



THE INTERNATIONAL SOCIETY FOR GYNECOLOGIC ENDOSCOPY

OPUS – The ISGE Newsletter

Issue 2, Autumn 2016

Important Dates

4th – 6th
November
2016

17th APAGE Congress,
Taipei, Taiwan

23th – 25th
March 2017

“MIGS & Fertility”, ISGE
Conference, in
association with AGES,
Kingston, Jamaica
Opatija, Croatia

18th – 22nd
October
2017

Joint ISGE –,ESGE ,
MESGE Meeting, Antalya,
Turkey

News & Views

We are delighted to present the next edition of Opus, the newsletter of the ISGE to coincide with the ISGE's Regional Asia-Pacific Meeting in Bali, Indonesia held jointly with the 5th Meeting of the Indonesian Gynaecological Endoscopic Society (IGES).

The conference, organized by both organisations, brings together the worlds leading gynaecologic endoscopic surgeons and teachers in the surroundings of Indonesia where we will share advances in surgical techniques, debate the current controversies in our practice and most importantly share in the fellowship and friendship of our global endoscopic family.

The last six months have seen the development of a number of projects, initiated by the ISGE which complement it's teaching and training roles in endoscopic surgery. The publication of our guideline on Entry Techniques gives all members an evidenced-based document to use in their clinical practice, ongoing projects in Accreditation in Endoscopic Surgery will be beneficial to members so they can demonstrate their training and compencies. Finally the Vaginal Hysterectomy Taskforce have commenced work on producing evidenced-based guidelines to encourage the dissemination of vaginal surgery skills which still have a role alongside endoscopy.

Hysterectomy – What Do You Do ?

The ISGE is undertaking a survey among its members to try to understand what is their main preference when performing hysterectomies : laparoscopic, vaginal or abdominal ? We want to understand why you choose one technique over another. Please help us with this important study at :www.surverymonkey.com/r/Q5MM399





Laparoscopic Entry Techniques

Recent publication of the landmark ISGE Guideline on Abdominal Entry examines evidence and gives practical advice

Entry into the abdominal cavity is a pre-requisite for performing laparoscopic surgery. The majority of gynaecologists use one of three techniques when performing laparoscopies, either closed (veress needle), open (Hasson) or direct entry. Veress needle is the most popular method.

Current published data shows no technique can claim superiority and claim to be the recommended technique

preferred technique. This data however must be treated with caution as most published trials were underpowered to statistically detect differences between different techniques, and maybe believing that all techniques are equally safe may be inaccurate.

As long as gynaecologists have used a recognized technique, if a complication does occur during initial entry it is generally defensible

defensible.

Most laparoscopic complications occur during initial entry – typical rates include bowel injury at 0.4 per 1000 laparoscopies, and major laparoscopies. Even though these complications are rare, they account for 50 % of laparoscopic complications and are a major contributor to medico-legal problems.

Use 25mm Hg for initial pneumo-peritoneum

Key tips for closed entry techniques include:

Veress placement : If trans-umbilical entry fails after 3 attempts use the left upper quadrant.

It is not recommended to lift the anterior abdominal wall during veress needle

insertion. It does not reduce the risk of injuries and increases the failed entry rate.

The angle of the veress needle should be adjusted from 45° for a normal weight patient, to 90° for an obese patient.

An initial veress needle pressure of <8mmHg is the only reliable indicator of correct veress needle placement.

(Djokovic et al, Eur Jnl Obs Gynaecol, 2016, 201, 179-88)





Meet Our President- Elect !

Rob O'Shea, based in Adelaide, Australia, has been a long-time key-opinion leader in global gynaecological endoscopy and a stalwart of the ISGE.

He explains what makes him tick...

1. What is your current state of mind ?

There are a number of challenges with the ISGE at the moment. I'm putting my energies into ensuring the academic and financial future of the society which is founded on our key principles of training and teaching, especially the next generation of surgeons.

2. Who was your biggest surgical influence ?

My original Professor, Warren Jones at Flinders University, even though he wasn't an endoscopic surgeon, he gave me a set of Kurt Semm's slides which inspired me to get into endoscopic surgery. I also owe a huge debt to Harry Reich, who taught me so much .

3. How has gynaecological endoscopy changed your life?

The journey has been fascinating. It's allowed me to contribute to developments, it's been a roller-coaster and most importantly I've made great friends world-wide. I've seen how an endoscopic surgical approach helps women.

4. What is your idea of a perfect holiday ?

Sitting on my brothers boat in Perth – off Rottnest Island, eating, fishing and drinking., nothing good be better !

5. What is your favourite drink ?

Red and white Burgundy

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

I love the original MASH film, why not Donald Sutherland

7. How do you choose to relax?

I love spending time with my family, playing golf and tennis.

8. What is your favourite surgical procedure?

I love performing laparoscopic sacral-colpopexy's, followed by total laparoscopic hysterectomies (TLH's). In my opinion, these are "the operations of the connoisseur"

9. Tell us something we don't know about you? My parents were both doctors, I grew up in

Ireland and then our family emigrated to Australia.

I went to Perth University for my initial training and now I live and work in Adelaide.



10.

What do you wish

“Endoscopic surgery has given me wonderful friends around the world”

you had invented?

I don't think the current vaginal tubes are great. I wish I had invented a better instrument for laparoscopic hysterectomy where a vaginal tube could maintain the peritoneum, as well as giving better manipulation.

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

Post-Operative Pain After Laparoscopy

One of the main causes of pain after laparoscopy is the effect of CO₂ on the peritoneum. An interesting randomized study from Leuven, Belgium looked at the effect of doing laparoscopies in women with conventional 100% CO₂ and those with 86% CO₂, 10% N₂O and 4 % O₂. All the women were undergoing the same surgical intervention robotic-assisted laparoscopic myomectomy.

Interestingly the group with the non-100% CO₂ gas mix had significantly less pain and pain-killer usage suggesting that this might be one way to further reduce post-operative pain.

The group wondered if the different gas mixture might reduce adhesion formation and performed a second-look laparoscopy 14 days later. Although fewer adhesions were noted, this did not reach statistical significance.

(Verguts, Gynae Surgery, 2016,13, 139-146)

Do You Ache After Laparoscopic Surgery ?

If so, you're not alone. Many of us, after long surgery feel like old men !

A recent survey by Dr Magro, Barts Hospital, London, presented at the annual scientific meeting of the British Society of Gynaecological Endoscopy (BSGE) showed that surgical soft-tissue injuries were very common.

Although the response rate was low, 87% of respondents complained of musculo-skeletal pain made worse after laparoscopic surgery. Commonest sites were : neck (63%), shoulders (41%), back (67%). Interestingly 71% of respondents had received no training in ergonomics and 97% thought these problems could be improved with better equipment and patient positioning.

As well as training in surgical techniques, we probably could reduce our injuries with training in ergonomics.

Laparoscopic Ovarian Drilling For Clomiphene Resistance-Bipolar or Monopolar Needle ?

A fascinating study from Egypt has presented the results of a randomized trial allocating women with polycystic ovarian syndrome who are not ovulating with clomid and required laparoscopic ovarian drilling (LOD) to LOD with either a monopolar or bi-polar needle.

Interestingly the group who had LOD performed with a bi-polar needle had a statistically significant higher level of resumption of ovulation and spontaneous pregnancy within one year compared to the monopolar group. While many of these patients will be directed to IVF, in many parts of the world where it is not readily accessible ovarian drilling still has an important role and this study should prompt surgeons to perform it using bi-polar needles. The authors speculate, adhesion formation may also be less but this is unproven. (Darwish, Gynae Surgery, 2016, 13:179-185)

ISGE – Vaginal Hysterectomy Taskforce

The ISGE Vaginal Hysterectomy Taskforce had its first working meeting during our last meeting in Opatija on 25th May 2016.

It has been tasked by the ISGE Board to develop an evidenced based commentary examining the indications, techniques, complications and outcomes of vaginal hysterectomy with a view to submitting this paper for publication, in a similar fashion to the ISGE Abdominal Entry

document.

The Taskforce will also develop educational materials demonstrating basic and advanced vaginal surgical techniques.

There has been a resurgence of vaginal surgery in the last few years, but with a rise in laparoscopic hysterectomy and fewer open procedures being performed there are relatively fewer gynaecologists

performing and teaching vaginal surgery. It is hoped that the work of the Taskforce will help to address these challenges and provide useful resources for members.

Members of the Taskforce are : Ellis Downes (Chairman), Viju Thomas, Bash Goolab, Annelize Barnard, Prashant Mangeshkar, Heshab Arab, Peter Maher, Bruno Van Herendel and Andreas Chrystoumou.

Tips For Consenting Patients For Surgery

Consenting a patient for surgery is something that, as busy surgeons, is a routine part of our day to day work. Recent changes in medical practice, and, in many parts of the world, a growing tendency for patients to consider legal advice if a complication occurs, means there is a greater need than ever for the consent process to be robust and thorough.

Consent is not just a patient signing a form five minutes before surgery. It is a continuous process from the moment the surgeon discusses an operation, to the moment the patient becomes un-conscious in the anaesthetic room and can be withdrawn at any time.

When consenting a patient, a good rule of thumb is to think, "what would I like to know about this operation if I was having it?". This includes discussing with a patient not just the proposed operation, but alternative procedures to allow the patient to consider all the options and reach a decision with their doctor. For example, if a patient has menorrhagia and the surgeon is considering hysterectomy, they should also discuss the pro's and cons of medical treatment, mirena and ablation. In the UK, following a recent ruling (The Montgomery Case), unless these steps are taken the patient will be deemed to have been inadequately consented.

Sadly complications are a fact of surgical life and patients must be warned about potential complications before surgery. Common complications (bleeding, infection etc) should be mentioned along with rarer, more serious ones, like bowel injury.

"If its not written in the patient's notes, it wasn't said" is a common legal phrase. Busy doctors sometimes write very brief notes and fail to adequately document what has been discussed with patients. In the event of a problem, the patients' lawyers will examine in detail what has been written down and what information was given to the patient. Giving patients information sheets (and documenting this fact) along with copying patients into clinical correspondence gives clear evidence of what information the patient has received prior to surgery.

If a complication does occur at surgery, as well as obviously dealing with it, a full detailed operating note should be made. A full and frank discussion with the patient explaining exactly what has happened in an open and transparent way will go a long-way to reducing the likelihood of subsequent legal action.

Following these steps will hopefully make the consent process more robust and benefit both the patient and surgeon alike.



Highest ISGE Award for Harry Reich

In Opatija, Harry Reich was presented with lifetime honorary membership of the ISGE by our President, Bruno van Herendael, in recognition of his remarkable pioneering contribution to gynaecological endoscopy. As the first person to perform a laparoscopic hysterectomy, his place in history is guaranteed.

Well-done Harry !



Following previous successful joint meetings, the ISGE is delighted to be holding a joint meeting with the European (ESGE) and the Middle East (MESGE) Societies of Gynaecological Endoscopy in the beautiful region of Antalya, Turkey.

Do come along for what will be an educationally, and socially stimulating time

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