

PROGRAM BOOKLET

5TH - 7TH MARCH 2020

HYATT REGENCY, SYDNEY

www.ages.com.au

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INVITED INTERNATIONAL FACULTY

Dr Chad Michener	USA
Prof Marc Possover	FRA

INVITED FACULTY

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Dr Marie Fidela Paraiso	USA	Dr Kerryn Phelps	NSW

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CPD POINTS
This is a RANZCOG accredited meeting. Fellows of the college can claim 18.5 hours for Full Registration (3 days).

MEMBERSHIP OF AGES
Membership application forms are available from the AGES website or from the AGES Secretariat.
https://ages.com.au/membership-application/

This brochure and online registration are available on the AGES website: **www.ages.com.au**

WELCOME LETTER

We would like to welcome you to Sydney, the city that dazzles by day and by night, and home of the Sydney Opera House, the Harbour Bridge and some of the world's most beautiful beaches, for the AGES XXX Annual Scientific Meeting "*Foundations & the Future*" to be held on from the 5th to the 7th March 2020.

The theme "*Foundations and the Future*" encompasses two sub-themes. Firstly, our society has solid foundations established by previous AGES Boards and its members but also needs to remain dynamic to remain of relevance to its Members so that best care for our patients is ensured. Secondly, core topics relevant to all gynaecological surgeons will always remain central to AGES' role in ongoing education for its Members; in addition, new and advanced laparoscopic surgical techniques, as well as cutting-edge technologies will be showcased so that our Members can stay abreast of modern gynaecological endoscopic options for their patients.

The AGES ASM 2020 scientific committee has developed a program showcasing a spectacular team of local and international speakers, including Marc Possover from France and Chad Michener from the USA. We are also joined by Marie Fidela Paraiso, the immediate past president of the AAGL. In addition, Annabelle Farnsworth will be the first female to have the honour of delivering the Dan O'Connor Perpetual Lecture, and to top it all off, in the very last session Dr Kerryn Phelps AM will have the vexed task of "herding the cats" in the *AGES Q&A Forum*.

We hope you enjoy the next few days, in a not to be missed meeting, taking us back to our foundations and guiding us towards the future of gynaecology, obstetrics and more – Foundations and the Future!

Dr Stephen Lyons
Conference Chair
AGES, Vice-President

Dr Bassem Gerges
Scientific Chair
AGES, Director

INVITED FACULTY

Dr Chad Michener

Prof Marc Possover

Dr Jan Baekelandt

A/Prof Annabelle Farnsworth

Dr Marie Fidela Paraiso

Prof Kerryn Phelps

Please find the Invited Faculty Biographies on the following page.

INVITED INTERNATIONAL FACULTY

Dr Chad Michener

Dr. Chad Michener is a board certified Gynecologic Oncologist and Associate Professor of Surgery in the Cleveland Clinic Lerner College of Medicine. Dr. Michener completed residency in Obstetrics and Gynecology at Bethesda Hospital in Cincinnati, OH. Following his residency he was a Cancer Research Fellow in the Molecular Signaling Section of the Laboratory of Pathology at the National Cancer Institute and subsequently completed his clinical fellowship in Gynecologic Oncology at the Cleveland Clinic. He joined the Division of Gynecologic Oncology in the Women's Health Institute at the Cleveland Clinic in 2004. He is currently Interim Chair of the Department of Subspecialty Services for Women's Health and serves as the Associate Fellowship Director for Gynecologic Oncology.

Research interests include genetic basis of Gynecologic cancers, screening and early detection of gynecologic cancers, chemoresistance in ovarian cancer, and the application of Single port, robotic and standard laparoscopy in the treatment of gynecologic cancers.

Prof Marc Possover

Prof Marc Possover began his medical studies at the University of Nancy in France at the age of 15 and graduated at the age of 22. He is a specialist in Gynecology and Obstetrics as well as a certified specialist in Special Operative Gynecology and Oncological Surgery.

Prof. Possover is Director of The Possover International Medical Center AG in Zurich, Professor of Neuropelveology at the University of Aarhus, Denmark, and Associate Professor at the University of Cologne, Germany. Prof. Possover is also President of the International Society of Neuropelveology (www.theison.org), the pioneer of minimally invasive surgical techniques for the treatment of pelvic gynecological tumors and deep infiltrating endometriosis, and the world's leading expert in the treatment of pelvic nerve disease.

Prof. Possover is the pioneer and founder of Neuropelveology - a new discipline in medicine that deals with neuropathic pelvic pain, endometriosis of the pelvic nerves and pelvic nerve dysfunctions. He has developed nerve-sparing pelvic surgery and a method for the laparoscopic implantation of neuroprostheses. Neuromodulation, which enables patients with spinal cord injuries to regain some functions, was also developed by Prof. Possover.

Prof. Possover is nationally and internationally renowned for his research, academic and clinical merits in the fields of gynaecological oncology, surgical endometriosis treatment and Neuropelveology. He has written scientific papers for numerous scientific journals and published articles in various medical textbooks and reference books. His numerous awards from leading and highly respected medical associations prove his competence and exceptional knowledge.

INVITED FACULTY

Dr Jan Baekelandt

Jan Baekelandt qualified as a medical doctor in 1999 and as a specialist in gynaecology and obstetrics in 2004 at the Catholic University of Leuven, Belgium. From 2004 to 2006, he subspecialised as a gynaecological oncologist in Pretoria, South Africa, and Koln, Germany. He currently consults at Imelda Hospital in Bonheiden, Belgium, specialising in gynaecological oncology and endoscopic and robotic surgery. Jan started his vNOTES research in 2012, introduced vNOTES in his daily practice in 2013, and has performed more than 1000 vNOTES cases to date.

A/Prof Annabelle Farnsworth

A/Professor Annabelle Farnsworth is a graduate of the University of Sydney and trained as a histopathologist at Royal Prince Alfred Hospital. She was Director of Anatomical Pathology at the Royal Hospital for Women, Paddington, before joining the Douglass practice in 1995. A/Professor Farnsworth is a specialist gynaecological histopathologist and cytopathologist and is the Director of Cytopathology and GynaePath at Douglass Hanly Moir Pathology where she also holds the position of Medical Director. She is well known throughout Australia and internationally for her contributions to cytology and gynaecological pathology. She is a past President of the Australian Society of Cytology and a member of the Executive Committee of the International Academy of Cytology. She is the current president of the Australian Society of Colposcopy and Cervical Pathology. Annabelle is Head of Pathology at the University of Notre Dame, School of Medicine Sydney. A/Professor Farnsworth has published numerous papers and is co-author of a respected textbook on ovarian pathology. In 2013 she was made an Honorary fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Dr Marie Fidela Paraiso

Dr. Paraiso is a staff physician in the Department of Obstetrics and Gynecology at Cleveland Clinic, where she also serves as Head of the Center for Urogynecology and Reconstructive Pelvic Surgery. She also sees patients in the Center for Specialized Women's health and has a joint appointment in Urology.

Dr. Paraiso is skilled in advanced laparoscopy, robotic surgery, midurethral slings, mini-slings, advanced vaginal reconstructive surgery, pelvic organ prolapse repair kit procedures, and sacral neuromodulation (bladder pacemakers). Most recently, Dr. Paraiso has embraced the burgeoning field of robotic surgery, adapting several of her innovative surgical techniques to robotic-assisted laparoscopic approaches.

Prof Kerryn Phelps

Dr Kerryn Phelps AM is a mother, doctor, business woman, health communicator, public health and civil rights advocate, author and media commentator.

Dr Phelps was the first woman and Independent to be elected to the seat of Wentworth in the House of Representatives, in the Federal By Election 2018. In 2016 she was elected to the City of Sydney Council, and was Deputy Lord Mayor from 2016 to 2017. She was first female President of the Australian Medical Association.

For two decades, Dr Phelps has been at the forefront of the struggle for LGBTQI inclusion and equality in Australia. She is also an Ambassador for Barnardo's child protection work, a Patron of ACON's Pride in Health+Wellbeing program.

Her media career includes medical reporting on morning television, health columnist for over 25 years for the Australian Women's Weekly and authoring six health books.

Dr Phelps was awarded an Order of Australia for her contributions to Medicine as well as the Centenary Medal.

Australasian Gynaecological
Endoscopy & Surgery
Society Limited

TOGETHER TOWARDS TOMORROW

THURSDAY 5TH MARCH 2020

0700 - 0800	REGISTRATION		*Maritime Ballroom & Foyer*
0800 - 1010	**SESSION ONE: FUTURE** *Session Chairs: Stephen Lyons & Stuart Salfinger*		*Grand Ballroom*
	Welcome		
	KEYNOTE: Neuropelveology - A new discipline in medicine - **Marc Possover**		
	KEYNOTE: Total abdominal hysterectomy - Please explain! - **Chad Michener**		
	Beyond sacral colpopexy: When robotics is most useful in pelvic organ prolapse surgery - **Marie Fidela Paraiso, AAGL President**		
	vNOTES and pathways to the future - **Jan Baekelandt** *(Sponsored by Applied Medical)*		
	Panel Discussion		
1010 - 1040	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		*Maritime Ballroom & Foyer*
1040 - 1230	**SESSION TWO A: HYSTERECTOMY - PAST, PRESENT, FUTURE** *Session Chairs: Bassem Gerges & Emma Readman*	*Grand Ballroom 1*	**SESSION TWO B: OFFICE GYNAE UPDATE** *Session Chairs: Erin Nesbitt-Hawes & Mark Ruff* — *Grand Ballroom 2*
	Evolution of hysterectomy - **Thierry Vancaillie**		Vulval dermatology - An update - **Jennifer Bradford**
	The LACC Trial - Not all that glitters is gold - **Helen Green**		Vulval pain syndromes - **Lauren Kite**
	Route of vaginal cuff closure at TLH - Where are we now? - **Chad Michener**		Dyspareunia and vaginismus - **Sherin Jarvis**
	Caesarean hysterectomy - **Ken Jaaback**		Prolapse and pessaries - **Lucy Bates**
	Vaginal hysterectomy - Preferred but unloved? - **Gil Burton**		Ambulatory hysteroscopy - **Jason Mak**
	Uterine Transplant - **Rebecca Deans**		Recurrent pelvic organ prolapse: What we have learned over the last 20 years at the Cleveland Clinic - **Marie Fidela Paraiso**
	Panel Discussion		Panel Discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		*Maritime Ballroom & Foyer*
1330 - 1500	**SESSION THREE A: FREE COMMUNICATIONS** *Session Chairs: Sarah Choi & Krish Karthigasu*	*Grand Ballroom 1*	**SESSION THREE B: FREE COMMUNICATIONS** *Session Chairs: Rachel Collings & Martin Ritossa* — *Grand Ballroom 2*
	Maternal Morbidities: A Challenge For Bangladesh - **Musarrat Sultana**		Increasing the adoption of ambulatory hysteroscopy in Australia - cost comparisons and patient satisfaction - **Pav Nanayakkara**
	Improved Low Anterior Resection Syndrome scores after rectal disc resection in women with Deep Infiltrating Endometriosis. - **Vanessa Lusink**		Temporal and external validation of the Ultrasound-Based Endometriosis Scoring System (UBESS) - **Mercedes Vaquero**
	Safety, technique and outcomes of stellate ganglion blocks for vasomotor symptoms - **Michelle W Emerson**		Pre-operative Imaging in Deep Infiltrating Endometriosis: predicting depth of disease in rectosigmoid specimens - **Kate Stone**
	International survey of obstetrician/ gynecologists on awareness of ultrasound for diagnosing endometriosis - **Mathew Leonardi**		Gynaecology trainees would benefit from a competency-based medical education model in learning ultrasound for endometriosis: A learning curve study for the detection of pouch of Douglas obliteration and deep endometriosis of the rectum in gynaecological sonology trainees - **Jozarino Ong**
	Visual Symptoms among Surgeons Performing Minimally Invasive Surgeries in Australia and New Zealand - **Ameer Alhusuny**		Is the World Endometriosis Research Foundation, WERF, Endometriosis Phenome and Biobanking Harmonisation Project (EPHect) Questionnaire a good triaging tool for women with ovarian and posterior compartment endometriosis? - **Kiran Vanza**
	MRI sliding sign: feasibility to assess bowel and uterine mobility using motion MRI in the preoperative planning for pelvic endometriosis? - **Rose McDonnell**		Correlation between Transvaginal Ultrasound (TVUS) findings and laparoscopy in prediction of Deep Infiltrating Endometriosis (DIE) - **Melinda Pattanasri**
	Risk factors for conversion to open surgery in benign gynaecological laparoscopies - **Lucy Richards**		Looks Can Be Deceiving: the Prevalence of Deep Endometriosis and Pouch of Douglas Obliteration When the Ovaries are Normal - **Kiran Vanza**

Interactive Hubs 1
(1330 - 1430)
Maritime Ballroom

	A systematic review of the literature of pregnancy after bilateral salpingectomy - **Tanja Baltus**	Cystic Spaces in the Endometrium, a Contemporary Retrospective Cohort Study in a Tertiary Centre - **Rosemary D McBain**
	Augmentation of Native Tissue Vaginal Repair with autologous biological graft: Safety, feasibility and efficacy - **Robert Carey**	Developing a tool to predict absence of endometriosis in women with pelvic pain - **Charlotte Reddington**
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Maritime Ballroom & Foyer*
1530 - 1700	**SESSION FOUR A - GONE IN 420 SECONDS ENDOSCOPIC SURGERY AND BEYOND** *Grand Ballroom 1* *Session Chairs: Dean Conrad & Lenore Ellett*	**SESSION FOUR B - GONE IN 420 SECONDS SEXUALITY, FERTILITY & OBSTETRICS** *Grand Ballroom 2* *Session Chairs: Supuni Kapurubandara & John Pardey*
	Energy sources - Where did we come from, where are we going? - **Amani Harris**	Foundation, not the future - Left lateral tilt at C-Section - **Matthew Doane**
	Protecting the posture - Laparoscopic Ergonomics - **Martin Ritossa**	Myomectomy for fertility or an exercise in futility? - **David Rosen**
	Ashermans - Is there a way out? - **Lalla McCormack**	The "perfect" caesarean section - **Rachel Green**
	Physiology of laparoscopy - What the anaesthetists wish we knew - **Stephen Ford**	Rest in peace dear forceps? The future of instrumental delivery - **Rachel Collings**
	Endometriosis pre-operative planning - IDEA guidelines - **George Condous**	Towards normal abdominal delivery - **Bassem Gerges**
	Caesarean section scar thickness and ultrasound assessment - **Karen Mizia**	Enhancing recovery after Caesarean section - **Erin Nesbitt-Hawes**
	Caesarean scar niche reconstruction - **Sarah Choi**	Fetoscopic Surgery - Past, present, future - **Margaret Harpham**
	What's in the name? Eponymous O&G - **Andrew McIntyre**	Pregnancy & hypertension - Opiates & NSAIDS? - **Gene Lee**
	Peri-operative VTE prevention - Hail Aspirin! - **Fariba Behnia-Willison**	Laparoscopic cerclage - **Krish Karthigasu**
	Haemostatic agents - An update - **Alison Bryant-Smith**	Who's doing what? Mature sexuality - **Harry Merkur**
	Peritoneal pockets - Who cares? - **Mark Ruff**	PCOS - where are we now? - **Michele Kwik**
	Laparoscopic surgery in pregnancy - **Christopher Smith**	Ovulation induction made easy - When? How? Why? - **Manny Mangat**
1700	CLOSE OF DAY ONE	
1700 - 1800	**WELCOME RECEPTION**	*Maritime Ballroom & Foyer*

FRIDAY 6TH MARCH 2020

0730 - 0800	REGISTRATION & LIGHT BREAKFAST	*Maritime Ballroom & Foyer*
0800 - 1000	**SESSION FIVE: NEUROPELVEOLOGY UNRAVELLED - LIVE CADAVERIC SURGERY** *Grand Ballroom* **Danny Chou, Marc Possover & Michael Wynn-Williams** *Session Chairs: Helen Green & Luke McLindon*	**Interactive Hubs 2** (0900 - 1000) *Maritime Ballroom*
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Maritime Ballroom & Foyer*
1030 - 1215	**SESSION SIX: ENSURING SAFETY FOR THE FUTURE - M&M LIVE** *Grand Ballroom* *Session Chairs: Stephen Lyons & Andreas Obermair*	**Interactive Hubs 3** (1030 - 1130) *Maritime Ballroom*
	Foundations of an effective M&M meeting - **Thomas Hugh**	
	SurgicalPerformance Update - **Andreas Obermair**	
	Live M&M - **Andreas Obermair & Stephen Lyons**	
	AGES Travelling Fellowship - **Supuni Kapurubandara**	**Interactive Hubs 4** (1145 - 1245) *Maritime Ballroom*
	AGES AAGL Exchange Lecture: Risk of Complication at the Time of Laparoscopic Hysterectomy; A Prediction Model Built from The National Surgical Quality Improvement Program Database - **Kristen Pepin**	
1215 - 1315	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Maritime Ballroom & Foyer*

1315 - 1445	**SESSION SEVEN: CHAIRMAN'S CHOICE** *Session Chairs: Amani Harris & Harry Merkur*	*Grand Ballroom*
	A randomised, double-blind, placebo controlled trial of fractionated carbon dioxide laser treatment for women with post-menopausal vaginal atrophy symptoms - **Fiona Li**	
	Bladder Care Following Laparoscopy for Benign Non-Hysterectomy Gynaecological Conditions: A Randomised Controlled Trial - **Lalla McCormack**	
	Superficial endometriosis can be seen on ultrasound: a diagnostic accuracy study of a novel ultrasound technique called saline-infusion sonoPODography - **Mathew Leonardi**	
	The Myometrial-Cervical Ratio (MCR): A new measurement to improve the ultrasound diagnosis of Adenomyosis - **Kate Stone**	
	The Traffic Light Pilot Study: a pilot study assessing the quality of interventions in obstetrics and gynaecology - **Krystle Chong**	
	Virtual Clinics in Gynaecology: Can we shorten the wait? Assessing the success, feasibility and patient acceptance of Virtual (Telephone) Clinics for Postmenopausal Bleeding - **Samantha Mooney**	
	Fight or Flight: Biological measures of surgeon stress during surgery - **Aaron Budden**	
	We live in a virtual world: Training the trainee using an integrated Visual Reality Stimulator training curriculum - **Samantha Mooney**	
	Botulinum toxin A (Botox) injection into muscles of pelvic floor as a treatment for chronic pelvic pain secondary to pelvic floor muscular spasm - A Pilot Study - **Alaina Francis**	
1445 - 1515	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	*Maritime Ballroom & Foyer*
1515 - 1700	**SESSION EIGHT: LESSONS LEARNT** *Session Chairs: Fariba Behnia-Willison & Martin Healey*	*Grand Ballroom*
	Video face-off! Surgical management of endometriosis - Cold-cut & bipolar vs monopolar vs ultrasonic vs robotic - **Alan Lam, Stephen Lyons, Alastair Morris & John Pardey**	
	Foolproofing the surgical future - ERAS - **Jason Abbott**	
	Panel Discussion	
	Dan O'Connor Perpetual Lecture - A brief history of cervical screening - **Annabelle Farnsworth**	
1700	CLOSE OF DAY TWO	
1700 - 1800	**AGES ANNUAL GENERAL MEETING**	*Wharf Room 3 - 5*
1900 - 2300	**AGES ANNUAL BLACK TIE GALA DINNER, AWARDS & CHARITY AUCTION**	*Grand Ballroom*

SATURDAY 7TH MARCH 2020

0715 - 0815	SurgicalPerformance Breakfast Session	*Wharf Rooms 1 - 3*
0800 - 0830	REGISTRATION & LIGHT BREAKFAST	*Maritime Ballroom & Foyer*
0830 - 1015	**SESSION NINE: SURGICAL FOUNDATIONS** *Session Chairs: Robert Ford & Rachel Green*	*Grand Ballroom*
	Re-laying the foundations - Managing the trainee in trouble - **Rosalie Grivell**	
	A solid foundation - The AGES Fellowship training program - **Anusch Yazdani**	
	LapCo TT - The solid foundation of teaching - **Luke McLindon**	
	Feedback - The foundation of learning - **Rebecca Szabo**	
	Maintenance and evolution after the fellowship - **Stuart Salfinger**	
	Is there a future for the Generalist - **Vijay Roach**	
	Panel Discussion	
1015 - 1045	MORNING TEA & TRADE EXHIBITION	*Maritime Ballroom & Foyer*
1045 - 1205	**SESSION TEN: THE FUTURE - PUSHING THE LIMITS** *Session Chairs: Kirsten Connan & Stuart Salfinger*	*Grand Ballroom*
	Menopause back to the future - **Rod Baber**	
	Neuropelveology and the future - **Marc Possover**	
	Laparoscopic hysterectomy - Keeping the surgeon safe - **Chad Michener**	
	It's time to consider "trauma-informed care" - **Angela Jay**	
	Tribes and Teams - **Victoria Brazil**	
1205 - 1305	**SESSION ELEVEN: THE FUTURE SURGEON - Q&A** *Moderators: Kerryn Phelps & Bassem Gerges*	*Grand Ballroom*
	Panel members: **Victoria Brazil, Kirsten Connan, Annabelle Farnsworth, Rosalie Grivell, Chad Michener, Marc Possover, Stuart Salfinger, Vijay Roach**	
1305 - 1330	CLOSE OF DAY THREE & LUNCH ON THE GO	

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

AGES INTERACTIVE HUBS

AGES is proud to once again announce the inaugural Interactive Hubs, held in conjunction with our Industry Partners. The Interactive Hub is the AGES Society's response to the changing needs of our members and industry partners. Industry want more than to simply show their product on a stand, they want AGES members to use their product as it is intended - at least in a simulated manner. AGES Members have frequently commented that they want more hands-on training; skill acquisition and technical improvement to see immediate changes in their clinical practice. Whilst there are many workshops available to gynaecological surgeons, none have access to the skilled faculty of the AGES membership and the multitude of products that our industry partners want to showcase for improved patient care. The Hub experience is a **Members only experience!**

Interactive Hub sessions will be held during the ASM on Thursday, 5th March at 1.30pm, Friday 6th March at 9.00am, 10.30am and 11.45am.

Please see below the industry sponsors hubs with more information available on the AGES website:

Applied Medical
Johnson & Johnson
Olympus
Avant
Karl Storz
Stryker
Hologic
Medtronic

NEUROPELVEOLOGY UNRAVELLED

LIVE CADAVERIC SURGERY

Dr Danny Chou
Prof Marc Possover
Dr Michael Wynn-Williams

SOCIAL PROGRAM

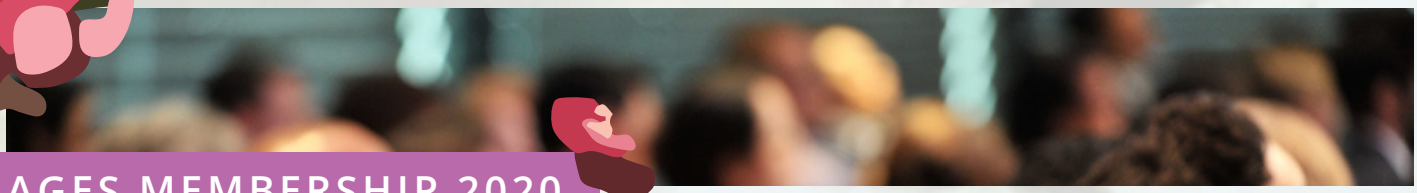
WELCOME RECEPTION

Trade Exhibition Maritime Ballroom, Hyatt Regency, Sydney
Thursday 5th March 2020
5.00pm – 6.00pm

AGES ANNUAL BLACK & WHITE TIE GALA DINNER, AWARDS & CHARITY AUCTION - *Celebrating 30 years of AGES*

Grand Ballroom, Hyatt Regency, Sydney
Friday, 6th March 2020
7.00pm - late

Ticket cost: $145.00
Dress: Formal, Black & White



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- Attend all three AGES Meetings in 2020 for only $1,800.00, saving of up to 50% per meeting. Only applicable for 3+ year members.
- Savings of up to 15% on member registration fees for AGES meetings.
- Exclusive access to the new "AGES Video Library – Members only".
- Eligibility to register for the AGES Laparoscopic Anatomy Pelvic Dissection & Demonstration Workshops (LAP-D).
- Eligibility to register for the AGES Interactive Hubs.
- Eligibility to apply for AGES Research Grants.
- SurgicalPerformance 1-year Premium subscriptions will be available at a subsidised rate of $100 to all Ordinary Members of AGES in 2020. This includes SurgicalPerformance's self-auditing Software and AGES/SurgicalPerformance webinars.
- Complimentary subscription to the Journal of Minimally Invasive Gynaecology (formerly AAGL Journal).
- Option to subscribe to the International Urogynaecology Journal instead of JMIG for an additional fee.
- AGES electronic newsletter, eScope, published three times annually.
- Eligibility to register for the "Who do you want to be when you grow up" Seminars.
- Member access to AGES website and resources.
- Downloadable "AGES Member Icon" available for use in signature blocks and websites.
- Listing on the Membership Directory of the AGES website.
- Eligibility to apply for a position in the AGES Training Program in Gynaecological Endoscopy

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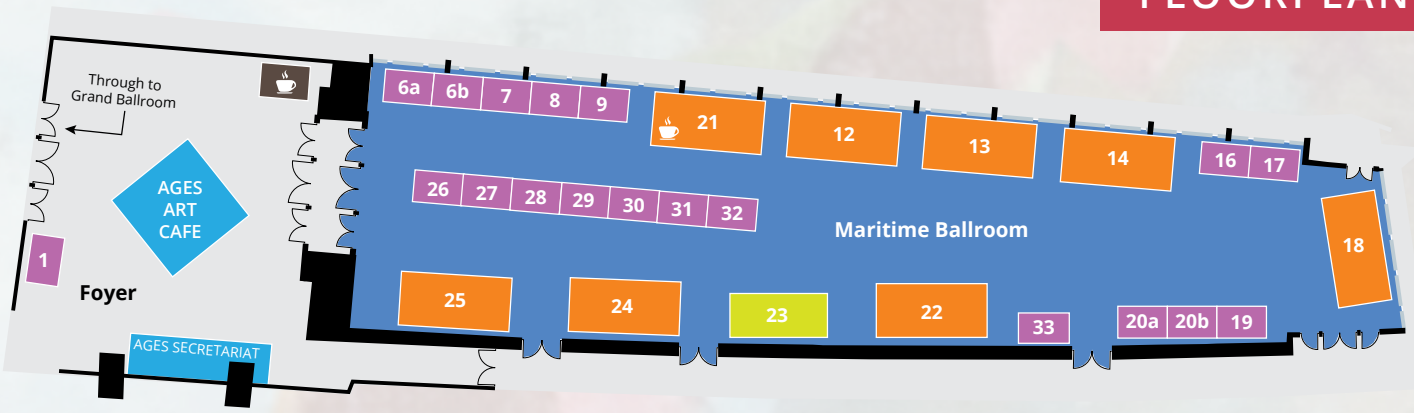
FLOORPLAN



31	Amily	**24**	Applied Medical	**16**	Aspen Australia
25	Avant	**33**	Bayer	**17**	Baxter Healthcare
27	BD Bard	**28**	ConMed	**23**	Device Technologies
7	Endotherapeutics	**19**	Guerbet	**8**	Gynaepath - Douglass Hanly Moir Pathology
26	High Tech Medical	**22**	Hologic	**12**	Johnson & Johnson
13	Karl Storz Endoscopy	**20a**	LifeHealthcare	**9**	Matrix Surgical
32	Medical Devices	**14**	Medtronic	**20b**	Mentone Educational
29	MSD	**18**	Olympus	**30**	The O.R. Company
6b	Rural Locum Assistance Program	**21**	Stryker	**1**	SurgicalPerformance
6a	Teleflex Medical Australia				

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AGES gratefully acknowledges the following Industry Partners that have confirmed their support at the time of publication:

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AGES Educational Training Partner

Applied Medical – A New Generation Medical Device Company

stryker

Gold Partners of AGES 2020

Avant mutual · Device Technologies · Hologic · Johnson & Johnson Medical Devices Companies · Storz Karl Storz – Endoskope · Olympus

Major Partners of AGES ASM 2020

Single Exhibitors

Amily	Aspen Australia	Bayer
Baxter Healthcare	BD Bard	ConMed
Endotherapeutics	Guerbet	Gynaepath - Douglass Hanly Moir Pathology
High Tech Medical	LifeHealthcare	Matrix Surgical
Medical Devices	Mentone Educational	MSD
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As a global leader in medical technology, services and solutions, Medtronic improves the lives and health of millions of people each year. We use our deep clinical, therapeutic, and economic expertise to address the complex challenges faced by healthcare systems today. Let's take healthcare Further, Together.

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Established by a small group of doctors as a mutual in 1893, Avant is now Australia's leading medical defence organisation, representing over 75,000 healthcare practitioners and students across every state and territory. We're here for the long term.

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We will be proudly exhibiting the KARL STORZ range of instruments which will include the latest in Operative Hysteroscopy, Virtual Reality Trainers, Laparoscopic Instrumentation plus Endoscopic Camera Systems including 4K and 3D technology.

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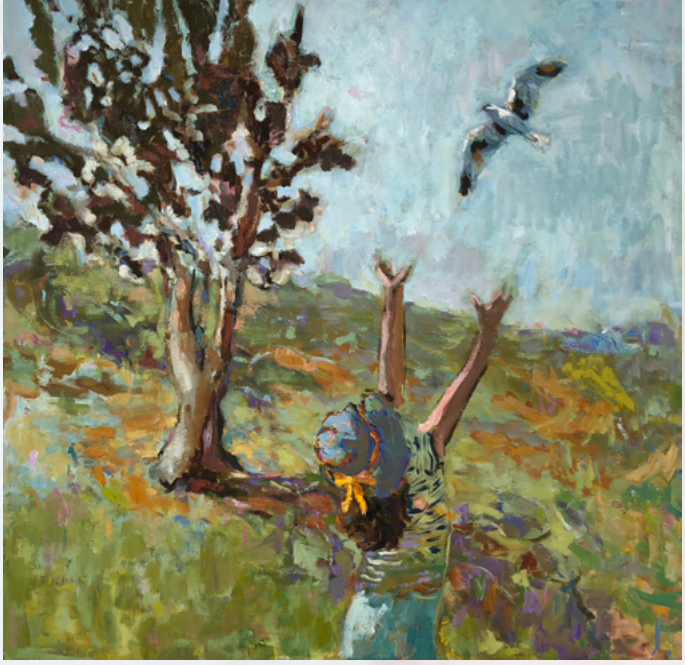


AGES ART PRIZE & CHARITY AUCTION

AGES is pleased to announce **Lucila Zentner** as the 2019/2020 AGES Society Art Prize winner.

Lucila Zentner is an Australian artist working predominantly in oils. Lucila combines a love and practice of fine art with a career in medicine, practicing as a Radiologist and Nuclear Medicine specialist.

She has lived and worked in Regional Victoria and NSW over the last 10 years and has now moved studio to Sydney. Lucila paints private commissions as well as for private and public institutions ranging from professional medical suites/hospitals to cafes.

Artist Statement

I paint to hold onto a moment, to thrill the senses, to delight, to mourn and to live. My paintings are oil on canvas or linen, representational, mildly abstracted, expressionistic. All are of people, places or ideas. I enjoy gestures, light and form and shadows. My muses are my family, my friends and the Australian landscape. My styles are diverse, but the brushstrokes are always solid, definite and final.

The artworks will be auctioned at the AGES Annual Black Tie Charity Auction & Awards Gala Dinner on Friday 6th March 2020 at the Hyatt Regency, Sydney.

The proceeds of the Charity Auction will be donated to a charity of the Board's choice.

We do hope you are able to join us on this vibrant and fun-filled night. To purchase a ticket to Black Tie Gala Dinner to participate in the charity auctions, please visit the AGES Secretariat in the foyer.

For more information please visit the website **www.ages.com.au**

KARL STORZ — ENDOSKOPE

BREAKFAST SESSION

SurgicalPerformance Breakfast Session

When: Saturday 7th March 2020
Time: 7.15am – 8.15am
Where: Hyatt Regency Sydney
Requirements: Please bring a laptop or iPad
Registration essential
*Breakfast included

This hands-on, interactive session will teach you how to make SurgicalPerformance work for you and provide valuable information such as:

- Claiming CPD points with SurgicalPerformance
- Optimising your own data entry
- How the use of Patient-Reported Outcome Measures (PROMs) will give you a knowledge advantage

Please ensure you bring your own questions as well – this is an interactive session!

FREE COMMUNICATIONS

SESSION 7: CHAIRMAN'S CHOICE
Friday, 6th March
1315 - 1445
Grand Ballroom

A randomised, double-blind, placebo controlled trial of fractionated carbon dioxide laser treatment for women with post-menopausal vaginal atrophy symptoms
Fiona Li

Bladder Care Following Laparoscopy for Benign Non-Hysterectomy Gynaecological Conditions: A Randomised Controlled Trial
Lalla McCormack

Superficial endometriosis can be seen on ultrasound: a diagnostic accuracy study of a novel ultrasound technique called saline-infusion sonoPODography
Mathew Leonardi

The Myometrial-Cervical Ratio (MCR): A new measurement to improve the ultrasound diagnosis of Adenomyosis
Kate Stone

The Traffic Light Pilot Study: a pilot study assessing the quality of interventions in obstetrics and gynaecology.
Krystle Chong

Virtual Clinics in Gynaecology: Can we shorten the wait? Assessing the success, feasibility and patient acceptance of Virtual (Telephone) Clinics for Postmenopausal Bleeding.
Samantha Mooney

Fight or Flight: Biological measures of surgeon stress during surgery
Aaron Budden

We live in a virtual world: Training the trainee using an integrated Visual Reality Stimulator training curriculum
Samantha Mooney

Botulinum toxin A (Botox) injection into muscles of pelvic floor as a treatment for chronic pelvic pain secondary to pelvic floor muscular spasm - A Pilot Study
Alaina Francis

SESSION 3A: FREE COMMUNICATIONS
Thursday, 5th March
1330 - 1500
Grand Ballroom 1

Maternal Morbidities: A Challenge For Bangladesh
Musarrat Sultana

Improved Low Anterior Resection Syndrome scores after rectal disc resection in women with Deep Infiltrating Endometriosis.
Vanessa Lusink

Safety, technique and outcomes of stellate ganglion blocks for vasomotor symptoms
Michelle W Emerson

International survey of obstetrician/ gynecologists on awareness of ultrasound for diagnosing endometriosis
Mathew Leonardi

Visual Symptoms among Surgeons Performing Minimally Invasive Surgeries in Australia and New Zealand
Ameer Alhusuny

MRI sliding sign: feasibility to assess bowel and uterine mobility using motion MRI in the preoperative planning for pelvic endometriosis?
Rose McDonnell

Risk factors for conversion to open surgery in benign gynaecological laparoscopies
Lucy Richards

A systematic review of the literature of pregnancy after bilateral salpingectomy
Tanja Baltus

Augmentation of Native Tissue Vaginal Repair with autologous biological graft: Safety, feasibility and efficacy
Robert Carey

SESSION 3B: FREE COMMUNICATIONS
Thursday, 5th March
1330 - 1500
Grand Ballroom 2

Increasing the adoption of ambulatory hysteroscopy in Australia - cost comparisons and patient satisfaction
Pav Nanayakkara

Temporal and external validation of the Ultrasound-Based Endometriosis Scoring System (UBESS)
Mercedes Vaquero

Pre-operative Imaging in Deep Infiltrating Endometriosis: predicting depth of disease in rectosigmoid specimens.
Kate Stone

Gynaecology trainees would benefit from a competency-based medical education model in learning ultrasound for endometriosis: A learning curve study for the detection of pouch of Douglas obliteration and deep endometriosis of the rectum in gynaecological sonology trainees
Jozarino Ong

Is the World Endometriosis Research Foundation, WERF, Endometriosis Phenome and Biobanking Harmonisation Project (EPHect) Questionnaire a good triaging tool for women with ovarian and posterior compartment endometriosis?
Kiran Vanza

Correlation between Transvaginal Ultrasound (TVUS) findings and laparoscopy in prediction of Deep Infiltrating Endometriosis (DIE)
Melinda Pattanasri

Looks Can Be Deceiving: the Prevalence of Deep Endometriosis and Pouch of Douglas Obliteration When the Ovaries are Normal
Kiran Vanza

Cystic Spaces in the Endometrium, a Contemporary Retrospective Cohort Study in a Tertiary Centre
Rosemary D McBain

Developing a tool to predict absence of endometriosis in women with pelvic pain
Charlotte Reddington

DIGITAL FREE COMMUNICATIONS
Thursday, 5th March
Morning Tea, 1010 - 1040
AGES Art Cafe, Foyer

Fumarate Hydratase Deficiency Leiomyomas
Sam Daniels

Laparoscopic Hemi-hysterectomy for Obstructive Uterine Didelphys with Unilateral Vaginal Hypoplasia
Bridie Stewart

Pelvic Microbiome - A potential new player in the understanding of Endometriosis.
Lior Levy

DIGITAL FREE COMMUNICATIONS
Thursday, 5th March
Lunch, 1230 - 1330
AGES Art Cafe, Foyer

Improving clinical outcomes through audit in a regional gynaecology unit
Cheryl Yim

Neck/Shoulder Problems and Headaches among Surgeons Performing Minimally Invasive Surgeries in Australia and New Zealand
Ameer Alhusuny

The Dalton Modified Hasson Technique: A 10 year review
Ann Marie Tan

How bad are these adhesions? A review of the classification of Asherman Syndrome and a video demonstration.
Dave R Listijono

Can we use the ovarian sliding sign at transvaginal ultrasound to predict the need for ureterolysis at laparoscopy for women with suspected endometriosis? A retrospective observational study.
Tanushree Rao

Clinical features of atypical polypoid adenomyoma of the uterus; a single sites review of three cases.
Vanessa El-Achi

Laparoscopic Transabdominal Cerclage - outcomes of 244 pregnancies
Alex Ades

Laparoscopic hysterotomy to drain haematometrocolpos: an alternative surgical approach to relieve a blocked hemiuterus in an adolescent with a didelphyic uterus
Zain Battikhi

Minimally Invasive Surgery in the Morbidly Obese Patient undergoing Hysterectomy - Single centre experience.
Vanessa El-Achi

Transvaginal Ultrasound Can Accurately Predict Endometriosis Severity: a Feasibility Study Applying an Ultrasound-based American Society of Reproductive Medicine (ASRM) Classification of Endometriosis to Laparoscopic Surgical Findings
Jozarino Ong

DIGITAL FREE COMMUNICATIONS
Thursday, 5th March
Afternoon Tea, 1500 - 1530
AGES Art Cafe, Foyer

Effect of diagnostic, imaging and surgical intervals on surgical outcomes in cases of suspected appendicitis in pregnant patients at a tertiary specialist obstetrics and gynaecology hospital and a general tertiary hospital.
Sean Copson

Risk-Reducing Salpingectomy - What do we know about Australian practice and where are we heading?
Helena M Obermair

Uterine Positioning System: First Australian series
Sam Daniels

Forewarned is Forearmed: The Surgical Implications of Ovarian Fixation in Endometriosis
Simona Marra

DIGITAL FREE COMMUNICATIONS
Friday, 6th March
Morning tea, 1000 - 1030
AGES Art Cafe, Foyer

Tackling the Tricky Cervix at Hysteroscopy
Alexander Chen

Prophylactic ureteric catheters in complex gynaecological surgery: a retrospective study.
Brindaa Tharmarajah

Oxidised regenerated cellulose mimicking post-surgical abscess
Cherynne Johansson

Assessment of preoperative and intraoperative factors associated with the degree of difficulty in performing a laparoscopic hysterectomy
Samuel Vo

DIGITAL FREE COMMUNICATIONS
Friday, 6th March
Lunch, 1215 - 1315
AGES Art Cafe, Foyer

The All-In-One Endometrioma Excision
Praveen De Silva

The Immediate Development of Colovaginal Fistula after Hysterectomy. An Unusual Presentation.
Praveen De Silva

Outcomes following disc resection for Deep Infiltrating Endometriosis.
Vanessa Lusink

Laparoscopic Transabdominal Cerclage outcomes of subsequent pregnancies with the same suture
Alex Ades

The frequency of ureterolysis in women undergoing laparoscopic surgery for suspected endometriosis: A retrospective observational study.
Tanushree Rao

Fumarate hydratase deficiency in leiomyomas. Post-operative management and counselling
Mikhail Sarofim

Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): standardising rectal shaving for bowel endometriosis
Mujahid Bukhari

Rates and route of hysterectomy in a tertiary teaching hospital
Kate Martin

Myomatous erythrocytosis in a large fibroid uterus
Chitra Varanasi

About 53 consecutive cases of Fertiloscopy (a.k.a. trans vaginal hydro laparoscopy). A single centre experience
Lionel Reyftmann

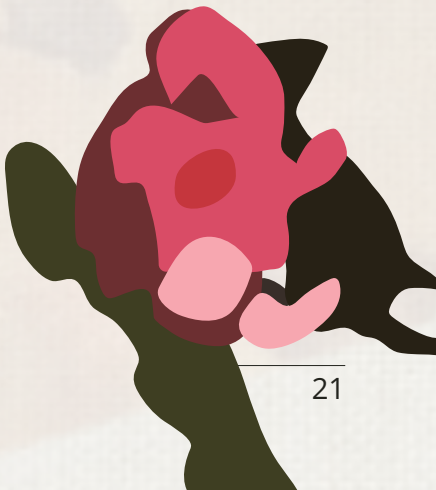
DIGITAL FREE COMMUNICATIONS
Friday, 6th March
Afternoon Tea, 1445 - 1515
AGES Art Cafe, Foyer

Appendiceal endometriosis - a challenging diagnosis
Reuben Chen

Intraovarian stem cells for ovarian rejuvenation: A review of the literature
Kate Tyson

Laparoscopic Burch Colposuspension Using a Burch Elevator
Rosemary D McBain

Bowel adhesions: divide and conquer!
Alison Bryant-Smith



FUTURE EVENTS

APR
AUG
NOV

AGES
LAP-D Workshops
MERF QUT Brisbane
April, August &
November 2020

JUN

AGES RANZGOG
Trainee Workshop
RACS, Melbourne
13th & 14th June 2020

JUL

AGES/AAGL AFFILIATED
SOCIETY FOCUS MEETING
'Advancing the Art: The Future of Endoscopic Surgery'
Hyatt Regency
Bangkok Sukhumvit
17th & 18th July 2020

OCT

AGES PELVIC FLOOR
SYMPOSIUM
'I can see clearly now!'
Adelaide Convention
Centre, Adelaide
30th & 31st October 2020

MULTIPLE
DATES

AGES/MEDTRONIC
Train the Trainer Workshop
Held 3-4 times annually
throughout Australia

MAY

AGES SEMINARS
Who do you want to be when you grow up?
Sydney, Brisbane &
Perth
May 2020

MAR
2021

AGES XXXI ANNUAL
SCIENTIFIC MEETING
Crown Promenade,
Melbourne
4th – 6th March 2021

www.ages.com.au

PROGRAM ABSTRACTS

THURSDAY, 5TH MARCH 2020

SESSION ONE: FUTURE / 0800 -1010

Grand Ballroom

KEYNOTE: Neuropelveology - A new discipline in medicine

Marc Possover

Abstract not yet received.

KEYNOTE: Total abdominal hysterectomy - Please explain!

Chad Michener

Background:
Total abdominal hysterectomy (TAH) rates have been steadily declining over the last 20 years. However, in many institutions the rates seem to have plateaued. This method of hysterectomy is associated with higher complication rates, cost, and longer recovery. The incorporation of total laparoscopic hysterectomy (TLH) into clinical practice is variable across institutions, regions and countries.

Objectives:
We will review benefits of minimally invasive hysterectomy, review the Cleveland Clinic experience with processes aimed at reducing TAH rates and discuss the impact of surgeon volume on efficiency and outcomes.

Outcomes:
In 2015 the rate of abdominal hysterectomy for benign disease was 27.8% prior to the implementation of a TAH reduction program. Following its implementation, TAH rates declined by a total of 63% between 2015 and 2018 (20.1% in 2016, 21.3% in 2017, 10.4% in 2018). Between 2015 and 2019 TLH increased from 35% to 54.3% of cases while robotic-assisted TLH went from 16.6% to 13.9%. Additionally, the number of low volume surgeons performing TLH dropped from 46 to 28 from 2015 and 2018

Conclusions:
Reduction in the number of TAH being performed is feasible and requires a team-based approach as well as buy-in from gynecologic surgeons at each institution. Continuous assessment of routes of hysterectomy may allow for steady decline in the rates of TAH and lower the overall morbidity of this common procedure

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Beyond sacral colpopexy: When robotics is most useful in pelvic organ prolapse surgery

Marie Fidela Paraiso

Abstract not yet received.

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vNOTES and pathways to the future

Jan Baekelandt

Abstract not yet received.

SESSION TWO A: HYSTERECTOMY – PAST, PRESENT, FUTURE / 1040-1230

Grand Ballroom 1

Evolution of hysterectomy

Thierry Vancaillie

This presentation will focus on the change through history with regard to indications for hysterectomy: prolapse, bleeding, pain, mass/malignancy and gender issues. The technical aspects of surgery such as tissue handling, haemostasis and suturing will also briefly be reviewed.

The LACC Trial - Not all that glitters is gold

Helen Green

Abstract not yet received.

Route of vaginal cuff closure at TLH - Where are we now?

Chad Michener

Background:
Vaginal cuff dehiscence is the partial or full thickness separation of the vaginal cuff after hysterectomy. In 35-67% of cases, it can lead to evisceration of peritoneal contents, which carries high morbidity. Fortunately, cuff dehiscence is a rare complication of hysterectomy with an overall incidence of 0.14 to 4.1% of all hysterectomies.

Objectives:
We will explore the incidence of VCD after total laparoscopic (TLH) and robotic-assisted hysterectomy (RA-TLH). We will review data from a retrospective case-control study at Cleveland Clinic to assess rates of and factors associated with VCD. We will then review patient and surgical risk factors associated with VCD and discuss best practices to minimize the risk of VCD.

Outcomes:
In 2016 we identified VCD in 9 of 1277 (0.70%) women undergoing TLH or RA-TLH. We did not identify any differences between suture type, fellowship trained surgeons, annual case volume. There was a non-significant difference between those undergoing transvaginal (0.35%) vs laparoscopic (0.81%) cuff closure (p=0.41). Comparing 29 VCD each with the next 7 consecutive cases from 2009-2016 there were no differences in outcomes between route of cuff closure, surgeon experience or suture types. There was a protective effect with each 1 year increase in age decreasing the odds of VCD by 5% while (p=0.015) each 1 unit increase in BMI decreasing the risk by 11% (p=0.007).

Conclusions:
VCD is a rare, but potentially life-threatening, complication of laparoscopic hysterectomy. The best route and method of closure has not been clearly elucidated. However, increasing age and BMI may be protective factors. We encourage gynecologic surgeons to look closely at their own data and continue to utilize the route that they are the most comfortable with unless they fall outside of the expected norms for VCD.

Caesarean hysterectomy

Ken Jaaback

Placenta accreta should always be considered a life-threatening obstetric condition that requires a multidisciplinary approach to management. The average blood loss at surgery is 3000-5000ml and 40% require more than 10 units of packed red blood cells. Maternal mortality with placenta accreta has been reported to be as high as 7%. In this presentation I will address the difficulties seen at surgery and describe our protocol and surgical technique to reduce operative blood loss and morbidity

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Vaginal hysterectomy - Preferred but unloved?

Gil Burton

Abstract not yet received.

Uterine Transplant

Rebecca Deans

Abstract not yet received.

SESSION TWO B: OFFICE GYNAE UPDATE / 1040-1230

Grand Ballroom 2

Vulval dermatology - An update

Jennifer Bradford

Many cases of chronic vulvo-vaginal discomfort and dyspareunia, including cases occurring post-operatively, are caused primarily by dermatological disorders. The most common disorders are:

- Chronic vulvo-vaginal candidiasis
- Lichen planus
- Lichen sclerosus
- Psoriasis

These disorders interact with wider pelvic visceral and neuromuscular functioning, creating complex clinical scenarios. Therefore, a working understanding of common VV disorders is essential for the gynaecologist.

Vulval pain syndromes

Lauren Kite

Possible aetiologies; including multifactorial pain
Presentation and assessment
Treatments option;

- Non-medical including physiotherapy and psychology
- Pharmacological
- Interventional
    - Procedures
    - Surgical

Outcomes

Dyspareunia and vaginismus

Sherin Jarvis

This presentation will address some of the many contributors to dyspareunia and vaginismus. Physical factors may include: vulval skin integrity eg dermatological issues, LT OCP use; introital and vaginal capacity; pelvic floor mm (PFM) and fascia; pelvic organs; pelvic girdle eg PS, SIJ; other MSK issues /or & Injuries eg LS, scoliosis, coccyx, #, CDH/hip dysplasia; peripheral sensitisation/neuropathy eg pudendal neuralgia, L-sacral; lapaparoscopies and other pelvic surgeries; vaginal delivery; central sensitisation via the spinal cord and brain-> central pain mechanisms eg IBS, FM, CF, migraine. The brain the experience of pain, then anticipation of pain, threat value.

Psychological factors may include: history of DV, abuse, CSA, SA, anxiety, depression and other MH issues; avoidance & subsequent relationship issues.

Some appropriate managements will be discussed. As dyspareunia and vaginismus are usually muliti-factorial, monotherapies less likely to be helpful eg only lap or only laser.

Prolapse and pessaries

Lucy Bates

Abstract not yet received.

Ambulatory hysteroscopy

Jason Mak

Contrary to popular belief, outpatient hysteroscopy is not a novel idea. In fact, the first ever hysteroscopy was performed over 150 years ago in a gynaecologists office, without an anaesthetic. In this discussion we review the capabilities of modern day office hysteroscopy. We look at the evidence behind the debate over its benefits and limitations, patient comfort and satisfaction, safety and the financial equation. Is it time to go back to the future with office hysteroscopy.

Recurrent pelvic organ prolapse: What we have learned over the last 20 years at the Cleveland Clinic

Marie Fidela Paraiso

Abstract not yet received.

SESSION THREE A: FREE COMMUNICATIONS /1330-1500

Grand Ballroom 1

Maternal Morbidities: A Challenge for Bangladesh

Musarrat Sultana

Introduction:
Gynaecological issues are roughly similar throughout the world. Prevalence of Gynaecological Malignancies, Infertility, AUB, Endometriosis, PCOS and other adolescent gynaecological problems are almost similar to the developing world. But we have numerous patients suffering from maternal morbidities, one of the least addressed issues.

Approach:
By retrospective analysis of available data, hospital admission records, outpatient records and day to day practice, it is evident that the number of women suffering from gynaecological morbidities like Genital Prolapse, Fistula , Perineal Tear etc are quite high. About half a million women who have given at least one birth suffer from stage 3 and 4 Pelvic Organ Prolapse (POP). There are about 17,500 women suffering from Obstetric Fistula and an alarming number of Perineal Tear patients. The women of marginalized population are the main sufferers. But this issue is neglected for a long time. There is no specialized public hospital dedicated for this problem.
Recently in 2012, *MAMM'S Institute of Fistula and Women's Health* was established
with a vision to provide treatment for Obstetric Morbidities. This hospital provides medical and surgical treatment to POP, Genital Fistula, OASIS, Vaginoplasty and
other Pelvic Floor Dysfunctions to the marginalized women absolutely at free of cost. But while working in this hospital, we face an abundance of challenges like crisis of funds, equipment, space and skilled human resources.

Conclusion:
Maternal morbidity is a neglected issue in our country that needs to be addressed to improve the quality of life of women. A targeted national level policy is needed to solve the issue. Allocation of funds & space, development of skilled human resources and awareness building are essential elements to improve the quality of care.

Improved Low Anterior Resection Syndrome scores after rectal disc resection in women with Deep Infiltrating Endometriosis

Julian C Ip 1 , Terence C Chua 2 , Vanessa Lusink 3 , Surya Krishnan 4 , Shing W Wong 1

1. *Department of Surgery, Prince of Wales Hospital, Randwick, NSW, Aus*
2. *Logan Hospital, Logan, QLD, Aus*
3. *RPA Hospital, Camperdown, NSW, Aus*
4. *Royal Hospital for Women, Randwick, NSW, Aus*

Rectal disc resection is a minimally invasive option for treatment of rectosigmoid endometriosis in women with deep infiltrating endometriosis (DIE). Retrospective cohort studies have shown acceptable functional outcomes with a more conservative surgical approach with DIE nodules <2cm. Symptom outcomes are comparable between segmental resection and disc resection (1, 2). A consequence of rectal surgery is the anterior resection syndrome, a constellation of symptoms including increased frequency, urgency, incontinence and/or constipation, lasting beyond the recovery period and impacting quality of life. The low anterior resection syndrome score classifies this as a mild, moderate or severe syndrome depending on symptoms post surgery (3).

Aim:
The aim of this study was to explore the short to medium term functional outcomes after rectal disc resection for endometriosis by utilising the validated low anterior resection syndrome (LARS) score, pre and post surgery.

Methods:
A prospective study was conducted to assess the short to medium term functional outcomes following disc resection for DIE. The validated LARS score was used to identify baseline bowel function pre op, and then 6 months post op. All surgeries were performed by a single colorectal surgeon and single gynaecologist in a tertiary centre.

Results:
Thirty-six women were included in this prospective cohort study, and all procedures were performed laparoscopically. Response rate was 100%. The pre-operative LARS score was 0 in five women (13.89%), 1-20 in 23 women (63.89%), 21-30 in 5 women (13.89%) and >30 in 3 women (8.33%). Post-operative LARS score was 0 in 8 women (22.22%), 1-20 in 22 women (61.11%), 21-30 in 5 women (13.89%) and >30 in 1 woman (2.78). Eighteen women showed a reduction in their individual LARS scores post operatively. Evaluation of the individual components of the LARS score showed a significant reduction in increased stool frequency post operatively, with 56% of women reporting a frequency score of 0 pre-op, vs 78% post op ($p<0.02$).

Conclusion:
Rectal disc resection is an effective management technique for deep infiltrating endometriosis. It results in lower LARS scores in 50% of patients and significant reduction in rates of increased stool frequency.

Safety, technique and outcomes of stellate ganglion blocks for vasomotor symptoms

Michelle W Emerson 1 , Jason Chow 1

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

Non-hormonal alternatives to treat vasomotor symptoms (VMS) are important because women choose not to or are not medically suitable for menopausal hormone therapy (MHT). Breast cancer survivors are particularly affected as their VMS can be “significantly more frequent, severe, distressing, and of greater duration”.

Stellate ganglion blocks (SGB) have been used for pain management, and there is emerging evidence for their use for vasomotor symptoms. This retrospective case series studies the safety and outcomes of SGB for VMS. This presentation also outlines the technique for SGB. We analysed all SGB for VMS at a tertiary campus in the last five years. Our primary outcome was looking at adverse surgical events, such as recurrent laryngeal and phrenic nerve palsy, pneumothorax, haematoma, and stroke. The secondary outcome was looking at success rates, as a subjective reduction in vasomotor symptoms.

There were 20 procedures performed, all of which were for VMS. Five women had the procedure done twice, and one woman had three blocks. The age range was 49 to 72, with the average age being 59. There was a history of breast cancer in 50% of the cases. Of previous treatment tried, 75% trialled MHT, 85% trialled non-hormonal medications, and 45% trialled alternative therapies (such as black cohosh root). No cases were performed where a woman had trialled no previous treatment.

Out of 20 cases, there was only one case of recurrent laryngeal nerve block, and no other serious adverse effects. There was a subjective improvement reported in almost 15 of the cases (79%), there was no follow up data available from one case, and there was minimal to no improvement after 4 of the procedures.

As previously reported by Othman,1 Walega,2 and van Gastel,3 our results indicate that SGB for VMS is safe and efficacious. To our knowledge this is the largest case series of SGB for VMS to date in Australia.

International survey of obstetrician/gynecologists on awareness of ultrasound for diagnosing endometriosis

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Objectives:

Advanced transvaginal ultrasound (TVS) as advocated by the International Deep Endometriosis Analysis group is accurate at diagnosing endometriomas, deep endometriosis (DE) and pouch of Douglas (POD) obliteration. In North America, the American Institute of Ultrasound in Medicine and the Society of Obstetricians and Gynaecologists of Canada recommend a TVS consisting of assessment of the uterus and ovaries only. In the United Kingdom (UK) and Australia/New Zealand (ANZ), recommendations are similarly limited. As such, there is a discrepancy between guidelines and what is possible in the domain of ultrasound diagnosis of endometriosis. Understanding the current state of knowledge and use of advanced ultrasound is important. This is the first step in improving awareness, education, guidelines, and finally, outcomes. Our aim was to compare how obstetrician-gynecologists in four English-speaking regions (ANZ, Canada, UK and United States (US)) think of and use TVS in the diagnosis and management of endometriosis.

Methods:

An international cross-sectional e-mail survey study was performed between May-November 2018 of obstetrician-gynecologists belonging to the general obstetrics/gynecology societies of ANZ, Canada and US and the UK gynecological endoscopy society. The formal invitation was distributed via e-mail through the respective societies. Responses were summarized using numbers and percentages, and comparisons were made using chi-square tests.

Results:

1140 obstetrician-gynecologists responded. Regional respondent number and response rate are as follows: ANZ 449/2200 (20.4%), Canada 156/1500 (10.4%), UK: 95/669 (14.2%), US: 440/31355 (1.4%). Less than 50% of respondents in all regions describe using advanced ultrasound for most or all of their patients with signs and symptoms of endometriosis. Variations between regions exist, with ANZ members seemingly adopting the technology more readily. Similarly, ANZ respondents had the highest rates of expectation/belief in the utility of ultrasound for endometriosis. A high rate of disbelief of ultrasound utility exists broadly. Lastly, ANZ and Canadian members reported bowel deep endometriosis as the most important feature of endometriosis to predict on imaging preoperatively, while British and American members ranked rectovaginal septum DE and endometriomas as most important, respectively.

Conclusions:

Overall, there is a low rate of utilization of advanced ultrasound for diagnosing endometriosis and regional differences were noted. Variations in responses indicate inconsistencies in education between regions but there is evidence of the beginnings of knowledge translation. This study should serve as an important stepping stone in raising awareness and introducing educational campaigns to improve the perception of ultrasound utility and adoption of this essential diagnostic tool.

Visual Symptoms among Surgeons Performing Minimally Invasive Surgeries in Australia and New Zealand

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Background:

Laparoscopy has become the standard for Minimally Invasive Surgeries (MIS), offering well-recognized patient benefits. However, musculoskeletal problems are an unfortunate consequence for many surgeons performing MIS. As MIS requires prolonged visualization of a computer monitor, it is possible that eyestrain may also be associated with performing MIS.

Aims:

a) To examine the prevalence of visual symptoms among Australian and New Zealand surgeons performing MIS;

b) To examine the association of visual symptoms with the individual, work-related and workplace factors and neck/shoulder problems.

Methods:

An invitation to a 62-item online survey was sent to surgical colleges, societies and health facilities in Australia and New Zealand. Standardized scales were included to ascertain the presence of visual symptoms and neck/shoulder problems. Items evaluating individual (e.g. demographics), work-related (e.g. surgical specialty, surgical experience), and workplace (e.g. lighting and temperature of the operating theatre, adjusting the monitor) factors were also included. Binary logistic regressions were conducted to determine the association between the various factors with the presence of visual symptoms.

Results:

Two hundred and ninety MIS surgeons completed the survey. Just over half (52.1%) of the surgeons reported one and more visual symptoms during surgery, while 29.0% reported 4-15 visual symptoms. More than one-third of the reported visual symptoms were moderate to severe in severity. The most commonly reported visual symptoms was dryness of the eyes and awareness that sight may be deteriorating, followed closely by difficulty focusing on close items and blurred vision. Surgeons reporting 4-15 visual symptoms were four times more likely to report neck/shoulder problems than other surgeons (OR=4.5, $p<0.001$). Visual symptoms were significantly associated with frequently adopting awkward postures (forward head movement and asymmetrical weight-bearing), adjusting the work environment (temperature and lighting), and using vision correction glasses ($p\leq0.05$).

Conclusions:

New knowledge gained is the prevalence of visual symptoms among surgeons while performing MIS. This study highlighted the association of visual symptoms with the presence of neck/shoulder problems, the surgeon's adopted posture and work environment during surgery. Further research is required to better understand the source of visual symptoms among surgeons and to minimize these problems.

MRI sliding sign: feasibility to assess bowel and uterine mobility using motion MRI in the preoperative planning for pelvic endometriosis?

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Background:

Women with complicated pelvic endometriosis require multidisciplinary preoperative planning, using diagnostic imaging information about the presence and extent of both superficial and deep infiltrating endometriosis (DIE). Although transvaginal ultrasound (TVUS) is the preferred modality, not all women can tolerate a transvaginal scan, with its comprehensive bowel assessment. Magnetic Resonance Imaging (MRI) provides an alternative, without intracavitary distension or probes, specifically to stage DIE (1)

Objective:

In this feasibility study we assessed interobserver agreement on the presence of superficial and deep infiltrating endometriosis as well as pelvic adhesions. This was assessed on a single sagittal motion MRI sequence and a comparison was made with the extent of observed rectouterine mobility or immobility agreed, with the reported TVUS sliding sign or pelvic fixation.

Methods:

A prospective observational study at King Edward Memorial Hospital, a single tertiary centre, in Perth, Western Australia. Eighty-one MRI studies reporting "endometriosis" or "DIE" from 1 May 2019 to 3 December 2019 were enrolled. Fourteen were excluded as they were not performed for endometriosis staging or did not contain an T2 motion series. Three subspecialist radiologists blinded to the MRI reports and each other re-interpreted the T2 sagittal series only to identify:

Bowel adhesions, Expected rectouterine mobility on TVUS, DIE.

Results:

Sixty-six women mean age 37 years (19-51) had an MRI. Eight were post hysterectomy. Twenty-nine had an available TVUS report; 9 reporting sliding sign and 20 reported the presence of a fixed pelvis.

Interobserver agreement and agreement with TVUS findings was higher for adhesions and immobility than normal findings.

There was complete agreement in 59% (39/66) of cases to identify adhesions, in 38% (22/58) expected pelvic fixation, including 65% (13/20) where TVUS reported a fixed pelvis.

There was complete agreement for 5% (3/66) of cases to be normal, and 7% (4/58) expecting normal rectouterine mobility but only 22% (2/9) where TVUS reported normal mobility.

Conclusion:

MRI is expensive but has high sensitivity for findings that predict complex operative procedures (2). It has a place specifically in women who are virgo intacta or refuse TVUS. This is a small proportion but significant clinically if MRI can identify women with pelvic organ fixation and adhesions and hence surgical difficulty when TVUS is declined or not possible.

Risk factors for conversion to open surgery in benign gynaecological laparoscopies

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3. Department of Obstetrics and Gynaecology, University of Melbourne, Melbourne, VIC, Australia

Background:

Conversion to laparotomy during laparoscopic surgery is one of the most serious complications of gynaecological laparoscopy and is associated with increased rates of surgical site infection, blood transfusion, severe sepsis and re-operation as well as prolonged recovery and post-operative stays. There are limited studies assessing gynaecological laparoscopies that were converted to laparotomy.

Objective:

To describe cases of conversion from laparoscopy to laparotomy in benign gynaecological laparoscopies and to find risk factors for conversion.

Methods:

Retrospective case control study comparing patients for whom laparoscopy was converted to open surgery to controls matched to age, surgical date and surgical unit within the hospital (1 case: 2 controls). Extracted from the medical record was patient demographic information, co-morbidities, peri-operative investigations and surgical details including most senior surgeon level, length of procedure, indication for conversion and complications.

Results:

There were a total of 85 cases of conversion from laparoscopy to conversion with 170 matched control laparoscopies. Among cases who were converted, the average patient age was 39.7 years. The most common indication for surgery within the cases of conversion group was removal of pelvic cyst/mass/ abscess.

The main factors that were found to be associated with conversion to open surgery were emergency surgery (30.6% of converted cases vs 10.7% of non-converted cases, $p<0.01$), presence of Pelvic Inflammatory Disease (PID) 10.6% of converted cases vs 2.9% of non-converted cases, $p=0.02$), previous open surgery (23.5% of converted cases vs 10.6% of non-converted cases, $p<0.01$). Level of the most senior surgeon, BMI and medical comorbidities did not differ between groups.

Conclusion:

Emergency surgery, particularly on a background of PID is the most important risk factor for conversion from laparoscopy to laparotomy. Surgeon level does not influence conversion rate. Prospective studies are needed to better understand risk factors and consequences of conversion from laparoscopy to laparotomy.

A systematic review of the literature of pregnancy after bilateral salpingectomy

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Background:

Permanent sterilization has commonly been accomplished by means of bilateral tubal ligation (BTL), Pomeroy method or partial salpingectomy. There is a recent trend towards bilateral salpingectomy (BS) as an alternative form of permanent contraception. Evidence suggests that BS provides a greater protective effect against ovarian cancer in a low risk women and potentially providing a more reliable form of contraception (1). Current literature supports BS to be a safe alternative to BTL and seems to be a changing trend internationally (2,3). There is very limited evidence in the literature regarding the rate of spontaneous pregnancy after BS. This is an important clinical question to answer which will assist in counselling patients on methods of permanent contraception.

Objective:

Our objective was to conduct a systematic review of the existing literature to assess the incidence of pregnancy following bilateral salpingectomy.

Method:

We followed the PRISMA guidelines and searched MEDLINE, EMBASE, SCOPUS, PubMED, Web of science and google scholar including reference lists from inception for all case studies, case series and cohort studies on spontaneous pregnancy after bilateral salpingectomy published up to December 31st of 2019. Two authors searched and selected studies, extracted data and assessed the risk of bias independently. Any disagreement was resolved by discussion or arbitration. Two authors searched and selected studies, extracted data and assessed the risk of bias independently. Any disagreement was resolved by discussion or arbitration. Women with a spontaneous pregnancy were included if the diagnosis was confirmed by definitive tests.

Results:

Our interim analysis revealed a total of 3 patients were included in the analysis who spontaneously conceived following BS. BS had been performed for other indications than permanent sterilization in all 3 cases (hydro salpinx and tubal ectopic pregnancies). Abdominal pain was the predominant symptom. Pregnancy location varied with a pregnancy of unknown location, an ovarian pregnancy and an intrauterine pregnancy described. All patients were managed surgically.

Conclusion:

BS seems to be an appropriate choice of permanent contraception with very low rates of spontaneous conception that have been reported in the literature. There are no trials comparing failure rate of this type of permanent of contraception with other options. Interestingly, no patients following BS for permanent sterilization have been reported to have had a procedure failure to date. With increasing rates of BS as an option of permanent contraception, long term outcomes including failure rate will be ascertained over time.

Augmentation of Native Tissue Vaginal Repair with autologous biological graft: Safety, feasibility and efficacy

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3. *Lyell McEwin Hospital, Elizabeth, South Australia, Australia*

Background:

Pelvic organ prolapse (POP) is a common condition, affecting up to 50% of women over the age of 50, and 50% of parous women. Previously vaginal mesh has been used to treat advanced POP and/or recurrence. However, the Therapeutic Goods and Administration (TGA) have withdrawn vaginal mesh and biologicals from Australian market since January 2018. Thus, gynaecologists are faced with complex POP cases but less tools in their armamentarium, which led to the innovation of platelet-rich plasma (PRP) to augment vaginal repair. Calcium gluconate is added to the PRP in a predefined ratio. This is then centrifuged in commercial bottles with a diameter of 3-4cm to create the autologous biological graft which is then sutured to the underlying tissue and augment the repair.

Study:

Women with recurrence of pelvic organ prolapse (POP) were referred to a private pelvic floor gynaecologist with a special interest in regenerative medicine. With informed consent, these women underwent vaginal repair augmented with PRP membrane. This prospective cohort study will report on the patient's questionnaire response, prolapse measurements (including POPQ scores), and complications with follow up out to 20 months.

Method:

Women who were consented for pelvic organ prolapse surgery were recruited to this study for PRP membrane augmentation of vaginal repair at the time of surgery. PRP kit was used to create autologous membrane, which required sequential centrifugation. The PRP membrane was sutured onto endopelvic fascia after site-specific vaginal repair. Follow-up was planned at 6 weeks, 6 months, and 12 months. Patient assessment included Pelvic organ prolapse quantification (POPQ), degree of vaginal atrophy, and Australia Pelvic Floor Questionnaire (APFQ).

Results:

There have been 60 cases of PRP membrane implanted at the time of vaginal repair. There was improvement within all domains of the Australian Pelvic Floor Questionnaire compared to pre procedure. There were no anterior or posterior compartment recurrence. There were no adverse surgical or medical events within the cohort. Two women have undergone further surgical management for apical compartment relapse. The apical compartment is repaired by a standard technique during the initial surgery but is not repaired using autologous membrane.

Conclusion:

PRP membrane appears to be a feasible treatment to supplement symptomatic utero-vaginal prolapse, especially in recurrent pelvic floor repair. Further research in the form of a randomised control trial is in development. Optimal techniques for management of apical prolapse needs elicitation.

SESSION THREE B: FREE COMMUNICATIONS / 1330-1500

Ballroom 2

Increasing the adoption of ambulatory hysteroscopy in Australia - cost comparisons and patient satisfaction

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Background:

Hysteroscopy is commonly performed under general anaesthesia in theatre and is still considered the gold standard for investigating abnormal uterine bleeding. Ambulatory hysteroscopy (AH) is the same procedure performed in the outpatient setting which offers greater convenience to patients, shorter procedural time, reduced number of visits, improved cost-effectiveness, as well as reduced staff and equipment

requirements. Despite these advantages, hysteroscopy under general anaesthetic is still the predominant form of intervention in Australia.

Objectives:
The aim of this presentation is to (1) provide an overview of the setup requirements for AH, (2) evaluate cost of AH in comparison to that performed in the operative setting and (3) present data on patient satisfaction of AH.

Methods:
A retrospective cohort study of all patients undergoing AH (May 2017 to October 2019) was performed. Collected data consisted of age, number of vaginal deliveries, menopausal status, cervical surgery, indication, ultrasound findings, peri-procedural medication, procedure performed, surgeon proficiency, duration of procedure, technical difficulty and patient satisfaction.

Results:
Between May 2017 and October 2019, 298 patients were seen. Patient age ranged from 21 to 91 years. 50.5% were pre-menopausal and 49.5% were postmenopausal. Indications for AH included postmenopausal bleeding (37.2%), heavy bleeding (24.5%), polyp (10.4%), retained intrauterine device (7.4%) and thickened endometrium (7%).

In terms of patient satisfaction, 266 patients completed the survey. The median pain score was 5 out of 10, with most patients rating their score 5 (n = 56). Despite pain, 94% of patients would undergo AH again and 97% patients would recommend AH to their friends. 97.7% felt that their concerns were fully listened to, 97.7% had complete confidence in their treating doctor, and 97.4% felt they were treated with respect (scored 5/5). Professionalism displayed by the doctor, nurses and clinic receptionists were given full score in 98.9%, 99.2%, 98.5% of the patients respectively. The average cost of AH was $214 compared with $3316 for a hysteroscopy performed in theatre.

Conclusion:
Ambulatory hysteroscopy is an effective and accessible alternative to hysteroscopy under general anaesthesia. We hope the findings of this presentation encourage healthcare providers to transition from operative to ambulatory hysteroscopy as the preferred option in Australia, in view of the significant cost benefits afforded by an ambulatory approach as well as high rates of patient satisfaction.

Temporal and external validation of the Ultrasound-Based Endometriosis Scoring System (UBESS)

Mercedes Vaquero 1 , Mathew ML Leonardi 1 , Kristine KA AAS-Eng 2 , Chuan CL Lu 3 , Reyftmann LR Lionel 4 , Tetstall ET Emma 4 , Slusarczyk BS Basia 5 , Ludlow JL Joanne 5 , Hudelist GH Gernot 6 , Reid SR Shannon 4 , Condous GC George 1

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6. *Obstetrics and Gynaecology, St John of God Hospital, Vienna, Austria*

Study Objective:
To externally and temporally validate the Ultrasound Based Endometriosis Staging System (UBESS) to predict the level of complexity of laparoscopic surgery for endometriosis.

Design:
Multi-centre retrospective diagnostic accuracy study between 2016 and 2018.

Setting:
Four different centres with advanced ultrasound and laparoscopic services were recruited

Patients or Participants:
Patients with suspected endometriosis who required surgery (laparoscopic excision of endometriosis).

Interventions:
UBESS I, II and III were correlated with the Royal College of Obstetricians and Gynaecologists (RCOG) surgical stages 1, 2 and 3. Comparison between temporal and external sites as well as each site was performed in terms of the diagnostic accuracy of UBESS.

Measurements and Main Results:
294/317 women were included in the final analysis. UBESS overall accurately classified 80%, 71% and 60%

of women to RCOG levels 1, 2 and 3 respectively (Table 1). When ureterolysis without bowel surgical cases (n=54) were excluded, the sensitivity of UBESS to correctly classify RCOG level 3 increased from 60% to 96.4% (p<0.005) (Table 2).

Conclusion:
UBESS externally validated did not perform as well as expected. When however, the cases of ureterolysis (RCOG 3) in the presence of a normal 'deep endometriosis' scan were excluded, the performance of UBESS improved dramatically. These findings justify the search for other ultrasound markers to predict superficial pelvic sidewall disease.

Pre-operative Imaging in Deep Infiltrating Endometriosis: predicting depth of disease in rectosigmoid specimens

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Background:
Among women with endometriosis, the prevalence of bowel involvement is approximately 12%(1) with the majority involving the rectum and sigmoid colon. Colorectal endometriosis is associated with chronic abdominopelvic pain, rectal bleeding, and change in bowel habit, however the degree of symptoms does not predict the extent of disease. In expert hands, both ultrasound (transvaginal or transrectal) and magnetic resonance imaging (MRI) have excellent diagnostic accuracy(2,3). However, there is limited literature assessing the accuracy of both modalities for predicting histological depth of disease. This is highly relevant as depth of lesion will inform surgeons with regards to suitability for conservative surgical approaches (such as a rectal shave), compared to more invasive options.

Methods:
We performed a single-centre retrospective longitudinal study on pre-operative diagnostic tests for colorectal endometriosis. Between January 2012 and December 2019 cases had pre-operative discussion at a multidisciplinary endosurgery meeting and subsequently underwent operative management for deep infiltrating endometriosis (DIE) with planned colorectal surgeon attendance. Prospectively reported imaging (blinded to surgical result) and corresponding histopathology were reviewed. The accuracy of each test modality was assessed, with analysis of the discriminative properties and predictive ability of MRI and transvaginal sonography for differentiating depth of rectal disease. For the majority of analyses, depth was dichotomised into superficial involvement (serosal only) and deeper wall involvement (muscularis, submucosa or mucosa).

Results:
Seventy-two women underwent surgery for DIE; 20 underwent a rectal shave, 14 had a disc/wedge resection, 33 an anterior/segmental resection, and 5 had no rectal surgery. Of those who underwent either a wedge or anterior resection, adequate imaging results were available for 44 women. At least one imaging modality was concordant with histological depth in 26 cases(59%), and at least one imaging modality predicted depth of disease to the same or deeper extent in 39 cases(89%). For those who had both a pre-operative ultrasound and MRI(n=30), these imaging modalities were highly sensitive and specific for any rectal wall involvement(sensitivity 89.7%, specificity 100%, PPV 100%, NPV 99%). When ultrasound alone was relied upon, the test remained highly sensitive for any rectal wall involvement(sensitivity 97%, specificity 66.7%, NPV 99%). When only MRI was performed, the test demonstrated both high sensitivity and specificity for rectal wall disease(sensitivity 91.7%, specificity 100%, PPV 100%, NPV 99%).

Conclusion:
Specialist transvaginal ultrasound and MRI are accurate in predicting depth of disease in rectal endometriosis. These modalities were similar in their diagnostic performance for depth of rectal wall involvement.

Gynaecology trainees would benefit from a competency-based medical education model in learning ultrasound for endometriosis: A learning curve study for the detection of pouch of Douglas obliteration and deep endometriosis of the rectum in gynaecological sonology trainees

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Objective:
For a gynaecology trainee, how much training is required to achieve an accurate and clinically safe level of competence in predicting pouch of Douglas (POD) obliteration and deep endometriosis (DE) using advanced specialized transvaginal ultrasound (TVS) techniques?

Accurately predicting extent of endometriosis and complexity pre-operatively is paramount in order to develop appropriate management plans and mobilise surgical resources effectively. TVS is recommended as the first-line preoperative investigation particularly with an expertly guided TVS. Advanced TVS techniques for detection of POD obliteration and DE of the rectum are superior to physical examination and have demonstrated benefits to patients and cost-savings to the healthcare system. Unfortunately most sonographic centres will only perform the basic TVS forgoing the specialised techniques to ascertain POD obliteration or DE.

Methods:
This prospective study included 145 patients with suspected endometriosis over a 12-month period and utilised the cumulative summation test for learning curve (LC-CUSUM) tool. Symptomatic patients referred to a tertiary endometriosis clinic in Sydney, Australia, were examined by an expert sonographer (ES) and one or two of three gynaecology fellow trainees (T1, T2 and T3).

Results:
Not all trainees in our study reached proficiency by the end of the study. Two of three trainees (T1 and T3) reached the defined proficiency level for POD obliteration detection at conclusion of the study (after 40 and 22 scans, respectively). Two of the three trainees (T2 and T3) reached the defined proficiency level for bowel DE detection at conclusion of the study (after 21 and 25 scans, respectively). The prevalence rate of POD obliteration as detected by the ES was 23% and for bowel DE was 18%. The sensitivity and specificity of T1, T2 and T3 in comparison with the ES for POD obliteration detection in this study were 70, 82, 85% and 98, 92, 100%, respectively. The sensitivity and specificity of T1, T2 and T3 in comparison with the ES for bowel DE detection in this study were 38, 86, 82% and 91, 95, 97%, respectively.

Conclusions:
The learning curve for each individual is unique. 50 sonographic scans may not be adequate for proficiency development. We advocate that gynaecology trainees would benefit from a competency-based medical education model in learning ultrasound for endometriosis.

Is the World Endometriosis Research Foundation, WERF, Endometriosis Phenome and Biobanking Harmonisation Project (EPHect) Questionnaire a good triaging tool for women with ovarian and posterior compartment endometriosis?

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Objectives:
We aim to demonstrate whether the WERF EPHect Questionnaire can be used as a triaging tool to determine which women, based upon symptoms, are more likely to have ovarian and posterior compartment endometriosis on ultrasound.

Methods:
Prospective observational study (July 2018 to March 2019). Women referred for a 'deep endometriosis' (DE) ultrasound to two specialized centres with a history of possible endometriosis, were emailed the online WERF EPHect Questionnaire. The DE ultrasounds were performed by advanced sonologists as per the IDEA consensus opinion. A subsection of the questionnaire focusing on bowel symptoms (during menses and in the preceding 3 months) was compared to DE ultrasound findings. Logistic regression analysis was performed to assess the correlation between online responses and ultrasound findings.

Results:
217 women were emailed the online questionnaire; 136/217 (62%) responded prior to their DE ultrasound. The ultrasound prevalence of ovarian endometriomas, rectal DE and complete pouch of Douglas (POD) obliteration on ultrasound were 24%, 18% and 18%, respectively. There was no significant difference in the prevalence of disease in the respondents versus non-respondents (47%/47% posterior compartment, 31%/24% ovarian, respectively (p-value<0.05)). Older age, blood and mucus in stool and fullness and bloating were significant predictors of ovarian disease. Older age and blood in stool were predictive of posterior compartment disease, specifically rectal DE and POD obliteration.

Conclusion:
When the WERF EPHect Questionnaire is applied, bowel symptoms have the potential to be utilized as a triaging tool to determine which women require DE ultrasounds. A structured international symptomatology survey may be able to better target the utility of the DE ultrasound.

Correlation between Transvaginal Ultrasound (TVUS) findings and laparoscopy in prediction of Deep Infiltrating Endometriosis (DIE)

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1. *Royal Womens Hospital, North Melbourne, VICTORIA, Australia*

Background:
Diagnosing endometriosis remains a challenge in view of the multiple presentations of the disease and the non-specific nature of the symptoms. Laparoscopy is the gold standard for definitive diagnosis. Knowledge of the presence, location and extent of DIE disease is essential for adequate pre-operative work-up. Detailed description of endometriosis with TVUS is a valuable instrument for pre-operative diagnosis of endometriosis. TVUS however is highly operator dependent and sound diagnostic results may only be achieved by an adequately-trained and experienced medical team.

Objectives:
The aim of our study was to (1) examine the correlation between TVUS findings and laparoscopy in the prediction of DIE and (2) quantify the differences seen between community and specialist ultrasound.

Methods:
A retrospective cohort study of patients who underwent laparoscopic excision of endometriosis between July 2014 to February 2019. Information collected included age, endometriosis symptoms, previous endometriosis treatment, subfertility, subfertility treatment, ultrasound location (community/specialist), bowel preparation and TVUS and laparoscopy findings. Location of DIE was categorised as: ovarian endometriomas/ovarian adhesions, Pouch of Douglas/Pouch of Douglas adhesions, bladder/uterovesical fold, rectosigmoid, rectovaginal and uterosacral.

Results:
A total of 119 patients were included. The majority received specialist TVUS (n = 75, 63%) and the remaining received community TVUS (n = 44, 37%). Overall, we found that TVUS in the diagnosis of DIE is useful in detecting all but bladder DIE. Community TVUS was no better than chance at identifying most DIE showing AUC of 0.5-0.6 for all categories. However, it demonstrated value in the detection of ovarian endometriomas and adhesions with an AUC of 0.84. Specialist ultrasound on the other hand correctly identified most DIE. Greatest utility was found for the detection of DIE in rectosigmoid AUC = 0.85, $p < 0.000$), followed by Pouch of Douglas/Pouch of Douglas adhesions (AUC = 0.82, $p < 0.000$), ovarian endometriomas/ovarian adhesions (AUC = 0.79, $p < 0.000$), uterosacral ligaments (AUC = 0.75, $p < 0.000$) and rectovaginal septum (AUC = 0.69, $p < 0.05$).

Conclusion:
Specialist TVUS is informative in examining the presence of DIE particularly in rectosigmoid and Pouch of Douglas areas which may increase surgical complexity. Community TVUS is significantly less beneficial however is more accessible to the general public. This adds to the argument that DIE-TVUS should become part of standard ultrasound training.

Looks Can Be Deceiving: the Prevalence of Deep Endometriosis and Pouch of Douglas Obliteration When the Ovaries are Normal

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Objective:
Patients with symptoms and signs of endometriosis are often investigated with transvaginal ultrasound (TVS) as a first-line imaging tool. Of the three phenotypes of endometriosis, only ovarian endometriomas (OE) are reliably detectable using basic TVS, which only assess the uterus and the ovaries. The diagnosis of an OE on basic TVS should raise suspicion for deep endometriosis (DE) and pouch of Douglas (POD) obliteration. The inability to diagnose DE or POD obliteration on a basic TVS leads to pitfalls in clinical practice. If one assumes that most patients have a basic TVS in their workup for the symptoms and signs of endometriosis where the ovaries appear normal, we must question how much isolated DE/POD obliteration is being missed. As such, we aim to determine the prevalence of DE/POD obliteration in patients without OEs.

Methods:
Analysis of data from a prospective multicenter data registry (Canadian Task Force classification II-2) was performed. Participants included patients presenting with signs and symptoms of endometriosis to one of eight hospitals in metropolitan Sydney, Australia for laparoscopic excision of endometriosis.

Results:
All patients had at least one ovary, with 6 and 1 having had a left and right oophorectomy, respectively. The ovaries did not contain an ovarian endometrioma (OE) in 319/410 (77.8%) patients. The prevalence of DE and POD obliteration in this cohort was 81/319 (25.4%) and 31/319 (9.7%), respectively (compared to those with OE, where DE and POD obliteration prevalence was 62/91 (68.1%) and 55/91 (60.4%), respectively ($p < .001$)). The most common site of DE was the uterosacral ligaments (right: 47/319 (14.7%); left: 42/319 (13.2%)).

Conclusions:
Approximately 1 in 4 patients had surgically-diagnosed DE and 1 in 10 had POD obliteration in the presence of normal ovaries. At present, pelvic ultrasound generally assesses the uterus and ovaries only. Yet, DE and POD obliteration can be reliably diagnosable using advanced ultrasound techniques. These prevalence rates should encourage the dissemination of knowledge and skill of advanced ultrasound to improve overall diagnosis and assist in triaging to advanced surgeons, when required, and surgical planning.

Cystic Spaces in the Endometrium, a Contemporary Retrospective Cohort Study in a Tertiary Centre

Rosemary D McBain 1 , Karen Reidy 1 , Ricardo Palma-Dias 1 , Martin Healey 1 , Martin Healey 2 , Karen Reidy 2 , Ricardo Palma-Dias 2

1. *Royal Women's Hospital, Parkville, Victoria, Australia*
2. *University of Melbourne, Melbourne, VIC, Australia*

Background:
An association between an ultrasound finding of cystic spaces in the endometrium and a histological diagnosis of endometrial cancer or hyperplasia has been described, but published low-powered retrospective studies and case series are conflicting and heterogenous1-3.

Methods:
We performed a retrospective cohort study, searching the ultrasound, pathology and gynaecological cancer databases at a tertiary teaching hospital in Victoria, Australia, between January 2014 and December 2016.

Results:
We identified 8728 women with either an ultrasound showing cystic spaces or a polyp, or pathology showing endometrial polyp, hyperplasia or cancer.

686 cases with both ultrasound and histology reports available were included in the analysis. Where an ultrasound performed in the preceding 12 months described cystic spaces, sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) for a histological finding of any hyperplasia were 28%, 80.7%, 10.2%, 93.6%, respectively; for hyperplasia with atypia were 22.6%, 80.2%, 5.2%, 95.8%, respectively and for endometrial cancer were 20.5%, 80.1%, 5.8%, 94.5%, respectively.

In a subgroup analysis, postmenopausal women (n=243) had a PPV of 73.7%, 11.8%, 5.3% and 5.3% for polyp, hyperplasia, hyperplasia with atypia and cancer, respectively. Postmenopausal women with a thickened endometrium (n=193) had a PPV of 77.1%, 27.1%, 5.7% and 5.7% for polyp, hyperplasia, hyperplasia with atypia and cancer respectively.

In a chi-squared analysis, There was no significant association between a finding of cystic spaces in the endometrium and hyperplasia ($x2(1)=2.10$, $p=0.15$), hyperplasia with atypia ($x2(1)=0.13$, $p=0.72$) or endometrial cancer ($x2(1)=0.95$, $p=0.95$), but cystic spaces did significantly correlate with polyps ($x2(1)=12.89$, $p<0.01$).

Discussion:
Our results in relation to cystic spaces in the endometrium may have failed to reach significance because a smaller number of women have this finding (n=137) compared to a finding of a possible polyp (n=365). The

PPV of polyp for findings of hyperplasia, hyperplasia with atypia or cancer (4.9, 3.7, 3.6, respectively) was less than the PPV of cystic spaces (10.2, 5.2, 5.8, respectively). This suggestion that cystic spaces was the stronger predictor is not confirmed in relative risk or chi squared analysis, which did not reach statistical significance. Although ours is the largest study on this subject to date, an adequately powered prospective study may determine whether cystic spaces are a discriminatory factor for endometrial hyperplasia and endometrial cancer.

Developing a tool to predict absence of endometriosis in women with pelvic pain / 1450- 1500

Charlotte Reddington 1 , Roshan Karri 1 2 , Samantha Mooney 3 , Emma Readman 3 , Claudia Cheng 1 2 , Jason Abbott 4 5 , Jane Girling 6 , Peter Rogers 1 2 , Sarah Holdsworth-Carson 1 2 , Uri Dior 1 7 , Martin Healey 1 2

1. *The Royal Women's Hospital, Parkville, VIC, Australia*
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4. *School of Women's and Children's Health, Univeristy of New South Wales, Sydney, NSW, Australia*
5. *Royal Hospital for Women, Randwick, NSW, Australia*
6. *University of Otago, Dunedin, New Zealand*
7. *Department of Obstetrics and Gynaecology, Hadassah-Hebrew University Medical Centre, Jerusalem, Israel*

Background:
Currently the diagnosis of endometriosis requires laparoscopy. As yet, there are no validated, symptom-based, patient reported questionnaires for endometriosis screening [1]. Ultrasound provides accurate pre-operative diagnosis of endometriomas [2] and increasingly of deeply infiltrative endometriosis [3] however is not able to distinguish absence of endometriosis from minimal to mild disease. Ideally a non-invasive screening tool would exist to provide women with a preoperative likelihood of endometriosis being present or absent. This would serve to reduce the number of diagnostic laparoscopies and their associated risks in women without endometriosis.

Objective:
To develop a screening tool based on history and demographic factors to predict absence of endometriosis in women with pelvic pain planned for laparoscopy with a normal pelvic ultrasound.

Design:
Retrospective analysis of prospectively collected data from 5 cohort studies of women undergoing laparoscopy for pelvic pain, literature review and survey of subject matter experts.

Methods:
Demographic and pre-operative history data and operative findings were collated from 1548 women undergoing laparoscopy for investigation of pelvic pain. Multiple analysis approaches were used including logistic regression and machine learning algorithms. A survey of subject matter experts and a literature review were performed seeking predictors of absence of endometriosis.

Results:
An 'ensemble' model built using the 'Scikit-learn' machine learning library yielded the best performing algorithm using a subset of 495 women who had complete datasets for variables of interest. Women with an operative finding of endometrioma were excluded as this would be expected to be diagnosed on routine quality pre-operative ultrasound. A Support Vector Machine, Random Forest, and Gaussian Naive Bayes classifier consolidated using a 'majority vote' method identified the best performing algorithm. The best performing algorithm was a 10 variable model which predicts for absence of visually proven endometriosis with a sensitivity of 0.88, specificity of 0.995 and negative predictive value of 0.995.

Conclusion:
This 10-variable model performs well in predicting absence of endometriosis in this cohort. Prospective validation of this tool is planned.

SESSION FOUR A: GONE IN 420 SECONDS – ENDOSCOPIC SURGERY AND BEYOND / 1530-1700

Grand Ballroom 1

Energy sources - Where did we come from, where are we going?

Amani Harris

This talk provides a brief overview of energy sources; their origins, current use and what we may expect in the future.

In 1926, the first ever electrosurgical unit, the Bovie was developed and the terms “cut” and “coag” were coined to describe continuous and interrupted electric current. The 1960s saw the use of monopolar electrosurgery to perform laparoscopic tubal occlusion by Palmer in France. As a consequence of the high morbidity associated with this technique, specifically thermal bowel injury and perforation, bipolar coagulation came to fruition. In 1964, the age of CO2 laser devices began after recognition of the complications of electrosurgery. However, with improvements in the safety of electrosurgery and the high expense of laser in capital and ongoing cost, most surgeons returned to electrosurgery.

More recently, ultrasonic energy devices became available, providing efficient vessel sealing and tissue transection without the passage of electrical current through the tissue. Advanced bipolar technologies followed incorporating tissue feedback monitoring and a cutting blade negating the need for laparoscopic scissors to cut tissue. Electrosurgical devices were then incorporated into robotic and single site surgery. The future of energy sources is advanced, smaller and safer devices that are universally applicable with high efficiency to offset its cost.

Protecting the posture - Laparoscopic Ergonomics

Martin Ritossa

Ergonomics is a branch of science that aims to study human abilities and limitations and apply this knowledge to improve our interaction with products, systems and environments. Laparoscopic surgery with all its patient advantages, complicates the surgeon’s interaction with their patients, staff and operating room equipment. In this 6 minute and 40 second presentation I will explain why ergonomics is important for both surgeons and patients and provide practical tips on how to maximise our interaction with the operating theatre environment.

Ashermans - Is there a way out?

Lalla McCormack

Abstract not yet received.

Physiology of laparoscopy - What the anaesthetists wish we knew

Stephen Ford

The aim of this presentation is to provide a brief overview of the common significant physiological changes associated with increasingly complex gynaecological laparoscopic surgery on patients often with a variety of co-morbidities. In this context there will be a particular emphasis on what your anaesthetist is dealing with at various phases of the operation and measures being undertaken by them to maintain patient clinical stability. Such an understanding fosters efficient communication intra-operatively and carries implications

for pre-operative planning and medical optimisation. Mention will also be made of recent advances in anaesthesia designed to improve laparoscopic surgical conditions and patient safety.

Endometriosis pre-operative planning - IDEA guidelines

George Condous

Expert transvaginal 'deep endometriosis' ultrasound is the key to planning endometriosis surgery. Mapping location and extent of disease not only facilitates multidisciplinary planning of surgery with urologists and colorectal surgeons, but also avoids two-step laparoscopy.

Caesarean section scar thickness and ultrasound assessment

Karen Mizia

An isthmocele, Caesarean scar defect or uterine niche, is any indentation representing myometrial discontinuity or a triangular anechoic defect in the anterior uterine wall, with the base communicating to the uterine cavity, at the site of a previous Ceasarean section scar. It can be This presentation will discuss

- the current methods of classification
- the association with abnormal or post-menstrual bleeding, chronic pelvic pain and infertility
- the association with adverse pregnancy outcomes and predicting uterine rupture

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Caesarean scar niche reconstruction

Sarah Choi

Abstract not yet received.

What's in the name? Eponymous O&G

Andrew McIntyre

Obstetricians and gynaecologists use eponyms every day in clinical practice, often to describe surgical tools, techniques and pathologies. Rarely however do we reflect upon their origins and the stories behind these historical figures who have made significant and wide-ranging contributions to our profession.

Peri-operative VTE prevention - Hail Aspirin!

Fariba Behnia-Willison

Abstract not yet received.

Haemostatic agents - An update

Alison Bryant-Smith

While the time-honoured aphorism "all bleeding stops eventually" endures, haemostatic agents serve a valuable purpose in laparoscopic gynaecology. However, many surgeons remain uncertain about which haemostatic agent(s) to use when.

Spray or powder? Mesh or gel? Foam or film? Sponge or liquid? Gelatin, fibrinogen and/or thrombin? Microfibrillar collagen or oxidized regenerated cellulose? Or a combination of the above?

This presentation will outline the range of haemostatic agents available and provide a practical structured approach as to which agent to use when.

Peritoneal pockets - Who cares?

Mark Ruff

Peritoneal pockets are present in nearly one fifth of women with endometriosis and can be a subtle marker of the disease. If they are not recognised at the time of surgery it can lead to underdiagnosis and undertreatment. This talk will cover the theory behind formation of peritoneal pockets, their clinical association with endometriosis and whether their removal is necessary for the treatment of pelvic pain and infertility related to endometriosis.

Laparoscopic surgery in pregnancy

Christopher Smith

The goal of surgical intervention during pregnancy is to minimise fetal risk without comprising the safety of the mother. Previous studies demonstrate laparoscopy to be both safe and effective during all trimesters, although research continues to accumulate as laparoscopy becomes more prevalent during pregnancy. My presentation on 'Laparoscopy in Pregnancy' will look to cover some key issues including the safety and timing of surgery, the indications and benefits of laparoscopy, as well as important peri-operative considerations.

SESSION FOUR B: GONE IN 420 SECONDS – SEXUALITY, FERTILITY & OBSTETRICS / 1530-1700

Grand Ballroom 2

Foundation, not the future - Left lateral tilt at C-Section

Matthew Doane

This unquestioned acceptance of medical standards and techniques without understanding their basis in evidence is common across disciplines, but these situations are where we often lose sight of the reasoning or evidence behind the science that guides us. This is when science transitions into Dogma. There is a pervasive fear of aortocaval compression in the parturient, especially in the setting of a caesarean section. Various methods of “uterine displacement" are often employed to combat this phenomenon, sometimes with fervent vigilance, but what is the evidence and history behind this?

Myomectomy for fertility or an exercise in futility?

David Rosen

Abstract not yet received.

The "perfect" caesarean section

Rachel Green

This talk will address an evidence-based approach to caesarean. From open to closure what is the evidence for each of the steps involved in caesarean delivery?

Rest in peace dear forceps? The future of instrumental Delivery

Rachel Collings

Do we need to examine the role of forceps more closely?
Should we be saying rest in peace dear forceps because of the injuries they can cause?
Should we instead be reaching for the vacuum or the caesarean section blade?
Or should we be reaching for the consent form well before the onset of labour, or reviewing the training and policies around their use?
This talk will explore these questions, aiming to stimulate conversation and discussion on the role and use of forceps in todays current climate.

Towards normal abdominal delivery

Bassem Gerges

Abstract not yet received.

Enhancing recovery after Caesarean section

Erin Nesbitt-Hawes

Abstract not yet received.

Fetoscopic Surgery - Past, present, future

Margaret Harpham

This presentation will outline the evolution of fetoscopic surgery, what is possible now, what are the challenges, and what are the possibilities for the future.

Pregnancy & hypertension - Opiates & NSAIDS?

Gene Lee

Abstract not yet received.

Laparoscopic cerclage

Krish Karthigasu

This presentation briefly decribes laparoscopic abdominal cervical cerclage - indications, techniques, results from studies and different scenarios that this uncommon procedure is undertaken

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Who's doing what? Mature sexuality

Harry Merkur

Who's doing what:

Defining sexual activity requires a look at the statistics of the engagement of women in sex. Taken to its potential limits this could look at all forms of sexual activity which would include heterosexual, homosexual, bisexual and the other many forms of gender. I will concentrate on the female and mainly in the heterosexual context.

Mature:

Obviously this is an arbitrary concept, but for the purposes of this talk I will confine my comments to the ≥50 yro woman.

Sexuality:

As with the various definitions of gender, the meaning of sexuality will be interpreted as a broad, generic term which encompasses the sexual aspects that go to make up a woman's persona. This would describe how the woman presents herself to the world sexually, but in addition the real inner world of a woman's sexual being is probably a closer and more accurate meaning.

PCOS - where are we now?

Michele Kwik

Polycystic Ovarian Syndrome: review of the new diagnostic criteria and management options, in light of the recent NHMRC approved Evidence-based Guideline for the assessment and management of PCOS.

Ovulation induction made easy - When? How? Why?

Manny Mangat

Abstract not yet received.

FRIDAY, 6TH MARCH 2020

SESSION SIX: ENSURING SAFTEY FOR THE FUTURE – M&M LIVE / 1030-1215

Grand Ballroom

Foundations of an effective M&M meeting

Thomas Hugh

Abstract not yet received.

SurgicalPerformance Update

Andreas Obermair

Abstract not yet received.

Live M&M

Andreas Obermair & Stephen Lyons

Abstract not yet received.

AGES Travelling Fellowship

Supuni Kapurubandara

Abstract not yet received.

Risk of Complication at the Time of Laparoscopic Hysterectomy; A Prediction Model Built from The National Surgical Quality Improvement Program Database

Kristen Pepin

Background:
While laparoscopic hysterectomy is well-established as a favorable mode of hysterectomy due to decreased perioperative complications, there is still room for improvement in quality of care. Though previous studies have described laparoscopic hysterectomy complication risk factors, there is currently no tool for predicting risk of complication at the time of laparoscopic hysterectomy.

Objective:
Create a prediction model for complications at the time of laparoscopic hysterectomy for benign conditions.

Study Design:
Retrospective cohort study including patients undergoing laparoscopic hysterectomy for benign indications between 2014 and 2017 at United States hospitals contributing to American College of Surgeons- National Surgical Quality Improvement Program Database (NSQIP). Data about patient baseline characteristics, perioperative complications (intraoperative complications, readmission, reoperation, need for transfusion, operative time greater than 4 hour or postoperative medical complication) and uterine weight at the time of pathologic examination were collected retrospectively. Postoperative uterine weight was used as a proxy for preoperative uterine weight estimate. The sample was randomly split to create two patient populations, one for deriving the model and the other to validate the model.

Results:
A total of 33,123 women met inclusion criteria. The rate of composite complication was 14.1%. Complication rates were similar in the derivation and validation cohorts (14.1% [2,306/14,051] vs 13.9% [2,289/14,107], p=0.7207). The logistic regression risk-prediction tool for hysterectomy complication identified seven variables predictive of complication; history of prior laparotomy (increases odds of complication by 21%), age (2% increase odds of complication per year of life), BMI (0.2% increase odds of complication per each unit increase in BMI), parity (7% increased odds of complication per delivery), race (when compared to white women, black women had a 34% increased odds and women of other races had a 18% increased odds of complication) and American Society of Anesthesiologists score (when compared to a score = 1, score = 2 had a 31% increased odds of complication, score = 3 had a 62% increased odds and score =4 had a 172% increased odds). Predicted preoperative uterine weight also had a statistically significant non-linear relationship with odds of complication. The c statistics for the derivation and validation cohorts were 0.62 and 0.62, respectively. The model is well-calibrated for women at all levels of risk.

Conclusion:
The laparoscopic hysterectomy complication predictor model is a tool for predicting complications in patients planning hysterectomy.

SESSION SEVEN: CHAIRMAN'S CHOICE / 1315-1445

Grand Ballroom

A randomised, double-blind, placebo controlled trial of fractionated carbon dioxide laser treatment for women with postmenopausal vaginal atrophy symptoms

Fiona Li 1 , Rebecca Deans 1 , Erin Nesbitt-Hawes 1 , Aaron Budden 1 , Lalla McCormack 1 , Sarah Maheux-Lacroix 1 , Eva Segelov 2 , Stephen Lyons 1 , Jason Abbott 1

1. *University of New South Wales, Randwick, NEW SOUTH WALES, Australia*
2. *Monash University, Melbourne, Victoria, Australia*

Vaginal atrophy symptoms affect over half of postmenopausal women, including women with induced menopause due to treatment of breast cancer, and can substantially decrease quality of life. Treatments including hormonal therapies are often ineffective, avoided or contraindicated. Fractionated laser treatments are proposed as a non-hormonal alternative for vaginal atrophy symptoms. Whilst data on the intervention to date are positive with symptom improvement in >90% of cases, and histological changes are reported, no placebo-controlled trial is currently reported.

Bladder Care Following Laparoscopy for Benign Non-Hysterectomy Gynaecological Conditions: A Randomised Controlled Trial

Lalla McCormack 1 2 3 , Sophia Song 2 3 , Christine Zhang 2 3 , Aaron Budden 2 3 , Amy Arnold 2 3 , Haryun Won 1 2 3 , Erin Nesbitt Hawes 1 2 3 , Rebecca Deans 1 2 3 , Jason Abbott 1 2 3

1. *Department of Endogynaecology , Royal Hospital for Women , Randwick , NSW , Australia*
2. *GRACE , Gynaecology Research and Clinical Evaluation , Sydney , NSW , Australia*
3. *UNSW , School of Women's and Children's Health , Sydney , NSW , Australia*

To compare rates of urinary retention and post operative UTI between women with immediate versus delayed IDC removal, following non-hysterectomy laparoscopy for benign gynaecological pathology.

Superficial endometriosis can be seen on ultrasound: a diagnostic accuracy study of a novel ultrasound technique called saline-infusion sonoPODography

Mathew Leonardi 1 , Mercedes Vaquero 1 , Kiran Vanza 1 , George Condous 1

1. *Acute Gynaecology, Early Pregnancy and Advanced Endoscopy Surgery Unit, Sydney Medical School Nepean, Nepean Hospital, University of Sydney, Surry Hills, NSW, Australia*

No previous studies on non-invasive diagnostic methods for endometriosis have been able to accurately diagnose superficial endometriosis (SE). Of the three phenotypes, SE is the most common. In the absence of ovarian endometriomas (OE) or deep endometriosis (DE) on non-invasive imaging, patients and physicians are reliant on diagnostic laparoscopy to visualise SE. The necessity for invasive testing has resulted in a trend to diagnose patients based on clinical symptoms, which carries many limitations. We recently described a novel ultrasound procedure called saline-infusion sonoPODography (SPG), whereby fluid is introduced into the pouch of Douglas (POD) through the uterus and Fallopian tubes via an intrauterine catheter and then the POD is assessed with a transvaginal ultrasound (TVS) probe1. We proposed SE could be directly visualised lining the peritoneum on SPG. As such, the objective of our study was to estimate the diagnostic accuracy of SPG for SE at the time of laparoscopy.

The Myometrial-Cervical Ratio (MCR): A new measurement to improve the ultrasound diagnosis of Adenomyosis

Samantha Mooney 1 , Rebecca Roberts 1 , Lenore Ellett 1 , Peter Maher 1 , Dorothy McGuiness 1 , Kate Stone 1

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

Adenomyosis is defined by the presence of endometrial glands and stroma in the myometrium, and is associated with enlargement of the uterus, heavy menstrual bleeding and dysmenorrhoea. Currently, a diagnosis of adenomyosis is made on histopathology evaluation of the hysterectomy specimen. Features that may suggest adenomyosis on pelvic sonography include asymmetric thickening of the myometrium, myometrial cysts, linear striations radiating from the endometrium, loss of the endomyometrial border, thickening of the junctional zone and increased heterogeneity of the myometrium(1,2). However, there is no standard threshold for an imaging diagnosis. An objective and reproducible diagnostic test for adenomyosis is sought. We present a novel imaging measurement for the diagnosis of adenomyosis.

The Traffic Light Pilot Study: a pilot study assessing the quality of interventions in obstetrics and gynaecology

Krystle Chong 1 , Mingxue Fan 1 , Rebecca McDonald 1 , Wentao Li 1 2 , Ben Mol 1 2

1. *Monash Health, Clayton, VICTORIA, Australia*
2. *Monash University, Clayton, Victoria, Australia*

Medical practitioners aim to achieve good outcomes for patients with every intervention performed. To do so, it is important to know that treatments are effective. Evidence-based medicine aims to support this practice, by integrating research-based evidence with clinical skills and patient values. In this pilot study we aim to assess the effectiveness of clinical activities performed in relation to local guidelines and primary research.

Virtual Clinics in Gynaecology: Can we shorten the wait? Assessing the success, feasibility and patient acceptance of Virtual (Telephone) Clinics for Postmenopausal Bleeding

Samantha Mooney 1 , Gurjot Gill 1 2 , Emma Readman 1

1. *Mercy Hospital for Women, Heidelberg, VIC, Australia*
2. *The University of Melbourne, Parkville, VIC, Australia*

To assess a novel model of clinic design for the management of women with PMB based on systematised referral, telephone assessment, and routine use of the outpatient hysteroscopy (OPH) clinic for see-and-treat care.

Fight or Flight: Biological measures of surgeon stress during surgery

Aaron Budden 1 2 , Sophia Song 2 , Jason Abbott 2

1. *Royal hospital for women, Randwick, NSW, Australia*
2. *University of New South Wales, Sydney, Australia*

To assess changes in biological markers of acute stress during live surgery from baseline and to assess if these changes are difference based on role in surgery and level of training.

We live in a virtual world: Training the trainee using an integrated Visual Reality Stimulator training curriculum

Samantha Mooney 1 , Shagun Narula 2 , Emma Readman 1 , Lenore Ellett 1

1. *Mercy Hospital for Women, Heidelberg, VIC, Australia*
2. *Monash Health, Clayton, VIC, Australia*

Gynaecology trainees continue to face difficulty in obtaining adequate procedural experience. Individual exposure is limited by increased trainee numbers, restrictions on working hours and advances in medical management(1). Larsen et al(2) examined the role of VRS-training for junior gynaecology trainees and demonstrated skill enhancement following VRS training. Several VRS-integrated programs have been

suggested since that time(3). Despite these contemporary findings, integration of VRS into current training paradigms to ensure transferability to the operating theatre remains incompletely understood.

Botulinum toxin A (Botox) injection into muscles of pelvic floor as a treatment for chronic pelvic pain secondary to pelvic floor muscular spasm - A Pilot Study

Samantha Mooney 1 , Alaina Francis 1 , Richard Hiscock 1 , Tony Ma 2 , Prathima Chowdary 3 , Emma Readman 1 , Lenore Ellett 1

1. *Mercy Hospital for Women, Heidelberg, VIC, Australia*
2. *University Hospital Barwon Health, Geelong, VIC, Australia*
3. *Waitemata District Health Board North Shore Hospital, Auckland, New Zealand*

Chronic pelvic pain (CPP) is a major cause of morbidity and the management of women with CPP continues to challenge clinicians, owing to the complex interaction between musculoskeletal, neurological, endocrine, and psychological factors(1). There is increasing evidence that muscular spasm of the pelvic floor may play a role in up to 85% of CPP cases. The exact nociceptive mechanism is incompletely understood. Injection of Botulinum toxin (Botox) into the spasmodic muscles of the pelvic floor is a novel treatment showing promising results in carefully selected women with CPP(2).

SESSION EIGHT: LESSONS LEARNT / 1515-1700

Grand Ballroom

Foolproofing the surgical future - ERAS

Jason Abbott

Abstract not yet received.

Dan O'Connor Perpetual Lecture - A brief history of cervical screening

Annabelle Farnsworth

In October 2018 an announcement was made as part of the International Papilloma virus conference held in Sydney, that Australia would eliminate cervical cancer by 2028 and be the first country in the world to so.

This prediction was made on the basis of modelling using data from both the successful human papilloma virus (HPV) vaccination program and the new cervical screening program based on primary HPV testing.

Australia has a long history of success in cervical cancer screening. We were one of the first countries in the world to recognise the importance of an organised approach to cervical screening and introduced such a screening program in 1991. That initial screening program was based on conventional cytology, the Pap smear and undertook educational programs of women and clinicians and recruitment drives. There was a large emphasis on quality assurance in all aspects of the screening pathway particularly cytology. The program saw a halving in the incidence and mortality from cervical cancer over the subsequent 20 years. Issues though remain with a significantly higher burdens of disease in our Indigenous population

During this period great strides were made in the understanding of the pathogenesis of cervical cancer and its association with human papilloma virus infection. Much of this work was done in Australia. It was Australian researchers who developed the HPV vaccine and Australia successfully introduced a nationally funded HPV vaccination program in 2007. With the development of improved testing methods for HPV, Australia changed to a risk based HPV primary screening program in December 2017.

The new program has been largely successful but issues remain with recruitment, the national cancer screening register, monitoring the program and more complex management issues. If we are to achieve the projected elimination of cervical cancer these issues need to be addressed.

SATURDAY, 7TH MARCH 2020

SESSION NINE: SURGICAL FOUNDATIONS / 0830-1015

Grand Ballroom

Re-laying the foundations - Managing the trainee in trouble

Rosalie Grivell

The aim of this talk is to briefly describe why trainees might find themselves in trouble or difficulty, what principles might best guide supervisors in assisting trainees and what supports are available to trainees and supervisors when trouble is encountered. The talk will also touch on best practice in training in order to avoid trouble and how impacted parties might move forward when trouble arises.

A solid foundation - The AGES Fellowship training program

Anusch Yazdani

Abstract not yet received.

LapCo TT - The solid foundation of teaching

Luke McLindon

Structured teaching is limited in surgical training programs. This talk will highlight the evidence surrounding the LapCo TT (Train the Trainer) workshops and the expected benefits to us as mentors, our trainees and our future patients.

We will explore the experiences of those who have participated in the first wave of courses run by AGES faculty. This is a real 'back to the future' journey as we work through the TT technique and gain insights into our own past surgical trainee experience. Building on this to optimise that received by our trainees now and into the future.

Feedback - The foundation of learning

Rebecca Szabo

This talk aims to build understanding of the continuous process of feedback. It is relevant for trainees and trainers as well as others wanting to understand the role of peer feedback.

It highlights:
What feedback is
What effective feedback feels like
How we can build a culture of feedback

Maintenance and evolution after the fellowship

Stuart Salfinger

Abstract not yet received.

Is there a future for the Generalist

Vijay Roach

Abstract not yet received.

SESSION TEN: THE FUTURE – PUSHING THE LIMITS / 1045-1205

Grand Ballroom

Menopause back to the future

Rod Baber

Whilst perhaps not as exciting as laparoscopic surgery, managing the menopause could never be described as boring.

Ever since HRT (MHT) (HT) was first used to alleviate menopausal symptoms every positive clinical trial result has been followed by a negative or misunderstood trial. Of the latter the most disturbing initially was the Women's Health Initiative Trial although subsequent re-analysis and long term follow up showed benefit when MHT was used in an appropriate population. As a consequence of that data prescribing habits changed, doses were reduced, more natural hormones were deployed and transdermal therapy encouraged. Women and doctors were reassured.

In late 2019 another tempest arrived with an observational study on the effects of MHT on breast cancer risk published in Lancet. Despite media enthusiasm spreading corona virus type fear far and wide this study was looking at mostly old data using olde hormone regimens and doses. Hardly any data was available for transdermal therapy nor for use of micronized progesterone.

Doctors and women should be reassured that modern low dose MHT is a safe option providing each woman is individually assessed before commencing therapy. The need for therapy should be reviewed annually but there is no mandatory stopping time

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Neuropelveology and the future

Marc Possover

Abstract not yet received.

Laparoscopic hysterectomy - Keeping the surgeon safe

Chad Michener

This session will review common methods for getting through a difficult TLH. We will review the pertinent anatomy for identification of the ureter, Isolating and controlling the uterine artery laterally and approaching

the stuck bladder. At the end of the seminar attendees should be able to describe approaches for managing these common scenarios.

Physician heal thyself

Angela Joy

Abstract not yet received.

Tribes & Teams

Victoria Brazil

Have you ever made a joke about orthopaedic surgeons? Or radiologists? Or anaesthetists on the golf course? It was probably all in good fun..., but..?

Great teamwork in healthcare is easier than we've been told, but harder than we think.

It matters - contemporary healthcare is complex, and patient outcomes are determined by the performance of teams and systems. We're not Formula one pit crews, and we're not pilots. Those groups approach to improving teamwork behaviours are useful, but not enough. We need a direct focus on health service culture, and development of trust and respect across department interfaces. In this session we'll look at teams, team training, the role of simulation, and how our institutions need high performance teamwork strategies.

Why are we so 'tribal' in healthcare? And can we be better? And still fun.
