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FOCUS ON AAGL

What is Ahead for the AAGL in the Next 3 Years?

The AAGL has undergone many changes during the last 3 years. A few of the major ones are:

• The number of members and the attendance at the annual meeting have both increased significantly.
• The Centers of Excellence in Minimally Invasive Gynecology (COEMIG) have come on line in 2012 with 174 hospitals and 347 surgeons currently in the application process; of those, 24 hospitals and 73 physicians have been approved.

• The Essentials in Minimally Invasive Gynecology (EMIG) program has developed a high stakes cognitive test and beta tested a skills test.
• The AAGL’s financial position has continued to strengthen, which has allowed not only for the retirement of the mortgage on its office, but the ability to commit to the establishment of new programs such as a patient website.

But what is ahead for the next 3 years? No one can predict the future but it is necessary to set out a course to follow if we are to be able to continue our growth and influence for the benefit of our members and their patients.

Accordingly, with the help of a consultant, the AAGL Board of Trustees met in a strategic planning session and developed a plan to help guide the AAGL in its growth.

Six Goals were determined.

1. **Membership** with the objective that “All members will derive exceptional value and benefit from joining and participating in the AAGL.”

2. **Professional Development** in order to “Allow the AAGL to continue to be the recognized provider for superior opportunities for lifelong learning while establishing a clear career path in MIGS.”

3. **Cooperative Relations** that will continue to “Allow the AAGL to be recognized as thought leaders and subject matter experts in MIGS”.

4. **Expand Technology Based Offerings** to “Further enhance creativity, features, interactivity and accessibility of the website while linking to other AAGL created and maintained relevant sites.”

5. **Leadership Development** to “Foster a collaborative and rewarding environment which is global, inclusive and diverse which promotes development of volunteer leaders for the organization and the profession at-large.”

6. **Governance** to “Ensure that the organizational structure addresses the future needs and expectations of AAGL members in a timely and efficient manner.”

These Goals will be explored in more detail in future “Focus on AAGL” reports. In the meantime, and on behalf of the AAGL Board of Trustees, I wish to thank all members for their support of MIGS and encourage each to make their thoughts known by addressing the Board at aaglboard@aagl.org.

Dr. Loffer

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Challenge and Opportunity – Year in Review

2012 has been a year of unprecedented accomplishments for the AAGL. We have launched a successful Center of Excellence Program that has been greeted with greater than expected enthusiasm, participation and potential for research. The AAGL has administered its first cognitive and skills test for the Essentials in Minimally Invasive Gynecology and the passing participants have received their certificates recognizing this achievement. We are close to publishing the AAGL Endometriosis Classification which has more accurate correlation with pain and fertility than the currently used classification system. Surgery U has expanded our international presence with innovative webcasts and live surgeries. JMIG has smoothly transitioned to a new JMIG editor with innovative ideas for the journal. The AAGL practice committee has produced high quality evidence-based clinical guidelines and we are in discussions with ACOG, the ASRM and other organizations to co-sponsor guidelines of interest to all of our members. And we will soon publish our first position statement on the use of technology in our field.

These accomplishments have put the AAGL in an influential position within the national and international community. I encourage each of you to think of personal and system challenges we currently face in healthcare as well as ideas on how the AAGL can help tackle these challenges. During my presidential address at this year’s annual meeting, I spoke of the patronizing restrictive laws enacted on physicians and industry in the state of Massachusetts. I am encouraged to report through the efforts of the health care community, that these laws were nearly completely reversed. This reversal gave me hope and optimism that physicians’ organizations such as the AAGL can influence industry and governmental policy. We now have a loud voice. We are the most influential gynecological surgical organization in the world.

My two personal goals are: first, to encourage our own members to become keenly aware of health care costs and to work with industry to help us minimize spending. If we don’t lead by example we will lose our credibility. We can document these efforts and results through clinical research sponsored by the AAGL. Second, I would like to see the AAGL partner with national and international organizations that share our common interests in the areas of standardized skills assessment, surgeon credentialing, and healthcare policy. Several of our sister organizations such as ACOG and the ASRM have hired lobbyists in Washington DC to effectively get their message to the policy makers. I suggest the AAGL does the same.

In summary, 2012 has been a fantastic year for the AAGL and for me personally. Again I want to thank everyone who works in the AAGL office as well as the Board of Trustees with whom I had the privilege to work. We are fortunate that every member of the AAGL can have a voice. Pick up the phone or write an e-mail (tweeting is not allowed) and communicate with any board member. Let him or her know what is important to you and ask how you can get involved. These next 3 to 5 years present us with challenges and opportunities that we have never faced before. This is our time to make a difference.

Keith B. Isaacson, M.D. is the 2013 Immediate Past President of the AAGL and Associate Professor of Obstetrics Gyn at Harvard Medical School and the Director of Partners Center for Reproductive Medicine and Surgery at Newton Wellesley Hospital MIGS Center, Newton, Massachusetts.

The 9th International AAGL Congress in Cape Town, South Africa Awaits You – April 9-13, 2013

On behalf of the Scientific Program Committee, I would like remind you that you still have time to register for one of the most exciting meetings that the AAGL has ever hosted here in Cape Town, under the majestic Table Mountain.

The South African Society for Reproductive Medicine and Surgery (SASREG) is proud to be the local host and much planning has gone into the scientific sessions including 2 days of hands-on PG courses, followed by invited lectures, abstract and video presentations and live surgeries from across the globe that will cover such topics as MIG surgery, infertility and urogynecology.

We are excited to hold the congress at the award winning Cape Town International Convention Centre (CTICC), situated adjacent to the lively Cape Town Waterfront where delegates can enjoy vast shopping malls, a choice of stylish restaurants, boat trips to Table Bay and Robben Island, as well as a bubbly night life. A choice of top hotels will be available in the vicinity of the Congress Centre and canal boats can ferry you between the conference venue and waterfront. Exciting tours will be available so that you can experience the beauty of Cape Town, including the wine lands and even a safari post-conference.

This is a terrific opportunity to bring your family along and go on an African safari that will allow you to see the “Big 5” of Africa in their natural habitat; all in the comfort of exquisite safari lodges. A fun social program for accompanying persons will be available to keep your better halves entertained while you acquire new endoscopic skills.

We are confident that this international AAGL event, with its excellent scientific program and unique Cape Town experience, is worth adding to your calendar for 2013! We look forward to welcoming you to our shores. To register for this meeting please go to www.aaglcapetown2013.org.za.

Johan Van der Wat, M.D., is an Advisory Committee member and Congress President for the 9th International AAGL Congress on Minimally Invasive Gynecology in partnership with the SASREG.
SurgeryU – A Powerful Resource for Teaching MIGS Through Surgical Video

As minimally invasive surgeons, it is important to recognize value of learning about new techniques and technologies from our peers in MIGS. SurgeryU – AAGL’s state-of-the-art platform for on-demand and streaming video – provides hundreds of hours of surgical video that can be used by residents, fellows, and practicing physicians to stay current on the latest development in our field. The SurgeryU Surgical Video Library is continually updated with new videos submitted by AAGL Members, as well as videos that were presented at the AAGL Global Congress on Minimally Invasive Gynecology, providing AAGL members with access to current examples of how surgeons around the world are performing their procedures.

The SurgeryU On-Demand Video Library provides several features that make it easy to find videos that pertain to your area of interest:

- **Simple Video Search:** Searching for videos in the SurgeryU video library has never been easier. You can simply visit AAGL.org, click on the SurgeryU tab, and type what you’re looking for in the search box near the center of the page. If you need access to our complete set of search options, you can click on the Advanced Options button to perform an expert search.

- **Featured Live Videos:** You can find a continual stream of featured videos on the SurgeryU home page that demonstrate some of the best work being done by the surgeons within the Association. These videos mainly consist of replays of our marquee SurgeryU HD Live video presentations.

- **Submit Your Video:** If you’d like to submit a video to demonstrate to others how you are performing minimally invasive surgery in your OR, go to the SurgeryU home page (http://aagl.org/surgeryu) and click on Submit Video. Our video review team will quickly review your video content, and then your video will be added to SurgeryU.

Our Interactive Media team is continually working on new features to expand the capabilities of SurgeryU. If you have suggestions on new features that you’d like to see added to SurgeryU, please feel free to contact us at surgeryu@aagl.org.

Assia A. Stepanian, M.D. is Editor-in-Chief of SurgeryU and serves as a member of the AAGL Board of Trustees. Dr. Stepanian is in private practice at the Academy of Women’s Health and Endoscopic Surgery in Atlanta, Georgia.
Close Port Sites Quickly and Safely

Eliminate Big Problems — Especially in Obese and Overweight Patients

Our new Suture Guide and Suture Passer have been reengineered to provide safe, quick and reliable port site closure for a range of laparoscopic gynecological procedures. The system offers numerous advantages:

• Suture Guide fully closes fascia and peritoneum with a single suture to prevent herniation
• The only Suture Guide that passes through the trocar for precise closure and enhanced safety
• Suture Guide’s anchoring wings provide gentle countertraction for better tissue approximation regardless of abdominal wall thickness
• Intuitive Suture Passer features extendable grasping fingers for easier suture retrieval
• Creates a precise angle for the Suture Passer to reliably capture all layers of tissue every time

For more information about the Carter-Thomason II Port Closure System, call 800.243.2974 or 203.601.5200 or visit www.coopersurgical.com
2012 Annual Meeting Wrap-up

It was another year and another great Annual Global Congress of AAGL, with a total of 1820 attendees from 55 countries and 486 members participating directly in some capacity.

My deepest THANKS to all attendees and to everyone who actively participated in one form or another. All of you made it a success.

A successful Congress like this one in 2012 does not happen by chance. It started by obtaining suggestions from the members of the Scientific Program Committee (Linda Bradley, C.Y. Liu, Rosanne Kho, Arnie Advincula, William Parker, Frank Loffer, Linda Michels, Keith Isaacson, Craig Sobolewski and myself). It was followed by a face-to-face meeting where a skeleton program was designed and subsequently redesigned at other meetings and followed by emails.

Thank you to everyone who submitted an abstract or video. Abstracts and videos were reviewed, graded, and categorized by many members who volunteered their time. Our AAGL office, under the direction of Linda Michels and Frank Loffer implemented and executed the Final Program, with the assistance of the personnel of the main office who worked behind the scenes to make it happen. In particular, Art Arellano ensured we followed ACCME rules and Jane Kalert organized the glamorous venue. Everyone in our main office was responsible or participated in some form of activities: Roman Bojorquez, Director of Information Technology, was responsible for the AV live telesurgeries; Craig Cocca, Manager of Web Development and Interactive Media; Barbara Hodgson who edited the program content; Gerardo Galindo who handled registrations; and Arcy Dominguez who organized the Fellowship activities. A big thank you goes out to the remainder of the staff including Lynn Bell, Patricia Evans, Dené Glamuzina, Tina Lombardi, Simona Long, Claudia Sahagun and Jennifer Sanchez. To all of them, my deepest gratitude for translating to
reality our thoughts on paper.

I am also indebted to our Industry supporters, who provide us with technological advances to benefit us and our patients, who organized educational sessions at their booths or breakfast and evening sessions, and provided financial support for the Global Congress. I thank them for helping us in another successful year.

Dr. Jack Masterson delivered a thoughtful lecture during the General Session. It was real information in conjunction with humor, and touching home in some many points. We learned the ups and downs in our career and in our personal lives. Thank you Jack. Dr. Bill Parker and two pilots from United Airlines provided a second General Session, providing clear reasons for accidents and methods to prevent them applicable to our operating rooms. Thank you Bill.

The live surgery session was very well attended as always. The laparoscopic hysterectomy of a 20 weeks size uterus will be made available to all of you and we’ll email you a web address for its viewing. Thank you Kathleen O’Hanlan. In addition, my big thanks to Ricardo Estape, Peter Lim, Linda Bradley, Samar Nahas, Johnny Yi, and Yukio Sonoda for their surgical demonstrations, which will also be made available to all members. The short pre-recorded presentations were a new format to the live surgery session, and your feedback will assist us in determining future programs.

We have a year until the next Annual Global Congress. Do you want to participate in 2013? Send us your abstract or video, and tell us how you would like to contribute. Ceanna Nezhat is the Scientific Program Chair for 2013 and already has planned what promises to be an exceptional program.

Not everything that happened in Vegas, stayed in Vegas.

Thank you to everyone again. We look forward to seeing you in Washington in November 2013.
WORKSHOP DESCRIPTION
This course is designed for residents, fellows and specialists interested in advancing their skills and knowledge in the fundamentals of laparoscopic and hysteroscopic surgery. Rather than focusing on specific endoscopic procedures, the curriculum focuses on fundamental skills and knowledge that are essential to laparoscopic and hysteroscopic surgical procedures. Both didactic and hands-on laboratory sessions are used to teach different methodologies for tissue manipulation and dissection, the safe use of electrosurgery and ultrasonic energy, laparoscopic suturing, techniques for tissue removal and morcellation, and both diagnostic and operative hysteroscopic procedures. A full spectrum of operative laparoscopic and hysteroscopic procedures including associated complications will be critically reviewed using an interactive case-study format. This course will also review and discuss the new spectrum of robotics in minimally invasive gynecology. The course emphasizes basic surgical principles emphasizing risk reduction and strategic thinking to insure risk reduction and optimal patient care.

Saturday, March 23, 2013
Lectures and Labs
7:30  Laparoscopic Anatomy - Focus on the Retroperitoneum
8:00  Peritoneal Access - Techniques and Safety
8:20  Tips for Safe Use of Electrosurgery in Laparoscopic Surgery
8:50  Efficient Surgeon - Set-Up, Planning and Strategy
9:10  Laparoscopic Complications - How to Avoid and Manage
9:40  Questions and Answers
10:05  Hysterectomy - Best Mode of Access? Intro
10:15  Vaginal Hysterectomy
10:25  Laparoscopic Hysterectomy
10:35  Robotic Hysterectomy
10:45  Single Port Hysterectomy
10:55  Abdominal Hysterectomy - When is this Needed?
11:30  Panel Discussion - Q&A - Audience Votes for Preferred Mode of Access
12:00  JMIG - How to Get Published
1:00  Luncheon Roundtables
Robotic Surgery in Gynecology
Tips for Tissue Extraction and Morcellation in Gynecologic Surgery
How Do I Get into a Fellowship Program?
Cervical Incompetence and Laparoscopic Cerclage
Tips for Laparoscopic Treatment of Endometriosis
Office Hysteroscopy - Set Up and Practical Tips
Laparoscopic Hysterectomy – Advanced
Endometrial Ablation - Tips and Tricks
Alternative Treatment Options for Uterine Fibroids
Laparoscopic Hysterectomy for Beginners
Special Considerations for Surgery in Obese Patients
Evaluation and Treatment of Patients with Pelvic Pain
1:30  Diagnostic Hysteroscopy and Fluid Management
2:00  Operative Hysteroscopy
2:15  Questions and Answers
2:30  Lab and Video Rotations - Group is Divided in Two
Group A = Video Session. Group B = Lab

LABS

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6:30  Meet the Faculty Reception – Adjourn

Sunday, March 24, 2013
Lectures and Labs
7:30  Minimally Invasive Treatment of Uterine Fibroids
8:00  Laparoscopic Treatment of Endometriosis
8:30  Role of Robotics in Gynecologic Laparoscopy
9:00  Questions and Answers
9:30  Lab and Video Rotations - Group is Divided in Two
Group A = LAB. Group B = Video Session

LABS

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12:30  Take Home Messages and Clinical Pearls
1:00  Adjourn

Lab & Video Groups
All attendees divide into Lab and Video Groups on Saturday, March 23rd from 2:30pm to 5:30pm and on Sunday, March 24th from 9:30am to 12:30 noon
Suturing Station
Energy & Tissue Morcellation Station
Hysteroscopy Station

For more information, visit www.aagl.org or call the AAGL office at (800) 554-2245.

• This is a non CME program •
Endometriosis Classifications Need to Be Revisited: A New One is Arriving

Since the first classifications were proposed by Sampson in 1927, a great many other have been suggested (Acosta, Kistner, Buttram, et al). More recently, some classifications were proposed which focused on specific topics: infertility (Adamson), histopathology (Abrao), deep endometriosis (Konincx, Adamyan, Martin, Batt, Chapron, Donnez, Haas and Keckstein, et al). In 1979 the American Fertility Society proposed the AFS Classification which was modified in 1985 (AFS Classification), and in 1996 (ASRM Classification). Actually, all around the world, the ASRM Classification is the most commonly utilized.

In daily practice the ASRM Classification presents major limitations: (i) the stages are solely defined on the basis of subjective visual examination during laparoscopic exploration; (ii) the scores are arbitrarily proposed with overestimation for ovarian endometrioma (16 or 20 points) and complete posterior cul de sac obliteration (40 points) compared to deep nodules (maximum of six points); (iii) certain lesions are not taken into account: ureter, extra pelvic lesions (bowel, diaphragm, etc.); (iv) there is no clinical correlation with fertility and pelvic pain; (v) there is no information concerning the evolutivity of the disease; (vi) heterogeneity of endometriosis is not considered; (vii) associated diseases such as adenomyosis are not taken into account; (viii) anatomic distribution and multifocality of deep endometriosis are not integrated; (ix) and finally, surgical difficulties are not addressed.

For all these reasons the commonly used classification needs to be revisited. The criteria for a good classification are the following: (i) simple, easy to perform and reproducible; (ii) objective evaluation in scoring system; (iii) taking into account all types of the disease; (iv) correlating disease stages with symptoms (pain and infertility); (v) correlating classification with surgical difficulties; (vi) correlate scores with prognosis of the disease; (vii) it should be helpful for therapeutic options.

“The preliminary results presented during the AAGL Las Vegas meeting are really very encouraging. This validated classifications for endometriosis correlates with pain, infertility and surgical difficulty.”

Over the last few years the AAGL Special Interest Group (SIG) on Reproductive Surgery and Endometriosis worked to prepare a new classification system for endometriosis. During the 2012 AAGL Annual Meeting in Las Vegas, the SIG proposed a new classification system in which surgical difficulties were categorized in four levels:

- Level 1: Excision or dessication of superficial implants, and simple thin avascular adhesions.
- Level 2: Stripping of ovarian endometriomas; appendectomy; deep endometriosis non involving vagina, bladder (not requiring suture), bowel, or ureter; dense adhesions non involving the bowel and/or the ureter.
- Level 3: Dense adhesions involving the bowel and/or the ureter; bladder surgery requiring suture; ureterolysis; bowel surgery without resection (shaving).
- Level 4: Bowel resection with end-to-end anastomosis; ureteral reimplantation or anastomosis.

Preliminary results presented during the AAGL Las Vegas meeting are really very encouraging. This validated classification for endometriosis correlates with pain, infertility and surgical difficulty. Preliminary AAGL results demonstrate that this new classification seems to be better than the existing classifications in correlating the stage to the pain intensity and level of surgical difficulties. Details concerning this classification and definitive results will be published in a short time.

References:

Charles Chapron, M.D. is Professor and Chair, University Paris Descartes, Department of Obstetrics, Gynecology and Reproductive Medicine, CHU Cochin, Paris, France, President of the French Society of Gynecologic and Pelvic Surgery.

Mauricio S. Abrao, M.D. is Director of the Endometriosis Unit at Sao Paulo University, in Sao Paolo, Brazil.

Charles E. Miller, M.D. is Director of Minimally Invasive Gynecologic Surgery at Advocate Lutheran Hospital in Park Ridge, Illinois and Clinical Associate Professor at the University of Chicago and the University of Illinois at Chicago, Illinois, USA.

This article is presented on behalf of the AAGL’s Special Interest Group on Endometriosis/Reproductive Surgery.
Eliminate Laparotomy in Your Practice

Compared to conventional laparoscopy, the unsurpassed visualization, dexterity and control allow surgeons to:

- Treat more pathology minimally invasively — safely, reproducibly and following open surgical technique\(^1\) — including patients with:
  - Adhesive disease\(^1\)
  - Large pathology\(^1\)
  - Obesity\(^2\)
- Greater access, precision and control for improved dissections\(^1\)
- Quicker, easier suturing during vaginal cuff closure\(^1\)
- Control of the camera and all three operative arms for the ultimate in surgical autonomy and efficiency\(^1\)

Contact Intuitive Surgical to learn more about *da Vinci* Surgery:
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www.davincisurgery.com

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The presentations described are for general information only and are not intended to substitute for formal medical training or certification. Independent surgeons, who are not Intuitive Surgical employees, provide procedure descriptions. Intuitive Surgical trains only on the use of its products and is not responsible for surgical credentialing or for training in surgical procedure or technique. As a result, Intuitive is not responsible for procedural content. While clinical studies support the use of the da Vinci Surgical System as an effective tool for minimally invasive surgery, individual results may vary. ©2011 Intuitive Surgical, Inc. All rights reserved. Intuitive, Intuitive Surgical, da Vinci, de Uteri S, de Uteri Si, InSite, and EndoWrist are trademarks or registered trademarks of Intuitive Surgical, Inc. PN 870561 Rev. B 9/11
4th Annual Workshop – December 7-8th on Video-Assisted Laparoscopy & Robotic-Assisted Laparoscopic Hysterectomy a Success!

On behalf of my Scientific Program Co-Chairs, Camran Nezhat and Ceana Nezhat, I would like to thank the faculty, proctors, and our industry partners for their dedicated efforts to make this workshop a success.

We were pleased to gather a renowned group of experts who addressed a wide range of methods to overcome barriers in minimally invasive gynecologic surgery.

In addition to the invited lectures two live surgical procedures were performed: a “Mini-Video Laparoscopy” by Fabio Ghezzi from A.O. Ospedale di Circolo e Fondazione Macchi in Varese, Italy and a “Robotic-Assisted Hysterectomy” by William Burke and Noah Goldman from Valley Health Hospital, Newark, New Jersey. The enthusiastic response to these surgeries was evident by the attendance in the general meeting room; every seat was taken and a robust discussion followed both events.

Another highlight was Anthony M. Vintzileos’ keynote address where he discussed the discrepancies of evidence based medicine and evaluated the shortcomings of randomized controlled trials in obstetrics and gynecology. To drive his point home he suggested that “real-life” evidence be your highest level of evidence.

The workshop attracted physicians from 15 different countries including: Australia, Canada, Chile, Costa Rica, England Denmark, Korea, Mexico, Pakistan, Romania, Saudi Arabia, South Africa, Spain, Taiwan, Turkey and the USA.

Unique to this meeting was the ability of the attendees to have their own suturing pelvic trainer where they worked under the guidance of a proctor for up to 5 hours per day. There was also a robotic lab for individual instruction. The highlight for the attendees was the ability to come back to the lab after 7:00 pm for additional instruction as needed. The hands-on experience would not have been possible without the exceptional support of our industry sponsors and I would like to acknowledge that we received educational grants and equipment (in-kind) from the following companies: 3-Dmed, CareFusion, Covidien, Inc., Ethicon Endo-Surgery, Inc., Ethicon Women’s Health & Urology, Intuitive Surgical, Mimic Technologies, Karl Storz Endoscopy-America, Inc., and Teleflex.

A review of the evaluation data indicates that 96% of the attendees stated that the course met its stated objectives to provide: appropriate patient selection and surgical instrumentation; better knowledge of anatomy; and improved knowledge of surgical techniques as enhanced by the step-by-step instruction provided in the labs. In addition, 78% stated that the course helped improve their laparoscopic skills and increased exposure to new innovations while 22% stated that before this course they could not perform intracorporeal knot tying.

We also had a full exhibit hall with the following companies present: Baxter Biosurgery, Conmed, Cooper Surgical, Covidien Surgical Devices, Ethicon/Biosurgery, Hologic, Lina Medical, Lumenis, Plasma, Karl Storz, Surgiquest, Teleflex, Vectec. Richard Wolf.

Finally, I would like to thank the AAGL staff; Jane Kalert, Lynn Bell, Roman Bojorquez, Craig Cocca, Art Arellano, Jennifer Sanchez and Linda Michels for their assistance in organizing the meeting and for their technical expertise onsite. In addition, I would like to recognize my assistant Dajana Babic for her dedicated efforts.

For those of you that missed the meeting this year, we encourage you to mark your calendars now so that you do not miss this exceptional meeting in 2013!

Farr R. Nezhat, M.D., FACOG, FACS is Professor of Clinical Ob/Gyn at Columbia University, College of Physicians and Surgeons. He is an Adjunct Professor for the Department of Obstetrics, Gynecology & Reproductive Medicine at the State University of New York, College of Medicine. Dr. Nezhat is also Director of Minimally Invasive Gynecologic & Robotic Surgery, and Fellowship Division of Gynecologic Oncology in the Department of Ob/Gyn at St. Luke’s and Roosevelt Hospitals. He is Director of Minimally Invasive Gynecologic Surgery in the Department of Ob/Gyn at Winthrop University Hospital in New York, New York.

The expert faculty reviewed and introduced topics as if they were looking at my patient or O.R. list. They advanced my knowledge on cuff closure, bladder and ureteric repair and I had my first exposure to the robot.

Dr. Balica (center) proctors a station on suturing.

(Left to right) Drs. Ceana, Farr and Camran Nezhat.

Robotic lab open for individual training.

Attendees learn advanced knot tying techniques.
The Fellowship in Minimally Invasive Gynecologic Surgery (FMIGS), an affiliate of the AAGL and the Society of Reproductive Surgeons, is sponsoring fellowships in advanced gynecologic endoscopy. These fellowships were created with the goal of producing a standardized training program. The Fellowship in Minimally Invasive Gynecologic Surgery actively encourages applications from postgraduate physicians aspiring to develop their surgical skills in minimally invasive gynecology.

Educational objectives focus on evidence based medicine, anatomical principles, instrumentation, operative laparoscopy and operative hysteroscopy. The Fellowship offers in depth experience using state-of-the-art techniques.

The overall goal of fellowship training in minimally invasive gynecology is for the graduate to serve as an independent specialist and consultant in the surgical management and techniques of minimally invasive gynecology surpassing competence expected at the end of a categorical residency. The graduate is anticipated to serve as a scholarly and surgical resource for the community and have the ability to care for patients with complex gynecologic disease and manage complications using minimally invasive techniques.
Fellowship in Minimally Invasive Gynecologic Surgery: Raising the Standards

Our fellowship training was first developed in 2001, under the direction of AAGL and the Society for Reproductive Surgeons of the American Society for Reproductive Medicine (SRS-ASRM). In 2009, the initial name, Fellowship in Gynecologic Surgery, was changed to Fellowship in Minimally Invasive Gynecologic Surgery (FMIGS). The program started with 7 programs and 7 fellows. Today we have 44 programs with 62 fellows (Fig.1).

The number of applicants steadily increased with 104 total applicants for the 2012-2013 year. Of interest, the ratio of female to male fellows has increased markedly. To date, 184 fellows have graduated from this fellowship program.

Due to variations in training and duration of fellowship among different training centers, the FMIGS Board decided to standardize the fellowship training. In 2013 all approved program will be 2 years. The Board has also developed guidelines for this two-year program.

Besides the conventional training at the individual institution, FMIGS fellows attend courses including the laparoscopic suturing and robotic courses. The Education Committee supervises the courses. In order to involve all program directors and fellows in the activities of FMIGS, this year we started having a Town Hall meeting. The Board recognizes the importance of our international members and is currently investigating the possibility of international Fellowships.

Clearly, the FMIGS Board has raised the bar. The challenge in the near future is to refine the matching program. Our objective remains; to educate gynecologists to become experts in minimally invasive gynecologic procedures in a standardized educational manner.

Togas Tulandi M.D., MHCM is President of the 2012 Board of Fellowship in Minimally Invasive Gynecologic Surgery (FMIGS) and a member of the AAGL Board of Trustees. He is a Professor and Academic Vice Chairman of Obstetrics and Gynecology, and Milton Leong Chair in Reproductive Medicine at McGill University, Montreal, QC, Canada.

2012 Fellowship Graduation Ceremony

Dr. Michael S. Collins (center) with faculty and fellows.

Dr. Togas Tulandi (1st left) presenting Drs. Adam M. Griffin (top row) and Dr. Fred M. Howard’s (1st right) fellow, Dr. Miya P. Yamamoto (2nd left), with her graduation plaque.

Dr. Ted L. Anderson (3rd left) with former and current fellows.

Program Directors and fellows during the ceremony.
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Changing the Paradigm, Again

Pelvic pain was once a very easy topic: if the patient’s pain wasn’t due to endometriosis, or cured by a hysterectomy, it was “in her head.” Unfortunately, like so many other aspects of life, it’s just not that simple. Dr. Fred Howard, one of the most accomplished pelvic pain physicians in this country and a pioneer in this field, estimates only 18% of patients with both endometriosis and pelvic pain diagnoses truly have endometriosis as the singular etiology of their pain. By deduction, this means a staggering 82% of patients with endometriosis and pelvic pain diagnoses have additional conditions contributing to their pain. To repeat, this means four in five patients with endometriosis have additional reasons for their pain! This phenomenon explains the high failure rates and recurrence of pain after medical and surgical treatments for endometriosis. For this reason, we need to shift the paradigm in thinking about endometriosis and chronic pelvic pain.

Pelvic pain encompasses the entire pelvis – muscles, connective tissue, and of course the gynecologic, gastrointestinal, and urinary structures. Additionally, the neurologic aspect of pain, such as central and peripheral sensitization, neuronal cross talk, and many other topics, are only recently studied and understood. We, as gynecologists and caregivers of women’s health, need to stop senselessly and reactively treating patients with antiquated medical and surgical protocols, such as simply ablating endometriosis and hoping for a cure. We need to be thorough and thoughtful, and treat the pelvis as a whole.

The last decade in medicine, and gynecology in particular, has seen many changes in the science, evaluation, and treatment of chronic pelvic pain. Conferences and courses in pelvic pain are more popular and better attended each year. The Pelvic Pain SIG course at this year’s AAGL Annual Meeting had a record number of attendees; standing room only with almost four times the participants compared to last year. Our affiliated organization, the International Pelvic Pain Society’s annual conference saw similar interest with more than 400 participants this year. These trends show the time is right for change, and the time is right to bring pelvic pain to the forefront of patient care. In 2011, the Institute of Medicine published a report entitled Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. The IOM recognizes chronic pelvic pain is a major driver for visits to physicians, taking medications, and causes for disability, and sent on to other physicians. This cycle of behavior on the part of the physician contributes to the misunderstanding of chronic pelvic pain, and directly impacts the patient and the relationships around her. These patients eventually lose hope of ever finding treatments.

Now is the time to embrace change. We should seek other, perhaps less common and less orthodox causes of pelvic pain. Physical therapy and multi-disciplinary treatment options should be the norm, not the exception. And we should push for research in all aspects of pain, including neuromodulation, ketamine infusions for centralized pain, and botulinum toxin use.

It has been my privilege to be the chair of the AAGL Pelvic Pain Special Interest Group. I am leaving its leadership in the brilliant hands of pelvic pain expert Dr. Georigne Lamvu. Additionally, I would like to thank my mentors, who have always inspired me to strive for the impossible: Dr. Javier Magrina, Dr. Fred Howard and Dr. Charles Butrick. Lastly, to paraphrase the new Quentin Tarantino movie, “Pelvic pain you had my curiosity, now you have my attention.”

“The IOM recognizes chronic pelvic pain is a major driver for visits to physicians, taking medications, and causes for disability, and is a key factor in quality of life and productivity.”

Michael Hibner, M.D., Ph.D., FACOG, FACS is Chief of Gynecology & Director, Division of Gynecologic Surgery at St. Joseph’s Hospital and Medical Center. He is also Professor of Obstetrics and Gynecology at Creighton University School of Medicine in Phoenix, Arizona.

Nita A. Desai, M.D. is Clinical Assistant Professor at the University of Arizona College of Medicine, Surgeon - Division of Gynecologic Surgery and Pelvic Pain, Associate Director of Minimally Invasive Gynecologic Surgery at St. Joseph’s Hospital and Medical Center, and Clinical Instructor at Creighton University School of Medicine in Phoenix, Arizona.

This article is presented on behalf of the AAGL’s Special Interest Group on Pelvic Pain.
Congratulations to the Newest COEMIG Designees

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Naglaa Rizk, M.D.
Wael Sammar, M.D.

Dr. Shepherd
Dr. Gimpelson

FMIGS Fellows Stump the Professors

This year’s 41st AAGL Global Congress hosted its first edition of “Stump the Professors” session. This classic contest created a friendly competitive atmosphere between the novice and the experienced, with each side having a chance of bragging rights.

In this year’s session, two cases were presented by Dr. Corey Wagner from St. Elizabeth Medical Center in Utica, NY, and Dr. Mario Castellanos from St. Joseph’s Hospital and Medical Center, Division of Advanced GYN and Pelvic Pain in Phoenix, AZ. The professors had good reason to be stumped—the cases presented were intriguing and created much discussion between the panel and the audience. The host Dr. Jessica Shepherd, was the coordinator of the event this year. The perpetually amusing moderator was Dr. Richard Gimpleson, who kept the audience entertained and the panel on their toes. The panel of professors consisted of a lively group, Dr. Alan H. DeCherney, Dr. David J. Levine, Dr. Peter J. Maher and Dr. Liselotte Mettler, who kept the session interesting and dynamic as they initiated dialogue between each other.

We look forward to having this session annually and the quest is on for cases relating to minimally invasive surgery and women’s health. We are looking for cases that are intriguing, extraordinary, and arduous for the next “Stump the Professors” program and will have a call for cases as early as June of 2013. The cases should require thought, attention to potential change in practice, and represent the depth and intrigue of minimally invasive gynecology, urogynecology and gynecologic oncology.

The Fellowship in Minimally Invasive Gynecologic Surgery (FMIGS) is a program designed to provide standardized training for gynecologic surgeons who have completed their residency in a variety of minimally invasive endoscopic procedures, and to ensure the continuity of minimally invasive gynecologic training in the community.

Jessica Shepherd, M.D., MBA is an Assistant Professor of Clinical Obstetrics and Gynecology at the University of Illinois, Chicago, Illinois. She also serves as the Director of Minimally Invasive Gynecology.

Richard J. Gimpelson, M.D., FACOG is Co-Director of Minimally Invasive Gynecology at Mercy Hospital in St. Louis, Missouri. He is also a past president of the AAGL and a past president of St. Louis Metropolitan Medical Society.
Bringing Surgical Procedures Into the Office

This course provides a basic introduction to the creation of an office-based surgical practice with an emphasis on guidelines for patient safety and regulatory issues, recommendations for transitioning from the hospital or ambulatory surgery center to the office, and examples of appropriate procedures to be considered for performance in an office setting.

The AAGL designates this live activity for a maximum of 1.0 Hour AMA PRA Category 1 Credit(s)TM.

Learning Objectives

• List patient co-morbidities that are contraindications to office surgery.
• List qualities of surgical procedures that make them appropriate for the office setting.
• List the Levels of Office-Based Surgery.
• List important features of an office-based surgical practice to promote patient safety.
• Describe the types of documentation necessary to maintain an office-based surgical practice.
• List the various agencies and associations that have published guidelines concerning office-based surgery.

www.aagl.org/onlinecourses
Learning Objectives

• List the various agencies and associations that have published guidelines concerning office-based surgery to promote patient safety.

• List important features of an office-based surgical practice to maintain an office setting.

• List the Levels of Office-Based Surgery.

• List qualities of surgical procedures that make them appropriate for the office setting.

• List patient co-morbidities that are contraindications to office surgery.

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September 19, 2012 – November 30, 2012

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The ways in which our Key Partners support the mission of the AAGL include:

- Committing year round support through our Corporate Sponsorship program.
- Funding our fellowship sites.
- Giving unrestricted educational grants to enhance our programs.
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- Advertising in *The Journal of Minimally Invasive Gynecology*, the official journal of the AAGL and ordering reprints of articles to disseminate to physicians.

The support from our Key Partners is in accordance with the Accreditation Council for Continuing Medical Education guidelines for commercial support.

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($150,000-$300,000)

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- HALI MEDICAL
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Education Calendar

The following educational meetings are sponsored by or endorsed by the AAGL.

February 14-16, 2013
Mayo Clinic Robotics Conference in Gynecology
Scientific Program Chair: Javier F. Magrina
Scottsdale Fairmont Princess
Scottsdale, Arizona

March 23-24, 2013
22nd Annual Comprehensive Workshop on Minimally Invasive Gynecology for Residents, Fellows and Specialists
Scientific Program Chair: Jon Ivar Einarsson
Hyatt Regency O’Hare
Rosemont, Illinois

May 17-18, 2013
15th Annual Advanced Workshop on Gynecologic Laparoscopic Anatomy & Minimally Invasive Surgery
Scientific Program Chair: Resad P. Pasic
University of Louisville
Louisville, Kentucky

November 10-14, 2013
42nd AAGL Global Congress on Minimally Invasive Gynecology
Scientific Program Chair: Ceana H. Nezhat
Gaylord National Resort & Convention Center on the Potomac
Washington, D.C.

November 17-21, 2014
43rd AAGL Global Congress on Minimally Invasive Gynecology
Scientific Program Chair: Arnold P. Advincula
Vancouver Convention Centre
Vancouver, British Columbia

April 9-13, 2013
9th AAGL International Congress on Minimally Invasive Gynecology in partnership with the South African Society of Reproductive Medicine and Gynaecological Endoscopy
Scientific Program Chair: Professor Thinus Kruger
Cape Town, South Africa

June 4-7, 2014
10th AAGL International Congress on Minimally Invasive Gynecology in partnership with the Spanish Gynaecological and Obstetrics Society (Gynaecological Endoscopy Section)
Scientific Program Chair: Francisco Carmona Herrera
Barcelona, Spain