Friends and colleagues, it’s time to share in my excitement as the 36th annual meeting of the AAGL is just around the corner. With a record number of abstract submissions (nearly 600) and the largest number of internationally acclaimed faculty ever assembled, this year’s World Congress of Minimally Invasive Gynecology promises to be the most ambitious program the AAGL has ever undertaken. At the core of this effort is our society’s desire to advance minimally invasive gynecology worldwide and to mentor physicians and allied health care workers throughout their careers in an atmosphere of camaraderie and fellowship that is distinctly the AAGL.

On Tuesday November 13th, plan to attend the pre-congress workshops. In the morning, one can participate in a “hands-on” course in laparoscopic suturing or didactic program on robotic assistance in gynecologic surgery. That afternoon a second laparoscopic suturing workshop, or a course designed to enhance practice productivity, provide strategies in accessing clinical information, and improving presentation skills will be offered. In addition, 24 pre-enrolled physicians will take part in a “hands-on” robotic lab.

Sixteen postgraduate courses, presented by the world’s recognized authorities in minimally invasive gynecology, will be presented on Wednesday, November 14th. Each postgraduate course is designed to impart evidence-based, up-to-date information in a comprehensive, concise and cohesive manner. New innovations in technology and surgical procedures will be reviewed and evaluated. Treatment regimens will be outlined and detailed. And don’t forget to participate in a round table luncheon discussion. This is the perfect opportunity to “pick the brain” of an expert, in a relaxed congenial environment.

The Scientific Program of the 36th Global Congress runs from Thursday, November 15th through Saturday November 17th. Make time for visionary discussions on natural orifice surgery or cosmeto-gynecology. Don’t miss a plenary session on ovarian conservation – risks and benefits, a panel on mesh erosion, or colorful crossfire debates on IVF vs. surgery for endometriosis, laparoscopic vs. vaginal approach to pelvic floor prolapse, and uterine artery embolization for patients interested in subsequent pregnancy.

Always a favorite, take advantage of the surgical tutorials. As enrollment is limited, sign up early for these lively interactive sessions. Open to all participants, we are once again indeed fortunate to have programs sponsored by four of our affiliated societies, the Asia-Pacific Association for Gynecologic Endoscopy and Minimally Invasive Therapy, Sociedad Iberoamericana de Endoscopia e Imagenologia Ginecológicas, Sociedade Brasileira de Endoscopia Ginecológica e Endometriose and the Societa Italiana di Endoscopia Ginecológica.

On Saturday, the ever popular telesurgery program will take place. Keeping in harmony with the AAGL’s global view, three of five scheduled surgeons come from the international community. Concurrently, there will be a special session on clinical research, designed to enhance the ability of investigators and their study coordinators to obtain and perform clinical trials.

Of course, the back bone of the annual meeting are the abstracts submitted by you, the general membership. I can absolutely assure you that the quality of this year’s submissions has been unparalleled in the AAGL’s thirty-six year history. Make plans to attend the plenary sessions, video programs and free communications. And of course, peruse the posters at your leisure.

And last, but certainly not least, the Congress could not be successful without the support of industry. Show them your appreciation by attending their engaging breakfast and afternoon symposia. Walk the exhibit hall and visit the numerous booths. It is amazing what knowledge can be gleaned from this experience.

Enjoy beautiful Washington D.C., our nation’s capital. Our Congress virtually coincides with a very active time for the Senate and House of Representatives, which will both be in session. Moreover, this is the beginning of the presidential election year – Washington D.C. will certainly be abuzz. Stroll the memorials, monuments and museums. Enjoy international cuisine or a hot dog in the park.

And don’t be a stranger, I’m looking forward to meeting you and saying “hi”!
My Take on Universal Health Care for All

I had first-hand experience with so-called universal health care when I practiced medicine in former Yugoslavia. At that time, I used to envy my colleagues in the U.S. for their unlimited resources – they worked in state of the art facilities and were able to buy every piece of expensive equipment that they wanted in order to treat their patients. What I did not know then was that a majority of Americans with low paying jobs did not have any health insurance to afford such treatments.

One could easily imagine the U.S. as the ultimate capitalist country where people get rewarded for their hard work and nobody gets a free ride. I have since learned about the Medicaid program which contradicts all such principles of capitalism. While the working poor in the U.S. cannot afford basic medical treatment, those who do not work are completely covered. Moreover, there is no rationale for Medicaid beneficiaries to find low paying jobs and lose health benefits they enjoy for free. In terms of health care, it seems that the working poor are better off if they do not work.

Is there a better way to organize health care in this country? Sure there is! We need to break our mental barriers and start challenging myths. Let us not be afraid of “universal healthcare.”

There is a way to rearrange the existing system for the benefit of all, as follows:

1. The money spent on Medicaid can subsidize private insurance coverage for the working poor and cover the 44 million uninsured Americans.
2. Doctors, hospitals, and insurance companies can service 44 million newly insured individuals.
3. Those who are old, sick or unable to work can be covered by Medicare.
4. No Americans are postponing treatment, making it more difficult, expensive and not amenable to minimally invasive procedures.

Health care in this country should not be a privilege but an affordable commodity available to all, similar to the coverage that many Western Europeans are currently enjoying but with a capitalist twist.
Laparoscopic Myomectomy

Myomas are the most common uterine neoplasm, affecting approximately 30-40% of women over the age of 30. Not long ago, management of myomas was either expectant observation or surgical extraction. Recently, a wide range of suppressive medications leading to pseudo-pregnancy or pseudo-menopause, investigative use of aromatase inhibitors and antiprogesterone have been tried. None have shown proven long-term benefits and some are associated with side effects. GnRH analogs can make surgery more difficult by diminishing planes of dissection. Surgical shaving, vaporizing, cooling or freezing have been tried. Other treatments include MRI-guided focused ultrasound (MR(f)US), a noninvasive treatment that destroys myomas by a focused beam of energy. Uterine artery embolization (UAE) causes necrosis and reduction in uterine fibroid size by about 50% and 60%, respectively. Relatively high failure rates of 19%-23% were reported in a recent randomized controlled trial, necessitating hysterectomy as a final solution of the symptoms. It can also adversely affect future pregnancies. This emphasizes the need for careful patient selection and proper counseling.

Surgical options are myomectomy by laparotomy, laparoscopy (LM), or combined laparoscopy and mini-laparotomy (LAM), and hysterectomy. Currently, robotic-assisted laparoscopic myomectomy is being added to the armamentarium of surgical options. The choice of approach depends on the experience of the surgeon, the size and location of the myomas, symptoms, and the patient’s fertility wishes.

Key steps in myomectomy are detaching the myoma from the uterus, uterine reconstruction, and extraction of the myoma from the abdomen. LM is considered one of the most advanced procedures performed by operative laparoscopy and requires special instrumentation, surgical technique, and dexterity with hand-eye coordination. The industry continues to introduce new instrumentation to facilitate this procedure. Electrosurgery, laser, and now harmonic energy are used for cutting the myoma away from the uterus. Numerous suturing devices with automatic or mechanical needle holders, suture material, and knot pushers have been developed for uterine reconstruction. The most recent needle holders have up to seven ranges of motion in contrast to the limited four of the human wrist. Extra- and intracorporeal knot tying techniques have been developed.

Myoma extraction can be a time-consuming procedure. Large myomas can be removed through a posterior colpotomy without additional risk of adhesion formation. Improvements in the design of electronic morcellators makes their use easier and faster. Still, the morcellator remains a bulky and expensive device, especially when dealing with calcified myomas. In spite of these limitations, it is a good example of the advancement of new technologies.

Several modifications of the technique can improve surgical outcome of myomectomy. Uterine artery ligation can reduce intraoperative blood loss during LM. This allows in situ morcellation of the myoma to decrease the volume.

The initial criticism of LM, a lack of tactile sensation to palpate the uterus and detect hidden intramural myoma resulting in incomplete treatment, remains valid. Preoperative use of US and MRI can map the exact number and location of the myomas. Computer-assisted design (CAD) is being investigated for planning and practicing the operation on simulators. LM is on the rise due to advanced training of a new generation of gynecologists, with improved hand-eye coordination and more experience with laparoscopic suturing. Patient demand is on the rise due to access to prospective randomized trials that have shown lower intensity of pain and shorter recovery time after laparoscopy compared with laparotomy. This said, LM remains limited to centers with advanced operative laparoscopic experience. Even in those centers, LM is applied only to selected patients with less than 3 or 4 myomas and size less than 8-10 cm. Although rare, uteroperitoneal fistula and uterine rupture during future pregnancy remains a concern.

Laparoscopically-assisted myomectomy (LAM), especially with the development of newer wound retractors, is an excellent alternative for large (> 8 cm) and numerous myomas. LAM is technically less difficult, reduces surgical time and the need for extensive laparoscopic experience. Since our initial report, studies suggest that LAM is associated with less blood loss, shorter length of stay and recovery time, and no significant difference in operating time when prospectively compared with laparotomy.

Deep intramural myoma in patients who desire future fertility makes them ideal candidates for LAM since proper closure of myometrial incision is easier to achieve with LAM. Morcellation is less technical and significantly faster. By allowing for simultaneous laparoscopic treatment of associated abdominopelvic pathology, such as endometriosis, the patient benefits from a more complete treatment than myomectomy by minilaparotomy. Reduced pain and faster recovery are similar to LM.

Use of robotics in LM facilitates suturing and uterine reconstruction, similar to laparotomy and LAM. It provides a 3D view, better range of motion, downscaled movements, and eliminates tremor. This makes laparoscopic suturing more intuitive in contrast to the counter intuitive environment of LM. I believe robots will help bridge the gap between laparotomy and laparoscopy. In its current shape, however, they are not readily available, are expensive and bulky, and require additional training of the staff and surgeon. It also inherits the same limitation of LM in terms of number, size, and location of the myomas.

In conclusion, laparoscopic myomectomy is an excellent and safe surgical choice for appropriately selected patients. It reduces recovery time and is associated with less postoperative pain and blood loss and has acceptable outcomes.

Suggested Reading


Palermo was the venue for the 1st AAGL International Congress on Minimally Invasive Gynecology in conjunction with the SEGi and the Italian Society of Gynendoscopy Annual Meeting, June 20-27, 2007. Our Congress was a great success with more than 800 registrants representing 33 countries. We had 51 major companies attend as sponsors and exhibitors. The scientific contributions by the faculty were very well focused on our field of interest and underlined the strong relationship between the AAGL and SEGi. This Congress has helped us to solidify our close, collegial relationship and to recognize a mutually respectful connection, improving the international role of AAGL.

On behalf of the Scientific Program Committee, I would like to thank both the AAGL and SEGi staffs for their invaluable work in organizing the Congress. A special thanks to Chiara Ronconi, Coordinator to the SEGi Secretariat, for her tireless efforts in organizing a major medical event in the Teatro Massimo (the Palermo Opera House) which first opened its doors in 1897. Because of her work and that of her staff, the attendees experienced not only a great scientific program, but also a diverse social program that included visits to the Villa Vignicella, Palazzo Butera, Orto Botanico and the Cathedral of Monreale.

The SEGi will continue to expand our relationship with AAGL by holding an Affiliated Society Session on Friday, November 16th at the AAGL 36th Global Congress of Minimally Invasive Gynecology in Washington, DC. In addition, many SEGi members plan to present abstracts, DVD’s, and posters at the Congress.

The 2nd AAGL International Congress on Minimally Invasive Gynecology in conjunction with SOBENGE in Brazil will be the next in fulfilling AAGL’s goal of reaching out to the international community. I know that the members of the SEGi are looking forward to being an active part of the Brazilian Congress.
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Full Attendance at Flagship Course

This year on May 18 and 19 the ninth annual Course on Gynecologic Laparoscopic Anatomy and Surgery on unembalmed cadavers was held in Louisville, KY. This flagship course, sponsored by AAGL and Department of Obstetrics Gynecology and Women’s Health at the University of Louisville, has attracted participants from six different countries around the world. The intense two day curriculum is focused on pelvic anatomy, pelvic floor support, and dissection of the retroperitoneal spaces, laparoscopic suturing and sling techniques for treatment of urinary stress incontinence. Working in small groups of three per each cadaver, the participants were taught retroperitoneal dissection techniques and how to improve their laparoscopic suturing skills. They were closely supervised by experienced faculty instructors.

The invited faculty for this course were Andrew Brill, Ginger Cathey, Grace Janik, David Levine and Timothy McKinney. They were helped by local faculty Alexandra Blinchevski, Ronald Levine, Jonathan Reinstine, Roysandra Smith and Jim Shwayder. The evaluations for this course were unanimously stellar and I would like to thank the faculty for doing such an excellent job and making this course so successful.

Prompted by a high interest for this course we are organizing the second annual Course on Gynecologic Laparoscopy for Gyn oncologists October 19 and 20, 2007 in Louisville KY. We have lined up a superb faculty and I am encouraging Gyn Oncologists as well as generalists to sign up to enhance their laparoscopic skills.

The Final Ones (maybe)...

In an effort to make coding for hysterectomy more granular and thus provide more succinct data on the annual incidence of these procedures, a new series of codes was developed and added to the hysterectomy family of codes. Last year, in my role as the AAGL liaison to ACOG’s Committee on Coding and Nomenclature, I presented new codes for Laparoscopically-performed Supracervical Hysterectomy (LSH) and hopefully, all of you have been using them when billing for these procedures.

The newest (and perhaps, final) additions to this family of codes will be those describing Total Laparoscopic Hysterectomy (TLH). I presented these new codes to the CPT editorial panel in February and the RBRVS Update Committee meeting in April. Many of you were instrumental in responding to the request of ACOG’s Coding Committee to complete online survey data which was then utilized to determine the proposed RVU values for the codes. Although the assigned values for the new codes 585XX1, 585XX2, 585XX3, and 585XX4 won’t be released until sometime around November, our initial indication is that they should fit logically in line with the current values for the other procedures within the hysterectomy family of codes.

So, beginning in January of 2008, all of us should be able to accurately bill for our hysterectomy procedures, regardless of the route by which they are accomplished.

New Products

**Baxter FLOSEAL (Hemostatic Matrix)**

Baxter is a global medical products and services company with expertise in medical devices, pharmaceuticals and biotechnology. FLOSEAL [Hemostatic Matrix], is a high-viscosity gel that is clinically proven to control bleeding from capillary oozing to pulsatile flow. ADEPT Adhesion Reduction Solution [4% Icodextrin] is a single use, sterile, clear and colorless fluid for intraperitoneal administration.

**Stryker Rev360™ Hysteroscopes**

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The Peruvian Society of Gynecological Endoscopy

Society Perúana de Endoscopia Ginecológica, or as it is more commonly known by the acronym SOPEG, is a relatively new national society devoted to the advancement of endoscopy. Nevertheless it is impressive that they have gained so many members in so few years. The AAGL is pleased to be able to consider SOPEG as part of our worldwide family of gynecologic endoscopists.

– Franklin Loffer, M.D.

Executive Vice President/Medical Director
AAGL "Advancing Minimally Invasive Gynecology Worldwide"

NS: What is your mission statement/primary goal?

Our mission is to promote and diffuse the laparoscopic techniques about gynaecology.

NS: When and how was your society established?

It was established on July 17th, 2001. The society was created by the initiative of experts in order to fulfill an important need of a Peruvian gynaecologist.

NS: What are some of the benefits of membership?

The benefits are discounts in courses and congresses about laparoscopic gynaecology and the continued assistance of our associates and open relations with the laparoscopic gynaecological masters of our country.

NS: Approximately how many members are there?

Approximately 160.

Affiliated Societies

NS: Approximately how many affiliated societies are there?

Approximately 160.

Oncology Committee News

Laparoscopy Training in Gynecologic Oncology

As recently as 6 years ago, almost three-fourths of gynecologic oncology fellows in Board Certified Gynecologic Oncology fellowship programs reported that they would not be comfortable performing laparoscopic lymph node dissections when they finished training [1]. Presumably this was due to lack of emphasis on training in laparoscopic techniques in gynecologic oncology as historically our discipline has been a specialty of surgical exploration through large, vertical incisions.

However, in the last several years, laparoscopy has taken a central role in the treatment of gynecologic oncology patients and accordingly new focus has been placed on learning and teaching these skills. In a survey of gynecologic oncology fellows in 2004, only 25% of fellows felt they were receiving very good or good laparoscopic training during their fellowship even though 86% felt that laparoscopy was very important or important in gynecologic oncology [2].

A follow-up study recently conducted revealed that now 100% of fellows feel that laparoscopy is very important or important in gynecologic oncology and 76% feel they are receiving very good or good laparoscopic training during their fellowship (unpublished data). The percentage of fellows planning on performing laparoscopic lymph node dissections when completing fellowship now approaches 90%. The adoption of laparoscopy into our field has been embraced fully and fellowship training philosophies have been altered to accommodate these new surgical approaches.

The paradigm shift from open procedures to laparoscopic approaches started with small groups of gynecologic surgeons who adopted the new technology for the treatment of gynecologic malignancies. Fellows today benefit from their pioneering work and “on the job” training. Even now, gynecologic oncologists, some of whom finished training decades ago, understand the importance of learning these skills for the benefit of their patients and continue to pursue learning opportunities. The cadaver “hands-on” laparoscopy course at the Annual Meeting of The Society of Gynecologic Oncologists, for example, continues to be the most well-attended course at the Meeting and always meets its enrollment quotas early.

In addition, laparoscopic training courses organized by the AAGL and our industry partners continue to be popular with gynecologic oncologists hoping to improve their skills. Only practice and experience can help a surgeon through the steep part of the learning curve to a point where laparoscopic outcomes are equivalent to open procedures [3].

What are the best ways to achieve “practice and experience”? None of us would advocate using our patients as a means to learn new, untested skills. Last year, we implemented a structured course using inanimate surgical models (i.e. simulators) as well as animal labs for the training of our fellows. These programs have been shown to significantly improve trainees’ skills further preparing them for the actual surgery [4]. In addition, newer technologies such as virtual reality simulators can also be used to improve surgical skills prior to going to the operating room [5]. Laparoscopic training, however, should not be limited to residents and fellows as seasoned surgeons should also be encouraged to improve their skills in these controlled environments where mistakes will not adversely affect patient outcomes.

Michael Frumovitz, M.D.
MD Anderson Cancer Center
Houston, Texas

References

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Welcome New Members
June 1, 2007 to August 31, 2007

Professor Marana Appointed

On June 1st, Riccardo Marana was officially appointed upon indication of the Pontificia Accademia Pro Vita, Director of ISI (Istituto Scientifico Internazionale Paolo VI). It is located on the grounds of the Catholic University in Rome. This Institute promotes research in the field of female fertility and infertility following the guidelines of the Catholic Church. It has a center for diagnosis and treatment of couples with infertility following the ethics of the Catholic Church. We congratulate Dr. Marana on this very important and distinguished appointment.

Professor Mettler Honored

The Kiel School of Gynecological Endoscopy recently hosted gynecologists from throughout the world at their “International Symposium On Hysterectomy- Where Do We Go From Here?” The meeting honored Professor Liselotte Mettler on her retirement from Kiel. Her friends, colleagues and students were pleased to learn she will continue to be an active surgeon. We wish Professor Mettler an enjoyable retirement.

New Members

Gazi Abdulhay, M.D.
Jaime Albornoz, M.D.
Asia Al-Shaikh, M.D.
Ilahe Amini, M.D.
Gokhan Anil, M.D.
Fred A. Avila, M.D.
Rodrigo Ayala, M.D.
Belinda K. Beck, M.D.
Elizabeth Belt Webster, M.D.
James J. Bendell, Ph.D., M.D.
Maureen L. Beurskens, M.D.
Amy R. Bruner, M.D.
Alejandro J. Carbone, M.D.
Mike M. Castaneda, M.D.
Belkys I. Chacin, M.D.
Han Chan Hee, M.D.
Wen-Chun Chang, M.D.
Joshua G. Cohen, M.D.
Leigh A. Corbey, M.D.
Ronald M. Cyr, M.D.
Patricia Daza Rueda, M.D.
David N. Dhanraj
Michaël I. Douso, M.D., FACOG
Patricia Dramitinos, M.D.
Denise M. Elser, M.D.
Elisabeth A. Erekson, M.D.
Ibrahim A.M. Erfan, M.D.
Jose L. Escobar, M.D.
Jonathan M. Espana, M.D.
Ehab Fawzy, M.D.
Limin Feng, M.D.
Shaun Ferguson, M.D.
Denard M. Fobbs, M.D.
Nastaran Foyouzi, M.D.
Stephen M. Gallousis, M.D.
Rocio C. Garcia Guzman, M.D.
Michele Germain, D.O.
Lorena Gonzalez Regal, M.D.
Cari Graber, D.O.
Afarin Y. Greijer, M.D.
Neeru R. Gupta, M.D.
Robert L. Halterman, D.O.
Brenda Jo Harris, M.D.
Yasuoshi Hayashi, M.D.
Jane T. Helwig, M.D.
Philip D. Hilldale
Gloria S. Huang, M.D.
Su-Cheng Huang, M.D.
Sherri Janani, M.D.
Marilyn C. Jerome, M.D.
Guoli Johnston, M.D.
Kadambari Kadambari, M.D.
Georgios Karnakis, M.D.
Russell Kellett, M.D.
Jin-Hong Kim, M.D.
Sue-Youn Kim, M.D.
Joan Kinniburgh, R.N.
Peter Klatsky, M.D.
Angela S. Kueck, M.D.
Minsun Kyung, M.D.
Dmitriy Ledin, M.D.
Jung Hoon Lee, M.D.
Shauna M. Leeson, R.N.
Christine M. Leitgen, M.D.
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Nathan D. Livers, M.D.
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Kelly JoAnne Morales, M.D.
Shawana Mufti, M.D.
Kerry Myckan, M.D.
Kirstiaan L. Nevin, M.D.
Jennifer L. Nichols, D.O.
Linda M. Nicoll, M.D.
Karen Nishida, M.D.
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Marco Orbea, M.D.
Alexandra Palenzuela, M.D.
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Todd Tillmanns, M.D.
Ramsey Unal, M.D.
Ivan Valencia, M.D.
Christine O. Vergara, M.D.
Pablo Vilchis-Nava, M.D.
Amy Jean Voedisch, M.D.
Colin Walsh, M.D.
Joanne White, M.D.
Xiaodong Xiang, M.D.
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Javier F. Magrina, Scientific Program Chair
Resad P. Pasic, Scientific Program Chair
October 19-20, 2007
University of Louisville • Louisville, Kentucky

**36th Global Congress of Minimally Invasive Gynecology/ AAGL Annual Meeting**
Charles E. Miller, Scientific Program Chair
Pre-congress Workshops – November 13, 2007
Congress - November 14-17, 2007
Marriott Wardman Park • Washington, D.C.

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World Congress of Gynecological Endoscopy
In affiliation with AAGL Advancing Minimally Invasive Gynecology Worldwide
Prof. Stefano Bettocchi, President
June 4-7, 2008
Bari, Italy

**2nd AAGL International Congress on Minimally Invasive Gynecology In conjunction with V Brazilian Congress of SOBENGE**
Paulo Roberto Cara, Scientific Program Chair
September 3-6, 2008
Hotel Serrano
Gramado-Rio Grande do Sul, Brazil

**37th Global Congress of Minimally Invasive Gynecology/ AAGL Annual Meeting**
Resad P. Pasic, Scientific Program Chair
October 29-Nov. 1, 2008
Paris Hotel • Las Vegas, Nevada

**3rd AAGL International Congress on Minimally Invasive Gynecology In conjunction with the Australian Gynecological Endoscopy Society and ASM**
May 2009
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**38th Global Congress of Minimally Invasive Gynecology/ AAGL Annual Meeting**
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Gaylord Palms, Orlando, Florida