BSGE Travelling Fellowship Report 2019

# Dr Lisa Knight, MRCOG

# Consultant Obstetrician & Gynaecologist with an interest in Sub-fertility and Minimal Access Surgery

### **Design of Fellowship**

A 4-week obsevership in Brisbane following the practice of two consultants: Dr Michael Wynn-Williams and Dr Chris Maher.

Dr Michael Wynn-Williams is a Senior Consultant in Minimal Access and reproductive endo-surgery in Brisbane and the clinical director of Eve Health in Brisbane. He works between the Royal Brisbane Hospital, the Mater Private and Public Hospitals and The Wesley Private Hospital. He teaches and demonstrates advanced laparoscopic surgery all over the world and is an accredited AGES (Australasian Gynaecological Endoscopy & Surgery Society) trainer for the advanced laparoscopic fellowship. He has also founded the first public dedicated Persistent Pelvic Pain Clinic at the Mater Hospital in 2017.

Dr Chris Maher is a Professor of Advanced Urogynaecology in Brisbane and is senior trainer in the Australian Urogynaecology Sub-speciality Fellowship. He is currently the chair of the Urogynaecology Society of Australasia (UGSA). He works across Brisbane at the Royal Brisbane Hospital, the Mater Private Hospital and The Wesley Private Hospital. I wanted to observe Professor Maher’s practice within the field of laparoscopic urogynaecology, in particular that of laparoscopic colposuspension, hysteropexy, colpopexy and the removal of mesh from the bladder.

The plan was to spend 4 weeks with both consultants, attending their theatre lists, clinics and post-operative follow-up patients. I was hoping to observe advanced skills and approaches in endometriosis surgery; observing the structure of a multi-professional team in endometriosis management; observing the set-up of a persistent/chronic pelvic pain clinic.

From Professor Maher, I was particularly interested in learning his approach to selection of patients suitable for laparoscopic colposuspension (given the pause on the use of mesh in the UK); his approach to removal of mesh, both vaginally and laparoscopically; and also to gain an overall improvement in my urogynaecology surgical knowledge.

### **Exposure & Learning**

My 4 weeks in Brisbane were spent approximately 50:50 between both consultant’s clinical activities. Operating days were long, often starting at 7am and finishing around 8pm, particularly in the private sector. This allowed for a great deal of surgical exposure to many different surgical procedures and challenging cases.

### **Specific clinical and surgical learning points:**

### Benign Gynaecology & endometriosis surgery

Persistent Pelvic Pain Clinic

* The importance of a robust multi-professional team of a dedicated ‘pain’ anaesthetist; physiotherapy support; pain psychologist and nurse.
* Use of book: “Endometriosis” by Susan Evans. An excellent resource for patients.
* Use of the website ‘Pelvic Floor Association of Australia’ which advises patients on how to understand their pelvic floor symptoms and home stretches they can try.
* The use of **ultrasound** in the clinic to assess anterior bowel mucosa for higher attenuation associated with an endometriotic nodule.
* Do not necessarily need to **down-regulate** patients prior to surgery. Michael’s experience is that this can make the tissue more scarred and difficult to obtain surgical planes.
* Use of **pelvic floor Botox** for pelvic floor pain symptoms resistant to physiotherapy. Michael has great success for his patients with this procedure, which uses 15mls of 300IU Botox. Do not allow anaesthetist to paralyse patient; using a nerve stimulator, inject 5mls bilaterally into each obturator muscle, 2.5mls into pubococcygeus muscle bilaterally. Procedure finishes with a pudendal block.

Endometriosis Surgery

* Avoid down-regulation prior to surgery – no evidence.
* Get used to using monopolar on ‘cut’ 50 + bipolar rather than ultrasonic devices
* Use suction only during surgery, constant washing out of the pelvic makes tissue oedematous
* Use four ports.
* Use of Coviden ‘Clearify’ to clean scope
* Use of AGES surgical performance database – which enables logging of surgical procedures and performance in terms of readmissions/surgical complications etc. Also acts as a national audit for AGES.
* Dissection of uterine vessels via pelvic sidewall. Finding the ‘healthy’ plane as high as the pelvic brim and following the course down into the pelvis. Use blunt dissectors.
* V-lock for vault closure

Laparoscopic Hysterectomy

* Vaginal morcellation: Once uterus is detached, place Alexis ‘orthopaedic’ bag in vagina and place uterus inside; pull ring of bag out of vagina, use long-handled blade to ‘cork-screw’ uterus out

Laparoscopic Myomectomy

* Open pelvic sidewall over ureter, identify internal iliac and uterine vessel passing over.
* Use ‘escalap vascular bulldogs’ to clamp and note time of application
* Open over fibroid with bipolar and use scissors to open
* Once capsule visible use myomectomy screw to shell out fibroid
* 0/0 PDS for repairing defect in uterus in 3-layers
* 2/0 PDS for uterine serosa
* In-bag morcellation

### **Urogynaecology**

Clinics

* Ask patient to complete the Australian Pelvic Floor Questionnaire – a useful tool for the patients to complete pre-visit to gain a more specific understanding of their pelvic floor issue. Also, a useful tool for primary care physicians in terms of ascertaining the patient’s main complaint and how to direct their referral.

Surgery: Uterine Prolapse

* Always consider a sacrospinous fixation post-hysterectomy for prolapse.
* Laparoscopic-assisted hysterectomy: continue dissection to level of US-ligaments then continue vaginally
* SSF: 2 capio sutures, right side
* Posterior repair and perineorrhaphy will make a real difference to sustainability of prolapse.
* Cystoscopy post-op: Indigo-carmin 20mg/5mls given 15mins approximately before the end of the procedure.

Surgery: Vault prolapse

* Suggest colpopexy and colposuspension
* Mesh is folded over the anterior and posterior wall: 2 sutures front leaf and 2 over the posterior leaf. Important to have no strain on the mesh. Maher et al., randomised controlled trial.
* Close peritoneum

Surgery: Colposuspension

* Use medial umbilical ligament as landmark and open retropubic space ‘champagne space’
* Retract bladder
* Palpate within vagina to identify urethra and push to one side
* 0-0 ethibond suture, two throws and extra-corporeal tie. Two either side of urethra ‘Adams-Tamargo technique’

Surgery: Mesh removal

* Gabapentin prior to surgery 75mg BD for 1/12
* Pre-op counselling: 5% transfusion; 50% improvement in pain (following an initial escalation in pain); 5% risk of organ damage
* Mesh removal from bladder involves laparoscopically opening bladder, teasing out mesh, 2/0 vicryl to repair bladder in two layers.

### **Gynaecology Surgery in Australia: Reflections**

Exposure to both the private and public sectors of work in Australia was incredibly interesting from both a clinical and a practical perspective. Observing how the consultants work just 1-2 days a week within the public sector means a certain degree of separation from them and the consultant body. The department benefit from their expertise and training of junior staff but not as much benefit is gained from their experience on a leadership and management front. The private sector however, appears to be an efficient system offering much wide-ranging clinical services than private hospitals in the UK, including emergency and intensive care. The private system is paid for by those above a certain income threshold and appears to be an efficient system. Interestingly, the private consultants need to be their own promoters and many referrals are received by word of mouth and reputation. Many have fantastic websites and have joined reputable ‘private groups’. The benefits are; copious operating lists and clinics; state-of-the-art equipment from the laparoscopic stack to the port cleaning devices; continual development of skills and training of junior staff and financial rewards. On the down-side, it appears these were long days of operating (often starting at 7am and finishing at 9pm) and long clinics (often 40 patients come through in an all-day clinic with one consultant). I wonder if this may have an impact on work-life balance and also patient care following such long lists which will inevitably lead to clinician fatigue. The private consultant teams at the private hospitals appeared to form consortiums in which the consultants met to agree on management approaches, but as a business first and foremost, most of these appeared financially driven. I did witness some exceptionally supportive practice between the gynaecology consultants however, who despite working as individuals primarily in the private sector, did take time to support one another. The more junior consultants calling upon the senior team members for support happened on occasion and they were happy to attend cases when needed.