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escope

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

EDITION HIGHLIGHTS:

TOGETHER TOWARDS TOMORROW

President's Letter

"Gynaecological Surgery – An Uncertain Future?"

Dear AGES Members,

As I write my third eScope President's Letter, the future continues to look bright with NSW, the ACT and Victoria all progressively being freed from the constrictions of hard COVID-19 lockdown. Indeed, whilst "not out of the woods yet", the effects of COVID-19 on our day-to-day lives continue to dissipate as the vaccination rates in Australia and New Zealand continue to climb. The AGES 2021 Annual Scientific Meeting (ASM) "Leading the New Paradigm" held in late October was another victim of the COVID-19 pandemic. Despite the best efforts of the AGES Board, the ASM21 Organising Committee and the AGES Secretariat, the meeting was the first ASM to be held virtually. Nevertheless, despite the overall number of attendees being less than would be expected for a face-to-face ASM, the program resonated with the membership with a focus on subjects as diverse as climate change, inequality in healthcare, leadership and doctors' wellbeing, as well a ground breaking "Live Surgery Uncut" session, and plenty of science and gynaecological surgery topics as well... Congratulations to all those involved in bringing this meeting to fruition, especially to Michael Wynn-Williams, the Conference Chair, and to Helen Green and Kirsten Connan, the Scientific Chairs.

I was very pleased to have the opportunity to speak about my vision for the future of AGES at the ASM21. Whilst the overall position of AGES is strong relative to all but the largest of surgical societies, I discussed that there were some black clouds on the AGES horizon that needed to be addressed to further the wellbeing of our Society. These include: 1) re-engagement with the "lost AGES members" who, for whatever reason, have let the AGES Membership lapse over the years; 2) recognition of the role AGES Accredited Training Program (AATP) Graduates as future leaders of AGES and the need for their career-long involvement with the society; 3) the recognition that the education of *all* AGES members, irrespective of their individual practice make-up (registrar, AATP candidate, generalist obstetrician & gynaecologist or advanced endoscopic surgeon), is the core business of AGES; and 4) the future of gynaecological surgery training in Australasia. In my opinion, the last of these is a not just a challenge to AGES but increasingly threatens to impact the profession of Obstetrics & Gynaecology per se, and is the focus of my letter.

By way of background, AGES, the Australasian Gynaecological Endoscopy and Surgery Society, is just one of many so called minimally invasive gynaecological surgical societies (*e.g.*, the American Association for Gynecologic surgery or AAGL recognises more than 40 affiliated and associated societies on its website, of which AGES is one), that are dedicated to the advancement of women's health care via the education of their respective memberships. These societies are all different in their own way, but are also similar in that their core business is to redress the gap in gynaecological surgical skills between those obtained during fellowship training and those required to safely perform advanced gynaecological endoscopic procedures. However, in this veritable sea of surgical societies, AGES is certainly not a minnow.

Founded in 1991, AGES is a not for profit, mutual society, run by the members for the members, and dedicated to the education and training of gynaecologists in reproductive surgery, the promotion of research and the staging of events. The AGES Research Fund was founded in 2003, to support surgical research in gynaecology. Since then, more than 96 different projects have been funded with more than 1.3 million dollars in grants allocated.

President's Letter cont.

The AGES Accredited 2-year Training Program or AATP was established in 2010 and developed for those gynaecologists wishing to learn more advanced procedures. 2021 saw the 10th intake of trainees into the program which encompasses 22 training sites and 22 current trainees – in total, 51 trainees so far have completed the program. A detailed strategic plan was developed for AGES in 2019 that describes a vision, purpose and values that coincide with goals, objectives and actions (details are available on the AGES website).

Our professional College, RANZCOG, is "dedicated to the establishment of high standards of practice in obstetrics and gynaecology and women's health. The College trains and accredits doctors throughout Australia and New Zealand in the specialties of obstetrics and gynaecology so that they are capable of providing the highest standards of healthcare" [source: RANZCOG website]. I am pleased to say that AGES share a productive and generally amicable working relationship with RANZCOG. Whilst RANZCOG focuses on certification, pre-fellowship education and continued medical education in both obstetrics and gynaecology, AGES focuses primarily on post-fellowship training and education in gynaecological surgery. The two societies' roles clearly overlap in some major areas of gynaecological surgery training and governance. Indeed, RANZCOG not uncommonly requests the opinion and input of AGES regarding important issues under discussion, for example, development of the Endometriosis Clinical Practice Guideline, the Medical Benefits Schedule (MBS) review and, most recently, the National Medicines Policy (NMP) review. Further, a conjoint committee, the RANZCOG/AGES Endoscopic Surgery Advisory Committee (ESAC), was created to develop a mutual understanding and progress common goals regarding surgical education and the development of required surgical skill sets for the Obstetrician & Gynaecologist. Part of the role of ESAC is the development and review of RANZCOG College Statements that pertain to gynaecological surgery. The aim of one of these College Statements, *C-Trg-2 – Guidelines for performing gynaecological endoscopic procedures*, is to stratify endoscopic procedures, according to their complexities, into various levels of Scope of Clinical Practice (SOCP; see Figure 1). C-Trg-2 will feature in the discussion below.

So, back to the future of gynaecological surgery training... If you have not gathered it already, I consider gynaecological training in Australasia to be in a somewhat parlous state and with an uncertain future. RANZCOG trainees undertaking the four years of basic training (Integrated Training Program or ITP) are currently required to perform, on average, at least 13 major gynaecological procedures per six-month term. By way of comparison, in my last 6 months of training in 2004 (before I commenced a 2-year fellowship in advanced training in endoscopic surgery), I performed 47 major gynaecological procedures – of these, a significant number included multiple procedures (e.g., vaginal hysterectomy with anterior and posterior repairs) which could now be counted as individual procedures. However, an increasing number of training hospitals are no longer able to reliably provide the requisite 13 gynaecological surgery procedures per 6-month period for all the RANZCOG trainees required to staff the hospital obstetric service. Even with the inventive carving up of a single major procedure into smaller major procedures for one or more trainees, as suggested by RANZCOG, some hospitals are in danger of losing RANZCOG accreditation as a training site. The reasons for the decreased surgical numbers are many and varied but include slashing of public hospital gynaecology operating lists and a flow-on effect to increased waiting lists and time to surgical procedures, with further pressure on women to have their procedure performed in the private sector (either self-funding, or after taking out private insurance and waiting out the exclusion time for pre-existing conditions).

President's Letter cont.

What is AGES's role in gynaecological surgery training? Put very simply, AGES plays no role in basic gynaecological surgery training (i.e., during the ITP), except for making available learning opportunities that are available to all AGES members such as educational meetings, workshops, webinars and other learning resources. However, AGES does play a significant and active role in the education of RANZCOG advanced trainees (training years 5 and 6). Understanding this relationship is best appreciated by referring to the RANZCOG/AGES SOCPs contained within C-Trg-2 (Figure 1). **Level 1-2** SOCP procedures are diagnostic or simple operative procedures, competency in which should be achieved by all those awarded FRANZCOG. Level 2 SOCP is considered the minimum requirement for a consultant in obstetrics & gynaecology, based on emergency gynaecological procedures likely to be performed in rural/remote practice. **Level 3** SOCP procedures include operative endoscopic procedures and competency should be achieved by those awarded FRANZCOG who have completed the Generalist Pathway. **Level 4** SOCP procedures include advanced operative endoscopic procedures and competency should be achieved by those awarded FRANZCOG who have completed the Hysteroscopic & Laparoscopic Surgery ATM. **Level 5** SOCP procedures include endoscopic procedures of advanced complexity and competency should be achieved by the completion of an accredited advanced training program, such as the AATP or a similar formalised training program of no less than 24 months' duration. **Level 6** procedures encompass the highest level of complexity and are domain specific (practitioners may be credentialed in more than one domain). Level 6 competency may be achieved by the completion of one the RANZCOG Subspecialist Programs with a surgical focus (i.e., CU, CREI or CGO) or another accredited advanced surgical training program, such as the AATP. Therefore, the AATP and similar training programs fill a void in the training of Level 5-6 SCOP procedures that are is not covered by the RANZCOG Sub-specialities.

Despite this clear benefit to our profession of having a proportion of gynaecologists complete the AATP and, therefore, be able to perform Level 5-6 SOCP procedures, the AATP is paradoxically under threat by the RANZCOG requirement that all ITP trainees perform the 13 major procedures per 6-month period. This threat is in the form of limitations of public hospital cases available to AATP candidates – specifically, at least one AATP Unit has had to give up a training position because the affiliated training hospital has had to significantly limit the operating lists available to the AATP candidate, itself in danger of losing RANZCOG accreditation because the ITP trainees do not have access to the required number of gynaecological procedures. A potential solution to this problem with the AATP trainee operating with the ITP trainees is not, however, a priority for public hospitals.

So, do we need a RANZCOG Sub-specialist Certificate of Minimally Invasive Gynaecological Surgery (CMIGS)? A small but significant number of AGES Members have argued the case for this. AGES is not supportive of such a step at this time for various reasons (for another time and place). Clearly, though, there are a range of advanced laparoscopic procedures that are not necessarily included in the remit of the current RANZCOG Sub-specialties (*e.g.*, laparoscopic hysterectomy for the large fibroid uterus, laparoscopic myomectomy, laparoscopic management of stage 4 endometriosis, laparoscopic removal of the residual cervix after previous sub-total hysterectomy, laparoscopic removal of the adnexa after previous hysterectomy, *etc*).

President's Letter cont.

No doubt RANZCOG, with the input of AGES, will continue to try to find a solution to this thorny issue of gynaecological surgery training. Ultimately, I fear that soon hard decisions will have to be made regarding the future of gynaecological training that may include the recognition that a proportion of RANZCOG Basic Trainees decide very early on that they do not wish to incorporate high-end endoscopic procedures into their future practices, with some not wishing to perform procedures above the RANZCOG/AGES Level 2 SOCP – accommodation of their preference would free up gynaecological procedures for those wishing to practise at the Level 3 SOCP and above. In the meantime, AATP positions will continue to threatened due to diminishing case numbers, which can only be to the detriment to the women we treat.

In conclusion, I am confident any dark clouds on the horizon for AGES will pass. Our society is healthy and remains relevant to registrars, generalists who occasionally perform gynaecological surgery but mainly deliver babies, generalists who have practices where the proportion of obstetrics to gynaecology is fairly even, and advanced laparoscopic surgeons who routinely perform more complex surgeries and are early adopters of new technologies. In short, anyone who wants to be a part of AGES is welcome and AGES will strive to fulfill all our members' particular learning needs. Indeed, the previous sentence is the overarching aim I have for AGES.

I look forward to seeing you at the ASM22 "Onwards & Upwards", in Melbourne in March next year, hopefully face-to-face and in much happier circumstances.

Stephen Lyons
AGES President

President's Letter cont.

FIGURE 1: RANZCOG/AGES Levels of Scope of Clinical Practice

RANZCOG and AGES have classified procedures that require similar endoscopic scope of practice.

LEVEL 1 SCOPE OF CLINICAL PRACTICE

Description: Level 1 procedures encompass *diagnostic endoscopic procedures*.

RANZCOG Training Pathway: Level 1 competency should be achieved by all those awarded FRANZCOG.

Inclusions: Level 1 procedures include, but are not limited to, diagnostic hysteroscopy and laparoscopy, including alternative entry techniques and port site placements.

LEVEL 2 SCOPE OF CLINICAL PRACTICE

Description: Level 2 procedures encompass *simple operative endoscopic procedures*.

RANZCOG Training Pathway: Level 2 competency should be achieved by all those awarded FRANZCOG.

Inclusions: Level 2-A procedures include, but are not limited to, simple operative procedures such as hysteroscopic retrieval of an intrauterine device, laparoscopic tubal ligation, simple cyst aspiration, simple adhesiolysis and ablation of ASRM stage 1 endometriosis.
Level 2-B procedures at this level include salpingotomy/salpingectomy for treatment of ectopic pregnancy.

LEVEL 3 SCOPE OF CLINICAL PRACTICE

Description: Level 3 procedures encompass *operative endoscopic procedures*.

RANZCOG Training Pathway: Level 3 competency should be achieved by those awarded FRANZCOG who have completed the Generalist Pathway (includes the Generalist Obstetrics and the Generalist Gynaecology ATMs).

Inclusions: Level 3-A procedures include, but are not limited to, operative procedures such as hysteroscopic polyp resection including the base, laparoscopic ovarian cystectomy without complexity, excision of ASRM stage 2 endometriosis and oophorectomy (without complexity).
Level 3-B procedures include laparoscopically-assisted vaginal hysterectomy (LAVH).

LEVEL 4 SCOPE OF CLINICAL PRACTICE

Description: Level 4 procedures encompass *advanced operative endoscopic procedures*.

RANZCOG Training Pathway: Level 4 competency should be achieved by those awarded FRANZCOG who have completed the Hysteroscopic & Laparoscopic Surgery ATM.

Inclusions: Level 4 procedures include, but are not limited to, operative procedures such as salpingo-oophorectomy with complexity, adhesiolysis, hysteroscopic sub-mucosal fibroid (type 0-1), hysteroscopic endometrial ablation; excision of ASRM stage 3 endometriosis, laparoscopically assisted vaginal hysterectomy with complexity (as described in this scope of clinical practice) and laparoscopic hysterectomy without complexity (other than described in this scope of clinical practice).

President's Letter cont.

LEVEL 5 SCOPE OF CLINICAL PRACTICE

Description: Level 5 procedures encompass *endoscopic procedures of advanced complexity*.

RANZCOG Training Pathway: Level 5 competency should be achieved by the completion of an accredited advanced training program, such as the AATP or a similar formalised training program of no less than 24 months' duration. This stage incorporates a capacity for endoscopic suturing.

Inclusions: Level 5 procedures include, but are not limited to, laparoscopic hysterectomy with complexity (such as endometriosis and fibroids), Burch colposuspension, myomectomy, management of ASRM stage 4 endometriosis, hysteroscopic myomectomy (type 2) and hysteroscopic septoplasty. This level also includes all single-site and robotic approaches.

LEVEL 6 SCOPE OF CLINICAL PRACTICE

Description: Level 6 procedures encompass *the highest level of complexity* and are domain specific. Practitioners may be credentialed in more than one domain.

RANZCOG Training Pathway: Level 6 competency may be achieved by the completion of one the RANZCOG Sub-specialist Programs with a major surgical focus (i.e., CU, CREI or CGO) or another accredited advanced training program, such as the AATP.

Inclusions: Level 6-B (benign gynaecological surgery) procedures include laparoscopic excisional surgery for ASRM stage 4 endometriosis necessitating bowel or urological resection, ureterolysis, removal of residual cervix, removal of residual ovaries with significant distortion of the anatomy and extensive adhesiolysis. This level includes coordination of a multidisciplinary team, including colorectal and urological colleagues.

Level 6-U (urogynaecological surgery) procedures include urogynaecological procedures (laparoscopic pelvic floor repair and sacrocolpopexy).

Level 6-R (reproductive gynaecological surgery) procedures include laparoscopic tubal reanastomosis and management of congenital disorders.

Level 6-O (gynaecological oncology surgery) procedures at this level laparoscopic oncological procedures such as laparoscopic pelvic/para-aortic lymph node dissection and radical hysterectomy.

NB: CREDENTIALLING

Although this statement will help guide institutional credentialing for a new Fellow, it should not be used to restrict scope of practice of any Fellow who is able to demonstrate training in a specific area of practice or procedure. Credentialing in endoscopic surgery must always proceed on an individual basis, and as such, may proceed outside of this framework, based on an individual's evidence of training, skills and currency. Refer to College statement Credentialing in Obstetrics and Gynaecology (WPI 23). Credentialling will sometimes need to be specific for procedures within a particular level of this framework and therefore a practitioner may not necessarily be credentialled for all procedures within the specified level.

ATM: Advanced Training Module

Editorial

Welcome to the 77th Edition of eScope.

This will be the last edition of eScope for 2021. I wish all our members a wonderful Christmas. Hopefully now most of our interstate borders have opened this year will allow for some family reunions. My thoughts are with all our members who remain unable to have this joy.

We all had the wonderful opportunity to join virtually last month for the ASM "Leading the New Paradigm". The tireless work of Michael Wynn-Williams, Kirsten Connan and Helen Green was noticeable. Although it was a great loss to not meet face to face, the meeting was a wonderful and unique mix of so many different aspects of modern gynaecological practice. Some memorable talks from Craig Reucassel, Kirsten Ferguson and Heidi Denning to mention just a few.

In this edition, the board member article has been provided by Dr George Condous. George is passionate about ultrasound diagnosis of Endometriosis, and has published numerous times on this topic. His article entitled *"All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging"* gives the reader a guide to how this image modality can affect surgical planning. A must read for all those involved in the care of Endometriosis.

The Fellow article provided by Dr Emily Twidale. Emily has written a fun piece on laparoscopic dry lab training with some engaging games to try. This could be a change from my usual Christmas puzzle tradition!!!

Our professional development alliance partner Avant have provided us with a useful summary on the use of clinical images. The legal consent required for obtaining and using clinical images is discussed in this article.

Planning is underway for our suite of meetings next year. The first Meeting of 2022 will be the ASM "Onwards and Upwards". This meeting is being curated by our President Stephen Lyons. The next meeting will be the Focus meeting in Queenstown. I am delighted to be the chair of this meeting. I welcome back Simon Edmonds to the team as Scientific co-chair with fellow NZ team mate Olivia Smart. This meeting will be popular both for its engaging content (totally biased) and its incredible location. I am so excited to return to one of my favourite places and hope to see many of you there.

So here is to happy reading. Goodbye 2021. It's not been a great ride for many. Merry Christmas to all and Happy 2022 filled with amazing face to face education.

Rachel Green
eScope Editor &
AGES Vice-President

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All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging

Cansu Uzuner MBBS, **Mathew Leonardi** MD FRCSC, **George Condous** MBBS FRANZCOG FRCOG MD

Endometriosis is estimated to have a prevalence of up to 10% in women of reproductive age, however the prevalence goes up to 50% in infertile women [1]. Surgical treatment is offered to women with pain refractory to medical therapies or with endometriosis associated infertility [1, 2]. The presence of deep endometriosis increases the complexity of the surgery, and the surgical expertise that is required to complete the operation. A multidisciplinary surgical team approach with colorectal surgeons and urologists is required and recommended for deep endometriosis involving the bowel, bladder or ureters [3].

Why is it necessary?

When deep endometriosis involving the bowel, bladder or ureter is diagnosed for the first time at laparoscopy, either an intra-operative colorectal surgery or urology consultation is requested, or the surgery is terminated for a two-step approach. Unforeseen intra-operative consultation with other surgical disciplines can lead to longer theatre case times and may disrupt other clinical duties of these surgeons. In smaller regional or rural hospitals, colorectal surgeons or urologists may not be readily available for an unplanned consult. An even bigger issue lies in the consent of the patient, as complete excisions of such deep endometriosis lesions cannot be completed if the patient has not been consented for bowel, bladder or ureteral resection. Even if the patient had been consented for a potentially more invasive excision, the bowel may not be prepared with bowel prep that may increase the chance of post-operative complications [4].

Another factor may lead to a two-step laparoscopy is the level of expertise and scope of practice of the gynaecological surgeon. Incomplete excision of deep endometriosis, due to incomplete ureterolysis or adhesiolysis or to mitigate risk of visceral injury, can lead to ongoing pain symptoms in the patient, necessitating a repeat surgery by an advanced gynaecological laparoscopic surgeon with experience in severe endometriosis. Having multiple laparoscopies for endometriosis not only increases surgical risks associated with each laparoscopy, but also exposes the patient to multiple post-operative recovery periods. The delay in treatment in the form of complete excision can have an adverse impact on the quality of life of the patient due to ongoing pain [2, 5].

Pre-operative prediction of complexity of surgery, the level of expertise of the gynaecological surgeon needed and the need for multidisciplinary surgical team would mitigate the previously forementioned risks and costs. Non-invasive deep endometriosis imaging can diagnose and map out the location and extent of deep endometriosis pre-operatively. The diagnostic performance of transvaginal ultrasound and MRI are similar in detecting deep endometriosis [6]. Ultrasounds are readily available and provide information real-time about adhesions and mobility of pelvic structures. 'Deep endometriosis' ultrasound scans can accurately identify deep endometriosis and stage the level of complexity of the laparoscopic surgery [6-11]. The 2016 Cochrane systematic review and meta-analysis on the diagnostic accuracy of transvaginal ultrasound concluded a sensitivity of 93% and specificity of 96% for ovarian endometriomas and a sensitivity of 79% and specificity of 94% for deep endometriosis [8]. Furthermore, the 'sliding sign, which demonstrates pouch of Douglas (POD) mobility or obliteration has an accuracy of 93%, sensitivity of 83%, and specificity of 97% [12].

All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging cont.

Cansu Uzuner, Mathew Leonardi, George Condous

Pre-operative mapping of deep endometriosis can assist in complete excision of all the endometriosis lesions, as the gynaecological surgeon can use it as a supplement to the visual diagnosis. If a deep endometriotic lesion is in the rectovaginal septum, hidden behind an adhesion, or the rectosigmoid colon has skip lesions of endometriosis, the pre-operative ultrasound diagnosis will ensure planning and careful surgical execution is taken to excise all the lesions.

Pre-operative deep endometriosis ultrasound can also facilitate the allocation of an appropriate surgeon by predicting the RANZCOG/AGES laparoscopic skill level required [9-11]. The ultrasound-based endometriosis staging system (UBESS) is divided into three levels: UBESS I to predict RANZCOG/AGES surgical skill levels 1/2, UBESS II to predict RANZCOG/AGES skill levels 3/4 and UBESS III to predict RANZCOG/AGES skill level 6 [9]. It has been validated that the rate of correctly predicting the exact level of laparoscopic skills needed for the endometriosis surgery via UBESS is 98.1% [9]. Pre-operative deep endometriosis scan and application of the UBESS can allow the general gynaecologist to assess the suitability of the patient and the laparoscopy to their skillset.

In regards to cost to the healthcare system, it has been demonstrated that a pre-operative deep endometriosis ultrasound can be cost saving to the healthcare system by up to AU$924,437 per annum by preventing the two-step laparoscopic approach [13]. By preventing delay in diagnosis and treatment, it can further reduce costs precured by Emergency Department presentations and inpatient admissions of patients suffering with undiagnosed endometriosis. It has been highlighted that low-value care in endometriosis management, defined as interventions with uncertain benefits, or in which the effectiveness is comparable to less expensive alternatives, should be reduced [14]. Laparoscopy for superficial endometriosis may not improve pain symptoms and it has been suggested that it may even worsen post-surgical pain in up to 20% of patients [1, 15].

An advanced transvaginal ultrasound can predict the revised American Society of Reproductive Medicine (rASRM) stage of endometriosis [16] and the diagnostic accuracy improves as the ASRM stage increases [7]. The overall accuracy of detecting ASMR Stage 3 and 4 with a transvaginal ultrasound is 94.6% [7] and can be used to rule out deep endometriosis without the need for a laparoscopy. A non-surgical diagnosis based on history and physical examination in conjunction with transvaginal ultrasound can be employed over a diagnostic laparoscopy, with laparoscopy being reserved for treatment [14].

What can it detect?

Advanced transvaginal ultrasound for ultrasound diagnosis of deep endometriosis has been standardised by International Deep Endometriosis Analysis (IDEA) Consensus statement [17] and provides a structured framework to assess the pelvis in compartments for ultrasound signs of endometriosis. The first step is routine evaluation of the uterus and adnexa, including assessment for endometriomas and adenomyosis. The second step is the evaluation of 'soft markers' such as ovarian mobility and site-specific tenderness. Third step involves assessment of the pouch of Douglas with the 'sliding sign' – where the transvaginal ultrasound probe is pushed against the cervix and the sonographer's free hand pushes on the lower abdomen to ballot the uterus. The gliding of the rectum over the posterior uterine fundus and posterior cervix in an anteverted uterus, and the posterior uterine fundus and lower anterior uterus in a retroverted uterus is expected in a free POD with a 'positive sliding sign'. If there are adhesions and the POD is obliterated, this gliding is limited or absent, indicting a 'negative sliding sign'. Lastly, the fourth step involves anterior and posterior compartmental evaluation of the pelvis for deep endometriotic nodules. The anterior compartment involves the bladder and ureters, and the posterior compartment involves the rectosigmoid colon, rectovaginal septum, posterior vaginal fornices, uterosacral ligaments and torus uterinus [17].

All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging cont.

Cansu Uzuner, Mathew Leonardi, George Condous

Below are some examples of what can be seen on a deep endometriosis ultrasound [18]:

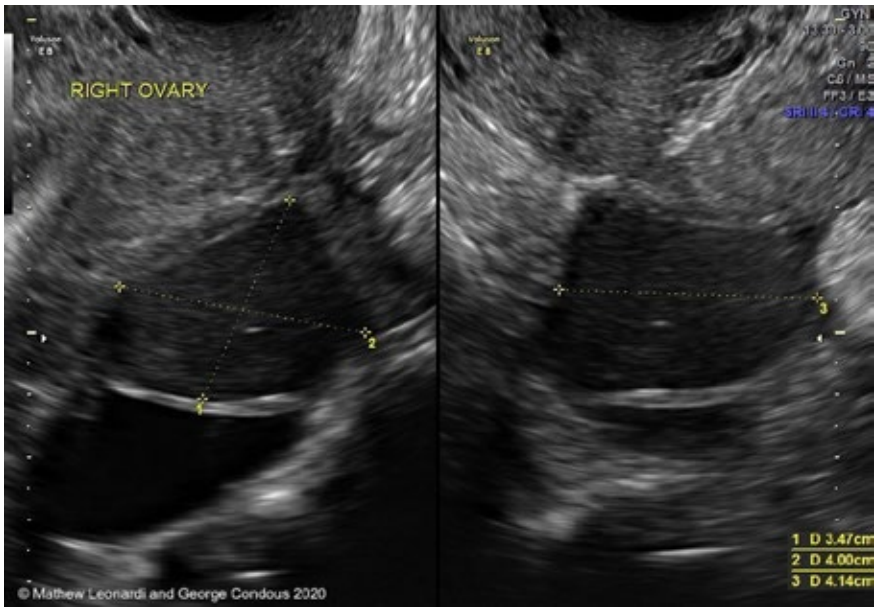

Figure 1 Ovarian endometrioma

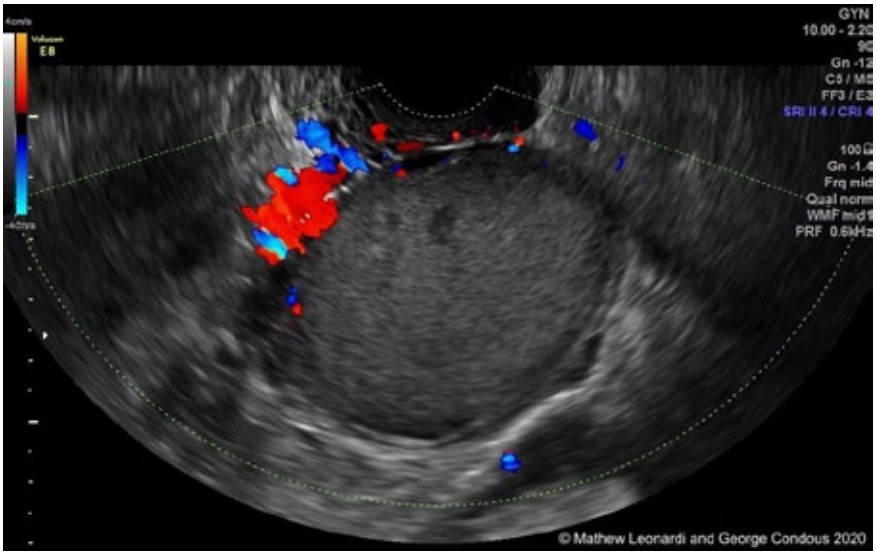

Figure 2 Ovarian endometrioma

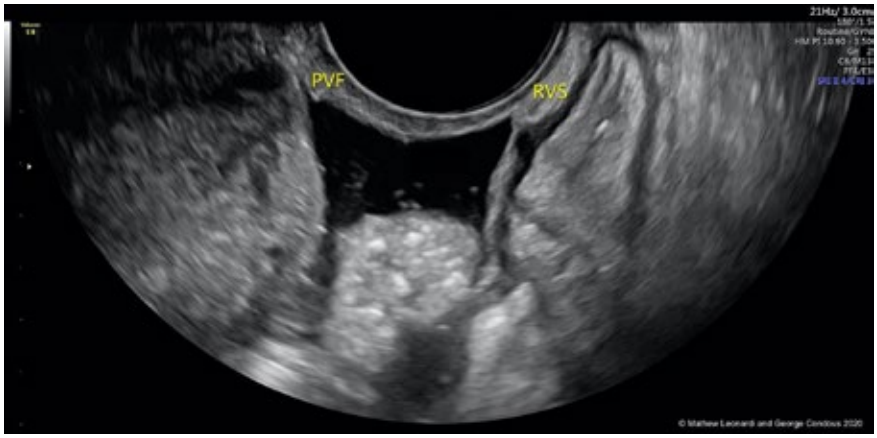

Figure 3 Normal posterior vaginal fornix (PVF) and rectovaginal septum (RVS)

All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging cont.

Cansu Uzuner, Mathew Leonardi, George Condous

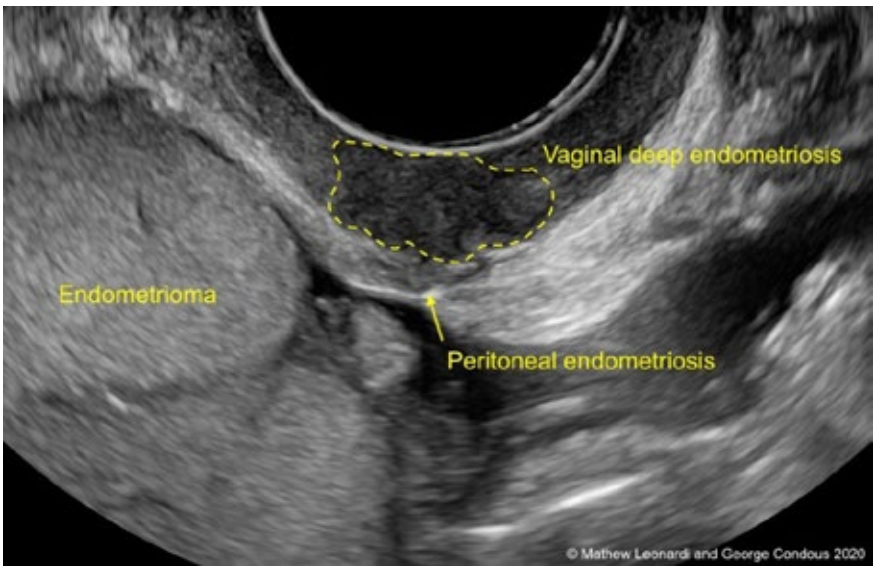

Figure 4 Vaginal deep endometriosis, with overlying POD peritoneal endometriosis

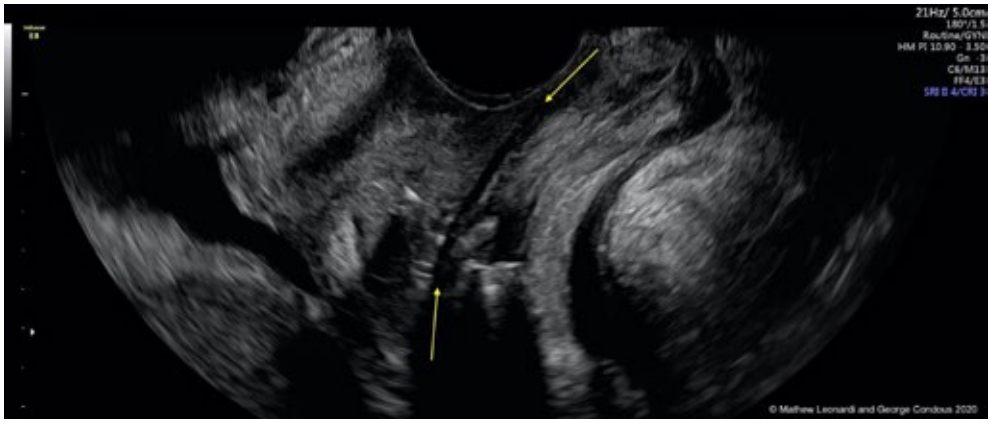

Figure 5 Normal anterior rectum with thin muscularis externa (propria)

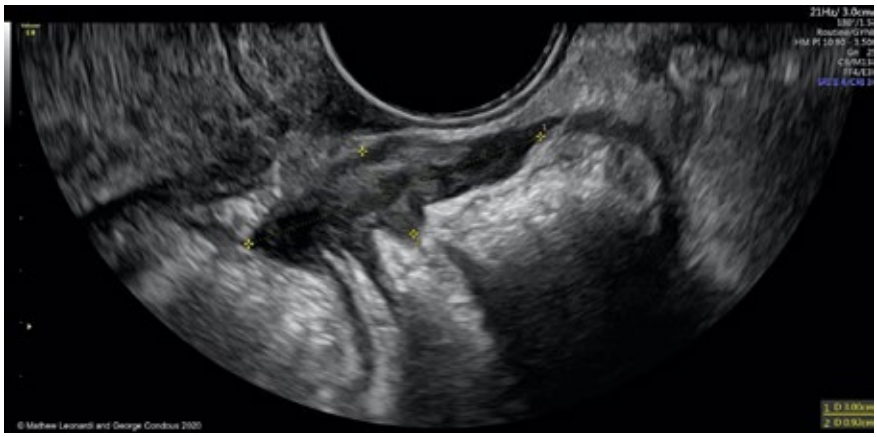

Figure 6 Large anterior rectal deep endometriosis

All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging cont.

Cansu Uzuner, Mathew Leonardi, George Condous

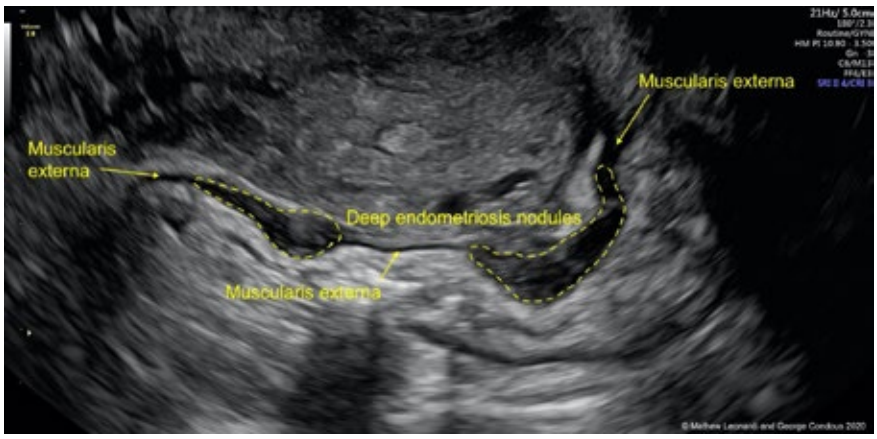

Figure 7 Two separate lesions of anterior rectal deep endometriosis

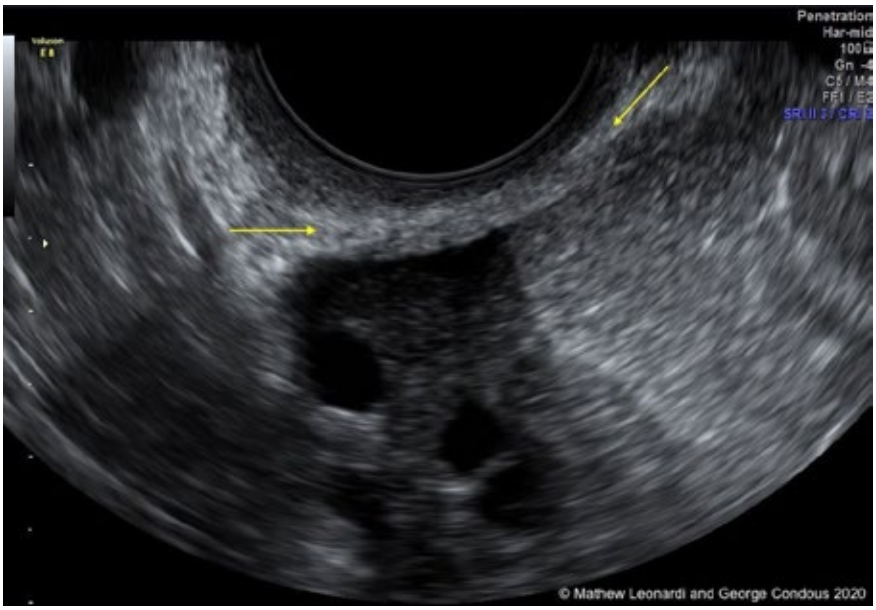

Figure 8 Normal uterosacral ligament

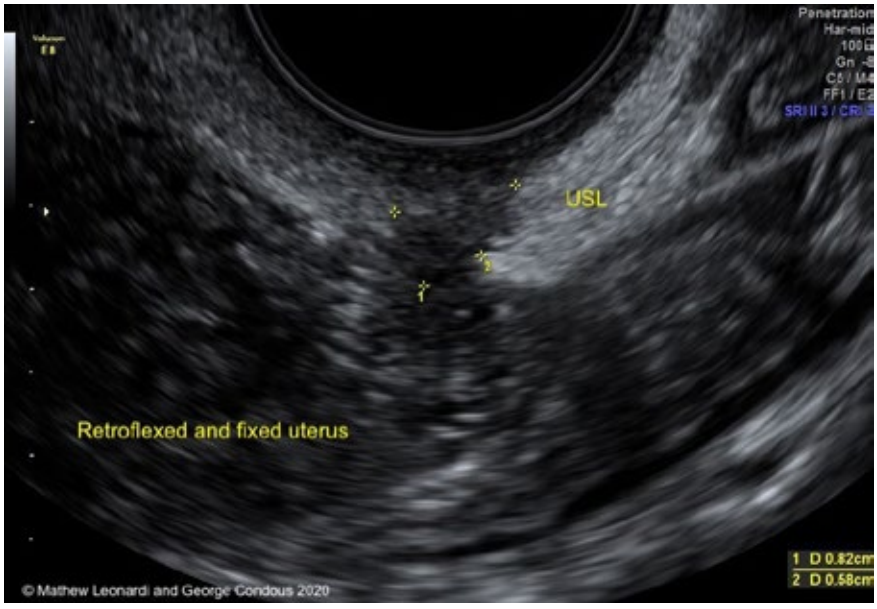

Figure 9 Deep endometriosis nodule of the uterosacral ligament (USL)

All women scheduled for endometriosis surgery should have pre-operative 'deep endometriosis' imaging cont.

Cansu Uzuner, Mathew Leonardi, George Condous

Cansu Uzuner

Mathew Leonardi

George Condous

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Novel laparoscopic simulation tasks – the case for lap craft

Emily Twidale

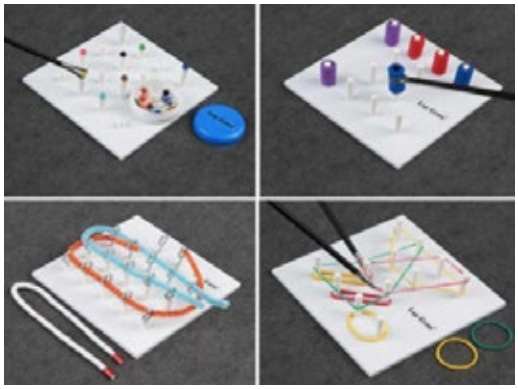
"Teacher, you're making me bored"

Writing this article, I was reminded of a schoolteacher friend of mine's story. He was doing his best with a quick didactic moment in class and was gifted the above heckle by a ruthlessly incisive teen.

Laparoscopic simulation box use is beset by low motivation amongst trainees worldwide [1,2]. This is partly because of lack of equipment availability, time and accountability [3]. I believe the unspoken issue with lap simulation is that the existing tasks recommended for these expensive sim boxes are dull. This article is an opportunity for me to show some simple, economical and fun alternatives.

There is a wealth of literature on external motivators for laparoscopic skill development through simulation, that are dependent on persistent collaboration with seniors. These include competitions, presence of facilitators to provide immediate feedback and in-house mandatory proficiencies [4]. Instead, I will focus on internal motivation via novel simulation tasks that are tricky, enjoyable and logically translate to in vivo procedural skills.

The laparoscopy simulation tasks I encountered in my RANZCOG and AGES training were simple. Their demands were in keeping with a RANZCOG level 3 laparoscopy. We had the peg transfer, paper cutting, stretching an elastic band around a ring of nails, threading loops of reducing diameter, making a tower of blocks only to watch it tumble. Completion takes seconds to minutes. Fundamentally, they are not the stuff to maintain the interest of an emerging advanced laparoscopic surgeon.



Lap Game® Laparoscopic Simulator Training Exercise Equipment.

Once a trainee has been accredited to perform basic laparoscopy, we should offer new and complex simulation activities. It is not enough to give them a silicone vaginal cuff to suture once and then bolt.

Above Simsei® Vaginal Cuff Model and Base.

Left Lapsim® Virtual Reality Simulator

Unfortunately, the high definition path of ultra-expensive lap simulation computer programs too has proven wanting for the prize of motivating budding gynaecologists [5]. So rather than exclusively fixating on an increasingly elaborate, but always inferior simulacrum of a surgical operation, let us think laterally. We should create simulation tasks that inspire the mindful satisfaction a surgeon *feels* when they are in the zone – operating autonomously and successfully. Tasks that can be approached incrementally, but take an hour or more to complete. Tasks that come with a memento of the student's victory.

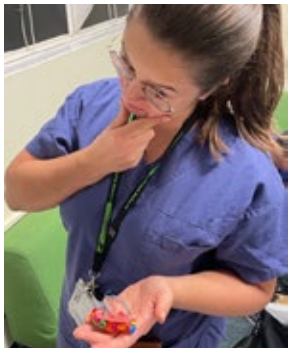
Please feel free to contact me if you would like instructions for making the tasks yourself, or to receive some to try.

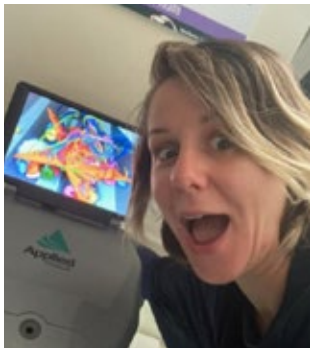
Novel laparoscopic simulation tasks – the case for lap craft cont.

Emily Twidale

1. Intracorporeal knot tying star

Students receive a cut out with at least 30 beads and pompoms attached to loose, conditioned thread pairs





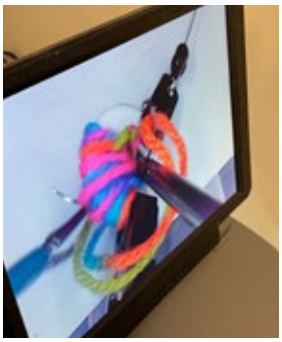
It is normal for the student to not look happy yet.

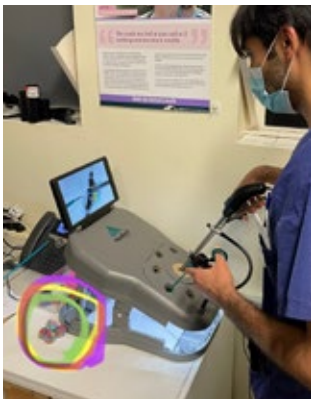
The task is to take the pair of same coloured threads and tie them together with a triple throw. This tightens the corresponding bead. The threads are trimmed and the task repeated until completion. At the conclusion, the student has made a decorative star which can be glued to the magnet I give them for display at home and future inspiration.

For this task, after providing the materials and initial instructions I offer no formal supervision or surveillance and yet they keep getting completed.

2. Continuous suturing

My continuous suturing task is a recent idea and it focuses on repeated needle loading. The skill is making a miniature pompom. It involves taking a pre-threaded curved needle and looping the wool through two perforated discs repeatedly until a tight circle has been formed. The outer border gets bisected, the inner border is tied together, the discs removed and the piece is trimmed until beautiful.





Novel laparoscopic simulation tasks – the case for lap craft cont.

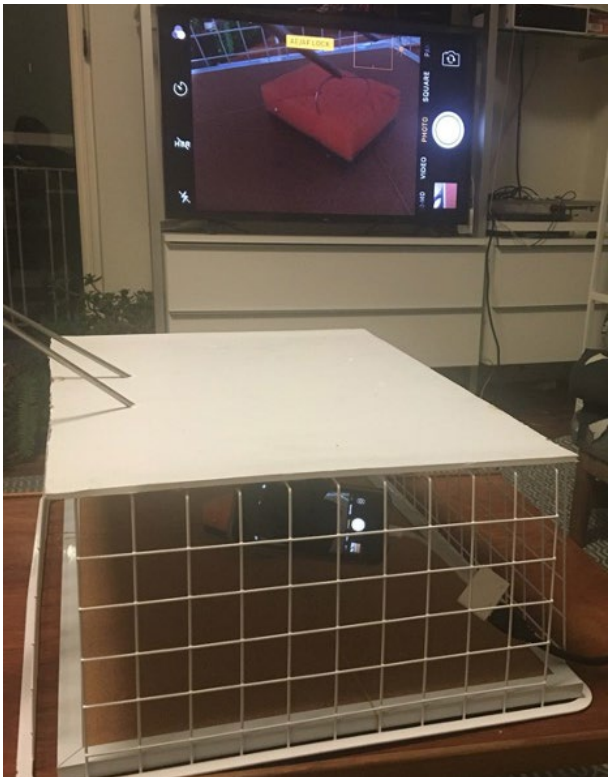
Emily Twidale

3. Do It Yourself Laparoscopic Simulation Box

The usual equipment for lap simulation is dear, but there are cheaper options. If price is a barrier to having a box at home, here are instructions on how I made mine on a dime. I have great image quality with the combination of my smartphone and TV. This beast has followed me far and wide and still gets a regular spin.

The frame is a wire basket 435 from Bunnings. The top is cut plastic sheet called Corflute (Bunnings). The base is a cork board from Officeworks. It nests in perfectly. The smartphone is held in place with a Cleanskin magnetic short arm mount (Officeworks). For needle holders, I used Ebay to buy 5x330mm straight tip ones. I spent $135 per holder. The task stabilisers are retractable clasps. I used Liquid Nails as glue. The smartphone should be set to have no 'sleep mode'. The magnet needs to be placed against the screen to avoid image reversal. I use an elastic band to hold the magnet in place. My light source is a freestanding lamp.

I see what you see, these tasks are 'quirky'. This label can be used to denigrate whimsical, cute and usually feminine pursuits. In 2019, 83% of RANZCOG trainees were female [6]. These women will often have gone through primary and secondary school with encouragement to pursue craft activities with a fine motor focus such as sewing, crochet, knitting or pottery. To me, craft can be separated from art by having a template with instructions; individual variation exists, but the foundation is concrete. Does that not sound like a model surgical procedure?



I recognise that internal motivation is individual and lap craft will not be for everyone. I still hope that we can make room for novelty in creating rewarding advanced lap simulation tasks. There should be a vast catalogue of fun box activities to suit different learners – it is our responsibility to try to keep our students interested.

Thanks to Drs Tanne Daniels Anamaria-Lelia Sarlau, Briar Mannering and Yousif Alyousif for modelling

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Novel laparoscopic simulation tasks – the case for lap craft cont.

Emily Twidale

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AGES XXXI Virtual Annual Scientific Meeting 2021 Report

It is strange to think that AGES ASM 2021 was originally planned to occur face to face in Melbourne in March and then moved to the Gold Coast with a number of different dates over seven months. Ultimately due to strict Covid lockdowns around Australia and New Zealand, it was finally held over three days in November in the virtual space of your own home for the first time. I think we can all agree that despite the virtual format the meeting was a great success.

We heard from leading speakers including; 'Change Agent' Kirstin Ferguson, Resilience and leadership expert, Heidi Dening. In the opening session "Change in Climate in Women's Health", Craig Reucassel from ABC's "The War on Waste" challenged us all to reduce our carbon foot prints by five tonnes.

There were too many highlights to include them all in this report but special mention must go to our international speakers Dr Lucky Saraswat(UK), Dr Sony Singh(Can), Dr Mark Slack (UK), Prof Barry O'Reilly (Ire), Dr Caprice Greenberg(USA), Dr Justin Dimick (USA), Dr Amy Park (USA) and Dr Donna Ghosh (UK). Despite significant personal health challenges, Dr Hilary Joyce gave an inspiring Dan O'Connor Oration.

We would like to specifically thank the local organising committee for their tireless work, all of the conference faculty, as well as Mary, Danielle, Amy and the team from YRD, for helping to make this ASM such a success.

AGES ASM AWARD WINNERS 2021

- AGES/AAGL Exchange Lecture: **Praveen De Silva**
- Best Free Communication Presentation, sponsored by Medtronic: **Tarana Lucky**
- AGES Outstanding New Presenter: **Russell Duncan**
- AGES Outstanding Video Presentation: **Assem Kalantan**
- AGES Outstanding Trainee Presentation, The Platinum Laparoscope Award: **Kate Martin**
- AGES Best Digital Communication Presentation: **Thomas Yeung**
- AGES Medtronic Travelling Fellowship: **Rachel Collings**
- AGES Hologic Hysteroscopic Travelling Fellowship: **Brydie Purbrick**

Michael Wynn-Williams
ASM Chair

Helen Green
Scientific Co-Chair

Kirsten Connan
Scientific Co-Chair

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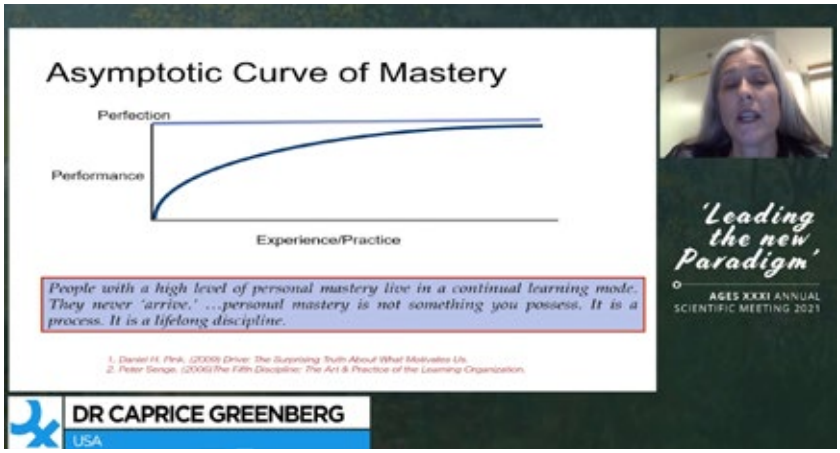

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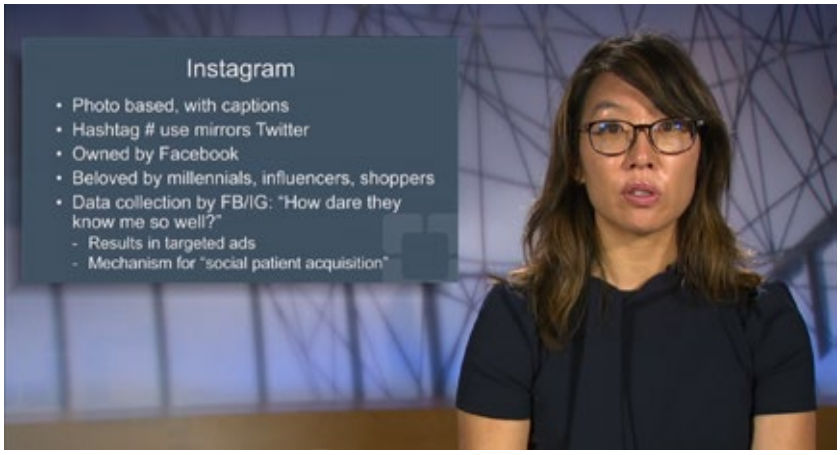

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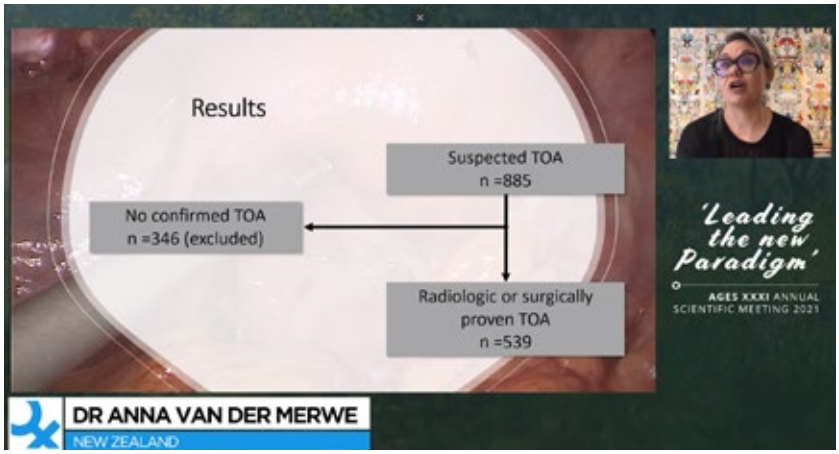

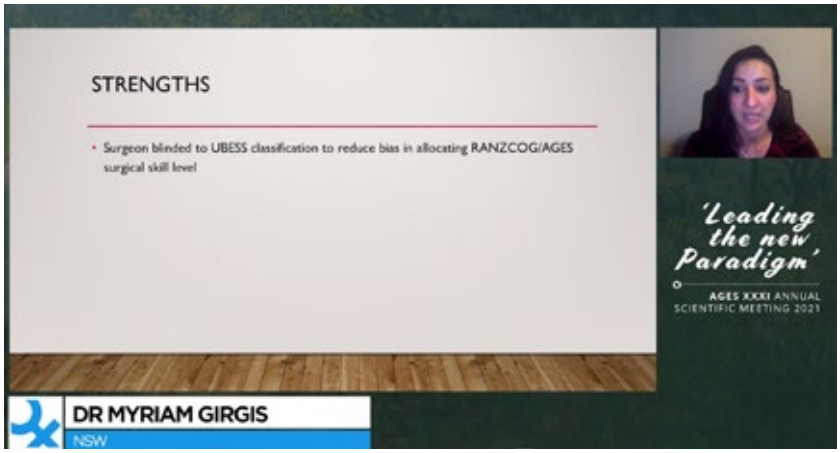

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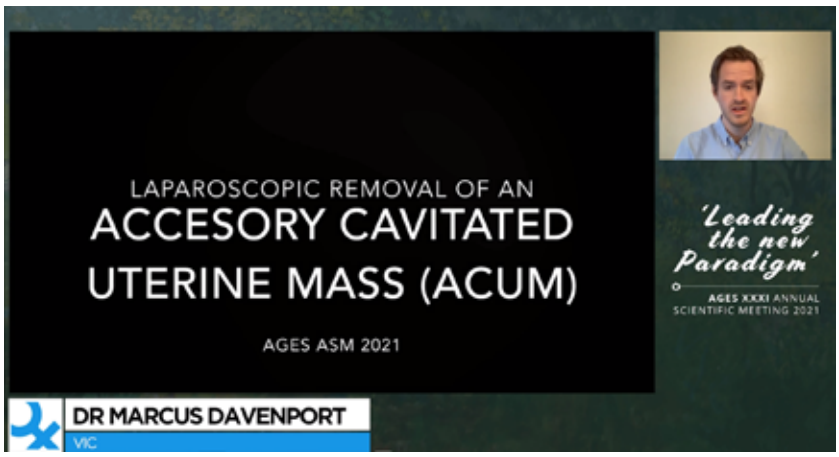

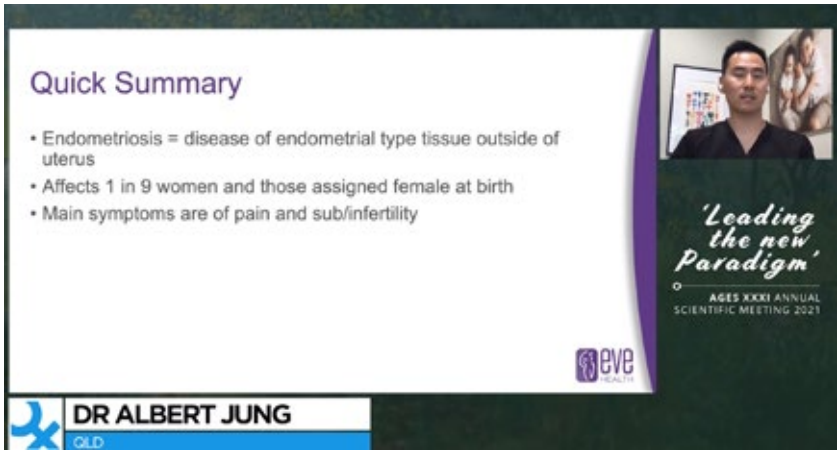

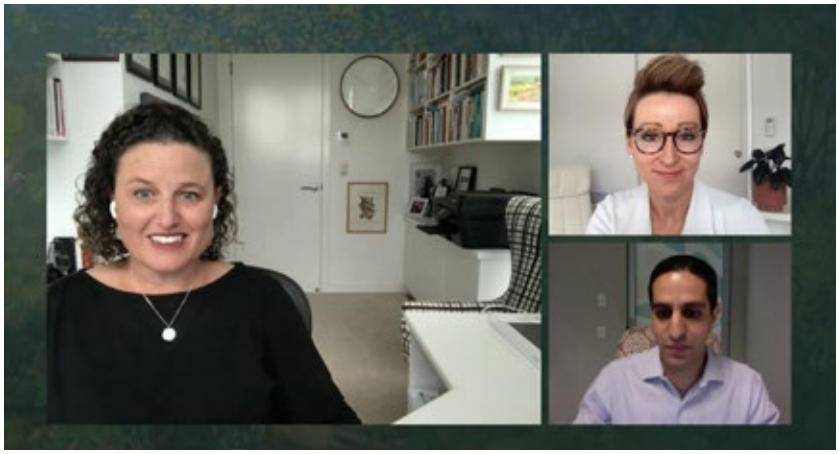

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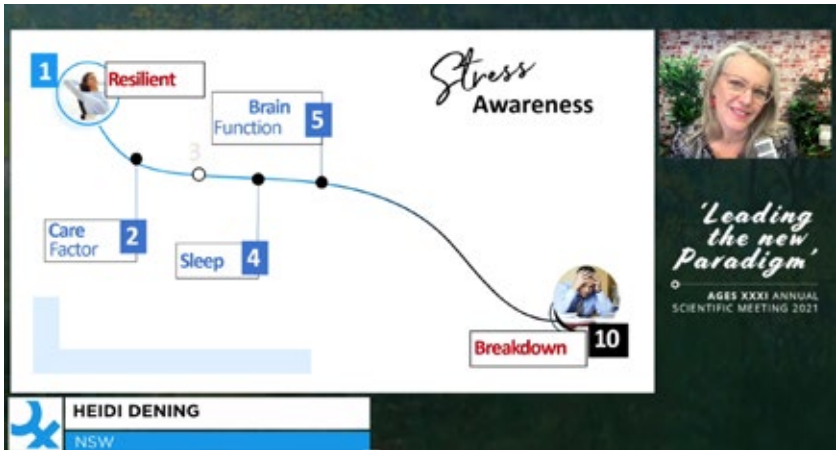

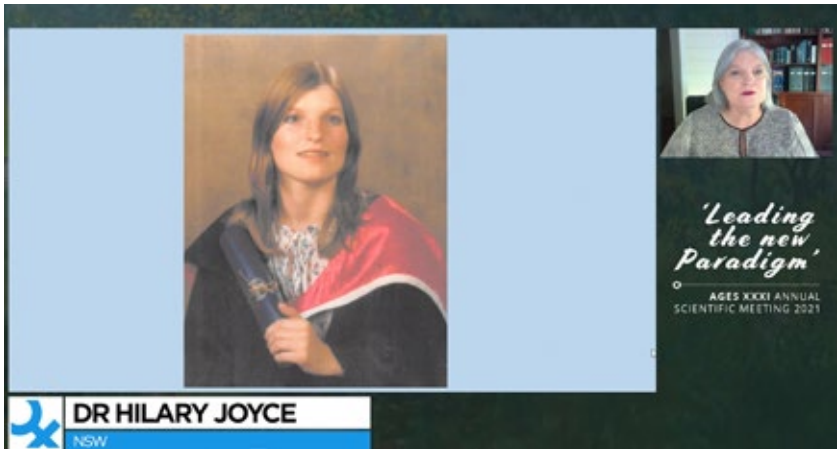

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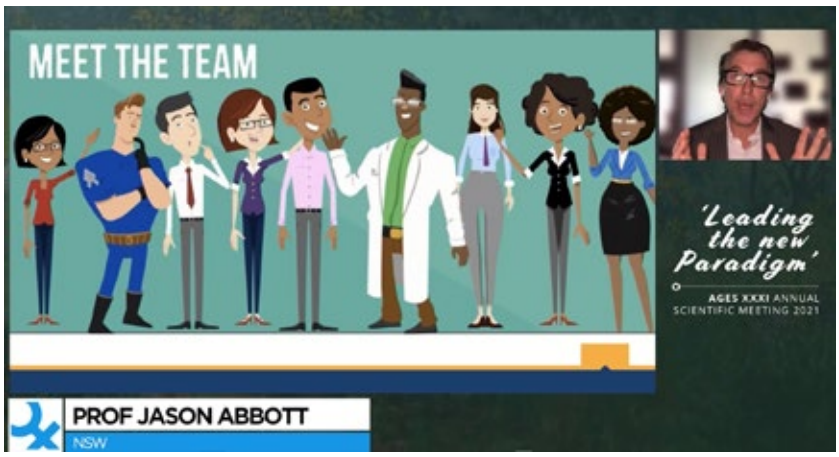

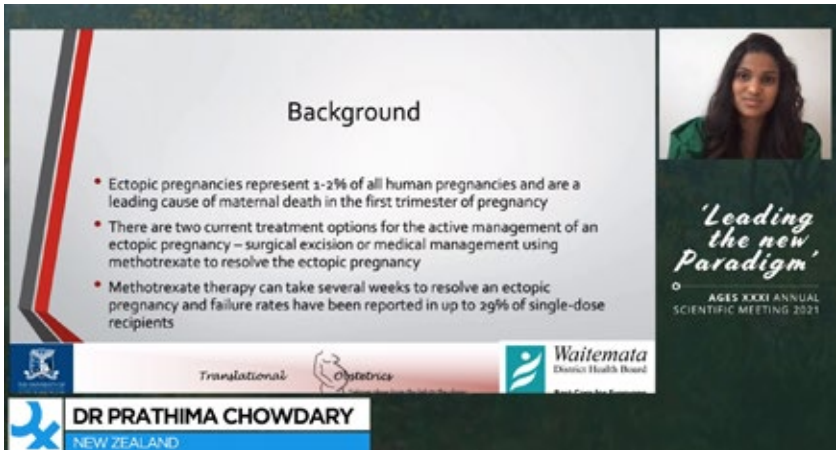

AGES XXXI Virtual Annual Scientific Meeting 2021 Report cont.

AGES XXXI Virtual Annual Scientific Meeting 2021 Report cont.

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AGES ASM21 Award Winner Abstracts

AGES/AAGL Exchange Lecture:
Praveen De Silva

Superior Hypogastric Plexus Nerve Block in Minimally Invasive Gynecology: a Randomised Controlled Trial (9279)

Praveen De Silva [1], Sam Daniels [1], Mujahid Bukhari [1], Sarah Choi [1], Andy Lieu [1], David MB Rosen [1], Dean D Conrad [1], Gregory Cario [1], Danny Chou [1]
1 Sydney Women's Endosurgery Centre (SWEC), Sydney, NSW, Australia

INTRODUCTION: Visceral pain sustained during surgery is transmitted through the superior hypogastric plexus. Neurolysis of this pain pathway has been studied in pelvic malignancy pain with good effect. Less research has been done on temporary blockade and on surgical patients. Our study is the first RCT assessing the effectiveness of a superior hypogastric plexus block in minimally invasive surgery.

OBJECTIVE: To assess efficacy of a superior hypogastric plexus block in reducing opioid requirements in the first 24 hours after minimally invasive surgery.

DESIGN: patient-blinded RCT

SETTING: Single-center institution, Sydney Women's Endosurgery Centre (SWEC).

PATIENTS: Patients undergoing either laparoscopic or robotic-assisted laparoscopic hysterectomy or myomectomy for benign indications.

INTERVENTION: 10mL 0.75% ropivacaine infiltrated into the retroperitoneal space overlying the superior hypogastric plexus vs control of no-block given at the completion of surgery.

MEASUREMENTS: Primary outcome was the total opioid use in first 24h after surgery, measured in Morphine Milliequivalents (MME). A standardized fentanyl patient-controlled analgesia (PCA) was given to all patients in the trial. Secondary outcome was pain measured on a visual analogue scale (1 to 10) at 1, 2, 6, 12 and 24-hours post-surgery.

MAIN RESULTS: 50 patients out of 56 patients approached for the study entered and completed the study (89.2%). Patients were randomized over a 5-month period, March to July 2020. 27 patients were randomized to receive a nerve block and 23 to the control. There was a difference of -21.8 MME in the block group compared to the no-block group (95% CI -38.2 – -5.5, p=0.008). This correlated to a 38% reduction in opioid use in the block group. The mean opioid use in block patients was 33.1 MME (95% CI, 24.2 – 41.9) and in the non-block group 54.9 MME (95% CI, 40.7 – 69.1). For the SHPB group opioid use ranged from 1.0-76.5 MME with an interquartile range (IQR) of 37 (14-51). For the control group the range was 7.5- 113.5 MME with a higher IQR of 60 (28-88). Pairwise comparisons of mean pain scores over the 24 hours showed a lower pain score with a nerve block of 1.8 (95% CI 1.5 – 2.1) compared to no-block of 2.6 (95% CI 2.3 – 2.9) No adverse effects of local anesthetic toxicity, nerve injury or bowel/vascular injury were noted in any patient.

CONCLUSION: superior hypogastric plexus blockade can reduce post-operative opioid requirements and pain in the first 24 hours after minimally invasive gynaecology.

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AGES ASM21 Award Winner Abstracts cont.

Best Free Communication Presentation (Sponsored by Medtronic): Tarana Lucky

Are we 'Gritty' enough? The importance of 'Grit' in O&G training – Association of passion and perseverance with burnout, thriving and career progression (9266)

Tarana Lucky [1 2 3 4], Belinda Lowe [3 5], Yasser Arafat [6], Evelyne Rathbone [5], Donald Angstetra [3 5]
1 Royal Women's Hospital, Melbourne 2 Griffith University, Gold Coast 3 Gold Coast University Hospital, Gold Coast
4 The Australasian Gynaecological Endoscopy and Surgery (AGES) Society, Melbourne 5 Bond University, Gold Coast
6 University of Queensland, Brisbane

BACKGROUND: The concept of grit and understanding its protective role against workplace burnout is highly relevant in the field of Obstetrics and Gynaecology. [1-3] However, despite an alarmingly high prevalence of burnout and workplace stress among Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) trainees (55% and 62%, respectively), [2] objective assessment of grit and its association with burnout among RANZCOG trainees/fellows remains underexplored.

AIM: This study utilises the Short Grit Scale and the Oldenburg Burnout Inventory to investigate the association of grit with burnout, thriving and career progression among O&G trainees and fellows in Australia/New Zealand. The key objectives were to determine grit and burnout level by seniority, understanding the relationship between grit and burnout, and to identify the factors that are significantly associated with high burnout.

MATERIALS AND METHODS: A cross-sectional survey of the RANZCOG members was conducted. Participants were categorised by level of seniority (core trainees, advanced trainees and fellows). Mean grit and burnout scores were compared with one-way ANOVAs. Correlation between grit and burnout was estimated using Pearson's correlation coefficient. Logistic regression models were used to determine factors associated with high vs low burnout. Grit was categorised as low/medium/high grit levels for regression models.

RESULTS: A total of 751 (26%) participants completed the survey. Fellows reported higher mean grit than core (p=0.02) and advanced trainees (p =0.03), and lower mean burnout than core trainees (p<0.001). Moderate negative correlation was demonstrated between grit and burnout scores (r =-0.34). In the multivariable model, only seniority (adjusted OR:0.40 for fellows vs core trainees, p=0.008) and grit levels (adjusted OR:4.52 for low vs high, p<0.001; 2.32 for low vs medium, p=0.001) were significantly associated with high burnout.

CONCLUSION: This study demonstrates the protective role of grit in combating burnout among RANZCOG trainees and fellows. To our knowledge, this study includes the largest sample size investigating the relationship between grit and burnout in a medical speciality training. This is also the first study in Australia and New Zealand to objectively assess the role of grit in predicting higher burnout among the O&G trainees and fellows. Findings are expected to help the college in developing effective, targeted interventions and subsequently minimise burnout-related adverse outcomes in high-risk groups. Interventions to expose trainees about the concept of grit, how to grow grit and its association with burnout can also be useful.

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AGES ASM21 Award Winner Abstracts cont.

AGES Outstanding New Presenter:
Russell Duncan

A potential role for the Ghrelin / LEAP-2 axis in Endometriosis (9810)

Russell Duncan [1 2], Dana Georgevsky [1], Michael Cooper [1], Lisa Chopin [3]
1 Royal Prince Alfred Hospital, Sydney, NSW, Australia 2 Royal North Shore Hospital, Sydney, NSW, Australia
3 Ghrelin Research Group, Transnational Research Institute Australia, Princess Alexandria Hospital, Brisbane, QLD, Australia

BACKGROUND: Endometriosis is a debilitating disease that can causes severe pelvic pain and infertility. Little is known about what influences the development and progression of this disease which limits treatment options. The ghrelin axis consists of ghrelin and its cognate receptor, the Growth Hormone Secretagogue Receptor (GHSR). Liver-Expressed Antimicrobial Peptide-2 (LEAP-2) is the most recent addition to this axis and has recently been recognised as an endogenous GHSR antagonist, inhibiting the cells response to ghrelin.

Ghrelin is a hormone which influences appetite, metabolism and bodyweight, with a wide range of functions, both physiological and pathological. The risk of developing endometriosis has been shown to be inversely proportional to BMI in data collected as part of the Nurses' Health Study II, women with a lower BMI have a much higher risk of developing endometriosis. Circulating ghrelin concentrations also follow this pattern, being higher in women with lower BMIs. Previous studies have shown GHSR to be present in endometriomas and concentrations of ghrelin are increased in peritoneal fluid of patients with endometriosis. LEAP-2 expression has not been investigated in endometriosis. We hypothesised that the Ghrelin and LEAP-2 may influence the development of endometriosis

AIMS:
- Evaluate the presence of the Ghrelin axis endometriosis samples
- Measure the fasting levels of Ghrelin and LEAP-2 in women with and without endometriosis

METHOD: 34 reproductive aged women undergoing a laparoscopic surgery were included in this study. 19 had confirmed endometriosis, and 15 controls (negative for endometriosis). Tissue taken during surgery were analysed using immunohistochemistry staining for Ghrelin and LEAP 2.

Fasting blood samples were taken and analysed via ELISA assays for Ghrelin and LEAP2.

RESULTS: Ghrelin and LEAP-2 are both expressed in endometriosis.

Ghrelin levels were not significantly different between the two groups. The circulating LEAP-2 levels were significantly decreased (p=0.0169) in women with endometriosis which would effectively increase the effect of ghrelin on its receptor due to lack of endogenous GHSR signalling suppression

CONCLUSION: Results show circulating LEAP-2 concentrations are lower in women with endometriosis which could increase ghrelin's effect in endometriotic nodules. This coupled with previous studies showing an increase in peritoneal concentrations of Ghrelin in women with endometriosis suggests ghrelin may have a direct role in the influencing the disease process. Further studies with a larger sample size are needed to confirm this result and the mechanism in which LEAP-2 is supressed in endometriosis patients warrants further investigation.

1 Shah DK, Correia KF, Vitonis AF, Missmer SA. Body size and endometriosis: results from 20 years of follow-up within the Nurses' Health Study II prospective cohort. Hum Reprod. 2013 Jul;28(7):1783-92. doi: 10.1093/humrep/det120. Epub 2013 May 14
2 Verit FF, Ayas S. Elevated ghrelin levels in the peritoneal fluid of patients with endometriosis: associations with vascular endothelial growth factor (VEGF) and inflammatory cytokines. Fertil Steril. 2010 Jun;94(1)
3 Milewski L, Wójtowicz K, Roszkowski PI, Barcz E, Ziarkiewicz-Wróblewska B, KamiĐski P, Malejczyk J. Expression of ghrelin and its receptors in ovarian endometrioma. Gynecol Endocrinol. 2012 Apr;28(4):310-3. doi: 10.3109/09513590.2011.631628. Epub 2011 Nov 16.
4 Fittipaldi AS, Hernández J, Castrogiovanni D, Lufrano D, De Francesco PN, Garrido V, Vitaux P, Fasano MV, Fehrentz JA, Fernández A, Andreoli MF, Perello M. Plasma levels of ghrelin, des-acyl ghrelin and LEAP2 in children with obesity: correlation with age and insulin resistance. Eur J Endocrinol. 2020 Feb;182(2):165-175

AGES ASM21 Award Winner Abstracts cont.

AGES Outstanding Video Presentation:
Assem Kalantan

Laparoscopic Reverse Submucosal Dissection (Sydney Shaving): Standardising rectal shaving for bowel endometriosis (9363)

Mujahid Bukhari [1], Dave Listijono [1], Aoife McSweeney [1], Shevy perera [2], Jason Abbott [3], Michael Wynn-Williams [4], George Condous [5], Sarah Choi [1], David Rosen [1], Gregory Cario [1], Danny Chou [1], Assem Kalantan [1]
1 Sydney Women's Endosurgery Centre, Sydney, NSW, Australia 2 Colorectal, St. George Hospital, Sydney, New South Wales, Australia
3 OBGYN, Royal Hospital for Women, Sydney, New South Wales, Australia 4 OBGYN, Eve Gynecology, Sydney, New South Wales, Australia
5 OMNI Gynecology and Ultrasound , Sydney, New South Wales, Australia

Surgery for bowel endometriosis is recognised as one of the most challenging surgical procedures, often requiring multidisciplinary team. Laparoscopic surgical treatment for bowel endometriosis has continually evolved and techniques refined. A major advance in the surgical workup for patient with deep endometriosis involving the bowel is the development of specialised deep endometriosis ultrasound imaging that allows precise characterization of the bowel lesion including location, size and depth of the involvement amongst others. Based on these accurate preoperative ultrasound characteristics one is able to formulate and plan for particular type of procedure[1]. Large multifocal lesions warrant segmental bowel resection and smaller unifocal lesions could be managed with disc excision with lesser degree of bowel dissection and corresponding lesser potential disturbance and associated morbidity. Alternative to disc excision is the rectal shaving, which is often reserved for smaller lesion of <3cm with lesser depth of invasion. Whilst the surgical technique for segmental bowel resection is very familiar to all colorectal surgeons and widely practiced, the transanal disc excision with circular stapler is a technique that is almost exclusively used for rectosigmoid endometriosis, which has also become well known and standardized. However when it comes to the technique of rectal shaving, little is published and there is paucity in the technical description of such procedure. At Sydney Women's Endosurgery we are conducting a pilot study on laparoscopic rectal shaving by borrowing a technique used by gastroenterologist and colorectal surgeon called Endoscopic Submucosal Dissection (ESD), which is used to excise intraluminal mucosal lesions. The essence of the technique lies on the ability to expand the submucosal layer by injection of liquid. In doing so it create a "plane" where the mucosa and muscularis can be "dissected" and lesions excised with higher margin of safety of not injuring the adjacent unaffected anatomical layer. Our technique is different to the ESD in that we are excising lesion not from the mucosal surface but from the serosal surface where endometriosis is located, often with sparing of the mucosa, therefore we have coined the term "Laparoscopic Reverse Submucosal Dissection" (LRSD). We would like to call this technique Sydney Shaving and share our experience with this exciting new technique, which we hope to contribute towards standardising the rectal shaving technique.

1 Abrao M, Petraglia F, Falcone T, Keckstein J, Osuga Y, Chapron C. Deep endometriosis infiltrating the recto-sigmoid: critical factors to consider before management. Hum Reprod Update. 2015 May-Jun; 21(3): 329-39

AGES ASM21 Award Winner Abstracts cont.

AGES Outstanding Trainee Presentation "The Platinum Laparoscope Award": Kate Martin

Instituting vNOTES hysterectomy: An alternative pathway to credentialling in the COVID era (9809)

Kate Martin [1], Martin Ritossa [1], Kate Walsh [1], Tran Nguyen [1]
1 Women's and Children's Division, Northern Adelaide Local Health Network, Adelaide, SA, Australia

BACKGROUND: Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is an emerging minimally invasive approach to performing surgery, including hysterectomy. The COVID era has presented new barriers to traditional mentoring and proctorship when instituting new surgical techniques. Due to COVID-19, the usual pathway of becoming credentialled was not feasible as it involved travelling overseas to work with a medical lead surgeon experienced in vNOTES. Instead, a modified pathway was formulated to implement and credential this new surgical approach.

AIMS: To evaluate the surgical outcomes of the first cohort of patients undergoing vNOTES hysterectomy at a tertiary teaching centre.

METHODS: We conducted a prospective audit of the first 17 cases who underwent vNOTES hysterectomy at a South Australian tertiary hospital between August 2020 and August 2021. Approval from the local health network was obtained to perform and assess the outcomes of this new route of hysterectomy. A team of three FRANZCOG surgeons with level six advanced laparoscopic skills performed the cases in pairs as primary operator and assistant.

Demographic data, surgical time, specimen weight, complications, and length of stay were recorded. Pain scores were measured using a visual analogue scale (VAS), and quality of life (QoL) was measured at baseline and 6-12 weeks postoperatively using the two-part EQ-5D-3L questionnaire (VAS and descriptive system) with permission of the EuroQol Research Foundation.

RESULTS: Of the first 17 cases of planned vNOTES hysterectomy, there was one conversion to LAVH which was due to an enlarged uterus with minimal vaginal descent and difficulty achieving colpotomy. Mean operating time to complete vNOTES hysterectomy was 68min (SD=20.4), and mean blood loss was 156mls (SD=249). Operating time demonstrated a negative linear correlation of moderate strength, which showed a trend towards statistical significance (p=0.071). Lack of statistical significance in operating time may be explained by the small sample size. The average specimen weight was 139g (SD=134). Complications included one bladder injury (5.8%) which was diagnosed at completion of the vNOTES hysterectomy and was repaired vaginally. The mean length of stay was 36.1 hours (SD=10.7). QoL data collection is ongoing and will be presented. There were no return to theatre or unplanned admissions postoperatively.

CONCLUSIONS: vNOTES hysterectomy was able to be instituted during the COVID-19 pandemic by utilising a new pathway for credentialling in a team of advanced laparoscopic surgeons. Operating time decreased over the first 17 cases. Complications were limited to those recognised to be associated with vaginal hysterectomy.

1 Baekelandt JF, De Mulder PA, Le Roy I, et al. Hysterectomy by transvaginal natural orifice transluminal endoscopic surgery versus laparoscopy as a day-care procedure: a randomised controlled trial. BJOG An Int J Obstet Gynaecol. 2019;126(1):105-113. doi:10.1111/1471-0528.15504

AGES ASM21 Award Winner Abstracts cont.

AGES Best Digital Communication Presentation:
Thomas Yeung

Impact of introducing new outpatient hysteroscopy service to clinical workflow and a solution to improve gynaecological trainee surgical exposure. (9239)

Thomas Yeung [1], Harjyot Gill [2], Vanessa Lusink [3], Jay Iyer [4]
1 RANZCOG, Townsville 2 James Cook University, Townsville 3 AGES , Townsville 4 AGES, Townsville

BACKGROUND: Introduction of an outpatient hysteroscopy (OPH) service is increasingly recognized to achieve superior patient satisfaction, post-operative recovery and cost efficiency all the while reducing the clinical load on dedicated operating theatres[1]. This provides a potential solution to the current barriers for gynaecological surgical trainees by improving access and experience for major procedures as well as improving clinical workflow.

AIM: To describe the impacts on departmental clinical workflow and improvements to trainee access to procedures with the introduction of outpatient hysteroscopy versus day case hysteroscopy.

METHODS: Retrospective data analysis of workflow patterns and trainee access to procedures at a tertiary level hospital in the first three months of the OPH service and equivalent three months in the preceding year. Major and minor gynaecological surgical procedures were classified as per Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) fellowship requirements[2].

RESULTS: A total of n=605 patients (pre- (n=271) and post- (n=334) OPH commencement) were included in the study. 52 cases of OPH were performed during the study period. Total operative major procedures increased by 49 cases (86%), minor procedures increased by 31 cases (24%). Category one (< 30 days) procedures were reduced by a mean waiting time of 7 days. Trainee exposure to major procedures increased from a mean of 0.90 to 1.93 cases per trainee per week. Exposure to minor procedures increased from a mean of 1.79 to 2.26 cases per trainee per week. Junior trainees (year 1-3) had a 37% increase in access to overall surgical cases compared with senior trainees (year 4-6) at 31%.

CONCLUSION: The adoption of an OPH service has achieved the goal of fast-tracking waiting times, freeing up operating theatres for major cases and overall improving trainee surgical exposure.

AGES/Medtronic Travelling Fellowship 2021:
Rachel Collings

AGES/Hologic Hysteroscopic Travelling Fellowship 2021:
Brydie Purbrick

Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES XXXII ANNUAL SCIENTIFIC MEETING

Onwards & Upwards

10 - 12 March 2022

Crown Promenade Melbourne

Earlybird Registrations Close

14 January 2022

WEDNESDAY 9TH MARCH 2022 - PRE-CONFERENCE WORKSHOP

AEDT	CROWN PROMENADE MELBOURNE, VIC
0800 - 1700	AGES AATP Workshop (Invite Only) - **Kate Martin, Chair**
0800 - 1200	Merging Advanced Laparoscopic and Ultrasound Skills in Endometriosis Workshop - **George Condous, Chair**
1300 - 1700	The MBS Explained Workshop - **April Armstrong**
0800 - 1700	Chronic Pelvic Pain Workshop - **Thierry Vancaillie, Chair**
AEDT	

THURSDAY 10TH MARCH 2022 - DAY ONE

AEDT	CROWN PROMENADE MELBOURNE, VIC		
0700 - 0800	Registration		
0800 - 0930	**SESSION ONE:** ONWARDS & UPWARDS - A GLOBAL PERSPECTIVE		
	Welcome to Country & Introduction		
	Keynote Presentations		
	Panel Discussion		
0930 - 1030	**SESSION TWO:** CHAIRMAN'S CHOICE		
1030 - 1100	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		
1100 - 1230	**SESSION THREE A:** FROM ONE SPECIALIST TO ANOTHER... LET'S TALK	**SESSION THREE B:** FIBROIDS!	
	Looks do matter - Update on wound closure management	Individualising care of women with fibroids	
	The other pelvic pain - Perspectives on functional bowel disease	Hysteroscopy and fibroid care	
	A pain in the butt - Chronic constipation, adhesions, diverticulitis and more	Large fibroid uterus hysterectomy - Big problems with simple solutions	
	Too little or too much? Causes, consequences and management of iron overload and deficiency	Tackling fibroids with a twist	
	Walking the line - Optimising perioperative pain management	Fibroid surgery and future pregnancy implications	
	Panel Discussion	Panel Discussion	
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		
1330 - 1500	**SESSION FOUR A:** FREE COMMUNICATIONS	**SESSION FOUR B:** FREE COMMUNICATIONS	**SESSION FOUR C:** FREE COMMUNICATIONS
1500 - 1530	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS		

PAGE 36

1530 - 1700	**SESSION FIVE A:** PECHA KUCHA - OFFICE GYNAECOLOGY & FERTILITY	**SESSION FIVE B:** PECHA KUCHA - ENDOSCOPIC SURGERY
	What to do? Non-surgical options for AUB	Planning for the future - Cancer and preservation of fertility
	It's her not me! Investigation of male infertility	What do I do? Stage 4 endometriosis & fertility
	The microbiome - Research implications for every day practice	Open for business? Assessment of tubal patency
	When, why & how? Androgen therapy	Finding the way - Evidence-based management of Asherman's syndrome
	Doctor, Doctor! The pathway from private practice research to higher degrees	It's in the bag! An update on power and manual morcellation
	More than the basics - Gynaecological ultrasound for the generalist	Keep your enemies close and your enemies closer - Avoiding ureteric injury during laparoscopic surgery
	Everything up to IVF - Ovulation induction for the generalist	What to do when - A PID management update
	Updates on cervical screening and colposcopy care	How to do it? A primer on hysteroscopic surgery for heavy menstrual bleeding
	It's time - Can I store my eggs please?	That shouldn't be there! Surgical management of polyps, fibroids, septae & niches
	Location, location - Update on non-surgical management of ectopic pregnancy	Please do interfere! The art of surgical assisting
		Tips & tricks - Optimising the the surgical field
1700	CLOSE OF DAY ONE	
1700 - 1800	WELCOME RECEPTION	

AEDT

FRIDAY 11TH MARCH 2022 - DAY TWO

AEDT	CROWN PROMENADE MELBOURNE, VIC	
0700 - 0745	Women in Surgery Breakfast	
0730 - 0800	Registration	
0800 - 1000	**SESSION SIX:** LIVE SURGERY	
1000 - 1030	MORNING TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1030 - 1230	**SESSION SEVEN A:** ENDOMETRIOSIS - THE CURRENT STATE OF PLAY	**SESSION SEVEN B:** ALL THINGS PREGNANCY
	How did this happen? An update on the aetiologies of superficial endometriosis, endometrioma and DIE	A stitch in time - Elective and emergency cervical cerclage
	Endometriosis medical management strategies before and after surgery	Doctor I'm bleeding - Management of threatened miscarriage and antepartem haemorrhage
	I'm going in! Surgical strategies for minimal, mild, moderate and severe endometriosis	Upping the ante - Laparoscopic surgery in pregnancy
	What to do? The unexpected finding of asymptomatic or severe endometriosis at diagnostic laparoscopy	What we leave behind... Management options for non-viable pregnancy and RPOC
	Fertility enhancement and preservation - What endometriosis surgeons should know	We all do it the same, don't we? Step-by-step evidence-based caesarean section
	What lies beneath... Nerve-sparing endometriosis resection	When childbirth isn't a beautiful thing - Caesarean hysterectomy
	The endometriosis multidisciplinary team - The BSGE Endo Centre experience	Closing the flood gates - Modern management of PPH
	Panel Discussion	Panel Discussion
1230 - 1330	LUNCH, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1330 - 1530	**SESSION EIGHT:** SPONSORED WORKSHOPS	
	Medtronic, Avant Mutual, Device Technologies, Hologic, Olympus, Stryker, Applied Medical	
1530 - 1600	AFTERNOON TEA, TRADE EXHIBITION & DIGITAL FREE COMMUNICATIONS	
1600 - 1700	**SESSION NINE**	
	Keynote Presentation	
	Dan O'Connor Perpetual Lecture	
1700	CLOSE OF DAY TWO	
1700 - 1800	AGES ANNUAL GENERAL MEETING	
1900 - 2230	AGES ANNUAL BLACK TIE GALA DINNER, AWARDS & CHARITY AUCTION	
AEDT		

PAGE 38

SATURDAY 12TH MARCH 2022 - DAY THREE

AEDT	CROWN PROMENADE MELBOURNE, VIC
0730 - 0820	SurgicalPerformace Breakfast Session
0800 - 0830	Registration
0830 - 1000	**SESSION TEN: ALL ABOUT THE ADNEXA**
	I'm all in a twist - Ovarian torsion management
	Crying over spilt milk? Decreasing the risk of upstaging ovarian tumours
	Missing in action? Unexpected absence of the adnexa
	Non-tubal ectopics - Is there any evidence?
	Worth the effort? Tubal reanastomosis & neosalpingostomy
	Just when I thought it was safe to get back in the water - Surgical management of the residual adnexae
	Panel Discussion
1000 - 1030	MORNING TEA & TRADE EXHIBITION
1030 - 1110	**SESSION ELEVEN:** THE FAST FIVE
	Bringing down the curtain - Bladder dissection at TLH
	Preparing for the worst - Dissection of pelvic side wall vessels
	Do no harm - Ovarian cystectomy fertility preservation techniques
	Finding my frenemy - Ureteric dissection techniques
	A primer - Endometriosis resection
	Panel Discussion
1110 - 1255	**SESSION TWELVE:** LIVING WITH COVID-19 - WHAT WE'VE LEARNT
	COVID-19 - Where to from here?
	Betting on the right horse - COVID vaccine development, take up and hesitancy
	Back from the brink - Vaccinating Fiji
	COVID is a sham! - Battling COVID misinformation
	Protecting the front line
	The kindness pandemic
1255 - 1325	**SESSION THIRTEEN:** PRESIDENT'S PANEL MODERATED BY NORMAN SWAN
1325	CLOSE OF CONFERENCE
1310 - 1400	LUNCH ON THE GO
AEDT	

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

AGES Women's Health Committee

The AGES **Women's Health Committee** (WHC) has been a part of AGES now since 2015.

With a focus on creating *free online resources* for consumers, the WHC oversees consumer resources including the **AGES patient video library**, the **AGES podcast library**. In 2021 the WHC also facilitated the AGES membership **AGES Endometriosis Webinar** held this year in September.

The **AGES video library** now includes the following videos for you and your patients to view prior to surgery. These are located under the 'patient' TAB on the AGES website. Topics include:

- Vaginal hysterectomy
- Abdominal hysterectomy
- Laparoscopic hysterectomy
- Hysteroscopy
- Outpatient Hysteroscopy
- Endometrial Ablation
- Laparoscopy
- Laparoscopy for Endometriosis
- Laparoscopic Ovarian Cystectomy

The **AGES podcast library** now includes the following podcasts for you and your patients. These are located under the 'patient' TAB on the AGES website. Topics include:

- Chronic Pelvic Pain
- Endometriosis
- PCOS

Under the 'patient' TAB on the AGES website, you will also find the AGES '***How to Choose Your Gynaecologist***' document. This was designed to assist consumers towards making an informed decision about their preferred gynaecologist.

Your 2021-2022 WHC committee comprises **Dr George Condous** (AGES board member), **Dr Kirsten Connan** (WHC Chair and AGES board member), **Dr Bassem Gerges** (AGES Executive), **Dr Rachel Green** (AGES Vice President), **Dr Emma Readman** (AGES board member), and **Dr Fariba Behnia-Willson** (AGES board member).

If you have any suggestions or feedback on the current WHC online resources, we would love to hear from you!

Dr Kirsten Connan
WHC chair
kirsten@tasogs.com

Visual learning: Consent and clinical images for education

Ruanne Brell

Clinical images, including scans and endoscopic images, are integral to patient care. They can also be powerful educational resources. Seek appropriate patient consent for all uses of an image to avoid breaching patient privacy obligations.

Ms L has been experiencing severe pelvic pain, bloating and menorrhagia for decades. When she is finally referred to Dr K, she is desperate for a diagnosis. She sends Dr K several photos she has taken of her abdomen to show the extent of bloating during her cycle. Dr K suspects endometriosis and recommends a pelvic ultrasound and laparoscopy to confirm the diagnosis. Ms L immediately consents. The images confirm the diagnosis, and that the condition has spread to involve her bowel and bladder.

*Later, Dr K is asked to provide a training presentation for interns at the hospital. She includes Ms L's photos and scans to illustrate the importance of early diagnosis and intervention. She does not seek specific consent to use the images in the presentation as they are for training and she does not intend to identify Ms L. The images are posted to a slide sharing site after the presentation.**

Images and patient care

Images may be essential to confirm certain diagnoses. They can also be valuable training tools and help increase awareness of conditions that might otherwise be poorly understood.

However, Avant has assisted doctors who have faced complaints connected with the use of images in clinical settings. This can arise when there is a concern about whether a doctor has sought proper patient consent for all uses of an image.

What did the patient consent to?

Images are considered health information and should be treated with the same privacy and confidentiality as any other health record or information. When using clinical images you are bound by the requirements of the privacy legislation that applies in your state or territory, and by your legal and ethical duty of confidentiality.

Privacy principles stipulate that health information can only be captured with consent and only if it is reasonably necessary to do so. Before taking an image of a patient, you need to consider whether it will help with their treatment

If you wish to take or share an image of a part of the patient's body, you need to obtain the patient's consent first. Discuss with your patient:

- why you want to take the image
- how the image will be used
- who will have access to the image.

For procedures, this might include discussion with the patient about taking intraoperative images. Make sure you follow any hospital or practice policies requiring signed consent forms for clinical images. Otherwise verbal consent is sufficient. Store the completed consent form, or document any verbal consent in the patient record, along with the images.

If you wish to also use the image for non-clinical purposes such as education or research, ask the patient for specific consent, ideally in writing.

How can you use the image?

Consent may be implied by the patient's actions. As in this case, where Ms L has shared some of her own images, it is reasonable for Dr K to infer consent to use these for Ms L's treatment. This would extend to sharing the images with other members of the treating team, or with a colleague for advice.

However that does not mean Ms L has consented to the images being used for any other purposes. If Dr K wishes to use an image for education or training, she needs patient consent for this particular purpose.

Sharing an image on a website or social media also requires specific patient consent.

Visual learning: Consent and clinical images for education cont.

Ruanne Brell

Could the image be identifiable?

In theory, information that can be sufficiently de-identified so that there is no reasonable likelihood of re-identification could be shared without consent.

The difficulty is that even cropping out the patient's face, or removing identifying details such as name, date of birth and medical record number may not be enough to prevent re-identification. In the case of scans, details such as time and date, the name of the clinic, the name of the referring doctor or a unique identifier code might make an image identifiable. Other details such as a distinctive tattoo or skin marking in a photograph, an unusual injury or condition, even distinctive jewellery might also be enough to work out who the patient was.

Further, it can be a combination of details that enable re-identification. For example, the time and date stamp of the clinic, combined with Ms L's social media posts about her successful diagnosis might enable someone to make the connection.

As a rule, it is safest to assume any image could be identified. It is best practice to always get consent to take and share any images.

Using clinical images safely

Clinical images are valuable tools for diagnosis and to improve patient care. Developments in technology have increased the ease and speed with which they can be used in clinical treatment. The key is to remember that clinical images are health information and assume they could be identified. Seek patient consent for all uses to avoid any concerns about re-identification and privacy breaches.

Further information:

- Avant factsheet: Clinical photography – a snapshot of the issues
- Avant factsheet: Storing retaining and disposing of medical records
- Australian Medical Association: Clinical images and the use of personal mobile devices
- Office of the Australian Information Commissioner: Taking photos of patients

**The scenario is based on content from the AGES Advances in Endometriosis and Pelvic Pain Management Webinar, available for AGES Members to access through this link.*

Ruanne Brell

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 2022
MARCH 10–12 2022
Crown Promenade, Melbourne
Theme – AGES: Onwards & Upwards

Australasian Gynaecological Endoscopy & Surgery Society Limited
FOCUS MEETING

AGES Focus Meeting 2022
AUGUST 11–12 2022
Millenium Queenstown, New Zealand

Australasian Gynaecological Endoscopy & Surgery
PELVIC FLOOR SYMPOSIUM

AGES Pelvic Floor Symposium 2022
NOVEMBER 4–5 2022
Adelaide Convention Centre, Adelaide

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

JUNE 18-19 2022
Royal Australasian College of Surgeons, Melbourne

Australasian Gynaecological Endoscopy & Surgery Society Limited
LAP-D WORKSHOP

AGES Laparoscopic Anatomy Pelvic Dissection/ Demonstration Workshops
2022 DATES
Dissection Workshops
5 February 2022 (AATP Trainees Only)
6 February 2022 (AATP Trainees Only)
21 May 2022
22 May 2022
11 September 2022
12 November 2022

Demonstration Workshop
10 September 2022

Advanced Dissection Workshop
13 November 2022

Medical Engineering and Research Facility, Brisbane

AGES Membership 2022

Renew your AGES Membership now for 2022!

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 "AGES Video Library – Members only".
- Eligibility to register for the AGES Laparoscopic Anatomy Pelvic Dissection & Demonstration Workshops (LAP-D).
- 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 2022
For full membership information, please visit the AGES website

AGES Accredited Training Program

Applications for the 2023/2024 position for the AGES Accredited Training Program are now open!

For further information please visit the AGES website at www.ages.com.au/training

Applications close 5pm AEST, Friday, 11th February 2022.

AGES Travelling Fellowships

Applications are now open for the AGES/Medtronic Travelling Fellowship and the AGES/Hologic Hysteroscopic Fellowship for 2022.

These Fellowships will be awarded at the AGES XXXII Annual Scientific Meeting 2022 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 – ages.com.au/members/awards-and-fellowships

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

Applications close 11:59pm AEST,
Monday, 14th February 2022.

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.

2022 Course Dates: on application.

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

FLINDERS PRIVATE ENDOGYNAECOLOGY MASTERING LAPAROSCOPIC SUTURING XXII
FLINDERS PRIVATE HOSPITAL ADELAIDE

2022 Course Dates: 1 & 2 September

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 2022
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.

2022: March 21-25, June 6-10, October 10-14
2023: March 20-24, June 5-9, October 16-20

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.

2022 Course Dates: 26 & 27 April, 30 & 31 August, 11 & 12 October

All enquiries should be directed to: Dr. Weng CHAN,
Gynae Endosurgery Consultant, 40 Lemana Crescent, Mt. Waverley, VIC 3149
P: + 61 3 9886 6248 F: + 61 3 9886 4468 Email: kkcha5@hotmail.com

Dates for Laparoscopic Workshops cont

LAPAROSCOPIC SURGERY FOR GENERAL GYNAECOLOGISTS
SYDNEY LAPAROSCOPIC WORKSHOPS 2022

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

2022 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.

2022 Course Dates:
Master Class in Hysterectomy, Myomectomy & Adnexal Surgery : March 14-18

Master Class in Endometriosis Surgery & Hysterectomy Techniques : June 06-10

Master Class in Hysterectomy, Myomectomy & Adnexal Surgery: October 24-28

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 78 coming out in February 2022

Contact Rachel Green (secretariat@ages.com.au) with your contribution
Deadline **14th January 2022**