New PG Courses at the Annual Meeting

This year, the AAGL will be offering PG courses relevant to health issues facing today’s woman, many of which gynecologists confront in their daily practice as well. Highlighted below are just two of the twelve PG courses to be offered at the annual meeting in Miami Beach, November 20-24, 2002.

**PG Course: Endometriosis**  
G. David Adamson, Chair

The objective of this course is to provide a comprehensive overview of the evidence supporting the contemporary management of endometriosis. This will include an overview of different types of evidence and why some studies are more useful than others. The evidence on laparoscopy for pelvic pain, and surgical approaches and techniques for endometriomas, laparoscopy, laparotomy and hysterectomy will be reviewed. The evidence to help choose among surgery, ovarian stimulation or assisted reproductive technologies for infertile patients will be discussed. The evidence to select treatments following surgery will be presented, as well as exciting information about impending pharmacological approaches to ovarian suppression, adhesion prevention and possible immunologic treatments. Ample time will be given for discussion with the internationally recognized faculty: G. David Adamson, Christopher J.G. Sutton, and Mauro Busacca.

**PG Course: Menopause & HRT**  
Anthony A. Luciano, Chair

The AAGL’s postgraduate course, Menopause and Hormone Replacement Therapy, will present current data on a variety of issues relating to menopause and osteoporosis. The course will discuss the importance of identifying those women who may benefit from HRT versus those for whom it could be harmful. Treatment options, such as the anti-estrogenRaloxifene, for women who are at risk for breast cancer, will be explored. Also,

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Robert Hunt Retires as Editor of the Journal

On March 1, 2002, Robert B. Hunt, due to health reasons, retired from his position as Editor-in-Chief of the *Journal of the AAGL*. Dr. Hunt served as the journal’s editor since it was established in April 1993 by Jordan Phillips and the AAGL Board of Trustees. Dr. Hunt was at the helm with the first published issue in November 1993 and saw the *Journal’s* rapid acceptance by Index Medicus in November 1996. He was instrumental in the ever-expanding range of papers published in the *Journal*. Whether an author submitted from Uzbekistan or New York, he treated them all with the same scientific measure and diplomacy. He also broadened the base of international authors; the *Journal* now publishes a diverse sample of papers, over 65% of which are by authors outside the United States. Dr. Hunt was always concerned for authors, and with insight and foresight selected papers by experienced clinicians as well as those in their early years as researchers and endoscopists. Thus he provided new authors with a respected forum in which to propose their ideas. He always understood the importance of less dramatic as well as revolutionary new approaches.

In 1993, the *Journal* had an editorial board of eight with a staff of six. Through Dr. Hunt’s guidance and leadership, it now has an editorial board of 17, an editorial advisory board of 27, an ad hoc review committee of 330, and a staff of 7. The impact factor, which measures the frequency with which the *Journal* is quoted in peer-reviewed articles, has continued to increase and now stands at 1.268.

The AAGL Board recently voted to appoint Dr. Hunt, Editor-in-Chief Emeritus. He will also be recognized as the Honorary Chair of the 31st annual meeting, to be held November 20–24, 2002 at the Fontainbleau Hilton in Miami Beach, Florida. A special tribute is being planned during the Honorary Luncheon, November 21, where Dr. Hunt’s contribu-
We do not hold political conventions, but we do have a nominating process in which you should be participating.

Each year the National and International Advisory Committee members are polled as to their choices for their representatives to the AAGL Board of Trustees. And they do speak out! Each committee then votes to select their choice for this one year commitment to the Board of Trustees.

At the same time, the Nominating Committee selects candidates from the general membership for two 2-year terms on the Board of Trustees, plus a secretary-treasurer who will advance to vice-president and eventually to the presidency. In addition, on alternate years, an additional international candidate is selected to run for a 2-year term on the Board of Trustees. It is mandated by the AAGL bylaws that this additional position can only be filled by a non-North American member.

And this is where you, as a member of the AAGL, should be voicing your opinion. Any member is eligible to be nominated for office, except for the one position reserved for a non-North American. The national and international advisors speak out and you should too! Call, fax, write or e-mail your recommendation for secretary-treasurer and the two Board positions to the Nominating Committee shown below.

**Members of the Nominating Committee**

- Jay Cooper, M.D. (Immediate Past President)
- William H. Parker, M.D. (Past President)
- Victor Gomel, M.D. (Past President)
- Errico Zupi, M.D. (Representative of the International Advisors)
- Grace M. Janik, M.D. (Representative of the National Advisors)
- D. Alan Johns, M.D. (Vice President)

They may be contacted directly or at nominations@aagl.com.

This position is open to all AAGL members, and we encourage interested individuals to apply.

The Editor-in-Chief is responsible for establishing the Journal’s editorial policies, overseeing manuscript acceptance, and heading the editorial boards. Minimum qualifications for this position include: 1) M.D. or D.O. degree, 2) Certified by the American Board of Obstetrics and Gynecology or similar certification body, 3) Excellent English writing and verbal skills.

A job description and application can be downloaded from our web site or you may contact Patricia Freeman, Senior Editorial Assistant at the Journal of the AAGL, (800) 554-2245 or (562) 946-8774 email: pfreeman@aagl.org.
Maximizing Future Fertility at Operative Laparoscopy

Brian M. Cohen, M.D.

**Introduction**

The goals of reconstructive fertility surgery are to repair and reconstruct normal tubo-ovarian relationships with minimal trauma, and to maximize the prevention of post-operative adhesion formation.

**General Principles**

Instrumentation should be gentle and anti-traumatic (e.g. grasping forceps for elevating and mobilizing the oviducts).

The surgery should be completed in the mid-proliferative phase of the menstrual cycle to minimize the risks of corpus luteal bleeding, which may increase the risk of infection and adhesion formation.

Hemostasis should be meticulous with minimal trauma to contiguous sites.

The insufflation gas should be warmed and moistened. Continuous irrigation of the tubo-ovarian areas with warmed Heparinized Ringers Lactate (not saline), containing corticosteroids and prophylactic antibiotics, is carried out throughout the procedure.

**Specific Procedures**

Multiple tubal ostia should be left alone.

Hydatids of Morgagni or paratubal cysts, which draw the fimbrial end of the oviduct away from the ovary, should be excised.

If excision of a paratubal cyst would possibly compromise significant tubal or ovarian vessels, these should be marsupialized and explored within to confirm their benign nature.

Phimosis of the distal oviduct should be dilated from the fimbrial end with gentle dilating forceps. When necessary, micro-bipolar coagulation is used to facilitate transection and enlarge the distal opening of the fallopian tube.

Bruhat serosal coagulation or vaporization, to evert the distal oviduct, maximizes the chance of postoperative patency.

When the distal fallopian tube is elevated and the fimbrial surface is greater than 2 cm from the ovarian surface, the mesosalpinx above the fimbria ovarica should be shortened using the bipolar button electrode and/or the carbon dioxide laser Bruhat method. This brings the distal end of the tubes within 2 cm of the ovarian surface and effectively restores normal tubo-ovarian relationships. Adhesions should be coagulated and excised.

Ovarian surface adhesions are best coagulated with a bipolar button electrode or laser vaporization with carbon dioxide intermittent pulsed mode. The adhesions are rubbed off with fine moist Kittner swabs. Major endometriomas should be marsupialized and explored within to salvage as much ovarian cortex and oocytes as possible. A 1-cm circle of the ovarian surface is excised and the coagulator and/or laser is taken into the cavity to coagulate and/or vaporize the inner surfaces of the endometrioma. Minimal surface suturing with non-reactive sutures are applied when necessary.

Ovarian cysts should be removed if they strip easily and minimal sutures applied.

In the surgical management of ectopic pregnancy, the contralateral oviduct should be checked. If this is a large hydrosalpinx, it should be excised or submitted to cruciate salpingo-neostomy with eversion of the tubal ends. If there is extensive tubal damage bilaterally, and in vitro fertilization is contemplated, the oviducts should be occluded proximally with bilateral clips placed as close to the cornu as possible.

In the contralateral side is healthy and patent, attempt to do the minimum at salpingotomy. Effective hemostasis by dissecting fine layer by layer, assisted by using Vasopressin as a solution of 5 units in 100mL saline. Once this is injected into the oviduct and blanching has occurred, the surface is transected with a bipolar button electrode or monopolar cutting needle in slow smooth repeated movements. Await spontaneous tubal expulsion of the products of conception, which may then be assisted out with grasping forceps. Use of cutting mode or bipolar pinpoint hemostasis should achieve minimal tubal damage and hydro-dissection via chromotubation and/or in the ectopic pregnancy bed should assist in the atraumatic evacuation of the products of conception. Residual products are most commonly found at the proximal site, so this area should be specifically checked.

**Laparoscopy for Distal Tubal Occlusion (Bilateral Hydrosalpinges)**

Where these are noted, the patient’s fertility will be best served by in-vitro fertilization.

Hydrosalpinges reduce the success rate for IVF 2–5 fold. Removal of the hydrosalpinges or bilateral cruciate salpingo-neostomy, with distal tubal eversion and proximal tubal clipping, are associated with a much higher success rate.

In the young patient (less than 35), who has essentially small hydrosalpinges and healthy endosalpinx, the tubes should be left patent by completing eversion salpingo-neostomy.

If the patient is over 35 and/or significant tubal damage is revealed with minimal healthy mucosa in dilated hydrosalpinges, these should be removed or opened but proximal tubal clipping is effected as close to the cornu as possible. This avoids the pressure pain of dilated hydrosalpinges and attempts to maximize preservation of tubo-ovarian blood vessels.

In major adhesive and endometriosis surgery, when one has completed removal of the endometriosis and/or pelvic adhesions, one should review and effectively restore or reconstruct tubo-gonadal.

See *Maximizing page 7*
I N T E R N A T I O N A L  N E W S

Highlighting the Gruppo Romano di Endoscopia Ginecologica (GREG)

The commitment of Italian gynecologists to endoscopy is again demonstrated by their organization of Gruppo Romano di Endoscopia Ginecologica (GREG). The national Italian society, Società Italiana di Endoscopia (SEGi), was previously highlighted as an AAGL affiliated society in the April–June 2001 issue of News Scope. The formation of GREG by those endoscopists in Rome demonstrates the value of local organizations who can speak to local issues. It is a model that other large geographical areas should emulate. GREG and the AAGL will support SEGi in the World Meeting of Minimally Invasive Surgery, which is to be held in Rome on June 25–29, 2003.

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

N S: When was the Gruppo Romano di Endoscopia Ginecologica established?
GREG: It was established in 1993. Its first president was Carlo Romanini. The current president is Errico Zupi.

N S: What is its mission statement?
GREG: To promote endoscopic surgery and to create a regular exchange between different Roman hospitals.

N S: Approximately how many members are there?
GREG: There are approximately 140 members.

N S: What are some of the benefits of membership?
GREG: No registration fee for many endoscopic meetings. Web site and e-mail for GREG-related purposes. The chance to have an experienced surgeon in OR for free.

N S: What kind of problems specific to physicians in Rome does your association address?
GREG: Medicolegal support.

N S: Has GREG participated in any meetings on gynecologic endoscopy?
GREG: In 1997 GREG organized the World Congress of Gynecological Endoscopic Surgery in Rome. In 2003, GREG will be strongly involved in the organization of the SEGi World Meeting on Minimally Invasive Surgery.

For further information on the Gruppo Romano di Endoscopia Ginecologica please contact Errico Zupi at Rivocatore Clinica Ginecologica e Ostetrica: Via Università di Tor Vergata, Viale Parioli 12: 00197 Rome, Italy; Tel. 39-066837416; E-mail: zupi@uniroma2.it

F O U N D A T I O N  N E W S

Successful Outcome for 2002 Resident’s Course

Andrew I. Brill, M.D.

I am extremely pleased to report that the Annual Comprehensive Workshop on Gynecologic Endoscopy for Residents, Fellows, and O.R. Personnel recently conducted in King of Prussia, Pennsylvania, was highly rewarding and invigorating for faculty and participants alike. Riding the coattails of last year’s extremely successful event, with more than 100 participants, this year’s program further refined our ambition to highlight the value of fundamental knowledge and techniques by focusing on process rather than procedure. Whenever possible, a premium was placed on risk reduction and the level of supportive evidence. Interpolated by a high-spirited session of theme-based luncheon roundtables, the formal didactic program was followed by both interactive video and digital media sessions: and an orchestrated series of in vitro laboratory exercises covering the breadth of endoscopic surgery. Using a case-study format, the video and digital media sessions were used to elucidate the underlying principles of common operative laparoscopic and hysteroscopic procedures, including a frank look at the evolution of real surgical complications. Utilizing a complement of endoscopic surgical instrumentation, including fully equipped imaging stations and tissue models; laboratory sessions were vigorously attended until the last moments of the closing session. Employing a high faculty-to-student ratio, participants were methodically guided through a series of laboratory exercises that focused on basic technical aspects of diagnostic and operative hysteroscopy, extracorporeal suturing, tissue dissection and manipulation, electromechanical morcellation, and the utilization of energy modalities, including ultrasonic energy, and monopolar as well as bipolar electrosurgery.

Naturally, every aspect of our success was intrinsically linked to my Co-Chair and Laboratory Director, Malcolm Munro; the tireless effort of Linda Michels and Jane Kalert with the AAGL office staff; the immense goodwill from our partners in industry who provided funding, equipment, and outstanding laboratory assistance; the spirited participation of our faculty - Drs. Olive, Roberts, Bajzik, Rogers, Indman, Levy, Loffer, Woodland, Lucente, and Garcia; and the spirited willingness to learn by all attendees.

Reflecting the AAGL’s ongoing prioritization of resident education, plans are now in motion to formalize a similarly designed program to take place just before the next Annual Meeting in Miami, Florida. Without question, our success and mission as an organization vitally depend upon an ongoing commitment to the

See Residents page 6
WE HAVE MET THE ENEMY—THEY ARE US!

Barbara Levy, M.D.,
Member,
ACOG Nomenclature Committee

Vincent Lucente, M.D.,
AAGL Representative,
AAGL Nomenclature Committee

AGL’s representation on the ACOG Coding and Nomenclature Committee has been an extremely beneficial relationship for endoscopic surgeons. With the support of Vincent Lucente and Ed Stanford from the AAGL coding committee, we were successful in proposing several new codes for inclusion in CPT 2003. There will now be a code for laparoscopic hysterectomy for uterus >250 grams as well as a code for multiple laparoscopic myomectomies requiring complex uterine reconstruction. We don’t think anyone would argue that removal of a uterus that is outside the true pelvis represents a significantly different and more complex service than standard laparoscopic hysterectomy. Similarly, the removal of multiple intramural myomas with uterine reconstruction laparoscopically is a technical challenge inadequately captured in the work value for the current laparoscopic myomectomy code.

We presented these codes to the CPT panel in November, 2001. Once they were accepted, it was time to survey the codes in order to develop a recommendation for the RBRVS update committee meeting at the end of April. ACOG relied upon the AAGL to find surgeons who perform these services so that surveys could be completed and the codes could be appropriately valued. AAGL provided 200 names to the college. Surveys were sent to our members along with a cover letter detailing the importance of the survey process in our ability to fairly compensate for the work we do. We both offered our assistance in completing the surveys for those who were unsure of the process.

Neither of us received a call, and of the 200 surveys mailed, only 9 were returned to ACOG! With this inadequate survey response, we will be unable to present these codes to the RBRVS Update Committee (RUC) in time for inclusion in the 2003 fee schedule. Both of these codes will appear in the 2003 CPT book, but they will not have a value assigned to them because we were unable to provide enough survey data. The RUC will not consider data from any specialty society with fewer than 30 responses. So, these codes will be “carrier priced” for 2003. That means that the carrier medical directors and third party payors will determine what they think we deserve.

Your representatives were seriously disappointed with this outcome as all members of the AAGL should be. We have worked diligently to represent you at the ACOG Coding Committee. We had plans to submit applications for additional codes including laparoscopic paravaginal repair, laparoscopic sacrocolposuspension and laparoscopic removal of deep infiltrating endometriosis (the laparoscopic equivalent of 49201). Without your support and help, however, we cannot succeed in developing adequate codes to describe what we do with adequate work values to support appropriate reimbursement for these complex procedures. We were terribly disappointed with the lack of response by our members. We must be prepared to follow the process and do the work required to value our codes. If we do not, others will tell us what they think we do and how they think we do it. They will assign the work values and our incomes will suffer.

We plan to have a working session at this year’s annual meeting in Miami to train AAGL members in completing the RUC surveys. We will be there to help you in this endeavor. Make the time to show up and participate in the process. If you do not, you have no one to blame for our poor reimbursement but yourself. The enemy is us, but if we work together we can make a difference. It is entirely up to us.

If you would like to participate in the session during the AAGL 31st Annual Meeting, please contact Linda Michels, Executive Director at the AAGL office or send an e-mail to lmichels@aagl.com.

Residents continued from page 4

Responsible education of residents and fellows. We heartily embrace our new resident physician members, and openly invite you to formally participate in the AAGL by creating a presentation for the Annual Meeting and/or volunteering for one of our many committees. The future is yours.

Please assist the Foundation of the AAGL in continuing to provide financial support to the Annual Resident’s Workshop by giving to the Resident’s Circle Program. The 12th Annual Workshop is scheduled for March 29–30, 2003 in Rosemont Illinois. You may donate through the AAGL web site at www.aagl.com, then go to the Resident’s Circle Program. Thank you for helping to educate the next generation of endoscopists.

PG Courses continued from page 1

The role of estrogen replacement therapy and HRT on primary and secondary prevention of cardiovascular disease will be examined. Changes in women’s sexuality during menopause is another subject that will be explored in the course. The course is targeted toward gynecologists who have a special interest in the care of middle-aged women and who have a passion for improving their quality and quantity of life.

The First Announcement will be mailed June 3rd. You may register online, June 10th at www.aagl.com.
An Evening to Remember

On May 14, 2002, at their Annual Society Evening, the Los Angeles Obstetrical and Gynecological Society presented the Annual Society Awards to three local leaders who have distinguished themselves in the profession of gynecology. Two of these three recipients are well-known members of the AAGL. Congratulations go out to Jordan M. Phillips and Phillip G. Brooks for the awards below:

Jordan M. Phillips, M.D., Chairman Emeritus and Founder of the AAGL, was presented with a Lifetime Achievement Award.

Philip G. Brooks, M.D., Past President and National Advisor of the AAGL, was presented with the Keith P. Russell Distinguished Service Award.

Tribute to Dr. Childers

Liselotte Mettler, M.D.
International Advisor
Kiel, Germany

Our dear friend and brilliant laparoscopist, Joel Childers, died in a motorbike accident in Tucson, Arizona on February 14, 2002. The loss of Joel is a loss to all of us.

His love of life, his laughter, the joy which he handled laparoscopic surgery and shared it with others will never be forgotten. We know that although life moves on, his skill, dedication and publications remain with us and surround us continuously. Joel Childers’ lectures on lymphadenectomy, endometrial cancer, cervical cancer, ovarian cancer, pelvic floor repair and skillful laparoscopy will never be forgotten.

As personal and professional friends, we have to say goodbye to Joel. He performed surgery in the United States, in Germany, and at many other locations throughout the world. We remember him for his charm, his grace, his skill, his wonderful co-operation, and his love for life. Joel, your friends will always hold you in their hearts.

Our sincere condolence to his family and two lovely children and to all close friends. The joy, the cheerfulness and the skill that Joel Childers brought to gynecologic laparoscopy will not escape our hearts, it will stay there forever.

Maximizing continued from page 3

relationships.

The oviducts should always undergo chromotubation, which includes the passage of 250–300mL of the medicated Ringers Lactate solution colored with indigo carmine to thoroughly lavage the uterus and fallopian tubes.

Use of barrier methods such as Intercede or GoreTex, or specialized solutions to minimize adhesion formation, are applied prior to completing the procedure.

Adequate hemostasis is confirmed at low intra-abdominal pressures.

Postoperative antibiotic therapy for 7–10 days is advisable and an early attempt at conception is ideal.

On occasion, although controversial, postoperative suppression of patients, who have extensive endometriosis, using GnRH agonists and/or progestin therapy for a period of four to six months is considered.

In all cases, assessment of adequate ovulation and additional fertility factors should be carried out in the course of postoperative care. Where pregnancy has not occurred within four to six cycles, serious reconsideration of assisted reproductive technology should be undertaken. Where extensive tubal damage has been confirmed at surgery, the patient should be referred for preparation and early in-vitro fertilization.

References:


David Pent, M.D.
1929–2002

David Pent, a member of the Board of Trustees of the AAGL from 1984–1986 died in Phoenix, Arizona on February 19, 2002. Dr. Pent was an early pioneer in laparoscopy and instrumental in teaching laparoscopy to over 500 practicing gynecologists from 1971 to 1978.
Pre-Congress Workshop on Advanced Laparoscopic Anatomy, Dissection & Reproductive Surgery Using Unembalmed Female Cadavers
In affiliation with Innovations in Medical Education & Training November 18–19, 2002 Location to be determined • Miami Beach, Florida

Global Congress of Gynecologic Endoscopy AAGL 31st Annual Meeting
November 20–24, 2002
(Registration begins evening November 19, 2002)
Fontainebleau Hilton Resort • Miami Beach, Florida

Strategies and Techniques for Advanced Laparoscopy and Hysteroscopy Including Live Telesurgeries Supported in Part by an Unrestricted Educational Grant from Gynecare, Inc./A Division of Ethicon, Inc. December 13–14, 2002 Endo-Surgery Institute • Cincinnati, Ohio

12th Annual Comprehensive Workshop for Residents, Fellows & O.R. Personnel
March 29–30, 2003 Rosemont, Illinois

Taking Your Laparoscopic Skills to the Next Level
April 10, 2003 The University of Phoenix Phoenix, Arizona

Congress on the Contemporary Management of Fibroids
April 11–13, 2003 Scottsdale, Arizona

Global Congress of Gynecologic Endoscopy AAGL 32nd Annual Meeting
November 19–22, 2003 (Pre-Registration: November 18, 2003) Paris Las Vegas • Las Vegas, Nevada