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

EDITION HIGHLIGHTS:

Innovation in
Gynaecology –
Use of PRP

Avant Article
– Managing
unprofessional
behaviours

Invitation
from National
Endometriosis
Clinical and
Scientific
Trials Network

JMIG Summaries

Partial Ureterolysis:
More than one way
to skin a ureter



TOGETHER TOWARDS TOMORROW

● President's Letter

“The New, New Normal”

Dear AGES Members,

As I write my second eScope President's Letter it seems appropriate to start off where I left off in my first President's letter ... *“I sincerely hope to see many of you, ideally in person, at the AGES ASM in July in sunny Queensland.”* Unfortunately, COVID-19 instead pulled a swifty or two and the AGES Board decided to postpone the ASM21, firstly to early September and subsequently to late October, in an attempt to provide the Membership with at least a hybrid face-to-face/hybrid meeting. With hindsight it seems a little crazy that a face-to-face ASM was considered a realistic option in 2021 (hindsight is a wonderful thing ... not!) and the ASM21 will now be fully virtual. To fully appreciate the circumstances, let's look back at the time of COVID-19 in Australasia. The first Australian case of COVID-19 was confirmed in Australia on January 25, 2020, and in New Zealand a month later on February 28. International borders were not closed yet, the subsequent spread of the virus seemingly slow but accelerated as more cases were diagnosed. Fast-forward to early March when the AGES ASM was held Sydney, to my knowledge, the last face-to-face scientific meeting to take place in Australia before the first lockdowns which soon followed. The *“new normal”* became limitation of societal freedoms, social distancing, handwashing and contact tracing, with the wearing of masks only when social distancing wasn't possible. The aim of the health policy was COVID-19 eradication, which could only be possible with the instituted international border closures with subsequent lockdowns in the event of further COVID-19 outbreaks. Despite the real fears of a “health care Armageddon” at the time, the COVID-19 strategy appeared to be sound for island nations and there was no apparent urgency from a political or healthcare perspective for widespread vaccination programs in Australasia.

It is now clear that the resultant lack of planning to ensure an adequate supply of COVID-19 vaccines was a grave error. This only became apparent, however, when it was appreciated that the COVID-19 strategy was fatally flawed by the inadequate quarantine arrangements for returning overseas travellers. However, lockdowns came and went and in between times we could visit restaurants and nightclubs and join crowds at festivals and theatres. Unfortunately, the “jig was finally up” with the arrival of the delta variant of COVID-19. The first confirmed Australian case of delta-COVID-19 was in May 2021, with prolonged lockdowns commencing firstly in NSW and then Victoria in July, and in New Zealand in August. As I complete this letter (October 10), NSW had 477 new cases yesterday (down from a peak of 1599 on September 10), Victoria had new 1890 cases (the peak of 1965 was the previous day) and New Zealand had 69 new cases (unfortunately the number appears to be increasing again). So, despite even the harshest lockdowns (including the addition of mandatory mask wearing), the increased transmissibility of the delta COVID-19 variant has heralded the *“new, new normal”* where the only way out of the cycle of COVID-19 outbreaks and lockdowns is [not too surprisingly] the prioritisation of the vaccination of the population. To date, NSW is the only state that has reached the “magic number” of 70% of the eligible population being double vaccinated – now “Freedom Day” beckons. Yes, tomorrow! Other Australian states and New Zealand are weeks-to-months away from this milestone, and the possibility of further outbreaks and lockdowns remains an ever-present spectre until then and possibly beyond. Fortunately, the other Australian states (apart from Victoria) are not currently in lockdown.

As October 10 is World Mental Health Day, it is appropriate to acknowledge that the COVID-19 pandemic has affected us, our families, and our colleagues and patients in ways we cannot yet begin to fully understand. The physical and psychosocial effects of a pandemic on the affected populations are often misunderstood or dismissed but may have severe effects on those afflicted.



● President's Letter cont.

For example, the effects on health workers during the shorter but deadlier SARS epidemic in Hong Kong in 2003, where the fatality rate of those infected was an extraordinary 17%, are well documented. The effects on first line carers in the SARS epidemic, however, are thought to have been less severe than the effects on COVID-19 health workers, probably due to the relatively short duration of the SARS epidemic (3 months), as well as the support and camaraderie amongst the SARS staff. Even so, a 10-year follow up of medical staff and SARS survivors showed about 1 in 10 had experienced years of post-traumatic stress disorder. Even populations of COVID-affected countries who have higher vaccination rates, lower case numbers and more freedoms than Australia and New Zealand are experiencing high levels of anxiety, depression and suicide. Not surprisingly, then, data from the Australian Bureau of Statistics has confirmed that at least 20% of Australian adults (higher in Victoria) are reporting high or very high levels of psychological distress due to the pandemic COVID-19 pandemic.

I think it's fair to say that the people of NSW are very much and justifiably looking forward to "Freedom Day" tomorrow. I also think the trepidation felt by many of the NSW population regarding the loosening of some restrictions for vaccinated people is very valid given that most of the population under age of 16 years remain unvaccinated. Consequently, the chance of increasing COVID-19 cases and COVID-related deaths is a real concern. To all of you during these difficult times of transition, especially to our Victorian and New Zealand colleagues, look after yourself and yours and please reach out to a friend or colleague if in need of help.

Anyway, getting back to the opening line of this letter ... in the meantime, I *still* sincerely hope to see many of you at the [AGES 2021 ASM](#) "*Leading the New Paradigm*", not in July or September (best-made plans, doh!) but in late October in sunny Queensland (virtually this time of course, damn you COVID-19!). Maybe we will be able to revert back to a "*better normal*" for the [AGES 2022 ASM](#) to be held next March in Melbourne and have the choice (dare to dream) of whether we meet face-to-face or virtually. Please understand that the AGES Board and the AGES Secretariat will continue to work extremely hard to bring you the quality education events that you have come to expect from your Society, but hopefully no more postponements. On another bright note, I'm looking forward to a haircut tomorrow!

Stay positive and test negative!



Stephen Lyons
AGES President



Editorial

Welcome to the 76th Edition of eScope.

This edition has taken a little longer than anticipated to produce. This seems to be a common feature of COVID life in 2021. Whether it is a home renovation (yes, I have been dealing with dust and drop sheets for too many months), or delayed surgeries, family visits and conferences. 2021 has proven to be a very challenging year for AGES and the membership.

We all hoped to meet in July on the Sunny Gold Coast, unfortunately the unpredictable nature of the Delta variant has made this impossible. In the [President's letter](#), Steve Lyons highlights some of the challenges the board have had to face, whilst still striving to provide quality education for the membership. Constant border closures and snap lockdowns have made face to face meetings impossible, leaving virtual meetings our only option for education. It's with great hope we enter 2022 as a vaccinated population and open travel borders, both local and international. I know I would be amongst many members with family overseas, desperate to see my family as well as the ability to finally reconnect with colleagues.

In this edition, the [Board Member Article](#) has been provided by Dr Fariba Behnia Willison. Many of our members would have heard Fariba talk passionately about the role of platelet-rich plasma (PRP) in gynaecology. This article summarises this innovative technique for treatment of various gynaecological conditions.

The [Fellow Article](#) written by Dr Tanushree Rao provides members with information on several approaches to performing ureterolysis. This article includes a link to a video presentation of a ureterolysis "in action".

A stable in the eScope for many years is the [JMIG summaries](#), once again provided by the SWAPS trainees Dr Lowes, Vanza and Dahiya. These summaries are invaluable for the time poor amongst us.

Once again our professional development alliance partner Avant have provided us with another [educational article](#). This time they have written a piece on managing unprofessional behaviour. This is a feature in 1:4 claims and should be of paramount importance to all our members.

So, what next for AGES and the membership? As a board, we continue to strive to provide quality education and representation. We will continue to deliver webinar and online education until we are able to meet face to face. As you are all aware the ASM 2021 is now being held virtually. This meeting will be an exciting and different ASM, with sessions suited to all our members. [Leading the new Paradigm](#) is being held from 28 to 30 October. I hope to see many of you online. We are also busy planning the ASM for March 2022 in Melbourne, "[Onwards & Upwards](#)". We are super excited to be going over to NZ for the Focus meeting in August. Dust off the skis and snowboards it's been a long while for many of us! The final meeting of the year will be the Pelvic Floor Symposium held over from 2021.

Until then we offer support to our friends and family interstate and overseas. We miss you all. We send you virtual hugs and well wishes until we can meet in person.



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● The Emerging Role of PRP in Gynaecology

Dr Fariba Behnia-Willison MBBS, MAST MIS, FRANZCOG

1. Platelet-Rich-Plasma Therapy

Platelet-Rich-Plasma (PRP) therapy is a non-invasive, non-hormonal method for tissue repair, healing, and regeneration. There are several ways of preparing PRP, the most common method consists of a two-step process, where a patient's blood is drawn and initially centrifuged to separate the red blood cells, which is followed by a second centrifugation step to concentrate the PRP [1, 2]. The PRP is the component of blood that is thought to promote tissue healing and regeneration as it contains important growth factors (GF), cytokines, chemokines, proteins, nutrients, minerals, and monocytes, all of which are known to play an important biological role in the process of wound healing [3-5].

The theory behind PRP, is that when applied to damaged tissue, it not only hydrates and nourishes the tissue with important minerals and vitamins, but following platelet activation, the release of various bioactive molecules contributes to cell migration, proliferation, differentiation, angiogenesis, removal of tissue debris, and regeneration of new healthy tissue [6]. The application of PRP has minimal risk and negligible side effects due to its autologous nature (i.e. immunological complications are mitigated as PRP is prepared from the patient's own blood) [7, 8].

PRP has been widely used in orthopaedics, dentistry, dermatology, and cosmetic surgery to facilitate tissue repair and regeneration, wound haemostasis, wound sealing, reduced scarring, augmentation of bone grafts, and treatment of tendonitis [5, 9, 10]. Increased epithelialisation has been demonstrated in both acute traumatic wounds and chronic diabetic wounds when treated with PRP [11]. PRP with or without microneedling has also been described as a new and promising modality for the treatment of atrophic acne scars [8, 12].

While the centrifugation method is the standard process for PRP preparation, new methods are being explored. For example, a study by Behnia-Willison et al. [64] investigated a new regenerative approach based on injection of PRP to treat 28 women with a histologic diagnosis of lichen sclerosis (LS) and were unresponsive to topical steroid therapy. The results were promising, such that a significant reduction in symptoms, atrophy and degree of sclerosis were observed.

2. Molecular Mechanism of Platelet-Rich-Plasma

In addition to supraphysiological platelet counts, PRP contains water, minerals, coagulation factors, GFs, chemokines, cytokines, and other plasma proteins. As outlined in Table 1, upon platelet activation, the release of numerous bioactive molecules is thought to facilitate wound homeostasis and healing, and tissue regeneration [13].

Table 1: The types of GFs present in PRP and their role in the process of tissue repair and regeneration [15].

GROWTH FACTOR	FUNCTION
Platelet-derived GF	Enhances collagen synthesis, bone cell proliferation, fibroblast chemotaxis and proliferative activity, and macrophage activation.
Transforming GF-β	Enhances synthesis of type I collagen, promotes angiogenesis, stimulates chemotaxis of immune cells, inhibits osteoclast formation and bone resorption.
Vascular endothelial GF	Stimulates angiogenesis, migration, and mitosis of endothelial cells, increases permeability of the vessels, stimulates chemotaxis of macrophages and neutrophils.
Epidermal GF	Stimulates cellular proliferation, differentiation of epithelial cells, promotes cytokine secretion by mesenchymal and epithelial cells.
Hepatocyte GF	Angiogenesis stimulator
Fibroblast GF	Promotes proliferation of mesenchymal cells, chondrocytes, and osteoblasts, stimulates the growth and differentiation of chondrocytes and osteoblasts.
Insulin-like GF-1	Promotes cell growth, differentiation, recruitment in bone, blood vessel, skin, and other tissues, stimulates collagen synthesis together with platelet-derived GF.



● The Emerging Role of PRP in Gynaecology cont. Dr Fariba Behnia-Willison

On a molecular level, the GFs stimulate healing by attracting stem cells in the new formed fibrin matrix, which triggers tissue repair and regeneration. The GFs also suppress the cytokine response, which limits inflammation. The recruitment of macrophages promotes tissue healing through phagocytosis of old cells, which are replaced with a population of new cells, that give rise to new and healthy epithelial tissue. PRP also contains a small quantity of leucocytes, which have an antimicrobial role in the tissue regenerative process [14]. Another mechanism of action of PRP is through its effect on fibroblast cells. Studies have shown PRP increases the proliferation, migration and colony formation of tissue fibroblast cells and thus can potentially repair scars [13].

In recent years, PRP has been the focus of many different research projects, each generating their own set of promising results. Given that the protocols for PRP preparation often vary widely between these studies, and are not well documented, it makes it very difficult to compare results across different studies. To establish a simple method for organising and comparing the results in the literature, the PAW classification system was developed. PAW is based on three main components: (1) the absolute number of platelets, (2) the mode of platelet activation, and (3) the presence or absence of white blood cells. By analysing these three components, publications on PRP can be compared with a reasonable degree of accuracy [15, 16].

3. Applications of PRP Therapy in Gynaecology

Recently, PRP therapy has been used to treat skin conditions, chronic wounds, scars, burns, and alopecia areata [13, 17]. In regard to soft tissue defects, since PRP contains antibacterial and anti-inflammatory compounds, it also plays an important role in diminishing edema, ecchymosis, and infection [10, 18].

The repair and restorative effects of PRP on bones, tendons, cartilage, muscles, and skin has led to its use in orthopedic and plastic surgery [19-21]. PRP has also been investigated as a means to treat osteoarthritis [19, 20].

In gynaecology, there is a notable focus towards the use of PRP to treat gynaecological conditions, by facilitating vaginal repair, regeneration, and rejuvenation. Conventional vaginal reconstructive surgery has been performed over many decades. PRP therapy has the potential to serve as a non-surgical method and/or as an adjuvant treatment for pre-, intra-, and post-operative management for various debilitating pelvic floor disorders (PFD) [21-23]. Various studies have also demonstrated that PRP therapy can improve sexual dysfunction by reducing vaginal dryness, atrophy, and laxity [24-26].

The successful application of PRP to treat other gynaecological conditions and disorders has also been reported and include cervical ectopy [27], vulvar dystrophy [28], reconstructive surgery for vulvar cancer [27, 28], urogenital disorders [29], as well as treatment of the endometrium and ovary to improve fertility [30, 31].

In conclusion, PRP has been confirmed to be a promising, innovative, non-hormonal, non-invasive and effective therapeutic modality that can be adopted easily with minimal risk of side effects such as bleeding, complications, infections, or nerve damage. With PRP presenting significant potential to revolutionise the way in which we treat people, it is important that we continue to conduct further research to understand the therapeutic benefits of this regenerative medicine. Future research must focus on conducting large-scale randomised controlled trials to appropriately establish the safety and efficacy of this therapy, such that it can be accepted as standard practice to provide first-line treatment for conditions not just within gynaecology, but across many fields of medicine. →



Dr Fariba Behnia-Willison
AGES Director

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● The Emerging Role of PRP in Gynaecology cont. Dr Fariba Behnia-Willison

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● Partial Ureterolysis: More than one way to skin a ureter and why you need to know it

Dr Tanushree Rao

In gynaecology, ureteric injuries occur at a rate of 0.02 percent to 0.78 percent.¹ This means we need to be cognisant of how to isolate it so that we may safely undertake our day-to-day surgeries. With increasing number of diagnostic laparoscopies done for pelvic pain to diagnose endometriosis we often encounter a suspicious patch of peritoneum overlying the ureter. Excising rather than ablating the peritoneum may potentially provide the histological evidence of endometriosis that we seek, without which there is a risk of endometriosis being over/underestimated. Even when ablation of the peritoneum overlying the ureter is performed, considerable caution must be exercised to avoid lateral thermal spread and damage to the underlying ureter. In addition, a Cochrane evaluation of the best way of treating endometriosis found that compared to diagnostic laparoscopy alone, laparoscopic surgery improved live birth and pregnancy rates.² They also found that excisional surgery enhanced spontaneous conception rates in the nine to twelve months following surgery when compared to ablative surgery in terms of infertility, although they did not specifically analyse peritoneal endometriosis. A. M. Dückelmann et al studied the effect of laparoscopic peritoneal stripping in symptomatic early-stage endometriosis and found that more than three-quarters of women reported pain relief post-surgery³. In order to be able to perform excision of peritoneal endometriosis safely, one must be familiar with ureterolysis, which is currently classified as an AGES/RANZCOG skill level 6. It is also important to understand that on occasion, partial ureterolysis rather than complete ureterolysis may be required. Additionally, we would need to isolate or be aware of the ureter's course in other scenarios, such as deep infiltrating endometriosis, oophorectomy, securing the uterine artery, residual ovaries, large size fibroids extending into broad ligament, and suturing the vault during hysterectomy, to name a few.

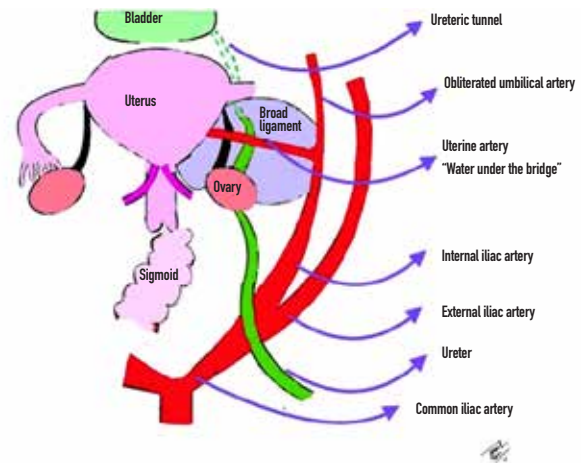


Figure 1 Ureteric course in the pelvis

This article intends to improve awareness about ureteric identification by demonstrating four easy steps for partially isolating the ureter. The medial approach, also known as the endometriosis approach, and the lateral method, also known as the Gynae oncology approach, are the two main approaches used to achieve this. To view a video demonstration of the procedure kindly click on the link over [here](#).

Medial approach/Okabayashi's space:

- 1) Transperitoneally, identify the ureter away from the area of pathology and draw the peritoneum overlying it medially. This can be done by locating a tubular structure on the lateral wall between the IP ligament and the uterosacral and gently nudge it to see if it makes peristaltic movements. Because the adventitia of the ureter is attached to the overlying peritoneum, stretching it in the opposite direction and grabbing only a tiny section of the peritoneum with no underlying structures in the grasped fold would improve the procedure's safety. In some cases, such as endometriosis, the peritoneum becomes thickened, and in those instances, the peritoneum should be grasped away from/above the area of pathology where it is normal.



● Partial Ureterolysis: More than one way to skin a ureter and why you need to know it cont.

Dr Tanushree Rao

- 2) Create the champagne effect by making a small incision in the peritoneum and enabling the pneumoperitoneum to flow in. This can be accomplished using a variety of energy sources, including monopolar scissors/ spatula, advanced bipolar (LigaSure™, harmonic, THUNDERBEAT), plasma energy, laser etc.
 - 3) Once the opening is established, stretch both ends of the peritoneum and put your device beneath the overlying peritoneum to create a tunnelling effect. To open the areolar tissue beneath the peritoneum, a push and spread method with dissecting forceps can be used, followed by cutting the overlying peritoneum. Alternatively, the peritoneum overlying the ureter can be cut with an energy device such as a monopolar spatula/scissors or harmonic after stretching the peritoneum between two forceps, and the ureter can then be peeled off its attachments either with sharp dissection or blunt dissection with a suction cannula. If there is bleeding, diathermy can be used to stop it. This is crucial because it avoids tissue staining. The goal is to pull the ureter away from its peritoneal attachments by exerting traction to the peritoneum at a 90-degree angle to the pelvic side wall. You can lateralize the ureter in situations of endometriosis excision or medialize it in situations of uterine artery ligation at the origin, based on the surgical intervention required.
 - 4) Depending on the amount of exposure needed, incise the peritoneum longitudinally. To achieve safe peritoneal endometriosis excision, uterosacral excision of severe endometriosis, or radical hysterectomy, you may need to extend it all the way down to the Wertheim ureteric tunnel.
- 2) Extend the incision cranially along the length of the IP ligament until it meets the external iliac vessels. When ureter identification is difficult, adequate peritoneum extension allows easy access to the ureter and should be performed. The round ligament can also be cut to aid this and increase space.
 - 3) The ureter can then be identified by its peristaltic movements, which is frequently attached to the peritoneum's medial leaf below the IP ligament at or below the level of the external iliac vessels. If the ureter cannot be identified, it must be traced higher up near the pelvic brim. Layer-by-layer dissection of the alveolar tissue aids in locating the ureter and avoiding injury to underlying vital structures. Anecdotally, the right side has been easier to identify than the left.
 - 4) Depending on the goal of the surgery, the ureter can then be medialised or lateralised from its attachment by hooking the ureter with the tip of scissors or blunt dissection with a suction cannula or dissecting forceps using the open and spread technique.

It can be difficult to identify vital structures when there is retroperitoneal fibrosis due to endometriosis, malignancy, or past procedures. As a result, familiarising oneself with the preceding strategies may be beneficial in navigating the pelvis. Stenting the ureters prior to surgery could potentially be beneficial, especially if retroperitoneal fibrosis is suspected. Externally tugging on ureteric catheters allows one to witness the catheter's motions in the pelvis and so be guided to the location of the ureters, along with tactile feedback of a rigid tubular structure due to indwelling stents in laparoscopy. Newer procedures, such as retrograde injection of indocyanine green (ICG) dye through ureteral stents and lighted/ infrared imaging system stents, are available on the market to increase visualisation of the ureter. To provide and detect near-infrared fluorescence, they would require the existence of a suitable light source and camera head. Pedro et al. investigated the efficacy and safety of lighted stents and discovered that even after 3 hours of surgery, there was no evidence of thermal injury to the urothelium or any significant changes in the ureteral mucosa.⁴

Lateral approach/Latzko's space

- 1) Locate the pelvic triangle, which is defined by the infundibulopelvic (IP) ligament medially, the round ligament anteriorly, and the external iliac artery/psoas muscle impression laterally. This can be aided by reorienting the uterus to the opposite side. Congenital sigmoid adhesions may also require division along the white line of Toldt, particularly on the left side. Incise the peritoneum parallel to the IP ligament.



● Partial Ureterolysis: More than one way to skin a ureter and why you need to know it cont.

Dr Tanushree Rao

Owing to the complexity associated with retrograde injection of dyes, newer dyes with fluorescence are being investigated that can be administered intravenously, have increased renal clearance, and thus be available in large quantities in the urinary tract system. Additionally, there is a risk of ascending pyelonephritis with these stents, and thus routine preoperative urine microscopy screening for infections is recommended. Preoperative prediction of ureterolysis has also been investigated using ovarian mobility as a predictor.⁵

As a result, ureterolysis is an important tool to have in your repertoire to maintain patient safety. Partial ureterolysis should not be a skill set reserved for advanced laparoscopic surgeons; generalists should be encouraged to become proficient in this procedure as well. Incorporating it into the AGES/RANZCOG skill level, possibly as a level 3, would help it become a more recognisable skillset. Workshops, lap simulators and cadaveric dissections could be arranged to enhance awareness and familiarise gynaecologists with the process.



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AGES Trainee

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I'd like to express my gratitude to my mentors, Drs. Timothy Chang, Derek Lok, Shannon Reid, Neera Lambert and Cherynne Johansson, for their guidance. The surgical footage provided above also includes contributions from Dr. Timothy Chang and Dr. Derek Lok.

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- 5 Reid S, Condous G. Can transvaginal ultrasound be used to predict the need for ureterolysis in women undergoing laparoscopy for suspected endometriosis? *Australasian Journal of Ultrasound in Medicine.* 2019;22(4):231-233. doi: <https://doi.org/10.1002/ajum.12186>



● Partial Ureterolysis: More than one way to skin a ureter and why you need to know it cont.

Dr Tanushree Rao

Medial approach

STEP 1

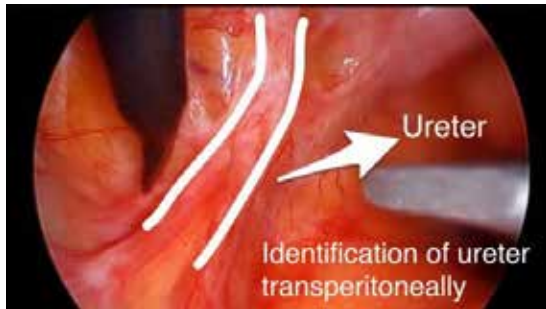


Figure 2 Transperitoneal identification of ureter

STEP 2

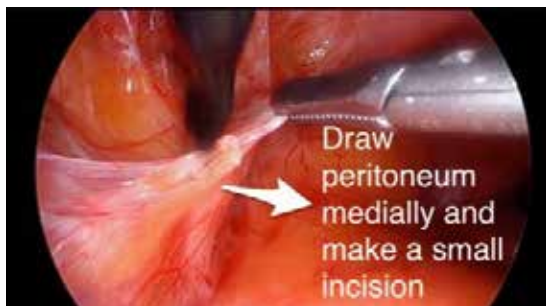


Figure 3 Draw peritoneum medially and make a small incision

STEP 3

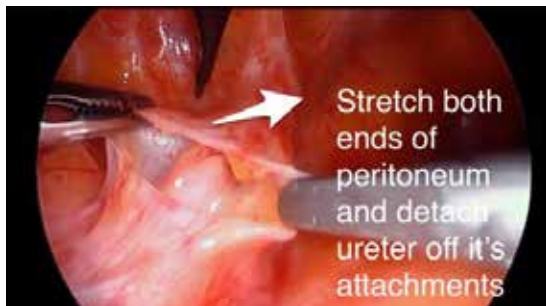


Figure 4 Stretch both ends of peritoneum and detach ureter off its attachment

STEP 4

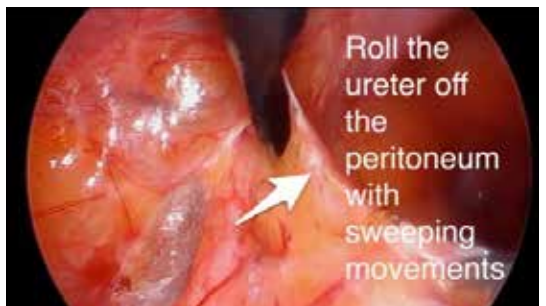


Figure 5 Roll the ureter off the peritoneum with sweeping movements

Lateral approach

STEP 1

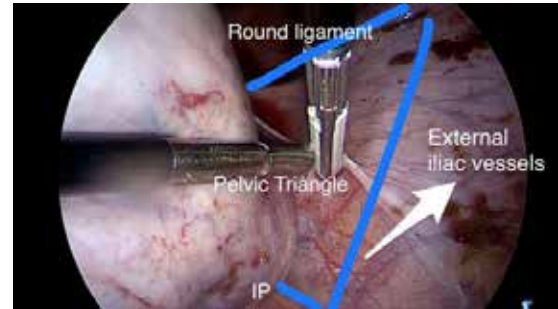


Figure 6 Identification of pelvic triangle

STEP 2



Figure 7 Incise peritoneum overlying the pelvic triangle

STEP 3

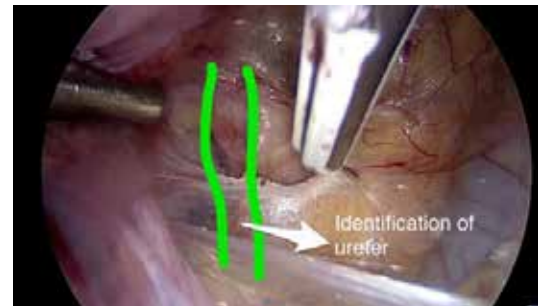


Figure 8 Identification of ureter

STEP 4

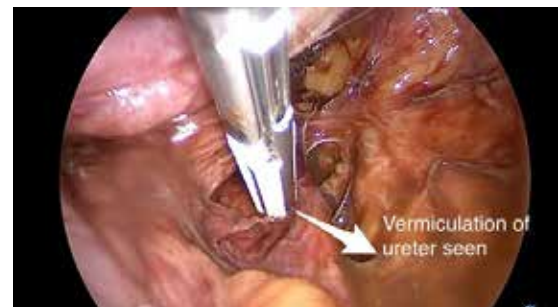


Figure 9 Vermiculation of ureter seen

AGES XXXI ANNUAL SCIENTIFIC MEETING 2021

'Leading the new Paradigm'

28TH - 30TH OCTOBER 2021



VIRTUAL MEETING

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THURSDAY 28TH OCTOBER 2021 - VIRTUAL MEETING DAY ONE

AEDT	PLEASE NOTE THAT ALL TIMINGS ARE LISTED IN AEDT
1800 - 2020	SESSION ONE: CHANGE OF CLIMATE IN WOMEN'S HEALTH <i>Chairs: Stephen Lyons & Michael Wynn-Williams</i>
	Introduction and Welcome to Country
	Doctors for the environment: Climate change - I don't see the problem? - Arnagretta Hunter
	RANZCOG position statement - Impact of the bush fires - Kristine Barnden
	Fertility and climate change - Manny Mangat
	The millennials' timebomb - Nadia Willison
	How to make your practice carbon neutral - Rob Burrell
	The war on medical waste - Craig Reucassel
	Panel Discussion
2020	CLOSE OF DAY ONE
AEDT	

FRIDAY 29TH OCTOBER 2021 - VIRTUAL MEETING DAY TWO

AEDT	PLEASE NOTE THAT ALL TIMINGS ARE LISTED IN AEDT		
0930 - 1110	SESSION TWO: SURGERY AND SURGICAL EDUCATION - ARE YOU READY FOR THE CHANGES AHEAD? <i>Chairs: TBC</i>		
	Leading surgical change through coaching - Caprice Greenberg		
	Changing the culture of surgery - Justin Dimick		
	Leading change through the use of social media - Amy Park		
	Engagement through education - Stephen Lyons		
	Panel Discussion		
1110 - 1125	MORNING TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		
1125 - 1325	SESSION THREE: SURGERY UNCUT: TECHNIQUES, ANAESTHESIA AND ERGONOMICS <i>Chairs: TBC</i>		
1325 - 1355	LUNCH, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		
1355 - 1515	SESSION FOUR A: FREE COMMUNICATIONS <i>Chairs: TBC</i>	SESSION FOUR B: FREE COMMUNICATIONS <i>Chairs: TBC</i>	SESSION FOUR C: VIDEO COMMUNICATIONS <i>Chairs: TBC</i>
	Modified UBESS and CA125 endometriosis severity prediction model - Preliminary Results - Brindaa Tharmarajah	The use of the Myometrial-Cervical Ratio in the Ultrasound Diagnosis of Adenomyosis – a Validation Study. - Tristan McCaughey	Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): Standardising rectal shaving for bowel endometriosis - Assem Kalantan
	Can transvaginal ultrasound predict the need for laparoscopic ureterolysis in women with suspected endometriosis? - Brindaa Tharmarajah	Central Sensitization in Persistent Pelvic Pain: A Cohort Study - Amelia Ryan	The vanishing fibroid: MyoSure hysteroscopic resection at lower pressure for a 'vanishing' submucous fibroid - Madison A Naidu
	Building a prediction model for ureterolysis in laparoscopic endometriosis surgery: the CLINUS model - José Vitor Zanardi	The Tubo-Ovarian Abscess Study(TOAST) - Anna-Marie Van Der Merwe	Combined robotic-assisted laparoscopic-hysteroscopic isthmoplasty using Firefly® near-infra red technology: a novel approach - Felix Chan
	Can we predict the revised American Fertility Society (r-AFS) stage using the pre-operative transvaginal Ultrasound-Based Endometriosis Staging System (UBESS) in women with suspected endometriosis? A retrospective observational study - Tanushree Rao	Correlation of the Ultrasound-Based Endometriosis Staging System (UBESS) for the prediction of RANZCOG/AGES levels 1 – 6 of surgical complexity - A retrospective validation study - Myriam Girgis	Carving out a niche: principles of laparoscopic Caesarean scar defect repair, as demonstrated by a video compilation of a case series - Jason N Mak
	Association between the localisation of endometriosis and 1-year postoperative digestive complaints: a 1,497 women comparative study - Shamitha Kathurusinghe	Outcomes following segmental rectal resection with vascular preservation in colorectal endometriosis - Naman Dahiya	Laparoscopic Excision of an Accessory Cavitated Uterine Malformation (ACUM) - Marcus Davenport

	Oocyte-secreted serum biomarkers GDF9 and BMP15 in women with endometriosis - Aiat Shamsa	The learning curve for the ultrasound detection of uterosacral ligaments and torus uterinus deep endometriosis: A repeatability and reproducibility study - Rodrigo Manieri Rocha	Laparoscopic Resection of Diaphragmatic Endometriosis in Left Lateral Decubitus Position - Albert Jung
	Getting square pegs out through round holes: A survey of RANZCOG Fellows regarding specimen extraction - Alison Bryant-Smith	Findings and outcomes in a post-vaccination cohort of young women under 25 years attending a tertiary colposcopy service - Cheryl Yim	Disc excision of deep endometriosis infiltrating the rectum - Dasuni Pathiraja
	Are we 'Gritty' enough? The importance of 'Grit' in O&G training - Association of passion and perseverance with burnout, thriving and career progression - Tarana Lucky	The significance of the ovarian sliding sign in relation to the Ultrasound-Based Endometriosis Staging System (UBESS) for surgical complexity - Myriam Girgis	Laparoscopic myomectomy for beginners: a video-based guide of suggested tips and tricks - Kate Tyson
	Instituting vNOTES hysterectomy: An alternative pathway to credentialing in the COVID era - Kate Martin	A potential role for the Ghrelin / LEAP-2 axis in Endometriosis - Russell Duncan	Laparoscopic Para-aortic Lymphadenectomy in a patient with Duplicated Inferior Vena Cava with Suspected Stage II Endometrioid Adenocarcinoma - Alexander Chen
		Evaluating pre-treatment β -hCG ratio in expectant and medical management of tubal ectopic pregnancy - Jason N Mak	

1515 - 1530 AFTERNOON TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS

1530 - 1645 **SESSION FIVE: CHANGE MAKERS IN O&G - HOW TO DRIVE SUCCESSFUL CLINICAL INITIATIVES**

Chairs: Bassem Gerges & Kirsten Connan

Gynaecological malignancy in the Pacific Islands - **Ai Ling Tan**

Health disparities amongst Maori & Pasifika Women in NZ - **Phil Suisted**

Migrant & refugee healthcare for women in Australia - **Jacqueline Boyle**

Indigenous Issues - **Marilyn Clarke**

Head & Heart: The Art of Modern Leadership - Dr **Kirstin Ferguson**

1645 CLOSE OF DAY TWO

AEDT

SATURDAY 30TH OCTOBER 2021 - VIRTUAL MEETING DAY THREE

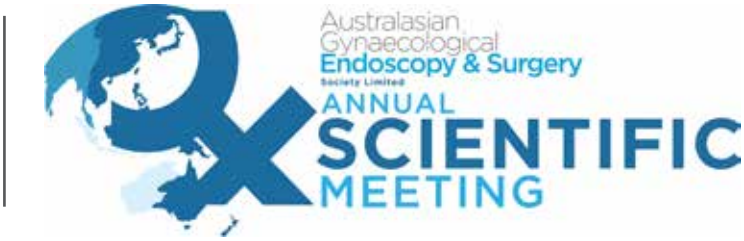
AEDT	PLEASE NOTE THAT ALL TIMINGS ARE LISTED IN AEDT		
1000 - 1045	SESSION SIX <i>Chairs: Jade Acton & Stephen Lyons</i> Tough times don't last. Resilient leaders do - Heidi Dening		
1030 - 1150	SESSION SEVEN: LEADING CHANGE IN DOCTORS' WELLBEING <i>Chairs: George Condous & Kirsten Connan</i> Leading a hospital wide wellbeing program for staff - Joanna Sinclair Professional resources for doctors' wellbeing - Vijay Roach Indemnity resources for doctors' wellbeing - Tracy Pickett Dan O'Connor Lecture - Hilary Joyce		
1150 - 1205	MORNING TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		
1205 - 1405	SESSION EIGHT A: ENDOMETRIOSIS AROUND THE WORLD: PROGRESS AND WORK FOR THE FUTURE <i>Chairs: TBC</i>	SESSION EIGHT B: PECHA KUCHA - TOPICAL UPDATES AND CHANGES FOR THE GENERALIST <i>Chairs: TBC</i>	SESSION EIGHT C: CHAIRMAN'S CHOICE -FREE COMMUNICATIONS <i>Chairs: TBC</i>
	New Australian endometriosis guidelines: A snapshot of the changes - Jason Abbott	The role of tubal surgery in the era of assisted reproductive technology - Devini Ameuratanga	Superior Hypogastric Plexus Nerve Block in Minimally Invasive Gynecology: a Randomised Controlled Trial - Praveen De Silva
		Management of fibroids - Amy Arnold	Effect of vasopressin hydrodissection in laparoscopic excision of endometrioma on ovarian reserve: study protocol for a randomised control trial and preliminary results - Dave R Listijono
	Time for change in the UK - Rapid diagnosis by 2030 - Lucky Saraswat	Hysteroscopic advances and surgical considerations - Yasmin Pilgrim	POMMS: Pre-Operative Misoprostol in Myomectomy Surgery - A Pilot Study - Lima Wetherell
		Evidence based laparoscopy - Bridget Gilsean	Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): A case series of 9 patients - Assem Kalantan
	Coordinating the future of NZ public endometriosis services - Michael Wynn-Williams	Pelvic pain and a negative laparoscopy - Matt Smith	The impact of surgery on the sexual function of women with deep infiltrating endometriosis: a prospective cohort study - Lauren Hicks
		Optimising laparoscopic recovery for the pain patient - Thea Bowler	Urinary Function after Surgery for Deep Infiltrating Endometriosis: A Prospective Study - Keryn Harlow
		Novel therapeutics for vestibulodynia/vaginismus - Sean Holland	Training for and undertaking gynaecological surgery in Australia: A comprehensive analysis of AIHW and MBS data - Lalla McCormack

	What can we learn from endometriosis management in North America? - Sony Singh	Ethnic variation in endometriosis - Albert Jung	Self and Body Compassion in Endometriosis: The predictive nature of endometriosis-related symptom presence and distress - Leesa Van Niekerk
		Uterine Niche: is it a problem? - Kellie Tathem	Vinorelbine as a treatment for stable ectopic pregnancy: An early phase clinical study - Prathima Chowdary
	COVID, lock downs and self-management strategies for endometriosis consumers - Catarina Ang	The role of pelvic floor ultrasound in evaluating patients with pelvic floor dysfunction - Vivien Wong	Anatomical distribution of deep endometriosis on transvaginal ultrasound and clinical features: implications on non-invasive diagnosis - Rodrigo Manieri Rocha
		Risk reduction for patients with inheritable genetic conditions - Emma Allanson	The impact of age and parity on regret and relief following hysterectomy for benign disease - Helen MacNamara
	Panel Discussion	Update on endometrial hyperplasia - Louise White	One of these things is not like the other: video-based discussion of intra-operative findings of unexpected leiomyosarcoma at laparoscopic 'myomectomy'. - Alison Bryant-Smith
		The Impact of Surgical Complications- the second victims - Rachel Collings	Laparoscopic excision of a pregnant, non-communicating rudimentary horn- the case of the super sperm - Keryn Harlow
		The silver lining of COVID for regional/rural practitioners - Elizabeth Jackson	
1405 - 1435	LUNCH, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		
1435 - 1605	SESSION NINE: ARE WE THERE YET? THE FUTURE OF MEDICAL TECHNOLOGY		
	<i>Chairs: Michael Wynn-Williams & Emma Readman</i>		
	"5G caused COVID" - Why would my specialist use it? - Barry O'Reilly		
	Digital healthcare - Nic Woods		
	Preparing our trainees for the future of surgery - Donna Ghosh		
	How can I innovate and develop future surgical equipment? - Prathima Chowdary		
	How to build your own surgical robot - Mark Slack		
	Panel Discussion		
1605	CLOSE OF CONFERENCE		
AEDT			

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



MARCH 2022
10-12
Crown Promenade,
Melbourne



Onwards and Upwards

We look forward to the year 2022 with cautious optimism that the spectre of COVID-19 will be increasingly diminished from our day-to-day lives. Hopefully, this will be our time to reunite, reconnect and re-establish the impetus within us to march onwards and upwards towards enriching gynaecological care for the women of Australasia.

The AGES 2022 ASM theme “Onwards and Upwards” is very apt in the current climate, focusing on our determination and resilience to progress forward despite the complex challenges brought upon all of us over the last 2 years by COVID-19. AGES will continue to move onwards in the provision of ongoing education to our members on “core” surgical topics of relevance to trainees, generalist consultants, and advanced laparoscopists alike. As a dynamic society, we move upwards as we push past the boundaries with presentations on new developments and advanced surgical themes to equip you with the motivation, tools, and skills to aim for an accelerated post-pandemic recovery. As always, the AGES 2022 ASM will offer the best of live surgery, core-learning sessions, surgical videos, and panel discussions presented by outstanding international and local guest speakers.

We cannot think of a better place to host the AGES 2022 ASM than Melbourne, given the severe impact of COVID-19 on this proud city. Melbourne has withstood and conquered multiple COVID-19 outbreaks, despite the profound challenges, by harnessing the strength and courage within its own community. We anticipate that this ASM will also be an opportunity for us to reunite and rejoice in a post-COVID vaccination setting whilst learning from each other to work towards a united, inclusive and stronger AGES community.

The AGES board and local organising committee are delighted to invite you to the AGES 2022 ASM, ‘Onwards and Upwards’. For so many reasons, this will be an AGES ASM like no other!



Stephen Lyons
Conference Chair
AGES Director



Shamitha Kathurusinghe
Scientific Co-chair



Haider Najjar
Scientific Co-chair

Onwards & Upwards

Hybrid Meeting

9 - 12 March 2022

Crown Promenade Melbourne

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

Dr Basia Lowes, Dr Kiran Vanza and Dr Naman Dahiya

Meta-analysis of Laparoscopic Single-site (LESS) and Vaginal Natural Orifice Transluminal Endoscopic (vNOTES) Hysterectomy Compared with Multiport Hysterectomy (MPL): Real Benefits or Diminishing Returns?

Chad M. Michener, MD, Erika Lampert, MD, Meng Yao, MS, Mary Pat Harnegie, MS, Julia Chalif, MD, and Laura M. Chambers, DO.

This recent meta-analysis evaluated the intraoperative and perioperative outcomes and success rates of laparoendoscopic single-site surgery (LESS) and vaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy in comparison with those of conventional multiport laparoscopic (MPL) hysterectomy.

LESS vs MPL Hysterectomy

This arm included 8 randomised-control trials, 4 prospective studies and 14 retrospective studies. It compared a total of 1950 women undergoing LESS hysterectomy with 2343 women undergoing MPL hysterectomy. Patient demographics were similar in both groups. The most common primary indication for surgery was uterine leiomyoma.

The mean operative time was shorter in MPL compared to the LESS group. Estimated blood loss was slightly lower in the LESS group than in the MPL group (not statistically significant). MPL trended towards higher pooled odds of conversion compared with LESS (not statistically significant). There was a low overall rate of intraoperative complications in all studies with no significant difference in rates of overall complications including to, ureter, bladder or bowel injury. MPL was associated with a significantly longer length of stay (LOS) compared with the LESS group. Pain scores at 48 hours were better for the LESS group compared to the MPL group. There was no significant difference in post-operative morbidity between the LESS and MPL groups.

vNOTES vs MPL Hysterectomy

This arm included significantly less evidence, with one randomised-control trial and 2 retrospective studies, comparing 222 women undergoing vNOTES hysterectomy with 520 women undergoing MPL hysterectomy.

Patient demographics were well balanced the RCT. Wang et al noted a significant difference in uterine weight which was significantly less in the vNOTES cohort.

The included RCT and one cohort study demonstrated shorter operative time and LOS in the vNOTES hysterectomy group compared to the MPL group. The RCT demonstrated no differences in conversion rate between the two groups. Both retrospective cohort studies reported no difference in intraoperative complication rates for vNOTES compared with LAVH. The RCT demonstrated a lower composite infection rate with vNOTES hysterectomy, but no difference in the groups when comparing surgical site infection or readmission. Wang et al demonstrated a higher rate of post-operative complications in women undergoing LAVH with uterine weight > 500g than for those undergoing vNOTES hysterectomy. vNOTES hysterectomy had decreased EBL for all uterine weights ($p < .001$) and decreased blood transfusions for patients with uteri > 500g ($p < .001$). There was also decreased total analgesic usage in the first 7 post-operative days in patients who underwent vNOTES.

In conclusion, the take home points from the meta-analysis are:

- » The risk of conversion to laparotomy is comparatively low across all three approaches;
- » LESS was associated with lower pain score at 48 hours compared with MPL;
- » The largest RCT in this meta-analysis showed no cosmetic benefit of LESS over MPL;
- » vNOTES is associated with comparable or improved outcomes for operative time and LOS without an increased risk of intraoperative complications compared with MPL hysterectomy. There is also decreased post-operative analgesia requirements with vNOTES.



**Short- and Long-Term Complications of Intraoperative Benign Ovarian Cyst Spillage:
A Systematic Review and Meta-analysis**

Eisenberg N, Volodarsky-Perel A, Brochu I, Catherine T, Gorak E, Hudon , Fortin S, Kogan L, Rivard C

As laparoscopic surgeons we frequently worry about the potential of intra-operative cyst spillage. We take great care to excise cysts intact and employ methods of minimally invasive cyst extraction, such laparoscopic bag systems. So, what is the true magnitude of risk to the patient when intra-operative benign cyst spillage has occurred? Although, we are aware that the release of malignant cells in misdiagnosed malignant ovarian cysts may lead to malignant cell dissemination, however this was beyond the scope of this study.

The aim of this study was to review short and long-term complications associated with intraoperative rupture of benign ovarian cysts. It examined randomized controlled and observational studies evaluating the operative outcomes of surgical treatment of ovarian cysts with intraoperative spillage compared with those of surgical treatment of ovarian cysts without spillage. Inadvertent cyst capsule rupture during laparoscopic surgery, leading to intra-abdominal spillage of its content, was reported to occur in 6% to 27% of cases.

A total of 28 studies were included in the qualitative analysis and 12 in the quantitative analysis. The number of cases in the included studies varied between 12 and 314 patients. Interestingly, increased ovarian cyst diameter was not found to be associated with increased risk for spillage (relative risk [RR] 0.75; 95% confidence interval [CI], -0.33 to 1.82).

Based on this study, intraoperative benign ovarian cyst rupture was not associated with adverse short and long-term outcomes such as reoperation (RR 1.16; 95% CI, 0.39–3.48), infertility (RR 0.73; 95% CI, 0.15–3.63), transient fever (RR 3.22; 95% CI, 0.83–12.51), and readmission (RR 1.00; 95% CI, 0.33–2.98). However, intraoperative spillage was found to be associated with increased risk for benign recurrence (RR 3.1; 95% CI, 1.05–9.14).

Chemical peritonitis is a very rare event with only 6 documented occurrences in 3 studies. A meta-analysis including these 3 studies did not show a significant difference in the incidence of chemical peritonitis between the spillage and no-spillage groups (RR 2.72; 95% CI, 0.26–28.90). However, a subgroup analysis of the studies that included only dermoid cysts showed an association between intraoperative cyst rupture and postoperative chemical peritonitis (RR 9.36; 95% CI, 1.20–73.28).

In conclusion, the results of this systematic review suggest that intraoperative ovarian cyst spillage of a benign cyst is associated with limited adverse clinical outcomes. The authors also suggest that, although the surgical approach (laparoscopic vs open) should not be impacted by the concern regarding risk of intraoperative cyst rupture, maximal efforts should be made to prevent intra-abdominal spillage.



Optimal Isthmocele Management: Hysteroscopic, Laparoscopic or Combination

Roy Mashiach and Yechiel Z. Burke

Journal of Minimally Invasive Gynaecology. 2021 March. 28 (3). 565 – 574

The precipitous rise in caesarean section rates have led to the emerging problem of an isthmocele, also known as caesarean scar defect, niche or diverticulum. An isthmocele is a pouch-like defect that occurs in the anterior wall of the uterine isthmus, secondary to previous caesarean section. It may be asymptomatic in many, however can lead to menstrual disturbances, secondary infertility and if pregnancy ensues, ectopic pregnancy and uterine rupture. Medical and hormonal treatment is reserved for patients who do not wish to get pregnant. Surgical treatment is by laparoscopic or vaginal and hysteroscopic techniques to remodel to defect to relieve symptoms. The consensus is to define an isthmocele as an indentation with a depth of more than 2mm at the site of a caesarean scar.

A systematic review of all prospective and retrospective studies for more than ten women were included from the past twenty years. 31 articles met the inclusion criteria (21 for hysteroscopic resection and 13 for laparoscopic or combination repair). Hysteroscopic approach is usually carried out by performing a triangular resection of the defect and this approach is thought to eliminate symptoms more effectively than only distal correction however Chang et al showed that the distal edge alone can also be resected which reduces the incidence of bladder injury and has similar outcomes. The base of the defect may be a source of non-menstrual bleeding and necessitates ablation and no difference was found comparing using a rollerball or loop resectoscope to perform this. Laparoscopic repair is advocated in patients with residual myometrial thickness of less than 2.5mm and/or for those desiring future pregnancies and this aims to not only remodel the defect but to repair it.

Hysteroscopic remodeling is associated with an improved outcome in abnormal bleeding patterns with 59.6% to 100% of patents becoming asymptomatic or showing a reduction in abnormal bleeding after hysteroscopic resection. Laparoscopy was shown to give similar results with 64.1% to 100% of patients being asymptomatic after repair and no significant difference was noted with single- or double-layer closure of the defect. After hysteroscopic

resection, pregnancy rates up to 46% to 90% were reported with, with a 90% delivery rate. Laparoscopic repair reported to have pregnancy rates of 37.5% to 90% with similar delivery rates.

Pain and dysmoerrhoea are less commonly reported and small studies (less than 10 women) showed up to 80% improvement with hysteroscopic remodeling and up to 66% improvement with laparoscopic repair. No prediction data retarding uterine rupture is available however a residual myometrial thickness of more than 3.65mm is associated with a lower likelihood of rupture. There seemed to be a significantly increased residual myometrial thickness post laparoscopic repair (1.6mm to 9.8mm) compared to hysteroscopic repair (4.67mm to 5.68mm).

Conclusion: Hysteroscopic remodeling is a valid option for improvement of abnormal uterine bleeding, pain and secondary infertility in patients with residual myometrial thickness more than 2 to 3mm. It is expert opinion that laparoscopic repair be performed with myometrial thickness less than 2.5mm, however no significant difference between hysteroscopic and laparoscopic treatment was shown.



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The National Endometriosis Clinical and Scientific Trials (NECST) Network: What is it and how AGES members can help.

Background

The National Endometriosis Clinical and Scientific Trials (NECST) Network is an Australian MRFF funded initiative to establish a research network, harmonise data collection and collation for endometriosis researchers across the country.

The NECST Registry is cloud-based and can only be accessed by authorised users with individual logins. Therefore, login can occur anywhere with internet access. There is a modular approach to the data collection in the NECST Registry. This allows for different medical pathways to be considered and data collected on each. This may be medical management alone, surgical management alone or medical and surgical management as a combination.

The modules of the NECST Registry are designed so that there is a patient interface that they can complete either before their consultation if they have been identified as a person with possible endometriosis, or after the consultation.

The Patient data and baseline questionnaires (that the patient enters and completes) include:

- 1) Consent and demographics
- 2) Clinical presentation and medical history
- 3) Patient reported outcome measures (PROMs)
 - i) EQ-5D (validated general health quality of life tool)
 - ii) Endometriosis health profile (EHP)-30 (validated endometriosis quality of life tool)

Once the data is entered by the patient, the NECST Registry will automatically undertake the follow-up assessments of patient related symptoms and PROMs.

The second component are the Clinical data that the clinician/clinical team enter onto the registry.

These modules include:

- 4) Clinical presentation diagnosis – Clinician
- 5) Imaging (ultrasound and/or MRI)
- 6) Medical management
- 7) Surgical management
- 8) Histopathology

Follow up visits and any changes to the management plan for the patient do require an update within the NECST Registry. However, this is quite easy and only takes a few minutes.

The consent process:

There is a 2-step consent process to activate a participants' record on the registry. The NECST Registry is ethics approved, which means that in the majority of cases, only Site Specific Assessments (SSAs) are required for clinical sites prior to starting recruitment and data entry. Each principal investigator and their clinical team who contribute data onto the NECST Registry will have ownership of their data. All members of the clinical team in a public hospital setting (with a Registry log in) will have access to the participant records for continuity of care as they would for their clinical data. For private patients, only the managing clinician will be able to access the data. The NECST Registry is hosted and maintained by the VCS Foundation Pty Ltd (VCSF), who also manage colposcopy data and are well versed in data management, security and the women's health care sector. The NECST Registry privacy and security policies align with and are overseen by VCSF for these reasons.



● The National Endometriosis Clinical and Scientific Trials (NECST) Network: What is it and how AGES members can help. cont

Support us and we can support you

The NECST Registry is collecting longitudinal health data to research endometriosis and adenomyosis initiatives in alignment with the National Action Plan on Endometriosis (NAPE). As part of this, the NECST Network is looking to support and provide AGES Members, Training Fellows and training sites with research funding and research projects to assist with participant recruitment and data entry into the NECST Registry.

How to take part, what is involved and required of me?

We want you to identify, invite, and consent eligible people who have or may not have endometriosis or adenomyosis. We will provide you with a business card containing a QR code for the quick link to the NECST landing page to make things easier for the patient. They can then complete the patient questionnaire. When the participant has completed their consent and information package, a record will be generated in the NECST Registry in 'inactive' mode. This allows you to confirm their participation in the registry and then you can make their record 'active' (Figure 1) and enter the clinical data and management plan.

The clinical data we want you to enter on participants include the following information:

- » Clinical presentation diagnosis – Clinician (mandatory) (Figure 2)
- » Imaging (US and/or MRI) (where relevant)
- » Medical management (where relevant)
- » Surgical management (where relevant)
- » Histopathology (where relevant, but mandatory if surgery is performed).

The longitudinal aspect of the NECST Registry are the automatic follow up questionnaires for participants. These are sent by the Registry at 6 months, 12 months and then annually. These questionnaires will ask participants if there have been any changes to their symptoms or any new treatments. You won't have to do anything for these automatic follow ups to occur.

Figure 1: Example of a patient's consent tab, confirming their consent and making their record "active" in the NECST Registry.

Figure 2: Example of the Clinical Presentation Diagnosis – Clinician (Clin Pres Dx – Clinician) episode. One of the mandatory clinical data modules we want you to enter health data on the participant in the NECST Registry.



● The National Endometriosis Clinical and Scientific Trials (NECST) Network: What is it and how AGES members can help. cont

What is the funding research support that will be provided?

We know that research is time consuming and does cost. We can support these costs for recruitment and data entry as well as support for stepping you (and/or your team) through the process. Funding is incremental and based on recruitment numbers. For every 25 participants recruited with completed datasets*, you will receive \$6250. The more participants you recruit, the more funding you will receive. The maximum pool of research funding available is \$250,000. The funding is available on a first-come-first-served basis and once this amount is exhausted, no further funding will be provided (and we will let you know that at the time).

*Completed datasets are defined as

1. Participants having completed their online baseline questionnaires
 - i) Consent and demographics,
 - ii) Clinical presentation and medical history
 - iii) PROMs (EQ-5D and/or EHP-30)

2. Clinical data entered on the participant
 - i) Clinical presentation diagnosis – Clinician and one or more of the following modules based on the care plan for the participant
 - ii) Imaging (ultrasound and/or MRI)
 - iii) Medical management (and medical therapy(ies) prescribed)
 - iv) Surgical management and associated Histopathology report uploaded.

More information

To register your participation or for further information or any questions, please contact the NECST Network's Clinical Trials Network Manager (Dr Cecilia Ng) at cecilia.ng@jeanhailes.org.au

● Can we talk about unprofessional behaviours?

Katinka Moran, Eunice Ku

Unprofessional behaviour by doctors when interacting with patients was alleged in one in four claims, according to Avant's recent analysis.*

Recently, we took a detailed look at claims across all specialities that specifically related to the issue of professionalism in doctor-patient interactions. Our data* shows that perceived lack of professionalism in the interaction between doctor and patient was raised as an issue in 1 claim in 4.

In some instances, unprofessional behaviour was the main issue in a claim. However more commonly, in just over two thirds of these claims, patients raised professionalism issues in addition to concerns about another issue such as the treatment, surgery or diagnosis.

So why do we analyse claims involving unprofessional behaviour?

One consequence of a perceived lack of respect is that patients may be more likely to complain. [1] [2] Multiple studies also suggest an association between reports of doctors' rude or unprofessional behaviour and an increased risk of surgical or medical complications in their patients. [3] [4]

As noted in our 'Compensation claims and complaints insights: obstetrics and gynaecology' published in *AGES scope* in June 2020, this is something O&G practitioners need to be aware of. Practitioner behaviours, such as communication issues, was raised as a concern in 18% of the claims involving [Avant's O&G members](#).

Perceived disrespect increases the likelihood of a complaint

Doctors are expected to be courteous, respectful, compassionate, and honest in their treatment of patients.[5] Patients who feel they have not been shown this level of respect may complain about the doctor's conduct.

In the claims we analysed, disrespect was the behaviour patients most commonly raised as a concern. Disrespect here was defined as the patient believing the doctor had shown a lack of respect or consideration in a range of areas:

- » values
- » preferences
- » autonomy
- » expressed needs
- » comfort
- » quality of life.

Academic studies confirm the patterns we found in our data – there is a link between rude or unprofessional behaviour and the likelihood of a medico-legal complaint. [1] [2]

When we receive a claim, a medico-legal evaluation is undertaken to assess the care provided. Claims of unprofessional behaviour can be difficult for regulators or medico-legal experts to evaluate, and often become debates about what exactly occurred. In our analysis, only 6% of allegations of disrespect could be substantiated. Nevertheless, in many cases, the doctor has gone through an extended complaints process, which is often both time consuming and stressful.

Ineffective communication and unmet expectations

When the issue centred on a failure to communicate effectively, such as making irrelevant comments or not communicating in an understandable way, the doctor's conduct was much more likely to be assessed as below the expected standard (22%).

While ineffective communication and disrespect were common focal points in these claims, they don't always occur in isolation. A doctor's perceived rudeness may lead to a breakdown in communication. For example, if the patient feels too intimidated to ask all the questions they want to, they may not fully understand the risks of a procedure or what outcomes they can expect.

"I asked Dr Y how long he thought the operation would take. He said, 'Look, your wife will die without this procedure. If you want to ask questions instead of allowing me to do my job, I can just go home and not do it.'" [3]

● Can we talk about unprofessional behaviours? cont.

Katinka Moran, Eunice Ku

Increased likelihood of complaint about other issues

Around two-thirds of claims involving a concern about unprofessional interactions with patients were primarily focused on another issue such as the treatment, surgery or diagnosis.

As we've mentioned above, academic studies confirm the link between rude or unprofessional behaviour and the likelihood of a medico-legal complaint. [1] [2] The hypothesis is that a poor relationship between the patient and doctor means a patient is more likely to complain if they experience an unexpected outcome.

Support in bad days and trying times

Even at the best of times, anyone may have an off day, or something they say may be misinterpreted. But the studies suggest that persistently rude and disrespectful behaviour increases risk for both doctors and patients.

Our sample mostly predates the period of the COVID-19 pandemic. At a time when doctors and patients may both be under considerable pressure, misunderstandings or miscommunications may be more common. In this context, it is even more important to be aware of your and your colleagues' stress levels and moods.

Research suggests that one important way to address problems in doctor-patient interactions is intervention by colleagues. Proponents of the 'Vanderbilt method' of graduated interventions – checking in with colleagues whose behaviour seems concerning, say there is evidence this can be very effective. It can encourage doctors to recognise and moderate their behaviour, or to seek help. [6] [7]

For doctors, being able to demonstrate professionalism, consideration and respect may reduce the risk of complaints. Finally and most importantly, it may improve patient outcomes.

WOULD YOU LIKE TO FIND OUT MORE?

Avant infographic: Professionalism in doctor-patient interactions: www.avant.org.au/Resources/Public/Professionalism-in-doctor-patient-interactions

Avant infographic: Disrespect toward patients: www.avant.org.au/Resources/Public/Disrespect-toward-patients

Avant infographic: Compensation claims and complaints – obstetrics & gynaecology: www.avant.org.au/WorkArea/DownloadAsset.aspx?id=23622328358

Avant podcast: Issues of patient consent. A conversation with Georgie Haysom and Dr Ian Incoll: www.avant.org.au/Resources/Public/Podcast--Issues-of-patient-consent--A-conversation-with-Georgie-Haysom-and-Ian-Incoll/

For articles, factsheets, case studies and other resources on a range of topics, including the following, visit the [Avant Learning Centre](#).

*Avant's report is based on analysis of the underlying themes in 3,089 claims for indemnity, including complaints to regulators and compensation claims for Avant member doctors from all specialties. These were finalised between July 2019 and June 2020.

ABOUT THE AUTHORS

Katinka Moran is a Research and Evaluation Manager and Eunice Ku is the Claims Coding Analytics Manager in the Advocacy, Education and Research team at Avant.



Katinka Moran

Research and Evaluation Manager
Advocacy, Education and Research
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Eunice Ku

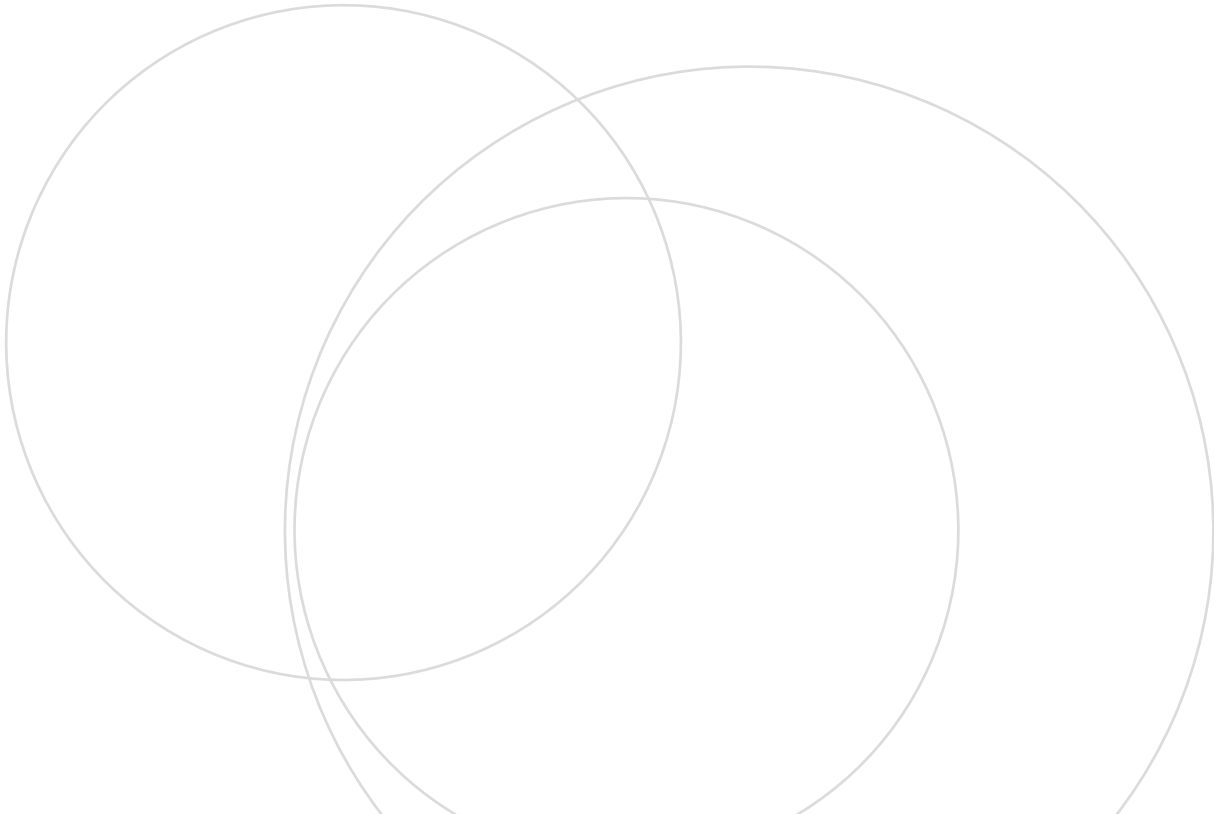
Claims Coding Analytics Manager
Advocacy, Education and Research
Avant

● Can we talk about unprofessional behaviours? cont.

Katinka Moran, Eunice Ku

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- 3 Cooper WO, Guillaumondegui O, Hines OJ, et al. Use of unsolicited patient observations to identify surgeons with increased risk for postoperative complications. *JAMA Surg.* 2017;152(6):522-529.
- 4 Catron TF, Guillaumondegui OD, Karrass J, et al. Patient complaints and adverse surgical outcomes. *Am J Med Qual.* 2016;31(5):415-422.
- 5 Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia, October 2020. Available at <https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx>
- 6 Australian Health Practitioner Regulation Agency. Taking care podcast. Dr Gerald Hickson on patient safety and high-risk practitioners. Available at <https://www.ahpra.gov.au/Publications/Podcasts.aspx>
- 7 Avant Mutual. Interview with Dr Gerald Hickson. 2013. Available at <https://www.avant.org.au/Resources/Public/20131001-interview-with-dr-gerald-hickson/>



● Membership, Awards and Scholarships committee

The Membership, Awards and Scholarships committee is one of the more longstanding committees in the AGES portfolio.

Its primary focus is on all things to do with the AGES membership. We want to make sure that all AGES members have a part in this dynamic society, and to that end we organise membership surveys to assess the composition and needs of the membership, generate ideas as to how to improve the membership numbers and oversee membership drives.

We also oversee the running of awards and prizes at conferences, including developing guidelines for the proper assessment of the awards/ prizes, making the final decision as to who is the recipient of awards/prizes, and the handing out of the awards/prizes at the relevant conferences.

One of the more important tasks of the membership committee is to consider local and international scholarships, and to develop pathways for people to attend AGES from overseas, and AGES members to travel overseas via traveling scholarships.

We were the proud instigators of the AGES Global scholarship, which invites gynaecologists from around the globe from developing economies to apply to come to AGES ASM, and we will fund the flights, accommodation, and registration for the 2 successful candidates. It's wonderful to watch 2 nervous Mongolians present a snapshot of their gynaecological practice in free communications, sharing their scholarship in a rigorous international community.

We have also watched the membership grow exponentially over the last 5 years, largely in response to the excellent calibre of the meetings, and the efficiency and professionalism of YRD, the secretariat of AGES.

The committee comprises George Condous, Helen Green, Bassem Gerges and Kate Martin, with the chair Emma Readman.

● Save the date

Please note that many event details are changing due to COVID-19.
Please visit www.ages.com.au for the latest information.



AGES Hologic Webinar
OCTOBER 20 2021
*Hysteroscopic Surgery:
an Australian and UK Perspective*



AGES Annual Scientific Meeting 2022
MARCH 10-12 2022
Crown Promenade, Melbourne
Theme - AGES: Onwards & Upwards



AGES Focus Meeting 2022
AUGUST 11-12 2022
Millenium Queenstown, New Zealand



AGES Pelvic Floor Symposium 2022
NOVEMBER 4-5 2022
Adelaide Convention Centre, Adelaide



● AGES Membership 2022

AGES Membership renewal notices will be issued late November 2021 for 2022.

For full membership information, please visit the [AGES website](#)

● AGES Accredited Training Program

Applications for the 2023/2024 position for the AGES Accredited Training Program will open on the 1st November 2021.

For further information please visit the AGES website at www.ages.com.au/training

● AGES Annual Scientific Meeting 2022 Abstract Submissions

AGES is now accepting applications for oral, video and digital poster presentations to be presented at the AGES XXXII Annual Scientific Meeting in March 2022.

The meeting will be held at the Crown Promenade Melbourne from the 10th – 12th March 2022

Please visit the [AGES website](#) for further information. Applications close: 11:59PM AEST, Friday 26th November 2021

Join us on the AGES social media sites ...



Facebook:

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LinkedIn:

linkedin.com/company/ages---australasian-gynaecological-endoscopy-and-surgery-society-limited



Instagram:

[@ages_society
instagram.com/ages_society](https://instagram.com/ages_society)

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.

2022 Course Dates: on application.

Details

www.covidien.com/pace/clinical-education/event/250875

FLINDERS PRIVATE ENDOGYNAECOLOGY MASTERING LAPAROSCOPIC SUTURING XXII FLINDERS PRIVATE HOSPITAL ADELAIDE

2022 Course Dates: on application.

Course Directors: Assoc. Prof. Robert O'Shea
Assoc. Prof. Elvis Seman

For information contact:

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

SWEC ADVANCED GYNAECOLOGIC LAPAROSCOPIC COURSES FOR 2022 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.

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

Register on-line at www.swec.com.au
or contact our course administrator
at: sweconline@gmail.com or
Assoc Prof Greg Cario, SWEC Director
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

2022 Course Dates: on application.

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

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 2022

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

2022 Course Dates:

to be advised

Course fees:

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

For further information contact:

Nicole Stamatopoulos: nic96@hotmail.com

Website: 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.

2022 Course Dates:

on application.

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
Web: www.sydneycare.com.au for registration forms



Volume 77 coming out
in December 2021

Contact Rachel Green (secretariat@ages.com.au)
with your contribution

Deadline **8th November 2021**