

Minimally Invasive Surgery Week

**MINIMALLY INVASIVE SURGERY WEEK 2013
ANNUAL MEETING & ENDO EXPO
HYATT REGENCY RESTON
RESTON, VA (WASHINGTON DC)**

ISGE BREAKOUT SESSION:

HOW TO AVOID COMPLICATIONS OF MINIMALLY-INVASIVE GYNECOLOGIC SURGERY

In order of presentation

Laparoscopic Weapons

Understanding Energy Sources and Potential Complications

Nash S. Moawad, MD, MS

Laparoscopic energy sources have developed significantly over the last two decades. Many surgical complications are attributed to the use of energy. Despite our best efforts, every busy surgeon will encounter such complications in their practice. Adequate knowledge of energy sources and basics, and electrosurgery, as well as intensive training, are paramount to minimizing the risk of encountering such complications. Basics of electrosurgery will be reviewed in this presentation, along with potential mechanisms of injury. Tips to maximize the benefits and minimize energy-related complications will be reviewed. Early recognition and appropriate repair are key to the safe management of laparoscopic complications to improve long term outcomes.

How to Get In: Tips and Tricks for Safe Entry

Matthew Siedhoff, MD MSCR

The umbilicus is the most common area for entry in laparoscopy, but it's not always the safest choice in all cases. In this session, we'll review the literature around various entry techniques, and review different approaches for different clinical situations--obesity, prior surgery, large fibroids or adnexal masses. We will also briefly review complications that can happen with laparoscopic entry and how to safely manage them.

Use of Simulation to Improve Efficiency and Safety

Ashley Carroll, MD

Adoption of advancing surgical technologies and procedures into clinical practice can be daunting and challenging for both the novice and the experienced surgeon. Traditionally, surgeons have relied on an apprenticeship-based model of training surgeons in the operating room. Once this training has been completed there is often a lack of opportunity for further skill refinement and teaching once newer techniques are developed. This leads many surgeons to continue to practice in the method they were trained which limits their ability to offer the patient a more minimally invasive or cost saving procedure with lower morbidity.

Currently there are various training options for experienced surgeons to learn new techniques including self-directed learning with video demonstrations, workshops with cadaver or animal labs that can be costly, as well as surgical proctoring by a trained surgeon. Simulation based training has become a favorable option for training due a wide variety in design and ability to structure the training based on specific needs without compromising patient safety. Simulation also allows for feedback and assessment that is specific to the clinically relevant task to determine proficiency. This lecture will focus on simulation based training as an effective method for developing technical skills as well as its ability to improve surgical efficiency and improve patient safety. We will discuss a specific example of a simulation model used to prepare a surgeon for a laparoscopic sacral colpopexy.

Safe Sacrocolpopexy: How to Manage Sacral Hemorrhage, Visceral Injury, and Mesh Exposure

Catherine A. Matthews, MD

In this lecture, we will cover the appropriate pre-operative patient selection for minimization of surgical complications. Women who have a history of multiple abdominal surgeries are not good candidates for those who are still in the learning curve for minimally-invasive SCP. We will discuss safe abdominal entry techniques. We will cover how to safely dissect the rectovaginal, vesicovaginal, and retrorectal spaces and what visual cues and tools are useful for isolating the correct surgical planes. We will discuss how to avoid bleeding at the sacral promontory and then a step-wise management strategy if bleeding is encountered. Finally, we will discuss how to investigate someone who presents with mesh exposure after SCP and the appropriate surgical steps in mesh removal. Videos of the above principles and techniques will be presented.

Tips and Tricks for Colpotomy and Cuff Closure: Selection of Uterine Manipulators and Suture

Matthew Siedhoff, MD MSCR

Colpotomy and cuff closure can be some of the more difficult steps of total laparoscopic hysterectomy. It is critical to use good technique for these parts of the operation as cuff dehiscence after TLH remains an ongoing problem. In this session we review available devices and sutures for colpotomy and cuff closure and review techniques to address some of the common challenges in completing these steps of the procedure. Finally, we will briefly discuss the diagnosis and management of cuff dehiscence.

Myomectomy: Maximizing Outcomes, Minimizing Risks

Nash S. Moawad, MD, MS

Minimally-invasive myomectomy has several advantages over open myomectomy. The size, number and location of fibroids pose several challenges to the safe performance of laparoscopic or robot-assisted myomectomy. Strategies to simplify the procedure, maximize the benefits and minimize the potential risks of the procedure will be discussed. Preoperative planning, trocar placement strategies, incision choice, hysterotomy closure techniques and methods to maximize hemostasis will be detailed. Tips to improve outcomes and minimize complications will be reviewed. Hysteroscopic, laparoscopic or robot-assisted myomectomy should be employed whenever feasible and safe.

Supracervical versus Total Hysterectomy: Issues to Consider At the Time of Concomitant Colpopexy

Ashley Carroll, MD

Sacral Colpopexy offers a highly durable repair for patients with apical support defects. For those patients without a prior hysterectomy, the decision surrounding what to do with the uterus and cervix can be perplexing with many risks and benefits

to weigh. This lecture will discuss the current literature and evidence supporting performing a supracervical hysterectomy versus a total hysterectomy at the time of the corrective procedure.

Risk of mesh exposure, abnormal pathology, postoperative cyclical bleeding and surgical morbidity are all considerations when deciding how to approach surgical planning in these patients. The rates of mesh exposure are higher for those who have a total hysterectomy compared to those with cervical retention. There is also a decrease in potential intraoperative complications and morbidity with a supracervical hysterectomy, such as blood loss, longer operative time and cuff dehiscence. Conversely, the risk of abnormal uterine or cervical pathology is eliminated with a total hysterectomy as well as the potential for persistent cyclical bleeding with cervical retention. With uterine morcellation required for laparoscopic supracervical, the potential for morcellation of a carcinoma exists. Each of these issues will be discussed in detail with time for further discussion and debate regarding this dilemma.