



Volume 73 June 2020

# escope

e-Newsletter of the **Australasian Gynaecological  
Endoscopy & Surgery Society Limited**

## **EDITION HIGHLIGHTS:**

President's letter

AGES/AAGL  
Focus Meeting  
2020 Program

Laparoscopic  
Abdominal Cerclage  
AGES Board  
Member Article

At a Glance –  
Summaries  
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Social Media and  
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A guide to using  
Twitter

Chronic pelvic pain  
AGES Trainee Article

Compensation  
claims and  
complaints  
Avant Article

AGES Accredited  
Training Program  
(AATP) update



# **TOGETHER TOWARDS TOMORROW**

# ● President's Letter

## Dear Friends and Colleagues

We have been living in a strange and unusual world for these last few months. Since our [ASM in March](#) we have seen huge changes to the world we live in, our practice, our way of life. All of us are affected, some more than others.

One of the great difficulties in providing information in such a rapidly evolving situation is advice one day may be different to what is up to date the next and vastly different to what is current the following week. Our vernacular has changed – availability of PPE, aerosol generating procedures, droplet protection and flattening the curve have become a part of our everyday discussion.

As this pandemic has swept the globe wreaking havoc, in both Australia and New Zealand we have remained in a fortunate position with regard to how infection and mortality from COVID-19 have affected us. This had been at the expense of the things that we have always taken for granted, contact with our friends and extended family, meetings with our colleagues and seeing our patients face to face. Our methods of interaction have changed with a dependence on phone and skype calls with family, Zoom teleconferences for our MDT's, Webinars replacing our meetings and conferences as learning events and telehealth replacing a large number of our regular consultations.

The most significant change in practice has been not seeing so many of our patients face to face. That contact with patients and the rapport that develops is difficult to replace on video or telephone. The most natural things of reaching out to a patient to tell them about a recurrence of their disease and to support them are what I really miss in clinical practice. From a clinical point of view the actual physical face to face meeting usually adds only a minimal amount and clinical examination again percentage wise probably adds less information to the overall picture in these days of extensive imaging. Nonetheless this part of the doctor patient relationship is something that many of us are missing, more so than time in the operating theatre and procedures.

As an oncologist I have been fortunate in a way that many of my theatre lists have continued. Maintaining our skillset over this time of lower activity is vitally important. Case volume and recency of practice as key determinants of outcomes need maintenance. This requires some clever thinking as to how to maintain procedural exposure. In my hospital we are doing this by having colleagues assist for the oncology cases and working together as co-surgeons on other cases. This is an underutilised modality of learning and I know that I have picked up some useful tips over the last few months by working in this way.

## Guidelines

AGES has sought through this time to provide our members with the best quality information to guide their practice. Very early on we launched our [COVID-19 bulletin board](#) to serve as a hub of information for all members and non-members alike. On the 24th March we published a series of [practical tips to keep your practice running](#) and to protect your patients, staff and yourselves. This was followed on the 27th March by our [statement on surgical urgency and guidance](#) for surgical categories to identify appropriate category 1 cases for gynaecologists. →

## ● President's Letter cont.

This was also accompanied by the [AGES COVID risk-minimisation tips](#) – AGES was one of the first surgical societies worldwide to clarify simple strategies for minimisation of surgical risk to surgical teams.

With the relaxation of the surgical restrictions we realised that Women's health and gynaecology in particular needed a stronger focus and guidance. For too long the health problems of our patients had not been clearly defined especially with regard to surgical categories. The current national document from as recent as 2015 has hysterectomy as category 3, no mention of the indication, malignancy, severe disabling symptomatology – all category three. We developed a comprehensive document for guidance of surgical categories for gynaecology recognising that all procedures have a number of indications which is the reality of contemporary practice. It is based on numerous international guidelines as there has been no document of this detail previously in Australia. This we hope is a living document that will grow and change over time that is useful and also highlights the importance of women's health not just in times of trouble but at all times.

### Webinars

Our new webinar team headed by Rachel Green got set and we launched our [webinar series](#) on the 4th April with our COVID webinar, followed by the AGES Telehealth Information webinar in conjunction with AVANT and NASOG, this was followed by our webinar on Mental Health and Wellbeing, most topical through these trying times. Most recently we held another of our popular AGES Morbidity and Mortality webinars again attracted a large audience and focussing on obstetric and gynaecology cases. Extensive resources on Telehealth service provision are also available through the [COVID hub](#). Coming up in July will be a further webinar on surgical safety and risk minimisation.

Our education committee currently chaired by Steve Lyons has developed a fair and equitable pathway for our AGES trainees that still preserves and maintains the high standards that we and our patients expect of AGES accredited fellows. I would like to also thank our industry partner Applied Medical who we worked with to be able to offer every AGES accredited training site a Lap trainer.

The most exciting development in education has been the appointment of Professor Debra Nestel who is one of the most prominent and well known figures in surgical education in Australia, to conduct a review of the AGES Training Program and Curriculum. Debra is the Professor of Surgical Education at Melbourne University where she is the Course Director of the Graduate Programs in Surgical Education, co-badged degrees with the Royal Australasian College of Surgeons. This almost certainly represents the biggest change to the educational program since its inception and will add structure, process and clarity to the system.

### Meetings

As I have said these are uncertain times, the planning of our year ahead has been thrown into (just a little) chaos. Currently [our workshops have been suspended](#) with the plan to hopefully run 2 Lap-D workshops back-to-back in late November. Our [AGES meetings](#) are also currently still pending. The [Focus Meeting](#) that was previously planned for Bangkok is now planned to run in Melbourne on 25th September and then our [Pelvic floor symposium](#) is scheduled for 30th October in Adelaide.

## ● President's Letter cont.

These meetings will undoubtedly be running in a different format to our usual educational offerings and how this evolves will depend on control of the virus within Australia and also the government restrictions on gatherings and travel.

Given the repercussions of the pandemic are likely to persist for some time there will remain an ongoing need for continuing medical education. Rest assured we are dedicated to delivering the usual high-quality offerings that our members expect over this time

There is light at the end of the tunnel now as significant levels of surgical activity begin to resume, but it is still a stressful time for many in the profession and our community. I urge you all to take time for your families, take time for yourselves.

Remember to work together and look after each other.

Phone a friend somewhere just because.

Never be afraid to ask for help.



**Stuart Salfinger**  
AGES President



# Editorial

## Dear AGES Members

Welcome to the 73rd edition of eScope.

Little did I know when I penned the last eScope Editorial that our our lives would be so abruptly turned upside down by the once-in-a-century event that is the COVID-19 pandemic. The optimism in my words regarding the year ahead now seem so far removed from the reality that has become our lives (“...likely to be a very rosy year ahead for AGES Members”, “...we can look forward with anticipation to a year of 3 great meetings as well numerous workshops for AGES Members”, etc). Now the “new normal” of COVID-19 has dashed such naiveties!

In this edition’s [President’s Letter](#) Stuart Salfinger details how COVID-19 has impacted our world both personally and professionally. Stuart details the swift reaction of AGES to the specter of COVID-19 pandemic providing information for our members on topics such as surgical safety, surgical case priority categories, surgical skills maintenance, member education and workshops and the AGES Advanced Trainee Program.

The [AGES Annual Scientific Meeting](#) held in Sydney in early March, possibly the last conference to be held in Australia before +the COVID-19 restrictions were instituted. The meeting itself was a great success with a record number of delegates (502!).

In this edition of eScope the AGES Board Member article is by Krish Karthigasu who reviews [laparoscopic cervical cerclage](#). Amy Feng and Bas Gerges have provided the Trainee article, a review of [chronic pelvic pain management](#).

Be Szabo’s [SMG](#) (Social Media for the Gynaecologist) article focusses on all things Twitter, a “how and how not to” if you like. Many thanks as always to the “SWAPS” Fellows who have again provided [JMIG summaries](#) of recent significant articles chosen to be of interest to AGES Members.

[Catarina Ang has provided her interesting musings](#) after attending the LapCo *Train the Trainer* Laparoscopic Hysterectomy Workshop. As part of the AGES Educational and Practice Partnerships, Avant has provided a very interesting article entitled “[Compensation claims and complaints insights](#)”, a sobering reminder that risk of litigation is never far away for the obstetrician & gynaecologist.

I usually sign off my editorial with “I look forward to seeing you at the *[insert next AGES meeting here]*”. In these uncertain times I can’t do the “insert here” bit but hopefully I will be able to see you at an AGES meeting later in the year – TBC!

Please look after yourselves!



**Stephen Lyons**  
eScope Editor &  
AGES Vice-President

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# Laparoscopic Abdominal Cerclage

Krish Karthigasu

## Mid trimester pregnancy losses are distressing for both patient, families and physician alike.

Cervical incompetence is thought to occur in 0.1% to 1% of all pregnancies and in up to 8% of second and early third trimester losses.

It is defined as: Inability of the uterine cervix to retain an intrauterine pregnancy to term or inability of the uterine cervix to retain a pregnancy in the second trimester, in the absence of uterine contractions.

The classical clinical scenario is painless dilatation and shortening of the cervix after the first trimester, in the absence of preterm labour with subsequent expulsion of the pregnancy, with no evidence of other pathology such as bleeding, infection, ruptured membranes or fetal abnormalities.

Vaginal cerclage procedures for the surgical treatment for cervical incompetence were described in the 1950's (Shirodkir and McDonald). The abdominal procedure was described in the mid 1960's (Benson and Durfee) in response to failed vaginal cerclage procedures and then progressed to laparoscopic approach in late 1990's (Scibetta, Lesser). More recently robotic approach has been used since mid 2000's.

The classical indications for an abdominal approach for cervical cerclage are used in patients with a) extremely short cervix in whom the transvaginal approach is not technically possible.

b) for those who have experienced unsuccessful transvaginal procedures.

c) short or no intravaginal portion of cervix due to previous surgery (repeated LLETZ, cone biopsy, trachelectomy), congenital malformations, severe cervical lacerations and failed vaginal cerclage. These indications have been broadened further in a recent publication (Ades *et al.*, 2018).

The technique of the laparoscopic approach is summarized below:

- » Laparoscopy – 4 port
- » Dissection of utero-vesical space, reflection of bladder, use of uterine manipulator when non-pregnant

- » Identify ureter and uterine arteries (consider ureterolysis)
- » Develop windows in broad ligament without dissecting vessels
- » Include the cervix in the region of the cervico-isthmic junction
- » Suture is placed medial to uterine vessels, just above utero-sacral ligaments
- » With needle
  - » Mersilene tape 0.5 mm (non-absorbable braided polyester)
  - » 1-0 Prolene
- » Needleless
  - » open window with no needle and pass tape
- » Knot ties anteriorly or posteriorly, not too tight (should allow for suction D&C in the event of a non-viable first trimester pregnancy).

The results of pre-pregnancy laparoscopic abdominal cerclage are exceedingly good with live birth rates of 90-100%. Deliveries over 34 weeks gestation over 80%, (Moawad JMIG 2018, Huang Eur J Obstet Reprod Biol 2016, Rissjaer Eur J Obstet Reprod Biol 2012, Chen Int J Clin Exp Med 2015, Burger JMIG 2011, Tulandi JMIG 2014). Ades *et al.* has published Australian data with perinatal survival at 98.4%, mean gestational age 35.2 weeks +/- 5.57 wks, and 79.7% delivering over 34 weeks gestation (ANZJOG 2018). At the last AGES ASM in March 2020 Alex Ades presented his updated figures of laparoscopic cerclage with 355 women, 255 pregnancies with perinatal survival of 95%, delivery over 34 week gestation of 93% and mean birth weight 2978 g.

The results of laparoscopic cerclage during pregnancy are also impressive:

Ades *et al.* (ANZJOG 2019) – 19 women, surgery performed done 6-11 weeks gestation, average gestation at delivery 37.1 weeks, 84.2% > 34 weeks.

Tulandi *et al.* (JMIG 2014) – post conception cerclage, 70% delivered in third trimester and 70%-100% live birth

Burger *et al.* (JMIG 2011) – Fetal survival when cervical suture placed during pregnancy 80.9%



# ● Laparoscopic Abdominal Cerclage cont.

Krish Karthigasu

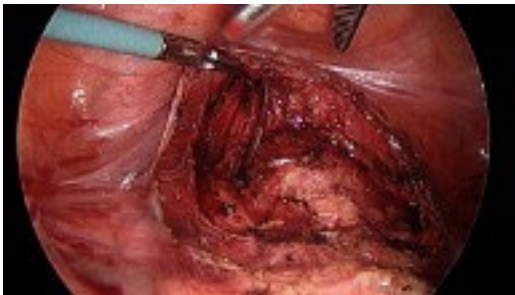
Thus, pre-pregnancy or after conception laparoscopic cervical cerclage is an extremely successful procedure in appropriately selected cases.

It should be noted that not all patient who have a pre-conception cerclage will achieve a pregnancy with 30-40% not pregnant. This can be due to a variety of factors:

- » Postponement of pregnancy due to fear of losing another pregnancy
- » Advancing maternal age
- » Fertility treatments
- » Change in social circumstances



**Krish Karthigasu**  
AGES Treasurer





# AGES XXX Annual Scientific Meeting 2020 report

**It seems like an age away that AGES held one of its most successful ASMs, with 502 delegates, an ASM record, attending in Sydney in early March.**

Whilst COVID-19 has changed our lives beyond our wildest dreams, we were very fortunate to have been able to host what was likely *the very last* conference in Australia before the implementation of COVID-19 restrictions.

There were too many highlights to include them all in this report but special mention must go to our fantastic international speakers, Marie Fidela Paraiso, Chad Michener, Marc Possover and Jan Baekelandt, and to Annabelle Farnsworth, our first female Dan O'Connor speaker. The Endometriosis Surgery Face-Off was especially notable for the callous disregard and lack of respect each of the surgeons had for their colleagues' referred techniques. The Live M&M session was very well received and may become a regular fixture at the AGES ASM.

We would like to specifically thank the local organising committee for their tireless work (Aaron Budden, Sarah Choi, Rachel Green, Erin Nesbit-Hawes, Martin Ritossa and Mark Ruff), all of the conference faculty, as well as Mary, Danielle and the team from YRD, for helping to make this ASM such a success.



**Stephen Lyons**  
AGES ASM20 Chair  
AGES Vice-President



**Bassem Gerges**  
AGES ASM20 Scientific Chair  
AGES Director

Editor's note:

It's always a pleasure working with Bas...  
well, most of the time!



● AGES XXX Annual Scientific Meeting 2020 report cont.



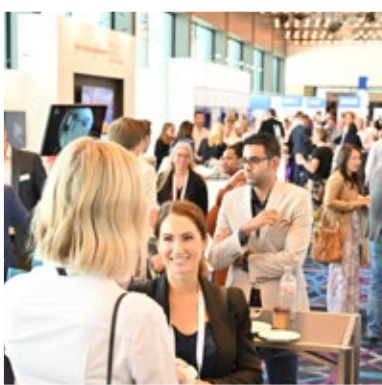
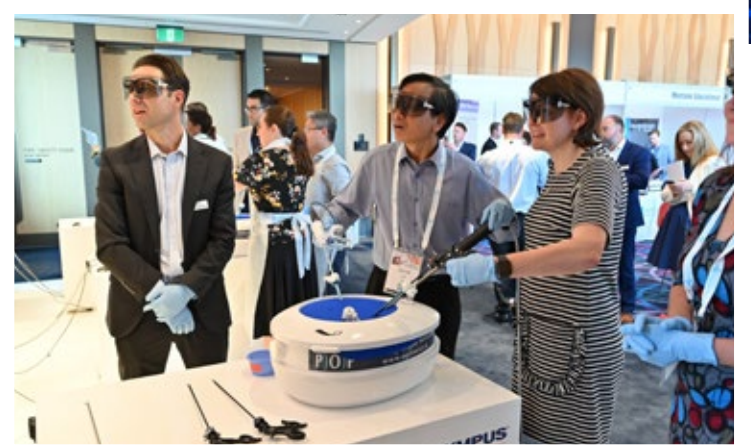


● AGES XXX Annual Scientific Meeting 2020 report cont.





● AGES XXX Annual Scientific Meeting 2020 report cont.





● AGES XXX Annual Scientific Meeting 2020 report cont.



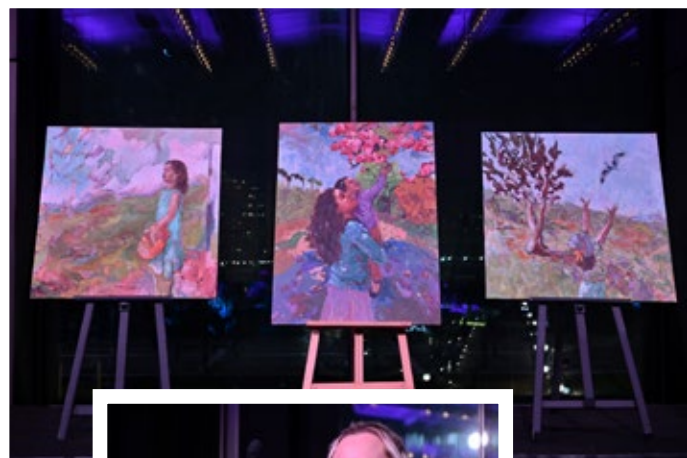


● AGES XXX Annual Scientific Meeting 2020 report cont.





● AGES XXX Annual  
Scientific Meeting  
2020 report cont.





AGES FOCUS MEETING 2020 25th & 26th September 2020  
**\*Subject to COVID-19 Government restrictions\***

For the latest updates visit [www.ages.com.au](http://www.ages.com.au)

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ADVANCING THE ART:

The  
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**25th & 26th September 2020**  
Melbourne

**Further updates to come**

Please visit [www.ages.com.au](http://www.ages.com.au) for further updates



# PROGRAM

## Friday 25th September 2020

0700 - 0800 Conference Registration

### 0800 - 1015 SESSION ONE: TRAINING & EDUCATION: PASSING ON AND CULTIVATING THE ART

Welcome

Surgical coaching: is it a necessity? - **Marie Fidela Paraiso**

Grandfathering in advanced laparoscopic surgery. "I'm good because I have done it for a long time" Is it true? Show us the proof? - **Krish Karthigasu**

A gynaecologists gender: Any advantages? - **Kirsten Connan**

Training in laparoscopy – what we can learn from the robotic experience - **Martin Ritossa**

Training our Trainees: Learning from each other from around the Globe. How do other countries train their trainees? What can we learn from each other? - **Rachel Collings**

Panel Discussion

### 1015 - 1045 MORNING TEA AND TRADE EXHIBITION

### 1045 - 1240 SESSION TWO: STATE OF THE ART UROGYNAECOLOGY AND OBSTETRIC CARE

Cosmetics, and lasers, and stem cells: Oh My! - **Marie Fidela Paraiso**

Vaginal hysterectomy a dying skill - **Rachel Green**

A decade of evaluation of the safety, efficacy, and outcome of laparoscopic mesh sacrohysteropexy - **Fariba Behnia-Willison**

Laparoscopic abdominal cerclage during pregnancy: the future of cerclage? - **Grace Liu**

Building a team for the CS hysterectomy - **Stuart Salfinger**

Panel Discussion

### 1240 - 1340 LUNCH AND TRADE EXHIBITION

### 1340 - 1540 SESSION THREE: COMPLICATIONS: ADVANCING BEYOND ADVERSE OUTCOMES

Urological Complications & Laparoscopic Gynae surgery & their management - **Shailesh Puntambekar**

Hysteroscopic complications - **Linda Bradley**

Managing the fallout from adverse outcomes - **TBC**

M&M session

### 1540 - 1610 AFTERNOON TEA AND TRADE EXHIBITION

### 1610 - 1700 SESSION FOUR: FREE COMMUNICATIONS & VIDEOS

### 1700 CLOSE OF DAY ONE

### 1900 - 2300 CONFERENCE DINNER

## SATURDAY 26th September 2020

0750 - 0820 Conference Registration

### 0820 - 1020 SESSION FIVE: UPDATING THE EVIDENCE, REFINING THE ART

Changing concepts in Pelvic Anatomy - **Shailesh Puntambekar**

Operative hysteroscopy (resectoscope and tissue retrieval systems) - **Linda Bradley**

How do we balance the limitations of surgical, medical and interventional radiological treatments for symptomatic myomas? - **Jason Abbott**

Stranger Things - a Series of Incredible Stories (basically a grouping of challenging cases) - **Jonathon Solnik**

Shake and Bake - An update on surgical site infections - **Bassem Gerges**

Panel Discussion

### 1020 - 1050 MORNING TEA AND TRADE EXHIBITION

### 1050 - 1240 SESSION SIX: ENDOMETRIOSIS: FROM SCIENCE TO ART

Lower GI symptoms - when to think endometriosis - **Stephen Lyons**

Surgeon performed transvaginal ultrasound for recto-vaginal endometriosis. Improving surgical decision making and patient consent. - **Michael Wynn-Williams**

MDT Panel and case discussion

### 1240 - 1340 LUNCH

### 1340 - 1545 SESSION SEVEN: ADVANCING THE ART THROUGH NON TECHNICAL SKILLS

Communication in the MeToo Era - **Jubilee Brown**

Optimizing Surgical Outcomes in Gynaecologic Surgery: The Next Step - **Jonathon Solnik**

Managing human factors in the operating theatre - **Helen Green**

AGES vs AAGL - The great debate

### 1545 - 1600 CONFERENCE CLOSE





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**PELVIC FLOOR  
SYMPOSIUM**

## AGES Pelvic Floor Symposium 2020

### I can see clearly now!

The AGES board and local organising committee invite you to the AGES Pelvic Floor Symposium in Adelaide on 30th & 31st October 2020. Undoubtedly, the challenges surrounding the COVID-19 pandemic forced us to face a period of uncertainty globally. The good news is that the COVID-19 curve is flattening in many countries and there is a light at the end of the tunnel.

This meeting has been a successful and popular fixture in the AGES calendar, and we have worked hard to build a spectacular program and workshop that you can look forward to. When we get through this difficult time, there will be a place that you can learn, present, share knowledge and improve your skills. Now more than ever, it is clear that human interaction is invaluable and irreplaceable, so let's look forward to the moment that our collective energy and face-to-face interactions will reinvigorate our gynaecology community.

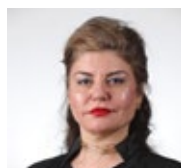
The 2020 Pelvic Floor Symposium theme "I Can See Clearly Now" encapsulates the new positivity and promise of the future of urogynaecology. We are excited to announce that Dr Erinn Myers and A/Prof Karl Jallad are members of our international faculty. Erinn completed her fellowship in female pelvic medicine and reconstructive surgery in North Carolina. Karl completed his fellowship in Urogynecology at Cleveland Clinic in Ohio. He is one of the few fellowship trained Urogynecologists in Lebanon. We look forward to hearing their insights into pelvic floor surgery where we are forced to be innovative and improve the foundation of the native tissue repair.

This meeting will cover a wide range of topics addressing pelvic floor issues in a very comprehensive way from conservative management to surgical approaches for our generalist and gynaecologist with special interest in pelvic floor reconstructive surgery. With a local organising committee comprising many different specialties and interests, we will strive to make this meeting appealing to a wide range of our membership.

The AGES Pelvic Floor Symposium Local Organising Committee hope you will join us for this exciting meeting in Adelaide and sincerely hope you and your loved ones are safe and healthy and thank you for your continued support.



**Rachel Green**  
Conference Chair  
AGES Honorary Secretary



**Fariba Behnia-Willison**  
Scientific Co-chair  
AGES Director



**Martin Ritossa**  
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MARCH 2021  
**04-06**  
Crown  
Melbourne



# AGES Annual Scientific Meeting 2021

## Leading the new Paradigm

COVID-19 has changed much of our world, and we acknowledge the challenges many of our members will have experienced since our Sydney AGES ASM earlier this year.

Whilst the current Covid-19 and world financial crisis is difficult for us, our families, and our patients, it does provide us with an opportunity to reflect and review the way we practice medicine, perform surgery, engage as an organisation, collaborate at conferences, and contribute to our world.

With this in mind, we are delighted to invite you to the 2021 AGES ASM, **'Leading the new Paradigm'**. This will be an AGES ASM with a difference!

The 2021 AGES ASM will offer the best of previous ASMs including live surgery, panel discussions, and international guest speakers from around the world. For the first time at AGES the Simulation Teaching Advisory Group (STAG) will run live surgical simulations, and we will showcase members of our community who are leading change within Australia and New Zealand on sustainability, wellbeing, and innovation. The 2021 AGES ASM will also host a new session featuring surgical videos submitted by AGES members and trainees, as well as provide opportunities for plenty of hands on industry-supported surgical upskilling.

Our organizing committee are excited to bring you this ASM program, aiming to equip us all for **'leading the new paradigm'**.

Please join us for a fabulous 3 days of learning and fun from the 4th – 6th of March at Crown Promenade, Melbourne.



**Michael Wynn-Williams**  
ASM Chair  
AGES Director



**Kirsten Connan**  
ASM Scientific Co-chair  
AGES Director



**Helen Green**  
ASM Scientific Co-chair  
AGES Director



# ● JMIG Summaries: the best bits of the most interesting recent papers

**Amy Feng, Basia Slusarczyk & Naman Dahiya**  
Sydney West Advanced Pelvic Surgery (SWAPS) Fellows

## **First Impressions Can Be Deceiving:**

### **Surgical Outcomes of Laparoscopic Myomectomy in Patients Pretreated with Ulipristal Acetate**

*Frasca C, Arena A, Esposti ED, Raimondo D, Del Forno S, Moro E et al.*  
*J Minim Invasive Gynecol.* 2020 Mar-Apr, 27(3):633-638

Fibroids are the most common benign neoplasms in reproductive women. Laparoscopic myomectomy offers a fertility sparing treatment in symptomatic women. Ulipristal acetate (UPA) has been shown to be effective in reducing myoma size and controlling bleeding. The primary indication for UPA is to reduce the myoma prior to surgery. There is yet to be a prospective study assessing the impact of pre-treatment with UPA on laparoscopic myomectomies.

This prospective observational pilot study compared surgical outcomes in women who were pre-treated with 3 months of UPA with women who received no hormonal medications. Inclusion criteria were women aged between 18-50 years, with a single ultrasound diagnosed myoma between 4-10cm who were planned for surgery. Exclusion criteria were postmenopausal women, submucosal fibroids (FIGO types 0-2), subserosal pedunculated myomas (FIGO type 7), suspected malignancy, and treatment with other hormonal therapy in the last 12 months. The surgeries were performed by 2 similarly experienced surgeons and surgeons were blinded to pre-treatment (another gynaecologist determined who would receive pre-treatment). Operative time, complications, need for blood transfusion, conversion rate and subjective surgeon assessment were recorded.

74 patients were enrolled: 29 in the UPA group and 45 in the control group. Pre-operative age, body mass index, fibroid size (mean size 63mm in UPA group vs 58.2mm in control group), FIGO type and location were similar in both groups. Subjectively, the surgeons noted softer fibroids in the UPA group (UPA 86.2% vs control 20%,  $p<0.001$ ), fewer good surgical planes (UPA 20.7% vs control 95.6%,  $p<0.001$ ), and more difficult separation of fibroids (scoring system 1-5; UPA 3.23 vs control 1.64,  $p<0.001$ ). Surgical outcomes were similar in both groups: enucleation time (UPA 6.69 mins vs control 5.42mins,  $p=0.08$ ), total operative time (UPA 116.4mins vs control 110mins,  $p=0.44$ ), hospital stay (UPA 4 days vs control 3.7 days,  $p=0.17$ ) and pain scores (UPA visual analogue score 2.1 vs control visual analogue score 2.2,  $p=0.73$ ). Post-operative anaemia was higher in the UPA group, and this corresponded to a higher post-operative haemoglobin drop, but both of these did not reach significance (Post-operative anaemia UPA 17.9% vs control 6.3%  $p=0.11$ , Hb drop UPA 2.4g/dL vs control 1.9g/dL  $p=0.06$ ). Potential reasons why objective parameters were similar included highly experienced surgeons and potentially reduced vascularisation after UPA.

*Conclusion: This is the first prospective study to evaluate the effect of pre-treatment with UPA at laparoscopic myomectomy. Subjectively, pre-treatment with UPA makes identification of planes and enucleation more difficult, however, objective parameters such as operative time are similar.*

**Minilaparoscopic Total Hysterectomy in Current Practice Feasibility and Benefits: A Unicentric, Randomized Controlled Trial**

*Beguinet M, Botchorishvili R, Comptour A, Curinie S, Campagne-Loiseau S, Chauvet P et al. Minim Invasive Gynecol. 2020 Mar-Apr; 27(3): 673-680*

The benefits of laparoscopic hysterectomy have been well researched. Mini-laparoscopy utilises 3mm instruments and hence allows for reduced incisional trauma and better cosmetic outcomes while maintaining triangulation and ergonomics, resulting in minimal change to the conventional laparoscopic technique.

This paper is a randomized controlled single blinded, parallel, non-inferiority trial comparing the use of 3mm mini-instruments for hysterectomy by all surgeons (assistants and seniors) compared to standard 5mm laparoscopic instruments. The primary outcome was operative time with various secondary outcomes recorded including conversion rates, surgeon satisfaction, complication rates and patient satisfaction. It was performed in a single tertiary centre. Inclusion criteria were all benign hysterectomies. Exclusion criteria were patients aged over 80 years with American Society of Anaesthesiologists scores III and IV, BMI >35, uterine weight >300g until Oct 2015, thereafter >500g, prior major laparotomy, patients with cancer, coagulation or haemostasis disorders. Sample size for noninferiority margin of 8 of 35 minutes, with 90% statistical power and 5% type 1 error was estimated to be 43 patients per group, total 96.

The surgical technique in the study arm involved placement of 4 trocars: one umbilical 5-mm optic trocar and three 3.5-mm trocars (1 suprapubic and 2 lateral in the iliac fossa). The comparator arm (conventional approach) also involved 4 trocars: one umbilical 10-mm optic trocar and three 5-mm trocars (1 suprapubic and 2 lateral in the iliac fossa). Vault closure was performed laparoscopically, and no intra-abdominal morcellation was performed. Conversion to conventional laparoscopy occurred whenever a patient in the study group had at least one 5-mm instrument used.

This study was stopped early after intermediate analysis failed to show inferiority of the mini-laparoscopic approach. In total, 32 patients undergoing hysterectomy for benign gynaecological conditions were randomised

to two groups with 16 in each arm (mini laparoscopy vs conventional laparoscopy). The duration of surgery (minutes) was higher in the 3mm group at 128 minutes (range, 122–150 minutes) versus 111 minutes (range, 92–143) for the 5-mm group (i.e., an absolute difference = 17 minutes [90% confidence interval: 6 to 39]).

No conversion to laparotomy was observed in either group however the conversion to 5mm instruments was high at 31% ( $p = 0.04$ ) and occurred mainly in cases of multifibroid uterus with difficult dissection and difficult haemostasis. The conversion rate was higher in cases performed by less experienced surgeons (33% for assistant vs 9% for senior,  $p = 0.12$ ). Conversion also occurred due to the fragility and dysfunction of several 3mm clamps. There was no instrument dysfunction in the 5mm group.

The surgeons reported performing hysterectomy with mini-instruments as more difficult and reported an increase in workload, physical effort, stress, and fatigue. Using mini-instruments required more concentration ( $p = 0.02$ ) and led to greater feelings of frustration ( $p = 0.009$ ) and failure ( $p = 0.006$ ).

No significant differences were reported between the 2 groups concerning post-operative pain, opiate use post-op, surgical blood loss, operative complication rates, length of hospital stay, or readmissions to hospital (at 2 months post-op). There was 1 case of vaginal vault dehiscence in each group, and 1 case of vault haematoma in the study group. Patients reported greater satisfaction with regard to scars; however, a significant difference was only found concerning scar pain ( $p = 0.037$ ) and scar firmness ( $p = 0.021$ ).

*Conclusion: Total mini-laparoscopic hysterectomy appears to result in increased operative time and a high conversion to conventional laparoscopy. This is also accompanied by an increase in mental and physical workload for the surgeon. However, the use of 3-mm incisional instruments may lead to improved aesthetic results. These results differ from previous studies in this area and further research is required before this technique can be used readily in practice.*



**Comparison of Combined Bipolar Radiofrequency Impedance-Controlled Endometrial Ablation with Levonorgestrel Intrauterine System versus Bipolar Radiofrequency Endometrial Ablation Alone in Women with Abnormal Uterine Bleeding**

*Zhao H, Yang B, Feng L, Li H, Shang H, Zhao Z and Dai Y.*

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Abnormal uterine bleeding (AUB) is a common condition that affects 10 to 30% of women of reproductive age. The Levonorgestrel Intrauterine System (LNG-IUS) and endometrial ablation have become commonly used treatment approaches for patients with AUB. One of the most popular endometrial ablation techniques is the bipolar radiofrequency impedance-controlled endometrial ablation, NovaSure.

This study was a single-center retrospective trial that sought to evaluate the effectiveness of combined NovaSure with LNG-IUS placement compared to NovaSure endometrial ablation alone in patients with AUB. The choice of treatment type was made based on the physician's assessment. Inclusion criteria was history of heavy menstrual bleeding (determined by a pictorial blood loss assessment chart score of more than 150 points), unresponsive or unwilling to undergo medical therapy, aged between 22 and 55, undesired future fertility, and at least 24 months of follow up data. Exclusion criteria were any patients with any evidence of hyperplasia or malignancy, a history of underlying coagulopathy, previously failed Mirena intrauterine device, intramural myomas or polyps larger than 3cm, uterine sound length <6cm or >10cm or a uterine cavity width <2.5cm, severe uterine dysplasia and acute genital or urinary tract infection.

Propensity score matching technique was used to ensure 1:1 matching of patient groups. Out of the 246 enrolled patients, 41 were matched and included in each group. The follow up status was evaluated by the operating surgeon at 24 months after the procedure. Patients were asked retrospectively to recollect their status at 6, 12 and 24 months after ablation. Follow up assessment included: menstrual changes, degree of dysmenorrhea, patient satisfaction and history of additional intervention or procedure. Rate of amenorrhoea was the primary outcome.

At post ablation months 6, 12 and 24, rates of amenorrhoea in the NovaSure+LNG-IUS group were 78.05%, 85.37% and 87.8% respectively, which were significantly higher than the NovaSure group (46.34%, 53.65% and 68.54% respectively) with  $p < 0.005$ . Patient satisfaction in the two groups had similar values at 6 months. However, at postoperative months 12 and 24, the number of patients satisfied with the treatment was greater in the NovaSure+LNG-IUS group (97.56% vs 80.49% and 97.56% vs 75.61% respectively) with  $p < 0.05$ . The rate of effectiveness in the NovaSure+LNG-IUS group exhibited a stepwise increase.

In comparing the NovaSure group and the NovaSure+LNG-IUS group, fewer patients in the latter group reported dysmenorrhea at postablation months 6, 12 and 24 (11/41 vs 5/41, 10/41 vs 4/41 and 10/41 vs 3/41 respectively). However, the difference in these numbers was not statistically significant. Furthermore, all patients in the NovaSure+LNG-IUS group reported complete or partial relief in dysmenorrhoea.

There were no instances of serious adverse events in the NovaSure+LNG-IUS group that necessitated the removal of the LNG-IUS device during follow up. The rates of reintervention in the 2 groups were similar at month 6, but significantly lower in the NovaSure+LNG-IUS group at 12 and 24 months (0% and 2.44% respectively) when compared to the NovaSure group (14.64 vs 21.95% respectively) with  $p < 0.05$ . At 24 months, 1 patient in the NovaSure+LNG-IUS group required a second hysteroscopic intervention compared to 9 patients in the NovaSure group.

*Conclusion: The combination of NovaSure and LNG-IUS helped achieve higher rates of amenorrhea and dysmenorrhea remission and lower rates of reintervention with compared to NovaSure endometrial ablation alone.*

# ● LapCo Train The Trainer (TTT) Total Laparoscopic Hysterectomy Course Reflection

Catarina Ang

**There is an adage that states “there are many ways to learn [grasshopper]”. Equally it could be said that there are many ways to teach.**

By curious evolution, it is our esteemed College that bestows hospitals with the status of being a teaching hospital worthy of accredited trainees. It specifies volumes and completion of certain competencies in various obstetric and gynaecological procedures. Yet no one questions who delivers these skills or how they should be delivered. Nor is any data collected on the cohort of specialist obstetricians and gynaecologists employed at the hospital.

In fact, the specialist is rarely directly specified in their hospital contract to teach or to have key performance indicator (KPIs) relating to the success of their teaching. First and foremost, the specialist is employed for clinical duties, funded by the taxpayer, with the premise that patient safety comes first: “First do no harm”. That any teaching has occurred from the specialist to the trainee could be miraculous since most of us have never been taught how to teach, but simply follow the Halsted dictum “see one, do one, teach one”. Fortunately, most specialists have also been inculcated with a sense of giving back and teaching our juniors as handed from one generation to another in a well-worn tradition. Some of us are motivated by a sense of legacy or obligation. Others enjoy the role of coach or mentor. A few of us realise our lives and quality of life may depend on the expertise of our juniors so it is in our interest to instil it well!

A historical tradition of learning by apprenticeship, with the gathering of pearls along a long duration of training, is not easily translatable to our current generation of trainees. Trainees have expressed lack of confidence to perform skill sets and achieve standards that the College has espoused. The current ecosystem does not encourage it. We see increasing numbers of trainees, shortened rotations, greater interest in a career in obstetrics, pressure to complete a requisite number of modules all as contributing factors. With the move to minimally invasive approaches, patients have reduced inpatient stays and this also contributes to a reduction of senior clinicians’ presence in hospitals, which in turn detrimentally affects the degree of mentoring or role-modelling.

Putting aside the argument of whether teaching is our responsibility or obligation, how does one become a better teacher? How does one acquire a wider variety of techniques that enable us to better engage our learners? This is what Lapco TTT (Train the Trainer) TLH workshop attempts to do: in the delivery of 1.5 days of a structured practical workshop that has been evaluated, in its original colorectal component, to Kirkpatrick level 4 successfully. Here, one achieves a small but relevant glimpse in to one’s own ability and facility to teach.

Whilst delivered for laparoscopic hysterectomy, the concepts are just as pertinent to other procedures, open surgery and to obstetrics. And whilst we do often moan that teaching takes time, the reality was that it did not take that much extra time. A couple of the sessions could be removed – mostly because to be complete, they require 2 hours rather than 15 minutes. The 6 steps offer a structured manner to pause and reflect, for both yourself and the learner. It can be applied to any level and was most demonstrable at the level of the naïve learner (a medical student).

Personally, I have instilled the preoperative huddle, with the feedback afterwards closing the loop, like an audit cycle if you will. You can be further challenged by having your own teaching evaluated too if you wish.

If you are indeed passionate about teaching and are committed to a public hospital, then consider this course. At the very least, you will spend an enjoyable day with other colleagues you rarely have a chance to hobnob with. And who knows you could learn something new that you can pass on.



Catarina Ang

# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach

Dr Amy Feng and Dr Bassem Gerges

Chronic pelvic pain is defined as “noncyclical pain of 6 or more months’ duration that localises to the anatomic pelvis, anterior abdominal wall at or below the umbilicus, the lumbosacral back or the buttocks, and is of sufficient severity to cause functional disability or lead to medical care”<sup>1</sup>. Chronic pelvic pain has a prevalence of up to 24% and can result in a 45% reduction in workplace efficiency<sup>2,3</sup>. Chronic pelvic pain often co-exists with other conditions and it can be difficult to differentiate which is the causative condition. The development of chronic pain usually begins from an initial injury resulting in a normal response which then becomes pathological.

## Normal pain pathways

### THE SOMATIC AND VISCERAL NERVOUS SYSTEMS

The pain response can be considered as two entities: the normal pain response and pathological pain response. Normal or nociceptive pain, is pain that occurs after any form of tissue injury<sup>4</sup>. This pain is useful in providing a warning about actual or impending harm. Pain can occur from the somatic or visceral nervous system<sup>5</sup>.

The somatic nervous system provides innervation to the bones, joints, ligaments, muscles and skin. The somatic nervous system provides specific pain sensation, which is focused to the area of injury. The somatic nervous system is sensitive to a variety of injuries, including temperature, stretch, vibrations and chemical irritation<sup>5</sup>. This type of pain usually worsens with activity and improves with rest. Because there is no autonomic innervation, there is usually an absence of nausea, vomiting or sweating. The somatic innervation to the vulva, perineum and lower vaginal is derived from the pudendal nerve. The upper vagina is relatively insensitive to pain compared to the lower vagina, whilst the vulva has a very high concentration of nerve fibres<sup>6</sup>.

Visceral pain arises from injury to the internal organs. Visceral pain occurs after ischemia, fibrosis, bleeding, malignancies or stretching or contraction of an organ and its overlying peritoneum. Only 2-10% of the afferent pain fibres in the spinal cord are derived from the viscera, making it poorly innervated; therefore visceral pain is usually difficult to localise<sup>7,8</sup>.

Visceral innervation is from the autonomic nervous system. Nerve fibres from T10 to L1 innervate the uterus, fallopian tubes, ovaries and visceral peritoneum<sup>6</sup>. The uterus is sensitive to stretch and contraction. However, the cervix is sensitive mainly to deeper incisions and stretch, allowing superficial biopsies to be mostly pain free<sup>8</sup>. The ovaries generally are sensitive only to disruption to the capsule. Irritation of the viscera can also result in autonomic symptoms such as nausea and vomiting and syncope<sup>8</sup>.

Visceral pain can also be referred to the somatic nervous system. This occurs as the visceral neurons converge with the somatic neurons at the dorsal horn of the spinal cord<sup>9</sup>. As there is much less visceral innervation compared to somatic innervation, the brain interprets the somatic pain signals as being more dominant.

### THE PAIN PATHWAYS

The pathway for the pain signal to travel to the brain involves at least 5 phases (see Figure 1 over page)<sup>5</sup>:

- » peripheral nociceptors,
- » dorsal horn neurons
- » ascending tracts (neurons travelling from the spinal cord to the brain)
- » supraspinal projections (areas within the brain that interpret the pain)
- » the descending modulation of the pain

Various areas within the brain are responsible for the physical aspects of the pain, such as identifying and locating the pain, and interpreting the quality and intensity. The cognitive aspects of the brain then interpret the pain in relation to higher functions, such as linking the pain to emotions and memories<sup>10,11</sup>.



# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

Dr Amy Feng and Dr Bassem Gerges

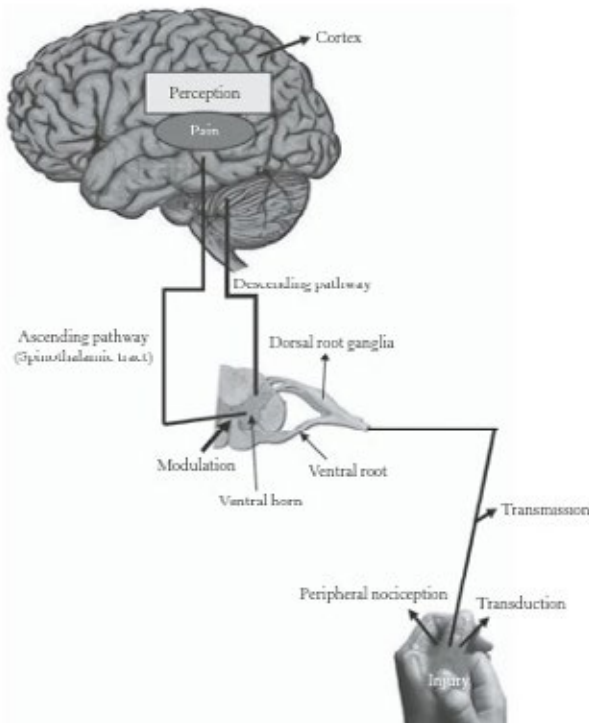


Figure 1. The pain pathway  
Reprinted from Das V. An introduction to pain pathways and pain "targets". *Progress in Molecular Biology and Translational Science*, Volume 131 (2015) Page 3. Elsevier Inc.<sup>12</sup>

## Pain modulation and the development of neuropathic pain

Pathological pain, also known as neuropathic pain, is associated with an abnormal response in the peripheral or central nervous system<sup>4</sup>. The initial injury may have occurred much earlier than the current pain episode<sup>9</sup>. There are four main theories which explain how pain can be modulated and result in chronic pain: gate control theory, wind-up phenomenon, central sensitisation and convergence.

Modulation can occur at the dorsal horn with the release of neurotransmitters from first order neurons<sup>1</sup>. This can serve to either increase or decrease transmission of pain neurons to the brain. This is termed gate control theory, first suggested by Melzack and Wall<sup>13</sup>. Gate control theory suggests that peripheral downregulation becomes lost, therefore increased levels of pain stimulation is passed through to the brain<sup>13</sup>.

Nerves can also exhibit a phenomenon known as "wind up", where pain fibres may be almost continuously activated<sup>14</sup>. These fibres can express signals without any stimulus. In addition, the nerves also appear to increase their peripheral receptive field<sup>15</sup>. This theory explains hyperalgesia and allodynia. However, neuroplasticity also suggests that with enough time and the correct treatment, these nerve fibres can be remodelled to improve hyperalgesia<sup>10</sup>.

Adding to this is central sensitisation. Several pathways within the brain modulate pain. The neurons in these pathways can change after an initial injury so that the signalling is much stronger and persistent pain is perceived<sup>16</sup>.

Frequently, in chronic pain patients more than one pain condition exists, for example endometriosis often coexists with irritable bowel syndrome. This occurs due to a process known as visceral-visceral convergence or visceral-somatic convergence<sup>17-19</sup>. This process occurs when pain at one organ results in pain or functional symptoms in a nearby organ due to convergence of the nerve fibres at the dorsal horn.

## Management of chronic pelvic pain - a multi-disciplinary approach

No clear causative pathology is found in up to 55% of patients who report chronic pelvic pain<sup>3,20</sup>. Whilst every effort should be made to treat any identifiable pathology, the focus of management in chronic pain syndromes should be on minimising the pain and encouraging a return to optimal functional living<sup>10,21</sup>. Although an injury does result in pain, it is frequently the psychosocial factors such as loss of identity or change in family dynamics, that determine the experience of pain<sup>22</sup>. Therefore, a multi-modal approach involving appropriate analgesia, optimising functional ability and promoting healthy coping techniques is the most effective long-term solution<sup>23</sup>.





# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

Dr Amy Feng and Dr Bassem Gerges

## The role of medications

Medications are an important adjunct to chronic pain management. Most gynaecologists are familiar with hormonal treatments and non-steroidal anti-inflammatory analgesics (NSAIDs), therefore this section will only briefly cover these medications.

## HORMONAL TREATMENTS

Progestins, the combined oral contraceptive pill (OCP), Danazol™ and gonadotropin releasing hormone agonists all have efficacy in reducing endometriosis deposits at laparoscopy<sup>24-26</sup>. Progestins appear effective regardless of route of administration<sup>24</sup>. Continuous use of the OCP is associated with lower fluctuations in progesterone and oestrogen levels, and therefore may reduce pain associated with hormonal withdrawal<sup>26</sup>.

Gonadotropin releasing hormone agonists (GnRH) have proven efficacy compared with Danazol®, progestins and the OCP, with double blinded placebo-controlled studies demonstrating 80-100% improvement of pain<sup>25,27</sup>.

## NON-STEROIDAL ANTI -INFLAMMATORY ANALGESICS

NSAIDs inhibit the cyclo-oxygenase (COX) isoenzymes which cause an inflammatory response. Therefore, they are effective in acute pain states, including an acute on chronic pain exacerbation. Different types of NSAIDs will have different activities on the COX isoenzymes and individuals have varying metabolic responses<sup>28</sup>.

## ANTIDEPRESSANTS

Tricyclic antidepressants such as nortriptyline, amitriptyline and desipramine have evidence for reduction of chronic pain and can be considered a first line treatment option in neuropathic pain<sup>29</sup>. In addition, they have been shown to be effective in women with pelvic pain and a normal laparoscopy<sup>30</sup>. Antidepressants work to reduce serotonin and noradrenaline reuptake. Noradrenaline is an inhibitory neurotransmitter; it has a key role in reducing pain through descending tracts within the brain. Generally, serotonin also promotes descending inhibitory tracts. However, there are a large

number of serotonin receptor subtypes and only a limited understanding of their effect on the pain response. Therefore, the effect of antidepressants varies in different individuals. Amitriptyline has additional anticholinergic activity, which is useful in patients with co-existing conditions such as interstitial cystitis.

Selective serotonin reuptake inhibitors have also been used, however a double-blinded placebo controlled randomised trial of sertraline in women with chronic pelvic pain did not find a significant difference after 6 weeks<sup>31</sup>. Additional studies are lacking suggesting that the role of sertraline in chronic pain patients may be to improve their mood and hence allow a return to normal activities rather than specifically as an analgesic.

## ANTICONVULSANTS

Anticonvulsants act on the calcium channels within the central nervous systems to reduce neuronal excitability. In chronic pain, anticonvulsants assist in reducing central sensitisation and “wind up” phenomenon related pain. They are generally also considered first line treatment options. Gabapentin has been shown to be more effective than amitriptyline in women with chronic pelvic pain at 12 months of treatment<sup>32</sup>. A pilot randomised controlled trial also found gabapentin to be more effective in improving pain and mood compared with placebo at 6 months of treatment<sup>33</sup>.

Other anticonvulsants have also been studied. Lamotrigine has been found to be effective in improving mood and pain in patients with vulvodynia after 8 weeks of use<sup>34</sup>. Sengun et al.<sup>35</sup> demonstrated that pregabalin was effective in reducing pain in women, with the most benefit seen in vulvodynia patients. However, these patients were only evaluated after 1 week of treatment. There is limited long term data on the use of anticonvulsants. Compliance with anticonvulsants is critical as inconsistent use can lead to withdrawal symptoms and reduced efficacy. Similar to antidepressants, the use of anticonvulsants may increase suicidal thoughts and therefore close monitoring of mood is required.



# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

Dr Amy Feng and Dr Bassem Gerges

## OPIOIDS

Endogenous opioids act to inhibit pain transmission on multiple levels. Peripherally, they can reduce the transmission of pain signalling. They also activate the descending inhibitory pathways to reduce pain awareness. Opioids also have central activity to reduce the sensation of pain<sup>36</sup>. They may be useful in the treatment of acute pain but opioid use in chronic pain can result in tolerance and addiction. Therefore, opiates for chronic pain should be managed by a pain specialist with focused goals and strict dosing and refilling criteria; they should not be a first line treatment option.

## The role of the physiotherapist

It is estimated that up to 64% of patients with chronic pelvic pain have a musculoskeletal component<sup>37</sup>. An experienced physiotherapist is crucial in chronic pain management and has been recommended by several key bodies including the Royal College of Obstetricians and Gynaecologists, and the Canadian Society of Obstetricians and Gynaecologists<sup>30,38</sup>. Case studies have demonstrated the beneficial effects of physiotherapy on both a functional level and quality of life<sup>39,40</sup>.

The musculoskeletal system can be the source of the initial pain and subsequently refer pain to visceral organs, or the visceral organs can refer pain to the musculoskeletal system. If the pain originates from the musculoskeletal system, initial mechanical or postural stressors lead to muscle hyperactivity and irritability, in a similar manner to the “wind up” phenomenon in neuropathic pain. This state of irritability becomes perpetuated by voluntary muscle contractions once the patient is aware of the pain. Sustained contractions then result in fibrosis and inflammation in the muscle. Tense contracted muscles can irritate visceral organs. Studies have shown that in chronic pain conditions such as interstitial cystitis and vulvodynia, treatment of co-existing musculoskeletal tension reduces pain<sup>30,41</sup>.

The physical examination is pivotal in identifying an accompanying musculoskeletal component. The abdomen, back, upper thighs and pelvis, including both

internal pelvic and rectal examinations if required, are all assessed<sup>30</sup>. Once the site/s of musculoskeletal dysfunction and pain are identified, physiotherapy then focuses on releasing the muscular contractions. After the initial pain and contractions have improved, physiotherapy shifts to focus on strengthening to prevent recurrences.

## The psychology of chronic pelvic pain

Psychological disorders are strongly linked to chronic pain states, with studies suggesting up to 80% of chronic pelvic pain patients also have a co-existing psychological disorder<sup>42,43</sup>.

Between 25% to 50% of chronic pain patients will develop depression, which then perpetuates the pain-mood cycle<sup>30</sup>. In addition, up to 50% of patients with chronic pelvic pain have reported some sort of physical, sexual or emotional abuse<sup>30</sup>. Failure to respond to traditional treatments should alert the doctor to exploring whether there is a history of abuse.

A useful psychological approach to understanding chronic pain is the Fear Avoidance Model, a concept which links physical pain with the psychological response and the subsequent effect on coping and function<sup>44</sup>. It comprises of pain related fear, anxiety and catastrophising. Patients with pain related fear and anxiety tend to avoid activities to prevent exacerbations of pain, however this can lead to deconditioning and a psychological sense of inability and hypervigilance<sup>45</sup>. Studies has shown that hypervigilance and catastrophising beliefs in vulvodynia patients results in reduced sexual arousal and increased pain<sup>43</sup>. Catastrophising behaviours include magnification and rumination. This not only perpetuates anxiety but can lead to helplessness behaviour. This often results in the patient believing that the pain is “uncontrollable”, that life’s challenges are insurmountable and that there is nothing the patient can do to improve their situation<sup>23,45</sup>. Catastrophising is the strongest predictor for persistence of pain, even when variables such as depression has been controlled<sup>23</sup>.



# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

Dr Amy Feng and Dr Bassem Gerges

Psychological beliefs can lead to changes within the brain. Chronic stress is associated with higher circulating adrenalin levels, which have been shown to modulate pain perception<sup>29-31</sup>. Psychological treatments to help the patient challenge and overcome limiting beliefs are pivotal to a multi-disciplinary approach to chronic pelvic pain. Cognitive behavioural therapy (CBT) has been shown to be effective in the treatment of pelvic pain<sup>46</sup>. This involves education on the psychological component of pain, challenging catastrophising beliefs and developing healthier coping mechanisms. This is combined with gradual exposure to activities which may be linked to their pain. Research continues to reveal the plasticity of the brain and CBT has been shown to reduce excitatory pain neurotransmitters<sup>10</sup>.

Interpersonal therapy is another evidence based approach, particularly in patients with a history of abuse or personality disorders<sup>47</sup>. Interpersonal therapy focuses on teaching the patient acceptable and healthy styles of interactions, which can lead to a reduction in conflict and anxiety. Finally, sexual counselling may be appropriate to address desire, arousal and intimacy concerns. Regular follow up psychological appointments should be provided, rather than allowing patients to make appointments only when the pain recurs, to break the pain behaviour cycle<sup>47</sup>.

## Conclusion

Chronic pelvic pain remains a challenge for the gynaecologist. It is a complex condition, which usually develops after an initial injury but is perpetuated by pathological neural and muscular responses. This then affects the patient's psychological state, which further impacts on functional ability. Treatment is aimed at minimising pain and improving function. This is best achieved with a multi-disciplinary approach that identifies and treats any organic pathology, provides tailored analgesic relief and involves an experienced physiotherapist and a compassionate psychologist.



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# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

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# ● Chronic pelvic pain – exploring the need for a multidisciplinary approach cont.

Dr Amy Feng and Dr Bassem Gerges

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## A GUIDE TO USING TWITTER

In the last AGES eScope published in February this year I introduced my journey with social media and specifically Twitter and covered what's it all about. That eScope was published just before the Sydney AGES ASM and before we knew our world was about to change so completely due to the COVID-19 pandemic.

### Why Tweet?

My focus this edition is on Twitter as the principal social media platform embraced globally by healthcare and science professionals to freely communicate with each other, journalists, politicians and the public to openly share expert information. Many of us active on Twitter have been in daily contact with other health professionals across Australia as well as in Singapore, Italy, USA, United Kingdom and elsewhere. This has provided us with early knowledge of the on the ground clinical impact of COVID-19 and knowledge of PPE, need for simulation and other practices.

At a time where we are all impacted globally having a tool to easily communicate with our peers across continents has been immensely useful. We have seen Twitter used for community and health professions education, peer review, networking and advocacy to significant effect during the COVID-19 pandemic, in some cases effectively replacing prior methods of learning and networking by breaking down traditional and geographical silos.

Twitter allows dismantling of usual hierarchical structures. I have had meaningful direct engagement with health professionals and scientists, journalists, politicians, professional colleges and others. Reciprocally, it allows those in power to have direct access to the community without the usual layers of bureaucracy – the ultimate ear to the ground. Access to free medical education on social media is of particular importance to health care professionals in low to middle income countries.

Doctors and medical students experience adverse mental health at alarming rates. Social media can provide a sense of community despite the geographic and craft group diversity. Twitter can provide psychological safety where users can be free to be authentic away from their workplace. Many reach out after-hours during

moments of personal and professional difficulty.

The support is available at all hours and is given genuinely and generously. This has been particularly true during the pandemic.

### What is Twitter?

Twitter is a social media platform where users share their thoughts, expertise and resources in tweets of 280 characters or less. It is a news and social networking service where anyone can join and see what others write (unless set to private). Users 'follow' other users who are of interest to them.

### Safety first managing risks

Users who identify as health care professionals are required to abide by social media policies set by their employers, regulatory authorities and professional bodies. All policies include obligations to respect patient confidentiality, maintain appropriate patient-doctor boundaries and be professional. We should all be mindful that Twitter like some other social media platforms is public (Tik Tok, LinkedIn, YouTube) and others can be set to private (Facebook).

Regardless of level of privacy settings, every post can be captured by screenshot and shared across social media platforms. Individual tweets can be lifted out of a thread and taken out of context. Be particularly mindful when posting photographs to avoid the inadvertent inclusion of identifying features in the background which can be seen when magnified.

The inherent risks and dangers of social media are well described. An awareness and adherence of regulations such as the Australian Medical Board / AHPRA and New Zealand Medical Council's social media policies and those of any organisations we are employed by or represent is essential.



The most consistent regulation for social media across jurisdictions applies to patient confidentiality.

The difficulty for some on Twitter, particularly those who mostly have conversations with medical and health professionals seems to be that it can be very easy to forget every tweet is public and can be read by anyone not just those on your personal Twitter timeline. For some that has resulted in not using the platform at all and traditionally medical board, insurance and organisation regulations have largely taken this philosophy. However, 'don't do it' is not a valid, practical or ethical solution.

A brief yet comprehensive 12-word social media policy from the Mayo Clinic covers the key points:

"Don't Lie, Don't Pry.  
Don't Cheat, Can't Delete.  
Don't Steal, Don't Reveal."<sup>(1)</sup>

## Twitter language

**Handle:** Your username (mine is @inquisitiveGyn ).

**Tweet:** A message of up to 280-characters.

**Like:** A function where you can like a tweet.

**Retweet:** A share of someone else's tweet which then appears on your feed.

**Feed:** The tweets which appear on your homepage. It consists of your tweets, and other peoples tweets you have shared.

**Mention (@):** A way to include another user's handle in a tweet. The other user is notified of their inclusion.

**Direct message (DM):** A private message between two or more people. You can only DM someone who follows you.

**Hashtag (#):** A tool which allows filtering to find topics of interest. Followed by a keyword or phrase. Can be created by you or pre-existing.

**Blue tick after user handle:** Signifies a Twitter verified account. This is particularly important if you are Madonna (@madonna) as it distinguishes you from fake Madonna accounts. High profile users can apply to have their account verified. During the pandemic Twitter have verified more expert medical and science accounts to ensure responsible social media use.

## Twitter – A brief 'how to'

In order to be part of the conversation, start by creating a profile. There are 330 million Twitter users, the Twitter community needs a way of finding you. Thoughtful set up will allow more meaningful interaction with others who share your interests and profession. Your handle can simply be your or your organisation's name (@salfingerstuart @AGES\_society) or something more creative which describes you or your location (@TasObGyn @DrAngOz\_Gyn). Be mindful of your handle length as when others mention ('@' you) it consumes some of their 280 characters.

Your Twitter account can include two photos. The profile photo is the image other users will see next to your tweets. Some use a professional photo for this (particularly physicians from North America), some use an Avatar, some use a non-identifiable image. The other photo is a header which is seen when others click on your profile. Create a brief biography which incorporates your interests plus as much personality as you are willing to share. This will be what others see when they click on your handle. Some insert hashtags here (#foamed, #gyn, #endo #MedEd ) to show their interests and allow others to find them. Many include a disclaimer such as 'tweets my own'.

## How to interact

Novice users can simply 'lurk' initially – reading conversations and threads without participating. You can then engage more actively using actions to 'like', 'retweet', 'retweet with comment' or 'reply' to a tweet. Filtering of tweets is essential as there are over 500 million tweets sent each day. You can choose to only engage with news, hobbies and non-medical interests, only with academic and medical information or all of the above.

## What is a Tweet?

Simply put a Tweet is a brief message sent from someone's twitter account. It can be made up of a photograph or Gif and no words or only words. A tweet can only be a maximum of 280 characters. Including a # hashtag will signal a topic, theme or group. These include #MedEd for medical education, #medtwitter for medical twitter and #gyntwitter for gynaecology twitter.

1 Timimi F. A 12-word Social Media Policy. Mayo Clinic <https://socialmedia.mayoclinic.org/2012/04/05/a-twelve-word-social-media-policy/2012> [Available from: <https://socialmedia.mayoclinic.org/2012/04/05/a-twelve-word-social-media-policy/>]

## How to write a Tweet

1. Click on the round blue feather symbol
2. A 'what's happening' box will appear, type content here
3. There are up to 280 characters per tweet
4. Be concise, deliver one message
5. Hashtags are included in the character limit, and can be anywhere in the tweet
6. There is no maximum number of hashtags, however using one or two is most effective. If at a conference, use the official hashtag, i.e. #AGES2020 plus perhaps one other if relevant i.e. #endometriosis
7. Cite appropriately
8. Check spelling, in particular that autocorrect has not created an error
9. Avoid excess use of acronyms, particularly those which may not be understood across professional or geographical silos.
10. Consider adding visuals. This could be a hand-written diagram, a picture of a slide or speaker, or a gif.
11. Consider adding a link to a paper.
12. Press done and then the blue tweet button – this sends the tweet to followers and may be retweeted or shared to their followers
13. Remember not only your followers can see tweets, everyone can see your tweets, including regulatory bodies, employers and patients.

## Who to follow?

Start by following people or organisations you know and are interested in and look at who they are following. Many conferences include speaker handles and their own # in their programs. As your interaction with Twitter grows, the algorithm will suggest people for you to follow based on your interests. Handles with a large number of followers usually (but not always) represent authentic active accounts where users are interacting frequently.

## SOME O&G AND AGES ACCOUNT

@AGES\_Society AGES Society  
@RANZCOG RANZCOG  
@SalfingerStuart Dr Stuart Salfinger, President AGES  
@TassieObGyn Dr Kirsten Connan, AGES Board Member  
@AProfAY Dr Anusch Yazdani  
@DrAngOz\_Gyn Dr Catarina Ang  
@RANZCOG\_Pres President RANZCOG  
@AAGL AAGL  
@IGCSociety IGCS  
@RCObsGyn RCOG

## Who to unfollow?

If you find an account is no longer of interest to you, or if your feed is swamped with excess content, it is perfectly acceptable to unfollow. More seriously, if content is offensive or you are subject to abuse, you can block and report the account. Blocking an account disables their ability to view your content and you can no longer see theirs. If someone is no longer providing education or joy, it's probably best to just step away from them as you would in real life.

## Your first tweet, go ahead '@' me

You are now ready to create your bio and first tweet. Click on the feather icon. Start typing your message in the 'What's happening?' box, and then click 'tweet'. You could start with 'This is my first tweet. How did I do @inquisitiveGyn?' I will be notified and give you a warm welcome and can introduce you to others on #gyntwitter! Good luck and enjoy!



Bec Szabo

# Compensation claims and complaints insights

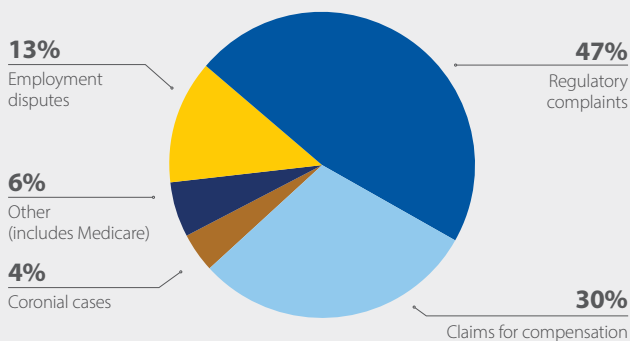
## Obstetrics & gynaecology



One in six Avant gynaecology or obstetrics & gynaecology members (O&G) had a claim for compensation, complaint

to a regulator, coronial inquiry or another matter raised about the provision of their care in FY2017-18. Doctors can sometimes have allegations made against them even though they provided appropriate care.

The types of matters Avant assists O&G members with include\*:



\*Data source: matters indemnified FY2014-FY2018

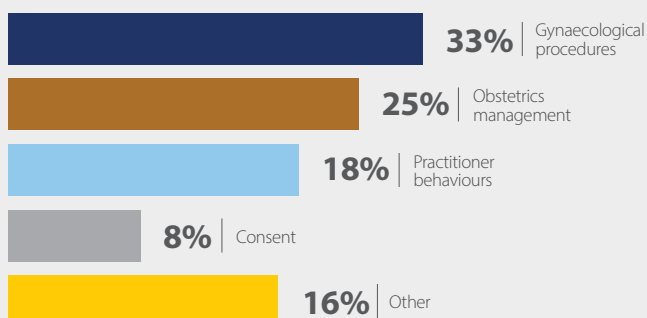
### Our medico-legal data

Members asked us for more information about medico-legal matters such as, claims for compensation and complaints to regulators. In response we conducted a retrospective review of routinely collected and coded data. The following is based on nearly 400 matters involving Avant gynaecology or O&G members from across Australia, indemnified and finalised over the four-year period from July 2014 to June 2018.

These insights may help you better understand and manage your medico-legal risks, and optimise the quality and safety of your care.

### Common claims and complaints

The majority of medico-legal matters were claims for compensation and regulatory complaints. These related to:



### Gynaecological procedures

33% of claims and complaints were related to gynaecological procedures. The stage of care during which these occurred:

**8%** were pre-operative issues (e.g. Delay/failure to order tests/investigations; or improper selection of procedural/surgical approach).

**19%** were intra-operative issues (e.g. Poor surgical performance/skill/competence, failure/misuse or improper insertion of medical device).

**5%** were post-operative issues (e.g. Delay/failure to diagnose complication; or poor performance/skill/competence).

Percentages relate to % of all O&G claims and complaints

### Obstetrics management

25% of claims and complaints were related to obstetrics management. The stage of care during which these occurred:

**9%** were antenatal issues (e.g. Failure to manage pregnancy appropriately/inadequate maternal monitoring; or antenatal testing issues).

**3%** were labour issues (e.g. Failure to manage labour appropriately).

**9%** were delivery issues (e.g. Poor performance of instrumental vaginal delivery; or inappropriate mode of delivery).

**3%** were postpartum issues (e.g. Delay/failure to recognise complication).

Percentages relate to % of all O&G claims and complaints

### Practitioner behaviours

Allegations relating to practitioner behaviours included communication issues (6%), boundary transgression (3%) and advertising (2%).

### Resolution of matters

When a medico-legal evaluation of expected standards of care was conducted, the doctor was considered to have met the standard in 67% of cases. Regardless, these cases can still take many years to resolve.

### Key insights and implications for practice

Our data highlights that claims and complaints against O&Gs are common, and it is not surprising the majority are related to surgical procedures and obstetrics management.

We also identified other issues that can give rise to claims and complaints such as communication. In our experience, paying attention to how you communicate with patients can help reduce the likelihood of experiencing a claim or complaint.

## Communication is a key risk management tool

Reports from Australian medical regulators consistently highlight communication issues as one of the top five underlying reasons for patient complaints. Our data also suggests, that while complaints primarily about communication are relatively infrequent, shortcomings in communication underlie a significant number of claims and complaints.

Almost every aspect of patient care involves communication, from obtaining history, to agreeing on a care plan, or recommending and obtaining consent to treatment. If something goes wrong, if patients feel they have been left in the dark, they were not listened to, or their concerns were dismissed, they are more likely to complain or take legal action than if their doctor is a good communicator.

Even with the most skilled care, patients may be unhappy with an outcome if they have not understood the limitations of a procedure, or the potential post-operative implications, considering their own circumstances. In these cases it's not uncommon for patients to believe that the procedure was performed poorly. This mismatch of expectations may explain why our data shows that in two-thirds of matters, where a medico-legal evaluation is conducted, the assessment found that the doctor met the expected standard of care.

## Providing information and developing care plans

In both obstetrics and gynaecology, communication is key to building trust and developing an effective ongoing relationship. While there are some obvious differences in discussing an obstetric care plan, screening test or alternative treatment options, there is also a common thread. Listening to the patient's perspective and communicating that you have heard and understood what is important to them are essential, whatever type of care is being discussed.

1. Consider the proposed plan and options from the patient's perspective, by exploring what is most important to them.
2. Explain the alternatives, including the option of not undertaking any procedure or test you may be suggesting.
3. Discuss the range of outcomes the patient can expect and give the patient context. Discuss what a common outcome or complication would mean to them, and how they can be managed.

4. Advise the patient of known risks of a procedure, based on the patient's situation, regardless of whether you have experienced these complications in your practice.
5. Ask the patient which risks, if any, particularly concern them, and whether they have any concerns which have not been mentioned.
6. Advise the patient of alternative contact arrangements in the event that you are unavailable, pre or post procedure.
7. Test the patient's understanding by asking them to repeat in their own words what you discussed.
8. Use tools such as diagrams or models to complement your discussions. Use relevant written supporting material, such as those developed by your college. Offer a copy to the patient and keep a copy or note in the patient's record.
9. Make sure the patient has time to absorb the information, reflect and come back with any further questions.
10. Document your discussions carefully. If possible, also note that they have read the supporting materials and had an opportunity to ask questions.

## Useful resources

If you receive a claim or complaint contact our Medico-legal Advisory Service on 1800 128 268 for expert advice on how to respond, available 24/7 in emergencies.

Read our articles, factsheets, case studies and other resources on a range of topics available at the Avant Learning Centre - [avant.org.au/avant-learning-centre/](http://avant.org.au/avant-learning-centre/)

For any queries please contact us at [research@avant.org.au](mailto:research@avant.org.au)



*We have come to believe that our medical knowledge and surgical skills represent the value proposition in professional care. These things can be taught. Patients judge us by their perception of our competence, but their acceptance of the outcomes of medical care is entirely based upon our understanding of their expectations, effective communication and our recognition of the need to personalise our provision of information in a way that is respectful of that particular individual's needs.*

– Dr Vijay Roach, President of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

IMPORTANT: Avant routinely codes information collected in the course of assisting member doctors in medico-legal matters into a standardised, deidentified dataset. This retrospective analysis was conducted using this dataset. The findings represent the experience of these doctors in the period of time specified, which may not reflect the experience of all doctors in Australia. This publication is not comprehensive and does not constitute legal or medical advice. You should seek legal or other professional advice before relying on any content, and practise proper clinical decision-making with regard to the individual circumstances. Persons implementing any recommendations contained in this publication must exercise their own independent skill or judgement or seek appropriate professional advice relevant to their own particular practice. Compliance with any recommendations will not in any way guarantee discharge of the duty of care owed to patients and others coming into contact with the health professional or practice. Avant is not responsible to you or anyone else for any loss suffered in connection with the use of this information. Information is only current at the date initially published (July 2019). © Avant Mutual Group Limited 2019. MJN-150 10/19 (1043-5)

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# ● AGES XXX ASM Award Winners

AWARD	TITLE	WINNER
<b>AGES/AAGL Exchange Lecture</b> Sponsored by AGES	Bladder Care Following Laparoscopy for Benign Non-Hysterectomy Gynaecological Conditions: A Randomised Controlled Trial	Lalla McCormack
<b>Best Free Communication</b> Sponsored by Medtronic	We live in a virtual world: Training the trainee using an integrated Visual Reality Stimulator training curriculum	Samantha Mooney
<b>Outstanding New Presenter</b> Sponsored by Johnson and Johnson	A randomised, double-blind, placebo controlled trial of fractionated carbon dioxide laser treatment for women with post-menopausal vaginal atrophy symptoms	Fiona Li
<b>Outstanding Trainee Presentation</b> <b>The Platinum Laparoscope Award</b> Sponsored by Stryker	Increasing the adoption of ambulatory hysteroscopy in Australia – cost comparisons and patient satisfaction	Pav Nanayakkara
<b>Best Digital Communications Presentation</b> Sponsored by Karl Storz	Pelvic Microbiome – A potential new player in the understanding of Endometriosis	Lior Levy
<b>AGES/Medtronic Travelling Fellowship 2020</b> Medtronic		Albert Jung
<b>AGES/Hologic Hysteroscopic Fellowship 2020</b> Hologic		Samantha Mooney



# ● AGES XXX ASM Award Winner Abstracts

**Award:** AGES/AAGL EXCHANGE LECTURE

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

**Co-Authors:** [Lalla McCormack](#)<sup>123</sup>, [Sophia Song](#)<sup>23</sup>, [Christine Zhang](#)<sup>23</sup>, [Aaron Budden](#)<sup>23</sup>, [Amy Arnold](#)<sup>23</sup>, [Haryun Won](#)<sup>123</sup>, [Erin Nesbitt Hawes](#)<sup>123</sup>, [Rebecca Deans](#)<sup>123</sup>, [Jason Abbott](#)<sup>123</sup>

<sup>1</sup> Department of Endogynaecology , Royal Hospital for Women , Randwick , NSW , Australia

<sup>2</sup> GRACE , Gynaecology Research and Clinical Evaluation , Sydney , NSW , Australia

<sup>3</sup> UNSW , School of Women's and Children's Health , Sydney , NSW , Australia

**Winner:** Lalla McCormack

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## BACKGROUND

Evidence-based guidance of bladder care and timing of indwelling catheter (IDC) removal following laparoscopic, non-hysterectomy gynaecological surgery is poor. A wide variation in practice results, ranging from immediate post-operative IDC removal to removal after one or more post-operative days. It is unknown if this variation in practice contributes to differences in clinical outcomes, specifically rates of urinary retention and urinary tract infection (UTI).

## AIM

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.

## METHODS

A randomised controlled trial between February 2012 and December 2019 allocated participants intra operatively to either immediate or delayed IDC removal. Trial of void data and the need to recatheterise, bladder diary and UTI occurrence were recorded and a chi squared statistical analysis was used to compare rates of primary outcomes. Secondary analyses of analgesia requirements, duration of hospitalisation and bladder function were also undertaken.

## RESULTS

Of 2147 eligible participants, 863 were recruited with 155 withdrawn before randomisation. 708 were randomised and 691 completed the study. Post-operative urinary retention occurred in 26/353 7.4% in the immediate group versus 13/338 3.8% (Chi2 4.05; p = 0.04) in the delayed group. UTI occurred in 4/203 1.97% in the immediate group versus 10/202 4.95% (Chi2 2.6; p = 0.105) in the delayed group. Both groups had similar analgesia requirements, length of hospital admission and pre and post-operative bladder function.

## CONCLUSION

There is a similarly low rate of post-operative urinary retention and urinary tract infection in women having immediate versus delayed IDC removal, following non-hysterectomy gynaecology laparoscopic surgery. There is a small trade off between need to recatheterise and post-operative UTI for these women. This study has an impact on post-operative nursing care and the performance of routine bladder scanning post IDC removal.



# AGES XXX ASM Award Winner Abstracts cont.

**Award:** BEST FREE COMMUNICATION

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

**Co-Authors:** [Samantha Mooney](#)<sup>1</sup>, Shagun Narula<sup>2</sup>, Emma Readman<sup>1</sup>, Lenore Ellett<sup>1</sup>  
<sup>1</sup> Mercy Hospital for Women, Heidelberg, VIC, Australia  
<sup>2</sup> Monash Health, Clayton, VIC, Australia

**Winner:** Samantha Mooney

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## BACKGROUND

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.

## DESIGN AND OUTCOMES

A prospective cohort study was conducted assessing the efficacy of a curriculum for gynaecology trainees. Both 'novice' (Group A) and 'experienced' (Group B) trainees were matched to a control cohort (Group C). Outcomes of interest included: impact of the VRS-incorporated training program on live operating performance at 6months, association between time logged on the VRS and live operating performance at 6months, correlation between simulation performance and live operating performance at 0- and 6-months, differential benefit of VRS training for novice and experienced trainees, and trainee satisfaction with the model.

## METHODS

All trainees were assessed at baseline, 3- and 6-months. The LapSim®(Surgical Sciences, Göteborg, 2017) salpingectomy module was used for VRS assessments. The intervention groups were provided didactic education, consultant-led workshops with small-group teaching using box-trainers, monthly supervised simulator sessions and unlimited access to the VRS. Group C underwent routine training only. At 6months, trainees completed a questionnaire and VRS salpingectomy along with an observed elective salpingectomy in the operating theatre. Exact logistic regressions and Spearman's rho were analysed to examine for associations between VRS and observed surgical assessment (OSAT) scores.

## RESULTS

35 trainees were enrolled in the study, with 17, 8 and 10 trainees in Groups A through C respectively. The VRS-salpingectomy scores at baseline were a poor differentiator of level of laparoscopic experience, with no significant difference between experienced and novice trainees( $p>0.05$ ). When controlled for routine training exposure and supervisor input during the live operating assessment, access to the VRS and time spent training on the VRS made no positive difference to operating ability in a live theatre environment( $p>0.05$ ). Interestingly, despite these results, the intervention group provided strongly positive feedback on the utility of VRS in their personal laparoscopic skill development.

## CONCLUSION

The role for VRS technologies in gynaecology laparoscopic training remains incompletely understood. Further research is required to establish the most effective manner of integrating VRS into training models to ensure transferability to the live surgery environment.

# AGES XXX ASM Award Winner Abstracts cont.

**Award:** **OUTSTANDING NEW PRESENTER**

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

**Co-Authors:** [Fiona Li](#)<sup>1</sup>, Rebecca Deans<sup>1</sup>, Erin Nesbitt-Hawes<sup>1</sup>, Aaron Budden<sup>1</sup>, Lalla McCormack<sup>1</sup>, Sarah Maheux-Lacroix<sup>1</sup>, Eva Segelov<sup>2</sup>, Stephen Lyons<sup>1</sup>, Jason Abbott<sup>1</sup>

<sup>1</sup> University of New South Wales, Randwick, NEW SOUTH WALES, Australia

<sup>2</sup> Monash University, Melbourne, Victoria, Australia

**Winner:** **Fiona Li**

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## INTRODUCTION

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<sup>1</sup>. Treatments including hormonal therapies are often ineffective, avoided or contraindicated. Fractionated laser treatments are proposed as a non-hormonal alternative for vaginal atrophy symptoms<sup>2</sup>. Whilst data on the intervention to date are positive with symptom improvement in >90% of cases, and histological changes are reported<sup>3</sup>, no placebo-controlled trial is currently reported.

## METHOD

This study is a randomised, double-blind, placebo controlled trial investigating the efficacy of fractionated carbon dioxide (CO<sub>2</sub>) laser treatment in treating post-menopausal vaginal atrophy symptoms. Participants underwent a protocol of 3 treatments, active or placebo, each 4-8 weeks apart, delivered by fractionated micro-ablative CO<sub>2</sub> laser (MonaLisa Touch™, DEKA Laser, Florence, Italy). Women in the active and placebo groups experienced an identical visual, olfactory, auditory and tactile experience, maintaining blinding of participants and research staff of group allocation. Participants had a primary comparative assessment at 6 months from baseline after the completed treatment course and again at 12 months from baseline. We assessed the vaginal health index at each visit, collected paired pre- and post-treatment vaginal histopathology and vaginal maturation index from consenting participants, evaluated self-reported symptom severity by VAS, and impact on livelihood, quality of life and sexual function by validated questionnaires.

## RESULTS

Of 232 women initially screened, 187 were eligible for assessment, 94 participants were consented, 4 were excluded and 5 withdrew prior to randomisation. 85 were randomised. 2 participants withdrew prior to completion to 6 months. 40 women had a prior history of breast cancer with induced menopause and 44 women had naturally occurring menopause. The most bothersome symptom is compared from baseline to post-treatment as an indicator of treatment efficacy. Data collection is complete to 6 months for all participants, with 12-month data nearing completion. The first data for this trial will be presented at the meeting.

# AGES XXX ASM Award Winner Abstracts cont.

**Award:** **OUTSTANDING TRAINEE PRESENTATION THE PLATINUM LAPAROSCOPE AWARD**

**Title:** **Increasing the adoption of ambulatory hysteroscopy in Australia – cost comparisons and patient satisfaction**

**Co-Authors:** [Pav Nanayakkara](#)<sup>1</sup>, Joyce Xiao<sup>1</sup>, MeHrnoosh Aref-Adib<sup>1</sup>, Alex Ades<sup>1 2</sup>  
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<sup>2</sup> Department of O&G, University of Melbourne, Melbourne, Victoria, Australia

**Winner:** **Pav Nanayakkara**

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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.



## ● AGES XXX ASM Award Winner Abstracts cont.

**Award:** BEST DIGITAL COMMUNICATIONS PRESENTATION  
**Title:** Pelvic Microbiome – A potential new player in the understanding of Endometriosis  
**Co-Authors:** Lior Levy<sup>1</sup>, Jim Tsaltas<sup>1</sup>  
<sup>1</sup> Endoscopy and Endometriosis surgery, Monash health, Melbourne, VIC, Australia  
**Winner:** Lior Levy

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Dr. John Sampson – known as the “father of endometriosis” – was the first to describe a series of perforating haemorrhagic ovarian cysts he called “chocolate cysts,” coining the term “endometriosis”.

His 1927 publication, suggesting the retrograde menstruating theory, was one of the most influential, and remains the prevailing teaching regarding the theory of endometriosis.

Despite its recognition for centuries, and the addition of other theories that may fill gaps left by Sampson’s theory for the development of the disease, such as the coelomic metaplasia and the induction theories, the pathogenesis of endometriosis is still poorly understood.

Endometriosis is a chronic inflammatory disease involving secondary inflammatory mediators. Primary inflammatory mediators, eg. bacterial endotoxin or lipopolysaccharides (LPS), have the potential to trigger the various secondary inflammatory mediators, such as cytokines, chemokines, and growth factors by activated macrophages in the pelvis.

A dysregulated immune response, characterised by increased production of pro-inflammatory cytokines, and decreased production of immune system components, may contribute to an immunosuppressive environment that enables the growth of escaped ectopic endometrial cells outside the uterus, potentially explaining why some women develop endometriosis following retrograde menstruation, while others do not.

As a result of recent advances in DNA sequencing technology, our understanding of microbial communities in the female reproductive tract has advanced substantially. In fact, in recent years, it has been shown that there is a microbiota continuum along the whole female reproductive tract, indicative of a non-sterile environment in the uterus and pelvis, contrary to what was thought in the past.

Lately, preliminary results from several studies point to bacterial contamination of the endometrium and the pelvis, as a potential new factor in the establishment of endometriosis. Khan et al. showed that the menstrual blood of women with endometriosis is highly contaminated with E.coli. Other studies showed that other pathogenic genera were predominantly identified in Endometriosis patients.

These findings raise a possible added mechanism for the development of endometriosis, in addition to the current known theories. However, more evidence is needed to enable the suggestion that the differences in microbiota along the female reproductive tract has a causal relationship with the development of endometriosis.

Here we review the current literature that surrounds the endometrial and pelvic microbiome, it’s potential role in the pathogenesis of Endometriosis, and possible future research directions, including a study which is planned to take place in our unit – the PELME study (Pelvic Microbiome in Endometriosis).

## ● Save the date

Please note that many event details are changing due to COVID-19.  
Please visit [www.ages.com.au](http://www.ages.com.au) for the latest information.



AGES/AAGL Focus Meeting 2020  
**SEPTEMBER 25-26 2020**  
Melbourne



AGES Pelvic Floor Symposium 2020  
**OCTOBER 30-31 2020**  
Adelaide Convention Centre, Adelaide



AGES Laparoscopic Anatomy Pelvic Dissection/  
Demonstration Workshops  
**2020 DATES**

CANCELLED Lap-Demonstration  
CANCELLED Lap-Dissection (Advanced)  
**November 28-29 Lap-Dissection**

Medical Engineering and Research Facility  
(MERF), Brisbane



**Postponed until further notice**



**Postponed until further notice**



AGES Annual Scientific Meeting 2021  
XXXI  
**MARCH 4-6 2021**  
Crown Promenade, Melbourne

# ● An update on the AGES Accredited Training Program (AATP)

**In 2013, the Australasian Gynaecological Endoscopy and Surgery Society (AGES) introduced the AGES Accredited Training Program (AATP) in Gynaecological Endoscopy. The AATP aims to facilitate endoscopic training in Australia and New Zealand, assuring consistency in education, access to resources and fair remuneration. The program was the result of extensive consultation with gynaecological endoscopists and training directors from the various informal training programs around Australasia.**

The AATP has become the most popular and competitive advanced training program in Australia and New Zealand. Interviews for training positions now occupy a full Saturday morning in parallel sessions at the ASM of the preceding year of training, a testimony to the success and popularity of the program. To date, 51 trainees have successfully completed the AATP, with the number of training units and available fellowship positions growing each year. AGES has successfully demonstrated that advanced training (incorporating the private sector) can occur post fellowship, with the AATP the only accepted formal pathway to Level 6 laparoscopic procedures endorsed by RANZCOG.

The initial design of the AATP was to establish a formalised role between the society and prospectively approved training units. AGES accredited each training site and delivered the mechanisms for assessment. However, AGES did not have any direct input into the training of fellows. Ultimately the responsibility to deliver training and assess competence lay with each individual unit.

Since its inception, the AATP has undergone a number of changes. In 2018, the Lap-D workshop (or equivalent) was made compulsory. This was the first time AGES had direct input into the training of fellows. This has now been expanded to include the anatomy of complications workshop, and a statistics course as formalised requirements. Summative assessment has seen the introduction of a theory exam in the form of 50 MCQs. The first of these was held in 2018, with trainees having had access to the questions (but not answers). The second exam was held in 2019, introducing a 50% component of previously unseen questions. In the same year, an Education committee was established to help outsource the increasing workload for overseeing training and accreditation.

These implementations have seen the structure of the AATP fundamentally change, with AGES no longer providing complete autonomy to each training unit to deliver training and assessment. The increasing involvement of the society was met with frustration by the 2019/20 training cohort leading to a formal written complaint. It became clear that the initial design of the AATP, relying on a cooperative and collegiate approach that enabled units to deliver training, was no longer an accurate reflection on the reality of the program. An adversarial relationship involving trainees, training units and AGES was developing, with legal ramifications threatening to shut down the training program indefinitely. After extensive consultation, a decision was made to change the core structure of the program.

The AATP is currently undergoing the biggest change since its inception. Up until 2020, the only financial relationship that AGES maintained with respect to training was through an annual fee paid by prospectively approved training sites. Now, all trainees will have a direct financial relationship with the society. This will be in the form of an annual membership fee as well as an annual AATP training fee, in line with other College training programs. Trainees are also required to sign a Terms and Conditions document outlining trainee obligations, limitations of liability, and mechanisms for dispute resolution. These changes allow for AGES and the AATP to be protected, ensuring future generations of trainees continue to receive the benefits of a formalised training program.



**Dean Conrad**

On behalf of the AGES  
Education Committee



# ● AGES Membership 2020

## It's not too late to renew your membership!

Membership of AGES includes the following:

- » Complimentary access to member only content such as webinars
- » 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

To renew your membership online or to update your details, please use the following link: [AGES MEMBERSHIP 2020](#)

# ● AGES Research Grant Applications Open!

**AGES Members are invited to apply for the 2020 AGES Clinical Research Grants. Applications open on the 1st June.**

Details and the application links are available in the Research tab in the members section of the [AGES website](#)

Thank you to our AGES Educational Training Partner Medtronic for their continued support of these grants.

# Dates for Laparoscopic Workshops

## ADVANCED LAPAROSCOPIC GYNAECOLOGICAL WORKSHOP ST JOHN OF GOD HOSPITAL SUBIACO

**COURSE DIRECTOR**  
DR STUART SALFINGER

A two day clinical immersion aimed at surgeons performing laparoscopic gynaecological surgery who wish to extend their skill set and knowledge of advanced minimally invasive techniques. Candidates will work with two certified Gynaecological Oncologists over the two days running in two theatres. The course aims to provide maximum operation experience to participants. They will have the opportunity to scrub in and be 1st and 2nd assist. The case load is 85% laparoscopic predominantly with exposure in total laparoscopic hysterectomy.

**2020 Course Dates:** on application.

### Details

[www.covidien.com/pace/clinical-education/event/250875](http://www.covidien.com/pace/clinical-education/event/250875)

## FLINDERS PRIVATE ENDOGYNAECOLOGY MASTERING LAPAROSCOPIC SUTURING XXI

**2020 Course Dates:** August 20-21.

### For information contact:

Robert O'Shea P: (08) 8326 0222 F: (08) 8326 0622  
Email: [rtooshea@adam.com.au](mailto:rtooshea@adam.com.au)

## SWEC ADVANCED GYNAECOLOGIC LAPAROSCOPIC COURSES FOR 2019 AT THE SYDNEY WOMENS ENDOSURGERY CENTRE (SWEC) AT ST GEORGE HOSPITAL SYDNEY. COURSE DIRECTOR: ASSOC PROF GREG CARIO

We invite you to participate in our advanced gynaecological laparoscopy course which has been running for the last 20 years. This 5 day course is aimed at consultants and registrars keen to develop laparoscopic skills, refresh their pelvic anatomy, and broaden their repertoire of laparoscopic surgery. It is also useful for those looking for an introduction to Robotic surgery. You will have exposure during live surgery to 5 different advanced laparoscopic surgeons and see their different styles and approaches for TLH, fibroids, endometriosis, pelvic floor reconstruction and incontinence surgery.

### Comprehensive Course Curriculum:

- » Laparoscopic pelvic anatomy instruction.
- » Dry lab training concentrating on curved needle suturing.
- » Robotic hysterectomy workshop.
- » Endometriosis workshop.
- » Live operating sessions running over 4 days with the opportunity to assist following pre-workshop accreditation.
- » Live animal workshop.
- » 43 CPD points (practice improvement points may also be claimed).
- » Small group participation of 8 – 10 registrants per course.

**2020:** October 12-18

**2021:** March 15-19, June 7-11, October 11-15

**2022:** March 21-25, June 6-10, October 10-14

Register on-line at [www.swec.com.au](http://www.swec.com.au)

or contact our course administrator

at: [sweconline@gmail.com](mailto:sweconline@gmail.com) or

Assoc Prof Greg Cario, SWEC Director  
[doc@drgregorymcario.com.au](mailto:doc@drgregorymcario.com.au)



Sydney Women's Endosurgery Centre

## MONASH MEDICAL CENTRE MONASH ENDOSURGICAL PRECEPTORSHIP

### PROGRAM DIRECTOR DR. JIM TSALTAS

The Monash Endoscopy Unit is offering a preceptorship in the following areas of advanced laparoscopic surgery:

- » laparoscopic hysterectomy
- » laparoscopic management of endometriosis and general gynaecological endoscopy
- » laparoscopic oncological procedures
- » laparoscopic colposuspension
- » laparoscopic pelvic floor repair

**2020 Course Dates:** October 13-14

**2021 Course Dates:** February 16-17, May 25-26, October 12-13

**All enquiries should be directed to:** Dr. Weng CHAN,

Gynae Endosurgery Consultant, Monash Medical Centre, 14-16 Dixon St, Clayton Vic 3168

P: + 61 3 9548 8628 F: + 61 3 9543 2487 Email: [kkcha5@hotmail.com](mailto:kkcha5@hotmail.com)

Each preceptorship is limited to only two surgeons for each two day preceptorship. The course aims to provide maximum operation experience to participants. The Monash preceptorship is primarily designed for FRACOG specialists. However, theatre nurses as well as senior registrars and registrars are welcome.

*This has been approved by RANZCOG for CPD points. 18 CPD points, 1 meeting point and 15 PR & CRM points are available.*

## Dates for Laparoscopic Workshops cont



### LAPAROSCOPIC SURGERY FOR GENERAL GYNAECOLOGISTS SYDNEY LAPAROSCOPIC WORKSHOPS 2020

**WORKSHOP CONVENORS:**  
A/PROF G. CONDOUS (Nepean Hospital),  
DR T. CHANG (Campbelltown Hospital) &  
DR N. CAMPBELL (RPAH)

Our intensive 2 day laparoscopic course (limited to 8 places) is aimed at helping the generalist and registrars up skilling and becoming confident at performing common, day to day laparoscopic procedures. The course is intended for those with an interest and has a basic skill base for laparoscopy including suitable for Trainees and well as Fellows.

#### LASGEG highlights:

##### » DAY 1

- > Live operating: endometriosis/cystectomy/oophorectomy/hysterectomy/ureterolysis
- > Theory of laparoscopy: instrumentation/setup/energy/entry techniques/anatomy/operative techniques/complications
- > Dry lab

##### » DAY 2

- > Full day live pig operating
- > 2 participants max per sheep
- > One to one hands on step by step guidance on how to perform laparoscopic procedures

#### 2020 Course Dates:

2-3 November 2020

#### Course fees:

fellows \$2000, Registrar \$1350 (limited places)

#### For further information contact:

Nicole Stamatopoulos: [nic96@hotmail.com](mailto:nic96@hotmail.com)

Website: [www.lasgeg.com](http://www.lasgeg.com)

### ADVANCED LAPAROSCOPIC PELVIC SURGERY TRAINING PROGRAM

#### PROGRAM DIRECTOR ASSOC PROF ALAN LAM

You are invited to participate in an integrated training program in Advanced Laparoscopic Pelvic Surgery. An internationally recognized faculty aims to give you the skills to practice safe endosurgery and increase the range of laparoscopic procedures you can perform.

#### 2020

CARE Master Class in Laparoscopic Excision of Endometriosis & Hysterectomy Techniques: 3-7 August (pending COVID 19 Restrictions)

CARE Master Class in Laparoscopic Hysterectomy, Myomectomy & Adnexal Surgery: 2-6 November

#### 2021

CARE Master Class in Laparoscopic Hysterectomy, Myomectomy & Adnexal Surgery: 15-19 March

CARE Master Class in Laparoscopic Excision of Endometriosis & Hysterectomy Techniques: 2-6 August

CARE Master Class in Laparoscopic Hysterectomy, Myomectomy & Adnexal Surgery: 25-29 October

#### CARE Course Features

- » Personalised tuition
- » A maximum 8 participants per course
- » Comprehensive tutorials including anatomy, energy sources, complication management/prevention
- » Two skills labs to help refine intra and extra corporeal suturing
- » Two live animal lab sessions
- » Eight theatre sessions during which you will 'scrub in'
- » Credited by RANZCOG with CPD and PR&CRM points

#### For further information contact:

CARE Course Coordinator, AMA House Level 4  
Suite 408, 69 Christie Street, St Leonards NSW 2065

P: (fax) + 61 2 9966 9121 F: + 61 2 9966 9126

Email: [care@sydneycare.com.au](mailto:care@sydneycare.com.au)

Web: [www.sydneycare.com.au](http://www.sydneycare.com.au) for registration forms



escope

Volume 74 coming out  
in September 2020

Contact Stephen Lyons ([stephen@drlyons.com.au](mailto:stephen@drlyons.com.au))  
with your contribution

Deadline **30th August 2020**