General Session II:
Presentation of Award Winning Abstracts & Videos

DISCUSSANTS
Amy L. Garcia, MD  Gerald J. Harkins, MD
Keith B. Isaacson, MD  S. Sony Singh, MD
M. Jonathon Solnik, MD

PRESENTERS
Julia K. Troncon, MD  Christina I. Ramirez, MD
Marie E. Shockley, MD  Maria V. Vargas, MD
Benjamin D. Beran, MD
General Session II:  
Presentation of Award-Winning Abstracts & Videos

Faculty: Benjamin D. Beran, Christina I. Ramirez, Marie E. Shockley, Julia K. Troncon, Maria V. Vargas

Discussants: Amy L. Garcia, Gerald J. Harkins, Keith B. Isaacson, S. Sony Singh, M. Jonathon Solnik

Course Outline

7:45 Analysis of the Differential Genetic Expression Between Symptomatic and Asymptomatic Endometrial Polyps  
J.K. Troncon, A.L. Garcia
7:55 Questions & Answers
8:00 Laparoscopic Management of Cesarean Scar Ectopic Pregnancy  
C.I. Ramirez, M.J. Solnik
8:10 Questions & Answers
8:15 The Sterility of Selected Operative Sites During Total Laparoscopic Hysterectomy  
M.E. Shockley, G.J. Harkins
8:25 Questions & Answers
8:30 Proficiency Based Robotics Training Curriculum for Suturing Tasks: Transferability of Skills to a Live Porcine Model  
M.V. Vargas, S.S. Singh
8:40 Questions & Answers
8:45 Laser Angiography with Indocyanine Green (ICG) to Assess Vaginal Cuff Perfusion During Total Laparoscopic Hysterectomy (TLH): A Pilot Study  
B.D. Beran, K.B. Isaacson
8:55 Questions & Answers
9:00 Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Amber Bradshaw
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Consultant: Olympus
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Contracted Research: Gynesonics
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Suketu Mansuria
Speakers Bureau: Covidien
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FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
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Consultant: Karl Storz
Christina I. Ramirez
Marie E. Shockley*
S. Sony Singh  
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M. Jonathon Solnik  
Consultant: Medtronic  
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Maria V. Vargas*  
Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Analysis of the Differential Genetic Expression between Symptomatic and Asymptomatic Endometrial Polyps

Júlia Kefalás Troncon, M.D.
MSc Student in Obstetrics and Gynecology,
Assistant Physician - Department of Obstetrics and Gynecology, Faculty of Medicine of Ribeirão Preto, University of São Paulo - USP, Ribeirão Preto (SP), Brazil

I have no financial relationships to disclose.

OBJECTIVES

• Discuss the association between endometrial polyps and endometrial cancer
• Evaluate if there is benefit in performing hysteroscopic polypectomy in asymptomatic postmenopausal patients

BACKGROUND

• PATHOGENESIS OF ENDOMETRIAL POLYPS
  - Differential hormonal receptor expression favouring hyperestrogenism
  - Unbalance between cellular proliferation and apoptosis favouring tissue growth

  Association with type I endometrial cancer?

• RISK FACTORS FOR MALIGNANCY
  - Age (> 60 years)
  - Menopausal status
  - Polyp size (> 15mm)
  - Postmenopausal bleeding

  Around 3.5% prevalence of endometrial hyperplasia and cancer

METHODS

• Cross-sectional study
• Tertiary referral hospital
• Postmenopausal patients undergoing hysteroscopic polypectomy
  - 39 symptomatic
  - 21 asymptomatic
• Exclusion: use of hormonal therapy or tamoxifen
• Signed informed consent
METHODS

- Sample of tissue from the extracted polyp
- DNA extraction and PCR (Polymerase Chain Reaction)
- Analysis of the differential genic expression: genes involved in endometrial carcinogenesis

GENES EVALUATED

- **PTEN**
  Tumor-suppressor gene (favors apoptosis)
- **MLH-1**
  Mismatch repair system (Microsatellite instability)
- **CTNNB1**
  Beta-catenin protein (WNT pathway of cellular differentiation)
- **BCL-2**
  Inhibits apoptosis

RESULTS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>N. Obs.</th>
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<th>Minimum</th>
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<td>21</td>
<td>2.55</td>
<td>1.5</td>
<td>4.6</td>
<td>0.86</td>
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DISCUSSION

- Lack of evidence establishing if endometrial polyps are in fact cancer precursors – **DETECTION BIAS**
- It cannot be determined if the bleeding was truly originated from the polyp – **LESS THAN 1% OF CANCERS CONFINED TO THE POLYP**
- **EPIDEMIOLOGICAL ASSOCIATION?**

CONCLUSIONS

- Evaluate the uterine cavity in its entirety
- Offer polypectomy in symptomatic patients whenever possible
- Individualize the conduct in asymptomatic polyps / Patient’s desire
- Further studies needed – are polyps only markers of endometrial disease and not cancer precursors?

REFERENCES

Laparoscopic Management of Cesarean Scar Ectopic Pregnancy

Presenter: Christina I. Ramirez, MD  
Magee-Womens Hospital of UPMC, Pittsburgh, Pennsylvania

Objective: To show how a cesarean scar ectopic pregnancy can be safely managed with laparoscopic resection.

Design: Stepwise demonstration of the technique with narrated video footage.

Setting: Cesarean scar pregnancies are a rare form of ectopic pregnancy with an estimated incidence of 1 in 2000 pregnancies. In these ectopic pregnancies, the overlying myometrial wall is weakened due to fibrous scar tissue which increases the risk of uterine rupture and hemorrhage. In this patient, medical management with 7 doses of systemic Methotrexate followed by intragestational injection of potassium chloride was unsuccessful. Using advanced laparoscopic techniques, the cesarean scar pregnancy was safely excised laparoscopically at 14 weeks while preserving the patient’s fertility.

Interventions: Laparoscopic approach to a cesarean scar ectopic pregnancy with several key strategies to minimize blood loss, lyse dense bladder adhesions and reconstruct the anterior uterine wall:

1. Development of the retroperitoneal space with temporary uterine artery ligation.
2. Temporary ligation of bilateral infundibulopelvic ligaments.
3. Injection of Vasopressin at the junction between the uterus and gestational sac.
5. Inflation of a Foley catheter within the uterus during anterior uterine wall reconstruction for orientation and to prevent incorporation of the posterior uterine wall.

Conclusion: Although cesarean scar ectopic pregnancies can be managed medically or surgically, the optimal treatment strategy is still unknown due to the rarity of the condition. In patients who desire fertility conservation, laparoscopic resection can be performed safely and effectively in the hands of a skilled laparoscopic surgeon. Here we demonstrated several techniques to successfully excise a cesarean scar ectopic pregnancy while minimizing intraoperative blood loss.
The Sterility of Selected Operative Sites During Total Laparoscopic Hysterectomy

Marie E. Shockley, M.D.
Fellow in Minimally Invasive Gynecologic Surgery
Cleveland Clinic Florida

Disclosure
- I have no financial relationships to disclose

Objectives
- Discuss the incidence of surgical site infection (SSI) in gynecologic laparoscopy
- Describe the types of bacteria found on various surfaces encountered during total laparoscopic hysterectomy (TLH)
- Prioritize when to perform intraoperative sterile attire changes

Background
- No RCTs
- Safety of TLH requires freedom of movement between the abdominal and perineovaginal fields
- Incidence of SSI following TLH is 1.0 – 2.7%3,4
- Cultures from infected hysterectomy patients demonstrate polymicrobial growth of the patient’s own vaginal flora4
- No established guidelines for preparation of concomitant abdominal and perineovaginal surgical fields4
- Tradition has dictated that the perineum and vagina are contaminated, and the abdomen is clean3,4

Methods
- IRB approval
- 31 women undergoing TLH for benign indications
- Exclusions
  - Bacterial vaginosis
  - Pre-existing cellulitis
  - Uterine size precluding vaginal extraction
- 100% received perioperative antibiotic prophylaxis
- Separate perineovaginal preparation and abdominal preparation with 4% chlorhexidine gluconate

Subject: Sterile field requirements for laparoscopic hysterectomy (NEW QUESTION)
I am having discussions with my OR team regarding best practices for laparoscopic hysterectomy.
I have read several articles in the past on whether or not it is necessary to change gloves, drapes, and reprep the patient when going from below to above. I would appreciate some references to cite for any randomized controlled trials to look at this, what the best evidence is and recommendations others have in their institutions.

- Richard P. Marvel MD
Collection of swab from:
1. Vaginal fornices
2. Abdomen

Preparation of abdominal and perineovaginal surgical fields

Collection of swab from:
1. Vaginal fornices
2. Abdomen

Draping of patient

Placement of uterine manipulator and Foley catheter

Collection of swab from:
1. Vaginal fornices
2. Abdomen

Laparoscopic closure of the vaginal cuff

Collection of swabs from:
1. Vaginal fornices
2. Abdomen

Total laparoscopic hysterectomy with transvaginal extraction of specimen(s)

Collection of swab from:
1. Vaginal fornices
2. Abdomen

Placement of uterine manipulator and Foley catheter

Draping of patient

Collection of swabs from:
1. Vaginal fornices
2. Abdomen

Methods

Anaerobic Agars
Brucella blood
Phenylethyl alcohol
Kanamycin vancomycin
Bacteroides bile esculin

Aerobic Agars
5% Sheep blood
Chocolate

Negative Cultures:
No bacterial growth

Contamination:
≥ 5,000 Colony Forming Units (CFU)/ml

Results

VAGINAL FUNDUS

Bacterial growth in positive swabs by species

<table>
<thead>
<tr>
<th>Anaerobic pathogens</th>
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</thead>
<tbody>
<tr>
<td>Aerobic pathogens</td>
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</table>

Number of samples with positive growth: 0

Number of samples with growth ≥ 5000 CFU/mL: 0

ABDOMEN

Bacterial growth in positive swabs by species

<table>
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<th>Anaerobic pathogens</th>
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<td>Aerobic pathogens</td>
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</table>

Number of samples with positive growth: 3

Number of samples with growth ≥ 5000 CFU/mL: 0

Results

SURGEON’S GLOVES FOLLOWING UTERINE MANIPULATOR PLACEMENT

Bacterial growth in positive swabs by species

<table>
<thead>
<tr>
<th>Anaerobic pathogens</th>
<th>Peptostreptococcus</th>
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<tr>
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<td>2/31 (6%)</td>
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<tr>
<th>Aerobic pathogens</th>
<th>λ- Hemolytic streptococci</th>
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<tbody>
<tr>
<td></td>
<td>1/31 (3%)</td>
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Number of samples with positive growth: 3

Number of samples with growth ≥ 5000 CFU/mL: 0

Results

SURGEON’S GLOVES FOLLOWING TRANSVAGINAL EXTRACTION OF SPECIMEN

Bacterial growth in positive swabs by species

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<th>Anaerobic pathogens</th>
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<table>
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<th>Aerobic pathogens</th>
<th>E. coli</th>
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<tbody>
<tr>
<td></td>
<td>1/31 (3%)</td>
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</tbody>
</table>

Number of samples with positive growth: 10

Number of samples with growth ≥ 5000 CFU/mL: 1

Highest absolute growth from any single sample: 8900 CFU/mL

Results

UTERINE FUNDUS AFTER HYSTERECTOMY

Bacterial growth in positive swabs by species

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<thead>
<tr>
<th>Anaerobic pathogens</th>
<th>Peptostreptococcus</th>
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<th>Aerobic pathogens</th>
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<td>2/31 (6%)</td>
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Number of samples with positive growth: 12

Number of samples with growth ≥ 5000 CFU/mL: 1
Results

<table>
<thead>
<tr>
<th>Type of Instrument Used</th>
<th>Bacterial Growth at Positive Sites by Species</th>
<th>Number of Samples with Growth ≥ 3500 CFU</th>
<th>Number of Samples with Growth &lt; 3500 CFU</th>
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<tbody>
<tr>
<td>Anaerobic pathogens</td>
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</tr>
<tr>
<td>Aerobic pathogens</td>
<td></td>
<td>0</td>
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<tr>
<td>Lactobacillus acidophilus</td>
<td>100 (3%)</td>
<td>22 (0%)</td>
<td>20 (20%)</td>
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<tr>
<td>Listeria monocytogenes</td>
<td>100 (3%)</td>
<td>2 (0%)</td>
<td>0</td>
</tr>
<tr>
<td>Staphylococcus epidermidis</td>
<td>100 (3%)</td>
<td>4 (0%)</td>
<td>0</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td>100 (3%)</td>
<td>1 (0%)</td>
<td>0</td>
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<tr>
<td>Enterococcus faecalis</td>
<td>100 (3%)</td>
<td>1 (0%)</td>
<td>0</td>
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<tr>
<td>E. coli</td>
<td>100 (3%)</td>
<td>1 (0%)</td>
<td>0</td>
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<tr>
<td>Number of samples with positive growth: 4</td>
<td>Number of samples with growth ≥ 3500 CFU: 0</td>
<td>Number of samples with growth &lt; 3500 CFU: 250</td>
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Bacterial growth in 98.9% of samples was below the infection threshold. No surgical site infections were diagnosed over a follow up period of 6 weeks.

Discussion

- Multiple species of aerobic and anaerobic bacteria can be cultured from selected sites encountered when performing TLH.
- Intraoperative bacterial counts during TLH are below the threshold which causes surgical site infection.
- Prioritize changing gloves following transvaginal extraction of specimen(s).

Conclusions

- 4% Chlorhexidine is an adequate preparation of the vaginal and abdominal fields prior to performance of TLH.
- Further studies are needed before approaching the perineal and abdominal fields as one.

References


Acknowledgements

- Benjamin Beran, M.D.
- Katrin Arnolds, M.D.
- Heather Nutting, M(ASCP)
- Michael L. Sprague, M.D.
- Stephen Zimberg, M.D.
Laparoscopic Management of Cesarean Scar Ectopic Pregnancy

Christina I. Ramirez, MD
Magee-Womens Hospital of UPMC, Pittsburgh, Pennsylvania

**Objective:** To show how a cesarean scar ectopic pregnancy can be safely managed with laparoscopic resection.

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**Conclusion:** Although cesarean scar ectopic pregnancies can be managed medically or surgically, the optimal treatment strategy is still unknown due to the rarity of the condition. In patients who desire fertility conservation, laparoscopic resection can be performed safely and effectively in the hands of a skilled laparoscopic surgeon. Here we demonstrated several techniques to successfully excise a cesarean scar ectopic pregnancy while minimizing intraoperative blood loss.
Proficiency Based Robotics Training Curriculum for Suturing Tasks: Transferability of Skills to a Live Porcine Model

Presenter: Maria V. Vargas, MD
Division of Gynecology, George Washington University Medical Faculty Associates, Washington, DC, 20037

Objectives

- Define proficiency based training
- Explain the impact of proficiency based training on the performance of live suturing tasks
- Identify gaps in available literature on the transfer of skills from virtual reality simulation to operative performance

Background

- Virtual reality simulation is a cost-effective approach for developing basic robotic surgical skills
- The daVinci Skills Simulator has been studied and validated
- Proficiency based curriculums are the standard
- Limited data about the transfer of skills from virtual reality simulation to the operating room environment

Objective

- To assess whether a proficiency-based simulation program improved the performance of novice surgeons on a suturing task using a live porcine model

Methods

- Design: Single-blind randomized controlled trial
- Participants: Medical students naïve to robotic surgery
- Intervention: Proficiency-based curriculum
  - Camara clutching 1
  - Suture sponge 1
  - Suture sponge 2
  - Tubes

Disclosures

I have no financial relationships to disclose.
Methods

• Final assessment: Blinded video review of cystotomy closure on a live porcine model
• Primary outcomes:
  – Global Evaluative Assessment of Robotic Skills score
  – Time to complete the task
• Sample size: 20 per group
  – 90% power to detect
    • 3 point difference
    • 3 min difference

Results

• No baseline differences in participants
• Intervention group:
  – Median total training time on the dvSS was 116 min (range 53-209 min)
  – Ten out of the 19 participants achieved proficiency in all of the four exercises

Conclusions

• In this study, a proficiency-based simulation curriculum on the dvSS did not improve performance of a cystotomy closure task on a live porcine model when compared to standard orientation to the robotic console.

Weaknesses:
  – Non-standardized selection of exercises
  – Proficiency not defined for virtual reality simulation

Strengths
  – Randomized controlled design with the use of blinded assessments and a validated assessment tool
  – First RCT to evaluate the effect of training with the dvSS on live performance
References


References continued


Acknowledgements

Gaby N. Moawad, MD1 - Co-investigator
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Samantha Margules, MD – Co-investigator
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Chertzi G. Mertor, MD – Principal Investigator
Jessica Oltino-Arena, MD – Co-investigator
Naya Misa – Co-investigator
Xian Li – Director of the Washington Institute of Surgical Education
Jenna Ebert – Research Coordinator

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Washington University, Washington, DC, 20037
3 Milken Institute of Public Health, George Washington
University, Washington, DC, 20052

School of Medicine
& Health Sciences
Laser Angiography with Indocyanine Green to Assess Vaginal Cuff Perfusion During Total Laparoscopic Hysterectomy: A Pilot Study

Benjamin D. Beran, M.D.
Fellow in Minimally Invasive Gynecologic Surgery
Cleveland Clinic Florida

Objectives

- Describe role of laser angiography in evaluating vaginal cuff perfusion following total laparoscopic hysterectomy
- Develop novel applications of existing advanced technologies for gynecologic surgery

Vaginal Cuff Dehiscence

- Risk factors:
  - Increased age
  - Vaginal atrophy
  - Poor wound healing
  - Valsalva
  - Post-operative cuff infection or hematoma

Vaginal Cuff Dehiscence

- Incidence varies by approach:
  - Robotic: 1.64%
  - Laparoscopic: 0.61%
  - Vaginal: 0.18%
- Possible association with laparoscopic approach for vaginal cuff closure?

Disclosures

- I have no financial relationships to disclose.

Laser Angiography

- Intravenous indocyanine green (ICG)
  - Binds plasma protein
  - Detection represents perfusion
  - Peak spectral absorption at 800nm
**Study Design**

- Feasibility trial with IRB approval
- To assess vaginal cuff perfusion
  - After colpotomy (pre-closure)
  - After cuff closure
- Women (20) undergoing TLH
  - Benign indications
  - No documented iodine allergy

**Randomization**

- TLH (n=20)
- Ultrasonic (n=10)
  - Barbed suture (n=5)
  - Non-barbed suture (n=5)
- Monopolar (50 watts cut) (n=10)
  - Barbed suture (n=5)
  - Non-barbed suture (n=5)

**Methods**

- Allocation and TLH per routine
- Colpotomy
- Pre-Cuff Closure
- Close vaginal cuff
- Post-Cuff Closure

**Results**

- Mean time to ICG appearance
  - 22.8 seconds
- Initial dose
  - 2.5 mg: 25% needed additional dose
  - 5 mg: 0% needed additional dose
Results

• No difference in perfusion detected
  - Energy
    • Ultrasonic: 67.5%
    • Monopolar: 59.1%
  - Suture
    • Barbed: 71.5%
    • Non-barbed: 68.9%

Conclusions

• ICG fluorescence is reliably present at vaginal cuff
• ICG 2.5 mg dose sufficient for most patients
• Colpotomy method and suture material had no measurable difference on cuff perfusion

• Future studies
  - Develop quantifiable fluorescence technique
  - Further analysis of instrument activation time effect on tissue

References


Acknowledgements

• Marie Shockley, M.D.
• Katrin Arnolds, M.D.
• Pedro Escobar, M.D.
• Stephen Zimberg, M.D.
• Michael L. Sprague, M.D.
• Novadaq: Equipment grant
Cultural and Linguistic Competency

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.