



# NewsScope

OCTOBER – DECEMBER 2007

## annual meeting

### 36th Annual Meeting Wins in a Landslide



Charles E. Miller, M.D.  
Scientific Program Chair  
President, AAGL

**T**he votes have been tabulated, and the 36th Global Congress of Minimally Invasive Gynecology in Washington D.C. has proven to be a runaway winner. Never before were so many abstracts submitted for oral, video or poster presentation. This was a record setting Congress for the number of presenters as well. Not only did the 36th annual meeting boast the largest number of international faculty, but the most attendees from outside the United States as well. Additionally, both the pre-congress program and the postgraduate courses, led by internationally recognized experts in the field of minimally invasive gynecology, were AAGL's most ambitious ever.

There just is not enough space to discuss all the highlights of the 36th Global Congress, however, there are several very special moments that warrant mentioning as they make this year's annual meeting so memorable.



View of the National Cathedral from the Marriott Wardman Park

The opening ceremony will long be remembered for Dr. David Grimes' stirring, albeit controversial, discussion of the politics of healthcare in the United States.

The next morning, our President, Grace Janik tugged at our hearts as she spoke of the impact of her hand injury on her passion – surgery. One could not help but feel her pain, both physically and emotionally, and

the joy of her triumph, as she overcame this adversity on her way to a successful recovery.

Attendance at both general sessions were beyond capacity. Leave it to AAGL's "House Visionary", Steve Palter to chair a futuristic panel on natural orifice surgery. Furthermore, who other than Alan DeCherney, can so quickly turn a discussion on ovarian preservation into an extremely informative, and at times, humorous debate.

At the honorary luncheon, attendees had the good fortune to hear Christopher Sutton as he recapped his illustrious career in medicine. Chris has proven to be the consummate clinician, researcher, thought leader, teacher and author.

Whether it be the lively debates, illuminating panels, intimate

surgical tutorials, informative affiliated society meetings, exciting telesurgery or the myriad of excellent plenary sessions, free communications, video, or poster presentations, the 36th Global Congress was a unique educational endeavor.

A personal highlight of the meeting for me was to have the opportunity to chair the press conference announcing an important AAGL initiative. Through industry support, our society will educate women about the advantages of minimally invasive gynecology.

As a final note, it was over 18 months ago that, as Scientific Program Chair, plans for 36th Global Congress of Minimally Invasive Gynecology were initiated.

I would like to personally thank the Scientific Program Committee, Honorary Chair, Chris Sutton, President, Grace Janik, the AAGL Board of Trustees, Frank Loffer, Executive Vice President and Medical Director, Linda Michels, Executive Director and her staff, the CME Advisory Committee, Abstract Review Committee, Video Committee, Scientific Poster Committee, Sessions Management Committee, Awards Committees and *The Journal of Minimally Invasive Gynecology* for their tireless effort and constant support. I also want to thank the presenters, industry partners and attendees for providing the infectious energy that permeated the annual meeting from start to finish.

I would also like to thank the membership of the AAGL for granting me the privilege to serve as this year's Scientific Program Chair. It truly has been an honor and I look forward to serving you as the incoming President of AAGL.

I now turn over the role of Scientific Program Chair to my very capable Vice President, Paya Pasic, as he leads preparation for the 37th Global Congress of Minimally Invasive Gynecology in Las Vegas, October 28th – November 1, 2008. Also, I look forward to seeing you at the 2nd AAGL International Congress on Minimally Invasive Gynecology in conjunction with V. SOBENGE Brazilian Congress, September 11-14, 2008.



Scientific Program Chair, Resad Pasic planning the 37th Global Congress



Paris Las Vegas,  
Las Vegas, Nevada

## 37<sup>th</sup> Global Congress of Minimally Invasive Gynecology

Resad P. Pasic, Scientific Program Chair

**SAVE THE DATE**

October 28 – November 1, 2008



www.aagl.org

## Time for a New Approach



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

**W**hen one compares the growth curve of laparoscopic cholecystectomies to laparoscopic hysterectomies there is a distinct difference. Fifteen years after the adoption 80% of cholecystectomies are done laparoscopically. On the other hand 15 years after the introduction of laparoscopic hysterectomies only about 15% are done by this technique.

So why is there this difference between general surgeons and gynecologists? The former depend on referrals from others physicians and the latter, by in large, self refer. In other words the general surgeon must stay competitive in the skills they offer where as the average gynecologist has much less need to do so.

This difference can't be explained because gynecologists have been slow in adopting minimally invasive techniques. It was, after all, gynecologists who, through the AAGL, first brought modern laparoscopy into their practices for the benefit of their patients.

But AAGL members have never been representative of the average gynecologist. We have always been "early adopters" who have brought to our patients the latest technologies available. For 36 years the AAGL has offered training programs, conferences and peer reviewed publications in an effort to bring all gynecologists into the AAGL realm of minimally invasive surgery. Our lack of success can be seen in the above figures. So we are trying a new approach.

With the very generous support of corporate sponsors American Medical Systems, Boston Scientific, Ethicon Endo-Surgery, Ethicon Women's Health & Urology and Karl Storz Endoscopy America we have engaged Ogilvy, a New York public relations firm, to help us spread the word of AAGL members to all patients. And what is that word? It is that patients should expect their gynecologist to offer minimally invasive techniques and if they do not they should seek a gynecologist who can. And the odds are good it will be an AAGL member they contact.

## from the editor

### The Land of Waste



Resad P. Pasic, M.D., Ph.D.  
Editor-in-Chief, NewsScope  
Vice-President, AAGL

**R**ecently, I had a self-paying patient who needed a laparoscopic hysterectomy. I requested all reusable instruments, including trocars and bipolar coagulator. Everyone at the operating room, from OR personnel to residents and fellows, seemed to be upset that we are not using the shiny disposable armor to uproot the mighty uterus.

It seems that only a few years ago I operated only with reusable instruments. Now my colleagues and I have gotten spoiled by the ease and the advantages of using disposable instruments.

However, in the United States, the cost of laparoscopic procedures, such as a hysterectomy, has quadrupled in the past 15 years while physician reimbursement has decreased. The excessive and, at times, unnecessary use of disposable instruments has probably contributed to this significant increase in the cost of laparoscopic procedures.

Moreover, in this time of increased awareness about global warming, we need to recognize the impact the manufacture and disposal of such instruments have on the environment.

Finally, the majority of our colleagues around the world do just fine with reusable instruments; while others may not have the basic equipment and resources to perform surgeries, let alone dispose of surgical instruments.

I am not advocating against the use of disposable instruments; quite the contrary. They do offer certain proven advantages, but their excessive use is wasteful. Sometimes we use very expensive disposable instruments just to make two cuts during surgery. Not to mention those disposable instruments which routinely get opened and placed on our trays and often never get used. Maybe in such cases it is warranted to pull out those reusable instruments hidden in our bottom drawers and create an uproar in the OR to raise sustainability awareness. Perhaps then our piles of waste and surgical bills might just get smaller.

## 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

## Laparoscopic Treatment of Endometriosis



Harry Reich, M.D.

**T**hank you for the opportunity to express my controversial opinions about endometriosis. I encourage AAGL to develop guidelines for its diagnosis and treatment. Extensive endometriosis surgery, often involving the rectum, is the most difficult surgery in gynecology.

I know a lot about this disease. I have been treating it by excisional surgery for over 30 years. I am convinced that what is excised never comes back. My results in over 1000 cases of deep endometriosis excised by laparoscopic surgery confirm that less than 20% of these women will require further treatment.

**My diagnostic approach:**

1. In most cases of severe endometriosis, the endometriosis, surrounded by scar tissue, can be diagnosed in the office by rectovaginal examination, with elevation of the cervix and palpation through the rectum. These areas are usually tender to palpation, and this tenderness is used to direct the surgeon to the area to be removed. Examination after surgery should be pain free if the appropriate area was excised.

2. Vaginal ultrasound as developed by Professor Mauricio Abrao in Brazil will become a non-invasive procedure to diagnosis and follow deep endometriosis, once expertise is obtained.

3. Diagnosis of endometriosis should require a positive biopsy documenting endometriosis glands at laparoscopy. Papers in the literature using visual documentation of endometriosis are worthless!

4. Most women with the diagnosis of endometriosis without biopsy do not have endometriosis! The diagnosis is often made visually by laparoscopy without a biopsy of these "hemosiderin laden macrophages", white blood cells filled with iron from evacuation of retrograde menstruant.

**My therapeutic approach:**

1. Enterolysis. Many women with extensive endometriosis have had multiple laparotomies resulting in adhesions of small bowel to the undersurface of the anterior abdominal wall. Thus, the first part of many endometriosis operations is release of these adhesions in order to see the pelvis. Then the rectum must be separated from the posterior vagina and cervix.

2. Separate all pelvic organs including the ovaries, uterus, cervix, upper vagina, and rectum.

3. Excise the endometriosis. Symptomatic endometriosis is surrounded by fibrous scar tissue from a repetitive longstanding inflammatory response. This scar tissue containing the endometriosis glands is excised from inside the ovaries, the posterior cervix and vagina, the rectum, and the uterosacral ligaments (and ureters if necessary).

4. Rectal resection in cases in which the endometriosis penetrates deeply into the rectal/rectosigmoid wall.

5. Various agents to separate operated upon organs during early healing.

6. GnRH agonists cure rates approach zero regardless of disease stage. Rarely use.

**Problems in the U.S.:**

1. Two distinct groups doing laparoscopic surgery have evolved: a very large cluster doing it for diagnosis and minimal treatment and a much smaller elitist segment doing it for optimum treatment.

2. Poor level of surgical training to deal with endometriosis, despite laparoscopic fellowships. We who do this type of surgery have very few disciples.

3. Poor reimbursement for complex endometriosis surgery despite increased medicolegal risk. Most surgeons who treat extensive endometriosis have problems participating within our managed care insurance system. One may have to do 100 cases to cover malpractice insurance! Office gynecology pays much better. Why get stuck with a complex endometriosis surgical case involving rectum, ureters, and, frequently, small bowel?

4. Many women who undergo multiple "endometriosis" laparoscopies have no disease. The surgeons do an easy diagnostic laparoscopy without biopsy followed by 6 months of GnRH agonist treatment followed by another "diagnostic" laparoscopy, extracting cash from the patient without any long-term benefit.

5. The concept that endometriosis comes back is just a good excuse for poor treatment. What is called recurrent disease is really persistent disease that was not treated in the first place.

If the above sounds depressing regarding the state of endometriosis diagnosis and treatment in the USA, it is! Our lawyers and our health insurance system have contributed.

*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.*

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**Fellowship year July 1, 2009 to June 30, 2010 — applications now being accepted!**

The Fellowship in Gynecologic Endoscopy, an affiliate of the AAGL and the Society of Reproductive Surgeons of ASRM, is sponsoring fellowships in advanced gynecologic endoscopy. These fellowships were created with the goal of producing a standardized training program. The Fellowship provides an opportunity for gynecologists who have completed their residency to acquire additional skills in minimally invasive gynecologic surgery.

This fellowship also aims to further research in the field of minimally invasive gynecology. Fellows are required to complete a scholarly contribution to be presented at the annual meetings of the AAGL and ASRM. The Fellowship in Gynecologic Endoscopy actively encourages applications from postgraduate physicians aspiring to develop their surgical skills in minimally invasive gynecology.

**Important Dates of the Fellowship:**

- **Deadline to submit your application for the 2009–2010 Fellowship year: July 1, 2008**
- **Interviews with applicants: To be determined by each site. To be scheduled no later than September 2008.**
- **Submission of Rank List: October 6, 2008**
- **Notification of match results: October 24, 2008**

election results

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2nd AAGL International Congress  
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"Endometriosis: Individualized Therapies and  
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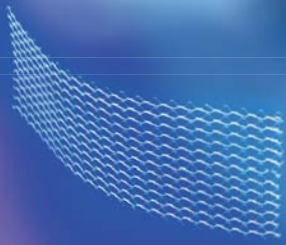
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## meeting news

## Gynecologic Oncology News from Louisville



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

**T**he University of Louisville School of Medicine in Kentucky again became the focus of the gynecologic oncology world recently, 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 on October 19 and 20, 2007 and the course participants came from several different countries, some as far as South Korea.

The faculty included Javier Magrina, M.D. from the Mayo Medical Clinic in Scottsdale, Arizona, who also served as the Scientific Program Chair; Nadeem Abu-Rustum, M.D. from Memorial Sloan-Kettering Cancer Center in New York; Andrew Brill, M.D. from California Pacific Center in San Francisco; Farr Nezhat, M.D. from Mount Sinai School of Medicine in New

York; and Pedro Ramirez, M.D. from M.D. Anderson Cancer Center in Houston, Texas. They were assisted by local faculty - Mary Gordinier, M.D., C. William Helm, M.D., Dan Metzinger, M.D., Lynn Parker, M.D. and James Shwayder M.D., all from the Department of Obstetrics Gynecology and Women's Health at the University of Louisville.

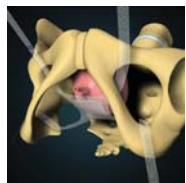
The didactic and hands-on sessions addressed the review of retroperitoneal pelvic anatomy with emphasis on laparoscopic radical hysterectomy, pelvic and periaortal lymph node dissection, and large bowel resection. The participants' feedback and the workshop evaluations were emphatically positive and we plan to organize a similar workshop again September 19-20, 2008.

Special thanks to Karl Storz Endoscopy - America and Ethicon Endo-Surgery for sponsoring this premier educational event.

## new products

## Bard Urological

The Avaulta Plus™ Biosynthetic Support System utilizes a nonabsorbable monofilament, polypropylene mesh to provide long-term reinforcement for support structures. The Avaulta Plus™ Biosynthetic Support System features a porous, acellular, ultra-thin crosslinked collagen attached to the polypropylene mesh which serves to establish a protective barrier between mucosal tissue and the mesh.



## Richard Wolf Instruments

Richard Wolf offers a complete line of instruments designed specifically for Laparoscopic GYN surgery, Hysteroscopic Surgery and instruments for the Office Hysteroscopy setting. The product portfolio includes classic products like the Bipolar Kleppinger, Panoview Plus Laparoscopes, Fluid Manager, and PowerBlade as well as new products like Bipolar Resection and the Chip E-Vac.

## membership news

## 17th Annual Workshop for Residents and Fellows

**T**he 17th Annual Workshop for Residents & Fellows will be held April 12-13, 2008 at the Hyatt Harborside in Boston, Massachusetts. The workshop is structured to include didactic sessions which will cover everything from organizing the OR to complications when practicing laparoscopic and hysteroscopic techniques. Luncheon round tables will allow attendees to interact one-on-one with the invited faculty and the afternoon lab sessions

will cover electrosurgical principles, suturing techniques, hysteroscopic techniques and robotics. The workshop is taught by a dedicated faculty consisting of AAGL Board members, advisors and fellowship directors. AAGL members that have been in practice less than 5 years may also find this course to be of benefit. We encourage you to register soon as space is limited!

## 10th Annual Cadaver Workshop Planned

**T**he AAGL is proud to announce the 10th Annual Advanced Workshop on Gynecologic Laparoscopic Anatomy and Minimally Invasive Surgery including TVT & TVO, May 16-17, 2008 at the University of Louisville. Known as our premier hands-on course, this comprehensive skills oriented workshop is limited to 27 registrants to allow for an intensive experience with world renowned faculty. Lab sessions will include demonstrations and surgery on unembalmed female cadavers to learn retroperitoneal and Space of Retzius anatomy and the various surgeries performed therein. Breakout sessions will highlight

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

The AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The AAGL designates this educational activity for a maximum of 16 category 1 credits toward the AMA Physician's Recognition Award (AMA/PRA). Each physician should only claim those credits that he/she actually spent in the activity.

To register now, go to the AAGL website at [www.aagl.org](http://www.aagl.org).

meeting news

# Washington DC Wrap Up



Attendees awaiting start of session



General Session Head Table



Lisa Roberts, Barbara Levy, Kristztina Bajzak



Ellis Downes presents at PG Course on Laparoscopic Pearls and Pitfalls



Suturing Pre-Congress Course



Telesurgery



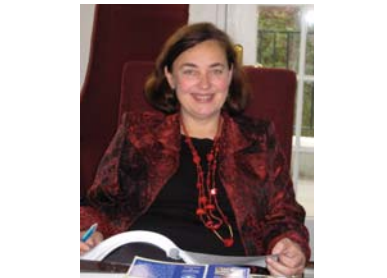
Attendees break from morning sessions



Chair Charles Koh (left) and faculty for pre-congress course



AAGL Booth



President Grace Janik presiding at her last Board meeting



Preceptors C.Y. Liu and Joseph Sanfilippo at Fellowship Breakfast



President Zupi (2nd from left) before the Societa Italiana di Endoscopia Ginecologica (SEGi) affiliated society meeting



AAGL 2007 Board of Trustees

## Robotic Surgery in Gynecologic Oncology



Pamela T. Soliman, MD, MPH  
Assistant Professor  
Department of Gynecologic  
Oncology  
University of Texas, MD  
Anderson Cancer Center  
Houston, Texas

**S** The role of minimally invasive surgery in gynecologic oncology has changed significantly with advancing technology. The use of laparoscopy in the staging of both endometrial as well as early ovarian cancer has been described by a number of authors [1-3]. In addition, there is an increasing body of literature supporting the role of minimally invasive surgery in the treatment of early cervix cancer [4-6]. While the laparoscopic approach to gynecologic cancers continues to grow, the steep learning curve and the development of skills needed to perform advanced laparoscopy continue to be a challenge for many physicians.

In 2005 the da Vinci surgical system (Intuitive Surgical, Sunnyvale, CA) received approval from the Food and Drug Administration for use in gynecologic procedures. Introduction of this robotic surgical system has addressed many of the obstacles of conventional laparoscopy including lack of depth perception, limited range of motion, unstable camera, and a steep learning curve. The da Vinci system provides 3-dimensional visualization, improved dexterity with 7 degrees of freedom mimicking the surgeon's actual wrist movements, restoration of proper hand-eye coordination, and an ergonomic position [7]. While the safety and feasibility of robotic-assisted surgical procedures has been published in other surgical fields, the role of robotic surgery in gynecologic oncology is still being established.

In 2005, Reynolds et al. published the first case series evaluating the feasibility of robotic-assisted laparoscopic staging in patients with gynecologic cancers [8]. In this preliminary series of 7 seven patients, 4 with endometrial cancer, 2 with ovarian cancer and one with fallopian tube cancer, all of the procedures were completed robotically. The median lymph node count was 15, mean operative time 257 minutes, and the average blood loss was 50mL. The median hospital stay was 2 days. This series provided the first evidence that robotic-assisted laparoscopy was a feasible approach to surgical staging.

Since that time two additional studies have been published evaluating the feasibility of robotic-assisted radical hysterectomy for the treatment of early cervical cancer. Kim et al. reviewed 10 patients who underwent robotic radical hysterectomy for FIGO stage IA2-IB1 cervical cancer [9]. In this series, there were no conversions to either conventional laparoscopy or laparotomy. The mean operative time was 207 minutes with a mean docking time of 26 minutes. The mean estimated blood loss was 355mL which is comparable to data in the literature for other surgical approaches. There were no ureteral injuries or fistula complications.

In a similar group of patients, Sert and Abeler compared seven patients who underwent a robotic radical hysterectomy to eight patients who underwent conventional laparoscopic radical hysterectomy [10]. The mean operative times were similar (241 versus 300 minutes,  $p=0.165$ ). The pathologic specimens retrieved were similar in both groups including number of lymph nodes, parametrial tissue, and vaginal cuff size. The robotic radical hysterectomy group was found to have

less blood loss and shorter hospital stay suggesting there may even be an advantage to the patient undergoing the robotic procedure when compared to conventional laparoscopy.

Although these studies represent preliminary data on the feasibility of robotic surgery in patients with gynecologic cancers, the data are certainly encouraging. With continuing advances in technology, the advantages of minimally invasive surgery will likely continue to grow. Our institution is developing the first prospective randomized trial evaluating the safety and feasibility of robotic or laparoscopic versus abdominal radical hysterectomy in patients with early cervix cancer. In this multi-institutional, international trial we will also compare disease-free interval and overall survival between the minimally invasive approach and standard laparotomy.

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## In Remembrance: James S. Holtman, M.D. 1949 – 2007

AAGL member and AAGL-SRS Fellowship preceptor, Dr. James S. Holtman, died September 11, 2007 of complications from his eighteen-month battle with leukemia. Dr. Holtman was from Louisville, Kentucky, where he served as a faculty member for the University of Louisville Fellowship for Gynecologic Endoscopy. He held many leadership positions, including Chief of Obstetrics and Gynecology and Medical Staff

President of Norton Hospital Medical as well as President of the Jefferson County Medical Society. All who knew him will miss his common-sense leadership.

Expressions of sympathy may be made to the David Holtman Memorial Scholarship Fund, The De Paul School, 1925 Duker, Louisville, KY 40205, or online at <http://www.depaulschool.org/contributions.html>.

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## new members

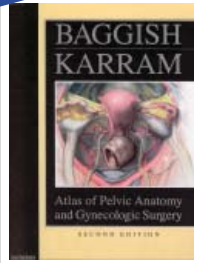
## Welcome New Members

September 1, 2007 to December 14, 2007

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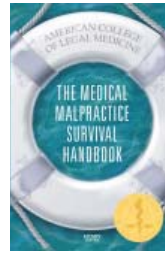
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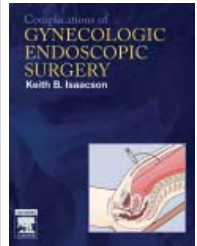
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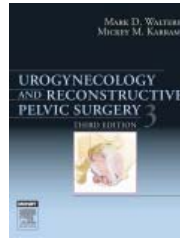
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Featuring the work of Dr. Isaacson - a recognized and respected member of the Ob/Gyn community - this new resource examines all aspects of complications that can potentially occur in gynecologic endoscopic surgery. Each chapter has a consistent format touching on the prevention, recognition, and management of a specific complication, and starts with a review of the literature on the likelihood that a specific complication will occur. Abundant diagrams and photographs of complications and management enhance the material and illustrate and clarify the concepts presented.

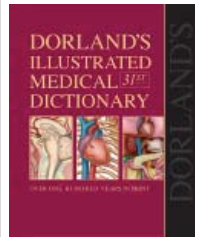
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## education calendar

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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

### 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"

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 19-20, 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