What’s Happening in Las Vegas?

With the resolute intent to make this the most important global event in minimally invasive gynecology, the upcoming Global Congress of Gynecologic Endoscopy / AAGL 32nd Annual Meeting in Las Vegas, Nevada, November 19–22 (pre-registration on November 18), will provide a dynamic tapestry of scientific information and welcome collegiality. This year’s scientific program will be spirited by our organization’s tradition to responsibly provide state-of-the-art education, critically examine current diagnostic and surgical practices, act as an open forum for new and potentially fruitful surgical procedures and technologies, provide an organized venue for the presentation of ideas and experiences by attendees, demonstrate technical innovation and exemplary surgical techniques, and freely expand into relevant areas that satisfy the mission of minimally invasive gynecology.

Using a widely-recognized international faculty, this year’s postgraduate courses were designed to answer the recognized needs of our membership, as well as the momentum of our organization to expand into relevant aspects of minimally invasive gynecology. For example, participants will be able to combine a morning postgraduate course in conventional vaginal hysterectomy or reconstructive surgery with an afternoon course in laparoscopic hysterectomy or reconstructive surgery. Focus will also be placed on disease states rather than procedures; separate courses will comprehensively address treatment options and algorithms for symptomatic uterine fibroids as well as dysfunctional uterine bleeding. Other courses will systematically cover best practice and innovation for an array of topics including urinary and fecal incontinence, pelvic pain, reproductive surgery, operative laparoscopy, operative hysteroscopy, and the specific challenges presented by the frozen pelvis.

Completely new to the annual program, surgical tutorials will allow attendees to directly interact with widely recognized endoscopic surgeons in a classroom setting. Constructed to invoke passion and fuel intrigue, debates will examine the use of adhesion adjuvants during laparoscopic surgery, whether less invasive techniques can supplant the Burch colposuspension for genuine stress incontinence, if traditional hysteroscopic endometrial ablation can be replaced by global technologies, and if all pelvic support defects can be managed laparoscopically. Panels will address the obsolescence of hysterectomy for uterine fibroids, laparoscopic surgery in the midst of extraordinary circumstances, new devices for treating genuine stress incontinence, and innovations in endoscopic training. And, general sessions will be separately devoted to the universal issues of peritoneal access and the growing array of energy technologies.

All of this, and more, will occur in the outstanding setting of the Paris Hotel in Las Vegas, Nevada. The state of the art convention center is conveniently located, spacious, and endowed with the best audiovisual technology. Add in some cheese with baguettes, gambling, a myriad of family activities, the daytime sunshine with cool evenings, the desert landscape, and the outstanding cuisine — and we have ourselves the ingredients for a momentous success! I look forward to sharing this experience with all of you in November.

For a copy of the first announcement, meeting registration, and hotel reservations, please visit www.aagl.org.
The Nominating Committee of the AAGL will soon select four members of the AAGL as candidates for the two trustee positions for the years 2003 and 2004. In addition, they will select two other members to run as candidates for the position of secretary-treasurer. This position leads to vice presidency and then the presidency of the AAGL. Members have always been encouraged to make their suggestions known to the nominating committee. The nominating committee this year are:

David Olive  Chair, Immediate Past President
Jay Cooper  Past President
William Parker  Past President
Arnaud Wattiez  Representative of the International Advisory Committee
Dan Martin  Representative of the National Advisory Committee
Andrew Brill  Vice President
Franklin Loffer  Executive Vice President/Medical Director
Linda Michels  Executive Director

This year for the first time, the by-laws require the nominating committee to consider nominating any member whose name has been supported by a letter from five or more AAGL members. For further information, contact the Nominating Committee at nominations@aagl.org or 800.554.AAGL.

The Nominating Committee will meet on or shortly after July 23, 2003. It is time for you to voice your opinion about your future elected officers.

AAGL Re-accredited for Another Four Years

The AAGL was re-surveyed by the Accreditation Council for Continuing Medical Education (ACCME) and awarded accreditation for four years as a provider of continuing medical education for physicians.

Accreditation seeks to ensure both physicians and the public that continuing medical education activities sponsored by the AAGL meet the high standards of Essentials and Standards for Accreditation as specified by the ACCME.

The ACCME rigorously evaluates overall continuing medical education programs of institutions according to standards adopted by its seven sponsoring organizations: the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Council of Medical Specialty Societies, Federation of State Medical Boards of the U.S., Inc., and the Association of American Medical Colleges.
You Make the Call:
Interesting Cases Presented by the Editorial Board

A 51-year old G2P2 woman consulted for 17 weeks-sized uterine fibroids, which were causing pelvic discomfort and urinary frequency. Past surgical history was significant for 2 prior C-sections. An MRI showed a 13 x 11-cm posterior myoma with cystic degeneration displacing the fundus and cervix. She requested laparoscopic surgery, preferably myomectomy, even if that meant laparoscopic hysterectomy, for family reasons.

Laparoscopy demonstrated dense adhesions from the anterior abdominal wall to the entire anterior surface of the uterus, and a large myoma in the posterior lower uterine segment. Myoma dissection was difficult because of degeneration and repeated tearing of the tissue by the tenaculum being used for countertraction.

After approximately 40 minutes of dissection with minimal progress, it became apparent that the myoma extended down into the cervix, and we elected to convert to laparoscopic hysterectomy. Attempts to find a tissue plane in the dense anterior adhesions were unsuccessful and the bladder could not be defined, despite filling it with 300 cc of saline. With reluctance, but fearing injury to the bladder if we continued, we converted to laparotomy.

A Pfannenstiel incision was made through the previous C-section scar. Upon incising the peritoneum, the densely adherent bladder was inadvertently entered at the dome. This turned out to be a fortunate complication in that it allowed us to identify the bladder as it was dissected away from the uterus. When the dissection was complete, it was apparent that the bladder had entirely replaced the anterior lower segment, and no anterior uterine wall remained. After removal of the soft, degenerating myoma, no posterior uterine wall remained and the cervix was noted to be dilated and flaccid. The fundus was attached to the cervix only by tenuous strands of cardinal ligaments and uterine vessels.

At this point, we elected to perform a supracervical hysterectomy. The right uterine artery was easily identified, ligated and cut. However, dense adhesions obscured the left uterine artery, but a pedicle was clamped, cut and ligated with good hemostasis. Oozing was noted from the dilated cervix and was controlled with sutures and gelfoam, and appeared dry. The bladder defect was closed and cystoscopy was performed revealing good ureteral efflux of indigo carmine and a good repair of the bladder. The abdomen was closed after four hours of tedious surgery. EBL was 1000 cc.

Preoperative hemoglobin had been 14 gm/dl and post-operatively it was 10 gm/dl. The patient did well the first postoperative night, next morning hemoglobin was 9.9 gm/dl, vital signs were stable and she looked remarkably well. She was allowed to ambulate and given clear liquids. However, on the morning of her second post-op day, she appeared pale, her pulse was 110/minute, and her abdomen was distended, consistent with a hemoperitoneum. A stat hemoglobin was 6.4 gm/dl. Clotting studies were normal. I did not think re-operation would reveal an easily correctable source of bleeding. The interventional radiologist was called and the patient was consented for embolization and transfused two units of packed cells. Angiography revealed abnormal vasculature near the left uterine artery, in the area of the dense scar tissue seen at surgery. No active bleeding was seen, but this appeared to be the area that was likely oozing and it was embolized. The patient recovered uneventfully and was discharged home on post-op day five with a Foley catheter. She has had no sequelae now one year following surgery.

Of interest, later questioning of the patient elicited a history of a severe infection following her second C-section, which required a prolonged hospitalization and IV antibiotics. It is likely that the lower uterine incision became infected and dehisced, allowing the bladder to fall into the lower uterine segment. The marked degeneration of the myoma was responsible for its difficult dissection.
Lesson Learned: It Pays to Be Prepared

CASE HISTORY

During an LAVH upon a 38-year old, para two, weighing 120 pounds, a major vascular complication during the insertion of the primary trocar occurred requiring an emergency laparotomy and repair. Later, after the patient was made stable, an abdominal hysterectomy was performed.

The indication for the surgery was pelvic pain and dysmenorrhea not responsive to conservative medical management. Her past history was unremarkable having delivered both children by natural childbirth, each child weighing slightly over eight pounds. The physician’s chart describes a discussion about an LAVH approach, but no mention is made of other surgical alternatives, especially vaginal hysterectomy.

The uterus was described on physical exam as tender and “enlarged,” however following surgery, the uterus weighed 89gm in the pathology laboratory. Post-operative complications due to acute occlusion of the repaired vessel occurred, requiring multiple surgical procedures. The patient left the hospital as a paraplegic.

THE COMPLAINT

The Plaintiff filed suit claiming that the risks and alternatives had not been explained. As the patient’s anatomy and parity made her a good candidate for a vaginal hysterectomy, there were no indications to do an LAVH. It was clear that the injury was secondary to the insertion of the primary trocar, which would not have occurred had a vaginal hysterectomy been employed. The injury by the trocar led to the causes of the permanent occlusion of the major blood vessel leading to the patient’s paraplegia.

THE DEPOSITION

During the deposition of the defendant, he stated that he had not read or reviewed the literature since the incident, and stated that he had read the medical records the night before. He claimed the disposable trocar malfunctioned, causing him to deviate off line, however, the trocar was discarded after the procedure without evaluation. He admitted he was skilled in vaginal hysterectomy and there was no contraindication to attempting that approach.

FINAL COMMENTS

The outcome of this case was a settlement awarded for plaintiff; the amount paid is confidential, but the deposition, as public record, has been read. The defendant’s surprise as to the plaintiff attorney’s knowledge of the subject and the defendant’s lack of preparation was clearly evident as the deposition progressed.

The lesson learned—be prepared. As one studies for a final exam, so should all defendants. Today’s plaintiff attorneys have a wealth of information available to them about laparoscopy, indications for surgery and complications that are for the most part preventable, not just a “recognized risk of the procedure.” The more prepared the defense becomes, the easier it is predict whether one should prevail at trial.

coding corner

RUC Update: April/June 2003

The AMA’s RVS Update Committee (RUC) met in Chicago, on April 25, 2003. Drs. Hill, Levy, Reed, and I attended the meeting as ACOG representatives. We presented a new CPT code: laparoscopy, surgical: colpopexy (suspension of vaginal apex). Thanks to the experience of Dr. Hill and the collaborative efforts of the AAGL and ACOG, the presentation went down without a hitch (aside from one physician who actually suggested laparoscopic surgery is “easier” than open surgery). After a detailed review of the data that was compiled from surveys completed by our membership, we were successful in securing approval for the value units that were proposed. If accepted, the code will appear in the AMA 2004 CPT Code Book.

I have enjoyed my work on the committee over the last 2 years, but with the demands of an extremely busy practice and active family, I find that it is time for me to step down as the AAGL Representative to the ACOG Nonmenclature Committee. The members of the committee spend an enormous amount of time reviewing procedures, survey data, and holding conference calls. Although I will remain a member of the AAGL Coding Committee, my former associate and close colleague, Craig Sobolewski, has been assigned to this position. Dr. Sobolewski just accepted an appointment as the Director of Endoscopic Surgery Training at Duke University and is a long-time member of the AAGL, who will serve as a strong advocate for our membership. He is also very familiar with the challenges we face in the coding world.

In the last issue of NewsScope, we asked for volunteers to help with ongoing surveys for codes to be presented to the RUC. We thank Vincenzo Sabella for offering to partake in the surveys. We still need more volunteers. If you would like to participate, please send an e-mail with your contact information and your area of expertise to Dr. Sobolewski at newsscope@aagl.org.
Which Device? Which Patient?
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Ultrasound

SIS

Hysteroscopy
The Dutch Society, whose members reside in both the Netherlands and the Netherlands Antilles, plays a role unique for most endoscopic societies. They are promoting endoscopy by building a national database, as well as assuming the responsibility for training residents in endoscopy.

Members of the Dutch Society are well known to the AAGL. They have been frequent contributors to the Journal of the American Association of Gynecologic Laparoscopists, and have often presented major papers at the annual AAGL meeting. Below, Dr. de Blok, their past President and an active endoscopist for over 20 years, acquaints NewsScope readers with this progressive endoscopic society.

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

**NewsScope:** When was the Dutch Society of Gynecological Endoscopy established?

DSGE: The society was established in 1992.

**NS:** What is its mission statement?

DSGE: Its main purpose is to organize and to provide teaching of endoscopy, to organize scientific studies and to achieve national standards of minimal endoscopic care.

**NS:** Approximately how many members are there?

DSGE: The number of members additive to membership of the Dutch Ob/Gyn society is 160.

**NS:** What are some of the benefits of membership?

DSGE: Members get a free Dutch journal on endoscopy, which is produced twice a year, and free attendance to the annual endoscopy meeting.

**NS:** What kind of problems specific to physicians in the Netherlands does your association address?

DSGE: The society is consulted on complications, and tries to maintain a national data base on endoscopy. The society is responsible for the official training in endoscopy for all Dutch residents in hysteroscopy and laparoscopy.

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**International News**

**Meeting Highlights**

Special Report:

International Congress on Uterine Fibroids

Dr. Jay Cooper and I enjoyed collaborating on the recent *Beyond Hysterectomy: The Contemporary Management of Uterine Fibroids—An International Congress*. The meeting was held in sunny, warm, and beautiful Scottsdale, Arizona on April 11–13, 2003. By all accounts, the meeting was a great success — due to dynamic speakers, excellent debates, and stunning PowerPoint presentations. Most important, registrants had ample time to mingle with presenters during coffee breaks and luncheon roundtable sessions. Almost everyone thought that we could have had more time for question and answer sessions, due to the thought-provoking lectures and debates that were presented. Many of the myths surrounding fibroid treatment were debunked by William Parker. New imaging techniques for evaluation of fibroids were beautifully demonstrated by Caterina Exacoustos. A lively debate regarding the role of uterine fibroid embolization occurred between the interventional radiologists (USA and Canada), and those surgically adept gynecologists who wish to reclaim fibroid therapy with laparoscopic occlusion of the uterine artery. Finally, the role of endometrial ablation technology in the treatment of uterine fibroids provided a lively exchange of ideas. While we did not solve the etiology of uterine fibroids, we certainly reviewed the many innovative techniques available to treat and evaluate uterine fibroids. All of our course objectives were met. The 152 participants from 14 countries enjoyed the warm hospitality of two of Arizona’s finest physicians and AAGL advocates, Jay Cooper and Franklin Loffer. Thanks for sharing your beautiful city with us!
Over 200 Attend 2003 Resident’s Workshop

The 12th Annual Workshop for Residents, Fellows and O.R. Personnel was held March 29–30, 2003 in Rosemont, Illinois. The workshop was a major success with 229 attendees representing 6 countries and 22 support faculty. The registrants experienced a full morning of didactic lectures, followed by faculty luncheon round tables and an afternoon lab that covered energy modalities and tissue dissection; visual motor skill development and suturing; and diagnostic and operative hysteroscopy.

The majority of the faculty volunteered their time and provided an excellent series of lectures and hands-on teaching.

Once again, the AAGL received a grant from the Foundation of the AAGL in honor of the Resident’s Circle Program. The next workshop will be held September 13–14, 2003 in Philadelphia, Pennsylvania. We encourage you to assist us in educating the next generation of minimally invasive gynecologists by giving a tax-deductible donation to the Resident’s Circle Program today.

The Foundation of the AAGL would like to thank those members that gave generously to the Resident’s Circle Program from March 31, 2002 to April 1, 2004:


We want to hear from you. Send your opinions, comments, suggestions, and announcements on anything relating to the AAGL, NewsScope, or gynecologic endoscopy. Email your letters to: newsscope@aagl.org, or by fax to 831.851.6706.

**Coding Issues**

Thank you for your work on the codes and RVU’S for laparoscopic surgeries. I am hoping that you can help me. I am struggling with insurance payers over the remuneration and codes for a laparoscopic supracervical hysterectomy (either with or without BSO). They are claiming that since I am doing a supracervical hyst, I am doing a “lesser procedure” and remunerating as such. Are there appropriate codes for LSH with ACOG recommended or RUC approved RVU? Thank you for your help.

Harold Vick, Portland, OR

**Response**

In fact, the insurance companies are correct. Supracervical hysterectomy does not involve the additional work of removing the cervix either translaparoscopically (total laparoscopic hyst) or transvaginally (LAVH) and therefore according to the methodology utilized to value physician work, the value of LAVH may be reduced. It is for this very reason that we have not pursued a separate code for laparoscopic supracervical hysterectomy. If we did, it would definitely be valued less than LAVH. I am certainly willing to propose a new code to ACOG if the membership desires. Fortunately, in most areas of the country payers are not discounting the supracervical hysterectomy. Therefore, there are a large number of our members who may suffer financially if a code were to be implemented and given a low value.

Barbara S. Levy, Chair Coding Committee

**The “NEW” in NewsScope**

I like the look and context of the new format. Looking forward to when you go online, especially with the videos. Keep up the great work.

Daphne Jones, Goldsboro, NC

**In Search of Collaborators**

I am looking for collaborators in research protocols involving pain mapping under conscious sedation. I am particularly interested in gynecologists performing laparoscopy under conscious sedation in women without pelvic pain, as in case of tubal ligations. I would appreciate any leads.

Tom Janicki, M.D.
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University Suburban Health Center
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Phone: 216-381-2223 Fax: 216-381-5975
E-mail: tij@att.net
Affiliated Society Meetings

First Regional Comprehensive Workshop on Gynecologic Endoscopy for Residents & Fellows
September 13–14, 2003
Crowne Plaza Hotel • Philadelphia, Pennsylvania

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

Hands-on Workshop on Taking Your Laparoscopic Skills to the Next Level
February 7, 2004
Arizona State University • Phoenix, Arizona

13th Annual Comprehensive Workshop on Gynecologic Endoscopy for Residents, Fellows & OR Personnel
March 6–7, 2004
Los Angeles, California

AAGL Meetings

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- Operative Hysteroscopy Without Anesthesia
- Operative Hysteroscopy
- Excision of Endometriosis

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Future Meetings

Second Workshop on Basic Anatomy and Advanced Technology in Laparoscopy
September 18–20, 2003
Kiel, Germany
Presented by German Society for Gynecological and Obstetrical Endoscopy (AGE) in affiliation with the European Society of Gynecological Endoscopy (ESGE), Deutsche Forschungsgeinschaft, and the AAGL
For information go to: www.uni-kiel.de/ufk/arzt/2003_or1b.pdf

International Congress of Gynecologic Surgery and Alternative Approaches
January 2004
Paris, France
Presented by Journees Parisiennes d’Endoscopic Societe Francaise D’Endoscopie Gynecologique in affiliation with the AAGL
For information go to: www.sfeg.net