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escope

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

EDITION HIGHLIGHTS:

TOGETHER TOWARDS TOMORROW

Editorial

Welcome to the latest edition of eScope. It's hard to believe it's already September and Christmas trees are in the shops!!!

AGES have had a busy few months with the return of face to face meetings. This edition sees a recap of our successful meetings both the "Pelvic Floor Symposium" and the "Focus Meeting". It was encouraging to see our members engaging once again. We remain positive for a good attendance at the upcoming "Annual Scientific Meeting". The meeting program is also included in this edition. Not only do we have a strong scientific program but we will finally get the chance to "frock up" and enjoy the black tie gala dinner.

This edition features the board article written by Dr Kirsten Connan. Kirsten is the chair of the Equity, Diversity and Inclusion committee. Fitting in well with that role, Kirsten has written a piece highlighting the issues raised in the USA following the overturning of Roe vs Wade and the access to abortion services in Australia.

The SWAPS fellows have provided us with 2 article summaries from JMIG to educate the time poor amongst us. They have reviewed an article on Laparoscopic Sacrocolpopexy and outcomes for hysterectomy associated with Endometriosis. Thanks again for their ongoing support and worthy contribution to this journal.

Avant have once again provided us with an article of medico-legal significance. This paper highlights the importance of guidelines in patient care.

The trainee article in this edition is authored by Eashan Tambimuttu who is the current fellow at the Royal Women's Hospital. Eashan's paper examines the importance of self-care during surgery, especially the care of ones back. This article takes me back to the "Live surgery" featuring Drs Helen Green and Tina Fleming being critiqued by a physiotherapist at the last virtual ASM. A very important consideration for us all in a surgical specialty to ensure longevity.

I hope you enjoy reading this latest edition. There will be a final edition prior to the end of the year. Any submissions are welcomed.

Rachel Green
eScope Editor &
AGES Vice-President

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Abortion and Australia

Dr Kirsten Connan

It was hard to ignore the media coverage of the US Supreme Court reversal of Roe v. Wade on the 24th of June 2022[1]. This decision overturned forty-nine years of established protection of abortion across the United States[2].

Following this change an immediate and total ban on abortion was enacted in Alabama, Arkansas, Mississippi, Missouri, Oklahoma, South Dakota, Texas, and Idaho. Severe restrictions on abortion were enacted in Georgia, Ohio, South Carolina, Tennessee, and some restrictions were enacted in Florida, Kentucky. Arizona legislated to enforce a law restricting abortion from September, and other states – Iowa and Louisiana, Michigan, North Carolina, North Dakota, Utah, West Virginia, Wisconsin, and Wyoming – continue to review their state-based abortion laws[3].

In the remaining 27 states or districts where abortion continues to be legal, only seven have no restrictions based on gestational age (Vermont, Oregon, New Mexico, New Jersey, District of Columbia, Colorado, Alaska), with most states banning abortion after 24-26 weeks' gestation.

With these rapidly changing abortion laws, Planned Parenthood, the largest provider of abortion care in the US, recommends women and providers review their website daily to ensure they remain informed of the restrictions locally in their state[4].

As a practicing gynaecologist, I found myself enraged by the US Supreme Court's decision. But sadly not surprised. As the 2018 documentary "Reversing Roe"[5] shows, these events were frustratingly predictable, having been a long-term project for the American conservative movement. Through interviews with politicians, abortion rights supporters and opponents, this Netflix documentary film lifts the lid on a decades-long political campaign to overturn Roe v. Wade.

The consequences on women's health and wellbeing from restricting abortion access have been well demonstrated. Most recently Bearak et al. (2020) identified that not only did abortion restriction increase the unintended pregnancy rate, but it was also associated with an *increase* in the abortion rate over the 30-year study period[6].

It is clear that restricting abortion access does not reduce abortions, it only reduces *safe* abortions.

The landmark longitudinal *Turnaway Study* from UCSF & ANSIRH looking at 12 years of data of women 'turned away' from abortion clinics, further reveals the negative consequences of denying abortion care[7]. Women denied an abortion suffer greater economic hardship, more domestic violence, greater mental health morbidity, higher morbidity & mortality, and their children suffer worse development.

I am pro-abortion access, and I am not alone in my views. The well-known 2010 MJA publication by de Crespigny et al revealed 61% of Australians believe abortion should be lawful without question in the first trimester of pregnancy, while 26% said it should be lawful depending on the reason[8]. A more recent 2022 survey revealed 70% of Australians believe that abortions should be legal for any women in the first 6 weeks of pregnancy (global average – 62%), and 59% expressed support for abortion access for all women in the first 14 weeks (global average – 45%)[9].

All women *must* have access to safe and timely abortion services. Now, more than ever, we should not take abortion access for granted in Australia. In Australia we do not have uniform national abortion legislation, although abortions are theoretically accessible in all states and territories.

Excluding Western Australia, where abortion is legalised but not yet decriminalised, legal abortions are now provided in all states and territories (acknowledging the recent changes in South Australia[10]). However, requirements differ across our nation when seeking access to an abortion. Availability of providers vary, gestational limits vary, and the number of doctors required to sign off an abortion vary. As is often noted, abortion accessibility in Australia is often a "postcode lottery"[11].

Abortion and Australia cont.

Dr Kirsten Connan

For women who reside in the ACT and Tasmania, abortions are legal up to 16 weeks of gestation. For those residing in NSW and Queensland, abortions are legal up to 22 weeks. The Northern Territory and Victoria allow abortion up to 24 weeks, and South Australia allow abortions up until 22 weeks and six days. Only a single medical practitioner (or nurse practitioner in some areas[12]) is required to support each abortion. After these specified gestational limits, states and territories (excluding the ACT) can allow for abortions at later gestational ages where a practitioner is reasonably acting within the scope of their practice and has consulted with another medical practitioner.

In Western Australia abortions can be performed up to 20 weeks, requiring the approval of two medical practitioners. Beyond 20 weeks' gestation an abortion requires the approval of six medical practitioners and can only be performed if the foetus is likely to be born with severe medical problems that have been confirmed by two independently appointed doctors[13].

Barriers to abortion are not only legal and geographic. In a 2021 study published by Penovic and Sifris[14] the three main non-legal barriers to abortion access were financial, geographic, and "deficiencies in practitioner attitudes, education and training". They also showed that barriers to abortion access have been amplified during the COVID pandemic, generating a "...disproportionate and intersectional impact on the most marginalised and disempowered women in society..." including women with disabilities, refugees, and First Nations women.

Abortion healthcare must remain accessible across Australia. The RANZCOG curriculum must continue to embed abortion healthcare within its curriculum, ensuring practitioner procedural training and abortion education. Public hospitals must ensure accessibility, and so reduce financial barriers. We as healthcare providers from RANZCOG and AGES, irrespective of our personal, political, or religious beliefs, must remain engaged as advocates for women making their own informed choices over of their bodies.

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MBBS (Hon), FRANZCOG,
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REFERENCES:

1 www.npr.org/2022/06/24/1102305878/supreme-court-abortion-roe-v-wade-decision-overturn
2 en.wikipedia.org/wiki/Roe_v._Wade
3 www.abortionfinder.org/abortion-guides-by-state
4 www.plannedparenthoodaction.org/abortion-access-tool/US
5 www.netflix.com/au/title/80192834
6 www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(20)30315-6.pdf
7 www.ansirh.org/research/ongoing/turnaway-study
8 onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2010.tb03732.x
9 www.ipsos.com/en-au/majority-australians-report-unwavering-support-abortion-access
10 www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/abortions/abortion+legislation+reform+and+the+new+termination+of+pregnancy+act+2021
11 www.crikey.com.au/2022/07/08/australia-abortion-law-states-territories/
12 www.theguardian.com/australia-news/2022/jun/27/explainer-abortion-laws-australia-is-it-legal-illegal-rights
13 www.childrenbychoice.org.au/resources-statistics/legislation/australian-abortion-law-and-practice/
14 www.sciencedirect.com/science/article/pii/S0277539521000340

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

Pelvic Floor Symposium 2022 Review

It was lovely to finally meet face to face for the first time since the AGES ASM in 2020! We would like to thank Adelaide for letting us in and hosting such a fabulous meeting. Personally, it was such a relief to be allowed to gather in one place and talk to each other. It is interesting to see how much more interactive people become when there is no delay in the audio, and no one has their video off! I did not miss the calls of "you're on mute". We had moved the meeting in time and place many times, and I would like to thank everyone for their patience and continued enthusiasm.

Sadly, poor Fariba Behnia-Willison, one of the scientific co-chairs, was unable to attend her own conference due to non-covid illness. We thank her for all her hard work leading up to the meeting. I would also like to thank the other scientific co-chair, George Condous. We would like to say how impossible it would be to run these conferences without the tireless work of Mary, Danielle, and the YRD team.

Some highlights for me were listening to Carolyn Van Dyken, a Canadian physiotherapist who brought us up to speed on central sensitization. It was also very interesting to hear about the value of "point D." from Dr Johnny Yi, assistant professor, and Urogynecology & Reconstructive Pelvic Surgery Specialist from the Mayo Clinic. We heard a lot about mesh, the problems, questions posed, alternatives, and lessons learned over the last few years. We also had a fascinating patient journey from the cradle onwards to tackle urogynecological problems a patient may encounter through her life.

We had some fascinating discussions on the value of testosterone in gynaecology by Stephen Birrell and Susan Evans and looked at urogynecological challenges in the Democratic Republic of the Congo. Thank you, Luc Mulimbalimba, for your insights there.

So many great speakers. It was as if people had been saving up their excellence during the hard covid years to give us their best when back together again! We also had some great photos of 'docs in socks' for doctors' mental health awareness day. How many crazy socks can one medical group own!

Thank you all.

A/Prof Dr Emma Readman
Conference Chair
AGES Director

Pelvic Floor Symposium 2022 Review cont.

Pelvic Floor Symposium 2022 Review cont.

Focus Meeting 2022 Review

The Focus Meeting was recently held in New Zealand. This was an opportunity to engage with our neighbouring colleagues. The theme for the meeting was 'Integration through Innovation' and allowed the local organising committee the opportunity to cover a wide range of topics from obstetric care to surgical innovation. All this with the stunning backdrop of Queenstown. With a large New Zealand faculty, this meeting delivered some excellent presentations. I would like to extend, once again, my thanks to all the speakers and organising committee.

Queenstown is a special destination with roots steeped in Maori tradition. This meeting was fittingly opened with a traditional Maori welcome and Haka provided by the local Queenstown Primary School and Maori Elder. A fitting and moving opening to the meeting.

We offered face to face attendance for those who could make it to Queenstown and allowing flexibility to our membership offered post conference access to the presentation recordings for anyone not able to join us. Those who chose to attend in person were treated to an opportunity to reconnect with old and some new faces. It was wonderful to see our society engaging together once again. The social function was held at Eichardt's Grille and represented another of AGES legendary dinner and dance function. Overall, the meeting was a great blend of stimulating talks, reconnection and great fun.

It was a pleasure to chair this meeting and welcome our members to this special destination. I look forward to greeting you at our next overseas Focus Meeting in Bangkok July 6th to 7th 2023.

Dr Rachel Green
Conference Chair
AGES Vice President

Focus Meeting 2022 Review cont.

Focus Meeting 2022 Review cont.

Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES XXXII ANNUAL SCIENTIFIC MEETING

3 - 5 November 2022

Crown Promenade Melbourne

Early bird registrations close **8th September 2022**

WEDNESDAY 2ND NOVEMBER 2022 - PRE-CONFERENCE WORKSHOP

AEDT	CROWN PROMENADE MELBOURNE, VIC
0800 - 1700	AGES AATP Workshop (Invite Only) - **Kate Martin, Chair**
0800 - 1200	Merging Ultrasound and Advanced Laparoscopic Skills in Endometriosis Workshop - **George Condous & Michael Wynn-Williams, Chairs**
1300 - 1700	The MBS Explained Workshop - **April Armstrong, Chair**
1300 - 1700	Chronic Pelvic Pain Workshop - **Thierry Vancaillie, Chair**
AEDT	

THURSDAY 3RD NOVEMBER 2022 - DAY ONE

AEDT	CROWN PROMENADE MELBOURNE, VIC		
0700 - 0800	Registration		
0800 - 0930	**SESSION ONE:** ONWARDS & UPWARDS - A GLOBAL PERSPECTIVE		
	Welcome to Country & Introduction		
	Is it time for MIGS certification for AGES? Lessons learnt from the Malaysian experience - **Aizura Adlan**		
	Evolution of treatment of endometriosis: where do we go from here? - **Ertan Saridogan**		
0930 - 1030	**SESSION TWO:** CHAIRMAN'S CHOICE		
1030 - 1100	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		
1100 - 1230	**SESSION THREE A:** FROM ONE SPECIALIST TO ANOTHER... LET'S TALK	**SESSION THREE B:** FIBROIDS!	
	Looks do matter - update on wound closure management	Individualising care of women with fibroids - **Ertan Saridogan**	
	The other pelvic pain - perspectives on functional bowel disease - **Ilana Gory**	Hysteroscopy and fibroid care - **Malcolm Munro**	
	A pain in the butt - chronic constipation, adhesions, diverticulitis and more - **Adele Burgess**	Large fibroid uterus hysterectomy - big problems with simple solutions - **Haider Najjar**	
	Too little or too much? Causes, consequences and management of iron overload and deficiency - **Briony Cutts**	Tackling fibroids with a twist - **Danny Chou**	
	Walking the line - optimising perioperative pain management - **Sumi Saha**	Fibroid surgery and future pregnancy implications - **Kym Jansen**	
	Panel discussion	Panel discussion	
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		
1330 - 1500	**SESSION FOUR A:** FREE COMMUNICATIONS	**SESSION FOUR B:** FREE COMMUNICATIONS	**SESSION FOUR C:** FREE COMMUNICATIONS
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		

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1530 - 1700	**SESSION FIVE A:** PECHA KUCHA - OFFICE GYNAECOLOGY & FERTILITY	**SESSION FIVE B:** PECHA KUCHA - ENDOSCOPIC SURGERY
	Pushing the limits - office hysteroscopy	Planning for the future - cancer and preservation of fertility - **Kate Stern**
	What to do? Non-surgical options for AUB - **Sam Mooney**	What do I do? Stage 4 endometriosis & fertility - **Tom Manley**
	It's her not me! Investigation of male infertility - **Sarah Catford**	Open for business? Assessment of tubal patency - **Genia Rozen**
	The microbiome - research implications for everyday practice - **Lior Levy**	It's in the bag! An update on power and manual morcellation - **Kate Tyson**
	When, why & how? Androgen therapy	Keep your friends close and your enemies closer - avoiding ureteric injury during laparoscopic surgery - **Bassem Gerges**
	Doctor, doctor! The pathway from private practice research to higher degrees - **Fariba Behnia-Willison**	What to do when - a PID management update - **Simon Edmonds**
	More than the basics - gynaecological ultrasound for the generalist - **Lufee Wong**	Hysteroscopic surgery for HMB - tips & tricks, excise or ablate - **Brett Marshall**
	Everything up to IVF - ovulation induction for the generalist	That shouldn't be there! Surgical management of endometrial polyps, septae & niches - **Amy Feng**
	Updates on cervical screening and colposcopy care - **Simon Hyde**	Finding the way - evidence-based management of Asherman's syndrome - **Rebecca Deans**
	It's time - can I store my eggs please? - **Kate McIlwaine**	Please do interfere! The art of laparoscopic assisting - **Katherine Whitton**
	Location, location! - Update on non-surgical management of ectopic pregnancy - **George Condous**	Post laparoscopy pain reduction project (POLYPREP) - **Aizura Adlan**
1700	CLOSE OF DAY ONE	
1700 - 1800	WELCOME RECEPTION	
AEDT		

FRIDAY 4TH NOVEMBER 2022 - DAY TWO

AEDT	CROWN PROMENADE MELBOURNE, VIC	
0700 - 0745	AGES breakfast session: fertility, family, and O&G	
0730 - 0800	Registration	
0800 - 1000	**SESSION SIX:** LIVE SURGERY	
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1030 - 1230	**SESSION SEVEN A:** ENDOMETRIOSIS - THE CURRENT STATE OF PLAY	**SESSION SEVEN B:** ALL THINGS PREGNANCY
	How did this happen? An update on the aetiologies of superficial endometriosis, endometrioma and DIE	A stitch in time - elective and emergency cervical cerclage - **Alex Ades**
	Endometriosis medical management strategies before and after surgery - **Thierry Vancaillie**	Doctor I'm bleeding - management of PV bleeding in pregnancy
	I'm going in! Surgical strategies for minimal, mild, moderate and severe endometriosis - **Jim Tsaltas**	Upping the ante - laparoscopic surgery in pregnancy - **Aizura Adlan**
	What to do? The unexpected finding of asymptomatic or severe endometriosis at diagnostic laparoscopy - **Roni Ratner**	What we leave behind - management options for non-viable pregnancy and RPOC
	Fertility enhancement and preservation - what endometriosis surgeons should know	Exploring the gynaecological health implications of a suboptimal CS section technique - does it really matter? - **Rachel Green**
	What lies beneath - nerve-sparing endometriosis resection - **Sarah Choi**	When childbirth isn't a beautiful thing - caesarean hysterectomy - **David Wrede**
	The endometriosis multidisciplinary team - the BSGE Endo Centre experience - **Kirana Arambage & Lisa Buck**	Closing the flood gates - modern management of PPH - **Kirsten Connan**
	Panel discussion	Panel discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1330 - 1530	**SESSION EIGHT:** SPONSORED WORKSHOPS	
	Medtronic, Avant Mutual, Device Technologies, Hologic, Olympus, Stryker, Applied Medical	
1530 - 1600	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1600 - 1700	**SESSION NINE:** KEYNOTE PRESENTATIONS - WOMEN IN MEDICINE AND SCIENCE	
	Keynote presentation	
	Dan O'Connor Perpetual Lecture - **Caroline de Costa**	
1700	CLOSE OF DAY TWO	
1700 - 1800	AGES ANNUAL GENERAL MEETING	
1900 - 2230	AGES ANNUAL BLACK TIE GALA DINNER, AWARDS & CHARITY AUCTION	
AEDT		

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SATURDAY 5TH NOVEMBER 2022 - DAY THREE

AEDT	CROWN PROMENADE MELBOURNE, VIC
0730 - 0820	SurgicalPerformace breakfast session
0800 - 0830	Registration
0830 - 1010	**SESSION TEN: ALL ABOUT THE ADNEXA**
	I'm all in a twist - ovarian torsion management - **Ertan Saridogan**
	Crying over spilt milk? Decreasing the risk of upstaging ovarian tumours - **Helen Green**
	Missing in action? Unexpected absence of the adnexa - **Stephen Lyons**
	Non-tubal ectopics - is there any evidence? - **Jade Acton**
	Worth the effort? Tubal reanastomosis & neosalpingostomy
	Just when I thought it was safe to get back in the water - surgical management of the residual adnexae - **Shamitha Kathurusinghe**
	Panel discussion
1010 - 1040	MORNING TEA & TRADE EXHIBITION
1040 - 1120	**SESSION ELEVEN:** THE FAST FIVE
	Bringing down the curtain - bladder dissection at TLH - **Martin Healy**
	Preparing for the worst - dissection of pelvic side wall vessels - **Michael Wynn-Williams**
	Do no harm - ovarian cystectomy fertility preservation techniques - **Anusch Yazdani**
	Finding my frenemy - ureteric dissection techniques - **Charlotte Reddington**
	A primer - endometriosis resection - **Russell Dalton**
	Panel discussion
1120 - 1300	**SESSION TWELVE:** NOT JUST A BAD COLD. LIVING WITH COVID-19
	COVID-19 - where to from here? - **Norman Swan**
	Understanding vaccine hesitancy and controversy through the COVID-19 pandemic lens - NCIRS findings decoded for the front line
	Improving health, building hope and The Kindness Pandemic - **Catherine Barrett**
	One variant away from disaster
1300 - 1330	**SESSION THIRTEEN:** PRESIDENT'S PANEL MODERATED BY NORMAN SWAN
1330	CLOSE OF CONFERENCE
1330 - 1400	LUNCH ON THE GO
AEDT	

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

Evolution not Revolution

Hyatt Regency Sydney

Medtronic

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9 - 11 March 2023

Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES XXXIII ANNUAL SCIENTIFIC MEETING

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

Dr Kiran Vanza and Dr Dhivya Thangavel

EFFECT OF AGE ON COMPLICATION RATE AND SURGICAL OUTCOMES IN WOMEN UNDERGOING LAPAROSCOPIC SACROHYSTEROPEXY AND SACROCOLPOPEXY

Ohad Gluck, Zdenek Rusavy, Ehud Grinstein, Yaya Abdelkhalek and Bruno Deval
J Minim Invasive Gynecol. 2022 Jul;29(6):753-758. doi: 10.1016/j.jmig.2022.01.017. Epub 2022 Feb 2. PMID: 35123043.

Introduction: Laparoscopic sacrohysteropexy (LSH) and laparoscopic sacrocolpopexy (LSC) have similar anatomic and clinical results compared to the abdominal approach. Despite the steep learning curve, there are several advantages of the laparoscopic approach including reduced blood loss, decreased operative pain and hospital stay, less wound and mesh infections and less adhesion formation compared with the abdominal approach. The literature regarding the safety and feasibility in older patients is controversial with relatively short postoperative follow up.

Aim: Study the rate of perioperative complications and long-term outcomes of patients undergoing LSH and/or LSC according to age.

Material and Methods: Retrospective cohort study of all patients undergoing LSH or LSC between July 2009-2019. Patients were stratified into 3 groups according to age; < 65 years, 65-75 years and >75 years old. Symptomatic anterior/apical prolapse was defined as anterior decent at or below the hymen (point Aa or Ba >=0) or apical decent at or below the midvagina (point C >= total vaginal length/2), according to the Pelvic Organ Prolapse Quantification (POP-Q). The surgeries were performed by the same surgeon and all patients were reviewed 1 month post operatively and then annually.

Results: 330 patients were included: 183 in group 1 (mean age 53.4 ± 8.2), 92 patients in group 2 (mean age 69.2 ± 2.9), and 55 patients in group 3 (mean age 79.3 ± 3.5). LSH was more common than LSC in all age groups, however its rate decreased with increasing age (group 1, 88.6%; group 2, 82.7%; group 3, 68.5%; p = 0.05). The younger cohort experienced a higher rate of stress urinary incontinence (SUI) than older patients (group 1, 50.3%; group 2, 34.5%; group 3, 28.9%; p = 0.003). There was no significant difference between stage of prolapse, duration of symptoms and disorders of defecation. The overall complication rate was 5.7%, with no difference between the groups. Mean follow-up duration was comparable amongst all groups. 37 patients (11.2%) presented with POP recurrence. The rates of postoperative function, POP recurrence and long-term complications was similar in all groups. There was a higher rate of SUI surgery in the older group.

Discussion: This study demonstrated LSH/LSC to be safe and effective regardless of patient age, with similar success rates and low complication rates compared to the literature. These findings were strengthened by the long duration of follow up postoperatively. Furthermore, there were fewer surgical confounders as the same surgeon performed all the surgeries utilising the same technique. Limitations of the study included only 63% of women undergoing a physical examination postoperatively due to technical issues or patient preference. No standardised postoperative evaluation questionnaires were utilised. No power calculation was performed a priori.

Conclusion: LSH/LSC have low complications and high success rates across all age groups.

Dr Kiran Vanza and Dr Dhivya Thangavel

COMPARING CHARACTERISTICS OF AND POSTOPERATIVE MORBIDITY AFTER HYSTERECTOMY FOR ENDOMETRIOSIS VERSUS OTHER BENIGN INDICATIONS: A NSQIP STUDY

Stewart KA, Tessier KM, Lebovic DI.
J Minim Invasive Gynecol. 2022 Jul;29(7):884-890.e2. doi: 10.1016/j.jmig.2022.04.009. Epub 2022 Apr 25. PMID: 35472598.

Endometriosis is a pervasive and complex disease that can result in infertility, debilitating pain, socioeconomic burden and diminished quality of life. The gold standard of diagnosis is through laparoscopy with histology demonstrating characteristic endometrial glands and stroma on biopsies. Whilst excisional treatment is associated with a reduction of pain and improved quality of life, it is technically challenging and fraught with increased surgical risk, particularly if the endometriosis is deeply infiltrative. As such, endometriosis has been highlighted as a risk factor for a number of operative complications, including surgical site infection, small bowel obstruction and urinary tract injury.

This recent retrospective cohort study utilised the National Surgical Quality Improvement Project, a US-based database of surgical procedures and their outcomes. Demographic data, ICD diagnosis codes for indication, presence and/or location of endometriosis and 30-day post-operative complications. From January 2018 to December 2019, there were 29742 patients aged 18 years to 55 years who underwent a hysterectomy. 3596 (12.1%) of these were performed for endometriosis as the primary indication.

Whilst the overall rate of morbidity (3.4%) and mortality (n=2, 0.0%) was low, major morbidity was more likely in the cohort undergoing hysterectomy for endometriosis (adjusted OR 1.25; 95% CI, 1.02-1.54; p=0.033. Minor complications including surgical site infections and organ-space infection was more likely in those undergoing hysterectomy for endometriosis. There was no significant difference in operative time and overall length of stay in those undergoing hysterectomy for other benign indications vs those undergoing hysterectomy for endometriosis. Locations of endometriotic lesions did not appear to impact the length of stay; however, endometriosis of the bowel was associated with a higher risk of major morbidity and prolonged surgical time compared to endometriosis of the urinary tract.

Interestingly, some ICD-coded cases where endometriosis was the indication did not demonstrate presence of endometriosis at the hysterectomy and conversely, some undergoin hysterectomy for benign disease were incidentally found to also have endometriosis. This highlights an important shortcoming of this study in which there was some inaccuracy in the dataset coding, which impacts the accuracy of the findings of the study. Additionally, as this represents the caseload of a wide spectrum of gynaecological surgeons and utilises data from a significant number of procedures, the results are generalisable to a broad cohort.

This study highlights the operative complexity that the presence of endometriosis, particularly when there is bowel involvement, adds to gynaecological procedures and their outcomes.

Dr Kiran Vanza
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Dr Dhivya Thangavel
Laparoscopic Fellow,
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Watch your back before you hurt your back!

Dr. Eashan Tambimuttu

Doctors are the worst patients, so let's try not to become one. Ergonomics in minimally invasive surgery has been discussed, but it cannot be understated; we are not as invested in promoting our surgical longevity as we could be. There are great articles in the O&G Magazine that address the semantics of it all, but I hope this just inspires you a little to think about it.

Recently, I have had mentors and colleagues take time off work because of musculoskeletal injuries that were caused or exacerbated whilst operating. Having had sprains, fractures, and flatter feet than a duck, I thought I should reflect. Short of spending a fortune on the latest Yeezy [Kanye West's orthotic shoe collaboration with Adidas] or insulting the olfactory nerves of those around me with Tiger Balm, I realised I knew very little.

A survey of 765 RANZCOG fellows reported that 54% had suffered a work-related musculoskeletal injury. Almost a third had experienced multiple injuries. 89% required treatment, and 26% of clinicians had to modify their practice. Laparoscopic surgery was reported as being the most common cause [1]. In 2014 a questionnaire of RCOG trainees found that few understood how to prevent musculoskeletal injury through correct theatre set-up [2].

So where do we start? Well, I suppose one of the major appeals of robotic surgery is the inherent ergonomics, endurance and longevity it affords the operator. Much like having a relaxed dinner, we can stay seated, elbows relaxed by our sides and with a console perfectly adjusted to our head and necks. A mentor once frantically gestured to me a comparison of the optimal neutral position for laparoscopic surgery as she exclaimed "We eat like this, not like this!". Perhaps it needs to be this simple and second nature.

Figure 1: Like this. *Photo: Studio Ghibli*

Figure 2: Not Like This. *Photo: Studio Ghibli*

So how do we get to there? It starts with the patient and appropriate theatre set-up. The body habitus of a patient is something that should be considered. 'Proper planning prevents poor performance'. Correct surgeon positioning height in relation to the table, port sizes, patient securing devices prove prudent in maintaining a safe and efficient working environment. Delays can be reflective of the difficulty experienced in the surgery which in turn can lead to physical and emotional strain.

Much like the eating habits of my mentor, the goal is to have a surgeon's arms relaxed by their side. Maintaining a 90–120 degrees elbow flexion is easier to do with ipsilateral ports and more challenging with a diamond format, as the wider the distance between your hands, the higher you must be to maintain that ergonomic position. Unfortunately, finding yourself the perfect standing platform is perhaps more feasible than having the perfect electronic bed that can go very low! Perpendicular port placement itself is also key. A port that has tracked-in obliquely leads to increased resistance through the instrument, less mobility and ultimately, unfavourable posturing to compensate.

→

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Watch your back before you hurt your back! cont.

Dr. Eashan Tambimuttu

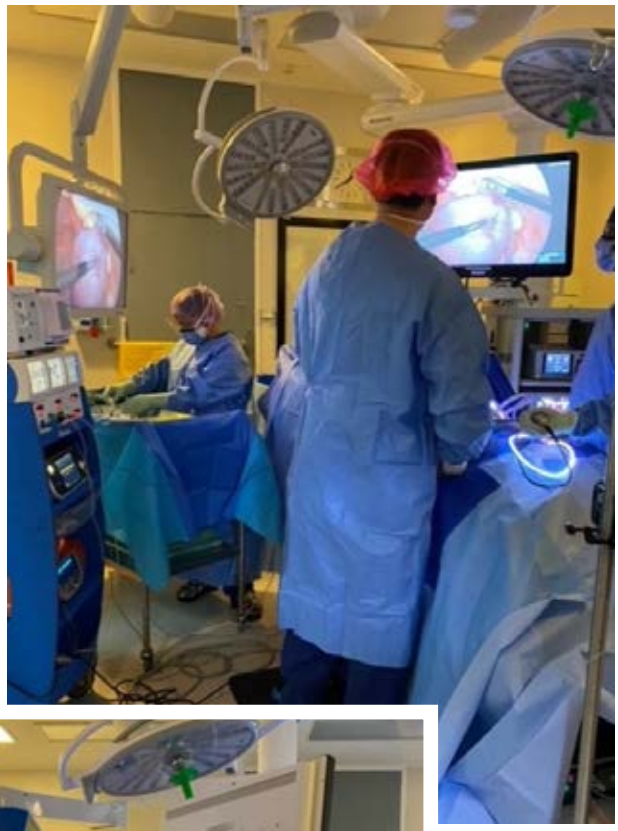

Figure 3: Theatre set-up. Mats, staff positioning, 3 screens.

Figure 4: Third screen for scrub nurse

The monitors should be positioned directly in front of the surgeon, assistant, and scrub nurse. Squared with the forearm axis with the centre 15 degrees downward so that you can gaze down without extending your neck [3]. Performing long arduous cases with one screen is commendable and highly resourceful, yet the sacrifice often goes unnoticed. However, two screens!? No, three screens!? Decadent. Your assistant and scrub team will sing your praises for protecting their necks and back.

Throughout our fellowship training, there is little formal teaching in optimal theatre set up and perhaps this is something that should be considered in surgical skills courses. Cable management, pedal placement, scrub nurse and table positioning, how to drape, port formation, where to place instruments and saddle bags are all things we are never formally taught, rather just pick up on the job. Poor set up can lead to awkward posturing, longer surgical times, strain, fatigue, and therefore less optimal decision-making.

Speaking of 'Ergonomics Training', there is little data. However, a survey following such training for robotic surgery led to 88% of participants changing their practice. If anything, this shows that experience and exposure subjectively improves surgeon ergonomics as it is a preference at the end of the day [4].

Now, let's shift the focus to our own selves. If any of you have attended an AGES meeting or course, you may have seen a cultural stretch-dance performed by our QLD and NZ colleagues, the microbreak. Studies have shown that many surgeons experience pain during laparoscopic surgeries. Microbreaks can alleviate this strain whilst improving surgical performance by 58% and mental focus by 38% [5]. It is something that can be implemented throughout a case at regular intervals.

For me, the strain I sometimes feel is in my lower back and feet. I have found through strength and core training, this reduces considerably. Our colleagues in sports medicine and cardiothoracic have already investigated this and shown that resistance and core training is protective against musculoskeletal injury [6]. We already know that core strength can rehabilitate those experiencing chronic pain while improving function and endurance, so it makes sense to focus on it too [7]. Lebron James obviously sees the importance in investing in himself as he allegedly spends up to $USD1.5 million on maintaining his body's health through personal chefs, doctors, trainers, hyperbaric chambers, and cryotherapy. All I'm saying is, a gym membership and personal training can be $AUD80 a week.

Watch your back before you hurt your back! cont.

Dr. Eashan Tambimuttu

In the spirit of investing in our bodies, let's go from the ground up, mats and shoes. I've recently become a fan of anti-fatigue mats. Much like a rare trinket in a videogame, this item is often only obtained through quests, levelling up, or making some sort of sacrifice to a guardian that protects them. An article from Louisville assessed the evidence on the benefits of anti-fatigue mats in both medical and non-medical professions. Although there is not a lot of evidence, the rate of participants reporting pain that impacted their job requirements was less [8]. Like these mats, we should also focus on a comfortable shoe. Asics and New Balance for example have midsole technology that reduces stress and strain on wearers with plantar fasciitis and in-built orthotic support for those with high arches. They can be slip proof, waterproof, breathable and easy to clean.

Finally, our tools. Advanced laparoscopic diathermy instruments can often be gender and size biased with up to 50% feeling too large. The discrepancy between the 5th and 95th centile of certain hand dimensions in both males and females can be double. Even 20% of males can have smaller hands than 75% of women [9]. The grips on many advanced diathermy handles can be larger and awkward to manipulate which in the end can lead to pressure and rotational injuries during surgery. A pilot study has echoed what we suspect, that adequately sized handles lead to improved economy of movement and reduced pressure exerted on hands [10]. Though designs have come a long way, there is still work to be done to ensure that devices are either graded in size, adjustable or neutral.

Ergonomics in surgery is something we should think about and continue to discuss. It is easy to ignore until we suffer. I hope after reading this, it is something you will consider advocating for.

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REFERENCES

1 Kapoor S, Mahomed K, Kapoor V. Work-related musculoskeletal injuries among obstetricians and gynaecologists: A cross-sectional survey of Fellows of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Aust N Z J Obstet Gynaecol. 2021 Oct;61(5):785-792. doi: 10.1111/ajo.13339. Epub 2021 Mar 25. PMID: 33763876.

2 Quinn, D., Moohan, J. The trainees' pain with laparoscopic surgery: what do trainees really know about theatre set-up and how this impacts their health. *Gynecol Surg* 12, 71–76 (2015). https://doi.org/10.1007/s10397-014-0875-z

3 F. M. Sánchez-Margallo, and J. A. Sánchez-Margallo, "Ergonomics in Laparoscopic Surgery", in Laparoscopic Surgery. London, United Kingdom: IntechOpen, 2017 [Online]. Available: https://www.intechopen.com/chapters/52944 doi: 10.5772/66170

4 Franasiak J, Craven R, Mosaly P, Gehrig PA. Feasibility and acceptance of a robotic surgery ergonomic training program. JSLS. 2014 Oct-Dec;18(4):e2014.00166. doi: 10.4293/JSLS.2014.00166. PMID: 25489213; PMCID: PMC4254477.

5 Park AE, Zahiri HR, Hallbeck MS, Augenstein V, Sutton E, Yu D, Lowndes BR, Bingener J. Intraoperative "Micro Breaks" With Targeted Stretching Enhance Surgeon Physical Function and Mental Focus: A Multicenter Cohort Study. Ann Surg. 2017 Feb;265(2):340-346. doi: 10.1097/SLA.0000000000001665. PMID: 28059962.

6 Dairywala MI, Gupta S, Salna M, Nguyen TC. Surgeon Strength: Ergonomics and Strength Training in Cardiothoracic Surgery. Semin Thorac Cardiovasc Surg. 2021 Sep 29:S1043-0679(21)00430-5. doi: 10.1053/j.semtcvs.2021.09.015.

7 Kumar T, Kumar S, Nezamuddin M, Sharma VP. Efficacy of core muscle strengthening exercise in chronic low back pain patients. J Back Musculoskelet Rehabil. 2015;28(4):699-707. doi: 10.3233/BMR-140572. PMID: 25467999.

8 H. Raake, "Decreasing Musculoskeletal Injuries among Operating Room Personnel through the use of Anti-fatigue Mats," *Doctor of Nursing Practice Papers*. , vol. https://ir.library.louisville.edu/dnp , 2019.

9 J. R. J. L. Michael Wiklund, "Addressing Women's Needs in Surgical Instrument Design," 1 Nov 2006. [Online]. Available: https://www.mddionline.com/news/addressing-womens-needs-surgical-instrument-design.

10 Sánchez-Margallo JA, González González A, García Moruno L, Gómez-Blanco JC, Pagador JB, Sánchez-Margallo FM. Comparative Study of the Use of Different Sizes of an Ergonomic Instrument Handle for Laparoscopic Surgery. *Applied Sciences.* 2020; 10(4):1526. https://doi.org/10.3390/app10041526

11 P. Thomas, "Ergonomics of laparoscopic surgery," *O&G Magazine*, vol. 21, no. 3, 2019. https://www.ogmagazine.org.au/21/3-21/ergonomics-of-laparoscopic-surgery/

Clinical guidelines, competing risks and competent professional practice

Georgie Haysom General Manager of Advocacy, Education and Research at Avant

Clinical guidelines are not infallible, but they are an important tool in helping clinicians manage and evaluate competing risks when providing care. If risks eventuate, demonstrating that guidelines were followed can be important in establishing that the care provided was appropriate.

Scenario – assessing risk of venous thromboembolism

Ms S had travelled five hours by bus to a large regional hospital for her laparoscopic hysterectomy. Based on a VTE risk assessment, nursing staff considered Ms S was at high risk. Hospital guidelines at the time recommended anticoagulant prophylaxis. However, the final decision on prophylactic anticoagulation was left to the surgeons.

Ms S's procedure was carried out without complication that afternoon. She was administered anticoagulant medication during the procedure, but the gynaecology team did not consider it necessary to prescribe post-surgery. They considered laparoscopic surgery was less risky due to the reduced recovery time. They were unaware of Ms S's 5-hour coach trip.

Ms S's in-hospital recovery was initially unremarkable. She was assessed as fit for discharge, but then reported chest pain, dizziness and sweating. Medical staff attended and urgently administered anticoagulants, but Ms S went into cardiac arrest and attempts to resuscitate her were unsuccessful. A post-mortem indicated the cause of death was pulmonary embolism. Ms S's case was referred to the coroner to investigate the circumstances surrounding her death. *

What is the role of guidelines in clinical decision making?

When something goes wrong in healthcare, a complaint, inquiry, inquest, or court case may follow. In such cases, questions will often be asked about whether the healthcare team provided care in accordance with the required standard.

With the benefit of hindsight, experts may disagree on what should have been done at the time. So courts and tribunals will look to see whether, at the time the care was provided, doctors were acting in a manner that was widely accepted by peer professional opinion as competent professional practice.

Clinical practice guidelines then become important evidence of what was known and accepted at the time.

When professional opinions differ

The legal position is clear that 'widely accepted' has its ordinary meaning. It does not mean 'universally accepted'. There can be more than one body of widely held peer professional opinion. These may even be inconsistent and still considered competent and appropriate.

However courts will generally not accept a practice that is "eccentric, idiosyncratic, experimental or 'alternative'" as being widely accepted by peer professional opinion. The law also leaves open the possibility that a court could find that widely held clinical opinion is 'irrational' or unreasonable. This seems to have been intended as a kind of mechanism for the law to overrule professional opinion if it were significantly out of step with community standards. Examples discussed have included research programs involving women or minorities that would now be considered unethical.

The role for clinical judgment

In the case of Ms S, the coroner was not critical of the VTE risk assessment protocol that dictated the final decision on treatment was to be made by clinician.

Clinical guidelines, competing risks and competent professional practice cont.

Georgie Haysom

This is consistent with the broader legal position that guidelines do not replace appropriate clinical decision-making.

Further, guidelines do not always provide clear consensus on management and determining a course of treatment will often involve an exercise of clinical judgment in evaluating competing risk factors. These may be individual risks, as in this case the potential risks of VTE compared with dangers of excessive bleeding associated with anticoagulant treatments. Other decided cases have addressed risks of infection and the role of prophylactic antibiotics compared with broader population risks of antibiotic resistance.

In Ms S's case, the coroner accepted guidelines can assist by setting out best practice as known at the time and when taking into account the different considerations that need to be weighed against one another. What they can do is attempt to help weave a pathway between competing risks.

Departing from guidelines requires careful reasoning

Even where guidelines are relatively clear, courts recognise that there may be good reason to depart from them in a particular situation. Doctors are expected to use their judgment and apply them to the clinical features of the patient's presentation and the circumstances of treatment.

Doctors are likely to come under severe censure if they wish to depart from standard treatment protocols based on their own unique views about treatment that are not supported by their peers. Varying accepted protocols on these grounds would often only be acceptable in a clinical trial setting with appropriate ethical safeguards in place.

If the circumstances mean you need to depart from applicable guidelines, you should only do so if you are satisfied your peers would agree that this departure was appropriate. Ideally, consult with peers to get their opinion and always document carefully the reasons guidelines were not followed.

The case of Ms S

The coroner found Ms S's death was due to natural causes and that the care provided was appropriate, based on what was known and guidelines at the time. She recommended that consideration be given to including a question about the type and duration of travel in the standard VTE risk assessment.

RESOURCES

Avant: Court finds following clinical guidelines "not irrational"

Australian Journal of General Practice Jan-Feb 2019: The role of clinical guidelines in establishing competent professional practice

** This case is based on a recent coronial case involving a different specialty and a different procedure. Details about VTE prophylaxis are taken from the case but other details have been changed for the purposes of this article.*

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.

Georgie Haysom
General Manager of Advocacy, Education and Research at Avant Mutual.

AGES Pelvic Floor Symposium 2022 Free Communications Awards

AGES Best Free Communication Presentation

The Changing Trend and Clinical Implications of the Use of Mid-urethral Sling in the Management of Stress Urinary Incontinence

Charlotte Rook [1], Alan Lam [1]
1 Centre for Advanced Reproductive Endosurgery (CARE), St Leonards, NSW, Australia

OBJECTIVE: To review and consider the clinical implications of recent trends in the surgical management of stress urinary incontinence (SUI) in Australia in the context of recent medico-legal and media attention into transvaginal mesh.

METHODS: We examined trends in mid-urethral sling (MUS) and alternative SUI management procedures in Australia over a fifteen year period in response to the controversies and restrictions surrounding implantable synthetic mesh.

Data was obtained from the Australian Government Department of Human Services database.

The total number of SUI procedures performed in Australia under the following Medical Benefits Schedule item numbers was searched by year and compared for the period between January 2007 and December 2021:

- 35599: Mid-urethral sling
- 37044: Burch colposuspension
- 37043: Stamey procedure, or similar
- 37042: Autologous fascial sling
- 37339: Peri/transurethral bulking agent injection

RESULTS: 66,767 MUS procedures, 5,105 Burch procedures, 1,033 Stamey procedures, 4,673 autologous fascial sling procedures, and 10,798 periurethral bulking procedures were performed between January 2007 and December 2021.

MUS procedures have declined significantly since around 2016. Prior to this, MUS represented 80.4% of SUI procedures, averaging 5562.4 cases per year. Between 2016 and 2021 this dropped to 63.9%. Only 1,413 MUS were recorded in 2021, compared to a highest annual case number of 5,878 in 2011. The effect of Covid-19 related pause on elective surgery cannot be ignored, however numbers were already significantly reduced in 2019, with 2,386 procedures recorded.

The proportion of surgical SUI management via alternatives to MUS has remained relatively steady for all but periurethral bulking, which saw an increase from 7.9% to 22.4% of recorded procedures between 2007 to 2015 versus 2016 to 2021. Absolute numbers increased from 419 (lowest) in 2009 to 1,147 (highest) in 2019.

The overall number of procedures declined from 6,677 in 2007, to 3151 in 2021. The highest number of annual cases was 7,201 in 2011. There was an expected drop during Covid-19 impacted 2020 and 2021, although a downtrend already existed with 4,085 procedures recorded in 2019.

The potential implications of such dramatic decline in MUS and total SUI procedures must be considered. Implications to consumers may include delayed presentation, reluctance towards treatment and increased suffering. Implications to providers may include surgical deskilling, less training opportunity and reduced income.

CONCLUSION: There is a clear downtrend in SUI procedures, especially MUS, being performed in Australia in recent years. The impact on surgical training and patient access to treatment options must be addressed.

AGES Pelvic Floor Symposium 2022 Free Communications Awards cont.

AGES Best Video Free Communication Presentation

Indocyanine green for intraoperative visualisation of bladder and ureters in laparoscopic Gynaecological surgery for benign conditions: video presentation

Reema Kohli [1], RK Mishra [2]
1 Gold Coast University Hospital, QLD, Australia 2 World Laparoscopy Hospital, Delhi NCR, India

BACKGROUND: Accurate delineation of ureters and bladder is extremely important in gynaecological procedures to avoid injury. The overall rate of urinary tract injury associated with pelvic surgery in women ranges from 0.3 to nearly 10 percent based on the complexity of the surgery[1]. Bladder injury is approximately three times more common than ureteral injury. Ureteral injuries can be missed easily. Potential consequences of lower urinary tract injury include pain, sepsis , readmission, ureteral obstruction, stricture, renal damage and dealth. When bladder injuries present postoperatively, genitourinary fistulas appear to be the most common presentation.

Regular or Illuminated ureteric stents have been used to delineate ureters and methylene blue or indigo carmine have been used to delineate the bladder in the past.

METHOD: This video demonstrates the technique to utilize the new optical tool- near-infrared fluorescence (NIRF) imaging and explores its potential applications and advantages in laparoscopic Gynaecological surgery for benign conditions. Before surgery, a 6-Fr catheter is inserted about 1cm into the ureteral orifice by cystoscopy and then retrograde injection of 25 mg ICG diluted in 10 mL of distilled water is made. Bladder and ureters light up as fluorescent green structures after 7-8 mins of injection of dye using the NIR mode of the high-definition stereoscopic camera connected to 0o laparoscope. Visualisation is usually possible throughout the surgery lasting up to 240 mins[2]

We performed this technique in 18 patients undergoing TLH using Stryker 1688 AIM 4K Platform with flouroscence mode. 8 patients had a multifibroid uterus. 3 patients had endometrioma. 4 patients had more than one previous Caesareans.

RESULTS: Successful identification of ureteric tract and bladder was seen in 100% cases. Ureters were usually visible after 7-8 mins of instillation of dye. Clear visualisation of urinary tract assisted with easy ureteric identification in pelvic side wall and at the level of infundibulopelvic ligaments. It was useful in bladder dissection and ureterolysis. No adverse effects were noted.

CONCLUSION: Indocyanine green provides excellent colour contrast in ureteric/ bladder visualisation specially in complex procedures like advanced endometriosis, broad ligament myomas, adhesions from multiple previous caesareans. It can be useful tool for surgical coaching for trainees and teaching ureteric anatomy. ICG urethral instillation is less expensive than other fluorescence-based systems such as illuminated catheters. No radiological support is needed, and the patient is not exposed to any ionizing radiation. It has potential for use in newer endoscopic modalities like vNOTEs.

1 Delacroix SE , Winters JC . Urinary tract injures: recognition and management. Clin Colon Rectal Surg 2010;23:104–12. doi:10.1055/s-0030-1254297
2 Mandovra P, Kalikar V, Patankar RV. Real-Time Visualization of Ureters Using Indocyanine Green During Laparoscopic Surgeries: Can We Make Surgery Safer? Surg Innov.2019 Aug;26(4):464-468. doi: 10.1177/1553350619827152.
3 Siddighi S, Yune JJ, Hardesty J. Indocyanine green for intraoperative localization of ureter. Am J Obstet Gynecol. 2014 Oct;211(4): 436.e1-2. doi: 10.1016/j.ajog.2014.05.017

AGES Pelvic Floor Symposium 2022 Free Communications Awards cont.

AGES Best Digital Communications Presentation

The feasibility of a new technique for sacral neuromodulation for Bladder Pain Syndrome; An assessment by Pelvic Pain Impact Questionnaire (PPIQ) scores.

Anne O'Connor [1], Jason Chow [1]
1 Royal Hospital for Women, Randwick, NSW, Australia

INTRODUCTION: Bladder Pain Syndrome is characterised by chronic pelvic pain associated with bladder filling, and the presence of another urinary symptom. Severe forms may be treated with surgical procedures that carry risk of significant morbidity. Sacral neuromodulation (SNM) is an alternative treatment for cases not responding to conservative management. Previous studies have primarily utilised S3 or pudendal leads. The technique employed in our study was placement of bilateral sacral hiatal leads in addition to S3 and/or pudendal leads, depending on symptomology and response to trial SNM placement. Outcomes were assessed by Pelvic Pain Inventory Questionnaire (PPIQ) scores before and at 12 months after permanent sacral neuromodulator placement.

METHODS: All patients with bladder pain syndrome who had permanent SNM placed by either of two surgeons at a Sydney hospital between 2017 and 2021 and had completed pre- and post-insertion PPIQ surveys, were included in this case series. Patients repeated the PPIQ 12 months after placement. Before and after PPIQ scores were analysed using descriptive statistics and paired T-test.

RESULTS: 15 patients had a permanent SNM placed for bladder pain syndrome between 2017 and 2021. 5 (33.3%) completed pre- and post-insertion PPIQ surveys. The median time from SNM placement to survey was 399 days (IQR 299-431). The mean age at placement was 42.9 years. There was a 55.5% reduction in mean total PPIQ score 12 months after SNM placement, that did not reach significance (22/32 vs 9.8/32, p=0.09). For the three patients who answered the optional Questions 9 and 10, there was a 53.5% reduction in total score 12 months after SNM placement (2/8 vs 4.3/8, p<0.05). No patients had significant complications.

CONCLUSION: In this small case series, sacral neuromodulation using hiatal and S3 leads was associated with a non-significant reduction in mean PPIQ scores at 12 months after permanent placement. Although small, this data suggests the described SNM technique is feasible for treatment of bladder pain. Study of the efficacy of this SNM protocol on patient outcomes would be improved by prospective data collection using a composite of questionnaires validated for study of bladder pain/chronic pelvic pain including the Interstitial Cystitis Symptom and Problem Index and Brief Pain Inventory. Durability of the effect of SNM should be assessed with further longer term study of patient outcomes.

1 Mahran A, Baaklini G, Hassani D, Abolella HA, Safwat AS, Neudecker M, Hijaz AK, Mahajan ST, Siegel SW, El-Nashar SA. Sacral neuromodulation treating chronic pelvic pain: a meta-analysis and systematic review of the literature. Int Urogynecol J. 2019 Jul;30(7):1023-1035. doi: 10.1007/s00192-019-03898-w. Epub 2019 Mar 14. PMID: 30874835.
2 Peters KM. Sacral neuromodulation is an effective treatment for interstitial cystitis/bladder pain syndrome: pro. J Urol. 2012 Dec;188(6):2043-4. doi: 10.1016/j.juro.2012.09.072. Epub 2012 Sep 20. PMID: 23000855.
3 Wang J, Chen Y, Chen J, Zhang G, Wu P. Sacral Neuromodulation for Refractory Bladder Pain Syndrome/Interstitial Cystitis: a Global Systematic Review and Meta-analysis. Sci Rep. 2017 Sep 8;7(1):11031. doi: 10.1038/s41598-017-11062-x. PMID: 28887515; PMCID: PMC5591255.

Save the date

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

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2022 Course Dates: on application.

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

All enquiries should be directed to: Dr. Weng CHAN,
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Dates for Laparoscopic Workshops cont

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SYDNEY LAPAROSCOPIC WORKSHOPS 2022

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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: 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

CENTRE FOR ADVANCED REPRODUCTIVE ENDOSURGERY

escope

Volume 81 coming out in December 2022

Contact Rachel Green (secretariat@ages.com.au) with your contribution
Deadline **4th November 2022**