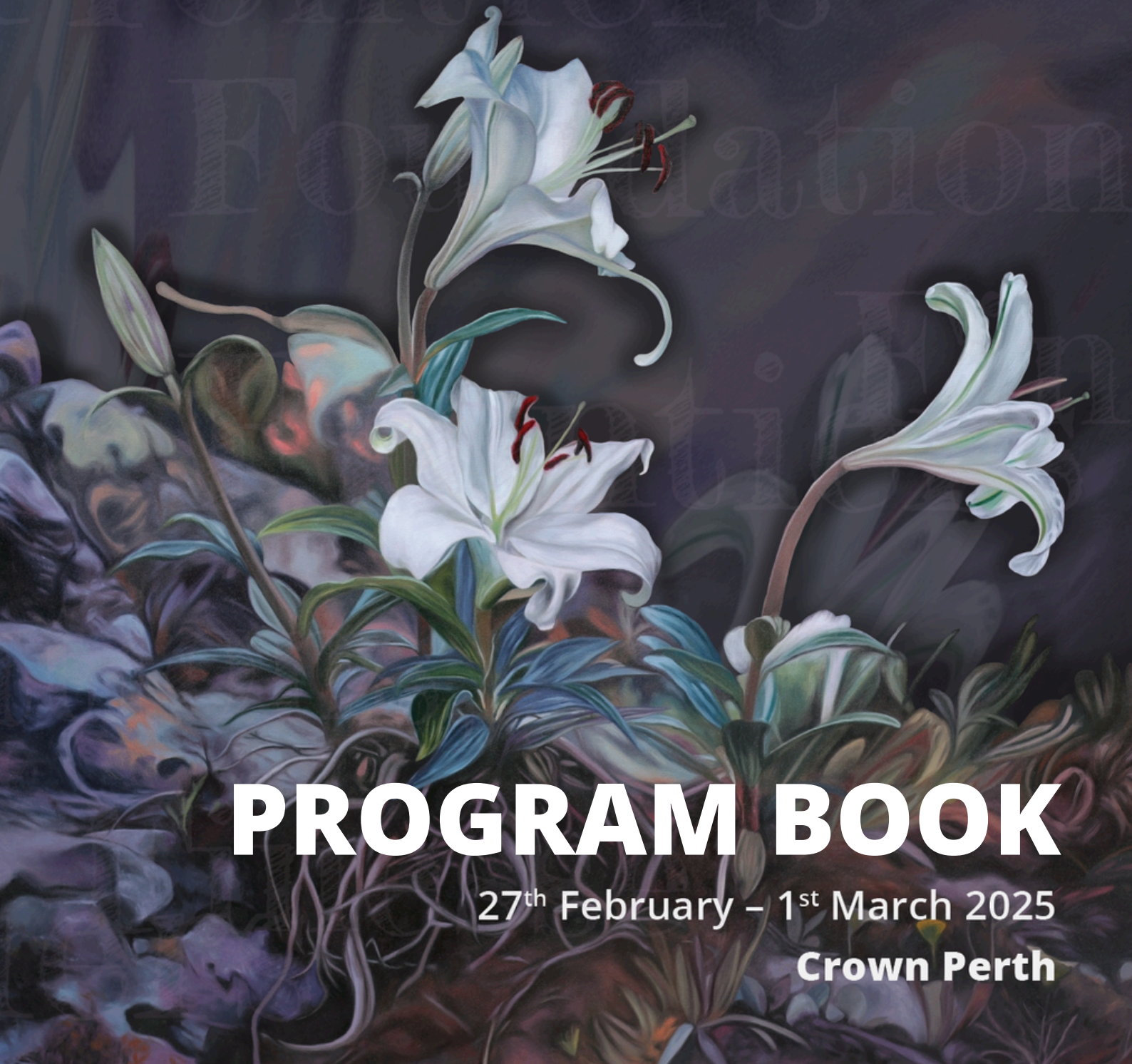


# Foundations, Finesse, Frontiers



## **PROGRAM BOOK**

27<sup>th</sup> February – 1<sup>st</sup> March 2025

**Crown Perth**



Dear Colleagues,

On behalf of the Australian Gynaecological Endoscopy & Surgery Society, I am delighted to welcome you to beautiful Perth, Western Australia, for the AGES Annual Scientific Meeting 2025. This year's theme is "Foundations, Finesse, Frontiers". With this theme, we return to our roots, namely the provision and oversight of the safest and highest standard of clinical and minimally invasive surgical care.

- 'Foundations' represents our commitment to revisiting our core surgical roots and refreshing knowledge in advanced laparoscopic pelvic surgery
- 'Finesse' signifies our dedication to refining techniques and elevating our practice to excellence
- 'Frontiers' embodies our forward-looking approach, embracing research and innovation to propel our specialty into the future.

We have designed an engaging program encompassing a wide variety of sessions, tailored to meet the needs of both generalists and experienced laparoscopists. Over the course of three days, participants will have the opportunity to attend a wide range of sessions and workshops. In addition to focusing on complex surgery, there will also be sessions on endometriosis, fertility, hysteroscopy and more. This comprehensive agenda is intended to explore the full spectrum of contemporary issues and innovation in minimally invasive gynaecological surgery.

We are excited to honour Perth as the home of the Anatomy of Complications (AC) Workshop. This workshop was the brainchild of Professor Ian Hammond and Dr John Taylor and has been running for almost 20 years. Current convenors Professor Yee Leung, Associate Professor Krish Karthigasu, and Dr Robyn Leake will facilitate a live, on-stage dynamic AC Workshop case discussion that promises to be highly educational, stimulating and entertaining.

We are also honoured to welcome many esteemed international speakers, in a meeting that will highlight AGES' new commitment to strengthening our relationships with several international societies including APAGE, ESGE, BSGE and AAGL.

We warmly welcome Dr Jeffrey Woo, a minimally invasive gynaecological surgeon and Assistant



Professor of Obstetrics and Gynaecology, hailing from Eastern Virginia Medical School. Dr Woo was elected by the AAGL in 2023 as the Editor-in-Chief of SurgeryU, an international peer-reviewed surgery video library. Some of you may already be familiar with his highly popular and educational Instagram page @MigsTips. He brings a wealth of experience in complex gynaecological surgery alongside novel surgical education techniques.

The conference is hosted at the Crown Perth Complex, located on the edge of the Swan River and close to the city centre and airports. It is a beautiful time to visit our city. We invite you to make the most of our wonderful weather and stunning beaches. Consider taking a short trip to the picturesque Swan Valley, the expansive Kings Park, or the renowned Margaret River wine regions during your stay. No visit is complete without a trip to Rottne Island with its incredible natural beauty, unspoilt landscape and endearing quokkas.

We look forward to a stimulating program filled with insightful discussions, innovative research, and opportunities for collaboration.

Thank you for joining us as we embark on this exciting journey together.

**A/Prof Emma Readman and Dr Jennifer Pontré**  
On behalf of the Organising Committee

# AGES BOARD



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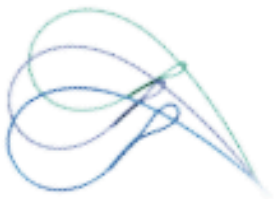
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1. Based on internal test report #RE00329878 rev A, Marketing evaluation of surgeon experience using the Sonicision™ 7 curved jaw cordless ultrasonic dissector. April 14-15 and 20-22, 2021.)





**CONFERENCE  
PROGRAM**





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# Foundations, Finesse, Frontiers

## AGES ASM 2025 PROGRAM Thursday 28 February – Saturday 1 March 2025

THURSDAY 27 FEBRUARY		
<b>0700 - 0800</b>	<b>Conference Registration</b>	<i>Crown Ballroom Foyer</i>
<b>0800 - 0930</b>	<b>Session 1: Opening Plenary</b> <b>Chairs:</b> Rachel Green & Jennifer Pontre	<i>Crown Ballroom 1</i>
0800 - 0815	Acknowledgement of Country & Introduction to the ASM – <b>Rachel Green &amp; Jennifer Pontre</b>	
0815 - 0835	The Five Stages of Surgical Training - and How Understanding Them Can Lower Your Complication Rate – <b>Sven Becker</b>	
0835 - 0900	Just Do It! Harness Surgical Videography to Boost Your Career - Inside and Outside the OR - <b>Jeffrey Woo</b>	
0900 - 0925	Does the Ovary Stay or Go? Rethinking the Guidelines Around Adnexectomy – <b>Stuart Salfinger</b>	
0925 - 0930	Panel Questions	
<b>0930 - 1030</b>	<b>Session 2: Chairman's Choice</b> <b>Chairs:</b> Michael Wynn-Williams & Emma Readman	<i>Crown Ballroom 1</i>
0930 - 0940	Intra-Operative Intravenous Tranexamic Acid During Laparoscopic Surgery for Severe Endometriosis and a Double-Blinded Randomized Placebo Controlled Trial – <b>Charlotte Reddington</b>	
0940 - 0950	Plasma Protein Biomarkers as an Innovative Tool for The Non-Invasive Diagnosis of Endometriosis – <b>Kirsten Peters</b>	
0950 - 1000	Robotic Subtotal Hysterectomy, Bilateral Salpingo-Oophorectomy with the Aid of Harmonic Scalpel for Removal Of >3kg Uterus with Cervical Fibroid – <b>Rebecca Nash</b>	
1000 - 1010	A Randomized Double-Blind Pilot Trial Evaluating the Efficacy of Intralesional Platelet Rich Plasma (PRP) Versus Placebo for Vulvovaginal Lichen Sclerosus (LS) – <b>Rituparna Dutta</b>	
1010 - 1020	Near-Infra Red Technology - Robotic-Hysteroscopic Assisted Isthmoplasty – <b>Vinita Rajadurai</b>	
1020 - 1030	Advanced Surgical Techniques for Complex Endometriosis: Ovary Dissection, Nerve Preservation, Unjackknife Method, And Rectal Shaving Technique – <b>Yael Yagur</b>	
<b>1030 - 1100</b>	<b>Morning Tea, Trade Exhibition &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>	<i>Crown Ballroom 2 &amp; 3</i>
<b>1100 - 1230</b>	<b>Session 3 Concurrent Sessions</b>	
<b>1100 - 1230</b>	<b>Session 3A: Menopause Speed Updating</b> <b>Chairs:</b> Catarina Ang & Bernie McElhinney	<i>Astral 1</i>
1100 - 1112	Below the Belt: Menopause after Cancer - <b>Lesley Ramage</b>	
1112 - 1124	PMDD and Progesterone Sensitivity in Menopause - <b>Sunita Chelva</b>	
1124 - 1136	Mood and Menopause – <b>Michelle Cotellessa</b>	

*Program is correct at the time of printing and subject to change without prior notice. Refer to the conference app for the most accurate program.*





# Foundations, Finesse, Frontiers

1136 - 1148	New and Old: Update on Best Practice – <b>Lucy Williams</b>	
1148 - 1200	Premature Ovarian Insufficiency: An Update - <b>Ashley Makepeace</b>	
1200 - 1212	Menopause: An Integrated Approach - <b>Lucy Caratti</b>	
1212 - 1230	Panel Discussion	
<b>1100 - 1230</b>	<b>Session 3B: The Ovary Speed Updating</b> <b>Chairs:</b> Bassem Gerges & Erin Nesbitt-Hawes	<i>Crown Ballroom 1</i>
1100 - 1112	Oophoropexy: To Let it Be or Not Let it Be? – <b>Kate McIlwaine</b>	
1112 - 1124	What's the Goss with PCOS? – <b>Helen McNamara</b>	
1124 - 1136	AMH: Are My Eggs Fried? – <b>Lauren Hicks</b>	
1136 - 1148	Progesterone Pearls – <b>Alison Bryant-Smith</b>	
1148 - 1200	Chocolate Cysts and the Baby: An Endometrioma Story – <b>Keryn Harlow</b>	
1200 - 1212	Post Menopausal Cysts - What's the Risk? - <b>Charlotte Reddington</b>	
1212 - 1230	Panel Discussion	
<b>1100 - 1240</b>	<b>Session 3C: Oral &amp; Video Free Communications</b> <b>Chairs:</b> Kate Martin & Aaron Budden	<i>Astral 2</i>
1100 - 1110	Intrauterine Suturing Device Using Hysteroscope - Proof of Concept – <b>Adi Dayan-Schwartz</b>	
1110 - 1120	Repeat Botox Injections for Treatment of Chronic Pelvic Pain and Pelvic Floor Overactivity – <b>Akshara Shyamsunder</b>	
1120 - 1130	Building A Surgical Legacy: Advancing Endoscopic Skills in Gynaecology for AGES and RANZCOG Trainees - The FNQ Experience – <b>Amanda Wee</b>	
1130 - 1140	Use of Intra-Operative Ultrasound During Laparoscopic Myomectomy: A Case Series – <b>Anna Brownson</b>	
1140 - 1150	Decisions, Decisions, Decisions. Shave, Disc or Resection – <b>Christine Foster</b>	
1150 - 1200	Informed Consent for Innovative Surgery – <b>Naomi Holbeach</b>	
1200 - 1210	Video Article: Laparoscopic Removal of a Retroperitoneal-Retrocervical Fibroid – <b>Omer Mor</b>	
1210 - 1220	The Girl with The Pearl Necklace: 17 Fibroids, Robotic-Assisted Myomectomy with Finesse - <b>Orla Donohoe</b>	
1220 - 1230	Pelvic Floor Muscle Tenderness in Women Undergoing Surgery for Endometriosis: A Reliability Study – <b>Pinar Cingiloglu</b>	
1230 - 1240	Pioneering Surgical Solutions: A Novel Technique for Anterior Bowel Resection in Colorectal Endometriosis – <b>Saima Wani</b>	
<b>1230 - 1330</b>	<b>Lunch, Trade Exhibition &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>	<i>Crown Ballroom 2 &amp; 3</i>



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# Foundations, Finesse, Frontiers

<b>1330 - 1500</b>	<b>Session 4 Concurrent Sessions</b>	
<b>1330 - 1500</b>	<b>Session 4A: Fertility</b> <b>Chairs:</b> Tal Jacobson & Yogender Yadav	<i>Astral 1</i>
1330 - 1350	Fibroids and Fertility: Evidence Not Opinion – <b>Pippa Robertson</b>	
1350 - 1410	Caesarean Scar Niche and Fertility: Truth or Fiction – <b>Anusch Yazdani</b>	
1410 - 1430	Deeply Infiltrating Endometriosis and Infertility: What to do in '25 – <b>Jennifer Pontre</b>	
1430 - 1450	Endometrioma Treatment Options in the Infertile - <b>Krish Karthigasu</b>	
1450 - 1500	Panel Discussion	
<b>1330 - 1500</b>	<b>Session 4B: International Society Partner</b> <b>Chairs:</b> Amani Harris, Bernard Chern & Alan Lam	<i>Crown Ballroom 1</i>
1330 - 1350	Establishing a Program for Training in Robotic Hysterectomy – <b>Ted Anderson, AAGL</b>	
1350 - 1410	Tips & Tricks for Robotic/Laparoscopic Myomectomy – <b>Sita Ayu Arumi, APAGE</b>	
1410 - 1430	Robotic Approaches to Managing Colorectal Endometriosis – <b>Sven Becker, BSGE</b>	
1430 - 1450	Neuropelvelogy: Where do we go with Pelvic Nerves? – <b>Benoit Rabischong, ESGE</b>	
1450 - 1500	Panel Discussion	
<b>1330 - 1510</b>	<b>Session 4C: Oral &amp; Video Free Communications</b> <b>Chairs:</b> Nyasha Gwata & Rose McDonald	<i>Astral 2</i>
1330 - 1340	The Endometriosis Longitudinal Fertility Study (ELFS): 36 Month's Experience with The ELFS App for Longitudinal Fertility Data Collection – <b>Sam Mooney</b>	
1340 - 1350	Ultrasound Assessment of The Uterosacral Ligaments and Diagnostic Accuracy for Peritoneal Endometriosis: A Pilot Single-Centre Prospective Study - <b>Sam Mooney</b>	
1350 - 1400	Laparoscopic Excision of Caesarean Scar Pregnancy at 11 Weeks Gestation in A Woman with A Bicornuate Uterus and Placenta Accreta Spectrum – <b>Sean Copson</b>	
1400 - 1410	Complete Removal of Retropubic Mid-Urethral Sling by Laparoscopic Approach – <b>Sebastian Jacob-Rogers</b>	
1410 - 1420	Unravelling Essure: A Case Report Highlighting Challenges and Surgical Techniques for Device Removal – <b>Sireen Jaber</b>	
1420 - 1430	Laparoscopic Resection of Caesarean Scar Ectopic Pregnancy with Application of Laparoscopic Bulldog Clips – <b>Sneha Parghi</b>	
1430 - 1440	Standardizing The Histopathological Diagnosis of Adenomyosis: An International Delphi Consensus – <b>Tristan McCaughey</b>	
1440 - 1450	The Endometriosis Longitudinal Fertility Study (ELFS): Pre-Pregnancy Treatment Decisions for Women with Moderate or Severe Endometriosis Who Are Trying to Conceive - <b>Vanessa Ross</b>	
1450 - 1500	Steps to a Robotic Assisted Abdominal Cervical Cerclage Using ICG To Aid in Vessel Identification – <b>Vinita Rajadurai</b>	
1500 - 1510	A Randomised Controlled Trial of Hysteroscopic Morcellation Versus Electrosurgical Resection for Submucosal Leiomyomas in Women With AUB-L – <b>Zaynab El-Hamawi</b>	

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<b>1500 - 1530</b>	<b>Afternoon Tea Trade &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>	<i>Crown Ballroom 2 &amp; 3</i>
<b>1530 - 1700</b>	<b>Session 5: Complex Surgery</b> <b>Chairs:</b> Jade Acton & Gillian Gibson	<i>Crown Ballroom 1</i>
1530 - 1550	Trouble in the Lower Uterine Zone: Tackling Isthmococele and Scar Ectopic, One Stitch at a Time! – <b>Jeffrey Woo</b>	
1550 - 1610	Ovary on the Edge: Surgical Solutions for Residual Ovaries – <b>Jade Acton</b>	
1610 - 1630	When the Vault Breaks: Insights into Vaginal Vault Dehiscence – <b>Amani Harris</b>	
1630 - 1650	Laparoscopic Hysterectomy Redefined: Navigating Complex Cases with Confidence – <b>Albert Jung</b>	
1650 - 1700	Panel Questions	
<b>1700</b>	<b>Close of Day One</b>	
<b>1700 - 1800</b>	<b>Welcome Reception</b> <i>Medtronic Suturing Café Competition</i>	<b>Crown Ballroom 2 &amp; 3</b>



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# Foundations, Finesse, Frontiers

## FRIDAY 28 FEBRUARY

<b>0700 - 0745 Sponsored Breakfast Sessions</b> <i>(Pre-registration required)</i>			
<b>0700 - 0745</b>	<p><b>Medtronic</b></p> <p>Robotic Gender Inequity for Australian and New Zealand Patients - how did we get here and how can we fix it? <i>Botanical 1</i></p>	<p><b>Avant</b> <i>By doctors for doctors</i></p> <p>AI Scribes – an Overview of both Technical and Practical Issues  <i>Botanical 3</i></p>	<p><b>stryker</b></p> <p>Fluorescence imaging in gynaecology: now and into the future  <i>Botanical 4</i></p>
<b>0730 - 0830</b>	<b>Conference Registration</b>		<i>Crown Ballroom Foyer</i>
0800 - 0835	Annual General Meeting <i>(Members Only)</i>		<i>Crown Ballroom 1</i>
<b>0900 - 1000</b>	<b>Session 6: Keynote and Dan O'Connor Lecture</b> <b>Chaira:</b> Rachel Green & Robert O'Shea		<i>Crown Ballroom 1</i>
0900 - 0930	Surgical Effectiveness: Perception Versus Reality - <b>Ian Harris</b>		
0930 - 1000	Dan O'Connor Lecture - Reflections on Gynaecological Endoscopy – <b>Ray Garry</b>		
<b>1000 - 1030</b>	<b>Morning Tea, Trade Exhibition &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>		<i>Crown Ballroom 2 &amp; 3</i>
<b>1030 - 1200</b>	<b>Session 7: Pain</b> <b>Chaira:</b> Stephen Lyons & Lauren Kite		<i>Crown Ballroom 1</i>
1030 - 1050	Microbiome & Pain - <b>Elizabeth Gannon</b>		
1050 - 1110	Placebo or Nocebo – <b>Damien Finniss</b>		
1110 - 1130	Pain Relief or Pitfall? Reassessing Opioids in Pelvic Pain – <b>Sonya Ting</b>		
1130 - 1150	How Language Can Influence Patient Outcomes – <b>Matt Jenke</b>		
1150 - 1200	Panel Discussion		
<b>1200 - 1315</b>	<b>Lunch, Trade Exhibition &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>		<i>Crown Ballroom 2 &amp; 3</i>
<b>1315 - 1445</b>	<b>Session 8: The Anatomy of Complications M&amp;M</b> <b>Chairs:</b> Krish Karthigasu, Robyn Leake & Yee Leung		<i>Crown Ballroom 1</i>
1315 - 1445	<b>Panellists:</b> Jason Abbott, Richard Naunton Morgan, Marina Wallace & Jess Yin		
<b>1445 - 1515</b>	<b>Afternoon Tea, Trade Exhibition &amp; Digital Free Communications</b> <i>Refer to Free Communications Program</i>		<i>Crown Ballroom 2 &amp; 3</i>
<b>1515 - 1645</b>	<b>Session 9: Not So Live Surgery</b> <b>Chairs:</b> Emma Readman, Michael Wynn-Williams & Catarina Ang		<i>Crown Ballroom 1</i>
<b>1515 - 1645</b>	<b>Presenters:</b> Jörg Keckstein & Mario Malzoni		
<b>1645</b>	<b>Close of Day Two</b>		
<b>1900 - 2300</b>	<b>AGES Annual Black-Tie Gala Dinner, Awards &amp; Charity Auction</b>		<i>WA Museum Hackett Hall Gallery</i>

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# Foundations, Finesse, Frontiers

SATURDAY 1 MARCH		
0830 - 0900	<b>Conference Registration</b>	<i>Crown Ballroom Foyer</i>
0900 - 1030	<b>Session 10: Complex Reproductive Surgery</b> <b>Chairs:</b> Shamitha Kathurusinghe & Pippa Robertson	<i>Crown Ballroom 1</i>
0900 - 0920	To Cut or Not to Cut: That is the Septum – <b>Roger Hart</b>	
0920 - 0940	Asherman's: Prevention in the Fertility Patient – <b>Devini Ameratunga</b>	
0940 - 1000	Mullerian Anomalies – <b>Rebecca Deans</b>	
1000 - 1020	Beyond the Binary: Gynaecology Care for Gender Diverse People – <b>Jennifer Beale</b>	
1020 - 1030	Panel Discussion	
1030 - 1100	<b>Morning Tea &amp; Trade Exhibition</b>	<i>Crown Ballroom 2 &amp; 3</i>
1100 - 1230	<b>Session 11: Endometriosis</b> <b>Chairs:</b> Michael Wynn-Williams & Emma Readman	<i>Crown Ballroom 1</i>
1100 - 1120	Lighting the Way: ICG in the Surgical Management of Endometriosis – <b>Tanushree Rao</b>	
1120 - 1140	Adenomyomectomy: Easier to Perform Than Pronounce – Tips for Smooth Sailing! – <b>Jeffrey Woo</b>	
1140 - 1200	A Preoperative Optimisation Map to Enhance Endometriosis Surgery Outcomes - <b>Shamitha Kathurusinghe</b>	
1200 - 1220	Surgical Innovation - A Framework for Change – <b>Naomi Holbeach</b>	
1220 - 1230	Panel Discussion	
1230	<b>Conference Close</b>	
1230 - 1330	<b>Lunch</b>	



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# Foundations, Finesse, Frontiers

## DIGITAL FREE COMMUNICATIONS (DCS) PROGRAM

THURSDAY 27 FEBRUARY		
<b>1030 - 1100</b>	<b>Morning Tea, Trade Exhibition &amp; Digital Free Communications</b>	Crown Ballroom 2 & 3
1040 - 1045	Demonstrating Excision of Diaphragmatic Extra-Pelvic Endometriosis Using a Combined Abdominal Robotic and VATS Approach.	Aditya Gaur
1045 - 1050	Deep Infiltrating Endometriotic Bladder Nodule - A Stepwise Approach & Excision	Akshara Shyamsunder
1050 - 1055	Patient Factors Associated with Significant Pain During IUD Insertion	Alaina Francis
1055 - 1100	The Persistent Pelvic Pain Study: A Nested Randomised Control Trial Comparing Long-Term Pain and Quality of Life Outcomes for Patients with Persistent Pelvic Pain Managed into Two Clinics	Alaina Francis
<b>1230 - 1330</b>	<b>Lunch, Trade Exhibition &amp; Digital Free Communications</b>	Crown Ballroom 2 & 3
1250 - 1255	Robotic Transabdominal Cerclage Using the VERSIUSTM Robotic System, Our Experience With 30 Cases	Alex Ades
1255 - 1300	Navigating Dangerous Waters: Surgical Approaches for Difficult Bladder Dissection During Laparoscopy: A Video Presentation	Alexander Chen
1300 - 1305	Disseminated Peritoneal Leiomyomatosis: A Rare Presentation Following In-Bag Power Morcellation	Alice Scott
1305 - 1310	Laparoscopic Myomectomy for a 6 Cm Pedunculated Fibroid Arising from A Uterine Bud in The Context of Mayer-Rokitansky-Küster-Hauser (MRKH) Syndrome	Bridie Stewart
1310 - 1315	Patterns Of Care for Patients with Endometriosis in The National Endometriosis Clinical and Scientific Trials (NECST) Registry.	Cecilia Ng
1315 - 1320	A Retrospective Study Examining the Rate of Post-Procedural Pain Flare Following Injection of Botulinum Toxin Type A and Local Anaesthetic Solution to the Pelvic Floor Muscles	Helen McNamara
1320 - 1325	Scarred Yet Unsilenced: Pioneering Surgical Frontiers in Caesarean Scar Pregnancies	Hiba Alzaidani
1325 - 1330	Fertility After Endometriosis Surgery: A Comparison of Primary Vs Multiple Surgical Interventions	Kate Tyson
<b>1500 - 1530</b>	<b>Afternoon Tea. Trade &amp; Digital Free Communications</b>	Crown Ballroom 2 & 3
1510 - 1515	What Lies Beneath- Adhesion and Injury Risk in Laparoscopy After Abdominopelvic Surgery	Lauren Hicks
1515 - 1520	Enhancing Sustainability: Single Sterile Field Approach for Laparoscopic Gynaecological Procedures with Vaginal Access	Lin Yang
1520 - 1525	Feasibility Of Office-Based Operative Hysteroscopy by A Tissue Removal System Without Anesthesia	Maayan Gal-Kochav
1525 - 1530	Partial Vaginectomy for The Excision of Deep Infiltrating Endometriosis of The Rectovaginal Septum	Madeleine C Ward

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# Foundations, Finesse, Frontiers

## FRIDAY 28 FEBRUARY

FRIDAY 28 FEBRUARY		
<b>1000 - 1030</b>	<b>Morning Tea, Trade Exhibition &amp; Digital Free Communications</b>	<i>Crown Ballroom 2 &amp; 3</i>
1010 - 1015	Synthetic vs Biologic Graft Sacrocolpopexy for Pelvic Organ Prolapse: A Systematic Review & Meta-Analysis	Jessica Vo
1015 - 1020	Uterosacral Ligament Colpopexy During Total Laparoscopic Hysterectomy for Benign Indications: A Video and Surgical Data	Omer Mor
1020 - 1025	A Comparison of The Use of The Myosure Manual® Device to Manage Endometrial Polyps in An Outpatient Setting to The Myosure Lite® Resectoscope	Patricia Car
<b>1200 - 1315</b>	<b>Lunch, Trade Exhibition &amp; Digital Free Communications</b>	<i>Crown Ballroom 2 &amp; 3</i>
1235 - 1240	Deceased Donor Uterus Transplantation: Public Perceptions Towards Including the Uterus as Part of The Current Multi-Organ Donation Program.	Rebecca Deans
1240 - 1245	Robotic Management of Caesarean Scar Niche Utilizing Firefly Mode: The Green Lantern Sign	Sireen Jaber
1245 - 1250	Laparoscopic Uterosacral Ligament Suspension: A Safe and Effective Technique	Stephanie Bowler
1250 - 1255	Global Gynaecological Scholarship Recipient	Menberu Ayele
1255 - 1300	AGES/Hologic Hysteroscopic Travelling Fellowship 2024	Lauren Hicks
1300 - 1305	AGES/Medtronic Travelling Fellowship 2023	Cherynne Johansson
1305 - 1310	AGES/Medtronic Travelling Fellowship 2020	Albert Jung

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# Foundations, Finesse, Frontiers

## DIGITAL POSTERS

POSTER TITLE	
Robotic Bladder Dissection in Complex Gynecologic Surgery: A Stepwise Approach Using The Da Vinci Xi System	Adi Dayan Schwartz
Retrograde Hysterectomy: A Modified Technique for Laparoscopic Hysterectomy. A Case Series and Surgical Outline	Alex Ades
Laparoscopic Management of a Degenerating Cystic Leiomyoma Mimicking an Intrauterine Polyp: A Case Report	Amani Harris
A Pilot Endoscopy Workshop in Lautoka, Fiji	Anna K Nicholson
A Diagnostic Challenge: Pseudomyxoma Peritonei Mimicking Ovarian Malignancy in A Gynecology Patient	Cassandra Carbone
The Burden on The Public Health System: A Look at Gynaecology Clinics at a Public Secondary Hospital in Sydney	Chitra Varanasi
Unplanned Hysterectomy Following Myomectomy: An Update	Elizabeth Cobden
Understanding Patient Decision-Making Factors in Management of Postmenopausal Vaginal Symptoms - A Discrete Choice Experiment	Fiona Li
Outpatient Hysteroscopy Protocols	Jasmin Sekhon
Retrospective Assessment of Bowel and Sexual Function After Surgery for Deep Infiltrating Endometriosis	Jessica Gollow
Myomectomy for Fertility - A Case Series	Jonathan Lui
Life-Threatening PR Bleeding Following Laparoscopic Hysterectomy & Excision of Rectal Endometriosis: Take-Back or Embolisation? A Case Report and Literature Review.	Justin Lam
Laparoscopic Management of a Large Round Ligament Fibroid	Kumaressan Ragnathan
Recurrent Cornual Ectopic Pregnancy: Minimally Invasive Surgical Management	Kumaressan Ragnathan
Tube-Ovarian Abscesses: Diagnosis, Management and Outcomes at A Tertiary Level Hospital	Kusam Nagi
The Relationship Between Endometriosis Type and Surgical Outcomes in Endometriosis Lesion Excision.	Lea Nevo
Restoring Balance: Surgical Tips and Techniques for Laparoscopic Oophoropexy Following Utero-Ovarian Ligament Autoamputation	Leah Mayne
A Tertiary Unit Experience with Indocyanine Green (ICG) Fluorescence in Laparoscopic Gynaecological Surgery for Identification of the Ureter.	Liam Shaw
Early Laparoscopy in The Management of Tubo-Ovarian Abscesses	Lin Yang
Ovarian Torsion Following Hysterectomy with Bilateral Salpingectomy: A Retrospective Case-Control Study.	Lucy Richards
Optimising Patient Outcomes in Abdominal Wall Endometriosis: The Importance of Multidisciplinary Teamwork in The Regional Space.	Lyndal Phelps

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Refer to the conference app for the most accurate program.*





# Foundations, Finesse, Frontiers

Co-Designing the Gynaecology Robotic Assisted Care Enhancement (GRACE) Protocol	Madeleine Ward
A Unique Case Series of Endometrial Vascular Dystrophy (EVD) - Increasing Incidence Curtailing Its Rarity.	Nanda Jambunath Bugude
A Case Report on Clot-Induced Bilateral Ureteric Obstruction Following Stage IV Endometriosis Excision: The Role of Prophylactic Ureteric Catheters	Nicola Flanagan
It's Never Black and White: Ultrasound-Based Models for Risk Stratification of Ovarian Tumours in Premenopausal Women	Orla Donohoe
Myosure Manual® Device to Manage Endometrial Polyps in An Outpatient Setting: A Prospective Study	Patricia Car
Spontaneous Bilateral Tubal Ectopic Pregnancy: A Case Report	Pauric O'Reilly
Perspectives And Priorities for Endometriosis Multidisciplinary Team Care in Australia: A Qualitative Mixed-Methods Study Involving Patients, Caregivers and Health Professionals	Pinar Cingiloglu
The Importance of Biobanking for The Advancement of Women's Health: A Focus on Endometriosis Research in Western Australia	Pippa Robertson
Review Of Biomarkers in Endometriosis	Pippa Robertson
Rate Of Vault Dehiscence After Hysterectomy at King Edward Memorial Hospital: A 10 Year Review	Pradeep Ruba
Is Methotrexate Comparable to Surgery for Management of Ectopic Pregnancies? A Retrospective Study.	Rebecca Chou
Round The Twist	Rebecca Everist
Recurrence Rates of Endometrioma and Ovarian Dermoid Following Ovarian Cystectomy	Rebecca Mann
Recurrent Poor In Vitro Fertilization (IVF) Outcomes in Severe Endometriosis - Time to Think Out of The Box	Rituparna Dutta
Complex Multidisciplinary Management of Ureteric Tortuosity and Hydronephrosis Following Obstetric and Gynaecological Surgery	Saima Wani
A Novel Technique for Uterine Manipulation During Total Laparoscopic Hysterectomy	Sarah Murphy
Well-Leg Compartment Syndrome Post Lithotomy - A Rare and Devastating Complication	Sarveshinee Pillay
Recurrent Infected Endometriomas: An Uncommon First Presentation of Stage 4 Endometriosis	Sarveshinee Pillay
A Comprehensive Review of The Documented Pathway of The Ureter in Women: A Foundational Step Toward Developing A Predictive Model For Ureteric Pathways In Severe Endometriosis And Abnormal Pelvic Anatomy	Shawn Tan
Repeated HIFU Treatment for Adenomyosis and Fibroids: Safety, Efficacy, And Fertility Outcomes	Sigit Pramono
Beyond The Blade: Exploring Patient Outcomes from Non-Surgical Modalities to Manage Persistent Pelvic Pain	Simon Scheck
Cerebrospinal (CSF) Leak in Pregnancy	Siveshan Silvam

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AGES XXXV  
 ANNUAL SCIENTIFIC MEETING 2025

# Foundations, Finesse, Frontiers

Haemophilus Influenzae and Pregnancy Loss	Siveshan Silvam
A Year in Review: Assessing Surgical Complications with the Comprehensive Complication Index.	Sophie Graham
Ruptured Ectopic Pregnancy in A Tubal Stump After Previous Salpingectomy	Stephanie Roydhouse
Association Between Diameter of The Tubo-Ovarian Abscess and Treatment Success - Validation of Measurements Accepted in Current Practice	Stephanie Zhu
Surgical Approach to Abnormal Fibroids and Smooth Muscle Tumours of Uncertain Malignant Potential (STUMP): A Review of Current Literature and Case Report	Stephanie Zhu
Heterotopic Pregnancies: A Diagnostic and Therapeutic Dilemma	Stewart McNamara
Innovative ICG Application in Benign Gynecological Surgery: Enhancing Safety and Precision	Theresia Yudianto
Linear Resection of Bowel Endometriosis: A Case Report and Literature Review	Theresia Yudianto
Anogenital Distance as a Diagnostic Marker for Endometriosis	Thomas Kavanagh
Fallopian Tube Dermoid Cyst: An Exceptionally Rare Find	Travis Bettsison
Laparoscopic Management of a Cornual Ectopic Pregnancy	Veddant Sharma
Transvaginal Tape Placement Under Direct Vision During Sacrocolpopexy	Yael Yagur
Incidence Of Malignancy and Myoma Variants at Surgery for Presumed Benign Symptomatic Myomas: An Update	Yoon Myat Thwe

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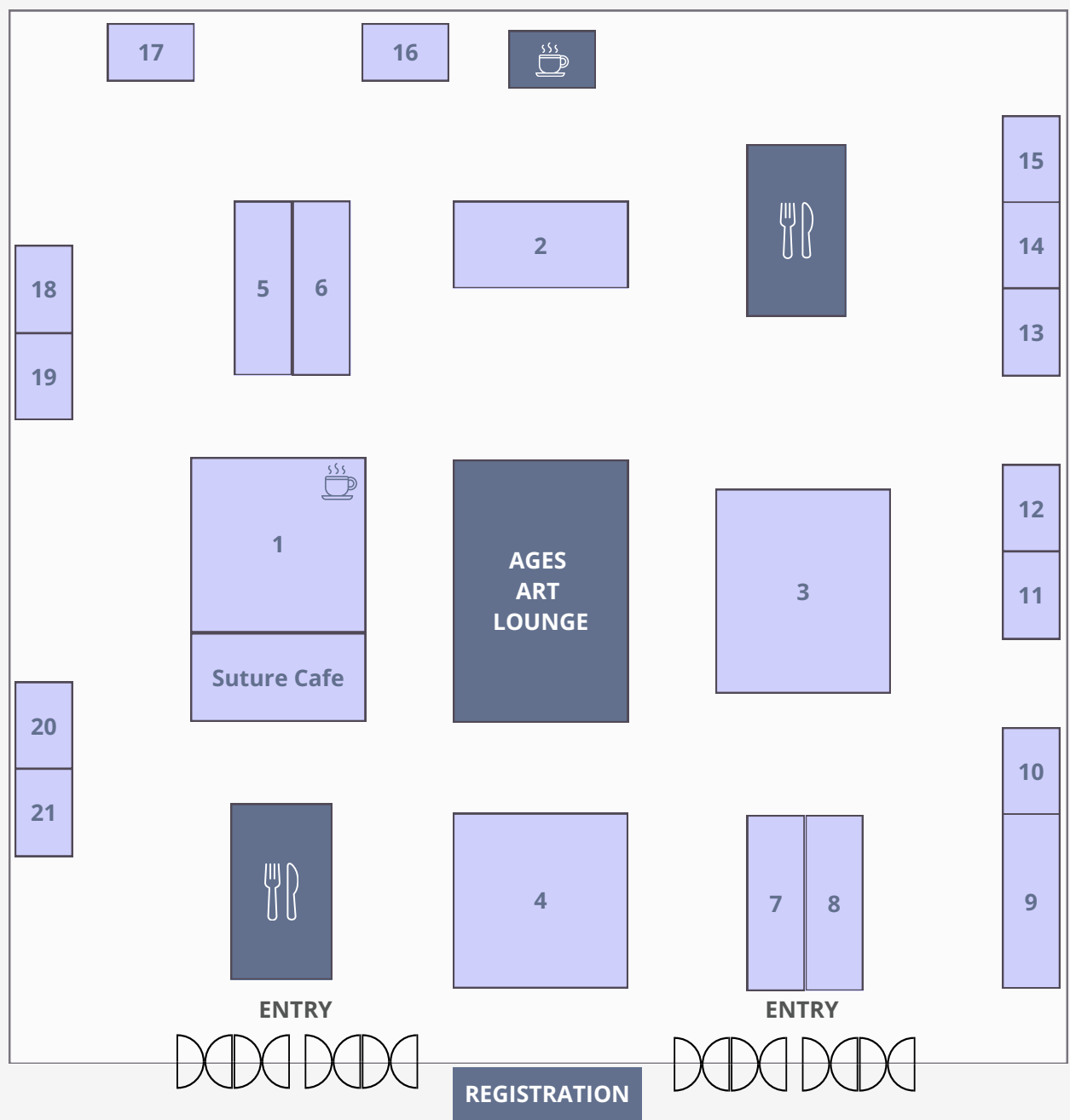
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# EXHIBITION



## INDUSTRY PARTNERS

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| 1 Medtronic           | 8 Olympus                 | 15 World Endometriosis Congress |
| 2 Avant               | 9 Stryker                 | 16 J&J MedTech                  |
| 3 Device Technologies | 10 Lawley Pharmaceuticals | 17 SurgicalPerformance          |
| 4 Hologic             | 11 ConMed                 | 18 Gedeon Richter               |
| 5 Karl Storz          | 12 Baxter Healthcare      | 19 Aspen Surgical               |
| 6 Applied Medical     | 13 BOWA Medical           | 20 GRC Surgical                 |
| 7 Endotherapeutics    | 14 RANZCOG                | 21 BD                           |





# BLACK TIE

## *Gala Dinner*

**DATE:** Friday, 28 March 2025

**TIME:** 7 - 11pm

**VENUE:** Hackett Hall, WA Museum  
Boola Bardip

**COST:** \$195.00pp  
(subject to availability)

**ATTIRE:** Black Tie / Formal

**NOTE:** Buses have been arranged to transfer guests to WA Museum. If you would like to take the coach, please be ready at Crown Towers valet area for a 6.25pm departure.

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# UPCOMING EVENTS

Click on the events below to read more or to register.



## PERI-OPERATIVE SURGICAL (PSM) MEETING 2025

28 - 30 AUGUST 2025

MELBOURNE



### TRAINEE WORKSHOP

RACS, MELBOURNE

14 -15  
JUNE



### LAP-D WORKSHOPS

MERF, BRISBANE

28 JUN | 16 AUG | 1 NOV  
2025



### LAP-DEMO WORKSHOP

VIRTUAL

17  
AUG



### ALAP-D WORKSHOP

MERF, BRISBANE

2  
NOV



### AGES 2025 WEBINAR SERIES

VIRTUAL | DATES ANNOUNCED SOON



# AGES XXXVI ANNUAL SCIENTIFIC MEETING 2026

12 - 14 March

*New Zealand*







**PRESENTER  
ABSTRACTS**



**Sven Becker:** *The Five Stages of Surgical Training - and How Understanding Them Can Lower Your Complication Rate*

Surgical Teaching is at the Heart of what our purpose as Surgeons really is. The worst complication in a surgeon's life is not the patient's death, but the death of the surgeon, who educated no-one. Surgery cannot be learnt from books. Furthermore, we only do things well that we have understood and we only understand what we have explained to someone. Teaching makes better surgeons because it forces us to be systematic. The lecture will reflect on surgical teaching and provide some detailed "systematics" that can help both the teacher and the surgeon.

**Jeffrey Woo:** *Just Do It! Harness Surgical Videography to Boost Your Career - Inside and Outside the OR*

- **Understand the significance of surgical videography** in enhancing gynaecological surgical training and skill development.
- **Learn the fundamentals of surgical video editing**, including techniques for trimming footage and applying anatomical overlays to improve educational content.
- **Explore the role of surgical videography in scholarly work and career growth**, highlighting its potential for research, presentations, and professional advancement.

**Stuart Salfinger:** *Does the Ovary Stay or Go? Rethinking the Guidelines Around Adnexectomy*

Modern guideline to the approach to the adnexa vary in their clarity to the recommended approach. There are several clearly different scenarios that need to be considered.

- Elective Oophorectomy
- Opportunistic salpingectomy
- rrBSO
- rr Salpingectomy with delayed oophorectomy
- Elective salpingectomy

The primary indication for surgery needs to be considered for example in endometriosis and likewise abscess management, oophorectomy decreases the risk of repeat surgery. In pelvic pain oophorectomy is often beneficial and the sequelae of residual ovarian syndrome should be discussed (ROS vs ORS).

Ovarian cancer risk reduction benefits need to be balanced with the long-term health risks – oophorectomy is associated with an increase in the following;

- All-cause mortality
- Cardiovascular disease and stroke
- Chronic kidney disease
- Cognitive function and neurologic disease
- Depression and anxiety
- Osteoporosis
- Sexual dysfunction

Estrogen therapy may mitigate some of these risks.

Whilst an age and risk-based approach to oophorectomy requires discussion, opportunistic salpingectomy should almost always be offered.

BRCA patients require a very specific multidisciplinary approach to risk and management and counselling. Approaches such as unilateral oophorectomy and elective salpingectomy alone are not supported by the evidence.

## **Introduction/Background**

Tranexamic acid (TXA) has been shown to significantly reduce surgical blood loss across a range of different specialties and procedures. We investigated its utility in laparoscopic treatment of severe endometriosis.

## **Materials and Methods**

Patients undergoing laparoscopic surgery for suspected severe endometriosis were randomized to receive 1g of intravenous tranexamic acid or placebo at start of surgery, in a single centre tertiary women's hospital. Primary outcome was weighed blood loss (suction output minus irrigation and cyst fluid). Secondary outcomes were estimated blood loss by surgeon as continuous (mls) and categorical (minimal/small/moderate/large) variables and surgeon reported impact of bleeding on surgical conditions (minimal/small/moderate/large).

## **Results**

*At time of abstract submission this study has primary outcome data for 196 out of 200 required participants with final recruits planned to undergo surgery in the next month. Results following are from blinded analysis of the near-complete cohort (reported as groups A and B). At the time of the conference complete, unblinded data will be presented.*

139/196 participants had a mean weighed blood loss in the negative range, due to irrigation fluid unable to be completely suctioned. Mean weighed blood loss in group A was -31ml vs group B -85ml,  $p=0.102$ . Estimated blood loss by surgeon was less in group A (134ml) vs group B (186ml)  $p=0.041$ . Estimated blood loss by category was also lower in group A with frequency of reporting minimal/small/moderate/large blood loss of 23%/39%/37%/2% vs group B of 20%/25%/50%/7%  $p=0.046$ . Impact of bleeding on surgery was reported as

minimal/small/moderate/large at a frequency of 31%/41%/26%/3% in group A compared to 27%/26%/38%/5% in group B,  $p=0.415$ .

## **Conclusion**

Tranexamic acid use in severe endometriosis surgeries appears to result in changed blood loss. Group A had lower blood loss in all domains measured, reaching statistical significance in estimated blood loss by surgeon (mls) and categorical amount of bleeding reported by surgeon. The overall differences are small and unlikely to be of clinical significance.

## **Kirsten Peters:** *Plasma Protein Biomarkers as an Innovative Tool for The Non-Invasive Diagnosis of Endometriosis*

Endometriosis is a common gynaecological condition affecting approximately 1 in 7 women and girls in Australia<sup>1</sup>. Diagnosis is challenging and often delayed (average 7 years) due to symptom variability and reliance on invasive laparoscopy or imaging. Non-invasive diagnostic methods, such as blood tests using biomarkers, are urgently needed. This study aimed to address these challenges by identifying and validating plasma biomarkers for the early detection of endometriosis.

A proteomics-based workflow was used to identify and validate plasma protein biomarkers for diagnosing endometriosis using samples from 805 women. A small discovery experiment ( $n=56$ ) identified candidate biomarkers before clinical validation in a larger cohort ( $n=749$ ), comparing three clinical groups: endometriosis cases ( $n=464$ ), symptomatic controls without endometriosis ( $n=132$ ) and general population controls ( $n=153$ ). All endometriosis cases and symptomatic controls were confirmed by laparoscopy/histopathology. Endometriosis severity was graded using the rASRM (revised American Society for Reproductive Medicine) score. Three statistical models for diagnosing endometriosis were developed combining a panel of protein biomarkers with age and BMI – Model 1 (endometriosis vs general population controls, Model 2 (stage II-IV endometriosis vs symptomatic controls), Model 3 (stage IV endometriosis vs symptomatic controls). Model 3 was subsequently tested across all endometriosis stages. The diagnostic performance of all models was assessed using the area under the receiver operating characteristic curve (AUC), with sensitivity, specificity, positive and negative predictive values determined.



A panel of 10 protein biomarkers was identified, adding significant value to clinical factors. Model 3 showed the highest performance (AUC 0.997) for distinguishing stage IV endometriosis from symptomatic controls. When tested on stages I, II, and III endometriosis, the model achieved AUCs of  $\geq 0.85$ , with sensitivity/specificity/PPV/NPV of  $\geq 72\%$ . Models 1 and 2 demonstrated strong predictive performance for discriminating endometriosis from general population controls and symptomatic controls (AUCs 0.993 and 0.729, respectively).

This study marks significant progress in developing precise, non-invasive diagnostic tools for endometriosis, leveraging proteomics and clinical expertise. A novel panel of plasma protein biomarkers was identified, enabling the creation of highly accurate diagnostic models. These biomarkers also provide valuable insights into the underlying mechanisms of endometriosis. Further validation will enhance the reliability of this diagnostic approach, facilitating its integration into clinical practice and ultimately improving care for individuals with endometriosis.

Data in this abstract have been accepted for publication in Human Reproduction (28 Nov 2024).

**Rebecca Nash:** *Robotic Subtotal Hysterectomy, Bilateral Salpingo-Oophorectomy with the Aid of Harmonic Scalpel for Removal Of >3kg Uterus with Cervical Fibroid*

This video presentation details the case of a 53-year-old female with a rapidly growing cervical fibroid leading to a 3kg uterus, managed via robotic subtotal hysterectomy with the Harmonic scalpel.

The patient, postmenopausal since 2023, had a fibroid that grew from <5cm to 20cm over three years. She presented with 18 months of pelvic pressure, bladder dysfunction, and constipation. Her history includes two vaginal births, T2DM, hypertension, and a BMI of 68. A Mirena device placed in 2021 was lost despite laparoscopy and hysteroscopy. She had been using Prometrium and EstroGel for menopausal symptoms since 2023.

An MRI revealed a 19cm posterior uterine fibroid with no signs of malignancy.

The patient consented to a robotic-assisted laparoscopic hysterectomy with in-bag morcellation, understanding the risk of conversion to open surgery due to the fibroid's size.

Intraoperatively, a Da Vinci robot with a 5mm LUQ accessory port was used. A bimanual pelvic examination showed a 4cm dilated cervix with a mass protruding through the internal os. The fibroid was confirmed to be cervical, with a normal uterine body.

The procedure began by isolating, cauterizing, and ligating the left infundibulopelvic ligament. The bladder peritoneum was safely reflected off the mass, aided by intermittent bladder backfilling.

Due to the mass's size, proximity to bowel, and uterine weight, robotic single-toothed grasping forceps, Pro-Grasp, and the Harmonic scalpel were essential for traction, bowel retraction, and dissection. Bipolar diathermy served as backup for hemostasis.

The right infundibulopelvic ligament was similarly addressed, followed by circumferential dissection of the peritoneum until the mass was freed. Subtotal hysterectomy was chosen to avoid bladder injury and manage anatomical distortion. The vascular pedicles were meticulously dissected and secured.

After completing the hysterectomy, the cervix was closed with 2-0 V-Loc sutures, and the peritoneum was closed in a second layer. Vascular pedicles were examined and sutured for hemostasis. A drain was placed, and cystoscopy confirmed no bladder injury.

The fibroid was placed in a 17cm retrieval bag, the robot undocked, and manual morcellation performed. Histopathology confirmed benign tissue, with the lost Mirena found within the fibroid. The patient recovered fully and was discharged on postoperative day three.

**Rituparna Dutta:** *A Randomized Double-Blind Pilot Trial Evaluating the Efficacy of Intralesional Platelet Rich Plasma (PRP) Versus Placebo for Vulvovaginal Lichen Sclerosus (LS)*

**Funding**

The study was funded by the AGES research grant.

**Background**

LS is a chronic inflammatory dermatoses affecting the anogenital regions in 1 in 30 women (1,2). The aetiology of LS, although not clearly understood, is thought to be multifactorial (3). There is currently no cure for LS. The first line treatment for LS includes potent topical steroids (4). Long term use of topical steroids can lead to skin atrophy and steroid induced dermatitis. Regenerative therapies like PRP aim to promote wound healing via various growth factors affecting the regulation of inflammatory processes (5).

**Objective**

This study aimed to assess the efficacy of two injections, six weeks apart, of autologous PRP compared to placebo (saline) in improving clinical signs and quality of life in patients with LS.

**Methods**

Thirty-one participants with biopsy-proven LS were randomised into two groups: autologous PRP (n=16) and saline (n=15). Participants received two intralesional injections (at baseline and 6 weeks) and assessments were made at four time points (baseline, 6 weeks, 6 months, and 12 months). The primary outcome was the change in the total LS Score of the clinical scoring system for LS, which assesses six clinical characteristics. Secondary outcomes included changes in severity of two symptoms – dyspareunia and pruritus, and changes to quality of life, measured using the Dermatology Life Quality Index (DLQI). Changes to pelvic floor function were assessed using the Australian Pelvic Floor Questionnaire (APFQ).

**Results**

A significant reduction in the total LS Score was observed at 12 months for the PRP group compared to the saline group (p=0.028). Between-group analyses were not significant at earlier time points. Participants in the PRP group showed significant improvements in quality of life (p=0.041) compared to the saline group. Improvements in symptoms were observed in the PRP group at all time points from baseline - however these were not large enough to be considered statistically significant compared to the saline group.

**Conclusion**

The study concluded that PRP injections significantly improved the clinical signs of LS and the quality of life of patients at 12 months compared to saline injections. However, larger trials are necessary to confirm these findings and to further validate the efficacy of PRP use for vulvovaginal LS.

**Vinita Rajadurai:** *Near-Infra Red Technology - Robotic-Hysteroscopic Assisted Isthmoplasty*

**Study Objective:**

A video presentation to describe the steps of caesarean scar defect repair (isthmoplasty) using firefly technology in a robotic assisted isthmocele repair.

**Design:**

A video presentation on a brief background of caesarean scar defects and a single surgical case highlighting the steps and approach to resection and repair with the aid of firefly technology.

**Setting:**

Sydney Adventist Hospital, Wahroonga, NSW

**Patients or Participants:**

A single patient's surgical video underdoing isthmocele repair for pelvic pain and inter-menstrual bleeding.

## Interventions:

Surgical steps for caesarean scar defect resection and repair using Firefly technology to identify defect.

## Conclusion:

Caesarean scar defect resection using a Robotic assisted approach with near-infrared fluorescence firefly system aids in landmark identification and ergonomic superiority with defect resection and closure.

## References:

1. He Y, Zhong J, Zhou W, Zeng S, Li H, Yang H, Shan N. Four Surgical Strategies for the Treatment of Cesarean Scar Defect: A Systematic Review and Network Meta-analysis. *J Minim Invasive Gynecol.* 2020 Mar-Apr;27(3):593-602. doi: 10.1016/j.jmig.2019.03.027. Epub 2019 Nov 5. PMID: 31698049.

**Yael Yagur:** *Advanced Surgical Techniques for Complex Endometriosis: Ovary Dissection, Nerve Preservation, Unjackknife Method, And Rectal Shaving Technique*

**Objective:** This video aims to present surgical techniques for managing complex endometriosis cases, focusing on ovary dissection, hypogastric nerve sparing, the UnJackknife approach for anatomical normalization, and the Sydney Rectal Shaving technique: Laparoscopic Reverse Submucosal Dissection, LRSD.

**Methods:** The following techniques were demonstrated in these cases:

*Ovary Dissection:* The release of ovaries adhered to the pelvic sidewall was approached using two methods. Blunt dissection, while straightforward, carries risks of bleeding and residual tissue. The alternative technique involved dissecting and reflecting the peritoneum beneath the ovary, ensuring a clean separation with reduced bleeding and more complete removal of endometriosis.

*Nerve Sparing:* Superficial dissection of the peritoneum revealed hypogastric nerve involvement, which was not apparent on initial examination. By meticulously lifting and reflecting the peritoneum, the hypogastric nerves were identified and preserved, allowing thorough lesion excision without compromising nerve integrity.

*UnJackknife Approach:* This method addressed cases with obliterated pouch of Douglas anatomy. Using uterine traction and careful pararectal dissection, the anatomy was restored in a stepwise manner. This approach minimized the risk of organ injury while ensuring comprehensive disease excision.

*Rectal Shaving:* A full-thickness excision of rectosigmoid lesions was performed using submucosal hydrodissection. The injection created a plane separating the muscularis from the mucosa, allowing precise lesion removal while preserving the bowel lumen. The procedure concluded with defect repair and integrity testing to ensure safe restoration of the bowel wall.

**Conclusion:** These techniques offer effective and safe management of advanced endometriosis. Further studies are warranted to evaluate their long-term impact and refine their application.

0930 - 1030

Session 3A: Menopause Speed Updating

**Lesley Ramage:** *Below the Belt: Menopause After Cancer*

Cancer rates continue to increase with an estimated 169,000 new diagnoses in 2024.

5-year survival rates are approaching 70% (across all types), this equates to > 1 million people living with or beyond cancer. This number is expected to increase to 1.9 million Australians by 2040.

Treatments for common female cancers (Breast, CRC and Gynaecologic) regularly induce a hypoestrogenic environment with systemic symptoms.

Vaginal (sexual) health is commonly impacted with data suggesting up to 87% of women will be affected, however it remains underdiagnosed and therefore under treated. It does not improve over time and as such, the impact in terms of QoL is reported to be equivalent to that of living with a chronic disease.

This presentation aims to raise the awareness of this chronic health condition and to provide an evidence-based approach to diagnosis and management.



### **Sunita Chelva:** *PMDD and Progesterone Sensitivity in Menopause*

**Premenstrual Dysphoric Disorder (PMDD)** is a severe, cyclical mood disorder affecting approximately 3–8% of menstruating individuals. Emerging research highlights the role of progesterone and its neuroactive metabolite, allopregnanolone, in triggering symptoms in susceptible individuals. With chaotic hormonal fluctuations, Perimenopause is often the most challenging time for these individuals and needs expert care. During this time, further complexities occur in these patients who often have adverse reactions to the Progestagen component of Hormone replacement therapy making management a challenging process.

The aim of this talk is to gain a greater understanding of PMDD and its overlap with progesterone sensitivity particularly in the context of the menopausal transition. PMDD has only been widely recognized since 2015, and hence clear assessment and treatment guidelines are not yet firmly established. Moreover, like most experiences in women's health, each sufferer has a *unique* course, thus an individually tailored multidisciplinary care model is paramount.

The importance of understanding PMDD for the gynaecologist is that some women will present at the end of the road, requesting Bilateral Oophorectomy with or without Hysterectomy, when all other measures have failed. By deepening understanding of progesterone sensitivity in PMDD, gynaecologists can refine their management strategies to improve patient outcomes overall.

### **Michelle Cotellessa:** *Mood and Menopause*

For many women transitioning through menopause, mood changes are a common experience, with depression being a significant concern for women in their mid-40s to early 50s.

Women with a history of major depressive disorder face a three to four times higher risk of recurrence and those aged 45–49 also have one of the highest suicide rates, underscoring the urgency for better recognition and treatment of menopausal depression. While some women transition through menopause without major mental health challenges, around 40% of perimenopausal women experience depressive symptoms that are often more severe and distinct from depression at other ages.

Although midlife stressors such as work, relationships, and caregiving can contribute to depression, hormonal fluctuations during menopause serve as a key biological trigger. Declining oestrogen and progesterone levels significantly impact brain function, affecting neurotransmitters like serotonin, dopamine, and GABA. There are groups of women who are more sensitive and vulnerable to mood changes and depression with hormonal fluctuation.

Despite growing evidence of hormonal treatment, current treatment guidelines focus on antidepressants, psychotherapy, and lifestyle changes, despite many women experiencing limited benefits or side effects from standard antidepressants.

Small-scale studies and clinical observations suggest hormone therapy can effectively treat menopausal depression. Many clinicians report positive outcomes, highlighting the need to integrate hormonal treatments into mainstream care.

Menopausal depression is influenced by both hormonal and psychosocial factors, yet its biological basis remains underrecognized. Greater awareness and integration of hormonal therapies could significantly improve outcomes for midlife women experiencing mood disturbances during menopause.

### **Lucy Williams:** *New and Old: Update on Best Practice*

Menopause is a major life event with potential for significant health and socioeconomic impact. Vasomotor symptoms can be severe and affect about 80% of women with 10-20% experiencing these long-term. Additionally, long-term loss of endogenous oestrogen has an impact on bone and cardiovascular health, with greater consequences for those who have early or premature menopause.

Since publication of the Women's Health Initiative Study there has been a steep drop in the prescription of menopausal hormone therapy (MHT). Many doctors have lost confidence in prescribing MHT and patients often have increased concerns about risks.

In this review I will give an update on the current recommendations for use of MHT, discuss the potential risks and when to consider alternative options. I will also discuss new non-hormonal treatments now available.

#### **Ashley Makepeace:** *Premature Ovarian Insufficiency: An Update*

POI is a clinical condition defined by the loss of ovarian function indicated by irregular menstrual cycles together with biochemical confirmation of ovarian insufficiency before the age of 40. POI can have significant effects on fertility, bone health, cardiovascular health, sexual function, psychological health and neurological function. The recently updated guidelines are best practice recommendations for the care of women with premature ovarian insufficiency (POI). Significant changes from the previous 2015 guideline will be discussed and include the recommendations required for diagnosis and work up of POI, oestrogen doses and use of the combined oral contraceptive and testosterone therapy.

#### **Lucy Caratti:** *Menopause: An Integrated Approach*

A brief overview of an integrative medicine approach to menopause, including foods and supplements, an overview of estrogen detoxification pathways and genetic variations that can affect the patient's response to HRT.

### **0930 - 1030**    **Session 3B: The Ovary Speed Updating**

#### **Kate McIlwaine:** *Oophoropexy: To Let it Be or Not Let it Be*

Dr Ellett will discuss three areas where oophoropexy should be considered. These are; 1. at the time of ovarian torsion, 2. when excising severe endometriosis and 3. at time of laparoscopic hysterectomy with or without bilateral salpingectomy.

The evidence for oophoropexy at the time of ovarian torsion is of low quality. However, when the patient has had a previous torsion or when the patient has had a previous adnextectomy, oophoropexy should be considered. The technique for oophoropexy is also controversial. Round ligament to ovarian ligament oophoropexy ("hot dog in bun technique") is a novel surgical procedure that may be superior. Previous techniques have included – plication of the ovarian ligament, oophoropexy to round ligament or pelvic side wall or uterosacral ligament. No technique has been proven superior to another. However, it makes biological sense that oophoropexy to more than one fixation point would be superior. Two small case series will be presented. Oophoropexy at the time of excision of severe endometriosis has been the subject of a recent meta-analysis and low quality evidence supports this.

Laparoscopic hysterectomy with or without bilateral salpingectomy is associated with reduced adhesions compared with open hysterectomy. The infundibulopelvic ligament is narrowed after salpingectomy and prophylactic oophoropexy should be considered. Once again, the evidence is of poor quality but the mechanisms are biological plausible.

#### **Helen McNamara** - *What's the Goss with PCOS?*

An update on the interpretation and application of the 2023 International Evidence-based Guideline for the assessment and management of Polycystic Ovary Syndrome: the role of AMH in diagnosis, diagnosis of PCOS across the lifetime – from adolescence to menopause, and the evolving realm of metabolic and weight loss management for PCOS in the era of GLP-1 receptor agonists and bariatric surgery.

#### **Lauren Hicks** - *AMH: Are My Eggs Fried?*

Anti-Müllerian hormone (AMH) is a commonly ordered test in women of reproductive age. Considered a marker of ovarian reserve, it has purported roles in the prediction of fertility, both for natural conception and with assisted reproductive technologies, age at menopause and diagnosis of polycystic ovarian syndrome and

premature ovarian insufficiency. There are several medical, surgical and lifestyle factors that are known to impact on the results, which can lead to challenges in the interpretation.

#### **Alison Bryant-Smith** - *Progesterone Pearls*

Progestins are everywhere in gynaecology—but not all are created equal. Their chemical structures and receptor interactions shape their clinical effects, side effects, and safety profiles. So, how do we choose the right one?

This talk will break down progestin pharmacology into practical takeaways, helping you navigate treatment choices for endometriosis, menopausal hormone therapy, hyperandrogenism, and endometrial hyperplasia, amongst other clinical scenarios. We'll also tackle the latest data on risks (including breast cancer, VTEs, and the possible link with meningiomas), so you can balance benefits with safety.

We'll spotlight micronised progesterone, explore the newest IUD guidelines, new PBS listings, and cut through the confusion to give you clear, evidence-based prescribing strategies. Walk away with clinical pearls that make progestin prescribing easier, safer, and more effective!

#### **Keryn Harlow** - *Chocolate Cysts and the Baby: An Endometrioma Story*

This presentation will provide an overview of conception with endometrioma. The current evidence regarding periconception management of endometrioma with or without Assisted Reproductive Technology will be discussed before delving into new research and theories to stimulate discussion and innovation in a field fraught of quality research.

#### **Charlotte Reddington** - *Post Menopausal Cysts - What's the Risk?*

Weighing up the risk of malignancy vs the risk of surgery or need for ongoing surveillance in post menopausal cysts can be tricky. So what's new in this age-old topic? This presentation will focus on the evidence behind key tools for assessing these cysts including the ORADS classification, Ca125 and the use of other decision making tools. We will also discuss surgical approach when required, and the evidence behind the newly updated RANZCOG guideline regarding BSO in postmenopausal women - is 50 the new 65?

0930 - 1030

Session 3C: Oral & Video Free Communications

#### **Adi Dayan-Schwartz**: *Intrauterine Suturing Device Using Hysteroscope - Proof of Concept*

##### **Introduction**

Current operative hysteroscopes lack suturing capabilities, presenting a limitation for addressing certain intrauterine conditions, such as the repair of uterine niche defects and the securing intrauterine devices (IUDs) after repeated expulsions.

The Apollo X-Tack system, originally designed for gastrointestinal defect closure via gastroscopy, offers promising dimensions and functionality that could be adapted for intrauterine suturing. The X-Tack system consists of a 1.5 mm-wide wire connected to a 5 mm barbed helix tip, along with a polypropylene suture that approximates defect margins using four anchored points.

By adapting this technology from the field of gastroenterology, we plan to explore its potential for intrauterine suturing, addressing unmet needs in gynecological procedures.

The study aims to evaluate the feasibility of hysteroscopic suturing using the Apollo X-Tack system inserted through a 7 mm hysteroscope – proof of concept.

##### **Methods**

The X-Tack system was tested using a TruClear Plus hysteroscope on a rubber uterine model. Sutures were applied to approximate defect margins following a structured 9-step technique involving the deployment of four docking helixes, polypropylene suture, and suture closure.



## Results

Successful hysteroscopic suturing was achieved, with defect margins securely approximated using the X-Tack system. The procedure was fully detailed in the video demonstrating all nine steps, including helix deployment and suture closure.

## Conclusion

This preclinical study demonstrated the feasibility of hysteroscopic suturing with the Apollo X-Tack system. The next phase will involve a human proof-of-concept study to assess the system's safety and efficacy in clinical settings, paving the way for innovative intrauterine surgical solutions.

## **Akshara Shyamsunder:** *Repeat Botox Injections for Treatment of Chronic Pelvic Pain and Pelvic Floor Overactivity*

### Introduction:

Botulinum Toxin A (Botox) is a therapeutic option for pelvic floor spasm and chronic pelvic pain<sup>1,2</sup>. The use of Botox to the pelvic floor has limited availability publicly and privately and is not remunerated on the Pharmaceutical or Medical Benefits Schemes. There is no consensus regarding number of injections, optimal dosing or dose intervals.

### Methods:

A retrospective analysis from a single private gynaecology practice between 2007 - 2024, identified women receiving 3 or more Botox injections to pelvic floor muscles for pain symptoms. Quantitative demographic data, visual analogue scale (VAS), EuroQOL-5D (EQ-5D), and Short Form 12 Health Survey (SF-12) data was collected. Semi-structured qualitative interviews were then performed to explore the benefits and barriers linked with recurrent Botox pelvic floor injections.

### Results:

22 patients were identified, with 15 recruited and consented. 8/15 (53%) of patients received > 5 botox injections and chronic pelvic pain was the main presenting symptom in 14/15 patients (93%) whilst 8/15 (53%) presented with dyspareunia.

Cost was a significant barrier to treatment with 8/15 (53%) of patients reporting this influenced their decision to have repeat injections. 4/15 (27%) patients reported travel times impacted their decision.

11/15 (73%) participants reported improvement in symptoms over 3-6 months with the highest mean VAS pelvic pain score with menstruation of 6.5/10 after treatment, and the greatest reduction reported in non-menstrual pelvic pain. EQ-5D scores suggested 7/15 (46%) patients symptomatically improved in comparison to the last 12 months and 10/15 (67%) felt they were in good or excellent health as per the SF-12 health survey.

Qualitative interviews underlined all participants had symptom improvement, with a variation in magnitude of effect depending on dose and timing. 9/15 (60%) patients planned to have further Botox pelvic floor treatments. Four themes were constructed through reflexive thematic analysis: complex emotional responses, pain invalidation, variation of healthcare provision, financial burden and geographical constraints.

### Discussion:

Recurrent pelvic floor botox injections keep patients in reasonable health, with recognition that this is a biased population who had improvement with primary injection. There is evidence that repeat injections allows women to stay at a good or excellent level of health. Importantly, cost factors and access, subsidisation for botox and investment in pain education and training to clinicians outside of metropolitan Sydney remains a focus of concern for patients.

## **Amanda Wee:** *Building A Surgical Legacy: Advancing Endoscopic Skills in Gynaecology for AGES and RANZCOG Trainees - The FNQ Experience*

There is anecdotal concern among trainees and fellows that the surgical component of RANZCOG training is inadequate, with new specialists lacking the confidence and competence to perform many "standard" surgical procedures[i]. In a survey conducted by Wilson et al, participants believed that simulation training benefits trainees and should be supported with a curriculum and teaching[ii]. This is what our AGES unit strives to achieve.

What comes to mind when you hear “Townsville”? Not uncommonly one is surprised to hear that it is a tertiary hospital with an AGES unit- one of only two hospitals in Queensland that offers AGES training. Located in a regional area (MM2)[iii], Townsville University Hospital is geographically isolated from Brisbane and other AGES units. Our unit has developed graduated surgical educational sessions for their AGES fellow and RANZCOG trainees ranging from simulation to “live” operating, one of the highlights being the Animal Wetlab.

The 4 main education sessions across the year include:

1. Hysteroscopy, Cystoscopy and Laparoscopic Simulation for new trainee intake (March)
  - Simulation set-up to practice Myosure™ and Novasure™.
  - Cystoscopic ureteric catheter insertion
  - Laparoscopic skills and basic suturing on Lap-trainers
2. Vaginal surgical skills workshop (May)
  - Surgical teaching across 2 days in theatre for all trainees on carefully selected patients (since 2010)
3. Laparoscopic skills and TLH workshop (October)
  - Surgical teaching across 4 days for all trainees on carefully selected patients in collaboration with SWAPS since 2012
  - Laparoscopic skills on Lap-trainers including TLH and vault suturing
  - In-bag morcellation using ox tongues
4. Animal Wetlab (November)
  - A joint project with JCU Vet school since 2014 featuring laparoscopic/open operating on anaesthetised goats

Additionally free access to a VR Simulator is available in the Registrar room all year.

All these educational sessions are unique learning opportunities for any trainee and have always received excellent feedback.

### **Anna Brownson:** *Use of Intra-Operative Ultrasound During Laparoscopic Myomectomy: A Case Series*

#### **Objective:**

To evaluate the role of intra-operative ultrasound in enhancing fibroid identification, ensuring complete excision, and improving surgical outcomes during laparoscopic myomectomy.

#### **Background:**

Laparoscopic myomectomy is the gold-standard surgical intervention for women with symptomatic fibroids desiring uterine preservation. Accurate pre-operative fibroid mapping is essential to facilitate complete excision, minimise residual disease, and prevent fibroid recurrence. Ultrasound is a readily available, safe, and portable imaging modality that is widely applied in gynaecology. Intra-operative ultrasound provides a valuable adjunct to conventional laparoscopic techniques by enabling dynamic real-time imaging, allowing for the precise identification of the location, size, and depth of fibroids particularly smaller, deeply embedded fibroids, which may be challenging to detect with laparoscopy alone, aiding in intra-operative decision-making.

#### **Methods:**

This case series analyses 8–12 patients with multiple fibroids who underwent laparoscopic myomectomy at a tertiary care centre. A combination of laparoscopic and transvaginal ultrasound techniques was utilised. Ultrasound was performed intra-operatively, both pre-myomectomy for fibroid mapping and post-myomectomy to confirm complete excision. Case information, including pre-operative MRI scans, intra-operative ultrasound videos (pre- and post-myomectomy), and surgical videos, will be presented to demonstrate key findings. Surgical outcomes were assessed, including the accuracy of fibroid identification, completeness of excision, operative time, and post-operative complications.

**Results:**

The incorporation of intra-operative ultrasound facilitated the identification of fibroid location, size, and depth, particularly for smaller and more deeply embedded fibroids that were challenging to detect using standard laparoscopic techniques. In several cases, intra-operative ultrasound revealed additional fibroids that were subsequently resected, ensuring optimal surgical outcomes and reducing the risk of residual disease. No significant complications related to intra-operative ultrasound use were reported, and all surgical outcomes adhered to established safety standards.

**Conclusion:**

This case series demonstrates the utility of intra-operative ultrasound as an adjunct during laparoscopic myomectomy. The integration of intra-operative ultrasound improves surgical precision, reduces the likelihood of incomplete fibroid excision, and enhances patient outcomes.

**Christine Foster:** *Decisions, Decisions, Decisions. Shave, Disc or Resection*

Bowel endometriosis is a complex condition that poses significant challenges in diagnosis, management, and treatment. Deciding between surgical options such as rectal shaving, disc excision, or segmental resection requires a tailored, multidisciplinary approach. This presentation explores the key factors influencing surgical decision-making, including disease extent, lesion depth, symptoms, and patient preferences. I will discuss the advantages, limitations, and risks associated with each technique. Additionally, I will highlight the importance of preoperative planning, imaging modalities, and collaboration between gynaecologists and colorectal surgeons to optimise outcomes.

**Naomi Holbeach:** *Informed Consent for Innovative Surgery*

Meaningful choice in health care decision-making requires that the patient have full information, especially in the context of innovative surgery. Despite the long history of innovation in surgery, surgical innovation presents a challenge for the consent process especially where they are being performed outside of a clinical trial. The challenges relate to the paucity of evidence, unknown outcomes and variable surgical experience that can accompany innovative surgery.

The legal analysis of professional and legal obligations about preoperative information-giving presented here demonstrates that more, not less information is required for informed consent about innovative surgery. This accords with patient expectations about the information that is offered. Australian disciplinary decisions require surgeons to specifically discuss the novel nature of the procedure, the experience and supervision needs of the surgeon, the risks and benefits of the procedure and detail the extent of the uncertainty about the outcomes. Although there is no Australian negligence case that has considered the duty to inform about novel procedures, the case of *Mills v Oxford University NHS Trust* in the United Kingdom provides a detailed analysis of the information that should be provided to patients.

This analysis concludes that meaningful choice about surgical innovation requires full information about the procedure, which should include:

- A full description of the novel procedure including possible planned deviations.
- The risks and benefits of the novel procedure including a clear acknowledgement that some risks are not yet known.
- Information about the established treatment(s) and what is usual practice.
- A comparison of the risks and benefits in relation to established alternative treatment option(s).
- Information about the surgeon's experience with the novel procedure.
- Information about the collection of any data for analysis or audit purposes, the inclusion of the patient in any registry, and
- Information on where to seek help in the short and long term.
- Disclosure of conflicts of interest

Additionally, consideration should be given to providing preapproved written information, a second appointment to rediscuss, a cooling-off period, and assistance to seek a second opinion.



### **Study Objective**

To demonstrate a surgical technique for a laparoscopic surgical removal of a retroperitoneal-retrocervical fibroid.

### **Design**

Presentation of the procedure using a video.

### **Setting**

Retroperitoneal fibroids are a rare entity. Poliquin et al in the only systematic literature review<sup>1</sup> of this topic have found the following. Only 105 retroperitoneal fibroid cases were reported worldwide between 1941-2007. Mean age ( $\pm$ SD) of the population was  $46.27 \pm 13.19$  years. Symptoms presented by these patients included: abdominal fullness (31.3%), urinary symptoms (18.8%), weight loss (18.8%), and pelvic pain (18.8%). 25% of patients were asymptomatic. Diagnostic evaluation was inconclusive, and surgical excision was undertaken in all but 1 case. Median leiomyoma size was 12.0 cm (range 2.0 –37.0 cm).

### **Interventions**

In this video, we describe the laparoscopic myomectomy technique used to remove the retroperitoneal fibroid. Consent was obtained from the patient. We present the case of a 40 years old woman, G3P3 presented to our clinic with symptoms of dysmenorrhea, menorrhagia and dyspareunia. She did not suffer from dyschezia or dysuria. She does not suffer from any chronic illness and does not receive any regular medication. Her surgical history comprises of 3 Cesarean deliveries. Her Ultrasound scan had reported an anteverted and bulky in size uterus, measuring 134mm length x 40mm AP x 66mm width (volume 186cc). The volume of the uterus did not include a large pedunculated right sided fibroid mass which possibly can be measured as two different fibroids. The more inferior one measures 40mm x 28mm and immediately adjacent to it is a larger superior one that measures 92mm x 58mm x 59mm. They behave as one fibroid mass with a broad stalk connected to the right lateral wall of the uterus. The bowel was described as “no evidence of bowel nodules but only the more distal part of the bowel can be assessed, probably only 10cm, as then the bowel disappears behind the fibroid and cannot be seen in detail”. No pathologies were seen while scanning her ovaries, cervix and pelvis.

### **Conclusion**

Laparoscopic removal of the fibroid was planned. The surgery was uneventful, and the patient was discharged home within 24 hours of her procedure. The pathology of the fibroid was benign, and no post-op adverse effects occurred.

### **Study Objective**

To demonstrate a consistent technique for achieving minimal blood loss in robotic-assisted myomectomy in a multi-fibroid uterus.

### **Design**

A case report detailing the surgical technique and outcomes of a single patient undergoing a robotic assisted myomectomy of multiple fibroids.

### **Patient**

A 38 year old nulliparous women, with very heavy menstrual bleeding, iron deficiency anaemia, and primary infertility with a strong desire to conceive. She had a history of an open myomectomy for a 17cm anterior fibroid which led to 3.5L blood loss, transfusion of multiple blood products, and admission to ICU. A recent MRI showed 20 - 30 intramural and subserosal fibroids, the 2 largest being 50cm and 56mm.

## Intervention

Seventeen myomectomies were performed in this single case, using the da Vinci Xi robotic system, utilising a camera port in the RUQ, force bipolar in arm one, a 15mm assistant port in the umbilicus, scissors in arm three, and tenaculum and suture cut instruments alternating in arm four. Firstly, adhesiolysis is performed to adequately expose the posterior uterus and restore normal anatomy, and endometriosis excised from the anterior abdominal wall. Secondly, vasopressin is infiltrated to the pseudo capsule of the fibroid until visible blanching is achieved. An incision is made with monopolar scissors over the fibroid until the pseudocapsule is breached. The tenaculum is then used to apply traction to the fibroid with the fourth robotic arm, while the bipolar and monopolar scissors systematically desiccate and separate the pseudocapsule from around the fibroid, maintaining an intracapsular dissection plane. The technique is repeated for each fibroid, and the fibroids are secured to a barbed suture as they are removed in turn. A 2-0 barbed suture is then used to close the myometrium and serosa. Once haemostasis is achieved, an adhesion barrier is placed over the incisions. An Espinar bag is introduced via the umbilical port, and the specimen is morcellated under vision within the bag.

## Main results

The procedure lasted 2 hours and 30 minutes. Seventeen fibroids were removed and endometriosis was excised. The blood loss was recorded as minimal (<50ml). She was discharged on day 1. She had an uneventful recovery. Pathology results showed benign leiomyomas weighing 177g in total, with endometriosis in excised samples.

## Conclusion

This video demonstrates the technique for robotic assisted myomectomy for multi-fibroid uteri in the presence of endometriosis, while maintaining minimal blood loss, short post-operative stay, and no complications.

## **Pinar Cingiloglu:** *Pelvic Floor Muscle Tenderness in Women Undergoing Surgery for Endometriosis: A Reliability Study*

### Background

Persistent Pelvic Pain (PPP) is common in patients with endometriosis, and may cause significant morbidity.<sup>1</sup> Pelvic floor muscle (PFM) tenderness has been observed in 14-79% of women with PPP,<sup>2</sup> however the prevalence of PFM tenderness in women with diagnosed endometriosis is not known. While assessment of PFM function in routine clinical practice is undertaken using digital palpation, these tests lack objective values, and thresholds of clinical significance of the findings directing therapy to treat these dysfunctions is unclear. Gynaecologists and physiotherapists assess PFM function and make decisions regarding indications for therapies to treat identified dysfunction, yet these two clinical groups may not rate these findings consistently.<sup>3</sup>

### Objective

This study aims to assess inter-rater reliability between gynaecologists and physiotherapists in digital examination of PFM tenderness and tone, and to determine the value of PFM algometry and pressure investigations alongside routine clinical assessment.

### Methods

This was an observational single-cohort reliability study. Participants completed a baseline demographic and pain questionnaire. They were subsequently examined by a gynaecologist and physiotherapist to assess PFM (obturator internus and levator ani) tenderness and tone using a digital examination. An additional algometry and pressure assessment using a Femfit<sup>®</sup> device was performed during the physiotherapist assessment. Participants then completed a survey on the acceptability of the assessments.

Inter-rater reliability in assessing PFM tenderness and tone between gynaecologists and physiotherapists will be measured using the intra-class correlation coefficient (ICC), assessing consistency in rating for site and participant. Prevalence and severity of PFM tenderness measured by the Femfit<sup>®</sup> device will also be reported. Acceptability of the assessment components will be evaluated by using the post assessment questionnaire with 7-point Likert scale.

## Results

Recruitment for this study has just been completed with a total of 30 participants. Data cleaning and analysis are underway and results will be ready to present at the conference should this abstract be accepted.

## Conclusion

This study demonstrates the inter-rater reliability of digital PFM examinations between gynaecologists and physiotherapists. These data will guide a future study on the prevalence and severity of PFM tenderness and increased tone in women with endometriosis-associated pelvic pain and the impact of endometriosis surgery on these variables.

### **Saima Wani:** *Pioneering Surgical Solutions: A Novel Technique for Anterior Bowel Resection in Colorectal Endometriosis*

#### **Background:**

Colorectal endometriosis, a manifestation of deep infiltrating endometriosis (DIE), affects 3.8% to 37% of women with endometriosis.<sup>1</sup> The sigmoid colon and rectum are most involved, followed by the ileum, appendix, and caecum.<sup>1</sup> Small lesions limited to the subserosal fat are typically asymptomatic, while larger nodules infiltrating the muscularis layer can cause significant symptoms, including dyschezia, constipation, diarrhoea, abdominal bloating, painful defaecation, mucous in stools, and cyclical rectal bleeding. Transvaginal ultrasound (TVS) and magnetic resonance imaging (MRI) have demonstrated high sensitivity and specificity for detecting rectosigmoid involvement, at 89%-97% for TVS and 86%-95% for MRI, respectively.<sup>2</sup> Current surgical options include minimally invasive techniques, such as bowel shaving and discoid resection, which target superficial and localized lesions, respectively, but may leave residual disease, and have inaccurate margins, particularly discoid resection. For extensive disease (>50% bowel circumference, multiple nodules, or nodules >3 cm), segmental bowel resection is the standard but carries risks of anastomotic leak and rectovaginal fistula.<sup>3</sup>

#### **Method:**

We present a novel surgical technique using a robotic linear stapler as an alternative to conventional anterior rectal resection and end-to-end anastomosis. Only the lesion affecting the bowel is removed. Compared to discoid resection, this technique eliminates the need for rectal access, is more accurate, results in less resection of normal rectum, and dramatically reduces the need for segmental resection in our extensive experience. Compared to segmental bowel resection, it avoids unnecessary removal of the uninvolved posterior bowel wall, preserving presacral nerves and reducing the risk of bowel, bladder, and sexual dysfunction. While there is a theoretical risk of bowel stenosis, no cases were reported in the 28 procedures performed using this technique.

#### **Conclusion:**

This innovative linear stapler technique offers a promising advancement in the surgical management of bowel endometriosis, balancing efficacy, and preservation of function. It minimizes risks associated with traditional methods, including nerve damage and postoperative complications, making it a suitable option for selected patients with localized colorectal endometriosis.

1330 - 1500

Session 4A: Fertility

### **Pippa Robertson:** *Fibroids and Fertility: Evidence Not Opinion*

Uterine fibroids (leiomyomas) are the most common benign tumours of the female reproductive tract, affecting up to 70% of women of reproductive age. While often asymptomatic, fibroids can have a significant impact on fertility and pregnancy outcomes. The relationship between fibroids and infertility is complex, influenced by factors such as fibroid size, number, and location.

Fibroids can impair fertility through multiple mechanisms, including disruption of endometrial receptivity, alteration of uterine contractility, and distortion of the endometrial cavity. Submucosal and intramural fibroids, particularly those distorting the endometrial cavity, have been associated with reduced implantation rates, increased miscarriage risk, and poor pregnancy outcomes. Additionally, fibroids can lead to local inflammation, affecting the expression of implantation-related genes and cytokines. The role of inflammatory mediators, such



as tumour necrosis factor-alpha (TNF- $\alpha$ ) and interleukins, in fibroid-related infertility is an area of active research.

Uterine fibroids play a significant role in infertility through mechanical and molecular mechanisms. A tailored, evidence-based approach to diagnosis and treatment is essential to optimise reproductive outcomes.

#### **Anusch Yazdani:** *Caesarean Scar Niche and Fertility: Truth or Fiction*

Caesarean section defects (CSD), more recently defined as visible reductions in the thickness of the myometrium on ultrasound scan of at least 2mm, are visible in 20 to 60% of individuals after the first and 100% after third C/Section. Isthmocoelae, on the other hand, are the pathological term for a CSD. Isthmocoelae are an increasingly recognised consequence of caesarean sections, and a significant factor in both infertility and the outcomes of in-vitro fertilisation (IVF).

The presence of an isthmocoele is associated with secondary infertility. Putative mechanisms include accumulation of menstrual and other fluids, with direct toxicity or chronic inflammation. Furthermore, a large isthmocoele can distort the anatomy of the uterus, presenting a physical barrier to conception.

Isthmocoelae have been shown to have a negative impact on IVF outcomes, including reduced live birth rates, clinical pregnancy rates, and implantation rates, alongside increased miscarriage rates. The accumulation of intra-cavitary fluid (ICF) before embryo transfer is a critical factor in this reduction of success. The size of the isthmocoele itself, defined by residual myometrial thickness, is inversely correlated with live birth rates.

Several factors can contribute to the development of an isthmocoele, including genetic and connective tissue disorders, obesity, smoking, hypertension, and endometriosis. Procedural aspects of the C-section, such as a low hysterotomy, prolonged labour, dilation greater than 5cm, and low station can also be factors. Furthermore, the surgical technique, including single-layer closure, incomplete closure, poor haemostasis and infection, can increase the risk of isthmocoele formation.

Diagnosis is predicated on the an appropriate clinical picture (infertility), the presence of a defect, the demonstration of fluid within the endometrial cavity, and the exclusion of other fertility factors.

Management strategies include hysteroscopy to assess the defect and assess the surrounding anatomy. Medical treatment may involve aspiration of the fluid, antibiotics, or polycresulen coagulation. Surgical options include vaginal repair for defects with greater than 3mm of myometrium or abdominal repair when less myometrium remains, via either open, laparoscopic or robotic approaches. For patients not seeking fertility treatment, combined contraceptive pills, Mirena, and hysteroscopic resection or ablation, and hysterectomy may be appropriate options.

It is important to understand that treatment of isthmocoele is intended to address bleeding, pain and secondary infertility related to pelvic factors, but will not reduce the risk of abnormal placentation or dehiscence in subsequent pregnancies.

#### **Jenni Pontre:** *Deeply Infiltrating Endometriosis and Infertility: What to do in '25*

*Abstract not available.*

#### **Krish Karthigasu:** *Endometrioma Treatment Options in the Infertile*

Ovarian Endometriomas and fertility are a controversial topic with varying opinions when it comes to fertility and have had changes in opinion over the years.

The aim of this talk is to discuss the current evidence of endometriomas and their effects on fertility, the role of surgery on fertility outcomes, the negative impacts of surgery and the various surgical techniques available. It also looks at the evidence of endometriomas and endometrioma surgery with ART and current data on impact of both on ART outcomes. It briefly looks at the role of fertility preservation.

**Ted Anderson:** *Establishing a Program for Training in Robotic Hysterectomy*

Technological advancements in hysteroscopic surgery have been limited by the small size of the uterine cavity and the need to access this space through a device that also provides for vision and exchange of distension medium. Further, interventions have been restricted to linear movements with only one instrument that is coupled to the telescope. This undermines fundamental surgical principles like traction and countertraction and application of electrosurgical energy perpendicular to tissue to minimize lateral thermal injury.

Current robotic platforms offer many advantages for gynecologic laparoscopy, including improvements in precision, dexterity and ergonomics. Although adaptation of robotic principles may enhance operative capabilities for hysteroscopic surgeons, this has been challenged by size and access limitations of uterine cavity, as well as the need to operate in a pressurized fluid environment, the need for broad visualization of the entire uterine cavity, and the need to apply significant forces to tissue to remove uterine pathology.

We describe the development of a cystoscopic/hysteroscopic robotic platform that provides a dexterous 2-armed instrument that decouples the movement of the endoscope view from the movement of the surgical instruments. The core technology of this system is based on concentric tube manipulators, which enable robotic tools to be miniaturized to a size amenable to deployment through a standard rigid endoscope. Each manipulator consists of 2 precurved nitinol tubes, which can telescopically extend and axially rotate with respect to one another to create "tentacle-like" motions at the tip of the endoscope. The tubes are actuated by brushless direct current motors (one for telescopic extension-retraction and the other for axial rotation). The outer diameter of each manipulator is 1.5 mm, and the lumen of the inner tube is 0.75 mm. Two of these manipulators can be passed through a 9-mm sheath, along with a standard 3-mm rod lens. These features provide for improved vision, improved exposure with finer dissection capability, and simultaneous use of 2 independently controlled instruments to enable traction and countertraction.

This is the first description of an endoscopic robotic system with multiple concentric tube manipulators adapted to the challenges of hysteroscopy, which enables the surgeon to precisely resect tissue along complex geometries. The hysteroscopic robotic platform may be able to offer advantages over conventional hysteroscopy that could be useful for some indications. In addition, it may offer ergonomic advantages to surgeons by allowing them to stand and hold the controls at an adjustable height comfortable for them.

**Sita Ayu Arumi:** *Tips & Tricks for Robotic/Laparoscopic Myomectomy*

**Introduction.** Robotic-assisted myomectomy is an advancing innovation in minimally invasive surgical techniques, offering superiority in precision, three-dimensional visualization, and enhanced suturing quality compared to conventional approaches. This technique serves as a strategic option for patients with fibroids located in complex anatomical sites or those with a history of infertility. Nevertheless, the inherent technical challenges of this procedure still require optimization, including appropriate patient selection, efficient operative strategies, and intraoperative risk mitigation.

**Methods.** This study was conducted through a systematic review of relevant literature on robotic-assisted myomectomy. Article selection was conducted rigorously, considering topic relevance, surgical technique effectiveness, procedural optimization, and complication management. The analyzed literature consists of recent publications evaluating technical strategies and clinical outcomes related to the implementation of this procedure.

**Discussion.** The success of robotic-assisted myomectomy is highly dependent on several key determinants. Optimal patient selection includes fibroids with a diameter of  $\leq 10$  cm and a number not exceeding four units to reduce operative duration and minimize the risk of significant bleeding. Optimization of operative techniques involves trocar placement with a minimum interval of 8 cm to avoid robotic arm collisions, fibroid excision with incisions parallel to the uterine muscle fibers to facilitate reconstruction, and myometrial defect closure using layered suturing with barbed sutures or the X-stitch technique to ensure postoperative uterine wall integrity.

Complication management focuses on intraoperative bleeding control through early identification of the uterine artery and the application of hemostatic agents such as fibrin sealant. Postoperative adhesion prevention is achieved through the use of an anti-adhesion barrier. Contained morcellation techniques are essential in reducing the risk of disseminating potentially malignant pathological tissue. Operational efficiency is enhanced by optimizing robotic docking within  $\leq 10$  minutes and ensuring seamless coordination between the console operator and bedside assistant. A faster learning curve compared to conventional laparoscopy can be achieved through simulator-based training and mentorship programs, with an estimated 20-30 cases required to reach optimal proficiency.

**Conclusion.** Robotic-assisted myomectomy offers significant advantages in surgical precision, hemostasis control, and superior uterine reconstruction, particularly in complex fibroid cases. However, the implementation of this technique must be selective, considering appropriate indications, surgical strategy optimization, and perioperative risk mitigation. Although challenges such as higher costs and longer operative durations remain concerns, the long-term benefits of this technique, especially in optimal uterine reconstruction, can outweigh these limitations. The success of this procedure requires stringent patient selection, standardized surgical approaches, and continuous training to improve clinical outcomes and enhance patients' quality of life.

**Sven Becker:** *Robotic Approaches to Managing Colorectal Endometriosis*

Robotic Surgery for Rectal Endometriosis needs to be approached with four questions in mind: 1) Is the surgery necessary at all. 2) When it is done, what is the best surgical technique. 3) Does the robotic approach offer any advantages? 4) When am I too old to switch to robotics. We will try to answer all these questions in a short overview, looking at technical, pathophysiologic and didactic aspects.

**Benoit Rabischong:** *Neuropelveology: Where do we go with Pelvic Nerves?*

*Abstract not available*

**1330 - 1500**      **Session 4C: Oral & Video Free Communications**

**Sam Mooney:** *The Endometriosis Longitudinal Fertility Study (ELFS): 36 Month's Experience with The ELFS App for Longitudinal Fertility Data Collection*

**Introduction:** Endometriosis is associated with reduced pregnancy rates.<sup>1</sup> At present, the effect of surgery on the fertility of women with moderate/severe endometriosis remains unanswered.<sup>2</sup> Mobile phone Apps are a novel research tool with important potential benefits in longitudinal data collection.<sup>3</sup> Optimal use of these tools requires ongoing assessment and consumer input.

**Aims:** This report aims to describe the use of mobile phone Apps as a novel research tool in gynaecology, and provide interim quantitative data on use of the ELFS App by study participants. We describe successes and shortcomings of the App, and the processes of redesign and rebuild.

**Methods:** The Endometriosis Longitudinal Fertility Study (ELFS) is a prospective cohort study aiming to measure and compare monthly fertility outcomes in women with evidence of moderate/severe endometriosis. Following baseline questionnaire completion, participants install the ELFS App – a purpose-built data collection tool – to their mobile phone and receive longitudinal cyclical surveys initiated by in-built logic. A new version of the ELFS App is being deployed in November 2024 aimed to improve participant and researcher functionality.

**Results:** Following 36 months of recruitment, 229 patients had enrolled in ELFS and 180 participants have begun using the study App. 1,425 cycle questionnaires have been prompted, with 1,296(91%) being completed. Twenty-six participants(11.3%) have failed to complete a single App questionnaire after baseline. 107(46.3%) have completed all App-initiated cyclical questionnaires (median(IQR), 6(2,11) cycles). The App re-design was prompted by an unreconcilable coding error, preventing some operating systems from accessing or saving App data. Quantitative assessment of App usage and App experience are planned for 3 months following the transition to the new ELFS App.



**Conclusion:** The purpose-built ELFS App is facilitating timely cyclical data collection, with superior response rates compared with prior longitudinal questionnaire-based studies in fertility. However, technology limitations and programming errors have necessitated App redesign. Long-term ELFS App use will be monitored as its functionality and participant usage is integral to study success.

**Sam Mooney:** *Ultrasound Assessment of The Uterosacral Ligaments and Diagnostic Accuracy for Peritoneal Endometriosis: A Pilot Single-Centre Prospective Study*

**Introduction:** Whilst laparoscopy with tissue biopsy is the 'gold standard' test for endometriosis, the use of laparoscopy as a diagnostic test places the patient at risk of adverse surgical outcomes and is costly. A retrospective study<sup>1</sup> highlighted the potential utility of using uterosacral ligament (USL) thickness to predict presence of superficial endometriosis. This pilot aimed to assess the protocol for the planned full study. Ultimate aims will be to assess the ultrasound assessment of USL thickness, mobility and tenderness as markers of superficial endometriosis.

**Methods:** This prospective pilot study enrolled premenopausal participants without prior diagnosis of endometriosis who were awaiting laparoscopic gynaecological surgery. Participants underwent a specialist pelvic ultrasound within 8 weeks prior to their surgery and completed a baseline questionnaire. Visual operative findings were noted, and histopathological results reviewed, including standardised USL biopsies. Protocol success was determined by recruitment rate and frequency of events within the data collection protocols. Cohort characteristics were summarized as mean(SD), median[IQR] or number(%) according to data type and distribution. Both Chi-squared and ANOVA tests were used to assess the relationship between USL thickness measurement(mm), and histological endometriosis, treating USL thickness as both a categorical (cutpoint 2mm) or continuous variable.

**Results:** Forty-one participants were recruited between 10/8/2021 and 29/5/2024. The study protocol was not feasible in our single centre unit due to inadequate recruitment rate (1 [IQR 0,2] per month). A total of 9 participants were withdrawn from the study after enrolment, including four participants who had unexpected deep endometriosis noted on the specialist ultrasound when earlier sonography had missed the diagnosis. Thirty-two participants completed the baseline questionnaire, standardised pre-operative ultrasound, and surgical assessment with standardised USL biopsies. No participant experienced a complication related to the USL biopsies. Mean age was 37.41(8.79) years and mean body mass index (BMI) was 27.74(6.20). Fifteen (46.9%) were parous. Eleven (34.3%) were using exogenous hormones. There was histological confirmation of endometriosis in 21 cases. Using the cut-off of 2mm, the USL thickness measurement had a poor sensitivity (23.8%;95%CI 8.22-47.17), but moderate specificity (81.82%;95%CI 48.22-97.92); PPV 71.43%, NPV 36%. BMI, age, nor parity were associated with USL thickness. Adding USL tenderness and mobility did not significantly improve accuracy.

**Conclusion:** A multisite study is required to successfully complete the study protocol. To date, there is insufficient prospective evidence to support the use of USL thickness as a marker for superficial endometriosis. The study protocol highlighted the importance of quality pre-operative sonography, identifying four patients with unexpected severe endometriosis.

**Sean Copson:** *Laparoscopic Excision of Caesarean Scar Pregnancy at 11 Weeks Gestation in A Woman with a Bicornuate Uterus and Placenta Accreta Spectrum*

**Introduction:** Caesarean scar pregnancy (CSP) occurs in 1 in 2000 pregnancies and accounts for 6 percent of abnormally implanted pregnancies among patients with a prior caesarean section.<sup>1</sup> CSPs are associated with high morbidity including uterine rupture, haemorrhage, placenta accreta spectrum (PAS) and maternal mortality. CSPs can be managed medically or surgically, with surgical management associated with higher success rates.<sup>2</sup> Surgical management can include hysterectomy, surgical resection, or dilation and curettage, with surgical choice depending on the gestation, desire for future pregnancy type of CSP and presence/absence of PAS.

In this patient desiring future pregnancy with a bicornuate uterus, at 11 weeks gestation with ultrasound findings suggestive of PAS, decision was made for laparoscopic excision of the CSP with bilateral uterine artery ligation for control of bleeding.

**Objective:** The purpose of this video is to demonstrate a laparoscopic excision of a Caesarean Scar Pregnancy on the Placenta Accreta Spectrum with a bicornuate uterus, with bilateral uterine artery ligation for control of bleeding which was technically difficult secondary to a bicornuate uterus.

**Design:** Technical video demonstrating the laparoscopic excision of a CSP.

**Setting:** Gynaecology Department, King Edward Memorial Hospital, Perth WA.

**Discussion:** Early treatment of CSP is critical because due to the high associated morbidity and mortality. Surgical treatment is necessary in patients of advanced gestation with options including hysterectomy, excision of the CSP or suction D+C. In this patient who desired future fertility with ultrasound findings consistent with PAS, at 11 weeks gestation, excision of the CSP was the appropriate surgical treatment. Surgical considerations to minimise bleeding include bilateral uterine artery ligation, bilateral ligation of the anterior branch of the internal iliac artery or vasopressin injection into the surrounding myometrium. Bilateral uterine artery ligation is not associated with adverse pregnancy outcomes in subsequent pregnancies due to the development of an anastomotic uterine blood supply and has the advantage over temporary clamping of ensuring haemostasis in the post-operative period.

**Conclusions:** Laparoscopic bilateral uterine artery ligation prior to excision of a Caesarean Scar Pregnancy on the Placenta Accreta Spectrum resulted in an almost bloodless surgical procedure with the additional benefit of excision of the Caesarean section defect including the abnormal myometrium with placental invasion.

#### **Sebastian Jacob-Rogers:** *Complete Removal of Retropubic Mid-Urethral Sling by Laparoscopic Approach*

**Introduction:** Retropubic mid-urethral sling (MUS) is an effective and minimally invasive treatment for stress urinary incontinence. It carries a 3% risk of complications, including mesh exposure or erosion into surrounding structures, recurrent stress incontinence, voiding dysfunction, dyspareunia and chronic pain. Removal of part or all of the sling may be necessary but can be a morbid procedure involving vaginal incisions to remove the vaginal component and typically a suprapubic transverse incision to remove the abdominal portion of the sling.

**Aims:** Present for educational purposes a laparoscopic approach to complete removal of a retropubic MUS.

#### **Methods:**

We present a case of a fifty-nine-year-old woman who underwent a retropubic MUS thirteen years ago for the management of stress urinary incontinence. The indication for removal was persistent symptoms of left sided pelvic pain, dyspareunia, voiding dysfunction and mixed urinary incontinence. On clinical examination, there was no mesh erosion or exposure. The decision for complete removal was made after extensive counselling on options including conservative management, partial removal and complete removal.

**Results:** Complete laparoscopic and vaginal removal was achieved without conversion to laparotomy with no surgical complications and an uncomplicated post-operative course. Our approach demonstrates the possibility and advantages of a laparoscopic approach to complete removal of a retropubic mid-urethral sling with enhanced recovery after surgery. A small 3cm suprapubic incision facilitated removal of the supra-fascial component of the sling.

**Conclusions:** Complete removal of retropubic mid-urethral slings is a difficult and morbid procedure. A combined vaginal and laparoscopic approach by an experienced surgeon is a feasible technique to enhance patient recovery and reduce surgical morbidity.

#### **Sireen Jaber:** *Unravelling Essure: A Case Report Highlighting Challenges and Surgical Techniques for Device Removal*

The Essure® hysteroscopic sterilization device (Bayer AG, Leverkusen, Germany) was discontinued in 2018 following an FDA review and reports of complications, including persistent pelvic pain, abnormal bleeding,

uterine or fallopian tube perforation, and device migration into the pelvis or abdomen. Systemic symptoms, such as headaches and irregular menses, have also been reported. Increasingly, women with Essure devices seek removal due to these adverse effects (1). However, the lack of standardized removal techniques poses challenges. Improper handling, including excessive traction, may result in device breakage, leaving fragments such as metal coils or polyester fibers in situ(2). This can lead to inflammation, chronic pain, and the need for further surgical intervention, including hysterectomy. Migration of the device and surrounding scar tissue often complicate visualization and removal during surgery. (3)

We present the case of a 48-year-old woman with intermittent stabbing pelvic pain and irregular menses since undergoing Essure insertion in 2013. Preoperative CT imaging revealed migration of the right Essure device into the abdominal cavity near the bladder, with fragments in the pouch of Douglas. The left device remained embedded in the fallopian tube, extending from the uterine fundus toward the adnexal region. Surgical removal was achieved using a combined hysteroscopic and laparoscopic approach.

Hysteroscopic exploration identified the left Essure device protruding into the uterine cavity; however, the proximal rectangular marker had fractured and was not visualized. The right ostium appeared patent without visible fragments. Laparoscopy revealed a perforated right-sided device embedded in the peritoneum of the pouch of Douglas. The left device was partially fragmented, with one portion embedded in the fallopian tube and another located in the omentum near the bladder.

The surgical procedure included removal of migrated fragments, right salpingectomy, and left salpingectomy with cornual resection. Vasopressin was injected into the left cornua to minimize bleeding, and the uterine incision was sutured with a figure-of-eight stitch. Gentle handling and avoidance of electrocautery near the devices minimized the risk of further fragmentation. Complete device removal was confirmed by inspecting all retrieved specimens. Peritoneal washings were collected for heavy metal analysis, revealing minimally elevated but non-toxic nickel levels. At six weeks postoperatively, the patient reported significant symptom relief.

This case emphasizes the importance of understanding Essure device anatomy and employing meticulous surgical techniques to ensure successful removal. A combined laparoscopic-hysteroscopic approach remains the preferred strategy, particularly in cases with device migration or fragmentation.

### **Sneha Parghi:** *Laparoscopic Resection of Caesarean Scar Ectopic Pregnancy with Application of Laparoscopic Bulldog Clips*

**Objective:** The accompanying video presents the laparoscopic management of a large and very vascular caesarean scar ectopic pregnancy with the use of the Aesculap laparoscopic bulldog clips for temporary vascular occlusion.

The patient had undergone two previous caesarean sections and presented with a large caesarean scar ectopic at 8+1 weeks, with a crown-rump length of 19.8mm and a vascular gestation sac of 86cc. Her presentation had been preceded by vaginal bleeding and her starting Hb was 80. She had a desire to retain her uterus.

The decision was made to proceed with laparoscopic resection of the ectopic with the use of the Aesculap bulldog clips. These clips provide temporary occlusion to key vessels and are applied laparoscopically via an applicator which is then removed, allowing the procedure to be performed unhindered. In this case, both uterine arteries were isolated using the "ring the bell" technique where gentle traction is applied to the obliterated umbilical artery. The clips were then applied to both uterine arteries. A further two clips were applied to the ovarian ligaments to reduce any collateral blood supply.

After dilute vasopressin intra-myometrial injection, the ectopic was resected in its entirety, the isthmocele edges removed sharply and the wound closed in two layers using a 2.0 v-loc suture. The clips were then removed laparoscopically once the resection had been completed.

The use of the bulldog clips resulted in a procedure with impressively minimal blood loss. Postoperative Hb was 78.



**Conclusion:** This technique is a valuable option to consider for difficult cases such as these.

**Tristan McCaughey:** *Standardizing The Histopathological Diagnosis of Adenomyosis: An International Delphi Consensus*

Currently there is no standardized histopathological criteria for identifying adenomyosis, leading to an inter-pathologist diagnosis range of 10-88%. This high inter-pathologist variability is concerning not only for individual patients' diagnoses, but also for designing studies that compare clinical outcomes and/or imaging diagnosis to histopathological diagnosis. This study aimed to address this by using the Delphi consensus methodology to establish standardized criteria for the histopathological diagnosis of adenomyosis.

Between April and September 2024, a modified three-round Delphi consensus study was conducted. Thirty-one gynecological pathologists from 18 countries participated in surveys to evaluate and refine a diagnostic framework for adenomyosis in hysterectomy specimens. Key areas achieving the highest level of agreement included: 4-6 blocks for routine histopathological examination of hysterectomy specimens with benign indications; defining adenomyosis as endometrial glands and/or stroma greater than 2mm into the myometrium or more than one-third of myometrial thickness; that the absolute number of glands or stromal tissue does not contribute to the diagnosis of adenomyosis; a single gland or stromal focus can be diagnostic; and definitions of focal, extensive, superficial and deep adenomyosis. In total, 93% of respondents were in favor of standardizing the diagnosis to reduce inter-pathologist variability.

This study proposes the first consensus-based guideline for the histopathological diagnosis of adenomyosis. Supported by the responses of 31 international experts through a modified Delphi method, this framework provides pathologists with clear diagnostic criteria. Further research should correlate these criteria with clinical symptoms and outcomes.

**Vanessa Ross:** *The Endometriosis Longitudinal Fertility Study (ELFS): Pre-Pregnancy Treatment Decisions for Women with Moderate or Severe Endometriosis Who Are Trying to Conceive*

**Introduction:** Endometriosis is associated with reduced pregnancy rates in women attempting both spontaneous and assisted conception.<sup>1</sup> At present, the effect of surgery on the fertility outcomes of women with moderate/severe endometriosis remains unanswered.<sup>2</sup> Treatment decisions are complex, particularly in those without pain symptoms seeking to optimise fertility outcomes.<sup>3</sup>

**Methods:** The Endometriosis Longitudinal Fertility Study (ELFS) is a prospective cohort study aiming to measure and compare monthly fertility outcomes in women with evidence of moderate/severe endometriosis. Comparisons are planned between participants undertaking surgical or conservative management pre-pregnancy, who attempt conception naturally or with assisted reproductive technologies (ART). The Austin Health Ethics Committee approved the ELFS protocol (HREC 65683). This interim report aims to assess outcomes for participants recruited during the first 36months of the study. Survey data is collected via the purpose-built ELFS App, with questionnaire timing dependent on a learned logic within the App.

**Results:** Following 36months of recruitment, there are 229 patients enrolled in ELFS. 154(67%) participants are in the surgical cohort (of which 86(56%) have undergone planned surgery) and 75(33%) are in the conservative cohort. Participants <35yrs and >35yrs of age have similar rates of pre-pregnancy surgical management. 59(26%) participants have indicated that they were actively trying to conceive during the study period and 279 survey cycles have been recorded for these participants. Of these, 80(29%) cycles utilised ART compared to 199(71%) cycles of natural conception attempts. A total of 33 pregnancies have been recorded, 19(58%) from the surgical cohort and 14(42%) from the conservative cohort. To date, there have been eight live births recorded, 5 from the surgical cohort(63%) and 3 from the conservative cohort(37%).

**Conclusion:** ELFS plans to continue recruitment for a further 24months. Additional long-term data is required to determine if fertility and pregnancy outcomes are influenced by surgical management of moderate to severe endometriosis.

## **Vinita Rajadurai:** *Steps to a Robotic Assisted Abdominal Cervical Cerclage Using ICG To Aid in Vessel Identification*

### **Study Objective:**

To demonstrate safe and easy surgical steps to facilitate preconceptional robotic assisted abdominal cervical cerclage.

### **Design:**

A video presentation to describe the steps of robotic assisted abdominal cervical cerclage placement. Surgical footage surrounding a case report is used to describe the steps and technique for robotic-assisted abdominal cerclage placement in women with recurrent pregnancy loss.

### **Setting:**

Sydney Adventist Hospital, Wahroonga, NSW

### **Patients or Participants:**

A 28yo G3P2-2 undergoing history indicated robotic assisted abdominal cervical cerclage placement.

### **Interventions:**

The patient underwent an uncomplicated robot-assisted abdominal cerclage.

### **Conclusion:**

Abdominally placed cervical cerclage's significantly improve pregnancy and neonatal outcomes in women who have previously failed transvaginal cerclage. Robotic assisted abdominal cerclage allows a minimally invasive approach with enhanced dexterity, elimination of hand tremor, better visualisation and wristed instrument rotation for the surgeon compared with conventional laparoscopy. The use of ICG is an additional benefit, used to aid in demonstrating the course of uterine vessels prior to suture placement in teaching cases.

## **Zaynab El-Hamawi:** *A Randomised Controlled Trial of Hysteroscopic Morcellation Versus Electrosurgical Resection for Submucosal Leiomyomas in Women With AUB-L*

**Aim:** Submucous leiomyomas (FIGO classification Type 0, 1 or 2) occur in up to 23.4% of women experiencing abnormal bleeding. Hysteroscopic resection of submucous myomas is an easily accessible surgical treatment option, with a number of devices available to achieve resection.

The aim of this study is to compare cost-utility of monopolar resection versus hysteroscopic morcellation of submucous myomas in women reporting abnormal uterine bleeding.

**Methods:** Recruitment occurred between January 2016 and December 2023. English-speaking women over 18 years of age undergoing an elective hysteroscopy for suspected or ultrasound confirmed leiomyoma were randomised during surgery to myomectomy with either monopolar resectoscope or Myosure XL mechanical morcellation. The primary outcome is cost-utility of hysteroscopic morcellation vs. monopolar electrosurgical resection, assessed by theatre time, intra-operative and post-operative consumables, post-operative visits, and re-intervention.

**Results:** 68 participants provided consent to participate, 30 were excluded (80% due to no submucous leiomyoma intra-operatively). 19 participants were randomised to Myosure and 19 were randomised to Monopolar Resection. The mean age was 44.5 years (SD 7.0) and 41.8 years (SD 8.3), mean BMI 23.5 (SD 6.8) and 26.6 (SD 5.1). Complete resection as achieved in 63.2% versus 78.9% ( $p=0.28$ ). Operative time was 61 minutes (SD 39 minutes) versus 58 (SD 22) minutes ( $p=0.74$ ).

Data regarding re-intervention, and cost-utility analysis is ongoing with expected completion of February 2025

**Conclusion:** There does not appear to be a statistically significant difference in operative time or completion of resection between the two groups. A conclusion regarding the most cost-effective device will be available for presentation at the AGES ASM 2025.

**Jeffrey Woo:** *Trouble in the Lower Uterine Zone: Tackling Isthmocolle and Scar Ectopic, One Stitch at a Time!*

**Learning Objectives:**

1. Understand the diagnostic criteria for uterine isthmocolle and cesarean section scar pregnancy
2. Evaluate a step-by-step approach to a robotically assisted laparoscopic removal of the uterine isthmocolle and cesarean section scar pregnancy
3. Understand and review the and treatment options for isthmocolle and cesarean section scar pregnancy

**Jade Acton:** *Ovary on the Edge: Surgical Solutions for Residual Ovaries*

*Abstract not available*

**Amani Harris:** *When the Vault Breaks: Insights into Vaginal Vault Dehiscence*

Vaginal vault dehiscence is a rare but serious complication following hysterectomy, with significant implications for patient morbidity. This talk explores the multifaceted aspects of vaginal cuff dehiscence, focusing on risk stratification, optimal prevention strategies, and repair techniques. The talk reviews the evidence for incidence of dehiscence by hysterectomy route. Identified risk factors will be explored such as surgical technique, energy device use, and patient-related variables.

The presentation will detail evidence-based recommendations for optimal vaginal cuff closure, including the use of barbed sutures, layered closure techniques, and minimizing tissue damage. Emphasis will also be placed on diagnosing dehiscence early and employing appropriate repair methods tailored to the extent of injury and patient condition. Techniques such as transvaginal, laparoscopic, and robotic-assisted repairs will be discussed, highlighting their indications and challenges.

This session aims to provide attendees with practical insights into improving surgical outcomes and minimizing risks associated with vaginal vault dehiscence.

**Albert Jung:** *Laparoscopic Hysterectomy Redefined: Navigating Complex Cases with Confidence*

This presentation will look at pre-operative and peri-operative strategies to tackle the increasing complexities around total laparoscopic hysterectomy. Topics covered will include: narrow vaults with reduced vaginal access, large fibroid uteri, significant adhesions and hysterectomy with a uterine manipulator.

**Ian Harris:** *Surgical Effectiveness: Perception Versus Reality*

Surgical effectiveness has traditionally been, and still is, driven by observational evidence and tradition (via mentorships, apprenticeships and thought leaders). This has led to a bias whereby practitioners overestimate the effectiveness and underestimate the harms of the procedures they perform.

Surgical effectiveness should be assessed by low bias experimental methods, yet despite evidence that such methods frequently provide a lower estimate of effectiveness compared to observational evidence, experimental evidence is infrequently used to determine effectiveness in the fields of surgery. Although many experimental studies are performed, very few test the effectiveness of any procedure compared to not doing the procedure; a comparison necessary to determine true effectiveness.

The flaws in relying on observation and tradition to support surgical procedures are discussed, along with the advantages of experimental studies.

The biases discussed need to be recognised by clinicians and the lack of experimental evidence in surgery needs to be addressed to avoid the costs and harms associated with performing procedures that may not be effective. I suggest that the burden of proof lies with the proponent practitioner and that the current "low bar" for the introduction and performance of surgical procedures, and the lack of incentives to perform



experimental studies be addressed. This has been done successfully in other fields of medicine and is gaining traction within surgical specialties.

**Ray Garry:** *Dan O'Connor Lecture - Reflections on Gynaecological Endoscopy*

I wish to reflect not just on "my journey" through a professional lifetime in gynaecological endoscopy but also to reflect on outcomes and possible reasons why things did not always work out as expected.

In an attempt to clarify such discrepancies between theory and results I embarked on this long-term observational study into the variations of endometrial anatomy during the menstrual cycle. Some 2000 images from 33 women at various stages of the menstrual cycle were studied. They were obtained from pressure-controlled hysteroscopic images collated with simultaneously obtained immuno-histochemical and SEM specimens.

Unclotted blood was lost continuously throughout the time of shedding/repair with the implication that vascular occlusion could not be the primary cause of functionalis loss. Such shedding is both piecemeal and asymmetrical with more stroma than glands being lost, leaving stumps of residual glands protruding above the surface. This shedding is associated with uNK cells. It had previously been thought that the epithelium of the 'old' glandular stumps were the source of the 'new' luminal epithelium, but our observations suggest that epithelial cells of the basalis glands are themselves shed and rapidly replaced by 'new' narrow horizontal glands lined by small undifferentiated cells

A previously little observed event is that once exposed, the surface of the basalis is almost immediately covered by a fibrin matrix. This mesh is bathed in blood flowing from damaged blood vessel with many blood born cells being trapped within this mesh.

We have shown that the speed of shedding/regeneration is remarkable and possibly completed in only 2 hours. Cells expressing the stem cell marker CD34 surround most glands and also form a line of stromal CD34 cells along the upper basalis. This combined with the finding that many 'new' epithelial cells expressing cKit a stem cell receptor suggest that the glandular epithelial cells regenerate by stem cell differentiation.

Laparoscopy unequivocally confirms the sometimes disputed, reality of retrograde menstruation. For the first time we have also shown that, just as in the eutopic endometrium, glandular epithelial cells in endometriosis are shed and immediately replaced. These ectopic glands are also surrounded by CD34+ cells and express cKit implying stem cell involvement in cellular growth of endometriosis.

These are highly selected observations and as they are not clinical trials do not, of themselves, prove anything. They do, however, raise questions about the veracity of some accepted theories on cyclical endometrial shedding/regeneration that I believe may affect clinical outcomes and may require further study.

1030 - 1200

Session 7: Pain

**Elizabeth Gannon:** *Microbiome & Pain*

*Abstract not available.*

**Damien Finniss:** *Placebo or Nocebo*

Placebo effects have been recognised in medicine for over two hundred years. Deceptive use of placebo treatments to appease patients and the evolution of placebo control groups in clinical trials (where strong results in the placebo arm can detract from the index treatment under investigation) has contributed to a negative connotation for some clinicians and patients alike. Conversely, individual clinician observations, significant placebo effect sizes in clinical trials and a dedicated field of research into placebo effects has dramatically changed the picture for researchers, clinicians, patients and the broader community. The field of placebo effects now provides opportunities ranging from exploration of mind-brain physiology to the direct harnessing of placebo mechanisms in daily clinical practice.

Almost all routine medical treatments involve a therapeutic ritual or context. To understand how that context affects a patient, one can remove the treatment itself and replace it with a simulation of that therapeutic ritual (a placebo). The therapeutic context itself can specifically modulate many biological processes, such as nociceptive processing, thereby altering patient's symptoms.

On this basis, the outcome of any medical treatment is likely to be due to both the targeted treatment itself and the effect of the treatment ritual on the patient's brain and body. The latter component is known as "placebo effects", because these are seen after placebo administration, although it is the psychosocial context which is triggering the responses (the actual placebo is inert from a biological perspective). That psychosocial context is a part of all medical treatments, particularly in the field of pain and analgesia, and therefore placebo mechanisms and effects can be harnessed during routine care, even if no placebo is given.

### **Sonya Ting:** *Pain Relief or Pitfall? Reassessing Opioids in Pelvic Pain*

Opioid prescribing is a common and often essential component in the management of acute pain. When used as part of a multimodal regimen effectively, opioid analgesics can be beneficial in improving function and reducing distress after surgery. However, it is becoming increasingly well known that opioid stewardship is necessary to avoid potentially serious adverse effects, particularly in long term settings. In 2022, recognising that opioid stewardship is an increasingly important patient safety initiative, the Australian Commission for Safety and Quality in Health Care (ACSQH) published the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard. This presentation aims to discuss these standards and how they may apply in the acute pain setting.

### **Matt Jenke:** *How Language Can Influence Patient Outcomes*

The patient experience is subject to a vast array of interactions and influences throughout the medical journey. The language used to convey information is often overlooked and underappreciated as to how it can transform and guide the patient. Developing language skills to provide a better patient experience is inexpensive, safe and can have rapid benefits to both patient and clinician alike. I invite you to take a moment to explore how subtle strategies and techniques can have lasting impacts on patient wellbeing and clinical outcomes.

## **1030 - 1200    Session 8: The Anatomy of Complications Workshop**

*Not Applicable*

## **1030 - 1200    Session 9: Not So Live Surgery**

### **Jörg Keckstein**

#### **Educational Surgical Video by Prof. Dr. Jörg Keckstein and Team, Austria**

##### **Introduction**

This educational video demonstrates a complex surgical procedure for deep endometriosis, showcasing advanced laparoscopic techniques and the use of specialized instruments.

##### **Patient Case**

The patient is a 32-year-old woman with a history of two previous surgeries. She presented to our center with long-standing endometriosis-related complaints and a right-sided hydronephrosis. The predominant symptoms included severe dysmenorrhea, dyspareunia, and dyschezia.

Preoperative diagnostics revealed extensive deep endometriosis within the pelvis, with significant findings including:

- Severe obstruction of the right ureter
- Extensive vaginal infiltration
- Bilateral parametrium and uterosacral ligament (USL) involvement

- Anterior rectal wall infiltration

### **Surgical Strategy and Objectives**

This video illustrates the strategic approach to addressing a highly complex surgical field in extensive endometriosis. The procedure requires meticulous dissection due to the complete infiltration of pelvic support structures, including the right pelvic sidewall and ureter. Key objectives include:

- Identification and preservation of critical anatomical structures
- Precise dissection of pathological tissue while maintaining nerve integrity
- Ureterolysis with detailed demonstration of decompression from severe constriction
- Bowel preservation according to the patient's preference
- Development of individualized solutions for highly challenging and unclear endometriosis cases

An important aspect of this video is the demonstration of how tailored solutions can be found in particularly complex and unclear endometriosis scenarios where standard approaches may not be sufficient.

Additionally, this video highlights the dynamic interaction between the lead surgeon and assistant, an essential aspect of surgical education.

### **Surgical Techniques and Instrumentation**

This laparoscopic procedure is performed using a three-instrument technique, with a distinctive approach in which the assistant plays an active role in the surgical process. The assistant primarily utilizes a bipolar forceps, taking responsibility for hemostasis, which contributes both to surgical efficiency and to the hands-on training of surgical fellows.

- Monopolar Needle Dissection: Demonstrates an effective technique for precise tissue preparation with minimal trauma to healthy structures.
- Traction and Counter-Traction Principles: Fundamental to the exposure of anatomical planes, enabling micro-surgical precision.
- Use of Specialized Instruments:
  - Uterine manipulator to enhance surgical exposure
  - Fine grasping instruments for delicate tissue handling
  - Microsurgical instruments to facilitate precise excision

This video provides an in-depth look at advanced laparoscopic techniques, focusing on both optimal patient outcomes and the training of future surgeons.

#### **Mario Malzoni**

*Abstract Not Available*

1030 - 1200

Session 10: Complex Reproductive Surgery

#### **Roger Hart: To Cut or Not to Cut: That is the Septum**

This talk will discuss the challenges in diagnosing a small uterine septum and discuss the evidence around the potential relevance of a uterine septum to a woman's history of infertility or miscarriage. It will discuss the approaches to the treatment of a uterine septum and whether treatment improves outcome and will discuss the challenging decision as to whether an incidental septum should be resected.

#### **Devini Ameratunga: Asherman's: Prevention in the Fertility Patient**

Intrauterine adhesion (IUA), including its severe form, Asherman's syndrome, is a complex and often debilitating condition. It can lead to significant reproductive challenges, including menstrual irregularities (such as amenorrhea), infertility, and recurrent pregnancy loss. Among these, infertility is particularly difficult to manage.



While various factors contribute to IUA, uterine instrumentation remains the primary cause. Advances in surgical technology have enabled more intricate intrauterine procedures, but they also elevate the risk of adhesion formation. As a result, effective strategies to prevent and minimize the severity of IUA are urgently needed.

This presentation aims to enhance understanding of IUA by covering: (1) the etiology and prevalence of IUA, (2) diagnostic methods, (3) classification systems, (4) pathophysiology, and (5) primary prevention strategies.

Preventive measures include refined surgical techniques, such as careful selection of instruments, energy systems, and pre-hysteroscopic management. Additionally, barrier methods, including anti-adhesive gels, intrauterine devices, balloons, and membranes containing hyaluronate-carboxymethylcellulose or polyethylene oxide-sodium carboxymethylcellulose, can help reduce adhesion formation. By deepening our knowledge of IUA, we can improve strategies for prevention and management, ultimately enhancing reproductive outcomes.

### **Rebecca Deans:** *Mullerian Anomalies*

Müllerian anomalies are a diverse group of congenital uterine malformations, arising from deviations of embryologic development, including fusion, or resorption of the Müllerian ducts. These abnormalities can have profound implications for reproductive health, including infertility, recurrent pregnancy loss, menstrual disorders, and chronic pelvic pain. Despite their prevalence, optimal management strategies remain a topic of ongoing clinical discussion and research.

The classification of Müllerian abnormalities and pathophysiology of Müllerian abnormalities remains controversial. Focus is on clinical manifestations, diagnostic approaches, and implications for fertility and quality of life. The decision-making process regarding surgical versus conservative management takes into consideration indications for interventions, such as hysteroscopic septum resection, laparoscopic metroplasty, anastomosis and rudimentary horn excision as well as symptomatology, surgical complexity and the reproductive aspirations of the individual.

Long-term management considerations include reproductive planning, pregnancy surveillance, and psychosocial support. Advances in imaging techniques, minimally invasive surgery, and fertility-sparing approaches will be explored, emphasising individualised patient care.

### **Jennifer Beale:** *Beyond the Binary: Gynaecology Care for Gender Diverse People*

This session will discuss various aspects of care to consider when caring for trans\* and gender diverse people from a Gynaecology perspective.

## **1030 - 1200**    **Session 11: Endometriosis**

### **Tanushree Rao:** *Lighting the Way: ICG in the Surgical Management of Endometriosis*

#### **Abstract: Use of ICG in Endometriosis Surgery**

The management of endometriosis often involves addressing complex anatomical distortions and deeply infiltrative disease. Indocyanine Green (ICG) fluorescence has emerged as a transformative tool in gynecological surgery, offering enhanced visualization of endometriotic lesions and critical structures. This abstract outlines the novel applications and impact of ICG in endometriosis surgery.

#### **Ureter Visualization:**

ICG fluorescence enables precise identification of ureteric involvement in endometriosis. This facilitates safe and effective dissection, reducing the risk of ureteric injury and ensuring preservation of function during excision of deep infiltrating disease.

#### **Bowel Endometriosis:**

ICG has dual applications in bowel endometriosis:

1. **Assessment of Vascularity Post-Resection:** ICG aids in evaluating blood supply to the bowel following resection, optimizing healing and reducing complications such as ischemia.
2. **Intraluminal Use:** ICG injected intraluminally allows surgeons to determine the proximity of lesions to the mucosa during shaving procedures, ensuring precision and minimizing the risk of mucosal injury.

### **Vaginal Staining:**

The innovative use of ICG to stain the anterior and posterior vaginal compartments enhances the identification of endometriotic involvement. This technique allows for a more thorough and accurate excision of disease in these challenging anatomical areas.

### **ICG Fluorescence for Superficial Lesions:**

Videos demonstrate how ICG fluorescence can be used to enhance visualization of superficial endometriotic lesions. However, it is important to note that not all lesions fluoresce with ICG. Current evidence and clinical experience suggest that ICG primarily highlights vascularized lesions, such as flame-like lesions with puckering, while less vascularized or fibrotic lesions may not exhibit significant fluorescence. This variability underscores the importance of combining ICG with other diagnostic tools for comprehensive lesion identification.

### **Impact on Surgical Outcomes:**

The incorporation of ICG fluorescence in endometriosis surgery offers substantial benefits, including improved surgical precision, reduced recurrence rates, and enhanced patient safety. By facilitating the identification and preservation of critical structures while optimizing lesion excision, ICG transforms the approach to complex endometriosis cases.

### **Conclusion:**

The application of ICG in endometriosis surgery represents a paradigm shift in the management of this challenging condition. While ICG is invaluable in highlighting certain types of lesions, understanding its limitations is key to optimizing its utility. Further research and adoption of these techniques will continue to refine and enhance its role in gynecological surgery.

### **Jeffrey Woo: Adenomyomectomy: Easier to Perform Than Pronounce – Tips for Smooth Sailing!**

#### **Learning Objectives:**

1. Understand the diagnostic criteria for adenomyosis and adenomyoma
2. Review the evidence for Adenomyomectomy
3. Compare and contrast - the step-by-step approach to myomectomy versus adenomyomectomy

### **Shamitha Kathurusinghe: A Preoperative Optimisation Map to Enhance Endometriosis Surgery Outcomes**

A surgical procedure's success relies on both surgeon and patient factors. A patient undergoing endometriosis surgery may experience significant deterioration of their physical and psychological health, leading to a decrease in their physiological reserve and an increase in their adverse stress response to surgery.

Prehabilitation before surgery allows the optimisation of modifiable risk factors that may otherwise impact post-operative recovery and surgical outcomes. This presentation will discuss implementing prehabilitation interventions to enhance patient preparedness for endometriosis surgery.

### **Naomi Holbeach: Surgical Innovation - A Framework for Change**

*Confidence-Based Surgical Innovation* is a framework that promotes responsible surgical innovation. It combines evidence-based medicine and philosophical reasoning to provide surgeons with a step-by-step guide to thinking clearly about innovation that aligns with their legal and professional obligations.

Surgical innovation is an essential part of surgical practice. While it is crucial to advancing surgical techniques and improving patient care, it is also inherently risky. The long history of innovation in surgery demonstrates both extraordinary advances in surgical care for patients. A prime example of this is minimally invasive surgery. Despite this, surgical innovation has also resulted in significant harm to patients. Vaginal mesh offers a recent

lesson in the harms of innovation, although there are many others. It is appropriate to adopt some precaution when innovating because there is uncertainty about the benefits and risks. At the same time, we must find ways to promote surgical innovation so that new solutions to patient problems are found. *Confidence-Based Surgical Innovation* aims to promote surgical innovation through a series of focussed questions balancing benefit and risk in situations where evidence is absent or low quality and peer professional support may be limited.

Rectal shaving for deep infiltrating endometriosis is an emerging technique that offers an opportunity to demonstrate the benefit of a systematic approach to clinical reasoning for surgical innovation. This novel alternative to bowel resection is claimed to be safer, but the evidence is still evolving. How can gynaecologists decide whether to adopt this technique, or wait? There are many unanswered questions, and the implementation of this novel technique must balance the interests of patient safety and promotion of responsible innovation.

I propose using the *Confidence-Based Surgical Innovation* framework to work through these questions systematically using the example of rectal shaving for deep infiltrating endometriosis. The example shows that this framework offers a systematic approach to therapeutic reasoning about novel surgery that is adaptive to evolving evidence and peer professional practice. Additionally, it offers transparency and reviewability of clinical decisions involving the use of innovative surgery, which may also aid proposals to new procedure committees and medical indemnity insurers. Ultimately fulfilling the goal of all surgical innovation, which is to become the established practice and benefit our patients.





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