Plenary 8: Research & Science

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Laura R. Matthews, MD

Patricia J. Mattingly, MD
Mireille D. Truong, MD
Target Audience
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# Table of Contents

Course Description .................................................................................................................. 1

Disclosure .................................................................................................................................. 3

Improving Cognitive Surgical Knowledge in Ob/Gyn Residents Using an Interactive Computer-Based Laparoscopic Hysterectomy Trainer  
A.S. Lichtman .......................................................................................................................... 5

Evaluation of MRI Fibroid Reporting  
R. Alammari .......................................................................................................................... 9

Trends in Gynecologic Surgery Malpractice Claims Involving Major Patient Injury,  
2010-2014  
L.R. Matthews ....................................................................................................................... 12

Postoperative Pain Management in Benign Laparoscopic Gynecologic Surgery:  
A Systematic Review  
E. Blanton .................................................................................................................................. 15

Simulator-Based Multi-Modal Task Decomposition of Robotic Surgical Technique  
for Vaginal Cuff Closure  
P.J. Mattingly .......................................................................................................................... 18

Why Did Current Fellows Choose a Fellowship in Minimally Invasive Gynecology? A Qualitative Evaluation  
A. Dave ....................................................................................................................................... 21

Meta-Analysis and Systematic Review to Determine the Optimum Imaging Modality  
for the Detection of Posterior Vaginal Fornix Deep Infiltrative Endometriosis  
B. Gerges .................................................................................................................................... 24

Video: Tissue Extraction: A Simulation Model and Technical Pearls  
M.D. Truong ............................................................................................................................... 27

Video: Teaching Vaginal Hysterectomy Using Vaginal Hysterectomy Task Trainer  
D. Malacarne ............................................................................................................................... 28

Cultural and Linguistics Competency ...................................................................................... 29
Plenary 8: Research & Science

Moderator: Douglas Miyazaki
Co-Moderator: Mark B. Woodland

Discussants: Isabel C. Green, Mary Brigid Holloran-Schwartz, John P. Lenihan, Deirdre Lum, Suketu Mansuria, Neeraj Mehra, Douglas Miyazaki, Noah Rindos

Faculty: Roa Alammari, Emily Blanton, Arpit Dave, Bassem Gerges, Allan S. Lichtman, Dominique Malacarne, Laura R. Matthews, Patricia J. Mattingly, Mireille D. Truong

This session reviews studies relating to pre-operative evaluation of fibroids, computer-based endoscopic training, vaginal hysterectomy, post-operative pain management, and the evaluation of surgical malpractice cases.

Learning Objectives: At the conclusion of this course, the participant will be able to: 1) Describe how to enhance endoscopy instruction for residents and fellows using computer-based trainers; and 2) discuss the current trends in gynecologic surgery malpractice cases.

Course Outline

3:25  Improving Cognitive Surgical Knowledge in Ob/Gyn Residents Using an Interactive Computer-Based Laparoscopic Hysterectomy Trainer  A.S. Lichtman
3:31  Discussant  I.C. Green
3:35  Evaluation of MRI Fibroid Reporting  R. Alammari
3:41  Discussant  M.B. Holloran-Schwartz
3:45  Trends in Gynecologic Surgery Malpractice Claims Involving Major Patient Injury, 2010-2014  L.R. Matthews
3:51  Discussant  D. Lum
4:01  Discussant  N. Rindos
4:05  Simulator-Based Multi-Modal Task Decomposition of Robotic Surgical Technique for Vaginal Cuff Closure  P.J. Mattingly
4:11  Discussant  N. Rindos
4:15  Why Did Current Fellows Choose a Fellowship in Minimally Invasive Gynecology? A Qualitative Evaluation  A. Dave
4:21  Discussant  S. Mansuria
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<tr>
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<td>N. Mehra</td>
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<td>Video: Tissue Extraction: A Simulation Model and Technical Pearls</td>
<td>M.D. Truong</td>
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<td>Discussant</td>
<td>D. Miyazaki</td>
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<td>4:55</td>
<td>Questions &amp; Answers</td>
<td>All Faculty</td>
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<td>5:05</td>
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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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Contracted Research: Gynesonics
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Stock Ownership: Titan Medical
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Patricia J. Mattingly*
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Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Improving Cognitive Surgical Knowledge In OB/GYN Residents Using an Interactive Computer-Based Laparoscopic Hysterectomy Trainer

Allan S. Lichtman, MD
Adjunct Clinical Professor
Department of Obstetrics & Gynecology
Keck School of Medicine
University of Southern California
Los Angeles, California

November 17, 2016
AAGL Global Congress
Orlando, Florida, USA

Disclosures
I have no financial relationships to disclose.

Objectives
• Differentiate the component skills of a surgical procedure
• Describe a tool designed to assess cognitive knowledge of performing a Laparoscopic Hysterectomy
• Evaluate the use of a Laparoscopic Hysterectomy Trainer in the education of a novice gynecologic surgeon

Consequences of Altered Educational Environment
• Increased Preventable Medical Errors 3,4,5,6
• Increased Complication Rates of Novice Residents 7,8
• Increased Costs of Residents in Operating Room 9,10,11
• Reduced knowledge of Open Procedures 12, 13, 14, 15

Components of Surgical Training 18
• Technical Skills = 25%
  Gentle Grasp without tearing
  Moving structures appropriately
  Meticulous dissection
• Cognitive Skills = 75%
  Comprehend: anatomy – pathology
  Errors and complications
  Planning: What do I do first, second, etc?
  Total teamwork – assistant, nursing, anesthesia

Abdominal Hysterectomy
Operative Hysteroscopy
Technical Skills Tools

1999 – 2011: Elegant and successful for “Out of OR” dexterity

**BUT ARE NOT SUFFICIENT AS COGNITIVE TOOLS**

Additional Innovative Cognitive Tools Are Required In Our Current Learning Environment

---

Methods: Study Design

- Three phased, multi-center, prospective, randomized, controlled study.
- Evaluate cognitive surgical knowledge of PGY1 Obstetrics & Gynecology residents before and after using the Laparoscopic Hysterectomy Trainer – Simpraxis© (LHT)
- Compare with controls not exposed to the trainer

**Participating Schools of Medicine**

University of Southern California,
University of California- Los Angeles,
University of Washington,
University of British Columbia,
University of Toronto

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Methods: phase 1

- Create two equivalent on-line knowledge tests using a modified Delphi Technique.
- Pilot tests at 2013 AAGL Global Congress
- Various Question types:
  - Multiple choice
  - Interactive hi-fidelity video
  - Fill in the blank
  - Matching

---

Methods: phase 2

- Participants (n=60):
  - PGY 3 and 4 Residents, Fellows, General Gyn Faculty, Minimally Invasive Surgeons (MIS)
- All take Test A and Test B - using crossover design
- Tests assessed for:
  - Reliability
  - Order Impact
  - Internal Consistency
  - Construct Validity
Results: phase 2

1. Are Test A and Test B different?
   • Mean score Test A 390.7 and test B 383.8
   • No significant difference between A and B (p=0.191)
   • ICC of 0.56 and Pearson correlation of 0.59 indicate fair reliability

2. Does order in which test is taken have a statistical effect?
   • No observed difference between test ordering. t-test (p = 0.347)

3. Is there internal consistency between tests?
   • Cronbach’s Alpha between Test A and B = 0.72, acceptable.

Results: phase 2

4. Does test A contain construct validity?

Level of training is highly significant in a one way ANOVA, p<0.001 demonstrating construct validity.

Results: phase 3

Methods: phase 3

Validation of the LHT

PGY1 Take Pre-Test
n = 61

100%-500 points

Site Specific Traditional Resident Curricula

Laparoscopic Hysterectomy Trainer

Control (C) n = 31

100%=

Intervention (I) n = 30

Within three months All PGY 1 Take Post Test

Summary

• The Interactive Hysterectomy Trainer can be used to “Pre-Train”
  PGY 1 novice surgeons PRIOR to being in the operating room,
  enabling them to be better learners during their OR exposures.

• The LHT should be considered for incorporation into a comprehensive gynecologic surgical training curriculum:
  • to help standardize the training for Laparoscopic Hysterectomy,
  • to assure that the novice surgeon has mastered the required pelvic anatomy, enhancing training for many of the other standard gynecologic surgeries.

Conclusions

1. Use of the computer based LHT significantly improves PGY 1 residents’ cognitive surgical knowledge of the Laparoscopic Hysterectomy procedure.

2. Two consistent, reliable and valid on-line tests have been developed that can be utilized independently to assess cognitive surgical knowledge of the Laparoscopic Hysterectomy procedure.
References


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Hendrik WR Schreuder, MD, PhD - Associate Professor, Division Women & Baby, Department of Reproductive Medicine & Gynecology, UMUC Cancer Center, Department of Gynecologic Oncology, University Medical Center Utrecht, Netherlands.
Evaluation of MRI Fibroid Reporting

Presenter: Roa Alammari, MD
Beth Israel Deaconess Medical Center
Division of Minimally Invasive Gynecology

Objectives

• To survey provider satisfaction with current MRI reporting of uterine fibroids

• To evaluate what fibroid information providers deem relevant for MRI reports

• Propose a new clinical system for MRI fibroid reporting

Methods

• Survey
  • Provider Demographics
  • Satisfaction with current reporting
  • Information valued by providers in reports
  • FIGO fibroid classification vs. new clinically modified classification system

• Subjects:
  • Obstetrician-Gynecologists and radiologists:
    • Fibroid reporters
    • Fibroid providers

FIGO Classification

<table>
<thead>
<tr>
<th>Submucosal</th>
<th>Pedunculated intracavitary</th>
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</tr>
<tr>
<td>0a</td>
<td>Pedunculated submucosal = entirely cavitary with stalk attachment</td>
</tr>
<tr>
<td>0b</td>
<td>100% Submucosal = entirely cavitary with broad base attachment</td>
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<table>
<thead>
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<td>7a</td>
<td>Pedunculated subserosal = entirely exophytic with stalk attachment</td>
</tr>
<tr>
<td>7b</td>
<td>100% Subserosal = entirely exophytic with broad base attachment</td>
</tr>
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</table>

Clinical Classification

Disclosures

I have no financial relationships to disclose.
Response rate, 94/136 (68%)

Gynecologists, 75/133 (66%)  
Radiologists, 18/23 (78%)

Reporters 22/75 (29%)  
Providers 50/75 (67%)

Reporters 10/18 (56%)  
Providers 8/18 (44%)

No response 3/75 (4%)

Satisfaction with current reporting

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Fibroid Reporters (n=32)</th>
<th>Fibroid Providers (n=58)</th>
<th>Radiology (n=18)</th>
<th>OB/GYN (n=75)</th>
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<tbody>
<tr>
<td>Satisfied</td>
<td>17 (53%)</td>
<td>22 (38%)</td>
<td>12 (67%)</td>
<td>28 (33%)</td>
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<tr>
<td>Neutral</td>
<td>7 (22%)</td>
<td>22 (38%)</td>
<td>3 (17%)</td>
<td>26 (35%)</td>
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<tr>
<td>Dissatisfied</td>
<td>1 (3%)</td>
<td>5 (9%)</td>
<td>1 (5%)</td>
<td>5 (7%)</td>
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<tr>
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<td>7 (22%)</td>
<td>9 (15%)</td>
<td>2 (12%)</td>
<td>16 (21%)</td>
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P value

More agreement between OB/GYN specialists and Radiology fibroid providers

Information valued on reports

<table>
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<th>Information</th>
<th>Radiology (n=18)</th>
<th>OB/GYN (n=75)</th>
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</thead>
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<tr>
<td>Fibroid vascularity important</td>
<td>15 (100%)</td>
<td>50 (67%)</td>
<td>0.0006</td>
</tr>
<tr>
<td>JZ, myometrium important</td>
<td>15 (83%)</td>
<td>53 (71%)</td>
<td>0.003</td>
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<tr>
<td>Fibroid number important</td>
<td>13 (72%)</td>
<td>70 (90%)</td>
<td>0.03</td>
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<tr>
<td>Fibroid type important</td>
<td>13 (72%)</td>
<td>71 (96%)</td>
<td>0.006</td>
</tr>
<tr>
<td>Proximity to serosa important</td>
<td>10 (55%)</td>
<td>60 (80%)</td>
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</table>

More agreement between gynecologists and radiologists who identify themselves as fibroid providers about what information is important to report

Structured fibroid MRI reporting can enhance communication between radiologists and gynecologists and facilitate surgical planning which can improve patient outcomes

Conclusions

• More radiologists (67%) are satisfied with the current MRI fibroid reporting compared to gynecologists (37%)

• More agreement between gynecologists and radiologists who identify themselves as fibroid providers about what information is important to report

FIGO vs Clinical

<table>
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<th>FIGO</th>
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<tr>
<td>FIGO</td>
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<td>3 (34%)</td>
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<td>18 (28%)</td>
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<td>2 (20%)</td>
<td>1 (5%)</td>
<td>1 (13%)</td>
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Next Steps

• Post-implementation survey

• Subjective and objective evaluation of newly implemented fibroid reporting system.

Acknowledgements

Olga Brooks, MD, Dayna Neo, MPH, Hope Ricciotti, MD, Hye-Chun Hur, MD, MPH
Trends in Gynecologic Surgery Malpractice Claims Involving Major Patient Injury, 2005-2014

Presenter: Laura Matthews, MD, MIGS fellow
Northwestern University Feinberg School of Medicine

Objectives
1) Identify the proportion of gynecologic surgeons affected by malpractice litigation
2) Characterize recent trends in gynecologic surgery malpractice claims
3) Compare these trends with those of other specialties

Introduction
• 74% of physicians practicing obstetrics and gynecology will face a malpractice claim by the age of 45
• “Major patient injury” is the most frequent primary allegation in gynecologic claims
• Salient factors in successful surgical claims
  – Failure to obtain appropriate consent
  – Inappropriate delegation of procedures
  – Failure of communication with patients

Malpractice Claims in Gynecologic Surgery

Methods
PIAA Database Search
• PIAA database search:
  – 2005 to 2014
  – Data from 20 insurance carriers, anonymized format
  – Focus: medical and professional liability trends across subspecialties
  – ICD-9 codes and unique PIAA codes
• 10,915 closed claims in obstetrics and gynecology surgery retrieved
  – Causation, outcomes, expenses, and method of resolution for specialty and specific procedures
  – Other subspecialty claims data reviewed for comparison

Disclosures
I have no financial relationships to disclose.
Closed Claims in Obstetrics and Gynecology, 2005 - 2014

- 10,915 closed OB/GYN claims
- 31.1% paid
- $423,250 (average)

Average indemnity:
- 27% higher than for other specialties
- 5th highest paid-to-closed ratio

Medical factors in Gynecologic Surgery Claims, 2010 – 2014

Closed Claims

- Improper performance 40%
- Error in diagnosis 30%
- No medical misadventure 18%
- Procedure not performed 7%
- Failure to supervise 7%
- Delay in performance 6%
- Foreign body 4%
- Procedure not performed 3%
- No medical misadventure 3%
- Medication errors 3%
- Error in diagnosis 2%
- Improper performance 2%

Paid Claims

- Improper performance 45%
- Error in diagnosis 13%
- Failure to supervise 9%
- Delay in performance 8%
- Foreign body 5%
- Procedure not performed 4%
- No medical misadventure 2%
- Medication errors 2%

Gynecologic Claims and Intraoperative Complications 2005 - 2014

- Injury to Pelvic Organs: 174 total closed claims, 40.8% paid, $240,876 (average)
- Injury to Gastrointestinal Tract: 36 total closed claims, 36.1% paid, $328,883 (average)

Conclusions

- Gynecologic litigation claims have higher average indemnity payments than other medical subspecialties
- Litigation claims most frequently result from preventable intraoperative factors
- Using this data, gynecologic surgeons have an opportunity to prepare future gynecologic surgeons for these claims as well as improve quality care
References


Acknowledgements

Farah Alvi, MD, MS
Magdy Milad, MD, MS
Postoperative Pain Management in Benign Laparoscopic Gynecologic Surgery: A Systematic Review

Presenter: Emily Blanton, MD*
Florida Hospital
†Orlando Veterans Medical Center

DISCLOSURES

I have no financial relationships to disclose.

OBJECTIVES

At the conclusion of this presentation the audience will be able to:

- Critically appraise current practices for managing postoperative pain in context of published evidence-based research
- Identify areas where critical gyn-specific research is lacking

INTRODUCTION

- ~ 400,000 hysterectomies annually in US, 16% laparoscopic / robotic1
- 74% postsurgical patients moderate to extreme pain after discharge2
- 1-15% pain as a new symptom after hysterectomy
- 3-5% reported increased pain in those with preexisting pain3
- Poor postoperative pain control associated with
  - Increased lengths of stay, emergency room visits and higher readmissions4,5
  - Development of chronic pain6
  - Psychological changes affecting recovery, quality of life7 and patient satisfaction8
- Review primary objective: To determine if there is enough evidence within the benign gynecology literature to make recommendations for postoperative pain control that can be used specifically in patients undergoing minimally invasive benign hysterectomies

METHODS

- Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines
- Inclusion/exclusion criteria
  - All studies involving gynecological MIS through 4/16
  - Medical non-opioid therapies only
  - Excluded those not in English, animal-based, involving only laparotomies, only malignant pathology and any studies limited to tubal ligations or intrauterine procedures
- Size effects calculated
- Grades of Recommendation, Assessment, Development and Evaluation (GRADE) approach used to rate quality of all RCTs9

Figure 1. Study selection

<table>
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<th>Study Selection</th>
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<th>Reasons Excluded</th>
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Diagrams showing Local Anesthetics

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15
SUMMARY TABLE

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FINDINGS

- IV acetaminophen and ketorolac show promise in treating postoperative pain in women undergoing benign laparoscopic hysterectomies
- Neuroleptics and dexamethasone demonstrate opioid-sparing benefits only
- Paracervical blocks benefit vaginal hysterectomies
- Local anesthetics appear to benefit non-hysterectomy gynecologic laparoscopies

STRENGTHS AND LIMITATIONS

- **Strengths**
  - First expansive assessment of its kind
  - A large number of studies (49) were evaluated in detail that addressed the topic of pain control after gynecological MIS
- **Limitations**
  - Varying primary outcomes – some studies reported pain scores but not opioid consumption or vice versa
  - Some articles reported opioid use while others described “analgesic use” without specifying which analgesics were given
  - The majority of studies evaluated outcomes up to 24 hours postoperatively while most patients have pain that persists beyond this timeframe

CONCLUSIONS

- Most of the literature on postoperative pain control is based on dental, orthopedic and general abdominal surgeries\(^{11}\)
- Heterogeneity and contradictory data
- Poor research methodology
- Pain is a complex human response and extrapolating outcomes from one population to another may be inappropriate.
- The pathology behind the indications for benign hysterectomies is unique from those driving the disease processes on which the majority of the postoperative pain literature is based on
- Women may respond differently to pain than men
- Clear need for more high-quality research evaluating each medication type for postoperative pain control in the gynecologic population
REFERENCES


Acknowledgements

Georgina Lennu, MD, MPH†
Insiyyah Patanwala, MD†
Kenneth I. Barron, MD†
†Florida Hospital
*Orlando Veterans Medical Center
Background
- Decrease in absolute number of hysterectomies
- Increased diversification of surgical route (Pulliam, 2009)
- Majority of ob/gyn residency programs utilize robotic surgery
- Many lack formal robotic training (Gebhart 2011, Smith 2010)
- Robotic hysterectomy has the lowest resident involvement (Jeppson, 2015)
- Increasing demand for training outside of the OR
- Robotic simulator skills translate to improved OR performance (Culligan, 2014)

Disclosures
I have no financial relationships to disclose

Study Objectives
- To use Cognitive Task Analysis to identify the essential steps to complete a robotic vaginal cuff closure
- Particularly those difficult to master
- Create an expert model of performance for this task
  - Encode the steps with sufficient precision that a computer program can determine the degree to which a human is following the steps and the degree to which they are deviating
  - Create Intelligent Tutoring software which can provide automated guidance and correction to a student learning the procedure

Methods
- GYN robotic surgeons performed vaginal cuff closure on RobotIX Mentor
  - Repeatable, standardized testing environment
  - Psychologist team recorded actions and possible deviations
  - Probe questions at each step
  - Identify cognitive, psychomotor and perceptual skills
Results

- 3 primary steps of cuff closure
- Standard path of 33 actions
- 8 reasonable alternatives
- 11 decision points
- Surgeon performed exercise using MMTA steps using all alternatives

Ongoing and Future Work

- Development of a Robot-assisted laparoscopic surgery intelligent tutoring system (RA-ITS)
- BBN Technologies, Office of Naval Research
- MMTA foundation for expert performance model
- Personalized, real-time instruction for accelerated learning
- Task-specific, immediate assessment
- Goal: Provide individualized instruction comparable to a human instructor

Summary

- Robotic surgery increasing in gyn residency programs
- Increased demand for training outside of the OR
- Task analysis can be used to identify essential steps required to perform a surgical procedure
  - May assist surgical educators how to teach tasks
  - This process may be useful to create structured checklists for residents
- Ultimate goal is intelligent software which can correct and guide a student while learning the procedure in a simulator

References


Acknowledgements

Alyssa Tanaka, PhD1, Danielle Julian, MB1, Anna Skinner, PhD2, and Roger Smith, PhD3

1Florida Hospital Nicholson Center, Celebration, Florida
2AnthroTronix, Inc., Silver Spring, Maryland
Thank you
Why Did Current Fellows Choose a Fellowship in Minimally Invasive Gynecology?

A Qualitative Evaluation

Presenter: Arpit Dave, MD | Mayo Clinic, AZ

Objective

- At the end of this activity, participants will be able to:
  - identify common career goals among fellows
  - identify key domains where fellows believe they lack preparedness for fellowship
  - hypothesize areas for targeted curriculum development in AAGL fellowship programs

Disclosures

- I have no financial relationships to disclose.

Methods and Response Rate

- e-Surveys sent Feb 2016-Apr 2016
  - First-year fellows
  - Program directors
  - Associate program directors

**Fellows**

- 66% (n=26/39)

**Directors**

- 50% (n=37/74)

 Fellows

“What was your principal reason for choosing to pursue an AAGL fellowship?”

 Directors

“I believe the principal reason my fellows chose to pursue an AAGL fellowship is:”

Results: Why Choose FMIGS?

Fig. 1. Reasons for Pursuing AAGL Fellowship. Note: 37% of PDs and 33% of fellows’ responses fell into more than one category.
Results: Career Goals for MIGS

![Bar chart showing career goals for MIGS, GYN Specialty, Academic/Research, Lifestyle, and unspecified.]

Fig. 2. Specific Career Goals. Subcategories of post-fellowship career goals among fellows (n=12) and PDs (n=14).

Differences in Perception of Preparedness for AAGL Fellowship

- Concordant domains
  - Professionalism
  - Academia and scholarship

- Discordant domains
  - Surgical independence
  - Psychomotor skills
  - Clinical evaluation/management

Less than 35% of Directors AGREED that fellows could:
- Recognize a critically ill patient
- Perform a basic robotic hysterectomy

Less than 60% of Directors AGREED that fellows could:
- Proficiently suture laparoscopically
- Place ports and dock the robot

Less than 30% of Fellows STRONGLY AGREED that he/she could:
- Proficiently suture laparoscopically
- Proficiently control bleeding

Less than 25% of Fellows STRONGLY AGREED that he/she is:
- Familiar with recent publications
- Able to understand basic statistics
- Able to write a cohesive manuscript
Potential Curriculum Development Areas

- **Skills and Experience**
  - Controlling bleeding
  - Laparoscopic suturing

- **Academia/Research**
  - Directed review of AAGL selected readings
  - Basic statistics
  - Scientific writing courses

Areas of Future Research / Suggestions

- Repeat survey yearly
  - Assess evolution of fellow needs
  - Aggregate data may reveal more specific areas for improvement

- Consider collecting related fellowship exit data
  - Identify high-performing programs
  - Disseminate excellent curricula among programs

- Continue publishing this data
  - Preservation of anonymity is important
  - Transparency may set FMIGS apart from ACGME fellowships

Bibliography


Evaluation Question

- Which of the following is the MOST COMMON stated reason why first year AAGL fellows chose to pursue fellowship?
  - A) career goals
  - B) master pelvic anatomy
  - C) insufficient residency training
  - D) obtain more skills/experience
  - E) better lifestyle

Acknowledgement

Johnny Yi, MD | Mayo Clinic, AZ
Meta-analysis and Systematic Review to Determine the Optimum Imaging Modality for the Detection of Posterior Vaginal Fornix Deep Infiltrative Endometriosis

Presenter: Dr. Bassem Gerges\textsuperscript{1,2}
MBBS (Hons), MRANZCOG
\textsuperscript{1}Acute Gynaecology, Early Pregnancy and Advanced Endosurgery Unit, Nepean Hospital \textsuperscript{2}Sydney Medical School Nepean, University of Sydney

Objectives

• Review deep infiltrating endometriosis (DIE)
• Discuss imaging modalities for posterior vaginal fornx DIE
• Describe overview of sonovaginography and International Deep Endometriosis Analysis (IDEA) Group consensus

Introduction

• Endometriosis is an heterogenous disease\textsuperscript{1}
• Greatest benefit is derived from maximal cytoreduction at the first surgical intervention\textsuperscript{2,3}
• Preoperative diagnosis of endometriosis type and location
• To review the optimum imaging modality for posterior vaginal fornx DIE

Methods

• Meta-analysis and systematic review
  • January 1990 to March 2016
  • MEDLINE, Embase, PubMed, Google Scholar
• Prospective studies assessing DIE and in particular posterior vaginal fornx DIE
  • Defined as any vaginal site
• Restricted to studies with at least 10 affected and 10 unaffected women

Results

• 1034 records retrieved
• 106 evaluated
  • 89 evaluated posterior vaginal fornx DIE
  • 55 excluded as they included less than 10 affected/unaffected women
  • 12 excluded due to potential redundant information
• 22 study groups included in the analysis

Disclosures

I have no financial relationships to disclose.
Results (cont’d)

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Notes: MRI = Magnetic resonance imaging, SVG = Sonovaginography, TRU = Transrectal ultrasound, TVS = Transvaginal ultrasound, WC = Water contrast

International Deep Endometriosis Analysis (IDEA) Group

- Released a consensus opinion on sonographic features
- Terms
- Definitions
- Five domains
  - Bladder
  - Rectovaginal septum
  - Posterior vaginal fornix
  - Uterosacral ligaments
  - Rectum and rectosigmoid

Conclusion

- Gel/water as contrast improves sensitivity for the detection of posterior vaginal fornix DIE
- These findings can assist clinicians with preoperative planning with particular regard to the required laparoscopic expertise that may be required
- More studies required using standardised definitions such as those proposed by IDEA

Sonovaginography


Reference

5. Guerriero S, Condous G., et al. 20165
Acknowledgements

Co-Authors: Batool Nadim1,2, Wellington Martins3, George Condous1,2

1Acute Gynaecology, Early Pregnancy and Advanced Endosurgery Unit, Nepean Hospital 2Sydney Medical School Nepean, University of Sydney 3Medical School of Ribeirao Preto, Department of Obstetrics and Gynecology, University of Sao Paulo

Thank you
Objective: To demonstrate the development of a simulation model for tissue extraction, specifically the Extracorporeal C-Incision Tissue Extraction (ExCITE) technique and to review tips and tricks for the ExCITE technique.

Design: Demonstration on how to build a cost-effective simulation model for the ExCITE technique in a stepwise fashion while reviewing key pearls for the technique via narrated video footage.

Setting: As a result of recent concerns regarding the use of power morcellation, clinicians have been faced with the need to develop alternative techniques for contained tissue extraction during minimally invasive gynecologic procedures such as myomectomy and hysterectomy. The Extracorporeal C-Incision Tissue Extraction technique was developed in order to create a simple, reproducible and minimally invasive approach to tissue extraction without the need for power morcellation. A cost-effective simulation model was created in order to provide educators and physicians a model for teaching, learning and practicing this technique.

Interventions: The video describes the four basics steps to creating a simulation model for the ExCITE technique with simple and readily accessible materials. The 4 steps include: 1) Creation of the self-retaining retractor 2) Building of the torso 3) Preparation of the specimen 4) Simulation of the technique. The total cost of the model is less than ten dollars per learner. The video also reviews 6 technical pearls for efficient tissue extraction.

Conclusion: Simulation is becoming an integral part of surgical training and maintenance of skills. Simulation allows the surgeon to learn, practice, troubleshoot potential challenges and understand the nuances of tissue extraction in a consequence-free environment, and can help improve efficiency in the OR. The ExCITE simulation model described in the video is simple, easy to assemble and cost-effective and can be used in various setting for practicing and teaching this technique such as for resident training or surgical skills workshops.
Teaching Vaginal Hysterectomy Using a Vaginal Hysterectomy Task Trainer

Presenter: Dominique R. Malacarne, MD
NYU School of Medicine, New York, New York

Objective: To design a teaching video using a vaginal hysterectomy task trainer, in order highlight the standard components of a vaginal hysterectomy and familiarize learners with anatomic landmarks, instrument handling and use of surgical assistants.

Design: Stepwise demonstration of performing a vaginal hysterectomy with narrated video footage and headings to assist with components of the task trainer used.

Setting: Academic University Hospital, Simulation Center

Interventions: This video demonstrates the use of a vaginal hysterectomy training model created using low cost, easily accessible materials. The use of simulation task trainers allows not only for teaching how to perform a specific surgical task in a more neutral environment, but also can serve as an effective assessment of surgical skills and a more directed understanding of anatomy. This video was viewed by those participating in the validation of our model as a demonstrative instructional tool.

Conclusion: In an age where vaginal hysterectomy proficiency is decreasing and resident teaching of this surgical skill is on the decline, use of various teaching tools such as this instructional video can help teachers to focus on key components of the vaginal hysterectomy in order to enrich fundamental knowledge of this technique, with the goal of facilitating a better understanding of the potential complications of this surgery.
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.