THE INTERNATIONAL SOCIETY FOR GYNECOLOGIC ENDOSCOPY

OPUS – The ISGE Newsletter

Issue 1, Spring 2016

Important Dates

11th – 15th April 2016	7th Workshop in Endoscopic Surgery, Yaounde, Cameroon
25th – 28th May 2016	I25th Annual ISGE Conference, Opatija, Croatia
15th – 17th September 2016	ISGE Asian Conference, Bali, Indonesia
Spring 2017 (dates to confirm)	ISGE Regional Meeting, Kingston, West Indies

News & Views

Welcome to the first edition of Opus, the new ISGE Newsletter. I am delighted to have been asked to be its editor. The aim of Opus, is to add another method of communicating with ISGE members, share news and events and solicit your views.

The ISGE is a truly global organization with members in 44 countries. All of us cope with the challenges of medical practice to try and give our patients the very best care. The ISGE allows us to learn new techniques, share our results and network with like-minded colleagues at meetings and through social media.

This newsletter needs YOUR input. We aim to publish four times a year, and I'd be delighted to accept any suggestions for news articles, comment pieces or research papers that have caught your imagination.

Under the leadership of our president, Bruno Van Herendael, and with the support of ExCo and the ISGE Board, the society is going from strength to strength with a growing number of members, and a range of educational and academic projects designed to support your practice in gynaecological endoscopy. We are also keen to play our role in the global family of endoscopic surgery and have exciting collaborations in place with sister endoscopic societies.

Abdominal Entry - Guidelines

The ISGE has developed an evidence-based guideline critically examining the evidence for the safest techniques of abdominal entry.

This important document will be published soon in the European – Journal Of Obstetrics & Gynaecology. ISGE Members will be emailed the guideline on publication

Notes From …Down Under

Rob O'Shea, President Elect, ISGE, comments on the current status of hysterectomy in Australia

In Australia, approaches to hysterectomy for benign disease have altered dramatically in the past fifteen years. In our health system, approximately 50% of the population have private health insurance. The remaining 50% will have their surgery in the public system where there is no national surgical data available.

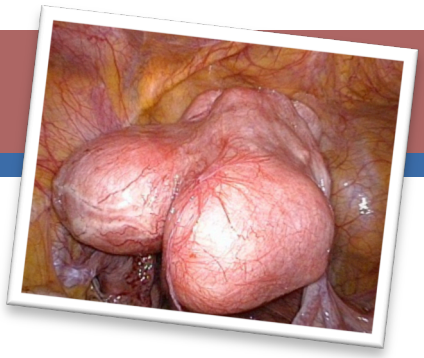
The Medicare data for benign hysterectomy in private patients makes interesting reading. In 2000-2001, 50% of hysterectomy were performed abdominally with 35% vaginally and only 15% having some laparoscopic component.

In 2014/2015 abdominal hysterectomy has fallen to 27.5%.

Vaginal hysterectomy nationally is 28.5%. Hysterectomy with a laparoscopic component is now 44% of hysterectomies performed in Australia.

Indeed in my own state of South Australia, vaginal hysterectomy counts for only 21% of cases with 47% having a laparoscopic component.

44% of hysterectomies are laparoscopic



The fall in vaginal hysterectomy may well reflect a switch to the laparoscopic procedure. In addition, Registrars in training are not exposed to the vaginal approach. Many of the experts and teachers in this area have either retired or are aging rapidly. More than a generation ago, most Australian trainees spent several years in the United often picking up the necessary vaginal skills.

Registrars now in training rarely go overseas for training and this is definitely evident in their diminished operative repertoire.

Meet The President

Professor Bruno Van Herendael leads the ISGE. A Gynaecologist based in Antwerp, he has been one of the leading pioneers in Gynaecological Endoscopic Surgery.

He explains what makes him tick…

1.What is your current state of mind ?

At this moment in time I am mostly concerned with the wellbeing of ISGE but also with the training schemes for MIS in West Africa and how to keep the company MEDCollege afloat that I and my partners did start just to get to this goal.

2. Who was your biggest surgical influence ?

My father who was a brilliant vaginal surgeon and later first Jacques Hamou with whom I collaborated and travelled the world and Harry Reich, who is not that much older but much more a doer and who did revolutionize the endoscopic fraternity.

3. How has gynaecological endoscopy changed your life?

Completely in the sense that one of my former registrars did ask me some ten years ago: sir this must be the first laparotomy you did in over 20 years. I did start as an hysteroscopist and later evolved to a laparoscopist. Treating all female abdominal disease with endoscopy.

4. What is your idea of a perfect holiday ?

Sitting in my house in Italy looking at the mountains – no television courtesy of my wife – sipping some local wine. Just my exercises in the morning not to get too stiff.

5. What is your favourite drink ?

Wine from which I know the origin.

6. Who would you choose to play you in a film of your life?

You could not find such an ugly character. Difficult question

7. How do you choose to relax?

Working in my vegetable garden at home in Schoten Belgium. Friends who did visit me know what I talk about. Getting my hands extremely dirty with the soil as opposed to the needed cleanness of the hands in theatre.

8. What is your favourite surgical procedure?

Pelvic Lymphadenectomy and radical hysterectomy.

9. Tell us something we don't know about you? The first part of my life up to 31 years of age was professional sport. From 18 until 31 I was a member of the Belgian National Rowing team training some 6 to 8 hours a day. At university I sometimes had my consultants stand in for me when rowing at championships. Their condition was invariably for me to show them my medals when back

A cocktail of surgery, gardening, rowing, colleagues and a good glass of wine!

on duty the same evening;

10. What do you wish you had invented?

An instrument capable to deliver: monopolar, bipolar, ultrasound and bipolar sealing all in one.

What's New : Snippets From The Journals Which May Change Your Practice

Bowel Prep Before Major Laparoscopic Surgery – What Do You Do ?

Some of us feel that it's vital to empty the bowel before performing major laparoscopic surgery, to reduce, in the unlikely event of a bowel injury, faecal contamination with a subsequent better patient outcome. Other colleagues feel that its not indicated.

Now Jason Abbott and his Australian colleagues have performed a major systematic review examining 43 trials in order to try and address this question.

They found that infectious morbidity and anastomotic leak rates were not affected whether patients had experienced pre-operative mechanical bowel preparation (MBP) or not, suggesting there is no benefit in subjecting our patients to this potentially uncomfortable experience. (Arnold, Journal of Minimally Invasive Gynaecology, 2015)

Are you a Robot Fan ?

I'm personally not, for me I can't see the advantages and I think that for benign gynaecological disease, the evidence that using a robot surgically improves success rates is lacking.

A recent study comparing the outcomes of sacro-colpopexy performed laparoscopically or with robotic assistance showed no benefit using the robot. I suspect the debate will rumble on. (Pan, Int J Gynecol Obstet, 2016).

Good-bye Speculum in Hysteroscopic Practice ?

A nice review from Mark Emanuel reminds us just how far hysteroscopic practice has come in the last few years. Newer more narrow instrumentation means that its unusual that cervical dilation needs to be performed.

The gold standard office hysteroscopy approach should now be vaginoscopic – randomized studies show its better tolerated that conventional techniques and is associated with the same success rates . (Emanuel, Best Pract Res Clin Obstet Gynaecol, 2013)

Don't Forget Roller-Ball and TCRE for Menorrhagia !

In this world of trendy ablation devices, a recent study reminds us that the long-term results of first generation ablation are "often under-estimated". Lets not forget teaching basic hysteroscopic skills to our trainees. (Knaepen, Gynecol Surg 2015)

ISGE – Training Opportunities

ISGE members can benefit from a range of educational activities designed to improve their surgical skills.

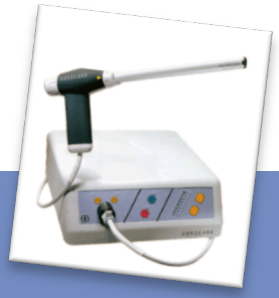
ISGE has developed a comprehensive laparoscopic suturing program, available on-line which will help develop the vital, but often challenging in the early days, technique of laparoscopic suturing.

Workshops- ISGE has developed a highly successful range of endoscopic workshops which have been hugely popular. The basics of endoscopic surgery are taught in a relaxed environment by a variety of visiting ISGE expert teachers. Special thanks to Alfonso, Bash, Bruno and Ornella for leading this very important work.

The ISGE is fortunate that Bash Goolab, Chairman of our Training Committee has also been appointed Head of the Endoscopic Committee at FIGO to develop close links between our two organizations.

Our hugely popular training website The Trocar has a huge range of educational articles and videos, its well worth a look and they're always looking for more material.

Finally ISGE is always happy to try to arrange personal mentoring, contact the ISGE Secretariat for more information.



Does morcellating fibroids increase the risk of spreading malignancy ?

The ISGE is organizing an international global registry to try to answer this controversial problem. Surgeons performing laparoscopic myomectomies are invited to share their data in the hope that, with enough numbers, we will be able to answer this controversial and topical question.

For more information contact

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ISGE Taskforce On Vaginal Hysterectomy

The ISGE is undertaking a major project to promote vaginal hysterectomy which is increasing in popularity after some years in decline.

A taskforce, led by Ellis Downes is undertaking work patterns examining hysterectomy rates, developing educational packages and promoting the benefits of vaginal hysterectomy.

More info :
ellis@ellisdownes.com

Endoscopic Surgery Around The World

The wonderful mixture of ISGE members from around the world highlights how different medical practice varies between our countries. While all ISGE members are convinced of the advantages of endoscopic surgery for our patients, how we actually put this into everyday clinical practice for our patients varies hugely depending on where we live.

In developed countries we may be faced with challenges of competition, demanding patients and an increasingly litigious environment to practice medicine. Financial challenges with falling incomes, rising medical costs, especially mal-practice insurance in some countries, mean that many gynaecologists are seeing their incomes fall.

In developing countries there may be huge shortages – of both suitably trained surgeons, and the equipment and resources to allow endoscopic surgery to be performed. Disposable equipment may be a luxury, and such limitations teach surgeons how to deliver good outcomes using the minimum of equipment, an important lesson for all surgeons, regardless of where they practice. Training needs are being identified and addressed, both in country, and with the assistance of organizations like ISGE and others, utilizing their members expertise and enthusiasm to lend support.

It can be a huge challenge as a consultant to learn new surgical procedures. Finding colleagues to mentor, over-coming political problems in hospitals and finding the time and money to travel to learn new techniques can be major barriers to knowledge acquisition. With the increasing range of ISGE educational initiatives, hopefully some of these challenges can be overcome.

Endoscopic gynaecologists have always had close links with our colleagues in the medical device industry, recognizing that without constantly developing and refining surgical instruments we will struggle to refine our surgical techniques. While this relationship will always be important, there appears to be a trend for using fewer disposable instruments and devices in these financially challenged times.

Whatever part of the world we operate in, the importance of good patient counseling, documentation and a frank discussion with patients in the rare event of a surgical complication is vital.

Only by constantly striving to deliver the highest surgical standards, never forgetting we work in a team and employing consistency in our surgical approach can we hopefully reduce our complication rates.

As surgeons we must share our outcomes and complications, wherever we work in the world, in this way we can hopefully continue to deliver good care.

Make the most of your ISGE Membership Benefits

World-class Educational Meetings

Discount on medical journals

Free access to scientific articles & videos at ISGE's pioneering www.thetrocar.com

ISGE Suturing Course

On-line textbook of Gynaecological Endoscopy

Inclusion in ISGE Directory

Contact the secretariat for more information:

secretariat@isge.org

ISGE ExCo Members:

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Robert O'Shea, Australia, Vice-President
Prashant Mangeshikar, India, Immediate Past President
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Alessandro Loddo, Italy
Guenter Noe, Germany

Stop Press: In Opatija, ISGE will be launching the new ISGE Accreditation Scheme and APP – watch this space

Please contact the Newsletter editor Ellis Downes (ellis@ellisdownes.com) with any suggestions for the next edition, which will be published in May 2016