Australasian Gynaecological Endoscopy & Surgery Society Limited

AGES PERIOPERATIVE SURGICAL MEETING 2025

TEAMS. TOOLS. TECHNIQUES.

THURSDAY 28TH - SATURDAY 30TH AUGUST 2025

GRAND HYATT, MELBOURNE

PROGRAM BOOK

WELCOME TO THE ASM

On behalf of the Australasian Gynaecological Endoscopy & Surgery Society, we warmly welcome you to Melbourne, Victoria, for the inaugural AGES Perioperative Surgical Meeting (PSM) 2025. This year's theme, "Teams, Tools, and Techniques," will explore the intersection of high-performing teams, advanced surgical tools, and innovative techniques. Our goal is to inspire delegates to reimagine the preoperative, intraoperative, and postoperative patient journey while also focusing on the crucial well-being of the healthcare teams involved in patient care.

We are excited to take a multifaceted approach in this conference, which will not only delve deeply into the patient experience, but also place a strong emphasis on surgical techniques and best practices in gynaecology. This is a unique opportunity for attendees to refine their surgical skills and expand their understanding of the latest advancements in the field. We are dedicated to exploring both the human and technical aspects of surgery, from the team dynamics in theatre to the physical tools that enhance our clinical abilities.

For the first time, we will feature an entire session dedicated to video communications submitted by our members, offering a platform for real-world insights into surgical techniques and tips and tricks to tackle different pathology or technology. This innovative session will allow us to learn from each other's experiences and showcase the diverse ways in which we approach surgical practice.

The program promises to be an exciting blend of theory and practice, with three days packed with thought-provoking content. Day one will feature hands-on workshops, specifically designed to meet the needs of all craft groups involved in gynaecological perioperative care. On the following days, delegates will have the chance to attend both plenary and concurrent sessions, where they can engage with cutting-edge research from junior and senior researchers, and explore the latest clinical developments.

We are honoured to welcome our international faculty, who will join our esteemed local and interstate faculty line-up. Together, they will bring fresh perspectives and invaluable expertise to the discussion.

The AGES PSM, held at the Grand Hyatt, Melbourne, is a vibrant location at the heart of the city. Melbourne is known for its exceptional dining, rich cultural experiences, and beautiful parks. While August brings a winter chill, the city will be buzzing with energy. For those who enjoy live performances, Keith Urban will be playing at Rod Laver Arena, and popular musicals such as Annie and Beetlejuice will be showing in local theatres. Take the opportunity to explore Melbourne's surrounding wine regions, including the Yarra Valley, Mornington Peninsula, and Bellarine Peninsula, all within an hour's drive. Whether you're a foodie, an outdoor enthusiast, or a lover of the arts, Melbourne has something to offer.

We eagerly anticipate the opportunity to learn, collaborate, and grow together in Melbourne. We look forward to welcoming you to this exceptional conference experience!

Warm regards,

Dr Amani Harris, Dr Sam Mooney,
& Dr Kate Tyson
On behalf of the Organising Committee

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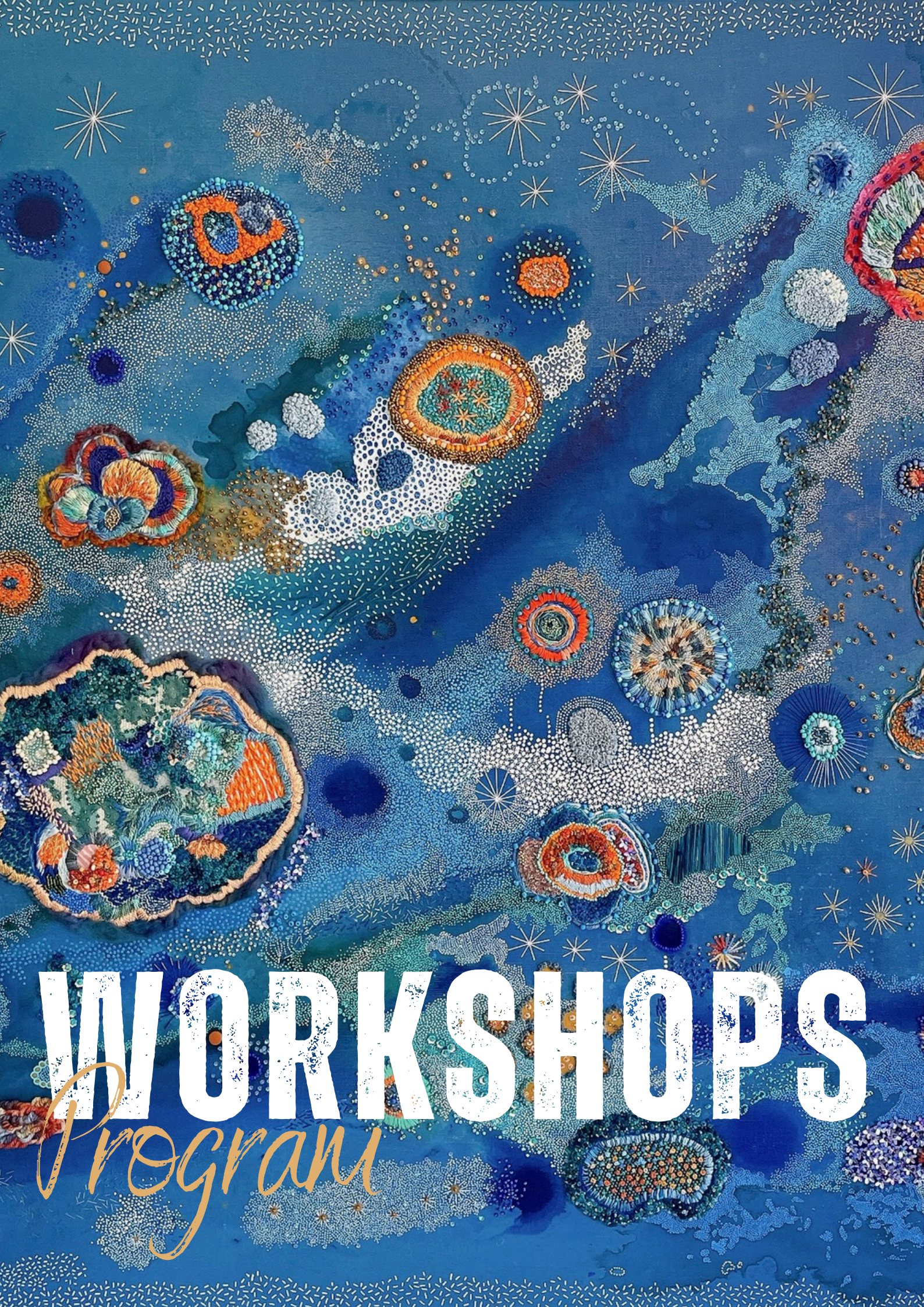
2025 ORGANISING COMMITTEE



WORKSHOPS

Program

THURSDAY 28 AUGUST

Grand Hyatt, Melbourne

- **Gender Affirming Care Workshop**
  Time: 8:00am - 12:30

  This workshop aims to cover a number of aspects of providing gynaecological care to a gender diverse and transgender population, involving interactive sessions aimed at those wanting to incorporate or improve their care in this space

- **Day Case Hysterectomy**
  Time: 8:00am - 12:30pm

  This workshop is designed for healthcare professionals seeking to develop and implement a day-stay hysterectomy program within their institutions.

- **Advanced vNOTES Techniques**
  Time: 8:00am - 12:30pm
  (SOLD OUT)

  This invitation-only workshop will focus on the pathway to offering vNOTES to more of your patients, providing benefits such as faster recovery, less postoperative pain, reduced operating time and shorter hospital stay

- **Advanced Operative Hysteroscopy**
  Time: 1:30 - 5:00pm

  This half-day course features two didactic sessions followed by a hands-on workshop, with Dr. Michelle Louie discussing the value of visual biopsy and Dr. Kate Martin covering advanced hysteroscopic techniques, concluding with guided practice on simulated models using mHTR equipment.

WORKSHOPS PROGRAM

Ultrasound for Endometriosis
Time: 1.30 - 5:00pm

This focused ultrasound workshop for laparoscopic surgeons covers the IDEA consensus on standardised pelvic ultrasound assessment, practical scanning techniques, and the evolving role of ultrasound in managing endometriosis, featuring live demonstrations, case discussions, and an interactive expert panel.

Mulitplatform Approch to Robotic Benign Gynaecology IMRA (Offsite)
Time: 08:00am - 5:00am
(SOLD OUT)

This immersive full day workshop offers hands-on training across four leading robotic platforms—Da Vinci Xi, SP, Hugo, and Versius—providing a comprehensive learning experience for surgeons at all levels.

Participants will practice essential skills such as docking, instrument handling, and suturing using high-fidelity Pindari hydrogel models, with tailored sessions for both beginners and advanced users.

Attendees can compare system functionalities side-by-side and explore VR surgery and simulator-based learning in a dynamic, risk-free environment. Designed to enhance surgical performance and confidence, this workshop blends practical experience with cutting-edge technology.

Path to vNOTES for MIGS
Time: 1:30pm - 5:00pm

This surgcal training workshop is designed to enhance your advanced laparoscopic surgery skills and prepare you for further training on the vNOTES technique in order to expand your armamentarium, offering an innovative minimally invasive approach.

Pain and the Gynaecologist: A Practical Workshop on Pelvic Pain
Time: 1:30pm - 5:00pm

This workshop for gynaecologists and JMOs focuses on improving chronic pelvic pain management, featuring expert-led sessions, case-based discussions, and practical strategies to predict surgical outcomes, enhance patient journeys, and address complex pain presentations.


CONFERENCE
Program

AGES PERIOPERATIVE SURGICAL MEETING 2025
PRE-CONFERENCE WORKSHOP PROGRAM

THURSDAY 28TH AUGUST 2025		
0730 – 0800	**Pre-Conference Workshop Registration**	*Mayfair Ballroom Foyer*
	Gender Affirming Care	*Mayfair 2*
0800 - 0815	Registration	
0815 – 0830	Welcome and Workshop Opening	
0830 – 0900	Current WPATH Guidelines	
0900 – 0930	Creating a Gender Diverse and Trans Friendly Practice	
0930 – 1000	Clinical Considerations with Regards to Gender Affirming Hormones	
1000 – 1030	**Morning Tea Break**	
1030 – 1100	Fertility Considerations in a Gender Diverse Population	
1100 – 1130	Management of Abnormal Vaginal Bleeding in a Gender Diverse Population	
1130 - 1200	Tips and Pearls for Hysterectomy and Other Surgical Procedures in a Gender Diverse Group	
1200 – 1230	Closing Discussion & Key Takeaways	

Day Case Hysterectomy		*Mayfair 3*
0800 – 0815	Registration	
0815 – 0845	Introduction to day case hysterectomy and experience at Gold Coast - **Graeme Walker**	
0845 – 0915	Day Case hysterectomy in USA - **Michelle Louie**	
0915 – 0930	Day case hysterectomy in New Zealand context - **Jessica Dunning, Megan Christie**	
0930 – 1000	Anaesthetic techniques to increase success with same day discharge - **Guy Amy**	
1000 – 1030	**Morning Tea Break**	
1030 – 1100:	Surgical techniques and best practices videos - **Michelle Louie, Sam Holford**	
1100 – 1130	Role of the clinical nurse specialist - **Megan Christie, Paula Parker**	
1130 - 1230	Discussion and Workshop Wrap Up	

Advanced vNOTES Techniques	*Grosvenor Room*
0800 - 0830	**Registration**
0830 - 0845	Workshop Commences
0845 - 0900	Why vNOTES
0900 - 0915	Inclusion and exclusion criteria for vNOTES
0915 - 0930	Algorithm for vNOTES case selection
0930 - 0945	Dynamic Ultrasonography
0945 - 1000	vNOTES with previous C-section
1000 - 1030	vNOTES Anterior Entry
1030 - 1045	vNOTES for Large Uteri
1045 - 1100	vNOTES for High BMI
1100 - 1115	vNOTES Adnexal Procedures
1115 - 1130	vNOTES Prolapse Repair - USLS
1130 - 1215	Hands-on practicum – vNOTES simulation
1215 - 1230	Discussion and Workshop Wrap Up

1230 – 1330	**Pre-Conference Workshop Registration & Lunch**	*Mayfair Ballroom Foyer*

Ultrasound for Endometriosis	*Mayfair 1*
1230 - 1330	**Registration & Lunch**
1330 - 1400	IDEA Consensus - What to Include in the Ultrasound Assessment of the Pelvis of Women with Endometriosis Symptoms - **George Condous**
1400 - 1420	How Ultrasound can Improve the Management of Women with Endometriosis - **Martin Healey**
1420 - 1450	Case Study: Correlation Ultrasound - MRI and Surgery - **George Condous**
1450 - 1520	**Afternoon Tea**
1520 - 1535	Role of Ultrasound in the Diagnosis of Superficial Endometriosis - **George Condous**
1535 - 1605	Learn How to Scan POD Obliteration and Bowel Nodules - **Rebecca Long**
1605 - 1645	Live Scan with Particular Focus on POD Obliteration and Bowel Nodules - **Sofie Piessens**
1645 - 1700	Q&A & Panel Discussion
1700	Workshop Concludes

Pain and the Gynaecologist: A Practical Workshop on Pelvic Pain	*Mayfair 2*
1230 - 1330	**Registration & Lunch**
1330 - 1345	Chronic Pelvic Pain - Not Just Biomedical - **Jason Chow**
1345 - 1420	Biopsychosocial Assessment - Why it Matters - **Jason Chow, Shanika Chandra, Shan Morrison**
1420 - 1450	Why Gynaecology Treatments Fail - **Jason Chow, Shanika Chandra, Angela Chia**
1450 - 1515	Physiotherapy Assessments for Gynaecologist - **Shan Morrison**
1515 - 1530	**Afternoon Tea**
1530 - 1600	Medications, Opioids and How to Harness Your Pain Specialist - **Angela Chia, Jason Chow**
1600 - 1620	Perioperative Care - **Angela Chia, Jason Chow, Shan Morrison, Shanika Chandra**
1620 - 1640	Patients in Emergency - **Jo Hatzistergos, Jason Chow, Angela Chia**
1640 - 1700	Challenging Behaviours - **Panel**

Advanced Operative Hysteroscopy	*Mayfair 3*
1230 - 1330	**Registration & Lunch**
1330 - 1415	The Value of the Visual Biopsy - **Michelle Louie**
1415 - 1430	Q&A
1430 - 1515	Advanced Hysteroscopic Techniques - **Kate Martin**
1515 - 1530	Q&A
1530 - 1600	**Afternoon Tea**
1600 - 1700	Hands on Workshop
1700	Workshop Close

The Path to vNOTES for MIGS	*Grosvenor Room*
1230 – 1330	**Registration & Lunch**
1330 - 1400	Welcome and introductions
1400 – 1415	What is vNOTES?
1415 – 1430	Why did we abandon vaginal surgery?
1430 – 1445	Why vNOTES?
1445 – 1500	Anterior Colpotomy
1500 – 1515	GelPoint™ V-Path setup and placement
1515 – 1530	vNOTES Hysterectomy
1530 – 1545	vNOTES Salpingectomy
1545 - 1700	Hands-on practicum – vNOTES simulation
1700 – 1730	Discussion and Workshop Wrap Up

Multiplatform Approach to Robotic Benign Gynaecology	*IMRA (Offsite workshop)*
0845 - 0900	Arrival & Registration
0900 - 0905	Welcome & Workshop Opening - **Danny Chou**
0905 - 0920	The Global Evolution of Robotic Surgery – **Sarah Choi**
0920 - 0935	Pathways for Training in Robotic Surgery – **Dean Conrad**
0935 - 0950	Comparative Overview of Robotic Platforms – **Mikhail Sarofim**
0950 - 1005	Hydrogel-Based Simulation in Robotic Surgery - **Cherynne Johansson**
1005 - 1020	**Morning Tea Break**
1020 - 1225	Hands-On Training: Fundamentals of Robotic Surgery (Workshop)
1225 - 1310	**Lunch Break**
1310 - 1645	Advanced Procedural Training – Pindari Hydrogel Models (Workshop)
1510 - 1525	**Afternoon Tea Break**
1645 - 1700	Closing Discussion & Key Takeaways – **Danny Chou**
1700	Workshop Close

AGES PERIOPERATIVE SURGICAL MEETING 2025

FRIDAY 29TH AUGUST 2025		
0700 - 0745	Pilates for Surgeons	*Grosvenor Room*
0730 – 0830	**Conference Registration**	*Savoy Ballroom Foyer*
0830 – 0915	**OPENING PLENARY** **Chairs:** Michael Wynn-Williams, Amani Harris	*Savoy Ballroom 1&2*
0830 – 0850	Welcome, Acknowledgement of Country and Setting the Scene – **Michael Wynn-Williams & Amani Harris**	
0850 – 0915	Sculpting Success: The Art and Science of the Surgical Setup – **Amy Park**	
0915 – 1040	**SESSION 1: Surgical Synergy: Teamwork in the Operating Theatre** **Chairs:** Sam Mooney, Tish Potter	*Savoy Ballroom 1&2*
0915 – 0920	Session Introduction – Our Teams in Action – **Sam Mooney & Tish Potter**	
0920 – 0940	Perioperative Teams: What Makes a Good Team 'Tick'? – **Paula Foran**	
0940 – 1010	Ferocious Warmth - Leading with the Head and Heart – **Tracey Ezard**	
1010 – 1030	Teamwork in a Crisis - Optimising the Surgical Team for Patient Safety - **Stuart Marshall**	
1030 – 1040	Panel Discussion	
1040 – 1110	**Morning Tea & Trade Exhibition**	*Mayfair Ballroom*
1110 – 1240	**SESSION 2: Precision in Pain: Advanced Surgical Management of Endometriosis** **Chairs:** Sam Mooney, Tim Chang	*Savoy Ballroom 1&2*
1110 – 1130	Cutting Through the Pain: Surgical Solutions for Endometriosis – **Clare Myers**	
1130 – 1150	Navigating the Depths: Surgical Solutions for Colorectal Endometriosis – **Jin Cho**	
1150 – 1210	Targeting Ureteric Endometriosis: Surgical Approaches for Better Outcomes – **Yee Chan**	
1210 – 1230	Targeting the Roots: Surgical Approach to Sciatic Nerve Endometriosis – **Danny Chou**	
1230 – 1240	Panel Discussion	
1240 – 1340	**Lunch, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom*
1340 – 1515	**SESSION 3: Concurrent Sessions**	
	3A: Surgical Innovation: From Controversy to Consensus **Chairs:** Michael Wynn-Williams, Nancy Peters	*Savoy Ballroom 1&2*
1340 – 1400	Laparoscopic Myomectomy – **Sam Soo**	
1400 – 1415	Training Pathways for Robotic Surgery Including Public Hospital – **Dean Conrad**	
1415 – 1430	Single Incision and Reduced Port Laparoscopic Surgery – **Haider Najjar**	
1430 – 1445	vNOTES Beyond Hysterectomy - **Supuni Kapurubandara**	
1445 – 1505	AI in Diagnostics and Imaging – **Michelle Louie**	
1505 – 1515	Panel Discussion	

	3B: Prehab to Post-Op: Strategies for Better Recovery **Chairs:** Akshara Shyamsunder, Kate Tyson, Shami Kathurusinghe	*Savoy Ballroom 3*
1340 – 1355	Establishing an ERAS Service – **Olivia Manos**	
1355 – 1410	Prehabilitation: What's the Buzz About? – **Debra Leung**	
1410 – 1425	Periop Pain Strategies – **Nick Christelis**	
1425 – 1440	The Right Size for Surgery: Weight and Weight Loss – **Cilla Haywood**	
1440 – 1515	Case Presentation of Complex Cases – **Shamitha Kathurusinghe, Kate Tyson**	
1515 – 1545	**Afternoon Tea, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom*
1545 – 1720	**SESSION 4: Concurrent Sessions**	
	4A: M&M - Surgical Storms: Navigating Complications and Team Morbidity **Chairs:** Kirsten Connan, Stephen Lyons	*Savoy Ballroom 1&2*
1545 – 1605	"Knowing Yourself" and the Imposter Syndrome – **Lenore Ellett**	
1605 – 1625	The Second Victim: The Personal Cost of Failure, and How to Fail Well - **Sam Mooney**	
1625 – 1645	Case Presentation of a Complex Case – **Martin Healey**	
1645 – 1710	Debriefing Hot and Cold, and Giving Bad News – **Stephen Warrillow**	
1710 – 1720	Panel Discussion	
	4B: From Septae to Scars: Modern Approaches in Hysteroscopic Surgery **Chairs:** Rachel Green, James Gledden, Charlotte Reddington	*Savoy Ballroom 3*
1545 – 1605	Surgical Approach to Mullarian Anomalies and Uterine Septae – **Melissa Cameron**	
1605 – 1625	Hysteroscopy – **Naman Dahiya**	
1625 – 1645	Fibroids – **Eashan Tambimuttu**	
1645 – 1710	When a Day Case Goes Really, Really Bad: Anaesthetic Management of Catastrophic Outcomes in Hysteroscopic Surgery – **James Gledden**	
1710 – 1720	Panel Discussion	
1720	Close of Day 1	
1900 – 2300	**Conference Dinner**	*The Residence*

SATURDAY 30TH AUGUST 2025		
0645 – 0730	Walk / Run	*Meet at Lower Lobby*
0730 – 0800	**Conference Registration**	*Savoy Ballroom Foyer*
0800 – 0950	**SESSION 5: The Hysterectomy Playbook: Expert Moves for Every Scenario** **Chairs:** Nyasha Gwata, George Hardas, Eric Daniel	*Savoy Ballroom 1&2*
0800 – 0820	Exploring the Foundations: Mastering Pelvic Anatomy – **Sarah Choi**	
0820 – 0840	Handling Giants: Effective Management of Large Fibroids – **Roni Ratner**	
0840 – 0900	Navigating Challenges: Mastering Difficult Bladder Dissection – **Lior Levy**	
0900 – 0920	Challenging Hysterectomy - Tips and Tricks – **Catarina Ang**	
0920 – 0940	Rising to the Challenge: Managing a Large Uterus in Vaginal Hysterectomy – **Amy Park**	
0940 – 0950	Panel Discussion	
0950 – 1020	**Morning Tea & Trade Exhibition**	*Mayfair Ballroom*
1020 – 1210	**SESSION 6: Concurrent Sessions**	
	6A: Preserving Function, Enhancing Fertility: Advanced Laparoscopic and Robotic Surgery **Chairs:** Kate Martin, Russell Dalton	*Savoy Ballroom 1&2*
1020 – 1040	Tubal Surgery for the Infertile Patient – **Anusch Yazdani**	
1040 – 1100	vNOTES Hysterectomy in the Higher BMI Patient; Practical Concerns and Solutions – **Grover May**	
1100 – 1120	Fertility Sparing Surgery for Pelvic Floor Problems Including Prolapse and Incontinence **Vivian Yang**	
1120 – 1140	Navigating the Niche. Surgical Management to Optimise Fertility - When and How? **Sireen Jaber**	
1140 – 1200	From Controversies to Consensus: Introducing and Reintroducing Tools Safely – **Anna Rosamilia**	
1200 – 1210	Panel Discussion	
	6B: Cutting Edge to Steady Hands: Training and Transition in Surgery **Chairs:** Jenni Pontré, Guy Fisher	*Savoy Ballroom 3*
1020 – 1040	Surgical Skills in Short Supply: Reimagining Gynaecological – **Emily Huning**	
1040 – 1100	Coaching & Mentors: A Framework for Continuous Improvement – **Michael Wynn-Williams**	
1100 – 1120	Think Twice, Cut Once: Mental Preparation for Surgical Performance – **Belinda Lowe**	
1120 – 1140	#SurgeonLife: Social Media for Gynaecologists – **Amy Park**	
1140 – 1200	From Scrubs to Self-Satisfaction: Transitioning to Retirement – **Leslie Reti**	
1200 – 1210	Panel Discussion	
1210 – 1310	**Lunch, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom*

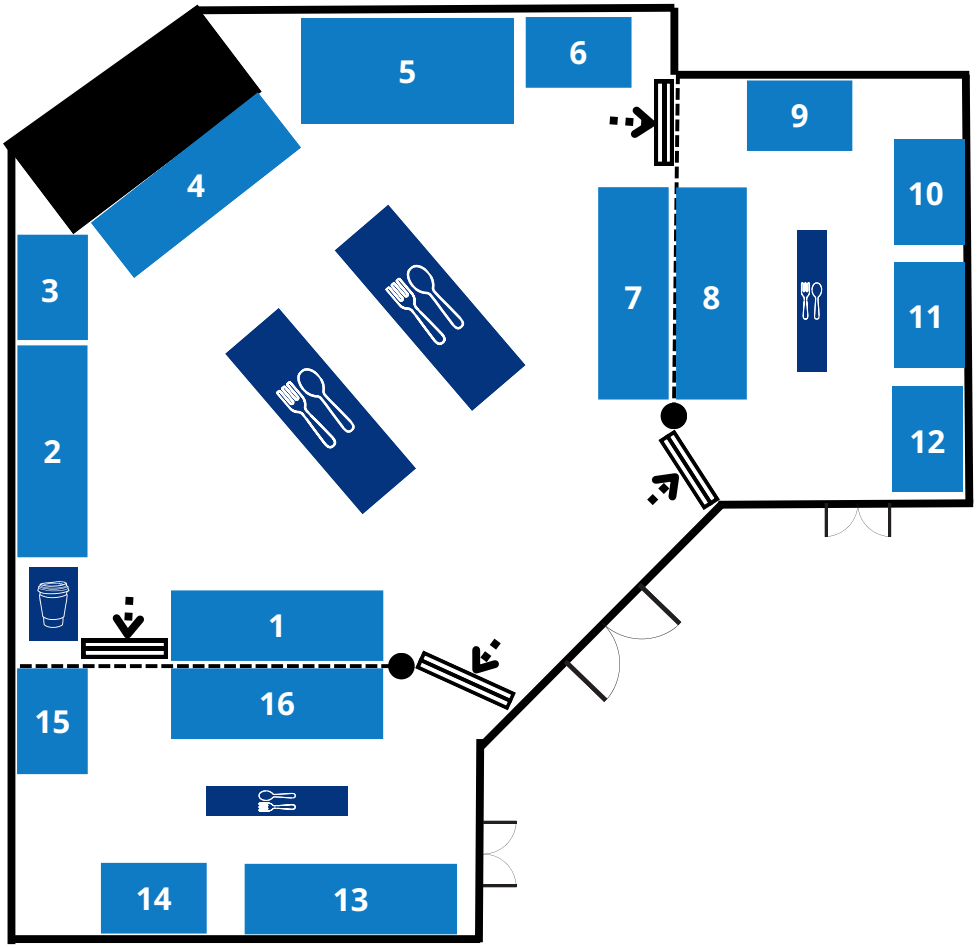
1310 – 1430	**SESSION 7: Concurrent Sessions**
	7A: Video Free Communications *Savoy Ballroom 1&2* **Chairs:** Emma Readman, Basia Lowes
1310 - 1320	Laparoscopic Myomectomy for a FIGO Type 3 Fibroid and in Bag Morcellation: 10 Surgical Tips and Tricks **Patrick Laws**
1320 - 1330	Bleeding Bloopers: What to Do and What Not to Do – **Michelle Louie**
1330 - 1340	Essential Strategies for Efficient and Safe Robotic Mesh Sacrocolpopexy – **Sireen Jaber**
1340 - 1350	Adopting the Hugo™ RAS System: Technical Insights from Initial Cases – **Sireen Jaber**
1350 - 1400	The Role of Lateral Space in the Vaginal Approach to Hysterectomy – **Anushka Kothari**
1400 - 1410	Cutting Through Complexity: Hysteroscopic Resection of a Myoma utilising Carboprost **Sarveshinee Pillay**
1410 - 1420	Vasopressin: Fundamentals and Applications in Gynaecologic Surgery - **Michelle Louie**
	7B: Video Free Communications *Savoy Ballroom 3* **Chairs:** Keryn Harlow, Philip Thomas
1310 - 1320	Laparoscopic Hemi-hysterectomy for an Advanced First Trimester Rudimentary Horn Ectopic Pregnancy **Philippa Nelson**
1320 - 1330	Small Bowel Endometriosis: Pre-Operative Diagnosis and Findings at Laparoscopy – **Sam Holford**
1330 - 1340	Laparoscopic Abdominal Cerclage: A Standardised Technique for Preventing Preterm Birth **Lucinda Beech**
1340 - 1350	Laparoscopic Management of Deep Infiltrating Endometriosis Requiring Rectal Discoid Resection Surgical Technique & Summary of Outcomes - **Lucinda Beech**
1350 - 1400	Surgical Navigation: Robotic Hysterectomy for a Large Cervical Fibroid and Key Anatomical Landmarks **Amani Harris**
1400 - 1410	Laparoscopic Management of Extrinsic Ureteral Endometriosis: Mitigating Complications During Ureteral Dissection – **Pattaya Hengrasmee**
1410 - 1420	Robotic Hysterectomy for a Ventrofixed Uterus with a 15 cm Anterior Wall Fibroid: Tips and Tricks **Iris Soria-Arikan**
1420 - 1430	Managing Adherent Bladder in Robotic Assisted Hysterectomy - **Nadin Alghanaim**
	7C: Oral Free Communications *Grosvenor Room* **Chairs:** Erin Nesbitt-Hawes, Simon Scheck
1310 - 1320	ENDOCOLOR Endometriosis Appearance with Hormonal Contraceptives at Laparoscopy: A Prospective Cohort Study – **Nancy Peters**
1320 - 1330	Reimagining Prehab and Rehab for Endometriosis Surgery with Digital Innovation – **Joanna Morris**
1330 - 1340	Comparing Efficiency and Complications between RUMI II and Biswas Colpotomisers at Laparoscopic Hysterectomy: A Randomised Controlled Trial – **Stephanie Bowler**
1340 - 1350	Concordance between Pre-operative Imaging, Intraoperative Findings, and Histopathology in Gastrointestinal Endometriosis. – **Jennifer Dean**
1350 - 1400	Randomized Trial of Time Efficiency of Electrosurgical Devices (LigaSure™ Blunt Tip & LigaSure™ XP) **Stuart Salfinger**
1400 - 1410	Patients as Partners: Co-Creating a Digital Pre- and Post-Op Program for Endometriosis - **Anna Fischer**
1410 - 1420	Perioperative Anaemia in Hysterectomy: Quantifying the Burden and Uncovering the Roadblocks for Optimisation - **Yves Charlesworth**
1420 - 1430	Total Laparoscopic Hysterectomy: Implementing a Same-Day Discharge Protocol - **Kasia Michalak**
1430 - 1440	Vaginal Assisted Natural Orifice Transluminal Endoscopic Hysterectomy (VANH) Versus Laparoscopic Hysterectomy for Complex Atypical Endometrial Hyperplasia: A Retrospective Cohort Study at a Tertiary Australian Hospital – **Patrick Laws**

1430 – 1500	**Afternoon Tea, Trade Exhibition**	*Mayfair Ballroom*
1500 – 1645	**SESSION 8: Reproductive Rights & Funding Fights: The Future of Women's Health** **Chairs:** Amani Harris, Michael Wynn-Williams	*Savoy Ballroom 1&2*
1500 – 1520	Bias in Women's Health: Medicare, Funding, and Access to Care in Australia – **Debbie Nisbet**	
1520 – 1540	Diversity in Women's Health Care – Driving Change – **Nisha Khot**	
1540 – 1600	Operating with Respect: Learning from Others – **Meron Pitcher**	
1600 – 1635	On the Couch – Is the Time Here to Divide Obstetrics and Gynaecology Training? **Rachel Green, Emma Readman, Alison Bryant-Smith, John Pardey, and Cameron Sharp**	
1635 – 1645	Conference Wrap-up & Awards Presentation	
1645	**Conference Close**	

DIGITAL FREE COMMUNICATION (DCS) SCHEDULE

FRIDAY 29TH AUGUST 2025		
1240 – 1340	**Lunch, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom Foyer*
1255 – 1300	Surgical Approaches to Two Cases of Caesarean Scar Pregnancy – Why Depth Matters **Anshula Ashish**	
1300 – 1305	A Case of Accessory and Cavitated Uterine Mass (ACUM) – **Smita Bhattacharjee**	
1305 – 1310	Looking in the Mirror: Surgical Considerations in the Gynaecological Management of a Patient with Situs Inversus Totalis – **Stephanie Bowler**	
1310 – 1315	Avoiding Failed Hysteroscopy: Technical Strategies for Challenging Cervical Access – A Case Series **Haylee Boyens**	
1315 – 1320	Endometrial Vascular Dystrophy – Pathological or Normal Variant? - **Alexandra Carter**	
1320 – 1325	IUD Insertion With or Without Hysteroscopy? Preliminary Findings – **Gajana Jeyaram**	
1325 – 1330	Double Trouble: Diagnosing and Managing Heterotopic Pregnancy – **Siveshan Silvam**	
1330 - 1335	Pelvic Retroperitoneal Abscess: Diagnostic Conundrum for Teams – **Michelle Yu**	
1515 - 1545	**Afternoon, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom Foyer*
1525 – 1530	Vaginal Vault Dehiscence as The Hidden Cause for Acute Abdomen Three Months After Laparoscopic Hysterectomy – Case Report – **Blessy John**	
1530 – 1535	A Video Case Presentation of Laparoscopic Management of Live Caesarean Scar Ectopic Pregnancy with Repair of Caesarean Scar Niche as per the Ban Caesarean Scar Ectopic Pregnancy Classification **Rebecca Li**	
1535 – 1540	Hysteroscopy for Retained Products of Conception Demonstrating Endometrial Vascular Dystrophy: A Case Report – **Cathy Liu**	
1540 - 1545	Redefining Surgical Boundaries for Complex Patients as a Team: A Case Report Of Multidisciplinary Surgical Excellence in Regional North Queensland – **Sally Magoffin**	
SATURDAY 30TH AUGUST 2025		
1210 – 1310	**Lunch, Trade Exhibition & Digital Free Communications**	*Mayfair Ballroom Foyer*
1225 – 1230	Concomitant Endometriosis and Pelvic Tuberculosis: A Case Report – **Kasia Michalak**	
1230 – 1235	Fear Me Not but Find Me Always: Tips and Tricks in Navigating the Challenging Pararectal **Puvana Raman**	
1235 – 1240	When the Uterus Speaks to the Bladder: Unmasking Uterovesical Fistula – **Siveshan Silvam**	
1240 – 1245	Driving Surgical Improvement Through Data: The NSQIP Journey at STARS Hospital – **Keisuke Tanaka**	
1245 – 1250	A Rare Case of Extrauterine Endometrial Stromal Nodule Mimicking Parasitic Fibroid Two Decades After Hysterectomy – **Saima Wani**	
1250 – 1255	Unleashing The Power of True Multidisciplinary Team Care: Featuring a Complex Patient Journey with Clinical Challenges That Led to a Successful Outcome – **Amanda Wee**	
1255 – 1300	Uterine Spindle Cell Cancer Complicated with Malignant Pelvic Fistula- **Michelle Yu**	

EXHIBITION FLOORPLAN



2025 PSM INDUSTRY PARTNERS & EXHIBITORS

1. Avant
2. Medtronic
3. BD
4. Hologic
5. Device Technologies
6. IMRA
7. Olympus
8. Paragon Care
9. Baxter Healthcare
10. Conmed
11. Aspen Surgical
12. Mailtda
13. Applied Medical
14. J&J MedTech
15. Trustmost
16. Stryker

CONFERENCE Dinner

The Residence

GRAND HYATT MELBOURNE

DATE:
Friday, 29 August 2025

TIME:
7 - 11pm

DRESS CODE
Cocktail

SOLD OUT

UPCOMING *Events*

AGES / ESGE WEBINAR
VIRTUAL (COMING SOON)
18 SEP

AGES M&M WEBINAR
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Australasian Gynaecological Endoscopy & Surgery Society Limited

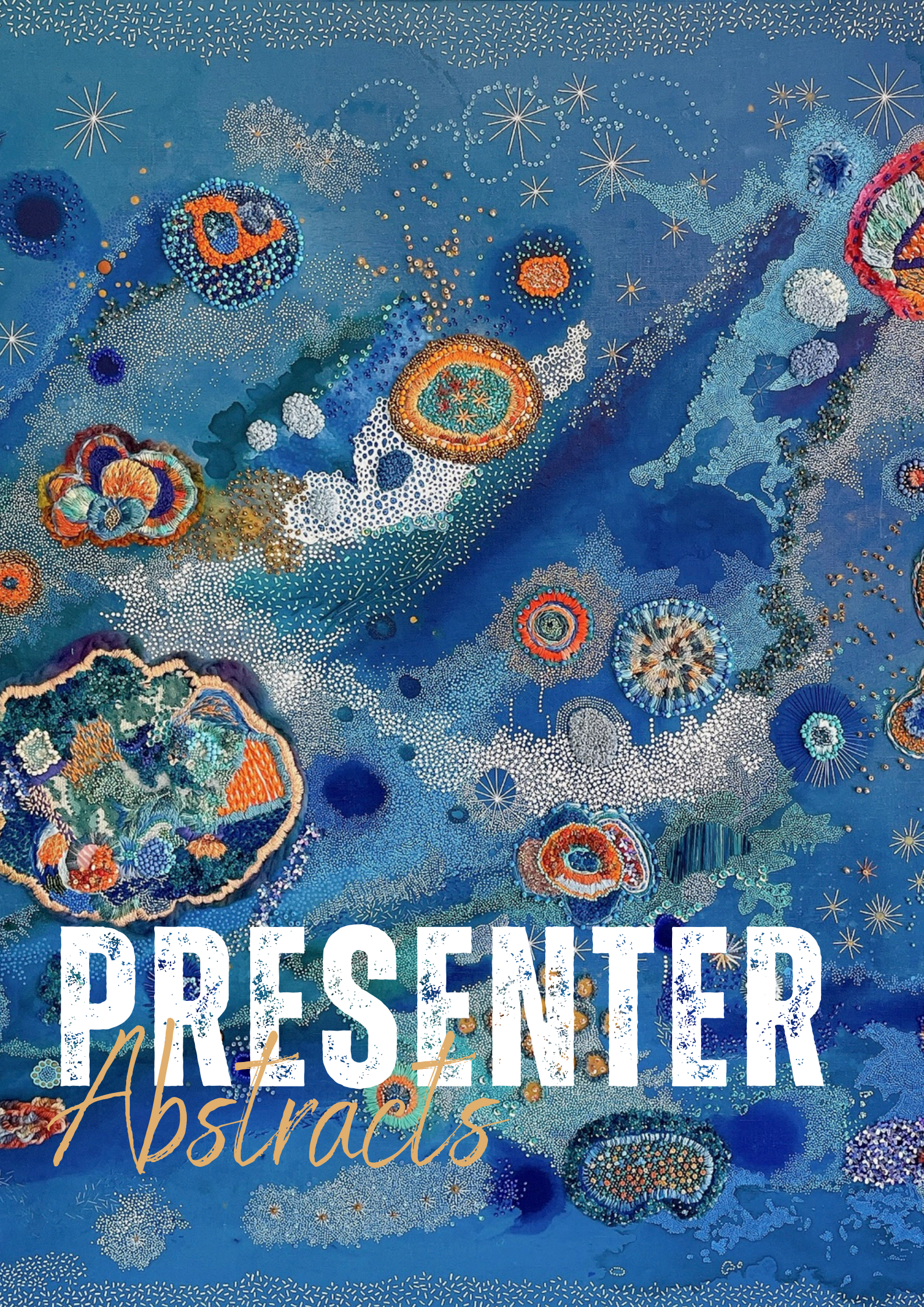
AGES ANNUAL SCIENTIFIC MEETING 2026

BRIDGING THE DIVIDE

AUCKLAND, NEW ZEALAND

12 - 14 MARCH 2026

NEW ZEALAND INTERNATIONAL CONVENTION & EXHIBITION CENTRE (NZICC)


PRESENTER
Abstracts

0915 – 1040	Session 1: Surgical Synergy: Teamwork in the Operating Theatre

Paula Foran: Perioperative Teams; What Makes a Good Team 'Tick'?

Topic Overview
When perioperative surgical teams work well together, they can produce efficient and safe patient outcomes and are a beauty to behold. However, when teams are not cohesive this can contribute to time delays, frustrations and serious patient outcomes such as near misses or adverse events.

Presentation Objectives
The objectives of this presentation are to discuss some evidence-based factors that can either impede or facilitate the safe efficient running of surgical teams, such as, communication, human factors, stable teams, and group think.

Tracey Ezard: Ferocious Warmth - Leading with the Head and Heart

Integrating trust, psychological safety, collaboration, and emotional intelligence into healthcare leadership is not merely a "soft" approach but a strategic imperative. These elements foster environments where staff are engaged, communication flows freely, and patient care improves. This session will look at a leadership framework that supports the daily dance of great leadership. Ferocious Warmth is an approach that can support leaders traverse both the strategic, cognitive skills of leadership with the emotionally intelligent, people-based skills that highly effective leaders embed.

Stuart Marshall: Teamwork in a Crisis - Optimising the Surgical Team for Patient Safety

If you could design your next clinical disaster, what would it look like?
Adverse events are inevitable no matter how careful we try to be. However, if we can ensure that our responses are rapid, accurate and coordinated when they occur, we can minimise their effects. This means that the environment as well as the individuals working within it are prepared.

In this talk I'll take you through some of the structural issues that stop us from performing our best in clinical emergencies and how we can address them in advance. These same enablers of decision-making, action and effective team behaviour can be implemented and helpful even when things are going well. By the end of the session you'll have some practical strategies to improve your day-to-day work and feel confident you are primed for a crisis should it strike.

1105 – 1235	Session 2: Precision in Pain: Advanced Surgical Management of Endometriosis

Clare Myers: Cutting Through the Pain: Surgical Solutions for Endometriosis

Brief outline of the role of surgery for endometriosis.
Tips and techniques for successful surgery when treating endometriosis.
Surgical approach to stage 4 endometriosis.

Jin Cho: Navigating the Depths: Surgical Solutions for Colorectal Endometriosis

Deep Infiltrating Endometriosis (DIE) is mainly located in the rectum. Different resection techniques will be shown to treat rectal DIE. Also, cases of DIE in other parts of the gastrointestinal tract will be shown as well as treatment for them.

Yee Chan: Targeting Ureteric Endometriosis: Surgical Approaches for Better Outcomes

Ureteric endometriosis is a rare but potentially serious manifestation of endometriosis. Urinary tract involvement occurs in 2% of women with symptomatic endometriosis and ureteric involvement occurs in 0.4%. It poses a significant risk to renal function due to progressive ureteric obstruction, often remaining clinically silent until late-stage disease. Patients are typically asymptomatic but may present with colic or haematuria. The left ureter is affected more commonly than the right and is usually located in the distal ureter. The condition can be bilateral in 10% of cases. Surgical management is considered the cornerstone of treatment, particularly in cases where medical therapy fails to alleviate obstruction or preserve renal function.

Ureteric endometriosis may present in two forms: intrinsic, where endometrial tissue invades the ureteral wall, and extrinsic, where fibrosis compresses the ureter externally. The extrinsic form is 3 times more common. Preoperative evaluation typically includes imaging modalities such as MRI, CT urography, or renogram, combined with endoscopic assessments to evaluate for intrinsic disease, differential diagnoses and to allow for ureteric stent placement where indicated.

Surgical management options include ureteric stenting, ureterolysis, ureteric reimplantation and nephrectomy. The latter options can be performed by open, laparoscopic and robotic approaches. Ureterolysis involves the meticulous dissection and release of the ureter from surrounding fibrotic or endometriotic tissue. In cases of intrinsic involvement or severe stenosis, ureteric reimplantation may be required. The choice between these depends on the location and length of ureteric involvement.

Robotic-assisted surgery has shown favourable outcomes in terms of precision, recovery time, and complication rates. Preservation of renal function and relief of symptoms remain the primary goals of surgical intervention.

Overall, surgical management of ureteric endometriosis requires a multidisciplinary approach involving gynaecologists, urologists, and radiologists. Early recognition and individualized surgical planning are critical to prevent irreversible renal damage and improve patient outcomes. Ongoing research into optimal surgical techniques and long-term results is essential to refine treatment algorithms and enhance the quality of life for affected individuals.

Danny Chou: Targeting the Roots: Surgical Approach to Sciatic Nerve Endometriosis

Abstract Not Available

1340 – 1515	Session 3A: Prehab to Post-Op: Strategies for Better Recovery

Olivia Manos: Establishing an ERAS Service

As part of the Prehab to Post-Op session, Olivia Manos will discuss the establishment of an Enhanced Recovery After Surgery (ERAS) service within a tertiary hospital. The ERAS pathway is a patient-centred, evidence-based approach to surgical care that aims to reduce recovery time, minimise complications, and improve overall patient outcomes. This session will discuss the previous efforts to introduce a formal ERAS program and how the Women's utilised the opportunity presented via the Elective Surgery Reform to re-establish an ERAS pathway in a more structured and sustainable way. Olivia will also discuss the unique opportunity that was created as a result of the COVID-19 pandemic, whereby traditional models of care were evaluated and reconsideration. The methods used to support the ERAS implementation will be discussed, specifically in relation to the adaptation of the ERAS protocols and guidelines, ongoing data collection and auditing. Olivia will also discuss key learnings that informed our implementation, transition to standard care and expansion.

Debra Leung: Prehabilitation: What's the Buzz About?

Abstract Not Available

Nick Christelis: Periop Pain Strategies

Abstract Not Available

Cilla Haywood: The Right Size for Surgery: Weight and Weight Loss

Abstract Not Available

Dr Michael Wynn-Williams, Dr Kate Martin, Dr Sarah Choi
Case Presentation of Complex Cases

Abstract Not Available

1340 – 1515	Session 3B: Surgical Innovation: From Controversy to Consensus

Sam Soo: Laparoscopic Myomectomy

Abstract Not Available

Dean Conrad: Training Pathways for Robotic Surgery Including Public Hospital

Robotic-assisted surgery (RAS) has seen exponential growth in Australia and New Zealand since its introduction in the early 2000s. There are now over 136 robotic platforms in use across both public and private sectors. While training in RAS has traditionally been limited to post-fellowship opportunities in private hospital settings, the expansion of public robotic systems has opened the door for pre-fellowship exposure [1].

Despite this growth, access to robotic platforms remains disproportionately limited, particularly for gynaecologists. Only 4% of robotic procedures in the public system are gynaecological, including both benign and malignant cases. This disparity is not due to clinical need or surgical complexity but reflects broader gender-based funding inequities. Comparable procedures for male and female patients receive markedly different Medicare rebates, with female-focused procedures systematically underfunded. The discrepancy also extends to private health reimbursement, with procedures like prostatectomy attracting significantly higher payments than equivalent gynaecological operations. These systemic funding gaps create disincentives for hospitals to invest in robotic gynaecology, limiting training and credentialling opportunities across all career stages [2].

Since the expiry of the Da Vinci platform's patent, the introduction of new robotic platforms such as Hugo (Medtronic) and Versius (CMR Surgical) has diversified the robotic landscape. While this diversification has the potential to reduce costs and expand access, it also brings new challenges. Each platform has unique console interfaces, docking systems, and training requirements, limiting skill transferability and complicating credentialling. Currently, there is no national standardised curriculum for robotic training. Education and credentialling are primarily vendor-led, raising concerns about consistency and clinical governance [1].

In response, the AGES Robotic Special Interest Group (RSIG) was established to provide evidence-based recommendations for credentialling, case volume thresholds, and ongoing professional development in robotic gynaecology. The Australian Institute of Robotic Surgery (AIRS) was founded in alignment with these goals, offering a surgeon-led, platform-agnostic approach to training. AIRS supports the development of national credentialling standards and fosters equitable access to robotic education, aiming to bridge gaps across specialties, platforms, and institutions [3].

As robotic surgery becomes increasingly widespread, it is critical that training pathways evolve to meet demand, both technically and equitably. Without addressing the structural and financial barriers that limit access, there is a risk of perpetuating gender and specialty-based disparities in surgical innovation and patient care.

Haider Najjar: Single Incision and Reduced Port Laparoscopic Surgery

Abstract Not Available

Supuni Kapurubandara: vNOTES Beyond Hysterectomy

Vaginal natural orifice transluminal endoscopic surgery (vNOTES) is gaining recognition as a significant advancement in minimally invasive gynaecology, offering the combined advantages of vaginal, single-site, and laparoscopic techniques—without the need for abdominal incisions. Vaginally assisted NOTES hysterectomy (VANH) is now well supported by systematic reviews and meta-analyses, establishing it as an effective alternative to conventional laparoscopic hysterectomy.

This presentation will explore the evolving role of vNOTES beyond hysterectomy, highlighting its potential application for other benign gynaecological indications. Drawing on institutional experience, international data, and video footage, the session will outline the technical considerations, procedural adaptations, and potential scope of this technique.

For experienced gynaecological surgeons, particularly those trained in both laparoscopy and vaginal surgery, vNOTES represents a natural evolution in practice. It offers opportunities to potentially reduce surgical footprint and access anatomically challenging spaces with improved ergonomics and cosmesis. As the technique improves, integration into routine practice will require structured training, clear governance frameworks, and robust outcome evaluation.

Through careful implementation and ongoing research, vNOTES is poised to become a standard option in the toolbox of advanced pelvic surgeons committed to innovation and excellence in minimally invasive surgical care.

Michelle Louie: AI in Diagnostics and Imaging

Artificial intelligence (AI) is rapidly reshaping the landscape of gynaecology by enhancing diagnostic accuracy, streamlining clinical workflows, and offering novel imaging capabilities. This presentation explores the current and emerging applications of AI across benign gynaecology, fertility care, and gynaecologic oncology, with a focus on how machine learning and deep learning are being integrated into clinical practice. This presentation will also review the data regarding the accuracy of AI for diagnosing common gynaecologic conditions including endometriosis, uterine fibroids, and specific adnexal masses.

AI also supports personalized medicine in complex gynaecologic surgery by enhancing preoperative planning, intraoperative navigation, and real-time image processing. Multimodal AI systems are beginning to integrate imaging, laboratory, and symptom data to deliver individualized care pathways.

Despite its promise, the integration of AI into gynaecology faces important challenges, including data bias, validation across diverse populations, regulatory hurdles, and ethical considerations regarding decision-making transparency and patient consent. The future of AI in gynaecology includes real-time diagnostic tools at the point of care, augmented reality in surgery, and cross-disciplinary predictive models that integrate multiple data streams.

This presentation aims to equip clinicians with an understanding of the principles, capabilities, and limitations of AI technologies in gynaecology, and to stimulate dialogue around responsible implementation to improve patient outcomes.

1545 – 1655 SESSION 4A: M&M - Surgical Storms: Navigating Complications and Team Morbidity

Lenore Ellett: "Knowing Yourself" and the Imposter Syndrome

Lenore has been asked to talk on Imposter Syndrome.

This talk will be one given from the heart – a deep dive into the pieces that go together to create a state of “being a fraud or a fake” of “being found out” and getting to one’s position in life through “good luck”. Some practical suggestions will be given about how to improve symptoms of Imposter Syndrome.

Sam Mooney: The Second Victim: Failure, Falling Forward, Self Care and Imposter Syndrome

Abstract Not Available

Martin Healey: Case Presentation of a Complex Case

Abstract Not Available

Stephen Warrillow: Debriefing and Managing Team Complications

Abstract Not Available

1545 – 1655	Session 4B: From Septae to Scars: Modern Approaches in Hysteroscopic Surgery

Melissa Cameron: Surgical approach to Mullarian Anomalies and Uterine Septae

Abstract Not Available

Naman Dahiya: Hysteroscopy

Hysteroscopic surgery continues to evolve rapidly, with technological innovation driving improvements in safety, precision, and procedural efficiency. As the scope of hysteroscopy expands beyond diagnostic use, and into therapeutic interventions, surgeons are increasingly turning to modern tools that offer greater control, reduced operative time, and enhanced outcomes.

A key advancement has been in fluid management systems, which are critical for safe and effective distension of the uterine cavity. Modern systems now incorporate automated pressure regulation, real-time fluid deficit monitoring, and closed-loop control mechanisms. These innovations allow surgeons to operate with greater confidence, particularly during longer or more complex procedures, by significantly reducing the risks associated with fluid overload and hyponatremia.

Another important shift has been the move away from traditional hysteroscopic resectoscopes towards compact, integrated hysteroscopic tissue removal systems. These newer instruments are designed to allow simultaneous cutting and aspiration of intrauterine pathology under continuous visualisation. This approach enables more efficient removal of polyps and submucosal fibroids, minimises repeated instrument insertion, and reduces thermal damage to surrounding tissue. As a result, many of these procedures can now be performed safely in an outpatient setting with shorter recovery times and fewer complications.

The final part of this presentation will explore the evolving role of hysteroscopy in tubal assessment and intervention. While traditionally the domain of laparoscopy or radiologic/sonographic techniques, hysteroscopic approaches to tubal evaluation and selective cannulation remain an often-overlooked yet a valuable tool, offering minimally invasive, fertility-preserving options in selected patients.

This talk will synthesise current trends and evidence in hysteroscopic surgery, providing a practical overview for surgeons looking to integrate modern instrumentation and perioperative strategies into their practice and broadening the scope of minimally invasive gynaecology.

Eashan Tambimuttu: Fibroids

Hysteroscopic resection of fibroids remains a cornerstone in the management of abnormal uterine bleeding and subfertility. This presentation will explore practical surgical tips and tricks to optimise outcomes, manage complications, and streamline workflows. We will examine the economic landscape - including cost-effectiveness in public and private settings - and evaluate emerging technologies and adjunctive therapies on the horizon.

Environmental sustainability and the role of recycling in operative hysteroscopy will also be discussed. Finally, we reflect on the dual roles of surgeon as teacher and lifelong student, highlighting how peer learning continues to shape safer, greener, and more precise gynaecological surgery.

James Gledden: When a Day Case Goes Really, Really Bad: Anaesthetic Management of Catastrophic Outcomes in Hysteroscopic Surgery

Join us for a riveting 20-minute exploration of an unsettling yet critical subject in hysteroscopic surgery.

In this presentation, I will present a de-identified case study from Victoria's Coroner's Court involving a catastrophic gas embolism that resulted from a routine day case hysteroscopy, leading to the tragic death of a patient.

While starkly serious, this session promises to focus on what we can do should the worst be happening to our patient and, more importantly, how we can prevent being in this situation in the first place.

I want to focus on gas embolism - how it occurs, how we detect it and what we would do, as anaesthetists, if it happens. When do we need to call for ECMO? What about paradoxical embolism? When do we need to take a deep dive and call Hyperbaric Medicine specialists?

Additionally, we'll discuss the pivotal role that Theatre Technicians play in preventing these catastrophic events.

Do they need more education and accreditation when setting up equipment that, when not done right, can have potentially life-threatening consequences?

The focus should be educating and empowering our teams to establish safer surgical environments.

This session is designed for gynaecology surgeons, nurses, and anyone interested in enhancing their understanding of anaesthetic safety in hysteroscopy.

Come prepared for an engaging discussion as we collectively aim to cultivate safer routines in the operating theatre.

Your presence is essential - let's turn tragedy into education and strengthen our practices together!

0800 – 0950	Session 5: The Hysterectomy Playbook: Expert Moves for Every Scenario

Sarah Choi: Exploring the Foundations: Mastering Pelvic Anatomy

Abstract Not Available

Roni Ratner: Handling Giants: Effective Management of Large Fibroids

Large uterine fibroids present unique surgical challenges requiring specialised techniques and careful planning. This presentation demonstrates evidence-based approaches to complex fibroid cases through comprehensive video analysis.

Video demonstrations showcase surgical techniques for cervical fibroids (requiring modified surgical planes and careful bladder dissection), broad ligament fibroids (demanding precise ureteral identification and vascular landmark recognition), and large posterior fibroids (requiring strategic positioning for optimal pouch of Douglas access).
Indocyanine green (ICG) fluorescence guidance enhances surgical precision by clearly delineating uterine vascular supply, tissue perfusion boundaries, critical anatomical structures, and optimal resection margins. This technology significantly improves surgical confidence and reduces operative complications.

The extraction methods used in minimally invasive surgery will be discussed including power morcellation and manual abdominal/vaginal morcellation.

Surgical safety pearls encompassing systematic theatre setup, equipment preparation, pre-operative imaging, and surgical approach strategies will be demonstrated to optimise complex surgeries.

Lior Levy: Navigating Challenges: Mastering Difficult Bladder Dissection

Bladder dissection is a critical and often underestimated step during laparoscopic hysterectomies. In complex cases—such as those involving prior cesarean deliveries, deep infiltrating endometriosis, or distorted pelvic anatomy—this step can pose significant risks for injury. This presentation explores the etiologies and risk factors contributing to difficult bladder dissection and provides a structured, evidence-based framework for navigating these scenarios safely and effectively.

Drawing from current literature and surgical experience at a high-volume tertiary minimally invasive surgery unit, the talk will outline key preoperative assessment tools, including imaging modalities and surgical planning techniques. Intraoperative strategies, including entry modifications, dissection sequencing, and energy use considerations, will be discussed alongside video demonstrations. Additionally, the session will cover practical approaches for early identification and repair of bladder injuries, ensuring optimal outcomes and minimal morbidity.

This talk aims to equip surgeons with both the cognitive and technical tools needed to confidently manage bladder dissection challenges and complications in laparoscopic hysterectomy, with an emphasis on safety, precision, and continuous surgical learning.

Catarina Ang: Challenging Hysterectomy - Tips and Tricks

Hysterectomy may be regarded as a core gynaecological procedure, yet a significant proportion present with anatomica or surgical complexity that challenges even the most experienced surgeons. Hysterectomy is now rarely "routine." Patients have complex pelvic anatomy, distorted planes, prior surgeries, large or immobile uteri, high BMI, or severe endometriosis, turning a standard case into a surgical minefield.

In this session, A/Prof Catarina Ang shares practical, high-yield tips and strategies for navigating difficult hysterectomies with, if not confidence, at least with hopefully less trepidation. Drawing on her experience in laparoscopic and robotic surgery, she explores preoperative decision-making & preparation, intraoperative problem-solving, and ureteric safety. Designed to complement talks focused on specific anatomical or procedural difficulties, this session will take a broader, integrative perspective—highlighting surgical principles, adaptability, and decision-making under pressure.

Whether you're an early career surgeon expanding your operative repertoire or a seasoned operator seeking to refine your approach, this session offers pragmatic insights into managing the complex hysterectomy safely and effectively.

Amy Park: Rising to the Challenge: Managing a Large Uterus in Vaginal Hysterectomy

Abstract Not Available

1020 – 1210	Session 6A: Preserving Function, Enhancing Fertility: Advanced Laparoscopic and Robotic Surgery

Anusch Yazdani: Tubal Surgery for the Infertile Patient

Abstract Not Available

Jay Hudgens: Uterine Preserving Surgery for Adenomyosis

Abstract Not Available

Vivian Yang: Fertility Sparing Surgery for Pelvic floor Problems Including Prolapse and Incontinence

Incidence of prolapse in child bearing age is reported to be 10-26% and SUI is 4-23%. The incidence will rise with increasing average age of the childbirth. Women with pelvic floor problems are usually recommended to defer surgery until childbearing is complete.

This session will try to answer 2 main questions.

1) What is the risk of failure of POP and SUI following pregnancy and delivery?
2) What is the preferred mode of delivery to prevent the recurrence?

Fertility sparing surgery for POP includes vaginal and abdominal/laparoscopic/Robotic route.

Sacrospinous hysteropexy has shown to have shorter operative time and less anatomical compartment with bothersome symptoms or repeat surgery compared to vaginal hysterectomy and uterosacral ligament suspension. However surgical failure increases in the case of elongated cervix and third and advanced stage prolapse.

High uterosacal ligament hysteropexy can be performed vaginally or abdominally. Laparoscopic/ Robotic route is preferred due to reduced risk of ureteric injury. Multiple studies have shown comparable success rate compared to hysterectomy.

Surgical method for Sacrohysteropexy is variable but usually involves mesh applied to the posterior uterus and cervix. Mesh can also be wrapped around the cervix and feed anteriorly.

Andebrhan et al. identified 215 cases from eligible 27 studies. 47 cases had Vaginal repair and 169 cases had abdominal repair. Overall recurrence of POP was low regardless of surgical approach and mode of delivery.

Mesh augmentation with Sacrohysteropexy has shown to be associated with higher incidence of adverse obstetric outcome. The primary concern is associated with potential compression of the uterine arteries by the mesh encircling the cervix. Regular doppler study is recommended. Pelvic pain, especially in third trimester could result from the tension caused by the band.

Midurethral sling is still considered gold standard treatment for SUI with success rate up to 85%. Nahshon et al. studied the effect of subsequent pregnancy and childbirth on SUI recurrence following midurethral sling procedure. 381 patients were identified to have had at least 1 childbirth from 6 eligible studies. There was no difference in the risk of SUI recurrence or re operation between patients with and without childbirth regardless of mode of delivery following MUS procedure.

In summary, surgery should be offered to women with distressing pelvic floor problems when future fertility is desired. However, many studies are observational and their results should be taken with grain of salt due to unavoidable confounding effect.

Sireen Jaber: Navigating the Niche. Surgical Management to Optimise Fertility - When and How?

Abstract Not Available

Anna Rosamilia: From Controversies to Consensus: Introducing and Reintroducing Tools Safely

Abstract Not Available

1020 – 1210	Session 6B: Cutting Edge to Steady Hands: Training and Transition in Surgery

Emily Huning: Training – RANZCOG

Abstract Not Available

Michael Wynn-Williams: Surgical Mentors and Coaching

Abstract Not Available

Belinda Lowe: Mental Rehearsals

What if you could improve your surgical skills without ever picking up a scalpel? Mental rehearsal, the systematic visualization of tasks without physical movement, is making us reassess how we approach skill acquisition and performance enhancement. From Olympic athletes to elite military pilots, top performers have long harnessed the power of mental practice, and now healthcare is discovering its potential. Neuroscience research reveals that when we mentally rehearse a procedure, our brains activate the same neural pathways as physical practice, with functional MRI studies showing similar activation patterns between imagined and real movements.

The evidence spans multiple domains, from improving basketball free throws to increasing muscle strength without access to fitness equipment. In surgical education, emerging evidence suggests mental rehearsal can benefit procedural learning in certain contexts. Mental rehearsal also may reduce stress in the operating theatre with studies showing that surgeons who performed 30 minutes of mental practice before procedures had significantly reduced stress levels, with lower heart rates and cortisol levels compared to controls. Mental rehearsal is not just for students or trainees as the benefits appear to scale with expertise. Experienced practitioners may actually gain more from mental rehearsal than novices, likely because they can create more accurate mental images of how skills should be performed.

This presentation will explore the science behind why "watching a mental movie" of yourself performing procedures could be the edge to improve your surgical performance. Attendees will learn about current research findings, practical considerations for implementation, and emerging team-based approaches like Visually Enhanced Mental Simulation. The session will provide insights into how mental practice might complement traditional training methods in surgical education.

Amy Park: #SurgeonLife: Social Media for Gynaecologists

- Examine current public perceptions of physicians and how these views are shaped by cultural, generational, and digital trends.
- Review how the Internet and social media influence understanding of medical knowledge, healthcare systems, and individual physicians.
- Discuss how misinformation and social media trends can impact patient care, trust, and health-seeking behaviour.
- Provide practical strategies for gynaecologists to effectively and ethically engage with social media to promote accurate health information and enhance public trust.
- Explore tools and techniques for curating a professional online presence while maintaining boundaries and protecting privacy.
- Share examples of how physicians can become leaders in digital advocacy, education, and evidence-based dialogue online.

Leslie Reti: From Scrubs to Self-Satisfaction: A Transition to Retirement

This presentation will cover advice for an individual's approach to retirement from clinical practice. It will not include financial planning. The psycho-social elements influencing when and how gynaecologists retire will be discussed.

Strategies covered will include appropriate timing of retirement and when one should start thinking about transition.

Issues such as workload redesign and clinical safety. Changes in scope of practice. The role of mentoring, coaching and surgical assisting. Legal and credentialling considerations. Concepts of identity, maintenance of dignity and a sense of purpose after retirement will also be discussed as well as other considerations for transition planning.

1310 – 1410	Session 7A: Free Communications (Oral, Video, Robotic)

Patrick Laws: Laparoscopic Myomectomy for a FIGO Type 3 Fibroid and in Bag Morcellation: 10 Surgical Tips and Tricks

Introduction:
Type 3 fibroids pose diagnostic and management dilemmas. Although classified as submucosal in the updated FIGO system due to their endometrial cavity distortion, they are deeply intramural and lack an intracavitary component (1). Their ambiguous location complicates preoperative planning and surgical approach. Management options include hysteroscopic resection—often limited by accessibility and risk of incomplete removal—or laparoscopic or open myomectomy. Laparoscopic myomectomy within bag morcellation is a feasible, safe alternative however does have a learning curve. Each part of the operation; the myomectomy, the suturing and the morcellation have tips and tricks to improve efficiency and flow of the operation which we will present in this video report.

Case:
We present an intra operative video of 49-year-old woman with heavy perimenopausal bleeding. She was nulliparous with a BMI of 26. After counselling, she opted for a uterine-conserving approach via laparoscopic myomectomy with in-bag power morcellation. A hysteroscopy performed before laparoscopy revealed a wide-based FIGO type 3 fibroid indenting the entire anterior uterine cavity wall.

10 tips and tricks for laparoscopic myomectomy with in-bag morcellation:

1. **Preoperative planning**: MRI and LDH.
2. **Have a good assistant!**
3. **Plan your port placement and your incision on the uterus.**
4. **Useful adjuncts to reduce blood loss**: misoprostol, vasopressin, TXA.
5. **Traction with a tenaculum is your best friend.**
6. **Be brave**—type 3 myomas are deep, with a chance to enter the endometrium.
7. **Suture barbed in two layers**—pull through and snug down. (Barbed unidirectional suture is shown to significantly reduce blood loss and operative time.)(2)
8. **Morcellation**: put the bag in so it opens up in the correct orientation, use a 5 mm scope to port-hop, tilt patient to keep the fibroid in the pelvis.
9. **Always ensure the bag insufflates before activating the power morcellator.**
10. **Have a good assistant and be a leader to a great team**

Outcome:
Operating time was 54 minutes with an estimated blood loss of 100 mL. The patient was discharged on Day 1 with a stable haemoglobin of 126. At her 6-week follow-up, her bleeding had significantly reduced, and she was happy with the cosmetic result. Histopathology confirmed a benign leiomyoma.

Conclusion:
This video presentation highlights the subtleties and skills needed to perform safe, efficient laparoscopic myomectomy and in-bag morcellation. These techniques are transferable across gynaecologic procedures and support a minimally invasive approach with excellent recovery and outcomes.

Michelle Louie: Bleeding Bloopers: What to Do and What Not to Do

Background: Intraoperative bleeding and hemorrhage are among the most common complications in gynecologic surgery and can lead to other serious complications including blood transfusion, hemorrhagic shock, conversion to a more invasive procedure, and visceral injury. Knowledge of preventative measures and techniques to control surgical bleeding can help to prevent serious sequelae of intraoperative bleeding.

Objective: The objective of this video is to demonstrate areas of gynecologic surgery where bleeding is commonly encountered, preemptive measures to prevent bleeding, and techniques for controlling intra-operative bleeding.

Methods: Surgical footage involving cases of significant intraoperative bleeding was edited to demonstrate key points.

Results: Our video presents techniques to manage intraoperative bleeding during common gynecologic procedures, including ligation of the uterine artery, dissection of the broad ligament, and ligation of the utero-ovarian artery. Key steps in controlling intra-operative bleeding are described including pressure, communication with anesthesia and operating room team, irrigation for visualization, and further dissection and exposure to avoid visceral injury. We also discuss the relative advantages and disadvantages of common hemostatic techniques including suture ligation, electrosurgical energy, and topical hemostatic agents.

Conclusion: There is no substitute for excellent surgical technique and adequate preparation, however, when intra-operative bleeding is encountered, it is imperative that gynecologic surgeons are methodical in their approach to control bleeding.

Sireen Jaber: Essential Strategies for Efficient and Safe Robotic Mesh Sacrocolpopexy

Background: Mesh sacrocolpopexy (SCP) remains the gold standard for apical pelvic organ prolapse (POP) repair. When utilized to its full advantage, rectocele and cystocele can also be effectively addressed. When combined with a concurrent hysterectomy, supracervical hysterectomy has been associated with lower mesh erosion rates compared to total hysterectomy. At our unit, we prefer total hysterectomy to reduce the risk of prolapse recurrence, cervical pathology, and abnormal post-hysterectomy bleeding.
We present a step-by-step technique for safe and efficient robotic mesh SCP. Our approach is specifically adapted to reduce the risk of vaginal mesh erosion when mesh SCP is performed alongside a total hysterectomy. The approach is designed to maximize anatomical success while mitigating the risk of mesh erosion, which remains one of the most concerning long-term complications of the procedure. Our method focuses on meticulous tissue handling, nerve-sparing dissection, individualized mesh tailoring, and avoidance of direct mesh contact with the vaginal vault suture line.

Design: The video provides a step-by-step narrated demonstration of the procedure. It includes real-time intraoperative footage with detailed explanation of anatomical landmarks, dissection planes, and critical steps in mesh preparation and placement. The goal is to provide both educational value and technical insight into the nuances of robotic SCP.

Patients or Participants: Patients undergoing robotic mesh SCP for symptomatic pelvic organ prolapse, with or without concurrent hysterectomy.

Interventions: A modified mesh SCP technique is demonstrated. Key steps include precise identification of anatomical landmarks at the sacral promontory, rectovaginal, and vesicovaginal spaces, along with nerve-sparing dissection of the presacral and pararectal spaces. The video presents strategies for challenging vesicovaginal dissections and methods to reduce mesh erosion. Techniques include tailored polypropylene mesh tensioning to address various prolapse defects while avoiding direct placement over the vault suture line. The robotic platform enhances precision, improves tissue plane identification, and allows accurate suture placement.

Conclusion: Our tailored technique aims to maximize anatomical outcomes while minimizing complications. We are currently conducting a retrospective study to evaluate mesh erosion rates with this approach and look forward to sharing our results.

Sireen Jaber: Adopting the Hugo™ RAS System: Technical Insights from Initial Cases

Background: Robotic-assisted surgery is increasingly used in gynecology, offering enhanced precision through 3D visualization, tremor filtration, and improved ergonomics. The Hugo™ Robotic-Assisted Surgery (RAS) system by Medtronic, launched in 2022, features modular arms, an open-console design, and flexible port configurations. This video and abstract summarize our initial two-year experience (March 2023–March 2025) using Hugo for benign gynecologic procedures.

Methods: This video summarizes our two-year experience using the Hugo RAS system (March 2023–March 2025) across 47 benign gynaecologic surgeries, all performed by a single experienced robotic surgeon with a consistent team and Medtronic support. Procedures included hysterectomy, endometriosis resection, Burch colposuspension, and adnexal surgeries. The video also showcases a representative case using a three-arm configuration for Burch colposuspension combined with uterosacral ligament plication, demonstrating technique and system capabilities in confined spaces.

Results: Procedures included 23 hysterectomies (5 with pelvic floor repairs), 15 endometriosis resections (including 2 with bowel shaving), 8 Burch colposuspensions, and 2 adnexal surgeries. Patient age ranged from 18 to 84 years. Mean port placement, docking, and console times were 12:36, 6:30, and 58:42 minutes, respectively. No intraoperative, perioperative, or postoperative complications occurred, and no conversions were required.
The featured case highlights the platform's advantages in fine dissection and intracorporeal suturing within narrow anatomical planes.
Technical challenges were noted, particularly during the learning phase, including external arm collisions, limited assistant access, inability to port hop with the 10 mm scope, and lack of an integrated suture cutter.

Conclusions: The Hugo RAS system is a safe and feasible option for benign gynecologic surgery. Its modular setup and open console offer ergonomic benefits, and the platform appears particularly useful in procedures requiring precise dissection and suturing in confined spaces. However, several limitations remain, and further refinements and user experience are needed to optimize its broader adoption in advanced gynecologic surgery.

Anushka Kothari: The Role of Lateral Space in the Vaginal Approach to Hysterectomy

Introduction: Vaginal hysterectomy remains the original minimally invasive option to hysterectomy and should be the preferred option when possible[1]. Despite compelling evidence there has been a global trend towards moving away from vaginal hysterectomy. This is likely due to anatomical and pathological factors, such as a large uterus, sub-optimal descent, high vesico-uterine fold, or dense adhesions, increasing the risk of intra-operative injury. The lateral space dissection technique has been proposed as an adjunct to facilitate safer access and dissection[2]. This technique can be utilised during

vaginal hysterectomy and vNOTES (vaginal natural orifice transluminal endoscopic surgery). This educational video aims to demonstrate the lateral space dissection technique, emphasising its application in challenging cases.

Design: Narrated video demonstration of the lateral space technique

Setting: The first case presented in the video is a vaginal hysterectomy in a 45-year-old female with pelvic organ prolapse and abnormal uterine bleeding secondary to adenomyosis. She had a high vesico-uterine fold and a long cervix. The lateral space technique allowed safe detachment of the uterine body and access to the vesico-uterine fold to complete the hysterectomy safely. The second case is a vNOTES approach to hysterectomy in a 37-year-old nulliparous female with abnormal uterine bleeding secondary to adenomyosis. As there was minimal decent of the uterus, the lateral space technique was used to lateralise the ureters and create decent.

Interventions: The key steps of this video and procedure highlight the following:

1. The anatomical landmarks encountered in a hysterectomy
2. Creating the lateral space in a vaginal hysterectomy between the bladder pillar and the cardinal ligaments.
3. Continued lateral space dissection to detach the long cervix and access the high vesico-uterine fold.
4. Demonstrating the lateral space dissection in a vNOTES hysterectomy to lateralise the ureter and prevent injury in a uterus with minimal decent.

Conclusion: This video demonstrates that the lateral space dissection is a valuable technique in vaginal hysterectomy and vNOTES, especially when faced with anatomical or pathological challenges. It allows for a safe retroperitoneal approach to hysterectomy. The approach also enhances the feasibility of minimally invasive vaginal procedures like vNOTES in complex scenarios.

Sarveshinee Pillay: Cutting Through Complexity: Hysteroscopic Resection of a Myoma utilising Carboprost

Surgical resection of FIGO type 2 myomas are challenging, with many patients requiring a multistep procedure. These lesions are clinically significant due to their association with abnormal uterine bleeding and impaired reproductive outcomes (1). Surgical management for symptomatic patients seeking fertility preservation typically involves a second or third hysteroscopic resection which can lead to significant inter-procedural symptoms and delays in fertility, as well as the inconvenience and expenses caused by repeat imaging and further surgical time.

Intramyometrial Carboprost injection has been described as a method to facilitate complete resection of Type 2 myomas. Carboprost is a synthetic analogue of prostaglandin F2α predominantly utilized in the management of postpartum haemorrhage. Its pharmacologic action is mediated through stimulation of uterine smooth muscle, resulting in myometrial contractions and vasoconstriction, thereby facilitating haemostasis and reducing uterine blood loss. Carboprost has been shown to have an adjunctive role of Figo Type 2 myoma resections by increasing myoma expulsion and thereby facilitating hysteroscopic access and complete excision (2).

We present a video presentation of a 37 old nulliparous woman with abnormal uterine bleeding and a FIGO type 2 myoma on ultrasound. We demonstrate the previously described three-step approach to perform complete resection of a FIGO type 2 myoma. Step one – identifying the myoma and resection of the intracavity portion using the Hologic MyoSure XL device. Step two – injection of carboprost into the endometrium/myoma junction using a Cook Medical Williams cystoscopic injection needle and step three – continue the resection as the myoma expels into the uterine cavity. In our video, the myoma is completely excised with an operative time of 23 minutes and cutting time of 1.42 minutes. A post operative ultrasound confirmed the myoma was completely excised.

Single step hysteroscopic resection of these fibroids are rare, but can be achieved with the use of carboprost.

Michelle Louie: Vasopressin: Fundamentals and Applications in Gynaecologic Surgery -

Background: Vasopressin is commonly used off-label in gynecologic surgery to improve hemostasis, blood loss, and visualization.

Objectives: The objectives of this video are to describe the mechanism of action of vasopressin, discuss safety considerations, and review the various methods of injection and applications in gynecologic surgery.

Methods: An audio-video educational aid was created using de-identified live surgical footage from the authors' surgical practice, demonstrating techniques for vasopressin use in gynecologic surgery. A literature review was performed and relevant data was compiled for this video.

Results: Vasopressin is used off-label to improve hemostasis and visualization during hysteroscopic procedures, open or minimally invasive myomectomy, and ovarian cystectomy. Applications in gynecologic surgery are supported by robust data and demonstrated in this educational aid. Methods for injection of vasopressin during minimally invasive gynecologic surgery include injection with a flexible cystoscopy needle, laparoscopic needle, butterfly needle, and spinal needle. The relative advantages and disadvantages of each technique are detailed in this video.

Conclusion: Vasopressin is a safe and effective method to decrease blood loss in gynecologic surgery. There are several techniques for vasopressin administration. Gynecologists should familiarize themselves with the uses of vasopressin and select a technique that best fits their practice.

Vivian Yang: Step-by-Step Robotic Sacrocolpopexy: A Technical Video Guide for Pelvic Organ Prolapse Repair

Background: The rising incidence of pelvic organ prolapse (POP) parallels global aging trends, with an estimated lifetime risk of 12.6% for symptomatic vaginal prolapse requiring surgical intervention1. Sacrocolpopexy is widely regarded as the gold standard treatment for apical POP, with abdominal, laparoscopic, and robotic approaches available—each with distinct advantages and limitations2.

Objective: This project aims to present a comprehensive, step-by-step video guide to robotic sacrocolpopexy, highlighting its technical ease, efficiency, and reproducibility.

Content: The video demonstrates the key anatomical landmarks, dissection planes, mesh placement, and suturing techniques involved in robotic sacrocolpopexy. With enhanced three-dimensional visualization, wristed instrumentation, and ergonomic control, the robotic platform facilitates precise dissection and suturing, particularly in the deep pelvis.

Conclusion: Robotic sacrocolpopexy is a safe and accessible technique for the surgical repair of POP. This video serves as an educational tool to support skill development and standardisation among surgeons adopting robotic approaches in pelvic floor surgery.

1310 – 1410 **Session 7B: Free Communications (Oral, Video, Robotic)**

Philippa Nelson: Laparoscopic Hemi-Hysterectomy for an Advanced First Trimester Rudimentary Horn Ectopic Pregnancy

Introduction: Rudimentary uterine horn pregnancies are a rare occurrence with a reported incidence of 1 in 76 000 to 1 in 150 000. A rudimentary uterine horn pregnancy is associated with a high chance of uterine rupture if the pregnancy progresses past the first trimester. (1) Due to the increased morbidity and mortality, surgical excision of the rudimentary horn is recommended. Anatomical variations and a gravid vascular hemi-uterus add to the surgical complexities of management with preference of surgical approach being laparotomy due to risk of haemorrhage and pregnancies too large for laparoscopic removal. (2)

Case: A 30-year-old female, G4P2M1, was diagnosed with a rudimentary horn ectopic pregnancy at the time of a laparoscopy for suspected tubal ectopic pregnancy. Her medical history included 2 prior term vaginal births and mild asthma. Imaging 3 years prior suggested a left adnexal lesion for which the differential diagnosis was a fibroid. At this point further imaging by way of Magnetic Resonance Imaging (MRI) was recommended but the patient was lost to follow up. This patient did have pelvic ultrasounds both before and after this which did not detect any abnormal findings. This was a planned pregnancy and initial presentation was for a dating ultrasound which reported a live tubal ectopic pregnancy of 11+4 week gestation. She underwent a laparoscopy at her local regional hospital where the surgeons were concerned for a mullerian anomaly. The surgery was abandoned, and the patient was transferred to a tertiary facility for further management. For surgical planning, imaging was obtained with a Maternal Foetal Medicine Ultrasound and MRI. Both confirmed a 12-week gestation pregnancy in a non-communicating left rudimentary horn with a right-sided unicornuate uterus. The patient underwent a successful laparoscopic excision of the rudimentary horn ectopic pregnancy. Postoperative recovery was uneventful.

Conclusion: Limited evidence consisting of mostly case studies guides current surgical practice and considerations. This video highlights the minimally invasive surgical management of a rare presentation and the surgical complexity of mullerian anomalies.

Sam Holford Small Bowel Endometriosis: Pre-Operative Diagnosis and Findings at Laparoscopy

Small bowel endometriosis (SBE) is a rare yet significant manifestation of deep endometriosis, often coexisting with pelvic disease and presenting with non-specific gastrointestinal symptoms. Diagnosis remains challenging due to its variable presentation and limitations of standard imaging techniques and operator recognition. Here we present three cases of small bowel endometriosis diagnosed pre-operatively on transvaginal ultrasound, with accompanying laparoscopic findings.

SBE affects approximately 5–17% of patients with bowel endometriosis, most commonly involving the distal ileum (1). Clinical presentation includes abdominal pain, bloating, altered bowel habits, and occasionally obstruction or bleeding (2,3). Imaging techniques such as MR enterography and transvaginal or transabdominal ultrasound may identify suspicious small bowel lesions, although diagnostic accuracy can be limited by lesion size, mobility, and overlying gas (1). Lesions frequently appear as subserosal hypoechoic nodules <2 cm, often adjacent to the appendix. However, differentiation from other gastrointestinal pathologies remains challenging prior to operative confirmation.

Endometriosis-specific protocols, including transvaginal ultrasound with bowel preparation (eTVUS-BP) and endometriosis protocol MRI (eMRI), are highly effective for rectosigmoid lesions but often fail to detect small bowel involvement. In our experience, transvaginal ultrasound has been effective in pre-operative diagnosis of small bowel endometriosis, but may fail to detect multifocal, superficial, or distant lesions. In equivocal cases, laparoscopy remains essential.

At surgery, lesions may appear as serosal nodules, fibrotic plaques, or cause kinking and retraction of bowel loops (2,3). Histologically, SBE typically involves the muscularis propria, with occasional submucosal or mucosal infiltration (3). Segmental small bowel resection is often required, particularly where obstruction or transmural disease is suspected, and allows definitive histological diagnosis.

Pre-operative diagnosis of small bowel endometriosis requires a high index of suspicion and may benefit from a multimodal imaging strategy. Despite advancements in imaging, laparoscopy remains the diagnostic gold standard. Pre-operative detection enables surgical planning, adequate counselling, and optimal outcomes.

Lucinda Beech: Laparoscopic Abdominal Cerclage: A Standardised Technique for Preventing Preterm Birth

Cervical insufficiency, affecting approximately 1% of pregnancies, is a recognised cause of recurrent second-trimester pregnancy loss and spontaneous preterm birth.[1] Cervical cerclage is often considered for individuals with a history of second-trimester loss, preterm birth before 34 weeks, or significant risk factors such as prior cervical surgery (e.g., cone biopsy). Although transvaginal cerclage in the early second trimester remains the standard approach, it can be technically challenging in patients with limited residual cervical tissue. Laparoscopic transabdominal cerclage (TAC) has emerged as a minimally invasive alternative to traditional open transabdominal and transvaginal techniques, offering advantages such as reduced postoperative morbidity, shorter hospitalisation, quicker recovery, and improved gestational outcomes.[2]

Several laparoscopic TAC techniques have been described.[3&4] This video presents a simple, modified pre-pregnancy technique using a RUMI II uterine manipulator and Mersilene™ tape, suitable for patients with significant risk factors. Following insertion of an indwelling catheter, an appropriately sized RUMI II uterine manipulator is placed. A standard CO_2 laparoscopy is performed using four 5 mm ports in a diamond configuration, with direct optical entry via the umbilicus. The vesicouterine peritoneum is incised and reflected caudally using monopolar scissors to expose the uterine vessels. The uterus is anteverted, and the entry site is marked just superior to the arc of the uterosacral ligaments. A 30 cm length of 5 mm Mersilene™ tape (Ethicon Inc.), mounted on a straightened CTX needle, is passed from posterior to anterior through the outer cervical stroma, just above the RUMI cup and medial to the uterine vessels, on both sides. The suture is secured with four anterior throws. The tape ends are trimmed and tacked down with 3-0 Vicryl to minimise the risk of erosion into the bladder. Finally, the vesicouterine peritoneum is closed with a continuous 3-0 Vicryl suture.

Our unit has performed 20 laparoscopic TACs using this technique. Of these, fifteen have resulted in clinical pregnancies, all delivering beyond 35 weeks' gestation. In one case, the suture migrated during her second pregnancy. No intraoperative or postoperative complications have been reported. The technique has a short learning curve, is reproducible, and uses equipment readily available in most minimally invasive gynaecologic surgery units. However, as it requires a uterine manipulator, it is not suitable for use during pregnancy.

Lucinda Beech: Laparoscopic Management of Deep Infiltrating Endometriosis Requiring Rectal Discoid Resection Surgical Technique & Summary of Outcomes

Background: Segmental bowel resection of deep infiltrating endometriosis (DIE) involving the rectum may compromise rectal function and cause low anterior rectal resection syndrome. The use of a more conservative discoid resection has been shown to minimise these complications with comparable outcomes[1]. However, there are few standardised, reproducible and teachable techniques described in the literature[2, 3]. We aim to demonstrate a standardised and reproducible laparoscopic approach for management of DIE involving the Pouch of Douglas and rectum, utilising disc resection for the removal of endometriotic bowel nodules. We will present the outcome data from a large single operator consecutive case-series which utilises this standardised approach for ASRM stage IV excision and disc resection.

Method: A standardised laparoscopic technique was developed by the operator highlighting their approach to excision of ASRM stage IV endometriosis and discoid resection for the management of bowel endometriosis. The video presents a disc excision of deep endometriosis infiltrating the rectum using a transanal circular stapler, following 8 steps: (1) nodule dissection and rectum releasing; (2) rectal shaving; (3) removal of fat tissue on lateral rectal wall; (4) placement of suture on the shaved area; (5) insertion of the closed transanalcircular stapler; (6) stapler opening at nodule level; (7) stapler closing and firing; and (8) performing a bubble test. This is a case-series of retrospectively collected data from 540 consecutive cases utilising the described procedure, performed by a single operator between January 2011 to December 2025. The primary outcomes included intra-operative complications, length of stay, post operative complications and nodule size.

Results: Of the 540 cases, there were no intra-operative complications. Hospital length of stay was 3days (+/- 1.1day). Twelve women reported PR bleeding post operatively, which resolved within 72hours. At the 6week follow up there were no cases of ongoing PR bleeding, compromised rectal function or low anterior rectal resection syndrome. The mean nodule size was 35mm (+/- 11mm). All 320cases were performed utlising the described step-by-step process.

Conclusion: This large case-series demonstrates this step-by-step technique is safe and reproducible, highlighting the relevant anatomical spaces, landmarks and technique to achieve excision of ASRM stage IV endometriosis and discoid resection. The technique will provide a systematic approach and a reference guide for advanced laparoscopic gynaecologists to use to ensure a standardised and teachable procedure.

Amani Harris: Surgical Navigation: Robotic Hysterectomy for a Large Cervical Fibroid and Key Anatomical Landmarks

Cervical fibroids are uncommon, accounting for only 0.6–2% of all uterine fibroids. They pose a distinct surgical challenge due to their deep pelvic location, size, distortion of normal anatomy, and close proximity to critical structures such as the ureters and vessels This video presents a complex robotic-assisted total hysterectomy in a patient with an 8 cm cervical fibroid and a significantly enlarged uterus. Emphasis is placed on thorough pre-operative planning and intraoperative strategy, including the use of indocyanine green (ICG) for real-time ureteral visualization to enhance safety. Key anatomical landmarks, meticulous dissection techniques, and strategies for navigating distorted pelvic planes are demonstrated. Additionally, the video highlights a robotic specimen bagging technique and showcases how to optimize robotic instrumentation in complex surgical scenarios.

Pattaya Hengrasmee: Laparoscopic Management of Extrinsic Ureteral Endometriosis: Mitigating Complications During Ureteral Dissection

Introduction: Laparoscopic surgery for deep endometriosis involving the ureter constitutes significant challenges due to difficult ureterolysis which may result in incomplete removal of endometriosis lesions or ureteric injury, or both. To achieve safe ureterolysis and complete deep endometriosis excision, a surgeon needs thorough understanding of pelvic anatomy, expertise MIS skills, and meticulous surgical techniques, as well as vigilant postoperative care.

Objective: To demonstrate a surgical VDO of a 34-year-old, nulliparous woman who presented with progressive dysmenorrhea (PS 10/10) and dyspareunia for 1 year. Pelvic examination revealed a fixed, globular top-normal sized uterus, bilateral adnexal masses, and thickened and tender both uterosacral ligaments with nodularity. Transvaginal ultrasound showed adenomyosis and bilateral endometriomas, left measuring 3.0 cm and right measuring 3.7 cm. Provisionally diagnosed with adenomyosis, bilateral endometriomas and deep endometriosis, she was scheduled for laparoscopic bilateral ovarian cystectomy and removal of deep endometriosis. However, MRI to evaluate for the extent of disease was not performed.

Method: This video demonstrates specific surgical techniques to facilitate ureterolysis including (1) mobilization of the sigmoid to improve access to the ureter, (2) ovariolysis, ovarian cystectomy, and ovariopexy to improve visualization, (3) entering pararectal space and dissection, (4) identification and cauterization of uterine artery, (5) gentle blunt and sharp ureteral dissection to preserve periurethral sheath and minimize tissue damage, (6) judicious use of bipolar diathermy and ultrasonic scalpel, and (7) entering and dissection into rectovaginal space (8) DIE excision from pelvic sidewall, uterosacral ligament, and RV septum. Following complete ureterolysis and DIE resection, stenotic point was found on left distal ureter. No intraoperative complications were encountered.

Results: Postoperative recover was uneventful. The patient was able to be discharged from the hospital on postoperative day 2. Dienogest was given to prevent endometriosis recurrence. At 6-week F/U visit, KUB ultrasound revealed narrowing of left distal ureter without point of obstruction. The patient later underwent double J stenting by a consultant urologist and Mirena IUD insertion. Double J Stent was subsequently removed after 6 months. The patient was very satisfied with the operative outcomes and there was no endometriosis recurrence.

Conclusion: Thorough knowledge of pelvic anatomy and expertise skills in laparoscopic surgery are mandatory for a safe approach to distorted surgical field, especially in deep endometriosis involving ureter.

Iris Soria-Arikan: Robotic Hysterectomy for a Ventrofixed Uterus with a 15 cm Anterior Wall Fibroid: Tips and Tricks

Robotic-assisted hysterectomy offers enhanced precision and access in complex surgical scenarios, including ventrofixed uteri and large fibroids. This video presents a case of a 42-year-old woman with a 15cm anterior wall fibroid and dense omental and anterior abdominal wall adhesions from prior cesarean sections, resulting in a ventrofixed uterus.

Key surgical strategies demonstrated include safe entry techniques in distorted anatomy, meticulous adhesiolysis of the anterior abdominal wall and bladder reflection, and optimal port placement to accommodate a large fibroid. The video also outlines the importance of early identification of anatomical landmarks, the use of uterine manipulators to aid dissection planes, and specific robotic instrument handling to facilitate safe morcellation or specimen retrieval.

This case highlights how robotic technology can be leveraged to achieve minimal blood loss, precise tissue handling, and faster recovery in anatomically challenging scenarios. Tips for managing the bladder flap in cases of dense scarring and strategies to avoid ureteric injury are also discussed.

Nadin Alghanaim: Managing Adherent Bladder in Robotic Assisted Hysterectomy

Objectives: This video presents two cases of robotic total hysterectomy involving an adherent bladder. The aims are to:

1. Review the incidence and risk factors associated with difficult bladder dissection during robotic-assisted total hysterectomy.
2. Demonstrate an approach to dissection designed to reduce the risk of bladder injury.

Incidence: The overall risk of urologic injury during robotic hysterectomy is approximately 0.87%, with bladder injury specifically estimated at 0.55% (1).

Risk Factors: The following factors may increase the risk of bladder injury (2):

- Prior caesarean sections and pelvic surgeries.
- Endometriosis.
- Fibroids.
- Surgeon experience.

General Approach:

1. Identifying Safe Dissection Planes and Spaces:
   - Dissection of the vesicovaginal and paravesical spaces.
   - Performing dissection in a lateral-to-medial direction
2. Delineating bladder edges using retrograde bladder filling.
3. Instrumentation:
   - Uterine manipulator.
   - 30-degree scope.
   - Fourth robotic arm for traction
4. Intraoperative Identification of Bladder or Ureter Injury:
   - Utilize cystoscopy to identify any injuries during the procedure.

1310 – 1410 Session 7C: Free Communications (Oral, Video, Robotic)

Nancy Peters: ENDOCOLOR Endometriosis Appearance with Hormonal Contraceptives at Laparoscopy: A Prospective Cohort Study

Endometriosis affects 10% of the population with significant pain, fertility and obstetric implications[1]. While imaging modalities are improving and are particularly useful for diagnosis of deep endometriosis and ovarian endometrioma, there are limitations in assessing superficial endometriosis non-invasively[1]. Laparoscopy continues to play a role in diagnosis, particularly of superficial endometriosis, and excision of endometriosis, with significant heterogeneity in appearance. (2)

METHOD: A prospective cohort study was performed to assess the effect of hormonal medication on the laparoscopic appearance of endometriosis in an urban Australian setting between 2022 and 2024. Women between the ages of 18-60 with the capacity to give consent freely, undergoing laparoscopic excision of endometriosis, were recruited pre-operatively, in the public and private gynaecology clinics.

They were excluded if they had previous surgical excision of endometriosis, were unsure of their current or recent hormone contraceptive use, or if they had used GnRH agonists/antagonists, danazol or selective estrogen receptor modulators in the six months prior to laparoscopy. Pre-operative use of hormonal medication was dictated by patient preference and clinician recommendations.

RESULTS: During the study period, 103 patients who underwent laparoscopic excision of endometriosis between September 2022 and August 2024 were recruited. 59 patients used hormone medication (HU), while 44 patients did not use hormone medication (NU).

Regarding the study primary outcome, there was no difference in the frequency of black coloured endometriosis lesions with hormone medication use, 18 (32%) in the HU group compared with 12 (34%) in the NU group (p=0.82, OR 0.88, 95% CI 0.36-2.16) (Table 3). There was a trend toward more white coloured endometriosis lesions in the HU group, 11 (34.4%) compared with the NU group 11 (19.3%), however this difference when assessed between all lesion colour categories did not reach statistical significance (p=0.55).

DISCUSSION: Ultimately, our study did not demonstrate a difference in black endometriosis lesions between those using hormone medication and those not using hormone medication prior to laparoscopic excision of endometriosis. Interestingly there was a non-statistically significant trend toward white lesions in the hormone user group which aligns with the findings of Weng et al who demonstrated an increase in clear endometriosis lesions in those with hormone exposure compared to those without hormone use(3). Ultimately this study adds to the growing perception regarding the potential effect on hormone medication on the appearance of endometriosis at time of laparoscopy, with the potential to benefit patients with increased awareness of this varied appearance.

Joanna Morris: Reimagining Prehab and Rehab for Endometriosis Surgery with Digital Innovation

Background: Surgery for endometriosis is often distressing, with preoperative anxiety and poor health contributing to poorer recovery and lower satisfaction. Enhanced-recovery-after-surgery (ERAS) protocols reduce length-of-stay without increasing complications in deep infiltrating endometriosis surgery (Douligeris et al., 2025). However, expanding access to structured prehabilitation and rehabilitation remains challenging due to fragmented care and limited availability of multidisciplinary support. Digital coaching programs with multidisciplinary education, exercise, mindfulness, and peer connection can improve patient activation and recovery (Nicola et al., 2023), offering a scalable way to improve outcomes and support surgery. However, no such digital multidisciplinary programs have been developed or evaluated for endometriosis surgery.

Objective: To evaluate the early outcomes of a co-designed digital program (Matilda App) that supports individuals before and after laparoscopic surgery for suspected or confirmed endometriosis.

Methods: A four-week prehab and four-week rehab digital care program was co-designed with people with lived experience and expert clinicians, then piloted in collaboration with high-volume endometriosis gynaecologists. The program provided structured education from multidisciplinary clinicians, endometriosis-friendly exercise classes (Yoga, Pilates, Pelvic Health Physiotherapy), connection to a community of peers also undergoing endometriosis-related surgery, and weekly check-ins, while also providing surgeons with timely patient-reported outcome and experience measures. Early outcomes were collected via surveys within the app.

Results: Since its launch, over 40 participants from three countries have enrolled, including individuals from rural/regional areas. Four participants accessed the Matilda Scholarship Fund for discounted or free access. Patients (n=10) reported an enhanced surgical experience, feeling more mentally prepared, less anxious before surgery, and more confident being discharged. No program adverse events were reported. Clinician feedback highlighted the value of structured preparation, clear information, and continuity of care, especially considering current limitations in standard surgical pathways.

Qualitative feedback indicated that patients appreciated the emotional reassurance, sense of community, and trustworthy information delivered through the platform. Gynaecologists cited confidence in the program team and observed benefits to patient recovery as key factors supporting adoption. Difficulties with referral processes, clinician behaviour change, patient motivation, and funding structures were identified as barriers to wider implementation.

Conclusion: This early evaluation supports the feasibility and value of a digitally delivered, multidisciplinary surgical optimisation program for endometriosis. Early findings indicate strong patient engagement, increased confidence, and improved surgical and recovery experience. Further investigation through larger, randomised studies and health economic evaluation will be essential to validate effectiveness and support future integration into routine clinical practice.

Stephanie Bowler: Comparing Efficiency and Complications between RUMI II and Biswas Colpotomisers at Laparoscopic Hysterectomy: A Randomised Controlled Trial

Study objective: To compare the RUMI II and Biswas colpotomisers at total laparoscopic hysterectomy, examining the primary outcomes of operating time (total and up until separation of uterus) and blood loss.

Design: A multicentre prospective randomised controlled trial

Patients: Patients scheduled for total laparoscopic hysterectomy for benign pathology with a uterus less than 14 weeks size.

Interventions: Patients were randomised to undergo total laparoscopic hysterectomy with either the RUMI II or Biswas colpotomiser.

Measurements and main results: A total of 96 patients were recruited, 48 patients per arm were included in the final analysis. There was no statistical difference in the patient characteristics or estimated blood loss. The mean time for insertion of the Biswas was 7.128 minutes compared with 7.293 minutes in the RUMI manipulator. The mean time for colpotomy was shorter 55.895 in the Biswas arm (55.895 minutes) vs the RUMI arm (60.025 minutes). The mean operating time was 101.711 minutes with the Biswas colpotomiser vs 101.683 minutes with the RUMI colpotomiser. A statistical significance between groups was not reached. There were limited complications with no episodes of blood transfusion, conversion to laparotomy, urinary tract injury, return to operating theatre or readmission. Of note two uterine perforations were documented with the Biswas colpotomiser with no ongoing sequelae. Surgeon satisfaction was compared and no statistical differences were found between the two colpotomiser options.

Conclusion: With comparable results amongst the primary outcome of operating time and blood loss along with comparable surgeon satisfaction, consideration should be made for the differing costs to the healthcare system associated with the single use components of the Biswas and RUMI II colpotmisers. In light of both being a safe and efficient instrument for total laparoscopic hysterectomies surgeons should reflect the other impacts of colpotomiser selection.

Jennifer Dean: Concordance between Pre-operative Imaging, Intraoperative Findings, and Histopathology in Gastrointestinal Endometriosis

Background: Pre-operative imaging is a vital tool for surgical teams planning combined endogynaecology and colorectal resections, particularly when informing the likely extent of bowel resection.

Aims: To observe the comparative accuracy of pre-operative imaging and intraoperative findings with the histopathology of gastrointestinal surgical resections for endometriosis.

Methods: A retrospective observational cohort study was carried out in a single tertiary -level unit by interrogating clinical coding and electronic medical records. Pre-operative imaging reports (ultrasound and MRI), intra-operative findings, and histopathology results of gastrointestinal resections for endometriosis were examined over a 12 monthperiod.

Results: 35 cases were identified over 12 months, of which 6 were excluded due to inaccurate clinical coding. In the 29 cases, 11 underwent rectal intervention for endometriosis; 4 patients received rectal shaves, 5 underwent disc resections and 2 underwent anterior resections The indication for intervention included pelvic pain and infertility.
Of the 5 patients undergoing a disc resection 4 had received a pre-operative MRI, of which 3demonstrated histologically proven endometriosis invading the rectal muscularis. The depth of invasion was correctly predicted by the pre-operative MRI. The fifth patient received a tertiary-level ultrasound which identified but did not comment on depth of invasion of the rectal nodule. On histology, endometriosis was also found to be invading the rectal muscularis.

No MRI was performed for 3 of the 4 patients who underwent rectal shaves, nor was bowel endometriosis identified on pre-operative ultrasound scans. However, endometriosis was histologically confirmed on 2 shaves. The final patient who underwent a serosal bowel shave had an MRI without convincing bowel endometriosis and both intra-operative findings and histological findings correlated with this prediction.

Of the 2 patients who underwent an anterior resection, 1 had a pre-operative MRI indicating rectal endometriosis but no comment was made on the expected depth of invasion. Histology confirmed focal endometriosis but the depth of invasion was not reported. The second patient received a tertiary-level ultrasound which commented that the nodule invaded the rectal muscularis which was confirmed on histopathology.

Conclusion: Overall, pre-operative imaging did not consistently comment on the depth of invasion of rectal endometriosis deposits. There was also inconsistency in the histopathological reporting of the depth of invasion. Greater standarisation in imaging and histology reporting could aid in planning of future complex cases.

Stuart Salfinger: Randomized Trial of Time Efficiency of Electrosurgical Devices (LigaSure™ Blunt Tip & LigaSure™ XP)

Background: This randomized trial compared two Medtronic electrosurgical devices to evaluate whether a newer, more costly technology provides any benefit in terms of time efficiency. The LigaSure™ LF 1837 (LF) was the standard device used in hysterectomy procedures before the trial. The newer LigaSure™ XP device features a longer jaw length and enhanced seal strength, requiring fewer seals during procedures. The trial aimed to determine whether these features resulted in shorter operating times compared to the current practice.

Objective: To compare the surgical operating times between LigaSure™ XP (XP) and the standard energy device, LigaSure™ Blunt Tip (LF), in laparoscopic hysterectomy procedures. The study also aimed to assess the potential health economics difference from a private hospital payer perspective.

Method: A total of 24 devices were tested: 12 LF and 12 XP, which were randomly assigned to consecutive cases. All surgeries were performed for benign conditions and involved total laparoscopic hysterectomy (TLH) with bilateral salpingo-oophorectomy (BSO). The "electrosurgical use time" was defined as the period from the first activation of the LigaSure™ device at the round ligament to the start of vaginal cuff closure. This standardized measurement excluded other patient-related factors (i.e. adhesions).

Results: The average age (57.7 vs. 58.7 years), height (1.64m vs. 1.64m), weight (76kg vs. 74.4kg), and BMI (28.1 vs. 27.4) were similar between the LF and XP groups, respectively. Uterine weight (147g vs. 119g) was also comparable, with no statistically significant or clinically meaningful differences. The electrosurgical use time was significantly shorter for the XP group (20.3 minutes) compared to the LF group (26.6 minutes) ($p < 0.01$).

Conclusions: The XP device resulted in a time saving of over six minutes per case. Using private health insurance data, the average cost per minute in the operating theatre for benign hysterectomy is $62.43 (Private Hospital Data Bureau: Annual Report 2023-24, Department of Health and Aged Care). This translates to a potential time-related cost saving of $390 per case. The savings in operating time sufficiently offset the additional cost of the newer device, and further cost reductions may be realized from a private hospital payer perspective. This could translate to greater benefit in more complex surgery requiring increased device use.

Anna Fischer: Patients as Partners: Co-Creating a Digital Pre- and Post-Op Program for Endometriosis

Background: Endometriosis surgery represents a critical point in a patient's care journey, yet many experience it as isolating, uncertain, and under-supported. Patients often report a lack of guidance on how to physically, emotionally, and logistically prepare for and recover from surgery. Although enhanced surgical tools and intraoperative techniques are advancing, there remains a significant gap in the perioperative support available to patients. Digital health offers a promising avenue to enhance patient outcomes and multidisciplinary care. Yet, no multidisciplinary, digitally delivered pre- and post-operative support program centred on the lived experience of people undergoing endometriosis surgery currently exist.

Methods: We conducted two hybrid co-design workshops with ten individuals who had undergone laparoscopic surgery for suspected or confirmed endometriosis. Using the Jobs-To-Be-Done framework, we identified key needs during the pre- and post-operative periods. A multidisciplinary advisory group (including gynaecologists, physiotherapists, psychologists, dietitians, nurses, and allied health professionals) guided content development. The program (Matilda Health) was iteratively refined over two months via fortnightly feedback sessions and then piloted in collaboration with ten gynaecologists. The digital app was released on iOS and Android platforms.

Results: Participants prioritised clear procedural information, anxiety reduction, and holistic preparation before surgery. After surgery, key needs included pain management, emotional support, regaining function, and guidance on recovery. Gynaecologists highlighted the value of structured, patient-centred tools that could support clinical care and improve communication across the surgical journey. Ongoing feedback from both patients and clinicians led to improvements in app navigation, tone, language accessibility, and peer support features, as well as the development of timely patient reported outcome and experience measures reported back to the gynaecologist. The result was a co-designed, pilot-ready digital surgery optimisation tool that enhances the patient experience while supporting the broader perioperative team.

Conclusion: Co-designing a digital prehabilitation and rehabilitation app for endometriosis surgery highlights the value of collaborative, team-based care. It demonstrates how person-centred digital tools can enhance the perioperative experience, not only for patients, but also for the healthcare professionals supporting them. By embedding lived experience at the core of the design process and fostering multidisciplinary input, this work establishes a strong foundation for broader clinical integration and meaningful system-level improvements in gynaecological care.

Yves Charlesworth: Perioperative Anaemia in Hysterectomy: Quantifying the Burden and Uncovering the Roadblocks for Optimisation

Background: Perioperative anaemia is common among patients undergoing hysterectomy. (1) It is a modifiable risk factor associated with increased transfusion requirements and adverse postoperative outcomes including prolonged hospitalisation, infection, and 30-day mortality. (1) The National Blood Authority recommends haemoglobin (Hb) testing 4-6 weeks prior to surgery and iron therapy for optimisation. (2) This audit aims to quantify the burden of perioperative anaemia in patients undergoing hysterectomy and identify system barriers to optimisation.

Methods: This retrospective audit included 226 patients who underwent elective hysterectomy between January 2023 and February 2025 at a tertiary hospital in Victoria. Data included demographics, surgical details, Hb levels, iron therapy, histopathology, perioperative transfusions, and postoperative outcomes such as length of stay, infection, ICU admission, and unplanned 30-day readmission. Anaemia was defined as Hb <130g/L and iron deficiency as ferritin <100µg/L. Statistical analysis was performed to determine the primary outcome of preoperative anaemia and the proportion of patients receiving iron optimisation.

Results: Of 226 patients, 90.3% had preoperative Hb tested within 6 weeks and 30.9% had anaemia. Iron studies were available for a small subgroup of patients (9.7%), and in this group iron deficiency was the predominant cause of anaemia. These findings are preliminary, with further results to be presented at the conference. Anaemia was most common among patients coded for abnormal uterine bleeding (40.9%), fibroids (37.5%) and heavy menstrual bleeding (32.0%).

19.1% of patients with anaemia received intravenous or oral iron. Documentation of oral iron was variable. Intravenous iron was administered at a median of 13 days prior to surgery, limiting its effectiveness. The timing of preoperative Hb testing was also a barrier to treatment with 29.5% tested ≤20 days before surgery.
Postoperative Hb was measured in 55.3% of patients, of whom 85.7% had anaemia. Only 4.8% received intravenous iron therapy prior to discharge. Vaginal hysterectomy predicted greater postoperative drop in Hb compared with laparoscopic hysterectomy (Mann–Whitney U= 1259.5, p= 0.0018, rrb= 0.398), corresponding to a moderate-to-large effect size. The overall postoperative complication rate was 12.4%.

Conclusion: Preoperative and postoperative anaemia are prevalent among patients undergoing hysterectomy but are under-recognised and suboptimally managed due to delays in testing and treatment. In response, a dedicated perioperative pathway was developed to embed early anaemia assessment into the surgical booking process and establish clear responsibility for follow-up and management in both the preoperative and postoperative settings.

Kasia Michalak: Total Laparoscopic Hysterectomy: Implementing a Same-Day Discharge Protocol

Introduction: Same-day discharge after a laparoscopic hysterectomy (TLH) is routine care in the United States [1], but in Australia the standard of care is overnight stay. The benefits of same-day discharge include cost benefits for the hospital, and potential reduction in nosocomial infection and deep venous thrombosis for patients. This study sought to evaluate the success rate of same-day discharge for carefully selected women having a TLH at a large hospital network in Melbourne, as well as the rate of and reasons for readmission.

Methods: Patients aged 18-80 years undergoing an elective total laparoscopic hysterectomy with or without salpingectomy and/or oophorectomy at Moorabbin, Casey or Dandenong Hospitals were offered enrolment into the study. Patients were excluded from participation if their BMI was greater than or equal to 40, their ASA was greater than or equal to 3, they had Type 2 Diabetes that was medicated or uncontrolled, their predicted uterine size was greater than 12 weeks or 350ml, they were predicted to have poorly controlled post-operative pain, or if they had an inability to consent. Given this study is a case series, no specific sample size was calculated; it was decided that 52 patients would be enrolled to gather adequate data.

Results: To date, 48 women have been recruited into the study, with 4 remaining. The mean age is 44 years (range 29-62). The mean BMI is 28 (18-45; with one outlier). The mean uterine volume as measured by pre-operative pelvic ultrasound was 139ml (32 - 336). So far 28 out of 48 women (58%) have successfully been discharged the day of surgery. The reasons for failed same-day discharge were complexity of surgery greater than expected (6 patients), pain (4), failed trial of void (3), post-operative nausea and vomiting (3), lack of transport (2), patient anxiety/choice (2), drowsiness (1) and low blood oxygen saturation (1). Three same-day discharged patients were readmitted within 6 weeks post-operatively - 1 with a vault infection, 1 with labial abscess and 1 for laparoscopic BSO following a diagnosis of endometrial carcinoma. Three patients who failed same-day discharge were readmitted - 2 with vault infection and 1 with constipation.

Conclusion: Same-day discharge for TLH has the potential to be a valid option for suitably selected patients. Patients need to be warned that they may need to stay if their surgery is more complex than expected, or if they have significant postoperative pain or difficulty voiding.

Patrick Laws: Vaginal Assisted Natural Orifice Transluminal Endoscopic Hysterectomy (VANH) Versus Laparoscopic Hysterectomy for Complex Atypical Endometrial Hyperplasia: A Retrospective Cohort Study at a Tertiary Australian Hospital

Background: Vaginal Assisted Natural Orifice Transluminal Endoscopic hysterectomy (VANH) is an emerging minimally-invasive technique that combines the benefits of vaginal access with endoscopic visualisation. Systematic reviews suggest VANH is associated with reduced blood loss, shorter operative time, and comparable complication rates compared to laparoscopic hysterectomy (LH).(1)

Complex atypical endometrial hyperplasia (CAH) is a recognised precursor to endometrial cancer, with up to 32.6% harbouring occult malignancy and an annual progression risk of 8.2%.(2) Definitive treatment involves total hysterectomy with intact specimen removal and adnexectomy. However, these patients are often older with higher BMI, making surgery more complex. Vaginal hysterectomy, though feasible, may be limited when en-bloc uterine and adnexal removal is required. VANH may offer a minimally invasive vaginal alternative for patients with CAH or suspected malignancy. (3)

Objective: To assess the feasibility and perioperative outcomes of VANH compared to laparoscopic hysterectomy in patients with CAH performed at a tertiary Australian hospital over a 5-year period.

Methods: We conducted a retrospective cohort study at Westmead Hospital from January 2019 to January 2025.Patients undergoing hysterectomy for CAH were identified via the hospital's Surginet database. Exclusion criteria included abdominal, robotic, vaginal hysterectomies and procedures performed by gynaeoncologists. Outcomes included demographics, ASA score, BMI, specimen weight, operative time, estimated blood loss, length of stay, conversions, and complications. Chi-squared and Mann-Whitney tests were used for categorical and continuous variables, respectively**.**

Results: Fifty-three cases met inclusion criteria: 14 VANH and 39 laparoscopic (including 2 LAVH). Mean age and BMI was similar between groups:(Age VANH 54.6 vs LH 53.6 years, BMI VANH 33.5 vs LH 31.8). Median specimen weights were comparable (VANH=121g vs LH=120g). Median operative time was longer in the VANH group (166 vs 128 minutes, p=0.01).Median Estimated blood loss was non significantly lower in the VANH group (149 mL vs 176 mL), median length of stay was shorter (40.5 vs 50.5 hours) Conversion rates were 21% in VANH (3/14) vs10% in LH group(4/39). There was 2 (CDIx2) minor complication in VANH group and 6 (CD I x 5, CD III)in the LH group.

Conclusion: This is the first study comparing VANH and laparoscopic hysterectomy for CAH. VANH took longer to perform but had comparable perioperative outcomes, with trends for reduced blood loss, and shorter hospital stay (not statistically significant). The increased operative time and higher conversion rate may reflect the learning curve (<10 cases)of this technique. These findings support the feasibility of VANH for CAH particularly in a complex patient cohort.

1440 – 1600	Session 8: Reproductive Rights & Funding Fights: The Future of Women's Health

Debbie Nisbet: Bias in Women's Health: Medicare, Funding, and Access to Care in Australia

There is no area of the Medicare schedule of fees in which the disparity between items for females / those with female pelvic organs and those for men, are more simple to demonstrate than in diagnostic ultrasound. All of us should be ashamed, as I am, to seemingly accept this.

I will shine a light on issues hidden under the surface, and the failure of our society to protect vulnerable pregnant women in particular.

In this presentation I will also explore the gendered bias in surgical items and those related to pain management. How did these discrepancies evolve, why do they persist?

What language about items for women and those who provide them with obstetric and gynaecological care is being used?

And finally - what we can do about it?

Nisha Khot: Diversity in Women's Health Care – Driving Change

Abstract Not Available

Jason Abbott, Emma Readman, Alison Bryant-Smith, John Pardey, and Cameron Sharp:
On the Couch – Is the Time Here to Divide Obstetrics and Gynaecology Training?

Abstract Not Available

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