Volume 75 June 2021

escope

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

EDITION HIGHLIGHTS:

TOGETHER TOWARDS TOMORROW

President's Letter

"Engagement & Inclusion Through Education"

Dear AGES Members,

It is with great pleasure that I write my first eScope communication to you as the 10th AGES President.

I firstly wish to acknowledge the out-going AGES Board Members of 2019-2021, Krish Karthigasu (Treasurer) and Martin Ritossa (Director), both of whom have had two stints on the Board, and Rachel Collings (Trainee Representative) – their dedication and hard work on the Board, especially over the last year when the COVID-19 pandemic was unfolding, is much appreciated and their collegiality and camaraderie will be missed. Jason Abbott's time as Immediate Past-President has also come to an end (using Jason's own terminology, I think that makes him a "Dead President"!), although that doesn't mean that I won't call on him from time-to-time to take advantage of his wisdom and counsel. Your contribution to AGES is much appreciated, Jason!

As Stuart Salfinger takes up the role of Immediate Past-President, it would be remiss of me not to highlight a few of the notable achievements of his Presidency. Registrations at both the AGES ASMs were sensational numbering 433 at Perth in 2019 (easily a record for a non-Sydney/Melbourne ASM) and 502 at Sydney in 2020 (the best ever attendance at an AGES ASM) – both of these results underscore the health, enthusiasm and resilience of our society. You will all remember well the uncertainty and trepidation that was born out of the arrival of the pandemic. Stuart was quickly out of the blocks releasing AGES guidelines on decreasing the risk of COVID-19 transmission during gynaecological endoscopic procedures, and on categorisation of gynaecological procedures according to urgency (when elective surgery was abruptly cancelled). But perhaps the best indicator of the health of AGES at the end of Stuart's Presidency was that the AGES Membership actually increased significantly in the period from February 2020 to February 2021, that is during the worst of times of COVID in Australia and New Zealand – this achievement suggests the suite of AGES Zoom education meetings and the virtual and the hybrid AGES Focus and Pelvic Floor meetings during this period resonated with a membership that had very limited opportunities to meet face-to-face. I think it is fair to say that Stuart's leadership, especially during COVID, was steadfast, despite the fact that the limited opportunities for the President to meet and mingle with the membership was no doubt very frustrating. Stuart will take over from me as the of Chair of the Education Sub-Committee, and I look forward to his advice and counsel throughout my Presidency.

The AGES Board for 2021-23 has not seen a large turnover in personnel. The AGES Executive include Rachel Green (Vice-President), Bassem Gerges (Honorary Secretary) and Michael Wynn-Williams (Treasurer). Fariba Behnia-Willison, Kirsten Connan and Helen Green continue in their roles as Directors, and the new Directors include Jade Acton (having completed two years on the Education Sub-Committee), George Condous and Emma Readman (returning for her second stint on the Board). Kate Martin comes onto the Board as the Trainee Representative. I think as a society we are very fortunate to have an incredibly diverse board with at least one Board member from every state of Australia, as well as Board member from New Zealand. Even more importantly, for the first time in the history of AGES we have a clear majority of female over male board members (6 to 4, or 7 to 5 if you include Kate and Stuart [the non-voting Board members]). Clearly this a great achievement for the society and for its Membership, perhaps a defining moment for AGES.

For the remainder of this communication, I will share my vision for AGES over the next two years. I would like to remind all Members that AGES is the premier surgical association representing gynaecologists in Australia and New Zealand and has been for over 25 years now. →

President's Letter cont.

With over 800 active members, AGES is also one the largest and most active of the surgical societies in the southern hemisphere, and is the largest gynaecological society. The Mission Statement of AGES reads as follows:

> *"AGES aims to improve the health and quality of life of women.*
> *Its members come together to advance gynaecological surgery and associated fields by providing education, training, research opportunities, standardisation and innovation."*

The primary role of the AGES Board is, therefore, to guide the society in achieving these aims.

I see several "dark clouds on the horizon" that may impact on AGES' capacity to live up to its Mission Statement. Firstly, there is no doubt that 2020 and the time of COVID was, and continues to be, a very difficult time for AGES, its Members and sponsors, most obviously manifested as a major disruption to the usual face-to-face meetings and workshops. Not only is the educational experience affected but also our relationships with other AGES Members, both friends and colleagues alike. Secondly, the makeup of AGES Members is diverse and is ever changing. It is a core responsibility of AGES to offer and oversee a two-year program of advanced training in gynaecological surgery, the AGES Accredited Training Program. There are now more than 50 graduates of this program, currently a small but ever-increasing proportion of the AGES Membership. What can't be forgotten, however, is that it is also a core responsibility of AGES to provide education for all Members, whether it be the obstetrician who only occasionally performs gynaecological procedures, the generalist obstetrician & gynaecologist or the more advanced gynaecological surgeon.

I believe AGES is a Society that can continue to re-invent itself to accommodate and engage *all* AGES members, in all their various guises. My vision for AGES over the next two years, therefore, is a simple one – *to promote engagement and inclusion through education*. The existing AGES Board Committee's activities will change tack where necessary to help to achieve this aim. Further, I have introduced three new AGES Sub-Committees (non-AGES Board). Firstly, the *Diversity, Equity & Inclusion Committee* chaired by Kirsten Connan will celebrate, embrace and protect the individual and the ongoing changes in the AGES Member population. Secondly, Bassem Gerges will chair the *AATP Graduate Engagement Committee*. The AATP Graduates should be celebrated but with that status carries a responsibility to remain in the AGES family and continue their life-long surgical education with one another, and other AGES Members. Finally, I will chair the AGES Member Mentorship Committee, the role of which is to engage Members through regular virtual presentations on core education topics, and to establish a surgical mentorship program whereby new procedures may be adopted and proctored with teaching from other AGES Members, whether by face-to-face attendance at surgeries or surgical video review. I will expand on this vision for AGES in a keynote presentation at the AGES ASM at the Gold Coast in July.

In conclusion, I consider serving the Society as President as a privilege, but one that also carries a great responsibility that I take very seriously. If you have any suggestions, queries or concerns about the progress of AGES, your Society, please do not hesitate to contact me through the AGES Secretariat or directly by email (president@ages.com). I sincerely hope to see many of you, ideally in person, at the AGES ASM in July in sunny Queensland.

Stephen Lyons
AGES President

Editorial

Dear AGES Members

Welcome to the 75th edition of eScope.

It's with great pride that I take over the reins of editor from Dr Stephen Lyons. This edition marks the start of a new term for the Board of AGES. I welcome all our board members, both those returning, and those new. I see a diverse board with many specialty interests and backgrounds represented. As Steve has noted in his president's letter, we have achieved significant gender balance on our board. I hope we can serve our membership well.

As a society, we have strived to continue to provide high quality education to our membership. Although large face to face meetings have been challenging, we adapted our FOCUS meeting to a new concept – that of a multi-site hybrid meeting. A summary of this innovative meeting has been provided by the chair and new Honary Secretary – Bassem Gerges and is included in this edition of eScope. We also have a summary of last year's pelvic floor meeting from the joint scientific chair Dr Fariba Behnia-Willison. This meeting saw delegates join virtually, as well as round 50 in person in Adelaide. A memorable moment from this conference was from our international speaker Professor Karal Jallard taking the Q and A in his car having been urgently called into the hospital in Beirut! Something only possible by the Oh so modern virtual meeting!!!

The fellow article in this edition of eScope has been provided by Dr Rebecca Young and Dr Stephen Lyons. This article examines the relationship between Endometriosis and a possible diagnosis of Appendicitis. A common scenario for Gynaecologists in the evaluation of a woman who presents with right sided pelvic pain. Many thanks again to the SWAPS trainees for the JMIG summaries. Dr's Lowes, Vanza and Dahiya, these summaries save us all the time in reading and evaluating these articles.

Our profession development alliance partner, Avant have also provided an article on boundary issues in clinical care. As gynaecologists, we are amongst the more likely specialists to be involved in such a complaint, and this article provides some timely insight into this issue.

So, I hope, with all fingers and toes crossed, to see you all at the next face to face meeting at the Annual Scientific Meeting to be held at The Royal Pines resort on the beautiful Gold Coast from July 15th - 17th. This will be our first opportunity to catch up in person for over 16 months and I'm certain, like you all, am really looking forward to sharing time with colleagues. A copy of the scientific program is included in this edition of eScope. This meeting is chaired and curated by Michael Wynn-Williams with Drs Helen Green and Kirsten Connan taking the role as scientific chair. The program is exciting and innovative and should appeal to the whole AGES membership

Rachel Green
eScope Editor &
AGES Vice-President

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Laparoscopy for assumed appendicitis: A missed opportunity to diagnose endometriosis?

Rebecca Young, Stephen Lyons

The known:

- Patients with endometriosis often report having had an appendicectomy of a normal appendix prior to diagnosis.
- Studies demonstrate a lower positive histopathology rate in females for acute appendicitis than in males.
- A small number of patients have endometriosis found on histopathology of the appendix.

The new:

- This study confirmed a significant difference in appendicitis for males and females undergoing acute appendicectomy.
- Despite this there was a lack of documentation as to how the female pelvis was examined.
- Of those with normal appendiceal histopathology a large number had gynaecological pathology.

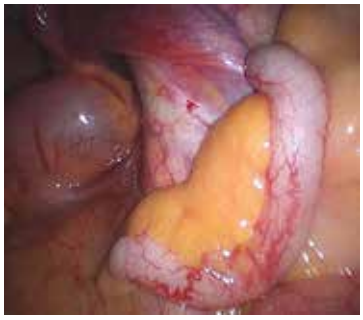
The implications:

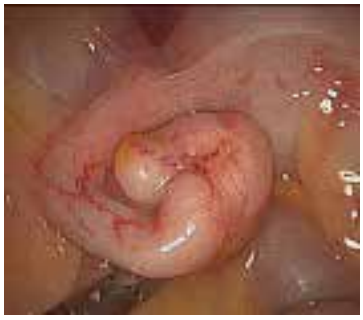
- Premenopausal females undergoing any laparoscopy should have the pelvis carefully examined for endometriosis and other gynaecological pathology.
- Involvement of gynaecology alongside surgical teams is required.
- Routine inspection of the appendix at gynaecological cases is recommended.

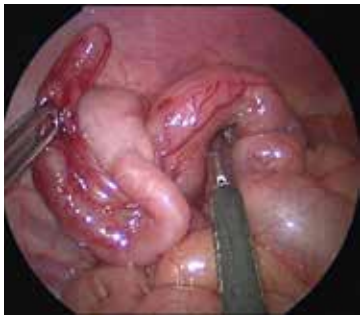
Introduction

There is currently an increasing awareness of the impact of endometriosis in Australia – both the symptoms women suffer and the costs to society in healthcare and lost productivity.[1] The incidence is estimated to be at least 10%, with variable clinical presentations. Most women present with pelvic pain or infertility, some are asymptomatic. Treatment is medical and surgical, with hormonal suppression of disease supported by time-appropriate excision or ablation. Diagnosis is confirmed by systematic review of the pelvis at laparoscopy, ideally with excisional biopsy for histological confirmation. Disease identified by careful inspection of the pelvis is then appropriately staged, with stages I – IV.[1-4] If the pelvis is not correctly inspected then endometriosis can remain unidentified. [5]

Many of our patients with endometriosis have reported a prior laparoscopy, without a diagnosis of the disease being made. This can occur at a laparoscopy for another condition, such as appendicectomy; or at a laparoscopy undertaken by a gynaecologist. It may be due to an incomplete view of the pelvis; a lack of ability to recognise endometriosis; or the possibility that endometriotic deposits were not present at that time. To appropriately view the pelvis, the patient should be placed in the Trendelenberg position. Ideally a uterine manipulator is used to elevate the uterus, and there is careful bowel retraction.[5] Diagnosis is important for appropriate long-term management, particularly in women with chronic pain, and has significant implications for fertility.[1-4]







Figures 1-3: A normal appendix, appendix affected by endometriosis, an inflamed appendix due to infection

Laparoscopy for assumed appendicitis: A missed opportunity to diagnose endometriosis? cont.

Rebecca Young, Stephen Lyons

Studies have also shown that endometriosis can present with symptoms similar to appendicitis.[6] This can occur due to endometriosis of the appendix or disease elsewhere in the pelvis.[6–9] For some women with endometriosis appendicectomy improves symptoms; however removal is usually performed only when disease of the appendix is visualised.[6,8] Existing evidence has demonstrated a lower positive histopathology rate for women with presumed appendicitis, thought to be due to gynaecological pathology.[10, 11] We set out to compare male and female histopathology rates of appendicitis in a tertiary centre, and examine more closely the reasons for any difference. We reviewed female cases over a two-year period to identify if appropriate gynaecological input occurred; the quality of pelvic review intra-operatively; and those that went on to have recurrent pelvic pain or a diagnosis of endometriosis.

Methods

This study used retrospective data analysis. All appendicectomies undertaken in a tertiary hospital in Sydney were identified for the two-year period from January 2016 to January 2018 by using electronic medical records coding data. Files were included if they were within the age range of 12 – 52 years at the time of appendicectomy. All cases done for an indication other than suspected acute appendicitis were excluded, as were females who were pre-menarchal or post-menopausal. All case notes were reviewed to ensure patients met criteria. There were 759 for the appropriate age range with 31 cases excluded (see Figure 4).

Histopathology results were reviewed to determine if appendicitis was confirmed. Comparison was made between rates of positive histopathology for male and female cohorts using the Chi-squared test. Operation reports and notes were read to document for all female cases whether there was intraoperative suspicion of appendicitis; if any significant gynaecological pathology was found intra-operatively; if pre/intra/postoperative gynaecological review occurred; the documented pelvic findings; and if patients re-presented to the local health district with pain. This was tabulated in Excel 2011 (Microsoft) for analysis. This project received ethics approval from the Northern Sydney Local Health District Human Research Ethics Committee.

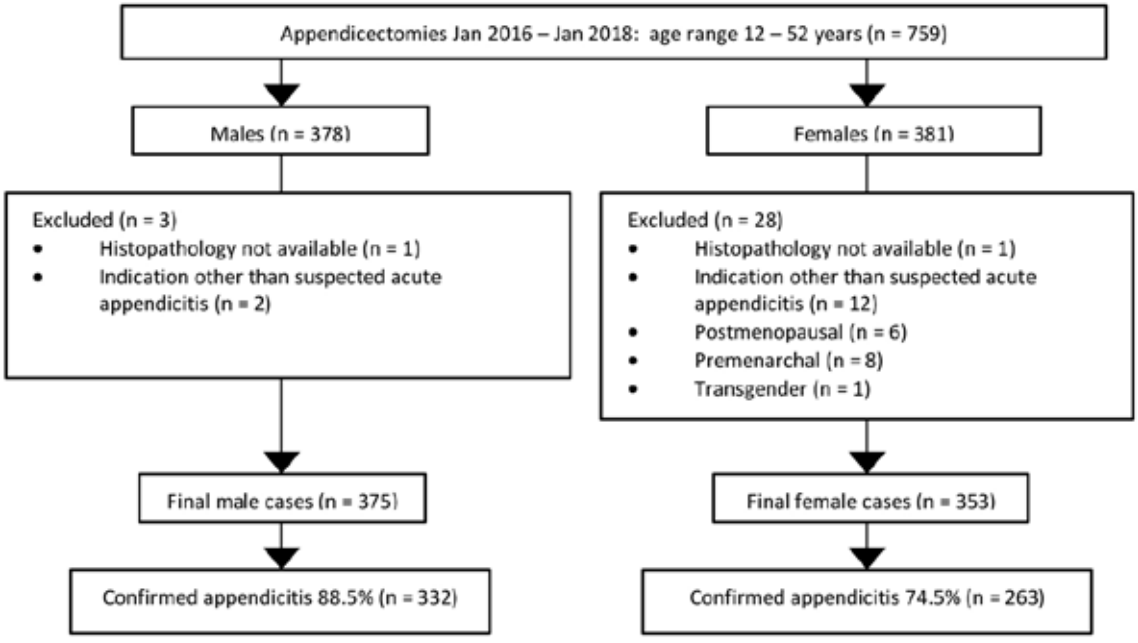


Figure 4: Inclusion and exclusion criteria

Laparoscopy for assumed appendicitis: A missed opportunity to diagnose endometriosis? cont.

Rebecca Young, Stephen Lyons

Results

Histologically confirmed appendicitis was present in 74.5% of female patients (263/353) compared to 88.5% of males (332/375). This is a statistically significant difference of 14% p<0.001 (CI 8.4% – 19.6%). When a female patient was thought to have appendicitis intra-operatively this was correct in 95.5% of cases (256/268). There were 64 cases of gynaecological pathology documented on either histopathology or intraoperative findings, of these 5 had preoperative gynaecological review and 13 intraoperative gynaecological review.

Those with appendicitis had gynaecological pathology noted intra-operatively by the surgical team in 6.8% (18/263) of cases. This compared to 48.9% (44/90) of those without appendicitis. When the surgical team did not have an impression of appendicitis intra-operatively, or was unsure, 46.4% (39/84) had documented gynaecological pathology. Only 16 of these 84 had full documentation regarding visualisation of pelvic anatomy (uterus, tubes and ovaries bilaterally). Only 10 had intraoperative gynaecological review, with 11 seen post-operatively.

There were two cases of endometriosis on histopathology of the appendix, one in each group. Neither had endometriosis noted intra-operatively or re-presented. Six patients received subsequent treatment via our service for suspected or confirmed endometriosis, of these two had intraoperative review by gynaecology (without biopsies taken). 10 patients re-presented with pelvic pain; 7 of these were due to dysmenorrhoea or dyspareunia. Table 1 on the following page outlines cases of particular interest. Overall the documentation of female pelvic findings was poor. There was no documentation in 57.5% (203) and partial findings in 31.7% (112). No cases specifically documented techniques undertaken to better visualise the pelvis, even those where intraoperative gynaecology review occurred.

Discussion

Our study confirmed a difference in male and female positive histopathology rates, similar to previously published studies.[10, 11] It also showed that a significant number of women undergoing appendicectomy have gynaecological pathology. Although we were unable to ascertain if pathology was causal and the reason for presentation or incidentally noted by the surgical team, we were able to demonstrate that the rate of gynaecological pathology was much lower in those with proven appendicitis. It was also clear that the surgeons had a high success rate for determining intra-operatively whether appendicitis was present. Despite this there were low numbers of intraoperative and postoperative gynaecology reviews requested. It was often also unclear from the documentation if patients were informed of gynaecological pathology found. Although there were only 6 patients who underwent subsequent treatment for suspected or confirmed endometriosis via our service (1.7%), there were several limitations to the identification of patients with disease. As a retrospective study we relied on the documentation in the notes. We were also limited to patients presenting to the local health district for further care, some may have re-presented elsewhere. Notes were reviewed 12 months to 3 years from the original operation dates; some may be yet to re-present.

There was a clear lack of documentation in the surgical notes regarding visualisation of the pelvis. For most women this was omitted entirely. Other documentation commented only on pathology that was found. This was the case even when there was no evidence of acute appendicitis intra-operatively. This does not necessarily mean that the pelvis was not fully visualised for these patients, possibly just that the documentation was poor. Most operation reports were written by registrars; some by more junior members of the team. No cases specifically documented techniques undertaken to better visualise the pelvis, even those where intraoperative gynaecology review occurred. Common practice during diagnostic laparoscopy is insertion of a uterine manipulator and positioning of the patient in trendelenburg.[5] Insertion of a manipulator allows elevation of the uterus to expose the cul-de-sac, often a site of endometriosis.[12]

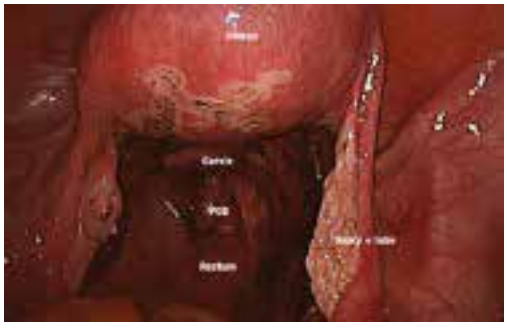


Figure 5: Complete view of the female pelvis, unobscured by bowel and with uterine elevation

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Laparoscopy for assumed appendicitis: A missed opportunity to diagnose endometriosis? cont.

Rebecca Young, Stephen Lyons

Table 1 outlines cases of particular interest. 3 patients (ages 15, 20 and 30) were all documented as having possible endometriosis. Despite this they were not referred to gynaecology either intra-operatively or post-operatively. There are significant implications of being incorrectly diagnosed with endometriosis, as well as implications if disease was present and these patients were not managed or followed up. These cases also demonstrate that although photos can be helpful, they are not ideal practice. A 30-year-old awaiting a laparoscopy for infertility should have had gynaecology present at her appendicectomy instead of only having photos taken. These photos were found to not be helpful for her case when seen at post-operative review and her pelvis had been incompletely viewed. These cases highlight the need for closer multidisciplinary care.

Table 1: Cases of interest

AGE	CASE DETAILS
15	Documented as having possible endometrial deposits. Pictures taken however there was no referral to gynaecology. HP of appendix NAD
20	Endometriosis on the right pelvic sidewall and posterior the uterus described on the operation report. She was not referred to gynaecology until a GP referral two months later due to dysmenorrhoea, after which an intra-uterine device was inserted. HP of appendix NAD
25	Normal intraoperative findings. Seen 15 months later by gynaecology due to three years of pelvic pain and dyspareunia; she had not been seen by gynaecology during initial admission. Is currently being managed with the combined pill with no plan for repeat laparoscopy at this stage. HP of appendix NAD
30	Found to have mild endometriosis in the right ovarian fossa. The pouch of douglas and left ovary were unable to be viewed with no documentation as to why. Gynaecology review had been planned due to a history of infertility, awaiting a laparoscopy. Despite this they were not requested to attend and were asked to see her postoperatively and review photos. The photos were of poor quality and she was sent back to see her IVF specialist. Confirmed appendicitis on HP.
30	Documented as having possible endometriosis. There was no referral to gynaecology. HP of appendix NAD
39	Reviewed intra-operatively by a gynaecology consultant due to a left ovarian cyst and congested left fallopian tube. The impression was pelvic inflammatory disease or retrograde menstruation. Due to ongoing pain she was seen as by a gynaecologist with an interest in endometriosis during the subsequent 12 months and had a resection and excision of a 6cm right-sided endometrioma. HP of appendix NAD.
40	Resection of endometriosis 12 months prior with ongoing care in the outpatient clinic. Gynaecology review pre-operatively gave an impression of acute appendicitis and for care by the surgical team. No comment made in the operative report on pelvic findings or presence/absence of endometriosis. She went on to have a further resection of endometriosis 12 months later due to symptoms. Confirmed appendicitis on HP.

Laparoscopy for assumed appendicitis: A missed opportunity to diagnose endometriosis? cont.

Rebecca Young, Stephen Lyons

It is estimated that six out of ten women with endometriosis remain undiagnosed.[2] Those diagnosed after a delay, often with many years of pain, are understandably frustrated. This is particularly the case when they have had a prior laparoscopy. Documentation of pelvic findings is important not only in cases when the patient does not have appendicitis, but for all female patients. Every laparoscopy should be considered diagnostic, and any potential sources of pain identified. We advocate systematic survey of the pelvis in all women undergoing laparoscopy, including routine inspection of the appendix. This will require an awareness of the importance in performing a thorough assessment of all patients at laparoscopy, as well as increased cooperation between surgeons and gynaecologists.

Rebecca Young

Stephen Lyons

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AGES Pelvic Floor Symposium 2020 report

Although this pandemic necessitated social distancing, we have remained connected nationally and internationally. This time has been crucial for our reflection and meditation about what truly matters in life. We feel that in the face of this adversity, we are and will become better humans with more dignity, integrity, and hope.

AGES successfully hosted the first hybrid/virtual meeting pelvic floor symposium in October 2020, with over 240 delegates attending either face-to-face or virtually. Pelvic floor dysfunction is still a major public health issue and can be very challenging for the gynaecologist. An era of class actions against mesh and its withdrawal from the TGA and FDA, which forced us to re-evaluate our approach from conservative to reconstructive pelvic floor surgery in a multidisciplinary approach. This approach to pelvic floor dysfunction is the core of new innovative, scientific and minimally-invasive treatment that places the patient at the heart of gold standard care.

Our International and National Faculty took us on a scientific journey addressing every aspect of pelvic floor dysfunction, thank you to all of the esteemed presenters involved.

Our international faculty Professor Karl Jallad presented on the "Treatment of prolapse – Where are we now" and "Apical repair – The limits of vaginal hysterectomy."

AGES pelvic floor symposium gathered the health care providers to share their peer reviewed research and experience giving their colleagues ongoing education and support in pelvic floor physiotherapy, pain management, and psychology. We also learned that the new pandemic can have major effect on incidence of pelvic pain due to its influence on the immune system.

We heard from a victim of female genital mutilation and her journey "from victim to victory", by Khadija Glba as well as the establishment of Desert Flower Australia which is a charity to assist women with FGM reversal.

We also heard the personal journey of our national faculty member, Dr Kym Jansen, as a Gynaecologist who has experienced the best and the worst of the COVID-19 crisis in Victoria, which touched many of us and gave us an appreciation of their hardship.

Dr Rachel Green
PFS20 Conference Chair
AGES Honorary Secretary

Dr Fariba Behnia-Willison
AGES PFS20 Scientific Co-Chair
AGES Director

Dr Martin Ritossa
AGES PFS20 Scientific Co-Chair
AGES Director

AGES Pelvic Floor Symposium 2020 report cont.

JULY 2021
15-17
Hybrid Meeting

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

Leading the new Paradigm

COVID-19 has changed much of the way of life that we had grown accustomed to. The dramatic effects of the pandemic have created a stark definition between our pre and post COVID-19 existence. Significant change has been thrust upon us suddenly and without warning and we have been forced to adapt professionally and socially.

Although more change is sure to come, we are delighted to invite you to the 2021 AGES ASM, **'Leading the new Paradigm'**. This will be an AGES ASM with a difference! Most importantly it will be our first large face to face congress since early 2020. We look forward to inviting members from around New Zealand and Australia to join us in the AGES ASM Bubble

The 2021 AGES ASM will offer the best of previous ASMs including live surgery, panel discussions, and international guest speakers from around the world.

We will also hear from acclaimed national speakers who specialize in leadership and adaptation including; 'Change Agent' Kirstin Ferguson and Resilience and leadership expert, Heidi Dening. Comedian and climate activist Craig Reucassel will close this meeting with what is sure to be a mixture of entertainment and enlightenment.

For the first time at AGES the Simulation Teaching Advisory Group (STAG) will run live surgical simulations, and our new paradigm meeting will showcase members of the AGES community who are leading change within Australia and New Zealand on sustainability, wellbeing and innovation.

We will also debut a session solely dedicated to surgical videos submitted by AGES members and trainees.

Our pre-congress workshops in Transvaginal Ultrasound for Endometriosis and Private Practice, Business / Medicare Compliance will be a fitting entrée for our members who are able to join us a day earlier on the Gold Coast.

Our organizing committee are excited to bring you this ASM program, aiming to equip us all for **'Leading the new Paradigm'**. Please join us for a fabulous 3 days of learning and fun at the RACV Royal Pines Resort Gold Coast in 2021.

Michael Wynn-Williams
ASM Chair
AGES Director

Kirsten Connan
Scientific Co-chair
AGES Director

Helen Green
Scientific Co-chair
AGES Director

AGES XXXI ANNUAL
SCIENTIFIC MEETING 2021

'Leading the new Paradigm'

HYBRID MEETING
RACV ROYAL PINES,
GOLD COAST, QLD

15 - 17 JULY 2021

WEDNESDAY 14TH JULY 2021 - PRECONFERENCE WORKSHOP

IN-PERSON: RACV ROYAL PINES, GOLD COAST, QLD	AEST
AATP Workshop - Invitation only (IN-PERSON)	0800 - 1700
Merging Advanced Laparoscopic and Ultrasound skills in Endometriosis Workshop (IN-PERSON)	0800 - 1200
The MBS Explained Workshop (IN-PERSON)	1300 - 1800

THURSDAY 15TH JULY 2021 - HYBRID MEETING DAY ONE

IN-PERSON: RACV ROYAL PINES, GOLD COAST, QLD AND VIRTUAL		AEST
Registration (IN-PERSON)		0700 - 0800
SESSION ONE: SURGERY AND SURGICAL EDUCATION - ARE YOU READY FOR THE CHANGES AHEAD?		0800 - 0955
Introduction and Welcome to Country		
Leading surgical change through coaching - **Caprice Greenberg**		
Changing the culture of surgery - **Justin Dimick**		
Leading change through the use of social media - **Amy Park**		
Engagement through education - **Stephen Lyons**		
Panel Discussion		
MORNING TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		0955 - 1025
SESSION TWO: AGES SIMULATION SURVIVOR *Role of simulation and clinical education in gynaecology*		1025 - 1200
Watch as the teams from North, East, South and West battle it out to be the AGES Simulation Survivor - **S.T.A.G.**		
LUNCH, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		1200 - 1300
SESSION THREE: CHAIRMAN'S CHOICE -FREE COMMUNICATIONS	**INTERACTIVE HUBS**	1300 - 1515
Superior Hypogastric Plexus Nerve Block in Minimally Invasive Gynecology: a Randomised Controlled Trial - **Praveen De Silva**		
Effect of vasopressin hydrodissection in laparoscopic excision of endometrioma on ovarian reserve: study protocol for a randomised control trial and preliminary results - **Dave R Listijono**	**INTERACTIVE HUB 1 -** (1315 - 1415)	
POMMS: Pre-Operative Misoprostol in Myomectomy Surgery - A Pilot Study - **Lima Wetherell**		
Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): A case series of 9 patients - **Mujahid Bukhari**		
The impact of surgery on the sexual function of women with deep infiltrating endometriosis: a prospective cohort study - **Lauren Hicks**		

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Urinary Function after Surgery for Deep Infiltrating Endometriosis: A Prospective Study - **Keryn Harlow**	CONTINUED **INTERACTIVE HUB 1 -** (1315 - 1415)	
Training for and undertaking gynaecological surgery in Australia: A comprehensive analysis of AIHW and MBS data - **Lalla McCormack**		
Self and Body Compassion in Endometriosis: The predictive nature of endometriosis-related symptom presence and distress - **Leesa Van Niekerk**		
Vinorelbine as a treatment for stable ectopic pregnancy: An early phase clinical study - **Prathima Chowdary**		
Anatomical distribution of deep endometriosis on transvaginal ultrasound and clinical features: implications on non-invasive diagnosis - **Rodrigo Manieri Rocha**		
The impact of age and parity on regret and relief following hysterectomy for benign disease - **Helen MacNamara**		
One of these things is not like the other: video-based discussion of intra-operative findings of unexpected leiomyosarcoma at laparoscopic 'myomectomy'. - **Alison Bryant-Smith**		
Laparoscopic excision of a pregnant, non-communicating rudimentary horn- the case of the super sperm - **Keryn Harlow**		
AFTERNOON TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS		1515 -1545
SESSION FOUR: CHANGE MAKERS IN O&G - HOW TO DRIVE SUCCESSFUL CLINICAL INITIATIVES		1545 - 1730
Gynaecological malignancy in the Pacific Islands - **Ai Ling Tan**		
Health disparities amongst Maori and Pasifika Women in NZ - **Phil Suisted**		
On the couch with **Dr Kirsten Connan**		
Abortion law reform and contraception access in Australia - **Caroline de Costa**		
Migrant and refugee healthcare for women in Australia - **Jacqueline Boyle**		
Indigenous Issues - **Marilyn Clarke**		
How to be effective in leading and making changes - **Kirstin Ferguson**		
Panel Discussion		
CLOSE OF DAY ONE		1730
WELCOME RECEPTION (IN-PERSON)		1730 - 1830
		AEST

FRIDAY 16TH JULY 2021 - HYBRID MEETING DAY TWO

IN-PERSON: RACV ROYAL PINES, GOLD COAST, QLD AND VIRTUAL			AEST
SurgicalPerformance Breakfast Session (IN-PERSON)			0700 - 0755
Registration (IN-PERSON)			0700 - 0800
SESSION FIVE: SURGERY UNCUT: TECHNIQUES, ANAESTHESIA AND ERGONOMICS		**INTERACTIVE HUB 2 -** (0900 - 1000)	0800 - 1000
MORNING TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS			1000 - 1030
SESSION SIX A: ENDOMETRIOSIS AROUND THE WORLD: PROGRESS AND WORK FOR THE FUTURE	**SESSION SIX B:** PECHA KUCHA - TOPICAL UPDATES AND CHANGES FOR THE GENERALIST	**INTERACTIVE HUBS**	
New Australian endometriosis guidelines: A snapshot of the changes - **Jason Abbott**	The role of tubal surgery in the era of assisted reproductive technology - **Devini Ameuratanga**	**INTERACTIVE HUB 3 -** (1030 - 1130)	
	Management of fibroids - **Amy Arnold**		
	Hysteroscopic advances and surgical considerations - **Yasmin Pilgrim**		
Time for change in the UK - Rapid diagnosis by 2030 - **Lucky Saraswat**	Evidence based laparoscopy - **Bridget Gilsenan**		
	Pelvic pain and a negative laparoscopy - **Matt Smith**		
	Peri-operative optimisation of women with persistent pain - **Thea Bowler**		
Coordinating the future of NZ public endometriosis services - **Michael Wynn-Williams**	Novel therapuetics for vestibulodynia/ vaginismus - **Sean Holland**		1030 - 1230
	Ethnic variation in endometriosis - **Albert Jung**		
	Uterine Niche: is it a problem? - **Kellie Tathem**		
What can we learn from endometriosis management in North America? - **Sony Singh**	The role of pelvic floor ultrasound in evaluating patients with pelvic floor dysfunction - **Vivien Wong**		
	Risk reduction for patients with inheritable genetic conditions - **Emma Allanson**	**INTERACTIVE HUB 4 -** (1145 - 1245)	
	2021 Updates to the National cervical screening guidelines - **Chris Arthur**		
COVID, lock downs and self-management strategies for endometriosis consumers - **Catarina Ang**	Update on endometrial hyperplasia - **Louise White**		
	Managing Complications - **Will Milford**		
	The Impact of Surgical Complications- the second victims - **Rachel Collings**		
Panel Discussion	The silver lining of COVID for regional/ rural practitioners - **Elizabeth Jackson**		
LUNCH, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS			1230 - 1330

SESSION SEVEN A: FREE COMMUNICATIONS	SESSION SEVEN B: FREE COMMUNICATIONS	SESSION SEVEN C: VIDEO COMMUNICATIONS	
Modified UBESS and CA125 endometriosis severity prediction model - Preliminary Results - **Brindaa Tharmarajah**	The use of the Myometrial-Cervical Ratio in the Ultrasound Diagnosis of Adenomyosis – a Validation Study. - **Tristan McCaughey**	Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): Standardising rectal shaving for bowel endometriosis - **Mujahid Bukhari**	
Can transvaginal ultrasound predict the need for laparoscopic ureterolysis in women with suspected endometriosis? - **Brindaa Tharmarajah**	Central Sensitization in Persistent Pelvic Pain: A Cohort Study - **Amelia Ryan**	The vanishing fibroid: MyoSure hysteroscopic resection at lower pressure for a 'vanishing' submucous fibroid - **Madison A Naidu**	
Building a prediction model for ureterolysis in laparoscopic endometriosis surgery: the CLINUS model - **José Vitor Zanardi**	The Tubo-Ovarian Abscess Study(TOAST) - **Anna-Marie Van Der Merwe**	Combined robotic-assisted laparoscopic-hysteroscopic isthmoplasty using Firefly® near-infra red technology: a novel approach - **Felix Chan**	
Can we predict the revised American Fertility Society (r-AFS) stage using the pre-operative transvaginal Ultrasound-Based Endometriosis Staging System (UBESS) in women with suspected endometriosis? A retrospective observational study - **Tanushree Rao**	Evaluating pre-treatment β-hCG ratio in expectant and medical management of tubal ectopic pregnancy - **Jason N Mak**	Carving out a niche: principles of laparoscopic Caesarean scar defect repair, as demonstrated by a video compilation of a case series - **Nargis Noori**	
Association between the localisation of endometriosis and 1-year postoperative digestive complaints: a 1,497 women comparative study - **Shamitha Kathurusinghe**	Correlation of the Ultrasound-Based Endometriosis Staging System (UBESS) for the prediction of RANZCOG/AGES levels 1 – 6 of surgical complexity - A retrospective validation study - **Myriam Girgis**	Laparoscopic Excision of an Accessory Cavitated Uterine Malformation (ACUM) - **Marcus Bavenport**	1330 - 1500
Oocyte-secreted serum biomarkers GDF9 and BMP15 in women with endometriosis - **Aiat Shamsa**	Outcomes following segmental rectal resection with vascular preservation in colorectal endometriosis - **Naman Dahiya**	Laparoscopic Resection of Diaphragmatic Endometriosis in Left Lateral Decubitus Position - **Albert Jung**	
Adenomyosis, a Predictor of Endometriosis Severity? - **TBC**	The learning curve for the ultrasound detection of uterosacral ligaments and torus uterinus deep endometriosis: A repeatability and reproducibility study - **Rodrigo Manieri Rocha**	Disc excision of deep endometriosis infiltrating the rectum - **Dasuni Pathiraja**	
Getting square pegs out through round holes: A survey of RANZCOG Fellows regarding specimen extraction - **Alison Bryant-Smith**	Findings and outcomes in a post-vaccination cohort of young women under 25 years attending a tertiary colposcopy service - **Cheryl Yim**	Laparoscopic myomectomy for beginners: a video-based guide of suggested tips and tricks - **Kate Tyson**	
Are we 'Gritty' enough? The importance of 'Grit' in O&G training - Association of passion and perseverance with burnout, thriving and career progression - **Tarana Lucky**	The significance of the ovarian sliding sign in relation to the Ultrasound-Based Endometriosis Staging System (UBESS) for surgical complexity - **Myriam Girgis**	Laparoscopic Para-aortic Lymphadenectomy in a patient with Duplicated Inferior Vena Cava with Suspected Stage II Endometrioid Adenocarcinoma - **Alexander Chen**	
AFTERNOON TEA, TRADE EXHIBITION AND DIGITAL FREE COMMUNICATIONS			1500 - 1530
SESSION EIGHT: LEADING CHANGE IN DOCTORS' WELLBEING			1530 - 1720
Tough times don't last. Resilient leaders do. - **Heidi Dening**			
Leading a hospital wide wellbeing program for staff - **Joanna Sinclair**			
Professional resources for doctors' wellbeing - **Vijay Roach**			
Indemnity resources for doctors' wellbeing - **Tracy Pickett**			
Dan O'Connor Lecture - **Hilary Joyce**			
CLOSE OF DAY TWO			1720
AGES ANNUAL BLACK TIE GALA DINNER, AWARDS AND CHARITY AUCTION (IN-PERSON)			1900 - 2200
			AEST

SATURDAY 17TH JULY 2021 - HYBRID MEETING DAY THREE

IN-PERSON: RACV ROYAL PINES, GOLD COAST, QLD AND VIRTUAL	AEST
Registration (IN-PERSON)	0730 - 0800
SESSION NINE: ARE WE THERE YET? THE FUTURE OF MEDICAL TECHNOLOGY	0800 - 0930
"5G caused COVID" - Why would my specialist use it? - **Barry O'Reilly**	
Digital healthcare - **Nic Woods**	
Preparing our trainees for the future of surgery - **Donna Ghosh**	
How can I innovate and develop future surgical equipment? - **Prathima Chowdary**	
How to build your own surgical robot - **Mark Slack**	
Panel Discussion	
MORNING TEA AND TRADE EXHIBITION	0930 - 1000
SESSION TEN: CHANGE OF CLIMATE IN WOMENS' HEALTH	1000 - 1215
Doctors for the environment: Climate change - I don't see the problem? - **Arnagretta Hunter**	
RANZCOG position statement - Impact of the bush fires - **Kristine Barnden**	
Fertility and climate change - **Manny Mangat**	
The impact of the climate crisis on millennials - **Nadia Willison**	
How to make your practice carbon neutral - **Rob Burrell**	
The war on medical waste - **Craig Reucassel**	
Panel Discussion	
CLOSE OF DAY THREE	1215
LUNCH ON THE GO	
	AEST

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

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Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

Next Generation! Focus Meeting 2021 report

It has been a few weeks since our Next Generation Focus Meeting, but I must say, the opportunity to meet with friends and colleagues again provided the dopamine surge we needed after the year that had passed. This was complemented by our local and international speakers who continued to keep us engaged and glued to our seats (and screens).

The hybrid set-up provided the organising committee the freedom to include speakers from around the country and the world. There were too many highlights to list, some of which included the excellent overviews by Silvia Vannuccini and Linda Bradley, to the inspiring and motivating journeys of Qendo President Jessica Taylor and the Queensland Attorney General Hon. Shannon Fentiman. The concept of EBM 2.0, and the whole research session as whole was engrossing, challenging us to question what we often presume as gospel while Carolyn Jameson, a bariatric surgeon, debunked many of the weight loss myths and was followed by the brave and moving patient perspective interview with Tenisha. The meeting was closed by the raw, confronting and emotive talk by Natasha Anu Anandaraja from the US, imploring us to start addressing and changing the bullying and discrimination that continues to this day. Enough is enough!

I would personally like to express my gratitude to the local organising committee (Supuni Kapurubandara, Shamitha Kathurusinghe, Luke McLindon, Tran Nguyen, and Jennifer Pontre) who seamlessly came together from around the country to bring the program together. I would also like to thank all of the conference faculty, our industry sponsors and Mary, Danielle and the team from YRD who were solely responsible for the successful running of, what is likely the first, Hybrid medical conference.

I eagerly look forward to the ASM in the Gold Coast, where we can, hopefully, meet together in person!

Bassem Gerges
FM21 Conference Chair
AGES Director

Next Generation! Focus Meeting 2021 report cont.

Next Generation!
Focus Meeting 2021 report cont.

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

Basia Lowes, Kiran Vanza and Naman Dahiya

Dienogest and the Risk of Endometriosis Recurrence Following Surgery: A Systematic Review and Meta-analysis
A Zakhari, D Edwards, M Ryu, J Matelski, O Bougie and A Murji.
Journal of Minimally Invasive Gynecology. Vol 27, No 7, November/December 2020 pg 1503-1510

Complete excision of all visible endometriosis results in the most substantial and long-lasting improvement in patients' symptoms, however such optimal debulking cannot always be attained, owing to challenging locations of lesions or extensive infiltration. Effective methods of suppressing postoperative recurrence are needed to ensure sustained benefit from surgery and reduce recurrence rates, which can be as high as 50% to 60%.

Dienogest is a fourth-generation synthetic progestogen with a high specificity for progesterone receptors, strong anti-proliferative effects on endometriosis and anti-androgenic, antiangiogenic and anti-inflammatory properties. Given its high tolerability and effectiveness, it has been approved for the treatment of endometriosis and as combined hormonal contraception across Europe and North America. A previous Cochrane review published in 2004, evaluating the evidence for postoperative hormonal suppression for endometriosis, showed no evidence of decreased disease recurrence, however, the data was limited to three trials, none which examined Dienogest.

This most recent systematic review and meta-analysis published in 2020, included 10 studies in the analysis (n9 retrospective cohort studies and 1 prospective cohort study). Retrospective and prospective observational and RCTs of premenopausal women undergoing conservative surgery (retained at least one ovary) for endometriosis were included. Participants required at least six months of daily Dienogest therapy with a minimum of six month follow up period. No patients in the included studies underwent a hysterectomy. Of the included studies, 8 were found to be fair or better when risk of bias and quality were accessed and 2 found to be poor.

The primary outcome was to determine the rate of endometriosis recurrence. This was defined as: radiographic evidence of endometriosis (endometrioma, deep endometriosis or plaques), symptom recurrence in patients after endometriosis surgery treated with Dienogest or findings from second-look laparoscopy and to compare this rate with controls (if available). Secondary outcome was to determine the odds of recurrence in patients treated with Dienogest compared with controls, who received no postoperative hormonal suppression.

A total of 2030 patients were included (1184 treated with Dienogest and 846 controls). Treatment duration varied in studies from 6 to 79 months and the mean follow up period for all studies was 28.5 months. Of the 10 studies included, 9 defined recurrence radiologically and 1 relied on patient-reported recurrence of symptoms.

Overall, the incidence rate of endometriosis recurrence in patients receiving postoperative suppression with Dienogest was 2 per 100 treated women over a mean duration of 28.5 months. In the control group, the incidence rate of endometriosis recurrence was significantly higher at 29 recurrences per 100 women over a mean duration of 35.7 months. Six studies had a control arm for comparison and when assessing secondary outcome, patient receiving Dienogest therapy compared with controls, were less likely to have recurrence of endometriosis ($p<0.001$).

In 9 of the included studies, recurrence was defined radiologically with the appearance of an ovarian endometrioma alone and this narrow definition may likely result in underreporting of recurrent disease. There is also no guidance on patient tolerability of treatment, predictors of responsiveness to treatment and efficacy compared with alternative regimens.

In conclusion, based on this systematic review, patients who receive Dienogest after conservative surgery for endometriosis have a low rate of disease recurrence compared with untreated patients, particularly endometriomas.

→

Basia Lowes, Kiran Vanza and Naman Dahiya

Reproductive Outcomes following Use of Barbed Suture during Laparoscopic Myomectomy

Kristen Pepin, Monalisa Dmello, Evelien Sandberg, Catherine Hill-Verrochi, Parmida Maghsoudlou, Mobolaji Ajao, Sarah L. Cohen, and Jon I. Einarsson,
Journal of Minimally Invasive Gynecology. Vol 27, No 7, November/December 2020 pg 1566-72

Barbed wire sutures have become an important tool for surgeons performing minimally invasive surgery. Advantages include decreased time required to repair a uterine wall defect, lower total operative time, and less intraoperative blood loss. There is, however, little published data on pregnancy outcomes following laparoscopic myomectomy repair with barbed sutures and the impact on fertility outcomes is unknown.

This retrospective cohort survey study that reports on the pregnancy outcomes of women who underwent a laparoscopic myomectomy using barbed suture (with or without robotic assistance) between April 2008 and December 2016 at a single, large academic medical centre. Other outcomes reported on include: achieving pregnancy, their interest in fertility, and delivery mode after myomectomy. In addition, perioperative characteristics were compared between those women who did and did not achieve pregnancy after surgery.

A retrospective review of operative notes was carried out by the authors and it was noted that adhesion barriers and size 0 polydioxanone barbed suture were used routinely in the study population (single centre), which demonstrated a predictable technique across patients. In addition, the women were sent a postoperative mail survey asking questions about fertility plans and pregnancy outcomes after their myomectomy. Women were contacted in 2 rounds, the fall of 2011 and winter of 2018 to allow for any time delay to achieving pregnancy.

Women younger than 18 years were excluded to avoid the need for parental consent, as were women with a history of permanent sterilization. Patients with additional procedures conducted at the time of the myomectomy, such as excision of endometriosis or hysteroscopic myomectomy, were included.

A total of 486 patients underwent a laparoscopic myomectomy between 2008 and 2016 at this centre. Of the 428 with viable contact information, 240 agreed to participate (56%). Of those who responded to the survey, 101 (42%) attempted to get pregnant, and there were 4 unplanned pregnancies. There were 110 pregnancies among 76 survey respondents. Twenty-two percent of pregnancies were conceived with reproductive assistance. In total, of the women attempting a postoperative pregnancy, 71% had at least 1 pregnancy. Comparing the women who did and did not conceive postoperatively, the group who got pregnant was on average younger, 33.8 +/- 4.5 years vs 37.5 +/- 6.5 years (p = .001); had fewer myomas removed, median = 2 (range 1-9) vs median = 2 (range 1- 16) myomas (p = .038); and had a longer follow-up period.

The mean time to first postoperative pregnancy was 18.0 months (range 2–72 months). Of the 110 reported pregnancies, there were 60 live births (55%), 90% by means of caesarean section. A total of 34 (30%) pregnancies ended in a spontaneous first trimester abortion. The mean gestational age at birth was 37.8 weeks. There were 8 preterm births, 3 cases of abnormal placentation, 2 cases of fetal growth restriction, 3 cases of hypertensive disorders of pregnancy, and 2 cases of myoma degeneration requiring hospitalization for pain control. There were no uterine ruptures reported.

The authors concluded that their findings on pregnancy outcomes after laparoscopic myomectomy with barbed suture were comparable with available literature on pregnancy outcomes with conventional smooth suture. Although this is a reassuring observation, the retrospective nature of the study and the large proportion of survey non-responders (44%) means that larger prospective cohort or case-control trials would be preferred.

Basia Lowes, Kiran Vanza and Naman Dahiya

Risk-reducing Bilateral Salpingo-oophorectomy: Assessing the Incidence of Occult Ovarian Cancer and Surgeon Adherence to Recommended Practices

Newcomb LK, Toal CT, Rindos NB, Wang L, Mansuria SM
Journal of Minimally Invasive Gynecology. Volume 27, Issue 7, November–December 2020, Pages 1511-1515

The primary aim of this paper was to determine incidental risk of ovarian cancer in women with BRCA mutation undergoing risk-reducing bilateral salpingo-oophorectomy (RRBSO).

A secondary objective was to determine adherence to recommended practices for performing RRBSO amongst gynaecologists with different training backgrounds, i.e., gynae-oncologists vs generalists (including minimally invasive gynaecology surgeons)

This was a descriptive, retrospective analysis (chart review) of all women who underwent RRBSO in Pittsburgh, Pennsylvania between July 2007 and September 2018.

The inclusion criteria were women with confirmed BRCA1 or BRCA2, familial genetic predisposition to breast and ovarian cancer and if undergoing prophylactic RRBSO. Exclusion criteria were women with an adnexal mass suggestive of ovarian cancer, undergoing surgery for another gynaecological malignancy, or genetic syndrome such as Lynch. The adherence to recommended operative procedure was assessed on review of operation and pathology reports.

A total of 269 patients were recruited. Of these, 146 (54%) had BRCA1 mutation, 120 (44%) BRCA2 mutation, 5 (2%) had a genetic predisposition. A total of 8 cases (2.9%) of tubal or ovarian cancer were diagnosed in this cohort. Three cases were diagnosed intraoperatively. The mean age was significantly greater in these 8 patients compared to those with no malignancy (58 vs 47.5 years, $p = .002$). A total of 220 women (82%) underwent RRBSO by gynae-oncologist and 49 (18%) by a generalist. Washings for cytology were undertaken by 95% of gynae-oncologists but only by 63% of generalists ($p \leq .001$). There was no significant difference between preoperative collection of CA-125, preoperative imaging or pathology specimens undergoing complete serial sectioning amongst the two proceduralist groups.

As the overall Incidence of ovarian cancer at RRBSO is low, this study suggest that RRBSO should not necessarily be performed by gynae-oncologists. However, gynae-oncologists better adhered to recommended procedure protocols compared with generalists, suggesting further education and training may be beneficial for generalists performing RRBSO.

Basia Lowes
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INVITATION

to the wider membership to join the AGES 'Equity, Diversity and Inclusion Committee'

The AGES society is committed to working towards an improved understanding and practice of equity, inclusion, and diversity.

The new AGES **Equity, Diversity and Inclusion Committee** will lead the AGES board and society forward in addressing issues including: driving gender equity and diversity policies, striving to achieve diversity at all levels of representation, maximising the inclusively of all members, and participating in research into issues of harassment, bullying and discrimination with our membership.

If you would like to be a part of this committee, please email AGES on ages@yrd.com.au with your name, your CV, and a short paragraph outlining your interest.

Dr Kirsten Connan
AGES board member

Avoiding boundary issues in clinical care

Ruanne Brell & Dr Ushma Narsai

A recent analysis of complaints to regulators found allegations of sexual harassment or assault comprised nearly 75% of sexual boundary complaints.

Obstetricians and gynaecologists were among those that were more likely to be subject to notifications of sexual harassment, along with psychologists and psychiatrists.

Professional and patient harm

This report examining allegations of sexual boundary violations notified to Australian Health Practitioner Regulation Agency (Ahpra) and NSW Health Professional Councils Authority from 2011-2016, was published in the Medical Journal of Australia.

The authors noted that just over 60% of closed cases resulted in no further action. They suggested at least in some cases, the "notifications may not describe actual sexual misconduct, but rather misunderstandings, the results of poor communication, or false beliefs."

This research suggests that, even if practitioners did not intend to act inappropriately, they may not have understood how their behaviour could be interpreted or have failed to recognise the impact of the power imbalance inherent in the doctor-patient relationship.

In seeking medical care, a patient must disclose a degree of personal information and often make themselves physically vulnerable. Individual patients may be even more vulnerable due to factors that can increase the power imbalance and potential for harm (for example, their age, a history of violence or abuse, their physical or mental conditions). In cases heard by disciplinary tribunals where patients have felt unsafe consulting a practitioner, they have avoided or delayed seeking treatment or, in some cases, have experienced other physical or mental health issues.

Explaining the reason for examinations

Conducting a physical examination that is unwarranted and not clinically indicated, or where the patient has not provided proper consent, may constitute assault. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients when the patient has not given explicit consent to the examination.

Misunderstandings can occur through poor communication and an incomplete explanation. This can lead, for example, to a patient believing that an examination was unwarranted and alleging it was an assault. If a patient does not understand the clinical relevance of questions (for example questions about sexual function) they may also believe these are inappropriate and evidence of sexual harassment.

If you need to examine a patient, it is important you explain clearly and fully what you need to do and why it is necessary.

What a patient considers to be an intimate examination may be affected by a patient's cultural values, beliefs or history. For this reason, it is important to be alert to signs of a patient's discomfort or reluctance. (For more information – see Medical Board of Australia's Sexual boundaries in the doctor-patient relationship and Avant factsheet on boundary issues).

It is also important not to assume that the patient will understand what to expect from an examination or why it is necessary. Once you have explained why you need to conduct the examination and the patient understands what is involved, ensure you obtain specific consent for the examination you are about to undertake. Depending on the examination, the patient's consent can be verbal or written but should be documented in the patient's medical record.

Using observers

The presence of an observer (previously called a chaperone) as a witness to a medical examination may also be helpful and reassuring to a patient who is fearful, vulnerable or embarrassed.

You may want to suggest this as part of the consent discussion.

Avoiding boundary issues in clinical care cont.

Ruanne Brell & Dr Ushma Narsai

The Medical Board of Australia does not specify when a practitioner should offer to have an observer present. Situations where you may wish to consider offering to have an observer present for an intimate examination include:

- if a patient appears uncomfortable/reluctant/distressed
- if you are uncomfortable (see AMA Position statement and Avant factsheet on observers).

Maintaining appropriate boundaries

Complaints of sexual misconduct by health practitioners are rare.

However, these cases, which necessarily involve a breakdown of the trust and good communication fundamental to the doctor-patient relationship, can cause significant harm to both practitioner and patient.

Maintaining appropriate boundaries, demonstrating respect for patients and taking care to avoid misunderstanding are essential parts of good patient care.

Ruanne Brell
Senior Solicitor, Medico-legal Advisory Service, Avant

Dr Ushma Narsai
Senior Medical Advisor, Avant

References and further reading:

- Bismark MM, Studdert DM, Morton K, Paterson R, Spittal MJ, Taouk Y. Sexual misconduct by health professionals in Australia, 2011–2016: a retrospective analysis of notifications to health regulators. Med J Aust 2020, available at https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.50706
- Medical Board of Australia: Sexual Boundaries in the doctor-patient relationship.
- Avant factsheet: Boundary issues
- Avant factsheet: Observers: chaperone, protect and reassure

Save the date

Please note that many event details are changing due to COVID-19.
Please visit **www.ages.com.au** for the latest information.

Australasian Gynaecological Endoscopy & Surgery Society Limited
ANNUAL SCIENTIFIC MEETING

AGES Annual Scientific Meeting 2021
JULY 15–17 2021
RACV Royal Pines Gold Coast
Theme: Leading the New Paradigm

Australasian Gynaecological Endoscopy & Surgery
PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium 2021
OCTOBER 29–30 2021
Crowne Plaza Sydney Coogee Beach
Theme: Healing & Inclusion in 2021

Australasian Gynaecological Endoscopy & Surgery Society Limited
LAP-D WORKSHOP

AGES Laparoscopic Anatomy Pelvic Dissection/ Demonstration Workshops
2021 DATES
July 18 Dissection **SOLD OUT!**
August 28 & 29 Dissection
November 27 Dissection

Medical Engineering and Research Facility (MERF), Brisbane

AGES Membership 2021

It's not too late to renew your membership!

Membership of AGES includes the following:

- Complimentary access to member only content such as webinars
- 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 Laparoscopic Anatomy Pelvic Dissection & Demonstration Workshops (LAP-D).
- Eligibility to register for the AGES Interactive Hubs.
- Eligibility to apply for AGES Research Grants.
- SurgicalPerformance 1-year Premium subscriptions will be available at a subsidised rate of $100 to all Ordinary Members of AGES in 2021. This includes SurgicalPerformance's 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 three 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 2021.

AGES Travelling Fellowship Applications Open

Applications are now open for the AGES/Medtronic Travelling Fellowship and the AGES/Hologic Hysteroscopic Fellowship for 2021.

These Fellowships will be awarded at the AGES XXXI Annual Scientific Meeting 2021 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 – https://ages.com.au/members/awards-and-fellowships/

AGES/Medtronic Travelling Fellowship – AUD $7,500
AGES/Hologic Hysteroscopic Fellowship – AUD $10,000

Applications close midnight Friday 2nd July 2021.

AGES Clinical Research Grant Recipients 2021

Congratulations to the successful applicants of the 2021 AGES Clinical Research Grants. Thank you to Medtronic for their continued support of this initiative.

SUBMITTER	AWARDED AMOUNT	PROJECT NAME
Emily Twidale	$4,016.00	MACH: Methoxyflurane analgesia for conscious hysteroscopy, a double-blind, randomised controlled trial
Lalla McCormack	$8,224.00	Crunching the Numbers in Gynaecological Surgical Practice in Australia? What is the current exposure of major gynaecological surgical procedures for RANZCOG trainees and Fellows?
Barbara (Basia) Lowes	$1,500.00	Diagnostic assessment tools to detect pelvic myofascial pain – A Systematic Review
Hillary Hu	$5,570.00	Surgical Start Time and Complications in Gynaecological Surgery
Tarana Lucky	$12,110.00	Role of Paracervical Block in reducing Post-operative Pain Following Benign Laparoscopic Hysterectomy: Objective Evaluation Of Parameters By Utilising A Single Centre Double Blind Randomized Controlled Trial (The ROPPE trial)
Tristan McCaughey	$4,930.00	The use of the Myometrial-Cervical Ratio in the Ultrasound Diagnosis of Adenomyosis – a Validation Study.
Sasha Skinner	$15,000.00	Perioperative intravenous lignocaine at operative gynaecological laparoscopy in women with chronic pelvic pain
Monisha Pillay	$480.00	Evaluating the usefulness of pre-operative GnRH Response In Predicting Pain relief following hysterectomy/oophorectomy for chronic pelvic pain (GRIPP Study)
Jessica Lowe	$10,800.00	Intravesical instillation of Platelet-Rich Plasma for recurrent urinary tract infections

Dates for Laparoscopic Workshops

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.

2021 Course Dates: on application.

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

FLINDERS PRIVATE ENDOGYNAECOLOGY MASTERING LAPAROSCOPIC SUTURING XXI
FLINDERS PRIVATE HOSPITAL ADELAIDE

2021 Course Dates: August 12-13.

Course Directors: Assoc. Prof. Robert O'Shea
Assoc. Prof Elvis Seman

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

SWEC ADVANCED GYNAECOLOGIC LAPAROSCOPIC COURSES FOR 2021
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.

2021: October 11-15
2022: March 21-25, June 6-10, October 10-14

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

2021 Course Dates: October 12-13

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.

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

LAPAROSCOPIC SURGERY FOR GENERAL GYNAECOLOGISTS
SYDNEY LAPAROSCOPIC WORKSHOPS 2021

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

2021 Course Dates:
to be advised

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

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

ADVANCED LAPAROSCOPIC PELVIC SURGERY TRAINING PROGRAM

PROGRAM DIRECTOR ASSOC PROF ALAN LAM

You are invited to participate in an integrated training program in Advanced Laparoscopic Pelvic Surgery. An internationally recognized faculty aims to give you the skills to practice safe endosurgery and increase the range of laparoscopic procedures you can perform.

2021

CARE Master Class in Laparoscopic Excision of Endometriosis & Hysterectomy Techniques:
2-6 August
(to be confirmed)

CARE Master Class in Laparoscopic Hysterectomy, Myomectomy & Adnexal Surgery:
25-29 October
(to be confirmed)

CARE Course Features

- Personalised tuition
- A maximum 8 participants per course
- Comprehensive tutorials including anatomy, energy sources, complication management/prevention
- Two skills labs to help refine intra and extra corporeal suturing
- Two live animal lab sessions
- Eight theatre sessions during which you will 'scrub in'
- Credited by RANZCOG with CPD and PR&CRM points

For further information contact:
CARE Course Coordinator, AMA House Level 4
Suite 408, 69 Christie Street, St Leonards NSW 2065
P: (fax) + 61 2 9966 9121 F: + 61 2 9966 9126
Email: care@sydneycare.com.au
Web: www.sydneycare.com.au for registration forms

CENTRE FOR ADVANCED REPRODUCTIVE ENDOSURGERY

escope

Volume 76 coming out in September 2021

Contact Rachel Green (secretariat@ages.com.au) with your contribution
Deadline **31st August 2021**

Inclusion & Healing in 2021

Hybrid Meeting

29th & 30th October 2021
Crowne Plaza Sydney Coogee Beach

Earlybird Registrations Close
3rd September 2021

Abstract Submissions Close
6th August 2021

AGES XXII Pelvic Floor Symposium

www.ages.com.au