EDITOR
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Lyons

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

IN THIS EDITION

President's Letter

Making your mark

"There is no real ending. It's just the place where you stop the story."
(Author Frank Herbert)

As I stand to write my last President's letter (standing is much better for my overloaded surgeons' anterior deltoids), there is substantial reflection as I come to the end of my "President of AGES" story. It has been a great read and I highly recommend it to all. The AGES story is made by people – you reading e-Scope in particular – and is a story that you have control over and can direct where it goes to from here (BYO Luckdragon and plenty of imagination).

Making a mark on the Society is something that was established at the beginning of this current board cycle and it is only through the collaboration and extraordinary efforts of the board, the YRD team and the many contributors to the Society that we have been able to achieve so many of our objectives. Our aims were few but have been important for our progress.

Our key achievements have included a review of the Educational program after its instigation and its continued elevation though an examination process for AGES trainees. Anusch Yazdani as chair of this committee has done a phenomenal job of making that happen with the first-ever MCQ examinations held late last year and an overhaul of the curriculum and syllabus for the education program. It was high marks all round on this one – trainees and team alike. Onwards and upwards! →

President's Letter cont.

The Women's Health Committee has been discussing ways of reaching the women we serve in the community with information packages to improve information dissemination on specific, common gynaecological surgical procedures. The first 6 women's health video's are now available for streaming by your patients and links from your own website to these video packages will provide another layer in communication, information and understanding. Rachel Green has been visionary in making this project happen and her team of Emma Readman, Bassem Gerges and Stephen Lyons and have brought these professional video interactions to you. With more videos under production, it is an ongoing project and one of our greatest achievements. But that is not the end of the Women's Health deliverables, with Rachel also masterminding the first AGES podcast for women. There are plans for many more and the foray into delivering accessible information to women shows no sign of stopping. A mark of distinction, a mark of progress, a mark of commitment.

Having personally been to several of the CAD workshops, which will be rebranded in 2019 to LAP-D workshops in Brisbane, there is no doubt that these are a new staple in the AGES pantry. Delivered by Michael Wynn-Willams and Danny Chou as directors, but supported by Luke McLindon, Emma Patterson and Tal Jacobson with a rolling cast of AGES board members to boot there is no-one who will not upskill in this workshop. The deep appreciation for vessels and nerves, the fine-tuning of surgical skills and the ability to share knowledge are core to this development program. AGES is deeply indebted to the donor program at MERF and the phenomenal gift that people provide in their donation to help us make our surgical mark just that much more precise, skilled and delicate. The Interactive Hubs are embedded into our ASM and have been a hit with both members and industry alike. The opportunity for hands-on experiences and education for surgeons is an all-party pleaser and their evolution has been another success story.

The AGES support program has been developed further, but not yet reached its full potential. Emma Readman has been driving this initiative and we have now had several years of AGES global scholarships, open to gynaecologists from low-resource areas to attend our meeting and have an exchange of ideas, culture and wisdom. The board has continued to lay the groundwork for future programs of support to our regional areas and have consulted widely in conjunction in an effort to bring the AGES experience to a much wider audience. The AGES mark is a recognized global brand and synonymous with quality, gynaecological surgical education and innovation.

The AGES research program has continued to produce high quality clinical and scientific research in the area of gynaecological surgery. Throughout this board's tenure, Louise Hull has chaired this important committee. With a team of reviewers outside of the board, Louise has done an extraordinary job of refining the policies and procedures of the committee and allocating funds. Louise will be stepping down at the completion of this round of grant funding and we thank her for her contribution to the program.

Where would we be without video? It transformed laparoscopy from the backbreaking laparoscope-to-the-eyeball torture of yesteryear to the predominant method for surgery in so many fields of medicine. Video was the backbone of AGES meetings and how we best demonstrated what it is we did and could do in the pelvis for gynaecological conditions. →

President's Letter cont.

It is therefore only appropriate that AGES now has a permanent educational video library for our members. The capacity to stream educational surgical resources for clinicians has long been a goal and now is reality. Simon Edmonds and the digital communications team of Stephen Lyons, Michael Wynn-Williams, Krish Karthigasu and Bassem Gerges have opened the library with finesse and style bringing you essential techniques and tools to improve everybody's surgery. A new and permanent digital mark that has been combined with the AAGL's international platform of SurgeryU to host our video and allow trainee access internationally – AGES for all the world to see.

Our educational meetings continue to surprise and provide clinicians beyond our membership with essentials in gynaecological surgery care. We have been offshore to Singapore and completed the loop in Canberra marking AGES having visited every state and territory in Australia and New Zealand for meetings. The pelvic floor meetings have gone way beyond mesh and they remain a pillar of our Society, been ably overseen by Ajay Rane. AGES has been delighted to work with our fantastic sponsors who have continued to provide support to the Society as we move towards patient-centred outcomes together. It has been a dialogue that both Society and Sponsors have engaged and feel very comfortable with, since the driver is improved knowledge and health for women.

The final two groups I want to acknowledge are the AGES executive; VP Stuart Salfinger, Treasurer Haider Najjar and Hon. Secretary Stephen Lyons. The executive team has taken on a fantastic workload in addition to portfolio contributions. Stuart has also overseen meetings, Stephen been editor of eScope and Haider has balanced the books and kept the Society in a very strong financial position They have provided guidance and support to me and their reliability, collegiality and commitment has been phenomenal. Thank you, thank you, thank you. I could not have steered the Society to these great destinations without your counsel and wisdom.

To the YRD team and in particular Danielle, Jess, Amy, Jayme and Karen who have never failed to deliver, are always gracious and have offered exemplary support to the entire board and the Society throughout our tenure. Progress is made not by individuals, but by truly great teams and we certainly have one.

Which brings me to the leader of the YRD team, the indefatigable Mary Sparksman. Passionate, thoughtful, committed and progressive she has been a constant colleague and ally, but become a truly wonderful friend. She is a capable and nurturing leader of her team and the gentle and measured operational force that ensures AGES is the pre-eminent gynaecological surgical Society in our region and a global brand. It has been an extraordinary ride on the AGES train Miss Mary and thank you for sharing it!

Being President of AGES is, and always will be, a career highlight for me. It has been a privilege to work with such a diverse and talented team on the board, with our secretariat and our industry partners. I am particularly proud of ensuring that AGES is seen as an inclusive and welcoming Society for all. I cannot say I have loved every minute of being President, since that would be untrue, and no leader ever loves every minute. →

President's Letter cont.

But I have constantly learned, constantly grown and become a better surgeon, a better doctor and I hope a better person through this time.

I was not there at the beginning of AGES when the sapling Society was planted by Dan O'Connor and Ossie Petrucco and I hope not to be there at the end of AGES, for it should continue long into the future. The Society has been nurtured by successive boards, gently fertilized and pruned and is now a strong and spreading tree with solid roots of governance and wonderful dividing branches that reach to new areas of light for its members. Having been a caretaker of the AGES tree I am humbled by the responsibility of not just keeping it alive but entrusted with its ongoing growth. This is not the end for me and AGES, but it is the start of a new story for those gardeners who take over that caretaker role. I will be content to sit under its glorious shading branches and enjoy the fact that the mark this board has made has not been a deep gouge in the bark, but the loving care that comes with enthusiasm, friendship and true collaboration.

Jason Abbott
AGES President

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Editorial

Dear AGES Members

Welcome to the 69th edition of eScope.

In Jason Abbott's first eScope President's Letter, he finished the 4-page tome with, "I have so much more to say (imagine!) [sic], but there are plenty of eScope editions to come and loads more newness to keep you posted on." Jason certainly kept to his word! It's been good sport (for me anyway) during my tenure as Editor of eScope's last 4 editions to undertake "careful editorializing" (quote of Jason Abbott) of the President's Letter to (very respectfully) have an appropriate cheeky dig at the AGES President whenever it was warranted. Alas, Jason's Presidency will soon come to an end and, in his inimitable idiom, he very elegantly synthesizes the achievements of the AGES Board under his leadership in his last President's Letter entitled "Making your Mark". Probably his best letter, Jason keeps improving as a wordsmith, just like a fine red responds to cellaring, I guess. But it's the actual achievements of AGES and the enhanced collegiality and comradery of our society, and a re-focused vision for its future described in the letter that makes it compelling reading for AGES Members. So, on this occasion, I will show restraint and respect, and refrain from careful editorializing. Jason, in fact, has been a mentor, colleague and friend of mine for many years – I am sure he will also long be remembered as a mentor, colleague and friend of AGES.

Speaking of restraint, the 2018 AGES Focus Meeting "Sex, Drugs & Politics" held in early November certainly lacked some of that! The first AGES meeting to be held in Canberra, a great time was had by delegates, faculty and sponsors alike (AGES Focus Meeting Report). The next meeting on the calendar is the AGES ASM "Perfection, Professionalism and Problems" – the Conference Chair, Stuart Salfinger, and the organizing committee have put together a great program and they look forward to welcoming you to Perth in early March.

In the AGES Board Member article, Bassem Gerges discusses the pitfalls and dangers of the [too] early adoption of new drugs and technologies (think vaginal mesh, Essure, Ulipristal, etc.). The Trainee Article is by Roni Ratner (AGES Fellow) and her supervisor, Haider Najjar, which compares and contrasts the complications associated with conventional operative laparoscopy and robot-assisted laparoscopy.

In this edition's Cool Apps, Amani Harris guides us through the best of health and mindfulness apps, an apparently burgeoning new class in the health app sector. In Gadget Geek, Mark Ruff takes us on a historical USB journey, concluding with a description of the latest and fastest version, USB-C. The "SWAPS" fellows have again provided JMIG summaries of recent significant articles which are always carefully chosen to be of interest to AGES Members. →

Editorial cont.

As part of the AGES Educational and Practice Partnerships, Georgie Haysom from Avant has provided an update on "Documenting Consent", something we all do, but perhaps could do better! Andreas Obermair also reports on the SurgicalPerformance VER3 update and how it can significantly improve the experience of the SurgicalPerformance user.

Finally, voting in the AGES Board General Election will take place from Wednesday 13th February to Wednesday 20th February. I would encourage you all to read the Election Statements of each candidate and then cast your vote. This is your chance to have a real impact on the future of your Society!

I look forward to seeing you in Perth in early March at the AGES ASM!

Stephen Lyons
eScope Editor &
AGES Honorary Secretary

Letters to the Editor

AGES is excited to present *"Letters to the Editor"*!

This is an email based forum where you, the AGES Members, can send your eScope questions and feedback, along with any other hot topics associated to AGES – straight to the Editor!

Selected entries will then be published in the following edition of eScope. Click on the link here to submit, we look forward to hearing from you.

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New drugs and devices: resisting the siren's song

Bassem Gerges

There have been a myriad of headlines over the past few years condemning pharmaceutical agents, devices, the companies promoting, and, the doctors prescribing them. Whilst there is no denying that there are many who have been seriously affected, one of the main concerns is that of accountability. Pharmaceutical and medical device companies are often made to the culprits.

To comprehend the complexity of this issue, some of the medications and devices that have been associated with harm will be discussed, followed by an overview of the phases of research and how drugs and medical devices get approved by governing bodies.

THALIDOMIDE

It is difficult to address this topic without considering thalidomide. Thalidomide was first marketed in West Germany in 1957 primarily as a sedative. However, its effect on alleviating nausea resulted in it being used in pregnant women for the treatment of hyperemesis gravida. In the following few years, there was a widespread adoption in Australia, Europe and Japan.

In 1961, Dr William McBride, a Sydney based obstetrician and gynaecologist, submitted a letter published in the Lancet, with his observations of thalidomide with birth defects, stating:

> *Congenital abnormalities are present in approximately 1.5 per cent of babies. In recent months I have observed that the incidence of multiple severe abnormalities in babies delivered of women who were given the drug thalidomide ('Distaval') during pregnancy, as an anti-emetic or as a sedative, to be almost 20 per cent.*
>
> *"These abnormalities are present in structures developed from mesenchyme—i.e. the bones and musculature of the gut. Bony development seems to be affected in a very striking manner, resulting in polydactyly [extra fingers or toes], syndactyly [fused fingers or toes], and failure of development of long bones (abnormally short femora and radii).*
>
> *Have any of your readers seen similar abnormalities in babies delivered of women who have taken this drug during pregnancy?*[1]

Later that year, thalidomide was withdrawn in Australia, amongst other countries, although this was after approximately 10,000 children being born with limb malformations, or phocomelia. Interestingly, the United States of America had few incidences of these birth defects owing to the fact that it was not approved by the U.S. Food and Drug Administration (FDA).

VAGINAL MESH DEVICES

There has been a significant focus on vaginal mesh used for the treatment of pelvic organ prolapse over the past couple of years, with particular regard to the associated complications of mesh erosion and chronic pelvic pain. This has led to a Senate enquiry which has ultimately resulted in the removal and restrictions placed on who, how and when vaginal mesh devices for prolapse can be used.

Interestingly, the approval of these devices for the treatment of pelvic organ prolapse was based on the efficacy and safety of abdominal mesh for the hernia repairs.

ESSURE

On the 4th of November, 2002, the Essure® contraceptive device, initially marketed by Conceptus Inc and later acquired by Bayer, was approved by the FDA[2]. The device involved metal coils which were inserted hysteroscopically into the tubal ostia thereby inducing fibrosis and subsequently blockage. Given its novelty, it was classified as a Class III device and thus underwent the FDA's stringent review prior to marketing. This involved providing two post-approval studies to gather five-year follow-up data and to evaluate device placement by newly trained physicians.

New drugs and devices: resisting the siren's song cont.

Bassem Gerges

Over the past 5 years, there have been increasing reports of side-effects including bleeding, pain, coil migration and complications associated with surgical extraction. This prompted the Therapeutic Guidelines Association (TGA) to update the product label hazarding against the potential risks in August 2017 and then the cancelling of the device from the register in February 2018.[3] Many countries followed suit ultimately resulting in Bayer halting sales in 2018.

ULIPRISTAL ACETATE

Ulipristal acetate, marketed as Esmya®, is a selective progesterone receptor modulator which was introduced as a promising treatment of symptomatic, benign, uterine leiomyomas. Unfortunately, following reports of serious, albeit rare, cases of hepatic injury, potentially leading to failure requiring transplantation, multiple agencies, associations and colleges released warnings and restrictions to the use of Esmya®.

ENERGY-BASED VAGINAL DEVICES

More recently, energy-based vaginal devices have been in the spotlight, specifically concerning vaginal "rejuvenation", a term used to describe the non-surgical treatment of vaginal laxity and atrophy, dysuria, dyspareunia and changes in sexual sensation.[4] There are many variations of these devices, however the two major groups adopt either laser or radiofrequency technology. The rationale involves the use of thermal or non-thermal energy to stimulate collagen regeneration contracture of elastin fibres, neovascularisation and improved vaginal lubrication.[5] In July 2018, the FDA released a warning against the use of these devices for the purpose of vaginal "rejuvenation" or cosmetic procedures4 as these devices were primarily cleared for the indications of "incision, excision, ablation, vaporization, and coagulation of body soft tissues in medical specialties, including aesthetic (dermatology and plastic surgery), podiatry, otolaryngology (ENT), gynaecology, neurosurgery, orthopaedics, general and thoracic surgery (including open and endoscopic), dental and oral surgery and genitourinary surgery".[6]

Phases of Clinical Research

So where are we going wrong? Should we stop prescribing or using new drugs/devices? I don't believe this is the solution. Overall, as clinicians we want to provide our patients with new and better options. Innovation and patient safety need to be closely aligned, and that is ultimately our responsibility. We are the gate keepers and therefore we should do the grunt work before offering patients their options. In order to do so, there needs to be understanding of the phases of clinical research, which are quite similar for both the TGA and the FDA with regards to drugs (Figure 1)[7].

Phase	Indicative number of participants	Objectives
Phase 0: Human pharmacology (micro-dosing)	10-15 Involves dosing a limited number of humans with a limited range of doses for a limited period of time	**Assess pharmacokinetics** Gather preliminary data on pharmacokinetics and bioavailability to determine if the drug behaves as expected from preclinical studies'Micro-dosing' studies
Phase I: Human pharmacology	10-100 May involve the first administration to humans, usually to small numbers of healthy volunteers or to patients	**Safety and tolerance** Define or describe pharmacokinetics and pharmacodynamics Determine dosing Explore drug metabolism and drug interactions Identify preferred routes of administration Phase Ia: Single ascending dose Phase Ib: Multiple ascending dose
Phase II: Therapeutic exploratory	100-300 May be undertaken in a larger group of human patients (several hundred)	**Efficacy and safety** Phase IIa: Demonstrate clinical efficacy or biological activity through pilot studies Explore therapeutic dose range Phase IIb: Determine optimum therapeutic dose and regimen (with efficacy as primary endpoint) Resolve uncertainties regarding the design and conduct of subsequent trials
Phase III: Therapeutic confirmatory	300-3000 Usually involve a large group of patients (from several hundred to several thousand)	**Safety, efficacy or effectiveness** Phase IIIa: Determine the therapeutic effect in patient populations for which the drug is eventually intended Provide a definitive assessment of risk-benefit balance (to support drug registration or change in clinical practice) Phase IIIb: Increase patient exposure and support marketing claims or publication
Phase IV: Therapeutic use	1000's	**Post marketing surveillance or resolution of treatment uncertainties** Monitor safety in real world populations To refine knowledge of the risk-benefit balance, detect rare or long-term adverse effects, drug interactions Pharmacoeconomics to gather data in support of the use Comparative effectiveness and community based research (sometimes described as Phase V trials) Trial combinations with existing products

Figure 1. Summary of clinical trial phases for medicines and biologicals

New drugs and devices: resisting the siren's song cont.

Bassem Gerges

Ideally, the majority of physicians would be reliant on the results of phase IV trials confidently provide patients with adequate safety and efficacy information.

Although rigorous approval systems are necessary for the protection of patients, the increasing requirements by the governing bodies have had significant effects on the drug development process. According to the FDA, approximately 70% of drugs meet the approval for Phase I, of which 33% meet the approval for Phase II, of which 25-30% meet the approval for Phase III.[8] Not surprisingly, one of the biggest limitations of drug development is cost, with estimates ranging between 1.4 and 2.9 billion US dollars[9], resulting in clinical approval success rates of approximately 14% to 19%.[10, 11] The implications of this is that there are potentially many effective drugs that cannot be introduced to the market.

In contrast to the approval process for drugs, the process for medical devices seems more complex, less transparent, and possibly less stringent as seen by the relatively smaller numbers required for pre-market approval (Figure 2)[12].

Stage	Indicative number of participants	Objectives
Pre-market pilot	10-30 Usually involves a small group of human patients	Exploratory investigations to determine preliminary safety and performance information to plan design modifications or provide support for a future pivotal study. (Includes first in human and feasibility studies or proof of concept)
Pre-market pivotal	100's	Confirmatory investigations to evaluate performance and safety for a specified intended use to satisfy pre-market regulatory requirements
Post-market	1000's	Confirmatory investigations to establish performance and safety, for example, in broader populations OR Observational investigations or surveillance to gain better understanding of device safety, long-term outcomes, health economics

Figure 2. Summary of clinical trial stages for medical devices

Furthermore, to streamline the approval system of medical devices, one of the recommendations by Australian Government from the Expert Panel Review of Medicines and Medical Devices Regulation (the Review) involves utilising marketing approval assessments by comparable overseas designating authorities or devices that have been approved by a comparable overseas national regulatory authority. This brings the focus to the FDA, and particularly Section 510(K), or Premarket Notification (PMN), of the Food, Drug and Cosmetic Act which provides manufacturers with the avenue to make a premarket submission to demonstrate that "the device to be marketed is at least as safe and effective, that is, substantially equivalent, to a legally marketed device... that is not subject to premarket approval".[13] This was the avenue used by manufacturers to obtain approval for the energy-based vaginal devices.

The Bottom Line

The development of drugs is both expensive and time-consuming, resulting in far fewer new drugs on pharmacy shelves. Ironically, seems that requirements for medical device manufactures may not be as rigorous, although this may not be entirely true given the difficulty interpreting the approval processes.

Whilst it is easy to assume the aim of all companies is to profit, the reality is that we need them as much as they need us. Research and development costs millions of dollars, let alone the process of patenting, applying for market approval and then marketing. Conversely, manufacturers need physicians to prescribe and use their products. It's a symbiotic relationship.

Innovation, medical device/drug companies or their representatives are not the problem. It is our responsibility consider the new drugs/devices, undergo the research, then analyse and consider where and how things might go wrong. Innovation will never have the evidence-based medicine to back it up, as by definition it is new, but one would expect it to be driven by both experience and evidence-based medicine.

Ultimately, the issue is that of consent. We can always offer women the options available in the market, but we need to ensure that they are aware that the long term data with the potential rare risks may not be available. If they're understanding of this, then why shouldn't they trial the new treatments?

New drugs and devices: resisting the siren's song cont.

In fact, if we didn't have women willing to do so, then innovation would cease. Furthermore, there is a need to be more active in research, seeking out active trials and encourage women to enrol in order to obtain the data sought after. To quote Albert Einstein *"The true sign of intelligence is not knowledge but imagination"*.

Bassem Gerges
AGES Trainee Representative

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Australasian Gynaecological Endoscopy & Surgery Society Limited

FOCUS MEETING

NOVEMBER
02-03
QT, Canberra

AGES 2018 Focus Meeting report
Sex, Drugs & Politics

The 2018 AGES Focus Meeting (FM) was held in association with NASOG in early November at the QT Hotel. The QT is well known for its quirky and offbeat political theme which set the scene nicely for a meeting entitled "*Sex, Drugs & Politics*". The meeting theme seemed to resonate with AGES Members and non-members alike with 183 delegates, a fantastic result for an AGES FM, especially given this was AGES' first foray into Canberra.

After the meeting opening by Jason Abbott, President of AGES, and Stephen Lane, President of NASOG, the scene was set with the first keynote presentation given by Clare Braund, the Executive Director of Women on Boards, on "Gender equity – has the battle just begun?" Conference sessions and presentations covered mainstream as well as more diverse and topical aspects of Sex, Drugs & Politics, pertaining both specifically to O&G and more general focuses.

Held at The Boathouse on the banks of Lake Burley Griffin, the conference dinner was the social highlight. More of a party than the more traditional conference dinner, delegates dined on a selection of delicious "party foods" before boppin' away to the sounds of the our very enthusiastic DJ [although our President did make an early exit – beauty sleep?].

The FM closed with an Expert Panel Discussion chaired by Claire Braund (CEO Women on Boards) and panel members Jason Abbott (AGES President), Michael Gannon (AMA Past-President), Stephen Lane (NASOG President), Janine Loader (CEO Mater Hospital Sydney), David Molly (Past President of AGES & NASOG), Gino Pecoraro (AMA Board Member & Past-RANZCOG Board Member, Michelle Thompson (CEO Marie Stopes Australia) & Julie Quinlivan (Chair Professional Review). Panel members responses to audience questions covering all aspects of "Sex, Drugs & Politics" made for a "lively" discussion, my highlight of the meeting!

As always, the support of AGES' Sponsors is gratefully acknowledged without which the AGES FM would not have been possible. The conference organisation by Mary Sparksman and her hard-working team at YRD was, as usual, seamless – thank you! I would like to also thank the members of the FM Organising Committee, Bassem Gerges (Scientific Chair), Catarina Ang, Rebecca Deans, Stuart Salfinger and Mark Ruff, who worked tirelessly to produce a cracker of a program backed up by a dynamic and expert faculty of speakers. In fact, without exception, delegates came up to me after every session to tell me how interesting the topics/speakers were – there was a real "buzz" about the place, a first for me, either as a conference organiser or delegate.

So last, but by no means least, I would like to the conference delegates who made the trip to Canberra to share in the "Sex, Drugs & Politics" and help make this AGES FM such a success.

Stephen Lyons
AGES Hon. Secretary
Meeting Chair

AGES 2018 Focus Meeting report cont.

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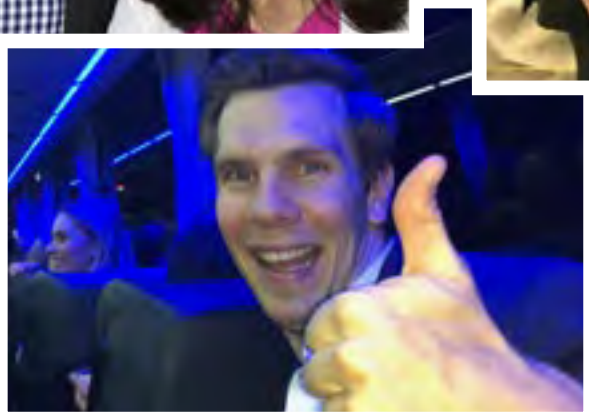

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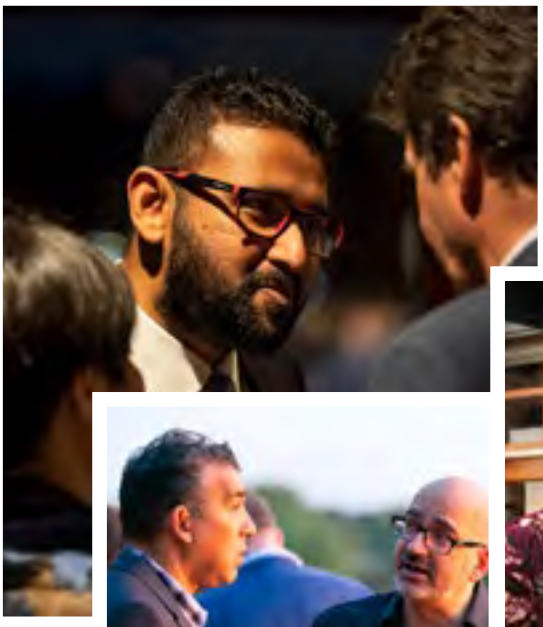
Meeting report cont.



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Dr Jubilee Brown	USA
Dr Roger Browning	WA
Dr Joseph Carpini	WA
Dr Stephanie Chetrit	WA
Dr Danny Chou	NSW
A/ Prof Paul Cohen	WA
Dr Jacinta Cover	WA
Prof Mark Hans Emanuel	NLD
Dr Nicola English	WA
Dr Mathias Epee-Bekima	WA
Dr Jemma Evans	VIC
Dr Susan Evans	SA
Dr Katya Fleming	WA
Ms Tracy Gaibisso	WA
Dr Marek Garbowski	WA
Dr Helen Green	QLD
Dr Tristan Hardy	SA
Prof Roger Hart	WA
Mr Saul Holt QC	QLD
Dr Tamara Hunter	WA
A/Prof Krish Karthigasu	WA
Dr Philip Kriel	WA
Dr Todd Ladanchuk	WA
Dr Robyn Leake	WA
Dr Raelia Lew	VIC
Dr Glen Lo	WA
Dr Aleksandra Luksyte	WA
Dr Stephen Lyons	NSW
Dr Nolan McDonnell	WA
Dr Bernadette McElhinney	WA
Dr Richard Murphy	WA
Dr Sally Murray	WA
Dr Haider Najjar	VIC
Dr Erin Nesbitt-Hawes	NSW
Dr Nicholas Pachter	WA
Dr Jennifer Pontre	WA
Dr Emma Readman	VIC
Dr Bernadette Ricciardo	WA
Dr Mark Ruff	NSW
Prof Christobel Saunders	WA
Dr Robert Schütze	WA
Dr Joseph Sgroi	VIC
A/Prof Kate Stern	VIC
Ms Lisa Stinson	WA
Dr Ai Ling Tan	NZ
Dr Marcus Tan	WA
Dr Judith Thompson	WA
Dr Pamela Thompson	WA
Dr Nicolas Tsokos	WA
A/Prof David Watson	WA
Dr Anthony Williams	WA
Dr Michael Winlo	WA
Dr Michael Wynn-Williams	QLD
A/Prof Anusch Yazdani	QLD
Dr Jessica Yin	WA

CPD POINTS

This meeting is a RANZCOG approved O&G meeting. Fellows of this college can claim 17PD points for full attendance.

MEMBERSHIP OF AGES

Membership application forms are available from the AGES website or from the AGES Secretariat.
https://ages.com.au/membership-application/

AGES CONFERENCE ORGANISERS

YRD Event Management
PO Box 717
Indooroopilly
QLD 4068 Australia

Ph: +61 7 3368 2422
Fax: +61 7 3368 2433
Email: ages@yrd.com.au

This brochure and online registration are available on the AGES website **www.ages.com.au**

Professionalism, Perfection and Problems

AGES heads west for our first ASM in Perth in 15 years!

WELCOME

Dear Colleagues,

I would like to invite you to Perth, Australia's sunniest capital city. Situated on the Swan River, Perth boasts beautiful sandy beaches, one of the world's largest inner city parks - Kings Park, and the Botanic Gardens, which offer a sweeping view of the city from Mount Eliza.

The scientific committee has developed a core program that covers these three key principles– Professionalism, Perfection & Problems.

As always we strive for Perfection in our surgery and patient care and also in teaching and education. We use Professionalism, in managing this journey and overcoming the many Problems that we face as we travel our pathway.

We have a stellar team of international keynote speakers already assembled for the meeting including Associate Professor Sawsan (Suzie) As-Sanie from the University of Michigan. Suzie is the Director of minimally invasive surgery at the University of Michigan, and is a world-renowned expert in the field of endometriosis and pain. We also have Professor Johannes (Hans) Evers of Maastricht University and Editor in Chief of Human Reproduction that will strengthen the scientific focus of the meeting and look at the scientific evidence basis of fertility management. Finally, Dr Marcello Ceccaroni from the International School of Surgical Anatomy in Verona will also be joining us, (previously called the Che Guevara of surgery). Marcello will give you a view of pelvic anatomy and dissection techniques beyond the realm of normal, including an exciting "Live" surgery session.

Along with this amazing international faculty, we have the local and Australasian faculty who will further complement this team, bringing you a meeting that simply cannot be missed!

I look forward to seeing you all in Perth in March 2019!

Stuart Salfinger
AGES Vice President
Chair AGES ASM 2019

INVITED INTERNATIONAL FACULTY

A/Prof Sawsan As-Sanie
Director of the Minimally Invasive Gynecologic Surgery Program and Fellowship, and Director of the Endometriosis and Chronic Pelvic Pain Center.
University of Michigan, Michigan, USA

Prof Johannes Evers
Professor Emeritus of Obstetrics and Gynaecology.
Maastricht University, Maastricht, The Netherlands

Dr Marcello Ceccaroni
Head of the Department of Obstetrics and Gynecology, Gynecologic Oncology and Minimally-Invasive Pelvic Surgery, Sacro Cuore - Don Calabria Hospital Negrar - Verona, Italy

WEDNESDAY 6TH MARCH 2019

0800 - 1700	AGES Advanced Trainee Workshop (Invitation Only)
0800 - 1700	Pre-Conference Hysteroscopy Workshop - Sponsored by Medtronic *For more information, please visit the AGES website*

THURSDAY 7TH MARCH 2019

0700 - 0800	Conference Registration	
0800 - 1000	**SESSION 1: PROFESSIONALISM, PERFECTION AND PROBLEMS**	
	Welcome	
	KEYNOTE: Comparing and contrasting nerve sparing surgical techniques in oncological and endometriosis surgery - **Marcello Ceccaroni**	
	KETNOTE: Hysterectomy and opioids: A match made in hell - **Sawsan As-Sanie**	
	KEYNOTE: Clinical trials... Is it true, is it new and do I care? - **Johannes Evers**	
	AAGL Exchange Lecture	
	Panel Discussion	
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1030 - 1230	**SESSION 2A: THE PROBLEMS OF PAIN**	**SESSION 2B: PERFECTING FERTILITY MANAGEMENT**
	The mystery of pain in endometriosis - **Sawsan As-Sanie**	Pituitary pathways and pregnancy - **Tamara Hunter**
	Peaky pain and persistent problems - **Susan Evans**	Paediatric problems - **Jennifer Beale**
	To chop or not to chop? What is the evidence? - **Jason Abbott**	Protecting and preserving the ovary - **Kate Stern**
	The P's of endometriosis - Puberty to perimenopause - **Erin Nesbitt-Hawes**	Cutting edge science... Receptive and rejective endometrium - **Jemma Evans**
	Pain and poo - **Jacinta Cover**	Perfecting PCOS - **Roger Hart**
	Perfection for the patient -Outpatient hysteroscopy in action - **Mark Hans Emanuel**	Fertility's 5 in 5 in 25 - **Johannes Evers**
	Panel Discussion	Panel Discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	1300 - 1400 INTERACTIVE HUBS 1
1330 - 1500	**SESSION 3A: FREE COMMUNICATIONS**	**SESSION 3B: FREE COMMUNICATIONS**
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1530 - 1730	**SESSION 4: THE PERFECT PICTURE - ANATOMY & RADICAL SURGERY**	
	Surgical neuroanatomy of visceral and somatic system of the female pelvis for nerve-sparing surgery - **Marcello Ceccaroni**	
	ABC - Anatomy Before Cutting - **Helen Green**	
	Contempory anatomy teaching - **Ruth Blackham**	
	How do I upskill in anatomy knowledge - **Michael Wynn-Williams**	
	Does size matter? Simplifying surgery for large fibroids - hysterectomy and myomectomy - **Haider Najjar**	
	Dan O'Connor Lecture - **Roger Hart**	
1730	CLOSE OF DAY ONE	
1730 - 1830	**WELCOME RECEPTION**	

FRIDAY 8TH MARCH 2019

0700 - 0800	Conference Registration	
0800 - 1000	**SESSION 5: FEAR THE LIVE DEAD SURGERY** Session Theme: LIVE SURGERY	0745 - 0845 INTERACTIVE HUBS 2 0900 - 1000 INTERACTIVE HUBS 3
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1030 - 1230	**SESSION 6A: PROGESSING ENDOMETRIOSIS**	**SESSION 6B: PRACTICAL PROBLEMS**
	KEYNOTE: Endometrosis Enigmas - **Sawsan As-Sanie**	Bowel prep, bowel adhesions and bowel repair - Is this the gynaecologists nightmare? - **Stephanie Chetrit**
		P's & Q's - Letters from a Urologist to a Gynaecologist - **Trent Barrett**

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	I dont want drugs, is there something natural I can do? - **Tracy Gaibisso**	Pulsations, Piercing and Puddles - **Marek Garbowski**
	Picture perfect - **Glen Lo**	The plastics perspective - **Anthony Williams**
	MDT for Endometriosis - **Nicola English**	Professionally managing poor outcomes - **David Watson**
	Perfecting the pit stop - **Stephen Lyons**	Personal risk reduction surgery - **Ai Ling Tan**
	Panel Discussion	Pop it in a bag - Protecting your patient and their specimen - **Danny Chou**
		Panel Discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	1250 - 1350 INTERACTIVE HUBS 4
1330 - 1500	**SESSION 7: CHAIRMAN'S CHOICE**	
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1530 - 1630	**SESSION 8A: PK'S**	**SESSION 8B: PK'S**
	Physio for pelvic pain - **Judith Thompson**	Eggs on ice - (pimp my ovary) - **Raelia Lew**
	Personality and pain - **Robert Schütze**	Strategies for preserving ovarian function during surgery for endometriosis - **Anusch Yazdani**
	Patient resources - What and how and do they work? - **Katya Fleming**	Fibroids, fertility and pregnancy - What does the data show? - **Krish Karthigasu**
	When to re-scope - My pain is no better - **Emma Readman**	Genetics for idiots - **Tristan Hardy**
	New therapeutic advances in Endometriosis, SERM, AI and others - **Bernadette McElhinney**	Pain in my perineum - **Robyn Leake**
	Problematic post op pain - **Philip Kriel**	Itchy scratchy - **Bernadette Ricciardo**
	Oestrogen what type given how and when - **Jennifer Pontre**	Vaginal organisms: friend or foe - Management of RVVC - **Sally Murray**
1630	CLOSE OF DAY TWO	
1630 - 1715	AGES Annual General Meeting	
1815 - 2300	**AGES ANNUAL BLACK TIE GALA DINNER, AWARDS & CHARITY AUCTION** (Buses depart at 6.15pm for a 6.30pm arrival for pre-dinner drinks)	

SATURDAY 9TH MARCH 2019

0700 - 0745	Women in Surgery Breakfast	
0730 - 0800	Conference Registration	
0800 - 1000	**SESSION 9A: WAKEY WAKEY - OBSTETRICS & UROGYN**	**SESSION 9B: TECHNOLOGY, BREAST DISEASE & MENOPAUSE**
	Obstetrics has ARRIVED - induction for all - **Richard Murphy**	The virtual shared medical record - **Joseph Sgroi**
	Please don't mess with my biome - Does caesarean section really affect the neonate? - **Lisa Stinson**	Gadget geek live - **Mark Ruff**
	Planning for perfection in the imperfect world - How to combat placental invasion - **Mathais Epee-Bekima**	Big data collection for the future - **Michael Winlo**
	Preventing coagulopathy as the patient bleeds - **Roger Browning**	Patient experience and modern technology - **Marcus Tan**
	Proper perfusion at placental invasion - an anaesthetic perspecive - **Nolan McDonnell**	Who needs to see a geneticist - **Nicholas Pachter**
	Problems with my pee after surgery - **Todd Ladanchuk**	Practical breast disease - **Pamela Thompson**
	Pondering urodynamics - Are they really that helpful? - **Nicolas Tsokos**	High risk breast patients - Managemnent in the MDT - **Christobel Saunders**
	The perfect mesh in the current climate - **Jessica Yin**	Managing menopausal symptoms after breast cancer - **Paul Cohen**
1000 - 1030	MORNING TEA & TRADE EXHIBITION	
1030 - 1230	**SESSION 10: PROFESSIONALISM IN PRACTICE**	
	Leadership in Medicine	
	What makes a good team in theatre? - **Joseph Carpini**	
	Montgomery Decision - **Saul Holt QC**	
	Its all in my head - **Jade Acton**	
	Management versus Leadership- Apples and Oranges - **Aleksandra Luksyte**	
	Panel Discussion	
1230	CLOSE OF DAY THREE & LUNCH ON THE GO	

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

PRE CONFERENCE WORKSHOPS

AGES Advanced Trainee Workshop
Crown Towers Perth
Wednesday 6th March 2019
0800 – 1700

The annual AGES Advanced Trainee Workshop will comprise of both didactic and practical sessions facilitated by prominent local and international speakers to enhance and compliment the current two year national fellowship in Advanced Gynaecological Endoscopy. This workshop is only open to Trainees currently enrolled in the AGES Trainee Program.

Hysteroscopy Pre-Conference Workshop *Sponsored by Medtronic*
CTEC, Perth WA
Wednesday 6th March 2019

In collaboration with internationally recognised operative hysteroscopists, Medtronic has developed an innovative training curriculum which provides the necessary educational components to support surgeons wanting to incorporate or further advance the use of operative hysteroscopy into their practice.

This half day program will focus on advanced surgical techniques for surgeons wanting to increase their knowledge and technical skills for performing operative hysteroscopy procedures. Participants will hear didactic presentations, which focus on critical procedural steps, clinical pearls, and instrumentation necessary to perform hysteroscopic tissue resection. A hands-on simulation lab will provide participants the opportunity to experience wet lab training on operative hysteroscopy techniques.

FEAR THE LIVE DEAD SURGERY

Dr Marcello Ceccaroni
Dr Michael Wynn-Williams
Dr Danny Chou

AGES INTERACTIVE HUBS

AGES is proud to once again announce the inaugural Interactive Hubs, held in conjunction with our Industry Partners. The Interactive Hub is the AGES Society's response to the changing needs of our members and industry partners. Industry want more than to simply show their product on a stand, they want AGES members to use their product as it is intended - at least in a simulated manner. AGES Members have frequently commented that they want more hands on training; skill acquisition and technical improvement to see immediate changes in their clinical practice. Whilst there are many workshops available to gynaecological surgeons, none have access to the skilled faculty of the AGES membership and the multitude of products that our industry partners want to showcase for improved patient care. The Hub experience is a Members only experience, and registrations are now open!

Interactive Hub sessions will be held during the ASM on Thursday, 7th March at 1.00pm, Friday 8th March at 7.45am, 9.00am and 12.50pm.

Please see below the industry sponsors hubs with more information available on the AGES :

Stryker	**Medtronic**
Applied Medical	**Device Technologies**
Karl Storz	**Hologic**
Ethicon	**Olympus**

CONFERENCE INCLUSIONS

Conference registration fees include:

- Attendance at AGES XXIX ASM 2019 conference sessions on Thursday 7th, Friday 8th and Saturday 9th March 2019
- All conference publications
- Conference lunches, morning and afternoon teas as per program on Thursday 7th, Friday 8th and Saturday 9th March 2018
- Conference satchel

SOCIAL PROGRAM

Welcome Reception
Crown Ballroom 2 & 3, Crown Perth Convention Centre
Thursday 7th March 2019
5.30pm – 6.30pm

AGES Annual Black Tie Gala Dinner, Awards & Charity Auction
Optus Stadium
Friday, 8th March 2019
6.15pm - late
Ticket cost: $145.00

FREE COMMUNICATIONS

AGES invites abstracts for oral, video and digital free communications at the AGES XXIX Annual Scientific Meeting 2019. The Free Communications sessions will be held during the meeting, between the 7th – 9th March 2018.

FREE COMMUNICATIONS INSTRUCTIONS FOR AUTHORS

1. The abstract submission deadline is MONDAY, DECEMBER 10TH 2018
2. All abstracts must be submitted online using the registration link. Faxed, posted, and abstracts submitted via any other email address will NOT be considered
3. Abstracts must be in English language only
4. Maximum 400 words/3050 characters with NO pictures, graphs, tables or images
5. References are excluded from the word limit but must be restricted to THREE ONLY
6. The decisions of the selection committee are final
7. All oral/video presentations will be 7 minutes in duration and 3 minutes question time, with no exceptions
8. Successful applicants for the Free Communications program will be notified
9. 9. Presenters of accepted abstracts are required to pay for registration to AGES ASM 2019
10. All presentations at the Conference will be via the Conference laptops. No personal laptops will be used for presentations. All presentations will need to be uploaded at the Speaker's Prep area. Details will be forwarded to you with acceptance of your abstract
11. Any conflict of interest/sponsorship must be declared at the commencement of any presentation
12. Failure to follow the instructions for submission of abstracts may result in rejection of your document
13. By submitting an abstract you agree that Copyright of the abstract(s) is assigned to AGES only for the purpose of publication in the Conference Abstract Book and (if applicable) media releases/reports
14. NO changes to any abstracts will be accepted after close of abstracts
15. Any questions should be directed to the secretariat at ages@yrd.com.au

Please note that when you proceed through the submission process that you must click save, before moving on to the next step. Up until the close of abstract submission you can log into your profile to continue your submission where you left it or make any changes. If you have any concerns please contact the secretariat office on **+61 7 3368 2422** or by email to **ages@yrd.com.au.**

APPLICATION DEADLINE: MONDAY, DECEMBER 10TH 2018 - **CLOSED**

SPONSORSHIP & TRADE EXHIBITION

AGES gratefully acknowledges the following sponsors and exhibitors which have confirmed their support at the time of printing.

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CONFERENCE VENUE & HOTEL

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Crown Perth brings a fully-integrated entertainment precinct to Western Australia. Renowned for its world-class facilities, entertainment, premium restaurants and luxury accommodation, Crown is located on the eastern banks of the Swan River, just minutes from the CBD and both domestic and international airports.

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Crown Towers Perth
Deluxe Room including once breakfast daily and standard in-room Wi-Fi access - $305.00 per night
**Upgrades available upon request and subject to hotel availability and additional costs*

Crown Metropol Perth
Luxe Room including once breakfast daily and standard in-room Wi-Fi access - $280.00 per night
**Upgrades available upon request and subject to hotel availability and additional costs*

Crown Promenade Perth
Superior Room including once breakfast daily and standard in-room Wi-Fi access - $245.00 per night
**Upgrades available upon request and subject to hotel availability and additional costs*

Hotel Check-in/Check-out
Check-in is from 3:00pm. Check-out is prior to 11:00am

Changes to hotel reservations
Any change must be made in writing to the Conference Organisers and not directly to the hotel.

Parking
There is a range of free, paid, undercover and open car parks at Crown, including over 3,000 free parking bays available across the resort (excludes Optus Stadium event days). Plus Crown have added new, dedicated senior bays in P4 for your convenience.

For more information please visit:
https://www.crownperth.com.au/general/parking/information

PRIZES & AWARDS

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Sponsored by Device Technologies

Outstanding Trainee Presentation
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Sponsored by Stryker & AGES

Best Digital Communications Presentation
Sponsored by AGES

AGES Travelling Fellowship 2019
Sponsored by Medtronic

AGES-AAGL Exchange Lecture
Sponsored by AGES

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REGISTRATION INFORMATION

REGISTRATION COSTS	Single Meeting Earlybird ASM Only *Paid by 14th December 2018*	Single Meeting Full Registration ASM Only *Paid after 14th December 2018*	Double Meeting Package ASM & PFS	Double Meeting Package ASM & FM	Triple Meeting Package ASM, PFS & FM
Fellow – Member 3+ Year *Ends 31st January 2019	$1095	$1295	$1841	$1729	$1500
Fellow –Member	$1095	$1295	$1841	$1729	$2440
Fellow – Non-member	$1315	$1515	$2188	$2080	$2912
Registrar/Trainee – Member	$495	$595	$770	$752	$1016
Registrar/Trainee – Non-member	$655	$755	$1039	$1013	$1381
Student/Nurse/Practice Manager	$490	$590	$774	$761	$1034

***All fees are quoted in Australian Dollars – AUD $*

FREE COMMUNICATIONS DEADLINE 10TH DECEMBER 2018 -* ***CLOSED*
** EARLY BIRD REGISTRATIONS CLOSE 14TH DECEMBER 2018 -* ***CLOSED***
*** REGISTER NOW* **www.ages.com.au**

AGES MEMBERSHIP

AGES MEMBERSHIP
JOIN FOR 2019 MEMBER BENEFITS:

- Attend all three AGES Meetings in 2019 for only $1,500.00, saving of up to 50% per meeting. Only applicable for 3+ year members.
- Savings of up to 15% on member registration fees for AGES meetings.
- Exclusive access to the new "AGES Video Library – Members only".
- Eligibility to register for the AGES Cadaveric Laparoscopic Pelvic Anatomy Dissection & Demonstration Workshops
- Eligibility to register for the AGES Interactive Hubs.
- Eligibility to apply for AGES Research Grants.
- Complimentary subscription to SurgicalPerformance self-auditing Software and AGES/SurgicalPerformance webinars.
- Complimentary subscription to the Journal of Minimally Invasive Gynaecology (formerly AAGL Journal).
- Option to subscribe to the International Urogynaecology Journal instead of JMIG for an additional fee.
- AGES electronic-newsletter, eScope, published four times annually.
- Eligibility to register for the "Who do you want to be when you grow up" Seminars.
- Member access to AGES website and resources.
- Downloadable "AGES Member Icon" available for use in signature blocks and websites.
- Listing on the Membership Directory of the AGES website.
- Eligibility to apply for a position in the AGES Training Program in Gynaecological Endoscopy

AGES ART PRIZE & CHARITY AUCTION

AGES is pleased to announce Shannon Hamilton as the 2018/2019 AGES Society Art Prize winner.
Shannon Hamilton creates appealing, familiar and exciting contemporary artwork which has found popularity throughout Australia and overseas.

Having loved art from a young age, Shannon developed her unique self-taught style during her career as an occupational therapist.

Giving occupational therapy away in 2000 to explore her own potential, Shannon has gone on to achieve outstanding success.

Shannon's paintings feature strong, bold strokes of colour, tastefully capturing the sensuality of the human form in the warmth of Australian sunlight.

Having travelled the world, she also draws upon African and Asian cultures with a focus on warmth of human relationships, especially of mother and child.

Shannon's work, more recently, focuses largely on the warmth or human relationships, especially the bond between mother and child. She is becoming increasingly known for her soulful works depicting such universal human moments whilst remaining characteristically Australian.

Most of Shannon's works are now sold studio direct, with buyers enjoying the experience of directly connecting with the artist.

Her artistic flair is also sought by those looking to find artwork to fit a particular space in homes, offices and newly developed buildings.

Shannon's works include use of chalk pastels, oils on canvas/ board and mixed media.

The artworks will be auctioned at the AGES Annual Black Tie Charity Auction & Awards Gala Dinner on Friday 8th March 2019 at Optus Stadium.

The proceeds of the Charity Auction will be donated to a charity of the Board's choice.

We do hope you are able to join us on this vibrant and fun-filled night. To register for the AGES ASM 2019 and purchase a ticket to Black Tie Gala Dinner to participate in the charity auctions, please visit www.ages.com.au/events

For more information please visit the website – **www.ages.com.au**

AGES Events 2018/19

Australasian Gynaecological Endoscopy & Surgery Society Limited
LAP-D WORKSHOP

AGES Cadaveric Workshop
MERF QUT, Brisbane

Dissection Workshop:
25th May 2019
30th November 2019

MAY 25 NOVEMBER 30

Demonstration Workshop:
17th August 2019

AUGUST 17

AGES SEMINAR

AGES "Who do you want to be when you grow up?" Seminars 2019
Dates and locations coming soon.

Please check the website for more information

Australasian Gynaecological Endoscopy & Surgery Society Limited
AGES/RANZCOG TRAINEE WORKSHOP

AGES/RANZCOG Trainee Workshop 2019
Brisbane
22nd & 23rd June 2019

JUNE 22 JUNE 23

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES Focus Meeting 2019
in conjunction with The World Endometriosis Society
Grand Hyatt, Melbourne
2nd & 3rd August 2019

AUGUST 2 AUGUST 3

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium 2019
Sheraton on the Park, Sydney
1st & 2nd November 2019

NOVEMBER 1 NOVEMBER 2

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https://ages.com.au/ages-events/

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WEDNESDAY
6 MARCH
Perth

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

AGES ASM Pre-conference Operative Hysteroscopy Workshop *Sponsored by Medtronic*

Medtronic
Further, Together

In collaboration with internationally recognised operative hysteroscopists, Medtronic has developed an innovative training curriculum which provides the necessary educational components to support surgeons wanting to incorporate or further advance the use of operative hysteroscopy into their practice.

This half-day program will focus on advanced surgical techniques for surgeons wanting to increase their knowledge and technical skills for performing operative hysteroscopy procedures. Participants will hear didactic presentations, which focus on critical procedural steps, clinical pearls, and instrumentation necessary to perform hysteroscopic tissue resection. A hands-on simulation lab will provide participants the opportunity to experience wet lab training on operative hysteroscopy techniques.

TECHNIQUES IN OPERATIVE HYSTEROSCOPY

SAVE THE DATE
WEDNESDAY 6TH MARCH 2019

Professor Mark Emanuel MD PhD

University Medical Center in Utrecht (The Netherlands)

Mark Hans Emanuel MD(with honours) PhD was trained at the Academic Medical Center of the University of Amsterdam. Since 1992 he was working in the Spaarne Hospital (University of Amsterdam) as a staff consultant gynaecologist and board certified trainer. Since 2016 he works in the University Medical Center in Utrecht (The Netherlands).

In 1998 he wrote his PhD-thesis entitled: Submucous Myomas and Abnormal Uterine Bleeding; epidemiology, diagnosis and treatment. His special field of interest is diagnosis and treatment of the uterine cavity (ultrasonography and hysteroscopy).

He is a specialist in advanced hysteroscopic surgery and he is directing an International Referral Center for advanced hysteroscopic surgery and Asherman Syndrome. He is a former Board Member of the Dutch Society of Obstetrics & Gynaecology (NVOG) and the International Society for Gynecological Endoscopy.

He was a joining FIGO Menstrual Disorders Committee Meetings on fibroids.

Recently he was appointed as visiting professor at the University of Ghent (Belgium).

He was awarded as Dutch Inventor of the Year for the development of Hysteroscopic Morcellation or Tissue Removal Systems. He won several awards from The Society of Reproductive Surgeons and The American Association of Gynecological Laparoscopists.

He holds three patents related to Hysteroscopic Morcellation, Gel instillation Sonohysterography and Hysterosalpingo Foam Sonography respectively.

Dr Stuart Hart

Physician Executive and Senior Director, Global Medical Affairs Medtronic

WORKSHOPS

Two workshop times available:
8am-12pm and 1pm-5pm

LOCATION

CTEC 35 Stirling Highway,
Crawley WA 6009

mHTR Workshop Overview

In collaboration with internationally recognized operative hysteroscopists, Medtronic developed an innovative training curriculum which provides the necessary educational components to support surgeons wanting to incorporate or further advance the use of operative hysteroscopy into their practice.

This half day program will focus on advanced surgical techniques for surgeons wanting to increase their knowledge and technical skills for performing operative hysteroscopy procedures. Participants will hear didactic presentations, which focus on critical procedural steps, clinical pearls, and instrumentation necessary to perform hysteroscopic tissue resection. A hands-on simulation lab will provide participants the opportunity to experience wet lab training on operative hysteroscopy techniques.

Medtronic Australasia Pty Ltd
2 Alma Road, Macquarie Park NSW 2113
Toll Free: 1800 668 670

Medtronic

COOL APPS

MHapps: Mental Health Apps and Mindfulness

Amani Harris

My inspiration for choosing the topic of this Cool Apps edition came from reflecting on the recent session on doctors' mental health during the AGES focus meeting in association with NASOG in Canberra. The poignant proclamation of Professor Steve Robson on his journey as a junior doctor with depression and suicidality many years ago has encouraged open discussion about a serious issue impacting many doctors; our mental health and wellbeing[1]. By providing a platform for these discussions, we can actively contribute to a systemic and cultural change crucial in reducing perceived stigma and improving attitudes towards help-seeking in mental health.

Scope of the problem in medicine

The World Health Organization (WHO) predicts that depression will become the global leading cause of disease burden by 2030[2]. Previous studies have shown that junior doctors are more likely to experience depression compared to the general population[3]. In a survey of 941 Australian and New Zealand junior doctors, 54% reported excessive workloads, 70% high levels of stress, 71% low job satisfaction and 69% reported burnout, with around 25% meeting criteria for depression[4].

Burnout is defined as the prolonged physical, emotional, and psychological exhaustion characteristic of individuals working in human service occupations. The practice of modern medicine involves a complex array of challenges with excessive workloads, administrative stressors and the emotional pressure of patient demands. As a result, the rate of burnout in clinicians is high[5]. Burnout has the potential to impact negatively on the surgical workforce[6,7]. The individual and social consequences of burnout include extreme fatigue, insomnia, drug and alcohol abuse, depression, relationship breakdown, anxiety and suicide[8]. Surgeons reporting higher levels of burnout are more likely to consider early retirement or retraining[9]. It is also possible that a surgeon suffering from burnout may be prone to making more errors in the work-place. In a survey of 1,287 younger fellows of the Royal Australasian College of Surgeons (RACS), almost 27% of younger Fellows reported high levels of personal burnout[10].

MHapps

Many Mental Health apps have been developed and made available for users in recent years. They are becoming increasingly popular with over 3,000 available for download. A survey of the Australian general public indicated that 76% of people would use their mobile phone for self-management and self-monitoring of mental health if the service were free[11]. Such a response reflects the acceptability and useful application MHapps have as a vehicle for enhancing access to evidence-based monitoring and self-help for individuals with mild-to-moderate common mental health conditions[11].

While there are many MHapps available, I have focused on mindfulness apps and their relevance to doctors in general and surgeons specifically.

So, what is Mindfulness? Well, it's not sitting in a lotus position chanting!...

Mindfulness is among the most misunderstood terms of modern culture. Although its roots stem some 2,500 years in Buddhist tradition where it is seen as a path for genuine happiness and enlightenment, modern views of mindfulness have nothing to do with religion or spirituality. Instead, it is about attaining a very particular mental state where one is continuously aware of the present moment and accepting of whatever will happen, ultimately resulting in a relaxed mind. Mindfulness is not a religion or a cult, it does not incorporate a divine being, spirits or the afterlife, instead it is a mind training exercise. →

COOL APPS

MHapps: Mental Health Apps and Mindfulness cont

Amani Harris

Life is full of disappointments and stress, although mindfulness cannot eradicate them, it equips us with techniques that allow us to accept these frustrations as part of life[12].

Humans often reverie and fixate on negative events, past failures and future worries[13,14]. The brain's reaction to these events is to produce feelings of anger, irritation, frustration, excitement, sadness or disgust. Allowing our minds to become highly reactive and untamed can result in depression, anxiety, addictions and interpersonal conflicts. In short, the untrained mind is prone to being unhappy[12].

Mindfulness for surgeons

Ideally, a surgeon is not only equipped with knowledge, compassion and aptitude for surgery but also attention, focus and the ability to deal with predicaments with calm, flexibility and resilience. An ideal surgeon is unaffected by previous cases and external situations[12].

Realistically, as with most humans, surgeons are not always present in the moment. We can allow our mind to wonder, becoming unsettled and distracted during the dynamic theatre environment. A typical surgeon's stressed and untrained mind, predisposes them to burnout and fatigue [10,15-17]. Mindfulness offers an alternative way of being that can also optimise a surgeon's performance and reduce error through taming the emotional parts of the brain (e.g. limbic system and amygdala) while enhancing the logical prefrontal cortex to produce a repertoire of options[18]. These effects are significant with a review reporting standardised effect size of 0.5 on health[19]. In the same way aspirin has been shown to prevent cardiovascular events, mindfulness appears to protect against physician burnout[16].

During training, senior colleagues often advise juniors, when faced with a complication in theatre once feasible, to stop and take a deep breath to regain focus and plan the next step. This technique often prevents the flow-on effect of a flustered surgeon cursing and yelling at the assistant who then makes more errors and creates a heavy theatre environment, diminishing the likelihood of good judgement and decision making by all in the room.

Does it work?

Research has shown mindfulness to be associated with better quality of life[14], subjective well-being and mood[20], subjective health[19], and sleep, lowered stress[21], anxiety and depression[20], emotional exhaustion[15,16] and prevents depression relapse[22]. Cognitively, mindfulness is linked to enhanced executive functioning[23], attention[24], situationally appropriate decision-making and behavioural regulation[25], in addition to reduced emotional interference in cognitive tasks[26].

An example of how to practise mindfulness

For novices, a short 5-minute daily mindfulness exercise is recommended, working up to established practitioner level of 30 minutes in addition to incorporating mindfulness in everyday life. The exercise is performed in a quiet place and time with minimal distraction or interruption. Close your eyes and assume a half smile (creates a gentle positive state) and take three slow, deep breaths; pay attention to the sensations of breathing. After that, simply breathe normally while paying attention to the process. Try to focus on the exercise for 5 minutes, despite the inevitable distractions of thoughts, sounds or judgments, for even then you are becoming aware of how busy your mind is. At the end of 5 min, gradually cease the practice and be grateful for having those 5 min of quiet[12].

COOL APPS

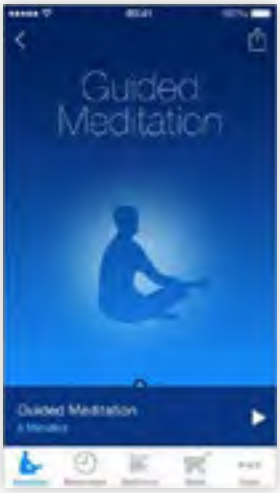
MHapps: Mental Health Apps and Mindfulness cont

Amani Harris

The 3 top-rated mindfulness apps on Healthline[27]

THE MINDFULNESS APP

Packed with features, this meditation app includes a five-day guided meditation practice, reminders for when it's time to relax, and other offers based on individual meditation habits. It can also be integrated with other health apps if users enjoy using their devices to improve their health. Users can create a personalised "Timed session", choosing the session length, voice guidance and background music. The "My Profile" feature provides users with data collected throughout the week on total and average time meditating, number of sessions and courses. The app is free to download with the option of upgrading to a "Premium" at a price.



HEADSPACE

Ideal for beginners, the app includes 10 exercises that can help them learn more about meditation as well as applying it to their life. It includes a personalised progress page, reward system for continued practice, and buddy system that lets users connect with others to stay on track. It links with Google Home and Amazon allowing one to immerse themselves into the "meditation world". Like other apps, users get a limited number of days free to trial after which, they require a monthly, yearly or lifetime subscription. While the monthly subscription is comparable to other apps, Headspace's lifetime memberships are more expensive ($399 Vs $299 for Calm). Headspace allows adjustment of meditation time (3, 5, 10 minutes, etc.), which other apps don't. Like all other mindfulness apps, the push notifications keep users engaged and practising which helps them make mindfulness a daily habit. Now to the voice; Headspace's voice is a soothing British male.

Headspace's interface is cartoon based, promoting fun with a social option to add friends and see how many of them are mediating.

COOL APPS

MHapps: Mental Health Apps and Mindfulness cont

Amani Harris

CALM

Named by Apple as the 2017 iPhone App of the Year, Calm is regarded as one of the best mental health apps available with a focus on mediation and mindfulness. It includes 3 - 25-minute sessions and a feature called Daily Calm, a 10-minute program one can practice before the beginning or end of their day. Calm provides people experiencing stress and anxiety with guided meditations, sleep stories (read by a variety of celebrities including Bindy Irwin and Steven Fry), breathing programs and relaxing music.
The most popular feature of this app is the meditation segment followed by the sleep aid. A unique aspect of this app's mediation segment is the different options for feature choice; anxiety, anger, sadness, etc. This helps users decide what they want to focus on and allows them to target their current emotional state, matching their goal with the specific mediation exercise. The main feature that distinguishes the Calm app is their pitch, which is incorporated into the meditation, reminding users of why it is important and beneficial for them to do the exercise. The voice in Calm is a feminine American voice.

Calm's interface is customisable with different backgrounds and sounds (mostly of nature) to compliment the meditation

To conclude, most mindfulness apps are free to try. Users can choose based on their preference for interface, voice or customisable features.

Amani Harris

MHapps: Mental Health Apps and Mindfulness cont

Amani Harris

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AUGUST 2019
02-03
Melbourne

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES/WES Focus Meeting 2019

In a world where collaboration is not just recognised as progressive, but essential, AGES announces our combined International Focus Meeting with the World Endometriosis Society in Melbourne, on the 2nd & 3rd August 2019.

This will be the first time that WES has held a regional meeting, however with a New Zealand President and an Australian President-Elect they are more family than family, and we have been piecing together an exceptional program on endometriosis and pelvic pain. Our previous collaborative meetings have been at our ASM, and we are anticipating our highest attendance ever at a Focus Meeting. You won't want to miss it.

Jason Abbott
Conference Chair

Stuart Salfinger
Scientific Chair

GADGET GEEK

Mark Ruff

USB

USB 2.0

USB 3.0

USB-C

Portable file storage has come a long way from the humble floppy disk, which with a storage capacity of 1.44MB was barely able to hold half a photo from a current iPhone 8. Fast forwarding through the zip disk and CD rom era, we arrived at the flash memory storage era. Flash memory allowed high density data storage and found wide application in digital cameras and media players. There were many types of cards produced by different manufacturers, unfortunately with a plethora of shapes, sizes and connectors (image 01). Fortunately, a standardised protocol for connecting peripherals to a computer had been developed in 1994 – the universal serial bus, or USB. It wasn't long before USB was adopted as the de-facto standard for memory sticks.

There have been some small changes to the USB standard over the years, USB 2.0 brought "plug and play" capabilities to devices, where the device's drivers do not need to be installed on the operating system. USB 3.0 significantly increased the speed of data transfers. These updates to the technology did not change or impact the familiar USB connector (image 02), and so devices were "backwards compatible". USB-C changes all of that.

USB-C brings with it a new connector (image 03). Don't mistake this for a mini-USB or a micro-USB, which may be small like the USB-C, but lack its symmetry. That's right, USB-C cables can be oriented "up" or "down", so no more guessing which way to plug it in. USB-C is also far more powerful, literally, meaning it can be used to charge larger devices like laptops and smaller devices such as mobile phones at a rapid rate. USB-C also has up to twice the data transfer speeds as USB 3.0.

USB-C will eventually become as ubiquitous as the current USB standard. However, it will take some time for all those old USB ports to disappear. I have suffered for the past 2 years with a laptop that only has USB-C ports, and would not have survived being and "early adopter" without hybrid USB memory sticks that offer both connectors (image 04). My hybrid USB memory stick is currently my favourite tool in the operating theatre. It allows me to collect operative images from the laparoscopic stack (standard USB), and subsequently plug directly into my phone (USB-C charging/data port), allowing me to show the pictures to the patient before they are discharged home.

Mark Ruff

NOVEMBER 2019

01-02

Sydney

Australasian Gynaecological Endoscopy & Surgery Society Limited

PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium 2019

Dr Emma Readman and Professor Ajay Rane welcome you to our pelvic floor meeting in Sydney on November 1st and 2nd 2019. After an extremely successful meeting in Brisbane, the AGES Pelvic Floor Committee and the Local Organising Committee have taken on board all feedback from the AGES Membership, and have risen to the challenge of bettering our last meeting. 'Dare to be Different 'is the challenge.

A different format, a different style of interactive discussions, a different debate and a cast of international speakers creating a point of difference, including Professor Kari Bo and Professor Sayeba Akhter from Bangladesh. This is ably supported by a host of national experts both from Australia and New Zealand.

We will continue to challenge our membership with innovative ideas, forums and presentations.

Welcome to Sydney PFS 2019

Emma Readman
Conference Co-Chair

Ajay Rane
Conference Co-Chair

Comparison of Complications between traditional Laparoscopic Surgery and Robotic Assisted Laparoscopic Surgery

Roni T Ratner & Haider Najjar

Robotic assisted surgery (RAS) was initially developed for use in the battlefield, but was approved by the Food and Drug Administration in the late 1990's for urological and cardiac surgery and then in 2005 for gynaecological surgery.[1] Some of the reported benefits of robotics include 3-D vision, greater freedom of motion due to the reticulation of the instruments, greater precision, easier suturing and a shortened learning process than conventional laparoscopy (CL).[2] There are over 40 hospitals currently providing the Da Vinci system in Australia and New Zealand, with the vast majority being located on the Eastern seaboard of Australia.[3] Worldwide, this number is in excess of 4400, with over 5 million surgeries having been performed over the last 23 years.[4] Indeed, one study in the US by Wright et al, showed that the rate of laparoscopic hysterectomy increased from 24.3% to 30.5% and robotic hysterectomy increased from 0.5% to 9.5% of all hysterectomies in the years from 2007 to 2010.[5] When compared with CL, the available data does not show any increased benefit for RAS.[1] The question remains, are CL and RAS comparable in regards to outcomes and complications?

Two of the main concerns regarding RAS are the altered haptics leading to more frequent complications and the increased length of operating time when compared to CL. In 2012, Sarlos et al. published a randomised controlled trial comparing TLH with robotically assisted hysterectomy (RAH). One hundred women were randomised to either TLH or RAH. There was no difference in complications, blood loss, use of analgesia or return to activity. However, there was a significantly higher operating time in the robotic group (106 vs. 75 minutes p<0.001).[6] Rosero et al. published a retrospective cohort study in 2013 reviewing the files of over 800,000 women undergoing hysterectomy in a two-year period. Of these, 20.6% underwent total laparoscopic hysterectomy (TLH) and 5.1% RAS. The overall complication rate was similar between the two groups (8.80% v 8.85% CI 0.89-1.09 p=0.91). Post-operatively, there was a reduced need for blood transfusion in the robotic group (2.1% v 3.1%, p<0.01). However, there was an increased rate of post-operative pneumonia (RR 2.2, 95% CI 1.24-3.78 p=0.005),[7] presumably due to the increased Trendelenberg required. A Cochrane review by Liu et al. demonstrated no statistically significant difference in intra-operative (RR 1.71, 95% CI 0.83-3.52) or postoperative complication rates (RR 0.62 95% CI 0.30-1.29) between robotic and CL hysterectomy. Again, there was a significant increase in operating time of 41.71 minutes (95% CI 17.08-66.33 p= 0.0009) associated with robotic surgery.[2]

In regards to cost, on average RAS in gynaecology is between $2189 to $2489 USD more expensive than CL.[5,7] However, it has been reported in the Cochrane systematic review that robotic surgery can lead to costs up to $8728 USD more.[2] It would seem that the expense of RAS is country dependent and can determined by mode of remuneration, for example health fund versus government compensation. The true comparison should rely on consumable required between the two modalities. Many studies have shown a reduced length of admission for robotic surgery[2, 5], which may not be factored into the overall cost.

In 2017, the first multicentre, randomised control trial investigating RAS for the treatment of endometriosis when compared with CL in the United States. There were a total of 73 patients included in the study, with 21 of these not having surgical evidence of endometriosis. There was no difference in intra-operative or postoperative complications or conversion to laparotomy. The mean operative time was 106.6+/- 48.4 minutes in the RAS arm vs. 101.6 +/- 63.2 minutes in the CL arm. The only statistically significant difference was that the patients in the CL arm were more likely to have higher stage disease (p=0.018).[8] A systematic review regarding the role of robotic surgery in the treatment endometriosis found that RAS did not provide any benefit over CL. Major complication rates were 1.5% for RAS compared with 0.3% for CL, however the rate of conversion to laparotomy was similar (0.3% v 0.5%). In five of the six comparative studies included, operating time was longer in the robotics group.[9] →

Comparison of Complications between traditional Laparoscopic Surgery and Robotic Assisted Laparoscopic Surgery

Roni T Ratner & Haider Najjar

There have also been comparisons between RAS and CL myomectomy in the literature. Bedient et al.[10] published a retrospective review of 81 patients undergoing either modality of myomectomy in 2009. They found that patients undergoing CL had significantly larger mean uterine size, fibroid size as well as more fibroids. However, when the groups were adjusted for these factors, there was no difference in mean operating time (141 vs. 166 minutes, p=0.61), mean blood loss (100 vs. 250ml p=0.37) and total length of hospital stay (p=0.81). Patients undergoing CL were more likely to have an intra-operative complication, such as a blood transfusion or conversion to laparotomy (20% v 2% p=0.01), however again, when adjusted for uterine size, fibroid size and number there was no difference between the two groups. There was no difference in postoperative complications or rates of readmission. In 2013, Göçmen et al. compared 38 patients undergoing RAS and CL myomectomy. They reported no significant difference in operating time or complication rates between the two groups.[11] A systematic review of RAS compared with abdominal and laparoscopic myomectomy performed in 2013, indicated that when robotic surgery is compared with CL, there were no significant difference in blood loss, operating time, complications and length of stay. However, costs and blood transfusion risk were higher. The authors' conclusion was that there is no short-term benefit of performing RAS compared with CL.[12]

There have been two randomised trials performed comparing robotic assisted sacrocolpopexy with CL. The study by Paraiso et al. randomised 78 patients, with findings of longer operating time (+67minute difference, 95% CI 43-89 p<0.001) and increased pain and cost (mean difference +1,936, 95% CI $417-$3,454, p=0.008) in the robotics group compared with CL.[13] Anger et al. also randomised 78 patients and had similar findings with longer operating time (202.8 minutes v 178.4 minutes, p=0.03), higher pain scores (3.5+/-2.1 v 2.6 +/- 2.2, p=0.04) and higher costs ($19,616 v $11,573, p<0.001).[14]

A literature review by Maerz et al[5] investigated the complications occurring at sites distant to the surgical site specifically as a result of RAS. The particular requirements of robotics surgery including longer operating time and steep Trendelenberg, as well as patient characteristics such as obesity can result in an increased risk of novel complications. Some of the complications that have been described include: cerebral oedema, pulmonary oedema, corneal abrasions and lower limb compartment syndrome.

In conclusion, the available evidence suggests that when comparing RAS and CL in gynaecology, the outcomes and complications are comparable. Operating times are similar if not longer and currently there is a higher cost involved in RAS. The AAGL position statement on RAS in gynaecology states that RAS should not replace conventional laparoscopy or vaginal procedure when appropriate, however this technique should be encouraged as a method of reducing procedures performed via laparotomy.[16] RANZCOG's view is less favourable stating that "the current place of robotic-assisted laparoscopic surgery for benign gynaecological procedures is yet to be established." Also, the position held is that only gynaecologists capable of performing a procedure laparoscopically should proceed with RAS, and only with the appropriate training.[17] More trials are required to determine whether or not there is an indication for the use of RAS in gynaecological surgery.

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Comparison of Complications between traditional Laparoscopic Surgery and Robotic Assisted Laparoscopic Surgery

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Documenting consent

Georgie Haysom
Head of Research, Education and Advocacy, Avant

In the October edition of eScope we wrote an article titled "Consent in 2018 – do I need a lawyer in the room?"[1]. Key aspects of the consent process include ensuring patient understanding and documenting the consent discussion. In this article we consider the use of written material to support the consent discussion, and outline the importance of documenting the consent process for you and your patient.

A mismatch of expectations

As we noted in our previous article, many claims and complaints against practitioners involving consent arise from a mismatch of expectations or a lack of understanding about the procedure and potential risks and complications. If a patient has not understood the limitations of treatment, or potential postoperative symptoms to expect, it is not uncommon for them to be unhappy with the outcome and to complain the procedure was performed poorly.

In many of the cases in which we have been involved, a patient bringing a complaint or claim may be adamant that they were not told about a risk or complication, even in the face of a record noting that risks and complications were discussed. This anecdotal experience is supported by the literature in our previous article we noted an Australian study of 10,000 complaints and claims over seven years that found that in nearly 80%, the patient complained that a complication of treatment had not been mentioned or fully understood.[2]

The literature also confirms that patients' recollection and understanding of what has been said during a consultation is often low.[3,4] It has been reported that 40-80% of medical information provided to patients is forgotten immediately.[4] Various factors contribute to low recollection and understanding, including age, stress and anxiety, education and literacy levels and the mode of delivery of the information.[4,5]

What can you do to help your patient understand the information and recall it later?

Using written material to aid understanding

Brochures and information sheets about a procedure or treatment can be useful if given to the patient as means of stimulating discussion and as a guide for you to use when talking to the patient.

The use of diagrams, models, handouts and language appropriate to your patient's education or ethnic background can improve their ability to retain information and understand.

Written material should not however be used as a substitute for that discussion or taken as grounds for assuming that the patient understands the nature of and the risks involved in the procedure. The provision of written information will not by itself discharge a medical practitioner's legal duty to disclose.

Provide the patient with a copy of any written material or diagrams or illustrations you have drawn during the discussion.

Documenting the consent process

Another advantage having good written material to assist patients understand the procedure is that this can help provide a record of what was discussed.

Keeping good medical records is a key component of professionalism, to facilitate good patient care. The Medical Board of Australia's Good Medical Practice Code of Conduct includes the requirement to keep: "accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners." (clause 8.4)

Make a detailed record of your discussions in the record, and in your correspondence back to the referring practitioner. This should not simply state 'discussed the pros and cons' but include details of the specific risks and complications discussed and any particular concern raised by the patient.

The use of standard paragraphs for your more common procedures may save time but should also reflect your discussions with that particular patient. Some practitioners dictate the correspondence while the patient is in the room. It is good practice to send a copy of any correspondence to the patient as well. Alternatively write to the patient confirming your advice, and their agreement, and copy the letter to the referring practitioner.

Make a note of any written material provided to the patient in the medical record, or better still, keep a copy of the material provided, including any diagrams you have drawn, in the record.

Keeping good records can have the added benefit of helping to protect you if a complaint or claim arises in the future. As the Supreme Court of NSW recognised[6] "The records are likely to be a far more reliable source of truth than memory. They are often the only source of truth."

[1] Le Goullon, J. Consent in 2018 – do I need a lawyer in the room? AGES eScope 2018;68 (October) 32-3
[2] Gogos, AJ et al. When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints. Medical Journal of Australia. 2011;195(6):340-4
[3] Sherlock A and Brownie S Patients' recollection and understanding of informed consent: a literature review ANZ J Surg 84 (2014) 207-210
[4] Kessels R Patients' memory for medical information J Royal Society of Med 96 May 2003 219-222
[5] Schubbe D et al Does pictorial health information improve health behaviours and other outcomes? A systematic review protocol BMJ Open 2018; 8:e023300.
[6] Albrighton v Royal Prince Alfred Hospital: [1980] 2 NSWLR 542

3004 12/18 (0977)

JMIG Summaries

Summaries by Sean Heinz, Andrew McIntyre and Stanley Santiagu

J Minim Invasive Gynecol. 2018 Nov-Dec; 25(7):1255-59.

Predictors of Long-Term NovaSure Endometrial Ablation Failure.

Lybol C, Coelen S, Hamelink A, Bartelink LR, Nieboer TE.

Heavy menstrual bleeding (HMB) is a common concern for women, with up to one-third of premenopausal women experiencing HMB at some stage in their reproductive life. HMB can have a significant impact on a woman's health and quality of life (QoL). In women who have completed their family and wish to avoid major surgery, endometrial ablation presents a good option. The NovaSure device by Hologic Inc. is a widely used system for endometrial ablation. The NovaSure is a disposable, bipolar device with a radio frequency controller. The device is automatically switched off when the impedance equivalent to that of ablated superficial endometrium is reached. Success rates for the procedure are quoted at up to 80%. However, further surgical intervention is required in up to 20%.

This retrospective multi-centre cohort study aimed to establish independent predictors for failed NovaSure endometrial ablation. Enhanced procedure pre-selection could improve success rates, reduce re-intervention, healthcare costs and minimise risks to patients. Investigators reviewed data from patients who underwent NovaSure endometrial ablation from 2008 to 2014 at two teaching hospitals in the Netherlands. All 486 included patients had a transvaginal ultrasound scan (TVS) before the procedure. Additional investigations included saline sonohysterography in 16% and pre-ablation hysteroscopy in 45%. Features noted on these investigations included intramural leiomyomas, adenomyosis, endometrial polyps, leiomyomas protruding into the uterine cavity and any anatomical abnormalities of the uterus. Average follow up was 45 months.

Following ablation, 94 patients returned with ongoing complaints:

- 34 with recurrent HMB; 24 with recurrent or de novo pelvic pain; and, 36 with both

Predictors for failed NovaSure endometrial ablation following univariate analysis included:

- **Younger age:** Odds Ratio (OR) = 0.96; 95% Confidence Interval (CI), 0.92–0.99; p = .031
- **History of sterilization:** OR = 2.19; 95% CI, 1.34–3.57; p = .002
- **Presence of dysmenorrhea:** OR = 3.70; 95% CI, 2.31–5.92; p < .001
- **Intramural leiomyoma on TVS:** OR = 2.23; 95% CI, 1.27–3.93; p = .005
- While not statistically significant, patients with a smaller uterine cavity width were more at risk for failure: OR = 0.72; 95% CI, 0.53–0.98; p = .039

There were 89 patients (of 94 patients with ongoing symptoms) who required a second treatment:

- 53 had hysterectomies; 17 required gonadotrophin-releasing hormones; 16 received other hormonal treatments, and 3 had repeat ablations
  - Of the 53 hysterectomies, adenomyosis was found in 40% on final histopathology despite not being suspected on initial investigations

Limitations of the study include that it is a small retrospective cohort study with the potential for insufficient power as well as recall and response bias. Also, procedures were performed by a variety of clinicians from registrars to consultants with no data on the number of procedures performed by each operator. →

JMIG Summaries cont

Summaries by Sean Heinz, Andrew McIntyre and Stanley Santiagu

J Minim Invasive Gynecol, 2018. 25(7): p. 1165-1178.

Managing Postoperative Pain After Minimally Invasive Gynecologic Surgery in the Era of the Opioid Epidemic.

Wong M, Morris S, Wang K, Simpson K.

The opioid crisis in the United States resulted in more deaths from overdose in 2014 than in any other year on record. Epidemiological data indicates that the lifetime rate of non-medical prescription opioid use is 11.3%, however the rising opioid addiction has coincided with medical providers prescribing more post-operative pain medications. While the rate of persistent post-operative opioid use is lower for minimally invasive gynaecological surgery (MIGS) than other major surgeries, 1.5% of opioid-naïve patients undergoing laparoscopic hysterectomy (LH) continue to use opioids for more than 90 days post-operatively. Beyond the risks of misuse and dependence, prolonged opioid administration may delay discharge from hospital due to side effects including nausea, vomiting, pruritus and constipation. This review article assessed the evidence behind various interventions that gynaecologists may use to minimise reliance on post-operative opioid analgesia.

Paracetamol and non-steroidal anti-inflammatories (NSAIDs) are both opioid-sparing, the latter particularly when given for 3-5 days post-operatively, and concurrent use has a synergistic effect. Anti-epileptic medications such as gabapentin and pregabalin inhibit excitatory neurotransmission associated with pain sensation. Pre-operative use has been shown to reduce opioid requirement by 20-60% at 24 hours post-operatively, however more research is required with regards to continued post-operative use. Dexamethasone given pre-operatively also reduces opioid consumption following LH, along with post-operative nausea and vomiting. More broadly, its use increases blood glucose levels without increasing rates of infection. Alpha-2 adrenergic agonists (such as clonidine) and NMDA receptor antagonists (such as ketamine) have been shown to effectively reduce post-operative pain, however their use is limited by potential side effects.

Epidural and spinal anaesthesia are effective after abdominal surgery, however evaluation in MIGS is currently lacking. Peripheral nerve block in the transversus abdominis plane (TAP) between the internal oblique and transversus abdominis muscles, under ultrasound guidance or direct visualisation, has mixed but mostly positive reports, particularly when placed pre-operatively. Paracervical block with bupivacaine reduces post-operative pain and opioid use following vaginal hysterectomy. Intraperitoneal instillation and subcutaneous infiltration of local anaesthetics may reduce post-operative pain scores, however more research is required to determine whether this translates to reduced opioid intake. While pre-incisional infiltration is thought to block the nociceptive stimulus, the evidence seems to favour wound infiltration at the time of skin closure.

Surgical technique plays an important role in reducing post-operative pain and the evidence supports the adoption of a minimally invasive approaches over laparotomy. Reducing laparoscopic trocar size plays a role in this, and comparison of LH performed with 5mm versus 10mm umbilical ports resulted in reduction in operative time and pain on post-operative days 1 and 7. The evidence does not yet extend to 3mm percutaneous instruments without trocar. Single port surgery allows all instruments to pass through a single 2-3cm umbilical gel port, however the available evidence does not show a reduction in post-operative pain compared with traditional laparoscopy. Bipolar vessel sealing devices reduce operating time and post-operative pain following vaginal hysterectomy, however superiority of any one device has not been demonstrated for LH.

With regards to gas insufflation, the most recent reviews show that the benefits of warm, humidified gas insufflation are minimal. Operating at lower intraperitoneal pressure reduces abdominal wall distension and shoulder pain without change in post-operative opioid use, and with risk of increased blood loss and operating time and worsened view of the operative field. Evacuation of the pneumoperitoneum at the end of the case by any method is beneficial. Such methods include passive deflation through open trocars, extended positive pressure ventilation, and displacement by instillation of saline. →

JMIG Summaries cont

Summaries by Sean Heinz, Andrew McIntyre and Stanley Santiagu

Enhanced recovery perioperative programs adopt multidisciplinary and multimodal approaches to optimise patient recovery. Despite robust data in other specialties, these protocols have been less widely adopted in gynaecology but have nevertheless shown promising results. One MIGS case-control study identified a 51.5% decrease in length of stay, cost savings of 9.25% and no difference in the rate of re-presentation or re-admission. In the midst of the current opioid crisis, it is imperative for surgeons to use these multimodal tools to minimise patients need for opioid pain medication.

J Minim Invasive Gynecol, 2018. 25(7): p. 1002-1008.
Comparison of Long-Term Fertility Outcomes after Myomectomy: Relationship with Number of Myomas Removed.
Shue S, Radeva M, and Falcone T.

Myomectomy is a commonly performed procedure for those of childbearing age with symptomatic myomas who wish to preserve their fertility. Multiple studies have shown that myomectomy for removal of submucosal myomas significantly improves fertility rates, but the patients in these studies only had 1 to 6 myomas removed. Improved pregnancy rates do not necessarily correlate to successful pregnancies in women frequently seen with many myomas (>6) who receive a myomectomy. This may be because women who get a single myoma removed rarely have their tumour recur. In contrast, women who get multiple myomas removed may quickly develop several more tumours within a few months

This was a retrospective cohort survey study to determine if the number of myomas removed during myomectomy for symptomatic relief affects long- term fertility outcomes in reproductive-aged women. One hundred forty-four patients who underwent robotic, laparoscopic, or abdominal myomectomy for symptomatic myomas and attempted to conceive afterward were included. Patients with >6 myomas removed were less likely to achieve pregnancy after myomectomy than patients with ≤6 myomas removed (22.9% versus 70.8%, respectively; $p < .001$). To achieve pregnancy, 45% of those with >6 myomas removed versus 17.6% of those with ≤6 myomas removed relied on fertility treatment. Of those with >6 myomas removed who became pregnant, 45.5% had a term birth, 45.5% miscarried, and 9.1% had an ectopic pregnancy. Of those with ≤6 myomas removed who became pregnant, 61.8% had a term birth, 23.5% had a preterm birth, and 13.2% miscarried.

Recall bias is a limitation of this study. Although it was controlled for confounding factors by excluding those with other known causes of infertility, comprehensive data regarding ovarian reserve or sperm concentration and motility were not available. The locations of the myomas were not stratified because most patients had myomas in all locations (submucosal, subserosal, intramural). The results may not be representative of all women with multiple myomas as the data only included women who can afford to have a myomectomy performed. Finally, although there was a relatively large sample size of 144 patients overall, some of the study groups were too small to reach statistical significance.

In conclusion, the number of myomas removed during myomectomy significantly affects fertility. Women with >6 myomas removed were less likely to become pregnant, more likely to require fertility treatment, and less likely to have a term birth when compared with women with ≤6 myomas removed. Although the current literature suggests that myomectomy improves fertility, as per the results of this study, this is not

necessarily true for women with >6 myomas. Increasing number of myomas removed is associated with increased intraoperative complications which may outweigh the fertility benefit for these women.

Surgical Performance VER3 is live!

Andreas Obermair

SURGICALPERFORMANCE HAS SWITCHED TO VERSION 3

SurgicalPerformance VER2 has been successfully in use since 2012. Since then, several new software features have become available, opening possibilities to improve the experience of our SurgicalPerformance users. Additionally, for some existing features support and updates were no longer available.

Introducing version 3 of Surgical Performance.

While we realize that all software upgrades come with change and inconvenience, the new possibilities that come along with VER3 and the lost opportunities we would have accepted in VER2 helped convince us of the need for an upgrade.

Two years in the making, we looked at every aspect of the system and created a brand-new user experience that makes it easier and faster to use SurgicalPerformance. VER3 was launched at the end of 2018.

Aside from a number of small improvements across the entire experience, the key new areas in the update are:

- Phone and tablet data entry ("data entry on the run")
- Faster entry of multiple procedures for one patient
- New interactive user support system - Intercom

Mobile phone and tablet data entry – Enter data on the go

The SurgicalPerformance website is fully responsive. This means that we provide an optimal viewing experience—easy reading and navigation with a minimum of resizing, panning, and scrolling—across a wide range of devices, no matter what device you use – from mobile phones to desktop computer monitors. The dashboard and records screens work perfectly on all modern devices whether you are on a tablet, phone or desktop.

The phone and tablet data entry is available to premium subscribers only. Lite users can still enjoy the new version on Desktop.

Real-time validation: We are now able to validate data as you enter them in the background, rather than waiting for a record to save. This makes entry faster and gives instant feedback.

New tag fields: The massive checkbox groups have been streamlined into tag fields making it easier to enter data, allowing you to click and choose from the dropdown, or type values with autocomplete and full keyboard access to enter multiple values rapidly. →

Surgical Performance VER3 is live! cont.

Andreas Obermair

Adding multiple procedures for one patient

Sub-records for gynaecological procedures are now available in the new version of SurgicalPerformance. When entering a new record, you have the option of saving and adding a related record. This new record will inherit the patient information from the original record helping you save time.

To add a sub-record, ensure that the first gynaecology procedure form is filled in, and click the '+' icon next to the Save Record button (see screenshot above).

This is useful if you have a patient who has a procedure (e.g., hysteroscopy D&C) plus another procedure. In the past, you needed to complete patient details twice. Now you only need to click '+' and the new patient record will have patient information from the first procedure prepopulated.

Each procedure still counts as a record and you still earn RANZCOG PRA points.

Alternatively, you can add **New Sub-records** directly from the records table in "Gynaecology" using the actions column.

We hope this feature will make data entry a little faster and more efficient.

New support and feedback options

We now have support with live chat built into the bottom right corner of every page. If you have any issues you can report it and get help directly within the system. No need to phone us or email us. Any chat is recorded and we will get back to you as soon as we have someone available to help.

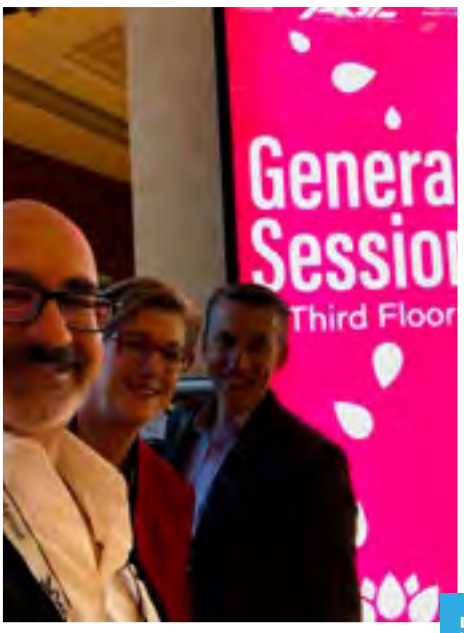
I hope that you will enjoy the new SurgicalPerformance features as much as many others in Australia and overseas do. For comments, please drop us a line at support@surgicalperformance.com

Andreas Obermair

NB: Let's catch up at our booth at the AGES conference in Perth. I look forward to seeing you there.

AGES at AAGL

AGES was well represented at the 47th American Association for Gynecologic Laparoscopists Global Congress on MIGS held in Las Vegas in November.



Save the date

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

XXIX
MARCH 7–9 2019
Crown Perth
"Professionalism, Perfection and Problems"

Australasian Gynaecological Endoscopy & Surgery
CADAVERIC WORKSHOP

Laparoscopic Anatomy Pelvic Dissection (LAP-D) Workshop
MAY 25 2019
Medical Engineering and Research Facility (MERF), Brisbane

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES/WES Focus Meeting
AUGUST 2–3 2019
Grand Hyatt, Melbourne

Australasian Gynaecological Endoscopy & Surgery
CADAVERIC WORKSHOP

Laparoscopic Anatomy Pelvic Demonstration (LAP-D) Workshop
AUGUST 17 2019
Medical Engineering and Research Facility (MERF), Brisbane

Australasian Gynaecological Endoscopy & Surgery Society Limited
PELVIC FLOOR SYMPOSIUM

NOVEMBER 1–2 2019
Sheraton on the Park, Sydney

Australasian Gynaecological Endoscopy & Surgery
CADAVERIC WORKSHOP

Laparoscopic Anatomy Pelvic Dissection (LAP-D) Workshop
NOVEMBER 30 2019
Medical Engineering and Research Facility (MERF), Brisbane

Australasian Gynaecological Endoscopy & Surgery
AGES/RANZCOG TRAINEE WORKSHOP

JUNE 22-23 2019
Brisbane

AGES Clinical Research Grant 2019 Recipients

Congratulations to the successful applicants of the 2019 AGES Clinical Research Grants. Thank you to Stryker for their continued support of this initiative.

SUBMITTER	AWARDED AMOUNT	PROJECT NAME
Anusch Yazdani	$20,384.00	The 100 Women Study: A prospective randomised controlled trial of in vitro fertilization versus surgery and tubal flushing for infertility
Charlotte Reddington	$7,292.00	Intra-operative intravenous tranexamic acid during laparoscopic surgery for severe endometriosis – a double-blinded randomized placebo-controlled trial
Mary Louise Hull	$28,000.00	Genetic Diagnosis after Medical and Surgical Management of Miscarriage
Jason Abbott	$14,324.00	A Double Blinded, Multi-Centre, Placebo Controlled Randomised Trial on The Efficacy of The Monalisa TouchTM Procedure for The Treatment of Vaginal Atrophy Symptoms

AGES Travelling Fellowship Applications Open

Applications are now open for the AGES Travelling Fellowship in 2019.

This Fellowship will be awarded at the AGES XXIX Annual Scientific Meeting 2019 to AGES Members who are Trainees or Fellows, within five years of graduation.

For further detail and to submit your application please visit the AGES website http://ages.com.au/members/awards-and-fellowships

AGES Travelling Fellowship - AUD $7,500
Applications close COB Friday 15th February.

AGES Membership 2019

Renew your membership now to continue to receive your AGES benefits in 2019.

Take advantage of the discounted registration fee for all three major 2019 AGES Meetings, as well as exclusive member's only Interactive Hub Sessions and Cadaveric Workshops.

Membership benefits include:

- Attend all three AGES Meetings in 2019 for only $1,500.00, saving of up to 50% per meeting. Only applicable for 3+ year members (closed 31st January 2019).
- Savings of up to 15% on member registration fees for AGES meetings.
- Exclusive access to the new "AGES Video Library – Members only".
- Eligibility to register for the AGES Cadaveric Laparoscopic Pelvic Anatomy Dissection & Demonstration Workshops
- Eligibility to register for the AGES Interactive Hubs.
- Eligibility to apply for AGES Research Grants.
- Complimentary subscription to SurgicalPerformance self-auditing Software and AGES/ SurgicalPerformance webinars, for more details, click here
- Complimentary subscription to the Journal of Minimally Invasive Gynaecology (formerly AAGL Journal).
- Option to subscribe to the International Urogynaecology Journal instead of JMIG for an additional fee^.
- AGES electronic-newsletter, eScope, published four times annually.
- Eligibility to register for the "Who do you want to be when you grow up" Seminars.
- Member access to AGES website and resources.
- Downloadable "AGES Member Icon" available for use in signature blocks and websites.
- Listing on the Membership Directory of the AGES website.
- Eligibility to apply for a position in the AGES Training Program in Gynaecological Endoscopy

To renew your membership online or to update your details, please use the following link: AGES MEMBERSHIP 2019.

Dates for Laparoscopic Workshops

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.

2019 Courses:

CARE Masterclass in Hysterectomy, Myomectomy and Adnexal Surgery: March 18-22
CARE Masterclass in Complex Endometriosis Surgery: August 5-9
CARE Masterclass in Hysterectomy, Myomectomy and Adnexal Surgery: October 20-November 1

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 2019

AT THE SYDNEY WOMENS ENDOSURGERY CENTRE (SWEC) AT ST GEORGE HOSPITAL SYDNEY. COURSE DIRECTOR: ASSOC PROF GREG CARIO

We invite you to participate in our advanced gynaecological laparoscopy course which has been running for the last 20 years. This 5 day course is aimed at consultants and registrars keen to develop laparoscopic skills, refresh their pelvic anatomy, and broaden their repertoire of laparoscopic surgery. It is also useful for those looking for an introduction to Robotic surgery. You will have exposure during live surgery to 5 different advanced laparoscopic surgeons and see their different styles and approaches for TLH, fibroids, endometriosis, pelvic floor reconstruction and incontinence surgery.

Comprehensive Course Curriculum:

- Laparoscopic pelvic anatomy instruction.
- Dry lab training concentrating on curved needle suturing.
- Robotic hysterectomy workshop.
- Endometriosis workshop.
- Live operating sessions running over 4 days with the opportunity to assist following pre-workshop accreditation.
- Live animal workshop.
- 43 CPD points (practice improvement points may also be claimed).
- Small group participation of 8 – 10 registrants per course.

2019: March 18-22, June 3-7 and October 14-18
2020: March 16-20, June 1-5 and October 12-16

Register on-line at www.swec.com.au
or contact our course administrator at: sweconline@gmail.com or
Assoc Prof 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.

2019 Course Dates: March 19-20, August 13-14, October 9-10

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

Dates for Laparoscopic Workshops cont

ADVANCED LAPAROSCOPIC GYNAECOLOGICAL WORKSHOP
ST JOHN OF GOD HOSPITAL SUBIACO

COURSE DIRECTOR
DR STUART SALFINGER

A two day clinical immersion aimed at surgeons performing laparoscopic gynaecological surgery who wish to extend their skill set and knowledge of advanced minimally invasive techniques. Candidates will work with two certified Gynaecological Oncologists over the two days running in two theatres. The course aims to provide maximum operation experience to participants. They will have the opportunity to scrub in and be 1st and 2nd assist. The case load is 85% laparoscopic predominantly with exposure in total laparoscopic hysterectomy.

2019 Course Dates:
on application.

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

FLINDERS PRIVATE ENDOGYNAECOLOGY
XXI MASTERING LAPAROSCOPIC SUTURING WORKSHOP "MASTERING LAPAROSCOPIC SUTURING 2018"

2019 Course Dates: 29-30 August 2019
Flinders Private Hospital, Adelaide

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

LAPAROSCOPIC SURGERY FOR GENERAL GYNAECOLOGISTS
SYDNEY LAPAROSCOPIC WORKSHOPS 2019

WORKSHOP CONVENORS:
A/PROF G. CONDOUS (Nepean),
DR T. CHANG (Campbelltown)

DR N. CAMPBELL (RPAH)

Our intensive 2 day laparoscopic course (limited to 8 places) is aimed at helping the generalist and registrars up skilling and becoming confident at performing common, day to day laparoscopic procedures. The course is intended for those with an interest and has a basic skill base for laparoscopy including suitable for Trainees and well as Fellows.

LASGEG highlights:

- **DAY 1**
  - Live operating: endometriosis/cystectomy/oophorectomy/hysterectomy/ureterolysis
  - Theory of laparoscopy: instrumentation/setup/energy/entry techniques/anatomy/operative techniques/complications
  - Dry lab
- **DAY 2**
  - Full day live pig operating
  - 2 participants max per sheep
  - One to one hands on step by step guidance on how to perform laparoscopic procedures

2019 Course Dates:
29-30 April 2019 (Campbelltown Private and Kolling Institute RNSH);
27-28 October 2019 (Nepean Public and Kolling Institute RNSH)

Course fees:
fellows $2000, Registrar $1350 (limited places)

For further information contact:
Nicole Stamatopoulos: nic96@hotmail.com
Website: www.lasgeg.com

Contact Stephen Lyons (**stephen@drlyons.com.au**) with your contribution
Deadline **14th June 2019**