AAGL *Advancing Minimally Invasive Gynecology Worldwide*

NewsScope

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The Dawn of a New Era

8th AAGL International Congress on MIGS ▪ PAGE 11
BUCHAREST, ROMANIA

COEMIG
Why and How?

NewsScope

the aagl vision

The AAGL vision is to serve women by advancing the safest and most efficacious diagnostic and therapeutic techniques that provide less invasive treatments for gynecologic conditions through integration of clinical practice, research, innovation, and dialogue.

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FOCUS ON AAGL

Why the COEMIG Program is Important


Dr. Loffer

It is true that many may view the Centers of Excellence in Minimally Invasive Gynecology program as simply a marketing tool. What may not be recognized is it will provide important value to 4 groups – patients, MIG surgeons, hospitals, and those who pay for medical care (the payors).

Patients – Everyone has at some time had a problem identifying a source for a qualified provider of a service. Whether this is for a plumber, dentist, or a surgeon, it is often necessary to rely on the recommendation of friends or some other equally, non-evidence based source. The COEMIG program will allow both patients and referring physicians to have a list of surgeons who have been identified through a peer-review process as providing quality care.

MIG Surgeons – An increase in referrals will occur but this is not, in the long term, the most important benefit. The BOLD outcomes program, which is an integral part of the COEMIG program, will allow surgeons to track and demonstrate their expertise in providing quality and cost effective care. This will be of special value as payors look to develop networks.

Hospitals – An immediate benefit will be to attract more patients and surgeons. But the real value will be in the institutional outcomes data. It has been well demonstrated that programs such as this result in improved patient care.

The Payors – It is becoming increasingly apparent to those who fund medical care that MIG surgery is very cost effective both by lowering true costs and by allowing a more rapid return to normal activities. The COEMIG program will provide them a resource for quality care. While many of the advantages listed above apply primarily to US surgeons there are also significant values to our non-US colleagues. The COEMIG program will allow surgeons at these sites to be recognized by their association with a premier hospital. Finally the BOLD outcomes data they will be inputting will be combined with their US colleagues and contribute to identifying best practices in gynecologic surgery.

Franklin D. Loffer, M.D. is the Executive Vice-President/ Medical Director of the AAGL and resides in Phoenix, Arizona.

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Taking AAGL to the Next Level


Dr. Isaacson

Throughout the history of the AAGL, there have been a number of milestones achieved by the organization which have elevated the credibility and respect, not only for society as a whole, but also for all members as well. Key moments include the organization of the first meetings by Jordan Phillips and his band of brothers; the election of Barbara Levy as the society's first female president; the birth of the Journal and the publication of evidence-based clinical guidelines, the incorporation of SurgeryU, and the successful launch of a highly competitive Fellowship in Minimally Invasive Gynecologic Surgery.

It is more than a coincidence that minimally invasive gynecologic surgery has become the standard of care in general gynecology, urogynecology, gynecologic oncology and reproductive surgery. This has been accomplished by the pioneering work of those "who have taken the road less traveled." In 2011, the AAGL published a hysterectomy position statement that, if possible, this surgery should be performed laparoscopically or vaginally. The statement was supported by strong evidence demonstrating better outcomes for our patients. This position statement was accepted by other gynecologic organizations. The AAGL and its members have worked hard to be the world leaders in innovation, research, education and public advocacy for minimally invasive gynecologic procedures for women.

Since the AAGL has come so far in 40 years, how do we take it to the next level?

FIRST sound infrastructural and fiscal decisions have secured our existence for the next 20 years. Under the direction of Franklin Loffer and Linda Michels, and several boards of trustees, the AAGL has run an efficient office and made wise conservative investments. We are in a good position to pursue our mission for years to come.

SECOND each AAGL member should encourage his or her institution to become a Center of Excellence in Minimally Invasive Gynecology (COEMIG). This will be the first program in gynecology to allow centers to have the distinguished designation by maintaining accurate documentation of case volume, surgical complexity and complications. When successfully launched by other groups such as cardiology and bariatric surgery, the complications for patients dramatically decreased while patient outcomes improved. This program will give patients and payors objective information they can use when selecting or referring to a MIGS surgeon or surgery center. Every AAGL member from all countries are encouraged to participate in the program.

THIRD is the development of the Essentials in Minimally Invasive Gynecology program. The AAGL has taken the lead in developing a curriculum, a cognitive test and a skills test that should be passed by every MIGS surgeon. The cognitive test is in its final development stages and will be beta tested by the Las Vegas meeting this November. The skills test will not be far behind. The Essentials program firmly places the AAGL as the leader in resident and fellow education as well as cognitive and skills assessment. It is my goal to see this test become mandatory for each resident to pass before he or she can sit for the oral board exam.

FOURTH the AAGL is working on several projects with our large sister organizations whose mission overlaps with our own. This includes ACOG, ASRM, CREOG, SAGES (the minimally invasive society for general surgery), and the AUA (American Urology Association). We don't just have a seat at the table. Minimally invasive gynecologic surgery is here to stay and the AAGL, now known as the respected leader in this field, will work with these societies to promote our shared mission of providing the best outcomes for our patients through research and education.

I am honored to be the AAGL President in these exciting, rapidly changing times for the AAGL. We are taking the society to the next level and that in turn will be a boost for our members around the globe and provide better outcomes for our patients.

Keith B. Isaacson, M.D. is President of the AAGL. He is also an Associate Professor of Ob/Gyn at Harvard Medical School and the Director of Partners Center for Reproductive Medicine and Surgery at Newton Wellesley Hospital MIGS Center in Newton, Massachusetts.

WE NEED YOUR OPINION

The AAGL is conducting two online surveys and would appreciate your participation.

The surveys are:

SMOKE SURVEY

Deadline to complete this survey is April 15, 2012

PREVELANCE OF MUSCULOSKELETAL PAIN AND DISORDERS IN GYN SURGEONS

Deadline to complete this survey is May 15, 2012

Thank you in advance for your help! The surveys can be found at www.aagl.org/surveys

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SPECIAL INTEREST GROUP – ROBOTICS

Advancing Minimally Invasive Gynecologic Surgery:
Is the Robotic Approach the Answer?


Dr. Pitter

In a recent statement by the American Association of Gynecologic Laparoscopists, a challenge was made in an effort to advance minimally invasive gynecology worldwide by encouraging "surgeons without the requisite training and skills required for the safe performance of a vaginal hysterectomy or laparoscopic hysterectomy to enlist the aid of colleagues who do."[1] In the United States laparotomy remains the route of choice for more than 60% of the 600,000 hysterectomy procedures performed annually.[2] The rate of adoption for laparoscopic hysterectomy, however, demonstrated an approximate 11.8% penetrance over 14 years (1989 – 2003) in contrast to the adoption of robotic hysterectomy 24% over a 6-year period .[3]

Legitimate questions based on that information, therefore, should include how do we train our residents and practicing physicians to safely perform advanced laparoscopic procedures with or without the robot, and are we sacrificing cases that would normally be performed vaginally or laparoscopicaly in order to get through the learning curve in robotic surgery? The answers to these questions will spark debates that will go on for a long time to come but recently two studies retrospectively analyzed and reported on some interesting trends.

Burkett et al.[4] conducted an online survey of graduating residents and program directors in 42 USA based obstetric and gynecology residency programs. They observed that although the graduating residents reported having adequate numbers of both vaginal and abdominal hysterectomies, both groups thought that they were inadequately prepared to perform all types of hysterectomies and that robotic surgery is negatively impacting their surgical training. While it was commendable that the rates of abdominal hysterectomy declined with the advent of robotic surgery this decrease should not be accompanied by a decrease in laparoscopic and vaginal hysterectomy procedures.

An effort has to be made to provide a more standardized approach and structure to the training of physicians at all levels so that the benefits of robotic surgery can be realized. In a separate study, Gobern et al. in *The Journal of Minimally Invasive Gynecology*[5] examined the status of residency training in robotic surgery. They found that although robotic surgery training occurred in 58% of programs in the US, half of the respondents in their survey were undecided on the effectiveness. This has to be addressed and was commented on during the recent meeting of the Robotics Special Interest Group at the 40th meeting of AAGL this past November in Hollywood, Florida. During that meeting, guidelines designed to set criteria for credentialing of surgeons (and residents) performing gynecologic robotic procedures were presented for approval and were unanimously adopted.

An effort has to be made to provide a more standardized approach and structure to the training of physicians at all levels so that the benefits of robotic surgery can be realized.

One of the major points discussed was the number of cases required for credentialing and re-credentialing. The consensus was that the absolute number should be determined by each hospital's robotic steering committee and guided by an acceptable rate of complications not outside 2.5 times the standard deviation of an average (rate of complications) for expert robotic surgeons practicing in that hospital. Hence the importance of surgical volume starting from residency onward and the need to not allow any significant sacrifices in other treatment modalities that are minimally invasive by definition.

The rate of adoption of robotic surgery in gynecology with a concomitant decline in abdominal procedures is welcome. The challenge remains to ensure that the indications for the use of this technology are appropriate training is adequate and evidenced based.

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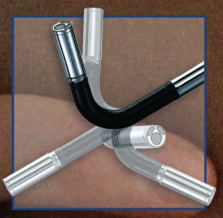

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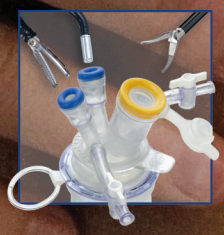

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SPECIAL INTEREST GROUP – ONCOLOGY

Extraperitoneal Lymphadenectomy in Gynecologic Malignancies


Dr. Fleming

Minimally invasive surgery has become standard practice for treatment of gynecologic malignancies. Traditional laparoscopy and robotics are currently being used in the treatment of cervical, endometrial, and early-stage ovarian cancers. Lymphadenectomy in these cases is typically performed using a transperitoneal technique, however, para-aortic lymphadenectomy in obese patients can often prove difficult. Using a retroperitoneal approach to the para-aortic region provides more rapid access to the nodal area, decreased risk of postoperative adhesions, and decreased risk of electrocautery damage to the bowel.[1-2] In addition, the extraperitoneal method avoids the difficulties with mobilization and retraction of the small bowel and sigmoid colon, and eases identification of the ureters, particularly in obese patients. There is also a decreased risk of adverse events such as postoperative ileus and intestinal obstruction with this technique. Animal models have also shown postoperative adhesion rates were approximately 30% less using the extraperitoneal approach.[3]

This technique has gained recent interest in detecting para-aortic nodal metastases in locally advanced cervical cancer (stages IB2-IVA). One of the most important predictors of disease recurrence in patients with cervical cancer is para-aortic nodal status and almost 25% of these patients will have disease spread to these nodal basins. However, prophylactic extended field radiation to the para-aortic region in all locally advanced cervical cancer overtreats 75% of patients, with risk of toxicity to the small bowel, spinal cord, and kidneys. PET has only shown a sensitivity of 85% and a specificity of 90-94% in detecting para-aortic nodal metastases.[4] Ramirez et al. recently reported a prospective series of patients with locally advanced cervical cancer (IB2-IVA) who underwent preoperative PET/CT followed by laparoscopic extraperitoneal para-aortic lymphadenectomy. Among 26 patients with negative pelvic and para-aortic nodes on PET/CT, 3 (12%) had histopathologically positive para-aortic nodes. Of 27 patients with positive pelvic but negative para-aortic nodes on PET/CT, 6 (22%) had histopathologically positive para-aortic lymph nodes. Furthermore, 18% of patients had a treatment modification based on surgical findings, highlighting the importance of surgical staging in patients with locally advanced cervical cancer.[5]

In order to better determine the true sensitivity of imaging for detecting nodal spread in cervical cancer patients, GOG-233/ACRIN 6671 trial is currently accruing patients to a prospective trial evaluating the utility of preoperative PET/CT in detecting lymph node metastasis in patients with locally advanced cervical cancer. All patients will undergo an extraperitoneal or laparoscopic pelvic and para-aortic lymphadenectomy if no evidence of metastatic disease outside of the nodal areas is seen by PET/CT. In an effort to determine if surgical staging improves patient outcomes, we have opened LiLACS (Lymphadenectomy in Locally Advanced Cervix Study), a multi-institutional prospective randomized evaluation of patients with locally advanced cervical cancer with PET positive pelvic nodes and PET negative para-aortic nodes. These patients will be randomized to either laparoscopic extraperitoneal para-aortic lymphadenectomy followed by tailored chemoradiation based on pathologic findings, versus whole pelvic radiotherapy. Study endpoints will include not only survival outcomes, but also surgical and radiation complication rates, cost-effectiveness, and anatomic location of positive para-aortic nodes.

Using a retroperitoneal approach to the para-aortic region provides more rapid access to the nodal area, decreased risk of postoperative adhesions, and decreased risk of electrocautery damage to the bowel.

Expanding the laparoscopic extraperitoneal technique to include both robotics and single-port laparoscopy may allow more surgeons to explore using this technique for staging gynecologic malignancies. The safety and feasibility of the technique has been evaluated in numerous studies. It can be performed as an outpatient procedure and appears to be equivalent in cost to a PET scan or MRI.[6] Further studies exploring the utility are ongoing.

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Nicole D. Fleming, M.D., is an Assistant Professor in the Department of Gynecologic Oncology at The University of Texas MD Anderson Cancer Center, in Houston, Texas. This article is presented on behalf of the AAGL's Special Interest Group on Oncology.

Recognition of Your Excellence: Transforming Your Practice With AAGL's COEMIG

Top Questions About AAGL's Center of Excellence in Minimally Invasive Gynecology (COEMIG) Program and How it Will Benefit You Today and Beyond


Dr. Palter

For years members of the AAGL have struggled with the limited acceptance and adoption of minimally invasive gynecology. We recognized that a minimally invasive approach was better for our patients and resulted in a quicker recovery, lower morbidity, and lower cost of care. Unfortunately, insurance payors were slow to accept these benefits and patients often knew nothing about their minimally invasive options or who were the best providers. AAGL members trained and developed their endoscopic skills because they knew it was best for their patients but reimbursement never reflected the time required or benefits.

Today the tide is clearly changing. Conversations we have had with major insurance company medical directors confirmed they now recognize the value of a minimally invasive approach in gynecology and are developing plans designed to steer patients to a minimally invasive approach. One critical piece missing is the existence of a reliable network of excellent minimally invasive gynecologists; either we create the network or one will be made for us. We have been actively working for the AAGL COEMIG network to meet all the requirements to serve as this network. Experience in other specialties (such as bariatric surgery) has shown that when plans such as this exist, surgeons in the center of excellence have the greatest access to patients and the highest reimbursement. What's more, participation in national programs of excellence raises the standards and outcomes of all participants and fosters a community of excellence in the institution.

This concept is not isolated to our specialty. More than a half dozen specialties have embraced the center of excellence model and it has been shown to have dramatic short- and long-term benefits to the surgeon, hospital, and patient.

Ever since the Council of Gynecologic Endoscopy (CGE) invited me to help address the certification and access challenges of minimally invasive gynecology I have been an avid proponent of a center of excellence program for our specialty. I'm proud to have been involved with its development from the beginning while serving on the CGE. AAGL's COEMIG program allows all minimally invasive gynecologic surgeons to band together and take control of our destiny by focusing on continuous quality improvement, objective standards and recognition of those committed to excellence, while generating and owning the evidence and data needed to take control of the debate about the value and benefits of our procedures.

AAGL has partnered with Surgical Review Corporation (SRC), the leading, non-profit administrator of center of excellence programs in other specialties to produce a comprehensive center of excellence program designed to meet the needs of our specialty. Now's the time to get involved – the Q&A below provides the information you need to understand the COEMIG program, its direct benefit to you and your hospital, and the information to help begin working toward your COEMIG designation.

Steven F. Palter, M.D., is the Program Director for COEMIG, and Chair of the COEMIG Outcomes Committee. Dr. Palter is the Medical & Scientific Director at the Gold Coast IVF in Syosset, New York, and Former President of the CGE.

How will the COEMIG designation benefit my practice or hospital?

Decreased complications and morbidity – Reducing outdated open procedures, decreasing postoperative recovery times and lowering the risk of complications that drive up the cost of healthcare.

Sharing best practice policies and pathways – Studies in other specialties such as cardiac surgery have clearly demonstrated that participation in cross-center quality improvement programs such as the AAGL COEMIG elevates each center to the level of the best.

Demonstration of better outcomes and reduced costs – Establishing a central outcomes database and universal standards to protect reimbursement rates, decrease malpractice costs, increase surgical volumes, and thrive within an accountable care organization (ACO) environment that mandates higher quality at lower costs. Our outcomes database will allow to prove the benefits of procedures and answer important research questions and control our own data. Our goal is "two minutes or less" for data entry.

Specialty growth – Increasing the adoption of less invasive techniques, proven clinical pathways and team-based approaches to drive best-in-class gynecologic surgery.

Professional recognition and distinction – Enabling patients and referring physicians to easily identify and access centers committed to a higher standard of minimally invasive gynecologic care and distinguish themselves based on objective verifiable standards recognizable to all in this increasingly competitive healthcare market.

What is AAGL's level of commitment to this new program?

The AAGL and its leadership are fully committed to the success of the COEMIG program. AAGL partnered with Surgical Review

Corporation (SRC), a leading nonprofit patient safety and quality organization, to administer the COEMIG program. Our organizations have worked together for two years to develop a comprehensive center of excellence program that meets the needs of our members and supports our vision. AAGL is incorporating the COEMIG program into all facets of the organization. COEMIG is a unifying concept that encompasses practice standards, educational programs, nursing, research and reimbursement initiatives, and fellowship and postgraduate education.

How many surgeons and hospitals have applied for COEMIG designation?

Over 150 surgeons and hospitals have registered and are in various stages of application completion. The first site inspection was conducted in late January, and a number of inspections are slated for April.

How does the AAGL ensure fairness in the review process and eliminate bias in the COEMIG program?

The AAGL partnered with SRC to remove itself from the administration of the COEMIG program. Based on the SRC's center of excellence administration model, three volunteer committees (Standards, Review and Outcomes) were formed comprised of prominent AAGL surgeons from diverse care delivery settings, areas of practice specialization, and geographic regions. Committee members work closely with SRC to define and develop program guidelines, review designation candidates, and ensure that COEMIG is responsive and relevant to AAGL's vision and membership. To ensure objectivity and fairness, review committee members are only provided de-identified surgeon/facility information, and they must recuse themselves from the review process if they suspect a conflict of interest. The nonprofit SRC objectively verifies the data and the Review Committee then reviews the blinded data to ensure excellence standards are met.

Should I be worried about the site inspection?

Absolutely not. The SRC team works hand-in-hand with you to ensure that your facility is prepared well before an inspection date is set. SRC clinical quality experts provide preliminary reviews and requirement templates to make certain that site inspections are very much open-book tests because much of the preparation is completed pre-inspection. If you are already at the top level you will qualify for recognition. However, if your program does not yet qualify we are committed to working with you to reach that goal.

What steps are involved in the designation process?

Step 1: Register online
Step 2: Start your application
Step 3: Achieve Provisional Status by meeting simple qualifications
Work towards meeting remaining requirements and prepare for pre-planned site inspection with guidance from SRC's clinical and administrative support team.
Step 4: Achieve designation

The entire application and approval process is designed to be able to be completed without needing any additional staff and to be as automated as possible. Total time to complete an application should be one to two weeks of part time work.

What is "Provisional Status"?

Provisional Status is provided to participants who start the application process and meet the program's provisional qualifications. These minimum standards are based on the requirements for COEMIG designation. Provisional Status is typically granted within one week of receiving the center's applications and does not require a site inspection. As Provisional participants work toward designation, the requirements serve as a guide for resource decisions and provide actionable goals for team members.

How do I get started?

The first step is to register online at www.surgicalreview.org, which takes only a few minutes to enter basic contact information. Following registration, surgeons and facilities can immediately begin working on their applications for Provisional Status.

Remember – Designation Is Easier Than You May Think

In less than five minutes, you can find out if your minimally invasive gynecology program is ready to be designated as a center of excellence. Answering 10 simple questions is all it takes. Visit www.surgicalreview.org today to take this important step towards recognition of your program.

Questions? Contact SRC Support at 1.877.459.0710 or coemigsupport@surgicalreview.org.

Call for Abstracts

41ST AAGL Global Congress on Minimally Invasive Gynecology

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AAGL is now accepting abstracts for the 41st Global Congress on MIGS
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Dr. Suciu

We are very pleased to have been chosen to host the AAGL 8th International Congress on Minimally Invasive Gynecology and hope that you will make plans to join us in Bucharest which is considered one of the most spectacular cities in the world. Founded in 1452, the city is known for its wide, tree-lined boulevards, glorious Belle Epoque buildings and a reputation for the high life. In the 1900's, it earned its nickname, "Little Paris."

The Congress will be held at the Palace of the Romanian Parliament located in the heart of Bucharest. The colossal Parliament Palace is the second largest administrative building in the world after the Pentagon. It took 20,000 workers and 700 architects to build. The palace boasts 12 stories, 1,100 rooms and a 328 ft-long lobby and four underground levels, including an enormous nuclear bunker.

Along with our regional societies, The Romanian Society of Obstetrics and Gynecology, the Romanian Society of Urogynecology and the Romanian Society of Endoscopic Surgery, we are actively preparing a scientific program that will allow those attending to expand their knowledge of minimally invasive gynecologic surgery. The congress will commence with postgraduate courses on:

- **Advanced Laparoscopic Techniques for Benign and Malignant Disorders**
- **Surgical Anatomy**
- **Reproductive Issues**
- **Laparoscopic Suturing**
- **Hysteroscopy**
- **Hysterectomy**
- **Urogynecology**

International experts will share their knowledge on these important topics. There will also be abstract and video sessions as well as live surgeries and sponsored symposia.

Given that this is a summer program, we encourage you to bring your families. Romania is beautiful at this time of year and we have a full social program planned that includes visits to the Parliament Palace, Village Museum, Museum of the Romanian Peasant, Prahova Valley, Peles Castle and the Bran Castle (Dracula's Castle).

I look forward to seeing you this summer.

Professor Nicholae Suciu, M.D., Ph.D. is the Executive President of the Congress and practices at the Polizu Hospital Clinic Bucharest, and is also President of the Romanian Society of Minimally Invasive Surgery in Gynecology.

To register or to receive additional information, please go to www.srcmig.medical-congresses.ro/ or contact the Romanian conference offices at srcmig@palomatours.com

AFFILIATED SOCIETIES SPOTLIGHT

British Society of Gynaecological Endoscopy

The British Society for Gynaecological Endoscopy has been a major force in shaping minimally invasive gynecological surgery in the United Kingdom since its founding in 1989. This has been possible because of the early acceptance of endoscopy by the Royal College of Obstetrics and Gynaecology.

This close relationship with the RCOG has resulted in the development of many important efforts such as a laparoscopic and hysteroscopic curriculum; the publishing of practice guidelines; the establishment of endometriosis centers; and other projects of benefit not only to surgeons but also to the patients they treat. Its leadership role in gynecology has also resulted in a membership which has contributed many major papers to the literature.

Franklin D. Loffer, M.D.
Executive Vice President/
Medical Director, AAGL


Dr. Frappell

The British Society for Gynaecological Endoscopy was founded in 1989 by a small group of enthusiasts determined to promote the benefits of endoscopic gynaecological surgery at a time when it was looked upon by many traditional gynaecologists as little more than a gimmick. Many of the founding members formed very close links with colleagues in America, none more so perhaps than Professor Chris Sutton who has indeed been a past board member of the AAGL.

BSGE is a flourishing society with a steadily increasing membership now standing at over six hundred. The majority of members are consultants and trainees in gynaecology and obstetrics, but we also have over sixty nurse hysteroscopists who work closely with medical colleagues in NHS hospital clinics throughout the UK. They are a very active group very much involved in promoting hysteroscopy as an ambulatory outpatient service.

BSGE has extremely close ties with the Royal College of Obstetricians and Gynaecologists, where indeed our permanent secretariat is based. Together with the RCOG, BSGE is responsible for producing and overseeing the curriculum for training in hysteroscopy, both diagnostic and operative, and laparoscopic surgery. Intermediate laparoscopic adnexal surgery is part of the training programme in benign gynaecological surgery. A more recent development has been a two-year training programme in Advanced Laparoscopic Surgery for Benign Disease which will produce our next generation of advanced laparoscopic surgeons.

BSGE also works closely with the RCOG in producing practice guidelines, most recently those related to Laparoscopic Entry Techniques, Hysteroscopic Management of Heavy Menstrual Bleeding and Laparoscopic Management of Benign Ovarian Cysts.

A recent initiative of which BSGE is particularly proud is the creation of BSGE accredited Endometriosis Centres, for the treatment of severe endometriosis.

To become an accredited centre, units need to have a minimum annual through put of twelve cases of recto-vaginal endometriosis, together with other cases of severe disease. Further criteria include working with a named colorectal surgeon, urologist and pain specialist. There must be a dedicated endometriosis clinic, supported by a specialist endometriosis nurse. All patients must be entered on the BSGE endometriosis database with follow up questionnaires at six, twelve and twenty four months post surgery.

The database now has over seven hundred eligible cases and the data from the first three years of this programme is currently being analysed and we anticipate will be published later this year. This will make it the world's largest series of cases of recto-vaginal endometriosis and we anticipate that the database will continue to be a source of very helpful information, in particular with regard to pain relief and complication rates.

Officers of the British Society of Gynecological Endoscopy:
President: Jonathan Frappell
Vice President: Kevin Phillips
Secretary: Mary E. Connor
Treasurer: Ertan Saridogan

As well as our links with AAGL and the RCOG, BSGE is very much at the centre of the European Society for Gynaecological Endoscopy. Indeed we hosted a very successful European Congress in London in September 2011 where we were very pleased to welcome many of our colleagues from across the pond. BSGE is holding its Annual Scientific Meeting in Cardiff this year, April 18th – 20th when it will be a particular pleasure to welcome Charles Koh, an old friend of BSGE, who will deliver the Alec Turnbull Memorial Lecture.

I shall be demitting the Presidency at that meeting when I hand over to our current Vice President Kevin Phillips whom I know looks forward to continuing the long and close association that our two Societies have enjoyed over so many years.

Jonathan Frappell, M.B.Ch.B., M.D., is the President of the British Society for Gynaecological Endoscopy, and is the Director of the Plymouth Endometriosis Centre. Dr. Frappell is also the Lead Clinician in the Department for Colposcopy at the Derriford Hospital, Plymouth, United Kingdom.

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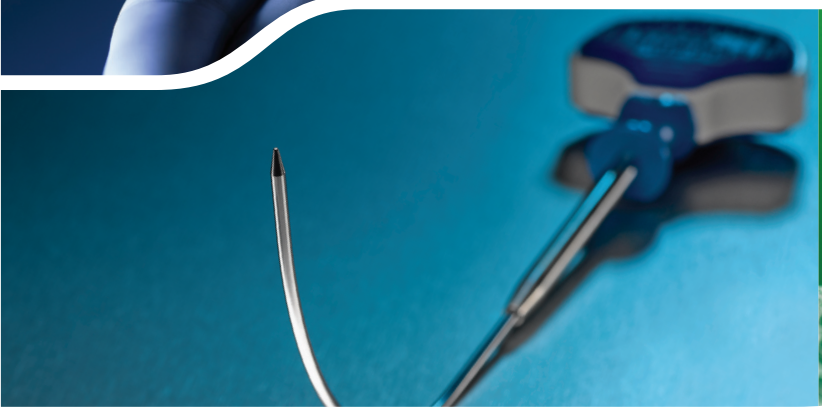

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Important Safety Information: InterStim® Therapy for Urinary Control is indicated for the treatment of urinary retention and the symptoms of overactive bladder, including urinary urge incontinence and significant symptoms of urgency-frequency alone or in combination, in patients who have failed or could not tolerate more conservative treatments. The following Warning applies only to InterStim Therapy for Urinary Control:

Warning: This therapy is not intended for patients with mechanical obstruction such as benign prostatic hypertrophy, cancer, or urethral stricture.

InterStim® Therapy for Bowel Control is indicated for the treatment of chronic fecal incontinence in patients who have failed or are not candidates for more conservative treatments. **Contraindications for Urinary Control and for Bowel Control:** Diathermy. Patients who have not demonstrated an appropriate response to test stimulation or are unable to operate the neurostimulator. **Precautions/ Adverse Events: For Urinary Control:** Safety and effectiveness have not been established for bilateral stimulation; pregnancy, unborn fetus, and delivery; pediatric use under the age of 16; or for patients with neurological disease origins such as multiple sclerosis. **For Bowel Control:** Safety and effectiveness have not been established for bilateral stimulation; pregnancy, unborn fetus, and delivery; pediatric use under the age of 18; or for patients with progressive, systemic neurological diseases. **For Urinary Control and for Bowel Control:** The system may be affected by or adversely affect cardiac devices, electrocautery, defibrillators, ultrasonic equipment, radiation therapy, MRI, theft detectors/ screening devices. Adverse events include pain at the implant sites, new pain, lead migration, infection, technical or device problems, adverse change in bowel or voiding function, and undesirable stimulation or sensations, including jolting or shock sensations. For full prescribing information, please call Medtronic at 1-800-328-0810 and/or consult Medtronic's website at www.medtronic.com. Product technical manual must be reviewed prior to use for detailed disclosure. USA Rx Only. Rev 0409

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Back by Popular Demand

Innovations in Minimally Invasive Gynecologic Surgery – Hysterectomy and Beyond • June 9-11, 2012

The second "Innovations in Minimally Invasive Gynecologic Surgery – Hysterectomy and Beyond…" workshop will be held at Magee Womens Hospital of the University of Pittsburgh Medical Center on June 9-11. Scientific Program Chair, Dr. Ted Lee has assembled a list of outstanding faculty which include Dr. Harry Reich, a pioneer in our field and several rising stars in minimally invasive gynecologic surgery including Dr. Jonathon Solnik, Dr. Suketu Mansuria, Dr. Amanda Fader, Dr. Hye Chun Hur and Dr. Aarathi Cholkeri-Singh.

The workshop from last year drew participants from 15 different states and 12 different countries. The participants gave the workshop and its faculty exceptional reviews. The following are just a few of the many raving reviews from the participants:

"I am starting to do more laparoscopic hysterectomy and this course has improved my confidence moving forward."

"It was worth the 12 hours of flying to have the opportunity to listen to the outstanding lectures and inspirational course."

"I learned a lot of tips and tricks on laparoscopic suturing as well as anatomy. This will course will change my approach to surgery."

At the Winter Institute for Simulation Education and Research (WISER) facility

of the University of Pittsburgh, workshop participants will experience expert didactics on minimally invasive gynecologic surgery. Topics include laparoscopic suturing, pelvic and retroperitoneal anatomy, surgical energy sources, and emerging trends in single incision and mini-laparoscopic procedures.

The highlights of the conference include Dr. Harry Reich's keynote speech in which he will share with us the pioneering spirit of the world's first laparoscopic hysterectomy and the interactive case-based surgical tutorial on difficult laparoscopic hysterectomy.

Didactic lectures will be reinforced with hours of proctored hands-on experience in various stations including basic and advanced suturing and knot-tying, morcellation, surgical energy sources, office and operative hysteroscopy, and single-port surgery simulation. The participants will benefit from one-on-one instruction from the experts in the field.

The workshop will conclude with three live surgeries including a laparoscopic supracervical hysterectomy, total laparoscopic hysterectomy and modified, single-port hysterectomy.

Ted Lee, M.D. is Director of Minimally Invasive Gynecologic Surgery at Magee Womens Hospital UPMC Pittsburh, PA.

Innovations in Minimally Invasive Gynecologic Surgery – Hysterectomy and Beyond…

The Magee Womens Hospital | Pittsburgh, PA | June 9-11, 2012

Workshop Objectives

At the conclusion of this workshop, the participants will be able to:

1. Determine the fundamental techniques in laparoscopic suturing.
2. Apply sound surgical principles and appropriate use of energy sources in laparoscopic hysterectomy.
3. Identify relevant pelvic anatomy in advanced gynecologic surgeries.
4. Summarize various techniques for single incision laparoscopic surgery in gynecology.
5. Diagnose, manage and prevent laparoscopic complications.

Scientific Program Chair: Ted Lee, M.D.

Accreditation

The AAGL is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The AAGL designates this live activity for a maximum of 20.25 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AAGL Position on Route of Hysterectomy

The AAGL position statement advocating a minimally invasive route for hysterectomy has garnered much press and interest from consumers.

Learn the skills to meet the demand from patients for a better hysterectomy at this workshop…

- Total laparoscopic hysterectomy
- Single-incision laparoscopic hysterectomy
- Supracervical hysterectomy
- Strategies and techniques for difficult hysterectomy
- Interactive live telesurgery

4 Hours of Hands-On Experience

Suturing, Energy & Hysteroscopy

- Basic suturing including needle and suture handling, loading needle and driving through tissue
- Extracorporeal knot tying
- Intracorporeal knot tying
- Morcellation station
- Surgical energy station
- Intracorporeal cinch knot, anchoring uniknot, Roder's loop
- Endo Stitch
- Single-port pelvic trainer

Register Online: registration.aagl.org

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Why You Should Customize Your Member Profile

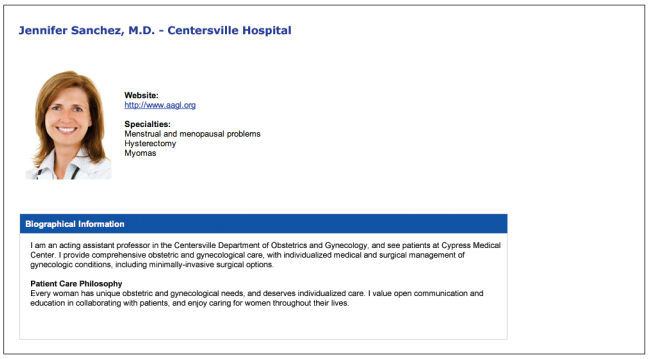
Every member of the AAGL is provided with a personalized listing in the AAGL Online Physician Finder, which is used by both patients and physicians to locate MIG surgeons throughout the world. Your physician member listing includes a photograph, contact information, a brief biography, and an overview of your practice specialty and medical background. For many of our surgeons, their listing in the AAGL Physician Finder is the "first-impression" that they make with a new patient who might be seeking their services. It's also a powerful way to network with other surgeons within the AAGL who have dedicated their careers to MIGS.

Hundreds of AAGL members have already taken the time to set up their online physician profile, a process that takes less than 10 minutes to complete! If you have not already set up your physician profile, simply visit AAGL.org/editprofile and follow the on-screen instructions to upload your photo and enter your personal information. If you have any questions about setting up your profile, please email support@aagl.org for technical assistance.

Blank Member Profile

A blank membership profile acknowledges that a physician is part of the AAGL, but does not include contact information, a biographical summary, or an educational and practice background – key information that a patient may be seeking.

Customized AAGL Member Profile



This completed member profile includes contact information, a biographical summary, a list of practice specialties, and other information that helps a prospective patient to identify you as a surgeon who may be able to address their medical needs.

NEW PRODUCT LISTINGS

Bovie®

The new **J-Plasma™ handpiece with retractable cutting feature** is used for soft tissue coagulation during surgery. The handpiece will be powered by Bovie's GS electrosurgical generator. J-Plasma™ is formed by passing an inert gas, such as helium, over a sharp conductive point which is held at high voltage and high frequency, producing a luminous discharge beam. The sharp conductive point can also be in the form of a retractable surgical blade, providing multiple modes of operation in a single instrument. The extended surgical blade can be used for incisions and other cutting procedures, and when retracted, the blade is used to form the J-Plasma beam for coagulation. The extended blade can also be used in combination with the J-Plasma beam, providing an enhanced cutting capability with minimal impact on surrounding tissue.

MEMBER NEWS

Dr. Levy Appointed Vice President of Advocacy for ACOG


Dr. Levy

Dr. Hal Lawrence, Executive Vice President of ACOG, announced that after carefully considering numerous excellent and extremely well qualified candidates, Barbara Susan Levy, M.D., will be the new Vice President for the Division of Advocacy.

Dr. Levy will officially start working part-time May 1, 2012, going full-time on July 1. Currently, Dr. Levy is in the private practice of gynecology in Federal Way, Washington, and is the Medical Director for Women's and Children's Services at the Franciscan Health System. She has also been active in advocating for appropriate coding and fair relative values for obstetric and gynecologic services.

Among other positions, she has been a member and chair of the RBRVS Update Committee (RUC) and has worked at length with members of Congress and the Centers for Medicare & Medicaid Services on reimbursement issues for our specialty. In the announcement, Dr. Lawrence highlighted, "Dr. Levy's 'in the trenches' clinical experiences combined with her leadership and advocacy skills will serve us exceedingly well as we prepare to address the difficult issues facing medicine in the future."

Dr. Levy was president of the AAGL in 1995, the first woman to serve as president, and has remained active in many AAGL committees: in 2011 she served as the Honorary Chair of the 40th AAGL Global Congress of Minimally Invasive Gynecology.

Please join us in congratulating one of our own on this prestigious and influential appointment.

Welcome New Members

December 1, 2011 – February 29, 2012

Frank Leopoldo Acuna, II, M.D.
Tod C. Aeby, M.D.
Omara Afzal, M.D.
Hayat Ahmed Alrabiah, M.D.
Elham Waheeda Altaf, M.D.
Ashley Lynn Alumbaugh, M.D.
Nicholas Andrews, M.D., Ph.D.
Cathy Andrus, M.D.
Kirana Sampath Arambage, M.D.
Rafael Julian Arcone, M.D.
David Baghdassarian, M.D.
Erika Balassiano, M.D.
Kenneth I. Barron, M.D.
Ercan Bastu, M.D.
Rupen P. Baxi, M.D.
Scott E. Beard, M.D., FACOG
Punita Bhardwaj, MBBS, DGO, DNB
Manjita Bhaumik, M.D.
Teresa T. Birchard, M.D.
Luciano J. Bispo, M.D., FACOG
Sonja Bodmer-Roy, M.D.
Christian Bogner, M.D.
Valerie Bohemier, M.D.
Olga Bougie, M.D.
Jennifer Mary Boyle, M.D.
Kelli Melissa Braun, M.D.
Kimberly Ann Brey, M.D.
Jennifer Brown Broderick, M.D.
Tommy Richard Buchanan, Jr., M.D.
Kristin Burns, M.D.
Amber Burridge, M.D.
Stephen H. Bush, M.D.
Susan D. Carter, M.D., FACOG, FACS
Beniamino Casalino, M.D.
Vladimir A. Casso, M.D.
Serena Chan, M.D.
Hector O. Chapa, M.D.
Charalampos Chastamouratidis, M.D.
Jen-Ruei Chen, M.D.
Rebecca Ann Chilvers, M.D.
Niles Choper, M.D.
Michelle Sue-on Chow, M.D.
Marcia Amelia Ciccone, M.D.
David Cohen Szobel, M.D.
Alejandro Correa Paris, M.D.
Paul John Corsi, M.D.
Callie Marie Cox Bauer, D.O.
Britton Crigler, M.D.
Daniel Cruz-Galarza, M.D.
Francisco Cuellar, M.D.
Gilson Barros Cunha, M.D.
Luqman Dabiri
Florian Dantes, M.D.
Janette Davison, M.D.
Giuseppe De Francesco, M.D.
Joao Correia De Pinho, M.D.
Stephen DePasquale, M.D.
Lorie Diaz, M.D.
Ericka Domalakes, M.D.
Rachel K. Dong, M.D.
Manuel Donoso, M.D.
Laura Anne Douglass, M.D.
Jennifer Nicole Duda, BSc, M.D.
Nelson Echebiri, M.D.
Evelyn Eng Stime, M.D.
Thomas Paul Enyart, D.O.
Jean Philippe Estrade, M.D.
Christopher Eswar, M.D.
Barbara Faife, M.D.
Pamela Susan Fairchild, M.D.
Janis Drexelius Fee, M.D.
Tamatha B. Fenster, M.D.
Rocco Jason Florio, M.D.
Susie Fong, M.D.
Andrea Forgy, M.D.
Thomas E. Fromuth, M.D.
Lisa R. Fusco, M.D.
Heather Gabai Hernandez, M.D.
David Garfinkel, M.D.
Justine Marie Gelinas, D.O.
Mohamed A. Ghafar, M.D.
Christian S. Ghattas, M.D.
Ryan Gholson, M.D.
Geoffrey Gill, M.D., FACOG
Geraldo Gomes-da-Silveira, M.D.
Leslie J. Gray, M.D., FACOG
Jerod Greer, M.D., FACOG
Leanne Griffin, M.D.
Ellen Haas, M.D.
Christina Harry, M.D., MBCHB
Rachel Haselhorst
Siobhan Hayden, M.D.
Robert Jason Heineck, M.D.
Francisco Javier Hernandez, M.D.
Malerva, M.D.
Erica Hinz, M.D.
Hikaru Hiraishi, M.D.
Mona Hirehally Mallikarjunaiah, M.D.
Hanh N. Hoang, M.D.
Mun Kun Hong , M.D.
Robin Houpe, M.D., FACOG
Diana Huang, M.D.
Nicole Hubner, M.D.
Catherine Hudson, M.D.
Robert John Hutchison, M.D.
Ionut Adrian Ion, M.D.
Sharon Michele James, M.D.
Isaiah Johnson, M.D., FACOG
Kiila Johnson, M.D.
Kimani Kamau, M.D.
Karen Beatriz Katiraee, M.D.
Susan J. Keeshan, M.D., FACOG
ANdrea M. Keller, D.O.
Aaron Kennedy, M.D.
Jonathan Kew, M.D.
Adeeb Khalifeh, M.D.
Sheema Khan, M.D.
Samara L Knight, M.D.
Jovana Koscica, M.D.
Vineela Kosuri, M.D.
Bruno Marcondes Kozlowski, M.D.
Sarah Kreider, M.D.
Ingrid Kristensen, M.D.
Mamta Kulkarni, M.D.
Eugenia C. Kuo, M.D.
Spencer Kuper, M.D.
Salim Lalani, M.D.
Amélie Larente, M.D.

New Members (cont'd)

December 1, 2011 – February 29, 2012

Erin Large, M.D.
Lenny Laureta-Bansil, D.O.
Jennifer Layne, Ph.D.
Robert Kar-Sing Lee, M.D., MBA, FACOG
Richard John Lewis, D.O., FACOG
Christina Liao, M.D.
Somi Lim, M.D.
Raquel Ferreira Lima, M.D.
Catherine Liu, M.D.
Jennifer Lopez, M.D.
Veronica Nicholas Mahon, D.O.
Jaimie Lynn Maines, M.D.
Veronica Thierry Mallett, M.D.
Danielle Mann, M.D.
Ahmed Mansour, M.D.
Leopoldo Martinez Marin, M.D.
Catharine Hunt Marshall, M.D., FACOG
Nobuyuki Maruo, M.D.
Marina Maslovaric, M.D.
Gary Matsumura, M.D.
James R. McBride, Jr., M.D.
Alireza Mehdizadeh
Alexis Melnick, M.D.
Cynthia Cecil Mercer, M.D.
Sara Anne Meyer, M.D.
Kavita Mishra, M.D.
Natu Mmbaga, M.D.
Herhold Makuka Moatshe, M.D.
Nina Mohammed, M.D.
Ecaterina Monica Moisa, M.D.
Ligia Maria Penteado Virmond Moreira, M.D.
Teresa Eelna Munoz, M.D.
Erin Lindsay Murata, M.D.
Claudia Georgina Naber, M.D.
Kyehyun Nam, M.D.
Maryam Nasr-Esfahani, M.D.
Kathryn Leigh Nauss, D.O.
Neely Nicole Nelson, M.D.
Georgiana Irina Nemeti, M.D.
William Brian Newman, D.O.
My-Linh Thi Nguyen, M.D.
Ronald A. Nichols, M.D., M.P.H.
Alpa Nick, M.D.
Lindsay Nordwald, M.D.
Mary Nowak, M.D.
Jaime Obst, D.O.
Anthony James O'Connell, M.D.
Fabio Ohara, M.D.
Hajime Oishi, M.D.
Takayuki Okazaki, M.D., Ph.D.
Kevin Patrick O'Neil, M.D.
Lami Oyewumi, M.D.
Jennifer Ozan, D.O.
Begum Ozel, M.D.
Reshma J. Pachikara, M.D.
Nicholas Packer, M.D.
Grace C. Park, M.D., B.Sc
Mahate Parker, M.D.
Tanya Pasternack, M.D.
Kalpesh R. Patel, M.D.
Suha Patel, M.D.
Elizabeth Patton, M.D.
Marci Lee Peralto, M.D.
Joy Peveto, M.D.
Michelle T. Pham, M.D.
Chailert Phongnarisorn, M.D.
Charlie Pickens, Jr., M.D.
Brent Joseph Pickett
Susan Pierce-Richards, MSN, ARNP
Helana Pietragallo, M.D.
Marjorie Pilkinton, M.D.
Michael Podraza, M.D.
Lily Primo, M.D.
Ramesh Pundi
Evgeny Rastegaev, M.D.
Kristin Ratliff, M.D.
Juan Carlos Reina, M.D., FACOG
Amy Rider, M.D.
Lisa M. Rimpel, M.D., FACOG
Brandi Ring, M.D.
Jennifer M. Risinger, M.D.
Tia Laurice Robertson, M.D.
Manuel Jose Rodriguez, M.D.
Gianni Rodriguez-Ayala, M.D.
Jessica Rose Rosenstock, M.D.
Amanda B. Rostkowski, M.D., Ph.D.
Marie Stormi Rowe, M.D.
Joyoti Saha, M.D.
Keisuke Saito, M.D.
Jose Salvador Saldivar, M.D.
Mary Temple Sale, M.D.
Sarah Saunders, BSc, M.D.
David B. Schwartz, M.D.
Zachary Shanitkvich, M.D.
Zhengzhuan Shi, M.D.
Yasuhiko Shiki, M.D.
Lauren Siff, M.D.
Crystal Simon, M.D.
Navkaran B. Singh, M.D.
Daniel H. Smith, M.D.
Karen Marie Smith, D.O.
Timothy Stewart Spaulding, M.D.
Dimitrios Spiliopoulos, M.D.
Amanda Spitalnik, M.D.
Aaron Staley, M.D.
John Patrick Stamp, M.D.
Elaine Stickrath, M.D.
Janelle Kay Strom, M.D., MBA
Ryan Summerall, M.D.
Jon Sweet, M.D.
Ricci Regina Rivera Sylla, M.D.
Chirisse Taylor, M.D.
Lauren Thaxton, M.D.
Christopher William Thiel, M.D.
Andrew Thomas, M.D.
Viju Varghese Thomas, M.D.
William Toussaint, M.D.
Amanda Tower, M.D.
Franco Tramontana, M.D.
Linh Le Tran, M.D.
Michael Trifiro, M.D.
Heather S. Turner, M.D.
Mary Jean Uy-Kroh, M.D.
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Amanda A. Whytal, D.O.
Susan Patrice Willman, M.D.
Stuart Solomon Winkler, M.D.
Joseph B. Witty, Jr., M.D., FACOG
Beth Wolek, M.D.
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Roberts Wood, III, M.D.
Yasuhiro Yamamoto, M.D.
Jeanie Yuh, M.D.

New! Bringing Surgical Procedures into the Office Online CME Course

This activity has been approved for AMA PRA Category 1 Credit

AAGL is pleased to announce the upcoming availability of its first online CME course, "Bringing Surgical Procedures into the Office." This course, presented by Dr. Micah Harris with valuable assistance from Dr. Ted Anderson covers the finer points of performing outpatient procedures in your office rather than in the OR, and is eligible for 1 hour of CME credit. This course will be available beginning on April 1, 2012 at AAGL.org

Learning Objectives

1. List patient co-morbidities that are contraindications to office surgery.
2. List qualities of surgical procedures that make them appropriate for the office setting.
3. List the levels of office-based surgery.
4. List important features of an office-based surgical practice to promote patient safety.
5. Describe the types of documentation necessary to maintain an office-based surgical practice.
6. List the various agencies and associations that have published guidelines concerning office-based surgery

The AAGL would like to recognize Hologic, Inc. for their support of this course by providing an unrestricted educational grant.

NewsScope

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for the 41st AAGL Global Congress
www.aagl.org
Deadline: April 15, 2012 (without fee)
April 30, 2012 (with $35 fee)

Education Calendar

The following educational meetings are sponsored by or endorsed by the AAGL.

Educational Workshops

May 18-19, 2012
14th AAGL Workshop on Gynecologic Laparoscopic Anatomy & Surgery on Unembalmed Cadavers
University of Louisville • Louisville, Kentucky

June 5-8, 2012
XXV International Congress with Endoscopic Course
" New Technologies for Diagnosis and Treatment of Gynecologic Diseases"
Moscow, Russia

June 9-11, 2012
Innovations in Minimally Invasive Gynecologic Surgery – Hysterectomy and Beyond
Magee Womens Hospital • Pittsburgh, Pennsylvania

September 22, 2012
Adding Office Hysteroscopy to Your Practice
Newton-Wellesley Hospital
Boston, Massachusetts

December 6-7, 2012
4th Annual Seminar – Video Assisted Laparoscopy & Robotic Assisted Hysterectomy and Intensive Hands-on Laparoscopic Suturing & Knot-Tying
A Step-by-Step Simulation Approach
New York, New York

AAGL Annual Meetings

November 5-9, 2012
41st AAGL Global Congress on Minimally Invasive Gynecology
Caesars Palace • Las Vegas, Nevada

November 10-14, 2013
42nd AAGL Global Congress on Minimally Invasive Gynecology
Gaylord National Resort & Convention Center on the Potomoc• Washington, D.C.

AAGL International Meetings

April 25-28, 2012
7th AAGL International Congress on Minimally Invasive Gynecology
in partnership with the Argentine Society of Laparoscopic Surgery (SACiL)
Buenos Aires, Argentina

June 27-July 1, 2012
8th AAGL International Congress on Minimally Invasive Gynecology
in partnership with the Romanian Society of Minimally Invasive Surgery in Gynecology
Bucharest, Romania

April 9-13, 2013
9th AAGL International Congress on Minimally Invasive Gynecology
in partnership with the South African Society of Reproductive Medicine and Gynaecological Endoscopy • Cape Town, South Africa

June 4-7, 2014
10th AAGL International Congress on Minimally Invasive Gynecology in partnership with the Spanish Gynaecological and Obstetrics Society (Gynaecological Endoscopy Section) • Barcelona, Spain