The AAGL 35th Annual Meeting is in the final stages of planning and is coming together beautifully. We have received a record number of abstract and video submissions, promising robust scientific content. We are taking care to avoid topics of similar interest being presented at the same time, so if your primary area of interest is gynecologic oncology, hysteroscopy, urogynecology, or infertility, you can create a schedule to meet your needs.

The program covers all areas of minimally invasive gynecology. The growing field of gynecologic oncology will have a postgraduate course this year and we are also offering two hands-on postgraduate courses; Laparoscopic Suturing and Hysteroscopy. Our general sessions promise to be highly educational and informative. The first, Three Dimensional Anatomy will precede the postgraduate courses; followed by a look into the future with Future Imaging in Medicine and Surgery and finally, Endoscopic Training and Credentialing – What Does the Future Hold for the Practitioner? New this year will be two special interest sessions: Clinical Research and Cosmetic Surgery in a Gynecologic Practice - Possibilities and Limitations, and there will be a pre-congress course on Advancing Your Career in Minimally Invasive Gynecology. Surgical Crossfire Debates, Expert Panels and Surgical Tutorials will cover a wide breadth of topics. In response to membership requests, syllabus material will be available at the Surgical Tutorials which will include leading experts from around the world. The live surgery is especially international this year, with surgeons from South America, Europe, and the USA.

I am pleased to announce that Dr. Harry Reich will serve as this year’s Honorary Program Chair. Harry is well known and loved throughout the world for his innovative contributions to endoscopy. Please plan to attend the Honorary Luncheon to join us as we recognize his accomplishments and contributions to the AAGL.

The excellent scientific content planned for the annual meeting will be well showcased in the Paris Hotel’s high quality convention center. The meeting rooms are conveniently located near each other and offer state of the art audiovisual technology. The Paris Hotel in Las Vegas is also an exceptional social venue for enjoying comradery with friends and colleagues. Mark your calendars for November 5-9th; I look forward to seeing you all in Las Vegas!
AAGL Nominations are Open

The AAGL Nominating Committee will soon select eight members of the AAGL as candidates for four trustee positions for the years 2007 and 2008. Four of the candidates will be from the general membership and four must come from specific regions. This year, two candidates each will be from Europe and North America. (Next year, the regional candidates will be from Asia/India/Pacific Rim and from South America). In addition, two other members will be selected to run as candidates for the position of secretary-treasurer. This position leads to vice presidency and then the presidency of the AAGL.

If you wish to be considered as a candidate for one of these positions, you should ask five AAGL members to submit your name along with a short letter or email of support. These should be sent to nominations@aagl.org. You are also encouraged to directly contact any member of the Nominating Committee to make your thoughts known. Their addresses can be found on the AAGL membership list (go to www.AAGL.org and click on “find a physician”)

The Nominating Committee will meet in early July, 2006. It is time for you to voice your opinion about your future elected officers.

Committee Members are:

G. David Adamson – Chair, Immediate Past President
Andrew I. Brill – Past President
D. Alan Johns – Past President
Grace M. Janik – Vice President
Brian M. Cohen – Representative of the Advisory Committee
Franklin D. Loffer – Executive Vice President/Medical Director
Linda Michels – Executive Director

A Quarter Century of Thanks to AAGL

June 30, 2006 is a memorable day in my life – 25 years ago I completed my residency in Ob-Gyn. Three thoughts immediately come to mind:

1) I’M OLD!!; 2) Surgical gynecology has certainly changed in the past 25 years; and 3) I am truly fortunate to be involved with the AAGL.

Twenty-five years ago we did not perform minimally invasive surgery with the laparoscope or hysteroscope, rather we performed minimal surgery. Except for laparoscopic tubal ligation or an occasional hysteroscopic or laparoscopic lysis of adhesions, both were merely diagnostic tools. A quarter of a century later, virtually all my surgery is performed via the laparoscope or hysteroscope. The fact is, I have actually forgotten the names of some of the “open” instruments! This usually brings a chuckle to my house staff and surgical team.

It is the AAGL that has provided me the opportunity to advance both my laparoscopic and hysteroscopic skills and to develop a “state-of-the-art” advanced gynecologic endoscopy practice. Whether it is picking up “pearls of wisdom” at the World Congress (Viva Las Vegas!) or smaller meetings, working with preceptors or studying the excellent articles in the Journal of Minimally Invasive Gynecology, it is the AAGL that has been my source for post graduate education. Today, more than ever, the opportunities for collegial interaction and learning exist for all members within the framework of the AAGL.

And am I still learning ……?

HELL YES! I am interested in performing more office based surgery. Hope to see you in Las Vegas. Please come up and introduce yourself!
The Use of Graft Material to Augment Anterior and Posterior Repair

Robert D. Moore, M.D.
Co-Director, Advanced Pelvic Surgery
Atlanta Center for Laparoscopic Urogynecology and Reconstructive Pelvic Surgery
Alpharetta (Atlanta), Georgia

John R. Miklos, M.D.
Director
Atlanta Center for Laparoscopic Urogynecology and Reconstructive Pelvic Surgery
Atlanta Medical Research Institute
Alpharetta (Atlanta), Georgia

Recently there has been growing interest in the use of synthetic and donor graft materials for the surgical correction of pelvic prolapse, due to suboptimal long-term cure rates noted with traditional surgical techniques. Traditional techniques depend on plication of attenuated endopelvic fascia or accurate identification of site-specific defects. The use of graft interposition, either synthetic or donor, helps to reduce failure rates from breakdown of weakened tissue or failure to identify all present defects. Furthermore, readily available synthetic and donor products obviate the need for a separate tissue-harvesting procedure, reduce operative time and procedure charges, and provide materials that may be stronger than the patient's own fascial tissue. Despite these potential benefits, widespread use of grafts in gynecologic surgery is still in its infancy, due to poor understanding of the in vivo response to the graft material and a paucity of long-term clinical data supporting its use. Although the basic ideas and techniques behind the use of grafts are generally understood, the indications for use and the choice of material remains controversial.

Much of the initial data on synthetic mesh and allografts are derived from surgery research for repair of abdominal wall hernias, reconstruction of joints, and cosmetic treatment of burn victims. In gynecologic surgery, mesh and graft use can be categorized based on surgical procedures used primarily for the correction of pelvic prolapse. Synthetic and autologous materials have been extensively used in the areas of urology and urogynecology as materials for the suburethral sling procedure, and there is currently great controversy regarding the optimal material that provides good long-term results with minimal complications.

Synthetic materials

Despite recent technological advances in the design and study of synthetic materials, the ideal synthetic biocompatible material has yet to be developed. Compared with autologous donor grafts, synthetic materials offer the advantage of ready availability, lower cost, consistent strength, and predictable in vivo tissue response. Disadvantages of synthetic material include failure of remodeling, limited stretch properties, and potential of erosion or infection. All mesh materials should be chemically and physically inert, noncarcinogenic, mechanically strong, and easily fabricated and sterilized. They should all have a high minimum tensile strength (> 50 N) that will provide adequate strength to withstand pressure placed on the pelvic floor during episodes of increased abdominal pressure. Synthetic mesh materials vary in their ability to withstand infection and promote healing depending on pore size. Prolene mesh is composed of a monofilament material which provides the theoretic advantage of increased interstices allowing polymorphonuclear leukocyte (PMN) and macrophage entry in addition to bacterial colonization. In contrast, the small interstices of multifilament mesh (20 × 10⁻³ μm) allow passage of bacteria but block larger cells such as macrophages and PMNs.

In addition to potential for infection, porosity characteristics including number, size, and shape of the pores may correlate with subsequent development of fibrous ingrowth into the mesh. In a comparison of commonly used synthetic materials, Mersilene is reported to be the most porous when compared with Teflon and Marlex. Teflon was noted to have the largest pore diameter (1630 × 10⁻³ μm), width correlates with in vivo tissue characteristics that reduce the ability of both Teflon and Gortex to effectively bond to surrounding tissues.

Mesh flexibility is another important property that may correlate with clinical complications. Marlex mesh has been reported to have the highest stiffness factor compared with Mersilene and Teflon. This physical characteristic may explain the high rate of mesh-related complications such as mesh extrusion, fistula formation, and visceral erosion. This characteristic is especially important in gynecologic surgery in which the synthetic mesh material needs to be soft and flexible to accommodate the natural stretching of the vaginal tissue during sexual intercourse. Rigidity of the mesh materials may lead to erosion and dyspareunia.

Natural materials

Autologous materials, including cadaveric fascia, human and porcine dermis, and small intestinal submucosa, have recently received greater attention for use in reconstructive pelvic surgery due to technologic advances in tissue harvesting and processing. Critical tissue properties of these tissues include tensile strength, antigenicity, and in vivo tissue remodeling. Compared with synthetic mesh materials, autologous donor grafts offer the advantage of in vivo tissue remodeling, histologic similarity to native vaginal tissue, and reduced incidence of erosion. Disadvantages include limited supply with increased cost, inconsistency of tissue strength, and lack of long-term outcome data.

In vivo tissue remodeling is the primary goal of all natural, acellular biomaterials used in gynecologic surgery. Ideally, the acellular graft provides a stable three-dimensional structure that attracts host cells and acts as an interactive scaffold for host cell migration, neovascularization, and tissue remodeling. However, studies to date have revealed that the implanted graft materials may either go through encapsulation with...

(continued on pg. 8)
The 15th AAGL Comprehensive Workshop on Gynecologic Endoscopy for Residents and Fellows was held on April 8th and 9th in Chicago at the Hyatt Regency O'Hare, and once again was successful and well attended. One hundred thirty-one residents, fellows, and practicing physicians attended and the feedback regarding the workshop was very positive. This workshop has a structured curriculum that stresses surgical skills and fundamental surgical knowledge for laparoscopy and hysteroscopy, rather than any specific endoscopic procedure. It emphasizes risk reduction and strategic thinking and is designed specifically for residents and fellows, although a number of practicing physicians attended this year as well. Didactic lectures, videos, and hands-on exercises are used to educate the participants about endoscopic anatomy, tissue manipulation and dissection, the safe use of electrosurgery and ultrasonic energy, laparoscopic suturing, techniques for tissue removal and morcellation, avoiding and managing complications, and diagnostic and operative hysteroscopic procedures. This year the hands-on time for laparoscopic suturing was significantly expanded based on the residents’ feedback from prior years regarding their need for enhanced education in laparoscopic suturing skills. This change was obviously appreciated by the attendants.

This course has a long tradition in the AAGL and is particularly important because of its focus on the education of residents. It is especially enhanced by its strong faculty participation, all of whom volunteer their time to teach in the Residents and Fellows Workshop. This year’s faculty was Krisztina I. Bajzak, Andrew I. Brill, Richard J. Gimpelson, Karen E. Fish, Gary R. Frishman, Grace M. Janik, Franklin D. Loffer, Charles E. Miller, Resad Pasic, Lisa M. Roberts, and Susan Tsai. Fred Howard was the Scientific Program Chair. The efforts of the faculty are sincerely appreciated by the AAGL.

Next year’s workshop will occur in April, 2007, and tentatively will be held in Chicago again, although other central locations are still being considered. Suggestions, ideas, and feedback from AAGL members are welcomed, as is interest in participation in the workshop. Please be sure to recommend this course to your residents and fellows.

Course Overview:

This hands-on course in hysteroscopy, hysteroscopic tubal occlusion and endometrial ablation is intended to familiarize the practicing gynecologist with the indications and use of equipment used for office hysteroscopy, operative hysteroscopy and global endometrial ablation. Every tool and technique that is described by the faculty will be available for the participants to learn and evaluate within the hands on laboratory. The topics discussed by the faculty include the use of office hysteroscopy for the evaluation of abnormal uterine bleeding, presurgical planning and the placement of the Essure hysteroscopic tubal occlusion device. As well, the use of the operative hysteroscope (monopolar, bipolar and mechanical morcellation) will be reviewed for the removal of intrauterine benign pathology. Lastly, a comprehensive review of all endometrial ablation techniques, standard and global, will be included.

For more information, please visit the AAGL website at www.aagl.org.
For over 30 years, leading physicians have relied on treatment options from American Medical Systems that focus on restoring pelvic health.

AMS is committed to becoming your first choice for female pelvic health solutions for incontinence, prolapse and menorrhagia.

**Incontinence**
- Monarc®
- SPARC®
- BioArc®

**Prolapse**
- Perigee®
- Apogee®

**Menorrhagia**
- Her Option®

Please do us the honor of visiting us at Booth 1035. You may even win* a pelvic floor model.

*Rules and regulations: Participant must be a physician registered as ACOG Annual Clinic Meeting attendee of American College of Obstetricians and Gynecologists 54th Annual Clinical Meeting May 6-10, 2006 Washington, DC Convention Center. Raffles and drawing may only occur before or after the official show hours. The winner need not be present to win. The winner's name will be posted in the booth and the winner notified. Other rules and regulations may apply.

For more information contact us at:
www.AmericanMedicalSystems.com
Are You Getting the AAGL-Endo ListServ?

The ListServ is one of the more popular benefits of AAGL membership. If you are not familiar with the ListServ, it is an interactive forum where members are able to post questions of clinical importance and have other members respond to that question. If you are not receiving these postings by email and would like to, please send a request to have your email address added to the attention of Gerardo Galindo at ggalindo@aagl.org.

The following is an example of a recent discussion:

Date: Thu, 1 Jun 2006
From: Andrew Blazar
Subject: Need to remove body piercings prior to cautery

I have heard much opinion but scant data concerning the need to remove body piercings before surgery in which the use of monopolar cautery is anticipated. Some surgeons state that piercings only need to be removed if they are near the site of the procedure and/or the grounding pad whereas others insist on the removal of all items. I have not been able to find any published literature on this. Is anyone aware of any data or formal recommendations?

Date: Sun, 4 Jun 2006
From: David Redwine

This is my first response on this list server. I think the only piercings that would need to be removed are those that are in direct contact with where surgical instruments are inserted, such as the umbilicus or the labia/vulvar area. Labial piercings could abrade the skin during movement of a uterine manipulator while umbilical piercings might not only abrade with movement of the umbilical port, but there is a small chance of direct or indirect energization of the piercing if electrosurgery is used through the umbilical port.

Direct energization of a metal piercing would occur if there were an insulation failure within the laparoscope or other instrument inserted down a metal sheath in the umbilicus, although the chance of significant thermal injury transmitted by a directly-energized piercing would be low because of the large surface area of energized metal (both the area of the metal umbilical trocar plus the area of the metal piercing) combined with quick, intermittent use of bursts of electrosurgery. Indirect energization or capacitance coupling would be very unlikely to dangerously energize an umbilical piercing because indirect energization falls off rapidly as the distance from the active electrode wire increases, plus the large surface area of metal in contact with the skin would reduce the current density to a level that wouldn’t be harmful. But since an umbilical piercing would get in the way and be unhygienic, it should just be removed. Piercings elsewhere on the body would have no danger at all, any more than an earring that remains in or a ring on a finger. These metal objects are so far away from the active electrode wire that the amount of indirect energization they receive is too low to cause damage. I hope this is helpful.

Date: Sun, 4 Jun 2006
From: Dick Soderstrom

Your best source of confirmed information would be to call the Valleylab Educational Department in Boulder Colorado @ 1-800-255-8322. In general, any exposed metal should be removed if easy to do, ie finger and ear rings. If not, cover each item with tape or a large bandaid. Remember, electrical energy flows the path of least resistance. Thus, keep the return electrode near the surgical site. Keep any metal piercing away from any conductive structure (metal stirrup) that might permit electrons to flow to ground. When possible, use bipolar energy.

Date: Sun, 4 Jun 2006
From: Joe Opie

As far as I know there is not any study that has been performed on electrocautery with piercing and without. The main concern as we all know is that we do not wish to create an aberrant circuit. Therefore, if a piercing allows the current to ground, then a potential for a burn exist.

Theoretically, if a piercing was in turn in contact with a wet drape it might form a circuit. Many surgical departments allow patients to wear their rings in the OR. These are typically wrapped in tape. The issue is the same here. Therefore it is probably safe to allow patients to keep their piercings in place. Having said this, I feel better having piercings removed and insist upon it. Feeling better is not scientific but it never hurts to error on the side of caution. Especially when a patient safety is at stake. Parenthetically, another issue of concern is tongue piercing.

Obviously there is a risk for choking here.

Date: Sun, 4 Jun 2006
From: Stephen Corson

The problem of body piercing and laparoscopy has been covered recently by V. Jacobs in JMIG, 2004:537
Introducing the latest innovation in the trusted GYNECARE TVT family of stress urinary incontinence products

Brand new thinking. The unique inside-out approach of GYNECARE TVT Obturator System is designed to minimize the risk of injury. By passing needles away from the urethra and avoiding the retropubic space, GYNECARE TVT Obturator System offers excellent safety.

From a name you trust. GYNECARE TVT has documented long-term efficacy and safety you can rely on. Remember, all GYNECARE TVT products use PROLENE® polypropylene Mesh, the same trusted material used in ETHICON sutures. With GYNECARE TVT Obturator System, our advance can now be your advantage.

For more information, call 1-888-GYNECARE to locate your local GYNECARE representative. Visit us online at www.GYNECARE.com.

INDICATIONS: GYNECARE TVT, GYNECARE TVT with abdominal guides, and GYNECARE TVT Obturator System are intended to be used in women as suburethral slings for the treatment of stress urinary incontinence (SUI) resulting from urethral hypermobility and/or intrinsic sphincter deficiency.

CONTRAINDICATIONS: As with any suspension surgery, these procedures should not be performed in pregnant patients. Additionally, because the PROLENE® polypropylene Mesh will not stretch significantly, it should not be performed in patients with future growth potential including women with plans for future pregnancy.

Refer to package insert for complete product information including warnings, precautions, and adverse reactions.

GYNECARE WORLDWIDE, a division of ETHICON, inc., a JOHNSON & JOHNSON company ©2005 ETHICON, inc. *Trademark **Stablemark SDTV012
graft fibrosis, breakdown with loss of support, or the desired incorporation with tissue remodeling. To date, there are few studies in the gynecology or urology literature assessing the in vivo tissue response when donor graft is implanted in the human vagina. Further research in this area is currently in progress.

**Anterior Vaginal Wall Reconstruction**

Anterior vaginal wall reconstruction concentrates on the surgical repair of the cystocele, a hernia that occurs when the bladder bulges into the vagina due to attenuation or site-specific defect of the pubocervical fascia. Traditionally, the cystocele has been repaired with an anterior colporrhaphy requiring plication of the attenuated pubocervical fascia with a series of sutures from the bladder neck to the bladder base. Alternatively, paravaginal defect repair for lateral detachment of the pubocervical fascia from the lateral side-wall is an alternative surgery which is theoretically the correct operation for patients with cystoceles due to paravaginal defects. This repair can be performed abdominally, vaginally, or laparoscopically. The use of graft material to reinforce either the midline plication repair or the lateral paravaginal defect repair generally involves anchoring of the graft material to the lateral pelvic sidewall or endopelvic fascia using a series of interrupted sutures from the ischial spine to the bladder neck or by using newer transobturator needle passage techniques. These techniques are recent additions to the gynecologic literature with current studies analyzing few patients with limited long-term outcome data.

**Posterior Vaginal Wall Reconstruction**

Posterior vaginal reconstruction mainly corrects a rectocele, a hernia with bulging of the rectum into the vagina. Traditionally, rectocele has been treated with posterior colporrhaphy, which consists of a midline plication of the rectovaginal fascia through a transvaginal approach. In an effort to improve anatomic and functional cure rates, site-specific defect repair of the rectovaginal septum for the treatment of rectocele has recently been introduced. Compared with traditional posterior colporrhaphy which assumes generalized laxity of the rectovaginal fascia, the site-specific theory postulates discrete breaks as the etiology of the vaginal wall prolapse. Unfortunately, both techniques have limitations including adequate fascial strength, accurate identification of discrete fascial defects, and restrictions with regard to lateral incorporation of levator muscle tissue. Recent work has been focused on utilizing graft materials to augment the rectovaginal septum and improve long-term surgical cure rates. The procedure is performed by recreating the rectovaginal septum using an allograft or synthetic grafts attached to the levator ani muscles bilaterally, the pubocervical fascia/vaginal apex proximally, and the perineal body distally. Some techniques also utilize transgluteal needle passage techniques which can incorporate the sacrospinous ligament for apical support.

**Conclusion**

Long term cure rates of vaginal wall prolapse continue to be suboptimal. This may be due to poor tissue strength, inadequate surgical repair or continued stress due to chronic straining, obesity and sustained increases in intraabdominal pressure. Regardless of the etiology, improved surgical technique and use of graft materials, either synthetic or donors, have the potential of improving our long-term success rates. Exciting innovations including new synthetic materials, mixed mesh-graft composition, and cloning of host cell grafts as well as new surgical approaches and delivery systems may completely change the landscape of gynecologic surgery. However, these new surgical procedures should be approached with great caution and should only be adopted when the appropriate research has been performed proving safety and effectiveness.
The Turkish Society of Gynecologic Endoscopy has been an Affiliated Society of the AAGL since 2004. As a sister Society, it has joined in the advancing of endoscopy and minimally invasive gynecology. Its 400 members make it one of the largest societies in Europe. It has already be responsible for publishing a textbook and establishing training programs. Its April 2007 program in Izmir should not only be scientifically excellent but a wonderful area of Turkey to visit.

—Franklin D. Loffer, M.D.

NS: When and how was your society established?
TSGE: The Turkish Society of Gynecologic Endoscopy (TSGE) was founded in 2003 under the auspices of Hikmet Hassa, Founder President; Ilkkan Dundar, Vice-President; Hakan Yarali, Secretary; Bulent Tiras, Treasurer; and Timur Gurgan, Recai Pabuccu, Yucek Karaman, Turan Cetin, Hakan Satioglu, Bulent Urman and Gurkan Zorlu as Executive Board Members. The Founding Board was composed of long time endoscopists, experienced in infertility as well as oncology.

NS: What is its mission statement/primary goal?
TSGE: The founding mission of TSGE can be summarized as gathering all Turkish gynecologists working in the endoscopic field to create a scientific platform to evaluate their training, certification and accreditation. For this purpose, the society aims to conduct courses in different parts of Turkey in addition to highly participated national and international congresses and finally, to institutionalize educational standards. Furthermore, one of the scopes of the society is to share knowledge and experience by affiliating with other societies in the USA and Europe. Through its website (www.jed.org.tr), it aims to communicate with endoscopists on a national and international basis. Following its establishment, the society released a textbook entitled: “Laparoscopic Surgery in Gynecology” with 37 chapters and 407 pages. Moreover, through the biannual release of the “Endoscopy Bulletin”, our society provides intimate communication with its members.

NS: Approximately how many members are there?
TSGE: We have over 400 members and expect this number to grow especially following our international congress in 2007.

NS: What are some of the benefits of membership?
TSGE: Apart from getting free benefits from our website, our members are informed in advance of training courses, workshops and congresses and they also benefit from reduced registration fees.

NS: Is there any additional information you would like to provide about your society?
TSGE: We plan to hold our annual congress April 3-7, 2007 in Kusadasi, Izmir, which is one of the main tourist areas of the Aegean coast. In addition to the internationally planned congress, we will hold pre-congress courses, scientific sessions, video and poster presentations as well as endoscopic surgeries to be performed at Ege University. You may obtain program details at the TSGE website: www.jed.org.tr

New Products

Richard Wolf Office Hysteroscopy System.

Richard Wolf has developed a complete Office Hysteroscopy System designed to provide everything needed to perform hysteroscopy and the Essure® procedure in the office setting. The system combines everything from distortion free hysteroscopes, sheaths, instruments and a complete office video system. Additionally, Richard Wolf Financing offers a fee-per-use program allowing for minimal cost per procedure. Contact Richard Wolf 800-323-WOLF (9653).
Welcome New Members

Christina Adams, M.D.
Cynthia Kay Anderson, M.D.
Angeli Riccardo Anselmi, M.D.
Robert J. Anstett, M.D.
Paul B. Araiza, M.D.
Nora M. Arronte, M.D.
Jaime Arruda, M.D.
Wilhelmina D. Azu, D.O.
Jun Kil Baek, M.D.
Keisha Y. Bailey, M.D.
Antonio Barbera, M.D.
Salvatore Benizio, M.D.
Laura S. Best, M.D.
Matthew Dunham, M.D.
Tao Duan, M.D.
Chengyan Deng, M.D.
Angela Dempsey-Fanning, M.D.
Rebecca Howard De Rosier, M.D.
Moushumi Shoma Datta, M.D.
Christopher J. Darus, M.D.
Emily C. Culbert
Heidi Cook-Andersen, M.D.
Erin Anne Clark, M.D.
SiHyun Cho, M.D.
Stephanie Champion, M.D.
Anthony J. Caruso, M.D.
Veronique Bussiere, M.D.
Tamura L. Burg, M.D.
Alexandra Bujor, M.D.
Darcy N. Bryan, M.D.
Alexandra Bujoj, M.D.
Tamara L. Burg, M.D.
Veronique Bussiere, M.D.
Anthony J. Caruso, M.D.
Stephanie Champion, M.D.
SiHyun Cho, M.D.
Erin Anne Clark, M.D.
Heidi Cook-Andersen, M.D.
Emily C. Culbert
Christopher J. Darus, M.D.
Moushumi Shoma Datta, M.D.
Rebecca Howard De Rosier, M.D.
Angela Dempsey-Fanning, M.D.
Chengyan Deng, M.D.
Tao Duan, M.D.
Matthew Dunham, M.D.
Stacie Elfrink, M.D.
Julia Embry, M.D.
Iwezuife A. Emmanuel, M.D.
Caterina Exacoustos, M.D.
Mehrnoush Faghhi, M.D.
Trudi Fahey, M.D.
Guangsheng Fan, M.D.
Qingbo Fan, M.D.
Youji Feng, M.D.
Stefano Ferrari, M.D.
Michael Finlon, M.D.
Eugenio Fiumano
Suk Yee Fung, M.D., MRCOG
Mingying Gai, M.D.
Dionne Gallagher, M.D.
Mahesh Gandhi, M.D.
Anupam Garg, M.D., MPH
Larisa Gavriloва-Jordan, M.D.
Dobie Giles, M.D.
Maria Mercedes Gonda, M.D.
Alain Gonga, M.D.
Katherine Goodrich, M.D.
Amy Gottlieb, M.D.
Ann Granadillo, M.D.
Akiba E. Green, M.D.
Natalie Gregory, M.D.
Adam Griffhn, M.D.
Francesco Guida, M.D.
Joslyn Gumbs, M.D.
Tomonori Hada, M.D.
Alexandra L. Haessler, M.D.
Anne V. Hale, M.D.
Jennifer L. Hamill, M.D.
Jennifer Hanan, M.D.
Tabetha Harken, M.D.
Sharon Harris-Ingram, M.D.
Ellen C. Hayes, M.D.
Fangfang He, M.D.
Brian Hearn, M.D.
Gretchen Heinrichs, M.D.
Kimberly Hennan, M.D.
Wes Hilger, M.D.
Richard M. Holland, M.D.
Jennifer Holmes, M.D.
Xinghua Huang, M.D.
Mark A. Hucke, M.D.
Patricia Huguelet, M.D.
Leslie Hurt, M.D.
Jennifer Huyer, M.D.
Holly A. Imlach, M.D.
Michiko Inagaki, M.D.
Rebecca Lee Jacob, M.D.
Corey Jacobs, M.D.
Ashwin R. Jadhav, M.D.
Summer L. James, M.D.
David Jaspan, DO, FACOG
Liayu Jin, M.D.
Meredith Johnson, M.D.
Bronwen Kahn, M.D.
Bruce Kahn, M.D.
Rupa Kakarla, M.D.
Leslie D. Kammire, M.D.
Amy Kelley, M.D.
Adolpho Kelm
Monica Kendrick, M.D.
Sarah Kerlin, M.D.
Janet Ko, M.D.
Katrin Kriotsangsottior, M.D.
Layne Michelle Kometz, M.D.
Jinghe Lang, M.D.
Edgar LeCalire
Kevin J. Lee, M.D.
Roger Lefevre, M.D.
Jinghua Leng, M.D.
Megan Lenhart, M.D.
Jin Li, M.D.
Michael S. Liao, M.D.
Jeffrey Y. Lin, M.D.
Lianlin Lin, M.D.
Shoumin Lin, M.D.
Juntai Liu, M.D.
Xinyan Liu, M.D.
Zhufeng Liu, M.D.
Jin Li, M.D.
Zhanbin Lu, M.D.
Shuang Ma, M.D.
Jacob Markovitz, M.D.
C. Ann Mashchak, M.D.
Ximena Matanala, M.D.
Kathy Mayo, D.O.
Kathleen Mayor-Lynn, M.D.
Sara Mazzi, M.D.
Stacy Mc Crosson, M.D.
John A. McAndrew, M.D.
Jacob Mcgee, M.D.
Lesley Michelle Meister, M.D.
Torri Metz, M.D.
Seva Milov, M.D.
Jennifer L. Milspaw, M.D.
Andrea B. Moore, M.D., FACOG
Rory Moore, M.D.
Sara S. Morrelli, M.D.
Paulo Moretti, M.D.
Vadim V. Morozov, M.D
Luis Alberto Murrain, D.O.
Dipty Naidkarni, M.D.
Erickson Nagib, M.D.
Luigi Nappi, M.D.
Hector Navarro, M.D.
Alexandra Nevin, M.D.
Khanh-Ha Nguyen, M.D.
Neil Niemi, M.D.
Angela L. Nix, M.D.
Luca Nobler, M.D.
Uchenna Christian Nwobu, M.D.
Kenji Oka, M.D.
Alessia Pace, M.D.
Andrea Palmer, M.D.
Lingya Pan, M.D.
Kiril A. Patel
Kenneth Jerald Payne, M.D.
Christian Perez, M.D.
Reenee L. Perry, DO.
Joshua Z. Press, M.D.
Michael Ramos Lao, M.D.
Saira P. Rana, M.D.
Jonathan F. Rehberg, M.D.
Russell G. Reitinger, M.D.
Natalia Rezvina, M.D.
Tracey Ann Roehrkkase, D.O.
Andre H. Saad, M.D., FACOG
Ashraf Morcos Sabry Ramzy, M.D.
Huda Salah, M.D.
Rhonda Schafer-Mclean, M.D.
Melanie Beth Schatz, M.D.
Tanja Scherm, M.D.
Amy Schmidt, M.D.
Debora Sedaghat, M.D.
Ammar Shammaa, M.D.
Keng Shen, M.D.
Danielle Shiller, D.O.
Nazema Y. Siddiqui, M.D.
Kerry Sims, M.D.
Bethany Skinner, M.D.
Bruce S. Smith, M.D.
Joanna Smith, M.D.
Nbalia Marie-Ange Soumah, D.O.
Rachel Spieldoch, M.D.
Casey N. Sprague, M.D.
Albert Steren, M.D., FACOG
Jennifer Strebel, M.D.
Aijun Sun, M.D.
Dawe Sun, M.D.
Cara Nicole Synth, M.D.
Elena Marie Szymanski, M.D.

see NEW MEMBERS on next page
NEW MEMBERS from previous page

Lon J. Taff
Qingjie Tian, M.D.
Vivien Tin, M.D.
Kurin Tohott, M.D.
Jakub Wojciech Tomaszewski, M.D.
Rudy Tovar, M.D.
Jillian Tyler, M.D.
Mary Ulrich, M.D.

Gurkan Uncu, M.D.
Aubrey D. Uretsky, M.D.
Steven verBeek, M.D.
Xirun Wan, M.D.
Lihui Wei, M.D.
James A. Wheeler, M.D.
Kyra Williams, M.D.
Sherida L. Williams, M.D.
Erik Foran Wolf, M.D.

Ming Wu, M.D.
Yang Xiang, M.D.
Xin Xie, M.D.
Guangwu Xiong, M.D.
Ling Xu, M.D.
Yunhua Xu, M.D.
Huxia Yang, M.D.
Jianqiu Yang, M.D.
Jiaxin Yang, M.D.
Qi Yu, M.D.
Elio Zambetti, M.D.
Kimberly Zander, M.D.
Wei yuan Zhang, M.D.
Yiwen Zhang, M.D.
Yingfang Zhou, M.D.
Lan Zhu, M.D.

AAGL Research Registries are Now Online

Three Research registries are now online at our societal website www.aagl.org. Existing registries are on the topics of pregnancy after endometrial ablation, trocar site hernias, and vaginal cuff complications. Others in the planning process will deal with urogynecologic and gynecologic oncologic topics. To date, we have received submissions to the registries from locations literally scattered throughout the world. In fact, there are more from outside North America than from within it. However, to be meaningful, greater participation is needed. Remember that you may submit a case of your own, or a case in which your involvement was in follow up. Submission is online, fast and straightforward.

Learn from the world’s most skilled minimally invasive surgeons in this video taken from the AAGL 34th Annual Meeting: Telesurgery Video

Only $50 for AAGL Members!

AAGL 34th Annual Meeting
Telesurgery Video

SERIES 2

Global Congress of Minimally Invasive Gynecology
November 8–12, 2005 • Hilton Chicago, Chicago, Illinois

ORDER FORM:

AAGL 34th Annual Meeting Telesurgery Video

PRICE:

AAGL Members $50
Member ID #
Non-Member $95

SHIPPING:

International $3.95 ea additional video
Domestic $4.95 ea additional video

TOTAL: $_____

Name:
Address:
City State Zip:
Phone (area code):

Send to:

Mail, fax, or telephone your order to: AAGL, Advancing Minimally Invasive Gynecology Worldwide
4577 Karrta Ave, Cypress, CA 90630-9135
Phone: 805-554-2436 or 213-997-8207 • Fax 714-599-6205 • 213-997-6252
Fax may also be sent by e-mail: E-mail generalsec@aagl.org • Web site: www.aagl.org

APRIL - JUNE 2006

11
f u t u r e  m e e t i n g s

AAGL & AFFILIATED MEETINGS

**Comprehensive Workshop on Hysteroscopy, Suturing & Hysterectomy (For Fellows Only)**
- August 11-13, 2006
- MIGS Training Center
- Boston, Massachusetts
- Web: www.aagl.org

**The Limits of Endoscopic Surgery**
- August 18-19, 2006
- The Westin Sydney - Sydney, Australia
- Email: conferences@ages.com.au

**Hands-On and Technological Update in Hysteroscopy, Endometrial Ablation and Tubal Occlusion**
- September 9, 2006
- Boston, Massachusetts

**International Congress of Minimally Invasive Gynecologic Surgery IV Congresso Barsileiro da SOBENGE**
- September 27-30, 2006
- Rio de Janeiro, Brazil
- Web: www.sobenge.com.br

Pre-Congress Course Advancing Your Career in Minimally Invasive Gynecology
- November 5, 2006
- Paris Hotel - Las Vegas, Nevada
- Web: www.aagl.org

Global Congress of Minimally Invasive Gynecology
**AAGL 35th Annual Meeting**
- November 6-9, 2006
- Paris Hotel - Las Vegas, Nevada
- Web: www.aagl.org

Pelvic Anatomy and Laparoscopic Surgery for Gynecologic Oncologists
- December 1-2, 2006
- University of Louisville - Louisvile, Kentucky
- Web: www.aagl.org

First AAGL International Congress on Minimally Invasive Gynecology - In Conjunction with the 4th Annual SEGi Meeting “Understanding and Treating Abnormal Uterine Bleeding”
- June 2007
- Palermo, Italy