

Minimally Invasive Surgery Week

MINIMALLY INVASIVE SURGERY WEEK 2013

ANNUAL MEETING & ENDO EXPO

HYATT REGENCY RESTON

RESTON, VA (WASHINGTON DC)

MIS13 Updates

Alphabetical by Presenter

Bariatrics Committee

Subcutaneous Placement of Lap Band Port Provides Safe and Durable Access

Ehab Akkary MD, Forrest Olgers PA-C

Introduction & aim: Laparoscopic adjustable gastric band access port has been routinely secured directly to the anterior fascia of the abdominal wall using non absorbable sutures. This technique requires relatively extended incision, increased OR time and possible difficult access in deep ports. We hypothesize that mesh fixation of the access port allows for a safe and durable placement of the port in the subcutaneous tissue.

Methods: Retrospective chart review included 102 patients who had Lap band surgery performed by single surgeon (EA) from June 2011 till April 2013. The port was sutured to a piece of polypropylene mesh and tunneled in the subcutaneous tissue away from the incision. Patients' demographics were analyzed as well as the following parameters: OR time for port placement (OTPP), follow up (F/U), port complications needing revision (PC), difficult access requiring imaging, port infection.

Results:

N 102 (M 23, F 79)

Age (y) 49

Weight (lbs) 284.7

Height (inches) 66.2

BMI (kg/m²) 46.3

OTPP (min) 4

F/U range (months) 2 - 22

PC 2 (2%)

Fluoro 3 (2%)

port infection 0

Conclusion: Subcutaneous placement of Lap Band Port, with mesh fixation, provides safe and durable access

Gastroesophageal Reflux Disease Committee

GERD: Establishing Standard of Care

Ehab Akkary MD, Jessica Murray RN, Mohammad Shakshak MD, Mohey Elbanna MD

Introduction: GERD is a term commonly used for various foregut symptoms. We hypothesize that there is a tendency in the medical practice to treat GERD imperially without establishing a definitive diagnosis.

Methods: Retrospective chart review included 74 patients who were evaluated for GERD by Dr. EA between March 2012 - June 2013. The patients were divided into operative group (OP, N = 39) and non operative group (NOP, N = 35), NOP was divided into (a) medical treatment (MT, N = 20), (b) pending surgery (PS, N = 6), (c) non compliance (NC, N = 9).

Demographics were measured. The following parameters were assessed: symptoms, duration, prior workup, empirical treatment & duration, GI/PCP referral, esophageal motility, DeMeester scores, UGI, EGD findings, Pathology, surgery, postoperative outcomes.

Results:

	Op arm	Non op arm
N	39 (M7, F32)	35 (M11, F28)
Age(Y)	50.6	49
Weight(lbs)	178.7	183.2
Height(inches)	64.6	65
BMI(kg/m2)	30.3	30

	GI sx	Resp Sx	Duration(y)	prior w/u	Med tx<wu	Duration PPI/H2b(Y)	PCP/GI referral
OP(N 39)	39 (100%)	14 (36%)	5.4	6 (15%)	26 (66.7%)	3.3	11 (28%)
MT(N 20)	20 (100%)	10 (50%)	3.3	2 (10%)	12 (60%)	2.2	8 (40%)
SP(N 6)	6 (100%)	3 (50%)	7.25	1 (16.7%)	4 (66.67%)	3.8	1 (16.67%)
NC(N 9)	9 (100%)	3 (33.3%)	4.63	0 (0%)	7 (77.78%)	4.63	4 (44.45%)

Conclusion: There is tendency towards symptomatic / empirical GERD treatment. This raises a concern of under diagnosing Barrett and esophageal cancer. We propose that a definitive diagnosis should be reached aiming at curative treatment.

Office Cosmetic Procedures Committee

Up-to-Date Office Cosmetic Procedures for the Gyn Cosmetic Surgeon

Yaniris R. Avellanet, MD

Cosmetic Surgery is a multi-disciplinary surgical specialty that utilizes various techniques with the main purpose of aesthetically improving those areas of the body that are problematic to the patient, resulting in a higher self-esteem and level of comfort for the patient in her/his own new body. Gynecologist, as surgeons, can pursue post-graduate training in aesthetics and cosmetic procedures. The most common procedures seek by patients are liposuction/liposculpting, breast enhancement, fat transfer, and injection of dermal fillers, neurotoxins, and stem cells. The newly recognized surgical area of Cosmetic Gynecology offers the Gyn Cosmetic Surgeon the opportunity to aesthetically enhance the body from the most intimate areas out. The objectives of this conference are: 1) to provide an overview of how Gynecologists can get trained as Cosmetic Surgeons; 2) to provide simple guidelines on how Cosmetic Gynecologists can start offering cosmetic and aesthetic procedures to patients; 3) to describe what is Cosmetic Gynecology; 4) to give an overview of the office invasive cosmetic procedures that can be offered with minimal anesthesia; and 5) to describe the non-invasive aesthetic treatments that can be offered with minimal down-time for the patient. The trained Gyn Cosmetic Surgeon can offer the patient a broad array of cosmetic procedures that will enhance the patient's body and improve self-esteem.

Robotic Surgery Committee

New Technology in Robotic Assisted Microsurgery

Jamin Brahmbhatt, MD

The increased use of the robotic platform for microsurgery has led to new surgical instrumentation. The benefits of the robotic platform include high definition 12-15x digital magnification, broader range of motion, fine instrument handling with decreased tremor, reduced surgeon fatigue, and improved surgical productivity. This update will highlight adjunctive tools that provide enhanced optical magnification, micro Doppler sensing of vessels down to a 1mm size to avoid vascular injury, vein mapping capabilities, high pressure waterjet dissection of small tissue planes, laser micro-dissection to decrease thermal injury, and confocal microscopy to provide imaging at a cellular level. All these instruments have been adapted for the robotic console and enhance the robotic assisted microsurgery experience. Microsurgical outcomes from the use of these tools in the management of patients will be reviewed.

Hysterectomy Committee

Hysterectomy: Where Do We Go From Here?

Jose Carugno, MD FACOG

Hysterectomy is the most common major gynecologic surgical procedure performed in the United States, with almost 600,000 cases performed each year.¹ Unfortunately, the abdominal route continues to be a very common surgical approach despite the existence of less invasive options.² Lately, the combination of advances in surgical minimally invasive technology and the availability of the robotic platform in gynecology have changed the management of many gynecologic surgical conditions. A recent large study reported an important change in the route of hysterectomy in the US during the last few years, with an increased rate of conventional laparoscopic and robotic approach. As a result, the rate of abdominal hysterectomy is finally dropping.³

When selecting the route of hysterectomy for the individual patient, the gynecologic surgeon should take several conditions

into account. The surgical indication, patient's body habitus, presence of comorbidities, patient's informed choice, and surgeon's preference, among others, are considered important factors that come into play when determining the approach of hysterectomy.

A thorough review will be presented of the latest evidence in regards to route selection, surgical technique, complications and perioperative outcomes of patients undergoing hysterectomy for benign disease. The role of intraoperative cystoscopy in laparoscopic hysterectomy^{4,5}, single incision approach⁶, elective salpingo-oophorectomy at the time of hysterectomy⁷ as well as vaginal cuff dehiscence^{8,9} and other surgical complications will be reviewed. Hysterectomy in patients with special consideration will also be reviewed.

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Minilaparoscopic (Needlescopic) Technique for Inguinal Hernia Repair Combining Transabdominal Pre-Peritoneal (TAPP) And Totally Extraperitoneal (TEP) – Pushing the Boundaries of Minimally Invasive Hernia Surgery

Gustavo L Carvalho MD, PhD

Endoscopic hernia repair has been considered to be slightly superior to open approaches, mainly because it is associated with an earlier recovery, less chronic pain, and a lower risk of infection. Several issues still prevent its widespread usage, including the fact that the cost of the procedure is higher, it is difficult to learn, and it carries the risk of severe complications, consequently is still an unpopular procedure among surgeons. In order to simplify the procedure and reduce costs, avoidance of dissecting balloons and mesh fixation has been advocated.

Over the years, TEP has proven to be slightly better than TAPP with results at least very similar to the best open techniques. Its main advantage relies on the option of no need for creation of peritoneal flap and no need for mesh fixation, resulting in less postoperative pain and faster recovery.

Minilaparoscopy (MINI) is a natural advancement of laparoscopy, which proposes to diminish surgical trauma by reducing

the diameter of the standard laparoscopic instruments. With the advent of new low-friction trocars, precisely engineered for low friction forces between the trocar and the mini instruments, improvement was found in surgical precision, especially during dynamic tasks (e.g. dissection of hernia sac), resulting in less stress and higher effectivity. Trocar dislocation and skin reinsertions were significantly diminished, consequently reducing skin trauma, resulting in improved aesthetics.

Although advantageous in several ways, TEP has not been widely adopted for being regarded as a complex procedure, especially for issues on creating the preperitoneal space and understanding its anatomy. In addition, TEP does not allow intraperitoneal inspection, which is crucial for treating incarcerated hernias. By combining the established advantages of TEP with those of TAPP associated with the precision and cosmetics of MINI, a combined technique to potentially become the gold standard of minimally invasive inguinal hernia surgery will be shown.

Abdominal/Pelvic Pain/Adhesions Committee

Laparoscopy and Hysterectomy for Chronic Pelvic Pain, is it Effective?

Maurice K. Chung, RPh, MD

Chronic pelvic pain is estimated to affect 1 in 7 women, or approximately 9 million US women, with associated health care costs approaching \$3 billion annually.¹ The vast majority of patients with chronic pelvic pain (CPP) do not seek treatment, and less than 20% consult a gynecologist. Approximately 20% to 40% of laparoscopies are done for CPP.²

In the gynecologic literature, chronic pelvic pain is associated with endometriosis in 30% to 87% of the cases. [i]3-9 Endometriosis has been regarded as one of the most common causes of chronic pelvic pain in which affects an estimated 5 million U.S. women.[ii]10 Definitive diagnosis of endometriosis requires operative laparoscopy evaluation. Even with new advances in treatment of this disease, the recurrent rate remains as high as 50%.¹¹ To make the matter worse it is considered as a progressive disease in more than 60% of patients.¹² This often leads to many reoperations, including laparoscopies and even hysterectomies. Treatment of endometriosis-related chronic pelvic pain remains challenging to the clinicians and the results have not been satisfactory. We are exploring the data of surgical treatment of pelvic pain to see whether it is an effective solution.

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Fibroid/Abnormal Uterine Bleeding Committee

Fibroid/Abnormal Uterine Bleeding Update: What's New and News with Fibroid Therapy

Herbert A Goldfarb, MD

Treatment of acute non obstetrical perimenopausal bleeding: Solutions vary from immediate transfusion and hysterectomy, to Foley catheter insertion with pressure to the uterine cavity.

This presentation will discuss the pathophysiology, diagnosis, and treatment options for acute post reproductive uterine hemorrhage

The author has published "The Use of Hydrothermal Ablation to Control Uterine Bleeding and Decrease Hysterectomy Rate" (JSL 2010 14:192-195)

The place for conservative therapy will be discussed.

Hysteroscopy Committee

Hysteroscopy: From the Lab to the Procedure Room

Stephen A. Grochmal, MD; Associate Clinical Professor (Adjunct Faculty), Division of Minimally Invasive Surgery, Department of Ob-Gyn, Howard University College of Medicine, Washington, DC.

James F. Carter, MD; Professor of Ob-Gyn and Director of the Minimally Invasive Surgery Lab, Department of Ob-Gyn, Medical University of South Carolina, Charleston, SC.

Hysteroscopy is well recognized as the preferred method for diagnosis of abnormal uterine bleeding and other uterine abnormalities and may be easily performed in the office setting. Despite increasing popularity as a useful tool in the gynecologist's armamentarium, available training options to acquire hysteroscopy skills remains sub-optimal. This is especially true for gynecologists already in practice where for a myriad of reasons there is a reluctance to learn hysteroscopy, especially in the office setting. The majority of gynecologists currently performing hysteroscopic procedures do so in the hospital setting using general anesthesia leading to increased healthcare costs and patient inconvenience – all that for a ten minute procedure safely performed in the office with a local anesthetic. There also is a lack of adequate hysteroscopy training at the post graduate resident/fellow level where in many teaching institutions academic professors and private practitioners lack advanced operative hysteroscopy skills to impart to their physicians-in-training. Often there is no other training method available, i.e. simulation training, which could help fill the knowledge gap.

Simulation training can provide the knowledge, skillset and help develop a confidence level for both the neophyte and senior attending physician alike. Simulation training also provides repeat testing to document skill proficiency leading to a controlled transition into the procedure room to perform hysteroscopic procedures. This Update describes the curriculum,

experience and tangible benefits of one such simulation training center focused on advanced hysteroscopic surgery at the Medical University of South Carolina.

Technology, Innovation & Surgical Standardization Committee

Trends in Evolving Technologies in the Operating Room of the Future

Doron Kopelman, Prof Dr Med

Traditional OR is being transformed. Present day operating rooms are inefficient and overcrowded. New technologies and devices are often introduced haphazardly into an already technologically complex environment. Patient data and images are not well integrated or displayed in a timely fashion. This lack of integration of technology and information further reduce efficiency. This in turn potentially impacts patient safety and costs. We examine some of the current trends that are likely to continue to impact the operating room environment and the OR of the future.

Current Relevant Trends: There is an ongoing migration from invasive to less invasive and noninvasive procedures. Image guided procedures, robotic surgery, telesurgery SILS and NOTES techniques are continuing to evolve and transform laparoscopic procedures and replace traditional surgical procedures. Procedures once requiring general anesthesia can now be performed using image-guided, vascular and endoscopic access technologies. Tumor ablation instead of resection is accomplished using different imaging guided modalities (RFA, microwave, cryoablation, lasers and interstitial laser therapy (ILT), HIFU), and focused radiation (gamma knife).

The future Impact: Patients will experience less pain, fewer procedures will require anesthesia, and shorter hospital stays. Traditional boundaries of the surgical space will blur. Many surgical procedures will only require an ambulatory setting. Less need for the conventional multidisciplinary OR and more need for specialized imaging guided procedure suites, hybrid ORs, endoscopic surgical/interventional suites, and endovascular surgical suites. These trends may promote either the scattering or assembly of interventional suites. Evolution of new medical/interventional professions, e.g. Endoscopic surgeon or Surgical Interventionist, is inevitable.

Core Competencies Committee

Credentialing, Determining Competency and Measuring Proficiency in Robotic Surgery: We Need to Get this Right

I. Michael Leitman, MD

Robotic surgical devices are now frequently used in minimally invasive general surgery, pediatric surgery, gynecology, urology, cardiothoracic surgery and ENT. As these devices continue to evolve, they will be more widely disseminated and more frequently utilized in surgical procedures. Until recently, the guidelines for the usage of robots in surgery and guidelines for training and credentialing were lacking.

How should training for both residents and practicing surgeons be accomplished? What is the appropriate process for credentialing robotic surgery? What are the appropriate clinical applications for robotic surgery? Is there medical evidence that efficacy has been demonstrated for these applications? What are the risks of robotic surgery to the patient? What additional costs are involved in robotic surgery and are they justified? What are the unanswered questions in robotic surgery? In what direction should future research take?

This presentation will provide data on the current utilization of the robotic platform among residents and surgeons. A template for the credentialing of surgeons in robotic surgery will be presented. Ways to measure efficiency and proficiency

using this new technology will be suggested.

Gastroesophageal Reflux Disease Committee

Twenty Years of Minimally Invasive Surgery for Gastroesophageal Reflux Surgery: What We Have Learned and Future Directions

I. Michael Leitman, MD

Half of Americans experience heartburn symptoms at least monthly. GERD is a serious health concern in the Western world. The prevalence is between 9% and 42%. Improved medical therapies have brought both symptomatic relief and effective resolution of esophageal mucosal damage but requires lifelong use. Antireflux surgery can provide a permanent anatomic and physiologic cure providing resolution of symptoms and the consequences from ongoing esophageal exposure to gastric contents.

In 1939, Rudolf Nissen performed the first fundoplication. In 1951, Allison and Barrett established the causal relationship among hiatus hernia, gastroesophageal reflux, and erosive esophagitis.

Surgical treatment is aimed at three mechanisms to prevent excessive esophageal exposure to reflux: limit the contact time of gastric contents with the esophageal mucosa, the creation of a region of high pressure located at the esophagogastric junction, and proper gastric emptying.

Open antireflux surgery produces good long-term control of disease. The popularization of minimally invasive approaches 20 years ago has been fueled by both patient demand and growing familiarity among surgeons. Randomized clinical trials comparing open and laparoscopic Nissen fundoplication have found no difference in long-term symptom relief, esophageal acid exposure, esophageal sphincter pressure, postoperative dysphagia, and overall satisfaction. Laparoscopic surgery is safe, effective, and durable. Mortality rates are very low, ranging from 0.008% to 0.8%.

This presentation will also compare antireflux surgery to medical therapy, cost-effectiveness, and outcomes from other procedures: (Toupet fundoplication, Thal fundoplication, endoscopic treatments including transoral flexible endoscopic suturing, radiofrequency, and dilation procedures).

Pediatric Surgery Committee

Endosurgery in Children in the 21st Century: Diverse Specialties, Different Approaches, Common Goals!

Oliver J. Muensterer, MD, PhD & Robert K. Zurawin, MD

Endosurgical operations have been performed in children for over two decades, and have had profound effects on perioperative pediatric outcomes, particularly in terms of earlier recovery, faster enteral feeding, and shorter hospital stay. Other potential benefits include less pain, lower wound infection rates, lower overall healthcare costs, better cosmesis, and fewer postoperative adhesive bowel complications. Pediatric endosurgery is currently practiced by a number of different pediatric specialties, including general surgery, gynecology, urology, neurosurgery, otorhinolaryngology, and orthopedics. Although similar equipment may be used, very little interdisciplinary networking and cross-pollination has occurred so far. With the recent diversification of endosurgical techniques such as combined endoscopy-endosurgery, robotic-assisted surgery, single-incision laparoscopy, and the introduction of novel microinstrumentation, collaborating among specialties is imperative to provide a critical appraisal of these approaches along with evidence-based practice guidelines. Our presentation highlights recent pediatric endosurgical advances, their application in children among disciplines, and the potential to network in order to provide the best surgical care to our patients.

Future Technologies Committee

New Technology: From OR to Everyday Practice

Vadim V. Morozov, MD

The practice of medicine, and particularly surgery, has undergone significant change in the last 10 years. Introduction of robotic surgery and computer-assisted techniques, implementation of the available technological advances, remote control of the surgical field – all these things have transformed the face of the medical and surgical practice. In this update, we will focus on new development in the medical and surgical disciplines, with the focus on the novel technologies available to surgeon in the near future. Particular attention will be given to the advances in the field of remote and computer-assisted surgeries from Gynecology to Urology to Peri-operative practice.

Infertility/Fertility Committee

Endometriosis and Infertility: What We Have Learned and Where We Are Going

Ceana Nezhat, MD & Erica Dun, MD, MPH

Endometriosis is a common and chronic condition affecting 10-15% of reproductive-aged women, but 40-50% of women with infertility or subfertility. No single mechanism has been found to explain the association of endometriosis and infertility, though there are multiple theories. This update will touch upon the current evidence and mechanisms of endometriosis-related infertility. We will then discuss the role of medical ovulation suppression to improve fecundity in women with endometriosis. Surgical treatment of endometriosis and endometriomas in the infertile patient will be the focus of the discussion, centering on the success rates of fertility-sparing surgery before and after assisted reproductive technology (ART). Lastly, ART, maximizing reproductive outcomes and the future directions for endometriosis-related infertility will be considered.

Endometriosis/Ovarian/Complex Pelvic Surgery Committee

Endometriosis Related Pain Is a Syndrome, NOT JUST ENDOMETRIOSIS

Alfredo Nieves, MD

The purpose of this talk is to review the pain mechanisms, identify the common triggers of pain in the pelvis. Review how to systematically evaluate a patient's pain, in addition to reviewing how to approach treatment in a multidisciplinary manner.

Chronic pelvic pain is responsible for 20 percent of all the laparoscopic, 10 to 20% of visits to gynecologist, 12% of the hysterectomies. A third have no obvious pathology and more than \$2 trillion in health dollars are spent each year.

Pain is defined by the IASSP as a unpleasant sensory and emotional experience associated with damage or potential damage tissue or described in quality of such damage. Chronic pain is defined as one that lasts more than three months and that remains without explanation or evidence of pathology.

Women who suffer from endometriosis related pelvic pain that is refractory to conventional therapy have co-existing and undiagnosed pain triggers contributing to the perpetuation of their symptoms. Identifying such conditions may re-direct and expand treatment options. Tailoring treatment to include underlying conditions may improve pain symptoms plus decrease the chances of undergoing additional invasive surgical procedures.

Summary of Preliminary Finding Reviewing Billing Data for last 86 charts (25% of total) between 4/1/2006 to 4/15/2011:

- A total of 347 patients with the diagnosis of endometriosis were seen at the PPRSC within the time frame of 4/1/2006 to 4/5/2011 as per Billing Records.
- The above data represents preliminary findings after reviewing a quarter of identified charts
- The co-existing visceral and somatic pain diagnoses are shown above in order of most to least common.

Out of the 86 chart reviewed, only 2 patients had Endometriosis as their only diagnosis = 2%, 93% had Endometriosis plus 2 additional pain diagnoses

Diagnosis	Total # Patients w Diagnosis	% Endometriosis + Specific Neuropathic Dx
Endometriosis	86	100%
Chronic Pelvic Pain	84	97.7%
Painful Bladder Syndrome	73	84.9%
Pelvic Floor Myalgia	54	62.8%
Vulvodynia	45	53.3%
Pudendal Neuralgia	27	31.4%
Chronic Pain Syndrome	8	9.3%

Pelvic Reconstructive Surgery/Stress Incontinence Committee

Laparoscopic Surgical Management of Pudendal Nerve Entrapment after POP Reconstructive Surgery Alfredo Neives, MD

The pudendal nerve is a mix motor sensory nerve that originates from S-2-S3 root, travels within the pelvis between the sacrospinous and sacrotuberous ligaments, and via ALCOCK'S canal to surface around the vulva and perineum. Inervates the vulva, clitoris and perineum, as well as motor fibers for the levator plate.

With the advent of mesh kits, traditional apical support surgeries anchoring at and into the sacrospinous ligament, we have seen an increase in pudendal nerve entrapment. Failure to recognize symptomatology early in the postoperative period can render these patients with a debilitating complex neuropathy. We intend with this review to raise awareness, review the clinical presentation and medical/surgical management laparoscopically of this unusual nerve entrapment syndrome.

Hepato-Biliary Disease & Cholecystectomy Committee

Tips and Tricks to Get Best Results in Lap Cholecystectomy- A Personal Experience of 20 Years Kuldip Singh, MS, FACS, FRCS (Eng), Ranbir Singh, MBBS

In the beginning of Laparoscopic surgery, the pioneer surgeons had a doubt of this newer technique being successful, acceptable and feasible in developing countries. The surgical unit introduced this technique with the aim and objective of evaluating the above mentioned parameters in developing countries. In the first five years, the patients selection criteria was to exclude complicated cholecystitis and there after our policy has been to take up each and every patient for Laparoscopy, who merits cholecystectomy. The acute cholecystitis patients were taken up within 72hrs. In the last 20 yrs, a total of 8720 cases of Laparoscopic cholecystectomy were undertaken and out of which we had, acute (1520), Gangrenous (46), empyematous (592) and other complicated cholecystitits (57). We followed the standard surgical guidelines, anatomical landmarks for dissection and modified our technique to sub total cholecystectomy, leaving the posterior wall of GB and fundus first method in difficult cholecystectomies. The overall conversion rate in the series has been 0.76% and it was 1.64% in acute, gangrenous, empyematous and complicated cholecystectomies with 04 bile duct injuries. These results are comparable to the best series quoted in the literature in terms of conversion and Bile duct injuries. To conclude, laparoscopic cholecystectomy is feasible, acceptable and cost effective in developing countries. The best results can be achieved if one follows standard surgical guidelines and could reproduce the conventional surgical steps of Langenbuch technique by Laparoscopic method.

Office and Outpatient Laparoscopy Committee

Outpatient Laparoscopic Hysterectomy

Kurian Thott, MD

With the advent of MIS procedures worldwide, technology has allowed us to perform advanced surgical procedures with better patient outcomes and recovery.

This update will be looking at the evolution of MIS procedures in the realm of same day or outpatient surgery, specific to Laparoscopic Hysterectomy. This update will include various options for the surgical staff to incorporate with their patients to aid in getting patients home the same day; from anesthesia to post-op recovery, and even what a surgeon can do intra-op that might allow their patients to go home without increased pain or nausea.

Will also discuss managing patient expectations pre-op and post-op and what they might need to do at home to help with their post-op recovery.

As minimally invasive GYN procedures evolve and patients' expectations increase we as surgical providers should always be challenging ourselves to be looking for new ways to have better outcomes. We should never rest on our laurels on what we do today will always be the best option for our patients tomorrow. Evolution and growth in medicine is an integral part of our journey as MIS surgeons.

Women in MIS Committee

A National Look at Practice Types for Women in Surgery

Jessica Ybanez- Morano, MD, MPH

There are many types of practice options for women in surgery. As recently as 2005, more than 2/3 of medical practices were physician-owned, here in the United States of America. But in recent years, that share has dropped below 50%. Some of changes have been attributed to complex corporate environments; high costs of malpractice insurance; difficulties in obtaining reimbursement; administrative duties; general risks and burden of solo or small group practice. Life balance is a big concern recently. The issue of achieving balance has been addressed more consistently and persistently.

Finally, the discussion is specifically focused upon the women's career development, the delineation of the practical tools

necessary to maintain a successful practice, and the identification of assets necessary to begin a practice. Some of these issues are reviewed in order to enhance growth of the practice.