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Professional Education Information

Target Audience
Educational activities are developed to meet the needs of surgical gynecologists in practice and in training, as well as, other allied healthcare professionals in the field of gynecology.

Accreditation
AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AAGL designates this live activity for a maximum of 3.75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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As a provider accredited by the Accreditation Council for Continuing Medical Education, AAGL must ensure balance, independence, and objectivity in all CME activities to promote improvements in health care and not proprietary interests of a commercial interest. The provider controls all decisions related to identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the activity. Course chairs, planning committee members, presenters, authors, moderators, panel members, and others in a position to control the content of this activity are required to disclose relevant financial relationships with commercial interests related to the subject matter of this educational activity. Learners are able to assess the potential for commercial bias in information when complete disclosure, resolution of conflicts of interest, and acknowledgment of commercial support are provided prior to the activity. Informed learners are the final safeguards in assuring that a CME activity is independent from commercial support. We believe this mechanism contributes to the transparency and accountability of CME.
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PG 102
Taking Your Laparoscopic Suturing Skills to the Next Level (Pig Lab)

Grace M. Janik, Chair
Elizabeth E. Ball, Co-Chair

Faculty: Krisztina I. Bajzak, Shan M. Biscette, Maurice K. Chung, Luigi Fasolino, Jason E. Foil, Lydia E. Garcia, Dobie L. Giles, Joseph (Jay) L. Hudgens, Charles H. Koh, Jamie Kroft, Cecilia B. Mejia Medina, Nash S. Moawad, Curtis E. Page, Anna Palatnik, Christopher J. Stanley

Course Description

Laparoscopic suturing is an essential skill for advanced laparoscopy both to perform procedures that require suturing as well as repair complications. The inability to perform laparoscopic suturing is the main driver of robotic laparoscopic surgery which is an expensive enabler.

The purpose of this course is to take surgeons who have acquired laparoscopic suturing skills from previous hands-on courses and advance those skills in an animal model. This course is designed for participants who are enrolled in course #101: “Laparoscopic Suturing in the Vertical Zone” or have taken a previous “Vertical Zone” suturing course. Interrupted, cinch knot, and continuous suturing will be practiced while performing bladder, bowel, and ureter repair. Working in an animal model provides the translational skills necessary for successful laparoscopic suturing in surgery.

Course Objectives

At the conclusion of this course, the participant will be able to: 1) Review the theory, ergonomics and rationale for reproducible laparoscopic suturing; 2) apply the skills in an animal model to closely mimic surgery; and 3) apply appropriate suture repair for the prevention and management of bowel, bladder, and urethral complications.

Course Outline

1:30 Welcome, Introductions and Course Overview G.M. Janik
1:35 Laparoscopic Suturing in the “Vertical Zone” C.H. Koh
1:50 Review Pig Anatomy and Exercises G.M. Janik
2:00 Lab I: Bladder Suspension, Cystotomy and Bladder Repair with Interrupted Suturing All Faculty
2:45 Video Review: Continuous Suturing
3:00 Lab II: Bladder Repair with Continuous Suturing All Faculty
3:30 Break
3:45 Continue Lab II: Bladder Repair with Continuous Suturing All Faculty
4:15   Video: Repair Bowel, Ureter, and Tubal Anastomosis

4:30   Lab III: Repair Ureter and Bowel Injury

5:15   Questions & Answers

5:30   Course Evaluation
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop and have no conflict of interest to disclose (in alphabetical order by last name).
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FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Asterisk (*) denotes no financial relationships to disclose.
LAPAROSCOPIC SUTURING IN THE VERTICAL ZONE

Charles Koh, M.D.

Disclosure

• Speaker’s Bureau: CooperSurgical, Karl Storz Endoscopy-America
• Other: Royalty: CooperSurgical, Karl Storz Endoscopy-America

Progressing to Advanced Laparoscopy

• Knowledge of anatomy
• Ability to suture

GOALS:

• Every participant will be able to Drive a Curved Needle suture and knot intracorporeally, and perform continuous suturing in a REPRODUCIBLE way.
• 90% will do this in <3 minutes in the time test
• advanced techniques like continuous suturing, sliding or cinch knot will be mastered
• ancillary skills - knot pusher, etc will be taught

ORIENTATION

• 3 doctors per STORZ VIDEOTOWER and trainer BOX
• Left and Right siders find similar partner for videotower. Left handed surgeon to pair with Right side right handed surgeon.
• pre test - 3 minute cutoff

PRE TEST

• Familiarize yourself with the needleholder and grasper. ratchet and release
• TIE AN INTRACORPOREAL KNOT standing from the RIGHT or LEFT - 2 double throws and a single to form surgeon’s knot.
• TIME OUT 3 minutes
• FACULTY will monitor
validation

- the data accumulated over the past few years indicate that 90 percent of preceptees accomplished intracorporeal knotting in less than 3 minutes at the conclusion of this course.
- Before instruction 30% were able to accomplish
- All improved on their performance time.

Equipment needed for Laparoscopic Suturing

- Needle Holder
- Assist Grasper
- Needle/Suture
- Optics
- Ports

vertical zone algorithm

- training box recreates exact attitude of arm, hand, instruments
- real equipment, instruments
- sequential algorithm for suturing
- end point - execution of tight surgeon’s knot within reasonable time
- recovery back to a point in algorithm from ‘accidental’ derailments
- FOLLOW THE STEPS OF THE DRILL
**Vertical Zone - ipsi-lateral**

- with the Vertical Zone algorithm you only use your preferred hand - Left or Right
- no ‘backhand’ or ‘alternate hand’ suturing is needed
- no need for ‘Triangulation’
- you tell us if there is a suturing need that cannot be met

**CONTRALATERAL TRAINER ‘triangulation’**

**contralateral trainers**

**triangulation**

- fatigue
- clash with camera holder

**Evolution of laparoscopic suturing to IPSILATERAL**

- poor needle angle for transverse closure
rationale

- most organs require transverse closure
- relaxed arm, two hands on same side (ipsilateral) needed for prolonged suturing
- relation to ‘open’ suturing allows intuitive moves
- ALL THESE OBJECTIVES ARE MET WITH THE VERTICAL ZONE ALGORITHM
- the needle moves down vertically every time
- ‘fulcrum’ effect eliminated. less degrees of freedom suffice

sutting in the VERTICAL ZONE

EXAMPLES

excellence in laparoscopic suturing and surgery

- LEARN
- PRACTICE
- ACHIEVEMENT
- REHEARSE
- LEARN NEW

PARAMETERS

FOR

EFFORTLESS AND EFFECTIVE SUTURING

RELAXED ARMS; IPSILATERAL STYLE
NEEDLE IN SAGITTAL PLANE
CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

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If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.