The 38th Global Congress of Minimally Invasive Gynecology and Annual Meeting of AAGL will be held at the fabulous Gaylord Palms Resort in Orlando, Florida November 15 - 19, 2009. I can promise you that this year’s Congress will be one of the best ever!

We have received a total of 642 abstracts for video and oral presentations -- the highest ever submitted in the history of AAGL! These superb abstracts have been organized into three days of clinical sessions, includes 12 video, 5 plenary, 18 open communication, and poster sessions. There will be the usual debates, expert’s panels, and surgical tutorials in between clinical sessions. But hallmarking this year’s Congress are the hands-on labs for the pre-congress and the state-of-the-art postgraduate courses. A total of 12 hands-on courses are slated, including two robotic courses, one of which is specifically designed for oncologists. Also offered will be unembalmed fresh cadaver courses for laparoscopic surgical pelvic anatomy, para-aortic lymphadenectomy, bowel resection, bladder, ureter dissections and repairs, and mid-urethral sling. Other hands-on courses focus on hysteroscopy, ultrasound, laparoscopic suturing, and endoscopic devices using various energy sources. Live telesurgery will be transmitted daily from around the world. On day 1 of the Congress, following Dr. John DeLancey’s keynote address, a live telesurgery of vaginal repair of POP (pelvic organ prolapse) will be transmitted from the University of Michigan at Ann Arbor. On Day 2, a live surgery of total laparoscopic hysterectomy with sutures will be transmitted from University of Toronto, and on the 3rd day, a total of 3 hours of live telesurgery of laparoscopic myomectomy, laparoscopic staging procedure for endometrial cancer, and laparoscopic surgery for severe endometriosis including bowel resection will be transmitted from California, Taiwan, and Florida.

Register early for this memorable, fun and excellent learning experience! You will be glad you did!

This year AAGL is partnering with Disney in offering exclusive discounts for attendees of the 38th Global Congress.

Go to www.aagl.org for more details

Empowering Aspects of AAGL Meetings...

I attended my first AAGL conference about 5 years ago, and it was such an epiphany that it completely changed my professional life. I had been in practice at that time for 20 years, and had not learned advanced laparoscopic techniques as a resident because the instrumentation didn’t exist back then. Seeing what was possible, and ultimately getting the training to perform minimally invasive gyn surgery changed everything for me. I went from doing almost all my hysterectomies abdominally to doing almost all of them vaginally or laparoscopically. I have greatly expanded what I will do hysteroscopically and laparoscopically, and have been pleased with how much better patients do (and how much happier they are!). My practice has thrived with this paradigm shift in practice, and I have much greater job satisfaction as well. The two most empowering aspects of AAGL meetings for me are hands-on sessions and the live telesurgery sessions.

Thank you for bringing me into the 21st century!

– From an AAGL member who wishes to remain anonymous
f y i

We Are Not the Proverbial “Old Boy’s Club”

For the past 38 years we have provided an open forum for ideas of all of our members. Our annual meeting has never been limited to just “thought leaders”. We elected our first female President over 15 years ago at a time when very few women were active in minimally invasive gynecology and we have had many international members on the Board.

So what are some of our more recent changes to continue broad participation?

• Dedicated 4 positions on the Board of Trustees for the members coming from the 4 different regions of the world.
• Encouraged younger members and our many female members to be more active in the AAGL. In addition to the international members, the 2010 Scientific Program Chair is one of the 4 women on the current Board of Trustees.
• Identified “high profile positions” at the annual meeting. These are Chairs of Pre-Congress and Postgraduate Courses, Debate, Panel, General Sessions and those surgeons who are performing live surgery. Board members are not eligible to fill these slots. In addition no one person can dominate the meeting by chairing more than one high profile position. These guidelines have opened up more opportunities for the general membership to participate at the Annual Meeting.
• Assigned more responsibilities to the chairs of committees whose recommendations are then brought to the Board for action.
• More recently, we developed Special Interest Groups (SIGs). These will allow our members with special areas of interest to work together in the name of the AAGL. (See www.aagl.org/Committees-SIG).

The AAGL Board wants to be even more inclusive. If you have thoughts as to how we could move the process more quickly or have an example where we have fallen down, please email the Board at AAGLBoard@aagl.org or contact any Board member directly.

f rom t he editor

Your Presence is Requested

The 38th Global Congress is right around the corner. Florida sunshine tempts us. The venue and hotels are superb. Most importantly the academic meeting is exciting. Every year we have consistently exceeded our goals and objectives. We have examined the metrics: more posters, more abstracts, and more video presentations than ever. We jam packed the program (and even have a few surprises too) with new themes and topics. With your help, we look forward to another excellent meeting, lively debates, live telesurgery, engaging videos and much interaction with the faculty.

In organizing the Annual Meeting, the Scientific Program Chair and Board reviews all prior comments, criticisms, and helpful suggestions. Our mission is to deliver the most robust program ever. Additionally, another goal is to increase our attendance. Long-time members are encouraged to return and to bring a new colleague. Current members are encouraged to bring a fellow staff member, resident, or fellow. Your active participation will help us exceed the number of participants. Wouldn’t it be great if we tally the count and discover that we have the most number of new members in attendance? This wish can be a reality with your help.

Please register early. Encourage colleagues to join the AAGL. I guarantee that you will have a great time this year! See you in Florida!!
It is with great pleasure I write to you as a Founder and now Managing Editor of the new AAGL SurgeryU international media journal, www.surgeryu.com! As announced in early June, SurgeryU was acquired by AAGL in an effort to facilitate an active and mutually enriching dialogue amongst our members.

The backbone of SurgeryU is a library of nearly 250 videos in essentially every field of gynecologic surgery, available for viewing 24/7 as part of your AAGL annual membership. This library was collected over the past 10 years. More than 100 new videos, mainly from the most recent AAGL annual meetings, will be added to the library within the next six months.

SurgeryU has an outstanding founding faculty of well known historic international authors, developers, and teachers in minimally invasive gynecologic surgery. Phase 1 of development will be to further expand the leading faculty to include many more individuals whose surgical and scientific work have impacted minimally invasive gynecologic surgery worldwide.

Phase 2 of development will be to honor the preceptors and the fellows from the Fellowship in Minimally Invasive Gynecologic Surgery. There are currently 35 sites and 99 graduates and all have been invited to submit their videos for posting to the site.

Phase 3 of development will be to expand our SurgeryUTube platform where members will be able to post a current photo, bio, and their most recent videos for sharing with colleagues in an interactive forum. Here you will be able to view and post questions for the authors.

In addition to the above, we have responded to your requests to learn more about equipment and instrumentation by creating the Equipment Catalog page. Manufacturing companies have been invited to send their videos on the most efficient and safest use of their equipment, instrumentation, and materials.

And what would a media journal be without live events and opportunities to meet interesting people and friends? We have several events planned for the coming months and will be informing you of the opportunities to “tune in” and participate through our live events portal.

I wish to express my gratitude to you for becoming part of this united journey of shared learning and invite your feedback as we continue to develop the site. Together with a team devoted to the success of SurgeryU, we will maximize the potential of online communication—enriching and cooperative learning from the old to the young, from the technical to the clinical, from the practical to the philosophical—through AAGL’s SurgeryU.

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**Phase 3 – SurgeryUTube Videos**

![Phase 3 – SurgeryUTube Videos](image-url)
Single Incision Laparoscopic Surgery: A New Frontier in Minimally Invasive Surgery

Laparoscopy is now the standard approach for many gynecologic conditions. The current method typically requires 3-5 ports. Each port contributes a small, but not negligible, risk for port-site complications.1 In an effort to minimize these risks and improve cosmesis, alternatives to conventional laparoscopy are available. The recent advent of multichannel ports has enabled surgeons to complete standard and conventional laparoscopic procedures through a single small incision hidden within the umbilicus leaving virtually no visible scar. Since its first description, multiple terms have been used to describe laparoscopy carried out via a single incision. A recent multispecialty international consortium has recommended the name Laparo-endoscopic single-site surgery (LESS).1 To perform the LESS technique, the peritoneal cavity can be entered using the standard open technique described by Hasson.2 A multichannel port is then placed within the umbilicus. Early barriers included difficulties with visualization and triangulation of instruments. To optimize visualization, we use a 5mm EndoEYE articulating camera (Olympus, Center Valley, PA) but angled laparoscopes can also be used. Articulating instruments (graspers, scissors, dissectors, needle drivers) are available to assist with triangulation, maximize the surgeon’s range of motion, and to minimize the instruments clashing with each other. With access to the uterus via a uterine manipulator, gynecologists have an advantage over other surgeons who must devise innovative techniques for tissue and organ retraction. In most gynecology procedures, these aren’t necessary. However, they can be helpful in difficult cases.

Our recent report with single incision laparoscopic procedures showed even complex procedures are feasible, well tolerated, and often result in essentially no visible scar.3 In addition to the cosmetic benefits, patients often went home the same day and started to resume normal activities in days to just a few weeks. Patients reported taking little or no narcotic pain medication following surgery. In some cases, patients returned to work in as few as 3 days – even after hysterectomy.

Single incision laparoscopy is an exciting new step that is less invasive than the traditional abdominal approach or even the current laparoscopic assisted vaginal or robotic assisted laparoscopic procedures. Initial reports suggest that this is a safe and effective option for surgical access. What role single incision laparoscopy will play in modern gynecology remains to be seen. Virtually all of the endoscopic device and imaging manufacturers are working on new instrumentation that will certainly improve efficiency. This year’s Global Congress features several presentations on the technique and robotics assistance in single incision laparoscopy was also recently described.4 While exciting, we must resist the temptation to take on procedures beyond our current realm of expertise. Although patients will ask for the procedure, it is our responsibility to transition responsibly into this new technique. Trainer boxes, courses and preceptors are available for practicing physicians to learn and hone their skills. I encourage anyone considering offering single incision laparoscopy to get adequate training, continue to refine their skills with trainers, and report their results in the peer-reviewed literature.

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Surgical Technique of Robotic Radical Trachelectomy

Radical trachelectomy is performed in select patients diagnosed with early-stage cervical cancer who wish to preserve their fertility. Since the procedure was first described by Dargent et al. in 1994, numerous reports have documented the safety and feasibility of the vaginal approach. Alternatively, the procedure may also be performed successfully via the abdominal approach.

The advantages of minimally invasive surgery have been well-documented with decreased blood loss, decreased pain medication requirements, decreased length of stay, quicker return of bowel function, and faster return to daily activities. More recently, the use of robotic surgical systems has allowed surgeons the opportunity to perform complex gynecologic oncology procedures through a minimally invasive approach. The following is a description of the surgical technique for robotic radical trachelectomy.

The patient is placed in the dorsal lithotomy position. A V-Care manipulator (Utica, New York) is placed in the uterus for manipulation. Once this is completed, attention is then focused on the abdominal part of the procedure. A 12-mm bladeless trocar (Ethicon Endo-Surgery, Cincinnati, OH) is introduced in the left upper quadrant approximately 2 cm below the left costal margin at the mid-clavicular line, and the abdomen is insufflated. This trocar is used during the procedure by the patient-side assistant. The patient is then placed in steep Trendelenburg position. The abdomen is explored for evidence of metastatic disease. Another 12-mm bladeless trocar is placed in the umbilicus under direct visualization. This second trocar is used for the robotic camera. The robotic trocars are then placed. The first robotic trocar is placed 8 cm lateral and 15 degrees below the patient-side assistant’s trocar. The second robotic trocar is placed 8 cm to the right of and 15 degrees below the trocar at the umbilicus. The third robotic trocar is placed 8 cm lateral to the second robotic trocar. The robotic instruments used include an EndoWrist (Intuitive Surgical, Sunnyvale, CA) bipolar grasping forceps through the first robotic trocar, an EndoWrist monopolar scissors through the second robotic trocar, and an EndoWrist Cardioline grasping forceps through the third robotic trocar. The DaVinci robotic system is then docked.

The radical trachelectomy is performed as follows. First, an incision is made over the round ligament and the peritoneum lateral to the infundibulopelvic ligaments is opened bilaterally. The paravesical and pararectal spaces are then developed. The ureters are then separated from the peritoneum down to where they enter the lateral parametrical tissue. The level of resection of the parametria is described as follows: The ureters are dissected from the parametria and mobilized completely to the bladder after division of the anterior and posterior vesico-uterine ligaments are divided. The bladder peritoneum is then incised, and the bladder is mobilized inferiorly over the anterior vaginal wall. The ureteral vessels are transected bilaterally at their origin and dissected over the ureters bilaterally. The anterior vesicouterine ligaments are then divided.

The peritoneum over the rectovaginal space is then incised, and the uterosacral ligaments are divided bilaterally. While upward traction is placed on the vaginal cuff, a circumferential incision is made approximately 2 cm below the vaginal stump. The V-Care manipulator is then removed. The specimen is then held by the parametria bilaterally using graspers. The monopolar scissors or Harmonic scalpel (Ethicon Endo-Surgery, Cincinnati, OH) is used to amputate the cervix leaving approximately 1 cm of cervical stump. The specimen including cervix, bilateral parametria, and upper vaginal margin is then removed through the vagina. The specimen is then sent for frozen section. The endocervical margin should be tumor-free at least 10 mm from the level of the tumor. A Smi sleeve (Nucletron, MD) is then introduced vaginally and placed into the uterus by using the robotic graspers. A cerclage is placed and the uterus is attached to the upper level of the vagina using 0 Vicryl sutures. This is done using the EndoWrist Mega Needle driver. The pelvic lymphadenectomy is performed bilaterally from the level of the mid-common iliac vessels to the circumflex iliac vein distally.

References
1. Dargent D, Roy M, Remy I. Pregnancies following radical trachelectomy for invasive cervical cancer. Gynecol Oncol 1994;

FOCUS ON ONCOLOGY AT THE 38th GLOBAL CONGRESS - November 15-19, 2009

The AAGL Oncology Special Interest Group has been active in preparing courses that will update the surgical skills of gynecologic oncologists. This year, the AAGL will present two very timely workshops: “Updates on Robotic Surgery in Gynecologic Oncology,” (PC 1A & 1B) Dr. Pedro Ramirez, Chair and “Hands on Practicum for Gynecologic Oncology,” (PG 5A & 5B) Dr. Javier Magrina, Chair. Experts from around the world will participate and present their surgical pearls. Workshop registration is limited and AAGL members are provided a discount on registration fees. Register for these courses and the 38th Global Congress at the AAGL website, www.aagl.org.
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**SIAEGI: Sociedad Iberoamericana de Endoscopia Gynecologica e Imagenologia**

SIAEGI (Sociedad Iberoamericana de Endoscopia Gynecologica e Imagenologia) which was founded 17 years ago is a wonderful example of interested gynecologists from different countries working together for the betterment of their patients. Although not a true regional society, they have brought together surgeons from Spanish-speaking regions to form this very active society. Their sharing of knowledge and surgical techniques culminates every 2 years at their biennial meeting. The AAGL is very pleased to count SIAEGI as one of our “sister” societies.

Franklin D. Loffer, M.D.
Executive Vice President / Medical Director, AAGL

**When and how was your society established?**

SIAEGI was founded in 1992, was born from the interests of various colleagues who had the need to create an international, non-profit scientific society, that could hold periodic meetings for the exchange of experiences and to spread knowledges related to minimal invasive surgery in the Spanish-speaking regions.

Due to the fact that all the courses in advance of surgical techniques were given in Europe and United States, this offered the opportunity for the Endoscopic Gynecologists of our countries to learn what was given at international congresses and courses, and to establish schools, courses and surgical techniques of our own.

**What is its mission statement/primary goal?**

The main goal of our society is the spreading, study, teaching and practice of endoscopy and diagnostic and surgical imaging in gynecology, obstetric and human reproduction.

**Approximately how many members are there?**

SIAEGI has approximately 125 active members, as well as, beneficiary, honorary and founder members.

**What are some of the benefits of membership?**

Our society has a board of directors of six members, and the national secretaries of different countries of Spanish speaking regions, chosen every two years in a general assembly by the active members and founders, at the International Congress.

Our members have the right to participate in scientific meetings, conferences, congress, and all the activities programmed by the society. They can also present proposals for debates, participate and refer members to the board of directors, have the privileges of special fees in congress and activities to the different societies with which SIAEGI is affiliated, such as AAGL.

**Is there any additional information you would like to provide about your society?**

The beautiful city of Cartagena de Indias, Colombia, held the X Congress of our society (May 24 – 30, 2009) with the participation of the most prestigious colleagues of minimally invasive surgery of different latitudes to share their experiences in an ethical and respectful environment, with a thorough scientific program taking in account the most important and controversial subjects, as well as, a social and cultural program that made our event a memorable and unforgettable experience.

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**AMA Annual House of Delegates Meeting**

**June 13-17, 2009 – Chicago, Illinois**

The main event of the AMA Annual Meeting was the appearance and speech by President Barack Obama. Although President Obama discussed preventive care and health information technology as a means of lowering health care costs, he did not cite any concrete evidence to support these strategies.

Although the President spoke of the need for liability reform, he said he was against caps on non-economic loss. This mixed message was not received well by the audience. Since numerous studies have shown that caps are one of the most important factors in keeping professional liability premiums affordable, it is difficult to understand how the President can be for liability reform and against caps.

The AMA addressed these important issues:

- The AMA is to research and present a report on the issues involved in “bundled payments” to hospitals so that independent, non-hospital physicians can participate to the same extent as hospital employed physicians.
- There was spirited discussion on a report from the Council on Ethical and Judicial Affairs (CEJA) on the financial relationships between physicians and industry. Confusing terms such as “ethically permissible” and “ethically preferable” were discussed at length and no conclusion drawn. This issue will continue to be debated.
- Another important issue was medical staff autonomy:
  - A resolution asked the AMA to encourage the Joint Commission to mandate that medical staff officers be elected by a majority vote in a confidential ballot and that all bylaws changes be approved by a majority vote in a confidential ballot.
  - A task force is to be appointed to look into reducing the annual AMA meeting from three to two days.
- The AMA advocates that hospitals with level one trauma centers compensate appropriately all physicians who are required to remain in-house for coverage.
- The AAGL maintains a delegate to the AMA to influence the activities and dialogue in this physician-member organization.
INDICATIONS: The HTA System is a hysteroscopic thermal ablation device intended to ablate the endometrial lining of the uterus in premenopausal women with menorrhagia (excessive uterine bleeding) due to benign causes for whom childbearing is complete.

CONTRAINDICATIONS: The HTA System is contraindicated for use in a patient: who is pregnant or wants to be pregnant in the future, as pregnancy after ablation can be dangerous to both mother and fetus; who has known or suspected endometrial carcinoma or premalignant change of the endometrium, such as adenomatous hyperplasia; who has active pelvic inflammatory disease or pyosalpinx; hydrosalpinx; who has any anatomical or pathologic condition in which weakness of the myometrium could exist, such as, prior classic cesarean section or transverse myomectomy; who has an intrauterine device in place; or who has active genital or urinary tract infection, e.g., cervicitis, endometritis, vaginitis, cystitis, etc., at the time of treatment. POTENTIAL ADVERSE EFFECTS that may occur include: thermal injury to adjacent tissue including cervix, vagina, vulva, and/or perineum; heated saline escaping from the device system into the vascular spaces; hemorrhage; perforation of uterus; complications with pregnancy (Note: pregnancy following ablation is dangerous to both the mother and the fetus); risks associated with hysteroscopy, post ablation tubal sterilization syndrome; infection or sepsis, complications leading to serious injury or death. WARNINGS: NOTE: Failure to follow any instructions or to heed any Warnings or Precautions could result in serious patient injury. CAUTION: Federal Law (USA) restricts this device to sale by or on the order of a physician. The physician using the device must be trained in diagnostic hysteroscopy.
CROATIA

Vacation on the Adriatic Sea
June 23 - 26, 2010

4th Annual AAGL
International Congress on Minimally Invasive Gynecology

Congress Chair:
Miroslav Kopjar

Scientific Program Chair:
Resad P. Pasic

Dubrovnik, Croatia
June 23-26, 2010
Rixos Libertas Dubrovnik

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This hands-on course is designed to develop hysteroscopic skills and to teach gynecologist how to safely perform hysteroscopy in an office setting and to expand its surgical uses. The enrollment is limited to 12 participants in order to provide maximum instruction and hands-on experience.

The course will assist gynecologic surgeons who wish to provide minimally invasive gynecological care using hysteroscopy in order to meet the expectations of their patients and insurance carriers. Gynecologists who wish to learn hysteroscopic skills to expand their office surgical practice and develop new operating room skills will benefit from this workshop.

7:30 am Registration
8:00 am Office Diagnostic and Operative Hysteroscopy: Indications, Equipment, and Technique
9:00 am Office Hysteroscopic sterilization - Essure and Adiana
9:40 am Office Endometrial Ablation
10:30 am Break
10:45 am Improving Your Operative Hysteroscopy Techniques
11:30 am Complications of Hysteroscopy and Proper Fluid Management
12:00 pm Case presentation and Lunch
1:00 pm 3-hour, hands-on lab with models. Equipment scheduled to be included are: flexible hysteroscope, rigid office hysteroscope, resectoscope, Essure, Adiana, fluid management machine, office ablation machines (HerOption, Microsulis, Novasure, Gynecare, HTA)
4:00 pm Wrap up
4:30 pm Adjourn

FACULTY
Andrew I. Brill, M.D.
Keith B. Isaacson, M.D.
Franklin D. Loffer, M.D.

These workshops are supported in part by an educational grant from Karl Storz Endoscopy-America in accordance with ACCME commercial support guidelines.
For 38 years the AAGL’s commitment to education has been paramount to our mission of serving women by advancing the safest and most effective treatments for gynecologic conditions. We gratefully acknowledge the generous educational grants from the following corporations who partner with us in achieving this mission.

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member news

Martin Farrugia was conferred his Ph.D. on July 9, 2009 at Queen Mary, University of London following acceptance of his thesis, *Electrosurgery on the Uterus: An Investigation of the Local and Systemic Effects*. Congratulations to Dr. Farrugia for his dedication to complete this degree.

Leonard Weather Jr., M.D., a gynecologist in New Orleans/Shreveport, LA was elected to serve as president-elect of the National Medical Association, at the association’s 107th Annual Meeting in July 2009. The National Medical Association represents over 30,000 African-American physicians. Dr. Weather will be installed as the 111th President, at the Annual Meeting in Orlando, FL, July 30-August 5, 2010.

Welcome New Members

June 13, 2009 – Sept 16, 2009

Maria Teresa Achilarre, M.D.
Royce Terrell Adkins, M.D.
Sunita Agrawal, M.D.
Munire E. Akar, M.D.
Mariam Al Hilli, M.D.
Hatim M. Aldabbagh, FRCS
Hanan M. Al-Ghasham, M.D.
Kathryn Louise Arendt, M.D., FACOG
Veerayyagari Annapurna, M.D.
Karin L. Andersson, M.D.
Warqa Saleh Alshayeji, FRCSC
Abdulaziz Alobaid, M.D.
Zakaria M. Almoumen, M.D.
Rebecca H. Allen, M.D., MPH
Hanan M. Al-Ghasham, M.D.
Hatim M. Aldabbagh, FRCSC
Mariam Al Hilli, M.D.
Munire E. Akar, M.D.
Sunita Agrawal, M.D.
Royce T. errell Adkins, M.D.
Maria T. eresa Achilarre, M.D.

Jennifer Pellegrin Baur, M.D.
Heather L. Bedell, M.D.
Timothy H. Bedell, M.D.
Patrick Bello Los, M.D.
Liliana Belks M, M.D.
Leah Benson, D.O.
Albertr G. Beraldo, M.D.
Colin Birch, MBBS.FRCS(C)
Kristin L. Bixel, M.D.
Holly-Mari Bolger, D.O.
Camila Locci Bombliempo, M.D.
Andre Bongain, M.D.
George Botros, M.D.
Giacomo Bruscoli, M.D.
Christopher S Bryant, M.D.
Tomas Budfa, M.D.
Miles Eugene Byrd, M.D.
Lynsey Michelle Caldwell, M.D.
Rafael Campanella, M.D.
Anna Lina Camperale, M.D.
Bernard Cantor, M.D.
Iurie Caraplan, M.D.
Erim Carey, M.D.
Luis Fernando Carvalho, M.D.
Richard Castillon, M.D.
Mahmet Nuri Ceydeli, M.D.
Pauline Lingping Chang, M.D.
Stephanie Ann Chase, M.D.
Priya Ajay Chauhan, M.D.
Dilin Chen, M.D.
Peter T. Chijumada, M.D.
Dimple V. Chudgar-Katira, M.D.
Jason C. Coletta, M.D.
Renée Cortland, M.D.
Jessica A. Crawford, M.D.
Damon Cudihy, M.D.
Roberto Cunningham, FACOG
Shuzhen Dai, M.D.
Ashraf M Dawood, MBBS
Mark Wesley Dassel, M.D.
Asnar M Dawood, MBBS
Erik Dean, M.D.
Imarn Deura, M.D.
Charu Dhingra, M.D.
Barbara Dias, M.D.
Daniel S. Dias, M.D.
Giuliano Dicuonzo, M.D.
Dah-Ching Ding, M.D., Ph.D.
Dragana Milenko Djordjevic, M.D.
Vladimir Durasov, M.D.
Kaci Lynne Durbin, M.D.
Ronald Eason, M.D.
Nazarin Ehsani, M.D., MPh
Said M El Makkaoui, M.D.
Raymond Geoffrey Elmore, M.D.
Joao Paulo Epprechti, M.D.
Alvaro Jose Escobar, M.D.
Merritt Evans, M.D.
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Jessica Gibney, M.D.
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Jennifer Godbout, M.D.
Shailles E. Gokavi, M.D.
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Mikel Gorostidi, M.D.
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Bulent Haydardedeoglu, M.D.
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To learn more, contact your Ethicon Endo-Surgery sales representative, call 1-800-USE-ENDO, or visit www.surgrx.com.
Would You Like to Join a Special Interest Group?

We would like to remind all members that there will be three new Special Interest Groups developed at the AAGL 38th Global Congress on Minimally Invasive Gynecology at the Gaylord Palms in Orlando, Florida. If you have an interest in getting involved, please note the date and time for each group meeting:

**Tuesday, November 17, 2009 – Naples 3 Room**

10:00 am – 11:00 am Reproductive Medicine
11:15 am – 12:15 pm Urogynecology
3:15 pm – 4:15 pm Robotics

We look forward to seeing you there!
Meet the mesh that blends with its surroundings.

PROLIFT+M™ with MONOCRIL®:
Designed with more flexibility to help deliver improved functionality with less foreign material left in the body. That way, you and your patients can get more with less.

Visit us at booth 601 for the whole story.

INDICATIONS: The GYNECARE PROLIFT+M™ Total, Anterior, and Posterior Pelvic Floor Repair Systems, through placement of GYNECARE GYNEMESH M™ Partially Absorbable Mesh, are indicated for tissue reinforcement and long lasting stabilization of fascial structures of the pelvic floor in vaginal wall prolapse where surgical treatment is intended, either as mechanical support or bridging material for the fascial defect.

CONTRAINDICATIONS: GYNECARE GYNEMESH M™ Mesh should not be used in infants, children, pregnant women, or women planning future pregnancies, as the mesh will not stretch significantly as the patient grows. • GYNECARE GYNEMESH M™ Mesh must always be separated from the abdominal cavity by peritoneum. • GYNECARE GYNEMESH M™ Mesh must not be used following planned intra-operative or accidental opening of the gastrointestinal tract. Use in these cases may result in contamination of the mesh, which may lead to infection that may require removal of the mesh. • The GYNECARE PROLIFT+M™ System should not be used in the presence of active or latent infections or cancers of the vagina, cervix, or uterus.

WARNINGS: Patients on anticoagulation agents undergoing surgery using the GYNECARE PROLIFT+M™ System must have their anticoagulation therapy carefully managed. • Do not remove the GYNECARE PROLIFT+M™ Cannulas from the patient until the mesh implant has been properly positioned. • A digital rectal exam should be performed to detect possible rectal perforation. • Cystoscopy may be performed to confirm bladder integrity or detect possible bladder or urethral perforation. • Post-operatively the patient should be advised to refrain from intercourse, heavy lifting and/or exercise (e.g. cycling, jogging) until the physician determines when it is suitable for the patient to return to her normal activities. • Use the GYNECARE PROLIFT+M™ System with care, and with attention to patient anatomy and to proper dissection technique, to avoid damage to vessels, nerves, bladder, bowel, and vaginal wall perforation. Correct use of the GYNECARE PROLIFT+M™ System components will minimize risks. • Transient leg pain may occur and can usually be managed with mild analgesics.

ADVERSE REACTIONS: Potential adverse reactions are those typically associated with surgery employing implantable materials of this type, including hematoma, urinary incontinence, urinary retention/obstruction, ureter obstruction, voiding dysfunction, pain, infection potentiality, wound dehiscence, nerve damage, recurrent prolapse, inflammation, adhesion formation, fistula formation, contracture, scarring, and mesh exposure, erosion, or extrusion. • Punctures or lacerations of vessels, nerves, bladder, urethra or bowel may occur during GYNECARE PROLIFT+M™ Guide passage and may require surgical repair. • Potential adverse reactions are those typically associated with pelvic organ prolapse repair procedures, including pelvic pain or pain with intercourse. These may resolve with time. • Dissection for pelvic floor repair procedures has the potential to impair normal voiding for a variable length of time.

**education calendar**

The following educational meetings are sponsored by or in affiliation with the AAGL

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Location</th>
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<tbody>
<tr>
<td>October 2 – 5, 2009</td>
<td>Update in Minimally Invasive Gynecology</td>
<td>Boston Harbor Hotel • Boston Massachusetts</td>
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<tr>
<td>November 15 – 19, 2009</td>
<td>38th Global Congress of Minimally Invasive Gynecology</td>
<td>Gaylord Palms Resort • Orlando, Florida</td>
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<tr>
<td>January 22 – 25, 2010</td>
<td>6th Annual Optimizing Minimally Invasive Gynecology</td>
<td>Ritz Carlton • Fort Lauderdale, Florida</td>
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<tr>
<td>January 23, 2010</td>
<td>Hysteroscopy Workshop</td>
<td>Newton-Wellesley Hospital • Boston, Massachusetts</td>
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<tr>
<td>February 4-5, 2010</td>
<td>4th Annual Workshop on Advanced Laparoscopic Techniques for Gynecologic Oncologists using Unembalmed Cadavers</td>
<td>Mayo Clinic-Arizona • Scottsdale, Arizona</td>
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<tr>
<td>February 19, 2010</td>
<td>Hysteroscopy Workshop</td>
<td>California Medical Center • San Francisco, CA</td>
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<tr>
<td>March 19, 2010</td>
<td>Hysteroscopy Workshop</td>
<td>California Medical Center • San Francisco, CA</td>
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<tr>
<td>March 19-20, 2010</td>
<td>Minimally Invasive Hysterectomy: A Comprehensive Review of Techniques including Live Telesurgery</td>
<td>University of Louisville • Louisville, Kentucky</td>
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<tr>
<td>April 10, 2010</td>
<td>Hysteroscopy Workshop</td>
<td>California Medical Center • San Francisco, CA</td>
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<tr>
<td>April 14 – 16, 2010</td>
<td>Laparoscopic Complications: Prevention and If Things Go Wrong, What Next?</td>
<td>Athens, Greece</td>
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<tr>
<td>May 21 – 22, 2010</td>
<td>12th Annual Advanced Workshop on Gynecologic Laparoscopic Anatomy &amp; Surgery on Unembalmed Cadavers</td>
<td>University of Louisville • Louisville, Kentucky</td>
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<tr>
<td>June 23 – 26, 2010</td>
<td>IV AAGL, International Congress on Minimally Invasive Gynecology in conjunction with the Croatian Society of Gynaecological Endoscopy</td>
<td>Caesar’s Palace • Las Vegas, Nevada</td>
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<tr>
<td>November 6 – 10, 2011</td>
<td>40th Global Congress of Minimally Invasive Gynecology</td>
<td>The Westin Diplomat • Hollywood, Florida</td>
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<tr>
<td>November 5 – 9, 2012</td>
<td>Vth AAGL International Congress on Minimally Invasive Gynecology in conjunction with the Turkish Society of Gynaecological Endoscopy</td>
<td>Caesar’s Palace • Las Vegas, Nevada</td>
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