2016 Annual Scientific Meeting
Cornwall 17-18th May 2016
Training in Endoscopic surgery

"from shifting sands to firm foundations"
PLATINUM SPONSOR

Olympus is one of the world’s leading manufacturers of innovative optical and digital equipment such as endoscopes and microscopes for medical, scientific and industrial use as well as cameras and voice recorders. Founded in Japan in 1919, Olympus has stood for pioneering spirit and innovation for more than 90 years.

The Olympus Medical Systems Division offers a variety of products and system solutions for the healthcare sector, constantly seeking to improve diagnostic procedures and, consequently, the treatment of many diseases. Olympus is committed to developing new technologies, products, services and financial solutions that comply with the toughest industry standards and offer our customers improved safety, security, quality and productivity.

Acknowledgement

The British Society for Gynaecological Endoscopy wishes to express its sincere gratitude and appreciation to our Platinum sponsors for the meeting and for their continuing support of the society.
KERNOW A’GAS
DYNERGH – WELCOME TO CORNWALL

It is my great pleasure, as Chair of the local organising committee, to welcome you all to this lovely venue for the 2016 BSGE Annual Scientific meeting. Cornwall is a special place – miles from anywhere as you have discovered – and I hope you will agree worth the effort of getting here. We have a great meeting arranged over the next two days with something for everyone in these splendid surroundings of the Bedruthan Hotel.

Our theme this year is Training in Endoscopy. The pre-congress masterclasses took place yesterday at the Royal Cornwall Hospital. The main conference programme, today and tomorrow, the nurses conference and breakout sessions are all designed around our theme and we have added ‘Meet the Expert’ sessions for you to access personal training tips. There has been a great response with over 300 registrations.

As ever, our Industry Sponsors have made the event possible, we are grateful to them for support of the BSGE. Please do spend time with the sponsors in the Exhibition halls to learn more about their products.

I would like to thank especially, the Local Organising committee and, of course, the unflappable Atia Khan who have worked tirelessly to make this a very special meeting. Thank you too, for attending.

Please enjoy the meeting, enjoy Cornwall and enjoy the company.

Best wishes

Susie Bates
Chair

Local Organising Committee

- Miss Susie Bates
- Mr Dominic Byrne – President elect- BSGE
- Ms Cathy Dean
- Mr Richard Keedwell
- Mr Jonathan Lord
- Mr Thomas Smith-Walker
- Miss Lisa Verity
- Atia Khan – BSGE Secretariat
FACULTY MEMBERS

- Miss Karolina Afors
- Mr Kirana Arambage
- Ms Elizabeth Ball
- Mrs Gill Barnes
- Miss Susie Bates
- Mr Alex Bates
- Professor Christian Becker
- Dr Robin Bell
- Professor Hans Bröllmann
- Ms Elizabeth Bruen
- Mr Dominic Byrne
- Mr Conor Byrne
- Ms Victoria Bytel
- Mr Tyrone Carpenter
- Mr Oliver Chappatte
- Mr James Clark
- Professor Justin Clark
- Ms Karen Cock
- Ms Mary Connor
- Ms Natalie Cooper
- Mr Alfred Cutner
- Ms Cathy Dean
- Mrs Helen Dewart
- Mr Reg D’Souza
- Mr Jonathan Frappell
- Professor Ray Garry
- Professor Fabio Ghezzi
- Miss Donna Ghosh
- Mr Matt Hickenbottom
- Ms Rah Holden
- Mr Tom Holland
- Ms Debra Holloway
- Mrs Heather Hudson
- Mr Thomas Ind
- Mr Simon Jackson
- Ms Rachel Jackson
- Mr Richard Keedwell
- Mr Shaheen Khazali
- Mr Jonathan Lord
- Ms Wendy Norton
- Ms Deborah Panes
- Dr Julia Pansini-Murrell
- Ms Carol Pearson
- Mr Ben Peyton-Jones
- Ms Natalia Price
- Ms Wendy Rae Mitchell
- Mr Ertan Saridogan
- Mr Fevzi Shakir
- Ms Gillian Smith
- Mr Paul Smith
- Mr Tom Smith-Walker
- Mr Arvind Vashisht
- Ms Lisa Verity
- Mr Sanjay Vyas
- Ms Natasha Waters
- Mr Mark Whittaker
CONTENTS

Welcome ..........................................................................................................................................................3
Faculty members ...................................................................................................................................4
Hotel floor plan .......................................................................................................................................7
Programme overview ...............................................................................................................8-9
Main conference room .................................................................................................. 12-13
Conference room 2 ............................................................................................................14-15
Lanai room ................................................................................................................................................16
Garden room ..........................................................................................................................................17
Meet the Expert ......................................................................................................................18-19
Catering and Sponsors .............................................................................................................20
Exhibition floor plan .....................................................................................................................21
Index of Authors ...............................................................................................................................24
Abstracts ...........................................................................................................................................25-65
Platinum sponsors ................................................................................................................ 2, 6, 10, 11, 22
Gold sponsors .......................................................................................................................................66
Silver sponsors ......................................................................................................................................66
Bronze sponsors .................................................................................................................................67

"From shifting sands to firm foundations"
From creating the first sutures, to revolutionizing surgery with minimally invasive procedures, Ethicon has made significant contributions to surgery for more than 80 years.

Our continuing dedication to Shape the Future of Surgery is built on our commitment to help address the world’s most pressing health care issues, and improve and save more lives.

Through Ethicon’s surgical technologies and solutions including sutures, staplers, energy devices, trocars and hemostats and our commitment to treat serious medical conditions like obesity and cancer worldwide, we deliver innovation to make a life-changing impact.

Learn more at www.gb.ethicon.com

Acknowledgement

The British Society for Gynaecological Endoscopy wishes to express its sincere gratitude and appreciation to our Platinum sponsors for the meeting and for their continuing support of the society.
# PROGRAMME OVERVIEW

## Tuesday, 17th May 2016

<table>
<thead>
<tr>
<th>Time</th>
<th>Main Conference Room</th>
<th>Conference Room 2</th>
<th>Lanai Room</th>
<th>Garden Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Registration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:00</td>
<td>Welcome address – Susie Bates</td>
<td>Welcome address – Cathy Dean</td>
<td>Meet the Expert</td>
<td>Breakout meetings</td>
</tr>
<tr>
<td>09:10</td>
<td>Health Economics – how it all works Mr Alex Bates</td>
<td>Endometriosis Nurse Training programme</td>
<td>How to do a sacrohysteropexy Natalia Price</td>
<td>VIDEO POSTER VIEWING</td>
</tr>
<tr>
<td>09:50</td>
<td>Heavy Menstrual Bleeding The Health Technology Assessment Explained Ms Natalie Cooper</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:10</td>
<td>Free Communications 1-5</td>
<td>How to do a TLH Tom Smith-Walker</td>
<td></td>
<td>Laparoscopy in Pregnancy experts meeting – By invitation only Elizabeth Ball</td>
</tr>
<tr>
<td>11:00</td>
<td>Tea, Coffee and Refreshments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:15</td>
<td>Platinum 1 Sponsored Lecture by Olympus – “Enhancing treatment choices for women with severe endometriosis” Mr Arvind Vashisht</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td>Is laparoscopy needed for diagnosis of Endometriosis? Prof. Christian Becker</td>
<td>Endometriosis Nurse Training programme</td>
<td>Ipsilateral suturing Elizabeth Ball</td>
<td>Meet the Expert</td>
</tr>
<tr>
<td>12:20</td>
<td>The BSGE National ‘LapHyst’ Project Introductory meeting Mr Ertan Saridogan</td>
<td></td>
<td></td>
<td>Menstrual Disorders Clinical Study Group meeting – By invitation only. Justin Clark</td>
</tr>
<tr>
<td>12:40</td>
<td>Modern management of Adenomyosis Prof. Hans Brölmann</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00</td>
<td>Lunch</td>
<td></td>
<td></td>
<td>13:00- 13:45 Platinum 5 Sponsored Lunchtime Symposium by Stryker “Optimising Theatre Efficiency” Mr Oliver O’Donovan</td>
</tr>
<tr>
<td>14:00</td>
<td>Sir Alec Turnbull Lecture “Creating Change” Mr Alfred Cutner</td>
<td>Endometriosis Nurse Training programme</td>
<td>How to resect a fibroid Oliver Chappatte</td>
<td>The BSGE National ‘LapHyst’ Project Introductory meeting</td>
</tr>
<tr>
<td>14:30</td>
<td>Free Communications 6-11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:30</td>
<td>Tea, Coffee and Refreshments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:00</td>
<td>Platinum 2 Sponsored Lecture by Ethicon “Innovation in Medical Devices” Mr Randy Byrum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:45-17:30</td>
<td>BSGE AGM 2016</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18:00</td>
<td>Transport to The Eden Project</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19:00</td>
<td>BSGE Drinks reception at The Eden Project</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20:30</td>
<td>BSGE Gala dinner at The Eden Project</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00:00</td>
<td>Transport from The Eden Project to Bedruthan Hotel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00:30</td>
<td>Arrive at Bedruthan Hotel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: The programme is subject to change.*
# PROGRAMME OVERVIEW

**Wednesday, 18th May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:15</td>
<td>Opening of Day 2 and Registration</td>
</tr>
<tr>
<td></td>
<td><strong>MAIN CONFERENCE ROOM</strong></td>
</tr>
<tr>
<td>09:00</td>
<td>Small is Beautiful: Mini and Micro-laparoscopy, Fad or Future? Prof. Fabio Ghezzi</td>
</tr>
<tr>
<td>09:40</td>
<td>Big is beautiful: Endometriosis Database analysis of over 4,500 patients with RVE Mr Dominic Byrne</td>
</tr>
<tr>
<td>10:00</td>
<td>Free Communications 12-13</td>
</tr>
<tr>
<td>10:20</td>
<td>Tea, Coffee and Refreshments</td>
</tr>
<tr>
<td>10:50</td>
<td>Does Laparoscopic Urogynaecology have a firm foundation or is it on shifting sand? Mr Arvind Vashishth</td>
</tr>
<tr>
<td>11:10</td>
<td>Evidence based management of tubal ectopic pregnancies and UK adoption of laparoscopic surgery. Mr Jim Clark</td>
</tr>
<tr>
<td>11:30</td>
<td>Contemporary management of ovarian torsion Mr Tom Holland</td>
</tr>
<tr>
<td>11:50</td>
<td>Free Communications 14-16</td>
</tr>
<tr>
<td>12:20</td>
<td>Platinum 3 Sponsored Lecture by Karl Storz “Winning with mindset” Mr Mark Colbourne, MBE</td>
</tr>
<tr>
<td>13:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00</td>
<td>Presidential address</td>
</tr>
<tr>
<td>14:35</td>
<td>Hysteroscopic resection of fibroids: Long term clinical outcomes Prof. Justin Clark</td>
</tr>
<tr>
<td>15:00</td>
<td>Platinum 4 Sponsored Lecture by Medtronic “Is there a benefit from colorectal modules in training advanced gynaecological surgeons?” Prof Donal Brennan</td>
</tr>
<tr>
<td>15:45</td>
<td>Tea, Coffee and Refreshments</td>
</tr>
<tr>
<td>16:00</td>
<td>Debate – This house believes that current training in laparoscopic surgery is not adequate for trainees needs. For: Mr Sanjay Vyas Against: Miss Donna Ghosh</td>
</tr>
<tr>
<td>16:45</td>
<td>Awards for Best Presentations</td>
</tr>
<tr>
<td>17:00</td>
<td>Close of meeting</td>
</tr>
</tbody>
</table>
Since its beginning in 1945, KARL STORZ has established itself worldwide as an international and highly regarded company with a diverse product range encompassing all surgical endoscopic disciplines. We are a privately owned family company where all the products we design, manufacture and service are of an assured quality.

KARL STORZ Endoscopy (UK) Ltd was established in 1995 and is responsible for the sales, service and distribution of KARL STORZ products to England, Scotland and Wales.

Our activities in the UK are supported by close association with many prestigious medical institutions, leading healthcare clinicians and veterinary clinics. Additionally it includes the establishment and support of all the UK’s leading Minimal Access education and training centres, and hands-on workshops.

BSGE 2016 sees the introduction of our new modular IMAGE1 S imaging platform with Indigo Cyanine Green (ICG) filters, for sentinel lymph node dissection and organ perfusion, and 3D technology. Further demonstrating our expanding laparoscopic portfolio, we will also be displaying the new KECKSTEIN Uterine Manipulator and Mini Laparoscopic Instruments.

Within hysteroscopy, our new hysteroscopic fluid management system, HAMOU Endomat, complements our outpatient hysteroscopy portfolio of BETTOCCHI and Trophy hysteroscopes.

Using purchasing options within our SMART solutions, acquiring equipment can be made easier and is inclusive of service and support from On Site Technicians.

Please visit our stand to ask us about the full product and service portfolio from KARL STORZ.

Karl Storz Endoscopy (UK) Ltd
415 Perth Avenue, Slough, SL1 4TQ United Kingdom
00 44 1753 500503  www.karlstorz.com
Linkedin: KARL STORZ Endoscopy (UK) Ltd  Twitter: @KARLSTORZUK

Acknowledgement

The British Society for Gynaecological Endoscopy wishes to express its sincere gratitude and appreciation to our Platinum sponsors for the meeting and for their continuing support of the society.
PLATINUM SPONSOR

As a global leader in medical technology, services and solutions, Medtronic improves the health and lives of millions of people each year. We believe our deep clinical, therapeutic and economic expertise can help address the complex challenges – such as rising costs, aging populations and the burden of chronic disease – faced by families and healthcare systems today. But no one can do it alone. That’s why we’re committed to partnering in new ways and developing powerful solutions that deliver better patient outcomes.

Founded in 1949 as a medical repair company, we’re now among the world’s largest medical technology, services and solutions companies, employing more than 85,000 people worldwide, serving physicians, hospitals and patients in nearly 160 countries. Join us in our commitment to take healthcare Further, Together.

Learn more at www.medtronic.com

Acknowledgement

The British Society for Gynaecological Endoscopy wishes to express its sincere gratitude and appreciation to our Platinum sponsors for the meeting and for their continuing support of the society.
## MAIN CONFERENCE ROOM

**Tuesday, 17th May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Chair/Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00-09:00</td>
<td><strong>Registration</strong></td>
<td>Miss Susie Bates</td>
</tr>
<tr>
<td>09:00-09:10</td>
<td><strong>Welcome address</strong> Chair of Local Organising Committee</td>
<td></td>
</tr>
<tr>
<td>09:10-09:50</td>
<td><strong>Session Chairs:</strong> Ertan Saridogan and Mark Whittaker</td>
<td></td>
</tr>
<tr>
<td>09:10-09:50</td>
<td><strong>Health Economics – how it all works</strong></td>
<td>Mr Alex Bates</td>
</tr>
<tr>
<td>09:50-10:10</td>
<td><strong>Heavy Menstrual Bleeding - The Health Technology Assessment Explained</strong></td>
<td>Ms Natalie Cooper</td>
</tr>
<tr>
<td>10:10-10:20</td>
<td><strong>FC1 Cadaveric surgery in core gynaecology training</strong></td>
<td>Mr Chou Phay Lim</td>
</tr>
<tr>
<td>10:20-10:30</td>
<td><strong>FC2 Are animal laboratory models superior to virtual reality simulation in Advanced Hysteroscopic Surgery training - going back to the future.</strong></td>
<td>Mr Zahid Khan</td>
</tr>
<tr>
<td>10:30-10:40</td>
<td><strong>FC3 A Comparative Study of Contrasting National Training Programmes in Advanced Gynaecological Endoscopy</strong></td>
<td>Mr James McLaren</td>
</tr>
<tr>
<td>10:40-10:50</td>
<td><strong>FC4 Minitouch Endometrial Ablation in an Office Setting without Anaesthesia - 4-year Experience</strong></td>
<td>Mr Benedikt Tas</td>
</tr>
<tr>
<td>10:50-11:00</td>
<td><strong>FC5 Does hysteroscopic myomectomy increase risk of placental disorders?</strong></td>
<td>Mr Nitish Narvekar</td>
</tr>
<tr>
<td>11:00-11:15</td>
<td><strong>Tea, Coffee and Refreshments</strong></td>
<td></td>
</tr>
<tr>
<td>11:15-12:00</td>
<td><strong>Session Chairs:</strong> Thomas Ind and Jim Clark</td>
<td></td>
</tr>
<tr>
<td>11:15-12:00</td>
<td><strong>Platinum 1 Sponsored Lecture by Olympus</strong></td>
<td>Mr Arvind Vashisht</td>
</tr>
<tr>
<td>11:15-12:00</td>
<td><strong>Enhancing treatment choices for women with severe endometriosis</strong></td>
<td></td>
</tr>
<tr>
<td>12:00-12:20</td>
<td><strong>Is laparoscopy needed for diagnosis of Endometriosis?</strong></td>
<td>Prof. Christian Becker</td>
</tr>
<tr>
<td>12:20-12:40</td>
<td><strong>NICE guidance on Hysterectomy and the BSGE.</strong></td>
<td>Mr Ertan Saridogan</td>
</tr>
<tr>
<td>12:40-13:00</td>
<td><strong>Modern management of Adenomyosis</strong></td>
<td>Prof. Hans Bröllmann</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td><strong>Lunch</strong></td>
<td></td>
</tr>
<tr>
<td>13:00-13:45</td>
<td><strong>Platinum 5 Sponsored Lunchtime symposium by Stryker</strong></td>
<td>Mr Oliver O’Donovan</td>
</tr>
<tr>
<td>13:00-13:45</td>
<td><strong>Optimising Theatre Efficiency</strong></td>
<td></td>
</tr>
<tr>
<td>14:00-14:30</td>
<td><strong>Session Chairs:</strong> Dominic Byrne and Tyrone Carpenter</td>
<td></td>
</tr>
<tr>
<td>14:00-14:30</td>
<td><strong>Sir Alec Turnbull Lecture “Creating Change”</strong></td>
<td>Mr Alfred Cutner</td>
</tr>
<tr>
<td>14:30-14:40</td>
<td><strong>FC6 Robotic assisted hysterectomy: experience of the first 85 cases</strong></td>
<td>Mr Chou Phay Lim</td>
</tr>
<tr>
<td>14:40-14:50</td>
<td><strong>FC7 Preventing Recurrence of Endometriosis by means of Long-acting Progestogen Therapy: the PRE-EMPT pilot study</strong></td>
<td>Dr Jane Phay Lim</td>
</tr>
<tr>
<td>14:50-15:00</td>
<td><strong>FC8 Uterine Endometriosis - Incidence and histological classification in patients undergoing laparoscopic surgery for severe recto-vaginal endometriosis: A Prospective cohort Study.</strong></td>
<td>Mr Fevzi Shakir</td>
</tr>
<tr>
<td>15:00-15:10</td>
<td><strong>FC9 Esmya and its effects: laparoscopic myomectomy after using Ulipristal acetate</strong></td>
<td>Ms Mehmoosh Aref-Adib</td>
</tr>
<tr>
<td>15:10-15:20</td>
<td><strong>FC10 Return to work post laparoscopic myomectomy and laparoscopic hysterectomy: is there a difference?</strong></td>
<td>Ms Mehmoosh Aref-Adib</td>
</tr>
<tr>
<td>15:20-15:30</td>
<td><strong>FC11 A comparison of the safety of two techniques for laparoscopic tissue morcellation in an extraction bag</strong></td>
<td>Ms Claire Park</td>
</tr>
<tr>
<td>15:30-16:00</td>
<td><strong>Tea, Coffee and Refreshments</strong></td>
<td></td>
</tr>
<tr>
<td>16:00-16:45</td>
<td><strong>Session Chairs:</strong> Jonathan Frappell and Kirana Arambage</td>
<td></td>
</tr>
<tr>
<td>16:00-16:45</td>
<td><strong>Platinum 2 Sponsored Lecture by Ethicon “Innovation in Medical Devices”</strong></td>
<td>Mr Randy Byrum</td>
</tr>
<tr>
<td>16:45-17:30</td>
<td><strong>BSGE AGM 2016</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Main Conference Room**

**Wednesday, 18th May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Session Chairs</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:15-09:00</td>
<td><strong>Opening of Day 2 and Registration</strong></td>
<td>Tom Smith-Walker and Chris Guyer</td>
<td></td>
</tr>
<tr>
<td>09:00-09:40</td>
<td>Small is Beautiful: Mini and Micro-laparoscopy, Fad or Future?</td>
<td>Prof. Fabio Ghezzi</td>
<td></td>
</tr>
<tr>
<td>09:40-10:00</td>
<td>Big is beautiful: Endometriosis Database analysis of over 4,500 patients with RVE</td>
<td>Mr Dominic Byrne</td>
<td></td>
</tr>
<tr>
<td>10:00-10:10</td>
<td>FCV12 Technical Video: Combined Laparoscopic, Vescoscopic and Vaginal Repair of a Vesico-Vaginal Fistula</td>
<td>Mr Fevzi Shakir</td>
<td></td>
</tr>
<tr>
<td>10:10-10:20</td>
<td>FCV13 A video of severe ureteric endometriosis - primary surgery, post surgical complications and minimal access solutions.</td>
<td>Mr Richard Keedwell</td>
<td></td>
</tr>
<tr>
<td>10:20-10:50</td>
<td><strong>Tea, Coffee and Refreshments</strong></td>
<td>Simon Jackson and Natasha Waters</td>
<td></td>
</tr>
<tr>
<td>10:50-11:10</td>
<td>Does Laparoscopic Urogynaecology have a firm foundation or is it on shifting sand?</td>
<td>Mr Arvind Vashisht</td>
<td></td>
</tr>
<tr>
<td>11:10-11:30</td>
<td>Evidence based management of tubal ectopic pregnancies and UK adoption of Laparoscopic surgery.</td>
<td>Mr Jim Clark</td>
<td></td>
</tr>
<tr>
<td>11:30-11:50</td>
<td>Contemporary management of ovarian torsion</td>
<td>Mr Tom Holland</td>
<td></td>
</tr>
<tr>
<td>11:50-12:00</td>
<td>FCV14 Unexpected encounters with ureters</td>
<td>Mr Suku George</td>
<td></td>
</tr>
<tr>
<td>12:00-12:10</td>
<td>FCV15 Laparoscopic excision of endometriotic nodule of the bladder with and without invasion of the bladder mucosa</td>
<td>Mr Charilaos Charalampidis</td>
<td></td>
</tr>
<tr>
<td>12:10-12:20</td>
<td>FCV16 Mini-laparoscopic transvesical approach for the management of urethral mesh erosion</td>
<td>Mr Ryan Hogan</td>
<td></td>
</tr>
<tr>
<td>12:20-12:30</td>
<td>Platinum 3 Sponsored Lecture by Karl Storz “Winning with mindset”</td>
<td>Mr Mark Colbourne</td>
<td></td>
</tr>
<tr>
<td>13:05-14:00</td>
<td><strong>Lunch</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td><strong>Presidential address</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-14:35</td>
<td>Evidence for the management of asymptomatic polyps</td>
<td>Mr Paul Smith</td>
<td></td>
</tr>
<tr>
<td>14:35-15:00</td>
<td>Hysteroscopic resection of fibroids: Long term clinical outcomes</td>
<td>Prof. Justin Clark</td>
<td></td>
</tr>
<tr>
<td>15:00-15:45</td>
<td>Platinum 4 Sponsored Lecture by Medtronic “Is there a benefit from colorectal modules in training advanced gynaecological surgeons?”</td>
<td>Prof. Donal Brennan</td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td><strong>Tea, Coffee and Refreshments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:00-16:45</td>
<td><strong>Debate</strong> – This house believes that current training in laparoscopic surgery is not adequate for trainees needs.</td>
<td>Mr Sanjay Vyas</td>
<td>For: Mr Sanjay Vyas Against: Miss Donna Ghosh</td>
</tr>
<tr>
<td>16:45-17:00</td>
<td>Awards for Best Presentations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17:00</td>
<td>Close of meeting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CONFERENCE ROOM 2

**Tuesday, 17th May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00-09:00</td>
<td>Registration</td>
</tr>
<tr>
<td>09:10-09:15</td>
<td>Welcome address from Endometriosis Training Day Session chair</td>
</tr>
<tr>
<td></td>
<td>Cathy Dean, Endometriosis Nurse Specialist/Nurse Sonographer, Royal Cornwall Hospital</td>
</tr>
<tr>
<td>09:15-09:45</td>
<td>Acupuncture for Pain</td>
</tr>
<tr>
<td></td>
<td>Reg D’Souza, Advanced Member of the Acupuncturists Association of Chartered Physiotherapists,</td>
</tr>
<tr>
<td></td>
<td>Royal Cornwall Hospital</td>
</tr>
<tr>
<td>09:45-10:15</td>
<td>Empowering Women</td>
</tr>
<tr>
<td></td>
<td>Carol Pearson, Patient Lead, Endo UK</td>
</tr>
<tr>
<td>10:15-10:35</td>
<td>Facilitating A Support Group</td>
</tr>
<tr>
<td></td>
<td>Wendy Rae Mitchell, Gynaec Nurse Specialist, Royal Surrey County Hospital</td>
</tr>
<tr>
<td>10:35-10:50</td>
<td>Tea, Coffee and Refreshments</td>
</tr>
<tr>
<td>10:50-11:50</td>
<td>Sex therapy: What it is and whom to refer</td>
</tr>
<tr>
<td></td>
<td>Dr Robin Bell, Associate Specialist in Sexual Health, Royal Cornwall Hospital</td>
</tr>
<tr>
<td>11:50-12:15</td>
<td>HRT and menopause</td>
</tr>
<tr>
<td></td>
<td>Debra Holloway, Nurse Consultant, Gynaecology, Guys and St. Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>12:15-12:40</td>
<td>Care and Advice of women following bowel resection</td>
</tr>
<tr>
<td></td>
<td>Karen Cock, Lead Colo-rectal Specialist Nurse, Royal Cornwall Hospital</td>
</tr>
<tr>
<td>12:40-13:40</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:40-14:15</td>
<td>A self-referral nurse led clinic model; decreasing emergency admissions and increasing patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Liz Bruen, Endometriosis Nurse Specialist, University of Wales</td>
</tr>
<tr>
<td><strong>Session Chair:</strong></td>
<td>Carol Pearson, Patient lead, Endo UK</td>
</tr>
<tr>
<td>14:15-15:15</td>
<td>Patient Experience</td>
</tr>
<tr>
<td></td>
<td>Rah Holden, Matt Hickenbottom and Rachel Jackson</td>
</tr>
<tr>
<td>15:15-15:30</td>
<td>Tea, Coffee and Refreshments</td>
</tr>
<tr>
<td>15:30-15:45</td>
<td>Endometriosis CNS Audit</td>
</tr>
<tr>
<td></td>
<td>Gill Smith, Nurse Consultant, Northampton General Hospital</td>
</tr>
<tr>
<td>15:45-16:05</td>
<td>Keeping up with Endometriosis! Guiding Nurse Specialists on Current Research Activities</td>
</tr>
<tr>
<td></td>
<td>Deb Panes, Endometriosis Nurse Specialist, St. Michael’s Hospital, Bristol</td>
</tr>
<tr>
<td><strong>Session Chair:</strong></td>
<td>Wendy Norton, RCN Woman’s Health Forum Committee Member and Senior Lecturer in Health and Social Care (Sexual Health), de Montfort University, Leicester</td>
</tr>
<tr>
<td>16:05-16:45</td>
<td>Reinforcing the role of the Endometriosis CNS: An open forum</td>
</tr>
<tr>
<td></td>
<td>Panel: Deb Panes, Endometriosis Nurse Specialist, St. Michael’s Hospital</td>
</tr>
<tr>
<td></td>
<td>Helen Dewart, Research Nurse and Pelvic Pain Specialist Nurse, Royal Infirmary of Edinburgh</td>
</tr>
<tr>
<td></td>
<td>Gill Smith, Nurse Consultant, Northampton General Hospital</td>
</tr>
</tbody>
</table>
## Conference Room 2

**Wednesday, 18th May 2016**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Chair/Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:15-09:00</td>
<td><strong>Opening of Day 2 and Registration</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Session Chair:</strong> Gill Smith, Nurse Consultant, Northampton General Hospital</td>
<td></td>
</tr>
<tr>
<td>09:00-09:10</td>
<td>Welcome/Introduction</td>
<td>Gill Smith, Nurse Consultant, Northampton General Hospital</td>
</tr>
<tr>
<td>09:10-09:30</td>
<td>Nurse Hysteroscopy Update</td>
<td>Julia Pansini-Murrell, Lead Midwife Educator Health, Bradford Teaching Hospital</td>
</tr>
<tr>
<td>09:30-09:50</td>
<td>Hysteroscopy Associated Research &amp; NH contribution</td>
<td>Justin Clark, Consultant Obstetrician and Gynaecologist, Birmingham Women’s Hospital</td>
</tr>
<tr>
<td>09:50-10:10</td>
<td>Hysteroscopic tissue removal systems in the outpatient clinic</td>
<td>Mary Connor, Consultant Gynaecologist, Royal Hallamshire Hospital</td>
</tr>
<tr>
<td>10:10-10:20</td>
<td>Neuropathic Pain</td>
<td>Liz Bruen, Nurse practitioner, University Hospital of Wales</td>
</tr>
<tr>
<td>10:20-10:50</td>
<td><strong>Tea, Coffee and Refreshments</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Session Chair:</strong> Heather Hudson, Nurse Hysteroscopist, St James Hospital</td>
<td></td>
</tr>
<tr>
<td>10:50-11:20</td>
<td>RCOG affiliate research</td>
<td>Victoria Bytel, Director of Membership, RCOG</td>
</tr>
<tr>
<td>11:20-11:50</td>
<td>Implementing effective 2 week wait clinics</td>
<td>Gill Barnes, Nurse Colposcopist / Hysteroscopist Gynaecology Endoscopy Suite Manager, Pennine Acute Hospitals NHS Trust</td>
</tr>
<tr>
<td>11:50-13:05</td>
<td>Discussion/Group work</td>
<td>Gill Smith, Nurse Consultant, Northampton General Hospital</td>
</tr>
<tr>
<td>12:40-13:40</td>
<td><strong>Lunch</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Session Chair:</strong> Chris Guyer and Thomas Ind</td>
<td></td>
</tr>
<tr>
<td>14:15-14:25</td>
<td>FCV17 Different routes of access to the uterine arteries for ligation prior to difficult uterine surgery</td>
<td>Ms Joanne Clay</td>
</tr>
<tr>
<td>14:25-14:35</td>
<td>FCV18 720-degree leiomyotic uterine torsion managed by total laparoscopic hysterectomy</td>
<td>Ms Donna Ghosh</td>
</tr>
<tr>
<td>14:35-14:45</td>
<td>FCV19 A different point of view: Gaining perspective on the ‘giant’ fibroid uterus.</td>
<td>Mr Richard Keedwell</td>
</tr>
<tr>
<td>14:45-14:55</td>
<td>FCV20 Vaginal NOTES Hysterectomy – A future with no scars?</td>
<td>Ms Joanne Clay</td>
</tr>
</tbody>
</table>
## LANAI ROOM

### Tuesday, 17th May 2016

<table>
<thead>
<tr>
<th>Session Chair: Natalia Price</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>09:10- 10:10</strong></td>
</tr>
<tr>
<td>How to do a sacrohysteropexy</td>
</tr>
<tr>
<td><strong>10:10- 11:00</strong></td>
</tr>
<tr>
<td><strong>11:00- 11:15</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Elizabeth Ball</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12:00- 12:40</strong></td>
</tr>
<tr>
<td>Ipsilateral suturing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Oliver Chappatte</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14:30- 15:30</strong></td>
</tr>
<tr>
<td>How to resect a fibroid</td>
</tr>
<tr>
<td><strong>15:30- 16:00</strong></td>
</tr>
</tbody>
</table>

### Wednesday, 18th May 2016

<table>
<thead>
<tr>
<th>Session Chair: Jonathan Lord</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10:50- 11:30</strong></td>
</tr>
<tr>
<td>How to do a laparoscopic subtotal Hysterectomy</td>
</tr>
<tr>
<td><strong>11:30- 12:20</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Sanjay Vyas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14:15- 15:00</strong></td>
</tr>
<tr>
<td>Laparoscopic surgical anatomy</td>
</tr>
</tbody>
</table>
## GARDEN ROOM

### Tuesday, 17th May 2016

<table>
<thead>
<tr>
<th>Session Chair: Elizabeth Ball</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:10- 10:20 <strong>Video Poster Viewing</strong></td>
</tr>
<tr>
<td>10:20- 11:00 Laparoscopy in Pregnancy experts meeting – By invitation only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Jonathan Frappell</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00- 12:40 <strong>Meet the Expert</strong> Medico-legal workshop</td>
</tr>
<tr>
<td>12:40- 13:00 Menstrual Disorders Clinical Study Group meeting – By invitation only</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Ertan Saridogan</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:30- 15:30 <strong>The BSGE National ‘LapHyst’ Project introductory meeting</strong></td>
</tr>
<tr>
<td>The BSGE has now launched its ambitious project to train 400 UK gynaecologists to perform Total laparoscopic Hysterectomy (TLH), so patients nationwide can gain access to this benefits of TLH. The meeting will explain the programme and report on progress. If you’re a senior trainee, or consultant and interested in learning how to perform TLH, come along and hear about the project.</td>
</tr>
</tbody>
</table>

### Wednesday, 18th May 2016

<table>
<thead>
<tr>
<th>Session Chair: Simon Jackson</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:10- 10:20 <strong>Video Poster Viewing</strong></td>
</tr>
<tr>
<td>10:20- 10:50 <strong>Tea, Coffee and Refreshments</strong></td>
</tr>
<tr>
<td>10:50- 11:30 <strong>Endometriosis Centres team meeting</strong></td>
</tr>
<tr>
<td>For Endocentres leads and their teams</td>
</tr>
<tr>
<td>A chance for BSGE Endometriosis Centre teams to hear about latest developments and active issues affecting BSGE Endocentres. Come along and meet with fellow Endocentre teams to discuss active issues and ideas for further development.</td>
</tr>
<tr>
<td>11:30- 12:20 <strong>Trainees Breakout Meeting- RIGS</strong></td>
</tr>
<tr>
<td>The registrars in gynaecological surgery (RIGS) session is an exciting new platform for trainees which is being launched at this year's Annual Scientific Meeting. It is a group for trainees as part of the BSGE that will focus on support and training in a structured way, ultimately providing useful information and resources. As part of this session trainees will have the opportunity to sign up to a competition to win a state of the art simulator for their base hospital for a limited period of time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Ray Garry</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:15- 15:00 <strong>Meet the Expert</strong> The Trials of Undertaking Trials: Re-Evaluating eVALuate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Lisa Verity</th>
</tr>
</thead>
<tbody>
<tr>
<td>16:00- 16:45 <strong>Video Poster Viewing</strong></td>
</tr>
</tbody>
</table>
MEET THE EXPERT

Tuesday, 17th May 2016 – LANAI ROOM

<table>
<thead>
<tr>
<th>Session Chair: Natalia Price</th>
<th>09:10- 10:10</th>
<th><strong>How to do a sacrohysteropexy</strong></th>
<th>Natalia Price</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Laparoscopic sacrohysteropexy: points of technique, anatomical variations, outcomes and complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10:10- 11:00</td>
<td><strong>How to perform a TLH</strong></td>
<td>Tom Smith-Walker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>From start to finish, how to cope with common challenges and apply some 'tricks &amp; tips'</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Elizabeth Ball</th>
<th>12:00- 12:40</th>
<th><strong>Ispilateral suturing</strong></th>
<th>Elizabeth Ball</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Why did no one teach me this earlier? ‘Makes perfect sense!’ Intuitive – faster learning curve’ - these are comments I hear when I teach ipsilateral (same side) laparoscopy including suturing at the Royal London Hospital or in the USA for the AAGL. Suturing is a basic and vital surgical skill in surgery and will help the novice and intermediate MAS surgeon to advance their skills to the next level. In this session I will explain the theory and benefits of ipsilateral suturing and will demonstrate suturing using this method.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Session Chair: Oliver Chappatte</th>
<th>14:30- 15:30</th>
<th><strong>How to resect a fibroid</strong></th>
<th>Oliver Chappatte</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>How to teach a trainee to resect from scratch and progress to resecting polyps, endometrium and Type 1 and 2 fibroids</td>
<td></td>
</tr>
</tbody>
</table>

Tuesday, 17th May 2016 – GARDEN ROOM

<table>
<thead>
<tr>
<th>Session Chair: Jonathan Frappell</th>
<th>12:00- 12:40</th>
<th><strong>Medico-legal workshop</strong></th>
<th>Jonathan Frappell</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>This will be an interactive session which will cover the following areas: 1) How clinicians can protect themselves from the threat of litigation. 2) Taking consent following the Montgomery ruling 3) Advice on getting started as a medico-legal expert</td>
<td></td>
</tr>
</tbody>
</table>
### MEET THE EXPERT

**Wednesday, 18th May 2016 – LANAI ROOM**

<table>
<thead>
<tr>
<th>Session Chair: Jonathan Lord</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10:50- 11:30</strong> How to do a laparoscopic subtotal Hysterectomy</td>
<td>Ben Peyton Jones</td>
</tr>
<tr>
<td>This session is designed to guide you through a laparoscopic sub-total hysterectomy step by step and also discuss tips and tricks to help you improve your technique. We will discuss equipment and port placement and anything else you want to ask.</td>
<td></td>
</tr>
<tr>
<td><strong>11:30- 12:20</strong> How to morcellate in a bag, my experience</td>
<td>Alfred Cutner</td>
</tr>
<tr>
<td>At this session the concept of contained bag morcellation will be discussed. Edited video of one type of containment bag will be presented and tips and tricks around usage will be explained. The video footage and the discussion will result in an understanding as to the advantages and disadvantages regards adoption of such a device. The session would be of interest to those clinicians who currently utilise a morcellator to remove specimens from the abdominal cavity.</td>
<td></td>
</tr>
</tbody>
</table>

**Session Chair: Sanjay Vyas**

|  |
|-----------------------------|--|
| **14:15- 15:00** Laparoscopic surgical anatomy | Fabio Ghezzi |
| The "meet the expert" session on pelvic anatomy is designed for gynaecologists with basic laparoscopic skills who wish to expand their knowledge of retroperitoneal vessels and anatomical spaces and the various operations performed for this. The focus will be on demonstration of pelvic sidewall dissection, preparation for a difficult laparoscopic hysterectomy, landmarks for a safe transvaginal specimen removal. Tips and tricks to avoid the most common vascular and urologic complications will be shown. |  |

**Wednesday, 18th May 2016 – GARDEN ROOM**

<table>
<thead>
<tr>
<th>Session Chair: Ray Garry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14:15- 15:00</strong> The Trials of Undertaking Trials: Re-Evaluating eVALuate.</td>
<td>Ray Garry</td>
</tr>
<tr>
<td>Over the centuries, many interventions that were initially widely accepted by the profession have subsequently been shown to be either harmful or ineffective. It is therefore morally and clinically essential to ensure that any new treatment or therapy is demonstrated to be safe and effective before it is widely introduced. It is widely accepted that the most appropriate method to demonstrate such efficacy is by means of well-structured randomised trials. These are more difficult than is first apparent, particularly if the new intervention is surgical.</td>
<td></td>
</tr>
</tbody>
</table>

**Wednesday, 18th May 2016 – HERRING ALCOVE**

<table>
<thead>
<tr>
<th>Session Chair: Conor Byrne</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>09.00- 16:45</strong> Training Sessions: Endocentres Database 1:1</td>
<td>Conor Byrne</td>
</tr>
<tr>
<td>Pre-booked appointments only</td>
<td></td>
</tr>
</tbody>
</table>
CATERING AND SPONSORS

Catering information

We are lucky to have excellent conference catering provided by the hotel. The ethos at Bedruthan is of simple contemporary food inspired by specialist local growers, farmers and fishermen.

Breakfast is available for all conference delegates in the Wild Café and Herring restaurant between 7am and 9am each morning. In the Exhibition marquee Cornish roasted coffee, homemade cakes and pastries, tea and biscuits and soft drinks are supplied through the day and there is a ‘bag’ lunch available when stated in the programme. Delegates and residents are welcome to order other food and drinks if required and can pay the hotel directly.

Don’t forget to visit the Cocktail Bar in the evening!

“Cocktails are a passion at the hotel and Ian, our resident mixologist, is a master of invention. From his own creations to twists on classics through the eras, there’s something to tingle all tastebuds. The menu is a feast for the senses and Ian home-makes a huge number of his constituent ingredients, often from seasonal or forageable local ingredients. You just have to try it!”

Industry Sponsors

Our Cornish BSGE conference is sponsored by our Industry partners and we appreciate very much their attendance and their contribution to the society. The Industry area is in the Exhibition Palladium and Plaza, both situated below the main conference suite. They welcome the chance to meet all the delegates and discuss their products in person. Refreshments and Lunch are served in the Exhibition halls.
EXHIBITION FLOOR PLAN
PLATINUM SPONSOR

Stryker UK are proud Platinum sponsors of the BSGE, Cornwall. We share collective purpose to help improve standards, promote training and to encourage the sharing of best practice within minimal access Gynaecological surgery.

Stryker ‘Visualisation’ and ‘Communications’ are complimentary units of our Endoscopy division, offering innovative technologies to help you deliver, manage and distinguish anatomy in Minimally Invasive Surgery. Stryker Visualisation enables end users to distinguish anatomy across a range of Gynaecological procedures, whilst providing a simple yet highly personalised experience; we help you to see and do more. The Stryker Communication portfolio presents a very unique single vendor solution in the form of Integrated Operating Theatres (iSuite), Operating Tables and Theatre Lights (Berchtold). With more than 10,000 iSuites worldwide, we have the expertise to help simplify the operating theatre by managing the complexity of equipment and workflow. We are very proud that a number of the BSGE council are Stryker iSuite users and advocates!

We look forward to meeting you on our exhibition stand, where we will give a European first pre-launch preview of the new Stryker 1588 AIM (Advanced Image Modality) camera platform, which has very exciting applications in Gynaecology.

Acknowledgement

The British Society for Gynaecological Endoscopy wishes to express its sincere gratitude and appreciation to our Platinum sponsors for the meeting and for their continuing support of the society.
## INDEX OF AUTHORS

### Author Index by First Author Surname

<table>
<thead>
<tr>
<th>Author Index</th>
<th>Video No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afars K</td>
<td>FC16</td>
</tr>
<tr>
<td>Bhatt D</td>
<td>FC18</td>
</tr>
<tr>
<td>Bidmead J</td>
<td>FC16</td>
</tr>
<tr>
<td>Byrne D</td>
<td>FC18, FC13</td>
</tr>
<tr>
<td>Cardozo L</td>
<td>FC12</td>
</tr>
<tr>
<td>Charalam Pais C</td>
<td>FC15</td>
</tr>
<tr>
<td>Cebal A</td>
<td>FC16</td>
</tr>
<tr>
<td>Clay J</td>
<td>FC17, FC20</td>
</tr>
<tr>
<td>Firth R</td>
<td>FC16</td>
</tr>
<tr>
<td>Fraser G</td>
<td>FC17, FC20</td>
</tr>
<tr>
<td>George S</td>
<td>FC07</td>
</tr>
<tr>
<td>Gogalatassos G</td>
<td>FC05</td>
</tr>
<tr>
<td>Grange P</td>
<td>FC14</td>
</tr>
<tr>
<td>Habib A</td>
<td>FC06</td>
</tr>
<tr>
<td>Holland T</td>
<td>FC15</td>
</tr>
<tr>
<td>Hunt T</td>
<td>FC17</td>
</tr>
<tr>
<td>Kent A</td>
<td>FC12, FC13</td>
</tr>
<tr>
<td>Khali Z</td>
<td>FC02</td>
</tr>
<tr>
<td>Kunde C</td>
<td>FC07</td>
</tr>
<tr>
<td>Kutiunde-Dada A</td>
<td>FC06</td>
</tr>
<tr>
<td>Lim C-P</td>
<td>FC09</td>
</tr>
<tr>
<td>Malik R</td>
<td>FC16</td>
</tr>
<tr>
<td>Milagros D</td>
<td>FC04</td>
</tr>
<tr>
<td>Mina G</td>
<td>FC01</td>
</tr>
<tr>
<td>Naveen N</td>
<td>FC11</td>
</tr>
<tr>
<td>Pandey S</td>
<td>FC03</td>
</tr>
<tr>
<td>Robinson D</td>
<td>FC14</td>
</tr>
<tr>
<td>Saridogan E</td>
<td>FC15</td>
</tr>
<tr>
<td>Shakir F</td>
<td>FC12, FC13</td>
</tr>
<tr>
<td>Swagilangam S</td>
<td>FC01</td>
</tr>
<tr>
<td>Taylor A</td>
<td>FC06</td>
</tr>
<tr>
<td>Thrasmooury G</td>
<td>FC12</td>
</tr>
<tr>
<td>Thomas A</td>
<td>FC14</td>
</tr>
<tr>
<td>Trehan A</td>
<td>FC16</td>
</tr>
<tr>
<td>Author Index</td>
<td>Video No.</td>
</tr>
<tr>
<td>Adar S</td>
<td>FC02</td>
</tr>
<tr>
<td>Adzi T</td>
<td>FC07</td>
</tr>
<tr>
<td>Alfi Y</td>
<td>FC03</td>
</tr>
<tr>
<td>Ahmad G</td>
<td>FC03</td>
</tr>
<tr>
<td>Ahn Y</td>
<td>FC02</td>
</tr>
<tr>
<td>Aplu T</td>
<td>FC04</td>
</tr>
<tr>
<td>Alam A</td>
<td>FC05</td>
</tr>
<tr>
<td>Al-Lamhan H</td>
<td>FC03</td>
</tr>
<tr>
<td>Ambatigage K</td>
<td>FC03</td>
</tr>
<tr>
<td>Asnoud M</td>
<td>FC06</td>
</tr>
<tr>
<td>Ashto S</td>
<td>FC07</td>
</tr>
<tr>
<td>Barnes G</td>
<td>FC09</td>
</tr>
<tr>
<td>Barneeri A</td>
<td>FC06</td>
</tr>
<tr>
<td>Bevan R</td>
<td>FC16</td>
</tr>
<tr>
<td>Bhandar H</td>
<td>FC05</td>
</tr>
<tr>
<td>Bhattachar K</td>
<td>FC14</td>
</tr>
<tr>
<td>Bhata K</td>
<td>FC14</td>
</tr>
<tr>
<td>Bethia S</td>
<td>FC10, FC30</td>
</tr>
<tr>
<td>Bines G</td>
<td>FC05</td>
</tr>
<tr>
<td>Bizzle C</td>
<td>FC18</td>
</tr>
<tr>
<td>Bioner E</td>
<td>FC05</td>
</tr>
<tr>
<td>Butler-Manuel S</td>
<td>FC01, FC39</td>
</tr>
<tr>
<td>Byrne P</td>
<td>FC03</td>
</tr>
<tr>
<td>Chaflou B</td>
<td>FC02</td>
</tr>
<tr>
<td>Charampatis C</td>
<td>FC02</td>
</tr>
<tr>
<td>Chase A</td>
<td>FC16, FC36</td>
</tr>
<tr>
<td>Clark J</td>
<td>FC03</td>
</tr>
<tr>
<td>Connor M</td>
<td>FC05</td>
</tr>
<tr>
<td>Cox E</td>
<td>FC08</td>
</tr>
<tr>
<td>Crooks M</td>
<td>FC08</td>
</tr>
<tr>
<td>Currer A</td>
<td>FC03</td>
</tr>
<tr>
<td>Das K</td>
<td>FC03, FC54</td>
</tr>
<tr>
<td>Dawoja O</td>
<td>FC01</td>
</tr>
<tr>
<td>Deller C</td>
<td>FC07</td>
</tr>
<tr>
<td>Dempsey A</td>
<td>FC08</td>
</tr>
<tr>
<td>DeDonata N</td>
<td>FC04</td>
</tr>
<tr>
<td>Dilley J</td>
<td>FC06</td>
</tr>
<tr>
<td>Dusi S</td>
<td>FC01</td>
</tr>
<tr>
<td>Dreicher A</td>
<td>FC02</td>
</tr>
<tr>
<td>Drosthen K</td>
<td>FC02</td>
</tr>
<tr>
<td>Brickington N</td>
<td>FC02</td>
</tr>
<tr>
<td>English J</td>
<td>FC06</td>
</tr>
<tr>
<td>Fenton L</td>
<td>FC04</td>
</tr>
<tr>
<td>Fox K</td>
<td>FC05</td>
</tr>
<tr>
<td>Forster LS</td>
<td>FC02</td>
</tr>
<tr>
<td>Gardiner S</td>
<td>FC06</td>
</tr>
<tr>
<td>Galliaqua J</td>
<td>FC06</td>
</tr>
<tr>
<td>George R</td>
<td>FC06</td>
</tr>
<tr>
<td>Goodall E</td>
<td>FC05</td>
</tr>
<tr>
<td>Georg A</td>
<td>FC04</td>
</tr>
<tr>
<td>Grant M</td>
<td>FC02</td>
</tr>
<tr>
<td>Gualit N</td>
<td>FC06</td>
</tr>
<tr>
<td>Gupta S</td>
<td>FC03, FC39</td>
</tr>
<tr>
<td>Guyer C</td>
<td>FC06</td>
</tr>
<tr>
<td>Haerizadeh H</td>
<td>FC02, FC03</td>
</tr>
<tr>
<td>Hafajangama D</td>
<td>FC05, FC06</td>
</tr>
<tr>
<td>Hartman S</td>
<td>FC03, FC04</td>
</tr>
<tr>
<td>Hayes K</td>
<td>FC02</td>
</tr>
<tr>
<td>Hogg L</td>
<td>FC06</td>
</tr>
<tr>
<td>Holw N</td>
<td>FC07</td>
</tr>
<tr>
<td>Holvy N</td>
<td>FC19</td>
</tr>
<tr>
<td>Hom G</td>
<td>FC06</td>
</tr>
<tr>
<td>Huph K</td>
<td>FC08</td>
</tr>
<tr>
<td>Inusami O</td>
<td>FC02, FC03</td>
</tr>
<tr>
<td>Ind T</td>
<td>FC02, FC35</td>
</tr>
<tr>
<td>Jackson S</td>
<td>FC03, FC30</td>
</tr>
<tr>
<td>Jani M</td>
<td>FC04</td>
</tr>
<tr>
<td>Jeffers H</td>
<td>FC04</td>
</tr>
<tr>
<td>Jobe Y</td>
<td>FC06</td>
</tr>
<tr>
<td>Johnson R</td>
<td>FC04</td>
</tr>
<tr>
<td>Juneja R</td>
<td>FC02</td>
</tr>
<tr>
<td>Kadwakadiar N</td>
<td>FC06</td>
</tr>
<tr>
<td>Kamar H</td>
<td>FC03</td>
</tr>
<tr>
<td>Kargar R</td>
<td>FC04</td>
</tr>
<tr>
<td>Karujaweanyjy W</td>
<td>FC07</td>
</tr>
<tr>
<td>Khalid S</td>
<td>FC06</td>
</tr>
<tr>
<td>Khan Z</td>
<td>FC02</td>
</tr>
<tr>
<td>Khashal S</td>
<td>FC04</td>
</tr>
<tr>
<td>Khine P</td>
<td>FC03</td>
</tr>
<tr>
<td>Kimes R</td>
<td>FC03, FC04</td>
</tr>
<tr>
<td>Kunde C</td>
<td>FC06</td>
</tr>
<tr>
<td>Labib M</td>
<td>FC04</td>
</tr>
<tr>
<td>Lahourides K</td>
<td>FC02</td>
</tr>
<tr>
<td>Lew M</td>
<td>FC05</td>
</tr>
<tr>
<td>Lima L</td>
<td>FC05</td>
</tr>
<tr>
<td>Lima S</td>
<td>FC03</td>
</tr>
<tr>
<td>Lind J</td>
<td>FC02</td>
</tr>
<tr>
<td>Lynch L</td>
<td>FC03</td>
</tr>
<tr>
<td>Macalwerry C</td>
<td>FC06</td>
</tr>
<tr>
<td>Madhira M</td>
<td>FC06</td>
</tr>
<tr>
<td>Magro M</td>
<td>FC09, FC10</td>
</tr>
<tr>
<td>Malhier R</td>
<td>FC04, FC06</td>
</tr>
<tr>
<td>Marten C</td>
<td>FC06</td>
</tr>
<tr>
<td>Mcclaren J</td>
<td>FC04</td>
</tr>
<tr>
<td>McGirk C</td>
<td>FC04</td>
</tr>
<tr>
<td>Middlebett B</td>
<td>FC01</td>
</tr>
<tr>
<td>Mingo O</td>
<td>FC02</td>
</tr>
<tr>
<td>Misfar N</td>
<td>FC04</td>
</tr>
<tr>
<td>Mistra S</td>
<td>FC07</td>
</tr>
<tr>
<td>Mitchell A</td>
<td>FC03</td>
</tr>
<tr>
<td>Mohamed R</td>
<td>FC06</td>
</tr>
<tr>
<td>Mohammad H</td>
<td>FC02</td>
</tr>
<tr>
<td>Moorhouse H</td>
<td>FC02</td>
</tr>
<tr>
<td>Mony E</td>
<td>FC01</td>
</tr>
<tr>
<td>Mustofa H</td>
<td>FC02</td>
</tr>
<tr>
<td>Mulki O</td>
<td>FC03</td>
</tr>
<tr>
<td>Mutuhas S</td>
<td>FC07</td>
</tr>
<tr>
<td>Naji O</td>
<td>FC04</td>
</tr>
<tr>
<td>Narang L</td>
<td>FC02</td>
</tr>
<tr>
<td>Nisser S</td>
<td>FC03</td>
</tr>
<tr>
<td>Nemat I</td>
<td>FC04</td>
</tr>
<tr>
<td>Nethra S</td>
<td>FC02</td>
</tr>
<tr>
<td>Nibbion M</td>
<td>FC03</td>
</tr>
<tr>
<td>Olaro O</td>
<td>FC03</td>
</tr>
<tr>
<td>OConnor C</td>
<td>FC05</td>
</tr>
<tr>
<td>Ofekomi F</td>
<td>FC08, FC02</td>
</tr>
<tr>
<td>Ottbabe M</td>
<td>FC02</td>
</tr>
<tr>
<td>Olivar R</td>
<td>FC08, FC02</td>
</tr>
<tr>
<td>Olorunshola D</td>
<td>FC01</td>
</tr>
<tr>
<td>Padmehr K</td>
<td>FC04</td>
</tr>
<tr>
<td>Page D</td>
<td>FC05</td>
</tr>
<tr>
<td>Papsidis D</td>
<td>FC05, FC12</td>
</tr>
<tr>
<td>Parry-Smith W</td>
<td>FC06</td>
</tr>
<tr>
<td>Pathak M</td>
<td>FC04</td>
</tr>
<tr>
<td>Palinska-Rudzka K</td>
<td>FC05</td>
</tr>
<tr>
<td>Parsley S</td>
<td>FC02, FC03</td>
</tr>
<tr>
<td>Perkell R</td>
<td>FC05</td>
</tr>
<tr>
<td>Peper J</td>
<td>FC06</td>
</tr>
<tr>
<td>Pickering R</td>
<td>FC01</td>
</tr>
<tr>
<td>Pickering G</td>
<td>FC01</td>
</tr>
<tr>
<td>Price N</td>
<td>FC05</td>
</tr>
<tr>
<td>Radmore A</td>
<td>FC05</td>
</tr>
<tr>
<td>Rahman R</td>
<td>FC07</td>
</tr>
<tr>
<td>Raees S</td>
<td>FC07, FC36</td>
</tr>
<tr>
<td>Rana A</td>
<td>FC03, FC04</td>
</tr>
<tr>
<td>Redjepova O</td>
<td>FC04</td>
</tr>
<tr>
<td>Richardson R</td>
<td>FC07, FC02</td>
</tr>
<tr>
<td>Riches L</td>
<td>FC04</td>
</tr>
<tr>
<td>Rodger M</td>
<td>FC01</td>
</tr>
<tr>
<td>Sabu B</td>
<td>FC05, FC02</td>
</tr>
<tr>
<td>Salar A</td>
<td>FC01</td>
</tr>
<tr>
<td>Saravanamuthu J</td>
<td>FC05, FC06</td>
</tr>
<tr>
<td>Sauravafshl F</td>
<td>FC02</td>
</tr>
<tr>
<td>Sennitt T</td>
<td>FC04</td>
</tr>
<tr>
<td>Sharma R</td>
<td>FC07</td>
</tr>
<tr>
<td>Shadjo K</td>
<td>FC04</td>
</tr>
<tr>
<td>Sharma K</td>
<td>FC01</td>
</tr>
<tr>
<td>Steele G</td>
<td>FC06</td>
</tr>
<tr>
<td>Subramanian M</td>
<td>FC03, FC54</td>
</tr>
<tr>
<td>Taggart C</td>
<td>FC05</td>
</tr>
<tr>
<td>Tahlra S</td>
<td>FC05</td>
</tr>
<tr>
<td>Tailor A</td>
<td>FC01, FC09</td>
</tr>
<tr>
<td>Taylor A</td>
<td>FC05</td>
</tr>
<tr>
<td>Tempest N</td>
<td>FC05, FC06</td>
</tr>
<tr>
<td>Teju U</td>
<td>FC05</td>
</tr>
<tr>
<td>Thompson M</td>
<td>FC01, FC07</td>
</tr>
<tr>
<td>Tomojoy I</td>
<td>FC01</td>
</tr>
<tr>
<td>Tong E</td>
<td>FC07</td>
</tr>
<tr>
<td>Tillett A</td>
<td>FC02</td>
</tr>
<tr>
<td>Umranikar S</td>
<td>FC01</td>
</tr>
<tr>
<td>Vandana A</td>
<td>FC01</td>
</tr>
<tr>
<td>Waters N</td>
<td>FC06</td>
</tr>
<tr>
<td>Yula A</td>
<td>FC05</td>
</tr>
<tr>
<td>Zaffiri L</td>
<td>FC06, FC04</td>
</tr>
<tr>
<td>Zabari Y</td>
<td>FC02</td>
</tr>
</tbody>
</table>
FCV12 Technical Video: Combined Laparoscopic, Vesicoscopic and Vaginal Repair of a Vesico-Vaginal Fistula

Author(s): Philippe Grange, Fevzi Shakir, Ganesh Thiagamoorthy, Dudley Robinson, Linda Cardozo

Institution: King’s College Hospital, Denmark Hill, London, SE5 9RS, UK

Study Objective: To demonstrate a combined laparoscopic, vesicoscopic and vaginal approach to repairing a complex vesico-vaginal fistula.

Design: Technical video demonstrating a combined laparoscopic, vesicoscopic and vaginal approach for repairing a vesico-vaginal fistula.

Setting: Urogynaecology and Urology Departments of a tertiary referral centre for Urogynaecology.

Interventions: A 38-year-old woman presented with a vesico-vaginal fistula secondary to a previous total abdominal hysterectomy. An initial attempt to repair the fistula vaginally was unsuccessful due to infection and co-morbidities. After counselling she agreed to a combined laparoscopic, vesicoscopic and vaginal repair of her vesico-vaginal fistula.

Conclusion: Vesico-vaginal fistula following a total abdominal hysterectomy for benign causes has an incidence of 1 in 540. Management of this can be challenging with varied success. Initially a laparoscopy was performed which allowed mobilisation of omentum to provide an interposition patch between the bladder and vagina after repair of the fistula. The fistula tract was then identified vesicoscopically and excised. Once closed and the patch secured, a vaginal approach was adopted to excise the remaining fistula tract as well as scar tissue. Interrupted closure of the vagina was performed in multiple layers to reduce the risk of recurrence.

We have employed vesicoscopy since 2007 for a variety of female urogynaecological problems including bladder diverticula, ureteric stenosis, vesico-ureteric reflux, foreign body removal and repair of vesico-vaginal fistulae. This combined multi-disciplinary approach offers a minimally invasive option for repair of complex vesico-vaginal fistulae, and should be considered in selected complex cases.

FCV13 A video of severe ureteric endometriosis - primary surgery, post surgical complications and minimal access solutions

Author(s): Richard Keedwell¹, Dominic Byrne¹, Anthony Koupparis²

Institution: ¹Royal Cornwall Hospital, Truro, Cornwall, UK, ²Southmead Hospital, Bristol, UK

Endometriosis obstructing the ureter is rare; estimated prevalence of ~0.3%. However it may be under-recognised as silent hydronephrosis is a diagnostic challenge. Symptomatic obstruction is associated with considerable therapeutic challenge and surgery carries a high risk of complication. Laparoscopic surgery carries significant advantage by providing optimal views and microdissection.

The video presentation shows a case of severe ureteric endometriosis and its management. The patient’s obstructed ureter was initially misdiagnosed as a congenital finding. However, subsequent investigation of her endometriosis symptoms confirmed extrinsic ureteric obstruction by endometriosis.

After full counselling excisional surgery was undertaken with ureterolysis and diligent dissection of the left pelvic sidewall to successfully liberate the ureter from an endometriotic nodule. The nodule extended into the recto-vaginal septum and vagina, so removal included a colpotomy. Initially post-surgical result was excellent with immediate and complete resolution of pain. On day five a urinary fistula into the vagina was diagnosed.

CT urogram and retrograde cystourerogram confirmed a distal ureteric leak, likely secondary to occult devascularisation. Images from these investigations are shown. An EUA with cystoscopy and dye test excluded an associated vesico-vaginal fistula. Initially managed by nephrostomy, ultimately the patient had a successful re-implantation of the ureter by robotic laparoscopic surgery (all included in the video). This successfully preserved the advantages of minimal access surgery in the case of severe post-operative complication.
**ABSTRACTS: VIDEO**

**FCV14 Unexpected encounters with ureters**

**Author(s):** Suku George¹, Anita Thomas²  
**Institution:** ¹Stockport NHS Foundation Trust, Stockport, UK, ²St Helens & Knowsley NHS Trust, Whiston, UK

Ureteric injuries are as common as 0.5–3% and are frequently missed. Delayed diagnosis can occur in up to 15% patients and can lead to serious morbidity such as fistula formation, peritonitis, loss of renal function and is a frequent cause of medico legal litigation. The common sites of ureteric injury are at infundibulopelvic ligament, ovarian fossa, uterine vessels, uterosacral ligament and anterior vaginal fornix.

Mechanisms of injury include transection, ligation or necrosis from energy damage or ischaemia. Detailed knowledge of pelvic anatomy, meticulous dissection skills, use of the avascular surgical spaces and good haemostatic principles will keep the pelvic surgeon safe around the ureter. Ureteric injury can be avoided by acquiring the ability to identify its course from the pelvic brim to the bladder, dissecting ureter away preserving the adventitia. Pre operative stenting may be useful in recurrent endometriosis, oncological surgery and when hydroureter is present on imaging.

Three surgical scenarios are presented in the video where the ureter required careful dissection at 1. IP ligament, 2. uterine artery and 3. pelvic sidewall with a duplex ureter.

First scenario shows the inherent danger of assuming ureteric safety by lifting the IP ligament and transection and the requirement for careful dissection along its pelvic course when anatomy is altered in the presence of fibrosis.

Second scenario demonstrates the close relationship of ureter to the uterine artery near the cervix when myomas are present and safe dissection with lateral ligation of uterine artery.

Third scenario shows the unexpected recognition of duplex ureter in a patient with recurrent endometriosis.

**FCV15 Laparoscopic excision of endometriotic nodule of the bladder with and without invasion of the bladder mucosa**

**Author(s):** Charilaos Charalampidis¹, Fawzia Sanaullah¹, Ashwini Trehan²  
**Institution:** ¹York Teaching Hospital, York, UK, ²Elland Hospital, Elland, UK

In this video presentation of 2 cases, we demonstrate the technique of laparoscopic excision of endometriosis nodule of bladder with and without invasion of bladder mucosa.

**Case Report (1):** A 33 year-old nulliparous, woman presented with dysuria, suprapubic pain and dysmenorrhea.

**Investigations:** Ultrasound, MRI and cystoscopy revealed hypoechoic nodule between bladder and uterus which was indenting the bladder. Intraoperatively: 3 cm endometriotic nodule found with deep scarring in the uterosacral pouch and advanced deep endometriosis with rectovaginal nodules. Laparoscopic excision of endometriosis mass in the uterosacral fold and rectal shaving were performed.

**Follow-up:** No urinary symptoms and no pelvic pain. The video demonstrate sharp dissection of vesicouterine space. Bladder nodule was reaching up to the mucosa. Methylene Blue dye in the bladder helped to delineate the muscularis from the bladder mucosa. We will demonstrate excision of the nodule from the muscularis of bladder sparing the unaffected mucosa. The muscularis was then stitched with vicryl 2/0 in two layers.

**Case Report (2):** A 37 year-old nulliparous woman presented with chronic pelvic pain and cyclical cystitis-type symptoms unresponsive to antibiotics.

**Investigations:** USS, MRI and cystoscopy revealed extensive pelvic endometriosis with both bladder and rectovaginal involvement.

**Intraoperatively:** Dense scarring and a bladder nodule found within the uterosacral fold and deep rectovaginal endometriosis. Bladder endometriosis was mobilized away from the uterus and then it was removed by using the Harmonic scalpel. The gap in the bladder sutured in two-layers and watertight seal was confirmed.

**Follow-up:** Symptoms improved and patient will undergo a second stage operation for rectovaginal endometriosis in case of persisting pain.
FCV16 Mini-laparoscopic transvesical approach for the management of urethral mesh erosion

Author(s): Ryan Hogan, Richard Flint, Alexandra Cobb, Kimmee Khan, Karolina Afors, John Bidmead

Institution: King’s College Hospital, London, UK

Tension free vaginal tapes (TVT’s) are widely accepted as effective management for the treatment of female stress urinary incontinence. This procedure is associated with complications, such as intraoperative bladder injuries, pelvic haematomas, and de novo voiding dysfunction. Late complications such as mesh erosion into the bladder and urethra has also been reported with a varying incidence of 0.3%-23%. The recommended treatment of intravesical or urethral mesh related complications is tape removal. Several surgical approaches for mesh removal such as cystoscopic, vaginal, open and laparoscopic techniques have been described in the literature, but no consensus has been reached on the best approach. We demonstrate a novel method for the management of tape related erosion complications using mini-laparoscopic transvesical approach.

We present a fifty year old woman with recurrent urinary tract infections, five years following TVT insertion for urodynamic-confirmed stress urinary incontinence. At cystoscopy, tape erosion into the proximal urethra was confirmed and the patient opted for definitive surgical excision. Using a mini-laparoscopic transvesical approach, the urethral portion of the transvaginal tape was successfully dissected and excised. Patient’s symptoms completely resolved following mesh removal.

This novel surgical approach uses smaller, 3.5mm ports, which in comparison to conventional laparoscopy serves to reduce post-operative pain, the risk of port site bleeding and fistula formation, whilst also reducing recovery time. The transvesical approach enables careful paraurethral dissection and facilitates the excision of challenging tapes not amenable to cystoscopic removal. It provides a safe and effective, minimally invasive alternative for the management of tape erosion.

FCV17 Different routes of access to the uterine arteries for ligation prior to difficult uterine surgery

Author(s): Joanna Clay, Rahul Gore, Georgina Fraser, Elias Kovoor

Institution: Tunbridge Wells Hospital, Kent, UK

Objective: To demonstrate three possible techniques to safely access and ligate the uterine arteries before total laparoscopic hysterectomy. Having alternative safe routes means that increasingly difficult hysterectomies can be performed laparoscopically without damage to the ureter or risk of significant blood loss.

Background: Various studies have discussed the possible benefit of uterine artery ligation at the beginning of total laparoscopic hysterectomy with respect to operating time and blood loss. Even if not adopted routinely, there are benefits to being able to perform uterine artery ligation for difficult surgeries with large or inconveniently sited fibroids. Fibroids may obstruct one route of access to the uterine arteries but our video aims to demonstrate three possible ways to ligate the uterine arteries.

The video shows three different routes to find the uterine arteries at the point they originate from the anterior branch of the internal iliac artery. Identification of the obliterated umbilical artery allows confident identification.

1) Dissect down broad ligament
2) Anterior approach: enter uterovesical fold
3) Lateral approach: enter at pelvic brim

Conclusion: Knowledge at practice at these techniques allows increasingly difficult hysterectomies to be performed laparoscopically.
ABSTRACTS: VIDEO

FCV18 720-degree leiomyotic uterine torsion managed by total laparoscopic hysterectomy

Author(s): Donna Ghosh, Daxina Bhatt, Nahid Gul
Institution: Arrowe Park Hospital, Wirral, UK

Introduction: Uterine torsion is a rare complication of uterine leiomyomas, and by definition is the rotation of the uterus more than 45-degrees along the longitudinal axis. We present a 720-degree (2 x full rotation) uterine torsion in a 28cm fibroid and surgical management of total laparoscopic hysterectomy (TLH).

Case: A 60-year old woman presented with acute abdominal pain and longstanding urinary frequency. Examination identified a large pelvic mass. CT findings suggested torsion of a uterine fibroid. The patient was booked for elective TLH following spontaneous resolution of acute symptoms. A 5mm direct optical entry port at Palms point was used to enter the abdominal cavity. A bi-lobed fibroid uterus, torted around its longitudinal axis by 720-degrees was identified.

Surgical steps included:
1) Division of the round ligaments and reflection of the bladder
2) Retroperitoneal dissection and ureterolysis
3) Securing of uterine arteries with surgical clips
4) Colpotomy with monopolar diathermy
5) Vaginal vault closure with interrupted sutures

The supra-pubic port was extended to 4cm and the 2.1kg specimen morcellated outside the abdomen. The patient made uneventful recovery. Histology confirmed a degenerate leiomyoma with no evidence of malignancy.

Discussion: Uterine torsion is a rare differential diagnosis that should be considered with acute abdominal pain in the presence of uterine leiomyomas. To our knowledge, this is the first case of leiomyotic uterine torsion managed laparoscopically. The video demonstrates the interesting surgical findings and technique in performing safe TLH in the presence of significant anatomical distortion.

FCV19 A different point of view: Gaining perspective on the ‘giant’ fibroid uterus.

Author(s): Richard Keedwell, Dominic Byrne
Institution: Royal Cornwall Hospital, Truro, Cornwall, UK

The large fibroid uterus has long since presented a significant challenge to laparoscopic surgeons at hysterectomy. Problems of access, distorted anatomy and poor visualisation can contribute to the difficulty of surgery. Consequently, the likelihood of heavy blood loss, surgical damage to adjacent structures and conversion to open surgery are all increased. One major factor in preventing these complications is good visualisation of critical structures.

The video demonstrates techniques to improve visualisation during the hysterectomy of a ‘giant’ uterus. A multifibroid uterus, of 22 week equivalent size, is observed from a standard viewpoint. Recognising the limitations of this perspective, a sub-costal port is inserted. However, visualisation of uterine vessels and the vaginal vault remains suboptimal. A 30-degree laparoscope is then used through the umbilical port and affords improved views to the uterovesical fold. However, visual access to the uterine vessels remains obscured by the enormity of the uterine body. The 30-degree scope is introduced via the subcostal port, and angled correctly toward the lateral aspect of the uterus. This allows safe and efficient diathermy and transection of the pedicles bilaterally. The vaginal vault is also visible posteriorly, allowing its safe opening with diathermy.

In this case, the advantages of the laparoscopic approach were preserved despite the significant challenge of the ‘giant’ uterus. The use of the 30-degree laparoscope saved operating time, and may have prevented complications. We recommend this approach when faced with sub-optimal views at operative laparoscopy.
FCV20 Vaginal NOTES Hysterectomy –
A future with no scars?

Author(s): Joanna Clay, Rahul Gore, Georgina Fraser, Elias Kovoor

Institution: Tunbridge Wells Hospital, Kent, UK

Natural orifice transluminal endoscopic surgery (NOTES) has been hailed by some as the new frontier of minimally invasive surgery. Avoiding abdominal incisions has a cosmetic benefit, but also removes risk of abdominal wound infections or port site hernias and potentially reduces pain and anaesthesia requirements.

A Cochrane review showed that vaginal hysterectomy has lower complication rates than abdominal hysterectomy. It has been shown to have a shorter operating time and less blood loss than laparoscopic hysterectomy with no significant difference in other complications.

The limitation of vaginal hysterectomy is the difficulty in operating on the adnexae. Recent moves to recommend bilateral salpingectomy with hysterectomy to reduce cancer risk may mean that a laparoscopic or abdominal hysterectomy is recommended over vaginal to allow salpingectomy.

We show a video of a vaginal hysterectomy and bilateral salpingo-oophorectomy performed via a vaginal NOTES procedure. This has the advantages of a vaginal hysterectomy with safe access to the adnexae using laparoscopic instruments and allows inspection of the abdominal cavity.

A colpotomy incision is made as one would for a vaginal hysterectomy, the anterior and posterior cul de sac is opened and the uterosacral ligaments are ligated. An Alexis retractor is placed into the colpotomy with a “glove port” and the operation is completed with laparoscopic instruments.

Please note: Abstracts are reproduced as submitted.
ABSTRACTS: ORAL

FC01  Cadaveric surgery in core gynaecology training

Author(s): Chou Phay Lim, Tony Chaloub, Mark Roberts
Institution: Royal Victoria Infirmary, Newcastle Upon Tyne, UK

Background: Cadaveric surgery is not part of core training within gynaecology. We aimed to determine the validity of cadaveric surgery in gynaecology.

Method: We conducted a surgical course for gynaecology trainees using fresh frozen cadavers. Facilitators were consultant gynaecologists from training units across the region. We assessed the validity by a delegate self-assessed confidence quotient scoring system on a scale between ‘no confidence’ (0 point) and ‘full confidence’ (10 points); a facilitator-assessed objective structured assessment tool (OSAT); and a delegate satisfaction survey.

Findings: All 13 trainees of similar seniority (ST3) within Health Education northeast (HEnE) participated as delegates in the course. Each workstation had one female cadaver torso to be shared between two or three delegates and one facilitator, making a delegate:facilitator ratio of 2.17. The improvement in mean confidence quotient score across the group was 2.85 for laparoscopic sterilisation, 4.15 for laparoscopic salpingectomy, 4.23 for laparoscopic oophorectomy, 4.31 for specimen retrieval, 2.23 for opening and closing the abdomen, 3.31 for optimising surgical field, and 3.85 for abdominal hysterectomy. The OSATs from the facilitators ensured active participation of all the delegates as primary surgeons in various procedures. The mode number of OSATs completed was 4 (3-6) per delegate. No delegates found the experience of cadaveric work unpleasant. The survey attracted universally complimentary feedback.

Conclusion: Cadaveric surgery with the use of structured assessment tools provides a positive improvement in trainees’ confidence on intermediate gynaecological procedures. It is a useful adjunct to conventional gynaecology training for the ultimate aim of safe surgery.

FC02  Are animal laboratory models superior to virtual reality simulation in Advanced Hysteroscopic Surgery training – going back to the future

Author(s): Zahid Khan, Ayman Ewies
Institution: Birmingham City Hospital, Birmingham, UK

Objectives: Advanced hysteroscopic surgery procedures have a slow learning curve and a narrow margin for error. Recently, due to reduced training opportunities, a major shift in surgical training is towards the use of virtual reality simulation over animal (wet-lab) models. There is limited evidence in favour of one over the other.

We have validated, evaluated and reviewed every single modality available for training in hysteroscopic surgery and aim to present our findings in favour of the animal models.

Methods: We organized an annual three-day hands-on advanced hysteroscopic surgery course where every modality available for training was made available to attendees. Our animal models included the ‘Cattle Uterus Model’ and ‘Pig Bladder Model’.

Candidates were instructed to complete feedback questionnaires, to thoroughly evaluate each of the practical skills stations. The feedback was collected from courses over a two year period.

Results: Simulation of hysteroscopic resection using cattle uterus scored the highest overall score of 94.65, markedly better than computer graphic based simulation stations that scored an average of 83.88 (lowest being 78.50).

Candidates preferred the realism of the resection on the animal models with comments such as it being ‘exceptional’, providing them with ‘a real feel of how it works’, by improving tactile feedback.

Conclusions: Despite the merits of virtual reality simulators, they are far from representing the real challenges encountered in theatres. We believe that animal models such as the ‘Cattle Uterus Model’ will facilitate rapid acquisition of skills complementing conventional surgical training, aiming to maximize clinical exposure and experience.
FC03 A Comparative Study of Contrasting National Training Programmes in Advanced Gynaecological Endoscopy

Author(s): James McLaren¹, Rasiah Bharathan², Thomas Ind¹
Institution: ¹Royal Marsden Hospital, London, UK, ²Royal Surrey County Hospital, Guildford, UK

Introduction: In collaboration with their respective Colleges, the British Society of Gynaecological Endoscopy (BSGE) and Australasian Gynaecological Endoscopy Society (AGES) have introduced a two-year national specialty programme in advanced gynaecological endoscopy. This is the first study aimed at comparing national programmes in advanced gynaecological endoscopy.

Methods: A questionnaire was developed based on UK Joint Committee on Surgical Training (JCST) quality indicators in three areas: Operative Case Volume, Supervision Level, Education & Research. The questionnaire was distributed electronically to 18 AGES & 25 BSGE endoscopic fellows.

Results: 53% (23/43) response rate (13 BSGE, 10 AGES). BSGE respondents had a median of 5 theatre and 2 clinic sessions per week compared with 4 (p=0.31) and 2 (p=0.36). BSGE respondents completed a median of 6.5 elective & 3 emergency cases as primary surgeon per week vs 6 elective (p=0.92) & 2 emergency (0.27). As first assistant, BSGE respondents completed 5 elective & 1 emergency case per week compared with 6 & 1. Consultant was ‘always’ or ‘often’ first assistant 85.7% (p=0.12) of BSGE respondents and 37.5% of AGES respondents. 30% (3/10) of AGES trainees were undertaking higher education compared with 8% (1/13) BSGE respondents. All respondents felt they would be competent to perform TLH & Stage IV Endometriosis (excluding bowel resection) at the completion of their fellowship.

Conclusions: BSGE and AGES respondents receive similar operative case volume. AGES trainees, appear to have less supervision and were more likely to be undertaking higher education. Despite these apparent differences, trainees appear to reach similar competences.

FC04 Minitouch Endometrial Ablation in an Office Setting without Anaesthesia – 4-year Experience

Author(s): Benedikt Tas
Institution: ZNA Stuivenberg, Antwerp, Belgium

Background: 59 women with metrorrhagia/ menorrhagia and no desire for fertility were treated via Minitouch over 4 years. A solo operator performed the procedures in a consulting office. Retrospective data is presented.

Methods: No pre-treatment, anaesthesia or cervical dilatation was employed. 400mg oral Ibuprofen, to be taken one hour pre-operatively, was prescribed. Cavity was assessed via transvaginal ultrasonography. Energy was delivered via microwaves during 60 to 90 seconds. Pain scores are on a 10-point scale.

Results: All 59 (100%) patients tolerated the procedure. At follow-up visits at 3 to 50 months, 53 (90%) patients were very satisfied, with vast majority reporting amenorrhea or spotting. There were no intra-procedural complications. 4 (7%) patients with persistent bleedings had a subsequent hysterectomy and were found to have adenomyosis. 1 (2%) patient underwent a subsequent TCORE procedure. She became pregnant one year later and had an uneventful pregnancy and delivery. 1 (2%) patient began menstruating after being amenorrheic for two years. After resection of a 2 cm submucosal fibroid and second Minitouch Procedure, she is again in amenorrhoea.

The pain scores were 4 to 9 (mean 7) intra-procedurally and 2 to 7 (mean 5) 10 minutes after. The patients were discharged immediately after the procedure. One patient returned within hours due to pain and cramps. She was given intravenous pain relief, admitted for observation and discharged the next day.

Conclusions: Minitouch can be performed without anaesthesia in an office setting. Safety and efficacy outcomes at up to 4 years are very satisfactory.
ABSTRACTS: ORAL

FC05 Does hysteroscopic myomectomy increase risk of placental disorders?

Author(s): Hina Pathak¹, Eleftheria Chrysanthopoulou², Nitish Narvekar¹

Institution: ¹Royal College of Obstetrics & Gynaecology, London, UK, ²General Medical Council, London, UK

Introduction: The impact of damage to the endo-myometrial interface during hysteroscopic myomectomy for the management of HMB and infertility, on future pregnancy outcomes such as placental disorders is poorly understood.

Methods: We undertook a single-center retrospective study of women who booked for antenatal care following hysteroscopic myomectomy at a London hospital between 2005-2013.

The principal outcome measure was incidence of placental disorders such as IUGR, PET, abruption, and, placenta praevia/accreta. Secondary outcome measures included live birth rates (LBR), manual removal of placenta, and, PPROM.

Results: 135 women underwent hysteroscopic myomectomy during the study period and 80 met the study criteria. Mean age was 36.8 (SD 5) years. Twenty (25%) women booked for antenatal care and mean time to conception was 21.9 (SD 15.7, range 5-58) months of which majority (18/20) conceived spontaneously. The LBR was 23.8% (19/80); median gestation at delivery was 38+1 (range 29+4 - 40+6) weeks and mean birth weight 2915 (SD 614.8) grams.

There was 1 case of placental abruption requiring emergency CS at 29+4 weeks and 1 case of placenta praevia. 1 woman was diagnosed with mild IUGR, and induced at 38 weeks. Therefore the total rate of abnormal placental disorders was 10.5% (2/19).

Discussion: Our study reported significantly higher rate of 10% for placental disorders following hysteroscopic myomectomy, compared to background rates of 0.5-1% for abruption, and, 0.5% for placenta praevia. Whilst no conclusive statement can be made due to small sample size, there is biological plausibility for our findings, and, future research is needed.

FC06 Robotic assisted hysterectomy: experience of the first 85 cases

Author(s): Chou Phay Lim, Tony Chalhoub, Mark Roberts

Institution: Royal Victoria Infirmary, Newcastle Upon Tyne, UK

Background: Robotic assisted hysterectomy is becoming increasingly common worldwide, but experience within the UK remains limited. We report our experience of the first 85 cases performed within our unit.

Method: Operative data was collected live at the time of surgery. Information on complications were followed up with case notes review.

Findings: 85 consecutive robotic hysterectomies done by two surgeons over a 15month period were analysed. The indications include HMB, endometriosis, endometrial cancer and hyperplasia, fibroids, cervical pathology, and prophylactic surgery. The mean BMI of the patients was 27.8kg/m2 (20.1 to 44.5). 33 cases had coexisting endometriosis and 42 had fibroids varying from 2 to 7cm. The mean time of robotic surgery was 102 minutes (56 to 175) in the first 10 cases and 60 minutes (29 to 170) in the subsequent cases. The mean time of vault suturing was 17 minutes (11 to 28) in the first 10 cases and 9 minutes (3 to 29) in the subsequent cases. There was one case of bowel injury, which was repaired robotically at the time of surgery without subsequent problems; and one case of postoperative urinary retention requiring indwelling catheter. An average 2.4 cases were done in each theatre list.

Conclusion: The time taken for a robotic hysterectomy shortens significantly after the first 10 cases. Complications are rare. However, there is room for improvement in the total number of cases that can be performed within a full day theatre list.
FC07 Preventing Recurrence of Endometriosis by means of Long-acting Progestogen Therapy: the PRE-EMPT pilot study

Author(s): Jane Daniels¹, Lee Middleton¹, Laura Gennard¹, Konstantinos Tryposkiadis¹, Lisa Leighton¹, Siladitya Bhattacharya², on behalf of the PRE-EMPT Collaborative Group¹,²

Institution: ¹University of Birmingham, Birmingham, UK, ²University of Aberdeen, Aberdeen, UK

Background: PRE-EMPT will evaluate the long-term effectiveness of post-operative long-acting reversible contraceptives (LARCs) in preventing recurrence. A BSGE survey indicated there was no consensus about which LARC or comparator should be evaluated.

Objective: We designed a ‘flexible-entry’ internal pilot to assess whether a four-arm trial was feasible in light of possible strong patient preferences.

Methods: Patients could be randomised to two, three or four treatment options, provided one was a LARC and one was a non-LARC. An assessment of feasibility based on recruitment to these options and a substantive, adequately powered trial design was considered by an independent oversight committee. The primary outcome for the substantive trial is the pain sub-scale of the 30 question Endometriosis Health Profile.

Results: The pilot study ran for one year from April 2014 and 74 women were randomised, from over 500 screened pre-laparoscopy for eligibility. At laparoscopy, 10% had no endometriosis identified. Only 5 (7%) women were happy to be randomised to all treatment options. 60 (81%) women had a preference for a LARC: 25/60 accepted the possibility of LNG-IUS and 35/60 accepted DMPA. 53 (72%) had a non-LARC preference, equally accepting of either COCP or no treatment.

Four-way and three-way randomisation designs were therefore ruled out. The substantive trial has a two-way randomisation of either LARC (with a pre-specified preference) vs COCP, stratified by LARC preference, and will recruit a total of 400 women.

Conclusions: The PRE-EMPT trial continues to recruit from hospitals across the UK within the new trial design.

FC08 Uterine Endometriosis – Incidence and histological classification in patients undergoing laparoscopic surgery for severe recto-vaginal endometriosis: A Prospective cohort Study.

Author(s): Fevzi Shakir, Haider Jan, Carol Pearson, Pat Haines, Wendy Rae-Mitchell, Andrew Kent

Institution: Minimal Access Therapy Training Unit, Royal Surrey County Hospital, Egerton Road, Guildford, Surrey, GU2 7XX, UK

Study Objective: To classify types of uterine endometriosis and identify its incidence in patients who underwent pelvic clearance for severe recto-vaginal endometriosis.

Design: A prospective cohort study looking at the outcome of patients undergoing laparoscopic surgery for severe recto-vaginal endometriosis.

Setting: A tertiary referral Centre for minimally invasive gynecological surgery.

Patients or Participants: Patients who had surgery performed for severe endometriosis were invited to participate in the study. Questionnaires were completed preoperatively and at intervals up to 1 year after (Endometriosis Health Profile(EHP)-30, Gastro Intestinal Quality of Life Index(GIQLI), EQ-5D and Visual Analogue Scores(VAS) for pelvic pain, dysmenorrhea, dysparunia and dyschezia). Those who did not have fertility desires were offered a pelvic clearance in addition to excising all endometriosis. The study was carried out from 2007 to 2014, with 99 patients included.

Measurements and Main Results: Significant improvement in symptoms and scores was seen in both the conservative group and in those that underwent pelvic clearance (P<0.01). However, those in the pelvic clearance group had improved scores compared to those in the conservative group (P<0.01). When analysing the specimens it was clear that 80% had uterine endometriosis, not only limited to adenomyosis (40%) but also serosal (14%) and subserosal (26%).

Conclusion: Uterine endometriosis is more common than we think. It should be defined as serosal, subserosal and adenomyosis, and histological criteria are used to define this. Understanding this and appreciating how common it is in patients with severe recto-vaginal endometriosis can aid in counseling and surgical planning.
ABSTRACTS: ORAL

FC09  Esmya and its effects: laparoscopic myomectomy after using Ulipristal acetate

Author(s): Mehrnoosh Aref-Adib, Reeba Oliver, Funlayo Odejinmi

Institution: Whipps Cross University Hospital, London, UK

Introduction: Uterine fibroids (leiomyoma) are the most common tumours in women of reproductive age, affecting 20-40% of women in this population. Fibroids can significantly affect a patient’s quality of life and can be managed medically and surgically. Ulipristal acetate (Esmya®) is a relatively new drug that is used the long-term management of uterine fibroids. In addition, similar to GnRH (gonadotropin-releasing hormone) analogues, it is also being used in the pre-operative treatment of fibroids. Studies have previously looked at the use of GnRH analogues prior to open or laparoscopic myomectomy and their effect on the surgical cleavage planes, histology of the fibroids and outcomes of surgery. The studies have found that the cleavage plane between leiomyoma and its pseudocapsule becomes less distinct but without any significant increase in the total operating time. To our knowledge there is no published data specifically looking at the outcome of open or laparoscopic myomectomy after the use of pre-operative Ulipristal Acetate.

Video: We present a video demonstrating how surgery needs to be adjusted following pre-operative administration of Esmya® and compare it with 2 other videos demonstrating laparoscopic myomectomy without Esmya and laparoscopic excision of adenomyosis.

Conclusion: Preoperative Ulipristal acetate on laparoscopic myomectomy would be of benefit. Studies addressing difficulty of surgery, operating time and outcomes will allow laparoscopic surgeons to consider whether or not to use the medication routinely.

FC10  Return to work post laparoscopic myomectomy and laparoscopic hysterectomy: is there a difference?

Author(s): Mehrnoosh Aref-Adib, Zwelihle Magama, Reeba Oliver, Funlayo Odejinmi

Institution: Whipps Cross University Hospital, London, UK

Introduction: The advantages of minimal access surgery are well documented, with one being earlier return to work (RTW). Both patient and surgical factors determine the speed of RTW. This study reviews two different laparoscopic procedures: hysterectomy and myomectomy and investigates how return to work differed.

Methods: Data was collected prospectively on patients undergoing laparoscopic myomectomy or hysterectomy performed by a single surgeon between January 2012 - March 2015. A RTW questionnaire was designed and a telephone survey was conducted post-operatively.

Results: 63 patients underwent laparoscopic myomectomy, with 33 completing the questionnaire (52%). The average age was 39(25-56yrs). The mean BMI was 27kg/m2(16-35).

66 patients underwent laparoscopic hysterectomy. The questionnaire was completed by 33 patients (50%). The average age was 47(38-56yrs). The mean BMI was 30.5(18-43).

32 patients (97%) in the myomectomy group were in employment, compared to 21 (64%) in the hysterectomy group.

27 of 33 (82%) women post myomectomy felt it took > 8 weeks to feel ‘back to normal’, compared to 12 (36%) women post hysterectomy. At 8 weeks post op 14 (44%) myomectomy patients had returned to work, compared to 16 hysterectomy patients (76%). Job satisfaction in the myomectomy group was 6.7 (range 5 -10), compared to 8.1 (range 7-9) in the hysterectomy group.

Conclusion: Recovery from laparoscopic myomectomy or laparoscopic hysterectomy may take longer than anticipated. The average age for hysterectomy patients was older, with fewer in work, but higher job satisfaction. Doctors must give patients appropriate counselling to help manage patient expectation and recovery.
FC11  A comparison of the safety of two techniques for laparoscopic tissue morcellation in an extraction bag

Author(s): Claire Park¹, Russell Luker¹, Ben Peyton-Jones², Rebecca Hopkins¹, Fiona Carter³

Institution: ¹Royal United Hospital Bath NHS Foundation Trust, Avon, UK, ²Royal Devon and Exeter Hospital, Exeter, UK, ³Southwest Surgical Training Network, Somerset, UK

Controversy concerning the morcellation of unsuspected sarcoma after hysterectomy has resulted in the modification of clinical practice. Extraction bags, containing the morcellator, specimen and laparoscope have been proposed to protect patients from potential spread of tumour cells.

This study aimed to compare the Sydney method, where an extraction bag is punctured with a balloon cannula to admit the laparoscope, versus a novel T-bag design, with access points for laparoscope and morcellator.

Following laparotomy on 9 ex-vivo pigs, two different extraction bags were inserted, each containing a 200g lamb heart. After closure of laparotomy and standardized port placement, a control sample of abdominal fluid was taken. The Sydney bag method was prepared, with 20ml of Fluorescein dye injected into the bag prior to morcellation, after which a second sample of abdominal fluid was taken. The T-bag method was then prepared, with 20ml of Methylene Blue injected into the bag, the specimen morcellated, and a final fluid sample taken. Operative times were recorded.

Samples were analysed by spectrometry and fluorimetry; statistical analysis performed using Students T Test with significance set at 95%.

Dye was detected in 5 of the 9 samples from the Sydney method, compared to 1 of the 8 T bag samples (p = 0.02). Operative time for the T-bag (22.61 minutes) was significant longer (p = 0.05) than the Sydney (18.65 minutes).

This study demonstrates that, while taking slightly longer to perform, the T-bag method produces significantly less spillage of fluid from the bag during morcellation.
VP01 A Large Cervical Fibroid: Overcoming a technical challenge encountered at total laparoscopic hysterectomy

Author(s): Subashini Sivalingam, Gourab Misra

Institution: UHNM, Stoke on Trent, UK

In this video we present total hysterectomy completed entirely by laparoscopic approach in spite of a large cervical fibroid and the removal of the specimen without extension of the abdominal scars. A 40 year old presented with recurrent urinary tract infection and urinary retention. Investigation with Trans abdominal and Transvaginal ultrasound showed an 8.2 cm diameter well-circumscribed fibroid mass posterior to the cervix and in the lower uterine segment. MRI scan showed an 8.6 cm diameter well-circumscribed mass suggestive of fibroid arising posteriorly within the lower segment and cervix. With no evidence of leiomyosarcoma. Following medical management with Ulipristal acetate 5mg's for three months, she was listed for total laparoscopic hysterectomy for a large fibroid uterus causing urinary symptoms.

At laparoscopy bilateral ureterolysis was performed and uterine arteries were clamped at their origin from the internal iliac artery. Ligasure devise was used for dividing and ligating the Round ligament, uterine artery and uterosacrals on both sides after bladder dissection and retraction. Mc Cartney tube inserted prior to colpotomy and TLH performed. Entire posterior cervix was distended and involved with cervical fibroid. This was excised completely. Post TLH removal of the specimen was facilitated by debulking the fibroid uterus with a morcellator and the remaining specimen was removed through the vagina. Then the vaginal vault closed with vicryl after securing angles and vaginal mucosa approximated with continuous sutures.

Histology confirmed normal uterus, cervix, fallopian tubes and cervical cellular leiomyoma. She had good post op recovery with no further urinary symptoms.

VP02 A third eye on my training – a trainee’s point of view in the journey towards becoming a gynaecological endoscopist

Author(s): Zahid Khan1, Oudai Ali2

Institution: ‘Birmingham City Hospital, Birmingham, UK. ‘West Cumberland Hospital, Hensingham, Whitehaven, UK

Status: Pending

Author’s preference: Video

A unique point-of-view perspective showcasing the timeline in the professional development of a trainee in the United Kingdom from the trainee’s first steps in theatre through to their first hurdles with laparoscopic suturing ending in a masterful, supervised, laparoscopic hysterectomy using the Enseal device. The video aims to showcase the basics of laparoscopic suturing such as loading the needle, laying on the tissue, the ‘puppet’ and the ‘coffee grinder’, the running suture such as the Z line and basic knotting techniques and their application in an advanced laparoscopic surgical procedure, to highlight the practice and progression expected of a trainee in gynaecology, in the path to becoming a gynaecological endoscopist.

State-of-the-art, future ready headsets such as the Foream x1 and the Oculus Gear VR were used in the making of this video to present their utility in training in laparoscopic surgery and consolidation of the two cardinal requirements of an endoscopic surgeon, thorough knowledge of pelvic anatomy and robust suturing skills.

VP03 An Alternative Technique for the Laparoscopic Dermoid Ovarian Cystectomy

Author(s): Georgina Fraser

Institution: Tunbridge Wells Hospital, Pembury, UK

Objective: To demonstrate that an incision near the infundibulopelvic ligament for a laparoscopic dermoid ovarian cystectomy is a more effective technique in terms of reducing spillage risk and is technically easier for the operator than the traditionally taught method.

Background: The Dermoid Cyst represents 21% of all ovarian tumours. They are mostly seen in women during their reproductive years. Less than 3% are malignant and these are seen predominantly in post menopausal women.

Traditionally the ovarian dermoid cystectomy is performed with an anti-mesenteric incision with subsequent enucleation of the cyst. With cysts of larger dimensions it can be technically difficult with this incision. There is a risk of spillage of cyst contents and increased operative time. Spillage can occur in up to 80% of procedures and can cause chemical peritonitis in 0.2% of these women.

Purpose: This video demonstrates the incision medial to the ovarian and infundibulopelvic ligament over the cystic part of the ovary as an alternative technique. During the procedure the assistant provides counter traction by holding the cyst with the capsule intact thereby making dissection and enucleation easier and so reducing spillage risk and operating time.

Conclusion: The incision medial to the ovarian and infundibulopelvic ligament should be taught as an alternative laparoscopic technique for the ovarian dermoid cystectomy.

VP04 Excision of deep peritoneal pelvic side wall endometriosis and ureterolysis

Author(s): Dimitrios Miligkos, Sameer Umranikar

Institution: Southampton University Hospital, Southampton, UK

This is the case of a 41 year old patient presenting with severe left dysmenorrhoea and premenstrual dyschezia. She underwent laparoscopy which demonstrated widespread deep peritoneal endometriosis in the POD, UV fold and left pelvic side wall (PSW) over the left ureter.

In this video we present the excision of the affected left PSW peritoneum.

The operation starts with suspension of the left ovary from the anterior abdominal wall with the T-lift device. This allows exposure of the PSW and makes the assistant’s instrument available to actively assist in the operation. The peritoneum is opened above the ureter. The ureter, left obliterated umbilical artery and left uterine artery are identified.

Entry of pneumoperitoneum into the soft tissues of the PSW helps to identify the avascular spaces and assist the dissection of the peritoneum from the uterine artery and the ureter. Meticulous haemostasis with short bursts of bipolar energy and use of cold scissors keep the thermal spread to a minimum and the operating field clear. The ureter is constantly under direct vision to avoid inadvertent injury. The whole affected peritoneum is excised and sent for histopathology.
VP05 Laparoscopic management of a caesarean scar ectopic pregnancy

Author(s): George Goumalatsos, Oliver Chappatte
Institution: 1Maidstone & Tunbridge Wells NHS Trust, Kent, UK, 2Basingstoke and North Hampshire Hospital, Hampshire, UK

This is a video presentation of Mrs BG who had laparoscopic management of her caesarean scar ectopic. Mrs BG is a 35-year-old woman with a BMI of 37 and three previous caesarean sections. She presented to our unit with PV bleeding, pelvic pain and suboptimally rising bHCGs. Serial scans depicted the gestational sac implanted within the caesarean scar.

In theatre, a hysteroscopy was attempted but abandoned due to fresh and heavy blood loss. The cervix was dilated to Hegar 12 and the dilator was left in situ for uterine manipulation. An indwelling bladder catheter was inserted.

We then proceeded to a diagnostic laparoscopy. The vesicouterine fold was dissected and the bladder reflected. A bulge on the caesarean scar revealed the position of the ectopic pregnancy. Pitressin was slowly injected laterally to the pregnancy sac to minimise bleeding during the incision. With a combination of energy devices including Harmonic and bipolar diathermy, we opened the uterine scar. We identified the unruptured gestational sac and removed it with minimal blood loss. Using the previously inserted Hegar dilator as a guide, we completely excised and dieutralised all visible trophoblastic tissue. The uterine incision was then repaired with three figure-of-8 sutures, using Monocryl 1. The intra-operative blood loss was minimal, and haemostasis was easily achieved.

Mrs BG made a good recovery and was discharged home the following day. Serial b-HCG follow-ups revealed a decline followed by a negative pregnancy test.

VP06 Laparoscopic management of a case of recurrent cornual ectopic pregnancy

Author(s): Adeyinka Latunde-Dada, Alexander Taylor
Institution: Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust, Bournemouth, UK

Cornual ectopic pregnancies are a rare in presentation and account for only 1-4% of all ectopic implantations. Due to their precarious location of the pregnancy within the interstitial portion of the fallopian tube that lies within the vascular uterine myometrium, they are liable to rupture, leading to catastrophic haemorrhage. Thus, cornual ectopic pregnancies often pose a challenge for clinicians to diagnose and manage successfully.

This report describes the case of a 27 year old woman who presented at 7 weeks and 1 day gestation with a case of recurrent left-sided cornual ectopic pregnancy. Within the time period of 6 months, the patient had previously undergone laparoscopies to manage a left-sided tubal ectopic pregnancy by salpingectomy and subsequently for a cornual ectopic on the same side. A year later, she represented with a recurrent, live left-sided cornual ectopic pregnancy, diagnosed on ultrasound.

Laparoscopic cornual resection of the ectopic pregnancy was successfully carried out using a variety of haemostatic techniques, including vasopressin intra-myometrial injection and Floseal © haemostatic matrix application.

VP07 Laparoscopic Vaginal Hysterectomy with Surgical Vaginal Morcellation

Author(s): Kumar Kunde, Ahmed Zaima
Institution: 1Guys and St Thomas NHS Foundation Trust, London, UK, 2Lewisham and Greenwich NHS Trust, London, UK

Aim: To demonstrate a new technique of laparoscopic vaginal hysterectomy (LAVH) with vaginal morcellation for enlarged uterus with limited pelvic access as an alternative to in-situ laparoscopic morcellation or open abdominal hysterectomy.

Design: Video presentation of the surgical technique of LAVH involving laparoscopic sealing of uterine artery followed by vaginal morcellation.

Interventions: This surgical technique is proposed for performing laparoscopic assisted hysterectomy for the enlarged uterus and limited pelvic access. This can be performed as an alternative to in-situ laparoscopic morcellation thus reducing risk as well as the cost while maintaining the advantages of minimal access surgery. The excision of an 18 week sized multiple fibroid uterus was achieved, with enhanced recovery and superior postoperative pain scores.

VP08 Nerve sparing excision of uterosacral endometriosis

Author(s): Suku George
Institution: Stockport NHS Foundation Trust, Stockport, UK

The pelvic autonomic nerves are the pathway for the neurogenic control of rectal, bladder and sexual arousal primarily controlling vaginal lubrication and swelling. The classical Redwine technique of excision of endometriosis is the most widely practiced and successful method to surgically treat endometriosis and this can be associated with significant post operative functional morbidity.

The goal of the nerve sparing approach is to better identify the visceral neural fibers and surgical landmarks thereby improving the dissection of the vascular portion from the neural portion of the parametrium.

Principle was to mobilize the obliterated cul-de-sac by a step wise approach. After excising the right adnexa by division of ovarian vessels, ureterolysis was performed laterally retracting it from the disease. Pararectal dissection with the aid of a rectal probe kept the rectum medially.

A transverse incision was created across the cervix and the uterosacral ligament is subsequently transected at its insertion into the posterior cervix. The caudal inferior hypogastric plexus is carefully dissected away keeping it lateral to the endometriotic nodule as it is freed.
VP07 Laparoscopic Vaginal Hysterectomy with Surgical Vaginal Morcellation

Author(s): Kumar Kunde1, Ahmed Zaima2
Institution: 1Guys and St Thomas NHS Foundation Trust, London, UK, 2Lewisham and Greenwich NHS Trust, London, UK

Aim: To demonstrate a new technique of laparoscopic vaginal hysterectomy(LAVH) with vaginal morcellation for enlarged uterus with limited pelvic access as an alternative to in-situ laparoscopic morcellation or open abdominal hysterectomy.

Design: Video presentation of the surgical technique of LAVH involving laparoscopic sealing of uterine artery followed by vaginal morcellation.

Interventions: This surgical technique is proposed for performing laparoscopic assisted hysterectomy for the enlarged uterus and limited pelvic access. This can be performed as an alternative to in-situ laparoscopic morcellation thus reducing risk as well as the cost yet maintaining the advantages of minimal access surgery. The excision of an 18 week sized multiple fibroid uterus was achieved, with enhanced recovery and superior postoperative pain scores.

VP08 Nerve sparing excision of uterosacral endometriosis

Author(s): Suku George
Institution: Stockport NHS Foundation Trust, Stockport, UK

The pelvic autonomic nerves are the pathway for the neurogenic control of rectal, bladder and sexual arousal primarily controlling vaginal lubrication and swelling. The classical Redwine technique of excision of endometriosis is the most widely practiced and successful method to surgically treat endometriosis and this can be associated with significant post operative functional morbidity.

The goal of the nerve sparing approach is to better identify the visceral neural fibers and surgical landmarks thereby improving the dissection of the vascular portion from the neural portion of the parametrium.

Principle was to mobilize the obliterated cul-de-sac by a step wise approach. After excising the right adnexa by division of ovarian vessels, ureterolysis was performed laterally retracting it from the disease. Pararectal dissection with the aid of a rectal probe kept the rectum medially.

A transverse incision was created across the cervix and the uterosacral ligament is subsequently transected at its insertion into the posterior cervix. The caudal inferior hypogastric plexus is carefully dissected away keeping it lateral to the endometriotic nodule as it is freed.

VP09 Posterior colpotomy for the retrieval of ovarian specimens in laparoscopy

Author(s): Chou Phay Lim, Neil Hebblethwaite
Institution: South Tees Hospitals NHS Foundation Trust, Middlesbrough, UK

Effective tissue retrieval techniques continue to be a challenge in laparoscopic surgery. There is scarce evidence in the literature on the use of posterior colpotomy for tissue retrieval.

We present a video demonstrating the use of posterior colpotomy tissue retrieval for large ovarian specimens. After the relevant adnexectomy, the surgeon would insert a tissue retrieval device with a non-permeable bag into the vagina aiming at the posterior fornix.

The uterus was anteverted to expose the pouch of Douglas and the outline of the tissue retrieval device between the uterosacral ligaments from a laparoscopic view. Posterior colpotomy was done with monopolar diathermy to the pouch of Douglas until it’s wide enough to introduce the device.

The non-permeable bag was opened within the abdomen so the specimen can be inserted into the bag and retrieved vaginally. The ovarian cysts can be ruptured and drained within the bag so that it can be removed through the colpotomy without surgical spill. The colpotomy can then be closed with absorbable sutures vaginally. In another case where the ovarian cyst was too big to fit in the bag, the cysts were ruptured so that they can fit in the bag. The surgeon would take care to cause minimal spillage and a thorough washout will have been carried out at the end of the procedure.

With appropriate pre-operative assessments to exclude malignancy, posterior colpotomy is a safe and effective method of ovarian specimen retrieval in laparoscopy.

VP10 Rectal perforation caused by a rigid sigmoidoscope during laparoscopic excision of deep infiltrative endometriosis

Author(s): Suruchi Pandey
Institution: Asford and St. Peter’s Hospitals, Chertsey, UK

We demonstrate primary repair of a rectal perforation caused by a rigid sigmoidoscope that was being used as a rectal probe during laparoscopic excision of deep infiltrative endometriosis.

The patient was a young nulliparous woman who had presented with pelvic pain. Laparoscopy revealed deep infiltrative endometriosis, involving the uterosacral ligaments with close proximity to the rectal wall but not invading the muscularis.

It is our usual practice to use a rectal probe to delineate the rectal wall in cases of severe endometriosis requiring entry into para-rectal space. Normally, we use a broad tip (2cm) manipulator (Apple manipulator). On this occasion, we used a rigid sigmoidoscope as the usual manipulator was not available. Although blunt, the conical tip of the rigid sigmoidoscope is only 3-4mm at the apex.

During rectal manipulation, the sigmoidoscope went through the rectal wall and the tip was visible within the pelvis. This happened most probably because the bend in the rectum was not straightened by the surgeon. There was no prior weakening of the rectal wall as no shaving had been done. The patient had not received bowel preparation.

The defect was identified and careful dissection was performed to ensure the edges were clean and not under tension. The hole was repaired laparoscopically, using three layers of vicryl 2-0 sutures. Patient was admitted for observation and made an uneventful and complete recovery.

Rectal manipulation, although useful in complex endometriosis surgery, does carry risk of perforation of the rectum. We share our learning from this unusual complication.

ABSTRACTS: VIDEO POSTER
VP11  Start-up experience of in-bag morcellation in Gynaecology

Author(s): Robin Edwards, Neelima Dixit, Nitish Narvekar
Institution: King’s College Hospital, London, UK
Status: Pending  Author’s preference: Video

Background: The US FDA issued an alert in 2014 limiting the use of power morcellation in Gynaecology to avoid risk of disseminating unsuspected leiomyosarcoma. The BSGE, and other international bodies, have emphasised the need for further research and the current R&D focus has shifted towards containment rather than avoidance of risk with the use of in-bag morcellation.

Methods: Our video presentation demonstrates our initial experience with in-bag morcellation during laparoscopic myomectomy. We describe the technique of safe deployment, use of the bag, and start-up challenges encountered. A video of a follow-on case is also presented, where some of these challenges were mitigated.

Case: A 36 year old underwent laparoscopic myomectomy for fertility and pressure symptoms. A four-port technique was used with intramyometrial injection of 1:20 diluted vasopressin, and 10cm fundal subserous fibroid (FIgo L6) excised through a transverse incision using bipolar spatula (PK spatula, Olympus, Cardiff, UK). The uterus was closed in 2-layers and specimen morcellated using medium-size MorSafe endobag (Veol Medical, Cardiff, UK). The uterus was closed in 2-layers and specimen morcellated using medium-size MorSafe endobag (Veol Medical, Cardiff, UK). Total incision-to-closure time was 180 minutes including morcellation time of 90 minutes. Blood loss was <100mls and the patient stayed 1 night without complications.

Discussion: We encountered challenges including maintaining pneumoperitoneum after enlarging the incision to insert the bag, manipulation of the specimen into the bag, and safe views during morcellation. These were addressed with our second case; eg the use of a longer optical trocar to optimise views. Otherwise the bag was effective, safe, and we anticipate further reductions in morcellation time with repeated use.

VP12  Technical Video: Bilateral tubal adhesiolysis with cuff salpingostomy

Author(s): Fevzi Shakir, Andrew Kent
Institution: Minimal Access Therapy Training Unit, Royal Surrey County Hospital, Egerton Road, Guildford, Surrey, GU2 7XX, UK

Study Objective: To demonstrate the steps involved in a bilateral tubal adhesiolysis and cuff salpingostomy.

Design: Technical video demonstrating in a step by step approach, tubal adhesiolysis and cuff salpingostomy.

Setting: A tertiary referral unit for complex gynaecological endoscopic surgery.

Interventions: A 38 year old woman presented with left sided pelvic pain and primary infertility for 13 years. An ultrasound scan demonstrated bilateral hydrosalpinx with suspected adnexal adhesions. Hystero-salpingogram (HSG) did not demonstrate spill of dye. After counselling she opted to have tubal adhesiolysis and bilateral cuff salpingostomy.

Conclusion: Tubal surgery for occlusion has become less popular due to the superior success rates of assisted reproductive techniques (ART). As a result tubal surgery may eventually become a historical operation. However, in cases of distal tubal blockage, following adhesiolysis and cuff salpingostomy or neo salpingostomy, pregnancy rates up to 35% have been reported in the literature. Furthermore, performing a bilateral salpingectomy instead in these cases renders a patient entirely dependant on ART for tubal factor infertility. A bilateral cuff salpingostomy should therefore be considered in a select group of patients.

VP13  Technical video: Laparoscopic Excision of a Niche with Uterine Reconstruction

Author(s): Andrew Kent, Fevzi Shakir
Institution: Royal Surrey County Hospital, Egerton Road, Guildford, Surrey, GU2 7XX, UK

Study Objective: To demonstrate a step by step technique of laparoscopic excision of niche with uterine reconstruction.

Design: Uterine niche formation is caused iatrogenically following lower segment caesarean section. We present a step-by-step explanation of this laparoscopic technique for excision of niche with uterine reconstruction, using a video. This case was complicated by the fact the patient had an attempted coil placed in another hospital to help control her symptoms. This however perforated through the niche. As she wished to conceive again, this area of weakness in the uterus would be at high risk of rupture throughout the pregnancy, if not repaired beforehand.

Interventions: Laparoscopic excision of uterine niche is performed by excising the uterine defect after initial reflection of the uterovesical fold. The area of uterine defect is identified preoperatively using flexible hysteroscopy. Once the margins of the defect are identified laparoscopically, it is circumferentially excised. The uterine manipulator helps to identify the cervical canal. Reconstruction is performed with interrupted sutures using an extracorporeal technique for secure tissue apposition. An adhesion barrier is then applied around the reconstructed area.

Conclusion: Excision of uterine sacculation (Niche) with uterine reconstruction is a conservative surgical laparoscopic technique that should be considered in a select group of patients where fertility sparing is desired and medical therapy in the form of progestogens, combined contraceptive pills or the mirena coil has failed to resolve their symptoms or is contraindicated, as in this case.
VP14  Technical Video: Vescicoscopic Excision of an Eroded Tension Free Vaginal Tape (TVT)

Author(s): Philippe Grange, Fevzi Shakir, Ganesh Thiagamoorthy, Dudley Robinson, Linda Cardozo

Institution: King’s College Hospital, Denmark Hill, London, SE5 9RS, UK

Study Objective: To demonstrate a vesicoscopic excision of an eroded tension free vaginal tape (TVT).

Design: Technical video demonstrating vesicoscopic excision of an eroded TVT.

Setting: Urogynaecology and Urology Departments of a tertiary referral centre for uro-gynaecology.

Interventions: A 52-year-old woman presented with suprapubic pain, haematuria and recurrent urinary tract infections four years after TVT insertion for stress urinary incontinence. Cystoscopy revealed an exposed tape with calcifications on the right aspect of the bladder. Video-urodynamics demonstrated normal bladder function and no stress incontinence. After counselling she opted to have the portion of tape excised via a vesicoscopic approach.

Conclusion: Exposed tapes are found in up to 4% of women who have undergone TVT procedures due to primary unrecognised bladder injury or secondary erosion. Management of this complication can result in a succession of invasive procedures. In this case vesicoscopy allowed complete excision of the exposed portion of tape. After mobilisation, the bladder wall was closed without tension, using Mignot-Grange’s extracorporeal knotting technique. The stumps of the tape were buried deeply to prevent recurrent erosion.

We have employed vesicoscopy since 2007 for a variety of female uro-gynaecological problems including bladder diverticula, ureteric stenosis, vesico-ureteric reflux, foreign body and vesico-vaginal fistulae. So far we have undertaken five tape excisions in four patients (one bilateral exposure). Incontinence has not recurred in any of the women. In conclusion vesicoscopy can facilitate excision of exposed intra-vesical tape without risking urethral trauma for recurrent tape exposure.

VP16  The use of carboprost in the laparoscopic resection of cornual ectopic pregnancies

Author(s): Rebecca Mallick, Tosin Ajala

Institution: Brighton and Sussex University Hospitals, Brighton, UK

Cornual ectopic pregnancies (EP) remain a rare, but potentially challenging form of EP to manage. They account for 2-4% of all EP and carry a 7 times higher mortality rate. This increased morbidity and mortality is mainly due to their late presentation and significant haemorrhage risk. Laparoscopic resection has been described successfully, often with the use of intra-myometrial vasopressin, however the procedure can be technically very challenging and can carry significant risks of bleeding, conversion to laparotomy and subsequent hysterectomy. Vasopressin has also been linked to several serious side effects in the literature such as bradycardia, cardio-vascular collapse and death. Carboprost is a synthetic prostaglandin analogue, used widely in the management of obstetric haemorrhage, with its main mode of action being myometrial contractions.

In our practice we have recently adopted using intra-myometrial carboprost as an alternative to vasopressin when resecting cornual EP with significant surgical benefits noted. This video demonstrates its use prior to the laparoscopic resection of a 4cm right cornual EP in a 28-year-old nulliparous patient. 500mcg carboprost is injected into the fundus of the uterus using a pudendal needle and within 3-5 minutes of administration benefits seen include sustained uterine contractions, reduced uterine blood flow with a whitening of the uterus and a significantly clearer demarcation of the ectopic with the trophoblastic tissue being pushed closer to the surface. Overall this resulted in a technically easier resection with minimal blood loss (<50mls). The patient was discharged later that day and follow-up HCG was negative confirming complete resection.

VP15  The ultrasound diagnosis and three techniques for the laparoscopic treatment of interstitial ectopic pregnancy

Author(s): Tom Holland, Alfred Cutner, Arvind Vashisht, Ertan Saridogan, Davor Jurkovic

Institution: University College Hospital, London, UK

Interstitial ectopic pregnancy is rare but is potentially very dangerous due to the risk of massive haemorrhage associated with rupture.

Previously surgical treatment was by open cornual resection however this removes myometrium which is unnecessary for most patients. In this video we show three different techniques for laparoscopic excision and reconstruction with minimal loss of myometrium.
VP17 Ureteric obstruction by severe endometriosis: Video contrasting first operation findings with repeat surgery. Should such cases be referred to tertiary level experts?

Author(s): Richard Keedwell, Dominic Byrne
Institution: Royal Cornwall Hospital, Truro, Cornwall, UK

Endometriosis obstructing the ureter is rare; estimated prevalence of ~0.3%. However it may be under-recognised as silent hydronephrosis is a diagnostic challenge. Symptomatic obstruction is associated with severe pelvic/ loin pain, plus other symptoms of deep pelvic endometriosis. It causes, hydroureter, hydronephrosis and ultimately loss of renal function. The optimal surgical management for this condition is complex and relates to severity; options include ureterolysis, ureteric resection and re-anastomosis, re-implantation, nephrostomy drainage and nephrectomy.

The video presentation, demonstrates two contrasting cases of severe ureteric endometriosis. The first case involves the dissection of left pelvic sidewall endometriosis after excisional surgery was attempted but not completed in a different unit. The incomplete excision and associated surgical scarring increases the danger and complexity of the subsequent surgery. The ureter is resected and re-anastomosed after complete excision of the endometriotic nodule. The contrasting case shows definitive primary surgery as the gold standard. An endometriotic nodule causing ureteric obstruction is dissected free from the pelvic sidewall allowing relief of extrinsic compression. The ‘virgin peritoneum’, untouched by previous surgery, allows an easier dissection albeit in the face of severe disease, with a good surgical result.

These contrasting cases may generate discussion among the delegates as to when complex excisional ureteric surgery should be attempted or referred. Should these cases be concentrated in tertiary centres to improve the effectiveness, and minimise morbidity, of surgical intervention?

VP18 Use of Ultravision surgical smoke clearance system in Gynaecologic Laparoscopy

Author(s): Andrew Kent, Fevzi Shakir, Gemma Clemente
Institution: MATTU, Guildford, UK

Surgical smoke continues to be a problem in operative laparoscopy. Smoke reduces vision with the risk of inadvertent injury and complications. Smoke can also interfere with energy delivery in true laser beam delivery systems eg. CO2 laser. CO2 laser continues to be one of the few energy modalities proven to be effective in the surgical treatment of Stage 1-3 endometriosis in randomised controlled trials (Sutton et al 1997, Kent et al 2014).

There are currently two types of smoke extraction, active suction and passive flow. Active suction is effective but is more complicated and requires a high flow insufflator to keep up with the rapid extraction of gas so maintaining the pneumoperitoneum. It also results in the passage of high volumes of CO2. Passive extraction through a filter is simpler but less effective depending on volumes of smoke generated.

Ultravision (Alesi Surgical) is a simple electrosurgical device which transiently charges smoke particles via a stainless steel wand introduced via a separate 2mm catheter or 5mm port assembly. This results in rapid electrostatic precipitation of the charged smoke particles within the abdominal cavity. It works on a similar principle to unipolar electrosurgical instruments so does require a standard return plate but it is operating at powers of 500-1000 times less than standard unipolar electrosurgical instruments, so the chance of inadvertent electrosurgical injury is negligible.

This video demonstrates the difference between the use of current passive flow smoke extraction systems and Ultravision surgical smoke control during laparoscopic CO2 laser vaporisation of endometriosis.

VP19 Video Presentation – Laparoscopic excision in a patient with advanced rectovaginal endometriosis which includes a rarely seen endometriotic cyst within the rectovaginal septum

Author(s): Ashwini Trehan
Institution: Eland BS GE Endometriosis Centre, Elland, West Yorkshire, UK

A 44 year old patient who had undergone 4 previous operations for endometriosis at various centres across the UK, as well as a left nephrectomy due to left ureteric endometriosis, presented with continued endometriosis-associated symptoms. At laparoscopy, the patient was found to have advanced endometriosis. Within the rectovaginal septum, as well as a rectovaginal nodule, an endometriotic cyst filled with “chocolate” material, similar to that normally found in endometriomas, was identified.

Surgical management for this patient was undertaken in two stages. In the first stage, diagnostic exploration and bilateral excision of bilateral ovarian endometriomas was undertaken. In the second stage, which is shown in this video, complicated rectal shaving, ureterolysis, and excision of the unusual rectovaginal endometriotic cyst is undertaken via a laparoscopic approach. A laparoscopic hysterectomy was also undertaken in this stage (not shown).

This video is of particular interest in that it demonstrates the unusual finding of an endometriotic cyst within the rectovaginal septum and its management, as well as demonstrating laparoscopic techniques involved in managing very severe endometriosis involving the bowel and ureter.

Please note: Abstracts are reproduced as submitted.
**ABSTRACTS: POSTER**

**P01**  
**A case series of laparoscopic excision of deeply infiltrating endometriosis of the posterior vaginal fornix with laparoscopic opening and suturing of the vaginal vault**  
**Author(s):** Rowena Sharma, Stewart Disu  
**Institution:** London North West Healthcare NHS Trust, London, UK  
**Case 1:** A forty-two year old lady, Mrs X, was referred to gynaecology by a colorectal surgeon to investigate complaints of abdominal pain, chronic pelvic pain and dyspareunia. Colonoscopy and initial pelvic magnetic resonance imaging (MRI) were negative for pathology. Biomanual examination revealed a tender left-sided uterosacral nodule. Mrs X underwent operative laparoscopy, which revealed stage four endometriosis and ovarian cystectomy confirmed an endometrioma. A rectovaginal nodule was discovered under the left uterosacral ligament but deferred due to difficult limited access. Subsequent MRI demonstrated thickening in the left uterosacral ligament and a 6mm lesion in the posterior vaginal fornix. Second stage laparoscopy revealed a 26mm x 30mm x 10mm rectovaginal nodule. This was excised following bilateral pararectal dissections and opening of the vagina laparoscopically. Continuous Stratafix Polydiaxone PDO® suture (Ethicon) was used laparoscopically to close the defect and hyalobarrier anti-adhesive gel was used following closure.  
**Case 2:** Mrs Y, a twenty-six year old nulliparous lady, presented with a history of chronic pelvic pain, dyspareunia and tenesmus. She had laparoscopic surgery that demonstrated stage four endometriosis, with a right-sided rectovaginal nodule measuring 30mm x 23mm x 15mm. This was excised laparoscopically in four parts using the same technique previously described for successful excision and closure. Follow up revealed a significant improvement in pain scores. This series supports laparoscopic closure of the vaginal vault conferring advantages such as a reduction in infection risk, bowel adhesion and vaginal discharge. It should be considered for all cases of rectovaginal endometriosis.  

**P02**  
**A descriptive study of surgical management of dermoid cysts in a teaching hospital**  
**Author(s):** Charilaos Charalampidis1, Sunday Adaji2, Hiran Muddada2, Fazwia Sanaullah1  
**Institution:** 1York Teaching Hospital, York, UK, 2Hull Royal Infirmary, Hull, UK  
**Objective:** To characterize surgical management of dermoid cyst and associated factors in a teaching hospital.  
**Methods:** Data was extracted from case/operation notes of patients using a predesigned Performa.  
**Results:** Over the study period (2010 -2015), a total of 105 cases were studied. The mean age was 42±15 years with a mean BMI of 26.4±5.3 (n=99). 57.6% of the patients within the overweight/obesity range, was associated with laparotomy approach (OR =1.404, 95%CI: 0.531 -3.708). Abdominal pain was the most common presenting symptom (55%). Surgery was performed electively in the majority of cases (91.4%). Cyst size was significantly smaller (6.8 ± 2.9 cm) in patients who had laparoscopy compared to laparotomy (9.0±3.9 cm), t (100) =3.22, p = 0.002. The laparoscopic approach was not longer in duration (88.2±43.6 minutes). Patients who had laparoscopy had a shorter length of hospitalization (1±1 day) compared to those who had laparotomy or laparoscopy/ laparotomy (3±1 days), t (103) = 9.267, p = 0.000. Of the majority (71.4%) of young symptomatic patients, only 14.3% had emergency surgery. Oophorectomy was more likely to be performed if emergency surgery was carried out (OR = 11.038, 95%CI 2.035 - 59.869). There was no case of chemical peritonitis in spite of spillage in 18%.  
**Conclusion:** Laparoscopy appears to be gaining popularity as the choice procedure for the surgical management of dermoid cyst. Attention needs to be paid to patient related factors which could influence route and extent of surgery. Laparoscopic skills of the operator should also be collected for future studies.  

**P03**  
**A Multidisciplinary Team Approach to managing Severe Endometriosis**  
**Author(s):** Sara Nasser, Alana Mitchell, Sonali Limdi, Peter Byrne, Gaity Ahmad  
**Institution:** Pennine Acute NHS Trust, Manchester, UK  
**Introduction:** Severe endometriosis can have significant psychological and physical consequences. Therefore, it is important to individualize the management of these patients. Monthly multidisciplinary team meetings (MDT) for endometriosis patients were developed in our unit in April 2014. All patients with severe endometriosis referred into the service were discussed and management plans developed.  
**Methods:** The pain scores and quality of life data was assessed for all 87 women recruited into the BSGE database that met the criterion for laparoscopic treatment of recto-vaginal endometriosis including dissection of the para rectal space and completed the standardized BSGE Quality-of-Life and Pain questionnaire pre-and post-operatively at 6 and 12-month intervals. Two independent authors reviewed the data  
**Results:** The study included a total of 87 patients. Laparoscopic treatment of severe endometriosis led to a significant improvement in pain scores post-operatively at 6 months and 12 months (p-values<0.01) compared to pain pre-operatively. There was no statistically significant difference between pain scores at 6 months compared to 12 months post-operatively. Patients perceived a significant improvement in quality of life at 6 months and 12 months (p-value<0.01). Interestingly, there was a significant improvement in quality of life between 6 and 12 months even though pain scores were not significantly different.  
**Conclusion:** Surgical treatment of endometriosis improves pain and quality of life. Streamlining management of these patients via a multidisciplinary team approach empowers women to choose between medical and surgical management. Further prospective studies are warranted to evaluate the impact of an MDT approach on the management of severe endometriosis.
P04  A New Technique in the Laparoscopic Resection of Cornual Ectopic Pregnancies

Author(s): Rebecca Mallick, Tosin Ajala
Institution: Brighton and Sussex University Hospitals, Brighton, UK

Cornual ectopic pregnancies remain a rare, but potentially very challenging form of ectopic pregnancy to manage. They account for 2-4% of all ectopic pregnancies and carry a 7 times higher mortality rate. This increased morbidity and mortality is mainly due to their late presentation and significant haemorrhage and hysterectomy risk.

Both medical and surgical treatments have been described in the literature with varying degrees of success. Laparoscopic resection has been described successfully, however the procedure can be technically very challenging and can carry significant potential risks of bleeding and conversion to laparotomy and subsequent hysterectomy.

Carboprost is a synthetic prostaglandin analogue, used widely in the management of obstetric haemorrhage, with its main mode of action being myometrial contractions.

We present a series of 4 cases where intramyometrial carboprost injection was used successfully, prior to the laparoscopic resection of cornual ectopic pregnancies, to produce consistent and reproducible surgical benefits including prolonged myometrial contractions and subsequent reduced uterine blood flow.

This results in a significant reduction of intraoperative blood loss as well as a clearer demarcation of the ectopic pregnancy and a technically easier resection. All cases had an estimated blood loss of less than 50mls and were discharged from hospital within 24 hours.

P05  A review of the activity in an outpatient hysteroscopy clinic: single-center results

Author(s): Olusegun Ilesanmi, Dimitrios Papoutis, Banchhita Sahu, Anuradha Radotra, Richard Foon
Institution: Princess Royal Hospital, Shropshire, UK

Objective: Our objective was to investigate the work activity in our outpatient hysteroscopy (OPH) clinics and identify potential risk factors for procedure failure in a cohort of women managed for postmenopausal bleeding (PMB).

Methods: This was a retrospective study of women attending OPH for PMB during the year 2015.

Results: We identified 354 women with a mean age of 66 years (range: 49-83 years), 97.6% of which were post-menopausal. The mean endometrial thickness on ultrasound scan was 5.8 mm (range: 1-30 mm). The reported abnormal findings at hysteroscopy were polyps, fibroids and suspicion of cancer. The failure rate was 4.5% with reasons for failure being cervical stenosis (9/16), previous endometrial ablation (3/16) and genital tract atrophy (4/16). An endometrial biopsy was taken in 93 women and the sample was reported as inadequate for diagnosis in 57%. The histological findings reported were normal endometrial histology (38/41 or 95.1%), endometrial hyperplasia (1/41 or 2.4%), endometrial cancer (1/41 or 2.4%) and cervical cancer (1/41 or 2.4%). All patients with an unsuccessful OPH subsequently underwent a general anaesthetic hysteroscopy. There was a significant correlation between the risk of having a failed procedure and the increasing patient’s age, previous endometrial ablation and previous cervical surgery.

Conclusion: Our findings have showed that outpatient hysteroscopy is an important tool in the evaluation of postmenopausal bleeding. Risk factors that need to be considered when referring PMB patients to OPH that could potentially increase the risk of procedure failure include the patient’s increased age, previous uterine ablation and previous cervical surgery.

P06  A Welsh District General Hospital experience of Laparoscopic Hysterectomy

Author(s): Nisha Kadwadkar1, Anusha Sivasuriam2
Institution: 1Singleton Hospital, Swansea, UK, 2Prince Charles Hospital, Merthyr Tydfill, UK

Hysterectomy is the commonest surgical procedure. Laparoscopic hysterectomy offers a means of converting an otherwise abdominal approach into vaginal approach. This helps early recovery with reduced post-operative mortality and morbidity. We evaluated our practice of laparoscopic hysterectomies in our district general hospital.

296 women underwent hysterectomies over 24 months for benign conditions. 44% were abdominal, 33% vaginal and 33% laparoscopic. A retrospective audit of 64 randomly selected laparoscopic hysterectomies was performed.

Laparoscopic assisted vaginal hysterectomy was performed in 19 women, total laparoscopic hysterectomy in 22, and 23 had subtotal hysterectomy. One case was changed to open due to poor access. 4.6% of cases had significant intra-operative bleeding (500-1000 ml), but did not need conversion to laparotomy. There were no visceral damages and deaths. Immediate post-operative complications being one case complicated by adult respiratory distress syndrome, another woman had aspiration pneumonia and one needed blood transfusion.69% of women were discharged on the first and 28% on second post-operative day. Only 3% were discharged home after second post-operative day. Readmission rates were 11% (7 cases). Five of these women presented with vaginal bleeding, one had wound infection and one presented with pelvic pain. All were treated conservatively.

The complication rates were comparable to NICE interventional procedure guidance 239. The study indicated that laparoscopic hysterectomy uptake has improved and the complication rates have decreased dramatically. We are aiming to further improve the uptake of laparoscopic hysterectomies by facilitating adequate support and training by senior laparoscopic surgeons.
ABSTRACTS: POSTER

P07 Abstract BSGE 2016: Enhanced Recovery Pathway for Elective Total Laparoscopic Hysterectomy: A Prospective Audit

Author(s): Amer Raza, Sughashini Murugesu, Rumana Rahman, Rowena Sharma, Richard Sharbinton

Institution: Chelsea and Westminster Hospital, London, UK

An Enhanced Recovery Pathway (ERP) is a model of care that aims to reduce the physical and psychological impact of elective gynaecological surgery on the patient, thus facilitating a more rapid recovery with better patient outcomes.

Method: We implemented an ERP for patients undergoing Elective Total Laparoscopic Hysterectomy in September 2015. We carried out a prospective study over a 6-month period by using patient records and discharge summaries.

We analysed information given pre-operatively, pathway followed, length of stay, deviations to protocol, complications, readmissions, cost and patient satisfaction.

Results: We found that 89% of women stayed less than 30 hours, and there was a 37% reduction in length of inpatient stay. The few that stayed longer than 48 hours either failed their TWOC or had a delayed discharge due to non-medical patient factors such as distance to home or transfer to another facility such as prison.

Discussion: Multidisciplinary involvement, preoperative assessment and patient information are the key to achieving objectives of ERP. Intraoperative anaesthetic modifications and postoperative pain management are important. Catheter management and timely discharge summaries are the next key steps. The patient satisfaction was high on this pathway. The important element to the success of this pathway was managing patient expectations by ensuring patients were counselled and given written information prior to the operation date. The financial benefits of a rapid recovery with better patient outcomes.

P08 An Audit into the use of ESMYA (Ulipristal Acetate) in reducing fibroid size and improvement of symptoms

Author(s): Melissa Crooks, Keren Orly Huff, Reeba Oliver, Funlayo Odejimi

Institution: Whips Cross University Hospital, London, UK

Background: ESMYA is a selective progesterone receptor modulator used in the management of uterine fibroids. ESMYA has been shown to achieve a 45% reduction in fibroid size, 89% amenorrhoea rate and 98% reduction in menorrhagia when used for 3 months in 2 randomised controlled trials. At Whips Cross University Hospital, ESMYA has been introduced as an alternative medical management of uterine fibroids prior to surgery.

Aims: To conduct a retrospective audit on the administration of ESMYA and to analyse patient outcomes.

Methods: 25 patients with symptomatic fibroids were given ESMYA from November 2013–November 2015.

Results: Mean age of patients was 43.8 and mean parity was 1.08. 44% were Afro-Caribbean, 24% Caucasian, 20% Asian and 12% were of unknown ethnicity. In 24%, licence guidelines were not followed as ESMYA was given for an incorrect duration, not completed or given post-operatively. For those who had scans prior to surgery, the average reduction in fibroid size was of 30.2%. 60% remained symptomatic post-treatment, with 53.3% showing no improvement. 26.6% became amenorrhoeic and 26.6% reported complete resolution of symptoms.*

Conclusions: Our study, though retrospective, demonstrates a reduction in fibroid size but symptomatic improvement was lower than quoted in existing literature. With the new Esmya licence and the anticipated shared prescribing with the community, a prospective audit is imperative in order to determine the real effect of Esmya.

*There was some overlap between the above outcomes therefore total percentages do not equal 100%.

P09 An audit of staff knowledge on ergonomics in gynaecological laparoscopic theatres

Author(s): Michael Magro, Jamna Saravanamuthu

Institution: Newham University Hospital, Barts Health NHS Trust, London, UK

Aim: To investigate current staff knowledge regarding equipment and patient positioning in laparoscopic theatres.

Method: A questionnaire designed to investigate level of knowledge in theatre ergonomics was sent to doctors and theatre staff.

Results: 32 doctors responded (9 Consultants, 14 Registrars and 8 SHOs). 71% (n=22) have no formal training in ergonomics and 65% (n=20) have no formal training in patient positioning. When asked if doctors knew that the table must be below the elbows operate 26% (n=8) were unaware of this and 6% (n=2) thought the screen should be positioned with a ‘head up’ position. 97% (n=30) have had to operate in an uncomfortable position and of those 30, 97% (n=29) felt this could have been improved by better theatre equipment or patient positioning.

14 theatre staff responded (1 matron, 5 theatre sisters, 3 nurses, 2 HCAs and 3 OPDs). 43% (n=6) had no training in ergonomics and 36% (n=5) had no training in patient positioning. 50% (n=7) did not know the correct position of the operating table and 88% (n=12) did not know how to correctly place a patient into lithotomy position. 64% (n=9) had witnessed surgeons operating in an uncomfortable position and of those 9, 89% (n=8) thought this could have been improved by better patient positioning.

Conclusions: There is a huge lack of knowledge from both doctors and theatre staff into correct patient and equipment positioning. This is possibly causing staff to operate in an uncomfortable position and has the potential to lead to patient injuries.
P10  An unusual complication of Ulipristal treatment for fibroids: Rebound Enlargement of fibroid with Cystic degeneration mistaken for Triplet pregnancy on Ultrasound

Author(s): Kalsang Bhatia, Husnoo Yasine Mohammad, Shankaralingaiah Nethra

Institution: East Lancashire NHS Trust, Burnley General Hospital, UK

Ulipristal is an orally active tissue-specific progesterone receptor (PR) modulator with established efficacy in emergency contraception and pre-operative management of fibroids. It modulates PR activity without suppressing estradiol to postmenopausal levels and hence has advantage over GnRH analogues with fewer side effects when used for pre-operative shrinkage of fibroids.

A single 12 week course has been shown to reduce fibroid volume by 40% with shrinkage maintained for up to 6 months. Recent publications confirm efficacy and safety with longer term repeated courses and promising role as the only medical treatment of fibroid related symptoms without resorting to invasive therapy.

With increasing longer term use of Ulipristal (Esmya 5mg / day) as a novel medical treatment for fibroid symptoms, it is important to report any unreported side effects, although its overall safety profile so far has been good. We would like to report an unusual complication of sudden rebound increase in size of submucous fibroid (increase from 2cm to 10cm) on discontinuation of treatment with unusual cystic degeneration, mistaken for a failing triplet pregnancy on the ultrasound. This clearly resulted in a management dilemma. To the best of our knowledge this has not been reported before.

We believe it is important to increase awareness of this fibroid treatment complication with misleading ultrasound images, especially in those with submucous fibroids. Hysteroscopic resection should be offered in favour of medical treatment in women with resectable submucous fibroids.

P11  Audit of the Outpatient See and Treat Hysteroscopy Clinic

Author(s): Bronwyn Middleton, Peggy Khine, Kirsty Brown, Enya Morsy

Institution: Western Sussex NHS Trust, West Sussex, UK

Outpatient hysteroscopy (OPH) provides many benefits for Trusts and patients. The purpose of this audit is to evaluate the newly established direct access See & Treat OPH Clinic at WSHT.

Retrospective review of 492 patients attending the OPH clinic between 01/07/15 and 31/12/15 through the data collected from the local OPH database. 46% of patients were referred directly by GPs; 29% through GpD and 20% by the two-week rule clinic. 72% were aged between 25 and 55 years, 26% were aged >55. 17% of patients were nulliparous and 13% of the parous had never had a vaginal delivery. BMI ranged between 20 and 30, the highest being 52. Referral indications were HMB/DuB (32%), pMB (25%), and PCB/iMB (17%), ILCD related procedures (10%), AUB on HRT (5%). 82% had a pelvic USS prior to referral in keeping with the referral pathway.

We undertook 338 diagnostic hysteroscopies, 315 of which were flexible and 117 polypectomies mostly by Myosure morcellation (106). 14% (n=67) of patients proceeded to elective admission: patients’ request (21%), endometrial ablation (25%); failed OPH (6%) and TCRF (19%)/GA myosure (28%) as the fibroid/polyps were not feasible to resect under LA. We observed minimal complications such as creation of a false passage (0.2%), fainting (0.8%) and vasovagal (0.4%).

This audit demonstrated patient acceptability as well as efficiencies in a direct access one stop OPH clinic. The findings of this audit will be used to inform future clients and GPs and to provide reassurance to allow the service to develop further.

P12  Auditing the success of Pipelle endometrial sampling taken in outpatient settings: Single-center results

Author(s): Olusegun Ilesanmi, Dimitrios Papoutis, Banchhita Sahu

Institution: Princess Royal Hospital, Shropshire, UK

Objective: The aim of our study was to audit the success rates of Pipelle endometrial sampling in a cohort of women managed in outpatient settings for post-menopausal bleeding.

Methods: This was a retrospective study of women having had endometrial sampling with the Pipelle endometrial sampler during the year 2015.

Results: We identified 185 women with a mean age of 59.8 years (range:40-91 years), 96.1% of which were post-menopausal.

The mean endometrial thickness on ultrasound scan prior to sampling was 5.8 mm (range:1-30mm) and the mean volume of endometrial tissue sampled was 0.73 ml (range:0.04-6.60ml).

Endometrial sampling was reported as insufficient for final diagnosis in 28.9% of cases, with 18.9% having a repeat Pipelle. The histological findings reported were normal endometrial histology (86.7%), endometrial hyperplasia (5.8%), and endometrial cancer (7.5%).

There was a significant correlation between the risk of having insufficient tissue sampling for diagnosis and the increasing patient’s age, a thin endometrium on ultrasound imaging and low volumes of endometrial tissue being sampled. The severity of endometrial pathology was found to increase from normal tissue to endometrial hyperplasia and malignancy in women with increasing age, increasing endometrial thickness on ultrasound imaging, and the increased volume of tissue being sampled.

Conclusion: We found that approximately two out of three women in our cohort have had a successful endometrial sampling, with only one in five undergoing a repeat Pipelle. There are certain risk factors that need to be considered when taking the endometrial sample that could potentially increase the risk of sampling failure.
ABSTRACTS: POSTER

P13 Caesarean Scar Endometriomas: Should Obstetricians take responsibility for this iatrogenic complication?

Author(s): Jemimah Obaro, Alex Cox, Kalsang Bhatia

Institution: Western Sussex NHS Trust, West Sussex, UK

Scar endometrioma is believed to be due to direct implantation of endometrial cells during surgical intervention, which are later activated by oestrogen. This occurrence has been noted with various incisions where endometrial tissues may have been disrupted, including episiotomy, laparoscopy and caesarean section. It is an iatrogenic complication which can be avoided. A large Swedish prospective cohort study reported that the risk of developing symptomatic endometriosis was doubled in women who had at least one Caesarean in a 10 year’s period; Caesarean scar endometriomas contributed to 9% of these. Whilst there is a dearth of publication on implications of caesarean section on future pregnancy, there is a lack of focus on non-obstetric long term complications and implications on women’s health. Scar endometrioma is one of the complications which can be minimised by paying attention to surgical technique. The Caesar Trial did not show any benefit in non-closure of peritoneum or single layer closure apart from saving few minutes of operating time and hence advised caution until long term outcomes are reported.

We would like to present two significant cases of scar endometrioma in women with no previous diagnosis of endometriosis, to generate awareness of this iatrogenic complication, to focus on potential pitfalls in current surgical practise and suggest changes in technique to avoid iatrogenic inoculation of endometrial tissue into the abdominal wall. There is a strong need for a new clinical guidance on caesarean section technique with emphasis on restoring anatomy to prevent long term complications and morbidity associated with endometriosis.

P14 Caesarean Section scar dehiscence in non-pregnant uterus: an overview of literature with focus on an interesting case presenting with sepsis and a large collection with MIRENA in the broad ligament

Author(s): Tommos Sennitt, Jennifer Riches, Nasira Misfar, Kalsang Bhatia

Institution: East Lancashire NHS Trust, Burnley, UK

The downstream effects and complications of rising Caesarean sections on non-pregnant uterus and other long term morbidity remain under-reported. This is because the extent of non-obstetric morbidity is considered to be less significant. Abnormal uterine bleeding and other gynecologic complications associated with a previous cesarean section scar are only recently being reported, some with life-threatening bleeding from the uterine scar. Management of these cases remains challenging and there is a strong need to increase awareness of these complications to health care professionals as well as patients.

We would like to present an overview of non-obstetric gynecological problems reported so far in literature, with particular attention to an interesting case recently encountered in our unit. A 28 year old woman with five previous caesarean sections presented as an emergency with severe lower abdominal pain and bleeding.

A MIRENA was inserted few years ago for contraception. At presentation, she was septic and ultrasound scan showed a large broad ligament collection with MIRENA lying in the collection. Due to on-going sepsis and bleeding despite antibiotics, she underwent gentle suction evacuation of the uterus under ultrasound and hysteroscopic guidance, followed by hysteroscopic retrieval of the MIRENA. Her symptom gradually improved and was commenced on depoprovera for contraception. At 8 weeks review she was still experiencing pain with persistent collection and a request for CT guided drainage was overruled due to anticipated difficulties by radiologists. Eventually with ensuing amenorrhoea from Depo-Provera, a repeat ultrasound at 6 months showed complete resolution of the collection.

P15 Case Report Laparoscopic hysterectomy for an anterior uterine wall defect: an unusual case of persistent vaginal discharge

Author(s): Ian Simpson, Alexander Taylor

Institution: Royal Bournemouth and Christchurch Hospital, Bournemouth, UK

Approximately 26% of babies in the UK are born by caesarean section, and a common indication for this method of delivery is a history of previous caesarean section. As a result, many women will undergo multiple hysterotomies during their reproductive life. A concern for those performing abdominal surgery in such patients is the potential for adhesion formation and increased risk of visceral organ damage. This can be a particular problem for women undergoing hysterectomy, where the bladder may be adherent to the anterior uterine wall. Here, laparoscopic hysterectomy has a distinct advantage, in that it gives a superior view of the pelvic anatomy compared to abdominal or vaginal routes.

This is a case of a 43 year old lady with a history of two previous caesarean sections, who presented with persistent vaginal discharge and lower abdominal pains. Investigations, including MRI and laparoscopy, identified a collection anterior to and contiguous with the uterine cavity. Total laparoscopic hysterectomy was performed, and a large anterior uterine wall aneurysm was identified during surgery. This defect made bladder reflection and colpotomy challenging, however the views obtained laparoscopically enabled safer tissue dissection than would be achievable by alternative routes. Examination of the uterus confirmed the perforating opened into the uterine cavity and histology demonstrated the presence of endometrial tissue. Although a rare presentation, increasing caesarean section rates have the potential to increase these unusual anomalies and pose a challenge to those undertaking pelvic surgery.
ABSTRACTS: POSTER

P16 Catamenial Pneumothorax
Author(s): Mohammad Ilyas Arshad, Rowena Bevan
Institution: Kingston Hospital, London, UK

A 36 year old teacher presented with her second episode of right sided pneumothorax, four months after her first presentation. She had a redo right sided VATS procedure and closure of her diaphragmatic fenestrations with endoscopic staples and repeat pleurodesis. Pathology revealed pleural endometriosis. The patient was initially prescribed norethisterone, and then six months of a GnRH agonist to reduce her chances of recurrence. The patient was afraid of another recurrence and the option of long term GnRH agonist with add back therapy or surgical oophorectomy was discussed. There is no consensus on the long term management for Catamenial Pneumothorax (CP) in young women to reduce the risk of recurrence.

Alifano defined CP as spontaneous pneumothorax occurring within 24 hours before and 72 hours after the onset of menstruation (1). The mean age of recurrence is 34-35 years and it is right sided in 85-95% of cases (2).

Most physicians agree that endometriosis is involved with concurrent pelvic endometriosis in 30-51% of cases. Surgical treatment of CP involves management with a chest drain, VATS and resection of endometriosis with or without repair of diaphragmatic defect and pleurodesis. This can be followed by medical management to reduce the risk of recurrence.

VATS surgery has negligible morbidity and mortality. The most common complication is recurrence. Alifano (1) reported that among 114 patients operated for recurrent spontaneous pneumothorax, the recurrence rates were 32% for CP after 6 months of GnRH treatment, at a mean follow-up of 32.7 months.

P17 Challenges in management of ectopic pregnancy in a university hospital
Author(s): Sudipta Banerjee, Gourab Misra
Institution: University Hospital of North Midlands, North Midlands, UK

Introduction:
Management of ectopic pregnancy is guided by local and national guidelines. In the era of emerging laparoscopic management, quality of laparoscopic training plays a crucial role. Increasing number of caesarean scar pregnancy demands new protocol.

Though laparoscopic salpingectomy is preferable for surgical management, salpingotomy has a role in contralateral tube disease. Expectant management is an option for clinically stable women with minimal symptoms in pregnancy of unknown location. Outcome of management of ectopic pregnancy in our department in 2015 reflects all these challenges faced.

Methods:
245 cases of ectopic pregnancies were treated in 2015. Data was collected for:
- Salpingectomy
- Medical management
- Salpingotomy
- Pregnancy of unknown location (PUL)
- Percentage of PUL resolving spontaneously
- Percentage of PUL requiring further treatment

Result: Total number of ectopic pregnancies in 2015 were 245. 150 laparoscopic salpingectomy were performed, none needed laparotomy. 2 cases of ruptured ectopic had laparotomy. 7 cases had salpingotomy for diseased or absent contralateral tube. There were two cases of scar ectopic, one treated by medical management and second one had laparoscopic excision. 32 had medical treatment.

There were 53 cases of PUL of which 34 resolved with expectant management and 19 needed further intervention (9 surgical and 10 medical).

Conclusion: As a department, we have done well with training in laparoscopic salpingectomy. However, limited number of salpingotomy is a challenge to trainees.

Caesarean scar pregnancy management is very individualized. Pregnancy of unknown location still poses a challenge in management.

P18 Changing Trends in Gynaecological Surgery in the UK over 10 years
Author(s): Rosamund Malhas, Chandrika Balachandar
Institution: Walsall Manor Hospital, Walsall, UK

The aim of this study was to investigate changing trends in gynaecological operating in a District General Hospital. Data were collected over a ten year period from 2005 to 2015 for all patients who underwent a gynaecological surgery at Walsall Manor Hospital UK. Overall the data showed a steady decline in numbers of inpatient surgeries from 2429 to 1489 procedures, despite the department taking on a larger number of Consultants. Numbers of hysterectomies via any route as a percentage of all surgeries performed remained steady over the 10 year period but abdominal hysterectomy declined over the time period and laparoscopic hysterectomy increased. Numbers of vaginal hysterectomy remained constant. Robotic surgery is not available at this centre. Inpatient endometrial ablation procedures increased from 2005-2008 but then showed a gradual decline in numbers after this time reflecting the introduction of outpatient facilities for ablation.

Training in the benign open and laparoscopic surgery in the UK occurs for most trainees in District General Hospitals. The decline demonstrated in number of hysterectomies performed may affect trainees’ exposure to procedures and have possible training implications with a longer time taken to achieve competency in both open and laparoscopic hysterectomy, arguably the more technically challenging operation. Consultants may find that as numbers reduce and complex cases have to be referred to tertiary centres they may have to subspecialise further to take on those cases or risk de-skilling.
ABSTRACTS: POSTER

P19  Comparison of Resource Requirements of Minitouch and Thermachoice Ablation Procedures

Author(s): Vandana Agarwal, Nicky Holvey
Institution: Lincoln County Hospital, Lincoln, Lincolnshire, UK

Background: Shortage of recovery beds was one of the factors limiting us to doing only three endometrial ablation procedures in a single list. Minitouch was trialed at our center since it could be performed without anaesthesia and patients recover without needing recovery beds.

Data: Thermachoice patients need to come at least an hour pre-procedure when they are administered: Diclofenac, Ondansetron, Diazepam, Pethidine and a local anesthetic. All patients needed opioids post-procedure and two-three hours on an average to recover. So, there was a significant workload for the nursing staff limiting us to three procedures per list. Novasure, which we trialed briefly, had similar requirements.

In contrast, Minitouch patients are treated without any preparation other than pre-procedure analgesia. The procedure is simple, is done without dilatation, and in most cases, without anaesthesia. The recovery period is short at about 15 minutes. Occasionally, one patient per clinic needs a recovery bed for not more than 30-40 minutes. We are able to do six Minitouch procedures in a single list.

Four consultants and one nurse hysteroscopist have completed 56 Minitouch procedures without any adverse events. Followup data from 26 patients is available. 22 (85%) patients reported significant improvement in their bleeding defined as lighter from 26 patients is available. 22 (85%) patients reported significant improvement in their bleeding defined as lighter

Conclusions: Minitouch is a simple procedure with a very short recovery period. It needs significantly less resources compared to Thermachoice and provides excellent outcomes. A nurse is no longer needed for the post-operative recovery area. From a service point of view, these are obvious advantages.

P20  Consent and Storage of Surgical Endoscopic Recording: Are we following GMC Guidance?

Author(s): Alexandra Tillett, Kostas Lathouras, Nick Elkington
Institution: Frimley Park Hospital, Frimley, Surrey, UK

Consent to record laparoscopic and endoscopic images is implicit in the consent given to the investigation or treatment. It does not need to be obtained separately (GMC, 2013). Recordings may be used for both primary and secondary purposes, if anonymised. Images and recordings should be stored as part of the patients’ record in a secure environment.

Our aim was to ascertain the extent of endoscopic recording within the British Society of Gynaecological Endoscopy (BSGE) membership and knowledge surrounding ethical and legal guidance.

We created a ten point questionnaire via an online website survey. The anonymous questionnaire was distributed to BSGE members. Our response rate was 107/900 (12%). Ethical approval for this study was not required.

Only 35% of respondents were aware of a written policy regarding consent and storage of recording despite 72% admitting to recording their endoscopic operations. 53% obtain consent for recording. 47% of respondents believe records are stored permanently but 90% of these records are not attached to individual patients. 5% of respondents are recording images on their own personal laptop or USB stick.

As a group of professionals, we are clearly placing ourselves at risk of prosecution by patients by not adhering to GMC guidance. From our small but representative study, local written policy and provision for secure storage for imaging is woefully inadequate. Apart from being both unethical and illegal, we potentially lose out on a valuable resource by not storing imaging securely, attached to individual patient records.

P21  Contralateral Recurrence of Interstitial Ectopic Pregnancy; Conservative Management with Good Outcome

Author(s): Morounfolu Olaleye Thompson, Isaac Oluwabamishie Ogunwumi, Dele Olorunshola, Caolin MacIver
Institution: Barking, Havering and Redbridge University Teaching Hospital, Essex, UK

We present the case of Mrs. AM, a Para 0 woman, who was first seen aged 34 years at 6 weeks gestation in her 1st successful pregnancy following assisted conception by IVF. A scan showed an empty uterine cavity despite positive hCG testing and a left interstitial ectopic pregnancy was diagnosed. She subsequently had a combined laparoscopy assisted, ultrasound guided hysteroscopic evacuation of the ectopic at 11 weeks gestation. Twelve months later she presented with exactly the same clinical picture and this time the pregnancy was in the interstitial portion of her right Fallopian tube and the same procedure was repeated. 12 months later she again conceived following IVF and this time implantation was normal and pregnancy went to term. An uneventful pregnancy except for low maternal serum PAPP-A levels in the first trimester and concerns over smallness for gestational age. A 2.9kg female baby was delivered by elective Caesarean following Doppler ultrasound changes indicating IUGR. This case illustrates the many difficult facets of interstitial ectopic pregnancies, the classic diagnosis, dilemmas regarding pregnancy interruption with a much desired baby. Attached images and videos available with the couples consent.

P22  Crisis Resource Management in Gynaecological Robotic Surgery: Multidisciplinary In Situ Simulation Training for Emergency De-Docking Procedure

Author(s): Yasamin Ziabari1, Olivia Mingo1, Rohit Juneja1, Annette Drescher1, Thomas Ind1
Institution: 1The Royal Marsden NHS Foundation Trust, London, UK, 2The Central London School of Anaesthesia, London, UK

Multidisciplinary Simulation Training can be used as a tool to managing uncommon yet serious incidents during robotic surgery.

Method: A high-fidelity simulation of a robot-assisted para-aortic lymphadenectomy was televised live to an audience of theatre personnel. The model consisted of a draped manikin with laparoscopic ports positioned, routine anaesthetic monitoring, and the da Vinci Surgical System®. After thirty minutes, an iatrogenic tear of the inferior vena cava was simulated using a
ABSTRACTS: POSTER

P23 Diagnosis and Management of Miscarriage: What is the practice in the United Kingdom?

Author(s): Suruchi Pandey
Institution: Asford and St. Peter’s Hospitals, Chertsey, UK
The National Institute of Clinical Excellence (NICE) have recently updated their guidelines on diagnosis and management of miscarriages. There is a growing awareness of non-surgical management and the importance of patient choice. We decided to measure our compliance to NICE guidance for diagnosis and medical management of miscarriage and to compare our practice with that of other EPUs.

Methodology: Telephonic and electronic email survey of EPUs in the United Kingdom (n=191) between November 2015 to February 2016. Response rate: 86 units (45%)

Subjects explored included:
- Ultrasound criteria for diagnosis of miscarriage
- Medical Management of Miscarriage Protocol

Key Findings:
- Only 13% of the units were completely compliant with all elements of the NICE guideline for diagnosis and management of miscarriage.
- 94% of EPUs offer medical management for miscarriage
- In units non-compliant with NICE, the cut-off values of Crown Rump Length (CRL) and Mean Gestational Sac diameter (MSD) were higher than NICE recommended values, except for one unit where the MSD was less than the NICE recommended value of 25mm.
- 97% of EPUs use recommended the Misoprostol dosage for missed miscarriage.
- 17% of EPUs use the recommended Misoprostol dosage for incomplete miscarriage.
- 52% of EPUs use Mifepristone which is not recommended by NICE.

Conclusion:
- Overall compliance with NICE guidelines for diagnosis and management is 13%.
- Diagnosis: new NICE criteria have been widely adopted.
- Management: Medical management is offered by most units. Protocols for medical management of miscarriage are variable.

P24 Diagnostic accuracy of rectal endoscopic sonography in recto-vaginal endometriosis for enabling surgical planning

Author(s): Liz Bruen
Institution: 1University Hospital of Wales, Cardiff, UK, 2Royal Gwent Hospital, Newport, UK

Study Objective: The aim of this study is to evaluate the diagnostic accuracy of rectal endoscopic sonography in prediction of infiltration depth of rectal endometriosis and plan the appropriate surgical management. Rectovaginal endometriosis (RVE) is severe variant, involves 30% of endometriosis cases. Rectovaginal endometriosis has the potential to infiltrate or involve rectal wall. Evaluation of involvement of muscularis propria and dissectible planes required to control the risk of recto-sigmoid bowel injury.

Design: A retrospective case review of women with laparoscopically identified rectovaginal endometriosis who underwent rectal endoscopic ultrasound prior to their surgical treatment between 2010-2014. Complete data for 150 cases was reviewed. Setting: University Hospital Wales, tertiary referral Hospital, a BSGE accredited Endometriosis Centre, performing advanced laparoscopic surgery. Patients or Participants: Women undergoing advanced endometriosis surgery with initial laparoscopic evidence of RVE.

Interventions: All suspected case of rectovaginal endometriosis underwent rectal endoscopic ultrasound. Operative notes were analysed to calculate post test prevalence.

Results: In our series results demonstrate that rectal endoscopic ultrasound is a particularly powerful pre-operative test with a good concordance between ultrasound and histological findings.

Conclusion: The knowledge of the depth of recto-vaginal endometriosis not only allows pre-operative surgical planning, effective and informative communication with the patient but has significant logistic benefits including; assessing the need for a colorectal surgeon input and efficient use of theatre time and resources.
P25  Diagnostic laparoscopy is not indicated in young adults with normal findings at examination and ultrasound scan

Author(s): Nicola Tempest1,2, Katerina Efstathiou2, Dharani Hapangama1,2
Institution: 1Liverpool Women’s Hospital NHS Foundation Trust, Liverpool, UK, 2Department of Women’s and Children’s Health, Institute of Translational Medicine, University of Liverpool, Liverpool, UK

Background: Endometriosis affects 1 in 10 women of reproductive age and definitive diagnosis requires diagnostic laparoscopy. ESHRE guidelines endorse empirical medical treatment prior to definitive diagnosis in women with endometriosis-associated symptoms. There is no evidence that treatment of peritoneal disease influences the natural course of the disease.

Aim: Compare the history, examination and operative findings of two cohorts of young women to determine the most appropriate time for a diagnostic laparoscopy.

Method: We retrospectively analysed all laparoscopies undertaken to investigate pelvic pain with a normal ultrasound scan (USS) at Liverpool Women’s Hospital from June to Dec 2015 in two different age categories, 16-20 years (n=41) and 25-29 years (n=34).

Results: Younger women had statically lower BMI and parity and suffered a higher incidence of migraine and IBS. Both groups had a high prevalence of anxiety and depression, 24% young vs 32% older. 5% younger and 9% older women had a previous laparoscopy. 58% younger and 47% older were on hormonal contraceptives and habitual use of analgesia was reported by 32% vs 41%. Medical treatment was offered prior to laparoscopy in 24% younger and 21% older. At laparoscopy, normal pelvis seen in 66% of the younger and 62% of the older group, and the diagnosis of stage 1-2 endometriosis was made in 24% and 21%. None had stage 3-4 disease.

Conclusion: Many young women are undergoing invasive investigations with normal findings at USS/physical examination without a prior trial of medical treatment, yet this didn’t change the management.

P26  Efficacy and safety of Hysteroscopic sterilisation in an outpatient setting: a retrospective study of 350 women

Author(s): Roshti George, Rosie Broadbent, Somia Khalid, Andrew Baxter
Institution: Royal Hallamshire Hospital, Sheffield, UK

Introduction: Hysteroscopic sterilisation (Essure) has been in the spotlight due to concerns about allergic reactions and reports that women are more likely to need additional surgical procedures. We report our experience with 350 women.

Objectives: To investigate the safety and efficacy of hysteroscopic sterilisation.

Methods: Retrospective cohort study of 350 patients attending for hysteroscopic sterilisation (14.11.02 to 22.06.15). Essure 339, Adiana 11. The original Essure device for the first 38 cases; modified device for latter 312 cases.

Results:

EFFICACY
1. Successful placement of essure was achieved in 96% (335/350); 98% (307/312) with the new device.
2. Pregnancy rate 0.05% (2/335). One patient was pregnant at time of insertion (Day 14, negative pregnancy test). The second patient had blocked left tube on hysterosalpingogram and essure could only be inserted into right tube.
3. Tubal occlusion was confirmed by HSG, or the position of micro-inserts confirmed by Xray/Ultrasound in 98.7% (320/324) of women who completed 3 months of follow up.

SAFETY
1. 1. Rate of unsatisfactory microinsert placement (expulsion migration to abdominal cavity) was 0.09% (3/335).
2. 3% (9/335) of women reported pain up to 4 weeks following procedure.
3. Rate of additional surgical procedure - 0.05% (2/335) (laparoscopy to remove the device from omentum and hysterectomy for pelvic pain.)

Conclusion: Hysteroscopic sterilisation is safe and effective. The procedure is well tolerated in the office with high successful bilateral placement rates. Allergic reactions, pelvic pain and additional surgical procedures were rarely reported. Our observations support its ongoing use highlighting the importance of audit.

P27  ESSURE hysteroscopic sterilization compliance rate to follow up ultrasound scan

Author(s): Sreebha Rajesh, Chris Guyer
Institution: Queen Alexandra Hospital, Portsmouth, UK

Objective: To determine completion rate, complications and compliance rate following ESSURE hysteroscopic sterilization.

Design: Retrospective review

Setting: Outpatient hysteroscopy clinic at Queen Alexandra hospital, Portsmouth.

Intervention: Data was collected of 51 patients who underwent ESSURE sterilization in our ambulatory unit without sedation or GA. Transvaginal ultrasound scan is performed in the ambulatory clinic 3 months post procedure to confirm correct placement of essure coils and establish occlusion of fallopian tubes bilaterally.

Results: Successful placement of both micro-inserts in the first clinic visit: 41/51.

Unsuccessful procedure in the outpatient clinic: 4/51. All due to distorted tubal anatomy.

Complications – There were no intra-op complications. Expulsion of both micro-inserts: 1 patient. Chronic pelvic pain: 1 patient requiring laparoscopic removal of essure coils.

No reported cases of pregnancy.

Compliance rate – 19.6% patients did not attend for their follow up TVS appointment.

Conclusion: ESSURE sterilisation can be safely performed in the ambulatory clinic setting. The compliance rate is not as high as observed in some studies. Need to send repeat appointments and telephone follow up for patients who failed to keep the follow up appointments.
P28 Establishing Total Laparoscopic Hysterectomy Services in a District General Hospital after successful Allocation of Formal Funding

Author(s): Amanda Airey1, Hadi Haerizadeh1, Aine Dempsey2

Institution: 1Musgrove Park Hospital, Taunton, UK, 2St Michael’s Hospital, Bristol, UK

Objectives: Total Laparoscopic Hysterectomy (TLH) has several advantages over Total Abdominal Hysterectomy (TAH) including shorter length of stay, less postoperative pain and wound infection, and improved patient satisfaction. In our district general hospital, two out of eight consultants can offer laparoscopic hysterectomies for benign disease. In October 2014 a business proposal achieved funding to establish a TLH service and practice was audited to assess its implementation. The data was then compared to a pre-implementation audit in 2013-4.

Methods: All TAH within a year of implementation (October 2014 – October 2015) were included. Using medical notes, preoperative imaging, and histology results, suitability for a TLH was assessed using clinical factors (vaginal access, fibroid position, likely adhesions) and uterine size of equal to or less then 12 weeks or 280 grams.

Results: Two hundred and ten cases of laparoscopic and abdominal hysterectomies were identified, including 129 open procedures. Eighty two case notes were reviewed and 11 patients were identified as potentially suitable for a TLH using the above criteria. Data on length of stay, estimated blood loss and operative complications was also collected.

Conclusions: The data suggests approximately 13% of the TAH procedures could have a laparoscopic approach considered. This compares favourably to pre-implementation data which estimated 60% may have been suitable for TLH. Overall it seems the Gynaecology department have been successful in implementing referrals to colleagues with the appropriate experience to offer a TLH, although there is scope for further utilisation of the service.

P29 Fallopian tube hyperplasia in patients undergoing prophylactic bilateral salpingo-oophorectomy

Author(s): Latika Narang, UL Teo, Kevin Hayes

Institution: St Georges University Hospitals NHS Foundation Trust, Tooting, London, UK

Introduction: Women who are carriers of gene mutations are currently managed by prophylactic bilateral salpingo-oophorectomy (BSO) and washings. Recent studies have postulated that ovarian cancer may originate from the fallopian tubes.

Aims: To determine the incidence of fallopian tube hyperplasia in patients who are deemed high risk for ovarian cancer (carriers of gene mutation) undergoing prophylactic BSO.

Materials and methods: A retrospective study was conducted of 134 patients who had prophylactic BSO over 5 ½ years period (January 2009 - June 2014) in a London tertiary referral centre. 52.5% women were pre-menopausal. Majority of women had BRCA 1 and 2 carrier status (45.1%). Histology results showed 84.3% specimens were normal, 6.9% had benign pathology, 6.7% hyperplastic tubal epithelium and atypia, 0.7% metastatic serous carcinoma, 0.7% serous cystadenocarcinoma of unilateral ovary and tube and 0.7% high grade serous carcinoma of fallopian tube.

Discussion: 8.8% of our patients had premalignant or malignant changes with 0.7% with asymptomatic metastatic serous carcinoma. Of these, 7.4% showed fallopian tube changes with no ovarian involvement. This correlates with the postulation that ovarian cancer may arise from fallopian tubes, with tubal hyperplasia being the precursor for serous ovarian carcinoma.

Conclusions: Prophylactic bilateral salpingectomy may also be sufficient in reducing the risk of serous ovarian carcinoma and therefore reducing the risk of coronary artery disease and osteoporosis for premenopausal women. Further research with randomised controlled trials is needed.

P30 How to provide high quality care at a low cost?

Author(s): Suruchi Pandey

Institution: Asford and St. Peter’s Hospitals, Chertsey, UK

In the present financial climate, it is essential to be aware of the costs of the treatments we provide. In order to understand our finances and improve our cost effectiveness, we at the Centre for Endometriosis and Minimally Invasive Gynaecology (CEMiG) at the Ashford and St. Peter’s Hospitals reviewed our surgical income and expenditure for the first 3 months of 2015/16 via Service Line Reporting (SLR).

We worked out the overall profit and loss for all cases depending on whether they were day-case (DC), elective (EL) or non-elective (NEL). Using SLR, we looked at the individual breakdown of costs of 10% of the most profit making and loss making surgical cases, the theatre time charged and the length of stay.

Key Findings:
- The main costs, documented below, were similar for both profit and loss making cases:
  1. Theatre costs and anaesthetic staff costs.
  2. Gynaecological staff costs.
  3. Ward costs.

- Theatre time and length of stay are significantly shorter for profit making cases.
- We were wrongly charged £12,700 due to incorrect coding.
- Day-surgical and elective cases were in general more profitable than non-elective cases.
- We had not been adequately remunerated in 2 cases due to incorrect coding.

Recommendations:
- Regular MDT meetings to streamline the enhanced recovery pathway.
- Routine telephonic support to same day discharge patients.
- Monthly meetings with coders to ensure correct coding.
- Type written and detailed documentation of surgical procedures.
- Theatre cards to ensure that theatre set up is standardised and not time consuming.
P29 Fallopian tube hyperplasia in patients undergoing prophylactic bilateral salpingo-oophorectomy

Author(s): Latika Narang, UL Teo, Kevin Hayes

Institution: St Georges University Hospitals NHS Foundation Trust, Tooting, London, UK

Introduction: Women who are carriers of gene mutations are currently managed by prophylactic bilateral salpingo-oophorectomy (BSO) and washings. Recent studies have postulated that ovarian cancer may originate from the fallopian tubes.

Aims: To determine the incidence of fallopian tube hyperplasia in patients who are deemed high risk for ovarian cancer (carriers of gene mutation) undergoing prophylactic BSO.

Materials and methods: A retrospective study was conducted of 134 patients who had prophylactic BSO over 5 ½ years period (January 2009 - June 2014) in a London tertiary referral centre.

Results: 52.5% women were pre-menopausal. Majority of women had BRCA 1 and 2 carrier status (45.1%). Histology results showed 84.3% specimens were normal, 6.9% had benign pathology, 6.7% hyperplastic tubal epithelium and atypia, 0.7% metastatic serous carcinoma, 0.7% serous cystadenocarcinoma of unilateral ovary and tube and 0.7% high grade serous carcinoma of fallopian tube.

Discussion: 8.8% of our patients had premalignant or malignant changes with 0.7% with asymptomatic metastatic serous carcinoma. Of these, 7.4% showed fallopian tube changes with no ovarian involvement. This correlates with the postulation that ovarian cancer may arise from fallopian tubes, with tubal hyperplasia being the precursor for serous ovarian carcinoma.

Conclusions: Prophylactic bilateral salpingectomy may also be sufficient in reducing the risk of serous ovarian carcinoma and therefore reducing the risk of coronary artery disease and osteoporosis for premenopausal women.

Further research with randomised controlled trials is needed. Parameters observed were menopausal status, genetic risks, findings on histology and complications of surgery.

P30 How to provide high quality care at a low cost?

Author(s): Suruchi Pandey

Institution: Asford and St. Peter’s Hospitals, Chertsey, UK

In the present financial climate, it is essential to be aware of the costs of the treatments we provide. In order to understand our finances and improve our cost effectiveness, we at the Centre for Endometriosis and Minimally Invasive Gynaecology (CEMiG) at the Ashford and St. Peter’s Hospitals reviewed our surgical income and expenditure for the first 3 months of 2015/16 via Service Line Reporting (SLR).

We worked out the overall profit and loss for all cases depending on whether they were day-case (DC), elective (EL) or non-elective (NEL). Using SLR, we looked at the individual breakdown of costs of 10% of the most profit making and loss making surgical cases, the theatre time charged and the length of stay.

Key Findings:
- The main costs, documented below, were similar for both profit and loss making cases:
  1. Theatre costs and anaesthetic staff costs.
  2. Gynaecological staff costs.
  3. Ward costs.
- Theatre time and length of stay are significantly shorter for profit making cases.
- We were wrongly charged £12,700 due to incorrect coding.
- Day-surgical and elective cases were in general more profitable than non-elective cases.
- We had not been adequately remunerated in 2 cases due to incorrect coding.

Recommendations:
- † Regular MDT meetings to streamline the enhanced recovery pathway.
- † Routine telephonic support to same day discharge patients.
- † Monthly meetings with coders to ensure correct coding.
- † Type written and detailed documentation of surgical procedures.
- † Theatre cards to ensure that theatre set up is standardised and not time consuming.

P31 Hysterectomy for endometriosis-associated pain: A 5-Year Follow-up to Investigate Need for Further Surgery

Author(s): Ritu Rana, Chris Kremer

Institution: Midyorkshire Hospitals NHS Trust, West Yorkshire, UK

Objective: To investigate need for further surgery after hysterectomy with ovarian conservation in patients with endometriosis-associated pain.

Methods: In this retrospective review, hundred consecutive women who underwent hysterectomy along with removal of all visible endometriosis were assessed for requirement for subsequent surgery. We have compared hysterectomies where there was conservation of at least one ovary with hysterectomies with bilateral oophorectomies. All hundred patients underwent hysterectomy at Midyorkshire Hospitals under the named consultant for endometriosis and were followed up for a minimum of five years.

Results: 62% women had hysterectomy with conservation of at least one ovary. All visible endometriosis was removed laparoscopically at the same time. Out of this group, 15% patients required further surgery for ongoing pain. In this group only 7% patients had severe endometriosis. From the bilateral salpingo-oophorectomy group, 9% patients required further surgery. In this group, as many as 31% patients had severe disease. Age of patients who underwent hysterectomy for endometriosis ranged from 30 to 51 years. The average age of patients who had bilateral salpingo-oophorectomy was higher than those who did not, with minimum age being 42 years which causes a significant age related bias.

Conclusions: The re-operation rate after preservation of ovaries is higher than the group without. Our results are comparable.
ABSTRACTS: POSTER

to the largest published trial in the journal of Obstetrics and Gynaecology in 2008. We conclude that conservation of ovaries is a viable option for women in the younger age group.

P32 Impact of Fluid Management System on Ambulatory Outpatient Hysteroscopy Service

Author(s): Forster LS, Lord JM

Institution: Royal Cornwall Hospital, UK

Summary: The fluid management system delivers improved low pain scores and overall patient experience at outpatient hysteroscopy compared with the saline pressure bag.

Introduction: The fluid management system replaced the saline pressure bag for all outpatient hysteroscopy procedures in our Ambulatory Gynaecology Service in June 2015. The system is preferred by operator and nursing staff in our unit. The aim of this study was to examine patient experience.

Methods: Consecutive patients undergoing a diagnostic or operative hysteroscopy from September 2011 to March 2016 from a single operator working in two locations were included. Data was collected from a patient satisfaction questionnaire including pain scores completed immediately after the procedure. Statistical analysis using SPSS was performed.

Results: 803 consecutive patients were included in the study. The first 582 patients underwent a saline pressure bag hysteroscopy and the following 221 patients the fluid management system. 28% of the fluid management group (vs. 15%) reported pain or discomfort to be much better than their expectations (p=0.03). 96% of the fluid management group (vs. 92%) stated that they would opt for outpatient hysteroscopy again in the future (p=0.01).

The fluid management system was superior in delivering a low pain score (<2) 35% vs. 26% (p=0.02). Mean pain scores and high pain score (>8) showed no statistical significance between the two groups.

Discussion: With the transition to a more office based Gynaecology service patient acceptability of outpatient hysteroscopy is of paramount importance. This study demonstrates that the fluid management system offers improved overall patient experience.

P33 Improving Patient flow and efficiency by restructuring of Outpatient Hysteroscopy services in Gynaecology – Heart of England NHS Foundation Trust experience

Author(s): Manjula Subramanian, Kausik Das, Susan Hartman, Linda Lynch

Institution: Heart of England NHS Foundation Trust, Birmingham, UK

Aim: To evaluate the effect of reconfiguration of outpatient hysteroscopy services.

The aim of the quality improvement evaluation was to explore the relationship between patient flow, costs and outcomes by examining patient flow through the out ambulatory gynaecology pathway, and developing pathways in which capacity can be better matched to demand.

Background: Best Practice Tariff (BPT) for hysteroscopy introduced in 2012 has led to the restructuring of gynaecology services resulting in efficient ambulatory gynaecology services in the UK. We present a snap shot of our experience at the Heartlands Hospital.

The purpose of the exercise was to identify the delays in the pathway, and to identify any inefficiency, waste and poor quality of the system.

Method: Cohort - All women who underwent Outpatient Hysteroscopy at the Birmingham Heartlands Hospital between July 2015 to December 2015.

Results: being analysed

• Theatre utilisation over this period
• Average referral to diagnosis time and referral to treatment time
• No. of visits to the clinic per patient

Costings were calculated taking fewer visits to clinic, reduce wait times for diagnosis and treatment planning, decrease in waiting list, improved theatre utilisation, financial incentive from the BPT into consideration.

Conclusion: will be based on the results. Focusing on flow does improve quality, maximizes capacity and is cost effective. The report summarizes key lessons from the evaluation and highlights important challenges for designing services and approaching change by focusing on flow.

P34 Incidence Of Pelvic Pain After Hysteroscopic Sterilization Using ESSURE Micro-Insert For Permanent Birth Control

Author(s): Oguljemal Redjepova, Osama Naji, Magdi Labib, Pritaibha Arya, Robert Johnson, Mamta Pathak

Institution: Worcestershire Royal Hospitals, Worcester, UK

Introduction: Hysteroscopic sterilization is a family planning method aimed to achieve permanent prevention of future pregnancy. The rate of performing this procedure rose from 1 to 25% over the last 10 years. There is limited evidence to date regarding the long-term health risks. However its failure rate is established at approximately 2 in 1000 cases.

Objective: To investigate the incidence of new-onset pelvic pain after Essure® (Bayer Healthcare Pharmaceuticals Inc. NJ, USA) sterilization, and its association with pre-operative and pre-existing risk factors.

Methods: A retrospective cohort of patients who underwent ESSURE hysteroscopic sterilization between November 2013 and December 2015 were reviewed through historical database. Descriptive analysis using the Chi-square was performed to establish the incidence of new-onset post-procedure pelvic pain and its relation to pre-procedure risk factors.

Results: A total of 102 patients were offered the procedure, out of which 6 patients (5.8%) reported new pelvic pain and requested removal of the micro-inserts. However on reviewing the individual
cases we found a background of irritable bowel syndrome, previous caesarean section and pelvic endometriosis in 3, 5 and 3 out of the 6 cases respectively. Therefore, the true incidence of new-onset pelvic pain was estimated at 1:102 (0.9%).

Conclusion: There is small a risk of new-onset pelvic pain after ESSURE hysteroscopic sterilization, this should be highlighted when counselling women on the risk and benefits of this procedure. Larger studies are required to establish the true incidence of pelvic pain in this cohort of patients.

P35 Indocyanine green sentinel lymph nodes in endometrial and cervical cancer – Preliminary data from the FRIENDS study.

Author(s): Marielle Nobbenhuis, Thomas Ind

Institution: Royal Marsden Hospital, London, UK

The Fluorencent Robotic Indocyanine Endoscopic Node Dissection Study (FRIENDS) was designed to ascertain which nodes were important for dissection in endometrial and cervical cancer.

To date, 52 patients have been recruited to the study. Complete data is available from 46 patients. In two women, the final histology was not available at the time of abstract submission and were therefore excluded. A further four women failed to have sentinel dissection due to an abandoned procedure or open operations.

Sentinel nodes were visible in 42/46 (91.3%) on the right hand side and 41/46 (89.1%) on the left. Amongst commonly dissected nodal groups, common iliac, external iliac, internal iliac, obturator & parametrial sentinel nodes were present in 16/46 (34.8%), 17/46 (37.0%), 3/46 (6.5%), 15/46 (32.6%), & 0/46 (0.0%) respectively on the right hand side and 10/46 (21.7%), 26/46 (56.5%), 4/46 (8.7%), 10/46 (21.7%), & 1/46 (2.2%) respectively on the left hand side.

Amongst rarely dissected nodal groups, para-aortic, aortic bifurcation, and pre-sacral sentinel nodes were present in 8/46 (17.4%), 4/46 (8.7%), & 5/46 (10.9%) respectively on the right hand side and 1/46 (2.2%), 2/46 (4.3%), & 1/46 (2.2%) respectively on the left hand side.

These data demonstrate that traditional pelvic lymphadenectomy for cervical and endometrial cancer does not encompass the nodal chains that commonly involve sentinel lymph nodes. Re-evaluation of the standard surgical approach is required.

P36 Initial Clinical Evaluation of the Liberata Handheld Thermal Balloon Ablation Device

Author(s): Christopher Guyer, Sree Rajesh

Institution: Queen Alexandra Hospital, Portsmouth, UK

A prospective observational study using a novel, battery driven, handheld balloon ablation device.

Patients already planned to have an endometrial ablation as an inpatient or outpatient were provided with information on the Liberata ablation device and consented for the procedure.

Normal demographic data was collected for each patient and data collected specific to the procedure were uterine cavity shape and length, presence of fibroids and need for cervical dilation. For patients undergoing an outpatient procedure, their maximum pain score on a visual analogue scale was recorded along with their requirement for additional medication following the procedure. Follow up data was collected at 6 months to assess the effectiveness of the procedure in providing hypomenorrhoea or amenorrhoea and the requirement for any additional intervention for their menstrual problems.

To date, 20 patients have been included in the study with 17 having a completed procedure, 5 as inpatients and 12 as outpatients. For patients having an outpatient procedure, the mean of their maximum pain score on a 0-10 visual analogue scale was 5 and 3 patients required additional analgesia after the procedure. There were no observed complications and no ward admissions following the intervention. At 6 months 15 of the 17 patients with a completed procedure were satisfied with the outcome with either hypo or amenorrhoea.

These initial results indicate that the Liberata ablation system appears to be safe and effective and suitable for outpatient use.

P37 Investigating factors facilitating efficient and cost-effective outpatient hysteroscopy services

Author(s): Omar Mulki, Elizabeth G H Thong, Hannan Al-Lamee

Institution: Imperial College London, London, UK

Hysteroscopy is a useful procedure to directly visualise the uterine cavity. This facilitates the diagnosis and treatment of intrauterine abnormalities. One of commonest referrals requiring investigation is irregular/post-menopausal bleeding.

These are often done as inpatient procedures, but can be inefficient, expensive and inconvenient for patients. In contrast, outpatient clinic is simple to establish, does not require inpatient bed usage and brings financial government remunerations. It is also beneficial to patient safety: general anaesthetic is avoided and can be in and out of hospital quickly and with minimum discomfort.

We aimed to identify the overall efficiency and cost-effectiveness of outpatient hysteroscopy services in our department. By auditing the data we could observe factors facilitating successful outpatient procedures.

We reviewed the data from two consultants and a nurse specialist. We analysed the conversion rate from outpatient to inpatient services for the consultants and nurse to assess success rates. We then calculated the total cost of running an outpatient hysteroscopy service, taking into account any extra inpatient procedures. Comparing the inpatient conversion rates for patients’ ethnicity, number of children and vaginal deliveries showed us which groups were more likely to have successful outpatient procedures, thus allowing better case selection.

With a lower inpatient conversion rate, the consultant had an overall more cost-effective outpatient service. However, we should consider the variability in consultant ability and patient inconvenience if an inpatient procedure is required. A consultant-run outpatient hysteroscopy service can be more efficient and cost-effective, and appropriate case selections can aid the service’s success.
ABSTRACTS: POSTER

P38 Investigation and Management of Patients on Tamoxifen in an Outpatient Hysterectomy Setting

Author(s): Lamia Zafrani, Sujata Gupta

Institution: Stepping Hill Hospital, Stockport, Greater Manchester, UK

Majority of cases of endometrial cancer occur in women who present with post menopausal bleeding, of which 96% will have an increased endometrial thickness.

Tamoxifen use can increase the risk of endometrial cancer but endometrial thickness in these patients as seen on transvaginal ultrasound scan (TV USS) can give misleading results due to the increased presence of subendometrial cysts in these patients, resulting in increased endometrial thickness.

All patients on Tamoxifen who present with post menopausal bleeding or abnormal uterine bleeding should be referred to secondary care under the two week urgent cancer pathway, and majority of these patients are normally investigated via hysteroscopy and endometrial biopsy under general anaesthetic. However we wanted to investigate the number of patients referred from community who were asymptomatic (no bleeding) but with an incidental finding of an increased endometrial thickness on TV USS who were referred directly from community to the Outpatient Hysterectomy (OPH) service at a local District General Hospital; whether hysteroscopy and endometrial biopsy were achieved successfully in an outpatient setting in these patients; and how many of these patients had malignancy detected on histology from biopsy.

The relevance of our findings will help to ascertain whether investigation and management of patients on Tamoxifen who are asymptomatic resulted in diagnosis of endometrial cancer and whether adequate investigation of this patient group can be achieved in an OPH setting.


Author(s): Sujata Gupta

Institution: Stockport NHS Foundation Trusts, Stockport, UK

The advantages of minimal access approach for hysterectomy are well established. Over last 10 years, the complications have declined significantly with the laparoscopic route. Despite this, most gynaecologists still prefer abdominal route. This qualitative study looked at the reasons that influence a surgeon’s choice in a benign case with no adnexal pathology and uterus less than 12 weeks in size.

Methodology:
This is a qualitative study for which NHS consultants practising benign gynaecology in the northwest of England were interviewed. A total of 22 participants were interviewed.

Results:
Key factors influencing surgical decision-making were surgeons’ perceptions of an increase in clinical indications of hysterectomy for which an abdominal route was more appropriate. Abdominal route was also often preferred due to familiarity. They felt that there was a lack of training in vaginal and laparoscopic hysterectomy. Due to this, many surgeons expressed concerns about higher complications with minimal access routes in their hands. Low case load, time pressures and lack of organisational support were other influencing factors which favoured abdominal route.

Conclusions:
Most surgeons prefer abdominal hysterectomy as this is the route they feel most comfortable with. Lack of training and experience are the main contributing factors limiting the use of minimal access approach. Most surgeons want to develop their laparoscopic skills but similar desire is lacking towards vaginal hysterectomy.

P40 Is Laparoscopy Safe (for those performing it)?

Author(s): Michael Magro, Jamna Saravanamuthu

Institution: Newham University Hospital, Barts Health NHS Trust, London, UK

Aim: To investigate the safety of laparoscopic gynaecological surgery for those who perform it and whether better patient/staff/equipment positioning would reduce the risk.

Method: An audit questionnaire was sent to doctors involved in laparoscopic gynaecological surgery

Results: 32 doctors responded (9 Consultants, 14 Registrars and 8 SHOs) all of whom have been involved with laparoscopic gynaecology surgery. 87% (n=27) have had musculoskeletal strain either caused by, or made worse by, laparoscopic surgery. Of those 27 doctors the breakdown of site of injury is: 63% (N = 17) Neck, 67% (n=18) Shoulders, 41% (n=11) Back, 67% (n=18) Hands/Arms, 19% (n=5) Knees/Feet. 42% (n=13) of all the doctors asked have had to use analgesia due to a laparoscopy related muscle strain or injury, however only 4% (n=1) have ever had time off work due to an injury. 71% (n=22) have no formal training in ergonomics and 65% (n=20) have no formal training in patient positioning.

Conclusion: A large number of doctors performing laparoscopic surgery are reporting having to operate in uncomfortable positions and subsequently developing muscle strain and a need to use analgesia. It is interesting to point out that the majority of those involved in laparoscopic surgery have had no formal training in ergonomics or patient positioning and we wonder if this is a causal relationship that needs investigating further.

P41 Laparoscopic hysterectomy: Face, content and construct validation of a virtual reality simulator.

Author(s): Rasiah Bharathan1, James McLaren2, Anil Tailor1, Omer Davaja1, Thomas Ind4, Simon Butler-Manuel1

Institution: 1Royal Surrey County Hospital, Guildford, UK, 2Lewisham Hospital, London, UK, 3Maidstone and Tunbridge Wells Hospitals NHS Trust, Maidstone, UK, 4St. Georges Hospital, London, UK

Background: Laparoscopic hysterectomy is a complex procedure. The learning of advanced laparoscopic skills needs to be supported by simulation based training. However, validation of such simulators is the first step in selecting an appropriate device. We present the first such study in laparoscopic hysterectomy.

Method: 12 novices, 9 intermediate and 14 experienced participants were recruited to this study from four hospitals. A LAP Mentor simulator module was the subject of the study. Feedback
P42  Laparoscopic supracervical hysterectomy for the large uterus (>500g): A case series and literature review

Author(s): Lauren McGurk, Reeba Oliver, Funlayo Odejinmi  
Institution: Whipps Cross University Hospital, London, UK  
Objective: To compare surgical outcome for laparoscopic supracervical hysterectomy (LSH) in the large uterus (equal or greater than 500g) compared to normal (<500g). Results were compared to the limited literature on this topic. 
Method: A retrospective review was undertaken of 207 women who underwent a LSH between 2005 and 2015 at Whipps Cross University Hospital. The operative outcome of patients undergoing surgery, for uteri both greater and less than 500g, were analysed. Data included patient demographics, intra-operative details and complications.

A literature search was performed using keywords “laparoscopic supracervical hysterectomy” and “laparoscopic subtotal hysterectomy” which yielded 6 informative articles.

Results: In the study group of 207 patients, 67 had a large uterus (56 patients: 500-1000g, 11 patients: >1000g). The operation time and intra-operative blood loss were both greater in the larger uterus cohort (P<0.001 and F=0.0021 respectively). The hospital stay and intra-operative complication rate was similar for the 2 study cohorts (6 for the study, n=207).

Review of the literature revealed 6 relevant studies evaluating patients with uteri greater than 500g. There was an agreement between all the studies that a larger uterus resulted in an increase in both intra-operative time and blood loss but this did not translate to increase in hospital stay or intra-operative complications.

Conclusion: The use of LSH for the larger uterus is feasible and safe due to the low level of operative complications as demonstrated in our study and following a review of the literature.

P43  Laparoscopic Urogynaecology – getting started

Author(s): Helen Jefferis, Simon Jackson  
Institution: John Radcliffe Hospital, Oxford, UK  
Laparoscopic urogynaecology is a relatively new area of subspecialty but is rapidly growing in the face of patient demand and clinician interest. Procedures on offer include pelvic floor reconstruction for prolapse, treatment of stress incontinence and management of mesh complications. The benefits of the laparoscopic approach are well established for patients, hospital management and surgeons.

Laparoscopic surgery is not a solo enterprise, and requires the appropriate hospital and theatre set up and experienced laparoscopic assistants. In addition the surgeon must have certain attributes, including knowledge of anatomy, visuo-spatial co-ordination and most importantly, insight into his/her own ability and limitations.

We present the learning experience of one subspecialty trainee in a laparoscopic urogynaecology unit, including tips for making the most of training opportunities and some valuable lessons learnt!

The process of learning new techniques is however not unique to trainees and we also discuss how established surgeons can access training including buddy operating and transferring skills learnt from other laparoscopic disciplines.

Laparoscopic urogynaecology, along with all endoscopic surgery, has a steep learning curve, and this presentation aims to give some insight into how to make this exciting field accessible to both trainees and consultants.

P44  Macroscopic multifocal bowel endometriosis – How common is it?

Author(s): Shaheen Khazali1,2, Roya Padmehr1, Atefeh Gorgin1, Khadijeh Shajidjo1, Nadine Di-Donato1, Roxana Kargar1, Behzad Nemati1  
Institution: 1CEMIG-St. Peter’s Hospital, Chertsey, UK, 2ACEMIG – Tehran, Tehran, Iran  
Background and Objectives: Multifocality is a well-documented characteristic of deep infiltrating endometriosis (DIE). In bowel endometriosis, microscopic implants are thought to be present in most cases. Macroscopic multifocality, however, has been reported to occur only in %19.2 in a recent report. We report the incidence of multiple macroscopic intestinal endometriotic nodules in our patient group and present images of the excised specimen.

Methods: Retrospective case series.

Results: From April 2014 to January 2016, 18 patients underwent segmental bowel resection in our centre (Avicenna Cnetre for Endometriosis and Minimally Invasive Gynaecology-Tehran) for deep infiltrative endometriosis involving the bowel musculans. Multiple macroscopic nodules were identified in 11 patients (61.1 %). 4 had 3 separate nodules and 7 had 2 nodules.

Discussion: Our series suggest a higher incidence of multifocal macroscopic intestinal endometriotic nodules than reported by other authors. Further research is needed to ascertain whether this difference is due to our patient characteristics and disease phenotype or if multifocality is underdiagnosed. Complete excision of all visible disease is paramount and pre-operative diagnosis of multiple nodules has a low sensitivity. A thorough and systematic laparoscopic inspection followed by palpation when loop of bowel is exteriorised, at least up to the level of proximal sigmoid colon is therefore suggested as a technique to reduce the possibility of missed nodules.

ABSTRACTS: POSTER
ABSTRACTS: POSTER

P45 MINITOUCH Endometrial Ablation: Perspective from a Nurse Hysteroscopist.
Author(s): Gillian Steele, Mohammed Alam
Institution: Arrowe Park Hospital, Upton, Wirral, UK

Background and Aim: Endometrial ablation is a safe and effective treatment for heavy menstrual bleeding with established NICE guidelines. It can be performed under local anaesthetic in selected patients, thus avoiding the risks associated with general anaesthetics.

At Arrowe Park Hospital, Wirral, Merseyside, within a nurse led outpatient clinic, we have been performing these procedures since 2008. Audits of our treatments showed satisfactory results with Novasure and Thermachoice.

In 2014, we started to trial a microwave ablation procedure, Minitouch. It is simple and quick and does not require cervical dilatation. We present data from all 44 Minitouch procedures regarding ease of use, use of local anaesthesia, patient acceptability, complications, patient satisfaction and outcomes.

Results: 39/44 cases were performed by a nurse hysteroscopist (GS), 3/44 by a community hospital doctor (LS), 2/44 by a consultant (MA). The patients’ average age was 44.1, parity 2.2 and sounding length 8.9 cm. The procedure was easy to use. Cervix dilatation was not needed in any patient. Local anaesthesia was used in only 12/44 cases. There were no reports of any complications, other than two patients who were given antibiotics for suspected infection. Patient satisfaction was high. The success rate was 80%.

Conclusion: Results were found to be very encouraging. Minitouch is a flexible device requiring no dilatation. The procedure is easy to use, safe, acceptable to patients and has positive outcomes. It is well-suited for use in a nurse led outpatient clinic.

P46 Minitouch endometrial ablation: The Walsall Manor experience.
Author(s): Nidhi Gulati, William Parry-Smith, Jonathan Pepper
Institution: Walsall Manor Hospitals NHS Trust, West Midlands, UK

Introduction: Ambulatory gynaecology is rapidly evolving. Minitouch endometrial ablation epitomises this evolution. Presently there is scarce data on its efficacy.

Aim: Describe the outcomes of patients who underwent Minitouch ablation for heavy menstrual bleeding between 1st March 2014 and 1st February 2016 (n=27); specifically the effect on menstruation and patient acceptability.

Methods: Patients took two forms of simple analgesia pre-procedure and received pre-ablation local anaesthesia in to the endometrium. Ablation was performed by the same consultant gynaecologist (JP) in our hospital's outpatient clinic. Procedure time was 60-90 seconds depending on cavity size. All patients were offered Mirena coil insertion post-ablation. In March 2016, patients were followed-up through a semi-structured telephone interview, conducted by NG and WPS to reduce response bias.

Results: Median age of patients was 46 years, with a median parity of 2. Median uterine cavity length measured 5.5cm. Response rate for follow-up was 81% (22/27). 59% (13/22) reported amenorrhoea 1-12 months post-procedure. An additional 32% (7/22) reported hypomenorrhoea. One patient received antibiotics for suspected infection 3-weeks post-ablation. No other complications were reported. 82% (18/22) consented to the Mirena and 78% (14/18) were satisfied with it. Despite 64% (14/22) describing Minitouch as "painful", 91% (20/22) of responders would recommend it to family and friends.

Conclusion: This overwhelmingly positive response to treatment demonstrates the effectiveness of Minitouch and its acceptability to patients. Further research is required comparing the outcome of Minitouch with and without the Mirena, but this preliminary data suggests the two treatment modalities combined provide a good outcome.

P47 Minitouch: A less invasive method of outpatient endometrial ablation
Author(s): Jagadeeswari Karuppaswamy, Suzanne Ashton
Institution: Leigh Infirmary, Leigh, UK

Introduction: Minitouch uses microwave energy to reduce the lining of the womb and is advantageous compared to older methods as it can be done as an outpatient with only need for simple pain relief. The procedure itself lasts seconds and due to its minimal invasiveness, patients can be discharged home quickly and safely.

Objectives: The Minitouch Project aimed to explore patient experiences of the procedure and their outcomes.

Method: We collected data from electronic patient records pertaining to details of the procedure, and questionnaires from patients which included pain scores. We also investigated if the patient had appropriate follow up and what eventual outcome they had.

Results: 61 patients underwent Minitouch at Leigh between July 2014 and October 2015. Of those patients 36 have had their 4-6 month follow up, 81% of these patients experienced a favourable outcome of either lighter periods or no periods. Twenty minutes post procedure, 64% of patients rated their pain between 1-3, and 36% between 4-6. No patients rated their pain >6 in the 20 minutes post procedure. The patients were discharged in less than one hour.

Conclusion: The results demonstrate the effectiveness of the Minitouch procedure in improving the symptoms of dysfunctional uterine bleeding. The procedure is tolerated very well by patients in an outpatient setting with minimal analgesia required. It is cost-effective given that these patients do not require admission or recovery ward. The guidelines would benefit from an update in response to this novel technology.

P48 National patient survey supports multidisciplinary approach for the management of endometriosis
Author(s): Mayank Madhra1, Emma Cox2, Lyndsey Hogg2, Cameron Martin1, Andrew Horne1
Institution: 1EXPECT Edinburgh, Edinburgh, UK, 2Endometriosis UK, Manchester, UK

Introduction: There is no integrated care model for endometriosis in the UK and wide variations in approaches to treatment exist. Expert clinical opinion and patient engagement suggest that women with severe endometriosis benefit from management in a multidisciplinary setting (’Endometriosis Centre’). However, there is a lack of published evidence that supports the proposed approach.

Results: In 2015, with the support of Endometriosis UK, we surveyed visitors to its national website about their personal experiences of endometriosis care. 862 women responded to our online survey. Despite symptoms being reported as
ABSTRACTS: POSTER

P49  Novasure endometrial ablation: How can we reduce the rate of failed procedures?

Author(s): Ritu Rana, Chris Kremer
Institution: Midyorkshire Hospitals NHS Trust, West Yorkshire, UK

Background and objective: Novasure endometrial ablation is performed for heavy menstrual bleeding. More than 100 procedures are performed on our unit in a year. A run of failed Novasure endometrial ablation procedures was noted in our unit. This led to wastage of theatre time and resources. We conducted an audit to compare our practice against standards set by the RCOG, NICE and the manufacturers and to work out ways to reduce the failure rates.

Methods: A retrospective case note review of 53 Novasure ablations done over a 6 months period was performed. Manufacturer's indications and contraindications for use of this device were used as our standard. NICE and RCOG guidelines and a literature search helped in setting standards for pre-operative assessment of endometrial pathology and assessment of suitability of endometrium for the procedure. This would help us in careful selection of cases in order to avoid failures.

Results: 11% (6/53) cases failed on the day of surgery. 67% (4/6) of these cases may not have been booked for Novasure if they had a prior assessment of uterine cavity in form of Hysteroscopy or ultrasound scan where indicated. 2 failed cases had a history of previous first generation endometrial ablation and should have had a hysteroscopic assessment prior to booking.

Conclusions: A careful assessment, investigations where indicated and following the booking criteria that we have formulated after this audit can help in reducing failed Novasure procedures.

P50  Our experience with Ulipristal Acetate treatment in ladies with symptomatic uterine fibroids

Author(s): Mei Kiang Liew1, Cliodna O'Connor2, Angela Yulia1, Harish Bhandari1, Tony Chalhoub1
Institution: 1Royal Victoria Infirmary, Newcastle Upon Tyne, UK, 2Newcastle University, Newcastle Upon Tyne, UK

Uterine fibroids occur in up to 50% of women, with maximal prevalence in the perimenopausal years1-3. Recently, selective progesterone-receptor modulators including Ulipristal Acetate (UA) have been shown to be effective in reducing fibroid symptoms and volume4, decreasing fibroid vascularisation5, and thus suppressing fibroid-associated bleeding4,5. Our study aims 1) to look at benefits and patients’ satisfaction on UA in our tertiary gynaecology unit, 2) to assess ultrasonographic reduction of fibroid volume with UA, and 3) to compare it with histological assessment following operation.

Our retrospective study covered 63 cases of symptomatic fibroid women commenced on UA over a 2-year period (August 2013-August 2015). These ladies were aged 25-56 years (mean 44.3 years), BMI 20-45 (mean 28.1) and parity 0-5 (mean 1.6). 60 (95%) ladies were referred with menstrual complaints, most commonly heavy periods, with 15 also having other fibroid symptoms, while 3 ladies were referred with pelvic mass only.

Mean length of UA course was 5.0 months with most ladies prescribed a 6-month course prior to follow-up or whilst awaiting surgery. 7 (11.1%) ladies discontinued UA due to side-effects. Of the 34 ladies with UA effect documented, 125 (73.5%) reported amenorrhea, 5 (14.7%) had improved symptoms while 4 (11.8%) had unchanged/worsening symptoms. 39 ladies had surgical procedure following UA treatment including hysterectomy (31), transcervical fibroid resection (3) and myomectomy (1). We also looked at pre- and post-UA ultrasound and compared them with historical findings following surgery where relevant. In conclusion, UA is useful in bridging management of patients with symptomatic fibroids awaiting surgery as it is generally well tolerated and mostly effective in reducing menstrual symptoms.

P51  Out patient endometrial ablation: An easy and safe answer to the treatment of menorrhagia. M Jani, M Rodger, C Taggart Stobhill Hospital, Glasgow

Author(s): Megha Jani, Mary Rodger, Christina Taggart
Institution: Stobhill Hospital, Glasgow, UK

Introduction: Menorrhagia is the most common problem seen in gynaecology outpatients. Hysterectomy has been the treatment of choice traditionally. Minimally invasive procedures to destroy the endometrium may reduce complications and recovery time. Endometrial ablation is usually performed in theatre under general anaesthesia. In our unit, we performed outpatient endometrial ablation under local anaesthesia and oral pain relief.

Method: Retrospective electronic case notes review of 144 patients was carried out from January 2012 to December 2015. All patients attended designated one stop clinic for endometrial ablation. The procedure was carried out by 2 named consultants, either with thermachoice balloon (36) or novasure (97).

Result: Menorrhagia and irregular bleeding were the main
indicators for the procedure. All except 4 patients had previous or current medical management, while for 4 patients ablation was the 1st line treatment option. Out of 144, 17 (11.8%) patients did not have the procedure due to following reasons: presence of a large submucosal fibroid (n=5), narrow cavity (n=4), cavity check failure (n=3), intolerance to procedure (n=3) and unable to dilate the cervix (n=2). Average time for successful novasure procedure was 125 seconds and 8 minutes for the thermochip balloon ablation. Out of 127 patients who had successful procedure, only 5 (3.93%) needed further surgical intervention.

Conclusion: Endometrial ablation is a well tolerated, safe and effective office gynaecological procedure for the management of menorrhagia. It has reduced the waiting time duration for the day surgical procedures in our unit.

P52 Outpatient Minitouch endometrial ablation in Sheffield

Author(s): Monika Oktaba, Lesley Bruce, Mary E Connor

Institution: Sheffield Teaching Hospital, NHS FT, Sheffield, UK

Minitouch, a novel endometrial ablation device, delivers microwave energy to the endometrium via an intra-cavitary induction loop. Its small diameter (3.5 mm) allows insertion without cervical dilatation. Treatment is up to 96 seconds, and so is potentially suitable as an outpatient procedure.

Objective: Gather information about the Minitouch endometrial ablation as an outpatient procedure, and outcome data after six months.

Method: Prospective, observational study.

RESULTS: Minitouch was performed on 36 women in our outpatient clinic, during 15 months. Most patients (34, 94%) took simple analgesia before treatment, 26 (72%) had an intracervical block. Cervical dilatation was not required.

Mean treatment pain (100 mm VAS scale) recorded by all patients was 68.5 (SD 27.36), 34 patients recorded post-procedure pain (after 30 minutes or prior to discharge) with mean of 41 (SD 28.33). Six (17%) required hospital admission for pain relief.

At initial follow up of 33 patients within 48 hours 8 (24%) reported mild treatment pain, 10 (30%) moderate, 8 (24%) severe and for 7 (22%) it was unbearable. Eight patients (24%) would have preferred a general anaesthetic, and 7 (22%) would not recommend it to a friend.

At six months 16/17 patients replied with 7 (44%) reporting amenorrhoea, 6 (37.5%) much reduced bleeding, for 2 (12.5%) the same and 1 (6%) is requesting hysterectomy.

Conclusions: Minitouch has potential for endometrial ablation treatment as 81% report amenorrhoea or much reduced bleeding at 6 months. However, our analgesia regime would need revising for us to offer it as an outpatient procedure.

P53 Oxford trainee’s Experience – A modular simulation package for Laparoscopic Salpingectomy

Author(s): Elizabeth Goodall, Georgie Baines, Kirana Arambage, Lee Lim

Institution: Oxford University Hospitals NHS Foundation Trust, Oxford, UK

Laparoscopy in Gynaecology training is amenable to simulation based learning, and through innovative design, can be used to broaden knowledge, acquire skills and highlight the importance and significance of human factors, situational awareness in the theatre environment. We have developed an effective learning package for laparoscopic salpingectomy for ST3-ST5 in Oxford Deanery.

It is a holistic programme for O&G registrars, and combined a multifaceted approach to a specific clinical problem: Ectopic Pregnancy. Our multidisciplinary faculty provided a forum that met curriculum and logbook standards through video simulation and hands on training. We utilised both dry boxes with low fidelity improvised models, but also simulated a full theatre environment, in which a scenario was developed to give the trainee the opportunity to improve human factors and practise the technical skills on a model suitable for diathermy and manage an emergency situation in the multidisciplinary team.

The workshop was highly regarded by participants, and rated fully for usefulness and enjoyment. In addition, trainees had the opportunity for workplace-based assessments through protected time with trainers in a non-pressurised environment. Whilst subjective scores for the trainee’s confidence in performing a laparoscopic salpingectomy increased from pre- to post- the workshop, we found by means of objective assessment that a video watched in the classroom pre and then again post-workshop lead to the participants giving more specific feedback regarding the technical performance, particularly pertaining to safety.

The final step of this package would be to perform laparoscopic salpingectomy on fresh cadaveric model.

P54 Patient experience at the Ambulatory Gynaecology Clinic – Birmingham Heartlands Hospital

Author(s): Kausik Das, Manjula Subramanian, Karolina Palinska-Rudzka, Ameena Salar, Susan Hartman, Lindora Fenton

Institution: Heart of England Hospital NHS Foundation Trust, Birmingham, UK

Aim: To evaluate patient experience at the outpatient hysteroscopy clinic and to identify areas that need improving.

Background: With the advent of therapeutic procedures introduced in the ambulatory clinics, this survey was performed to evaluate patients' views on the newly developed services.

Methodology: A prospective questionnaire survey of patients’ experience of the Ambulatory Gynaecology Services at Birmingham Heartlands Hospital was collected between June and September 2015.

Likert psychometric (6 point) scale was used in the above survey.

Results: A total of 62 responses were obtained and analysed. A combination of diagnostic hysteroscopies, +/- insertion of Mirena IUS, Myosure polypectomies & Endometrial ablation were performed for the above women. 98% were happy with the facilities at the clinic and 96% of women were happy with the information & the support that was given to them. 95% felt that they were in control of the procedure and their concerns were listened to. 94% had a positive overall experience and 93% commented that they would recommend the service to friends and families.

Conclusion: Majority of the patients were happy with the service. However there was room for improvement in offering women written information before coming to the clinic so that they are aware what to expect.
P55 Preliminary experience of the Innovative Micro Endometrial ablation technique (Minitouch) in the University Hospital Of Wales Gynaecology Out Patient Department with and without local anaesthetic

Author(s): Richard Penketh
Institution: University Hospital of Wales, Cardiff, UK

Study Objective: To describe the procedure; patient acceptability and initial outcomes. This micro technique delivers microwave energy via an induction loop placed in the uterine cavity. Cervical dilatation is not required (diameter 3.5mm) and the procedure is of rapid duration (60 seconds).

Design: Prospective observational study using patient, physician and nursing staff evaluation questionnaires. All women chose this intervention, were provided with written and verbal information prior to procedure and informed that this was an innovative approach without long-term follow up data.

Patients: All pre and peri-menopausal women with subjective evidence of menorrhagia not requiring future fertility.

Intervention: Independent evaluation of acceptability by patient questionnaire; interviews with clinical staff; initial assessment of pain scores during and post procedure and evaluation of symptomatic improvement to menstrual blood loss.

Measurements and Main Results: Despite no long term follow up data women chose the mini-touch procedure in preference to alternative outpatient (office) endometrial ablation techniques. Preliminary findings indicate a high acceptability and efficiency of this procedure in the office setting with minimal pain. Short-term impact on symptoms, are above those anticipated for global endometrial ablation devices. Ease of use has been reported by the clinical team, and intra-procedure pain scores were acceptable.

Conclusion: This new device represents the dawn of a third generation in endometrial ablation technology in terms of miniaturisation, ease of use and patient acceptability. This represents a step change in comparison with currently available technology but clearly final validation of this device will require further data.

P56 Radio frequency endometrial ablation performed by a Nurse Consultant: Seven year review

Author(s): Gillian Smith
Institution: Northampton General Hospital, Northampton, UK

This review aims to establish whether it is feasible for appropriately trained specialist nurses to perform endometrial ablation, using the Novasure device, in the outpatient setting, with no adverse effect on outcomes. The review will examine the practice of a Nurse Consultant performing endometrial ablation, using the Novasure device over a seven year period, between 1st January 2007 and 31st December 2013. Data collected and analysed included, patient age, date of procedure, anaesthetic used, completion of procedure, reason for failure, outcome following failure, follow up performed and outcome of follow up, further surgery required and histology result of further surgery. Of the 202 procedures performed by the nurse Consultant, 138 (68%) were performed in the outpatient setting using local anaesthetic. Failure to complete the endometrial ablation procedure occurred on 10 (5%) occasions. Of the 159 patients successfully reviewed at 3 months, the outcome of amenorrhoea is documented for 62 (39%) patients. Of the 192 patients who had a Novasure endometrial ablation procedure successfully performed, 20 (10%) patients went on to have a hysterectomy for heavy menstrual bleeding symptoms. This seven year review demonstrates that endometrial ablation, using the Novasure device, performed by appropriately trained specialist nurses in the outpatient setting is feasible with no statistical difference in clinical outcomes compared to the rates reported in the literature.

P57 Robot-assisted gynaecological surgery – The Derby Experience

Author(s): Simon Tarsha, Anish Bali
Institution: Royal Derby Hospital, Derby, Derbyshire, UK

Introduction: Robot-assisted gynaecological surgery has been hotly debated since the launch of the da Vinci Robot System in 1999. Despite its controversy and lack of hard evidence of clinical benefit over ‘straight-stick’ laparoscopic surgery, there continues to be a steady rise in its procurement in the UK, from 8 units in 2010 to 61 in 2016. We present our experience of setting up a robotic service in Derby.

Method: To evaluate the service, all 27 cases performed between March 2015 to February 2016 were audited.

Results: 16/27 (58%) patients were obese. 22/27 (81%) cases were for confirmed or potential malignancies. 26/27 patients had a robot-assisted hysterectomy, with or without pelvic lymph node dissection and 1/27 required conversion to abdominal hysterectomy. The average docking time was 12.1 minutes and console time 73.4 minutes. 87% had a documented blood loss of 200 millilitres or less. The median length of stay was 32.5 hours and 67% of patients’ pain was controlled with simple analgesia. 1/27 patients represented and 1/27 was readmitted.

Conclusion: Robotic surgery is an efficient and acceptable alternative approach to gynaecological surgery, although still in its relative infancy compared with more traditional techniques. This study adds to the ever-growing evidence base supporting the use of the robotic technique. Our aim is to consolidate our experience by widening the case mix and increasing our caseload, whilst measuring patients’ postoperative quality of life scores and assessing the robotic service’s relative cost-effectiveness.

P58 See & Treat Hysteroscopic morcellation (TRUCLEAR) of endometrial polyps in women presenting with Postmenopausal bleeding – a successful Quality Improvement service development for 2 week rule patients in the NHS

Author(s): Kalsang Bhatia, Shankaralingaiah Nethra, Susan Gardiner
Institution: East Lancashire NHS Trust, Burnley General Hospital, UK

Women with postmenopausal bleeding are triaged as 2 week rule patients in the NHS improvement service development for endometrial polyps, some of which may well be...
malignant or pre-malignant. Conventionally within NHS settings, majority of these cases are admitted as Day Case for resection of polyps / lesions under general anaesthetic. A significant proportion of these postmenopausal women have medical co-morbidities posing risk for general anaesthesia and require intensive pre-operative assessment before they can have this relatively minor operation. Apart from patient inconvenience, unnecessary utilisation of theatre slots and resource implications for preoperative / anaesthetic assessments, it also adds to the delay in 2 week rule diagnostic and treatment pathway. As a result the UK government has now introduced Best Practise tariffs for See & Treat therapeutic hysteroscopy procedures in clinic setting.

TRUCLEAR hysteroscopic morcellator is now recognised to be the most effective outpatient modality for removing endometrial lesions under direct vision with unique tissue retrieval system. To ensure a See &Treat service that is cost effective and clinically effective, we submitted a business plan for the purchase of TRUCLEAR and obtained approval from the Commissioners for appropriate Best Practise tariff. We would like to share our experience in the ups and downs of starting a new Quality improvement service under the current NHS financial situation and present our data on the new service which started in December 2014.

P59 Spontaneous vaginal vault dehiscence and bowel evisceration 17 years following total abdominal hysterectomy.

Author(s): Georgina Baines, Simon Jackson, Natalia Price
Institution: Oxford University Hospitals Trust, Oxford, UK

Vaginal vault dehiscence and bowel evisceration following hysterectomy is a rare but potentially morbid complication of hysterectomy. It can result in peritonitis, bowel obstruction and necrosis. The mean timeframe for dehiscence has been reported from 6 weeks to 1.6 years but has been seen up to 30 years following hysterectomy. There is currently no consensus on the best method of repairing the defect. The approaches reported include vaginal, abdominal, laparoscopic or a combination of two.

Here we discuss a case of vaginal cuff dehiscence and bowel evisceration 17 years following total vaginal hysterectomy and bilateral salpingo-oophrectomy for endometriosis. The patient presented with bowel protruding from the vagina. On examination there was found to be a 1.5cm defect in the vaginal vault. The vaginal approach was used to carefully reduce the defect. The approaches reported include vaginal, abdominal, laparoscopic or a combination of two.

The patient made an uneventful recovery using topical oestrogen and 16 weeks post closure underwent laparoscopic sacrocolpopexy to re-inforce the vaginal vault and prevent the recurrence.

P60 The benefits of total laparoscopic hysterectomy over total abdominal hysterectomy in the treatment of benign gynaecological disease: a retrospective review over 5 years.

Author(s): Rebecca Mallick1, James English1, Natasha Waters2
Institution: 1Brighton and Sussex University Hospitals, Brighton, UK, 2Western Sussex Hospitals NHS Foundation Trust, Worthing, UK

Hysterectomy remains one of the most common gynaecological procedures performed in the UK. However unlike other parts of Europe and America, where laparoscopic hysterectomy (LH) rates have significantly increased, in the UK abdominal hysterectomy (AH) rates remain high and often the first choice for many surgeons. The minimal access route offers significant patient benefits over open surgery and the purpose of this study was to evaluate the role of total laparoscopic hysterectomy (TLH) versus total abdominal hysterectomy (TAH) in the management of benign gynaecological conditions. This retrospective study was carried out over a 5-year period and 296 procedures were included. Outcome measures included operating time, estimated blood loss (EBl), intraoperative and postoperative complications, postoperative analgesia requirements and length of hospital stay. TLH was associated with a significantly lower mean operating time (63.4 versus 75.3min P=<0.001) and reduced EBl (145.1 versus 277.0ml P=<0.001). Intraoperative complications were significantly less in the TLH group (1.9 versus 7.0% P= 0.029) with no ureteric injuries noted. Analgesia requirements were also significantly less with fewer requiring breakthrough analgesia (6.2 versus 26.6% P=<0.001). TLH was also associated with a significantly shorter inpatient hospital stay (1.7 versus 3.0 days P=<0.001) and lower postoperative complication rates (6.8 versus 15.6% P=0.016). The results from our study highlight that TLH is superior to TAH in all operative outcome measures. With adequate training and experience TLH is a safe, reproducible technique that should be offered to all women requiring a hysterectomy for a normal sized uterus in the absence of significant adhesions.

P61 The clinical presentation of Endometriosis in a patient with a Serous Ovarian carcinoma.

Author(s): Hajeb Kamali, Hadi Haerizadeh
Institution: Musgrave Park Hospital, Taunton, Somerset, UK

We present the case of a 35-year-old lady who presented to accident and emergency with sudden onset right iliac fossa pain following intercourse on a background of 3 months of severe dysmenorrhoea, dyspareunia and dyschezia. A pelvic ultrasound at the time revealed a 7cm complex right adnexal mass and her CA125 was 48. An urgent MRI reported a rectovaginal endometriotic nodule, adenomyosis and a right sided haemorrhagic cyst. The patient was referred to an endometriosis specialist with a date for laparoscopic excision of endometriosis for over 9 months from her initial presentation. At laparoscopy, there was an unusual appearance of widespread peritoneal disease and therefore a sample was sent for cryosection. This revealed a rare low grade serous carcinoma of the ovary. The patient underwent a staging laparotomy, anterior resection and re-anastomosis under the Gynaecology team and has since commenced chemotherapy. Histology confirmed a stage 3b low grade serous carcinoma of the ovary.
ABSTRACTS: POSTER

This case highlights the false reassurance that imaging techniques such as MRI can provide. Clinicians must remain mindful of the sensitivity and specificity of such techniques when making a diagnosis, which in the case of MRI for endometriosis is poor. Ultimately, laparoscopy remained the gold standard for diagnosis, but the initial presentation and investigations lead to a significant delay in management. It is also imperative that clinicians always remain aware of the possibility of an atypical presentation of more sinister disease, even in the younger low risk patient, to prevent delay in diagnosis and management.

P62  The LapTAC Project - putting the Laparoscopic Cervico-Isthmic Cerclage back on the agenda.
Author(s): Zahid Khan, Yousri Afifi
Institution: Birmingham Women's Hospital, Birmingham, UK
Objectives: We present the development, validation and establishment of the LapTAC Project – a secure, encrypted, cloud based database system in an effort to strengthen the evidence base behind the practice of Laparoscopic Trans-abdominal Cerclage.
Material: The database was developed for its purpose using sophisticated software and is held on a central, secure platform that encrypts communications. No patient identifiers are used. Each user has a unique password protected login to the database. The database is easily accessible through any device and data entry is simplified for the user.
Methods: To establish face, content and construct validity, the database was put through a rigorous pilot phase. Data for a case series of 35 pre-conception laparoscopic trans-abdominal cerclage surgeries, between 2009 and 2014, was collected retrospectively by several users.
A detailed discussion was carried out with the users to establish the overall ease, convenience, practicality, workability and application of the database.
Results: The Overall satisfaction was extremely high, with zero negative comments. All suggestions for improvement made during the pilot run were taken on board and the system was further improved.
The information collected represented a live birth rate of 85.7%. 1 case suffered a minor complication.
Conclusion: The LapTAC Project provides a secure, easy to use platform for data collection and analysis, simplifying the process of audit and review of clinical outcomes for patients undergoing laparoscopic cerclage.
Our current case series suggests that cervico-isthmic cerclage placed laparoscopically compares favourably with the traditional approach and should be integrated into clinical practice.

P63  TitleOptimising care for short stay, ambulatory and emergency gynaecology in Exeter
Author(s): Jim Clark, Consultant
Institution: Royal Devon and Exeter NHS Trust, Devon, UK
Introduction: Exeter has suffered progressive reduction in beds from 28, 9 years ago to 10 in 2015, losing its dedicated gynaecological ward and expertise associated with experienced gynaecological nurses. Additional financial pressures require innovative and more efficient care pathways to preserve services within constrained budgets.
Methods: This presentation describes the ongoing and sometimes painful development of an efficient and integrated service to amalgamate care of women with urgent early pregnancy and gynaecological conditions, outpatient ambulatory services, and two track cancer referrals and the post-menopausal bleeding services. Collaboration of benign and oncology consultants with shared resource and training of supporting specialist nurses allows a rapid referral and assessment system that enables electivisation of much emergency care. Enhanced recovery programs, with development of laparoscopic surgery has reduced bed days, readmissions and costs associated principally with hysterectomy. Amalgamation of out-patient hysterectomy with PMB services has reduced double histological sampling, referral to diagnosis of endometrial cancer intervals and referral to hysterectomy time. Gynaecological inpatient stay has been further reduced by means of an out-patient hyperemesis service, medical management of miscarriage and TOP out-patient surgical treatment of miscarriage, and integration of the nursing, medical and admin staff and equipment associated with the above into a single service.
Results and conclusion: The successes and failures, staffing profiles, and results of auditing the individual care pathways will be presented along with some protocols and care pathways, and pitfalls to avoid if setting up a similar service.

P64  To Morcellate, or not to Morcellate: that is the question
Author(s): Rasha Mohamed1, Lamia Zafra1, Andrew Pickersgill3
Institution: 1Lancashire Women and Newborn Centre, Burnley, UK, 2Stepping Hill Hospital, Stockport, UK, 3University Hospital of South Manchester NHS Foundation, Wythenshawe, UK
In recent years there has been ample publicity regarding the seeding of fibroids, post use of power morcellators at laparoscopic gynaecological surgery. This is usually during laparoscopic myomectomy or hysterectomy. In 2014, the FDA released a statement discouraging the use of power morcellation in gynaecology. This was in relation to laparoscopic hysterectomy or myomectomy, on the basis that this may lead to dissemination of undiagnosed cancerous tissue. The FDA estimates that 1 in 350 women undergoing a hysterectomy or myomectomy may in fact have a uterine sarcoma, which may be disseminated if power morcellation is used.
We present two cases, where power morcellation was used at laparoscopy. The first underwent a laparoscopic myomectomy, and the second a laparoscopic hysterectomy. At the end of both procedures, all morcellated tissue was apparently removed. Both patients underwent further laparoscopies thereafter for different gynaecological pathology. At repeat laparoscopy, morcellomas were evident. These were biopsied, and confirmed to be fibroids on histology. This opens up the debate on the use of power morcellation at gynaecological laparoscopic surgery. It adds weight to the argument of morcellation being conducted in a bag, to prevent seeding of tissue.
P65 To treat, but not to diagnose; The use of laparoscopy in ectopic pregnancies.

Author(s): Nicola Tempest1,2, Oliver Page1, Dharani Hapangama1,2
Institution: 1 Liverpool Women’s Hospital, Liverpool, UK, 2 The University of Liverpool, Liverpool, UK

Background: RCOG guidelines advocate the combination of transvaginal ultrasound scan (TVUS) and hCG measurement for confident diagnosis of ectopic pregnancy without resorting to laparoscopy. The use of laparoscopy should be limited to the treatment of some ectopics only, due to their obvious potential detrimental side effects.

Aim: To determine the specific pre-operative clinical and investigatory findings that may increase the accuracy of diagnosing ectopic pregnancy and to reduce the incidence of negative laparoscopy.

Method: We retrospectively analysed all laparoscopies undertaken to treat presumed ectopic pregnancies at Liverpool Women’s Hospital for 12 months from June 2014.

Results: 2 laparoscopies intended to treat presumed ectopics were analysed (44 confirmed (84.6%) and 8 negative (15.4%)). Negative laparoscopies were associated with younger age, low BMI, primiparity and higher pre theatre hCG. Previous history of an ectopic (9.1%), bleeding (59.1%) and abnormalities identified at TVUS (86.4%) were more common in true ectopics.

Conclusion: Although diagnostic laparoscopy should not be undertaken unless for the treatment of ectopic pregnancies, accurate preoperative diagnosis can be difficult. Further improvement of current diagnostic tools are needed to reduce associated morbidity and mortality with negative laparoscopies.

P66 Unplanned hospital admissions following day case gynaecological laparoscopic surgery

Author(s): Amrita Banerjee, Apryll Chase, Kumar Kunde
Institution: Guy’s and St Thomas’ NHS Foundation Trust, London, UK

Introduction: With advances in surgical technology and anaesthetic experience the complexity of day surgery has increased with a wider range of patients considered suitable. Day surgery provides high quality, cost-effective care, including patient benefits of reducing the risk of nosocomial infections, venous thromboembolism and early recovery at home.

Method: We performed a retrospective audit on unplanned hospital admissions following elective day case benign gynaecological laparoscopic surgery. Patients included were admitted to a tertiary unit in London between July 2015 and December 2015.

Results: 13/45 (29%) patients required overnight admission following surgery. The mean duration of stay was 2 days postoperatively. 7/13 (54%) patients were admitted due to postoperative side effects of pain, nausea and vomiting. 5/13 (38%) patients were admitted overnight due to increased complexity of the surgical procedure and were monitored for signs of early post-operative complications e.g. bleeding. 12/13 (92%) operations leading to unplanned admissions were undertaken by the Consultant as the primary surgeon with 11/13 (85%) patients having significant co-morbidities.

Discussion: Day surgery is a continually evolving specialty with its success largely depending on appropriate patient selection, effective pre-operative optimisation and enhanced postoperative recovery protocols minimising symptoms of sedation, pain, nausea and vomiting. It is recommended that the unplanned admission rate should be below 2% for day surgical cases, while the target of 75% of elective surgery to be performed as day cases from the NHS plan remains. Identifying the predisposing factors contributing to unplanned admissions is vital to reduce costs and pressures on acute hospital beds.

P67 Urgent Primary Care referrals for Postmenopausal Uterine Bleeding in Women above 60 years – A Patient Satisfaction Audit

Author(s): Morounfolu Olaleye Thompson, Lois Delchar, Tania Adib
Institution: Barking, Havering and Redbridge University Teaching Hospitals, Essex, UK

In the estrogen declining years any intimate examination may be uncomfortable, associated with anxiety and apprehension. A unit pilot survey identified a 50% failed outpatient hysteroscopy rate in elderly women. Associated factors included pelvic discomfort, increased stress from waiting for procedures and results, inadequate understanding and opportunity for questions. Previous studies evaluated patient acceptability, clinical outcomes and pain. We additionally sought the women’s preferences.

We investigated the women’s experiences during ambulatory hysteroscopy for abnormal and post-menopausal bleeding using self-completed anonymous questionnaires comprising 10 domains adapted from the Bodle 2008 chart focusing on women’s satisfaction after outpatient hysteroscopy. A five point Likert scale was used to assess participant satisfaction and a 10 point visual analogue scale was used to characterise pain tolerance.

There were 37 completed questions from women over the age of 60 years who attended the clinic, 43% were aged 61-70, 46% between 71-80 and 11% above 80 years. These were mostly Caucasian but not necessarily English speaking as medical interpreters had to be used in some cases. 89% felt they were given adequate information about the procedure and 13.5% experienced delays and felt the wait to be seen was too long. Pain tolerance varied widely with a nearly Gaussian distribution. 95% felt the procedure was satisfactorily explained to them while 95% felt they were given adequate time to ask questions. 100% of the women felt that the clinicians involved had listened thoroughly to their concerns though only 89% would recommend the procedure to a friend who needed it.

P68 Use of vasopressin to reduce the intraoperative blood loss in myomectomy: a case control study

Author(s): Yadava Jeve, Tarek Gelbaya
Institution: University Hospitals of leicester, leicester, UK

Introduction: Uterine fibriods are most common pelvic tumours in women. Myomectomy involves significant blood loss. Surgical haemorrhage may result in anaemia, hypovolemia, coagulation abnormalities and blood transfusion. Bleeding can be prevented or decreased with mechanical or pharmacologic methods. Intramyometrial vasopressin injected into the planned uterine incision site for each fibroid reduces blood loss. Vasopressin acts by constricting the smooth muscle in the walls of capillaries, small arterioles, and venules. It also reduces overall operation time. This case control study is aimed to analyse use of vasopressin for myomectomy.
**Method**: The study group comprised of women who had myomectomy performed using intramyometrial injection of vasopressin. The comparison group was women who had myomectomy with use of traditional methods and mechanical methods to control the blood loss. The study period was 2013 to Jan 2016. All operations were performed at a teaching hospital in the UK. Primary outcome measure was intra-operative blood loss. Secondary outcome measures were blood transfusion rates, operative time, operative complications and drug adverse reactions. The study group comprised on (n=25) women.

**Results**: We found the blood loss and the risk of having blood transfusion were significantly less with use of vasopressin. Vasopressin was associated with reduced operative time. There was no adverse reaction noted with its use in our study population.

**Conclusion**: Use of intramyometrial vasopressin during myomectomy operation is associated with reduced blood loss, ITU admissions and lower risk of hysterectomy. Vasopressin is more effective than mechanical methods of reducing blood loss during myomectomy.

**P69 Vaginal vault suturing simulation: a systematic review.**

**Author(s)**: Rasiah Bharathan1, James Dilley2, Anil Tailor3, Simon Butler-Manuel4

**Institution**: 1Royal Surrey County Hospital, Guildford, UK, 2Imperial College, London, UK

**Background**: Minimally invasive hysterectomy has many proven benefits. With non-surgical management of uterine pathology, fewer hysterectomies are performed. Therefore, case mix, changing population profile and restricted working hours, can limit the training opportunities. Vault suturing is a rate limiting step in the learning and dissemination of the MIS technology. Simulation is a proven educational aid. We present a systematic review of simulation models for vault suturing.

**Method**: Multiple databases were searched. Two researchers extracted data. Quality assessment of the studies was performed. Newcastle-Ottawa scale was used for quality assessment.

**Results**: Studies were included are 4 robotic, 2 laparoscopic, and 1 open suturing models; one vaginal simulator study only assessed face validity. All studies assessed synthetic models and two included virtual reality models too. In terms of validation face, construct and content validity were assessed by 4, 5 and 3 studies respectively. Five studies were observational, one randomized and one mixed methods. Participants included medical student, residents, fellows and attendings. One study used time as the only parameter, another used dexterity metrics and five others used time and global rating scales. Time taken and global rating scales were revealed significant differences (P<0.05), confirming construct validity. In two studies training improved time and GRS scores. 4 studies demonstrated reliability. No study assessed learning curves. Study quality: 5 studies were moderate, one poor and one good.

**Conclusion**: Review demonstrates construct valid vault suturing simulators. Research is required to establish learning curves, skill retention and cost effectiveness.

**P70 Validity & utility of a porcine model for gynaecological laparoscopic surgical training.**

**Author(s)**: Rasiah Bharathan1, Alfred Cutner2

**Institution**: 1Maidstone and Tunbridge Wells Hospital NHS Trust, Pembury, UK, 2University College London Hospitals NHS Trust, London, UK

**Background**: Laparoscopic surgical training is complex due to the technical skills required, trainee aptitude, theatre environment conditions and potential ethical issues of learning procedures on a patient. The evidence base, supporting simulation based training as an educational aid is strong. Indeed, a plethora of surgical simulation is available to meet the broad range of task paradigms encountered during laparoscopic surgery. In this observational study we assessed face validity and utility of a fresh cadaver porcine model for training in a range of gynaecological laparoscopic procedures.

**Method**: A one-day workshop was attended by 27 consultants and trainees in obstetrics and gynaecology. Initially, the faculty delivered a didactic session comprising anatomy, instrumentation and details of the task paradigms. Each pair of candidates had one model. E-mail responses were collected on a 10-point likert scale.

**Results**: 58% of participants had previously attended a cadaver or live porcine simulator. Advantages included access, cost, fresh tissue characteristics and model versatility. Disadvantages included odour, uterine anatomy and bowel distension. Candidates’ median scores were: port placement (7), port-geometry (6), intra/extra-corporeal suturing (9), vault closure (8), cystotomy closure (8) retroperitoneal dissection (9), ovarian suspension (9), ultracision instrument use (8), NOTTS (8). Significant difference in ratings between the groups was noted for port geometry.

**Conclusion**: Cadaver porcine model is a valid and useful training device. This study contributes to existing literature on porcine model. The simulator will be an invaluable addition to laparoscopic training strategy in gynaecology.
P71  Vault complications following laparoscopic hysterectomies – evaluation of suture materials

**Author(s):** Mark Pickering, Wee-Liak Hoo, Sameer Umranikar

**Institution:** University Hospital Southampton NHS Foundation Trust, Southampton, UK

**Objectives:** To assess the incidence of vault complications following laparoscopic hysterectomies according to the suture materials used.

**Methods:** This was a retrospective study of all total laparoscopic hysterectomies at the Princess Anne Hospital, Southampton performed in 2013. Four suture materials were used to close vaginal vault: V-loc (barbed suture, Covidien), Monocryl (poliglecaprone), Vicryl (polyglactin) and PDS (polydioxanone).

**Results:** A total of 144 total laparoscopic hysterectomies were performed in 2013. 67 patients (46.5%) had V-loc vault closures, 41 (28.5%) had Monocryl, 34 (23.6%) had Vicryl and two (1.4%) had PDS closures. The mean age was 52.6 years (range 28-83). Mean blood loss was 67.0mls. Mean operating time was 120.3 minutes (range 45-255). There were no cases of vault dehiscence.

Nine patients (6.3%, 95%CI 2.3-10.3) developed vault granulation, of which, five patients were treated using silver nitrate, three managed conservatively and one had excision under general anaesthesia. In granulation cases, V-loc was used in four patients (6.0% of V-loc), Vicryl in four (11.8% of Vicryl) and Monocryl in one patient (2.4% Monocryl).

**Conclusion:** Incidence of vault dehiscence is low. Granulation tissue was more common when Vicryl was used. Vault haematomas were more common following V-loc vault closures, although the majority resolved conservatively.

P72  Wherever possible hysteroscopy should be performed in the outpatient setting1 – how well do comply?

**Author(s):** H Moorhouse, R E Richardson, M Grant

**Institution:** Chelsea and Westminster NHS Foundation Trust, London SW10 9NH

**Audit period:** 4 week (Jan 11th – Feb 5th)

**Design:** Prospective

**Inclusion criteria:** All patient having hysteroscopy as a sole procedure during that month (n=57)

**Data:** From the 4 weeks period and from yearly data from 2011

**Outcome:** 96.5% adherence to Audit standard, although due to patient choice and valid indications a significant number are still done under GA (n=12). (4 previous failures, 4 “valid” medical indications, 2 patient choice, 2 no valid contraindication to OPH)

**Detail:** We have done more hysteroscopies in the outpatient setting (OPH) year on year. Patient choice and “having a valid medical indication for GA hysteroscopy” are significant factors in determining whether the procedure is done under GA. Subset analysis of the data showed that GA was more likely to be chosen if the patient had consent taken by a nurse or doctor who did not perform OPH. This suggests a potential bias in the counselling and defining “valid indications for GA hysteroscopy” and an opportunity to educate the workforce and improve the numbers that are actually performed in the outpatients.

**Failure rate:** this, as a proportion, has not increased as a greater percentage of hysteroscopies are done in the outpatients. This is important as it demonstrates we are very capable of doing the majority of OPH in the outpatient setting. This lack of increase is significant and encourages us to continue trying to reduce the proportion done under GA.

Patients failing to attend (DNA) is a significant problem in outpatient hysteroscopy service and needs further investigation. Data analysis outside the audit period show that the majority merely delay the procedure, and thus the patients are investigated appropriately but this initial non-attendance has a significant resource cost. As currently there are no capacity issues within the hysteroscopy service but if there were it would significantly extend waiting times. As these clinic are small over booking to address DNA is difficult as if all turn up there would be significant over run.

Please note: Abstracts are reproduced as submitted.
GOLD SPONSORS

Espiner Medical Ltd
By Surgeons – For Surgeons

BRAUN
SHARING EXPERTISE

SILVER SPONSORS

CooperSurgical

ConMED

HOLOGIC

KEBOMED

Lotus

mpl

Medical Perspectives UK Ltd

Acknowledgement
The British Society for Gynaecological Endoscopy wish to express their sincere gratitude and appreciation to all of our sponsors for this meeting and for their continuing support.”
The British Society for Gynaecological Endoscopy wish to express their sincere gratitude and appreciation to all of our sponsors for this meeting and for their continuing support.