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LAPAROSCOPY AND SLS REPORT

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SLS Mission Statement

The Society of Laparoendoscopic Surgeons (SLS) is an educational non-profit organization established to help ensure the highest standards for the practice of laparoendoscopic, endoscopic and minimally invasive surgery. SLS serves surgeons from various specialties and other health professionals who are interested in advancing their expertise in the diagnostic and therapeutic uses of laparoscopic and endoscopic techniques. A fundamental goal of SLS is ensuring that its members have access to the newest ideas and approaches, as rapidly as possible. SLS makes information available from national and international experts through its publications, videos, conferences and other electronic media. In addition, SLS members have opportunities to exchange information on a regular basis.
Laparoscopy into the Future: The Role of the Society of Laparoendoscopic Surgeons

Farr Nezhat, MD, FACOG, FACS

During the past two decades, minimally invasive surgery has become a part of almost every field of surgery. Results documented in the literature indicate that advanced operative laparoscopy, when performed by trained laparoscopic surgeons in centers with appropriate technical amenities and with adequate laparoscopic support staff, is at least as safe and effective as, and in certain situations superior to, more traditional open procedures, with the added benefit of significantly shortened postoperative recovery and disability. These results are, however, somewhat biased, as they are based on the experience of a select group of expert laparoscopists and may not reflect the community experience. The National Institutes of Health Consensus Panel on laparoscopic surgery suggested that the single most important factor in determining the efficacy and safety of endoscopic surgery is the skill and the laparoscopic experience of the surgeon performing the procedure.

The need for formal training in laparoscopic surgery is obvious, and it is evident that assistance is needed on the resident and postgraduate levels. The challenges of resident education in endoscopic surgery include time limitations as well as the lack of exposure to an adequate number of minimally invasive procedures. More than two decades after the introduction of minimally invasive surgery, the amount of exposure to advanced laparoscopic procedures varies widely. To ensure development of future surgeons, an adequate volume of advanced laparoscopic procedures must be a high priority of any training program. The acquisition of skills for non-dominant hand dexterity, two-handed dissection, adequate instrument targeting, and intracorporeal suturing is strongly recommended for resident level programs. To reach these goals, programs should include both training modalities outside the surgical suite as well as resident participation in the operating room.

Challenges are even greater at the postgraduate level where adequate surgical skills must
be combined with critical clinical judgment to ensure efficient and safe patient care. This can be achieved through fellowship programs or formal accreditation courses. The programs should include didactic teaching of laparoscopic surgical philosophy, instructions on laparoscopic set-up and equipment, practice on inanimate objects, and surgery on animal models. However, teaching by an experienced laparoscopic surgeon must be a mainstream of educational strategy. As of now, the granting of surgical privileges lies only with individual hospitals. However, for the maximally effective teaching process a continuous surveillance program must be in place with adequate ongoing educational support. Ideally, the accreditation process would involve various medical boards and academic societies. To initiate a formal training program in endoscopic surgery, to oversee its implementation and assiduous practice in a cost-effective, continuous manner, is the noble challenge our Society faces.

The Society of Laparoendoscopic Surgeons, consisting of laparoscopic experts in different surgical disciplines, has yet another unique role. Surgical interventions are rapidly and radically changing. Many branches of the surgical profession work in concert. For example, the laparoscopic treatment of extensive endometriosis involving reproductive organs, the bladder, ureter, diaphragm, bowels and/or major blood vessels, may require the collaboration of a laparoscopic gynecologist, general and thoracic surgeon, urologist, and pelvic reconstruction surgeon. While such division of the profession into stereotyped categories may be out-of-date and potentially damaging, it will be encouraging to see the different disciplines in collaboration. As the new endoscopic skills are likely to take longer to acquire, working as a surgical team under the guidance of subspecialists in different types of procedures may accelerate the experience. Direct exchange of experiences in surgical techniques and innovation brings benefit to both the patient and the surgeon. My goal as President of the Society of Laparoendoscopic Surgeons is to use the experience and knowledge of my dear friends and colleagues who have been involved in SLS to facilitate the achievement of these goals.

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Robotic Surgery: The Promise and Early Development

William E. Kelley Jr, MD, FACS

The Evolution of Minimally Invasive Surgery. The concept of minimally invasive surgery (MIS) originated in the early 20th century when European gynecologists, and subsequently European surgeons began endoscopic evaluation of the abdomen and pelvis as a diagnostic technique. In 1966 Kurt Semm, M.D. performed several laparoscopic procedures using an automatic insufflator, and subsequently developed many endoscopic gynecologic procedures, thereby founding the era of laparoscopic surgery. During the 1970's and 1980's, isolated surgeons, such as Berci, Cushieri, and Warshaw, championed laparoscopy as an important diagnostic and staging technique.

The technique of laparoscopic cholecystectomy was developed independently, and at first quietly, by German surgeon Eric Mohe, in 1985 by the Frenchman, Philip Mouret in 1987, and by Americans, McKernan and Saye in 1988. Shortly thereafter, Reddick and Olsen performed the first US series of laparoscopic cholecystectomy and refined and propagated the technique among general surgeons.

The basic techniques of laparoscopic cholecystectomy were rapidly embraced by the surgical community, and laparoscopic cholecystectomy became the standard of care by late 1990. Laparoscopic techniques and instrumentation were refined and expanded to most areas of digestive surgery over the subsequent two to three years. Postgraduate courses in advanced laparoscopic surgery, including colorectal surgery, were commonplace by 1991. However, the advanced laparoscopic procedures were relatively slow to be embraced by general surgeons on a broad scale because of perceived limitations of the laparoscopic techniques. By the year 2000, less than 3% of colon resections were performed by MIS.

Limitations of MIS and the Promise of Robotics. Most advanced laparoscopic procedures require suturing techniques, precise dissection involving delicate structures, and/or the manipulation of significant vascular structures. Many surgeons felt that the limitations imposed by laparoscopic techniques made the advanced procedures too hazardous, tedious, and time-consuming when performed by MIS. The important limitations include impaired visualization caused by two-dimensional visual systems and awkward, often unreliable manipulation of the visual field by nurses or junior house staff holding the laproscope. Moreover, the instruments are very long and operate through a fixed fulcrum at the abdominal wall trocar sites, resulting in limited range of motion, restricted access to non-contiguous structures, reversed or counter-intuitive response of the instrument tips to movements of the hand, diminished tactile feedback, and exaggeration of natural tremor.
The limitations of access and of instrument motion, and two-dimensional vision make suturing and knot tying difficult to master and contribute heavily to the longer learning curve of complex operations. The long length of the instruments compromises the ergonomics of MIS and the limitations of access contribute significantly to surgeon fatigue and discomfort, especially during the somewhat longer, advanced procedures early in the learning curve.

Computer enhanced instrumentation has long been recognized for its potential to solve the limitations of laparoscopic surgery. Visual systems could be controlled by the surgeon and held steady, without fatigue or distraction, by a robotic arm. The potential for three-dimensional vision would improve the dexterity and precision of both fine and broad movements. Motion scaling can translate large, coarse hand motions into fine movement by the instruments, and electronic filtering can remove all tremor from the instrument. Robotic software allows camera and instrument movement to be direct and intuitive, electronically removing the fulcrum effect at the trocar sites. Perhaps most importantly, robotic instrumentation can place a joint or a wrist near the tip of the instrument, producing deflection of the effector tip of the instrument vertically (pitch) and/or laterally (yaw), resulting in one or two degrees of motion at the point of impact that are not available in traditional laparoscopic or open instruments. Robotic instruments respond as though the surgeon’s fingertips were at the end of the instrument, directly holding the needle, scissor tips, scalpel blade, energy source, or grasping tips at the point of impact with the tissue. The cumulative effect of these robotic characteristics is a dexterity and precision that cannot be duplicated by human hands or traditional instruments.

The Evolution of Robot-Assisted MIS. The first commercially available robotic surgical instrument, RoboDoc® (Integrated Surgical Systems, Sacramento, California), was designed for orthopedic surgery in 1992. Orthopedic surgeons can achieve a 75% accuracy drilling the shaft of the femur with traditional instruments, but with RoboDoc® the precision improves to 96%. The first surgical robotic instrument for abdominal surgery was designed to hold and manipulate the laparoscope during minimally invasive surgery. AESOP® or Automated Endoscopic System For Optimal Positioning (Computer Motion, Santa Barbara, California) was FDA approved in 1994. AESOP® gives the surgeon complete control of the laparoscope and provides a stable visual field directed by voice commands from the surgeon. The first integrated robotic surgical system for clinical application, da Vinci™ Robotic Surgical System (Intuitive Surgical, Inc., Sunny Vale, California), was introduced in 1997 in Brussels. The first clinical robot-assisted surgical procedure was performed in March 1997 by Drs. Cadiere and Himpens, using the da Vinci™ System for a cholecystectomy. The first robot-assisted cardiac procedure was performed in May 1998, and the first closed chest coronary artery bypass graft was performed with this instrumentation in June of that year. In 1998 the Zeus® Robotic Surgical System (Computer Motion, Santa Barbara, California) was introduced. The first robot-assisted operation in the US was performed using this system pre-FDA clearance in 1998. Following randomized clinical trials, the da Vinci™ Surgical System was FDA approved for surgery in the US, July 12, 2000. Clinical trials are presently underway with the Zeus® system in preparation for FDA approval.
The da Vinci™ and Zeus® robotic systems are conceptually similar, with a surgeon console or workstation connected by cables to a system of robotic arms to manipulate the laparoscope and surgical instruments. The da Vinci™ console places two independent monitors in front of the surgeon’s eyes, providing true three-dimensional vision and the perception of immersion of the surgeon into the surgical field. The Zeus® workstation is more open, giving the surgeon a more direct external view of the operating room environment, and the surgeon views a traditional monitor with a computer simulated three-dimensional system using special glasses. Both systems have adjustable motion scaling allowing the surgeon to control the precision of instrument movement. Both have electronic filtering to remove tremor and wrists near the instrument tips to provide added flexibility and dexterity. The da Vinci™ wrists have 6 degrees of freedom with both pitch and yaw to give 360-degree rotation of the wrist. The latest version of Zeus® has 5 degrees of freedom to give either pitch or yaw deflection, and full 360-degree wrist rotation is performed by torquing the shaft of the instrument. The Zeus® system has three separate working arms (one camera arm and two robotic arms for the surgeon’s instruments), which are independently fixed to the operating room table. The da Vinci™ System has a patient side tower with a robotic arm for the camera and two robotic working arms. With these robotic systems, the surgeon has complete control of the camera operation and the surgical instruments, with a precision that cannot be duplicated by human hands with traditional instrumentation. The latest version of the da Vinci™ comes with a fourth robotic arm and software that allows the surgeon to assist himself or herself without releasing the master controls.

Fulfilling the Promise? Since FDA approval for the da Vinci™ System, thousands of robot-assisted laparoscopic digestive and urological procedures have been performed in the US. Most traditional laparoscopic procedures are now being performed by robot-assisted technique. Clearly, robots are not essential for basic laparoscopic procedures. Robotic precision is most useful for extremely fine dissection, for precise suturing techniques, and for dissection and suturing in awkward or narrow anatomical locations. Horgan and Melvin demonstrated the robot to be more precise for the dissection of the cardiomyotomy for Heller procedures. At their respective institutions, 80 Heller myotomies were performed with no esophageal mucosal perforations. The reported incidence of mucosal perforations with traditional MIS ranges between 5% and 15%.10 Several groups, including Dr. Horgan’s and our own, are using the robot to suture the gastrojejunostomy for gastric bypass procedures, finding that suturing in this awkward location is far easier and more precise than with traditional MIS. Few studies comparing the results of robot-assisted and traditional MIS have been reported thus far, but many will be forthcoming now that the feasibility and safety have been established.

The most salient value of robotics is the enabling function of this technology and its potential to allow surgeons to perform complex tasks which exceed their abilities with traditional MIS. Laparoscopic radical prostatectomy was first reported in 1992.11 However, relatively few centers have embraced this procedure because very few urologists have the
laparoscopic experience to feel comfortable with the technique, especially with suturing the urethral anastomosis. In some centers, however, urological surgeons with no previous laparoscopic experience are now performing robot-assisted laparoscopic radical prostatectomy. Cardiac surgeons typically have no background experience with laparoscopic techniques, but many centers internationally are now performing robot-assisted closed chest coronary artery bypass and mitral valve procedures, some experiencing two day lengths of stay. Laparoscopic aortofemoral bypass surgery was first reported by Dion in 1993. Dion and Gracia, and others have reported substantial series, but very few surgeons are currently performing laparoscopic aortic surgery. Although many vascular surgeons perform basic MIS, almost none have experience with laparoscopic suturing. In June 2001, the first robot-assisted fully laparoscopic aortofemoral bypass was performed in our community hospital in Richmond, Virginia by Dr. Barklie Zimmerman, a vascular surgeon with no advanced laparoscopic experience. Assisted patient-side by an advanced laparoscopic surgeon, Zimmerman’s first clinical experience with laparoscopic suturing was a successful aortofemoral bypass. Enabled by the robotic technology, he was able to complete the complicated aortic anastomosis very comfortably. The patient was discharged two days after surgery and played golf fourteen days after his aortic surgery.

A mere two years after FDA approval of the da Vinci™ Robotic Surgical System, however, the scope of MIS has been significantly expanded for several surgical specialties. As the instruments become smaller and more refined, similar advances in image-guided neurosurgery and intrauterine fetal surgery are anticipated. Evaluations are currently underway using the robot-assisted surgery for pancreatic surgery, biliary reconstruction, and pediatric surgery. The promise of closed chest cardiac surgery and of hybrid endovascular and closed CABG procedures appears to be nearing fruition.

Robotic technology is still in its infancy. With current robotic instruments the surgeon lacks proprioception and haptic feedback. One truly remote, transseacnic cholecystectomy was performed by Gagner and Marescaux in 2001 with the Zeus® system at the cost of one million dollars. However, the problem of latency between the surgeon’s movements and the response of distant instruments remains to be solved before remote operations can be done routinely. These current limitations of robotics will be resolved as the technology matures. Subsequent robotic systems will doubtless bear little resemblance to the present instrumentation. By way of comparison, however, the evolution of this technology should be compared to laparoscopic surgery circa 1988. As the robotic platforms and instruments evolve, the interposition of computers between surgeons and new, very smart instruments will continue to expand the horizons of minimally invasive surgery. Institutions will have to develop responsible credentialing criteria for the new technology.
The economic feasibility of these new technologies will remain a source of controversy, and evidence-based outcome evaluation will be of crucial importance.

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References:
Laparoscopy in the Management of the Patient with Right Lower Quadrant Abdominal Pain

Raymond J. Lanzafame, MD, MBA, FACS

Diagnostic laparoscopy was once the province of some gynecologists and a few surgeons in the pre-lap chole era. The medical literature nowadays has numerous articles describing the use of laparoscopy under local anesthesia, with nitrous oxide insufflation, in office-based and emergency department venues in order to evaluate the acute abdomen in trauma and other indications. Such applications may become more commonplace in the future, but are beyond the capacity of many facilities due to logistical and technical concerns.

The patient with acute abdominal pain is more likely to be evaluated by clinical and laboratory examination, followed by a CT scan, an ultrasound examination, or both. Proponents of the triple contrast CT and ultrasound evaluations often cite the ability of these modalities to simultaneously evaluate a number of organ systems and to reduce the incidence of negative laparotomy. Recent studies however, indicate that these modalities do not reduce the misdiagnosis of appendicitis and can result in delayed diagnosis and treatment.\(^1\sim4\)

Anecdotal evidence from my own institution, where the emergency room physicians order scans and ultrasounds seemingly routinely prior to obtaining a surgical or gynecological consultation, supports this thesis. The following case is presented to demonstrate the utility of laparoscopy in the diagnosis and treatment of the acute abdomen:

Case 1: A 23 year-old, sexually active female, G0 P0, LMP 3 weeks PTA, with daily spotting, presented with abrupt onset of RLQ abdominal pain 15 hours ago. The pain was described as constant, persistent and severe, and was associated with anorexia. She had changed OCPs 3 weeks previously and used an Advair\(^\text{®}\) inhaler bid for asthma. On exam, the patient was quite uncomfortable, lying very still in bed. Abdominal exam demonstrated hypoactive bowel sounds, with marked RLQ tenderness and guarding, mild LLQ tenderness and an equivocal Rovsing's. Rectal exam was negative and GYN exam was negative, except for a small
amount of blood in the vaginal vault. Labs demonstrated HCT 40, WBC 18,000, with 83 SEGS and 4 BANDS. Urinalysis was unremarkable and βHCG was negative. A triple contrast CT scan ordered by the Emergency Room physician demonstrated “inflammation” in the area of the cecum, with “fullness” in the area of the right ovary. The appendix was not visualized. Laparoscopy demonstrated a small amount of bloody fluid in the pelvis and an enlarged and grossly hemorrhagic right salpinx (Figure 1), with a fibrotic, normal-appearing retrocecal appendix. (Figure 2). A partial salpingectomy was performed after intraoperative GYN consultation. Incidental appendectomy was not performed. Histology demonstrated acute inflammation, edema and hemorrhage. No placental or fetal tissue was identified. The patient's postoperative course was uneventful.

Discussion: This case illustrates several points relative to the management of the young female with right lower quadrant abdominal pain. The patient had findings on physical examination and an elevated white count with a left shift that were indicative of an acute abdomen.

Gynecologic examination was not helpful in distinguishing between a tubovarian or bowel process and the CT scan similarly failed to establish the diagnosis, and resulted in a delay in definitive surgical therapy. Sarfati, et al reviewed the preoperative evaluation and outcomes for 203 patients undergoing appendectomy. They concluded that routine use of adjunctive testing was not helpful and that outcomes were improved by early surgical intervention.

Prompt surgical consultation followed by diagnostic and therapeutic laparoscopy would have facilitated patient care in a cost effective and efficient fashion. Several authors have documented the utility of diagnostic laparoscopy in the evaluation and management of patients with acute abdominal pain. However, laparoscopic appendectomy remains controversial despite a growing body of evidence demonstrating outcomes that are equivalent or superior to laparotomy. Conversion to an open procedure is reported in approximately 10% of cases and is usually determined by intraoperative findings, skill and experience of the surgical team, and patient anatomy.
Management of the normal appendix is equally controversial. Some authors have advocated routine removal of the appendix regardless of the absence of clinical evidence of acute inflammation. Advocates of routine appendectomy often cite the same arguments used to justify appendectomy during open surgery for presumed appendicitis. Others have argued that a clinically normal appendix has a low probability of subsequently becoming acutely inflamed and that one of the advantages of laparoscopy is the ability to avoid unnecessary procedures. Our patient clearly demonstrated an acute gynecologic process and had a normal, fibrotic appendix. The decision to leave the appendix in-situ was based on the fact that this anatomy should preclude the development elevated intraluminal pressure and subsequent vascular compromise.

Our case also demonstrates the benefits of collaboration between surgical and gynecological laparoscopists in the management of patients with an unclear presentation or intraoperative findings deserving of intraoperative consultation and dialog. Collegiality and cooperation facilitate high quality patient care.

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References:
Musculoskeletal Causes of Pelvic Pain: Hernias

James E. Carter, MD, PhD, FACOG

Introduction: Hernia has been defined as a protrusion of organs or parts thereof from their natural place in a cavity through an abnormal opening. However, it is the hernial defect, the opening through which a protrusion may occur, that characterizes hernias, not the protrusion of a viscus. Consistent with this, the designation of various hernias uses not the protruded viscus but the location or region in which a hernia can take place. Hernias can occur in the following locations: 1) Hernias of the pelvic wall, perineum, and pelvic floor (sciatic hernia, obturator hernia, perineal hernia); 2) Groin hernias (direct inguinal hernia, indirect inguinal hernia, femoral hernia); 3) Hernias of the abdominal wall (epigastric hernia, umbilical hernia, Spigelian hernia, incisional hernia); 4) Internal abdominal hernia (internal supra-vesical hernia and hernia through broad ligaments); 5) Sports hernias; 6) Pelvic floor support defects. Each of these hernias has characteristic symptoms and signs. Of these three will be discussed: incisional hernias, groin hernias, and sciatic hernias.

Incisional Hernias: An incisional hernia is the abnormal protrusion of peritoneum through a separation of the edges of a musculoaponeurotic wound. They are common after open abdominal procedures and occur in 0.5% to 14% of abdominal operative procedures. Seventy percent occur within the first year and 97% within 5 years of surgery. Incisional hernias occur after laparoscopy with risk of herniation through a 12 mm trocar site (3.1%) approximately 13-fold greater than that for a 10 mm trocar site (0.23%). Laparoscopic incisional hernias can be prevented, however, by mass closure of the fascia and peritoneal layers under direct laparoscopic vision.

Etiology: Infection, obesity, postoperative strain, inadequate suture material, and nerve injury are some of the etiological factors of incisional hernias.

Symptoms and History: Patients may complain of intermittent pain or dragging sensation. They may also complain of distention and severe abdominal pain if they have herniated small bowel.

Physical Examination: Palpation of the wound site may identify separation and tenderness in the area of the separation without a small bulge being present. When the patient is
asked to cough, a small bulge may be seen or a pulsation felt by the examining finger.

**Diagnostic Studies:** The diagnosis of herniation into an incision site can be made by CT scan or ultrasonography. If only the separation is present without the protrusion of tissue, the diagnosis may be difficult without exploration. However, the defect can frequently be palpated and is a source of pain.

**Treatment:** The treatment of the incisional hernia is surgical placement of graft material of an appropriate size for the hernia present.

**Groin Hernias:** Groin hernias include direct inguinal, indirect inguinal, and external supravesical which emerge through the abdominal wall by way of the external inguinal ring above the inguinal ligament and femoral hernia that emerges beneath the inguinal ligament by way of the femoral canal. The incidence of inguinal hernias is 10% to 15%. Indirect inguinal hernias are congenital, and direct inguinal and femoral hernias are considered acquired.1

**Etiology:** The processus vaginalis is a diverticulum of the peritoneal cavity which is patent in 80% of 90% of newborns, but which closes until at adulthood 15% to 30% have a patent processus vaginalis. Many women with patent processus vaginalis remain asymptomatic. However, this is held to be a prime cause of indirect inguinal hernia. Three factors are involved in generating inguinal hernias: the presence of a preformed sac, repeated elevation in the intraabdominal pressure, and weakening of the body muscles and tissues with time. Raised intraabdominal pressure, such as that which occurs during pregnancy, can make a hernia appear for the first time. The cause of hernia is multifactorial. In the case of indirect hernia, a performed sac (patent processus vaginalis), is present, but bowel is prevented from entering by efficient muscular action. A sudden and unusually high increase in intraabdominal pressure may be sufficient to overcome this protective mechanism and a hernia may quite suddenly appear. In direct hernia there is no performed sac; in fact there is no real peritoneal sac at all. The protective mechanisms fail. The weakened transversalis fascia, on its own, cannot withstand the repeatedly raised intraabdominal pressure and stretches or simply tears.

**Symptoms or History:** The primary symptoms are pain, and in the case of an acute event, ecchymosis of the inguinal region. The patient may feel some discomfort in the groin and notice a small bulge when coughing or straining that immediately subsides.

**Physical Examination:** Physical examination reveals tenderness along the edges of separation, or a bulge that increases in size with coughing that can usually be reduced. When the patient stands, a cough impulse can be felt at the tip of the finger after introducing it into the inguinal canal through the external ring by invagination.

**Diagnostic Studies:** Herniography can be performed for the diagnosis of inguinal hernia. Laparoscopically an indirect inguinal hernia is evident as an opening adjacent to the round
ligament. A direct or femoral hernia may not be clearly seen until the peritoneum is open.⁶

**Surgical Treatment:** A sheet of prosthetic mesh is used to reconstruct the inguinal floor. These procedures can be performed laparoscopically and the prosthesis used to cover and overlap all potential defects in the myopectineal orifice.⁶

**Femoral Hernia:** Femoral hernia is a protrusion of preperitoneal fat or intraperitoneal viscus through a weak transversalis fascia into the femoral ring and the femoral canal. It is not unusual for individuals to develop a femoral hernia who have had a previous repair of an inguinal hernia.

**Etiology:** Natural weakness of the tissues and loss of elasticity is the basic cause. They are more common in multiparous women.

**Symptoms or History:** The patient may notice a small reducible lump in the medial aspect of the groin.

**Physical Examination:** The diagnosis can usually be made on finding a soft tumor at the femoral fossa.

**Diagnostic Studies:** If suspected by symptoms, a gentle push with a blunt instrument at the time of laparoscopy will reveal weakness in the peritoneum.

**Surgical Treatment:** Non-absorbable mesh is placed appropriately to occlude the orifice.

**Sciatic Hernia:** A sciatic hernia is a protrusion of a peritoneal sac and its contents through the greater or lesser sciatic foramen. In one study of women with CPP diagnosed and treated during laparoscopy, sciatic hernia was diagnosed in 20 of 1100. This gives an incidence of 1.8% in women with Chronic Pelvic Pain (CPP) requiring laparoscopic intervention.⁷

**Symptoms or History:** Sciatic hernias present with pain originating in the pelvis. Patients may report ipsilateral posterior thigh or buttocks pain or both. Compression of the sciatic nerve may occur, causing pain to radiate down the posterior thigh that is aggravated by dorsiflexion.

**Physical Examination:** Sciatic hernias pass downward and may present under the lower border of the gluteus maximus muscle in the posterior medial aspect of the thigh. Sciatic hernias, however, are only rarely evident on physical examination. If the ureter herniates into the sciatic foramen it may give rise to a urographic appearance of a redundant, horizontally oriented ureter within a hernia sac that has been called a “curlicue” ureter. Laparoscopically a sciatic hernia may be found to be filled with the ipsilateral ovary or fallopian tube. A prior history of laparoscopic evaluation may not preclude the need for reevaluation.

**Surgical Therapy:** When the sciatic hernia is approached laparoscopically, its contents are reduced and the peritoneum overlying the sciatic hernia is elevated and transected trans-
versely with scissors. Mesh is then placed in the space created by the atrophic piriformis muscle. A second piece of mesh is trimmed to the size of the peritoneal defect and placed over the folding mesh. This overlying mesh is secured to the obturator internus fascia laterally and the coccygeus medially. The peritoneum is then closed over the mesh.

References:

Guidelines for Laparoscopy and SLS Report Contributors
Submit all manuscripts (articles, case studies, review articles, product reviews, and/or news about SLS) as an e-mail message or attachment. Materials may also be submitted on 3 1/2 inch diskettes, zip disks, or CDs.

All submissions should include the telephone number, fax number, and e-mail address of the corresponding author.

All material should be prepared in accordance with the American Medical Association Manual of Style with references listed in citation-sequence format.

Images may not be embedded in manuscripts. To inquire about specifications for artwork submissions, please contact SLS.

All material is subject to copyediting.

Send materials and editorial inquiries to J. Gisele Muller, Laparoscopy and SLS Report, Society of Laparoendoscopic Surgeons, 7330 SW 62nd Ave, Suite 410, Miami, FL 33143, USA. Telephone: 305 665 9959, Fax: 305 667 4123, E-mail: gisele@sls.org
Where Does the Art of Medicine Fit Today?

Harry Rein, JD, MD

This is a jurisprudence column, and you may wonder whether or not the philosophical approach regarding the practice of medicine discussed herein has anything to do with law or surgical technique and skill. Do personality and the art with which one practices the doctor-patient relationship have anything to do with medical malpractice? They certainly do and are pervasive in the courtroom. Personality and the philosophic approach to patients have a great deal to do with the discovery process, and it almost always is one of the bases of a patient seeking legal help. Litigation in the health care fields has leveled off. It seems that there are fewer claims and lawsuits this year than in the past few years, but I don’t think that is necessarily true in the “newer procedure” specialties. Perhaps this is because there is more willingness to discuss fault in these fields or because those litigating such specialties are becoming more informed and more sophisticated. But doctors in active practice, such as those developing newer procedures involving minimally invasive surgery, tell me that medical malpractice lawsuits they see affect most of the fundamental aspects of patient care. You become much concerned with this litigation, either consciously or subconsciously, because of all the publicity you constantly hear, mail you continuously get, and most recently, due to the increasing malpractice insurance premiums. We clearly become concerned with medical malpractice when it is time to pay the premium. Risk management seminars are required in some states; but they, along with our medical journals, unfortunately do not discuss those things which affect doctors the most. What seem to be disappearing are “art of medicine” discussions and teaching methods implementing the doctor patient dialogue techniques; they have been displaced by laparoscopic entry techniques, newer laser beams, and an overwhelming array of microsurgical instruments. We therefore wonder if the art of medicine ever existed except to merely fill in those spaces where the science, technical knowledge, and mechanics of medicine left a void. Surely the “art of medicine” of which we speak so reverently refers primarily to the doctor-patient relationship. It lives and is well, needs to be nurtured, and must survive. However, most other forms of patient care are becoming truly scientific, including even many of the psychiatric disciplines. Certainly most if not all of laparoscopic surgical care is scientific, technical, and mechanical. No one can claim that it is the art of medicine when the laser is directed (or mis-
directed); no one can claim that it is an art form to dissect an ovary or to insert a first trocar or to clearly visualize the ureter. Unless we say that the learning and proper application of these skills is an art form, we must mean only the personal relationships. The malpractice defense in every case, "...medicine is an art form and not a science..." is disappearing, although still used. The elders among us with years of practice might consider the change undesirable. Yet it is no longer accurate to say that the amount of knowledge a physician possesses and his surgical skills are an art. They are a scientific application of the current state of knowledge.

Doctors have increased public expectations by educating, promoting, and advertising. We now accept that defensive medicine merely means good medical care, consideration of our patients' persona, and following certain basic rules and procedures in our medical practice similar to what we do in daily living. Professional liability, a better phrase than medical malpractice because it seems to create less emotional reaction and far less anger, is merely a system by which we are held accountable for our actions as everyone should be. We must learn to accept it. It is an equalizer, some say. That is, others are watching us. We have not been used to this. Doctors did not have others watching, do not like others watching, resent being questioned or challenged by anyone, and in particular, resent the testing that accompanies the discovery process by someone in a different profession outside the academic arena of medical grand rounds.

A former Florida senator friend of mine told me that when she was in the hospital, she could sense the "imperial walk" and aura approaching her room down the hall. There are positive aspects to this point of view. Perhaps that was what is still meant by the art of medicine, the doctor-patient relationship. Patients can benefit from positive influences and total control by the physician over the health care management of that particular illness. This benevolent dictatorship - if that is what it is - has historically done a great deal of good and accomplished much. There are also dictators who are feared but against whom there is revolution when the fuse is lit. The fuse is what is known as the "triggering process," that which begins investigation into the medical care of an unhappy patient with a bad result. It rarely is the bad result, the injury, the second operation, or the failed procedure, which brings the patient to a lawyer. It is something, which happened between the doctor and his patient, between his representative and the family, or perhaps best put, due to absence of "art" in the way he dealt with the emotional moments that needed him the most.

With that in mind, we then look at the concept of accountability for all people and may well be able to say that those who seem to care less end up paying more for improper actions. The system is not only intended to compensate for losses, but also to deter negligence and to improve substandard practices. The system asks for compensation, but is always directed at those other parts, which are only discussed obliquely in the courtroom. Perhaps the practicing physician does not have the opportunity to short-cut.
compensation for losses, but he certainly has the opportunity to deter negligence and to elevate substandard practices to higher levels. This should be the intent of quality assurance departments, risk management, continued medical education, and improved teaching practices at all levels of medical education. Physician controlled, health care provider managed, hospital initiated quality assurance efforts have not worked well enough, are not pervasive throughout our country, and do not change in response to others’ faults and failures. This concept is totally under doctor control and if properly managed could without more, cut malpractice losses by fifty percent. Until we take control of teaching each other and recognizing inferior quality and lose the fear of showing the way to our peers, the deterrence of negligence and the elevation of substandard practices through medical malpractice litigation will continue. Some feel it must continue for the benefit of patients, since so-called self-policing has failed. Look around your own community to determine which physicians have been chastised, had their licenses revoked, or have been taken under an education wing to improve their techniques and practices. For the most part, regulating boards and peers find it easier to go after doctors who abuse drugs, rape patients, act otherwise feloniously, or earn too much money through excess surgical procedures. Is it not interesting that the overwhelming majority of chastised physicians – chastised by their peers – are from the various minorities who practice among us and that “Mr. Clean” is rarely among them? Is it because he is clean, or is it because he belongs to the right organizations? Human nature causes these errors. If we teach standards to control damage, if we emphasize accepted methods throughout the community to which all must subscribe, and if malpractice cases, litigation, claims, complaints, and adverse reactions become part of the teaching process rather than the enemy, the situation will change.

Our system must provide behavior modification processes for physicians instead of defensive behavior. The defensive posture is aggressive, angry, destructive and creates anxiety; but it can create a good framework for education. Positive behavior modification means deriving something good from every adverse reaction, preventing a harm because of every previous malpractice case, improving the quality of care because of every previous adverse reaction, preventing recurrences, and using patient complaints as teaching guides rather than calling such patients noncompliant. Even the clinical pathologic conferences, which might still exist in some institutions, do not focus adequately and selectively on the professional performance of the doctors as much as on the poor outcomes and complications. The key questions, which must always be asked, are: Was the event foreseeable (even remotely)? What could have been done to prevent it? Were there signs and symptoms as the adverse reaction was developing? Was more attention paid to the minor, albeit more common causes of such signs and symptoms? What if the procedure that initiated the
bad result had never been done?

The cost of doing business includes medical malpractice insurance premiums, and all doctors know all their costs well. In my interviews with dozens of physicians and in my conversations with hundreds of doctors on these subjects, they never include the emotional stress, the fear, the anxiety, the anger, and its spin-offs as the costs of doing business. These are greater costs. They can be controlled by the physician himself and are not in the hands of the economic spiral in which we find ourselves. This pervasive problem began when medical malpractice became a major topic of conversation in 1975. Since then we have been following false prophets. We have challenged, fought with, resented, and developed an adverse relationship with those on whom we depend most of all, our patients. Elders of generations gone by used to teach us that if we take care of our business properly, it will take care of us. It is impossible to properly take care of your patients if you consider them your enemies or if you fear them. Patient are not your enemies; they are, and will remain your best friend, the finest juror you can find, and the person who wishes to sue you the least. Believe it. Consider medical malpractice litigation for what it really is, something other and more than you perceive it. It is a mechanism with which patients catch your attention, ask you to change your ways, and let you know of their dissatisfaction.

I say you in the generic sense. We must learn and profit from everything that happens to our colleagues. Don’t think of medical malpractice litigation as a lawsuit that occurs every time something goes wrong. You know that is not true and can prove it to yourself by merely looking at all the adverse reactions you have had in your career which have resulted in satisfied patients, that is, at least satisfied with your approach to the problem. You may be angry, and you may point a finger at the system and at plaintiffs’ attorneys to no avail. Physicians have tried since 1975 to change this, but we have now wasted 20 years aimlessly acting out and pursuing legislation adverse to our patients’ interests. Remember that the only one who counts is the patient. Behavior modification, changing our thought processes, and looking at the problem objectively while searching for palliation, if not a cure, requires that we protect the patient, take care of the patient, keep the patient our friend, while remembering that if we properly take care of our business it will take care of us. Knowledge is power. With power we get control. With control we can elevate habits and practices to safer medicine and reinstitute the art of medicine by eliminating some of the triggers that result from a breakdown in the relationship when the strongest sense of caring is needed.

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Dr Rein writes and actively teaches medical malpractice to health care providers and is “of course” to several dozen law firms. His publications include The Primer on Soft Tissue Injuries, The Horizonal Review of Medical Records, and his Medical Malpractice Thoughtbook. Dr Rein developed the SLS Postgraduate Course “Annual Law School for Doctors,” now entering its third year. The program teaches doctors how to regain and maintain control, save time and money, prevents and relieves anxiety by recognizing, preventing, and mitigating harm and knowing what to do when it happens. From experiences with over 12,000 cases, his trial techniques have become standards.
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The Society of Laparoendoscopic Surgeons presents
11th International Congress and Endo Expo 2002
SLS ANNUAL MEETING
New Orleans Marriott
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SEPTEMBER 11-14, 2002

The Only Conference Offering a Multi-Specialty Approach for Gynecologists, General Surgeons, Urologists and other specialists who practice minimally invasive techniques. Plan now to attend.
PROGRAM AT-A-GLANCE

Tuesday, September 10, 2002
3:00 pm - 6:00 pm  Postgraduate Course Registration

Wednesday, September 11, 2002 • Pre Congress Postgraduate Courses
7:00 am - 9:00 am  Postgraduate Course Registration and Continental Breakfast
9:00 am - 4:30 pm  **CONCURRENT POSTGRADUATE COURSES**
  PG #1  Prevention and Management of Laparoscopic and Endoscopic Surgical Complications
  PG #2  ACS Program on Coding, Compliance and Reimbursement (Presented by American College of Surgeons)
  PG #3  Hysteroscopy and Hysteroscopic Surgery: Current Status
  PG #4  Part A: Diagnosis and Treatment of GERD: Surgical Approaches  
         Part B: Laparoscopic Cholecystectomy and Common Bile Duct Management: The 21st Century
  PG #5  General Surgery Problems for the Minimally Invasive Surgeon
  PG #6  Advanced Laparoscopic Management of Myomas, Endometriosis and Pelvic Floor Disorders, including Hysterectomy and Conservative Repairs
  PG #7  Masters Class in Laparoscopic General Surgery
  PG #8  The SLS 3rd Annual Law School for Doctors: An Advanced Medical Law Course For Doctors
12:00 pm  CONGRESS REGISTRATION OPENS
5:00 pm - 6:30 pm  Opening Ceremony: Entertainment, Chairman’s Welcome, Presidential Address, and Honorary Chair Presentations
6:30 pm - 8:30 pm  Welcome Reception at the New Orleans Marriott

Thursday, September 12, 2002 • Day 1 of International Congress and Endo Expo
7:00 am  Congress Registration/Continental Breakfast in Exhibit Hall
7:30 am - 8:30 am  **GENERAL SESSION: Laparoscopy Updates**  Key Laparoscopy Updates presented by SLS Special Interest Group Committees highlighting the newest developments and future expectations of surgical and diagnostic procedures.
8:30 am - 10:00 am  **PLENARY JOINT SESSION: Gynecology, General Surgery, Urology**
10:30 am - 12:30 pm  **GYNECOLOGY SESSION: Laparoscopy for Benign and Malignant Ovarian Pathology**
10:30 am - 12:30 pm  **GENERAL SURGERY SESSION: Bariatric Surgery-Band vs. Staples**
10:30 am - 12:30 pm  **UROLOGY SESSION: Challenges in Laparoscopic Urology**
1:00 pm - 1:30 pm  Poster Presentations
1:45 pm - 5:00 pm  **CONCURRENT SESSIONS:** Over 200 Scientific Papers, Open Forum Presentations, and Videos will be presented
6:30 pm - 10:00 pm  Gala Dinner with Faculty/Musee Conti Wax Museum [Open to all Congress attendees; see Registration Form]

Friday, September 13, 2002 • Day 2 of International Congress and Endo Expo
7:00 am  Congress Registration/Continental Breakfast in Exhibit Hall
7:30 am - 8:30 am  Presentation of Award Winning Scientific Papers and Videos
8:30 am - 11:30 am  **LIVE TELESURGERY:** Robotic Surgery from University of Illinois at Chicago
11:30 am - 12:30 pm  Lunch Break and Visit Exhibits New Product Presentations and SLS Innovations of the Year will be featured.
12:30 pm - 12:45 pm  Presentation of Best Poster and Resident Award Winning Paper  
                    Featured will be the winner of the $1,000 Resident Award for Best Paper
12:45 pm - 1:45 pm  **EXCEL AWARD LECTURES AND PRESENTATIONS**  Recipients: Liselotte Metter, Prof. Dr. Med. and Philippe Mouret, MD
1:45 pm - 5:00 pm  **CONCURRENT SESSIONS:** Over 200 Scientific Papers, Open Forum Presentations, and Videos will be presented

Saturday, September 14, 2002 • Day 3 of International Congress
7:30 am - 8:15 am  **Guest/Spouse Breakfast** with Keynote Speaker Polly Pook, PhD.  
                    Guests are invited to attend at a nominal charge and are welcome to remain for the morning’s sessions. [see Registration Form]
8:00 am - 8:55 am  Future of Robotics
8:55 am - 10:30 am  **FUTURE TECHNOLOGY SESSION:** Next Generation Robots – What Surgeons Can Expect
10:30 am - 10:45 am  **CLOSING CEREMONY**  Passing the Presidential Gavel
10:45 am  11th International Congress is adjourned
10:45 am - 11:15 am  **SLS Business Meeting**  – Members are encouraged to attend

Faculty, Program, and Topics subject to change. All postgraduate courses and congress events are held in the New Orleans Marriott unless otherwise noted.
PRE-CONFERENCE POSTGRADUATE COURSES

Wednesday, September 11, 2002 • 9:00am – 4:30pm

POSTGRADUATE #1
Prevention and Management of Laparoscopic and Endoscopic Surgical Complications

Designed to provide information about the latest techniques in prevention and management of complications during minimally invasive surgical procedures. After attending this course, participants will be better able to: 1) identify and help to avoid complications in laparoscopic and endoscopic surgeries; 2) discuss indications and contraindications for laparoscopic and endoscopic surgery; 3) identify and discuss specific conditions which affect the appropriateness of patient selection; 4) describe and explain when to convert to the procedures’ open technique counterpart; 5) react to complications that may arise with alternative methods; and 6) become familiar with the latest literature on the laparoscopic techniques presented for examination and discussion.

Course Director: Carl J. Levinson, MD
Co-Director: Raymond J. Larazame, MD, MBA
Faculty: Michael S. Kavic, MD; Ceesa Nezhat, MD; Joseph Petelin, MD; Carlos A. Suarez, MD; Arnaud Wattiez, MD

POSTGRADUATE #2
Presented by the American College of Surgeons: ACS Program on Coding, Compliance and Reimbursement*

The course will provide the latest information on essential coding and formatting principles for reporting surgical procedural services, such as the CPT and Medicare “global surgical package” rules, surgical modifiers, “unlisted” procedures, and operative report dictation. Participants will also receive instruction in CPT rules for Evaluation Management Levels of Service and the HCFA “Documentation Guidelines.” Additionally, you will see how to develop a compliance program, how to self-audit patient charts understanding the types of reviews insurance carriers mean and how to handle them.

Upon completion of the course participants will better 1) understand the methodology for coding surgical procedures, 2) be able to deal with complexity and confusion inherent in the coding process and avoid coding errors, 3) code surgical procedures and services accurately to receive fair reimbursement, 4) understand and be able to avoid causes for audits which may result in fines, 5) be able to create compliance plans to fit individual practice settings, 6) create policy for dealing with an on-site audit, 7) understand the Medicare Global Surgical Package rules, surgical modifiers, “unlisted procedures,” and operative report dictation and, 8) know the CPT rules for Evaluation/Management Level of Service. This course will also be available to Office Administrators.

Course Director: Carlos A. Suarez, MD Faculty: Mary Le Grand
*CME credit is awarded by the American College of Surgeons.

POSTGRADUATE #3
Hysteroscopy and Hysteroscopic Surgery: Current Status

This course has been designed to review the basic and advanced applications of hysteroscopy and hysteroscopic surgery and will bring the gynecologist up-to-date in the use of hysteroscopy in clinical practice. The diagnostic aspects of hysteroscopy as well as the therapeutic applications will be reviewed, with interaction among faculty members and participants encouraged in order to enhance the didactic value of the lectures and derive meaningful clinical pearls. The objectives of this course are: 1) practitioners will be able to put into perspective the diagnostic role of hysteroscopy in the evaluation of abnormal uterine bleeding and uterine abnormalities; 2) understand the role of hysteroscopy and ultrasonography in the evaluation of the uterus, particularly from a practical office setting approach; 3) review the hysteroscopic operative approaches to uterine diseases; 4) understand the possibility of complications, their prevention and management; 5) know the appropriate methods of endometrial ablation for abnormal uterine bleeding and their realistic expectations; 6) understand the best hysteroscopic approach for the treatment of submucous myomas, intrauterine adhesions, and symptomatic uterine anomalies (septa).

Course Director: Ray Valle, MD
Co-Director: Franklin Loffer, MD
Faculty: Richard J. Gimpelson, MD; Jacques Harrou, MD

POSTGRADUATE #4
Part A: Diagnosis and Treatment of GERD: Surgical Approaches Part B: Laparoscopic Cholecystectomy and Common Bile Duct Management: The 21st Century

Participants will increase their knowledge of various aspects of gastroesophageal reflux disease, including GERD preoperative assessment, indications and techniques, complications and special situations, and alternate techniques in laparoscopic cholecystectomy. Additionally, faculty will speak on the role of ERCP, and sphincterotomy stents. There will be a section on ultrasound vs. cholangiogram. Panel discussions throughout the day will provide a platform for interactive discussion.

Course Director: Michael E. Fenoglio, MD
Co-Director: Alan P. White, MD
Faculty: W. Peter Geis, MD; William E. Kelley, Jr., MD; Jeffrey Ponsky, MD

POSTGRADUATE #5
General Surgery Problems for the Minimally Invasive Surgeon

Designed for general surgeons to bring them up-to-date on selected topics, but may be of interest to other specialists who practice minimally invasive surgery within the abdomen and have an interest in minimally invasive breast surgery. Participants will increase their knowledge of: 1) laparoscopic splenectomy and adrenalectomy; 2) the use of laparoscopy in staging for abdominal malignancies; 3) laparoscopic colorectal surgery; and 4) laparoscopic anti-obesity surgery. There will be a discussion of fully endoscopic therapies for GERD, including endoscopic suturing and the Stretta procedure. There will be a section on minimally invasive breast surgery, including minimal access breast biopsy, sentinel lymph node biopsy, and new minimal access approaches.
to breast cancer therapy. The current status and future direction of robotic surgery will also be addressed.

Course Director: William E. Kelley, Jr., MD
Co-Director: W. Peter Geis, MD
Faculty: Michael E. Fenoiglio, MD; Dennis Lee Fowler, MD; Michel Gagner, MD; Philip Schauer, MD

POSTGRADUATE #6

Advanced Laparoscopy Management of Myomas, Endometriosis and Pelvic Floor Disorder, Including Hysterectomy and Conservative Repairs

This course is designed for the gynecologic and other endoscopic surgeons who desire to expand his/her knowledge and surgical skills in diagnosis and endoscopic management of the most common gynecological and pelvic disorders. Faculty will present methods of laparoscopic evaluation of chronic pelvic pain, diagnosis of typical and atypical endometriosis, peritoneal and retroperitoneal, and ovarian endometriosis and endometriomas. Procedures to be discussed include laparoscopic treatment of mild to extensive pelvic endometriosis with the bowel, bladder, ureter and diaphragm involvement, laparoscopic and laparoscopic-assisted myomectomy and myolysis.

Indications, contraindications and different techniques for performing laparoscopic assisted vaginal hysterectomy (LAVH), total and supracervical laparoscopic hysterectomy will be presented. Diagnostic, office and operative hysteroscopy and different techniques for endometrial ablation, uterine septum, leiomyoma and adhesions and complications of hysterectomy will be discussed. At the end of the course, participants will possess up-to-date knowledge of the role of the laparoscope and hysteroscope for the management of pelvic disorders in the year 2002.

Course Director: Camran Nezhat, MD
Co-Director: Dan C. Martin, MD
Faculty: Jacques Hamou, MD; Franklin Loffer, MD; Liselotte Mettler, Prof Dr Med; Ceana Nezhat, MD; David B. Redwine, MD; Arnaud Wattez, MD

POSTGRADUATE #7

Masters Class in Laparoscopic General Surgery

This course is designed for general surgeons, gynecologists and urologists who wish to expand their knowledge in, and understanding of, abdominal and pelvic anatomy, fascial defects and associated hernias.

Presentations will examine the anatomy of the anterior abdominal wall, myopectineal orifice, infra and retroperitoneal regions, upper and lower abdomen, female and male pelvic floor anatomy, obturator, sciatic and perineal hernia sites. Imaging studies of the normal and abnormal abdominal and pelvic cavities will be presented. The emphasis will be on how to avoid vascular and nerve injury during laparoscopic surgery and how to diagnose and repair various fascial defects. Laparoscopic pelvic and para-aortic lymphadenectomy will be presented as a model for retroperitoneal operative procedures. Repair of incisional, lumbar, inguinal-myopectineal orifice, obturator, sports and sciatic hernias will be discussed. Information regarding laparoscopic vaginal vault suspension, anal incontinence repair, enterocoele, high rectocoele, para-vaginal repair, and urinary incontinence will also be presented. The avoidance of complications during these procedures will be stressed throughout the program.

At the conclusion of the course participants will be able to describe the anatomy of the abdominal and pelvic areas. Participants will also have increased knowledge in laparoscopic surgical intervention of abdominal and pelvic hernias, lymphadenectomy, urinary bladder suspension, and management of conditions associated with vaginal prolapse. Participants will have information to aid in the intervention of complications.

Course Director: Michael S. Kavic, MD
Co-Director: William E. Kelley, Jr., MD
Faculty: Dennis Fowler, MD; Michel Gagner, MD; Jeffrey Ponsky, MD; Philip R. Schauer, MD

POSTGRADUATE #8

The SLS 3rd Annual Law School for Doctors: An Advanced Medical Law Course for Doctors

This postgraduate course will be an entertaining and educational experience for all the participants. It will take you through an abbreviated law school curriculum with emphasis on "you as a doctor" in a legal scenario. You will become familiar with expert witnessing, deposition preparation and testimony, and the background secrets of medical trials, while emphasizing your rights and obligations as expert physician witnesses and even possible defendants. Every registrant will participate in the ever-popular mock trial, this year to be longer and more intense than ever. Be prepared to come away thinking "outside of the box." We will show you how the law is designed and how it should be used to assist your practice, your money management, relationships with patients, prepaid health insurers, and even how to safeguard your wealth. For those who need a refresher about the democratic process, we will answer the question "What is this Constitution all about?" Medical malpractice, trials and risk prevention, contracts, partnerships, professional corporations, agency, insurance, and estate planning will be discussed.

This course is designed to improve the quality and enhancement of the physician's life, raising the joy of professional work, and decreasing stress management. After attending, participants will be able to: 1) know how to choose an attorney and investment counselor; 2) understand the law as it applies to its use within their practice; and 3) understand and solve practical problems and individual situations relating to patients, suppliers, employees and their practice. This course is taught by Dr. Harry Rein, the only doctor-lawyer-judge in the US.

Course Director: Harry Rein, JD, MD

Take Advantage. Register early for this Advanced Medical Law postgraduate course and be able to meet with Dr. Rein for a free consultation by making an appointment to meet him privately at the SLS meeting site.
SCIENTIFIC ABSTRACT PRESENTATIONS

SCIENTIFIC PAPERS

Comparison of Stapled Hemorrhoidectomy Versus Conventional Hemorrhoidectomy P. N. Agarwal, MD
Laparoscopic Specialized Endoscopy of Endometriosis Larry Demco, MD
Esophageal Carcinoma Following Bariatric Procedures Jeff Allen, MD
Telerobotic Laparoscopic Donor Nephrectomy: Case Series Juan Arenas, MD
GI Lymphatic Mapping: A Guide for Laparoscopic Sentinel Node Biopsy Michael Boyle, MD
Extrapleural Laparoscopic Radical Prostatectomy: The Future is Here James Brown, MD
Intra-Abdominal Adhesions After Laparoscopic Cholecystectomy Miguel Caiozzo, MD
Laparoscopic Jejunostomy Tube Placement: Reevaluation and Continued Evolution of Operative Technique Brian Cantor, MD
Force-sensing Laparoscopic Tool for Robotically Assisted Minimally Invasive Surgery Andres Castellanos, MD
Laparoscopic Uterine Ligation Leroy Charles, MD
Ingual Hernia Repair: A Novel Surface-Endoscopic Approach Saurabh Chawla, MD
Ramicotomy (Selective Division of T3 Rami Communicantes): The More Physiologic Surgical Method for Palmar Hyperhidrosis Hyun-min Cho, MD
Comparison of Pubovaginal Sling and TVT in the Treatment of Genuine Stress Incontinence in Obese Women Maurice Chung, MD
The Evil Twin in the Chronic Pelvic Pain Syndrome Maurice Chung, MD
Hand-Assisted Laparoscopic Donor Nephrectomy: Fad or Future for Transplantation? Douglas Constant, MD
Laparoscopic Ventral Hernia Repair: A Prospective Evaluation of 49 Initial Cases Jan Dahlenback, MD
Adhesions Prevention By Hyaluronic Acid Gel Nicola Di Lorenzo, MD
Laparoscopic Colon Resection for Early Stage Colon Carcinoma Titus Duncan, MD
Laparoscopic Total Extraperitoneal Hernia Repair Using Non-Fixation Technique Titus Duncan, MD
Spleenic Infarction Following Laparoscopic Nissen Fundoplication: Management Strategies Kurt Edwards, MD
Laparoscopic Ileocystoplasty Faheem El Bassioni, MD
Laparoscopic Appendectomy: Gynecologist or General Surgeon? Mark Elfan, MD
Cost Effective Method to Laparoscopically Retrieve Specimens in Gynecological Operations Mark Elfan, MD
Three Approaches to Laparoscopic Left Adrenalectomy John Fessendon, MD
Laparoscopic Cholecystectomy and ERCP Fausto Fiocca, MD
Laparoscopic Resection of Liver Tumors: Results of a European Multicenter Experience Jean-Francois Giot, MD
Reducing Costs with Handsewn Gastrojejunosuturing During Laparoscopic Roux-en-Y Gastric Bypass for Morbid Obesity Rodrigo Gonzalez, MD
Laparoscopic Versus Open Umbilical Hernia Repair Rodrigo Gonzalez, MD
Impact of Laparoscopic Nissen Versus Toupet Fundoplication on Patient's Quality of Life Frank A. Granderath, MD
Combining Myoma Coagulation with Endometrial Ablation: Resection Reduces Subsequent Surgery Rates Herbert Goldfarb, MD
Role of Hysteroscopy in Recurrent Pregnancy Loss Sonia Kamboj, MD
Laparoscopic Refundoplication with Prosthetic Hiatal Closure for Recurrent Hiatal Hernia After Primary Failed Antireflux Surgery Frank A. Granderath, MD
Cholecysto-duodenal fistula Neeraj Gupta, MD
Problems and Complications in Laparoscopic Donor Nephrectomy Neeraj Gupta, MD
Is Conversion Independent of Identifiable Risk Factors? Ahmed Hamed, MD
Treatment of the Postoperative Anal Pain With Pudendal Nerve Block in Proctologic Surgery Marcos Hurvitz, MD
Laparoscopic Appendectomy: Our Experience and Indications Marcos Hurvitz, MD
Routine Vs. Selective Intraoperative Cholangiography During Laparoscopic Cholecystectomy: A Survey of 2130 Patients Undergoing Laparoscopic Cholecystectomy Heshmatollah Kalbasi, MD
Results of Laparoscopic Cholecystectomy: Acute Cholecystitis vs. Cholelithiasis Heshmatollah Kalbasi, MD
The Failures, Mistakes and Complications of Laparoscopic Cholecystectomy Valeri Khrachikov, MD
Laparoscopic Appendectomies Versus Open Appendectomies: Comparison in Pediatric and Adult Populations Alexander Kim, MD
Laparoscopic Heller Myotomy for Megaesophagus Due to Achalasia James Koren, MD
Indication, Results and Follow up of 400 Toupet-Antireflux Procedures in the Therapy of GERD Ernst Kraas, MD
Bilateral Inguinal Hernia Repair: Comparative Study on External Preperitoneal, Endoscopic Totally Extraperitoneal (T.E.P.) and Laparoscopic (T.A.P.P.) Enric Laporte, MD
Laparoscopic Colorectal Surgery in the Elderly: Safety in a Daily Practice Joel Leroy, MD
Laparoscopic Burch Colposuspension for the Treatment of Stress Urinary Incontinence Zhiging Liang, MD
Four Years Experience and Surgical Outcome Following Corrective Prolapso Surgery in the Treatment of Hemorrhoids Marco Lombardi, MD
Results of Laparoscopic Adrenalectomy for Adrenal Tumors and Comparison with Open Adrenalectomy Franco Lumachi, MD
Evaluation of Specialized Suturing and Tying Device Atul Madan, MD
Laparoscopic Colectomy for Benign and Malignant Disease: A Review of 176 Cases Atul Madan, MD
Primary Vascular Dissection for Laparoscopic Adrenalectomy: A Standardized Surgical Technique Jacques Marescaux, MD
Remote Surgery: The First Transatlantic Operation Between New York and Strasbourg Jacques Marescaux, MD
Robot-Assisted Remote Telesurgery Jacques Marescaux, MD
Comparison of Wound Healing and Device Efficacy: Stapler Versus New Needle-Free Suturing Device in a Canine Model of Bowel Anastomosis Stephen McCollan, MD
Antecolic/Antegastric Approach to the Roux-en-Y Gastric Bypass Vishal Mehta, MD
Outcome of Laparoscopic Fundoplication for GERD: Eight Years Experience, A Review of 436 Cases Magid Michel, MD
The Incidence of Port-Site Metastases in Gynecological Malignancies Nirmesh Nagarsheth, MD
Factors That Predict Conversion in Patients Undergoing Laparoscopic Surgery for Crohn's Disease Krishna Moorthy, MD
Performance and Error Analysis Under Multiple Stress Inducing Conditions Krishna Moorthy, MD
Laparoscopic Excision of Giant Renal Cyst as Primary and Prophylactic Treatment Joseph Moran, MD
Operative Modifications of Classic Infravesical Supracervical Hysterectomy (MISI) for Improved Cost Effectiveness John E. Morrison, MD
The Advantages of 3D Visualization in Surgical Performance with the Da Vinci Telemanipulation Robotic System Yaron Munz, MD
Evaluation of a New Technique in 3-Dimensional Virtual Cholangiography Didier Mutter, MD
A New Device for Sentinel Node Detection in Laparoscopic Colon Surgery Didier Mutter, MD

Single Surgeon’s Experience and Results with Laparoscopic Ventral Hernia Repair David Naar, MD

The Treatment of Malignant Effusions Using VATS Parietal Pleurectomy and Talc Pleurodesis Marc Neff, MD

Application of Doppler Technology as an Aid in the Identification of Vascular Structures During Laparoscopy Marc Neff, MD

Right Colectomy for Cancer: Validity of Laparoscopic Approach Vincenzo Neri, MD

841 Thoracoscopic Sympathectomies in Vienna: Indications, Results, and New Techniques Christoph Neumayer, MD

Laparoscopic Gastric Bypass is Safe for Older Patients David Olaik, MD

Humidified Carbon Dioxide Preserves Peritoneal Integrity and Sustained Peritoneal Cell Viability Douglas Ott, MD

Extent of Peritoneal Damage Using Dry Gas During Laparoscopy Douglas Ott, MD

Bilateral Laparoscopic Radical Nephrectomy for Tumors in Acquired Cystic Disease of the Kidney Robert Pedraza, Jr., MD

Laparoscopic Roux-en-Y Gastric Bypass for Recalcitrant Gastroesophageal Reflux Disease Yaron Perry, MD

Laparoscopic Management of Acute Gallstone Pancreatitis Toma Pajarlev, MD

An In Vivo Study of Vessel Burst Strength Using the Gyrus Plasma Kinetic’s Tissue Management System Charles Ranaboldo, MD

Laparoscopic Hand Assisted Donor Nephrectomy Sahyasarathi Saharsh, MD

Seven Year Experience of Using Videendoscopic Techniques in the Treatment of Chronic Venous Insufficiency Alexander Schulzko, MD

Retroperitoneoscopy in Lumbar Sympathectomy for Buerger’s Disease Lakhvinder Singh, MD

Comparison Between Laparoscopy and Minilaparotomy in the Surgical Treatment of Early Endometrial Cancer Ornella Sizi, MD

Hand Assisted Laparoscopic Donor Nephrectomy: A Single Center’s Early Experience C. Daniel Smith, MD

Superior Heminephrectomy and Ureterectomy by Retroperitoneoscopy in Children Henri Steyaert, MD

Minimally Invasive Management of Urinary Tract Stones in Children Henri Steyaert, MD

Deep Infiltrating Endometriosis: Retroperitoneal Approach Alphonzo Rossetti, MD

Laparoscopic Lysis of Adhesions in Children Gustavo Stringel, MD

Retroperitoneal Laparoscopic Pyelolithotomy for the Management of Renal Calculi Manav Suryavanshi, MD

Re-Operative Surgery for Gallstones Suresh Ugale, MD

Laparoscopic Resection of Prostatic Utricle: A Novel Approach Richard Vangtangendorck, MD

Laparoscopic Splenectomy Reduces the Need of Platelet Transfusion in Patients Operated on for Idiopathic Thrombocytopenic Purpura Rosario Vecchio, MD

Clipless Cholecystectomy: Broadening the Role of the Harmonic Scalpel James Westervelt, MD

Laparoscopic Colecctiony for Cancer is Still Controversial Shigeki Yamaguchi, MD

Impalpable Testis and Laparoscopy: When the Gonad is Not Visualized Antonio Zaccara, MD

PREVENTION OF URETERAL INJURY IN DIFFICULT LAPAROSCOPIC DISSECTION VIA INFRARED URETERAL STENTS Erik Dutton, MD

Endoscopic-Transhepatic Treatment of Traumatic Transection of Biliary Ducts Fausto Fiocca, MD

Pelvic Varicocele: Laparoscopic High Ligature Tigello Gargiulo, MD

Sentinel Lymph Node Laparoscopic Assessment in Endometrial Cancer at Early Stage Tigello Gargiulo, MD

Laparoscopic and Thoracoscopic Simultaneous Resection of Synchronous Rectal and Lung Cancer Orlando Goletti, MD

Complete Intracorporeal Repair of a Diaphragmatic Injury Paulette Holley, MD

Laparoscopic Treatment of Choledocho-duodenal Fistula and Choledocho-choledocholithiasis Sebastiano Lactiguillio, MD

Laparoscopic Resection of the Duodenal-Jejunal Junction for Benign Tumors Francesco Rubino, MD

Laparoscopic Boari Flap Gilberto Ruiz-Deya, MD

Laparoscopic Resection of Hepatic Hemangioma Douglas Staley, MD

Laparoscopic Transhiatal Esophagogastrectomy Daniel Vanuno, MD

Needleless Peritoneal Dialysis Catheter Placement Daniel Vanuno, MD

Thoracoscopic Pericardial Cyst Excision Daniel Vanuno, MD

Laparoscopic Gastric Mobilization and Transhiatal Esophageal Dissection for Cervical Gastric Pull-Through Rodolfo Vincenti, MD

Laparoscopic Treatment of Benign Gastric Tumors Rodolfo Vincenti, MD

Laparoscopic Staging in a Patient with Fallopian Tube Carcinoma Nilesh Nagarseth, MD

OPEN FORUMS

Relaparoscopic Operations in Treatment of Complications After Conventional and Laparoscopic Procedures S.A. Afendulov, MD

Laparoscopic Operations for Abdominal Trauma S.A. Afendulov, MD

Individual Treatment of Ulcerative Disease After Laparoscopic Repair of Perforated Duodenal Ulcer S.A. Afendulov, MD

Management of Choledochocholithiasis in the Modern Era of Laparoscopy: Our Experience in India P. N. Agarwal, MD

The Role of Mesh in the Prevention of Recurrence After Laparoscopic Operations in Large, Parsaephegal Hernias Miroslav Bevkavac-Beslin, MD

Minimally Invasive Treatment of a Ureteral-Iliac Artery Fistula: Short and Long Term Results Andrew Brown, MD

Use of Fibrin Glue Sealant During Laparoscopic Radical Prostatectomy James Brown, MD

Laparoscopic Procedures and Peritoneal Catheters Zoran Cala, MD

Injection Therapy with Sodium Hyaluronate in Upper Gastrointestinal Bleeding Gianpaolo Cengia, MD

4-D Imaging: A Novelty in Surgical Oncology Robrecht Cuvelmans, MD

Video-Assisted Thoracoscopic Wedge Closure of the Blebs to Treat the Primary Spontaneous Pneumothorax Yu-Jen Cheng, MD

Liver Gastrinoma Treated with Laparoscopic Radiofrequency Ablation Zoe Doel, MD

Laparoscopy: The Preferred Approach to the Complicated Ventral Hernia Zoe Doel, MD

Laparoscopic Nonanatomical Partial Hepatic Lobe Resection: A Safe Alternative Bruce Dunne, MD

Evolution of Video-Assisted Thoracoscopic Surgery in a Community Hospital Venkata S. Erella, MD

Results of Standardized Laparoscopic Ventral Hernia Repair: A Nine Year Study Norman Estes, MD

Lifting of the Colon Using a Thread in Laparoscopic-assisted Colectomies for Colon and Rectal Cancer Shoji Fujii, MD

The Visible Patient Alain Garcia, MD

VIDEOS

Treatment of Peritoneal Implants of Endometriosis Using the Argon Plasma Coagulator Larry Demco, MD

Laparoscopic Surgery for Sphincter-Preserving Therapy in Rectal Carcinoma Ivo Baca, MD

Telerobotic Laparoscopic Stoppa Repair of an Incisional Ventral Hernia with Dual Sided Mesh Garth Ballantyne, MD

LAPAROSCOPY AND SLS REPORT
Intra-Thoracic Stomach and Colon Migration Following Minimal-Dissection Fundoplication Alain Garcia, MD
Laparoscopic Abdominoperineal Resection with Total Ano-Rectal Reconstruction For a Very Low Rectal Cancer Orlando Goletti, MD
Laparoscopic Treatment of Blunt Abdominal Trauma: Is There a Role for Laparoscopic Sonography? Orlando Goletti, MD
Quality of Life After Laparoscopic Antireflux Surgery Frank A. Grandercrath, MD
Evaluation of Fundus First Cholecystectomy Amit Gupta, MD
Complication of Laparoscopic Cholecystectomy CBD Fistulas and Biliary Peritonitis: Successful Management of 10 Cases Amit Gupta, MD
Selective Cholangiography in Laparoscopic Cholecystectomy Maria Haddad, MD
Use of Hydroxyapatite Integrated with Periosteal Flap of the Rib as an Alternative for Vascularized Bone Graft Akiteru Hayashi, MD
Automatic Detection of Polyps and Virtual Colonoscopy: A New Approach From MRI Margaret Henri, MD
Development of a New, Thinner, and Flexible Type of Hysteroscope Volker Jacobs, MD
Incidence and Management of Hernias Associated with Ventricular Assist Devices Used as a Bridge to Orthotopic Heart Transplantation Justin Hurie, MD
Evaluation of Pancreatic Allograft Dysfunction by Laparoscopic Biopsy Lisa Kayler, MD
The Aspects of the Introduction of Laparoscopic Surgery in Russia: Its Problems and Perspectives Arazat Kazayyan, MD
The Role of Laparoscopy in the Localization and Management of Undescended Testes Vinod Malik, MD
Periportal Oxidative Stress during Surgery: A Comparison between Laparoscopy and Laparotomy Rogers Michael, MD
Laparoscopic Splenectomy: Experience in 10 Cases Carlos Moran, MD
The Impact of Laparoscopic Training in a Colon and Rectal Surgery Fellowship Program Shekar Narayan, MD
The Laparoscopic Approach to Abdominal Hydatid Cysts Fatin R. Polat, MD
Primary Trocar Insertion and Adjunctive Ultrasound Utilization for Difficult Cases Gerard Pregerzen, MD
Technique of Introducing Various Materials Through a 5-mm Trocar Into the Intra-Abdominal Cavity Gerard Pregerzen, MD
Cosmetic Placement of Laparoscopic Trocars Gerard Pregerzen, MD
Renal Laparoscopic Surgery in High Risk Surgical Candidates Gilberto Ruiz-Deya, MD
Intracorporeal Laparoscopic Colovesical Fistula Resection Albert A. Samadi, MD
Age-generation of the Gallbladder: Can Laparoscopy/ Laparotomy Be Avoided? Alexander Schoenclair, MD
Critical Review of Our Six Year Experience Performing the Schwartz-Pregenzer Ureteropyelostomy for Stress Urinary Incontinence Marlan Schwartz, MD
A New Method of Preventing Endoscope Fogging Michael Seitzinger, MD
Retropitonealoscopic Surgery as a Viable Alternative to Open Surgery Lakhivinder Singh, MD
The Role of Laparoscopy in the Management of Retropitoneal Tumors in Children Gustavo Stringel, MD
Update on Fertiloscopy in the Diagnosis of Pelvic Malignancy Radha Syed, MD
Culdoaparoscopic Assisted Vaginal Hysterectomy: A True Minilaparoscopy Procedure Daniel Tsin, MD
Laparoscopic Hartmann's Reversal Operation: Is It Still a Challenging Procedure? Paolo Ubaldi, MD
Agenesis of Gall Bladder Surendra Ugle, MD
A Cholecystitis Case in 11 Year Old Girl Following Laparoscopic Cholecystectomy Mustafa Unalniser, MD
Use of 2-mm-Bipolar Coagulator for Division of Cystic Artery During Mini-Laparoscopic Cholecystectomy Ben-Long Yu, MD
LVAH of the Large Uterus Utilizing a Two Trocar Technique Marlan Schwartz, MD

POSTERS

A Complication of Laparoscopic: Broken Trocar During Laparoscopic Bypass Oscar Brasecosa, MD
Incarceral Rectal Prolapse Treated by Laparoscopic Assistance Pere Bretinha-Boix, MD
The Prognosis of Rectoscopic Myometomy of Submucosal Myomas Sung-Tack Oh, MD
Use of Monitoring Worksheets “Scorecards”: Decreasing Operating Room Inefficiencies in Advanced Laparoscopic Minimally Invasive Surgery Jacqueline Carey, RN
Incidence of Adenomatous Polyps in Patients After Colonoscopic Diagnosis of Hyperplastic Polyps Kurt Davis, MD
Laparoscopic Diagnosis and Treatment of Mucinous Cystoma: Case Report and Literature Review Nick Dobrlic, MD
Teaching Gynecological Laparoscopic Procedures Ada Husulak, MD
Antireflux Surgery in Germany-Techniques and Results Thomas P. Hutt, MD
Laparoscopic Surgery for Diaphragmatic Disease Thomas P. Hutt, MD
Virtual Gastroscopy Using Spiral Computer Tomography Giovanni Illomei, MD
Computed Tomography Colonography: Initial Experience Giovanni Illomei, MD
Virtual Esophagoscopy Using Spiral Computer Tomography Giovanni Illomei, MD
Video Assisted Neck Surgery by Axillary Approach Fumito Kumanishi, MD
Laparoscopic Herniplasty Accompanied with Mesh Yuzhou Lee, MD
Radioguided Parathyroidectomy in Patients with Primary Hyperparathyroidism Franco Lumachi, MD
A Simple, Less Expensive, But Quite Effective Laparotrainer Yoshio Miura, MD
The Prognosis of Rectoscopic Myometomy of Submucosal Myomas Sung-Tack Oh, MD
Laparoscopic Repair of Colovesceral Fistula Albert A. Samadi, MD
Laparoscopic Colon Resection: Report of First 300 Cases at a Community Hospital Sahir Shroff, MD
Laparoscopically Assisted Endoscopic Resection and Endoscopically Assisted Laparoscopic Resection in the Treatment of Tumors of Stomach and Colon Fritz W. Spieberg, MD
Pseudoneurosis of the Inferior Epigastric Artery Following Laparoscopic Inguinal Hernia Repair Samuel Szomstein, MD
Laparoscopic Operations on Uterine Appendages Obidion Timirov, MD
Laparoscopic Roux-en-Y Gastric Bypass: A Comparison of Mortality and Morbidity Rates Observed with Increased Experience and Modified Surgical Technique Nirman Tulsyan, MD
Intraoperative Autologous Blood Transfusion For Heavy Hemothorcteum Due to Ectopic Pregnancy or Ovarian Bleeding Under Laparoscopic Surgery Takashi Yamada, MD
Culdoaparoscopic in Gynecology and Surgery Daniel A. Tsin, MD
GENERAL INFORMATION

Congress Credit Hours

Accreditation  The Society of Laparoendoscopic Surgeons (SLS) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Designation  SLS designates this educational program, the 11th International Congress, for a maximum of 19.25 hours in Category 1 credit towards the AMA Physician’s Recognition Award. SLS also designates postgraduate course educational activities for a maximum of 6 hours each in Category 1 credit towards the AMA Physician’s Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activities.
(Credit for Postgraduate Course #2 on Coding, Compliance and Reimbursement will be awarded by the American College of Surgeons.)

Congress Educational Methods and Objectives

The 11th International Congress and Endo Expo employs a variety of educational formats including topical general sessions, presentation of scientific papers, open forums, posters and original videos offered in small specialty-specific breakout sessions, and informal gatherings of participants and expert faculty.

The increasing complexity of minimally invasive diagnostics and therapy requires a continuous educational process. The exchange of knowledge and expertise among the physicians taking part in this congress contributes to the continuation of excellence in minimally invasive surgery.

Upon completion of the congress participants will be able to:

• Increase comprehension of the basic and fundamental principles of laparoscopic, endoscopic, and minimally invasive techniques, enhancing the participant’s understanding of these techniques;
• Understand the recent advances in laparoscopic, endoscopic, and minimally invasive techniques;
• Determine the appropriate use of laparoscopic, endoscopic and minimally invasive equipment as part of a treatment plan in the care of patients;
• Comprehend the developing technologies that will be available in the future to enhance the standard of patient care; and
• Acquire educational information within the physicians’ specialty, which will enhance their professional development and patient care.

Accommodations-Official Hotel and Meeting Site

New Orleans Marriott
555 Canal Street, New Orleans, Louisiana 70130
Telephone: (504) 581-1000  Fax: (504) 523-6755

Rates  Single Rooms and Double Rooms $224.00

These rates are European plan (no meals) plus tax. The SLS room block will be released after August 19, 2002 and rooms will be on a space available basis only. Rates are applicable 3 days before and after the conference based on availability. In order to qualify for the special rate, you must make reservations by August 19, 2002 and mention that you are attending the Congress.

For those who require special assistance, please contact the conference and exhibit management company no later than August 4, 2002.

Laparoscopy Updates

Where we are...
And where we’re going:

Abdominal/Pelvic Pain
James E. Carter, MD, PhD
Antonio Luciano, MD
Deborah Metzger, MD

Biliary
Kevin Gillian, MD

Cardiac Surgery
Francis J. Podbielski, MD

Colon
Arthur P. Fine, MD
Mohammad Abdul Jawad, MD
Constantinos Stratoulias, MD

Fertiloscopy/Transvaginal Endoscopy
Antoine Watrelot, MD

Fibroids/Abnormal Uterine Bleeding
Herbert Goldfarb, MD

Future Technology
Bruce Ramshaw, MD

Hernia
Lawrence Biskin, MD
Phillip P. Shadduck, MD

Hysterectomy
Ceana Nezhat, MD

Infertility
Philippe G. Judlin, MD

Office and Outpatient Laparoscopy
Oscar D. Almeida, MD
Larry A. Demco, MD

Pelvic Reconstructive Surgery/Stress Incontinence
Maurice K. Chung, MD
Jim Ross, MD

Telemicine, Video and Multi-Media Communications
Stanley C. Hewlett, MD

Ultrasound
Kevin Gillian, MD

Urologic
Sakti Das, MD
Marelyn Medina, MD
EXHIBIT HALL EVENTS

SLS CYBER CAFE: Stop by for a cup of coffee and check your e-mail or log onto the Web for hands-on online resources.

TOP GUN LAPAROSCOPY SHOOT OUT: This is a fun and challenging approach to training in the use of the non-dominant hand in minimally invasive surgical procedures. Presented by Dr. James C. Roeser, Jr. of Beth Israel Hospital, New York.

SLS INNOVATIONS OF THE YEAR: All companies are encouraged to submit an entry of their most innovative product, as the winners will benefit from exposure generated at the Congress. It is not necessary for a company to exhibit or advertise to be eligible for this prestigious award. SLS encourages all commercial entities to enter their most innovative product for consideration.

NEW PRODUCT PRESENTATION: All exhibitors are welcome to share information about new products, technology and developments during the New Product Presentation Session. Exhibitors who submit new product information will be allowed a one-minute presentation during the lunch break, Friday, Sept. 13, 2002. Each exhibitor will be allowed to present only one product developed within the past year.

SPONSORSHIP AND BENEFACTOR PROGRAM

The Society of Laparoendoscopic Surgeons (SLS) is pleased to announce that Karl Storz Endoscopy-America has become our first Platinum Benefactor, the highest level. SLS appreciates their Platinum support and the corporate membership of those companies listed below. We look forward to expanding this program to continue to serve our 6,000 plus members from various specialties who are interested in advancing their expertise and education in the diagnostic and therapeutic uses of laparoendoscopic techniques.

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SLS MEETING CALENDAR

February 21-22, 2003: Interamerican MultiSpeciality Congress of Laparoscopy and Minimally Invasive Surgery Alexander All-Suite -Ocean Front Resort, Miami Beach, Florida
September 15-18, 2003: The Society of Laparoendoscopic Surgeons 12th International Congress and Endo Expo 2003 Bally’s Las Vegas, Las Vegas, Nevada
REGISTRATION FORM

11th International Congress and Endo Expo
SEPTEMBER 11-14, 2002

Register before July 11 and take advantage of advance registration fees!
Deadline for Registration: August 19, 2002 (See Fee Section on page 12) Fax this form to (305) 667-4123

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Your Specialty: ☐ General Surgery ☐ Urology ☐ Gynecology ☐ Other

(Advance Registration Discount for Physician SLS Members only. To qualify for Advance Registration, please register by July 11, 2002.)

See New Member Enrollment and start taking advantage now of SLS Membership Benefits!

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Postgraduate Course (circle one): 1 2 3 4 5 6 7 8

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Gala Dinner with Faculty Fee: $85.00 per person
Open to all Congress registrants and their guests. I would like to purchase ________ ticket(s) to the Gala Dinner with Faculty Friday September 13 Number of Persons ________ x $85

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Accompanying person's registration fee includes: Attendance at the Wednesday, September 11 Welcome Reception, and Saturday, September 14 seated breakfast with Keynote Speaker and Future Technology session.
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- FREE SUBSCRIPTIONS TO:
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  - Laparoscopy and SLS Report
- ACCESS TO SLS VIDEO LENDING LIBRARY consisting of videos produced by surgeon members and videos donated by the corporate community.
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