Greetings NewsScope readers! As Mars brushes the evening sky and the lower light of autumn heralds a new season, the full administrative and executive force of the AAGL is at maximum throttle to bring the upcoming annual meeting to complete fruition. This year’s Global Congress of Gynecologic Endoscopy/AAGL 32nd Annual Meeting is slated for Wednesday, November 19th (with pre-registration on Tuesday, November 18th) through Saturday, November 22nd at the Paris Hotel in Las Vegas, Nevada.

Hoping to eclipse the memorable successes of prior annual meetings, this year’s scientific program is buttressed by a dynamic substratum of high quality oral, video, and poster presentations interlinked by a series of educational events including general sessions, timely panels, engaging debates, industry-sponsored symposia, and telesurgeries during successive morning and afternoon sessions.

Completely new to the scientific program, surgical tutorial sessions, designed to provide personalized education in a classroom setting with limited seating, will be taught in parallel to the program by pairs of widely respected endoscopic surgeons covering a broad range of minimally invasive surgical topics.

In keeping with our organization’s core philosophy to engage emergent areas of minimally invasive gynecologic surgery, recently introduced surgical procedures that directly challenge the role of retropubic colposuspension for genuine stress urinary incontinence will be critically compared and contrasted by an engaging educational series including balanced debate, a comprehensive panel, and even telesurgeries.

True to our tradition, a broad spectrum of timely topics in endoscopic surgery will be taught by a talented group of international faculty during an array of twelve half-day postgraduate courses, given as morning and afternoon sessions on Wednesday, November 19th. Recognizing the broad interests of our membership in gynecologic surgery, for the first time attendees will be able to match a morning course in conventional vaginal hysterectomy or reconstructive surgery with an afternoon course in laparoscopic hysterectomy or reconstructive surgery. And, acknowledging the diminishing role of hysterectomy for benign conditions, special attention will be given in separate course offerings to decisively address nascent, as well as recently established, surgical and non-surgical solutions for abnormal uterine bleeding and the uterine fibroid.

With great fortune, this year’s scientific program is matched with a spacious and state of the art convention facility in Paris Hotel. Centrally located, attendees will be able to seamlessly migrate between all program events and their hotel room, a fitness center, restaurants, shopping, and the call of the casino. Enough can’t be said about the wealth of recreational and entertainment opportunities that abound in and around Las Vegas for you and your family. I am confident that all of the pieces are now firmly connected for an explosive success!

On behalf of the Board of Trustees, we look forward to seeing you and your family in Las Vegas. You are strongly encouraged to register as soon as possible to help secure your personal selection of educational events. All details of the Scientific Program are now fully accessible on the AAGL website at www.aagl.org.

Warm regards, Andrew I. Brill.
It is Always So Obvious—In Retrospect

Many of the members of the AAGL with whom I talk are frustrated that endoscopy and minimally invasive surgery is still not fully recognized for its potential. Insurance companies do not adequately compensate for it. Many patients do not understand its advantages, and too many of our training programs do not provide teaching of anything but basic techniques.

But, I believe this is changing. New CPT coding does allow for the differentiating of more difficult procedures (see NewsScope Jan-Mar 2003; Vol 17, No 1); with the help of the internet patients are now asking their gynecologists for minimally invasive surgical techniques; and probably most important, there appears to be some movement to address training of our new specialists. The Council for Residency Education in Obstetrics and Gynecology (CREOG) at its summer retreat asked the AAGL to present a session entitled, “Can Surgical Training Be Measured and Related To Competence? — The Endoscopic Model.” Many residency program chairs attending that session seemed anxious to improve training in their programs. This will mean endoscopy and minimally invasive surgery will continue to become more mainstream.

Members of this society have recognized for years the advantages of endoscopy and minimally invasive surgery. It is difficult for us to understand why what has been so obvious to us has not been more obvious to others. But I think others are recognizing, albeit in retrospect, that endoscopy and minimally invasive surgery is better patient care.

We need to accept it is human nature not to recognize the value of new things. Progress is slow. We need only to ask why our own specialty ignored laparoscopy after a flurry of papers in the late 1930’s until the Green Journal published in March 1968 two back-to-back articles on laparoscopy.1,2

It is all so obvious — at least in retrospect.

References:

Searching for a New Position?

We are pleased to bring you CareerScope, a new online career placement program that can be found on the AAGL’s website. Access hundreds of jobs listed locally, regionally, and nationally. Post a resume, manage your profile, and receive email notification of new job postings. On CareerScope you can do all this and more — free of charge! Your resume on CareerScope will be visible to thousands of healthcare employers nationwide. So, what are you waiting for? Visit CareerScope today at www.aagl.org!
Hysteroscopic Fluid Monitoring

Fortunately, gynecologists are enthusiastically embracing diagnostic and operative hysteroscopy as a means to evaluate women with menstrual disorders, infertility, postmenopausal bleeding, recurrent pregnancy loss, and when ultrasound is equivocal. In general, operative hysteroscopy is a safe procedure, easily learned, and has excellent surgical outcomes. As more obstetrician/gynecologists perform hysteroscopy, they must remain cognizant about salient complications. Recognition of complications and prompt intervention will prevent adverse sequelae, as well as minimize undesirable patient outcomes and reduce legal risks.

The uterine cavity is a potential space. CO₂, hypotonic or isotonic fluids, can distend it. Diagnostic procedures often utilize CO₂, whereas, operative hysteroscopy requires a fluid medium and continuous flow hysteroscope, so that debris can be easily removed. When fluid is used, it is imperative that the surgeon has continuous knowledge of the fluid deficit, since the amount of fluid absorbed affects patient safety.

Fluid management is of paramount importance and determines intraoperative and postoperative patient safety. Meticulous detail to fluid management and consultation with a critical care specialist is required when fluid overload, hyponatremia, cardiac or pulmonary edema is suspected.

An exceptional surgeon cannot be judged on manual dexterity and technical skills alone. The hallmark of an excellent adept surgeon requires an understanding of the nuances of surgery. When is an intraoperative consultation needed? When should the procedure be abandoned and rescheduled? When should intraoperative laboratory tests be obtained? When should the patient be referred to another surgeon? A savvy surgeon must know how to perform a surgical procedure, understand the instrumentation, but most importantly recognize, manage, and treat surgical complications.

The solution-to-solution complications are basic—surgical teams need vigilant and continuous monitoring of fluid absorption. The importance lies not so much in the amount of fluid used, but in the amount that is not calculated in the canister or estimated on the floor. All fluids used in hysteroscopic procedures can be associated with complications. Cavalier attitudes, poor fluid documentation, and failure to respond to complications lead to lawsuits. If fluid overload occurs, co-management and consultation with an intensive care specialist is advised.

Using Evidence to Assess the Surgical Literature—Possibilities and Pitfalls

The use of evidence-based medicine in gynecologic practice has become an important standard in modern clinical care. The medical literature, with its attendant hierarchy of study designs, has aided us all in making informed decisions about the appropriate approaches to a wide variety of dilemmas encountered on a regular basis. For example, we have all become familiar with the concept that evidence from a randomized trial should be given more weight than that of a retrospective chart review. In addition, when randomized trials fail to agree, a meta-analysis may help resolve the issue and direct the clinician toward the approach to care best supported by the evidence.

However, as surgeons we must rely upon evidence generated and published by other surgeons. These data have significant limitations as well as well established caveats; it is important for the discerning surgeon to understand these shortcomings and thus be able to place the surgical literature into its appropriate context.

First, we must recognize that the quality of the surgical literature is poor and far inferior to that of non-surgical fields. We have few randomized trials, and those that exist are often small and conducted by a single center. Most randomized trials involving surgery are not blinded, much less double-blinded, and thus are subject to substantial bias. Allocation is often a problem, for if patients are randomly allocated to one of two treatment groups it is often not clear that the surgeon is equally facile at both procedures. Finally, for most operations there exists an evolutionary period during which the procedure is improved and refined; if the study is conducted before this evolution is complete the results may not be pertinent, yet to wait until the operation is fully developed may mean significant surgery and equipment development for an untested procedure.

A far more important limitation, however, involves the nature of the investigators. With medical treatment trials, researchers are generally representative of the entire spectrum of practicing physicians. This design allows for generalization of the study results: it is expected that any clinician can duplicate the results of the study by simply administering the same medication in the same way in
medical legal corner

Never, Never Alter Records!

During a diagnostic laparoscopy for suspected endometriosis in a 42-year-old patient, the findings were described as normal and the procedure as uneventful. The operative note described a direct trocar insertion with ease and the procedure took less than fifteen minutes. The patient’s stay in the recovery room was as expected, until three hours had passed when she began to complain of increasing pain. The nursing records stated that her surgeon was paged but there was no response. One hour later she was discharged by the recovery room staff with instructions to call her doctor in two days if she did not improve.

Two days later, the patient was admitted in a moribund state, rushed to the operating room, where a through and through perforation of the transverse colon was found amidst a large volume of fecal material. After repair of this injury her postoperative course was complicated by abscess formations requiring several repeat laparotomies.

Litigation ensued claiming improper trocar insertion technique, the use of a reusable trocar, and lack of response. During the discovery, a copy of the hospital records, which had been sent to the surgeon several days later were compared to the same records retrieved sometime later from the hospital. There was no entry in the surgeon’s copy stating that he had been notified of her recovery room problems prior to discharge, as was stated in the hospital copies. After forensic investigations, it came to light that the nurse assigned to the patient, after hearing of the patient’s subsequent complications, had altered the record.

Once the plaintiff’s attorney received a substantial settlement from the hospital, he turned to the issues of trocar technique and a claim stating he should have used a shielded trocar. The expert for the defense was able to show that the direct trocar technique is a recognized method of trocar insertion and is within the standard of care. A notice sent by the FDA to all trocar manufacturers in 1996 was admitted into evidence. It stated that there was no evidence a shielded trocar was any safer than reusable trocars, requesting that the manufacturer consider removing any claim of increased safety with such trocars.

A defense verdict prevailed. What is a sobering fact is that the alteration of records provided the plaintiff with sufficient funds to then attack the physician on more controversial issues hoping for an empathetic response from the jury.

coding corner

Our New Representative on Coding Issues

On July 21–22, I had the opportunity to attend my first ACOG Coding and Nomenclature Committee meeting in Washington, D.C. As your new AAGL liaison to this Committee, I was impressed by the vast amount of knowledge, enthusiasm and dedication manifested by the members present. It is through their efforts that the tedious and time-consuming process is accomplished of getting the CPT codes we all need in order to achieve the appropriate reimbursement we deserve. Filling the vacated shoes of my predecessor, Vincent Lucente, will not be easy; he accomplished much on our behalf during his tenure as the AAGL liaison.

One area that the Committee will focus upon in the immediate future is the issue of bundled services. As many of us are all too aware, oftentimes a service that is distinct and separate from the main procedure is not separately reimbursed during surgeries involving multiple procedures. There are many such examples, and the Committee plans to devote time to correcting this practice. Also in the immediate future, is our plan to develop a mechanism for reimbursement that is commensurate with the increased work involved with the excision of retroperitoneal endometriosis. We will also plan to continue to work on the next steps for obtaining a code for laparoscopically performed paravaginal defect repairs.

I am excited and honored to be serving the association by sitting on what is, in the words of ACOG Vice President for Fellowship Activities, Albert Strunk, “One of the strongest committees that does some of the most important work in the College.” I look forward to the challenges that lie ahead as, together, we fight to achieve reimbursement at a level that is both fair and appropriate.
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Fellowship Gains Momentum and Prize Paper

The AAGL/SRS fellowship in gynecologic endoscopy, now several years old, has begun to grow in response to demand. Initially a small joint program of the two premier organizations involved in endoscopic surgery in the United States, the fellowship program has expanded from a small number of sites to the currently approved 13 locations. Furthermore, recent additions have increased the scope of fellowships, such that they now encompass both private and university-based programs, as well as a wide variety of geographic areas in the United States and Canada.

Significant attention will be given to the Fellowship at this year’s annual meeting in Las Vegas. For the first time, a prize paper will be selected among fellow submissions and presented during a plenary session at the meeting. This year’s award recipient is Rania Bou-Habib, (co-authors Grace M. Janik and Charles H. Koh) of the Reproductive Specialty Center in Milwaukee, Wisconsin, for her paper entitled, “Radical Laparoscopic Excision of Endometriosis: What is the Risk of Adhesion Formation?” Dr. Bou-Habib will receive a $1,000 cash prize, along with free registration to both the AAGL and ASRM annual meetings. Dr. Bou-Habib will also present her paper at the ASRM’s annual meeting as well.

The Fellowship Board will be in action in Las Vegas, reviewing applicants for new fellowship sites, preparing for a December match, and 2004 site visits to programs. A breakfast will be held Thursday, November 20th for all past and current fellows, fellowship applicants, and any residents possibly interested in future fellowships.

This growing interest in endoscopy fellowships is a response to the apparent need expressed by residents and practicing physicians alike. With more preceptors, applicants, and structure of the fellowships on the horizon, these are indeed exciting times for training in gynecologic endoscopy.

The AAGL recently published a consensus paper on the importance of fluid management. The authors strongly support monitoring with a mechanical device, which is capable of monitoring both isotonic and hypotonic distending media, because it “is highly desirable since it removes the human factor in measuring fluid deficit, allows for early warning of excessive intravasation by real-time totals, and indicates the rapidity with which the loss is occurring.”

Modern operative hysteroscopy demands utmost patient safety. The use of a monitoring system, while expensive, saves lives. We can avoid human error and harm resulting from discrepancies in calculation of fluid deficit, inaccurate labeling of collection canisters, and failure in not accounting for the 10–15% excess fluid in bags.

Like many other protective and safety mechanisms available in the health care arena, automatic hysteroscopic pump systems are life saving. Most modern automated fluid pumps have unique safety advantages. These include: weighing the irrigant solution and precisely measuring a deficit, displaying real time deficit continuously, audible alarms when the predetermined deficit is reached, continuous flow and intrauterine pressure manipulation, and ability to display the installation pressures continuously. There are many hysteroscopic fluid management pumps available. Minor differences including cost, ease of use, disposables, portability, and surgeon preference will determine which one is favored by the surgical team. Ultimately, as surgeons, we must embrace this new technology, insist that our hospitals and surgery centers purchase it, and use it faithfully. Our patients’ lives depend upon it!

References:
In Tribute to Professor Kurt Semm
A True Innovator—1927–2003

On July 16, 2003, after a long illness, Professor Kurt Semm passed away. It is only fitting that we take pause to reflect on the life of this great teacher and innovator in laparoscopic surgery. The following represents the views of AAGL members: Lisolette Mettler, who was Kurt Semm's right hand for many years; Paul F. Vietz, who was one of the earliest Americans to study with Professor Semm, later lecturing with him around the world; and Charles E. Miller, who learned Semm's techniques through AAGL sponsored courses in the United States.

Professor Semm is survived by his wife, Dr. Isolde O’Neil Semm; daughter, Tara Virginia; son, Patrick; and brother, Herst Semm.

It is an honor for me, as his student and friend, to briefly review Kurt Semm's professional life, dedicated to operative laparoscopy, which he liked to call pelviscopy. From 1965 until 1985, Kurt crusaded to establish operative laparoscopy in gynecology and general surgery. Kurt endured much resistance, including a request for him to undergo a brain scan to rule out brain damage when attempting to introduce operative laparoscopy, the laughter of general surgeons when he recommended laparoscopic cholecystectomy in the late 1970's; a call for suspension by the President of the German Surgical Society after a 1981 lecture of laparoscopic appendectomy; and rejection of a paper on laparoscopic appendectomy to the American Journal of Obstetrics & Gynecology as "unethical." Even I was advised by a famous German professor in 1972, "My young colleague, if you wish to advance in the German academic world, don't pay any regard to Semm's nonsense."

From 1986, the AAGL was responsible for organizing 75 laparoscopic surgical training courses in the United States for Professor Semm and our team. Kurt produced over 30 endoscopic films, 20,000 colored slides, and published 1,000 papers. His books were the bible of operative laparoscopy and endoscopic surgery for over 30 years. Kurt possessed a brilliant inventive mind. He built his own medical instrument company, WISAP. Today, many companies produce an electronically powered version of his original CO₂ pneumo-electronic insufflator.

It has been an honor to have witnessed the milestones Kurt Semm achieved. Students, friends, and peers will never forget him. He was a man of great reputation whose methods were well understood and developed further.

— Lisolette Mettler, M.D., Kiel, Germany

Encouraged by scores of my patients in the early 1970's, I attended my first AAGL Congress in Las Vegas to learn all about laparoscopy. After numerous trips to WISAP and Karl Storz, our "system" was finally complete.

Ten years and more than a thousand laparoscopies later, I met Kurt Semm, the “father of operative laparoscopy,” at another AAGL Congress in Phoenix, Arizona; tying and suturing arterial bleeders, removing cysts and tumors, lysing extensive bowel adhesions, making laparotomy a rare necessity—he received a standing ovation.

Two years later, Kurt, with his Kiel team and the AAGL, presented the first operative laparoscopy course in Miami Beach, Florida. Having attended this course, and having studied his manual from cover to cover, Semm graciously allowed me to be his first assistant for a week in Kiel. My friend and colleague T. Samuel Ahn attended a course in Kentucky with Ronald Levine (the first gynecologist in the United States to perform a laparoscopic oophorectomy) to obtain certification for operative laparoscopy. Now our team was complete.

Numerous courses with live surgery followed in the United States as well as in Europe, Asia, Africa, and South America. It was the highlight of my career to travel with a world famous professor and to lecture and perform laparoscopic operations most colleagues had never seen.

Strictly adhering to Semm’s techniques, we have been able to serve our patients well with great satisfaction and minimal complications. Professor Semm has been a great inspiration. We are grateful for his many inventions and his meticulous techniques. The medical profession, and most of all, our specialty of gynecology have lost a great pioneering surgeon. Every time we perform a successful operative laparoscopy instead of a laparotomy, we owe thanks to the genius of Kurt Semm.

— Paul F. Vietz, M.D., Baltimore, Maryland

In the mid 1980’s, if a gynecologist performed advanced laparoscopy, invariably he held a laser in his hand. In fact, the most popular terms of the time were video laser laparoscopy or videolaseroscopy. In reality, this technique had its limitations.

I met Professor Semm in Chicago, at the first course on pelviscopy sponsored by the AAGL in 1986. Having known several physicians who made the pilgrimage to Kiel, I was anxious to see what pelviscopy really entailed. It was clear to me that we were now entering the period of pelviscopy, of endoloops, roeder slip knots, tissue morcel-lation and extraction.

Professor Semm was not only a mentor, he provided the laparoscopic surgeon with the instrumentation to complete the procedure. His design is still the basis of current insufflators. Fifteen years later many of the instruments I use are from his original WISAP line.

Years later, he would lead the charge for conservation of the cervix at the time of hysterectomy. While the C*I*S*H* hysterectomy has not achieved universal acceptance, the number of supracervical hysterectomies is increasing.

I am certain when medical historians archive this era of surgery, Professor Kurt Semm will be honored not only as a pioneer and teacher, but as a visionary as well. We will all miss the essential contributions of this brilliant man.

— Charles E. Miller, M.D., Chicago, Illinois
future meetings

AAGL MEETINGS

Global Congress of Gynecologic Endoscopy
AAGL 32nd Annual Meeting
November 19–22, 2003
(Registration begins evening November 18, 2003)
Paris Las Vegas
Las Vegas, Nevada

Hands-on Workshop on Taking Your
Laparoscopic Skills to the Next Level
February 7, 2004
Arizona State University
Phoenix, Arizona

14th Annual Comprehensive Workshop on
Gynecologic Endoscopy for Residents, Fellows &
OR Personnel
March 6–7, 2004
Los Angeles, California

Global Congress of Gynecologic Endoscopy
AAGL 33rd Annual Meeting
November 10–13, 2004
(Registration begins evening November 9, 2003)
San Francisco Hilton & Towers
San Francisco, California

AFFILIATED SOCIETY MEETINGS

International Congress of Gynecologic
Endoscopic Surgery
January, 2004
Paris, France