Plenary 1: Laparoscopy

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Sara R. Till, MD, MPH
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

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

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Faculty: Kenneth I. Barron, Xiaoming Guan, Lea Luketic, Tony J. Ma, Saori Nakajima, Sara R. Till

This session presents several high-quality studies concerning some of the more common laparoscopic techniques and procedures we provide for our patients every week.

Learning Objective: At the conclusion of this course, the participant will be able to: 1) Discuss current data concerning a variety of issues encountered on a daily basis in the operating suite.

Course Outline

11:00 Implementation Rate of Risk-Reducing Salpingectomy at Time of Benign Hysterectomy

11:06 Discussant

11:10 Can Narrowband Imaging Improve the Laparoscopic Identification of Superficial Endometriosis? A Prospective Cohort Trial

11:16 Discussant

11:20 A Randomized Trial of Wound Infiltration with Extended-Release versus Short-Acting Bupivacaine before Laparoscopic or Robotic-Assisted Hysterectomy

11:26 Discussant

11:30 Does Ulipristal Acetate Objectively Affect Surgical Experience at Laparoscopic Myomectomy?

11:36 Discussant

11:40 Video: Laparoscopic Single Incision Supracervical Hysterectomy for Extremely Large Uterus with Bag Tissue Extraction

11:46 Discussant

11:50 Video: Urinary Tract Complications and Repair Strategies in Total Laparoscopic Hysterectomy at Kurashiki Medical Center

11:56 Discussant

12:00 Adjourn
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The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Amber Bradshaw
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Other: Proctor: Intuitive Surgical
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Consultant: Olympus
Erica Dun*
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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).
Sawsan As-Sanie
Consultant: Myriad Genetics Lab
Kenneth I. Barron*
Richard W. Farnam
Consultant: Intuitive Surgical
Xiaoming Guan
Consultant: Applied Medical
Richard S. Guido
Contracted Research, Gynesonics
D. Alan Johns*
James D. Kondrup
Speakers Bureau: Ethicon Endo-Surgery, Myriad Genetics Lab, Pall Medical, Teleflex
Royalty: Laparoscopic Innovations
Lea Luketic *
Thomas L. Lyons*
Tony J. Ma*
Dan C. Martin*
Saori Nakajima*
Sara R. Till*
Linda C. Yang*
Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Implementation rate of risk-reducing salpingectomy at time of benign hysterectomy

Presenter: Sara R. Till, MD, MPH

Disclosure
- I have no financial relationships to disclose

Objectives
- To delineate the change in rate of risk-reducing salpingectomy over the study period
- To examine patient, operative, surgeon, and hospital-level factors associated with implementation of salpingectomy

Background
- High-grade serous ovarian carcinoma
  - 75% ovarian cancer cases
  - 90% ovarian cancer deaths
- Increasing evidence for distal fallopian tube origin
- Significant variation in adoption of risk-reducing salpingectomy

Methods
- Retrospective cross-sectional design
  - Michigan Surgical Quality Collaborative
  - Hysterectomy performed between January 2013 and April 2015
- Inclusion criteria
  - Abdominal, vaginal, laparoscopic or robotic route
  - Benign, non-obstetric surgical indication
- Abstracted patient, operative, hospital, and surgeon characteristics
- Primary outcome
  - Salpingectomy at time of benign hysterectomy with ovarian preservation

Results: Cohort selection

| Total hysterectomy cases (n=18,642) | Received BSO (n=8,260; 44.3%) |
| Hysterectomy with salpingectomy (n=8,260; 44.3%) |
| Did not receive risk-reducing salpingectomy (n=5,714; 55.1%) |
### Results: Bivariate analysis

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Comorbidities</th>
<th>Perioperative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age*</td>
<td>ASA &gt;3</td>
<td>Surgical approach*</td>
</tr>
<tr>
<td>Race</td>
<td>Diabetes</td>
<td>EBL</td>
</tr>
<tr>
<td>Parity*</td>
<td>Tobacco use</td>
<td>Operative time*</td>
</tr>
<tr>
<td>BMI*</td>
<td>HTN*</td>
<td>Length of stay*</td>
</tr>
<tr>
<td>Insurance*</td>
<td>VTE History</td>
<td>Postoperative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital/surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon volume*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching hospital*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital size*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student's t-test or Chi-square

### Results: Hierarchical logistic regression

<table>
<thead>
<tr>
<th>Variable</th>
<th>Crude OR</th>
<th>Adjusted OR</th>
<th>95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt; 60</td>
<td>2.6</td>
<td>1.68</td>
<td>1.42-1.98</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Laparoscopic approach</td>
<td>3.13</td>
<td>2.93</td>
<td>2.69-3.2</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

* Adjusted for BMI >35

### Results: Change in rate over time

#### Frequency and proportion of complications post-operatively by time period, Michigan Surgical Quality Collaborative 2010-2015

**Results: Change in rate by patient age**

#### Age

**Results: Change in rate by surgical route**

#### Surgical Approach

**Results: Change in rate by surgeon volume**

#### Surgeon Volume
Conclusion
- Rate of risk-reducing salpingectomy is increasing.
- Laparoscopic approach and patient age <60 associated with increased likelihood.
- No association with hospital teaching status or surgeon volume.
- No increase in perioperative or postoperative risk.
- Performance of risk-reducing salpingectomy is an important target for quality improvement.

References
Can Narrowband Imaging Improve the Laparoscopic Identification of Superficial Endometriosis? A Prospective Cohort Trial

MHW Endosurgery Unit
Presenter: Dr Tony Ma

Objective

• To demonstrate that Narrow Band Imaging (NBI) can be of benefit to assist in the laparoscopic identification of superficial endometriosis.

Background

• Histological confirmation of suspected endometrial biopsies varies depending on
  – the experience of the surgeon
  – the severity of the disease (Hsu, Barrueto)

2008 Prospective cohort study of 21 patients
• NBI detected additional histopathological proven endometriosis in 14 (70%) of patients
• 4/7 (57%) of patients who were negative for endometriosis on white light had endometriosis proven with NBI

Disclosures

• I have no financial relationships to disclose.

Narrow Band Imaging (NBI)

• NBI- mixture of 415nm (blue) and 540nm (green) light
• Causes blood vessels to be more visually prominent
• Neovascularisation associated with endometriosis becomes easier to detect
• Non-invasive

Study design

• Objective:
  – To assess if the use of NBI improves the detection of superficial endometriosis at diagnostic laparoscopy for pelvic pain.
• Method:
  – Prospective cohort study- Sept 2014- Oct 2015
• Eligibility
  • Patients undergoing diagnostic laparoscopy for pelvic pain without endometrioma/deep endometriosis on pre operative ultrasound in a tertiary laparoscopic specialty unit
  • 57 Eligible patients of which 53 were recruited
• Prospective ethics approval- R14/17
Technique

- Standard survey of the pelvis conducted with white light with location of suspected endometriosis noted
- Secondary survey with NBI with additional areas of suspicion for endometriosis noted
- Excision of all identified areas for blinded histopathological analysis

Results

- 53 patients
- 32 lesions white light
- 24 Pos for Endometriosis
- 21 no white light lesions
- 7 NBI lesions
- 6 Pos for Endometriosis
- 4 NBI lesions
- 1 Neg for Endometriosis
- 4 Neg for Endometriosis

Discussion/Summary

- NBI is a simple non-invasive adjunct that can assist in the identification of additional sites of endometriosis at laparoscopy
- It was often found that after an area of suspicion was identified with NBI, in retrospect the lesion could also be seen with white light
  - Thus NBI can be a useful self education tool
- The shortened depth of field with NBI requires the operator to perform a very close inspection of the peritoneal surfaces

References

Acknowledgments

- Dr. Lenore Ellett, Dr. Alex Eskander, Dr. Kate McIlwaine, Dr. Janine Manwaring, Dr. Emma Readman, Prof Peter Maher
A Randomized Trial of Wound Infiltration with Extended-Release versus Short-Acting Bupivacaine Before Laparoscopic or Robotic-Assisted Hysterectomy

Presenter: Kenneth I. Barron, MD, FACOG
Assistant Professor of Obstetrics/Gynecology
Advanced & Minimally Invasive Gynecology
University of Virginia School of Medicine

Objective

- Be able to assess the efficacy of liposomal bupivacaine for pain control for laparoscopic hysterectomies.

Liposomal Bupivacaine

- FDA approved October 2011
- Encapsulated bupivacaine in microscopic spherical lipid-based particles of varying size to allow dispersion of the drug over an extended period of time
- Expected effect lasting up to 72 hours
- Half-life of 14.6-23.8 hrs
- Cost: Retail $280 vs. $1.83 (bupivacaine)\(^1\)

Our study: Objective

To evaluate if pre-incision infiltration with extended-release liposomal bupivacaine provides improved pain relief compared to 0.25% bupivacaine after laparoscopic or robotic-assisted hysterectomy.

Methods

- Double-masked randomized controlled trial
- Florida Hospital, Orlando; 11 surgeons
- Inclusion criteria:
  - Multiport laparoscopic or robotic-assisted total hysterectomy (± BSO)
  - Benign indication
  - Fluent in spoken and written English

Disclosure

- I have no financial relationships to disclose
Exclusion criteria

▪ Hx of hepatic or renal disease
▪ Current use of MAO Inhibitors or tricyclic antidepressants
▪ No mobile phone
▪ History of alcohol or substance abuse within the preceding 2 years
▪ Planned additional procedures including prolapse repair

Primary outcome

▪ Pain intensity using 0-10 Numerical Rating Scale (NRS)
▪ Average pain1 on POD3
▪ Telephone administered questionnaires
▪ “Please rate your overall average pain level today where 0 means ‘no pain’ and 10 means ‘pain as bad as you can imagine.’”

Secondary outcomes

▪ NRS pain scores at 0, 2, 4, 8, 12, 16, and 24 hours postop
▪ NRS average & worst pain scores on POD1, POD2 and POD14
▪ Cumulative opioid use in hospital, by POD3 and POD14
▪ Brief Pain Inventory (BPI)1 interference questions to assess function/quality of life

Allocation/Power analysis

▪ 80% power (α= .05) to detect 30% reduction in pain score = 56 participants
▪ Anticipated 15% loss to follow up
▪ 91 patients screened
▪ 64 enrolled
▪ 59 completed POD3 surveys
▪ 56 completed all surveys

Results: select patient & surgical characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>LBup (n=32)</th>
<th>0.25% Bup (n=32)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>45±8.6</td>
<td>45.4±9.1</td>
<td>.87</td>
</tr>
<tr>
<td>BMI</td>
<td>29 (19.8-83.9)</td>
<td>27.6 (19.3-43.7)</td>
<td>.38</td>
</tr>
<tr>
<td># previous laparotomies</td>
<td>11 (34)</td>
<td>11 (34)</td>
<td>1.00</td>
</tr>
<tr>
<td># previous laparoscopies</td>
<td>.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hx of chronic pain syndromes</td>
<td>.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode of surgery</td>
<td>.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laparoscopic</td>
<td>14 (44)</td>
<td>12 (38)</td>
<td></td>
</tr>
<tr>
<td>Robotic-assisted</td>
<td>18 (56)</td>
<td>20 (62)</td>
<td></td>
</tr>
<tr>
<td>Length of surgery (min)</td>
<td>93 (54-278)</td>
<td>105 (56-260)</td>
<td>.83</td>
</tr>
<tr>
<td>LBup</td>
<td>0.25% Bup</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Number of trocars</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>19 (61)</td>
<td>15 (47)</td>
<td>.44</td>
</tr>
<tr>
<td>4</td>
<td>5 (16)</td>
<td>9 (28)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>7 (23)</td>
<td>8 (25)</td>
<td></td>
</tr>
<tr>
<td>Conversions to open</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Method of uterine extraction</td>
<td>.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>30 (94)</td>
<td>31 (97)</td>
<td></td>
</tr>
<tr>
<td>Mini-lap</td>
<td>1 (3)</td>
<td>1 (3)</td>
<td></td>
</tr>
<tr>
<td>Abdominal</td>
<td>1 (3)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Uterine mass (g)</td>
<td>140 (49-966)</td>
<td>136 (54-818)</td>
<td>.87</td>
</tr>
<tr>
<td>Length of stay (hrs)</td>
<td>23.9 (2.8-75.4)</td>
<td>24.3 (3.4-147)</td>
<td>.65</td>
</tr>
</tbody>
</table>

Values are mean ± SD, number (%), or median (range)
Average pain scores

Worst pain scores

Opioid medication use (oral morphine equivalents)

BPI pain interference scores

Should we use liposomal bupivacaine in laparoscopic hysterectomy?

Conclusions

Routine use of liposomal bupivacaine as port site local anesthetic in laparoscopic hysterectomy is not justified based on current data.
Bibliography


Acknowledgements

Georgine Lamvu, MD, MPH, R. Cole Schmidt, BS, Matthew Fisk, MD, Emily Blanton, MD, Insiyyah Patanwala, MD, Frederick Hoover, MD
Does Ulipristal Acetate Objectively Affect Surgical Experience at Laparoscopic Myomectomy?

Presenter: Lea Luketic, MSc, MD
University of Toronto and McMaster University

1 Disclosure
I have no financial relationships to disclose

Objectives
By the end of this session, the participant will be able to
- Convey the effects of medical pre-treatment with Ulipristal Acetate (UPA) on surgical experience at the time of laparoscopic myomectomy
- Use our new Surgical Assessment Tool at laparoscopic or robotic myomectomy

Background
Ulipristal Acetate
- Initial data on effectiveness stems from two landmark double-blind RCTs1,2
- Although most participants underwent surgery no mention of nuances of surgical management
- Since initial trials more than 300,000 women treated with UPA in over 50 countries
- Lack of data on the surgical experience at myomectomy for pre-treated patients
  - Limited to hysteroscopic myomectomy3-5
  - Anecdotal information is abundant and guiding clinical decision making
- No objective assessment currently available

Study Design
- Multi-center
- 50 laparoscopic or robotic videos included
  - 25 with UPA pre-treatment
  - 25 with no medical pre-treatment
- Blinded, independent review of all videos
- Each procedure scored using a new surgical assessment tool

Surgical Assessment Tool
- Primary Outcome: 22-point surgical global rating score (sum of 6 subscales)
  1. Depth of Myometrial Invasion
  2. Cleavage Plane Identification
  3. Myoma Detachment
  4. Blood Loss- Myoma Detachment
  5. Blood Loss- After Detachment
  6. Myoma Consistency
Surgical Assessment Tool

<table>
<thead>
<tr>
<th>Aspect of the grading tool</th>
<th>ICC</th>
<th>ICC Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Depth of myometrial invasion</td>
<td>0.74</td>
<td>Substantial</td>
</tr>
<tr>
<td>2 - Ease of myometrial plane identification</td>
<td>0.83</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>3 - Ease of myometrical plane incision</td>
<td>0.83</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>4 - Speed loss during myometrial detachment</td>
<td>0.79</td>
<td>Substantial</td>
</tr>
<tr>
<td>5 - Ability to achieve complete myometrial detachment</td>
<td>0.85</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>6 - Myoma consistency</td>
<td>0.92</td>
<td>Almost perfect</td>
</tr>
</tbody>
</table>

Global rating score: 0.93 High

Inter-rater Reliability

<table>
<thead>
<tr>
<th>Pre-Treatment with UPA</th>
<th>UPA Affects at Myomectomy</th>
<th>UPA</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Rating Score, mean (sd)</td>
<td>Total Score</td>
<td>12.4 (3.2)</td>
<td>13.4 (2.9)</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Conclusions

Affect of UPA at Surgical Experience

- First peer-reviewed report to objectively compare surgical experience at laparoscopic and robotic myomectomy
- No differences in those pre-treated with UPA compared to those with no medical pre-treatment
- New grading tool that examines six components of surgical experience and a global rating score demonstrates high inter-rater reliability

References


Acknowledgments

Lindsay Shireeff, Sari Kives, Grace Liu, Ramadan El Suga, Nicholas Leyland, Jonathon Solnik and Ally Murji
Laparoscopic Single Incision Supracervical Hysterectomy for Extremely Large Uterus with Bag Tissue Extraction

Presenter: Xiaoming Guan, M.D., Ph.D.
Baylor College of Medicine, Houston, Texas

Objective: To describe the single-incision laparoscopic technique with an articulated energy device for uterus larger than 20 cm.

Design: Stepwise demonstration of the single site surgical technique and tissue extraction with narrated video footage.

Setting: Single-incision laparoscopic hysterectomy can be difficult because of longer surgery time, steep learning curve, and the need for articulated instruments, but it is especially challenging in patients with a uterus larger than 20 cm. However, the advantages of single-site laparoscopic surgery may include less bleeding, infection, pain, and better cosmetic outcome. A 49 year-old G3P3 female with 24 weeks sized fibroid uterus requested supracervical hysterectomy presented with a 2-year history of pelvic pain and menorrhagia.

Interventions: Laparoscopic single-incision supracervical hysterectomy with contained bag tissue extraction.

Conclusion: Rotating between the patient's right and left side allows the surgeon to access the entire abdomen from a single umbilical port. Single-incision laparoscopic hysterectomy for larger than 20 cm uterus is not only possible, but leads to better outcomes.
Urinary Tract Complications and Repair Strategies in Total Laparoscopic Hysterectomy at Kurashiki Medical Center

Presenter: Saori Nakajima, MD
Kurashiki Medical Center, Kurashiki, Okayama, Japan

Objective: To clarify cases with urinary tract injury during total laparoscopic hysterectomy (TLH), and to review strategies for repairing urinary tract complications.

Design: Retrospective review of total laparoscopic hysterectomy videos.

Setting: Participants comprised all 2604 women who underwent TLH in our department from January 2011 to December 2015.

Interventions: The ureter was injured in 8 cases (0.31%), the bladder was perforated in 7 cases (0.27%), and the bladder muscle layer was injured in 27 cases (1.04%). Among the 8 cases with ureter injury, 2 cases needed ureteroneocystostomy, 3 cases needed end-to-end anastomosis, and 3 cases needed repair by suturing part of the ureter. In all cases of bladder injury, we repaired the bladder by suturing in either one or two layers. During the study period, no cases needed conversion to laparotomy to repair urinary tract complications. Some example cases of urinary tract complications are presented to explain how these complications were managed.

Conclusion: Great care must be taken to avoid causing urinary tract complications in the first place. However, when such complications are encountered, appropriate treatment with manipulation can prevent the need for conversion to laparotomy and reoperation.
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.

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.