SYLLABUS

PLENARY 8:
Robotics

Be a Surgical “Multiplier” in MIGS
Inspire Brilliance Through Teamwork

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For more information or to view the policy please go to:
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Plenary 8: Robotics

Moderator: Jin Hee J. Kim, Khara Simpson

Description
This session provides a look into trends and best practice in robot-assisted gynecologic surgery. Participants will be exposed to a wide range of robotic approaches to benign gynecologic conditions.

Objectives

Learning Objectives: At the conclusion of this activity, the participant will be able to: 1) Identify trends in the use of robotic surgery in comparison to alternative approaches; 2) identify best practice for safety in robotic surgery; and 3) review robotic approaches to other benign gynecologic conditions including fibroid, other benign pelvic masses and endometriosis.

4:10 Minimally Invasive Burch Colposuspension – The Robotic Approach
Discussant: V. Cela
J. Mourad

4:20 Case Series for Same-Day Discharge for Minimally Invasive Robotic Surgery for Endometrial Cancer
Discussant: L.S. Mihalov
K.A. Kleinberg

4:30 Robotic Colostomy Take-Down
Discussant: S.J. Radtke
L. Mutlu

4:40 Robotic Interval Cytoreductive Surgery for Stage IV Epithelial Ovarian Cancer
Discussant: K. Simpson
W. Khadraoui

4:50 Isthmocele Repair: Robotic-Assisted Laparoscopy with Simultaneous Hysteroscopy
Discussant: V.V. Morozov
S.J. Seaman

5:00 Increased Same Day Discharge Rate after Laparoscopic Guided 4-Point Transversus Abdominis Plane Block for Robotic Assisted Gynecologic Procedures
Discussant: G. Moawad
C. Ladanyi
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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Erin T. Carey
Consultant: MedIQ
Mark W. Dassel
Contracted Research: Myovant Sciences
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Speakers Bureau: Laborie Medical Technologies, Teleflex Medical
Other: Unrestricted educational grant to support NC FPMRS Fellow Cadaver Lab: Boston Scientific Corp. Inc.
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Grace Phan, Professional Education Specialist, AAGL*
Harold Y. Wu*
Linda C. Yang
Other: Ownership Interest: KLAAS LLC

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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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Wafa Khadraoui*
Jin Hee J. Kim
Consultant: AbbVie
Speakers Bureau: Intuitive Surgical
Katherine A. Kleinberg*
Camille Ladanyi*
Linda S. Mihalov
Consultant: Gynesonics, KitoTech Medical
Contracted Research: AbbVie
Gaby Moawad
Speakers Bureau: Intuitive Surgical
Vadim V. Morozov
Consultant: AbbVie, CooperSurgical, Lumenis, Medtronic
Jamal Mourad*
Levent Mutlu*
Steven J. Radtke*
Sierra J. Seaman*
Khara Simpson*

Content Reviewer has nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

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Consultant: Applied Medical, Caldera Medical, CooperSurgical, Olympus
Amanda C. Yunker
Consultant: Olympus
Linda Michels, Executive Director, AAGL*
Video Objective: To demonstrate a minimally invasive technique to the Burch procedure for treatment of stress urinary incontinence as an alternative therapeutic modality for women who do not want or cannot have mesh products.

Setting: Surgical intervention for a 68 yo G12 P10-0-2-10 with prolapse and stress urinary incontinence (SUI). After undergoing appropriate counseling and discussion regarding risks, benefits and alternatives the patient and family declined use of mesh products for any portion of the repair. The decision was made to proceed with a hysterectomy, uterosacral colpopexy and Burch colposuspension. Preoperative optimization of her health and multiple co-morbidities required a multidisciplinary approach. Blood pressure control, diabetes and thyroid management as well as topical estrogen treatment of vaginal epithelium for 3 months prior to surgery.

Interventions: Robotic colposuspension for genuine SUI following a robotic hysterectomy and uterosacral colpopexy. The procedure took 62 minutes to complete, the blood loss was minimal and there were no complications. She was observed overnight, had a successful voiding trial in the morning and was discharged shortly after. Follow up at 2 and 6 weeks after surgery she reported no pain and no complications. She reports significant improvement in bladder function and bladder control.

Conclusion: The Burch procedure is well know as an effective treatment for SUI but generally not frequently performed due to morbidity associated with laparotomy requiring procedures and the availability of less invasive approaches such as a transvaginal suburethral sling. With the minimally invasive surgery evolution being inclusive of nearly all gynecologic procedures, a robotic or laparoscopic Burch colposuspension as an alternative to transvaginal suburethral sling with mesh should be considered. This video demonstrates a reproducible, safe and efficient approach to this procedure.
Objectives
- Validate same-day discharge after minimally invasive robotic surgery for endometrial cancer
- Determine factors that affect the length of hospital stay after surgery

Introduction
- Endometrial cancer most common gynecologic cancer in women
- First-line treatment is primary surgical resection
- Historically, overnight observation for early detection of perioperative complications
- Feasibility and safety of same-day discharge
- Enhanced recovery after surgery (ERAS)

Methods
- Patients
  - Inclusion criteria: robotic total hysterectomy (RTH) with bilateral salpingo-oophorectomy (BSO) and pelvic/para-aortic lymphadenectomy for endometrial cancer
  - Excluded chronic pelvic pain
  - N = 78
- Design
  - Retrospective study
  - Single gynecologic oncologist
  - Analysis using Chi-square test, unpaired t-test, and linear regression

Demographic and clinical characteristics: same-day discharge vs. admitted cases

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Same-day discharge (N = 56)</th>
<th>Admitted (N = 22)</th>
<th>p-value</th>
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<tbody>
<tr>
<td>Age, y</td>
<td>62.25 (28 – 91)</td>
<td>61.09 (40 – 88)</td>
<td>0.628</td>
</tr>
<tr>
<td>≤ 60, &gt; 60</td>
<td>20 (36.0%), 36 (64.0%)</td>
<td>14 (64.0%), 8 (36.0%)</td>
<td>0.025*</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>35.22 (21.79 – 55.78)</td>
<td>32.26 (18.44 – 50.07)</td>
<td>0.129</td>
</tr>
<tr>
<td>≤ 30, &gt; 30</td>
<td>17 (30.4%), 39 (69.6%)</td>
<td>10 (45.5%), 12 (54.5%)</td>
<td>0.207</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>26 (46.4%), 30 (53.6%)</td>
<td>6 (27.3%), 16 (72.7%)</td>
<td>0.788</td>
</tr>
<tr>
<td>Histologic grade</td>
<td>26 (46.4%), 30 (53.6%)</td>
<td>6 (27.3%), 16 (72.7%)</td>
<td>0.122</td>
</tr>
<tr>
<td>Operating room time, min</td>
<td>150.98 (68 – 256)</td>
<td>170.36 (103 – 233)</td>
<td>0.048*</td>
</tr>
<tr>
<td>≤ 210, &gt; 210</td>
<td>52 (92.9%), 4 (7.1%)</td>
<td>19 (86.4%), 3 (13.6%)</td>
<td>0.367</td>
</tr>
<tr>
<td>Surgery start time</td>
<td>9 (16.1%), 47 (83.9%)</td>
<td>3 (13.6%), 19 (86.4%)</td>
<td>0.789</td>
</tr>
<tr>
<td>Estimated blood loss, cc</td>
<td>32.68 (10 – 100)</td>
<td>51.59 (10 – 200)</td>
<td>0.021*</td>
</tr>
<tr>
<td>≤ 30, &gt; 30</td>
<td>44 (78.6%), 12 (21.4%)</td>
<td>12 (54.5%), 10 (45.5%)</td>
<td>0.34*</td>
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<tr>
<td>Surgical complexity</td>
<td>14 (25.0%), 42 (75.0%)</td>
<td>13 (59.1%), 9 (40.9%)</td>
<td>0.004**</td>
</tr>
<tr>
<td>Surgical stage</td>
<td>36 (64.3%), 20 (35.7%)</td>
<td>7 (31.8%), 15 (68.2%)</td>
<td>0.009**</td>
</tr>
<tr>
<td>Length of stay, min</td>
<td>698 (29 – 1427)</td>
<td>2790 (1455 – 10105)</td>
<td>&lt; 0.00001***</td>
</tr>
</tbody>
</table>

Disclosure
- I have no financial relationships to disclose
Multivariate correlation of factors associated with same-day discharge

<table>
<thead>
<tr>
<th></th>
<th>Pearson r</th>
<th>95% CI</th>
<th>p value</th>
<th>Pearson r</th>
<th>95% CI</th>
<th>p value</th>
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<tbody>
<tr>
<td>Age</td>
<td>0.075</td>
<td>-0.492</td>
<td>0.514</td>
<td>-0.145</td>
<td>-0.505</td>
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<tr>
<td>Comorbidities</td>
<td>0.200</td>
<td>-0.226</td>
<td>0.854</td>
<td>-0.018</td>
<td>0.251</td>
<td>0.193</td>
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<tr>
<td>BMI</td>
<td>0.005</td>
<td>-0.573</td>
<td>0.967</td>
<td>-0.102</td>
<td>-0.509</td>
<td>0.387</td>
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<tr>
<td>Surgery start</td>
<td>-0.250</td>
<td>-0.448</td>
<td>0.004</td>
<td>-0.030</td>
<td>-0.448</td>
<td>0.507</td>
</tr>
<tr>
<td>Surgery length</td>
<td>0.014</td>
<td>-0.766</td>
<td>0.992</td>
<td>-0.106</td>
<td>0.318</td>
<td>0.507</td>
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<tr>
<td>FIGO grade</td>
<td>0.009</td>
<td>-0.573</td>
<td>0.967</td>
<td>-0.102</td>
<td>-0.509</td>
<td>0.387</td>
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<td>-0.102</td>
<td>-0.509</td>
<td>0.387</td>
</tr>
</tbody>
</table>

Conclusions

- High-volume single surgeon
- No ERAS protocol – could it improve outcomes?
- Placebo effect
- Exclusion of chronic pelvic pain patients
- Advantages of same-day discharge

Length of stay characteristics

<table>
<thead>
<tr>
<th>Reason</th>
<th>Proportion</th>
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<tr>
<td>Electrolyte disturbance</td>
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</tr>
<tr>
<td>Pathology</td>
<td>2</td>
</tr>
<tr>
<td>Pre-op UTI</td>
<td>2</td>
</tr>
<tr>
<td>SIRS</td>
<td>1</td>
</tr>
<tr>
<td>Electrolyte disturbance</td>
<td>1</td>
</tr>
<tr>
<td>Pathology</td>
<td>2</td>
</tr>
<tr>
<td>Pre-op UTI</td>
<td>2</td>
</tr>
<tr>
<td>SIRS</td>
<td>1</td>
</tr>
</tbody>
</table>

Acknowledgments

- J. Salvador Saldivar, MD, MPH, FACOG, FACS
- RGU Cancer Center

References

Robotic Colostomy Take-Down

Presenter: Levent Mutlu, MD
Obstetrics, Gynecology & Reproductive Sciences, Yale School of Medicine
New Haven, CT

Video Objective: To demonstrate a surgical video where-in a robotic-assisted colostomy take-down was performed with anastomosis of the descending colon to the rectum after reduction of ventral hernias and extensive lysis of adhesions.

Setting: Tertiary referral center in New Haven, Connecticut.

Interventions: This 64-year-old female was diagnosed with Stage IIIA endometrial cancer in 2015 when she underwent an optimal cytoreductive surgery. She required sigmoid resection and a descending end colostomy with Hartmann’s pouch, mainly secondary to extensive diverticulitis. Following adjuvant chemoradiation, she remained disease-free and desired colostomy reversal. Imaging was notable for a ventral hernia and a parastomal hernia. Colonoscopy was only notable for narrowing of the distal rectum above the level of the levator ani. Following extensive enterolysis, the splenic flexure of the colon was mobilized to provide an adequate proximal limb to the anastomosis site. The anvil was then introduced into the distal descending colon through the colostomy site. A robotic stapler was utilized in order to seal the colostomy site and detach it from the anterior abdominal wall. Unfortunately, the EEA sizer perforated through the distal rectum, caudad to the stricture site. Thus, a significant length of the distal rectum had to be sacrificed, requiring further mobilization of the splenic flexure. Rectum was then re-approximated with 3-0 barbed suture in two layers. With 6-8cm of distal rectum available, end-to-side anastomosis of descending colon to distal rectum was performed. Given the low colorectal anastomosis, a protective diverting loop ileostomy was then performed. The patient has had an uneventful postoperative course. Hypaque enema performed after three months showed neither anastomotic leak nor stricture. Ileostomy was then reversed.

Conclusion: Robotic-assisted colostomy take-down and anastomosis were successfully performed. Minimally invasive techniques should be considered as an alternative to laparotomy for patients with colostomy, as long as they are recurrence-free.
Robotic Interval Cytoreductive Surgery for Stage IV Epithelial Ovarian Cancer

Presenter: Wafa Khadraoui, MD
Obstetrics and Gynecology, Yale New Haven Health, Bridgeport Hospital
Bridgeport, CT

Video Objective: To demonstrate a surgical video where-in interval cytoreduction to no gross residual disease was performed robotically in a patient with Stage IV epithelial ovarian cancer

Setting: Tertiary referral center

Interventions: 43-year-old Caucasian female was diagnosed with stage IV-A high-grade serous ovarian adenocarcinoma after presenting with shortness of breath. Computed tomography showed bilateral pleural effusions, adnexal masses, retroperitoneal lymphadenopathy, omental caking. Thoracentesis confirmed adenocarcinoma of Mullerian primary. She received three cycles of neoadjuvant carboplatinum and paclitaxel with excellent clinical response and was taken to the operating room for robotic-assisted interval cytoreductive surgery.

Trocars were placed on a straight horizontal line along the umbilical fold. The rectosigmoid colon was mobilized medially. Pararectal and paravesical spaces were developed. Ureterolysis was completed bilaterally. The uterine vessels were sealed at the hypogastric bifurcation. Infundibulopelvic (IP) ligament was sealed and cut. Bilateral pelvic sidewall peritoneum was resected. Bladder flap was developed. Colpotomy was performed and the hysterectomy specimen was removed. Procedure was then continued with debulking of enlarged lymph nodes, from bilateral pelvic sidewalls and peri-aortic area.

The robotic arms were targeted to the upper abdomen for total omentectomy. Access to the lesser sac was gained by resecting short gastric vessels, along the greater curvature of the stomach. The incision was then extended to the splenic flexure and hepatic flexure. Total omentectomy was completed. Remaining subcentimeter tumoral nodules along the peritoneal surfaces were ablated with argon beam coagulator. The patient had an uneventful postoperative course and was discharged home on postoperative day 1. Pathology confirmed high grade serous ovarian carcinoma. She was resumed on chemotherapy two weeks after her cytoreductive surgery.

Conclusion: Laparoscopic/robotic interval cytoreductive surgery should be considered in advanced ovarian cancer patients, who have an excellent clinical response to NACT. Studies to accurately identify the appropriate patient population for laparoscopic/robotic debulking procedures are urgently encouraged and needed.
Isthmocele Repair: Robotic-Assisted Laparoscopy with Simultaneous Hysteroscopy

Presenter: Sierra J. Seaman, MD
Obstetrics and Gynecology, Columbia University Irving Medical Center - New York Presbyterian Hospital
New York, NY

Video Objective: To illustrate the use of robotic-assisted laparoscopy with simultaneous hysteroscopy for the repair of an isthmocele.

Setting: An isthmocele is a pouch-like anterior uterine wall defect at the site of a previous cesarean scar. The incidence is not well known, but is estimated in the literature is between 19 and 88%1,2. Complications arising from an isthmocele may include abnormal uterine bleeding (especially postmenstrual bleeding), abdominal pain, diminished fertility, ectopic pregnancy, or obstetric complications such as uterine rupture. Repair of isthmocele may be indicated for symptomatic relief and preservation of fertility. Multiple surgical approaches have been described in the literature including laparoscopic, hysteroscopic, and vaginal approaches1,2,3.

Interventions: In this video, we illustrate the key surgical steps of robotic-assisted laparoscopy with simultaneous hysteroscopic guidance for the repair of an isthmocele. Key surgical steps include:

- Pre-surgical planning with MRI
- Diagnostic hysteroscopy for confirmation of isthmocele
- Simultaneous laparoscopy for identification of borders
- Strategic hysterotomy
- Excision of scar tissue
- Tension-free closure

Conclusion: Robotic-assisted laparoscopy with simultaneous hysteroscopy is a feasible and safe approach for the repair of an isthmocele.

Resources:
Increased same day discharge rate after laparoscopic guided 4-point transversus abdominis plane block for robotic assisted gynecologic procedures

Camille Ladanyi, MD
Erlanger Hospital
University of Tennessee
College of Medicine
Chattanooga, TN

Objectives

Discuss the indications and benefits of a transversus abdominis plane (TAP) block
Review the method of placing a 4-point TAP block
Report data from our retrospective review

Supplies

- Blunt tipped regional anesthesia needle
- 21G x 4"
- 30 cc syringe x 2
- EpiPent 1.3% 20 mL
- Marcaine 0.25% plain 20 mL
- Injectable saline 40 mL
## Cadaveric dissection demonstrating anatomic landmarks

![Cadaveric dissection demonstrating anatomic landmarks](image1)

## Cadaveric dissection demonstrating neurovascular plane for TAP

![Cadaveric dissection demonstrating neurovascular plane for TAP](image2)

---

### Retrospective review on 4 point TAP block

<table>
<thead>
<tr>
<th>Study Participants</th>
<th>Anesthetic associated procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>N=284, Mean 40.6 (19-80)</td>
</tr>
<tr>
<td>BMI</td>
<td>N=284, Mean 30.6 (17.2-53.3)</td>
</tr>
<tr>
<td>Adverse effects of TAP block</td>
<td>None</td>
</tr>
<tr>
<td>Same day discharge rate</td>
<td>70.7%</td>
</tr>
<tr>
<td>Admission rate due to pain</td>
<td>20.0%</td>
</tr>
<tr>
<td>Admission rate due to pain among all study participants</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

---

### References

Acknowledgements

- University of Tennessee, College of Medicine, Chattanooga TN
- My mentor, Shanti Mohling MD, who helped design our study, create our video, powerpoint presentation, and manuscript.
- While studying this technique we were privileged to complete a dissection on a female cadaver. We would like to thank those individuals who have generously donated their bodies so that we may expand our medical knowledge.
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.