



# NewsScope

JANUARY – MARCH 2008 VOL. 22 NO. 1

## president's message

### The Globalization of the AAGL: The Dream Becomes a Reality



Charles E. Miller, M.D.  
President, AAGL

**W**hen I was elected in 2005 as Secretary/Treasurer of the AAGL, I expressed that “The AAGL must foster a closer relationship to the international community of minimally invasive gynecology. As active members of the AAGL, their surgical innovations and practice concerns must be recognized and incorporated into the AAGL.” Proudly, as the President of our society, I can report to you, the membership, that the AAGL has made great strides in engaging physicians involved in the practice of minimally invasive gynecology throughout the world. In so doing, the AAGL is now the premier international gynecologic society working cooperatively with physicians abroad and their affiliated societies to increase awareness of the advantages of minimally invasive gynecology worldwide.

In June of 2007, the AAGL held The First International Congress on Minimally Invasive Gynecology in conjunction with the Italian Society of Gynecologic Endoscopy (SEGI).

Members of the AAGL lectured side by side with our SEGI colleagues in this unique forum, a beautiful lecture hall in the Palermo Opera House.

We are now looking forward to the next collaborative international program. From September 11-14, 2008, Sao Paulo, Brazil will be the site of the 2nd AAGL International Congress on Minimally Invasive Gynecology in conjunction with the Brazilian Society of Gynecologic Endoscopy and Endometriosis (SOBENGE). The topic will be “Endometriosis: Individualized Therapies and Strategies for Prevention.” Yet again, this conference is sure to provide the attendees with a superior and collegial scientific experience within the confines of one of the most notable and exciting cities in the world.

At the past 36th Global Congress of the AAGL, our international members had greater representation than ever before. Thirty-nine of the 158 invited faculty were from outside of the United States. Of the 449 presenters,

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## annual meeting

### What Happens in Vegas Does Not Stay in Vegas!



Resad P. Pasic, M.D., Ph.D.  
Scientific Program Chair  
Vice President, AAGL

**U**nlike the popular saying “What Happens in Vegas Stays in Vegas,” when the AAGL Annual Meeting convenes in Vegas, the news and the knowledge will be spread all around the world. At this year’s meeting we are expecting over 1,500 physicians, with a total of 2,500 participants coming from over 65 countries. One of the reasons the AAGL repeatedly returns to Las Vegas is the attractive and exciting location, which always generates a large turnout.

There are many reasons for visiting Las Vegas besides gambling. This city showcases many international themes and offers striking hotels, gourmet restaurants, magnificent shows and superb shopping. One who has not visited Las Vegas has not lived in the 21st century! Our international colleagues should note that the dollar exchange is

currently favorable to them, providing additional savings on hotels and shopping. There are other tourist attractions surrounding Las Vegas such as the Red Rock Canyon, the Grand Canyon and the Hoover Dam. However, in the case of the AAGL, Las Vegas also provides the backdrop for great science to be shared by the finest experts in the field of minimally invasive gynecologic surgery.

This year, the 37th AAGL Annual Meeting will again be held at the landmark Paris, Las Vegas hotel. However, this meeting will be unlike any other before. For the first time, AAGL will offer two full days of postgraduate

courses, with intensive hands-on training. There will be two hands-on laparoscopic suturing courses and a hands-on hysteroscopy course, all on pelvic trainers. Responding to requests of many AAGL members, for the first time we

*(continued on page 6)*

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## Readers Voice Opinions On the AAGL Patient Awareness Campaign



Franklin D. Loffer, M.D.  
Executive Vice President/  
Medical Director, AAGL

I received several very thoughtful responses to my December 2007 FYI column entitled "Time for a New Approach". (page 2 on <http://www.aagl.org/content/PDF/nscp1007.pdf>). Several in essence were telling me I should have done a better job in writing about the AAGL patient awareness campaign. They were the catalysts for me to write this column.

The first writer suggested I had overly simplified the beneficial effect the AAGL patient awareness campaign would have on the number of laparoscopic hysterectomies that would be done. It pointed out that there were many disincentives not the least of which is reimbursement. But general surgeons overcame similar problems when they incorporated laparoscopic cholecystectomies into their practices.

It may be a stretch for the near future, but I am hopeful that eventually our patient awareness campaign, through patient pressure demanding better access to laparoscopic hysterectomies, will result in gynecologists being more appropriately compensated for doing what is best for many patients. I base this hope on what happened in the United States several years ago when patient pressure forced insurance companies to allow direct self referral to their gynecologists.

Another writer was critical of industry support of our patient awareness campaign. I should also have made it clearer that the support we have received from industry is completely unrestricted and how it is used is only at the discretion of the AAGL. It was given to help raise the profile of the AAGL and to educate patients about all less invasive procedures AAGL members offer their patients (this goes beyond my example of hysterectomies). Yes, we do hope that more women will seek out members of the AAGL for care but, the biggest beneficiary of this initiative is the patient. Empowering women with this information will help them to seek help and make informed treatment choices.

Another point that needs to be emphasized is this patient awareness program will not highlight or discuss individual products. Rather it will hopefully bring an increased awareness to women that minimally invasive procedures are available and should be offered to them as a choice by their gynecologists.

Again my thanks to all of our members who took the time to write.

Readers may comment on this column or other articles by writing  
[NewsScope@AAGL.org](mailto:NewsScope@AAGL.org)

### from the editor

## Should Patients Rate Their Physicians?



C.Y. Liu, M.D.  
Editor-In-Chief  
Secretary-Treasurer, AAGL

According to a recent issue of USA Today (January 17, 2008), this month about a million subscribers of health insurer WellPoint will rate their physicians by using Zagat Survey format.

The article begins as follows:

*Most people know more about finding a good steak dinner than finding a good doctor. That's because scores of guides, magazines and reviewers are devoted to dissecting every aspect of dining out, from food and service to décor and cost. But finding out about physicians? Not so easy. Never mind that a bad dinner can ruin your evening, but a bad doctor can ruin your life.*

Indeed "a bad doctor can ruin your life," but the suggested solution under the guise of consumerism defeats its very purpose. Physician scrutiny is essential, but it must be done by those in the best position to make judgment, not by the insurers and the media. Federal and state governments have been attempting to find valid ways to measure the quality of medical care and provide that information to the public. A federal website ([www.hospital-compare.hhs.gov](http://www.hospital-compare.hhs.gov)) provides data on quality of care in hospitals across the nation. A similar website covering physicians is currently being

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### the aagl vision

The AAGL vision is to serve women by advancing the safest and most efficacious diagnostic and therapeutic techniques that provide less invasive treatments for gynecologic conditions through integration of clinical practice, research, innovation, and dialogue.

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## clinical opinion

## Looking to the Future



Philippe Koninckx, M.D., Ph.D.  
Professor  
University Hospital Gathuisberg  
Leuven, Belgium  
Advisor, AAGL

**I**t was the innovative character of gynecologists that started and developed endoscopic surgery—both hysteroscopic and laparoscopic. This innovation continues today with new techniques for vaginal surgery. Yet as discussed by Dr. Loffer, “only 15% of hysterectomies are done by laparoscopy in contrast to 85% of cholecystectomies.” It looks as if we are missing the boat. What is more worrisome is that procedures introduced by gynecologists, are today being performed commonly by urologists, and deep endometriosis surgery is shifting rapidly from discoid resection to bowel resection by surgeons.

It seems that we are not able to keep the benefits of our innovations in our discipline. This observation is not new, and has been discussed on many occasions. The explanations range from “gynecologists self refer, with less need to stay competitive” (Dr. Loffer), to “poor training, poor reimbursement and high medico-legal risk” (Dr. Reich). The bottom line is less experienced surgeons who tend to overuse expensive equipment (Dr. Pasic) resulting in the cost of medical care, which increases while our income decreases. If the Belgian experience can be extrapolated, the future will even be worse. Many of the new generation of gynecologists seek work schedules offering flexibility or set hours, further decreasing the opportunity for surgical experience. These factors contribute to the increasing trend for gynecologists to ask the surgeons for help rather than

referring to another gynecologist.

Many solutions have been suggested. Improved training is an unrealistic dream since we do not have the budgets or the patient load. Improved reimbursement of difficult surgery by paying lump sums including the equipment used is realistic but meets fierce resistance. To involve the patient as will be done by the AAGL patient awareness initiative is new, and as quality control of the individual surgical procedure (Video Registration as Quality Control, P. Koninckx, JMIG in press). It will, however, be our responsibility to organize and channel this into an instrument of prevention, like the black box in aviation, and not as an instrument of competition or repression.

The mentality of gynecologists must change. We chose our specialty because it is broad and includes endocrinology, surgery, and obstetrics. We have subspecialties such as reproductive medicine, which includes IVF in addition to surgery and oncology with its chemotherapy and surgery. What is needed is further support for gynecologists who want to become ‘pelvic surgeons’ dealing with the advanced surgery of our discipline, and working largely on a referral basis to help their fellow gynecologists. There will be support from those of us who have already made this choice. It should become a mission of the AAGL to defend this concept in spite of the fact that it may conflict with what some of our subspecialists feel only they should be doing.

*The opinions, viewpoints, conclusions, recommendations and statements in the Clinical Opinion column are solely those of the author(s) and are not attributable to the sponsor, publisher, editor or editorial board of NewsScope, the AAGL, or any of its affiliates.*

*We have received scores of reader response to Frank Loffer’s FYI column “Time for a New Approach” that appeared in the Oct–Dec 2007 NewsScope. These letters, some positive and some negative, nevertheless evidence thoughtful reflections upon AAGL’s call for us as patient advocates regarding the availability and superiority of minimally invasive gynecological procedures.*

*Dr. Loffer’s dismay over the fact that although 20 years have elapsed since the first laparoscopic hysterectomy was performed, the vast majority of hysterectomies are still being performed using essentially the same surgical technique developed in 1920’s (Richardson EH: A simplified technique of abdominal panhysterectomy. Surg. Gynecol Obstet 1929;48:248). Our 21st century patients have the right to knowledge about the progress and advancement of modern gynecology. One of the readers, Dr. Philippe Koninckx, raised such salient points that his letter appears below as part of the Clinical Opinion section of this issue.*

*- C.Y. Liu, M.D.  
Editor-in-Chief, News Scope*

## oncology perspective

# Minimally Invasive Surgery in Gynecologic Oncology: Sentinel Node Detection in Endometrial Cancer



Eugenio Solima, M.D.  
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Institute of Milan  
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Francesco Raspagliesi, M.D.  
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**T**he improvement in the prognosis of early stage cancer allowed in the past few years the researchers to reduce the invasiveness of some surgical procedures and increase the quality of life of these patients. This is the starting point of the spread of laparoscopic techniques even in surgical oncology. However the concept of mini invasiveness may be extended to reducing not only the surgical approach, but more extensively reducing the surgical procedure per se.

Lymph node status is one of the most important prognostic factors and one of the most important decision criterion for adjuvant therapies for women with vulvar, cervical and endometrial carcinoma. Complete lymph node dissection has historically been an integral part of the surgical procedure to stage and treat these diseases. However, lymphadenectomy is a complex, time consuming and sometimes difficult procedure, especially in overweight and obese patients and it may cause severe immediate and late complications. Working nearby vital structures like pelvic and paraortic vessels, major complications can be caused by lymphadenectomy like vessel rupture or ureter injuries. Furthermore, lymphocyst formation and lymphedema are common late complications after a complete pelvic and/or paraortic node dissection that may impair the quality of life of a patient survived to cancer.

To avoid or reduce the immediate and late complications of lymphadenectomy, the concept of sentinel node has been introduced. Using this technique when the sentinel node is accurately identified and multiple histological sections have confirmed its negativeness, the risk of further nodal metastasis is minimal. This technique has been pioneered by Cabanas in the late seventies on penile carcinoma, extended into clinical practice of staging melanoma in the nineties and in breast cancer surgery in the early two thousand.

In gynecologic oncology, the utility of sentinel node mapping is under investigation for staging vulvar, cervical and endometrial cancer.

In endometrial cancer, the utility of sentinel node mapping could be implemented not only to avoid unnecessary and difficult lymphadenectomies, but also to select patients who may benefit from paraortic lymphadenectomy. Indeed, although the incidence of nodal metastasis is around 11-17%<sup>1</sup> in stage I disease, in 35% of them a paraortic nodal involvement is recognized and in 9% an exclusive paraortic nodal metastasis is

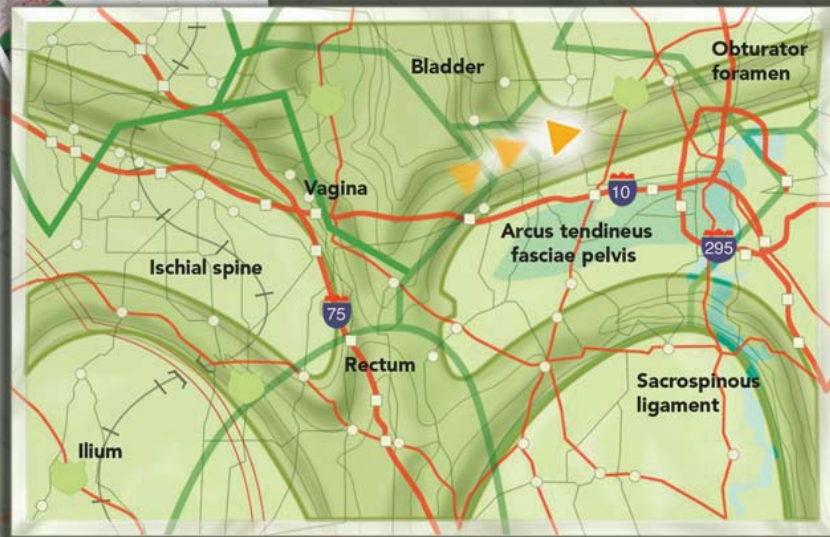
diagnosed.<sup>2</sup> However, considering the complexity of paraortic lymphadenectomy in these patients and the low incidence of nodal metastasis, at the moment endometrial cancer is in most of the centers under staged and treated exclusively with pelvic lymphadenectomy excluding stage Ia.

Several technical points are under investigation to increase the sensitivity and the specificity of sentinel node detection in endometrial cancer. The site of injection is a major problem for endometrial cancer. Indeed in contrast to melanoma, breast cancer and vulvar cancer, endometrial cancer is not visible from outside and to inject the peritumoral area is very important to select the real sentinel node of that area. Hysteroscopic injection has been confirmed recently by our group the most precise, safe and reliable technique using Tc99 marked albumin as a tracer to guide the subsequent radio guided surgical sentinel node detection.<sup>3</sup> Using this technique, the detection rate is in our experience close to 100%.<sup>4</sup> At the moment we are completing a multicenter study to confirm the sensitivity and specificity of this technique. We are far from introducing sentinel node detection in endometrial cancer into clinical practice, however, if the preliminary results of this technique will be confirmed, it could represent a chance to avoid unnecessary surgical procedures and select patients who may benefit of extensive surgical dissection.

### References

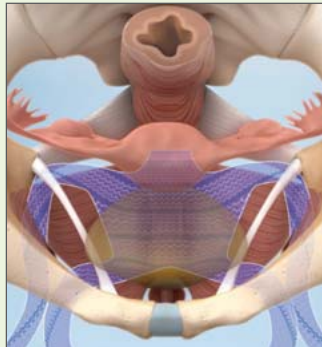
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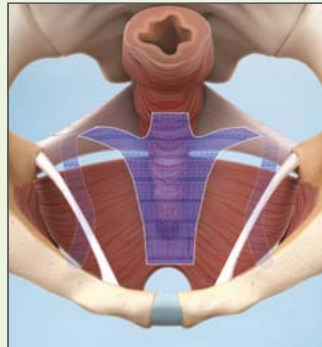


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## meeting news

## Gynecologic Oncology Workshop to be Repeated in Louisville



Resad P. Pasic, M.D., Ph.D.  
Associate Professor  
Department of Obstetrics and  
Gynecology & Women's Health  
University of Louisville  
Louisville, Kentucky

The University of Louisville School of Medicine in Kentucky again became the focus of the Gynecologic Oncology world when renowned experts from leading institutions in the U.S. came to teach and share their expertise at the 2nd Annual Workshop on Advanced Laparoscopic Techniques for Gynecologic Oncologists Using Unembalmed Female Cadavers. This workshop was held October 19-20, 2007, with the course participants coming from several different countries—some as far as South Korea.

The faculty included Javier Magrina from the Mayo Medical Clinic in Scottsdale, Arizona, who also served as the Scientific Program Chair; Nadeem Abu-Rustum from Memorial Sloan-Kettering Cancer Center in New York; Andrew Brill from California Pacific Center in San Francisco; Farr Nezhat from Mount Sinai School of Medicine in New York; and Pedro Ramirez from MD Anderson Cancer Center in Houston, Texas. They were assisted by local faculty - Mary Gordinier, C. William

Helm, Dan Metzinger, Lynn Parker, and James Shwayder, all from the Departments of Oncology and of Obstetrics Gynecology and Women's Health at the University of Louisville.

The didactic and hands-on sessions addressed the review of retroperitoneal pelvic anatomy with emphasis on laparoscopic radical hysterectomy, pelvic and periaortal lymph node dissection, and large bowel resection. The participants' feedback and the workshop evaluations were emphatically positive. Special thanks to Karl Storz Endoscopy—America and Ethicon Endosurgery for providing educational grants to support this premier educational event.

The next course offering in gynecologic oncology, the 3rd Annual Workshop on Advanced Laparoscopic Techniques for Gynecologic Oncologists Using Unembalmed Female Cadavers will be held once again at University of Louisville on September 26-27, 2008. For more information, visit [www.aagl.org](http://www.aagl.org).

### president's message *(continued from cover)*

43 were international in origin. Furthermore, 40% of the physicians attending last year's 36th world congress of the AAGL were from foreign soil. As the Scientific Chairman of last year's world congress in Washington D.C., I was especially gratified to see the large number of attendees from Asia.

We have also noted a dramatic increase in the number of articles submitted and accepted to our *Journal of Minimally Invasive Gynecology (JMIG)* from physicians outside of the United States. International authored articles now account for 40% of the total number of accepted papers. Along with the Journal's publisher, Elsevier, and Stephen Corson, the Journal's editor, the Board of the AAGL is evaluating novel ways to make JMIG more accessible to

physicians throughout the world. Online options are being considered as well.

Do I believe the international growth of our society negatively impacts our North America constituency—ABSOLUTELY NOT!

I challenge any North American AAGL member who questions my belief to attend a lecture conducted by an international faculty member, view a poster submitted by a physician member from outside the United States., attend the 2nd AAGL International Congress on Minimally Invasive Gynecology in Sao Paulo, Brazil or read a journal article of our colleagues from abroad. I assure you that you will agree the globalization of the AAGL has complemented the clinical and scientific advancement of our society.

### annual meeting *(continued from cover)*

will offer a postgraduate course in cosmetic gynecology. There will be three additional hands-on cadaver courses covering anatomic dissection, gynecologic-oncology and urogynecology.

In addition to this, we will be offering 10 video sessions, 10 surgical tutorials and four debates on: 1) robotic surgery; 2) hysterectomy v. ablation for treatment of bleeding; 3) intramural fibroids and infertility; and 4) treatment of bowel injuries. Finally, for the first time, AAGL will offer

two live telesurgery sessions – one on Thursday and one on Friday, both in the morning. As you can see, there will be a variety of scientific activities and we look forward to a fruitful exchange of knowledge and ideas for the ultimate benefit of our patients worldwide. Remember, when AAGL convenes, what happens in Vegas does not stay in Vegas! We invite all of you to participate in this endeavor, and would like to remind you to submit your abstracts.

I look forward to seeing you in Vegas!

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<sup>1</sup> Carter, J. Endometrial Ablation: More Choices, More Options.

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affiliated societies

# Sección de Endoscopia Ginecológica de la SEGO



Angel Martin Jimenez, M.D.  
President  
Sección de Endoscopia  
Ginecológica de la SEGO  
Madrid, Spain

**T**he AAGL's newest Affiliated Society member is Sección de Endoscopia Ginecológica de la SEGO. Roughly translated this is a special interest section within the Spanish Society of Obstetrics and Gynecology. Because of this large base, their activities promoting endoscopy and minimally invasive gynecology touch essentially all gynecologists in Spain. We welcome the members of SEGO and hope they enjoy the benefits the AAGL offers in being a "sister" society.

- Franklin D. Loffer, M.D.  
Executive Vice President/  
Medical Director, AAGL

techniques about gynaecology and the organization through a biannual national congress of gynaecologic endoscopy.

**NS: Approximately how many members are there?**  
Currently there are about 700 members in SEGO.

**NS: What are some of the benefits of membership?**  
The benefits are discounts in gynecological laparoscopic courses, symposiums and congresses. These discounts amount to approximately 20% for meetings held in Spain.

**NS: When and how was your society established?**  
1980

**NS: What is its mission statement/primary goal?**  
Our mission is to promote and diffuse the laparoscopic

**NS: Is there any additional information you would like to provide about your society?**  
Additional information can be found on our website at [www.SEGO.es](http://www.SEGO.es)

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- Secretary**  
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## 2nd AAGL International Congress On Minimally Invasive Gynecology In conjunction with V SOBENGE Brazilian Congress

"Endometriosis: Individualized  
Therapies and Strategies for Prevention"

September 11-14, 2008  
Maksoud Plaza  
São Paulo, Brazil








Fotos: Marcos Hirakawa      Foto: André Stefano

## Educational Opportunity Offered

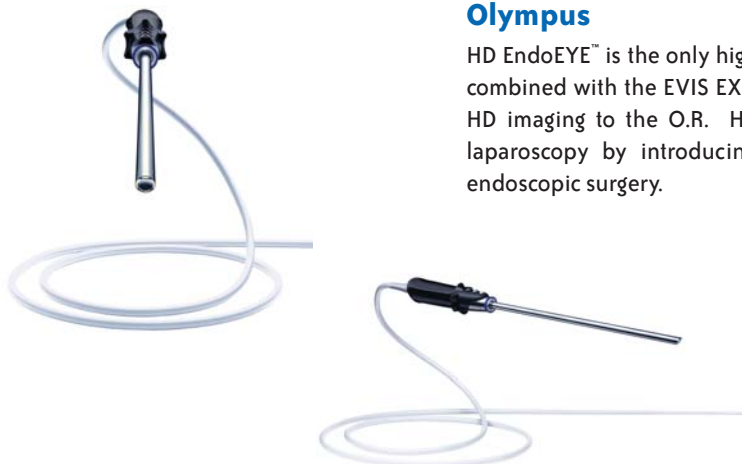
Women's Surgery Center (WSC) has two positions for physicians interested in advanced laparoscopic GYN surgery. WSC is located in the metro DC area, with offices in MD, VA, and DC. The practice is extremely busy, and offers both benign and oncologic laparoscopic procedures. Candidates will receive extensive training with a BC GYN Oncologist for at least 6 months in all aspects of GYN laparoscopy. Additional procedures include pelvic floor reconstruction, laparoscopic management of prolapse, open oncologic and related complex cases. WSC has been awarded a fellowship per Johnson and Johnson/Ethicon, and works extensively with residents of George Washington University Medical Center. There is no OB or ER call with the position. Salary and benefits are exceptional, including 401K match. Interested candidates should email WSC at [qamssr@hotmail.com](mailto:qamssr@hotmail.com) for immediate consideration.

## new products



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### Olympus

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## from the editor (continued from page 3)

developed by the federal government as well. The assumption is that competition and a vigilant public will improve medical care.

While I believe that knowledge is power, and patients have the right to know and be empowered to make informed choices regarding health care, I am fearful about the implications of subjecting the profession to such ratings. First of all, medical quality can never be reduced to simple numerical ratings used for customer satisfaction of hotel, restaurant, or car repair services. The findings would not only be invalid but also misleading. Secondly, on what basis can a patient judge her physician? Personality? Bedside manner? Unfortunately, the general public is not in a position to assess clinical competence. Such findings would

merely be a popularity poll; but the more frightening consequence is the suffering, disability, and even death resulting from inappropriate or incompetent medical care.

We see this in our own field. What a travesty that in this day and age, most women undergoing hysterectomies are doing so, unbeknownst to them, with near-century-old surgical techniques! We at AAGL have a special responsibility to the public in the following ways:

1. To educate patients about advances in our field.
2. To inform patients about the availability of minimally invasive gynecological procedures.
3. To lead patients to the appropriate physicians in their communities for their specific problem.

Sponsored by the  
AAGL  
Advancing Minimally Invasive Gynecology Worldwide



# Tenth Annual Advanced Workshop on Gynecologic Laparoscopic Anatomy & Surgery on Unembalmed Female Cadavers May 16-17, 2008

The University of Louisville  
Louisville, Kentucky



### Enrollment Information

AAGL Advancing Minimally Invasive Gynecology  
6757 Katella Avenue, Cypress, CA 90630-5105  
Phone: (800) 554-2245 or (714) 503-6200  
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E-Mail: [generalmail@aagl.org](mailto:generalmail@aagl.org)  
Web Site: [www.aagl.org](http://www.aagl.org)

### Overview

This postgraduate workshop has been designed for gynecologists with advanced laparoscopic skills who desire to master retroperitoneal and Space of Retzius anatomy and the various surgeries performed therein, including the performance of TVT/TOT surgery and cystoscopy. These goals are achieved using unembalmed female cadavers in an extensive two-day course of lectures and hands on laparoscopic experience. No more than three participants are assigned to each cadaver and are closely supervised by experienced faculty instructors, including some of the most outstanding physicians in this field. The faculty members are selected based on surgical experience as well as expertise in teaching in this setting.

During each hour of hands on experience with the cadaver, each participant will operate, assist and observe. With this rotational format, participants learn pelvic anatomy and laparoscopic suturing skills in a meaningful manner. Faculty members will lead participants through procedures such as pelvic sidewall dissection, preparation for laparoscopic hysterectomy, uterosacral colposuspension, Burch retropubic colposuspension, and paravaginal defect repairs through the laparoscopic approach.

Breakout sessions will highlight the use of TVT/TOT while a separate group works with instructors in laparoscopic suturing.

### Program

Friday, May 16, 2008

8am Introduction and Course overview

8:15 Fundamental Laparoscopic Pelvic Anatomy

9:00 Pelvic Floor Anatomy and Reconstruction

9:40 Question and Answer

9:50 Refreshment Break

10:00 Applied Pelvic Anatomy for Management of Endometriosis and Adnexal Disease

10:50 Laparoscopic Suturing

11:20 Energy Modalities in Endoscopic Surgery

12:00 Working Luncheon

Question and Answer/Discussion

Video: Laparoscopic Dissection and Laparoscopic Suturing

1:00pm – 5:00pm Hands-on Cadaver

Dissection (three participants per cadaver)

Review Surface

• Anatomy of the Pelvis

• Anatomy and Technique of Performing

• Uterosacral Ligament Suspension

• Retroperitoneal Spaces, Vessels, Nerves Dissection

• Dissection of Pelvic Sidewall

• Basics of Laparoscopic Suturing Tutorial

Saturday, May 17, 2008

8am Pearls of Laparoscopic Hysterectomy

8:40 Laparoscopic Treatment of Apical Prolapse

9:15 Slings and Things

10:00 Complications of Laparoscopy and How to Avoid Them

10:45 Question and Answer

10:50 Refreshment Break

11:00 Hands-on Cadaver Dissection

• Anatomy and Refined Techniques of

Performing Laparoscopic Hysterectomy

• Dissection of the Space of Retzius

• Laparoscopic Suturing

12:45 Luncheon

1:30 Continue Hands-on Cadaver Dissection

• Review of Laparoscopic Anatomy,

• Laparoscopic Bowel Injury Repair

• TVT, Trans Obturator Slings, TVT Secure

4:30 Complete Evaluation Forms - Adjourn

## member news

## German Society Honors Dr. Rainer Deckhardt



In 2007, the Society for Gynaecological Endoscopy (AGE) of the German Society for Gynaecology and Obstetrics, honored Dr. Rainer Deckhardt the MIC III qualification, the highest possible surgical qualification level. A rare and exceptional degree, it is awarded to individual surgeons who treat gynecological disorders through minimally invasive surgery. This qualification is awarded at different levels of training (MIC I, II and III).

In order to qualify for the MIC III, the highest level of qualification, proof is required of over 800 major laparoscopic procedures performed in the previous

five years. These procedures must meet a prescribed level of difficulty, a stipulation that excludes purely diagnostic procedures or straightforward procedures such as sterilizations. In addition, at least 100 surgical hysteroscopic procedures over the same period are required as well, the required level of difficulty of which is also prescribed.

This honor has been bestowed by the German Society for Gynecology and Obstetrics to only 24 gynecologists throughout Germany. AAGL congratulates Dr. Deckhardt on this most esteemed recognition.

## Welcome New Members

December 15, 2007 – March 6, 2008

- |                               |                              |                            |                                |
|-------------------------------|------------------------------|----------------------------|--------------------------------|
| Paula Amato, M.D.             | Victor Figueroa, M.D.        | Sapna Marthy, M.D.         | Sarah Richards, M.D.           |
| Mark H. Amols, M.D.           | Arin Ford, M.D.              | Deirdre Masterton, M.D.    | Guadalupe Rodriguez, M.D.      |
| Romel C. Antolin, M.D., FACOG | Alexander M. Friedman, M.D.  | Giuseppe Marzo, M.D.       | Aiko Sakamoto, M.D.            |
| Valeria Arancio, M.D.         | Amy M. Fry, M.D.             | Koji Matsuo, M.D.          | Anthony L.D. Sanders, M.D.     |
| Maninderjit Atwal, M.D.       | Nichole Giannios, D.O.       | Betsy McAdory, M.D.        | Lauren Self, M.D.              |
| Fadel Azer, M.D.              | Brooke Grizzell, M.D.        | Maged Mestrah, M.D.        | Neelam Sharma, M.D.            |
| Andrea G. Baglioni, M.D.      | Kristina Cross Hawkins, M.D. | Jennifer Miller, M.D.      | Olivia M. Sementi, M.D.        |
| Jason Bailey, M.D.            | Leah Harris, M.D.            | Erinn Morgan, M.D.         | Matthew Siedhoff, M.D.         |
| Suzanne Barnhart, M.D.        | Jennifer Howell, D.O.        | Whitney Moses, M.D.        | Mary C. Simpson, M.D.          |
| Adrianna Y. Barrett, M.D.     | Erin M. Hurley, M.D.         | Heidi D. Oberhansli, M.D.  | Shiloh Suzanne Smajstrla, M.D. |
| Jennifer P. Baur, M.D.        | Ali Jaffry, MBBS             | Meagan O'Brien, M.D.       | Pamela T. Soliman, M.D.        |
| George T. Barnett, M.D.       | Shevon Joseph, M.D.          | Ben Palmer, M.D.           | Marsha Solomon, M.D.           |
| Mohammed A. Bedaiwy           | Jennifer A. Kang, M.D.       | James M. Palmer, M.D.      | Paul B. Spartzak, D.O.         |
| Rachel Bevins, D.O.           | Michelle J. Khan, M.D.       | Nina Park, M.D.            | Hasmik Stepanyan, M.D.         |
| Andrew Clark, M.D., Ph.D.     | Shunaha Kim, M.D.            | Yong-Joo Park, M.D.        | Chere L. Stewart, M.D.         |
| Cecil Collins, M.D.           | Nicole B. Korbly, M.D.       | Samuel Allen Pauli, M.D.   | Jackie Stone, M.D.             |
| Karenrose Contreras, M.D.     | Donald P. Kratz, M.D.        | Joseph Earl Peterson, M.D. | Rabiya Suleman, M.D.           |
| Sarah M. Al Darei, M.D.       | Stephan P. Krotz, M.D.       | Kara Pfenning, M.D.        | Karen Y. Tang, M.D.            |
| Sean Davis, M.D.              | Elizabeth Lambert, M.D.      | I. Podzielinski, M.D.      | Nam Tran, M.D., Ph.D.          |
| Alison Desano, M.D.           | Kyeong Ho Lee, M.D.          | Marc Possover, M.D.        | Anupama Vansadia, M.D.         |
| Amber D. Dudar, M.D.          | Veronica Lerner, M.D.        | Shannon Price, M.D.        | Terry Lee Williams, D.O.       |
| Ime B. Essien-Lewis, D.O.     | Jack Alexandre Long, M.D.    | Christopher J. Pugh, M.D.  | May S. Yazeji, M.D.            |
| Jennifer Evans, D.O.          | Alejandro Lozano, M.D.       | Timothy S. Raichle, M.D.   | John S. Ziegler                |
| Meriah S. Fahey, M.D.         | Mohamed Mabrouk, M.D.        | Jennifer Nicole Redd, M.D. |                                |
| Parastoo Farhady, M.D.        | Mohamad Mahmoud, M.D.        | Jhansi Reddy, M.D.         |                                |
| Kelly A. Fogleman, M.D.       | Jennifer Marrone, M.D.       | Rachel Reed, M.D.          |                                |

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## education calendar

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### 17th Annual Comprehensive Workshop on Minimally Invasive Gynecology for Residents & Fellows

Grace M. Janik, Scientific Program Chair  
April 12-13, 2008  
Hyatt Harborside • Boston, Massachusetts

### 10th Annual Advanced Workshop on Gynecologic Laparoscopic Anatomy and Surgery on Unembalmed Cadavers

Resad P. Pasic, Scientific Program Chair  
May 16-17, 2008  
University of Louisville • Louisville, Kentucky

### XVII Annual Congress of International Society of Gynecological Endoscopy (ISGE)

World Congress of Gynecological Endoscopy In Affiliation with AAGL Advancing Minimally Invasive Surgery Worldwide  
June 4-7, 2008  
Bari, Italy

### 3rd Annual Workshop on Suturing, Operative Hysteroscopy & Advanced Laparoscopic Techniques

Charles H. Koh, Scientific Program Chair  
August 22-24, 2008  
St. Mary's Hospital • Milwaukee, Wisconsin

### 2nd AAGL International Congress in conjunction with SOBENGE "Endometriosis: Individualized Therapies and Strategies of Prevention"

Paulo Roberto Cará, President of Congress  
Marco Aurélio P. Oliveira, President of Scientific Committee  
Luiz Fernandez, President of Organizing Committee  
September 11-14, 2008  
Maksoud Plaza • São Paulo, Brazil

### 3rd Annual Workshop on Advanced Laparoscopic Techniques for Gynecologic Oncologists using Unembalmed Female Cadavers

Javier F. Magrina, Scientific Program Chair  
Resad P. Pasic, Course Director  
September 26-27, 2008  
University of Louisville • Louisville, KY

### Global Congress of Minimally Invasive Gynecology

37th AAGL Annual Meeting  
Resad P. Pasic, Scientific Program Chair  
October 28-November 1, 2008  
Paris Las Vegas • Las Vegas, Nevada

### 3rd AAGL International Congress in conjunction with the Australian Gynecologic Endoscopy Society

May 2009 - Brisbane, Australia

### Global Congress of Minimally Invasive Gynecology

38th AAGL Annual Meeting  
C.Y. Liu, Scientific Program Chair  
November 16 – 19, 2009  
Gaylord Resort • Orlando, Florida