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escope

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

EDITION HIGHLIGHTS:

Laparoscopic
hysterectomy
and vaginal cuff
dehiscence

At a glance –
JMIG summaries

Medtronic Article –
Visual D&C in early
detection of rare
adenosarcoma

Pelvic floor
meeting invitation

2022 AGES
clinical research
grant recipients



TOGETHER TOWARDS TOMORROW

● President's Letter

We're "only as good as the next variant" as our pandemic becomes endemic

Dear Members,

I sincerely hope your festive season was happy and safe, despite the special guest appearance of the Omicron Christmas Grinch, and that you managed to have some quality time with family and friends.

A [somewhat] interesting factoid... those of our members who were born in 1970 arrived into this world 52 years after the outbreak of the Spanish Flu outbreak (1918), and their 52nd birthdays will take place during the COVID-19 pandemic. What does this mean? Nothing really, I guess, although it is a salient reminder that the most devastating known viral pandemics, Spanish Flu and COVID-19, have occurred in the last 100 years. It also should not be forgotten that the following viral diseases originated in the intervening years: Zika virus (1947), Ebola virus (1976), Hendra virus (1994), SARS (2003), Swine flu (H1N1; 2009), MERS (also a coronavirus; 2012).

Not so quickly forgotten was the Spanish Flu (named because nations under media blackout during the first world war could only read of this new viral disease in reports sourced from Spain – the actual place of origin of the disease is still debated but it was not Spain!), which is thought to have killed 25-50 million people. A chance favourable mutation resulted in a less virulent virus that persists as the seasonal influenza that returns as a different strain yearly.

The 21st of January 2022 marked the second anniversary of COVID-19 in Australia which has now persisted twice as long as the Spanish Flu, the road to recovery dashed in turn by the Delta and Omicron variants. The number of deaths caused by COVID-19 is currently thought to be about 5.1 million, much less than the Spanish Flu. However, in September 2021, the number of deaths caused by COVID-19 in the United States surpassed the number of deaths caused by the Spanish Flu – a salient reminder for world governments that COVID-19 may not "go away" and that a virus should never be expected to act as they may want it to. Australia also learnt this lesson with the marking of "Freedom Day" in NSW last December where virtually all COVID-19 restrictions (except in health care facilities) were eased. A much more infectious but less virulent Omicron strain rapidly spread through the populations of successive Australian states, eventually even breaching the barricade of the Western Australia border. With the massive spike in overall case numbers, the number of deaths has also increased significantly. As tragic as this is, Australia will open its international borders later this month as we are begin to "live with the virus".

To live (relatively normally) with COVID-19 in Australia will involve a transition from an epidemic to an endemic disease. As vaccination rates continue to climb and infections continue to spread through the population (and people get vaxxed & boosted), the prevalence of the virus should decrease, limiting its ability to spread. Together with sensible strategies such as mask wearing, hand hygiene and social distancing, hopefully COVID-19 transmission will become more predictable, perhaps returning seasonally like the common cold and influenza, also endemic diseases.

Unfortunately, but inevitably, the population of New Zealand has now also been exposed to the Omicron variant. Things are looking up, however, with the announcement by Prime Minister Jacinda Ardern that long lockdowns are no longer indicated and that New Zealand nationals will be allowed to return home later this month (with self managed isolation).



● President's Letter cont.

Sequential opening of the borders to eligible travellers from other countries will follow. Most importantly, it is anticipated that Australian travellers will be able to enter New Zealand by July, by which time the quarantine period may no longer be necessary.

There is no doubt that the organisation of face-to-face AGES meetings in the time of COVID-19 has been a challenge, more often than not, impossible. With the Omicron surge came the inevitable realisation that the chance of being able to proceed with the AGES Annual Scientific Meeting (ASM22), scheduled for March in Melbourne, was slim. Consequently, we polled the AGES members on their preferences for the AGES meetings this year, and I sincerely thank those members who provided their opinion. The majority voted to reschedule the ASM22 to later in the year and that it should be face-to-face. The AGES Board unanimously agreed with the will of the members. The ASM22 will now be held in November (at the time that had been allocated for the Pelvic Floor Symposium [PFS22]) with the PFS22 moved forward to June. The Focus Meeting dates are unchanged in August.

With many other societies scrambling to reschedule meetings (e.g., UGSA have moved their ASM from late March to later in the year), finding appropriate dates and venues for our meetings has proved extremely challenging and I want to express my gratitude to Mary and her AGES Secretariat team for "jumping straight back on the horse", after too short a Christmas break, and finalising the AGES meeting dates for 2022:

- » [AGES Pelvic Floor Symposium: 3rd & 4th June 2022 at Adelaide Convention Centre](#)
- » [AGES Focus Meeting: 11th & 12th August at Millennium Hotel Queenstown](#)
- » [AGES Annual Scientific Meeting: 3rd – 5th November at Crown Promenade Melbourne](#)

As the ASM will now be held later in the year, the following dates have also been confirmed for events usually held during the ASM in March:

- » AGES Annual General Meeting (AGM22): Thursday 10th March 2022 (virtual)
- » AATP interviews: Saturday 12th March 2022 (virtual)
 - » AATP Applications close: 5pm AEST Friday 11th February 2022
- » AATP Workshop & all Pre-Conference Workshops: Wednesday 2nd November 2022 (face-to-face at Crown Promenade Melbourne)

The AGES Secretariat is currently working through these changes and will provide further information about the AGM22, AATP Interviews and conference registrations in the coming weeks. I sincerely apologise for these changes that have unfortunately been necessary, but hopefully COVID-19 will cut us some slack and allow the AGES community and the community at large to return to some sort of normality in 2022. We all appreciate your patience and understanding during these times of uncertainty.

In the meantime stay safe, test negative and avoid variants!



Stephen Lyons
AGES President



Editorial

Welcome to the first edition of eScope for 2022. This is the 78th edition.

I trust the readers had some down time over the Christmas and New Year despite a less than prosperous start for many with the Omicron crisis. Ongoing case numbers, hospitalisations and surgical restrictions continue to place our speciality under significant stress. We all hope for brighter times.

This edition starts with the [President's letter](#). This has been a challenging presidency for Steve, with the constant reorganisation of meetings and as yet not a single face to face meeting. The board and YRD have been busy trying to find suitable times and locations for face to face meetings. In fear of repeating myself and others, we all have hope that we will be able to meet this year in person. As the chair of the [Focus meeting](#) this year I am very hopeful for the prospect of a meeting in Queenstown – one of my all-time favourite places. We have a wonderful local organising committee and are preparing a diverse meeting with wide ranging appeal.

[The board article has been provided by Dr Jade Acton](#). Jade has written an excellent piece on Vaginal Cuff Dehiscence. She examines the evidence for contributing factors to this complication in an attempt to guide best practice. Jade also encourages a willing researcher to further examine this – maybe a great research project for an upcoming AATP trainee or fellow?

[Medtronic, our Platinum Education Partner, have kindly provided an article for this edition](#).

Their ongoing support of the society has been invaluable during these extremely difficult times. Without ALL [our sponsors AGES](#) would not be able to continue to function, and I would like to take this opportunity to thank them all for their ongoing support.

[Dr Huda Younis has written an article](#) and case report on visual diagnosis of uterine Adenosarcoma using Medtronic's mechanical hysteroscopy system. This case highlights the benefits of newer technologies allowing direct visualisation and sampling of uterine pathology.

The SWAPS trainees have once again provided us with [summaries from recent JMIG editions](#). The summaries cover 3 articles: LESS and vNOTES vs MPL hysterectomy, Complications of ovarian cyst spillage at benign surgery, and Optimal management of Isthmocele. Many thanks once again to this hard-working cohort of trainees.

[The Avant article addresses a timely problem](#), that of discharging patients from day surgery who may not have adequate home support. COVID has certainly made it hard for some of our patients to rely on their normal support network, meaning some may be discharged without a suitable person to care for them post anaesthetic. The responsibility for the treating team is outlined in this article.

So that wraps up this latest edition of eScope. As always, any submissions or suggestions for content are always welcomed. I can be contacted through YRD at the [email](#) shown in the details to the left.



Rachel Green
eScope Editor &
AGES Vice-President

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● Laparoscopic Hysterectomy and Vaginal Cuff Dehiscence

Dr Jade Acton St John of God Hospital, Subiaco
MBBS, MSurgEd, FRANZCOG, AGES Fellowship

Introduction:

Hysterectomy is a commonly performed procedure among women in Australia, with approximately 30,000 cases annually. Over the last 2 decades, the use of minimally invasive techniques for hysterectomy, particularly laparoscopic and robot-assisted techniques, has substantially increased. Compared with abdominal hysterectomy, laparoscopy leads to faster return to normal activity and shorter hospital stay, with overall low complication rates.

Vaginal cuff dehiscence (VCD) is defined as the partial or complete separation of the margins of the vaginal cuff after hysterectomy. Although rare, a delay in its identification and management can lead to life-threatening complications such as bowel perforation, peritonitis, and sepsis. Patients can present with abdominal or pelvic pain, bleeding, discharge, and pressure, from 3 days to 30 years¹.

Overall, the incidence of VCD is low, with estimates varying widely from 0.14%-5%². The rate of VCD in laparoscopic hysterectomy has been shown to be 3 to 13 fold higher compared to other routes. As more surgeons move towards a minimally invasive approach, the overall number of VCD is increasing².

A recent systematic review revealed that the overall incidence of VCD after endoscopic hysterectomy is 0.54% or approximately 1 in every 185 cases³. This cumulative figure, however, came from mostly retrospective studies thus when considering only randomized trials that were designed and powered to detect this complication, the incidence was much higher (1.78% or 1 in every 56 endoscopic hysterectomies).³

As vaginal dehiscence is rare, it is difficult to correctly identify predisposing factors, however, given the serious nature of the complication it is vitally important that we as gynaecologic surgeons, seek to find ways to reduce this incidence. Despite the importance of the issue,

to date there is no consensus, and nor are there any practice guidelines regarding the best strategies for VCD prevention. Many strategies have been proposed to prevent VCD after laparoscopic hysterectomy, including delayed resumption of sexual activity after surgery, sparing use of electro-surgery, and technique and choice of suture material and this article will aim to review the available literature.

Risk Factors and Modifiable Factors:

Many studies have attempted to evaluate risk factors for dehiscence, but these studies are limited by the infrequency of the outcome and are primarily retrospective. The first identified risk factor is smoking and this may be due to poorer tissue healing as well as chronic cough and thus increased intra-abdominal pressure⁴. Smoking is an easily identifiable and modifiable factor for patients. A case-controlled study identified older age and obesity (body mass index [BMI] >30 kg/m²) to be protective factors for cuff dehiscence⁵ and another demonstrated that patient with VCD were more likely to have complex surgical histories¹

In general, cuff dehiscence is associated with risk factors for infection, poor wound healing, excessive pressure at the vaginal incision site, or pelvic floor defects but despite being suspected there is no evidence to definitively support their causative effect. Evidence does exist to show that treatment of vaginal infection pre-operatively will improve rates of post-hysterectomy infection, however this has not been studied to improve rates of VCD⁶.

Coital activity has been associated as the main trigger event in more than half of the VCD cases in studies that reported it.² To date, however, no study has investigated the optimal time for sexually active women to resume coitus after laparoscopic hysterectomy. In general, scar tissue attains approximately 40 percent of its final strength in the first postoperative month, and strength continues to increase for as long as one year after injury².

Laparoscopic Hysterectomy and Vaginal Cuff Dehiscence cont.

Dr Jade Acton

The advice for resumption of intercourse after laparoscopic hysterectomy can vary between 6-12 weeks and there is no consensus. Individuals with potential 'higher risk' histories may be counselled to avoid intravaginal activities for an extended period, although supporting data for this approach are lacking⁸.

Vaginal atrophy has also been proposed as a mechanism for VCD and there is suggestion that perioperative estrogen therapy may promote vaginal wound healing. One trial randomly assigned 315 postmenopausal patients undergoing vaginal hysterectomy for benign indications to transdermal estrogen therapy for 14 days before and after surgery or vaginal estrogen therapy for 14 days before surgery and no postoperative estrogen therapy⁷. At four weeks after surgery, individuals in the transdermal estrogen therapy group had a reduced incidence of incomplete re-epithelialization of vaginal suture sites (5 versus 17 percent) and visible wound opening (0 versus 2 percent). Whilst vaginal oestrogen did improve vaginal mucosa healing, VCD was not reported in this study. There have been no studies examining oestrogen therapy in laparoscopic hysterectomy and thus the data must be interpreted accordingly.

Surgical Technique:

Healthy debate exists regarding the technique surrounding the vaginal vault at laparoscopic hysterectomy. In particular, the choice of energy source for completing the colpotomy, as well as the choice of suture material and closure technique create the greatest deliberation. Overall, the evidence again is poor, however evidence does exist for laparoscopic over vaginal suturing of the vault and potentially for the use of a barbed suture³.

Extensive use of electrosurgery has long been considered the main factor responsible for the higher risk of vaginal breakdowns observed after laparoscopic hysterectomy compared with vaginal and abdominal hysterectomy. Various authors have tried to identify the effect of monopolar current vs cold knife or other types of energy or the use of monopolar cut vs coagulation modality^{2,3}.

but unfortunately, there is limited data regarding the impact of different energy sources used for colpotomy and therefore, there is no standard approach to colpotomy to minimize the dehiscence risk.

Similarly, there is insufficient evidence to standardise the method of closing the vault at laparoscopic hysterectomy. A variety of suturing methods have been evaluated with regards to dehiscence risk including continuous versus figure-of eight interrupted, single versus double layer and single versus single continuous with the addition of interrupted figure of 8 second layer but overall there is no evidence in favour of reinforced or double-layer sutures compared with the standard single-layer approach².

Evidence does however exist examining the risk of VCD in laparoscopic cuff closure (LCC) or vaginal cuff closure (VCC). The most recent meta-analysis examining VCD showed that VCC was associated with a significantly higher risk of dehiscence than LCC (23/1002 [2.3%] vs 11/944 [1.16%]; OR 1.97; 95% CI, 1.00-3.88)². Potential reasons have been hypothesized to explain the lower incidence of dehiscence among patients including the magnified view allowing for more adequate re-approximation of the cuff with less tension, decreased bleeding at cuff edges, and better incorporation of the peritoneum¹.

Suture choice is also debatable with a significant difference between type of suture or rate of absorption and risk of dehiscence not established². Only small, retrospective studies have been performed with mixed results – some delayed absorbable sutures to be superior and others showing no difference at all⁸.

There is potentially evidence to suggest that barbed sutures may decrease the rate of VCD compared to non-barbed², however the data must be critically examined and interpreted accordingly. Ucella et al performed the most recent systemic review on VCD in 2020 and compared the use of barbed sutures and the rate of VCD and included 11 studies². A reduced risk of dehiscence was demonstrated with barbed suture (0.4% [4/1108] vs 2% [22/1097]; odds ratio [OR] 0.25; 95% confidence interval [CI], 0.11-0.57),

Laparoscopic Hysterectomy and Vaginal Cuff Dehiscence cont.

Dr Jade Acton

however this finding and the subsequent recommendation for the preferred use of barbed sutures should be taken with caution for several reasons due to some methodological flaws. Of the 11 studies, only 2 found a statistical difference in the risk of VCD in favour of closing the vagina with barbed sutures. These studies both had methodological flaws – one included robotic hysterectomy in its control group and the other used a mixture of sutures types and techniques to close the vault in the control group. Robotic hysterectomy has been shown to have a higher rate of VCD than laparoscopic hysterectomy⁹ and once these were removed on subanalysis the finding was no longer significant². Barbed sutures have been associated with rare but serious complications such as small bowel obstruction and thus higher level evidence on larger series of patients is necessary before strong recommendations can be made in support of their use for prevention of VCD³.

In summary, overall there is lack of well-designed, adequately powered studies on VCD which makes it difficult to produce evidence based protocols. Smoking and surgical complexity has been shown to increase

the risk of VCD and obesity and age potentially decrease the risk of VCD. The use of vaginal oestrogen may improve mucosal wound healing in post-menopausal women and pre-operative treatment of vaginal infection will reduce the risk of cuff cellulitis. There is no evidence to support the optimal use of electrosurgery, suture type, or layers of closure. There is potentially evidence to support the use of a barbed suture to reduce the risk of VCD but further well designed studies are required before a strong recommendations can be made and finally there is level 1 evidence to support the closure of the vault laparoscopically over vaginally during laparoscopic hysterectomy.

Whilst it is disappointing as a surgeon to not be able to find the evidence to improve outcomes, this lack of data does show that there is a great need for well-designed and adequately powered studies for anyone out there looking for research topics!



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Inclusion, Healing & Recovery

Hybrid Meeting

3rd & 4th June 2022
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AGES XXII Pelvic Floor Symposium

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Inclusion, Healing & Recovery in 2022

Dear colleagues,

How can we reflect on the two years that have gone by since the advent of our global pandemic? It's been a time we would rather forget, and yet it keeps rearing its ugly head, and lashing its barbed tail again and again. Within Australia our colleagues on the east coast have borne the brunt of the pandemic, however it is worth remembering that, for the most part, we have been fortunate to be in Australia.

It's time to reflect on the things that bring us together, and it's in this spirit that we have launched the 2022 AGES Pelvic Floor meeting, crossing our fingers that we will all be able to meet in person and share things face to face. We will be focussing our minds on inclusion, healing, and recovery in all its varying colours and shades.

We will be talking about mesh (again!) and the alternatives, prolapse throughout the lifespan of a woman, discussing pain and sexual function. All this and so much more.

With the change of timing to June 3rd and 4th, we are in the process of finalising our international speakers and will get back to you as soon as possible with the confirmed list. Be assured that we will have some truly world class speakers with relevance to the day-to-day practice of gynaecology.

Look forward to catching up and learning something along the way.



Emma Readman
Meeting Chair
AGES Director



Abstract Submissions

AGES invites abstracts for oral, video*, and digital free communications at the AGES Pelvic Floor Symposium 2022. The Free Communications sessions will be held during the meeting on Friday 3rd June 2022.

APPLICATION DEADLINE: SUBMISSIONS WILL CLOSE MONDAY 28TH MARCH 2022.

FREE COMMUNICATIONS INSTRUCTIONS FOR AUTHORS

- 1 The abstract submission deadline is **midnight AEST on Monday 28th March 2022**
- 2 All abstracts must be submitted online using the registration link. Faxed, posted, and abstracts submitted via any other email address will NOT be considered
- 3 Abstracts must be in English language only
- 4 Maximum 400 words/3050 characters with NO pictures, graphs, tables or images
- 5 References are excluded from the word limit but must be restricted to THREE ONLY
- 6 The decisions of the selection committee are final
- 7 All oral/video presentations will be 7 minutes in duration with no exceptions
- 8 Successful applicants for the Free Communications program will be notified by **COB Friday 6th May 2022**
- 9 Presenters of accepted abstracts are required to pay for registration to AGES Pelvic Floor Symposium by **Friday, 20th May 2022**
- 10 All presentations at the Conference will be via the Conference laptops. No personal laptops will be used for presentations. All presentations will need to be uploaded at the Speaker's Prep area. Details will be forwarded to you with acceptance of your abstract
- 11 Any conflict of interest/sponsorship must be declared at the commencement of any presentation
- 12 Failure to follow the instructions for submission of abstracts may result in rejection of your document
- 13 A presenting author can only present a maximum of 2 presentations.
- 14 By submitting an abstract you agree that Copyright of the abstract(s) is assigned to AGES only for the purpose of publication in the Conference Abstract Book and (if applicable) media releases/reports
- 15 NO changes to any abstracts will be accepted after **midnight AEST on Thursday, 19th May 2022**
- 16 Any questions should be directed to the secretariat at ages@yrd.com.au

Please note that when you proceed through the submission process you must click save, before moving on to the next step. Up until the close of abstract submission, you can log into your profile to continue your submission where you left it or make any changes. If you have any concerns, please contact the secretariat office on +61 7 3368 2422.

*PLEASE NOTE ADDITIONAL DETAILS FOR VIDEO SUBMISSIONS

Abstracts for video presentations must be submitted in conjunction with the video file that will be presented.

Please submit your abstract and video file in the following order

- 1 Submit your abstract. Once submitted you will receive a confirmation with a Dropbox link and abstract ID number for uploading your video file.
- 2 Upload your video file. Please ensure your video file name is in the following format; *Last Name_First Name_Abstract ID Number* and upload via the supplied Dropbox link

Onwards & Upwards

3 - 5 November 2022
Crown Promenade Melbourne



Visual D&C with Mechanical Hysteroscopy Aided Diagnosis and Correct Management of Uterine Adenosarcoma

Dr Huda Younis
Gaia Women's Specialists, Canberra
MBCHB, FRANZCOG

Mechanisms for adequate sampling of intrauterine tissue with reduced patient risks are evolving, now permitting greater confidence that truly indicative samples are taken. The use of mechanical hysteroscopy methods provides an opportunity to perform a completely visual dilatation and curettage (D&C), allowing the operator to ensure sample has been taken from all areas required to provide a truly indicative result. Visual D&C also minimises the risks to the patient, such as the concern for risk of perforation, as the operative field is visualised throughout, and mechanical hysteroscopy systems using a fluid management system can, in real time, indicate perforation as inflow and outflow are constantly monitored. Rapid inflow without a similar outflow may indicate perforation and allow for fast response.

Truly indicative sampling is vital to ensure the correct steps are taken to manage our patients. This is something that visual D&C with mechanical hysteroscopy can provide. With a good sample, we can be confident that steps to manage situations from investigating the true source of abnormal uterine bleeding, to preparation for hysterectomy, can be carefully and appropriately mapped out.

A recent case study is documented below, involving the use of a mechanical hysteroscopy system, TruClear (Medtronic), which enabled a good indicative sample to be obtained, resulting in early diagnosis and correct management of a rare uterine adenosarcoma.

The patient was a 52-year-old female, with eight years of menorrhagia. A pelvic ultrasound showed a bulky uterus with fibroids and adenomyosis. The patient was reluctant to have a hysterectomy. The patient had

a number of hysteroscopies to investigate menorrhagia, and a history of LETZ treatment for CIN3.

Initially the patient was treated with a Mirena, which seemed to manage her symptoms for a few years until December 2018 when her symptoms recurred, and she opted to undergo endometrial ablation with laparoscopic bilateral salpingectomy. The intraoperative findings were those of bulky uterus, normal fallopian tubes and ovaries, and normal pelvis. Hysteroscopic assessment showed a normal endocervical canal, 7 cm uterine cavity with no visible endocervical or endometrial abnormality. Histopathology showed menstrual endometrial tissue, normal fallopian tubes, and negative peritoneal washings. Postoperatively, the patient had very light monthly periods and by the end of 2019 her period had stopped completely. A co test was performed and was clear.

In December 2020 the patient began bleeding again, initially light, and gradually became very heavy by January 2021. Pelvic ultrasound showed a bulky uterus measuring 102 x 82 x 75 mm, thickened 10 mm cystic endometrium with a 20 x 7 x 7 mm focal echogenic area with a stalk in the endometrial cavity suggestive of a polyp. There was a 29 mm right fibroid. The patient was scheduled for a hysteroscopy to screen for endometrial neoplasia prior to hysterectomy.

The TruClear Elite Hysteroscope Mini (Medtronic) was used with an oscillating Soft Tissue Shaver Mini to perform the hysteroscopy and visual D&C. During hysteroscopic examination there was a large firm polyp-like lesion with a smooth surface distending the proximal cervix and thick pedicle attachment to the lower uterine cavity wall.



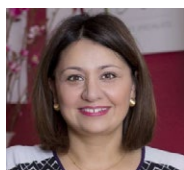
● Visual D&C with Mechanical Hysteroscopy Aided Diagnosis and Correct Management of Uterine Adenosarcoma cont.

Dr Huda Younis

The hysteroscope was passed into the uterine cavity showing atrophic endometrium, both ostia were identifiable. The oscillating function of the Soft Tissue Shaver Mini was used to excise the polyp, revealing small polyps underneath. All polyps were removed in this way. Histopathology showed concern regarding atypical spindle cells within the stroma. The histopathology was reviewed by the tumour board and extended hysterectomy was advised.

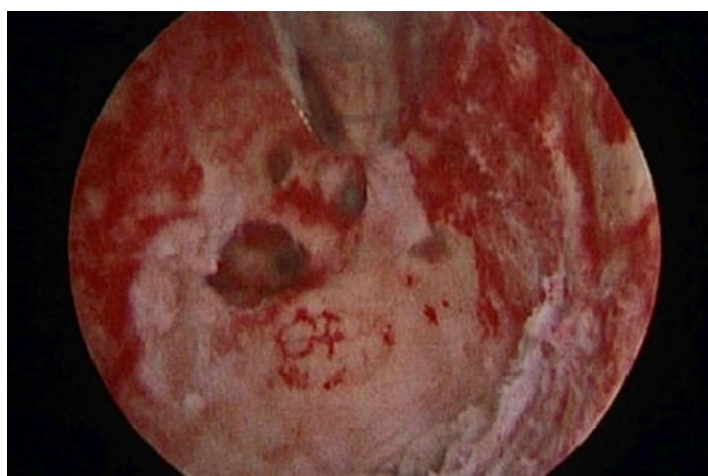
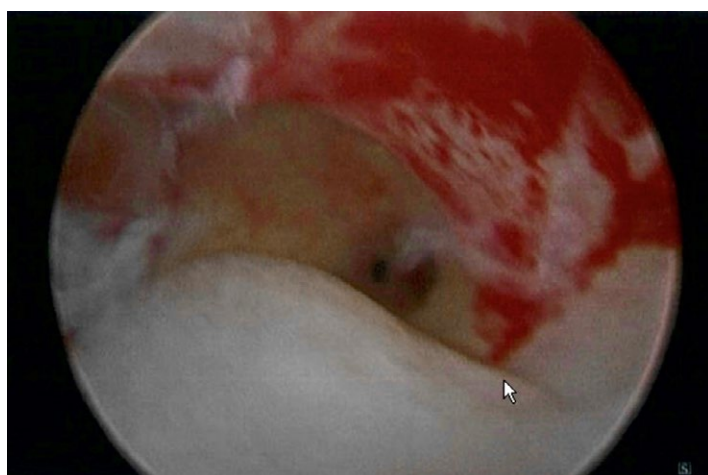
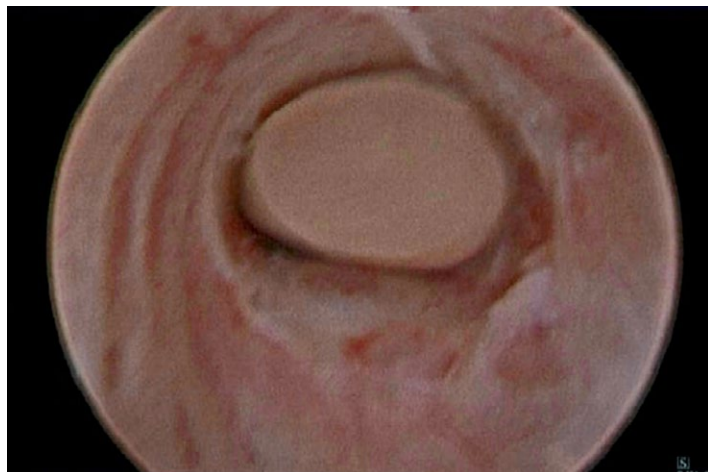
The patient was later referred to a gynaecologist and underwent a total laparoscopic extended hysterectomy in April of 2021. Histopathology confirmed adenosarcoma confined to the inner half of the myometrium, FIGO stage 1B. Ki67 was promisingly 5% at most. Atypical stromal cells to stain positive for desmin, actin, CD10 and for DC34. Peritoneal cytology was negative, and the patient was found to have normal ovaries. The patient is currently under observation.

Gaining a truly indicative sample hysteroscopically before undertaking a total laparoscopic hysterectomy provided the insight required to take the next necessary steps correctly and safely. Visual D&C with a mechanical hysteroscopy system, here the TruClear system, allowed continuous visualisation to gain a good indicative sample, while providing additional patient safety benefits. This is a vital step in patient centred care, and thanks to new technologies permitting accurate sampling under full visualisation, this step has been made easier, safer, and provides increased confidence.



Dr Huda Younis

Gaia Women's Specialists, Canberra
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● JMIG Summaries: the best bits of the most interesting recent papers

Basia Lowes, Kiran Vanza and 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. *Journal of Minimally Invasive Gynaecology*. 2021 March. 28 (3). 698-709

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 in 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
Journal of Minimally Invasive Gynaecology. 2021 May. 28 (5). 957-970*

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, 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 the 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.

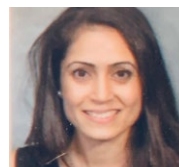
Pain and dysmoerrhoea are less commonly reported and small studies (less than 10 women) showed up to 80% improvement with hysteroscopic remodeling and up to 66% improvement with laparoscopic repair. No prediction data retarding uterine rupture is available however a residual myometrial thickness of more 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.



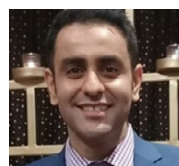
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● I'll be fine: when a patient wants to leave alone after a day procedure

Ruane Brell Senior Solicitor, Medico Legal Advisory Service, Avnt
Dr Patrick Clancy Senior Medical Adviser, Avnt

Sixty-eight-year-old Ms Lee has just arrived for her scheduled hysteroscopy procedure. She lives alone and explains her daughter is now a close COVID-19 contact and needs to isolate, so Ms Lee is unable to stay with her. You are worried about the risk of post-operative complications.

Professional responsibility for patient safety

Sometimes, despite being advised they need to be collected and accompanied after a day procedure, a patient will not have arranged support, or arrangements might fall through. These scenarios can raise concerns for practitioners about their responsibility if a patient is alone and:

- » injures themselves or someone else when travelling home, or
- » experiences a post-procedure complication.

In a small number of cases, patients have suffered harm and healthcare providers have been criticised over discharge practices. This may have been because processes broke down or responsibilities were unclear. Patients may not have been appropriately assessed for discharge, or not clearly advised of the risks, such as driving themselves.

Guidelines on good professional practice

In assessing a patient's fitness for discharge, practitioners are expected to exercise clinical judgement guided by applicable professional and regulatory guidelines.

The Australian and New Zealand College of Anaesthetists (ANZCA) [Guideline for the perioperative care of patients selected for day stay procedures](#) (PG15) (DSP Guideline) sets out good professional practice for such procedures. It is intended to apply to all practitioners and facilities providing procedural or diagnostic services where patients are discharged within 24 hours of receiving anaesthesia or sedation.

The DSP Guideline provides patients should only be discharged when a responsible adult is available to transport them in a suitable vehicle (not a train, tram, or bus). A responsible person should stay with the patient at least overnight.

Planning and preparation

Clearly explain discharge criteria, expectations, and risks well before the scheduled date of the procedure so patients can plan appropriately. Ensure the facility and treating team have clear policies and patients are getting consistent information. Confirm these arrangements with patients.

However, as in this scenario, despite good preparation, arrangements can fall through.

Home alone

Often doctors are concerned because a patient plans to drive themselves home after sedation or anaesthesia. In this case, Ms Lee assures you she is not planning to drive herself. You may still be concerned about the risk of post-procedure complications and her safety as she'll be alone.

POST-PROCEDURE EFFECTS AND RISKS

Good practice involves ensuring the patient understands the risks material to their situation. As with any procedure, you need to warn Ms Lee of the potential effects and risks of the procedure and medications.

Issues can arise because patients have not understood that anaesthesia or analgesia may affect activities such as driving for some time after even a minor procedure. It is important to give Ms Lee clear advice on how these may affect her ability to resume regular activities, including driving. This will always involve questions of clinical judgement based on her individual circumstances. Your advice should also consider any applicable hospital policies or professional guidelines.



● I'll be fine: when a patient wants to leave alone after a day procedure cont.

Ruane Brell and Dr Patrick Clancy

CONTACT FOR EMERGENCY CARE

You need to provide Ms Lee with written and verbal instructions about post-anaesthesia and post-procedural care. She needs to know what symptoms to be aware of and how to contact emergency medical care if necessary.

The general principles of informed consent would apply to any risk of post-procedural complications. Provided she has capacity, Ms Lee can make the decision whether to go ahead with the procedure.

For more information on consent discussions and capacity, please see Avant's factsheets – [Consent: the essentials](#) and [Capacity: the essentials](#).

Managing difficult situations

It can be helpful to consider some difficult situations in advance and options for responding.

ALTERNATIVE CARE ARRANGEMENTS

Sometimes the solution is simply to check whether Ms Lee has someone else who can collect her and stay with her. She may not have realised this was an option or may have felt uncomfortable asking someone else. If you explain why she needs someone with her, she may have another person she can call.

She may need more time today to make other arrangements, in which case the solution may be to rearrange the list, or delay discharging her.

DELAYING THE PROCEDURE

It may be appropriate to reschedule the procedure to a day when Ms Lee has suitable care arrangements, or to a facility where she can be admitted overnight. In such situations, the DSP Guideline needs to be applied using clinical judgement and considering all circumstances, including the risks of postponing the procedure.

OBSERVATION AND DISCHARGE

If the procedure cannot be postponed, and Ms Lee cannot arrange for support, you may need to advise her to stay until the effects of sedation have worn off enough and she can safely leave alone.

This assumes your facility has arrangements for staff to stay until she has recovered, and that you can transfer a patient to hospital if there are unexpected complications and they are not going to be able to go home. However, in practice, this would usually mean the procedure will be changed to occur in a facility that can admit patients overnight.

If Ms Lee insists on leaving on her own and against your advice, in most cases she will be free to do so. A patient can only be detained in hospital against their will if they meet the requirements for involuntary admission under the relevant legislation.

She should be advised to travel home in a taxi or hire car, rather than using public transport.

Consider also the most appropriate follow-up arrangements so that someone checks in on her the next day.

DRIVING HOME

Although it does not arise in this scenario, doctors often ask what to do if a patient insists on driving after sedation.

Practitioners are expected to advise patients not to drive until they have sufficiently recovered, physically and mentally, but do not generally have a duty to report to the licensing authority. However, if you are concerned a patient may pose a serious risk to their own health and safety, or that they may put someone else at risk, there may be grounds to breach patient confidentiality and report them to the police.

This situation can be complex, so seek advice before taking this step.

● I'll be fine: when a patient wants to leave alone after a day procedure cont.

Ruanne Brell and Dr Patrick Clancy

Further reading

For more information on your responsibilities when discharging patients after day procedures, see

- » Avant factsheet: [Discharge from day procedures](#)
- » Australian and New Zealand College of Anaesthetists (ANZCA) [Guideline for the perioperative care of patients selected for day stay procedures](#)
- » Austroads [Guidelines on assessing fitness to drive following temporary conditions.](#)

Disclaimer: This article is intended to provide commentary and general information. It does not constitute legal or medical advice. You should seek legal or other professional advice before relying on any content, and practise proper clinical decision making with regard to the individual circumstances.



Ruanne Brell
Senior Solicitor, Medico Legal
Advisory Service, Avant



Dr Patrick Clancy
Senior Medical Adviser, Avant

● AGES Education Committee

In September last year, Steve asked if I would Chair the Education Committee, and although I have been incredibly passionate about our training program, the thought of following in the footsteps of giants was very daunting!

Ever since the establishment of the AGES training program about 10 years ago, the program has continued to improve and grow, evolving to the AGES Accredited Training Program (AATP) in 2020. We have seen 51 graduates complete the program, with 24 awaiting one workshop due to the COVID restrictions and 27 currently in training. There are now 24 accredited units across Australia and New Zealand with 4 newly accredited units starting this year. All this has been possible due to the guidance of many who toiled tirelessly, including Alan Lam, Jim Tsaltas, Anusch Yazdani, Jason Abbott, Stephen Lyons and Stuart Salfinger. With the ever-growing demands of the AATP, the Education Committee was established in 2019, now consisting of Catarina Ang, Dean Conrad, Kate Martin, Erin Nesbitt-Hawes and Martin Ritossa, all of who make light of a very heavy task.

At the risk of repeating what has been the bane of the last two years, as with practically everything in our lives, COVID has had a significant effect on our AATP trainees. The restrictions on elective surgery and interstate travel have resulted in a decrease in surgical training and inability to run and attend the required workshops, namely Lap-D and Anatomy of Complications (ACW) workshops. In an effort to assist trainees to graduate, the AGES Board decided to make the ACW a recommended but not compulsory requirement, however border closures have still made it impossible for 24 trainees to attend Lap-D. Indeed, it looked like this would finally be solved in February this year, with all of them booked in to the workshop, and then... Omicron!

Since its inception, the AATP has been quite dynamic, having morphed and developed dramatically over the years. We intend for it to continue to do so. Increasing standards expected from the growing evidence, as well as society as a whole, has resulted in more stringent requirements of all those involved in training and those being trained, which the Committee continue to attempt to carefully navigate.

The Education Committee's responsibilities are varied, including facilitating the progression of the trainees, accrediting new Units, renewing existing Units, and everything related to the exam. We are also overseeing a curriculum review, with the assistance of Prof Debra Nestel, although this has been a mammoth undertaking and will continue to take some time. With the rapid growth in the AATP in recent years, in terms of both the number of Units and Trainee Requirements, we are currently in the process of implementing a database for record maintenance and management.

Despite COVID playing havoc on our lives, I would specifically like to thank the Board, Jason and Anusch for their support. I would also like to thank the Education Committee members for the hours voluntarily spent in ensuring the AATP standards are met and continue to improve. We're also very grateful for all the AATP Unit Directors and Supervisors for being the ones on the floor responsible for the training of our fellows. I am particularly thankful to the AATP trainees for their patience and understanding in such challenging times. Not least of all, we are very grateful for Mary and the YRD team for the time spent in the background, ensuring that everything runs smoothly.

Without sounding cliché, if there is anything the Committee or I can do, please do not hesitate to contact me. Here's hoping 2022 gets better from here!



Dr Bassem Gerges
Education Committee Chair
AGES Hon. Secretary

● 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 Pelvic Floor Symposium 2022
JUNE 3-4 2022
Adelaide Convention Centre, Adelaide
Theme - Inclusion, Healing & Recovery



AGES Focus Meeting 2022
AUGUST 11-12 2022
Millenium Queenstown, New Zealand
Theme - Integration Through Innovation



AGES Annual Scientific Meeting 2022
NOVEMBER 3-5 2022
Crown Promenade, Melbourne
Theme - AGES: Onwards & Upwards



AGES Laparoscopic Anatomy Pelvic Dissection/
Demonstration Workshops
2022 DATES
Dissection Workshops
21 May 2022
22 May 2022
11 September 2022
12 November 2022
Demonstration Workshop
10 September 2022
Advanced Dissection Workshop
13 November 2022



JUNE 18-19 2022
Royal Australasian College of Surgeons,
Melbourne

Medical Engineering and Research Facility,
Brisbane

● AGES Membership 2022

Renew your AGES Membership now for 2022!

Membership of AGES includes the following:

- » Complimentary access to member only content such as webinars
- » Savings of up to 15% on member registration fees for AGES meetings.
- » Exclusive access to the “AGES Video Library – Members only”.
- » Eligibility to register for the AGES Laparoscopic Anatomy Pelvic Dissection & Demonstration Workshops (LAP-D).
- » Eligibility to apply for AGES Research Grants.
- » SurgicalPerformance 1-year Premium subscriptions will be available at a subsidised rate of \$100 to all Ordinary Members of AGES in 2022. This includes SurgicalPerformance’s self-auditing Software and AGES/SurgicalPerformance webinars.
- » Complimentary subscription to the Journal of Minimally Invasive Gynaecology (formerly AAGL Journal).
- » Option to subscribe to the International Urogynaecology Journal instead of JMIG for an additional fee.
- » AGES electronic newsletter, eScope, published three times annually.
- » Eligibility to register for the “Who do you want to be when you grow up” Seminars.
- » Member access to AGES website and resources.
- » Downloadable “AGES Member Icon” available for use in signature blocks and websites.
- » Listing on the Membership Directory of the AGES website.
- » Eligibility to apply for a position in the AGES Training Program in Gynaecological Endoscopy

To renew your membership online or to update your details, please use the following link: [AGES MEMBERSHIP 2022](#)

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

● AGES Travelling Fellowships

Applications are now open for the AGES/Medtronic Travelling Fellowship and the AGES/Hologic Hysteroscopic Fellowship for 2022.

These Fellowships will be awarded at the AGES XXXII Annual Scientific Meeting 2022 to AGES Members who are Trainees or Fellows, within five years of graduation.

For further detail and to submit your application please visit the AGES website – ages.com.au/members/awards-and-fellowships

AGES/Medtronic Travelling Fellowship – AUD \$7,500

AGES/Hologic Hysteroscopic Fellowship – AUD \$10,000

Applications close 11:59pm AEST, Monday, 10th October 2022.

● AGES Clinical Research Grant Recipients 2022

Congratulations to the successful applicants of the 2022 AGES Clinical Research Grants.

SUBMITTER	AWARDED AMOUNT	PROJECT NAME
Blake Knapman	\$18,300.00	Investigating immediate pain and post surgical recovery following laparoscopic surgery for diagnosis or treatment of endometriosis: A prospective.
Evangeline Shalou	\$19,821.12	Hysteroscopic Morcellation vs Bipolar Resection for Retained Products of Conception: A Pilot Randomised Control Trial.
Eashan Tambimuttu	\$10,000.00	Developing a Simplified MRI Diagnostic Algorithm to Identify and report Fibroid Variants. A Retrospective Cohort Study Correlating Histopathology with MRI Features.
Madeleine Ward	\$3,277.00	Telementoring in gynaecology endosurgical procedures during the COVID-19 pandemic.

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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: 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

2023: March 20-24, June 5-9, October 16-20

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: 26 & 27 April, 30 & 31 August, 11 & 12 October

All enquiries should be directed to: Dr. Weng CHAN,
Gynae Endosurgery Consultant, 40 Lemana Crescent, Mt. Waverley, VIC 3149
P: + 61 3 9886 6248 F: + 61 3 9886 4468 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:

Master Class in Hysterectomy, Myomectomy & Adnexal Surgery : March 14-18

Master Class in Endometriosis Surgery & Hysterectomy Techniques : June 06-10

Master Class in Hysterectomy, Myomectomy & Adnexal Surgery: October 24-28

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 79 coming out
in June 2022

Contact Rachel Green (secretariat@ages.com.au)
with your contribution
Deadline **6th May 2022**