



Volume 74 December 2020

# escope

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

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Ureteric Injuries  
at time of  
Gynaecological  
Surgery

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the era of COVID-19

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is harmed  
Avant Article

Save the date



# **TOGETHER TOWARDS TOMORROW**

# ● President's Letter

## Dear Friends and Colleagues

So, I pretty much didn't imagine that 2020 would be a year during which a global pandemic would bring so much of life as we know it to a grinding halt. It has been an unusual and difficult year for all. Many of our members have struggled through difficult times in lockdown. The areas of medicine we know, and love have changed. The way we deliver care has changed. We know that there is significant trauma and difficulty to follow. The states which only experienced minimal lockdown measures are only just now seeing late presentations of advanced disease as our patients venture out to see their doctors again. It is hard to imagine the tsunami of patients in need that will eventually present in those states that had more prolonged lockdowns and restrictions on caseload. Whilst it has been a difficult year, and thankfully things are looking better we know that there will be much more pain to follow even without further second and third waves.

In the face of this adversity within AGES we have endeavoured to adapt and rise to the challenges that have presented. We remain committed to raising the standard of meetings, education, and training. It is interesting that last year at our strategic planning meeting, your board decided on a vision for the society – **Together, Towards Tomorrow**. This vision for the society and more so a culture of working together to achieve better for all is what has been so important to survive this difficult year. It has also highlighted the importance of education and engagement as vitally important within this new world we live in.

Since our last eScope back in June we have continued our newly founded [Webinar series](#). In July we ran our fifth Webinar "[Protecting the Surgeon and Surgical Team](#)" held in conjunction with Stryker. During the height of the pandemic for Australia & New Zealand this was an important webinar featuring presentations from Menna Davies, updating us on the latest technology for safely managing smoke evacuation and surgical plume, Margaret Land who shared her experience in the ergonomics of minimally invasive surgery and how to mitigate some of the physical risks of the surgeon-workplace interface and Devini Ameratunga gave a lively assessment of theatre equipment for a diverse surgical population and tips for finding the best surgical equipment for your individual needs. Recordings of this and all of our Webinars, are [available on our website](#).

September saw AGES branch out holding our very first fully virtual event – [the AGES/AAGL Virtual Focus Meeting](#). Themed Advancing the Art: The Future of Endoscopic Surgery with our new online platform. The online meeting attracted a high number of delegates and we were honoured with multiple presentations from our affiliated society, the AAGL. Having experienced a number of international virtual meetings now as presenter and delegate I cannot be prouder of what we have delivered, which has stood head and shoulders above the rest for what delegates and sponsors experience. Whilst our amazing faculty has been part of the key to this, more importantly was the many weeks of research and trialling of different platforms by Mary, Danielle and the YRD team. We would not have been able to deliver such high-quality events without this dedication to lifting AGES events up above the rest.

Following very closely on the heels of the Focus meeting was the AGES Pelvic Floor Symposium – Bridge Over Troubled Water saw ongoing adaption as we hosted this meeting as our first hybrid event, offering both the virtual experience as well as a face-to-face option. We were joined by 45 South Australian delegates at the InterContinental Adelaide and it was great to see AGES members reconnecting. The international aspect and amazing worldwide connectivity were highlighted when Karl Jallad carried on the panel discussion from his car in Lebanon after being called into his hospital!



## ● President's Letter cont.

Our Trainee's need to be recognised for their dedication to training during a time of much change in the industry. Medtronic also hosted the first trainee Journal Club in July, allowing our Trainee's to have open discussions with their colleagues and members of our Education Committee. These journal clubs for the AGES trainees are planned to continue in 2021. For all trainees we again ran the ["Who Do You Want to Be When You Grow Up"](#) Seminars for RANZCOG Trainee's, a virtual meeting was held in Queensland with a return to face to face meetings in Perth and Sydney. Personal experiences from varying areas across the broad church that makes up FRANZCOG graduates are always a highlight of these events. Not only do they help identify areas of interest but also remind us of the need for ongoing lifelong education and training.

The AGES curriculum review is in full swing as Professor Debra Nestel is continuing to review the AGES Advanced Training Program (AATP) and Curriculum. The Education Committee along with numerous volunteers has been working hard alongside her to ensure our Trainees are provided with a structured training program placing them at the forefront of education.

A big congratulations to Basia Slusarczyk, Nargis Noori, Tanushree Rao, Alison Bryant-Smith, Naman Dahiya, Vanessa Lusink, Kate Martin, Keryn Harlow, Lauren Hicks and Kate Tyson who sat and passed their AATP exam, across the country, at the end of October.

[The Research Grant Committee](#) and AGES Board have recently announced a total of \$62,630.00 was awarded to successful applications from 9 projects. A special thank you to Prof Roger Hart Chair of the AGES Research Grant Committee, your leadership and passion for research has been unwavering.

Hopefully 2021 will provide a world where we can again reconnect in person with our colleagues across the country at AGES events. You will notice our year has been a little rejigged with the focus meeting and ASM swapping places. The ["Next Generation" Focus meeting](#) set for 5-6th of March as a hybrid meeting with hubs in each state and a virtual component. Bas Geroges is heading up an organising committee entirely of graduates of the AGES training program the future leaders of the profession. Our [ASM "Leading the New Paradigm"](#) will be 15-17th July at RACV Royal Pines on the Gold Coast. We are determined to provide you with events which suit the needs of the new world and will offer both virtual and face to face options where possible.

I would say very few societies are lucky enough to be in the sound position that AGES is currently in, but it's not luck, it is hard work and dedication by a team over years that has built the solid foundations that hold us steady. A special thank you to all of my board, you have been supportive and hardworking throughout the year and risen to the challenges of the year. Also, to Mary and her entire team at YRD, Danielle, Jayme, Taryn, Amy, Lydia and Karen, your hard work and dedication to the society have made this year work.

As the year comes to a close, we say goodbye (or perhaps a less convivial farewell) to 2020 and all the challenges it brought with it. We have learnt many things, we have connected on different levels, we have learnt not to take anything for granted and to appreciate the love of family and friends. I would encourage you to take some time to reflect on everything that has been and how we have grown.

Hoping your holidays are filled with love, family and happiness.



**Stuart Salfinger**  
AGES President

# Editorial

## Dear AGES Members

Welcome to the 74th edition of eScope.

With strict social distancing rules, hand sanitising and the wearing of masks, we seem to be holding our own against the surprise and rapid onslaught of COVID-19. In the words of Basil Faulty, “don’t mention [winning] the war” just yet, although with the release of several promising vaccines looming, hopefully we may find life returning to near normalcy in 2021. Indeed, as I make final changes to this editorial, I am flying from Sydney to Melbourne to attend Christmas celebrations with friends and family – even a month ago this would have seemed an impossibility.

Despite the impact COVID-19 has had on our patients, and colleagues and families, 2020 has been a busy year for AGES. In this edition’s [President’s Letter](#) Stuart Salfinger summarises the AGES events and activities that have been held during this very difficult time. The fifth AGES Webinar entitled “Protecting the Surgeon and Surgical Team” was held in July. Building on the skills gained from its webinars AGES held its first virtual conference event, the AGES/AAGL Virtual Focus Meeting [“Advancing the Art: The Future of Endoscopic Surgery”](#) in September. As a first effort on this platform, this meeting was an outstanding success. A summary of the meeting has been provided by one of the meeting’s Scientific Co-chairs, Helen Green. With barely a chance to catch one’s breath the AGES Pelvic Floor Symposium was held in October. Aptly themed “Bridge Over Troubled Waters”, this meeting was held in Adelaide and was AGES’ first hybrid meeting with a small but enthusiastic audience attending face-to-face and other delegates attending remotely. This meeting was also a great success, a wrap-up of which will be held over to the next edition of eScope in February.

In this edition of eScope we are treated to not one but two Trainee articles. Vanessa Ross and Catarina Ang provide a very timely insight into [“Surgical training in the era of COVID-19”](#). A great review on an ever-present risk for gynaecological laparoscopists, namely [“Bladder and ureteric injuries at time of gynaecological surgery”](#), has been provided by Ahalya Sathiyaselvan and Mike Wynn-Williams.

Supuni Kapurubandara has provided us with a great insight into her invaluable learning experience as an [AGES Travelling Fellow](#), hopefully inspiring others to follow in her footsteps. The “SWAPS” Fellows have again provided their [JMIG summaries](#) of recent significant articles chosen to be of interest to AGES Members – a very big thank you for making our busy lives a little simpler. As part of the AGES Educational and Practice Partnerships, Avant has provided an article entitled [“When a patient is harmed”](#), a guideline for managing inadvertent patient injury at gynaecological surgery.

I wish all AGES Members a happy Christmas break with family and friends and a safe and prosperous new year. I look forward to seeing you at the [AGES Hybrid Focus Meeting](#) in March, hopefully face-to-face!



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

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# ● Bladder and Ureteric Injuries at time of Gynaecological Surgery

Ahalya Sathiyaselvan & Michael Wynn-Williams

**Bladder and Ureteric Injuries are a known complication of pelvic surgery, complicating 0.3% to 1.5% of all benign gynaecological surgery<sup>(1,2)</sup>. Therefore, a sound understanding of the identification and management of urinary tract injuries is essential knowledge for the gynaecologist. This article provides information regarding the assessment and management of urinary tract injuries.**

## Risk factors

When assessing patients at risk of urinary tract injury, an individual's risk factors must be taken into account. These include: distorted pelvic anatomy from prior surgery including Caesarean delivery, adhesions, endometriosis, pelvic masses and uterine fibroids (particularly if inter-ligamentous or para-cervical)<sup>(3,4,5)</sup>. Also, factors such as high BMI, prior pelvic irradiation and urinary tract anomalies are of importance<sup>(3,4)</sup>. Surgeon risk factors include lack of surgical experience and low surgical volume<sup>(3,4,5)</sup>. The risk of urinary tract injury should be discussed with all patients pre-operatively but must be highlighted in the presence of the above risk factors.

## Types of Injury

There are several types of bladder injury. There can be contusion injuries to the bladder, thermal injuries, lacerations, perforations and in the context of vaginal surgery, erosion of suture or mesh or intravesical suture or mesh<sup>(4,5)</sup>. Types of ureteric damage include transection, inclusion in pedicle sutures, crushing by clamps, thermal injury from energy sources, kinking / angulation, laceration and resection<sup>(4,5)</sup>. When performing a hysterectomy, the ureter is most commonly injured at the level of the infundibulopelvic ligament or at the level where the ureter tunnels under the uterine artery<sup>(5)</sup>. Identifying the type of injury allows for appropriate repair.

## Intra-operative detection of injury

Intra-operative detection of the injury is preferable to postoperative detection because it facilitates timely repair and reduces the risk of significant morbidity and long-term sequelae<sup>(5,6)</sup>.

Signs that may help detect a bladder injury include a visible urinary catheter, a hole visible in the bladder, gaseous distension of Foley catheter bag, macroscopic haematuria and copious fluid in the operative field<sup>(6)</sup>. The dome is the most commonly injured portion of the bladder<sup>(5)</sup>.

Ureteric injuries are more difficult to detect and localise than bladder injuries, with only one-third of ureteric injuries seen intra-operatively<sup>(4)</sup>. Ureteric catheters are sometimes placed pre-operatively in patients at higher risk of ureteric injury. Evidence has not demonstrated that urinary catheters decrease the risk of ureteric injury, but they do increase the intra-operative identification of injuries<sup>(3,5,6)</sup>.

Intraoperative cystoscopy has also been shown to increase the detection rate of urinary tract injuries<sup>(3,6,7)</sup>. The surgeon must be aware that ureteric jets can be seen with partially occlusive ureteric injuries and therefore, a small injury may be present even in the presence of bilateral ureteric jets<sup>(3)</sup>. During the cystoscopy, the administration of oral or intravenous agents to provide urinary contrast can also be used<sup>(3)</sup>.

In the case of a suspected injury, intra-operative cystoscopy and ureteric catheter insertion are recommended to help with detection of injury<sup>(3,4,7)</sup>.

## Post-op injury presentation

While intra-operative detection of bladder and ureteric injuries is preferable, sometimes these injuries are only diagnosed in the postoperative course.



# ● Bladder and Ureteric Injuries at time of Gynaecological Surgery cont.

Ahalya Sathiyaselvan & Michael Wynn-Williams

There are several symptoms and signs that should alert the medical and nursing team to the possibility of a bladder injury or ureteric injury. These include copious clear fluid or urinary leakage from drains, the vaginal vault or incision sites <sup>[5]</sup>. Macroscopic haematuria, an inability to void or low urine output, abdominal distension, abdominal pain, ileus, renal dysfunction, fever or sepsis can also be symptoms and signs of a urinary tract injury <sup>[4,6]</sup>. With a ureteric injury in particular, patients can experience flank pain <sup>[4]</sup>. These symptoms and signs usually present within the first 48 hours but symptoms caused by thermal injuries to the urinary tract may present up to two weeks after surgery <sup>[4]</sup>. Delayed recovery after laparoscopic surgery should also alert the treating team to a possible urinary tract injury <sup>[4]</sup>.

## Investigations

The most useful blood test is the serum creatinine, which may be abnormally elevated due to reabsorption of urine creatinine through the peritoneal membrane. However, a normal creatinine does not exclude a urinary tract injury <sup>[4]</sup>. Peritoneal fluid from a pelvic drain or obtained from a collection, removed under radiological guidance, can be tested for elevated creatine, urea and nitrogen. Levels that are significantly elevated above plasma levels, indicate that the fluid contains urine <sup>[8]</sup>. A CT-IVP (Intravenous pyelogram) or CT Cystography can be used to diagnose a ureteric injury <sup>[5,8]</sup>. Ultrasound is often the first-line imaging test due to its accessibility and the benefit of no radiation, but it is the least helpful imaging modality. Ultrasound may identify hydronephrosis which would raise clinical suspicion of a ureteric injury and can also identify absent bilateral ureteric jets <sup>[5]</sup>.

## Management of Bladder Injury

Small injuries (<2mm) will heal spontaneously <sup>[5]</sup>. Injuries 2-10mm can also be managed conservatively with bladder drainage for 10-14 days <sup>[5]</sup>.

For defects in the bladder measuring 10mm-20mm, surgical repair with a single layer of absorbable/delayed absorbable suture, e.g. 2-0 or 3-0 polyglactin / Vicryl is recommended <sup>[4,5]</sup>. For a bladder injury measuring

>20mm, surgical repair with a two-layered running closure using absorbable/delayed absorbable sutures, e.g. 2-0 or 3-0 polyglactin / Vicryl is appropriate <sup>[4,5]</sup>.

The principles of repair are opposing mucosa to mucosa and running non-locked sutures placed 0.5 to 1cm apart and 0.5 to 1cm lateral to the cystotomy angles <sup>[4]</sup>. An absorbable suture with a non-cutting needle should be used and the sutures should not be under tension.

Postoperative management of a bladder injury involves keeping an indwelling catheter in for 7-14 days <sup>[4,5]</sup>. The patient should have a trial of void on the ward.

Cystography is optional, before a trial of void <sup>[6,9]</sup>. Cystography can be considered in the context of more extensive bladder injuries > 20mm or complicated repairs. It should also be considered if the patient has risk factors for abnormal healing (e.g. smoking or diabetes mellitus) or if the patient has had an unusually challenging postoperative course <sup>[6,9]</sup>. Lastly, if the Urology team has recommended cystography, it would be appropriate to organise this.

## Management of Ureteric Injury

Conservative management is appropriate for minor crush or needle injuries of the ureter.

Ureteric stent insertion is the management option of choice in the context of suture ligation injuries or inadvertent clamping injuries <sup>[6]</sup>. The first step in managing this type of injury is the removal of ligature/clamp <sup>[5]</sup>. Then a ureteric stent should be inserted by a Urologist under I-I guidance <sup>[6]</sup>. If there is the concern of a significant crush or ligature injury, a cystoscopy and retrograde pyelography can also be performed.

The ureteric stent normally remains in situ for 2-6 weeks. These patients require careful follow up to ensure that the stent is removed, as a forgotten stent can cause serious complications. Additional follow up by a Urologist may be necessary to exclude late strictures and vesicovaginal fistulae.



# ● Bladder and Ureteric Injuries at time of Gynaecological Surgery cont.

Ahalya Sathiyaselvan & Michael Wynn-Williams

For more extensive ureteric injuries, surgical repair is appropriate. The general principles of surgical repair of the ureters are to avoid obstruction of the ureteric orifices and the intramural ureter <sup>[6]</sup>. Careful handling of the ureter will minimise tissue damage <sup>[4,6]</sup>.

Injuries above the pelvic brim can be divided into those involving more or less than 50% of the ureteric circumference. Partial injuries involving less than 50% of the ureteric circumference can be managed with a simple surgical repair, using interrupted absorbable sutures over a ureteric stent <sup>[5]</sup>. More extensive injuries, involving more than 50% of the ureteric circumference, require debridement and end-to-end anastomosis (uretero-ureterostomy) over a stent with absorbable suture <sup>[5]</sup>. Ureteric stent placement, in addition to surgical repair, prevents urine extravasation and ureteric structuring, promoting normal healing of the ureter.

For ureteric injuries below the pelvic brim, ureteric re-implantation is the recommended management <sup>[3,5,6,10]</sup>. The ureter is re-implanted into the bladder (uretero-neocystostomy). This can be supported with a Boari flap and a Psoas hitch<sup>[5]</sup>. This involves distal ureterolysis, mobilisation of the bladder, incision of the distal bladder and then tubularisation to form a Boari flap. The distal ureter is anastomosed to the Boari flap <sup>[10,11]</sup>. A Psoas hitch can be performed when the bladder is sutured or 'hitched' to the Psoas muscle, which allows for tension-free anastomoses <sup>[10,11]</sup>.

Any patient with a ureteric injury should have an IDC for 10-14 days <sup>[5]</sup>. Following this, they should be brought back for a formal trial of void. A cystogram should be organised for 4-6 weeks post-repair and if there is no leakage of urine, the stents can be removed.

## When to involve your Urologist colleagues in a bladder or ureteric injury?

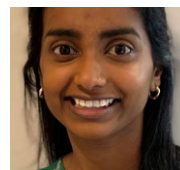
The answer depends on your surgical experience and relationship with your urological colleagues. For the high-risk patients, you may give them a heads up they may be required during a procedure or you may get them involved in the actual procedure. With experience,

the majority of gynaecologists can repair recognised intraoperative bladder injuries and perform a cystoscopy to confirm no other injuries are present <sup>[3,4]</sup>. You may choose to contact or ask for a urologist to come to the theatre for surgical support. Recognised intraoperative ureteric injuries will generally involve a urologist becoming involved as the surgical management is out of the scope of practice of most gynecologists <sup>[6]</sup>.

For postoperative bladder or ureteric injury, it is recommended to involve a Urologist early in the patients care. Whether there is a high suspicion of injury or an injury has been confirmed, a Urologist will provide valuable diagnostic, clinical and collegial support on available management options.

## Summary

In this article, we have provided a structured approach to identifying, investigating and managing urinary tract injuries. In summary, it is important to discuss the risk of urological injuries with the patient pre-operatively. Being vigilant for symptoms and signs of urinary tract injury, both intra-operatively and post-operatively is important in ensuring timely identification of the injury. Diagnosing the type of injury and calling for help when required are also key factors in providing safe care. Lastly, open disclosure and debriefing with the patient is essential, as well as engagement in local quality improvement systems. Urological complications are a part of gynaecological surgery, but if managed well, we can limit the associated morbidity and long-term sequelae for the patient and the anxiety and distress for the surgeon.



**Ahalya Sathiyaselvan**  
Obstetrics and Gynaecology  
Registrar



**Michael Wynn-Williams**  
AGES Board Member





# ● Bladder and Ureteric Injuries at time of Gynaecological Surgery cont.

Ahalya Sathiyaselvan & Michael Wynn-Williams

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# Advancing the Art: The Future of Endoscopic Surgery AGES/AAGL Affiliated Society Focus Meeting 2020 report

This year has seen us rethink and change so many aspects of our everyday lives and adapt to a new normal. The AGES/AAGL Focus Meeting was no exception. Moving to an online platform we took this meeting into the world of virtual events making it one to remember, not only for this exciting new method of education but to incorporate so many international presenters from our sister society, the American Association of Gynecologic Laparoscopists (AAGL). COVID-19 has presented us with many challenges, however we were committed to remaining connected with our colleagues around the world, dialling them in virtually and gaining insight into how they have been affected throughout the year.

Our fantastic line-up of international speakers included Jubilee Brown, Marie Fidela Paraiso, Linda Bradley, Jonathon Solnik, and Cara King. Jubilee opened the conference with a moving presentation on the prevalence of sexual and racial harassment in gynaecological practice while Cara King impressed us all with her energetic tour through current and future innovations in endoscopy and surgical education. To conclude the meeting, an Endometriosis Panel full of experts in their field discussed the multidisciplinary management of two difficult cases. We also received an update from Marilla Druitt on projects that have been funded by the Endometriosis Action Plan, and enjoyed Mathew Leonardi's presentation of his research on the pre-operative USS diagnosis of endometriosis.

We must acknowledge our local and international faculty, our Industry Partners, and of course all the delegates who attended – thank you for adapting to the virtual world and making AGES' first virtual meeting a very successful one!



**Stuart Salfinger**  
AGES FM20 Conference Chair  
AGES President

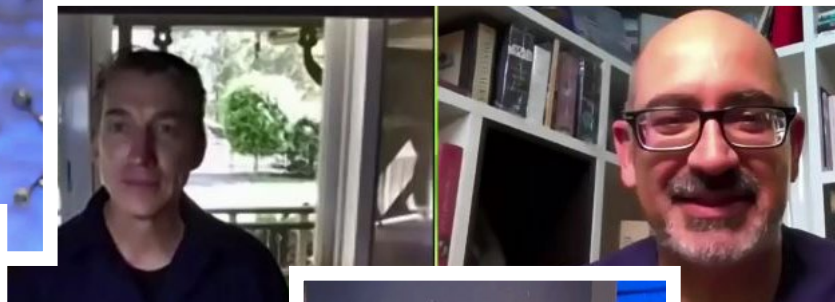


**Helen Green**  
AGES FM20 Scientific Co-Chair  
AGES Director



**Kirsten Connan**  
AGES FM20 Scientific Co-Chair  
AGES Director

● AGES/AAGL Affiliated Society Focus Meeting 2020 report cont.





MARCH 2021  
**05-06**  
Hybrid Meeting



## Next Generation

The AGES Focus Meeting 2021 will be our first conference of the year and is set to be an innovative and thought-provoking meeting! For the first time in AGES' history the Local Organising Committee is compiled fully of AGES Accredited Training Program Graduates from across Australia, whom have put together the meeting, titled "*Next Generation*" to be held on the 5th and 6th of March 2021.

Whilst the world is slowly progressing to COVID-19 normal, we are mindful the challenges faced in 2020 are still present and we are yet to return to our normal method of conferencing. The Focus Meeting 2021 will be offered as a Hybrid event, we aim to host mini-sites in multiple locations throughout Australia (pending government regulations and advice) and will offer a virtual component for those who are unable to join us in person.

The AGES Focus 2021 organising committee have developed a program highlighting many of the current issues faced by all, including advances in gynaecological practices, challenges with research and collaboration and confronting cultures issues. We have a spectacular team of international and local speakers, including Natasha Anandaraja and Linda Bradley from the USA, Nick Bourdel from France and Silvia Vannuccini from Italy. In addition, amongst the local speakers, Anand Senthil will introduce the concept of EBM 2.0 and Ea Mulligan will unpack all that is the clitoris.

I am excited for the *Next Generation* to make their mark and carry the torch for the future of Women's Health, we hope you are able to join us in March!



**Bassem Gerges**  
FM21 Conference Chair  
AGES Director





✦ AGES FOCUS MEETING 2021

# 'Next Generation'

*Hybrid Meeting*

5<sup>th</sup> & 6<sup>th</sup> March 2021



# FRIDAY 5<sup>TH</sup> MARCH 2021 - HYBRID MEETING DAY ONE

## VIRTUAL & IN-PERSON

	AWST	AEST	ACDT	AEDT	NZDT
VIRTUAL EVENT PORTAL ACCESS & CONFERENCE REGISTRATION					
<b>SESSION ONE: WHAT'S NEW?</b>	1000 - 1205	1200 - 1405	1230 - 1435	1300 - 1505	1500 - 1705
Welcome				1300	
The new generation surgeon - at what cost?				1310	
Managing endometriomas – have things changed?				1330	
Excision of endometriosis - out with the spatula?				1350	
Uterine artery embolization - what the gynaecologist needs to know: just the facts				1410	
The clitoris - unpacking the enigma				1430	
Panel Discussion				1450	
<b>AFTERNOON TEA &amp; TRADE EXHIBITION</b>	1205 - 1235	1405 - 1435	1435 - 1505	1505 - 1535	1705 - 1735
<b>SESSION TWO: COVID – THEN AND NOW</b>	1235 - 1410	1435 - 1610	1505 - 1640	1535 - 1710	1735 - 1910
Future of training				1540	
Pelvic pain - elective surgery? Time for a change!				1555	
When not operating - have we exhausted the medical options?				1610	
Simulation – what works?				1625	
Areas of need and medical tourism?				1640	
Panel Discussion				1655	
<b>CLOSE OF DAY ONE</b>	1410	1610	1640	1710	1910
<b>AGES ANNUAL GENERAL MEETING</b>	1415 - 1515	1615 - 1715	1645 - 1745	1715 - 1815	1915 - 2015
	<b>AWST</b>	<b>AEST</b>	<b>ACDT</b>	<b>AEDT</b>	<b>NZDT</b>



# SATURDAY 6<sup>TH</sup> MARCH 2021 - HYBRID MEETING DAY TWO

## VIRTUAL & IN-PERSON

	AWST	AEST	ACDT	AEDT	NZDT
VIRTUAL EVENT PORTAL ACCESS & CONFERENCE REGISTRATION				0920 - 1000	
<b>SESSION THREE: OBESITY - THE PROBLEM AT LARGE</b>	0700 - 0840	0900 - 1040	0930 - 1110	1000 - 1140	1200 - 1340
Welcome				1000	
Anaesthetics and laparoscopy				1010	
PCOS, endometrial hyperplasia and infertility – an update				1025	
Pre-conception nutrition or IVF?				1040	
Weight loss myth busters - separating fact from fiction				1055	
What about me? Patient perspective				1110	
Panel Discussion				1125	
<b>LUNCH &amp; TRADE EXHIBITION</b>	0840 - 0940	1040 - 1140	1110 - 1210	1140 - 1240	1340 - 1440
<b>SESSION FOUR: RESEARCH AND INTEGRITY</b>	0940 - 1115	1140 - 1315	1210 - 1345	1240 - 1415	1440 - 1615
EBM 2.0				1245	
Do you swear to tell the whole truth?				1300	
Is research of any type useful?				1315	
Top 5 reasons why projects get knocked back / Battling the shifting sands of ethics committees				1330	
Collaboration				1345	
Panel Discussion				1400	
<b>AFTERNOON TEA &amp; TRADE EXHIBITION</b>	1115 - 1145	1315 - 1345	1345 - 1415	1415 - 1445	1615 - 1645
<b>SESSION FIVE: CULTURE BEAT OR BEATING THE CULTURE</b>	1145 - 1400	1345 - 1530	1415 - 1600	1445 - 1630	1645 - 1830
Bullying – institutional peer talk				1450	
Civility in the workplace and operating room				1510	
Equality vs Equity				1525	
I feel the need...the need to lead! But how?				1540	
It's not burnout...it's moral injury				1555	
Panel Discussion				1615	
<b>CLOSE OF CONFERENCE</b>	1330	1530	1600	1630	1830
	<b>AWST</b>	<b>AEST</b>	<b>ACDT</b>	<b>AEDT</b>	<b>NZDT</b>

# ● AGES Travelling Fellowship Report Supuni Kapurubandara

**I would like to thank AGES Board for choosing me as the recipient of the AGES Travelling Fellowship in 2019. I have penned down my journey and I would hope my experience would encourage others to pursue such learning opportunities.**

In the last decade, there has been a surge in complex surgical procedures that are being performed adopting smaller and fewer incisions. This has improved post-operative pain and length of stay resulting in reduced health care costs. Similar to the advent of anaesthesia and anti-sepsis, emerging minimally invasive surgical techniques continue to transform patient care and experience.

Hysterectomy is one of the most common gynaecological procedure performed in Australia with the majority performed as a laparoscopic hysterectomy (LH)<sup>1</sup>. Vaginal hysterectomy (VH) rates have been declining with a rate of 13.3 per 10,000 women in 2013-2014 as compared to 23.2 in 10,000 women in 2000-2001<sup>1</sup>.

Factors contributing to this trend of lower rates of VH include diminishing appropriate case numbers, difficult access and visualization due to patient factors such as previous caesarean section, obesity and other comorbidities as well as challenges encountered while teaching vaginal surgery. This leads to a surgical culture in which competency in vaginal surgery diminishes with time.

The most recent Cochrane review demonstrated that VH, as compared to LH, was associated with reduced length of stay, shorter operating time and was more economical, with no difference in the short-term or long-term complications<sup>2</sup>. This was further reinforced in another systematic review and meta-analysis<sup>3</sup>. Given the benefits of VH, it is imperative to maintain vaginal surgical skills to offer this option to the appropriate patient.

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) allows vaginal access (natural orifice) to the intra-abdominal and pelvic cavity to perform procedures including adnexal surgery and hysterectomy which was first described in 2012<sup>4,5</sup>. The ability to visualize and magnify using the laparoscope helps to overcome some of the issues faced with conventional vaginal

surgery such as the need for adequate uterine descensus and concerns of scarring from previous caesarean sections. I first heard about this technique at an AAGL conference in 2018 and the concept of potentially scarless surgery intrigued me to want to pursue it.

The vNOTES approach to surgery has distinct advantages in a wide range of situations where it is risky or unsuitable to enter the abdominal cavity. Risks may exist due to a patient's history of abdomino-pelvic surgeries or difficulties in positioning the patient in steep Trendelenburg. In addition, vNOTES can allow for specimen extraction enbloc without a laparotomy. This is particularly important with our current population who are generally more obese and have multiple co-morbidities. Recent limited outcomes of an RCT (n=70) demonstrates that the vNOTES approach is non-inferior to laparoscopic hysterectomy<sup>6</sup>.

I believe, the excellent training in multi-port laparoscopy and vaginal surgery during my AGES fellowship at Westmead Hospital was a solid foundation for me to pursue training in vNOTES surgery which combines the use of the endoscopic, single-site and vaginal principles for surgery

My goal was to safely perform vNOTES hysterectomy as it was not a technique that was available in NSW and only two other surgeons in Australia offered it at the time. As part of this journey, I attended a hands-on vNOTES workshop facilitated by the Asia-Pacific Association for Gynecologic Endoscopy (APAGE) society in Bangkok, Thailand. The highlight of this course was to be surgically taught and mentored in real-time by renowned vNOTES experts such as Professor Jenny Liu who pioneered the world's first report of vNOTES sacrocolpopexy and Professor Lee and Dr. Hsuan Su who pioneered the first case of vNOTES hysterectomy<sup>5,7</sup>.



I went on to subsequently be mentored and taught by Dr. Jan Baekelandt who is a leader in vNOTES approach to gynaecological surgery and conducts a course that is endorsed by the international Natural Orifice Transluminal Surgery Society (iNOTESs) in Imelda, Belgium. He pioneered the world's first total vNOTES and robotic-assisted vNOTES hysterectomy<sup>8,9</sup>. He has performed over 1000 cases, from a unit where the default approach to any benign gynaecological surgery is vNOTES (provided no contraindications to vNOTES exist).

Following this course, I purchased access to the vNOTES teaching app (available on Apple and Android) which contained 32 video tutorials. This offers an excellent theoretical foundation to build on the practical surgical experience. All these opportunities to learn from such a wide variety of surgeons from different units not only imparted me with vNOTES skills but overall improved my knowledge, and skills in laparoscopy and vaginal surgery.

Back in Australia, I went on to be remotely proctored by Dr. Jan Baekelandt and proceeded to successfully introduce vNOTES hysterectomy procedure as an option to the patients in my local health district. With the guidance and support of my surgical mentor, Dr. Jenny King (Urogynaecologist) we selected cases that were unsuitable for total VH and would have otherwise been performed as an LH.

Following the completion of ten proctored cases (minimum), I am awaiting formal certification as a vNOTES surgeon. Given the recency of this technique iNOTES recommends all cases to be added on to the growing prospective registry to monitor for complications which also aids in self audit and research.

The AGES travelling scholarship, enabled me to add vNOTES into my growing armamentarium of minimally invasive surgical options that we can now offer to the women that we care for. I have had the opportunity to pass this knowledge and skill to my peers and the next generation of doctors in training. I am currently collaborating with other surgeons across the world with respect to vNOTES research.

On reflection, one never stops learning especially as a consultant which makes up the bulk of our career. As Dr Atul Gawande points out, "no matter how well-trained people are, few people can sustain their best performance on their own". Having a coach or mentor and continuing to learn from one another are essential components to achieving surgical mastery.

I am grateful for the great foundation of surgical knowledge and skills that the AGES fellowship provided. I am very thankful for the networking and collegiality that exists within AGES and AAGL which allows us to connect and learn from one another. Lastly, the AGES travelling fellowship provided me with the ability to visit and learn from a variety of international surgeons and ultimately bring back a technique that we did not offer before.

To anyone reading this and thinking of applying for such a scholarship or pursuing a learning opportunity, I would like to encourage you to follow through and I hope it to be a career-changing experience for you as it was for me.



**Supuni Kapurubandara**

## REFERENCES

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

Amy Feng, Naman Dahiya & Basia Lowes

## **Intrauterine Instillation of Tranexamic Acid in Hysteroscopic Myomectomy: A Double-Blind, Placebo-Controlled, Parallel-group Randomised Clinical Trial.**

*Rasheedy R, Makled A, Abou-Gamrah A, Giuma H.*

*JMIG 2020 September; 27(6):1264-1272*

Tranexamic Acid (TXA) inhibits fibrinolysis by blocking the lysine binding site on plasminogen. Its topical administration has been shown to reduce bleeding and transfusion requirements.

The aim of this study was to evaluate the effect of intrauterine instillation of TXA during hysteroscopic myomectomy. The primary outcome was change in haemoglobin level 24 hours after surgery compared with preoperative values. Secondary outcomes were the surgeon's rating of the amount of bleeding, quality of operative view, duration of surgery, the volume of injected media, intraoperative complications, and myomectomy completion in 1 procedure. Intrauterine use of TXA is off label but not a contraindicated route as per the Food and Drug Administration.

Women with a single submucous myoma type 0 or 1, smaller than 4cm in largest diameter with a myometrial free margin of larger than 1cm, undergoing hysteroscopic myomectomy were recruited. Pregnant women, women with active pelvic infection, current or history of cervical or uterine cancer, uterine structural abnormality, bleeding diathesis, women with cardiopulmonary, thromboembolic, hepatic, or renal disease or women undergoing anticoagulant treatment were excluded from the study. A priori sample size calculation required 40 patients in each arm with a power of 80% at the 0.05 significance level and allowing for 15% attrition.

All participants had a pelvic examination, ultrasound and an office hysteroscopy. All myomectomies were scheduled in the proliferative phase and performed by a single experienced operator. A maximum fluid deficit of 1000mls was allowed. Women were randomized on 1:1 ratio allocation to receive either TXA 1g for every 1000ml of the distending medium (1.5% glycine), whereas in the control group, 10ml of 1.5% glycine was used.

80 women were randomized, with 40 in women in each group. There was no difference between the studied groups in terms of baseline characteristics. Postoperative mean haemoglobin values were significantly different between the groups (TXA =10.08 +/- 1.16g/L, placebo = 9.26 +/- 0.86g/L, p=0.001), however its clinical significance is likely minimal.

No statistically significant differences were found between the groups regarding volume of distension medium used and the distension medium deficit. The quality of hysteroscopic view was better in the TXA group compared to the placebo (p <0.001). The proportion of good visual field throughout the procedure was 60.5% in the treatment group and 20.5% in the control group (relative risk 2.95, 95% CI 1.51-5.76). The number needed to treat was 2 to obtain 1 case with a good view. Subjective excessive bleeding was reported in 23.1% of placebo cases and only 2.6% of the TXA group (relative risk 0.11, 95% CI 0.015-0.85). The number needed to treat was 5 to avoid 1 case of excessive bleeding. The median operative time did not differ between both groups (20.0 minutes), however the mean operative time was reduced (TXA group=19.36 +/- 6.2 mins, placebo 28.30 +/- 16.23 mins). In the TXA group, there was one incomplete myoma resection and one procedure abandoned due to equipment failure. In the placebo group, 1 case with incomplete myoma resection and 3 cases of uterine perforation, other complications were not reported.

**Conclusion:** Intrauterine instillation of TXA with the distension medium during hysteroscopic myomectomy resulted in a small but statistically significant lower decrease of postoperative haemoglobin concentration, subjective improvement in the visualization of the surgical field and subjectively reduced excessive bleeding when compared to placebo.





**Hysteroscopic evaluation of endometrial changes in breast cancer women with or without hormone therapies: results from a large multicentre cohort study**

*Chiofalo B, Mazzon I, Antonio S, Amadore D, Vizza E et al. JMIG 2020 May-June;27(4):832-839*

Breast cancer increases the risk of endometrial pathologies including polyps, fibroids, hyperplasia and cancers. Treatments for breast cancer include tamoxifen (TAM) and aromatase inhibitors (AIs). TAM tends to stimulate the endometrium, which can increase the risk of uterine pathologies. There is no clear consensus how to screen women receiving TAM treatment.

The primary aim of this study was to investigate the incidence of endometrial pathologies in women with breast cancer undergoing hysteroscopy. The secondary aim was to identify which ultrasound features could indicate that a hysteroscopy is required.

This multicentre retrospective study included women with a history of breast cancer who had undergone hysteroscopy for either ultrasound or clinical indications between 2007 to 2016. Ultrasound indications for hysteroscopy included: endometrium >7mm for patients treated with TAM or >4mm on either AI or no treatments, polyps, fibroids or suspected malignancies. Abnormal bleeding was the clinical indication for hysteroscopy. Patients were excluded if they had significant co-morbidities or were on any other kinds of treatment apart from TAM or AIs.

A total of 1129 patients over 4 centres were enrolled: 681 in the TAM group (56.8%), 132 in the AI group (11%), 386 in the no treatment (NTP) group (32.2%). Median age was 55 years and median endometrial thickness was 9.6mm (range 0-44mm). The majority of hysteroscopies were performed for ultrasound indications (89.7%), whilst only 10.3% were for abnormal bleeding.

Ultrasound indications included increased endometrial thickness (67%), polyps (19.8%), myomas (2.7%) and suspected endometrial malignancies (0.2%). The comparison between ultrasound indications and hysteroscopic findings showed a low concordance (21%). However, there was good concordance between hysteroscopic findings and histologic findings ( $p < 0.0001$ ). Histology diagnosed 32 women (2.1%) with endometrial malignancies.

TAM users were more likely to have a thickened endometrium on ultrasound (TAM 75.5%, AI 66.7%, NTP 52.1%,  $P < 0.0001$ ), whilst the NTP group were more likely to have polyps on ultrasound (TAM 13.2%, AI 19.7%, NTP 31.6%,  $P < 0.0001$ ). At hysteroscopy, AIs and TAM users were more likely to have normal endometrium (TAM 42.9%, AI 49.2%, NTP 29.5%,  $p < 0.0001$ ), and this was confirmed with histology (TAM 48.5%, AI 49.2%, NTP 35.2%,  $P < 0.0001$ ). Rates of endometrial hyperplasia on histology were slightly higher in the NTP group (TAM 2.3%, AI 0.8%, NTP 4.4%,  $p = 0.05$ ), whilst endometrial cancer was similar in all groups (TAM 2.2%, AI 3%, NTP 3.4%,  $p = 0.51$ ).

**Conclusion:** In women with breast cancer, this multi-centre retrospective study found that tamoxifen users were not at increased risk of endometrial cancer compared to women on aromatase inhibitors or no treatment. Ultrasound demonstrated low concordance level with hysteroscopic findings, however, there is yet to be a better screening tool in asymptomatic women.



**Prediction of Occult Uterine Sarcoma before Hysterectomy for Women with Leiomyoma or Abnormal Bleeding**

*Lentz SE, Tucker L, Lee C, Lazo IM, Niihara A, et al.*  
 JMIG May-June; 27(4): 930-937

Uterine sarcomas have similar clinical features to benign leiomyomata, making them difficult to reliably identify before hysterectomy. The identification of patients at higher risk for an occult uterine sarcoma would allow for tailored surgical preparation and counselling.

This study attempted to develop a risk prediction model for occult uterine sarcoma using preoperative clinical characteristics in women undergoing hysterectomy for uterine myoma or abnormal bleeding. It is a retrospective matched case-control study comparing women with occult uterine sarcoma (cases) and women undergoing hysterectomy for leiomyoma or abnormal uterine bleeding (controls). Patients were classified as occult uterine sarcomas and if the surgeon did not report clinical suspicion of malignancy in the preoperative clinical notes, the admitting history and physical exam, or the operative note. Controls were matched to cases based on age and race/ethnic group in a 2:1 ratio to increase statistical power.

Over the study period, 45 461 hysterectomies were performed in women with leiomyoma or abnormal bleeding; 273 uterine sarcomas were identified, of which 118 (43.2%) were classified as occult (one with missing data). The final matched case-control cohort consisted of 117 cases and 234 controls. From this study, women with occult sarcomas were more likely to have myomas (solitary myomas more association than multiple myomas), uterus >500g, >50% growth in myoma size, pain requiring opioids or hospitalisation, or requiring blood transfusions in the 3 months prior to surgery. Therefore, the final risk prediction model included age, race/ethnicity, body mass index, number of myomas, uterine weight, uterine size increase, degree of pelvic pain, and blood transfusion. For calculating predictive values, the population risk of occult sarcoma was 0.26%.

Risk levels of 0.5%, 1%, 1.5%, and 2% were selected as potential thresholds. Using the lowest risk threshold (0.5%), 60% of women with occult sarcoma and 12% of controls would be considered higher risk for occult sarcoma (sensitivity = 0.60, specificity = 0.88). The 2% threshold would capture 41% of women with occult sarcoma as higher risk and only 2% of controls (sensitivity = 0.41, specificity = 0.98). The theoretical PPV would be 1.3% at a 0.5% risk threshold with an NPV of 99.9%. The PPV would only increase to 4.84% using a 2% risk threshold with little loss in NPV at 99.8%. The positive predictive value of the model is thus low.

Using the risk threshold of 0.5%, of this model for a hypothetical population of 10,000 with a 0.26% population prevalence of occult sarcoma would narrow the number of women classified as high risk to 1213 and correctly identify 16 cases of occult sarcoma in this group. However, the model would potentially miss 10 of the 26 cases of occult sarcoma among the 8787 women who would be classified as low risk.

**Conclusion:** This large retrospective study of 45,461 hysterectomies identified several characteristics associated with occult sarcoma, however neither single characteristic nor the proposed model could provide sufficient predictive value. This is partly due to the low prevalence of sarcomas. This study highlights the difficulty of diagnosing uterine sarcomas and the need for novel diagnostic tools.

# ● Surgical training in the era of COVID-19

Vanessa Ross & Catarina Ang

The COVID-19 pandemic has completely changed our way of life. Consequently, it is not surprising that it has had such a significant impact on medical and surgical training across all disciplines and at all training levels <sup>(1-7)</sup>. The Australasian Gynaecological Endoscopy and Surgery (AGES) Accredited Training Program (AATP) is no exception. When reflecting on the overall impact of the COVID-19 pandemic on advanced surgical training, it is clear that there are multiple flow-on effects for AGES trainees. Whilst many of these effects would be perceived to have negative implications for training, it is important to highlight that there are still many things to be gained from experiencing a 'once-in-a-lifetime' global event such as this.

It is important to firstly acknowledge the substantial effect that the COVID-19 pandemic has had on all healthcare professionals. Such an unprecedented life event is bound to have a significant impact on a trainee's personal and professional life. This will take an inevitable toll on both mental health and physical wellbeing, which will have varying consequences for each individual <sup>(8)</sup>. Concerns about elderly or vulnerable family members is further compounded by the genuine fear and anxiety of attending the workplace itself. Each day, they take a risk. This risk is not just for the individual, many take a risk on behalf of their entire household. Some have relocated and choose to live away from their families to avoid this risk, only adding to their financial and mental burden. Others are unable to visit loved ones living interstate or overseas, whilst some have the added responsibility of home schooling their children. There is overwhelming uncertainty and a need to constantly adjust to new hospital guidelines, protocols and recommendations as the situation evolves day by day. There is also a feeling of unease as different workplaces offer inconsistent and conflicting advice about how healthcare professionals can protect themselves and their families. Unfortunately, some will personally experience the distress of being infected with COVID-19 themselves or have a loved one, friend or colleague unwell with this life-threatening illness.

The most obvious consequence for surgical training during the COVID-19 pandemic is the considerable reduction in 'hands-on' training opportunities within the hospitals. Elective operating has been drastically reduced to accommodate the needs of the community affected by this pandemic. It is imperative that hospitals have the resources and staff to care for patients infected

with COVID-19. As a result, only the most urgent surgical cases are making it to the operating theatre. Once inside the operating theatre, the priority is to minimise any potential for COVID-19 exposure to staff. It is therefore recommended that the most experienced surgeon on the team performs the surgery to reduce operating times, with teaching and training becoming a lower priority in these circumstances <sup>(9)</sup>. Some trainees have been 'redeployed' to support other critical services within the hospital or to cover for infected or furloughed colleagues. This has further reduced their opportunity for surgical training.

With caseload and exposure being reduced, an important consideration for current AGES trainees is the associated uncertainty of whether they will meet the training requirements of the AATP. Historically, surgical training has always relied on an apprenticeship model with an overarching principle of role modelling one's teachers. This concept was initially introduced by visionaries such as Sir William Halsted and is still very relevant to modern-day surgical training <sup>(10)</sup>. These principles promote a gradual increase in complexity and graded responsibility within the operating theatre <sup>(11)</sup>. AGES advanced surgical training is no different and relies on exposure to a diverse caseload incorporating increasingly challenging procedures. Unfortunately, most elective surgical procedures do not meet current triaging criteria as an urgent procedure and the diversity of cases is largely diluted. In addition, COVID-19 has resulted in the postponement of examinations, educational events and courses across all medical disciplines. Recruitment for research projects has been indefinitely postponed in an attempt to reduce all non-critical services and non-essential patient contact within hospitals. →

## ● Surgical training in the era of COVID-19 cont. Vanessa Ross & Catarina Ang

Consequently, the ability to participate in compulsory research activities or present research findings at annual conferences and meetings has also been compromised. Many current surgical trainees are directly affected by these changes and a number will be anxious about whether they will be able to complete their training within the original timeframe. Furthermore, many will be required to put their future career aspirations on hold in order to meet their training goals and requirements to complete the AATP.

It is impossible to predict the duration of the COVID-19 pandemic so it is imperative that we all adapt to this 'new normal', particularly with regard to alternative ways to maintain the delivery of healthcare services and to train future specialists. This is a dilemma that is not unique to surgical specialties but rather one that all medical schools and specialty colleges face both in Australia and internationally <sup>[1,2,12]</sup>. So how does the AGES community adapt and move forward to ensure that the integrity of surgical training remains intact? How can we maintain the learning curve? It is important to remember that surgical training is not solely accomplished by spending time in an operating theatre, but is in fact dependent on a multitude of training modalities encompassing theoretical knowledge, hands-on experience, educational seminars as well as skill-based workshops. At the core of all of this is the vital mentorship and support from senior colleagues and supervisors. To maintain momentum during COVID-19, it is widely recommended across all educational communities that formal education must continue and that progress through a program's curriculum should not be abandoned. However, social distancing requirements to 'flatten the curve' have inevitably disrupted standard practice with education delivery <sup>[13]</sup>. Therefore, the AGES community needs to re-imagine the possibilities for training and re-format the delivery of education to trainees.

We are fortunate that in recent years we have seen the development of new technologies and new ways of delivering education. Online and virtual platforms have become commonplace, allowing for educational collaboration between different institutions across the world. This has been an incredible tool in recent times, supporting ongoing education and encouraging

both individual and collaborative learning. Scientific meetings, workshops and seminars have been conducted successfully in recent months, some involving multinational collaboration. Scientific communities have reported that the ease and convenience of logging into an event from any location has encouraged a greater attendance at conferences compared to those requiring physical attendance in the past <sup>[14]</sup>. Whilst these formats are not without the odd technical issue, surgical trainees should be encouraged to navigate through these challenges to allow ongoing education at a time where local and international travel are restricted for an indefinite period. Remote learning with peers is also achievable allowing participation in journal clubs, didactic lectures and group learning activities that have been widely adopted across all medical and surgical disciplines <sup>[15]</sup>. The convenience of these formats and relative success so far suggests that this might become a routine platform offered as an educational tool in the future. It is likely that we will see 'hybrid' conferences and scientific meetings with the option to attend virtually or in person.

The move to online formats and connectivity is not only useful for educational opportunities outside the workplace, but has formed an important part of current clinical practice. The COVID-19 pandemic has encouraged substantial innovation in the field of healthcare delivery to the community. Medicare funding has adapted to allow for telehealth consultations and videoconferencing as an alternative to face-to-face assessments. This has completely changed the landscape of service provision across all medical disciplines. It is important to remember the aphorism 'A careful history will lead to the diagnosis 80% of the time' <sup>[16]</sup>. Therefore, despite a lack of face-to-face consultations, surgical trainees can continue to provide care for their patients via these new platforms and maintain a similar caseload and exposure that they would have had prior to the pandemic. Whilst there are still requirements for face-to-face assessments in particular circumstances, primarily for the clinical examination of the patient, it is evident that a significant proportion, if not all of the clinical assessment, can now be offered remotely <sup>[17, 18]</sup>. Consequently, the development of a trainee's clinical skills, knowledge and acumen can still continue whilst minimising potential exposure to COVID-19.



## ● Surgical training in the era of COVID-19 cont. Vanessa Ross & Catarina Ang

It is well recognised that surgical training thrives in an active-learning model that utilises a hands-on approach to master laparoscopic procedures<sup>[19]</sup>. However, recent years have already challenged this notion as the training bottleneck has resulted in less hands-on training opportunities and a need for alternative training solutions<sup>[20]</sup>. In the absence of the usual surgical volume seen prior to the pandemic, it is important to maintain surgical skills by alternative educational platforms outside of the operating theatre. Simulation provides an interactive platform for training that is known to enhance learning, challenge cognitive load and offer an element of surgical diversity. There are different types of simulators available including virtual reality and mechanical box trainers. Whilst not every centre will have access to virtual reality trainers, mechanical box trainers are readily available and there is no advantage seen when comparing one simulation system over the other<sup>[21,22]</sup>. Interestingly, simulation has not become a mainstay of surgical education despite its growing popularity in recent years. The utility of simulation training during the pandemic may also be challenged by social distancing requirements that limit options for direct supervision, however, it is possible to facilitate this remotely. Video-based surgical education and coaching is also an effective training method which could be utilised during this time<sup>[23]</sup>. It may be an ideal option for surplus hospital teams with cancelled surgical lists as it allows for reflection and feedback about previous cases. Similarly, training sites could consider live-streaming surgical procedures as a training tool for those with limited access to the operating theatre during the COVID-19 pandemic, particularly medical students and junior medical staff<sup>[24]</sup>.

Whilst technical skills are a crucial endeavour for all AGES trainees, well developed non-technical skills are an essential attribute of an accomplished AGES accredited surgeon. Experiencing a pandemic of this nature is an extraordinary event in history. As future leaders of our profession, trainees should be encouraged to take on leadership roles and to be involved in crisis management within their department. There are opportunities to participate in the hospital's pandemic response, protocol development as well as co-ordination of both junior and senior staff. Undoubtedly, these roles would require expert communication and interpersonal skills. Some trainees

may even have an interest in becoming involved in the COVID-19 response at an executive or government level. Such involvement would require teamwork, critical decision-making and professionalism. All fundamental skills a trainee should aim to embody both inside and outside of the operating theatre.

As the COVID-19 pandemic escalated in Australia, some surgical trainees have been redeployed to other departments to cover for infected or furloughed colleagues. Whilst these transitions may seem counterintuitive, particularly when they are in non-surgical roles, it is important to remember that experience outside of one's comfort zone encourages adaptation and resilience. It also helps to breakdown silos and tribalism which become completely superfluous as local and international communities unite to face the common enemy of COVID-19 together.

Across the world, we are all learning how to tackle this pandemic whilst simultaneously sustaining the workforce required to provide the necessary healthcare to the community. Training the future generation of surgeons is still a crucial part of this endeavour. We need to evolve, and we need to evolve rapidly. Experiencing a pandemic of this nature will create better surgeons with a breadth of experience and well established non-technical skills. Such experiences will undoubtedly inspire teamwork, courage, leadership and most importantly, comradery in the face of diversity. Qualities and experiences that are particularly desirable for the future leaders of our profession. However, the lack of hands-on surgical exposure is a source of anxiety amongst many surgical trainees. We must have a strategy for building on core competencies whilst still meeting clinical demand. We also need to be mindful of the wellbeing of trainees as they navigate the uncertainties of surgical training during a pandemic.

It is essential that we pursue a fundamental revolution in surgical teaching, the likes of which has not been seen since the era of Halsted and Osler at the turn of the last century. The pandemic represents a remarkable opportunity for innovation and for the re-invention of how surgical education is delivered. →

# Surgical training in the era of COVID-19 cont. **Vanessa Ross & Catarina Ang**

It should encourage the increased uptake of established educational approaches, such as simulation, and also embrace online and virtual platforms for education. Despite the challenges posed by COVID-19, it is important to remember that trainees still stand to learn a tremendous amount of skills that are crucial to being well-rounded, adaptable and resilient AGES surgeons.



**Vanessa Ross**  
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**Catarina Ang**  
AATP Unit Director

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# ● Surgical training in the era of COVID-19 cont. **Vanessa Ross & Catarina Ang**

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# ● When a patient is harmed

Ruanne Brell & Dr Ushma Narsai

## Gynaecological procedures and adverse outcomes

When we examined Avant's data on gynaecology or obstetrics & gynaecology compensation claims and complaints between July 2014 and June 2018, we identified that [one-third of the complaints and claims related to gynaecological procedures](#).

Nevertheless, a complaint relating to a gynaecological procedure does not necessarily indicate the doctor's care was below standard.

In two-thirds of the cases we analysed, when a medico-legal evaluation was conducted, the doctor's care was considered to have met the expected standard. However, the number of complaints does reflect the number of patients who believed they had a poorer outcome than they expected as a result of their treatment and serves as a reminder of the need for good procedures for responding to adverse events in healthcare.

## Responding to adverse events

The Medical Board of Australia's [Good medical practice: a code of conduct for doctors in Australia](#) outlines how practitioners are expected to respond if a patient is harmed.

The [National Safety and Quality Health Service Standards](#) set out a framework for responding to adverse events and recognise that harm arising from healthcare may be physical, social or psychological. This means that a patient may be harmed even though the incident was managed and they recovered.

## Communication with patient and family

The first priority once an adverse event is identified is to ensure the patient receives any necessary care and support. After this, it is important to provide an explanation to patients and/or their family as soon as possible.

In some cases, patient complaints after an adverse event are driven by a sense they have been left in the dark. Alternatively, they may feel that they have not been given a satisfactory explanation of what has occurred or what is

being done to address the issue. Conversely, an appropriate explanation and apology after an adverse event can help repair a healthcare relationship and help the patient feel that they have been heard and their concerns validated.

Patients are also often comforted if they are assured that the clinical team has learnt from the incident and processes have been adopted to reduce the chance of the adverse event occurring to others.

## The power of an apology

For an apology to be effective, the person receiving the apology needs to believe it is sincere.

The choice of words can make a real difference to whether or not an apology conveys genuine regret. Expressions such as 'I would apologise' or apologising 'for any inconvenience caused' can have the opposite effect such as making an apology seem crafted for political or legal effect. These expressions can also make an apology seem insincere.

Australia's national open disclosure framework provides [guidance](#) on communicating with patients and their families and supporters after a patient has experienced harm during healthcare. This recognises that being clear and direct (for example, using the words 'I am sorry' or 'we are sorry') is important.

## Does an apology lead to legal liability?

Doctors may be concerned that offering a direct apology could lead to legal liability. However, the [open disclosure framework](#) makes it clear that the apology is for what has happened to the patient. It is not necessarily about any personal error or failing on the part of healthcare professionals. Even if it is not yet clear how the harm occurred, it is still possible to offer a direct expression of regret such as 'I am sorry xxx happened to you' or 'I am sorry you had this experience'

In Australia, there is legislation that protects statements of apology or regret made after healthcare incidents from being used later in various legal contexts. →

# ● When a patient is harmed cont.

Ruanne Brell & Dr Ushma Narsai

When apologising you should not speculate about what happened or about responsibility or fault for the incident. However, you should feel comfortable expressing regret.

## Focus on the patient's experience

It is important the apology is about the patient's experience so be careful to keep the focus on the patient's experience and avoid anything that sounds like self-justification. The [open disclosure framework](#) offers examples of appropriate wording and expressions to avoid.

## Following up

It is important to follow up and the appropriate steps will depend on the situation. It may involve providing ongoing clinical care or handing this over to a colleague. Be clear about the next steps, so the patient knows the plan and how to get in contact and with whom if they have further questions. A patient's decision to take legal action or complain may result from feeling abandoned after an adverse event. It is also useful to communicate with them about any changes to practices or procedures because of the incident.

After the discussion, take care to make clear notes of any discussion and steps taken. These notes may form part of the clinical records or there may be notes that are not part of the clinical records but should be made separately, for example as a practice records or incident report.

### Ruanne Brell

Senior Solicitor – Medico Legal Advisory Service

### Dr Ushma Narsai

Senior Medical Adviser

## Further reading:

[Avant factsheet: Compensation claims and complaints insights: obstetrics and gynaecology](#)

[Avant factsheet: Open disclosure: how to say sorry](#)

[Avant video: Open disclosure: how to say sorry](#)

[Avant factsheet: Managing adverse clinical events](#)

[Avant guide: Dealing with adverse clinical events](#)

## ● 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 Focus Meeting 2021  
**MARCH 5-6 2021**  
Hybrid  
*Theme: Next Generation*



AGES Laparoscopic Anatomy Pelvic Dissection/  
Demonstration Workshops  
**2021 DATES**

April 17 LAP-Dissection **SOLD OUT!**  
April 18 LAP-Dissection  
July 18 Lap-Dissection  
August 28 LAP-Demonstration  
November 27 LAP-Dissection

Medical Engineering and Research Facility  
(MERF), Brisbane



AGES Annual Scientific Meeting 2021  
**JULY 15-17 2021**  
RACV Royal Pines Gold Coast  
*Theme: Leading the New Paradigm*

## ● AGES Membership 2021

AGES Membership renewal notices were issued late November 2020 for 2021.

For full membership information, please visit the [AGES website](http://www.ages.com.au)

## ● AGES Accredited Training Program

Applications for 2022/2023 positions for the AGES Accredited Training program opened the 1st November 2020.

For further information please visit the [AGES website](http://www.ages.com.au)

# 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.

**2021 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

**2021 Course Dates:** August 19-20.

### 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 2021 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.

**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)



## 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

**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 2021

**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

#### 2021 Course Dates:

to be advised

#### 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.

#### 2021

CARE Master Class in Laparoscopic  
Hysterectomy, Myomectomy & Adnexal Surgery:  
15-19 March  
(to be confirmed)

CARE Master Class in Laparoscopic Excision  
of Endometriosis & Hysterectomy Techniques:  
2-6 August  
(to be confirmed)

CARE Master Class in Laparoscopic  
Hysterectomy, Myomectomy & Adnexal Surgery:  
25-29 October  
(to be confirmed)

#### 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 75 coming out  
in February 2021

Contact Stephen Lyons ([stephen@drlyons.com.au](mailto:stephen@drlyons.com.au))  
with your contribution  
Deadline **22nd January 2021**