



Volume 79 June 2022

# escope

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

## **EDITION HIGHLIGHTS:**

President's Letter

The unanticipated  
fertility  
consequences  
of a career in  
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Communicating  
effectively and  
professional  
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Hysteroscopic  
Mechanical Tissue  
Removal Systems

JMIG Summaries



# **TOGETHER TOWARDS TOMORROW**

# ● President's Letter

## A New Dawn?

Dear AGES Members,

It appears that the COVID 19 pandemic is here with us to stay, for the foreseeable future anyway. Despite the fact that the COVID infection rate remains high with proportionately high levels of hospital/ICU admissions and deaths, Australasia seems to be getting used to "living with the pandemic". Indeed, little remains of the COVID-related restrictions that affected the lives of the Australasian populations for the first two years of the pandemic. [Of course, some select groups, such as healthcare workers, are still subject to mandatory COVID vaccinations, extended isolation and/or regular COVID testing if deemed a close contact of a COVID-infected person, and the wearing of face masks and social distancing whilst at work].



In keeping with these new-found freedoms, I am thrilled to announce that AGES has opened again for "face-to-face business", heralded by the successful running of the first **Lap-Dissection** workshops on the 21st and 22nd of May, the first time this workshop has been held for both National and International attendees since the beginning of the pandemic. We did manage to squeeze in one event with Queensland only attendees, last year during the pandemic. Many thanks to Michael Wynn-Williams and the Lap-D faculty for finally ending the COVID curse!



On the 3rd & 4th of June the 2022 Pelvic Floor Symposium (PFS22), one of AGES' stable of 3 conferences that are held every year, was the first of the society's meetings to be held face-to-face in Adelaide at the Adelaide Convention Centre since the AGES Focus

Meeting, which was held in March 2021 (at five separate sites around Australia). The theme of PFS22 *Inclusion, Healing, & Recovery in 2022* is also very relevant to the pandemic recovery with the scientific program seeming to resonate with AGES Members, tempting them to hit the AGES conference circuit again with 209 registered delegates (148 face-to-face in Adelaide, and 61 attending virtually). This was a COVID-safe event with delegates reminded to frequently use hand sanitizer and encouraged to wear masks and to practice social distancing when in the confines of the conference space. Congratulations to Emma Readman (Conference Chair), Fariba Behnia-Willison and George Condous (Conference Scientific Co-chairs) for all their hard work towards making this meeting such a success. →



## ● President's Letter cont.

The AGES meetings for the rest of the year include:

**[AGES Focus Meeting 2022 – Integration through Innovation](#)**

11th & 12th August, Millennium Hotel, Queenstown

**[AGES XXXII Annual Scientific Meeting 2022 – Onwards and Upwards](#)**

3rd – 5th November, Crown Promenade, Melbourne

Serendipitously, *Crazysocks4docs Day* is held on the first Friday in June every year, and so coincided this year with the first day of PFS22. Taken from the Crazysocks4docs website, “The Crazysocks4docs Trust Foundation was established to fulfil Geoff Toogood’s vision of breaking down the stigma around mental health issues in doctors and health professionals. We took advantage of this coincidence to offer delegates some really crazy socks to wear, and to reflect upon those of our colleagues affected by mental illness, some who have been tragically lost to us. It has been well known for many years that doctors are more likely to suffer from mood issues, and the suicide rates are higher than in the general community. Not surprisingly, a study by Prof Samuel B Harvey et al., at the Black Dog Institute (University of New South Wales) have found that doctors are struggling even more during the pandemic (Lancet, 2021; DOI: [https://doi.org/10.1016/S0140-6736\(21\)01596-8](https://doi.org/10.1016/S0140-6736(21)01596-8)).



The pandemic has taken, and continues to take its toll on us as clinicians, our families, our patients and the general community. To top it all off, for those of us living on the east coast of Australia, the current La Niña weather pattern that has caused widespread and repeated flooding events along the east coast of Australia is persisting longer than expected, and the possibility of a third consecutive La Niña is looking more and more likely for next summer. So, please take care of yourselves and don't wait for *Crazysocks4docs Day* or *R U OK? Day* to reach out for help if you are struggling, or to ask the question of a troubled colleague.

In closing, on behalf of the AGES Board, I would like to take this opportunity to congratulate Professor Ajay Rane for his inclusion on the Queen's Birthday Honours list. Ajay was awarded a Public Service Medal for his outstanding public service to women's health in Queensland. Ajay is a past board member and long-serving member of the Pelvic Floor Committee.

I look forward to seeing many of you in Queenstown! Stay positive and test negative.



**Stephen Lyons**  
AGES President

# Editorial

## Welcome to the second edition of eScope for 2022.

This edition follows the success of the first face to face single state meeting for AGES since the ASM in March 2020. It was also our first face to face Board meeting since the ASM in 2020 with some of our Board never having personally met each other before. Whilst we could run the Focus Meeting in several separate states early last year, this was our first attempt at all gathering together. My congratulations to Emma Readman, Fariba Behnia-Willison and George Condous for their efforts with putting this meeting together despite several date changes. How nice was it to finally be able to all get dressed up and have a Gala Dinner? Even if the band didn't make it as they had.... COVID of course!!!

So back to this edition of eScope. We have a few regular features such as the [JMIG summaries](#) and [Presidents letter](#). The [Fellow article](#) has been provided by one of our new AGES graduates (and new mum – presenting at the recent Pelvic Floor Symposium with her 3-week-old baby Juno!!) Dr Alison Bryant-Smith. Alison has produced an article looking at the AGES fellowship and possible post nominal qualifications. This is an area of interest to the Board and we plan to explore this further.

The [Board article](#) has been provided by Helen Green. Helen has written a piece close to her heart – interrupting your career and surgical training to have a baby. This topic was recently picked up by the “Australian” and I must say the reader comments were astounding. We will feature this topic in our “women in surgery” breakfast at the ASM in November.

This edition also contains information regarding our upcoming meetings – [Focus Meeting](#) and [ASM](#). These meetings again allow us the opportunity to meet face to face. As Chair of the Focus Meeting I extend a warm welcome and look forward to seeing many of you in vibrant Queenstown. [The Focus Meeting program](#) is included in this edition.

The snow has started to fall on what looks like a great winter season for Queenstown – a welcome sight given the huge challenges the town has faced with extremely limited tourism over the last 2 years. Our conference will assist with the much-needed tourist numbers for this small town. All at the same time as providing our members with some excellent education!

Happy reading. Looking forward to seeing you all in person very soon.



**Rachel Green**  
eScope Editor &  
AGES Vice-President

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# ● The unanticipated fertility consequences of a career in medicine: Can we really have it all?

Dr Helen Green

**I am writing this article in the evening on Mothers' Day. A day that is a celebration of motherhood for many, but also a day of mixed emotions for those whose hopes and experience of family building have been difficult. It seems an appropriate evening to compose my thoughts on the intersection of my identity as a gynaecologist and a woman who wishes to conceive.**

For various reasons (some of which are out of my control), I remain childless having been a consultant for 5 years and having turned 40 on my last revolution around the sun. It is a position which can feel quite lonely when one works in a group practice with a waiting room filled with expectant mothers and newborns. But I am grateful to other women in surgical disciplines who have publicly told stories of similar struggles.<sup>1,2,3,4</sup>

I feel fortunate to be able to use my position on the AGES board to amplify what is an infrequently discussed, but nevertheless common narrative. This article aims to bring attention to our stories, but also the data that demonstrates the difficulties doctors face when trying to build their families. I also aim to present some suggestions for how we may disrupt this trend so doctors of all genders who wish to build their families can have the best chance of fulfilling this goal.

## The data:

It can be said that the structure of medical training is still biased towards young, single men. But in 2022, doctors in training are more diverse and the impact of training and eventual practice as a specialist affects doctors of all genders and family structures.

Despite this, much of the available published data regarding the impact of a medical career on fertility focusses on women.

Recent publications estimate that  $\frac{1}{4}$  –  $\frac{1}{3}$  female doctors are diagnosed with infertility. (This is in contrast with a rate of 1 in 8 in the general population).<sup>5,6</sup>

Anna Todd and colleagues published a comprehensive systematic review on this topic in 2020.<sup>7</sup>

Synthesizing the information in 27 high quality articles revealed that:

- » 18-28% of female surgeons access ART compared with 5.2-12% in the general population.
- » 8-13% of conceptions are achieved with ART compared with 1.7% in the general population.
- » 25-82% of female doctors experience obstetric complications (compared with 5-15% in the general population).
  - » These include high rates of pre-term labour (10.5% vs 5.9%), IUGR (10.5% vs 3.9%), involuntary miscarriage (13.3% vs 4.2%) and placental abruption (5.2% vs 0%).
  - » Statistically significant increases in risk were associated with >6 night shifts/month, >8 hours/day and >60 hours/week.

At this year's RACS annual scientific congress (2-6th May), Dr Jasmina Kevric (a surgical registrar at Northern Hospital in Melbourne) presented data from her survey of 1099 Australian doctors. She showed that the Australian experience is very similar:

- » the average age of female doctors having their first child was 32.5
- » 1/4 of Australian doctors accessed IVF treatment.
- » 1/3 of female doctors worked more than 12 hours/d in their 3rd trimester<sup>8</sup>

There are many possible reasons for these findings:

Firstly, female surgical residents were on average 10 years older than the general population at the birth of their first child.



# ● The unanticipated fertility consequences of a career in medicine: Can we really have it all? cont.

Dr Helen Green

In qualitative studies, female doctors voluntarily delayed childbearing to avoid disruption to training, there was a pervasive perception that childbearing would stifle career progression, female doctors also reported concerns regarding the negative reproductive effects of demanding training rosters. Other factors that are indirectly affected by a career in medicine e.g., relationship status and finances impacted family building decisions.<sup>9,10,11</sup>

A 2014 survey of US surgical trainees highlights that these are pervasive concerns showing 82% of women and 60% of men felt childbearing would adversely affect their careers.<sup>11</sup>

On a personal note, three interstate moves, long working hours that left little time to maintain personal relationships and a job structure that necessitated opening a private practice immediately after graduation have all been contributing factors.

Of course, the extra-ordinary circumstances of the COVID-19 pandemic have also affected the reproductive choices of many doctors, some of whom may have been approaching the end of their fertile years.<sup>12</sup>

## The consequences:

In her article in the NEJM, Erica Kaye highlights that the magnitude of anxiety and grief experienced by fertility patients can be equivalent to that experienced by patients being treated for cancer, HIV or heart disease.<sup>13</sup> Marshall et al. suggest that the increased burden of infertility may worsen the already greater rates of burnout seen in female doctors.<sup>14</sup>

Published data also suggests that female doctors experience discrimination and guilt surrounding family building. These changes contribute to the leaky pipeline of women ascending to leadership roles in our craft. As reported in a 2018 study, 39% of women who were pregnant during their residency reconsidered a career in surgery based on their experience.<sup>15</sup>

## Organised Action:

In 2020, Academic Medicine published an Invited Commentary: "Physician Fertility: a Call to Action" to draw attention to this common issue, but also to start to provide pathways for improvement.<sup>14</sup>

This year, as part of the National Infertility Awareness Week in the US the American Medical Women's Association (AMWA) held its inaugural Physician Fertility Summit in response to the call to action.

The stated vision for this summit is: an environment where women in medicine can thrive, whether in practice, research, or academia, without having to choose between having a career or building a family.

Their Mission is: Improve the culture of care around family building in medicine and empower women physicians with the knowledge and tools to address fertility challenges, overcome barriers and drive policy change on a local, regional, and national level.

Part of the advocacy of this group has included providing education to medical students and junior doctors about their fertility and helping them to create a reproductive life plan to avoid involuntary infertility due to a lack of information. They have also advocated for appropriate insurance plans so women can access fertility preservation and treatments at an appropriate age.

Beyond education and advocacy, the call to action suggests that future research should aim to collect data on physicians' fertility-related needs to improve the experience of medical trainees and practicing physicians dealing with this commonly experienced challenge. Given the overwhelming evidence that a career in medicine hampers the dream to build a family for many, it is important to define the barriers faced by doctors of any gender and situation. This will allow more accurate targeting of advocacy efforts to improve the ability of all doctors to build a family if and when desired.



# ● The unanticipated fertility consequences of a career in medicine: Can we really have it all? cont.

Dr Helen Green

Of note, a 2020 systematic review article in the MJA did not find any high-quality data relating to motherhood and medicine from the Australian setting.<sup>16</sup>

Dr Jasmina Kevric's study will provide important insight into the Australian situation. Through her personal experience and collated data, she advocates for flexible training, improved working conditions and access to safe breastfeeding spaces.<sup>8</sup>

## Areas for change

Published data identifies a negative perception of pregnancy during training, lack of formal policies and difficulty balancing work and parenthood as some of the barriers faced by medical professionals.<sup>7</sup>

In terms of formal policies from our professional bodies, at the time of writing the RANZCOG statement for clinical training during pregnancy is under review. The version of this document (last reviewed in 2017) is brief and for the most part places the responsibility on the trainee to ameliorate the impact of pregnancy on training.

This is not dissimilar to the findings that 34-80% of training programs in the US had formal guidelines for pregnant trainees. However, many did not specify call requirements, define duties based on weeks of gestation, or provide options for call coverage or flexible rotation schedules.<sup>7</sup>

Commonly reported barriers at the point of return to work are access to breast feeding facilities and appropriate childcare. Of note, Kin et al report that >50% of male doctors with children had a spouse for primary childcare compared with female doctors who were 10 times more likely to require childcare from an external provider (91% vs 48%).<sup>17</sup>

2/3 of women with children reported they would have found a mentor helpful.<sup>15</sup>

The AMWA's advocacy also acts to reframe institutional perceptions of family building in their medical staff. Education around support for doctors wishing to become parents demonstrates that institutions also enjoy benefits when their employees are adequately supported such as increased staff retention and increased rates of return to work after parental leave.

There is still work to do in this area as 38-61% of program directors in US surveys felt becoming a parent negatively impacted a female trainee's work, but only 12-34% felt this about male trainee's work.<sup>18,19</sup>

Anecdotally, the local situation is not dissimilar.

The power of shared stories was underscored in the AMWA's Seminar on Advocating for Change at your institution.

During the US infertility awareness week Dr Annie Hess (Washington University general surgery resident) shared her suggestions on social media to improve the experience of physicians seeking to build a family:

"Normalize all residents prioritizing their own health. They need time for doctors' appointments, mental health upkeep and time to reboot. If this is the norm, it won't seem so abnormal when those struggling with infertility need to leave for an ultrasound, med time, or their appointment. Continue to talk about the issue. Normalize the topic in med school and training. It will allow for early intervention (if desired), better outcomes and less burnout."

## Continuing the conversation:

We can learn from the leadership of the AMWA's recent summit. The four cornerstones used in their strategy for effecting change were persistence, vulnerability, courage, and community. It is my hope that this article can add to the ways we can persistently keep this conversation in the attention of our students, trainees, specialists, and institutions.





# ● The unanticipated fertility consequences of a career in medicine: Can we really have it all? cont.

Dr Helen Green

Those of us whose family building has been impacted by our chosen profession need to share our stories with vulnerability. We need to have the courage to create a community that can advocate for the urgent collection of data regarding the family building needs of doctors and for the creation of strategies to meet these needs.

If this article has brought up difficult emotions, assistance can be sought via:

- » RANZCOG training support unit (08) 61022096, [traineeliason@ranzocog.edu.au](mailto:traineeliason@ranzocog.edu.au)
- » The Employee Assistance program at your local hospital
- » Your GP to organise psychological counselling and support
- » Lysn: [welysn.com](http://welysn.com)
- » Beyond Blue 1300224636



**Dr Helen Green**  
AGES Director

## REFERENCES:

- 1 Mroz, Jacqueline. "A Medical Career, at a Cost: Infertility". The New York Times, 13 Sept 2021. Accessed online at <https://www.nytimes.com/2021/09/13/health/women-doctors-infertility.html>.
- 2 Salles, Arghavan. "I spent My Fertile Years training to Be a Surgeon. Now, It Might Be Too Late for Me to Have a Baby". TIME, 3 Jan 2019. Accessed online at <https://time.com/5484506/fertility-egg-freezing/>
- 3 Mahalingaiah, Shruthi. "POV: If You're a Doctor or Med Student Thinking about Having a Family, You May Want to Get Pregnant Sooner Rather Than Later". Boston University Today, 3 Jan 2022. Accessed online at <https://www.bu.edu/articles/2022/doctors-may-want-to-get-pregnant-sooner/>
- 4 Kevric, Jasmina. "Don't get pregnant, it will ruin your career": The unspoken cost of becoming a surgeon. Women's Agenda. Sept 20, 2021. Accessed online at <https://womensagenda.com.au/latest/dont-get-pregnant-it-will-ruin-your-career-the-unspoken-cost-of-becoming-a-surgeon/>
- 5 Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and childbearing among American female physicians. J Womens Health. 2016; 25:1059-1065.
- 6 Phillips EA, Nimeh T, Braga J, Lerner LB. Does a surgical career affect a woman's childbearing and fertility? A report on pregnancy and fertility trends among female surgeons. J Am Coll Surg. 2014; 219:944-50.
- 7 Tood, Anna R, Cawthorn, Thomas R., Temple-Oberle, Claire. Pregnancy and Parenthood Remain Challenging During Surgical Residency: A systematic Review. Academic Medicine. 2020; 95(10):1607-15.
- 8 Booth, Sarah. "Pregnancy Crisis for Medic Mums". Herald Sun. 10 May 2022. Pg 5.
- 9 Mundschenk MB, Krauss EM, Poppler LH, et al. Resident perceptions on pregnancy during training: 2008-2015. Am J Surg. 2016;212:649-659.
- 10 Mulcahey MK, Nemeth C, Trojan JD, O'Connor MI. The perception of pregnancy and parenthood among female orthopaedic surgery residents. J Am Acad Orthop Surg. 2019;27:527-32.



# ● The unanticipated fertility consequences of a career in medicine: Can we really have it all? cont.

Dr Helen Green

## REFERENCES CONT:

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- 11 Pham DT, Stephens EH, Antonoff MB, et al. Birth trends and factors affecting childbearing among thoracic surgeons. *Ann Thorac Surg.* 2014;98:890-895.
- 12 Morgan S, Levy, Kelly Amelia G, Salles Arhavan et al. The Impact of COVID-19 on Family Building Among Physicians and Trainees. *Journal of General Internal Medicine.* 2022.
- 13 Kaye, Erica C. One in Four – the Importance of Comprehensive Fertility Benefits for the Medical Workforce. *N Engl Med.* 2020; 382:1491-93.
- 14 Marshall, Ariela L; Arora, Vineet; Salles, Arghavan. Physician Fertility: A Call to Action. *Academic Medicine:* May 2020, 95(5): 679-81.
- 15 Rangel EL, Lyu H, Haider AH, Castillo-Angeles M, Doherty GM, Smink DS. Factors associated with residency and career dissatisfaction in childbearing surgical residents. *JAMA Surg.* 2018;153:1004-11.
- 16 Hoffman, Rebecca; Mullan, Judy; Nguyen, Marisa; Bonney, Andrew. Motherhood and medicine: systematic review of the experiences of mothers who are doctors. *Med J Aust* 2020; 213 (7): 329-334.
- 17 Kin, C. Yang R, Desai P, Mueller C, Girod S. Female trainees believe that having children will negatively impact their careers: Results of a quantitative survey of trainees at an academic medical center. *BMC Med Educ.* 2018;18:260.
- 18 Sandler BJ, Tackett JJ, Longo WE, Yoo PS. Pregnancy and parenthood among surgery residents: Results of the first nationwide survey of general surgery residency program directors. *J Am Coll Surg.* 2016;222:1090-96.
- 19 Tang, AL, Miller A, Hauff S, et al. Maternity and paternity leave in otolaryngology residency training in the United States. *Laryngoscope.* 2019;129:1093-99.

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# *Focus Meeting:* *Integration through Innovation*

Millennium Hotel, Queenstown New Zealand  
11 & 12 August 2022

[www.ages.com.au](http://www.ages.com.au)

# THURSDAY 11<sup>TH</sup> AUGUST 2022

0700 - 0800 Conference Registration

0800 - 1015 **SESSION ONE: THE FUTURE OF WOMEN'S HEALTH**

Whakatau

Welcome

The big picture - strategic thinking in the NZ health plan - **Andrew Connolly**

COVID and law reform: the medicalisation of abortion - **Michelle Wise**

Equity of access to women's health in Australasia - **Vijay Roach**

Transformation of the delivery of women's health care in Australia - the SPHERE approach - **Danielle Mazza**

The new gynaecology MBS schedule - **Jason Abbott**

1015 - 1045 MORNING TEA & TRADE EXHIBITION

1045 - 1230 **SESSION TWO: INTEGRATING EVIDENCE INTO PREGNANCY CARE**

RANZCOG guidelines and policies for the future - **Gillian Gibson**

39 is the new 38 - **Aaron Caughey**

First 1000 days - reversing the impacts of intergenerational poverty - **Johan Morreau**

Patient outcome calculators for the perfect birth

Panel Discussion

1230 - 1330 LUNCH & TRADE EXHIBITION

1330 - 1500 **SESSION THREE: INNERVATION INNOVATIONS**

Dimensions in diagnosing dyspareunia - **Charlotte Reddington**

Feedback from my pelvic floor - **Jennifer Kruger**

Navigating nerve blocks - **Praveen De Silva**

The magic of the wand - **Hannah Orr**

Post natal pain - **Louise Tomlinson**

Panel discussion

1500 - 1530 AFTERNOON TEA & TRADE EXHIBITION

1530 - 1700 **SESSION FOUR: SIMULATION SURVIVOR (S.T.A.G. - Simulation Trainee Advisory Group)**

Role of simulation and clinical education in gynaecology

The Simulation Survivor brains trust consists of the simulation minded Dr Katrina Calvert (KEMH, Perth), Dr Rebecca Szabo (RWH, Melbourne), Dr Doug Barclay (Middlemore Hospital, NZ) and Dr Sarah Janssens (Mater Mothers Brisbane).

Watch as the teams from North, East, South and West battle it out to be the AGES Simulation Survivor. Team will attempt to outwit, outplay and outlast across the domains for feedback, debriefing and psychological safety. The competition will be moderated by simulation experts, but your vote will determine which team stays on Simulation Island and wins the title of the Ultimate Simulation Survivor.

1700 **CLOSE OF DAY ONE**

1900 - 2200 **CONFERENCE DINNER**

# FRIDAY 12<sup>TH</sup> AUGUST 2022

0730 - 0800 Conference Registration

0800 - 0950 **SESSION FIVE: SURGICAL INNOVATION THROUGH TECHNOLOGY**

Robots rolling on the red carpet - **Marcus Carey**

My energy source is better - **Kate Tyson**

First with the head, then with the hands - **Supuni Kapurubandara**

Old dog new tricks - the ascending colon neo-vaginoplasty for male to female transgender surgery - **Peter Walker**

Quality & quantity - does it matter? - **Pelle Kempe**

Mentoring through my monitor - **Michael Wynn-Williams**

Panel Discussion

0950 - 1020 MORNING TEA & TRADE EXHIBITION

1020 - 1200 **SESSION SIX: THE ONCOLOGY BIOLOGY**

Born this way - hereditary cancer syndromes - **Ai Ling Tan**

Reducing my risk with surgery - **Bryony Simcock**

When bigger is not always better - **Sathana Ponnampalam**

MIS in cervical cancer - is it gone forever? - **Susannah Mourton**

The future is bright for our people - **Michael Burling**

HPV screening, did Australia get it right – differences across the ditch - **Lois Eva**

Panel Discussion

1200 - 1300 LUNCH & TRADE EXHIBITION

1300 - 1450 **SESSION SEVEN: MIDLIFE MATTERS**

How low can you go? Comparing hysterectomy rates in NZ and Australia

Hold on for your life - retaining ovaries beyond the menopause - **Rod Baber**

MHT for all - practical prescribing for the gynae surgeon

The end of the enigmatic smile - **Erin Nesbitt-Hawes**

Long COVID - new ideas for women

Panel Discussion

1450 - 1520 AFTERNOON TEA & TRADE EXHIBITION

1520 - 1635 **SESSION EIGHT: ARDUOUS, AMBIGUOUS AND ADVENTUROUS CASES**

Aggressive Adenomyoma vs Leiomyosarcoma - **Keryn Harlow**

Awkward decisions before take-off

Noodles in my heart – cardiac leiomyomatosis - **Cecile Bergzoll**

Atypical endometriosis in pregnancy - **Sarah Fitzgibbon**

1635 **CLOSE OF CONFERENCE**

**AUGUST 2022**  
**11-12**  
New Zealand



# Integration through Innovation

**Dear Colleagues,**

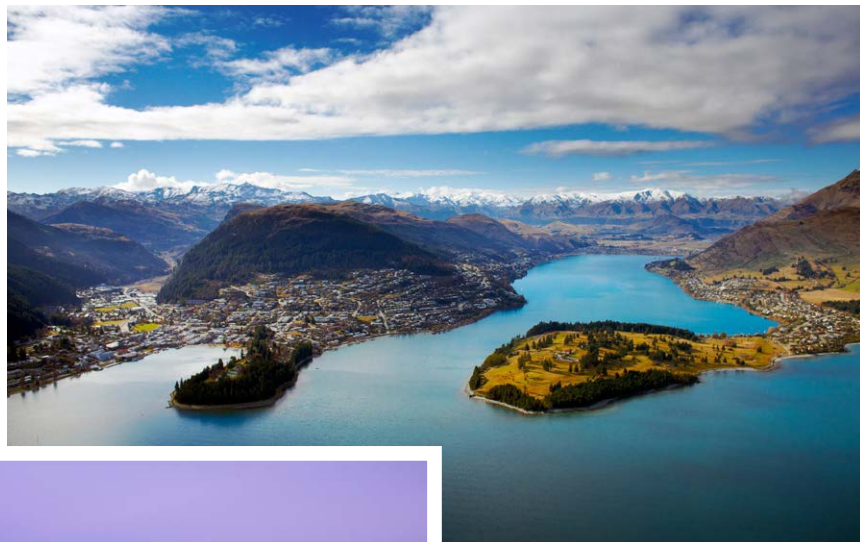
I would like to take this opportunity to invite you to join us in beautiful Queenstown, New Zealand, for the AGES 2022 Focus Meeting. Overseas travel has been a distant memory for many of us, but with the opening of the NZ borders, our Australian members can now travel abroad, spread our wings and be educated. We are looking forward to reconnecting with our New Zealand colleagues and sharing our combined knowledge. Pack your passport and your winter woollies!

The theme of 'Integration through Innovation' has allowed us to curate a program with wide appeal to our membership; the local organising committee believe there is something for everyone in there. We will take you on a journey through the future of women's health with a plenary session involving leaders in this field and further cover topics including surgical innovation through technology midlife management, evidence based pregnancy care, and the oncology biology. We will also have a session from the STAG simulation team, where players will pitch against each other to win a coveted title – all to be revealed later.... Our final session will be a series of puzzling cases and tales of the unexpected.

So please join us for this exciting meeting...



**Dr Rachel Green**  
Conference Chair  
AGES Vice President



Photos from:  
[queenstownnz.co.nz](http://queenstownnz.co.nz)

# Onwards & Upwards

**3 - 5 November 2022**  
Crown Promenade Melbourne

# ● Communicating effectively and professional healthcare interpreters

**Dr Patrick Clancy** Senior Medical Adviser –  
Advocacy, Education and Research, Avont

**Ms L came to the consultation accompanied by her sister-in-law, who explained that she would help translate anything Ms L didn't understand. The surgeon suspected endometriosis and recommended laparoscopy. She was concerned that the women seemed to be arguing and the sister-in-law asked repeatedly about whether Ms L would be able to have children. Ms L nodded but did not say anything when asked if she understood the procedure.**

Healthcare practitioners have a duty to take all reasonable steps to communicate effectively with patients – including using qualified language interpreters wherever necessary. However, recent research<sup>1</sup> suggests that culturally and linguistically diverse patients are not always being offered access to professional interpreters.

Think about how much information you exchange in even the most straightforward patient consultation. As well as being a professional responsibility, it is in your interests as well as the patient's to communicate effectively and avoid misunderstandings. Inadequate or selective translation may mean patients are unable to provide voluntary and informed consent to treatment. In other cases, poor communication may lead to inadequate history-taking; missed or delayed diagnosis; patients being unable to follow medication or treatment plans; or the need for additional referrals and tests.

There may be multiple reasons why doctors do not engage professional interpreters. In some cases they may assume a family member can translate, or that a patient will ask if they need an interpreter. Sometimes the concern may be about the cost of an interpreter, or the time it will take to access, or simply not knowing how to access an interpreter.

## **Use professional interpreters wherever possible**

The Medical Board of Australia's [Good medical practice: a code of conduct for doctors in Australia](#) (Code of Conduct) requires doctors to be familiar with and use qualified language interpreters wherever necessary. This includes access to sign language interpreters if required for deaf or hearing-impaired patients.

As this scenario highlights, relying on the patient's relatives or friends to interpret can be risky and may be inappropriate.

Patients may be unwilling to disclose clinical issues to a family member, particularly a child. Children may be traumatised by having to interpret sensitive health information about their parents. Despite having good conversational English, a relative or friend may not be able to translate medical terminology.

Family members may also filter what they relay to the patient. Even if this is well-intentioned, out of a desire to soften the message or please the practitioner, it means the patient does not receive the information they need. More problematically, refugee and women's health advocates have highlighted examples of coercive behaviours being perpetuated where family members or non-professionals are being used to interpret.<sup>2</sup>

## **Identify the need for an interpreter**

There are several guides to help practitioners identify when an interpreter may be needed (see the resources below). Often it is as simple as asking open questions. 'Yes' or 'no' answers can mask a lack of understanding. Having the patient describe their symptoms or explain in their own words how they would manage a risk or complication can make it easier to spot a language barrier.

## **Accessing professional interpreters**

Make sure that the practice team understand how to access professional interpreters when needed to assist patients who use another spoken language or sign language. Practices may have posters or signage letting patients know they can ask for an interpreter →



# Communicating effectively and professional healthcare interpreters cont.

Dr Patrick Clancy

and the languages available. (For more information on interpreter services, see the resources below.)

Patients sometimes feel concerned about involving an interpreter, particularly in the context of intimate or sensitive health issues. Using telephone interpreters can help preserve anonymity and it can be helpful to reassure patients that professional interpreters are required to maintain confidentiality. An interpreter can help you explain this part if necessary.

## Save time by communicating clearly

Whether or not you are using an interpreter, communicating clearly can take time. However, it generally saves more time and misunderstandings later.

If you haven't worked with an interpreter, it can feel a little awkward to get the balance right. Key tips include:

- » Allow time initially for the patient to speak with the interpreter and to feel comfortable and confident about the arrangement, especially if the interpreter is on the phone.
- » Speak directly to the patient and engage with them rather than asking the interpreter to relay questions. "Do you have someone to help you at home while you recover?" not "Can you ask the patient if they have access to support at home?"
- » Pace your communication. Think about how much information you deliver at once. Pause so the interpreter has time to relay the information.
- » It can also be helpful to signpost the consultation – explain the steps you will be working through – so both the patient and interpreter know what's coming.
- » Allow plenty of time for questions.
- » Use diagrams and other printed materials where appropriate to help convey information.

## Think about follow-up

Ensure the patient knows how to get in contact if they have questions, and check whether they wish you to share their personal information with any family members or support people.

## Resources

Avant factsheet: Use of interpreters

[www.avant.org.au/Resources/Public/use-of-interpreters/](http://www.avant.org.au/Resources/Public/use-of-interpreters/)

Western Sydney Local Health District: Assessing the need for an Interpreter [\[www.wslhd.health.nsw.gov.au/Health-Care-Interpreter-Service-/Assessing-the-need-for-an-Interpreter\]](http://www.wslhd.health.nsw.gov.au/Health-Care-Interpreter-Service-/Assessing-the-need-for-an-Interpreter)

Migrant & Refugee Women's Health Partnership: Guide for Clinicians Working with Interpreters in Healthcare Settings [\[culturaldiversityhealth.org.au/wp-content/uploads/2019/10/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf\]](http://culturaldiversityhealth.org.au/wp-content/uploads/2019/10/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf)

TIS National: Hints and tips for working with interpreters [\[www.tisnational.gov.au/About-TIS-National/Videos/Hints-and-tips-for-working-with-interpreters-video.aspx\]](http://www.tisnational.gov.au/About-TIS-National/Videos/Hints-and-tips-for-working-with-interpreters-video.aspx)

National Auslan Interpreter Booking & Payment Service: How to Work With a NABS Interpreter [\[www.nabs.org.au/how-to-work-with-an-interpreter.html\]](http://www.nabs.org.au/how-to-work-with-an-interpreter.html)

*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.*



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## REFERENCES

- 1 Abdelmessih et al, Exploring the health care challenges and health care needs of Arabic-speaking immigrants with cardiovascular disease in Australia, *Pharmacy* 2019, 7, 151; doi:10.3390/pharmacy7040151
- 2 Professionals Australia, The critical role of language services for CALD women affected by family violence, submission to the Royal Commission into Family Violence on behalf Translators and Interpreters Australia, 2015, accessed 21 April 2022

# ● Elephants in the room: 'tracking' obstetrics and gynaecology training; why advanced laparoscopic gynaecology shouldn't be a formal RANZCOG subspecialty (yet)

**Dr Alison Bryant-Smith**  
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**A few years ago, a colleague sought themes worthy of debate at future AGES conferences. 'Splitting obstetric and gynaecology training! AGES training as a formal subspecialty!' was my enthusiastic reply. Her bemused response? 'No-one will touch those topics with a barge pole!'**

While all patients deserve highly skilled and experienced surgeons, gynaecological training is 'in a somewhat parlous state... with an uncertain future'.<sup>1</sup> Would splitting obstetrics from gynaecology training and/or gaining RANZCOG subspecialty accreditation for advanced laparoscopic training improve patients' surgical outcomes? It's high time we openly discussed the elephants in the (conference) room...

## **RANZCOG trainees' diminishing surgical skills**

Most RANZCOG trainees do not acquire the surgical skills expected of gynaecologists. A 2009 survey concluded that trainees lack confidence in a surprisingly wide range of surgical procedures.<sup>2</sup> Dr Lalla McCormack recently concluded that the 'available volume [of gynaecological surgery] is unlikely to provide exposure for optimal training and practice for all trainees'.<sup>3</sup> Consider hysterectomy, which sits at the heart of gynaecological training: only 40% of graduating Fellows of the American College of Obstetricians and Gynecologists can independently perform a hysterectomy (by any route), and only 22% feel 'completely prepared' to perform a total laparoscopic hysterectomy (TLH).<sup>4,5</sup> I doubt recently-elevated RANZCOG Fellows share their American counterparts' confidence or competence.

Many factors underlie trainees' inadequate surgical exposure, including:

- » More RANZCOG trainees: there was a 131% increase in trainees from 2011 – 2020<sup>6</sup>
- » Reduced working hours, causing 'considerable downsides' for surgical training<sup>7</sup>
- » Truncated surgical training: while general surgeons

train for 5 years, O&G trainees spend approximately 18 months undertaking gynaecological surgical training<sup>8</sup>

- » Many conditions previously treated surgically can now be managed with non-surgical strategies<sup>9</sup>. Hence, there are fewer major gynaecological procedures to be performed.
- » Increasing complexity of the remaining surgical cases, necessitating steeper learning curves<sup>10</sup>
- » A breakdown of the 'surgical apprentice model', which disrupts trainees' capacity to learn from any one particular consultant<sup>11</sup>
- » Onerous (largely obstetric) service provision demands, to the detriment of gynaecological training<sup>2,12</sup>
- » A vicious cycle, in which consultants who are still climbing their own laparoscopic learning curves take primary operator experiences from trainees<sup>13,14</sup>
- » A broader range of surgical techniques to be mastered (e.g. hysterectomy via abdominal, vaginal, laparoscopic, and laparoscopic-assisted vaginal [LAVH] routes, let alone robotic, single incision laparoscopic or vaginal natural orifice transluminal endoscopic surgery [vNOTES] approaches)<sup>8</sup>

Hence, RANZCOG trainees' gynaecological procedure numbers are 'among the lowest anywhere'.<sup>7</sup> How can any educational institution teach greater breadth and depth, with fewer work hours, in the same number of training years?<sup>15</sup> Something's got to give...

Some commentators argue that obstetrics and gynaecology should be separated back into two distinct specialties, from whence they came. However, I believe we (as a specialty) are better poised to advocate for women's health as a united front of obstetricians and gynaecologists. →

# ● Elephants in the room: ‘tracking’ obstetrics and gynaecology training cont.

Dr Alison Bryant-Smith

## ‘Tracking’ of advanced RANZCOG trainees into areas of interest

Currently, RANZCOG training produces a high number of low-volume surgeons, which hinders optimal surgical outcomes. Introducing so-called ‘tracking’ (which is at the forefront of O&G education) into RANZCOG training presents an attractive solution to waning surgical volumes.<sup>16,17</sup> Pioneered at the Cleveland Clinic in the US, ‘tracking’ enables advanced trainees to self-select into rotations in their area(s) of interest, thereby gaining valuable experience in their intended scope of practice.<sup>10</sup> For surgically-oriented trainees, ‘tracking’ improves the likelihood of accumulating sufficient surgical volumes

to achieve competency.<sup>18</sup> As noted by Prof Jason Abbott, patients’ demands for perfect outcomes necessitates training fewer surgeons to a higher level.<sup>19</sup>

Purported benefits of ‘tracking’ include:

- » Increased operative and clinical experience
- » Increased mentorship in an area of interest
- » Improving trainees’ research output
- » Affirming the vital role of generalist obstetrician / gynaecologists
- » Development of a ‘labourist’ track, in which some clinicians focus on managing labouring patients and obstetric emergencies<sup>17,20</sup>

If O&G training is analogous to a tree, ‘tracking’ could be represented as:

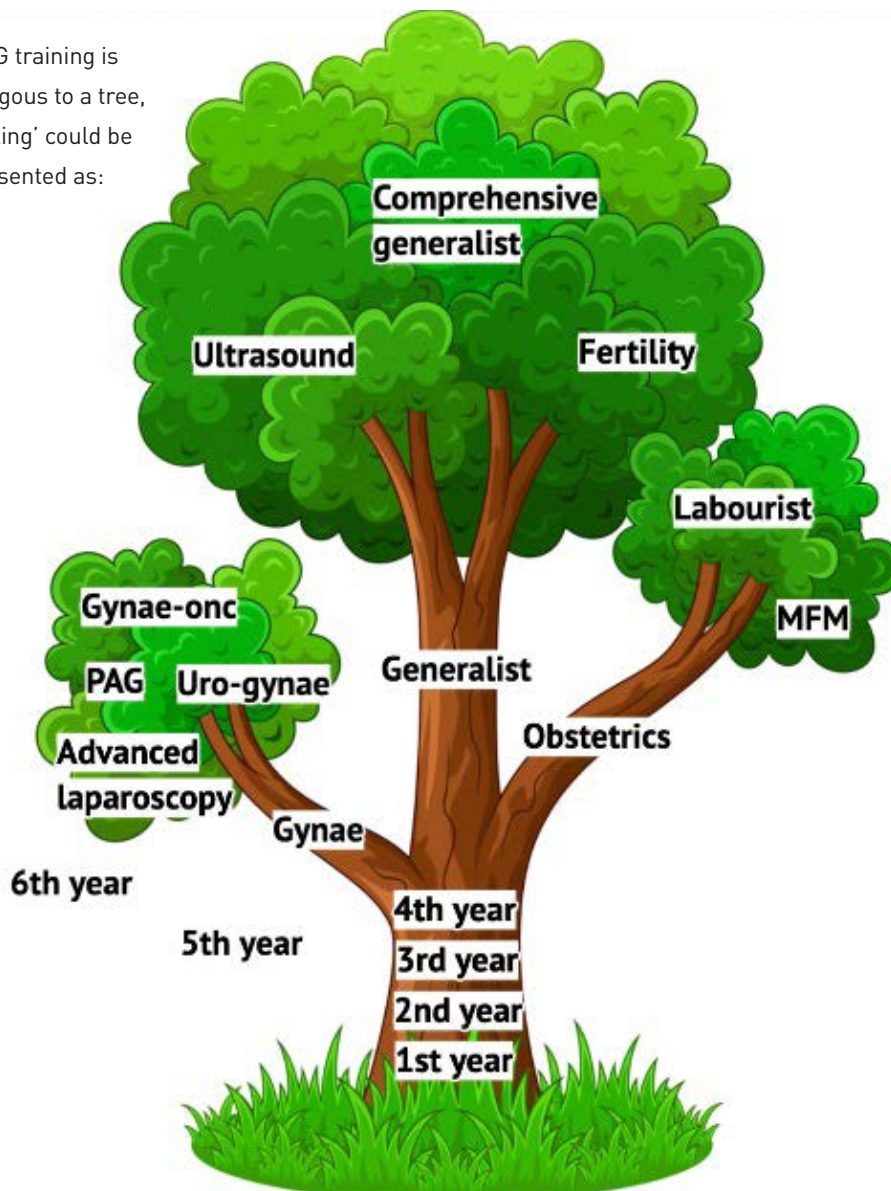


Figure 1: how ‘tracking’ could work in RANZCOG training.

Each text box represents how one year of the six-year RANZCOG training program could be spent. Trainees start their training at the base of the trunk, and spend the first four years moving up the trunk undertaking general basic training. For fifth year, trainees choose one limb, with the options being gynaecology, generalist or obstetrics. For their sixth year of training, trainees can choose any branch of their fifth year limb.

(MFM = maternal fetal medicine, PAG = paediatric and adolescent gynaecology.)

Edited from Shutterstock image.<sup>21</sup>

# ● Elephants in the room: ‘tracking’ obstetrics and gynaecology training cont.

Dr Alison Bryant-Smith

One challenge inherent to ‘tracking’ is defining which ‘mission-critical’ skills and procedural knowledge fall within the purview of the ‘comprehensive generalist’; by exclusion, this means determining which skills are no longer part of the generalist’s arsenal.<sup>18</sup> As noted by AGES President

Dr Steve Lyons:

‘hard decisions will have to be made... that may include the recognition that a proportion of RANZCOG basic trainees decide very early on that they do not wish to perform procedures above the RANZCOG/AGES level 2 SCOP [scope of clinical practice] [e.g. laparoscopic salpingectomy] ... [this] would free up gynaecological procedures for those wishing to practise at the level 3 SCOP [e.g. LAVH] and above.’<sup>1</sup>

Stakeholders must reach consensus on this, while ensuring that core competencies align with population-level patient needs.<sup>18</sup>

One potential disadvantage of ‘tracking’ is over-emphasising subspecialisation. However, creating a ‘comprehensive generalist’ track would better prepare trainees choosing that ‘branch’ for generalist practice.<sup>17</sup> RANZCOG oversight would enable the number of trainees in each ‘track’ to be guided by workforce needs, thereby optimising the balance of ‘comprehensive generalist’ and other ‘specialty interest’ Fellows. In our geographically disparate countries, the presence of ‘comprehensive generalists’ in regional and rural centres (in particular) is essential. This necessitates a paradigm shift, and an increased understanding of the inter-relationship between surgical volume and surgical skill in these settings.<sup>22</sup>

Additional challenges include administrative logistics, and some training hospitals having too few trainees to allocate into tracks.<sup>23</sup> If ‘tracking’ is introduced to RANZCOG training, it could be trialled in tertiary maternity hospitals with large numbers of trainees. If successful, appropriate tracks could then be introduced into regional hospitals, based on the hospital’s capacity to provide them.

Training hospitals must evolve beyond allowing obstetric service provision to drive staffing decisions: ‘tracking’ (with RANZCOG oversight) would promote this. As recommended by former RANZCOG President Prof Michael Permezel,

RANZCOG ‘must progressively withdraw trainees from ITPs [integrated training programs] where trainees are being used as ‘cheap obstetric labour’ and not adequately trained across the spectrum of obstetrics and gynaecology.’<sup>17</sup>

## The benefits of high-volume surgeons

When evaluating innovative surgical education initiatives, the benefits of so-called ‘high-volume surgeons’ should be considered. Operations performed by ‘high-volume’ gynaecologists (i.e. clinicians performing at least 1 major gynaecological operation per month) are associated with:

- » Increased utilisation of minimally invasive techniques
- » Lower rates of conversion to laparotomy
- » Fewer intra-operative complications (e.g. bowel and urinary tract injuries, excessive blood loss)
- » Fewer post-operative complications (e.g. unplanned readmission)
- » Shorter hospital admission
- » Fewer intensive care admissions<sup>8,17,24</sup>

While surgical volume alone is insufficient to predict outcomes, there is a dose-response relationship between a surgeon’s volume and optimal outcomes.

In the US, approximately 80% of obstetrician/gynaecologists are low-volume surgeons.<sup>8</sup> This is probably similar in Australia/NZ, given RANZCOG training produces a high number of low-volume surgeons. In geographically disparate countries such as Australia, any potential gains from limiting advanced gynaecological surgery to high-volume surgeons must be balanced against optimising access for patients in regional and rural areas. Regionalisation of care is often impractical, and many patients prefer to receive care locally.<sup>25</sup> Introducing low-volume cut-offs would restrict the surgical privileges of most Antipodean gynaecologists, many of whom have excellent outcomes.<sup>26</sup>

We would all do well to:

‘put our egos aside and to always put the patient first... It’s not about me or the surgeons or whether I can technically perform the procedure. It is about trying to achieve the best possible outcome for every patient. When it comes to optimizing outcomes, surgical volume does matter’.<sup>27</sup>



# ● Elephants in the room: ‘tracking’ obstetrics and gynaecology training cont.

Dr Alison Bryant-Smith

## Would making advanced laparoscopic gynaecology a formal RANZCOG subspecialty improve patient outcomes?

General surgical literature consistently demonstrates the positive impacts of subspecialty training on patient outcomes.<sup>28</sup> Even if a ‘tracking’ system was introduced, there may still be an insufficient number of advanced laparoscopists to provide optimal gynaecological care for all Antipodean women. Would making advanced laparoscopic gynaecology a formal RANZCOG subspecialty improve this?

The five subspecialty training programs that are currently RANZCOG-accredited consist of: three years’ full-time equivalent training; satisfactory completion of formative and summative assessments, written and oral examinations; and completion of a ‘scholarly elective study’.<sup>29</sup> Graduating subspecialists receive a post-nominal qualification. AGES-accredited Fellowship training may be considered a ‘subspecialty-lite’: two years’ full-time training, with a written examination, assessment of surgical competencies, and research, publication, conference presentation, and biostatistics components. Despite this, and to the chagrin of some AGES Fellows, graduates do not currently receive a post-nominal qualification: a concern that has been raised with the AGES Board. If advanced laparoscopy was a RANZCOG-accredited subspecialty, patients with the most complex surgical needs may find it easier to receive care from surgeons with this advanced training. However, as recently noted by Dr Steve Lyons, ‘AGES is not supportive of such a step at this time for various reasons’.<sup>1</sup>

Generalist obstetrician/gynaecologists would likely push back against proposals to gain RANZCOG subspecialty accreditation for advanced gynaecological laparoscopic training. Subspecialisation projects are problematic: advocates for the proposed new subspecialty must posit ‘the establishment’ as lacking the skills and/or knowledge to service a segment of the profession’s market.<sup>30</sup> In doing so, they challenge many clinicians’ *raison d’être*, and stir up trouble: hence my colleague’s reluctance to touch this topic with a barge pole.

Productive relationships between generalists and advanced laparoscopists must be maintained, and a peaceful coexistence preserved. However, AGES Fellows deserve formal recognition of their advanced surgical training, and the many sacrifices (professional, personal, and financial amongst them) demanded of them while completing the rigorous AGES training program. Without seeking formal RANZCOG subspecialty status, bestowing AGES Fellowship graduates with a post-nominal (e.g. ‘FAGES’, or ‘Fellow of AGES’) would support this goal. It would also enable patients to seek out surgeons who have received advanced laparoscopic training, thereby improving patient outcomes.

## Conclusions

As surgeons and educators, we have an ethical duty to optimise trainees’ surgical knowledge and skills: an evolving challenge, where innovation is key. ‘Tracking’ provides a potential solution which meets the surgical needs of trainees and patients alike.

The RANZCOG/AGES conjoint Endoscopic Surgery Advisory Committee (ESAC) was created ‘to develop a mutual understanding and progress common goals regarding surgical education’.<sup>1</sup> Hence, it is well-placed to lead discussions about both ‘tracking’ of RANZCOG trainees, and the potential benefits and drawbacks of making advanced laparoscopic training a formal subspecialty. As noted by ESAC Chair Prof Jason Abbott, asking ‘the difficult questions and perhaps suggesting difficult answers is what needs to be done’.<sup>19</sup> More for our patients’ sakes than anything else, it is time to openly discuss the elephants in the room.



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# ● Elephants in the room: ‘tracking’ obstetrics and gynaecology training cont.

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## REFERENCES

- 1 Lyons S. President’s Letter. eScope: e-Newsletter of the Australasian Gynaecological Endoscopy & Surgery Society Limited. 2021.
- 2 Obermair A, Tang A, Charters D, Weaver E, Hammond I. Survey of surgical skills of RANZCOG trainees. Aust New Zeal J Obstet Gynaecol. 2009;49(1):84–92.
- 3 McCormack L. Training for and undertaking gynaecological surgery in Australia: a comprehensive analysis of AIHW and MBS data. In 2021.
- 4 Guntupalli SR, Doo DW, Guy M, Sheeder J, Omurtag K, Kondapalli L, et al. Preparedness of obstetrics and gynecology residents for fellowship training. Obstet Gynecol. 2015;126(3):559–68.
- 5 Hall EF, Raker CA, Hampton BS. Variability in gynecologic case volume of obstetrician-gynecologist residents graduating from 2009 to 2017. Am J Obstet Gynecol. 2020;222(6):617.e1–617.e8.
- 6 The Royal Australian and New Zealand College of Obstetricians and Gynecologists. 2020 - 2021 Activities Report. Activities Report. 2021.
- 7 Permezel M. How can safe working hours produce a safe specialist obstetrician & gynaecologist? Aust New Zeal J Obstet Gynaecol. 2017;57(5):491–2.
- 8 Glaser LM, Brennan L, King LP, Milad MP. Surgeon Volume in Benign Gynecologic Surgery: Review of Outcomes, Impact on Training, and Ethical Contexts. J Minim Invasive Gynecol. 2019;26(2):279–87.
- 9 Gressel GM, Potts JR, Cha S, Valea FA, Banks E. Hysterectomy Route and Numbers Reported by Graduating Residents in Obstetrics and Gynecology Training Programs. Obstet Gynecol. 2020;135(2):268–73.
- 10 Cohen SL, Hinchcliff E. Is surgical training in OB/GYN residency adequate? Contemp Ob Gyn. 2016;August:24–9.
- 11 Fenner DE. Training of a gynecologic surgeon. Obstet Gynecol. 2005;105(1):193–6.
- 12 Lauer JK, Advincula AP. The Future of the Gynecologic Surgeon: Rationale for and Steps toward Subspecialization of Complex Gynecologic Surgery. J Minim Invasive Gynecol. 2021;28(4):726–9.
- 13 Hammond I, Karthigasu K. Training, assessment and competency in gynaecologic surgery. Best Pract Res Clin Obstet Gynaecol. 2006;20(1):173–87.
- 14 Kolkman W, Wolterbeek R, Jansen FW. Implementation of advanced laparoscopy into daily gynecologic practice: Difficulties and solutions. J Minim Invasive Gynecol. 2006;13:4–9.
- 15 Dilts P. The end of the beginning. Am J Obstet Gynecol. 1989;160(6):1311–5.
- 16 Cleveland Clinic. Obstetrics and Gynecology Residency Program: tracking program [Internet]. 2022 [cited 2022 Jan 6]. Available from: <https://my.clevelandclinic.org/departments/obgyn-womens-health/medical-professionals/education-programs/residency-program#tracking-program-tab>
- 17 Siedhoff MT, Truong MD, Wright KN. Gynecologic surgery tracking in obstetrics and gynecology residency. Curr Opin Obstet Gynecol. 2020;32(4):298–303.
- 18 Brown HL, Carson SA, Lawrence HC. The First National Summit on Women’s Health: The Future of Obstetrics and Gynecology Training. Obstet Gynecol. 2018;132(3):755–62.
- 19 Connan K. Leaders in Focus: Prof Jason Abbott. eScope e-Newsletter Australas Gynaecol Endosc Surg Soc Limited. 2019;21(3):10–2.
- 20 Weinstein L. The laborist: A new focus of practice for the obstetrician. Am J Obstet Gynecol. 2003;188(2):310–2.
- 21 Shutterstock [Internet]. 2022 [cited 2022 Jan 26]. Available from: <https://www.shutterstock.com/editor/image/green-tree-cartoon-317936303?task=text>
- 22 Tracy EE, Zephyrin LC, Rosman DA, Berkowitz LR. Credentialing based on surgical volume, physician workforce challenges, and patient access. Obstet Gynecol. 2013;122(5):947–51.
- 23 Hariton E, Freret TS, Nitecki R, Hinchcliff E, Stagg A. Program Director Perceptions of Subspecialty Tracking in Obstetrics and Gynecology Residency. J Grad Med Educ. 2018;10(6):665–70.
- 24 Mowat A, Maher C, Ballard E. Surgical outcomes for low-volume vs high-volume surgeons in gynecology surgery: A systematic review and meta-analysis. Am J Obstet Gynecol [Internet]. 2016;215(1):21–33. Available from: <http://dx.doi.org/10.1016/j.ajog.2016.02.048>
- 25 Ruiz MP, Chen L, Hou JY, Tergas AI, St. Clair C, Ananth C V., et al. Outcomes of hysterectomy performed by very low-volume surgeons. Obstet Gynecol. 2018;131(6):981–90.

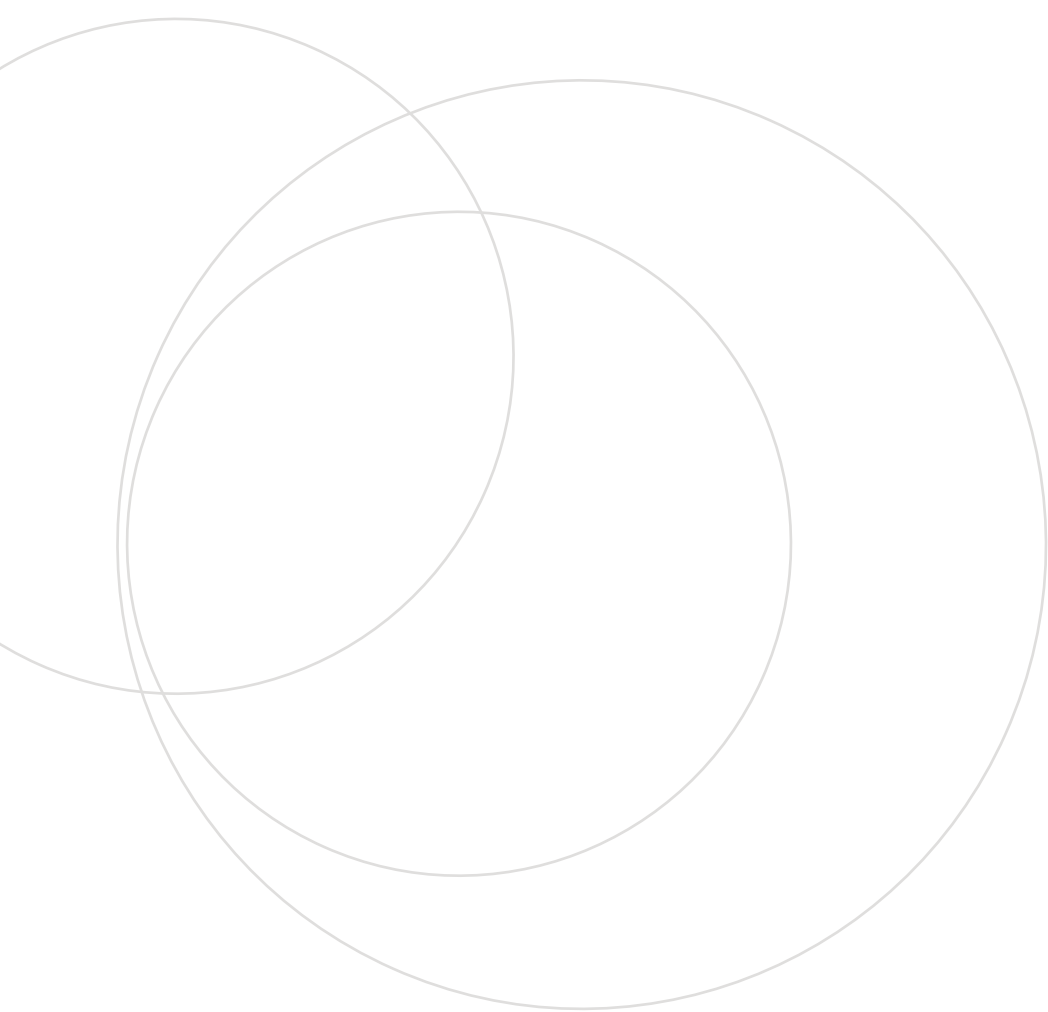
# ● Elephants in the room: ‘tracking’ obstetrics and gynaecology training cont.

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## REFERENCES CONT.

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- 26 Ruiz MP, Chen L, Hou J, Tergas A, St. Clair C, Ananth C, et al. Effect of Minimum-Volume Standards on Patient Outcomes and Surgical Practice Patterns for Hysterectomy. *Obstet Gynecol.* 2018;132(5):1229–37.
- 27 Brown DN. Doing what is best for the patient: When surgical volume matters. *Obstet Gynecol.* 2018;131(6):977–9.
- 28 Vargas M V., Milad MP. Matching Trends for the Fellowship in Minimally Invasive Gynecologic Surgery Since Participation in the National Residency Match Program. *J Minim Invasive Gynecol.* 2018;25(6):1060–4.
- 29 The Royal Australian and New Zealand College of Obstetricians and Gynecologists. Subspecialist training programs [Internet]. 2021 [cited 2022 Jan 25]. Available from: <https://ranzcog.edu.au/training/subspecialist-training>
- 30 Zetka JR. Establishing specialty jurisdictions in medicine: The case of American obstetrics and gynaecology. *Sociol Heal Illn.* 2011;33(6):837–52.





# Update: Hysteroscopic Mechanical Tissue Removal Systems

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Abnormal uterine bleeding secondary to intrauterine pathologies is one of the most common causes of gynaecological visits. Functional and structural disorders such as endometrial polyps and submucosal leiomyomas are reported to be the main cause contributing forty percent of the total disease burden<sup>1</sup>.

Hysteroscopy is considered the gold standard for endoscopic evaluation of the uterine cavity. Hysteroscopy incorporating conventional resectoscopy has revolutionised gynaecological practice for the treatment of structural disorders since 1970<sup>2</sup>. Resectoscopes pose several intraoperative challenges specifically visualization of the operative field which can be challenging by formation of bubbles produced by heated distention fluid along with the free floating resected tissue. Cervical trauma, TURP syndrome, uterine perforation and difficulty avoiding secondary endometrial damage due to the use of electric current and thermal energy during electrical resection can not be ignored<sup>3</sup>.

Integration of the simultaneous excision and aspiration of the tissues via the distal window of mechanical tissue removal devices can almost eliminate these challenges<sup>4,5</sup>. A systematic review and meta-analysis by Shazly et al. concluded that women treated with intrauterine morcellation have a shorter procedure duration than those treated with electrosurgical resection<sup>6</sup>. Compared to hysteroscopic resectoscopy, Hysteroscopic Tissue Removal Systems are easier to master. A randomized controlled trial by van Dongen et al. reported that approximately one fifth of the resectoscopy procedures had to be taken over by the trainer, whereas only 3% of the morcellator procedures could not be completed by the residents unassisted<sup>7</sup>. A study by Smith et al. demonstrated that for the removal of endometrial lesions in an office setting, compared to traditional bipolar

resectoscopy, intrauterine morcellation was less painful and more acceptable to women<sup>4</sup>.

In 2005, TruClear (TruClear 8.0 System; Smith & Nephew) was the first hysteroscopic mechanical tissue removal device cleared by the Food and Drug Administration (FDA)<sup>4,5</sup>. In recent years, based on the same procedural principal, several companies have developed various tools of slightly different shapes and sizes. The tissue is sucked into the cutting window and cut into small fragments by a rotating blade. The system instantly aspirates the tissue fragments through the central tube and is collected in a suction trap. To maintain an intracavity pristine view during the procedure, a reliable irrigation system is pivotal. Currently, there are three major Hysteroscopic Tissue Removal Systems available in Australia: TruClear™, MyoSure®, and BIGATTI Shaver®.

## Structural Design

Hysteroscopic tissue removal devices with modern fluid management systems were developed in an attempt to overcome the drawback of conventional resectoscopes. Hysteroscopic morcellation offers the advantage of simultaneous visualization and minimally invasive resection and/or sampling of uterine lesions without the use of energy, thereby improving the procedures efficiency and outcomes<sup>8</sup>. Most mechanical Hysteroscopic Tissue Removal Systems have similar structural designs consisting of the following:

- » Power control unit with dedicated software
- » Footswitch
- » Hand-piece
- » Hysteroscope
- » Shaver blades
- » Window lock
- » Irrigation and suction system





# Update: Hysteroscopic Mechanical Tissue Removal Systems cont.

Dr Sumi Saha



## Hysteroscopic Fluid Management System



TruClear™  
INCISOR™ device



TruClear™  
INCISOR™ Plus device



TruClear™  
ULTRA Plus device



TruClear™  
ULTRA Mini device



OPERATING ROOM

FIBROIDS ≤ 5 CM and ALL POLYPS

FIBROIDS ≤ 3 CM and ALL POLYPS

DIRECTED BIOPSY and POLYPS ≤ 3 CM

DIRECTED BIOPSY and POLYPS < 1 CM

OUTPATIENT SETTING

MyoSure™ XL device

MyoSure™ REACH device

MyoSure™ LITE device

MyoSure™ MANUAL device

**The MyoSure® suite  
FOR A FULL SPECTRUM OF  
INTRAUTERINE PROCEDURES**

Use the full capabilities of the MyoSure suite to:

- Perform a variety of procedures to help treat a wide range of intrauterine pathology
- Bring efficiency and consistency to your procedural choices
- Have the flexibility to perform procedures in any setting
- Achieve more complete resections and tissue collections

MyoSure®  
Tissue Removal Simplified



# Update: Hysteroscopic Mechanical Tissue Removal Systems cont.

Dr Sumi Saha

## Clinical Application of Hysteroscopic Tissue Removal Systems

Recent clinical evidence demonstrated that Hysteroscopic Tissue Removal Systems are an effective and safe, minimally invasive alternative to conventional operative hysteroscopy to treat structural endometrial abnormalities<sup>9</sup>. The working mechanism of the device is very simple. Once the cutting blade window is placed in close contact with the pathology to be removed, this innovative technology simultaneously cuts and aspirates the tissue improving visibility and reducing the need for multiple removal and insertion of the device from the uterine cavity<sup>10</sup>.

### Potential Uses of Hysteroscopic Tissue Removal Systems

- » Targeted biopsy sampling
- » Endometrial polypectomy
- » Removal of Submucosal leiomyomas
- » Resection of intrauterine synechiae
- » Metroplasty
- » Resection of missed abortion
- » Removal of retained product of conception

## Resection of Endometrial Polyps with Hysteroscopic Tissue Removal Systems (HTR)

The feasibility and effectiveness of Hysteroscopic Tissue Removal Systems have been well researched by several randomised trials. Compared with conventional loop resectoscopy, HTR Systems are significantly faster for the removal of polyps<sup>5</sup>. Another two studies by Smith et al. and Pampalona et al. demonstrated a higher and more complete removal of polyps in a shorter procedural time with manual HTR Systems in comparison to the bipolar electrode<sup>4,11</sup>. The incidence of polyp recurrence is reported to be higher following resectoscopic removal compared with the HTR System<sup>12,13</sup>

## Myomectomy with HTR Systems

The rate of complete resection and removal of myoma with the manual HTR Systems are considerably dependent on the size and type of myoma. A randomized trial by Wessel et al. demonstrated that hysteroscopic morcellation using the TruClear™ System is faster than bipolar resection for

the removal of smaller type 0 and 1 myomas<sup>14</sup>. Arnold et al. demonstrated that the removal of the entire pathology ranges from 90% for myomas smaller than 2 cm to 48% for myomas larger than 4 cm<sup>15</sup>.

A meta-analysis by Shazly et al. showed significantly less fluid deficit among women who underwent myomectomy treated with morcellation comparing to resectoscopy<sup>6</sup>.

## Hysteroscopic Metroplasty with HTR Systems

Congenital uterine anomalies are a failure of müllerian duct development and are thought to occur in 5.5% of the general female population<sup>16</sup>. Many patients remain asymptomatic and go unnoticed for several years. Hysteroscopic removal of a uterine septum is recommended because of its association with a reduced risk of spontaneous abortion compared with untreated women<sup>17</sup>. In patients with a history of primary infertility, treatment of a uterine septum is indicated as a prophylactic procedure to improve the chance of achieving pregnancy<sup>18</sup>. Simons et al. have proposed that the use of manual HTR Systems might be an effective and safe alternative for resectoscopy in removing avascular uterine septa and may cause fewer complications such as fluid overload or thermal injury<sup>19</sup>.

## Endometrial Sampling with HTR Systems

Traditionally, blind endometrial biopsy and dilation & curettage (D&C) have been the mainstay of endometrial tissue sampling for pathological evaluation<sup>20</sup>. However, several studies have indicated the limitations of curettage and blind biopsy in obtaining adequate samples and diagnosing focal intrauterine lesions. Rosenblatt et al. demonstrated the superiority of manual HTR Systems over dilation and curettage procedures for the collection of targeted large quantities of tissue suitable for precise histological analysis among postmenopausal bleeding patients<sup>21</sup>.

## HTR Systems for Lysis of Adhesions

Intrauterine adhesions (IUA), also known as Asherman's syndrome, can commonly present with hypomenorrhoea or amenorrhoea in the setting of previous uterine instrumentation of the gravid uterus<sup>22</sup>. Avoiding the



# Update: Hysteroscopic Mechanical Tissue Removal Systems cont.

Dr Sumi Saha

use of electrosurgery is preferred, because of the cumulative negative effect on pregnancy outcomes compared with adhesiolysis without application of energy<sup>23</sup>. Patients with moderate to severe IUA are at an inherently greater risk of uterine perforation during adhesiolysis, with rates of 3% to 5% per adhesiolysis procedure<sup>22</sup>. A smaller diameter HTR System can provide a safer alternative for adhesiolysis and minimise the risk of perforation and recurrence.

## HTR Systems for Management of Retained Products of Conception (RPOC)

Retained products of conception are known to occur after miscarriage, vaginal or caesarean delivery, and medical

or surgical pregnancy termination<sup>24</sup>. The number and frequency of patients with RPOC have been increasing<sup>25</sup>. Traditionally, blind dilation & curettage (D&C) is the method of choice for surgical evacuation of residual trophoblastic remnants. This procedure is well known to be associated with higher risk of complication such as uterine perforation, infection, and intrauterine adhesion formation<sup>26</sup>. Intra uterine adhesions are reported to occur in about 15% of patients with a single curettage and 40% of patients with repeated curettage<sup>24,27</sup>. Hysteroscopic Tissue Removal Systems have been proven to be an effective & safe alternative to D&C<sup>28,29</sup>. A study by van Wissel et al. reported higher live birth rate in patients with HTR compared to those treated with loop resection techniques<sup>30</sup>

**Table 1:** Characteristics of the devices currently available on the Australian market

	TruClear™ 8.0 System	TruClear™ 5C System	MyoSure System®	Integrated BIGATTI Shaver®
Manufacturer	Medtronic	Medtronic	Hologic	Karl Storz
<b>HYSTEROSCOPE</b>				
Diameter (mm)	9.0	5.25	7.25, 6.25	6.3
w/o outflow sheet (mm)	8.0	5.6	7.25, 6.25	---
Optic Size (mm)	3.5	0.8	2.0	6.3
Optic System	ROD Lens	Fiberoptic	ROD Lens	ROD Lens
Optic device	0°	0°	0°	6°
<b>CUTTING DEVICE</b>				
Outer Diameter (mm)	4.0 Disposable	2.9 Disposable	3.0, 4.0 Disposable	4.5 Reusable
Action	Rot/Recip	Rot/Recip	Simultaneous Rot/Recip	Rotation
Window closure	Operator to set	Operator to set	Automatic	Automatic

Mm: Millimeters; w/o:without; Rot: Rotation; Recip: Rreciprocation; RF: radiofrequency

**Figure 2:** Illustration of steps involving mechanical hysteroscopic tissue removal system, TruClear™ Device



# Update: Hysteroscopic Mechanical Tissue Removal Systems cont.

Dr Sumi Saha

## Conclusion

Hysteroscopic Mechanical Tissue Removal Systems are fast, safe and well tolerated procedures for patients which require a shorter learning curve. Mechanical morcellation of polyps and myomas do not appear to impact histopathological evaluation of retrieved tissue specimens<sup>12</sup>. Based on the current data, all commercially

available Hysteroscopic Tissue Removal Systems show comparable properties and are gaining an important role in our daily clinical practice. Undoubtedly, there is no better time than now to say goodbye to blind intrauterine procedures.



### Dr Sumi Saha

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MReprodMed, FRANZCOG,  
MPain Management

## REFERENCES

- 1 TurKaspal, Gal M Hartman M, et al. A prospective evaluation of uterine abnormalities by saline infusion sonography in 1,009 women with infertility or abnormal uterine bleeding. *Fertil Steril.* 2006;86:1731-1735
- 2 Jacobsen L J, DeCherney A. Results of conventional and hysteroscopic surgery. *Hum Reprod.* 1997;12:1376-81
- 3 Friedman J A, Wong J M K. Hysteroscopic myomectomy: a comparison of techniques and review of current evidence in the management of abnormal uterine bleeding. *Current opinion in Obstetrics & gynaecology.* 2018;30(4):243-351
- 4 Smith PP, Middleton LJ, Connor M, Clark TJ. Hysteroscopic morcellation compared with electrical resection of endometrial polyps. *Obstet Gynaecol.* 2014;123:745-751
- 5 Emanuel MH, Wamsteker K. The Intrauterine Morcellator: a new hysteroscopic operating technique to remove intrauterine polyps and myomas. *J Minim Invasive Gynecol.* 2005;12:62-66
- 6 Shazly AMS, Laughlin- Tommaso KS, et al. Hysteroscopic Morcellation Versus Resection for the Treatment of Uterine Cavitory Lesions: A Systematic Review and Meta-analysis. *JMIG* 2016;23:867-877
- 7 Van Dongen H, Emanuel MH, Wolterbeek R, et al. Hysteroscopic morcellator for removal of intrauterine polyps and myomas: a randomized controlled pilot study among residents in training. *J Minim Invasive Gynaecol.* 2008;15:466-471
- 8 Vitale S G, Sapia F, et al. Hysteroscopic morcellation of submucous myomas: a systematic review. *Biomed Res Int.* 2017
- 9 Yin X, Cheng J, et al. Hysteroscopic tissue removal systems for the treatment of intrauterine pathology: a systematic review and metanalysis. *Facts Views Vis Obgyn.* 2018;10:207-213
- 10 Noventa M, Ancona E, et al. Intrauterine morcellator device: the icon of hysteroscopic future or merely a marketing image? A systematic review regarding safety, efficacy, advantages, and contraindications. *Reprod Sci.* 2015;22:1289-96
- 11 Pampalona J R, Bastos M D, et al. A comparison of hysteroscopic mechanical tissue removal with bipolar electrical resection for the management of endometrial polyps in an ambulatory care setting: Preliminary results. *J Minim Invasive Gynecol.* 2015;22: 439-445
- 12 Ceci O, Franchini M, et al. Comparison of endometrial polyp recurrence in fertile women after office hysteroscopic endometrial polypectomy using two widely spread techniques. *J Obstet Gynaecol Res.* 2020;46:2084-91
- 13 AlHilli Mm, Nixon K E, et al. Long-term outcomes after intrauterine morcellation vs hysteroscopic resection of endometrial polyps. *J Minim Invasive Gynecol.* 2013;20:215-221
- 14 Van Wessel S, van Vliet A A M H, et al. Hysteroscopic morcellation versus bipolar resection for removal of type 0 and 1 submucous myomas: A randomized trial. *European J of Obst& Gynecology & repor Biology.* 2021;259: 32-37
- 15 Arnold A, Ketheeswaran A, et al. A prospective analysis of hysteroscopic morcellation in the management of intrauterine pathologies. *J Minim Invasive Gynecol.* 2016;23:435-41
- 16 Chan Y Y, Jayaprakasan K, et al. The prevalence of congenital uterine anomalies in unselected and high- risk populations: a systematic review. *Hum Reprod Update.* 2011;17:761-771
- 17 Venetis CA, Papadopoulos S P, et al. Clinical implications of congenital uterine anomalies: a meta- analysis of comparative studies. *Reprod Biomed Online.* 2014;29:665-683



# Update: Hysteroscopic Mechanical Tissue Removal Systems cont.

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## REFERENCES cont.

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- 18 Bakas P, Gregoriou O, et al. Hysteroscopic resection of uterine septum and reproductive outcome in women with unexplained infertility. *Gynecol Obstet Invest.* 2012;73:321-325
- 19 Simons M, Hamerlynck T W, et al. Hysteroscopic morcellator system can be used for removal of a uterine septum. *Fertil Steril.* 2011;96:118-121
- 20 Munro M G, Critchley H O, et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nonpregnant women of reproductive age. *Int J Gynaeco Obstet.* 2011;113(1):3-13
- 21 Rosenblatt P, Barcia S, et al. Improved adequacy of endometrial tissue sampled from postmenopausal women using the MyoSure Lite hysteroscopic tissue removal system versus conventional curettage. *Int J Womens Health.* 2017;27:789-794
- 22 Hanstede M M, van der Neij E, et al. Results of centralized Asherman surgery, 2003-2013. *Fertil Steril.* 2015;104:1561-1568, e1
- 23 Di Spiezio Sardo A, Calagna G, et al. Prevention of intrauterine post- surgical adhesions in hysteroscopy. A systematic review. *Eur J Obstet Gynecol Reorod Biol.* 2016;203:182-192
- 24 Westendorp I C, Ankum W M, et al. Prevalence of Asherman's syndrome after secondary removal of placental remnants or a repeat curettage for incomplete abortion. *Hum Reprod.* 1998;13(12):3347-3350
- 25 Van den Bosch T, Daemen A, et al. Occurance and outcome of residual trophoblastic tissue: a prospective study. *J Ultrasound Med* 2008;27:357-61
- 26 Pacheco L A, Timmons D, et al. Hysteroscopic management of retained products of conception: a single centre observational study. *Facts Views Vis Obgyn.* 2019;11:217-22
- 27 Salzani A, Yela D, et al. Prevalence of uterine synechia after abortion evacuation curettage. *Med J .* 2007;125: 261-264.
- 28 Ansari S H, Bigatti G, et al. Operative hysteroscopy with Bigatti shaver (IBS®) for the removal of placental remnant. *Facts Views Vis Obgyn.* 2018;10:153-159
- 29 Capote S, Cubo-Albert M, et al. Role of office hysteroscopic morcellation and 3 dimensional transvaginal ultrasound in conservative management of retained placenta accrete. *Eur J Obstet Gynecol.* 2018;230:199-200
- 30 Van Wessel S, Coryn N, et al. Reproductive and obstetric outcomes after hysteroscopic removal of retained products of conception. *J Minim Invasive gynecol.* 2020;27:840-846
- 31 Van Dongen H, Emanuel MH, Wolterbeek R, et al. Hysteroscopic morcellator for removal of intrauterine polyps and myomas: a randomized controlled pilot study among residents in training. *J Minim Invasive Gynaecol.* 2008;15:466-471

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

Dr Kiran Vanza and Dr Dhivya Thangavel

## REPRODUCTIVE OUTCOMES AFTER LAPAROSCOIC MYOMECTOMY: CONVENTIONAL VERSUS BARBED SUTURE

*P. G. Paul, MBBS, DGO, Sumeetkaur Mehta, MBBS, DNB, Anjana Annal, MBBS, MS, DNB, K. Anusha Chowdary, MBBS, MS, George Paul, MBBS, MS, and Manali Shilotri, MBBS, MS, DNB*

*Journal of Minimally Invasive Gynecology, The, 2022-01-01, Volume 29, Issue 1, Pages 77-84, Copyright © 2021 AAGL*

Uterine leiomyomas are one of the most common benign neoplastic conditions in women. Laparoscopic myomectomy is offered to women who wish to preserve their fertility and when performed with conventional sutures, requires advanced laparoscopic skills. The introduction of barbed sutures has significantly reduced operative times and intraoperative blood loss, though reproductive outcomes have not been assessed. This was a retrospective study comparing the reproductive outcomes using absorbable barbed sutures with conventional (nonbarbed) sutures in the closure of the myometrium in laparoscopic myomectomy.

During the study period from January 2004- December 2017, 399 women aged between 20-45 years underwent a laparoscopic myomectomy. 56 women were excluded due to multiple types of suture material being used (n=49) or no suturing being performed, in the cases of pedunculated fibroids (n=7). 343 women were remaining and sent questionnaires regarding reproductive outcomes including questions regarding success in conception, time to achieve pregnancy after surgery, whether ART was required, gestational age at delivery, mode of delivery and pregnancy outcomes. 235 women responded of which 182 had attempted pregnancy, with n=97 being in the nonbarbed group (Group A) and n=85 in the barbed suture group (Group B).

There was no statistical difference between the average age (32.4 years) and number of previous abdominal surgeries or myomectomies between the two groups. The number of nulligravida women was significantly higher in the barbed suture group, as was a significantly larger uterine size and size of the largest myoma. Pregnancy outcomes were followed for 2 years. The overall pregnancy rates for both groups were comparable, Group A = 52.5% and Group B 49.4%. There was no significant difference in the number of miscarriages or ectopic pregnancies in either group. There was a significantly higher caesarean section rate in Group B vs Group A (91.1% vs 71.1%). The incidence of pregnancy related complications was comparable in both groups and no antenatal scar rupture. The incidence of preterm labour and fetal growth restriction was lower in group A but did not reach statistical significance.

### Conclusion

There was no difference in reproductive outcomes when comparing conventional (nonbarbed sutures) with barbed sutures used for myometrial closure at laparoscopic myomectomy.

**Maintenance Therapy for Preventing Endometrioma Recurrence after Endometriosis Resection Surgery – A Systematic Review and Network Meta-analysis.**

*Chiu CC, Hsu TF, Jiang LY, Chan IS, Shih YC, Chang YH, Wang PH, Chen YJ.*

*J Minim Invasive Gynecol. 2022 May;29(5):602-612. doi: 10.1016/j.jmig.2021.11.024. Epub 2022 Feb 2. PMID: 35123042.*

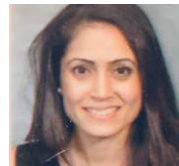
Endometriosis is a chronic relapsing condition affecting 10% of women of reproductive age, characterised by pain and infertility. Endometrioma is a common feature of endometriosis, affecting 17-55% of women. Ovulation and menstrual suppression with hormonal treatment aims to improve surgical outcomes when used for six months or less, whereas when used long-term, it aims to prevent recurrence. While ovarian cystectomy reduces pain and infertility, the recurrence rate after surgery is approximately 50% without hormonal suppression.

This recent systematic review and meta-analysis examined and compared long-term suppressive hormonal treatment efficacies after excisional surgery for endometriosis on the recurrence of endometrioma. The specific treatment regimes measured were as follows: Oral Contraceptive pill (OCP), GnRH antagonist (GnRHa), Dienogest (DNG), GnRHa plus OCP, GnRHa plus LNG-IUS, GnRH plus DNG. The meta-analysis included 11 studies – 2 randomised-controlled trials and 9 cohort studies, evaluating data from 2394 participants. These studies involved a mean treatment duration of at least 12 months (except for those receiving adjuvant GnRHa therapy), with an end-point follow-up of at least 24 months with anatomic recurrence measured as ultrasound or MRI detected ovarian endometrioma measuring 1cm or greater.

Whilst all long-term intervention regimes except for GnRHa alone significantly reduced endometrioma recurrence compared to expectant management, GnRHa plus DNG was superior (OR, 0.04; 95% CI, 0.01-0.27) followed by DNG (OR, 0.11; 95% CI, 0.04-0.32), GnRHa plus OCP (OR, 0.12; 95% CI, 0.02-0.64), GnRHa plus LNGIUS (OR, 0.13; 95% CI, 0.03-0.66), OCP (OR, 0.21; 95% CI, 0.13-0.36). Again, pooled data was directly and indirectly compared and demonstrated that GnRHa combined with either OCP (OR, 0.26; 95% CI, 0.10-0.64), DNG (OR, 0.29; 95% CI, 0.13-0.62) or LNG-IUS was significantly more effective than GnRHa alone (OR, 0.09; 95% CI, 0.03-0.30).

Interestingly, despite some intervention groups not being directly compared in the component studies of this meta-analysis, the authors' statistical analyses were able to assign a SUCRA (surface under the cumulative ranking curve) score to each intervention group. A SUCRA value is a numerical score from 0 to 100, with a higher score demonstrating a higher probability of top-ranking, enabling direct comparison of therapies. The following SUCRA scores reflect the ORs above in efficacy: (1) GnRHa plus DNG: 94.0; (2) DNG: 69.7; (3) GnRHa plus OCP: 63.4; (4) GnRHa plus LNG-IUS: 59.4; (5) OCP: 43.6; (6) GnRHa: 17.3; and (7) expectant management.

The study is a robust meta-analysis; however, it possesses the usual limitations of generalisability. Not all clinically significant recurrences of endometriosis are characterised by an endometrioma on ultrasound. Therefore, we cannot extrapolate that these interventions also reduce the recurrence of endometriosis after excisional surgery. However, the paper does demonstrate the vital role of post-operative hormonal suppression in preventing endometrioma recurrence.



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## ● Save the date

Please note that many event details are changing due to COVID-19.  
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AGES Focus Meeting 2022  
**AUGUST 11-12 2022**  
Millenium Queenstown, New Zealand  
*Theme - Integration Through Innovation*



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AGES Annual Scientific Meeting 2022  
**NOVEMBER 3-5 2022**  
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*Theme - AGES: Onwards & Upwards*



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AGES Laparoscopic Anatomy Pelvic Dissection/  
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**2022 DATES**  
*Dissection Workshops*  
10 September 2022  
11 September 2022  
12 November 2022  
13 November 2022

Medical Engineering and Research Facility,  
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**MARCH 9-11 2023**  
Hyatt Regency, Sydney  
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## Applications are now open to AGES Members for 2023 AGES Clinical Research Grants.

The AGES Society Research Fund has been a principal provider of surgical research in Australasia for the last 18 years. During this time, more than \$1,300,000 has been granted to over 96 research projects, and there is an ongoing commitment to continue the research program into gynaecological surgery and its impact on improvements in women’s health.

Applications close Wednesday 31st August 2022.

Visit the members section of the [AGES website](#) for more information and to submit your grant application.

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## 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](https://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.

# 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](http://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](mailto: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:** October 10-14

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

Register on-line at [www.swec.com.au](http://www.swec.com.au)  
or contact our course administrator  
at: [sweconline@gmail.com](mailto:sweconline@gmail.com) or  
Assoc Prof Greg Cario, SWEC Director  
[doc@drgregorymcario.com.au](mailto:doc@drgregorymcario.com.au)



## MONASH MEDICAL CENTRE MONASH ENDOSURGICAL PRECEPTORSHIP

### PROGRAM DIRECTOR DR. JIM TSALTAS

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

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

**2022 Course Dates:** 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](mailto:kkcha5@hotmail.com)

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

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

## ● Dates for Laparoscopic Workshops cont



### LAPAROSCOPIC SURGERY FOR GENERAL GYNAECOLOGISTS SYDNEY LAPAROSCOPIC WORKSHOPS 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](mailto:nic96@hotmail.com)

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

### ADVANCED LAPAROSCOPIC PELVIC SURGERY TRAINING PROGRAM

**PROGRAM DIRECTOR ASSOC PROF ALAN LAM**

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

#### 2022 Course Dates:

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- » Personalised tuition
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- » Two skills labs to help refine intra and extra corporeal suturing
- » Two live animal lab sessions
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- » Credited by RANZCOG with CPD and PR&CRM points

#### For further information contact:

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