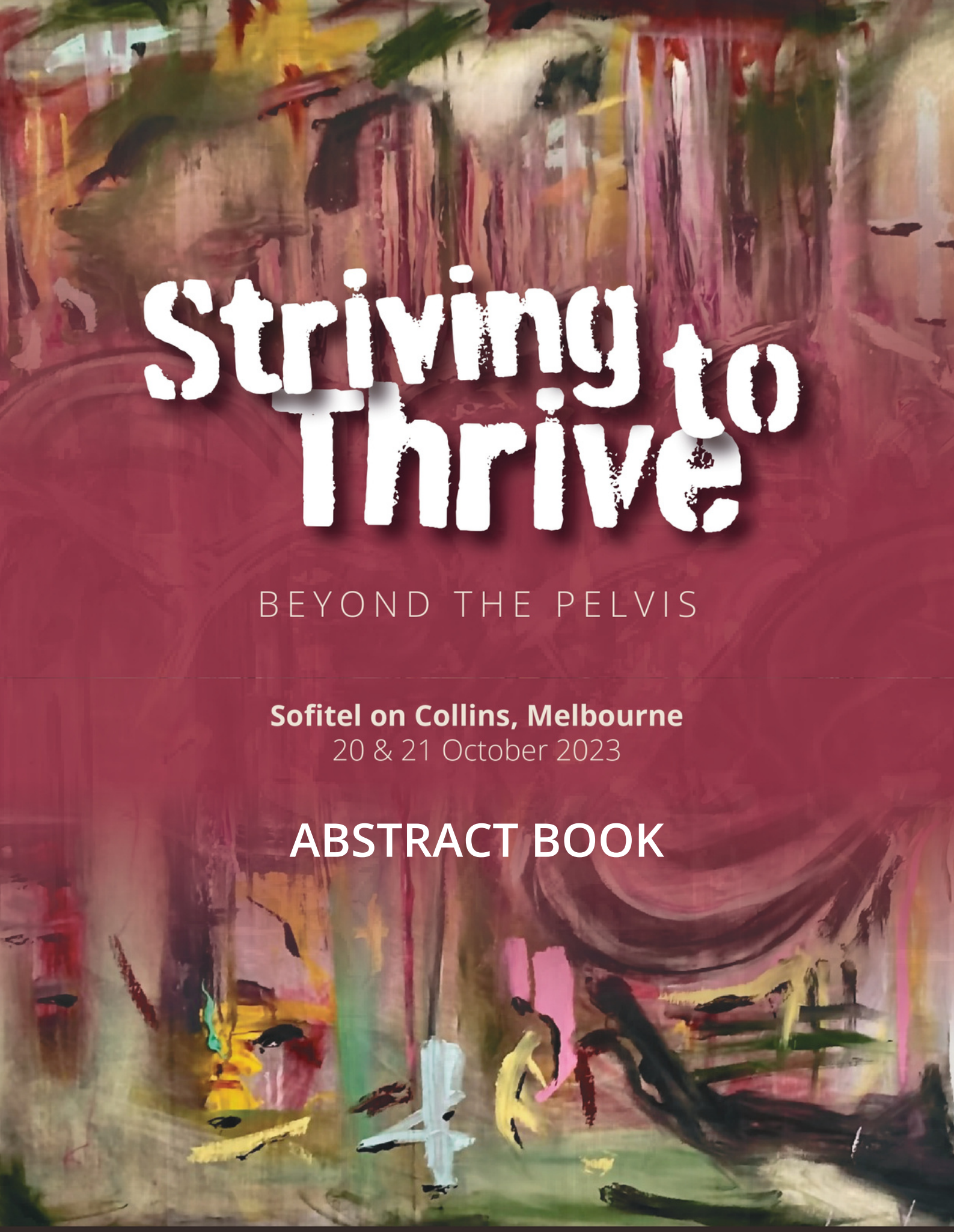


Striving to Thrive

BEYOND THE PELVIS

Sofitel on Collins, Melbourne
20 & 21 October 2023

ABSTRACT BOOK

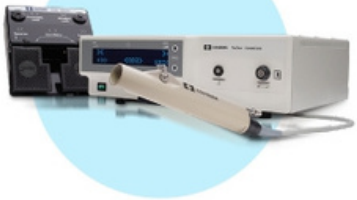
Australasian Gynaecological Endoscopy & Surgery Society Limited

Medtronic

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

Better for Women

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



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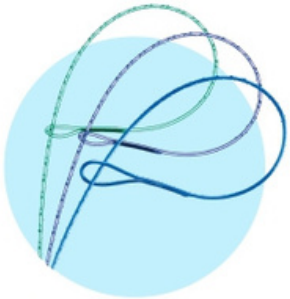
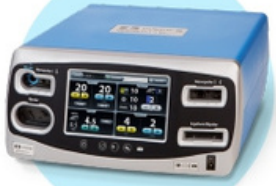
Wound protector with retractable ring



V-loc™
Wound Closure Device



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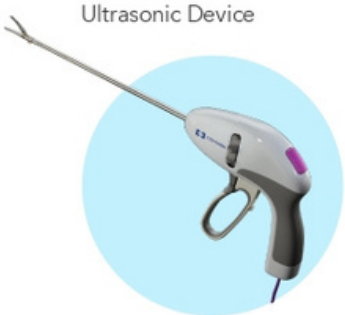

Ligasure™ XP
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Please refer to the product insert or Instructions for Use for a complete list of indications, contraindications, warnings, precautions and other important medical information. Always read and follow the Instructions for Use.

In Australia, Hugo™ Robotic Assisted Surgery System is currently indicated for certain urology, gynaecology and general laparoscopic surgical procedures.

Friday 20th October 2023	
0700 - 0805	Conference Registration
Session 1: Pain Demystified	*Chairs: Rachel Green & Shamitha Kathurusinghe*
0805 - 0815	Welcome from Board and Welcome to Country
0815 - 0835	Cannabis & Healing: CBD's Promise for Endometriosis & Pelvic Pain – **Dr Alex Capano**
0835 - 0855	POTS of Pain – **Dr Chris O'Callaghan**
0855 - 0915	Pain and the Brain – **Prof Antonina Mikocka-Walus**
0915 - 0935	What Does a Pain Specialist Actually Do? – **Dr Megan Eddy**
0935 - 0955	Unravelling the Truth: CBD's Role in Gynaecological Cancer & Treatment Outcomes – **Dr Alex Capano**
0955 - 1015	**Panel Discussion**
1015 - 1045	**Morning Tea and Trade Exhibition**
Session 2: Profession, Practice & Protection	*Chairs: Amani Harris & Kate McIlwaine*
1045 - 1100	Time Poor? Die Poor! Life Insurance & IP – **Aaron Zelman**
1100 - 1115	Are you CPD Home Ready – **Fiona Shipman**
1115 - 1130	Cyber Protections: Victim to Expert - **John Papatheohari**
1130 - 1145	Private Health Fund Trends: What Does the future hold? - **Claire Sime**
1145 - 1200	Mandatory Reporting: Key Insights – **Caroline Tuohey**
1200 - 1230	**Panel Discussion**
1230 - 1330	**Lunch & Trade Exhibition**
Session 3: Free Communications	*Chairs: Nyasha Gwata & Jenni Pontre*
1330 - 1340	Pre-procedural urinary culture for women undergoing urodynamics. Is there a role? – **Dr Candice Houda**
1340 - 1350	Inverted Y vault closure technique with prophylactic vault suspension - **Dr Ali Mohamed**
1350 - 1400	Laparoscopic Burch Colposuspension: Does it Stand the Test of Time? A Retrospective Study of Patient Outcomes - **Dr Anna Nicholson**
1400 - 1410	Robotic Sacral Colpopexy & Rectopexy: A Collaborative Minimally Invasive Approach for Pelvis Organ Prolapse & Rectal Prolapse - **Dr Nina Reza Pour**
1410 - 1420	The Surgical Management of Pelvic Organ Prolapse in Australia – Recent Trends and Potential Implications - **Dr Charlotte Rook**
1420 - 1430	Time to hysterectomy following endometrial ablation based on age: A retrospective review of outcomes following transcervical resection of the endometrium for management of abnormal uterine bleeding - **Dr Madeleine Ward**
1430 - 1440	Autologous fascia lata sacrohysteropexy (SHP) for treatment of uterine prolapse – **Dr Chin Yong**
1440 - 1510	**Afternoon Tea and Trade Exhibition**
Session 4: Pelvic Floor	*Chairs: Bassem Gerges & Madeleine Ward*
1510 - 1525	Let's get to the bottom of it! – **Dr Susan Shedda**
1525 - 1540	Uncompounding the Vagina – **Dr Samantha Mooney**
1540 - 1555	Supporting the Perioperative Pelvis – **Elise Fraser**

*** Please note this program is subject to change without notification***

1555 - 1610	Update on bladder pain syndrome & recurrent UTIs - **Dr Sandra Elmer**
1610 - 1625	The evolving vulva – **Dr Alice Rudd**
1625 - 1645	Urogynae Speed Updating – **Dr Mugdha Kulkarni**
1645 - 1700	**Panel Discussion**
1700	**End of Day One**
CONFERENCE PARTY	

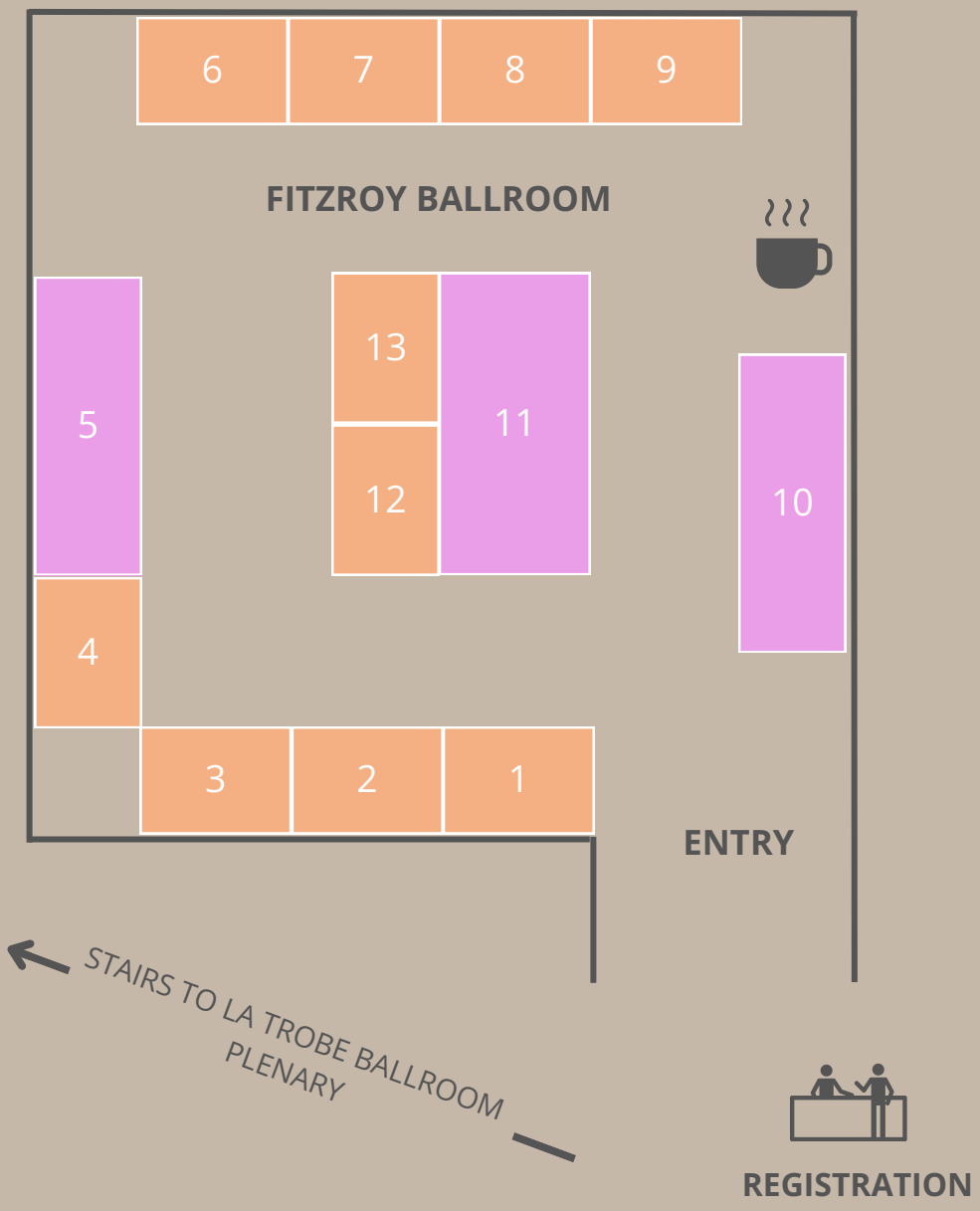
Saturday 21st October 2023	
0800 - 0830	Conference Registration
Session 5: Let's Talk Fertility	*Chairs: Emma Readman & Lior Levy*
0830 - 0850	Ovarian Rejuvenation – What's the evidence? - **Prof Roger Hart**
0850 - 0915	The Surgical Management of Ovarian Endometrioma: Pearls & Pitfalls – **Dr Charles Miller (Virtual)**
0915 - 0930	PCOS Pitstop – **Dr Rashi Kalra**
0930 - 0945	It's not his fault – **Dr Daniel Lantsberg**
0945 - 1000	**Panel Discussion**
1000 - 1030	**Morning Tea and Trade Exhibition**
Session 6: Recharge Session	*Chairs: Stephen Lyons & Kimberley Sleeman*
1030 - 1100	Finding your Fierce – **Nikki Ellis**
1100 - 1120	Strengthening the Surgeon – **Lynne Watts** and **Kathyrn Anderson**
1120 - 1140	Wellbeing for All: How do we do it? – **Dr Emily Amos**
1140 - 1200	Power of the Breath – **Anna Tetlow**
1200 - 1230	**Panel Discussion**
1230 - 1330	**Lunch & Trade Exhibition**
Session 7: Thinking Outside the Scope	*Chairs: Kate Martin & Amy Feng*
1330 - 1345	Surgery & Innovation **– Dr Vinayak Smith**
1345 - 1400	Train the Trainer: Surgical Coaching & Mentoring – **A/Prof Douglas Stupart**
1400 - 1415	Straight Sticks vs All The Other Robots – **Dr Phil Dundee**
1415 - 1430	Navigating Asherman's – **Prof Thierry Vancaillie**
1430 - 1445	**Panel Discussion**
1445 - 1515	**Afternoon Tea and Trade Exhibition**
Session 8: Sustainability	*Chairs: Catarina Ang & Tal Jacobson*
1515 -1535	Minimising our health care footprint – **Dr Forbes McGain**
1535 - 1555	Sustainability in the Suburbs – **Laura Trotta**
1555 - 1615	Strive to Thrive – What really matters? – **Dr Neela Janakiramanan**
1615 - 1630	**Panel Discussion**
1630	**END OF CONFERENCE**

*** Please note this program is subject to change without notification***

DIGITAL FREE COMMUNICATIONS

	Friday Lunch Time 1300 - 1330	Saturday Lunch Time 1300 - 1325
1300 - 1305	A Case of Parasitic Fibroids - **Anna Brownson**	Prevalence of Anxiety in Gynaecological Surgery - **Tasveer Singh**
1305 - 1310	Identification, Aetiology and Management of an Atypically Presenting Vesicovaginal Fistula (VVF), Post Total Laparoscopic Hysterectomy (TLH) - **Rituparna Dutta**	Management of an Unknown Pelvic Mass - **Eashan Tambimuttu**
1310 - 1315	Laparoscopic Sacrocolpopexy and Sacrohysteropexy in the Post Mesh Era - **Candice Houda**	The Use of Mental Rehearsal in Gynaecology Trainees and its Impact on Improving Intraoperative Cognitive Load - **Jessica Walsh**
1315 - 1320	Utilisation of Vaginal Natural Orifice Surgery (vNOTES) in a Case with Pronounced Upper Abdominal Adhesions - **Nina Reza Pour**	Video Presentation of Colpocleisis: A Minimally Invasive Surgical Technique for Pelvic Organ Prolapse - **Madeleine Ward**
1320 - 1325	Isolated Torsion of the Fallopian Tube - **Sara Shahid**	Case Series on Surgical Management of Acquired Uterine Arterio-Venous Malformations with Retained Products of Conception - **Stephanie Zhu**
1325 - 1330	Stress Urinary Incontinence - Not that Simple - **Akshara Shyamsunder**	

EXHIBITION FLOOR PLAN



EXHIBITORS

1 Device Technologies
2. Genea
3. No 1 Fertility
4. Medical Developments International
5. LifeHealthcare
6. Ananda Hemp
7. AMSL
8. Baxter Healthcare
9. Hologic
10. Avant Mutual Group
11. Medtronic
12. Applied Medical
13. Trustmost

Striving to Thrive: Beyond the Pelvis

ABSTRACTS

Striving to Thrive: Beyond the Pelvis Symposium 2023
Presentation Abstracts

SESSION 1: PAIN DEMYSTIFIED
Friday 20th October, 0815-1015

Cannabis & Healing: CBD's Promise for Endometriosis & Pelvic Pain
Alex Capano, 0815 - 0835

Abstract not provided.

POTS of Pain
Chris O'Callaghan, 0835 - 0855

Numerous factors adversely affect an individual's interaction with the healthcare system. These factors include youth, female sex, neurodiversity and heightened adrenergic tone. Postural tachycardia syndrome (PoTS) is the newest of the inadequate labels to describe patients who have inadequate circulation. Patients with pots have complaints that are numerous, obscure, insidious, ephemeral and which often defy description in conventional medical terms. Separating organic disease from psychological illness or personality traits can be challenging. However, identification of a link between abnormal connective tissue elasticity and PoTS has provided a mechanistic understanding of how, why and when the circulation fails, and the reaction this provokes. The paradigm of abnormal connective tissue also permits an understanding of why PoTS is usually associated with complaints in other organ systems.

Pain and the Brain
Antonina Mikocka- Walus, 0855 - 0915

Pain is a biopsychosocial phenomenon. However, the treatment of pain has been predominantly biomedical, resulting in the opioid epidemic. Recent research advances utilising mind-body approaches to persistent pelvic pain show efficacy in terms of improving severity of pain and quality of life and appear safe in those with pelvic pain.

This presentation will provide a brief overview of the persistent pain mechanisms in the context of pelvic pain disorders. It will then discuss the evidence-base of various mind-body approaches for pelvic pain (e.g., yoga, cognitive-behavioural therapy, hypnotherapy) with a focus on endometriosis, where over 90% of those affected rely on pain relief medication, yet only 24% are completely satisfied with this treatment. The presentation will draw on evidence from gastroenterology and particularly irritable bowel syndrome, a pelvic pain condition where the mind-body approaches have been extensively examined. Finally, an integrated supportive care approach for endometriosis will be introduced, focusing on the ongoing studies in this evolving field.

Striving to Thrive: Beyond the Pelvis Symposium 2023
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What does a Pain Specialist Actually Do?
Megan Eddy, 0915 - 0935

What happens when your patients see a pain specialist? What treatments do they offer? Do they work?

Megan will discuss above with illustrative case studies.

Unravelling the Truth: CBD's Role in Gynaecological Cancer & Treatment Outcomes
Alex Capano, 0935 - 0955

Abstract not provided.

SESSION 2: PROFESSION, PRACTICE & PROTECTION
Friday 20th October, 1045-1230

Time Poor? Die Poor! Life Insurance & IP
Aaron Zelman, 1045 - 1100

Doctors can spend as much of a third of their income on various insurances. Getting financial risk management 'right' is not only about reliable and adequate insurance – it is about keeping it in line with one's changing needs and budget. Beyond a refresher on the basics of personal insurances, the presentation covers 7 common mistakes doctors make when it comes to life and disability insurance and how to avoid them in future.

Are you CPD home Ready?
Fiona Shipman, 1100 - 1115

The Medical Board of Australia (MBA) has changed the CPD requirements for medical practitioners, with the new *Registration Standard: Continuing professional development* (the Standard) coming into effect 1 January 2024.

CPD homes are AMC accredited providers that help doctors meet the Standard. Australian registered doctors required to subscribe to a CPD home by 1 January 2024 include:

- medical specialists
- IMGs not on a specialist pathway, with limited or provisional registration
- PGY3+ doctors not in a specialty training program
- all other general registration doctors including non-vocationally registered medical practitioners.

Accredited by the Australian Medical Council (AMC), the AMA's CPD Home provides a CPD Program and learning support services to all doctors.

This session explores important considerations for being CPD home ready and understanding how the AMA's CPD Home can support you through the transition to meet the new Standard.

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Cyber Protections: Victim to Expert
John Papatheohari, 1115 - 1130

We are regularly reminded of the ever-present cybersecurity threat and the harmful implications of a successful attack; financial, operational, reputational, legal. In an increasingly digitised world where cybersecurity risk continues to evolve exponentially, this session will outline pragmatic measures that can be undertaken to manage risks most efficiently; including the ability to respond quickly to minimise business impact.

Mandatory Reporting: Key Insights
Caroline Tuohey, 1145 -1200

When it comes to their own wellbeing, doctors often find it difficult to admit they're struggling. Avant has always been concerned that the mandatory reporting laws create an additional barrier to seeking help.

The laws and guidance on mandatory notification of health practitioners changed in March 2020. The aim was to make it clearer when notification was required, and to encourage practitioners to seek treatment for health issues without fear of notification. However, three years on and many practitioners report to Avant avoiding disclosure of a medical condition to a treating doctor for fear of being reported to the Medical Board.

Caroline Tuohey will explain the Medical Board's guidelines on mandatory notifications, what concerns may trigger a mandatory notification and the different thresholds for making a mandatory notification. This presentation will also assist you to make a decision about whether you are legally obliged to make a mandatory notification.

SESSION 3: FREE COMMUNICATIONS
Friday 20th October, 1330-1440

Pre-procedural urinary culture for women undergoing urodynamics. Is there a role?
Candice Houda, 1330 -1340

Candice Houda [1 2] , Paul Knight [2] , Carolyn Marlow [2 3] , Jessica Feeney [3] , Tran Nguyen [1 2] , Fariba Behnia-Willison [1]

1. *FBW Gynaecology Plus, Adelaide, SA*
2. *Gynaecology Department, The Queen Elizabeth Hospital, Woodville, South Australia, Australia*
3. *Gynaecology, The Royal Adelaide Hospital, Adelaide, SA, Australia*

Introduction: Urodynamics studies(UDS) are an integral component of the pre-operative assessment for many endoscopic pelvic floor procedures. There is no consensus of the role of pre-procedural urine culture in women undergoing UDS.(1) The prevailing concern with UDS pertains to urinary tract infection, which is the most common complication associated with the procedure. Advice differs between guidelines to screening all, to those at risk, to none at all.(2)

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Purpose: To evaluate clinical characteristics in women undergoing UDS to identify the incidence of urinary tract infections(UTIs) prior to UDS, risk factors for UTIs, and patients who may benefit from routine urine culture. We also sought to consider the role of urine culture in minimising day of procedure cancellations to maximise the efficiency of our service.

Study design: This is a prospective cohort study of women who underwent urodynamics at our centre from September 2018 to January 2023, (52 months, 169 patients). Patient characteristics were recorded, as were the results of a urinary dipstick test taken the day of the procedure. Those with a positive screening test had a urine culture sent, and were commenced on antibiotics (cephalexin unless precluded due to allergy). Those women who had a positive culture were booked two weeks later and remained on antibiotics until the UDS were completed.

Results: 3.55% of women presenting for UDS had a positive urine dipstick, all 6 of these women had a positive urine culture. The women with a UTI were older, mean age 79 years vs. 58 years, all were post menopausal and had pelvic organ prolapse. One woman, aged 92 had a positive urine culture at her second presentation, no antibiotic resistance was found.

Discussion: Rates of UTI in women presenting for UDS are low and not dissimilar to those the rates of UTI seen after UDS. Given the strong correlation of UTI to age, menopausal status and the presence of prolapse, pre-procedural screening could be targeted to those at high risk. In the absence of guidelines, each unit needs to consider the cost and risk of screening vs. the cost of cancelled procedures to determine if it is of benefit.

Conclusion: Pre-procedural UTI is uncommon (3.55%) and the role of routine urine cultures for all women is not supported by our study. Targeted pre-procedural urine culture may be beneficial in some women who are deemed high risk such as those who are post-menopausal or with prolapse.

1. Working Group of the United Kingdom Continence Society; Abrams P, Eustice S, Gammie A, Harding C, Kearney R, Rantell A, Reid S, Small D, Toozs-Hobson P, Woodward M. United Kingdom Continence Society: Minimum standards for urodynamic studies, 2018. Neurourol Urodyn. 2019 Feb;38(2):838-856. doi: 10.1002/nau.23909. Epub 2019 Jan 16. PMID: 30648750.
2. ACOG Practice Bulletin No. 195: Prevention of Infection After Gynecologic Procedures. Obstet Gynecol. 2018 Jun;131(6):e172-e189. doi: 10.1097/AOG.0000000000002670. PMID: 29794678.

Inverted Y vault closure technique with prophylactic vault suspension
Ali Mohamed, 1340 -1350

Ali Mohamed [1] , John Pardey [1]

1. *Obstetrics and Gynaecology, Nepean Hospital, Sydney*

Study Objective: To present our technique for vaginal vault closure following total laparoscopic hysterectomy.

Design: A stepwise video demonstration of our surgical technique

Setting: Tertiary teaching hospital.

Patients or Participants: Patients undergoing TLH for any indication at our hospital.

Interventions: Inverted Y technique for vaginal vault closure. The aim is to provide suspension and prophylaxis against vault prolapse and rupture.

Measurements and Main Results: N/A

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Conclusion: Vaginal vault dehiscence in an uncommon complication following hysterectomy. If not identified in a timely manner, It could lead to serious complications, such as sepsis and bowel perforation. The reported incidence ranges between 0.036% to 1.78%. There is no consensus, to date, or international guidelines to advice on measures to reduce incidence of vault dehiscence. Inverted Y closure is a feasible technique to close the vaginal vault following TLH, which might reduce the risk of future prolapse and dehiscence.

Laparoscopic Burch Colposuspension: Does it Stand the Test of Time? A Retrospective Study of Patient Outcomes
Anna Nicholson, 1350 -1400

Anna K Nicholson [1] , Martin Ritossa [1] , Kate Martin [1] , Jessica Barnes [1] , Robert Thomas O'Shea [2]

1. *Northern Adelaide Local Health Network , Adelaide, South Australia*
2. *Southern Adelaide Local Health Network, Adelaide, South Australia*

Study objective: To assess the long-term outcomes of laparoscopic Burch colposuspension (LBC) for the management of stress urinary incontinence (SUI) in women.

Design: Retrospective case series.

Setting: A tertiary university hospital.

Patients: Women who underwent LBC for the treatment of SUI between April 1993 and December 1999 by experienced surgeons working at Flinders Medical Centre in South Australia.

Interventions: Demographic data was extracted from medical records and a patient-completed survey comprising the Urinary Distress Inventory Short Form (UDI-6) and the Patient General Impression of Change tool, and information about subsequent surgeries to treat SUI.

Measurements: The primary outcome was subjective cure of SUI as measured by answering 0 ('Not at all') to question 3a on the questionnaire, i.e. 'how often do you experience leakage related to physical activity, coughing or sneezing?'. Women who reported having a subsequent procedure to treat SUI were treated as a failure. Secondary outcomes were subjectively improved symptoms of SUI, new onset symptoms of overactive bladder, voiding dysfunction, or pelvic pain and reoperation rate.

Main results: 33 participants were eligible and completed the questionnaire. 45% of participants reported no current symptoms of SUI. 64% reported either no symptoms or improved symptoms at 14 – 20 years post-operatively.

34% of participants reported new or worse symptoms of voiding dysfunction, 21% reported new or worse symptoms of abdominal pain or discomfort. 88% of participants reported symptoms of overactive bladder and 51% report their symptoms are worse since their LBC. There was a 13% reoperation rate.

Conclusions: For the treatment of SUI in women, outcomes of LBC are acceptable over a 23 – 29 year time period and are comparable to that of the mid-urethral sling and open Burch colposuspension. The data from this study can be used to counsel patients in selecting a procedure for management of SUI.

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Robotic Sacral Colpopexy & Rectopexy: A Collaborative Minimally Invasive Approach for Pelvis Organ Prolapse & Rectal Prolapse
Nina Reza Pour, 1410 -1420

Nina Reza Pour [1] , Imad Mahmoud [1]

1. *Gynaecology, Sydney West Advanced Pelvic Surgery Unit (SWAPS), Sydney*

Objective: To showcase the synergistic application of robotic sacral colpopexy and rectopexy in a patient with procidentia, along with a significant rectal prolapse.

Design: This technical video provides a comprehensive step-by-step demonstration of sacral colpopexy using delayed absorbable mesh for correcting pelvic organ prolapse following a total robotic-assisted hysterectomy and rectal resection.

Setting: Sydney West Advanced Pelvic Surgery Unit (SWAPS), Sydney

Interventions: The video demonstrates a surgical procedure known as robotic sacral colpopexy, wherein a resorbable mesh was utilised. Initially, a colorectal surgeon robotically resected approximately 30cm of prolapsed rectum. Subsequently, a robotic-assisted hysterectomy wss performed.

The Phasix ST resorbable mesh was accurately trimmed to provide support to the specific area within the vaginal vault. It was affixed to both the anterior and posterior vaginal walls using 2-0 GORE-TEX sutures, while the tail of the mesh was anchored to the anterior longitudinal ligament of the sacrum using 0 Prolene suture. As a result, the vaginal vault was suspended using the mesh as a sling, successfully restoring its anatomical position and correcting all three compartment prolapses.

After careful evaluation, it was determined that rectopexy was unnecessary since the sacral colpopexy procedure had effectively corrected the rectal prolapse, returning it to its proper anatomical position.

Conclusion: The use of a resorbable mesh provides the advantage of gradual dissolution over time, which may lead to a reduction in long-term complications associated with non-absorbable materials. Robotic sacral colpopexy has proven to be an effective surgical approach for addressing pelvic organ prolapse and rectal prolapse. Notably, the resection and reanastomosis of 30 cm of the large bowel also played a crucial role in reducing the rectal prolapse, eliminating the need for rectopexy. This comprehensive approach offers patients the potential for improved quality of life and better functional outcomes.

The Surgical Management of Pelvic Organ Prolapse in Australia – Recent Trends and Potential Implications
Charlotte Rook, 1420 -1430

Charlotte Rook [1] , Alan Lam [1]

1. *Centre for Advanced Reproductive Endosurgery (CARE), St Leonards, NSW, Australia*

Objective: To review and consider the clinical implications of recent trends in the surgical management of pelvic organ prolapse (POP) in Australia.

Methods: We examined trends in the surgical management of prolapse in Australia over a fifteen year period from January 2008 to December 2022. We plotted these trends against the timing of recent medico-legal events encompassing the controversies and restrictions surrounding implantable synthetic mesh.

Data was obtained from the Australian Government Department of Human Services database[1].

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The total number of procedures performed in Australia under the following Medical Benefits Schedule item numbers was searched by year and compared:

- 35568: Sacrospinous or iliococcygeus fixation
- 35570: Anterior vaginal compartment repair
- 35571: Posterior vaginal compartment repair
- 35573: Anterior and posterior vaginal compartment repair
- 35577: Manchester procedure
- 35578: Colpocleisis
- 35595: Uterosacral ligament suspension
- 35597: Sacrocolpopexy

Results: 167,639 vaginal compartment repairs (35570, 35571, 35573), 74,741 transvaginal vault suspensions (35568, 35595), 11,825 sacrocolpopexies, 1410 colpocleisis and 818 Manchester procedures were performed over the study period.

A downtrend in vaginal repair procedures was observed. A year-high 12,852 anterior and/or posterior repairs was performed in 2013, declining annually to 8,333 in 2022 reflecting a 35.2% reduction. Claims for each item remained stable until 2016 when numbers dropped with velocity. This timing corresponds to the TGA publically appealing for mesh device adverse event reporting and the first device approval cancellations[2].

There was a reciprocal increase in suspension procedures (sacrospinous, iliococcygeus or uteroesacral fixation and sacrocolpopexy) from 4283 cases in 2008 to 6,868 in 2021 – a 62.4% rise. Uterosacral suspensions in particular observed a 542.5% increase.

Colpocleisis observed steady growth, increasing by 614% in these years (35 to 215 cases).

Sacrocolpopexy gained popularity between 2008 (509 cases) and 2014 (1061 cases), before rebounding (598 cases in 2022). Sacrospinous ligament suspensions remained stable.

These changes likely reflect provider and consumer attitudes towards mesh, access to mesh devices and limited options for severe or recurrent prolapse.

The potential implications of changes in management must be considered. For consumers this may include delayed presentation, reluctance towards treatment, lack of options for recurrence and increased suffering. Implications to providers may include need for retraining, less training opportunity and reduced income.

Conclusion: Surgical prolapse management has evolved and the impact of legal and media influences must be considered. The impact of such trends on surgical training and patient access to treatment options must be addressed.

1. Australian Government Services Australia. Medicare Statistics: Medicare Item Reports. Last Updated 8 July 2023. Available from: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp
2. Australian Government Department of Health and Aged Care Therapeutic Goods Administration. Australian Government actions: Information about Australian Government actions related to urogynaecological (transvaginal) surgical mesh. Commonwealth of Australia: TGA. 13 April 2023

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Presentation Abstracts

Time for hysterectomy following endometrial ablation based on ages: A retrospective review of outcomes following transcervical resection of the endometrium for management of abnormal uterine bleeding
Madeleine Ward, 1430 -1440

Renee Cocks [1] , Madeleine C Ward [2 3] , Oliver Dalton [4] , Russell V Dalton [2]

1. *Rural Clinical School, University of Melbourne, Ballarat, Victoria, Australia*
2. *Obstetrics and Gynaecology Ballarat, Ballarat, Victoria, Australia*
3. *Monash University, Clayton, Victoria, Australia*
4. *Ballarat Health Service, Ballarat, Victoria, Australia*

Introduction: Abnormal menstrual bleeding (AUB) affects 1 in 5 Australian women of reproductive age. (1) Endometrial ablation (EA) is the recommended first line surgical intervention in Australia as it is a less invasive and uterine sparing procedure as compared to a hysterectomy. (2) If EA is unsatisfactory in treating AUB further surgical intervention may be required.

Study Objective: To determine the rate of hysterectomy over time after transcervical resection of the endometrium (TCRE) based on age.

Design: Retrospective audit.

Setting: A single gynecology clinic in regional Victoria, Australia.

Patients: A total of 1078 patients who had undergone TCRE for abnormal uterine bleeding.

Interventions: The likelihood of hysterectomy was compared across age groups using the chi-square test. Time to hysterectomy was summarized as a median with the 25th and 75th percentiles and compared across age groups using the Kaplan-Meier plot (log-rank test) and Cox proportional hazards regression.

Measurements and Main Results: The overall rate of hysterectomy was 24.2% (261 of 1078, 95% confidence interval [CI] 21.7–26.9). When age was categorized into <40 years, 40 to 44 years, 45 to 49 years, and >50 years, the rate of hysterectomy after TCRE was 32.3% (70 of 217), 29.5% (93 of 315), 19.6% (73 of 372), and 14.4% (25 of 174), respectively (p <.001). The likelihood of hysterectomy at any time point after TCRE among those aged 45 to 49 years and older than 50 years was 43% and 59% lower, respectively, than patients under 40 years (hazard ratio, 0.57; 95% CI, 0.41–0.80, and hazard ratio, 0.41; 95% CI, 0.26–0.65, respectively). The median time to hysterectomy was 1.68 years (25th to 75th percentiles, 0.77–3.76).

Conclusion: This study demonstrated that patients who underwent a TCRE before the age of 45 years had a higher chance of having a hysterectomy than patients older than 45 years. This information will enable clinicians to inform patients of their chance of undergoing a hysterectomy at any time after TCRE.

1. Bayram C, Pollack A, Wong C, Britt H. Obstetric and gynaecological problems in Australian general practice. Australian family physician. 2015;44(7):443-6
2. Australian Commission on Safety and Quality in Health Care. Heavy Menstrual Bleeding Clinical Care Standard. Sydney: ACSQHC; 2017.

Striving to Thrive: Beyond the Pelvis Symposium 2023
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Autologous fascia lata sacrohysteropexy (SHP) for treatment of uterine prolapse
Chin Yong, 1440 -1450

Chin Yong [1] , Xiamin Liang [1] , Pav Nanayakkara [1]

1. *Epworth Freemasons, East Melbourne, VICTORIA, Australia*

Objective: There is growing interest and implementation of mesh-free uterine preservation pelvic organ prolapse surgery in response to pelvic mesh controversies. This video demonstrates the surgical techniques of SHP using autologous fascia lata for treatment uterine prolapse.

Methods: Consent was obtained from the patient for recording of a robotic-assisted fascia lata SHP procedure after appropriate counselling for this surgery.

Results: Patients who are at risk of native tissue repair failure and who desire uterine preservation are appropriate candidates for SHP. Traditional SHP was performed using a U-shaped polypropylene mesh through the broad ligament windows with the tail end attached onto the anterior longitudinal ligament of the sacral promontory[1]. In autologous fascia lata SHP, the graft is implanted in a hockey stick fashion (graft attached onto anterior and posterior cervix) through the broad ligament before fixating the tail end onto the sacral promontory. This technique utilises less graft material and creates less suture tension over the promontory attachment compared with the U-shaped graft technique. The fascia lata graft is reperitonealised to avoid the risk of bowel obstruction secondary to bowel wrapping around the graft or adhesions. Concurrent incontinence surgery or vaginal repairs can be performed when indicated. A surgical pelvic organ prolapse (S-POP) device is inserted at the end of the procedure to minimise tension on the fascia lata graft and promote tissue healing. SHP has been shown to have reduced operative time, blood loss and hospital stay length, whilst having greater vaginal length preservation than the alternative of hysterectomy with sacrocolpopexy[2].

Conclusions: Autologous fascia lata SHP is a suitable alternative native tissue uterine sparing surgery for treatment of uterine prolapse for patients who decline pelvic mesh use.

1. N Price, A Slack, SR Jackson. Laparoscopic hysteropexy: the initial results of a uterine suspension procedure for uterovaginal prolapse. BJOG 2010 117(1):62-68 2. KV Meriwether, EM Balk, D Antosh, CK Oilvera, S Kim-Fine et al. Uterine preservation vs hysterectomy in pelvic organ prolapse surgery: a systematic review with meta-analysis and clinical practice guidelines. International Urogynaecology Journal 2019 30:505-522

SESSION 4: PELVIC FLOOR
Friday 20th October, 1510-1700

Let's Get to the Bottom of It!
Susan Shedda, 1500 -1515

Anorectal Pelvic Floor Disorders are a complex interplay between anatomy, function and the presenting symptoms with investigations used to define the aetiologies involved. The treatment relies upon a management plan targeted at improving symptoms and may require correction of anatomy or function or both. A pelvic organ prolapse case study is used to illustrate current diagnostic and operative controversies.

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Uncompounding the Vagina
Samantha Mooney, 1515 - 1530

Abstract not provided.

Supporting the Perioperative Pelvis
Elise Fraser, 1530 -1545

Abstract not provided.

Update on Bladder Pain Syndrome & Recurrent UTI's
Dr Sandra Elmer, 1545 - 1600

Abstract not provided.

The Evolving Vulva
Alice Rudd, 1600 - 1615

Dermatology for the gynaecologist. Recognising how skin conditions commonly present in the vulva and looking for other cutaneous clues as to the diagnosis.

Urogynae Speed Updating
Mugdha Kulkarni, 1615 -1645

Urogynaecology Speed Up-Dating" this innovative talk redefines traditional learning by condensing the latest clinical updates, and best practices in a rapid focussed session. Gain essential insights into pelvic organ prolapse, stress incontinence, and overactive bladder by uncovering their key points

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SESSION 5: LET'S TALK FERTILITY
Saturday 21st October, 0830-1000

Ovarian Rejuvenation: What's the Evidence
Roger Hart, 0830 -0850

For our patient with limited ovarian reserve, we are continually striving to find ways to safely get more oocytes from the ovary to assist conception in an IVF cycle. One of these approaches is ovarian treatment with Platelet Rich Plasma. This presentation will aim to objectively unpack the rationale for this surgical intervention, presented by a clinician who has not actually performed the procedure-yet!

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Surgical Management of Ovarian Endometrioma: Pearls & Pitfalls
Charles Miller, 0850 -0915

During training, a minimally invasive gynecologic surgeon is taught to surgically manage the ovarian endometrioma, whether it be via ovarian cystectomy or oophorectomy. Especially in the case of a woman desiring pregnancy, now or in the future, the proper surgical management of the ovarian endometrioma is of paramount importance. It is imperative to decide who requires surgery, what type of surgery is needed, when and where should that surgery best be performed, and finally, why is surgery required. This is because both surgery and surgical avoidance can have a detrimental impact on ovarian health. Moreover, it is not surgery alone, but surgical technique that can have future impact on ovarian reserve.

This lecture will review the literature regarding patient selection and proper timing of endometrioma surgery. Moreover, proper surgical technique to mi□gate impact on ovarian health will be emphasized. Finally, recommendations will be made in regards to egg cryopreservation.

PCOS Pitstop
Rashi Kalra, 0915 -0930

Abstract not provided.

It's Not His Fault
Daniel Lantsberg, 0930 -0945

Background: Male factor infertility accounts for a significant proportion of infertility cases worldwide. While Intracytoplasmic Sperm Injection (ICSI) combined with In Vitro Fertilization (IVF) has been the cornerstone of treatment, it may not always yield successful outcomes. As the medical community strives for better solutions, it is imperative to explore and evaluate alternative interventions and techniques.

Objective: This talk aims to provide a comprehensive review of the current evidence on alternative or supplementary interventions for male factor infertility when IVF ICSI fails to achieve the desired results.

Methods: A systematic review of the literature was conducted to identify studies and clinical trials that have investigated interventions for male factor infertility in IVF. The efficacy, safety, and outcomes of these interventions were analyzed.

Results: Preliminary findings suggest several promising interventions, including advanced sperm retrieval techniques, antioxidant therapy, hormonal treatments, lab adjuvants and techniques and lifestyle modifications. The evidence varies in terms of quality and outcomes, with some interventions showing significant promise in specific subgroups of male infertility.

Conclusion: While IVF ICSI remains a valuable tool in the arsenal against male factor infertility, it is not the sole solution. A personalized, evidence-based approach considering alternative interventions can offer hope to many couples struggling with infertility. This talk aims to shed light on these alternatives, guiding clinicians in offering holistic, evidence based, patient-cantered fertility care.

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SESSION 6: RECHARGE SESSION
Saturday 21st October, 1030-1230

Finding your Fierce
Nikki Ellis, 1030 -1100

Abstract not provided.

Strengthening the Surgeon
Lynn Watts & Kathryn Anderson, 1100 - 1120

Do you get aches and pains in your lower back, neck or arms after long surgeries or on days with several operations? Are you concerned about the long term implications for your body and your ability to perform your work? Join us for an overview of the common postural issues we see in surgeons, some considerations for your ergonomic set up and a mini practical session to determine which issues may apply to you and some exercises you will be able to put into practice next week at work, between patients!

Welling for All: How do we do it?
Emily Amos, 1120 - 1140

Wellbeing is a subjective measure of contentment and capacity. In the helping and healing professions, the wellbeing of our workforce can often be considered secondary to the importance of the work we do. Many of us put aside our own wellbeing in favour of caring for others in the false hope that one day the demand for our services will wane and we can make time for ourselves then. Yet the demand stays high and our needs begin to fall by the wayside. Today's talk is about learning how to serve others from a place of abundance– where the wellbeing of those doing the caring is as important as the wellbeing of those being cared for.

Supporting the exploration and cultivation of wellbeing in the health workforce is about not only capacity building and career longevity, it is also about supporting self awareness and self compassion. In a resource limited system like healthcare scarcity will always be present, but when it invades our whole lives and informs not only our professional but also personal decisions and actions, we tend to live lives full of stress, worry & rumination. Many of us know this feeling well. Through the process of compassionate self inquiry, we begin to cultivate a sense of self awareness that helps us to shift from a scarcity mindset to an abundance mindset- one where joy and fulfilment abound.

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Power of the Breath
Anna Tetlow, 1140 -1200

Anna Tetlow will share her story of life as an elite ballet dancer and how she came to develop the Selah Technique of breath work and parasympathetic skills for enhancing peak performance, stress resilience and recovery.

She will highlight the negative breath patterns associated with chronic stress and teach participants the role of respiration, to manage stress effectively and thrive in challenging situations. Participants will learn the 3 zones of breathing and practice breath work and muscle relaxation skills to enable them to consciously re-engage with their body's physical sensations.

These skills provide a window of opportunity to communicate through the bodies breathing and muscularskeletal systems to the brain (Damsaio, 1999).

SESSION 7: THINKING OUTSIDE THE SCOPE
Saturday 21st October, 1330-1445

Surgery & Innovation
Vinayak Smith, 1330- 1345

Abstract not provided.

Train the Trainer: Surgical Coaching & Mentoring
Douglas Stupart, 1345 - 1400

There are clearly defined minimum standards of training and performance in surgical and clinical practice, and well established processes to ensure that we attain and maintain those standards within our professions. There are many course available to teach us new techniques, and congresses to learn new information, but there are few opportunities available if we aspire to excellence, or even to ensure that we maintain our performance after our training is complete. It is uncontroversial that even the most elite sportspeople require coaches to optimise their performance, but a culture of coaching is mostly absent from the medical and surgical specialities. This talk aims to discuss some of the ways that coaching may be beneficial in our practice, and to explore some of the barriers to its acceptance in our professions.

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Straight Sticks Vs All the Other Robots
Phil Dundee, 1400 - 1415

In this presentation, our speaker will delve into the realm of modern surgical technology, exploring the key differences and similarities between standard Laparoscopy and three cutting-edge robotic systems: the da Vinci Surgical System, the Hugo surgical robot, and the Versius surgical robot. The audience will gain insights into the evolution of surgical techniques, from traditional methods to advanced robotic assistance. The speaker will analyze the benefits and limitations of each technology, including precision, visualization, dexterity, and potential applications across various medical specialties. By comparing these approaches, the presentation aims to provide a comprehensive understanding of how robotic-assisted surgery is transforming the landscape of minimally invasive procedures and its impact on patient outcomes and healthcare practices.

Navigating Ashermans'
Thierry Vancaillie, 1415 - 1430

Asherman syndrome is a failure of the uterus to heal properly in response to a trauma. The presentation will focus on misconceptions in diagnosis and management of this condition: Asherman's is more than 'traumatic amenorrhea'. Certain common surgical practices such as insertion of a balloon catheter will be discussed.

SESSION 8: SUSTAINABILITY
Saturday 21st October, 1515-1630

Minimizing our HealthCare Footprint
Forbes McGain, 1515 -1535

We now know why we need to reduce our environmental footprint at work, though do we know how? Is this all just about carbon and energy, and just the dominion of hospital engineers? Or can doctors also play a role in the transition to low carbon healthcare? What about low value care; is that important to our contribution to high carbon healthcare? Can we really measure such things anyway? What on earth can a busy doctor do about all of this?!

We will discuss such questions and others posed by the audience in a wide ranging environmental discourse!

Sustainability in the Suburbs
Laura Trotta, 1535 - 1555

Our world is changing. Fast.

Idyllic summer holidays are being disrupted by bushfires bearing down on holiday hot spots and smoke blanketing major cities. The increased intensity and frequency of storms are causing record-breaking flood levels, washing away major highways, livestock and food crops and even entire towns. Our rate of biodiversity loss is the highest it's been since dinosaurs became extinct. Glaciers and polar ice caps are melting at an increasing rate. And our food system is on the brink of failure.

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That's the bad news.

The good news is humans have caused these changes to our world and humans can fix them by changing the way we live. But that change needs to start NOW.

How do we change though?

We've all got jobs to juggle and mouths to feed. The number of hats we're wearing mean we're already feeling like we're stretched to our limit.

In this presentation, environmental engineer and multi award-winning sustainability educator Laura Trotta will show that you don't need to give up your favourite comforts and move to a commune in the hills to save the planet. You can start right now. In your own home. In the suburbs.

You can start small and build from there.

It doesn't matter how small you start; it just matters that you do. Laura offers plenty of ideas to get you going.

Strive to Thrive: What really Matters?
Neela Janakiramanan, 1555 -1615

Abstract not provided.

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DIGITAL FREE COMMUNICATIONS ABSTRACTS

Friday, 20th October 2023

A Case of Parasitic Fibroids
Anna Brownson, 1300-1305

Anna L Brownson [1]

1. *Gynae 1 Unit, The Royal Womens Hospital , Melbourne, VIC, Australia*

A presentation of the multidisciplinary approach to and surgical management of rare case of parasitic fibroids following laparoscopic myomectomy with morcellation.

A 43-year-old woman with a long-standing history of multifibroid uterus, who presented with abnormal uterine bleeding, iron deficiency, and bladder symptoms of urinary urgency/frequency and incomplete emptying. In 2015, underwent a laparoscopic myomectomy with morcellation. Following a caesarean section four years ago, developed persistent issues related to a left port site fibroid. Pelvic MRI scan demonstrated multiple atypical fibroids, including extrauterine fibroids in the right iliac fossa port site, pouch of Douglas, and right pre-psoas region, raising concerns of hyper mitotic leiomyomata or possible invasive leiomyomatosis vs. STUMP tumors.

Given its complexity and concern with malignancy, the case was referred to a Gynaeoncologist. After comprehensive multidisciplinary discussion, a joint case planned with a Colorectal surgeon to assist in excising extrauterine fibroids. The team proceed with a robotic-assisted laparoscopic total hysterectomy, bilateral salpingectomy, multiple myomectomy, excision of the port site mass, washings, and cystoscopy. Histology confirmed benign leiomyoma.

Identification, Aetiology and Management of an Atypically Presenting Vesicovaginal Fistula (VVF), Post Total Laparoscopic Hysterectomy (TLH)
Rituparna Dutta, 1305-1310

Rituparna Dutta [1] , Robert O'Shea [1]

1. *Obstetrics and Gynaecology, Flinders Medical Centre, Bedford Park, SA, Australia*

Background: Incidence of pelvic organ fistula after hysterectomy is 0.1-4%.(1)

Clinical profile:42 years old lady presented with abnormal uterine bleeding secondary to adenomyosis, refractory to medical treatment and endometrial ablation. She had 7 prior laparoscopies for ovarian cysts, 2 prior caesarean sections, and bilateral tubal ligation. She was planned for a TLH and bilateral salpingectomy.

Procedure:

1. Laparoscopy complicated by dense bladder adhesions, adhesions between the ovaries and the pelvic side walls
2. Difficult bladder dissection
3. Bladder dome injury noted during vault suturing - 2cm posterior injury, trigone uninvolved, repaired laparoscopically by urologist in 2 layers, watertight

Follow-up:

1. Recovered well and discharged with indwelling urinary catheter (IDC) on day 3 post-op
2. Day 9 cystogram: no leakage identified, IDC removed
3. Presented 11 days later (20 days from surgery) with a gush of clear fluid per vaginum after vaginal insertion of a foreign object
4. CT cystogram showed passage of contrast to upper one-third of the vagina, with a 5mm posterior bladder opening and a 24mm tract - diagnostic of VVF
5. Per speculum : Fistulous tract opening not seen, gush of clear fluid noted

Further management:

1. Commenced on conservative management with IDC - patient opted out after 3 weeks, keen for surgical management
2. Underwent an open abdominal repair of the VVF and bilateral rigid retrograde pyelogram along with omental flap anchoring by urology, 45 days after primary surgery
3. Repeat CT cystogram in 2 weeks : Nil further leakage

Discussion:

1. VVF is an uncommon complication after TLH
2. Risk factors include pelvic adhesions, iatrogenic injury to urinary tract (70% unrecognised during surgery) and postoperative infections (2)
3. Mechanisms of fistula formation include unrecognised cystotomy, insufficiently repaired cystotomy/breakdown of repairs, inadvertent incorporation of bladder into surrounding tissues, devascularising/thermal injuries (2)

What is unusual about this case?
As the fistula was not seen on the first cystouretherogram and appeared on the second one after vaginal insertion of the foreign object, we hypothesise that the trauma from that could have been the cause of the fistula. VVF has been seen after sexual trauma. VVF after consensual sexual intercourse, or insertion of foreign objects into the vagina although much more rare, has been reported as well. (3)

Learning points:

1. High index of suspicion and perseverance needed to diagnose VVF (as uncommon)
2. Vigilance for multiple bladder injuries during TLH (especially with significant adhesions)

1. Forsgren C, Altman D. Risk of pelvic organ fistula in patients undergoing hysterectomy. Curr Opin Obstet Gynaecol 2010; 22(5): 404-407
2. Thayalan K, Parghi S, Krause H, Goh J. Vesicovaginal fistula following pelvic surgery: Our experiences and recommendations for diagnosis and prompt referral. Aust N Z J Obstet Gyanecol 2020; 60:449-453
3. Mengistu Z, Ayichew Z. Large vesicovaginal fistula after vaginal insertion of a plastic cap healed with two weeks of catheterisation: A case report. Int Med Case Rep J 2022; 14:437-441

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Laparoscopic Sacrocolpopexy and Sacrohysteropexy in the Post Mesh Era
Candice Houda, 1310-1315

Candice Houda [1 2] , Tran Nguyen [1 2] , Priti Pradhan [2] , Fariba Behnia Willison [1]

1. *FBW Gynaecology Plus, Adelaide, SA*
2. *Gynaecology Department, The Queen Elizabeth Hospital, Woodville, South Australia, Australia*

Introduction: 11-19% of women undergo surgery for pelvic organ prolapse, with 30% of this cohort undergoing an additional prolapse procedure. (1) Mesh sacrocolpopexy is associated with better anatomical results and lower recurrence, (2) but is no longer offered outside of a research setting due to complications including erosions (19.5%) and chronic pain (12%)(3).

Purpose: To evaluate mesh free laparoscopic sacrocolpopexy and sacrohysteropexy, using delayed absorbable or permanent sutures.

Study design: This is a case series of women who underwent a laparoscopic mesh free sacrocolpopexy or sacrohysteropexy from May 2019 to June 2023(16 patients). Five women had a laparoscopic sacrocolpopexy with hysterectomy as a primary prolapse procedure, six women a laparoscopic sacrocolpopexy for recurrent prolapse, five women a sacrohysteropexy, two as an initial and three as a repeat prolapse procedure.

Laparoscopically the sacral promontory is identified. Dissection of the prevetebral parietal peritoneum is commenced to expose the anterior vertebral ligament, and further extended along the right pararectal space, inferior to the ureter, opening the recto- and vesicovaginal spaces.

A continuous barbed 45cm suture, permanent (v-loc PBT) for secondary procedures or delayed absorbable (v-lock 180) for primary procedures is anchored to the sacral promontory. This suture is interlaced through the fibres of the right uterosacral ligament, shortening this complex and then secured onto the vault or posterior cervix. The suture continues through the lower third of the left uterosacral ligament, and then back onto the vault/posterior cervix, shortening this complex. Any superior vaginal prolapse is incorporated into the vault and then anchored to the right uterosacral ligament.

Results: The women all had vaginal births, had a mean age of 61, mean BMI of 30.3 and a mean POP-Q prolapse stage of 2.4. The pre-operative mean Australian Pelvic Floor Questionnaire scores were 10, 8, 7 for urinary, bowel and prolapse symptoms respectively. All procedures were completed without complication. At the 8 week and 6 month check all women had a POP-Q prolapse stage of 0 with nil complications. 3 women thus far have been seen 12 months post operatively and report nil prolapse symptoms, all have a stage 0 prolapse on exam with nil complications.

Conclusion: Mesh-free laparoscopic sacrohysteropexy and scarocolpopexy shows a promising and safe alternative. Further follow up data is required to support this method as a viable option in the post mesh era.

1. Olsen AL, Smith VJ, Bergstrom JO, Colling JC, Clark AL. Epidemiology of surgically managed pelvic organ prolapse and urinary incontinence. Obstet Gynecol. 1997 Apr;89(4):501-6. doi: 10.1016/S0029-7844(97)00058-6. PMID: 9083302.
2. Zhang W, Cheon WC, Zhang L, Wang X, Wei Y, Lyu C. Comparison of the effectiveness of sacrospinous ligament fixation and sacrocolpopexy: a meta-analysis. Int Urogynecol J. 2022 Jan;33(1):3-13. doi: 10.1007/s00192-021-04823-w. Epub 2021 Jun 3. PMID: 34081163; PMCID: PMC8739324.
3. Maher C, Feiner B, Baessler K, Christmann-Schmid C, Haya N, Brown J. Surgery for women with apical vaginal prolapse. Cochrane Database Syst Rev. 2016 Oct 1;10(10):CD012376. doi: 10.1002/14651858.CD012376. Update in: Cochrane Database Syst Rev. 2023 Jul 26;7:CD012376. PMID: 27696355; PMCID: PMC6457970.

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Utilisation of Vaginal Natural Orifice Surgery (vNOTES) in a Case with Pronounced Upper Abdominal Adhesions
Nina Reza Pour, 1315-1320

Nina Reza Pour [1] , Bassem Gerges [1]

1. *Sydney West Advanced Surgery Unit , SWAPS, Sydney, NSW , Australia*

Objective: To showcase the application of vNOTES in patients with pre-existing adhesions, rendering the laparoscopic approach unfeasible.

Design: This instructional video presents a comprehensive vNOTES hysterectomy and uterosacral ligament suspension procedure in a patient with pelvic organ prolapse, abnormal uterine bleeding and a significant history of prior abdominal surgeries.

Setting: Sydney West Advanced Pelvic Surgery Unit (SWAPS), Sydney

Interventions: This video features a vNOTES hysterectomy and bilateral uterosacral ligament suspension performed on a patient with a significant history of upper abdominal surgeries, making laparoscopy unfeasible. To mitigate the invasiveness associated with open surgery, vNOTES was selected as a minimally invasive alternative approach for the procedure.

The cervix was infiltrated with a diluted local anesthetic agent (0.25% bupivacaine with adrenaline) and then circumscribed. A posterior colpotomy was performed, followed by reflection of the bladder and an anterior colpotomy. Bilateral uterosacral ligaments were clamped, cut, and ligated using 1-0 Vicryl sutures. A medium Gelpoint V-Path ring was inserted into the pelvis, with three ports used. The uterine arteries, utero-ovarian ligaments, and round ligaments were ligated and cut using a LigaSure device. The bilateral ureters were identified, and ureterolysis was performed. Two 0-PDS sutures were placed high on each uterosacral ligament and passed through the posterior vaginal wall. The vaginal vault was closed with interrupted 1-0 Vicryl sutures. The uterosacral suspension sutures were tied, resulting in an excellent outcome.

Conclusion: vNotes is an innovative and minimally invasive approach that has been underutilised in Australia, but it holds great potential as a safe alternative to conventional laparoscopy, particularly in carefully selected patient populations, with favorable outcomes. In cases like ours, where significant abdominal adhesions make laparoscopy impractical, vNOTES offered a viable and minimally invasive alternative to successfully complete the procedure under direct visualisation.

Isolated Torsion of the Fallopian Tube
Sara Shahid, 1320-1325

Nina Reza Pour [1] , Bassem Gerges [1]

1. *Gynaecology, Sydney West Advanced Pelvic Surgery Unit (SWAPS), Sydney*

Introduction: Chronic pelvic pain is a complex condition that requires thorough evaluation to identify its underlying cause. We present a unique case of chronic left-sided pelvic pain, ultimately attributed to isolated torsion of the fallopian tube.

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Case Presentation: A 33-year-old, G1P1, presented with chronic left-sided pelvic pain persisting for about 9 months. Diagnostic investigations, including pelvic ultrasound and MRI, showed a 4cm para-ovarian cyst with three small nodules, with all tumour markers being normal. Laparoscopy revealed a torted left fallopian tube twisted approximately five times, with engorgement, a necrotic fimbrial end, and adhesion to the left pelvic side wall and rectum. No isolated para-tubal cyst was found. A left salpingectomy was performed using the Ligasure device, and the patient had a successful recovery and was discharged the following day.

Discussion: Isolated tubal torsion is an extremely rare condition that can occur at various stages of a woman's life, including premenarchal, postmenopausal, gestational, and reproductive age. It lacks specific clinical, laboratory, and imaging findings, but typically presents with lower abdominal pain that may be continuous, paroxysmal, and may radiate to the leg or hip. Nausea, vomiting, and peritoneal irritation symptoms may also be present. Colour Doppler ultrasound can aid in diagnosis, showing diastolic reverse flow and high impedance waveforms in the affected tube, but normal Doppler findings do not rule out torsion. In the case of our patient, the ultrasound did not reveal any colour Doppler abnormalities.

Interestingly, our patient had an isolated left tubal torsion, while the majority of reported cases more commonly involve the right tube. This asymmetry is possibly due to the left tube's proximity to the sigmoid colon and its limited mobility.

The definitive diagnosis often requires laparoscopy or laparotomy, with preoperative diagnosis being infrequent. Unfortunately, the tubal torsion in our patient was not diagnosed during the perioperative workup. This emphasises the need for increased vigilance in diagnosing and managing such cases, as delayed diagnosis can have implications for future fertility.

Conclusion: Early diagnosis and treatment are crucial for safeguarding the fallopian tube, especially in women of reproductive age. Despite its rarity, isolated tubal torsion should be included in the list of differential diagnoses for acute onset abdominal pain.

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8. Milki A, Jacobson DH. Isolated torsion of the fallopian tube. A case report. J ReprodMed 1998; 43: 836-838.

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Stress Urinary Incontinence- Not that Simple
Akshara Shyamsunder, 1325-1330

Akshara Shyamsunder [1] , Juman Farjo [1] , Stefaan Pacquee [1] , Sara Ooi [1]

1. *Royal Hospital for Women, Sydney, NSW, Australia*

Tension free vaginal tape (TVT) has been a widely used surgical management for stress urinary incontinence (SUI). TVT incorporates a retropubic approach with the tape exiting the anterior abdominal wall along the superior border of the pubic symphysis. The documented complication of bladder perforation is well established, and this complication is more commonly associated with TVT due to passage of the trocar through the retropubic space. The incidence of bladder injury at time of TVT varies in the literature but is reported to be between 4-10%, mostly collated from retrospective cohort studies. Risk factors for intraoperative bladder injury include surgical proficiency, previous colposuspension, previous caesarean sections, BMI over 30 and pelvic organ prolapse[1].

The case we are presenting is of a 41 year old Para 4 with a known Grade 1 Cystocele presenting with symptoms of stress urinary incontinence (SUI) and Urodynamics consistent with intrinsic sphincter deficiency. The patient underwent an Anterior Vaginal Wall Repair and attempted TVT however sustained bilateral bladder perforations with insertion of the trocar. Her in dwelling catheter remained in situ for 4 days whilst awaiting a micturating cystogram which revealed normal findings. Unfortunately, her severe stress incontinence symptoms persisted. Further surgical options of a Transobturator Vaginal Tape (TVT-O), Burch Colposuspension and a Pubovaginal sling was discussed. She subsequently underwent a Pubovaginal Fascial Sling placement, where she again sustained a through and through perforation at the right bladder wall. Dissection was attended more laterally and the Stamey Needle was advanced with normal cystoscopic findings and the Fascial Sling was attended to.

The literature supports the use of autologous fascial pubovaginal slings as an effective surgical technique for the treatment of SUI, particularly in those who have failed a mid-urethral sling[2]. However, the management of these women is often complex and requires additional post operative interventions to address the persistent, recurrent, or de-novo lower urinary tract symptoms. Calinescu et al underwent a Systematic Review of the surgical treatments for women with stress urinary incontinence in June 2023 and deemed that mid urethral slings are the most extensively studied with the lowest documented complication rates. However, there has been a renewed interest in fascial slings but the potential morbidity of harvesting fascia makes this less appealing to patients. This review highlights the need for more high-quality research and establishing a database regarding an approach to surgical management for stress urinary incontinence[3]

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Striving to Thrive: Beyond the Pelvis Symposium 2023
Presentation Abstracts

Saturday, 20th October 2023

Prevalence of Anxiety in Gynaecological Surgery
Tasveer Singh, 1300-1305

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Background: Anxiety is an emotional state described as a vague, uneasy feeling often due to an unclear source. It has been associated with physical manifestations of symptoms from sympathetic, parasympathetic and endocrine stimulation [1]. Evidence demonstrates that increased anxiety has an adverse impact on surgical and patient outcomes [2] and that women undergoing gynaecological surgery have heightened levels of anxiety due to the sensitive and emotional nature of the treatment [2].

Method: Women 18 years or more undergoing elective procedure (n=50) will be invited to participate in the prospective on the day of the procedure. The study will utilise the self-evaluation State Trait Anxiety Inventory for Adults (STAI) – short form tool; collect selected demographic information along with recording of anaesthetic and recovery times.

Results: Prevalence and pattern of anxiety in this population will be determined and reported based on mean scores of anxiety in different scales of the demographic data as well as anaesthetic and recovery times.

Aim: To assess the prevalence of anxiety in a group of women undergoing elective gynaecological surgery, evaluate if certain demographic features affect anxiety patterns and if anxiety affects total anaesthetic and recovery times.

References:

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Management of an Unknown Pelvic Mass
Eashan Tambimuttu, 1305-1310

Eashan Tambimuttu [1]

1. *Gynae 1 Unit, Melbourne, VIC, Australia*

A case study of the work-up and management of a pelvic mass with uncertain aetiology

An overview to the multidisciplinary approach to what became a very large urachal cyst tumour occupying retroperitoneal territory with a focal area of mucinous adenocarcinoma in situ.

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Presentation Abstracts

The Use of Mental Rehearsal in Gynaecology Trainees and its Impact on Improving Intraoperative Cognitive Load

Jessica Walsh, 1310-1315

Background: Mental rehearsal involves using mental imagery to practice a task prior to performing it. It is widely recognised as critical for effective performance within the elite sport, music and military fields, but despite this it has been less formally integrated into the medical field (1).

This review aims to examine the literature about the use of mental rehearsal in the surgical training of gynaecology trainees, and examines the role of mental rehearsal in improving intraoperative cognitive load, and operative performance. With limited research into this area, but growing awareness around the effectiveness of mental rehearsal, and the value of tools that enhance cognitive performance, there is opportunity to explore how this can be utilised in training programs going forward.

Methods: A systematic review of the literature was conducted across the online databases of Ovid Medline, Embase and PsychInfo, using keywords for mental rehearsal, and surgical trainees. Inclusion criteria included that studies had to specifically be in doctors undertaking a gynaecology training program, participants had to engage in mental rehearsal, before completing or simulating completing a gynaecology surgery or procedure, and no limitations were placed on publication year or location. Exclusion criteria included studies that were not primary research studies.

Results: From 404 titles, 4 full text studies met the inclusion criteria. Mental rehearsal prior to surgery resulted in trainees self-reporting improved confidence, increased preparedness, and increased ability to visualise the procedure. There were mixed results around the improvement of technical operative skills following mental rehearsal.

Conclusion: Gynaecology trainees reported increased confidence in their ability to perform surgeries after mental rehearsal, reported increased clarity of visualising completing the surgery, and perceived mental rehearsal as useful for surgical preparation. This finding highlights how the use of mental rehearsal can help in priming neuronal pathways, to assist in the acquisition of confidence in surgical skills. Whilst there was some improvement in some trainee's technical operative skills following mental rehearsal, the results were not conclusive. This suggests that mental rehearsal, has a valuable role in optimising gynaecology surgical training programs, but in conjunction with repetitive physical practice of surgical skills. Because of the limited literature on mental rehearsal in gynaecology trainees, further research into the implementation of mental rehearsal in training programs should be conducted.

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Presentation Abstracts

Video Presentation of Colpocleisis: A Minimally Invasive Surgical Technique for Pelvic Organ Prolapse
Madeleine Ward, 1315 – 1320

Madeleine C Ward [1] , Michael Bardsley [2]

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2. *OGB Ballarat, Wendouree, VIC, Australia*

Introduction: Pelvic organ prolapse (POP) is a prevalent condition affecting women worldwide, characterised by the descent of pelvic organs into the vaginal canal. Colpocleisis, a surgical procedure aimed at treating POP, has emerged as an effective and minimally invasive technique to restore pelvic anatomy and alleviate associated symptoms. This abstract aims to present a video demonstration of the colpocleisis procedure, highlighting its surgical approach, benefits, and outcomes.

Aim: The primary objective of this video presentation is to showcase the colpocleisis technique as a viable treatment option for pelvic organ prolapse. By providing a comprehensive visual overview of the procedure, we aim to enhance the understanding of its surgical intricacies and promote its adoption among healthcare professionals.

Findings: In this video presentation, we exhibit a step-by-step demonstration of the colpocleisis procedure, performed by an experienced pelvic floor surgeon. The surgical technique involves a minimally invasive approach, to effectively obliterate the vaginal canal and provide support to the prolapsed pelvic organs.

Key findings of this video presentation include:

- Surgical Technique: The video showcases the meticulous steps of the colpocleisis procedure, to achieve optimal anatomical restoration.
- Minimally Invasive Approach: Colpocleisis offers the advantage of being a minimally invasive surgery, resulting in reduced surgical trauma, shorter hospital stays, and faster patient recovery compared to traditional open procedures.
- Patient Outcomes: The video presentation includes insights into the postoperative outcomes of patients who underwent colpocleisis, demonstrating significant improvement in POP symptoms, such as vaginal bulging, urinary incontinence, and discomfort.
- Safety and Efficacy: The video highlights the safety profile of the colpocleisis technique, with low complication rates and a high rate of successful anatomical support restoration.

Conclusion: The video presentation of colpocleisis demonstrates the technique's efficacy, safety, and minimally invasive nature in treating pelvic organ prolapse. By offering a comprehensive visual guide, this presentation aims to expand knowledge and familiarity with the procedure among medical practitioners, ultimately contributing to improved patient outcomes and quality of life for women suffering from pelvic organ prolapse.

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Case Series on Surgical Management of Acquired Uterine Arterio-Venous Malformations with Retained Products of Conception

Stephanie Zhu, 1325-1330

Stephanie Zhu [1] , Sonal Karia [2] , Timothy Chang [2]

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Acquired uterine arteriovenous malformations (AVM) are a rare cause of abnormal bleeding in patients, with a reported incidence of up to 0.63% following delivery or abortion (Easton-Carr et al 2022). This is a case series on the surgical management of 2 patients who presented following pregnancy loss that presented with retained products of conception (RPOC) and ultrasound findings of extensive vascularity suggestive of AVM.

The first case was a 23-year-old G1P0 who had a medical termination of pregnancy and presented with heavy vaginal bleeding. An ultrasound demonstrated a small focus of possible RPOC, associated with extensive vascularity which extended through the myometrium and in continuity with parametrial vessels, likely an AVM. She had surgical management with an injection of vasopressin into the intracervical tissue and the anterior uterine RPOC with an operative hysteroscope. Intraoperative ultrasound was used which demonstrated reduced vascularity following the injection of vasopressin. The RPOC and AVM were resected with an electrosurgical loop with minimal bleeding. Bipolar diathermy was used to achieve haemostasis. The histopathology report demonstrated secretory endometrium and hyalinised immature chorionic villi. The patient recovered well postoperatively and was discharged home on oral oestradiol 4mg twice daily for 4 weeks for adhesion prevention.

The second case was a 22-year-old G2P0 who presented with vaginal bleeding following a spontaneous miscarriage. An ultrasound demonstrated RPOC and increased vascularity, again suggestive of AVM. She had surgical management with vasopressin which was injected into the RPOC under direct visualisation with an operative hysteroscopy and ultrasound visualisation. The RPOC was again resected with an electrosurgical loop with minimal bleeding. Histopathology for this demonstrated products of conception and decidual fragments. She was also discharged home on oral antibiotics and oral oestradiol for 4 weeks.

This case series highlights surgical management of an AVM, with a hysteroscopic resectoscope loop, as a viable, safe and fertility preserving method. The evidence behind use of estrogen therapy post-operatively to prevent intrauterine adhesions is controversial and the evidence for the optimal formulation and duration is lacking. Recommendations from observational studies have suggested that the risk of estrogen therapy is low and suggest potentially better outcomes with oestrogen than with no postoperative therapy (Cedars & Adeleye, 2022).

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