EDITOR
Stephen
Lyons

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escope

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

IN THIS EDITION

President's Letter

Surgical Culture

No, it is not an oxymoron and no, it is not some new form of MRSA/VRE or any other acronym to denote the latest superbug that is going to wipe out humanity. This is how we as gynaecological surgeons understand our profession and ourselves. Surgical culture is something we all practice – even if we don't realise it and it is one of the best ways for us to continue to learn in the 85% of time that we are not trainees, teach and pass on our knowledge and contribute to research and development so that when we leave the surgical specialty there are more answers to the questions that troubled us when we started being a specialist gynaecological surgeon.

At the Sydney Annual Scientific Meeting this year, Associate Professor John Pardey gave an extraordinary presentation on civility – how we embed culture into our everyday. John's practical mantra of taking a deep breath when things are bad and avoid the 'screaming surgeon' approach is something we all could work on – and I have tried (reasonably successful) since, with good effect. You catch more flies with sugar than vinegar, right? The other aspect of culture that John highlighted and one that many of us do is to communicate more effectively. Every surgeon thinks that they are wonderful communicators, but you only have to spend several sessions explaining a procedure to a patient with words, with pictures, with diagrams and videos to consent them and then pass by the operating bay as they are wheeled in and asked by the nurse "What procedure are you having done" with their response: "She/he is cutting something out of me" to realise we don't always hit the communication mark. →

President's Letter cont.

But consider other aspects of culture – the way you secure a knot each and every time you tie one. Is it always square? Is it the right tension for the purpose of that part of the procedure? Are you using the correct number of throws to increase tension (if appropriate) depending on whether you are using a multifilament or monofilament suture? One hand or two? Cutting or round bodied needle? So many questions that you need to ask – and answer – at every step of every procedure. And to have good technique and to make good technique your culture (optimal surgery) that means when things are not going well (less than optimal surgery – and everyone has been in that black and dark space), your surgical culture is allowing you to think about the other steps to improve the outcome for the woman you are treating right there and then. Now apply that same surgical culture to electrosurgery, to instrument handling, to wound closure, continue to learn and ask and focus each time you operate, each time you teach and the outcome for your patient – the woman on the operating table right now – will be improved. There is nothing more traumatic than surgery (we damage; the patient heals) and to optimize the outcome, optimize the input.

At the recent AGES Pelvic Floor Symposium, we addressed "Challenging Times" and challenging times they are. Our profession is in the hottest of spotlights at the moment with a senate enquiry into transvaginal mesh implants and we must all be aware of the events that will unfold in the next few months. AGES always have and always will support the specialist gynaecological surgeon and we must stay at the forefront of pelvic floor assessment and surgery. This is part of our surgical culture. Gynaecological surgery has been around for well over a hundred years and – it is suggested – millennia with Soranus of Ephesus accredited at doing the first vaginal hysterectomy for a gangrenous and prolapsed uterus in the second century AD. Back to this millennia, it is possible that we may see the disappearance of some or all of the implantable materials for pelvic organ prolapse and incontinence from our armamentarium, but what will not disappear are the women with prolapse and incontinence who turn to us – specialist gynecological surgeons – for help, just as they have for centuries. With only 37 subspecialist urogynaecologists, it is neither possible nor appropriate for them to be burdened with each of the 1 in 3 Australasian women with incontinence or the 1 in 4 Australian and New Zealander women with prolapse. Surgical culture and research has been so important in the preparation for the senate enquiry. The fact that we have more than 2000 studies on midurethral slings, that they have been around for nearly 20 years and that they have been compared in the most scientifically valid manner against 'gold standard' treatments, makes the argument for us performing and continuing to offer this simple, effective and safe procedure to women so much more powerful. With such strong surgical culture (in this case, evidence), when that spotlight is turned to us, it will not burn us but rather allow us to stand in the glow of information and knowledge. Our thoughts, sympathy and apology goes to any woman who has been injured during surgery, but we must also recognize and support what has been a life-changing procedure for millions and millions of women worldwide. Our culture of help demands it and that foundation of evidence is the scaffold on which we can solidly stand. We must embrace such culture on every new procedure, instrument or technique that we undertake for this very reason. →

President's Letter cont.

Part of the Senate enquiry line of questioning comes back to figures – training, education and credentialing. This is so variable from hospital to hospital that it is essential that we all do our own record-keeping and self-monitoring and appraisal. One of the most efficient methods for this is a surgical database and Surgical Performance is free to all AGES members. Over 100 of our members have signed up to SP and more than 60 are active database users (defined as having entered more than 10 cases). I freely admit to needing to change my culture on this front, since my previous personal database was inwardly focused – it only assessed what I did and provided outcomes for comparison – but compared to whom? Me? Hardly a decent sample size. Although I was a little slow to start using Surgical Performance, it is now so engrained into my surgical routine that it is second nature. Less than 2 minutes between cases and simple to follow-up for returning surgical cases. The records generated allow very simple and easy comparison of your numbers and where your strengths lie surgically. Navigating what you do in terms of volume may direct future procedural performance. There are broad-brush recommendations of how many procedures you need to stay competent (one a month *after* training), but that will vary from surgeon to surgeon and procedure-to-procedure, since many procedures are series of steps (access, dissection, securing vascular pedicles, specimen retrieval, closure) and often build on each other. Reviewing your own surgical procedures allows you to increase your insight (we all think we do many more procedures than the true number – how many hysterectomies do you do a year? A hundred? That is two a week every week and no holidays….). And consider referring on when your numbers drop too low in one area. So, part of my new surgical culture has been to review my own Surgical Performance – enlightening, worthwhile and I encourage you to do the same.

The evolving AGES culture has been to return to members and the community and the AGES Dissection Workshops, the Interactive Hubs and our Art projects (what a great preview of the fantastic artworks in Adelaide that will be auctioned at the Melbourne ASM for charity) are all examples of this. Our Focus meeting in Singapore is also a direct result of you, the membership telling us you wanted an offshore meeting and Singapore was your chosen destination. For good food, good fun and that equatorial heat join us in Singapore for Preserve, Protect, Promote where we focus on conservative surgery, conserving ourselves and conserving function for women. Rachel Green and Krish Karthigasu have led the team putting together a fantastic program and there is a topic for everyone and an outstanding Singaporean as well as Australasian faculty presenting and you can register by going to the AGES website. Personally, whilst I know that the scientific program is going to be the gleaming star of that trip, I am secretly looking forward to the hawker street food markets, checking out the amazing looking new Gardens by the Bay area and the Singapore Flyer. Now that is my kind of cultural experience.

Singapore is our last scientific meeting for the year, but the Brisbane dissection workshop will round at this year (but is all sold out, so register early for 2018 workshops). But fear not, the year to come will be just as extraordinary – Melbourne for our ASM where we will undergo the "Evolution towards Excellence" with surgical superstar Ted Lee, former AAGL President and supreme vaginal surgeon Barbara Levy and French/Italian hybrid Pietro Santulli (the team have done nothing but say his name and if you think his name sounds good, come hear him speak – definitely not disappointing). Haider Najjar, Emma Readman, Stuart Salfinger, AGES stalwart Jim Tsaltas (you remember him, right?), and evolving stars Lenore Ellett and Kate McIlwaine are the team to lead the evolution revolution. →

President's Letter cont.

The black-tie dinner is back bigger and better than ever complete with awards and the presenting of the Graduating AGES fellows. That dance floor will burn, so come let's tear it up again. Pelvic floor moves to Brisbane as we look for the opportunities from this calamitous state and rising like a phoenix will be new thoughts, technical revelations and the positivity that follows hardship. Focus 2018 will be in Australia's capital – the all grown up Canberra. I am delighted that we will be going to Canberra, since that will mark AGES' foray to every single state and territory of Australia and New Zealand. The venue – the hip QT hotel is sophistication and style just as you would expect in this New AGE.

The culture of this AGES board is to innovate, to support, to progress and to produce. I am enormously thankful that they give their time, their vitality and their good humour to collectively work towards these goals. We are fantastically supported by Mary, Danielle, Jayme and Jess and the YRD team who always smile and for every hair-brained scheme, left-of-centre thought or work-heavy proposal we come up with they always say 'yes we can help with that'. That is civility (thanks John). That is the culture I want to foster and that is the AGES I am phenomenally lucky to be part of.

And finally we would like to congratulate and recognise our platinum sponsor Stryker who have just been awarded the *No 1 ranked Best Place to Work in Australia for companies between 100 – 1000 employees*. Sensational news, and on behalf of all the AGES members, I want to express our thanks for their support and collegiality – it is a great pleasure to work with the Stryker team.

Jason Abbott
AGES President

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Editorial

Dear Members

Welcome to the 65th edition of eScope. As I take over the reins as Editor of eScope I would like to acknowledge the wonderful contribution that the outgoing Editor, Stuart Salfinger, has made over the last 6 years in this role. Big shoes to fill (literally and figuratively) but I look forward to the challenge and I am sure that I will be ably supported by my co-editor Dr Simon Edmonds in keeping eScope interesting, educational and hopefully a little controverisal in the "New Age of AGES".

In this edition of eScope Jason Abbott waxes lyrical about "surgical culture", a central tenet of any successful surgical society, in his excellent President's Letter. In particular, I read with interest that Jason had been inspired by John Pardey's Perpetual Dan O'Connor Lecture (he gave at the Sydney ASM on "Civility") to adopt the "take a deep breath" rather than the "screaming surgeon" approach – if only John had given his presentation in 2005, I may have had an easier time during my two years as Jason's fellow!

Other highlights of this edition of eScope fit in nicely with the surgical culture theme and include in a great piece by Michael Wynn-Williams and Thea Bowler on the AGES Laparoscopic Pelvic Anatomy Workshops. I would encourage all AGES Members to head up to BrisVegas at some stage for an educational and fun experience that can only enhance one's pelvic surgical skills. In addition, Harry Merkur's "SWAPS" fellows have again provided us with their "hot of the press" JMIG summaries. As part of AGES educational and practice partnerships with SurgicalPerformance and Avant there is a piece by Andreas Obermair about working with unfamiliar theatre teams and an article by Harry McCay and Walid Jammal on credible medical expert witnesses.

The Pelvic Floor Symposium held in Adelaide in August was a great success, especially given the current controversy surrounding pelvic floor surgery and our profession – my impression was that most delegates came away with the renewed confidence that our profession can continue to help women afflicted by pelvic floor pathology – indeed, to be proud of our surgical culture. The meeting report, photographs and award winners are included for your information. Never a dull moment, the Focus Meeting "Preserve, Promote, Protect" is the next AGES event and will be soon upon us, to be held Singapore in October. Then not long after the festive season the AGES 2018 ASM will fire up in Melbourne in March.

Finally, I would like to announce several new initiatives that have recently been introduced to help enhance the surgical culture of AGES. Firstly an "AGES Volunteers" section has been added to the AGES website where members can volunteer for various roles within our society, e.g., presenting at a conference/workshop, chairing a conference session, judging awards, and becoming a member of a conference/workshop organizing committee. →

Editorial cont.

We hope this initiative will enable members to better engage with their society. Secondly, the brainchild of Board Director Emma Readman, AGES is proud to announce the AGES global gynaecology scholarship, which is open to all gynaecologists from developing economies who have the capacity to influence their hospital systems. The annual scholarship will cover accommodation, conference fees and a ticket to the gala dinner for the AGES ASM. We hope it will become a highly sought after opportunity and one way that AGES can extend its reach beyond our shores. We would anticipate that award of the scholarship will help to create or cement international collaborations. The application is now live on the AGES website (http://ages.com.au/ages-global-gynaecology-scholarship/)

I look forward to seeing you all in Singapore for refinement of our (not just surgical) culture!

Stephen Lyons
AGES Honorary Secretary
eScope Editor

PS: Hey Mr President, just kidding!

AGES Laparoscopic Pelvic Anatomy Workshops

Dr Thea Bowler *AGES Fellow*
Dr Michael Wynn-Williams *AGES Director*

The AGES cadaveric laparoscopic pelvic anatomy workshops are held in Brisbane biannually and deliver a premium hands-on laparoscopic anatomy experience. In an era where the decline of anatomical teaching in Australasian medical schools continues, how important are such workshops in educating future generations of gynaecologists and when is the optimum time during a medical career for in-depth anatomical instruction?

Anatomy is one of the cornerstones of safe and successful surgery however, its ever-decreasing emphasis in Australasian medical schools has long been lamented. The introduction of problem-based learning has shifted the focus to clinical and ethical teaching, with gradual devaluation of gross anatomy as core knowledge. Indeed, the hours devoted to the teaching of anatomy in crowded medical curricula has decreased significantly since the advent of post-graduate programmes[1,3]. A study conducted by the University of Sydney reported time devoted to the teaching of gross anatomy to have decreased from 500 hours in the undergraduate medical degree to 52 hours in the postgraduate course [3]. Similar reductions in teaching hours have been noted in other medical schools [1, 5]. This deficit is noted by students; An Australian Medical Association survey of all Australian medical schools undertaken in 2006 reported that 73% of respondents regarded the number of hours of anatomy teaching to be too little and only 40% felt they would graduate with sufficient anatomical knowledge to become a competent clinician[4]. And while anatomical instruction should be vertically integrated throughout the entire curriculum, it is largely concentrated in the first two years where basic sciences are emphasised, with limited exposure to anatomy during clinical years. While proponents of the modern curriculum argue that in-depth knowledge of basic sciences is often irrelevant to clinical practice[2], there has been widespread contention that the resultant degree of anatomical knowledge may be inadequate[1], certainly for those interested in pursuing a surgical career.

If exposure to detailed anatomy teaching is gradually declining in Australasian medical schools, logic dictates that further instruction must in fact be undertaken during specialty training and even continue in post-fellowship years. One could argue that this is perhaps a more relevant application of resources, given that in depth knowledge of anatomy is certainly more important in some specialties. However, participant pre-workshop surveys from the AGES cadaveric anatomy courses reveal access to anatomy teaching decreases throughout the gynaecologists' career with 84% of respondents reporting some form of anatomical instruction (extensive dissection, hands-on workshop or observational workshop) during medical student years, 75% during training years and only 29% during post-fellowship years. While yet to be formally adopted into specialist training curricula, the development of various anatomy courses gives trainees and specialists the opportunity to voluntarily revise and solidify their knowledge of working anatomy. While many surgical anatomy courses are run internationally, there are few in Australia focussing on pure surgical pelvic anatomy and even fewer that offer hands-on cadaveric dissection. The main factors that limit the availability of such courses relate to the high financial costs involved and a limited number of facilities in Australia with adequate equipment or donor bequeathment programs.

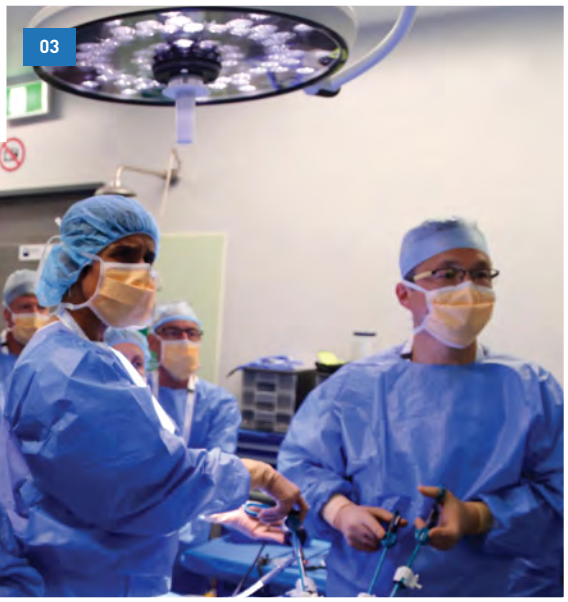
Methods for teaching anatomy include cadaveric dissection, prosected or plastinated specimens, computer based learning (including simulation programs and 3D printed specimens), medical imaging and didactic teaching. Cadaveric dissection has been used as a teaching tool for hundreds of years and has been described as 'the gold standard for technical skills training'[6]. While there is limited evidence that skills acquired on cadavers result in improved operating-room performance, clinicians regard the experience as a valuable learning tool [7]. Supporters for the use of cadavers argue that only dissection can provide tactile manipulation of tissue, 3D interaction and active engagement of senses [7]. Use of cadavers is also thought to enhance understanding and retention of spatial information and relationships [8, 9]. →

AGES Laparoscopic Pelvic Anatomy Workshops cont.

Dr Thea Bowler *AGES Fellow*
Dr Michael Wynn-Williams *AGES Director*

The AGES laparoscopic anatomy workshops are designed to provide gynaecologists with a detailed pelvic anatomy experience. Two course formats have been developed; a one day cadaveric demonstration workshop aimed at all levels from resident to specialist gynaecologist, and a one day hands-on dissection workshop appropriate for more experienced trainees and specialist gynaecologists. The demonstration course allows 30 registrants to participate in lectures, watch live anatomical dissection and interact with highly skilled laparoscopic surgeons. Interactive presentations are followed by relevant focussed dissection on six compartments of the pelvis and abdomen. During the dissection workshop, brief didactic sessions are followed by 6 hours of directed laparoscopic dissection on fresh frozen female donor cadavers. Three participants are assigned to each donor and each has the opportunity to operate, assist and observe throughout the day. Experienced facilitators supervise each group and provide invaluable instruction in both pelvic anatomy and laparoscopic dissection techniques.

The workshops are held at the Medical Engineering Research Facility (MERF) at the Queensland University of Technology, a state of the art facility offering cadaveric surgical training as well as biomedical research and prosthesis development. The centre was opened in 2008 at the Prince Charles Hospital in Brisbane with funding provided from the Queensland Government and QUT. Facilities for the anatomy workshops include fully equipped surgical operating theatres with five operating table cadaver workstations. Laparoscopic equipment is provided by the sponsors Stryker, Olympus, Ethicon Surgical, Medtronic and Applied Medical. →



01: Peter Gourlas, Michael Wyn-Williams, Danny Chou and Tal Jacobsen.
02: Danny with registrants.
03: Gather round and learn.

AGES Laparoscopic Pelvic Anatomy Workshops cont.

Dr Thea Bowler *AGES Fellow*
Dr Michael Wynn-Williams *AGES Director*

The key to performing any surgical procedure safely and efficiently is a good working anatomical knowledge and dissection technique. As a specialty, it is imperative that we acknowledge the reduced emphasis on anatomical teaching in our medical schools. RANZCOG and other professional bodies, such as AGES, need to respond by ensuring the provision of adequate high quality didactic and hands on anatomical training opportunities at both a post-graduate and specialist level. The AGES Laparoscopic Pelvic Anatomy Workshops have received tremendous feedback from participants over the last two years. With many trainees and specialists attending both the observational and hands on courses on more than one occasion. Workshops are held in May and December in Brisbane. Registration is via the AGES website.

Dr Thea Bowler
AGES Fellow

Dr Michael Wynn-Williams
AGES Director

01: March 2016 Dissection Workshop

The AGES board would like to take this opportunity to thank the faculty of the AGES Laparoscopic Pelvic Anatomy Workshops for giving up their weekends to teach and demonstrate anatomy and for helping to make them so successful.

Dr Tal Jacobson
Gynaecologist

Dr Danny Chou
Gynaecologist

Dr Luke McLindon
Gynaecologist

Dr Thea Bowler
AGES Fellow

Dr Emma Paterson
AGES Fellow

A/Prof Chris Maher
Uro-Gynaecologist

Dr Naven Chetty
Gynae-Oncologist

Dr Peter Gourlas
Colorectal Surgeon

Dr Carina Chow
Colorectal Surgeon

Dr Stuart Philip
Urologist

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"Hot Off The Press" – JMIG Summaries

Summaries by Bassem Gerges, Stanley Santiago and Maree Wallwork

J Minim Invasive Gynecol. 2017 Jul-Aug;24(5):747-756

Laparoscopic Excision Versus Ablation for Endometriosis-associated Pain: An Updated Systematic Review and Meta-analysis Pundir, J., Omanwa, K., Kovoor, E., Pundir, V., Lancaster, G., Barton-Smith, P.

The surgical management of peritoneal endometriosis, specifically ablation or excision, has long been a contentious issue. Generally, gynaecologists with an interest in endometriosis are likely to excise lesions, whilst general gynaecologists may either not see or treat lesions with electrosurgical ablation. The Cochrane review by Duffy, et al. in 2014 is often quoted to justify ablation versus excision as they found that both had similar effectiveness for endometriosis-associated pain relief. However, only included one trial and thus this conclusion is based on low quality evidence. The purpose of this study was to provide an update on the evidence regarding ablative versus excisional surgical management for the reduction of pain associated with endometriosis, namely dysmenorrhea, dyspareunia, dyschezia and chronic pelvic pain.

This was a systematic review and meta-analysis of randomised controlled trials (RCT) comparing ablation and excision in women scheduled for laparoscopic surgery for endometriosis. Three studies were included (n = 335), however only two of these were pooled for meta-analysis, due to incomplete data of the third study. The outcomes for the reduction of pain were assessed using the Visual Analogue Score (VAS) 12 months post-surgery. There was a greater reduction in VAS scores in the excision group for dysmenorrhea (mean difference [MD] = 0.99; 95% confidence interval [CI], 20.02 to 2.00; p = .05), dyspareunia (MD = 0.96; 95% CI, -0.07 to 1.99; p = .07), dyschezia (MD = 1.31; 95% CI, 0.33-2.29; p = .009) and chronic pelvic pain (MD = 2.57; 95% CI, 1.47-3.67; p < .00001).

Although one of the main limitations of this study is the inclusion of two studies for meta-analysis, the results are different to those of the abovementioned Cochrane review, which only included one study. Better designed studies are required, however, in the meantime, it appears that excision of endometriosis is superior to ablation at 12 months post-operatively, particularly with regard to dysmenorrhea, dyschezia and chronic pelvic pain, with a statistically non-significant improvement in dyspareunia.

J Minim Invasive Gynecol. 2017 Jul-Aug; 24(5):797-802

Does Ulipristal Acetate Affect Surgical Experience at Laparoscopic Myomectomy?
Luketic, L., Shirreff, L., Kives, S., Liu, G., El Sugy, R., Leyland, N., Solnik, M.J., Murji, A.

Ulipristal acetate (UPA) is a selective progesterone receptor modulator used for the medical treatment of uterine myomas to suppress uterine bleeding and decrease the size of myomas. UPA is TGA approved in Australia for the treatment of myomas, however, it is not currently covered by the Pharmaceutical Benefit Scheme.

This trial compared the surgical experience of laparoscopic/robotic myomectomy in premenopausal patients pre-treated with UPA to women not hormonally pre-treated. It was a multicentre, retrospective, cohort study of procedure videos of premenopausal women who underwent laparoscopic/robotic myomectomy for intramural or sub-serosal myomas of any size over a 3 year period (2012-2015).

The experimental arm consisted of 25 patients who were received UPA 5mg daily for three months preoperatively. The control arm of 25 patients received no hormonal therapy in the six months prior to the surgery. Patients treated with UPA were likely to be older than patients without treatment (mean age 38.3 vs 33.5 years, p = .002). Other baseline characteristics were matched between both arms. A cohort of seven, experienced, minimally invasive gynaecological fellowship-trained surgeons, performed and recorded the procedures, each contributing to an average of 7 videos. Two blind investigators independently reviewed the video presentations of each surgery, during which they compared and scored key aspects of the procedure including the depth and consistency of the myomas, ease of identifying cleavage planes and the associated haemorrhage. →

"Hot Off The Press" – JMIG Summaries cont

Summaries by Bassem Gerges, Stanley Santiago and Maree Wallwork

Upon independent review, there were no differences between both groups regarding the required depth of the myometrial incision, ease of myoma-myometrium cleavage plane identification, ease of myoma detachment, blood loss during myoma detachment, myometrial blood loss after myoma detachment, and myoma consistency.

In conclusion, pre-operative treatment with UPA does not negatively affect experience at laparoscopic/robotic myomectomy and therefore should be considered pre-operatively to reduce myoma volume, correct anaemia or ameliorate symptoms associated with myomas prior to surgery.

J Minim Invasive Gynecol. 2017 May-Jun;24(4):665-669

Incidence of Occult Uterine Malignancy Following Vaginal Hysterectomy with Morcellation.

Wasson, M., Magtibay, P 2nd., Magtibay, P 3rd., Magrina, J.

Electromechanical morcellation has been available for many years to aid with minimally invasive surgery but has been at the forefront of scrutiny due to the risk of inadvertent morcellation of uterine malignancy. Literature pertaining to cold-knife vaginal morcellation is limited and unclear.

This study was conducted to determine the incidence and impact of occult uterine malignancy following vaginal hysterectomy and uncontained morcellation. 2296 women underwent total vaginal hysterectomy without (n = 1685) and with (n = 611) vaginal morcellation via cold-knife wedge resection. Occult uterine malignancy was found in 10 (0.44%) of the 2296 women undergoing vaginal hysterectomy. In the non-morcellation group, incidence of occult uterine malignancy was 0.30% (n = 5). 4 patients (0.24%) had stage 1A, grade 1 endometrial adenocarcinoma, and 1 patient (0.06%) had low-grade stromal sarcoma. In the vaginal morcellation group, the incidence of occult uterine malignancy was 0.82% (n = 5). This included stage 1A, grade 1 endometrial adenocarcinoma (0.49%, n = 3) and low grade stromal sarcoma (0.33%, n = 2). Abnormal uterine bleeding was the indication for hysterectomy in all 5 women. All 5 patients underwent endometrial sampling and pelvic imaging prior to hysterectomy in the vaginal morcellation group. Demographic included mean age of 48.8 years, mean body mass index of 32.36 kg/m2, and median parity of 2.

Compared to uncontained intraperitoneal morcellation, morcellation at time of vaginal hysterectomy has a lower risk of disease dissemination as the uterine fundus is intact. The limitation to this study is its retrospective nature. A larger sample may have changed the results. Also, the surgery was performed by gynaecologists with subspecialty training hence there is a selection bias of patients deemed as good candidates for vaginal hysterectomy and morcellation.

In conclusion, the incidence of occult uterine malignancy in women undergoing vaginal hysterectomy and morcellation is low. To date, all the patients in this group have remained well and disease free. Morcellation of an occult malignancy during vaginal hysterectomy does not appear to contribute to a poor prognosis.

Australasian Gynaecological Endoscopy & Surgery Society Limited

PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium XVII Report

The eighteenth AGES annual pelvic floor meeting was held in the city of churches, Adelaide in August, appropriately themed theme "Challenging Times". The international speakers were Dr Ty Ericksson, Dr Eric Sokol and Professor Khalid Ismail. Dr Stuart Salfinger was the Conference Co-chair with Dr Emam Readman the Scientific Chair. The Local Organising Committee included Dr Fariba Behnia-Wilson, Dr Rob O'Shea and Dr Elvis Seman.

The meeting was very well attended and the main issues raised were about slings and meshes. Recent evidence on these were presented and the Senate enquiry and the role of TGA was discussed. AGES members showed concern about the direction this was taking in the treatment of Australian women with pelvic floor disorders.

The conference workshops sponsored by Boston Scientific and Coloplast were well attended and practical tips were well received by the attendees. The conference sessions were very interactive and the popular sessions of "Stump the Professors" and "Obstetric Trauma" yet again delivered lively debates and discussions. The program culminated with a lively debate between Drs Eriksson, Sokol and Ismail entitled 'In the world of no slings and meshes'.

We are very grateful for the support our loyal sponsors without which these meetings would not be possible. Thanks is also due to all the attendees and we hope to welcome them to the next meeting in Brisbane in 2018.

Professor Ajay Rane
Conference Chair

AGES Pelvic Floor Symposium XVII Report cont.

AGES Pelvic Floor Symposium XVII Report cont.

AGES Pelvic Floor Symposium XVII Award Winners

AWARD	RECIPIENT	SPONSORED BY
Best Oral Free Communication	Author: Joan Melendez-Munoz Presenter: Anna Rosamilia	AGES
Best Digital Communication Presentation	Myriam Girgis	AGES

AGES Pelvic Floor Symposium XVII Award Winners Abstracts

Award: **Best Oral Free Communication (Sponsored by AGES)**

Title: MiniArc vs TVT Abbrevo Midurethral Sling in Women with Stress Urinary Incontinence – an RCT – 6 and 12month follow up

Co-Authors: Joan Melendez Munoz [1] , M Braverman [1] , Anna Rosamilia [1] , N Young [1] , A Leitch [1] , J Lee [1]
1. Monash Medical Centre, Moorabbin. Melbourne 3165, VIC

Winner: **Author: Joan Melendez-Munoz Presenter: Anna Rosamilia**

INTRODUCTION

Single incision slings (SIS) were introduced in an attempt to decrease the complications associated with retropubic and transobturator slings. The TVT Abbrevo is a modification of the TVT-O with a reduced length and less immediate postoperative pain[1]. The Miniarc SIS has been shown to be equivalent to outside-in transobturator sling, Monarc at 12 month follow-up[2].

OBJECTIVE

To evaluate objective and subjective outcomes of MiniArc SIS and TVT Abbrevo midurethral sling (MUS) in women with stress urinary incontinence

METHODS

Female subjects who were assessed and referred for stress urinary incontinence surgery were eligible to participate in this study. Exclusion criteria included women with intrinsic sphincter deficiency previous failed midurethral or fascial sling, untreated detrusor overactivity or significant voiding dysfunction.

Patients' randomisation was performed with computer-generated blocks of 4-8, with concealed allocation. Assuming an objective cure rate of 90% for TVT AbbrevoTM with a power of 80%, a sample size of 79 in each arm was required to detect a clinical difference of 15%, using a one sided α of 0.05.

The target recruitment number was 220 allowing for an attrition rate of 15%. Institution ethics approval was obtained and the trial was registered. →

AGES Pelvic Floor Symposium XVII Award Winners Abstracts cont.

Routine preoperative assessment was conducted for objective data, whilst patient reported outcome tools (PRO) were utilised for subjective outcomes. These include ICIQ UI SF, ICIQ OAB, IIQ7, EQ5D, PISQ12, PGIs & PGII.

TVT AbbrevoTM or MiniarcTM were performed in a standardized fashion, together with any concomitant prolapse surgery. Review was conducted at 6 weeks and at 6 and 12 months.

Objective cure was defined as a negative cough stress test with a comfortably full bladder. Subjective cure was defined as no report of leakage with physical exertion. All Data was collected and outcomes were analysed statistically.

RESULTS

Between 2011 and December 2015, a total of 246 women were randomized to receive MiniArc (121) or TVT Abbrevo (125) with 21 withdrawals over the first 12 months. Baseline characteristics were clinically balanced in both groups.

At the current time-point, 183 women were assessed. There were significant differences in subjective cure at 12 months though no differences were seen in objective cure rates and patient reported outcomes.

CONCLUSION

There were no significant differences in objective cure rates at 6 and 12months between MiniArc and TVT Abbrevo. Subjective cure rate was significantly higher for TVT Abbrevo compared with MiniArc at 12months but not at 6 months.

1 Shaw JS, Jeppson PC, Rardin CR. Decreasing transobturator sling groin pain without decreasing efficacy using TVT-Abbrevo. Int Urogynecol J. 2015 Sep;26(9):1369-72.

2 Lee JK-S, Rosamilia A, Dwyer PL, et al. Randomizes trial of a single incision versus an outside-in obturator midurethral sling in women with stress urinary incontinence: 12 months results. Am J Obstet Gynecol 2015;213:35.e1-9

Award: **Best Digital Communication Presentation (Sponsored by AGES)**

Title: **Is total vaginal length a confounder between cervical descent and symptoms of pelvic organ prolapse?**

Co-Authors: Myriam Girgis [1] , Ka Lai Shek [2] , Hans Peter Dietz [3]

1. Obstetrics & Gynaecology, Liverpool Hospital, Sydney, NSW, Australia 2. Obstetrics & Gynaecology, Western Sydney University, Liverpool Hospital, Sydney, NSW, Australia 3. Obstetrics & Gynaecology, University of Sydney, Penrith, NSW, Australia

Winner: **Myriam Girgis**

INTRODUCTION

The POP-Q prolapse quantification system was introduced in 1996 to standardise clinical assessment and staging of pelvic organ prolapse (POP) and it is now widely employed for this purpose [(1)]. It requires total vaginal length (tvl) for the staging of central compartment prolapse [(2,3)]. Some clinicians use absolute values for central compartment descent, without reference to vaginal length, which has the potential to simplify the assessment.

OBJECTIVE

To determine whether tvl is a confounder of the relationship between central compartment descent and POP symptoms. →

AGES Pelvic Floor Symposium XVII Award Winners Abstracts cont.

METHODS

This is a retrospective observational study on patients seen in a tertiary urogynaecological unit for POP symptom and/ symptoms of lower urinary tract dysfunction between March 2014 and November 2015. All underwent a standardized interview, POP-Q and 4D translabial ultrasound assessment [2]. Statistical analysis was carried out using SPSS v20.

Binary logistic regression was performed to determine the association between prolapse symptoms and station of cervix or vaginal vault (i.e. C). Age, BMI, menopausal state, history of previous hysterectomy and/or prolapse and/or incontinence surgery and vaginal parity were tested as potential confounders. Variables that were significant on binary logistic regression ($P<0.05$) were included in a model for ROC statistical analysis. This was repeated after adding tvl to the model.

RESULTS

During the inclusion period 721 women were seen. Mean age was 56.9 (18.8 – 88.6) years, BMI was 29.2 (15.7-64.4) and 458 (64%) were menopausal. Mean parity was 2.6 (0-8), 646 (90%) were vaginally parous. 275 (38%) had had a previous hysterectomy or incontinence/prolapse procedure. 365 (50.6%) reported prolapse symptoms, i.e. lump/drag.

A prolapse of POP-Q≥ stage 2 was found in 548 women (76%). It was a cystocele in 417 (58%), uterine prolapse in 190 (35%), enterocele in 29 (4%) and a clinical rectocele in 360 (50%). Mean Ba was -0.8cm (-3 to +4.5), C -4cm (-11 to +7), Bp -1.2cm (-3 to +6).

On binary logistic regression a highly significant association ($P<0.001$) was noted between symptoms of prolapse and C, age and menopausal status.

ROC analysis with these variables in the model yielded an area under the curve (AUC) of 0.74. Adding tvl to the model yielded an AUC of 0.749.

CONCLUSION

Adding tvl marginally improved ROC curves of cervical/ vaginal vault station in predicting prolapse symptoms. However, the difference is small and unlikely to be clinically significant. It seems reasonable to stage central compartment descent in POP assessment without reference to tvl.

1 Dietz HP. Ultrasound imaging of the pelvic floor. Part I: two-dimensional aspects. Ultrasound Obstet Gynecol. 2004; 23; 80-92.

2 Bump RC et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. Am J Obstet Gynecol. 1996; 175; 10-7.

3 Pham T et al. Current use of pelvic organ prolapse quantification by AGUS and ICS members. Female Pelvic Reconstr Surg. 2011;17:67-9.

Credible medical expert witnesses:
the role, knowledge and legal obligations

By Harry McCay BComm, LLB
Senior Solicitor, Avant Law, ACT and
Dr Walid Jammal MBBS (Syd), DipChildHealth, FRACGP, M Health Law
Senior Medical Advisor, Advocacy, Avant

In the first of our two-part series, we take a look at the role of medical expert witnesses, required specialised knowledge and legal responsibilities.

Providing expert evidence in any legal proceeding is a professional privilege. Doctors can play an important role as expert witnesses in helping courts, tribunals or other dispute resolution processes make informed, fair decisions on cases involving clinical issues. A dearth of expert witnesses in Australia, means doctors who are able to provide impartial and credible expert opinions are in demand.

Expert witnesses: there's a difference

There are different types of expert witnesses. These include evidence sought as a witness of fact (the treating doctor) or as a witness of opinion (the independent expert witness). Sometimes a doctor may be asked to fulfil both roles, for example, to describe a bruise seen as a treating doctor (factual evidence), and then be asked for an opinion as to the time the bruise may have been present (expert evidence).

The capacity in which you are asked for an opinion may not always be clear from a solicitor's letter. Look for any references to the court's 'Expert Witness Code of Conduct' as this may be an indication that you are being asked to provide evidence or a report as an expert as opposed to a treating doctor or a witness of fact.

When are expert witnesses used?

When it comes to courts and disciplinary matters, expert witnesses are usually called upon to give evidence in three situations:

1. In a civil case an expert witness will be asked to give their opinion about whether the doctor acted in accordance with the accepted standard of care with knowledge that was available to the doctor at the time, or whether any departure from the standard of care led to the harm suffered.
2. In cases where a doctor faces a disciplinary body, the expert witness will be asked to give their opinion about whether the doctor has acted either below or in line with the peer standard for their level of experience.
3. Less frequently, an expert may be engaged during a coronial inquest to assist the coroner to decide on the cause of death, and what role any individual or institution may have played in that death.

Understanding the role of legal proof

An important part of being an effective expert witness is understanding the difference between scientific proof and legal proof. In any legal proceedings, the court must make a decision which is based on the facts and opinions before it. Courts cannot sit on the fence, and court decisions need not be based on scientific certainty. Doctors are trained to apply scientific certainty as the standard of proof. In comparison, legal proof is based on the balance of probabilities (more likely than not) in civil cases, and beyond reasonable doubt in criminal matters. The courts themselves have recognised that the disciplines do not always share the same approach. One judge described it as 'law marching with medicine, but in the rear and limping a little.'[1]

What does it take to be an expert witness?

The expert's role

An expert witness must have specialised knowledge and skills based on their training, study or experience that is relevant to the matter at hand. Expert witnesses are also required to demonstrate to the court that their opinion expressed in evidence 'is wholly or substantially based on that knowledge.'[2]

Legal obligations and mindset

Doctors acting as expert witnesses have an important duty in the legal system. It is not up to the expert witness to decide on the facts, as in what and how something happened. Neither is it up to the expert witness to decide on whether a doctor or party is 'negligent'.

Most state and territories have an Expert Witness Code of Conduct or guidelines, which outline the requirements for expert evidence. It is important to obtain a copy of the relevant code when preparing a report.

In summary, expert witnesses should[3]:

- Provide independent evidence to the court which is not influenced in terms of its form or content by the rigours of litigation.
- Assist the court by giving an objective and unbiased opinion in relation to matters within their expertise.
- Never assume the role of an advocate.
- State the facts or assumption upon which their opinion is based and not omit to consider material facts which could detract from their conclusion.
- Make it clear when a particular question or issue falls outside his expertise.
- State their opinion is no more than a provisional one, if they consider that there is insufficient data available to form an educated opinion. In cases where an expert witness has prepared a report but cannot assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, this needs to be stated in the report.
- Communicate if they have changed their view on a material matter, for example, after reading the other side's expert's report. This should be communicated through legal representatives to the other side without delay and when appropriate, to the court.

Experts also represent their professional colleagues in defining the acceptable standard of care. Therefore, it's important that the expert correctly understands the range of acceptable practice and recognises that although they might have taken a different approach, this should not influence whether the practice was in accordance with the appropriate legal duty of care.

Making the time

If you are considering becoming an expert witness, it's also important to have enough time to fulfil your duties. Thinking you can read a brief and provide an opinion in your 'spare time' may be overly optimistic, however these tips should help:

- Medico-legal reports take time and they should not be rushed
- Devote a portion of your working week to carrying out work as an expert witness
- Do not take shortcuts
- If you do not have the time to perform the work in the agreed time frame, say so. The legal team may be able to ask for more time.

References

[1] *Mt Isa Mines Ltd v Pusey* (1975) 125 CLR 283 at 395
[2] *Dasreef Pty Limited v Hawchar* [2011] HCA 21
[3] *James v Keogh* (2008) SASC 156.

Read part two in our series on the Avant website.

OCTOBER
13&14
Parkroyal on Pickering,
Singapore

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

The AGES board and local organising committee are excited to extend the invitation for you to join us at our first Asian Meeting. Registrations are open and we are looking forward to many of our AGES friends, and new overseas friends joining us for this Focus Meeting.

This meeting is a truly landmark event for AGES. We have designed a program that will stimulate and invigorate. The program is built around the idea of Preservation. This is a topic with a wide diversity of content.

The sessions of this one and a half day conference will focus on preservation of our pelvic organs, the pelvic floor, fertility, and the uterus. We will also discuss our own preservation. In a specialty with a high level of demand and stress, how do we cope with our working lives? How are we ever able to balance our working life with work commitments? With a recent focus on the metal health and well being of the medical profession there has never been a more pertinent time to consider this.

The program has been designed to have appeal to all members of our society with sessions pitched towards the generalist, high-end laparoscopists and those practising obstetrics. We will have local faculty from Singapore, as well as Australian talent. We are also excited to welcome some of our AGES Fellows to present.

Our venue, The Parkroyal on Pickering, is a beautiful new hotel in the heart of Singapore. With views across the river and close connections to the city, you will have this vibrant destination on your doorstep. The hotel is proudly eco friendly and has won awards for its design and sustainability. Take some time to explore this city and you will find it so much more than just a stop over destination.

The social function of the conference will be a highlight. We will be whisked down the river on bum boats to the brasserie at the landmark Fullerton Hotel. We will enjoy a special night of wining and dining, with some dancing in this special location. Our conference will conclude with a cocktail party before we return to our home towns.

We have been asked by our members to consider a destination outside Australasia for our meetings for many years. The new age of AGES has listened. We hope you will take the opportunity to joins us in Singapore.

Dr Rachel Green
Conference Chair

PRESERVE
PROTECT
PROMOTE

OCTOBER 13&14

PARKROYAL ON PICKERING, SINGAPORE

Australasian Gynaecological Endoscopy & Surgery Society Limited

FOCUS MEETING

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EARLY BIRD REGISTRATIONS CLOSE: **FRIDAY, 1ST SEPTEMBER 2017**

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Dr Asha Short	NSW
Dr Michael Wynn-Williams	QLD
A/Prof Anusch Yazdani	QLD

PROTECT PROMOTE

FACULTY CPD POINTS

This meeting is a RANZCOG approved O&G meeting. Fellows of this college can claim 12PD Points for full attendance.

MEMBERSHIP OF AGES

The AGES membership application form is available online from the AGES website or from the AGES Secretariat. For further details visit the AGES website at www.ages.com.au or to join click the following link https://yrd.currinda.com/register/organisation/43

AGES CONFERENCE ORGANISERS

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EARLY BIRD REGISTRATIONS CLOSE **FRIDAY, 1ST SEPTEMBER 2017**

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AN INVITATION TO THE AGES FOCUS MEETING

Dear Colleagues,

On behalf of AGES, we would like to invite you to Singapore. This is a landmark event for our society, being our first SE Asian meeting. We have listened to you, our members, and are taking this meeting to the Lion City, and we hope you can join us in this truly diverse sovereign city state. From the bustling hawker centres and night markets to the tranquillity of the Gardens by the Bay, Singapore has much more to offer than simply a stopover destination.

The two day program has been developed with similar diversity to appeal to the generalist and advanced laparoscopist alike. We will cover topics such as self-preservation and managing stress, to modern day issues affecting fertility and pelvic floor function. Our speakers are a range of local Australian talent as well as some names from Singapore - we are sure they will inspire and educate all.

The social highlight of this meeting will be a bumboat trip down the river to La Brasserie at the landmark Fullerton Hotel. Here we will enjoy an evening of wining and dining in this spectacular river city in a fashion that AGES has become renowned for. Our conference will conclude with a cocktail party before we return to our home towns.

This event is not to be missed as numbers are strictly limited. We look forward to welcoming you all to Singapore this October to "Preserve, Protect, Promote".

Dr Rachel Green
Board Member, AGES
Conference Chair
On behalf of the Organising Committee

FRIDAY OCTOBER 13

0715 - 0815	**Conference Registration**
0815 - 1000	**SESSION ONE: PRESERVATION OF THE UTERUS** In this opening session we will consider the gynaecologists territory of the uterus. With worldwide hysterectomy rates falling and new technologies emerging, what are the options for the women of today? How does this influence us in our obstetric practice and how does modern practice affect our women?
	Welcome ***Rachel Green & Jason Abbott*** "I Only Want to see Polyps, Hyperplasia or Cancer": The Role of Primary Care Assessment in AUB ***Simon Edmonds*** Big Fast Bleeding needs Big Fast Response ***Stuart Salfinger*** Motherhood after Mullerian Melodramas ***Asha Short*** Balancing all the Options for the Myomatous Uterus ***Bernard Chern*** Adenomyosis in the Woman Wanting to Conceive ***Timothy Chang*** **Panel Discussion**
1000 - 1030	**Morning Tea & Trade Exhibition**
1030 - 1215	**SESSION TWO: PRESERVATION OF FERTILITY** With ever advancing maternal age and medical co-morbidities, this session will examine options for women. In this session we will look at recent advances in infertility management and what measures we can take to preserve fertility for the demands of modern life?
	Cancer Diagnosis and Fertility – A Match Made in Hell? ***Rachael Rodgers*** Oocyte Options for the Older Woman ***Ben Kroon*** Intra and Extra Pelvic Endometriosis and its Impact on Fertility ***Haider Najjar*** The Fit and Thin of Fertility – How Can Over Exercise and Under Eating Impact Fertility ***Anusch Yazdani*** I Made a Mistake – Now Make My Tubes Work ***Tan Heng Hao*** Modern Management of Ectopic Pregnancy: "Saving the Tube" ***Kim Dobromilsky*** **Panel Discussion**
1215 - 1315	**Lunch & Trade Exhibition**
1315 - 1500	**SESSION THREE: PRESERVATION OF SEXUAL FUNCTION** In this session we will examine ways to improve sexual function. What options are available to improve this basic need? Is there a role for plastic surgery? What are the implications of prolapse and pain on sexual function?
	Plastic Surgery of the Vagina ***Amani Harris*** Dyspareunia and Pelvic Pain ***Catarina Ang*** Prolapse Management and Changes in Sexual Function ***Salwan Al-Salihi*** Can Your Smart Phone Improve Your Sex Life? ***Fariba Behnia-Willison*** Trans-cendence ***Jason Abbott*** Obstetric Trauma: Mental Impact of Traumatic Birth ***Theresa Lee*** **Panel Discussion**
1500 - 1530	**Afternoon Tea & Trade Exhibition**

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

FRIDAY OCTOBER 13 (CONT.)

1530 - 1700	**SESSION FOUR: PRESERVATION OF OURSELVES** What can we do to improve our working lives? How can we better manage stress? What is the future of our profession? What happens when we have to manage adverse outcomes? This session will end with a frank presentation and discussion of cases with adverse outcomes.
	Work Life Balance: How do we Get it Right? ***Rachel Green***
	Preserving our Muscles ***Michael Wynn-Williams***
	Cognition in Decision Making ***Krish Karthigasu***
	There is no "I" in Teamwork ***Yee Leung***
	Case Presentation: A Challenge For Clinicians. ***Jennifer Pontre & Panel***
	Panel Discussion
1900 - 2300	**Conference Dinner - La Brasserie, Fullerton Bay Hotel**

SATURDAY OCTOBER 14

0730 - 0830	**Conference Registration**
0830 - 1015	**SESSION FIVE: PRESERVATION OF PELVIC FLOOR** What can we do to preserve the function of the pelvic floor? What are the real causes of pelvic floor dysfunction? Should generalists be performing pelvic floor repairs or is this now purely the domain of the urogynaecologist?
	Pelvic Floor Damage – What are the Real Causes? ***Salwan Al-Salihi***
	Strategies to Reduce Pelvic Floor Damage ***Bassem Gerges***
	How do we Repair Defects now Mesh is so Last Year? ***Vinay Rane***
	Is Examination Enough? Detecting Damage in the New Era ***Erin Nesbitt-Hawes***
	Who Should Repair the Pelvic Floor? Does the Generalist Have a Role? ***Ajay Rane***
	What's New in Incontinence ***Philip Hall***
	Panel Discussion
1015 - 1045	**Morning Tea & Trade Exhibition**
1045 - 1300	**SESSION SIX: PRESERVATION OF TECHNIQUES** Has our hunger for technology taken over from old fashioned skills? Should we all be trained in robotics? In this session we will look at outcomes of new technologies. We will consider skill acquisition as well as skill preservation.
	Forget Traditional Training – Just Use a Robot ***Dr Suresh Nair***
	"Open the Harmonic Scalpel" - I Don't Need to Know How to Suture ***Hugo Fernandes***
	From Idea to Reality ***Fong Yoke Fai***
	Do we Really Need to Know That Much Surgery? ***Emma Readman***
	Techniques to Improve Skill Acquisition ***Bernadette McElhinney***
	How Much Exposure are our Trainees Really Getting? ***Jade Acton***
	Old School Obstetrics – Twins and Breech Deliveries ***Stephen Lyons***
	Family Feud
1300	**Close of Meeting**
1300 - 1330	**Lunch**
1700 - 1900	**President's Reception**

CONFERENCE VENUE

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Check-in is from 2:00pm. Check-out is prior to 12:00pm

CHANGES TO HOTEL RESERVATIONS
Any change must be made in writing to the Conference Organisers and not directly to the hotel.
**All fees are quoted in Australian Dollars – AUD $
**Tax invoices will be issues on receipt of registration and payment

SOCIAL PROGRAM

Conference Dinner | La Brasserie, Fullerton Bay Hotel
Friday 13th October 2017 | 7.00pm
Ticket Cost: $175.00 per person

President's Reception
Saturday 14th October 2017 | 5.00pm
More information to come soon.

INCLUSIONS

CONFERENCE REGISTRATION FEES INCLUDE:

> Attendance at AGES Focus Meeting 2017 sessions on Friday 13th and Saturday 14th October 2017
> All conference publications
> Conference lunches, morning and afternoon teas as stated in the program
> Conference satchel

CARRIE PITCHER is an emerging contemporary artist based in Melbourne, notable for her portraits, that are at once both representational and abstract.

Working with acrylic on canvas, she marries abstract expressionism: swathes of bold colour, and opportunistic mark making, with the narrative of the portrait.

Close-cropped composition and sheer scale create a feeling of intimacy, while layer upon layer of abstract colour impart dynamic energy as if projected across the motif—chosen for a particular quality that engages the artist's aesthetic sensibility.

Exploring themes of feminine dynamism and identity, the figurative and the abstract are brought together in a body of work that expresses an undefined personal significance, an extension of the artist herself.

REGISTRATION FEES

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REGISTRAR/TRAINEE – NON-MEMBER	$470	$570
STUDENT/NURSE/PRACTICE MANAGER	$355	$455

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FUTURE AGES EVENTS

Australasian Gynaecological Endoscopy & Surgery CADAVERIC WORKSHOP

AGES CADAVERIC WORKSHOPS
MERF QUT, BRISBANE
DISSECTION WORKSHOPS: 2ND DECEMBER 2017, 27TH MAY 2018 & 1ST DECEMBER 2018
DEMONSTRATION WORKSHOP: 26TH MAY 2018

Australasian Gynaecological Endoscopy & Surgery Society Limited PELVIC FLOOR SYMPOSIUM

AGES
PELVIC FLOOR SYMPOSIUM XIX 2018
BRISBANE, 3RD – 4TH AUGUST 2018

Australasian Gynaecological Endoscopy & Surgery ANNUAL SCIENTIFIC MEETING

AGES XXVIII ANNUAL SCIENTIFIC MEETING 2018
CROWN PROMENADE, MELBOURNE
8TH – 10TH MARCH 2018

Australasian Gynaecological Endoscopy & Surgery Society Limited FOCUS MEETING

AGES
FOCUS MEETING 2018
CANBERRA, 2ND – 3RD NOVEMBER 2018

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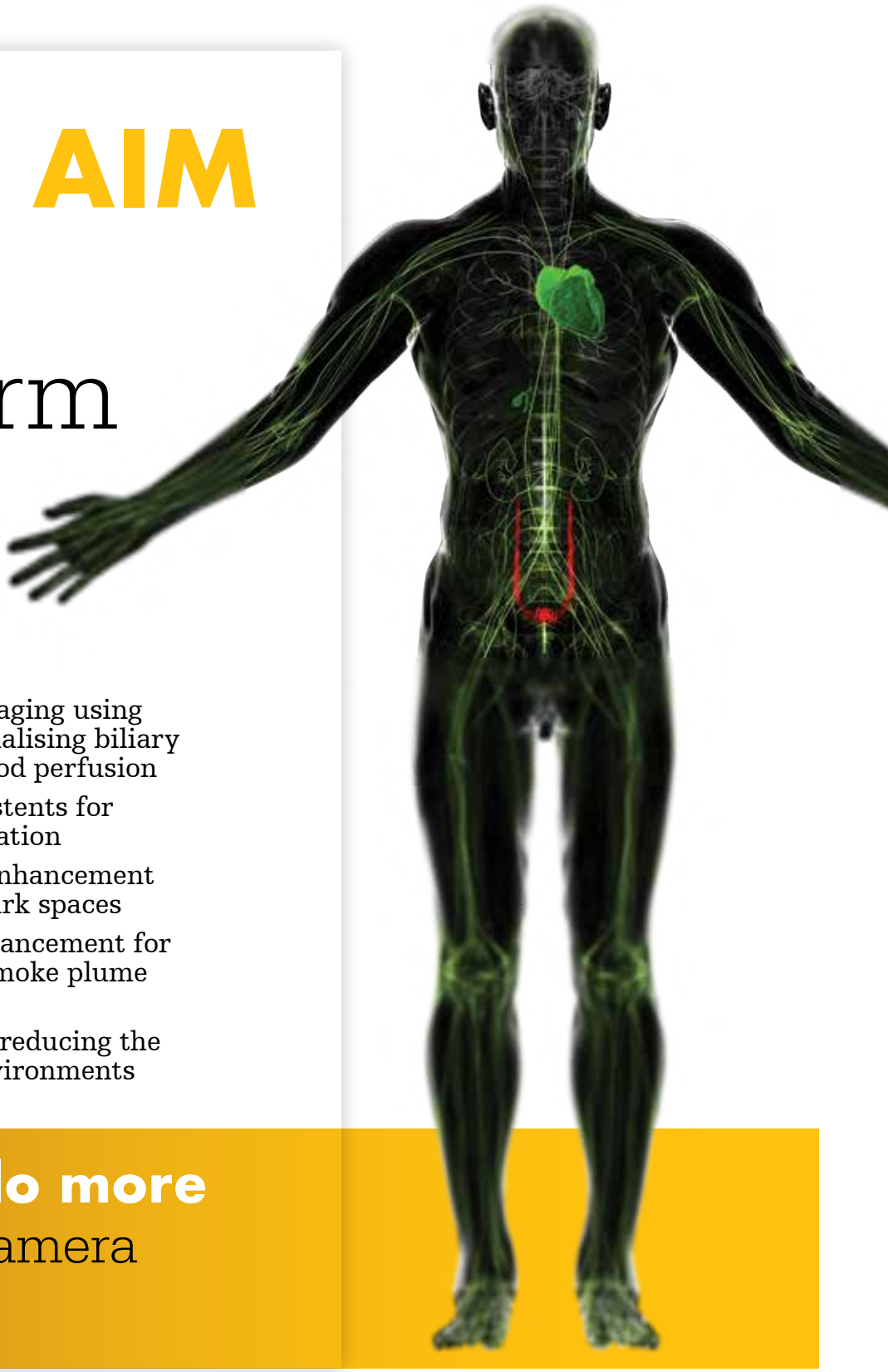

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What's your glove size, doc?

A SurgicalPerformance tale about the impact that working with unfamiliar teams can have on surgical outcomes.

Andreas Obermair

It was one of those Monday mornings when I entered the operating room – "Good morning everybody!" The patient was still in the anesthetic bay, and our anaesthetist concentrated to place an epidural; the fellows were busy pulling up CT scan images and blood test results on the computer stations; and my scrub nurse's focus was on her instrument count. I didn't recognize her nor her scout.

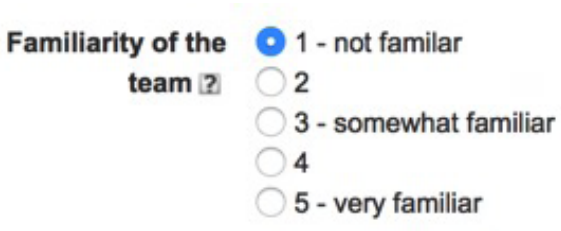
Then the scout slowly turned to me and asked "By the way, what's your glove size, doc?". "Doc, this is our new Hasson cannula. Would you like to try it today?"

I did not know what to say. How would she not know my glove size? I'd operated in that hospital for many years. Had she not read my preference card? Had we not worked together before? Slowly, it began to dawn on me that, apart from my trainees, I recognized no one in "my theatre". I wondered – "Am I in the right location?"

Here was "my" anaesthetist inserting an epidural, which I passionately try to avoid whenever possible. In one of the LACE papers, we have shown that epidurals are associated with a significantly higher incidence of postoperative complications.

Here were "my" two scrub nurses I had never met before or worked with. One of them proudly shows me the new Hasson cannula. For the last 15 years, I have been an advocate for 5 mm ports and avoid any incision longer than 1 cm as much as possible (except for highly invasive cancer surgery).

I did not think this was a particularly good start of the day. In SurgicalPerformance, I would rate the "familiarity of the team" for this case as a "1 – not familiar". Should it proceed with surgery? Or would the patient be better off delaying the operation and having surgery done with a better team, where all team members are on one page?



SurgicalPerformance and Working with Strangers

Flash forward to the present, and SurgicalPerformance has now collected data from more than 65,000 gynaecology surgery cases.

Recently, we analysed data on the impact of familiarity of the team on surgical complication rates. Would it have an impact on surgical outcomes?

In collaboration with Professor Robert Huckman from Harvard Business School, SurgicalPerformance introduced this data field 3 years ago.

In his seminal article "The Hidden Benefits of Keeping Teams Intact" (Harvard Business Review October 2013), Huckman describes the impact of well-functioning and dysfunctional teams from various professions. I highly recommend reading it.

In the article, he describes an orthopaedic surgeon who performs 550 knee operations a year (2.5 times as many as the second most productive knee surgeon in that hospital) and completes the procedure in 20 minutes, compared to 60 to 120 minutes it takes for all other surgeons. This surgeon managed to secure a dedicated team of nurses and some of those nurses have worked with him for the last 18 years. His complication rates are comparably low.

Huckman provides another example from software engineering where a 50% increase in team familiarity was followed by a 19% decrease in defects, a 30% decrease in deviations from budget, etc. →

What's your glove size, doc? *A SurgicalPerformance tale about the impact that working with unfamiliar teams can have on surgical outcomes* cont.

Andreas Obermair

However, no academic group has previously examined the association of familiarity of surgical teams with complication rates.

In my case, where I come to the operating theatre to meet obvious unfamiliarity – can we quantify the impact of unfamiliarity or even unfriendliness on patients' outcomes (including complication rates)?

30% Data from SurgicalPerformance show that surgical cases performed by unfamiliar surgical teams have a 30% higher complication rate compared to surgical cases performed by familiar surgical teams.

Surgical teams who are familiar with each other, where team members get on well with each other, where not every request needs to be verbalized but the nurse can anticipate the need of the surgeon, preparing for the next step without the need of a word said – these are well working teams. The Familiarity of the team is reflected in a significantly lower surgical complication rate.

Members of well-working teams know when and how to communicate; communication gets things done well and quickly.

Team members who know each other will know each other's limits.

Team members who know each other respond easily to change; stress levels are much lower.

Do you often find yourself complaining that you are thrown into theaters with unfamiliar team members you have to work with?

If you have not done so already, I encourage you to take up AGES' offer of a free Premium subscription to SurgicalPerformance and start collecting data about how familiar you feel with your team – on a case-by-case basis.

You can document "familiarity of the team" in SurgicalPerformance and review your numbers. If you feel that you draw the short straw too often, you now have data at your reach that you can show your hospital executives.

Every case where you have to work with an unfamiliar team is a lost opportunity for them to save money. Working with strangers is a huge lost opportunity not only to practice better medicine but also to do so at lower costs.

Join SurgicalPerformance today and collect data that will help develop your surgery. If you need any help to join, please go to www.surgicalperformance.com and use one of the many help functions.

Regards,
Andreas Obermair
Gynaecological Oncologist
Founder SurgicalPerformance
www.surgicalperformance.com

NB: More than 100 AGES members have taken up the offer of a free SurgicalPerformance Premium subscription since January 2017.

MARCH
08–10
Crown Promenade Hotel,
Melbourne

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

Evolution towards Excellence

AGES is proud to invite you to it's 28th Annual Scientific Meeting which will be held in Melbourne on 8-10 March 2018 at the Crown Promenade Hotel.

Under the title "Evolution towards Excellence", the scientific committee has developed an excellent program that will focus on the training and ongoing development of the surgical and clinical practice. It will provide an opportunity to learn the latest clinical advances as well as the international development in research, practice and treatment of the common gynaecological conditions.

The international faculty of Dr Barbara Levy, Dr Ted Lee, and Dr Pietro Santuli, is promising to bring a lot of energy to the discussions and the debates.

The Live surgery session will make a come back in 2018. This will provide an excellent opportunity to learn invaluable tips and surgical techniques in an engaging and interactive environment.

The highly successful hands on Training Hubs will be expanded in 2018 to allow more delegates to participate.

AGES, as always, will endeavour to provide an excellent social program that will allow participants and their partners to enjoy what our lovely city of Melbourne has to offer.

Looking forward to seeing you all in Melbourne in March 2018!

Haider Najjar
Conference Chairman

Save the dates

Australasian Gynaecological Endoscopy & Surgery Society Limited

SOLD OUT!

Laparoscopic Pelvic Anatomy Dissection Workshop

DECEMBER 2 2017

MERF, Brisbane

Australasian Gynaecological Endoscopy & Surgery Society Limited

ANNUAL SCIENTIFIC MEETING

XXVIII

MARCH 8–10 2018

Crown Promenade, Melbourne

Australasian Gynaecological Endoscopy & Surgery

CADAVERIC WORKSHOP

Laparoscopic Pelvic Anatomy Dissection Workshop

MAY 26 2018

MERF, Brisbane

Australasian Gynaecological Endoscopy & Surgery

CADAVERIC WORKSHOP

Laparoscopic Pelvic Anatomy Dissection Workshop

MAY 27 & DECEMBER 1 2018

MERF, Brisbane

Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES/RANZCOG TRAINEE WORKSHOP

JUNE 23 & 24 2018

Kolling Institute, Sydney

Australasian Gynaecological Endoscopy & Surgery Society Limited

PELVIC FLOOR SYMPOSIUM

XXVIII

AUGUST 2–4 2018

Brisbane

Australasian Gynaecological Endoscopy & Surgery Society Limited

FOCUS MEETING

NOVEMBER 1–3 2018

Canberra

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.

2017 Courses: Hysterectomy, Myomectomy & Adnexal surgery: Oct 30 – Nov 03

2018 Courses: Endometriosis Surgery: August 06-10
Hysterectomy, Myomectomy & Adnexal surgery: March 19-23, Oct 29 – Nov 02

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

SWEC ADVANCED GYNAECOLOGIC LAPAROSCOPIC COURSES FOR 2017

AT THE SYDNEY WOMENS ENDOSURGERY CENTRE (SWEC) AT ST GEORGE HOSPITAL SYDNEY. COURSE DIRECTOR: DR GREGORY M 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.

Course Dates 2017:
23-27 October

Register on-line at www.swec.com.au
or contact our course administrator at: sweconline@gmail.com or
Dr Greg Cario, SWEC Director
doc@drgregorymcario.com.au

SWEC
Sydney Women's Endosurgery Centre

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

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.

2017 Dates: fully booked **2018 Dates:** TBA

All enquiries should be directed to: Dr. Weng CHAN
Gynae Endosurgery Consultant, Monash Medical Centre
14-16 Dixon St, Clayton Vic 3168
P: + 61 3 9548 8628 F: + 61 3 9543 2487
Email: kkcha5@hotmail.com

LaSGeG
Laparoscopic Surgery For General Gynaecologists

Invite you to attend:

DAY-TO-DAY LAPAROSCOPIC

INTERACTIVE COURSE Day 1 Live Surgery / Day 2 Pig Model

Convenors A/Professor George Condous & Dr Tim Chang

NORWEST PRIVATE HOSPITAL /
KOLLING BUILDING,
ROYAL NORTH SHORE HOSPITAL

Monday 27th Nov 2017
Tuesday 28th Nov 2017
RANZCOG approved for 16 CPD meeting points

For more information contact Dr Babak Shakeri
babak_shakeri@hotmail.com

Only 4 spots available!

Applied Medical
A New Generation Medical Device Company

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FLINDERS PRIVATE ENDOGYNAECOLOGY
XX ANNIVERSARY WORKSHOP "INNOVATION, EDUCATION AND CELEBRATION" "MASTERING LAPAROSCOPIC SUTURING 2018"

2018 dates TBA
Flinders Private Hospital, Adelaide

For information contact:
Robert O'Shea P: (08) 8326 0222 F: (08) 8326 0622
Email: rtoshea@adam.com.au

ADVANCED LAPAROSCOPIC GYNAECOLOGICAL WORKSHOP
ST JOHN OF GOD HOSPITAL SUBIACO

COURSE DIRECTORS
DR STUART SALFINGER
DR JASON TAN

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.

Dates:
This course will run monthly throughout 2017.

Details
www.covidien.com/pace/clinical-education/event/250875

escope

Volume 66 coming out in January 2018

Contact Stephen Lyons (**stephenlyons@me.com**) or Simon Edmonds (**simon.edmonds@middlemore.co.nz**) with your contribution
Deadline **2nd January 2018**