THE SCOPE

Newsletter of the British Society for Gynaecological Endoscopy

All the latest news including

Details of the upcoming ASM22 in Birmingham

"Standing Tall after the Fall"

BSGE Elections

The Scope meets... Ray Garry and Fabio Ghezzi

LAVA trial update

And much more

Issue 19 | Spring 2022

BSGE

BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Welcome

Welcome to the bumper Spring edition ahead of ASM22

Message from the Editor

Fellow BSGE members welcome to another exciting, though "bumper", issue of @TheBSGE SCOPE. In this issue we highlight our forthcoming ASM in Birmingham showcasing the event and social events that I, for one, am really looking forward to.

March is Endometriosis Awareness Month- I hope we are all participating in increasing awareness as well as raising the standards of care for women who suffer from endometriosis. Rebecca Mallick and team have put together a series of events including webinars and Instagram events on behalf of the BSGE, which she highlights also in this issue.

In our interview section Mez Aref-Adib talks with two inspirational minimal access superstars. Ray Garry details his journey and the evolution of minimal access surgery. I was personally influenced by his 1996 article in Gynaecological Surgery back in the day "The laparoscopic treatment of ectopic pregnancy, long road to acceptance" as well as the EVALUATE studies. Prof Ghezzi details his hysterectomy work. I particularly like his comparison of rules of climbing to the rules we should always obey in laparoscopic surgery.

These interviews are followed by current hysterectomy research highlighted by Justin our current President. Completing this minimal access hysterectomy theme is Krupa Madhavni in the news section personalising conversion risk at laparoscopic hysterectomy. We also have our "usual suspects" keeping us up to date with BSGE activities through the subcommittees.

Most importantly, it is election time again. Please exercise your voting rights to keep our Society progressive and vibrant

I'm looking forward to seeing everyone in Birmingham.

Funlayo Odejinmi (Jimi)

Scope Editor and Membership Relations Portfolio Chair
email: bsge@rcog.org.uk

Contents

IN THIS ISSUE

President's Message

Dear all, this will be my last President's message in Scope as I will be handing over the reins to Andrew during our AGM at the rapidly approaching BSGE ASM in Birmingham.

I am very excited about this event, given it will have been almost three years since we last gathered together in Celtic Manor The scientific programme is packed into three streams with areas of interest for all, with diverse presentations and sessions covering all aspects of our practice. We have unprecedented industry support, and there will be a huge array of exciting new technologies to see and try including a range of 'Bots' to play with. The venue is impressive, the social programme is tip-top, and the area around the ICC (Broad Street, Brindley Place, the canals and the Mailbox) will be buzzing with nightlife. So I look forward to seeing as many of you as possible.

I would like to take this opportunity to thank you all for your support. The Covid pandemic has been a challenge and prevented me from fully delivering some of my planned objectives during these last two years. However, I have been proud of how we pulled together and what we managed to achieve; providing rapid clinical and strategic guidance, maintaining our educational objectives with innovative webinars, podcasts, virtual meetings and training programmes, as well as expanding our desire to advocate for endoscopic surgery and benign gynaecology. The in-roads we have made politically into changing training to improve access to theatre and pushing the need for suitable gynae only job plans will hopefully be progressed further with the RCOG and NHSE, fulfilling my mantra "training the best and allowing them to excel". The benchmarking data in endometriosis surgery and hysteroscopy will enhance practice, patient experience, and safety. The large multi-centre endoscopic trials we are supporting as a society will ultimately benefit us all, optimising patient care.

I look forward to seeing how our international membership proposal and project to better coordinate and improve care for thoracic endometriosis develop.

None of this would have been possible without the input, innovation, enthusiasm and expertise of you, our BSGE members, my Council colleagues, Officers and of course, the 'engine room' of Atia and Babs. A big 'shout out' to you all from me. Also, many thanks to Lesley Hill who left the BSGE in 2021, after more than 25 years of service.

Finally, please remember to get your colleagues and trainees to join our vibrant society. Any healthcare professional that holds an endoscope to inspect the uterine cavity or pelvis can join! I have been delighted to see our membership grow to over 1700 members – the larger we are, the greater the voice we can have.

Enjoy the improving weather, and I look forward to catching up in Birmingham in April and beyond.

With all best wishes and thanks

Professor Justin Clark MD (Hons) FRCOG
BSGE President

ASM22

2022 ANNUAL SCIENTIFIC MEETING

THURSDAY 21ST APRIL AND FRIDAY 22ND APRIL
THE ICC, BIRMINGHAM

'STANDING TALL AFTER THE FALL'

www.bsge.org.uk/asm22

Illustration by vectorjuice / Freepik

Justin Clark and Donna Ghosh, co-chairs of the local organising committee for ASM 2022, invite BSGE members to join them in Birmingham- Worcester in April

We are delighted to invite registration for the Birmingham-Worcester BSGE Annual Scientific Meeting which will be held at the International Convention Centre in Birmingham on the 21st – 22nd April.

The meeting is themed 'Standing Tall after the Fall' – always learning, improving safety and enhancing outcomes. We acknowledge the challenges faced over the last few years and this provides an opportunity for us to come together at a face-to-face meeting to learn, share experiences and socialise. There is the added option for delegates to attend virtually to access live streaming of the conference if they are unable to attend in person.

The local organising committee has developed an exciting scientific programme with leading speakers, clinical experts and academics from around the world. Content will be delivered across three parallel streams and popular sessions such as the Alec Turnbull Lecture, Pecha Kucha and the debate are included. This year's hot topic for debate is:

'This house believes that a uterine septum should be removed in all women with recurrent miscarriage seeking future pregnancy.'

There will also be sessions dedicated for nurses and trainees across gynaecological endoscopy disciplines.

The ICC is set in the heart of Birmingham, providing the perfect backdrop for our meeting. The ICC incorporates the iconic Symphony Hall, directly facing Centenary Square, and opens out onto Birmingham canals with an abundance of bars and restaurants within a stone's throw away. There will be plenty of opportunity to explore the nearby art, culture and entertainment on offer.

Pre-congress workshops will be held on the 20th April 2022 at Birmingham Women's Hospital and Worcester Royal Hospital.

We look forward to seeing you in Birmingham!

NEW DATES FOR ASM22

The BSGE announced a date change for the Birmingham-Worcester ASM 2022..

The new dates for the 2022 Annual Scientific Meeting (ASM) are Thursday April 21st to Friday 22nd April, with pre-congress workshops taking place on Wednesday 20th April.

The BSGE Council and ASM 2022 Local Organising Committee felt these spring dates on a Thursday and Friday are preferable and more in keeping with the timing of the BSGE's usual ASMs. The LOC apologised for the inconvenience caused but emphasised that they hoped that delegates understood the reason for the late change and could support it.

Co-chairs Justin Clark and Donna Ghosh said:

"We were concerned over the ability of our members, mostly working in the NHS, to attend the ASM with the Omicron variant situation affecting the staffing and provision of health services.

The ICC offered us April dates, which were previously unavailable. The weather in Birmingham will be superb by then so you can enjoy the canals, bars and restaurants even more. Most importantly, we should be over the worst of Omicron staffing situation so obtaining study leave should be less problematic.

We are keen for as many of our members as possible to have the opportunity to attend the Birmingham-Worcester ASM and this is our main objective."

Delegates who had already registered and paid for the BSGE ASM 2022 or any of the workshops could change to the new dates or get a full refund of their registration fee.

ASM22 HIGHLIGHTS

Justin Clark, BSGE President and ASM 2022 co-chair shares his top tips ahead of the meeting in April: I am pleased that Springtime is drawing near and that means that our Birmingham-Worcester ASM is getting closer!

Here are a few of the highlights and sessions that I am looking forward to:

The virtuoso laparoscopic dissections of Prof Marc Possover and his views on current state of play regarding the developing field of neuropelveology.

A whole session devoted to safety and avoiding litigation in keeping with the theme of our ASM.

Sage advice from experts including **Bertie Leigh**, a highly experienced lawyer.

And our own **Jonathan Frappell** providing us with his wisdom derived from his long career pioneering endoscopic surgery.

A 'hot' debate on whether we should be removing uterine septums to enhance fertility.

Recent publications have highlighted the strong opposing views across our specialty internationally. I am especially anticipating this because we have 2 experts and hugely entertaining international speakers in Profs Mark Hans Emanuel and Attilio Di Spiezio Sardo.

I am also hugely looking forward to our other international speakers who will be covering highly topical areas;

Dr Tjalina Hamerlynk covering resection or mechanical tissue resection in hysteroscopy,

Prof Bas Verseema highlighting the lessons we can learn from the hysteroscopic sterilisation story and

Prof Judith Huirne, a world expert in surgery for cervical niches, pathologies that we are increasingly recognising and wondering how and when we should offer surgical treatment.

The upcoming roll out of the National Consultant Improvement Programme project led by Professor Sir Norman Williams.

He will address us about this important project that I believe will be hugely impactful. It provides data summaries of our individual surgical practices (numbers and spread of procedures and some outcomes including average lengths of stay and rates of readmission etc. presented in a clear graphical format), which can be compared locally, regionally and nationally.

There is of course so much more...

Pecha Kucha, free comms that always excite and inform, a lap urogynae session, practical surgical tutorials, Oncology, reproductive surgery, careers, development, training, hysteroscopy, endometriosis, robotics, clinical service development, 'tips and tricks', meet the experts, clinical case discussions, the Alec Turnbull oration and our platinum sponsored lectures amongst other things. The social programme is fab too see page 11.

There is truly something for everyone so please book now if you have not already done so – I don't want you to miss the early bird discounted rate that closes on 28 March.

PRE-CONGRESS COURSES

There's a range of pre-congress courses taking place immediately before ASM 2022 on Wednesday, April 20th.

The courses offer an opportunity to extend your stay in the Midlands and improve your skills and knowledge. Pre-congress workshops will be held at Birmingham Women's Hospital and Worcester Royal Hospital.

As we go to press, course vacancies are limited, especially for the hands-on workshops in hysteroscopy and laparoscopic hysterectomy and the RIGS Intermediate Laparoscopic Course. To secure your place, click and register now. Choose between:

RIGS Intermediate Laparoscopic course:

Designed for trainees at ST3+ level. This practical workshop will cover the theory and practice of intermediate level gynaecological procedures including salpingectomy, cystectomy and an introduction to laparoscopic suturing. This course was first established in 2018 and has been an extremely popular course for O&G trainees intending to improve their laparoscopic skills in gynaecology.

Click here

Surgical Management of Deep Endometriosis:

Available in person in the state-of-the-art Postgraduate Education Centre at the Royal Stoke University Hospital or by online stream. The morning session will cover advanced laparoscopic surgical techniques required for the excision of deeply infiltrating endometriosis with interactive discussions and consensus building exercises. The afternoon will deliver as live surgery with complex joint cases for Stage IV disease.

Click here

BSGE GESEA examination:

The BSGE in collaboration with the ESGE runs the Gynaecological Endoscopy Education and Assessment (GESEA) Programme in the UK. This is a structured training programme set up by the ESGE and the European Academy of Gynaecological Surgery.
As part of the GESEA Programme, BSGE will run Level 1 and Level 2 Certification Examinations. All e-learning modules must be completed before the examination to qualify to sit the examination. The examination itself consists of both theoretical and practical assessment.

Click here

Endometriosis Nurse workshop:

This very popular workshop will include presentations and discussions around fertility, medical treatment of endometriosis, setting up a new nurse led clinic, nutrition and endometriosis and the bowel.

Click here

Hysteroscopy workshop:

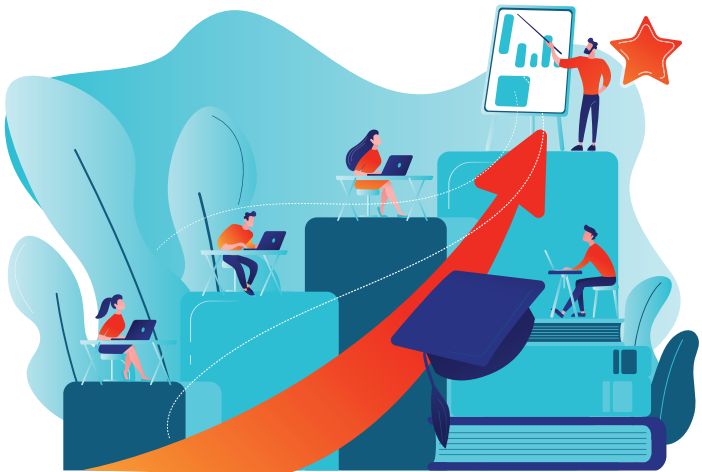
The workshop will combine lectures, case study discussion and practical stations. It will help delegates recognise when and how diagnostic hysteroscopy should be performed, understand how to perform procedures in the outpatient setting and become familiar with operative hysteroscopic equipment.

Click here

Laparoscopic Hysterectomy workshop:

This is a 2 day workshop, with day 1 being in person at Birmingham Women's Hospital and day 2 being a virtual live stream. Day 1 will include talks on theory and techniques followed by a hands-on simulation session. The second day will include live-streamed surgery including laparoscopic hysterectomy for benign condition and laparoscopic hysterectomy for cancer. There will be plenty of time for questions and answers after the surgical session.

Click here



MARY CONNOR TO DELIVER THE SIR ALEC TURNBULL LECTURE

Sheffield Teaching Hospitals NHS FT

Mary Connor will deliver the prestigious Alec Turnbull Lecture at the upcoming ASM in Birmingham.

Sir Alec Turnbull was a Professor of Obstetrics and Gynaecology in Oxford and a key figure in the development of minimally invasive surgery in the UK. Every year the BSGE organises a lecture at the ASM in his honour. The very first lecture was given more than a quarter of a century ago by Professor Jacques Donnez in 1990

Mary Connor is a Consultant Gynaecologist at Sheffield Teaching Hospitals, NHS Foundation Trust, and Honorary Senior Lecturer at the University of Sheffield.

Mary has a long-standing interest in research and teaching and has developed and run hysteroscopy courses locally, nationally and internationally. As a member of the BSGE and the Honorary Secretary for several years, she has contributed to the development of hysteroscopic services nationally. She is co-editor of the book 'Diagnostic and Operative Hysteroscopy.' So it should be a fascinating talk.

The Alec Turnbull lecture will take place on Thursday, April, 21st from 14:00-14:30 in the main conference room.

SOCIAL PROGRAMME AT ASM22

The ASM is a great opportunity to get together with colleagues and have fun after two years of cancelled meetings and Zoom events. In Birmingham and Worcester, the Local Organising Committee has put together an excellent social programme to complement the scientific one.

Welcome drinks

A drinks reception at the ICC will welcome all delegates to Birmingham. It will take place on Wednesday, 20th April, from 6pm. This year you can enjoy drinks, catch up with colleagues and listen to gospel singers. The drinks are sponsored by Gynesonic. Sarah Field told The Scope:

"Gynesonics are really excited to be sponsoring the welcome event at this year's ASM. Please do come and join us, especially as we will all have the opportunity of watching a performance from the Rose Gold Choir.

"Gynesonics manufacture The Sonata® Treatment which is an incision-free treatment option for women with symptomatic uterine fibroids. Using an intrauterine ultrasound device to locate and target individual fibroids, radiofrequency energy is delivered directly to the fibroid to reduce their size and ease symptoms. The team would be pleased to give you more information during the evening. We also offer you the opportunity to watch a demonstration of the treatment with our simulator. We look forward to seeing you there."

Annual RIGS dinner

The popular RIGS trainee dinner will take place on the evening before the ASM, April 20th at 19.30. The event will take place at the Malmaison, Birmingham. The stylish venue is a converted Royal Mail building in the heart of the city. It serves colourful, vibrant and creative food. Trainee reps Angharad and Mikey told The Scope:

The RIGS dinner provides an ideal opportunity to mingle with minimal access gynaecology trainees from across the country. At this year's RIGs dinner the after-dinner speaker will be Marc Possover with a talk titled 'Anatomy for the gynaecologist- how much knowledge is enough?

Tickets are just £20 but are limited, so please book with your registration to avoid disappointment. Dinner tickets are only available to delegates who register for the ASM.

BSGE opening night dinner

The BSGE is holding a dinner on the night before the conference in Asha's, a landmark Indian restaurant a short walk from the conference venue. Asha's offers an unforgettable dining experience in a setting of unashamed opulence.

From soulful street food to the menus of maharajas the menu transports you across the length and breadth of the Indian subcontinent. The meal is on Wednesday, 20th April 2022 at 19:30. Tickets are £20 but are limited, so please book with your registration to avoid disappointment. As The Scope goes to press there are only four tickets available.

Please note that the BSGE Dinner at Asha Restaurant and the RIGS Dinner at Malmaison on 20th April will be taking place at the same time. Please do not purchase tickets for both events as refunds might not be possible.

Asha's

BSGE Gala Dinner

The annual Gala Dinner is the social highlight of the BSGE year. This year's event will be held on Thursday, 21st April in the stunning ICC.

With welcome drinks, entertainment and dancing after the meal, it's always a very popular event. As the first Gala Dinner since Celtic Manor in 2019 this one should not be missed. Please ensure you secure your place when registering for the conference. Following the success of the Welsh event, there will be again be a limited number of tickets for delegates' guests. One guest per delegate can purchase a ticket, subject to availability.

AN INSIDER'S GUIDE TO BIRMINGHAM AND WORCESTER

Preth de Silva and Jon Hughes from the ASM local organising committee give us the low down on the places to go in Birmingham and Worcester:

We are very excited to be hosting you all in the wonderful city of Birmingham and the beautiful cathedral city of Worcester for the next BSGE Annual Scientific Meeting. The meeting will now take place from 21st – 22nd April 2022 at the International Convention Centre (ICC). With the first opportunity for BSGE members to get together in person rapidly approaching, we thought we would recommend some of our favourite places, so that you can make the most of your visit.

Birmingham highlights and hotspots

Birmingham is Britain's second-largest city and the geographical heart of the country with many theatres, the famous Electric Cinema and a diverse collection of canal-side bars and restaurants. Preth de Silva gives his insider guide on what to see and where to eat and drink while you're out and about:

Brindley Place

Distance from ICC: 5-minute walk

Best bits: A stone's throw away from the conference venue, this pretty area overlooks one of Birmingham's infamous canals and has plenty of places to eat and drink

Places to drink: Pitcher & Piano, The Alchemist, Bank, The Gin Vault

Places to eat: Pulperia, Cosy Club, Qavali, Siamais

Jewellery Quarter

Distance from ICC: 12-minute walk

Best bits: Not too far from the city centre, St. Paul's square forms the iconic centre of the highest concentration of jewellers in the country, however, if you're not after a present for your loved one you've ditched back at home to come to the ASM, there's a load of trendy restaurants and bars overlooking the square.

Places to drink: The Rectory, St Paul's House, 1000 trades

Places to eat: Cucina Rustica, Indian Brewery, Otto Pizza

Mailbox

Distance from ICC: 8-minute walk

Best bits: Full of high-end boutique shops and some cool restaurants and bars can be found in this complex; the view from the top overlooks the city!

Places to drink: Gas Street Social, Aluna, Medicine

Places to eat: Marco Pierre White, Rodizio Rico, Indico

Digbeth and The Custard Factory

Distance from ICC: 25-minute walk / 10-minute taxi

Best bits: A bit further afield, but one of the coolest parts of the city since undergoing a huge amount of gentrification over the last five years. Also, the place where the term "Peaky Blinders" was coined. There's plenty to do here, including crazy golf, batting cages, video game bars and street art tours.

Places to drink: The Old Crown, The Floodgate, NQ64, Mama Roux, The Spotted Dog

Places to eat: Rico Libre, Baked in Brick, Locked & Loaded

Birmingham highlights and hotspots continued

Edgbaston, Harborne, the Botanical Gardens and the University of Birmingham (UoB)

Distance from ICC: 7-minute train journey from New Street to UoB / 10-minute taxi

Best bits: The slightly posher part of Birmingham (yes, it does exist), here you'll find the leafy suburbs of Harborne and Edgbaston where the University of Birmingham and Birmingham Women's Hospital can be found. The Plough is a local favourite, and the Botanical Gardens are a picturesque escape from city life.

Places to drink: Loki, Hop Garden, The Plough

Places to eat: The White Swan, The Physician, The Plough

Bournville and Cadbury World

Distance from ICC: Distance from ICC: 13-minute train journey from New Street to Bournville / 15-minute taxi

Best bits: It goes without saying that if you like chocolate, Cadbury World is a must. Bournville itself is steeped in Tudor history as the home of the Cadbury family. Such is their influence still, Bournville remains under Quaker rule, so if you do fancy a tipple, then you'll have to head to nearby up and coming Stirchley.

Worcestershire highlights and hotspots

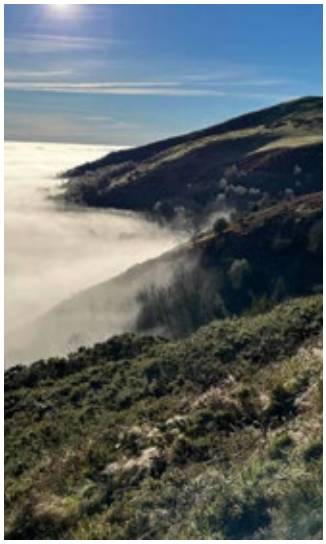
The beautiful cathedral and university city of Worcester is famous for Royal Worcester Porcelain and Lea and Perrins sauce. However, one of the highlights of Worcester is its proximity to stunning countryside. If you want to get away from the hustle and bustle of the city, you can escape to the tranquillity of the Severn River and the scenic Malvern hills. Jon Hughes gives his insider guide on what to see in Worcester:

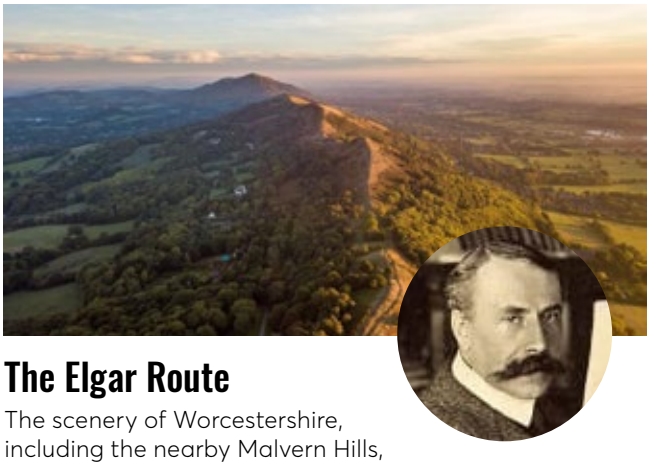
Worcestershire landscapes

Worcestershire is a large county in the mid-western area of England, easily accessible by road, rail and air from Birmingham, London, Bristol and further afield.

The Worcestershire landscape is stunning with the majestic Malvern Hills and the Severn River. It was, apparently, the inspiration for JRR Tolkien's the Shire and the rural beauty of 'Middle-Earth' is very much evident.

https://en.wikipedia.org/wiki/The_Shire





The Elgar Route

The scenery of Worcestershire, including the nearby Malvern Hills, inspired Sir Edward Elgar as he composed some of his most famous pieces of music. The Elgar Route is a 40-mile circular driving route passing through Elgar's birthplace, Great Malvern, the Malvern Hills, Elgar's grave, Upton upon Severn and back to Worcester City. From the top of the Malvern Hills, for example, at British Camp, there are breath-taking views across Worcestershire, Herefordshire, and as far as Shropshire; the large Iron Age hill fort is thought to date back to the 2nd century BC.

https://elgarroute.org.uk/

The Severn River

The longest river in Britain, the River Severn, flows through Worcestershire. Walk alongside the river, or pop into one of the riverside pubs to admire it with a drink!

https://theoldrec.co.uk / https://www.theholtfleet.co.uk

Worcester Cathedral

The imposing Worcester Cathedral dates back to 1084. The building is situated on the river banks and hosts the tomb of the 'bad King John'.

Historic Worcester

For those based in the city of Worcester, one of the oldest cities in the country, there are plenty of attractions from the cobbled Tudor streets, elegant Queen Anne architecture, the Museum of Royal Worcester (formerly the Worcester Porcelain Museum) and Greyfriars House and Garden, a merchant's house built around 1490, now a National Trust property. You can grab a drink or a bite to eat in one of the bars and restaurants in the original mediaeval timbered buildings of Friar Street (surely one will have Worcestershire sauce).

https://www.visitworcester.co.uk/worcesterhistory/

Worcester's medical heritage

Sir Charles Hastings, famous for founding the Provincial Medical and Surgical Association, known to us as the British Medical Association (BMA), grew up in Worcestershire, starting as a house surgeon at Worcester Infirmary, before gaining his medical degree from the University of Edinburgh in 1818.

Hastings returned to Worcester and spent his career treating cholera and successfully fighting for improved housing, receiving his knighthood from Queen Victoria in 1850.

You can find Worcestershire Royal Hospital on Charles Hastings Way, and we are proud of our eponymous modern education centre that will host you for the pre-congress workshops. We look forward to welcoming you to Worcester in April.

BSGE Elections 2022

It's BSGE election time again. This year the Society will elect a new Vice President. During ASM 2022 in Birmingham / Worcester, Andrew Kent will move up to the role of President of the BSGE and Justin Clark will stand down after completing his two years as President.

Launching the elections, BSGE Honorary Secretary Kirana Arambage said:

"I would like to personally thank Justin for all his significant contributions to improve both clinical and research profile of our Society over the years and especially organising hugely successful first BSGE virtual ASM 2021."

The Society has welcomed nominations for Vice President who will subsequently become President of the Society. One post of Trainee Representative is also up for election. Any junior member of the BSGE was eligible for nomination. Angharad Jones has completed her second term as a Trainee Representative and stands down after four years . Kirana said:

"Well done to Angharad who has made valuable and enthusiastic contributions to the Society. Angharad and Mikey have initiated RIGS regional courses and meetings specially over Covid period and helped a lot of our trainees to maintain their gynaecological surgical skills. Thank you very much."

Online voting commenced on February 21st and finishes on Wednesday, 23rd March 2022 at 5 pm. Members are required to log in to the website in order to vote.

Election results will be announced at the BSGE AGM on April 21st 2022.

Kirana added:

"We have over 1,700 members in the society, I do encourage you all to take an active part in the elections and helping shape the BSGE's future by voting for your chosen candidate."

The candidates are:

Vice President and future BSGE President

Funlayo Odejinmi

Whipps Cross University Hospital, Barts Health NHS Trust

Proposer: Ertan Saridogan

Seconder: Saikat Banerjee

Read profile

Arvind Vashisht

University College Hospital, London

Proposer: Justin Clark

Seconder: Gilly Macdonald

Read profile

Senior Representative

Ilyas Arshad

Liverpool Women's Hospital

Proposer: Dharani Hapangama

Seconder: Andrew Drakely

Read profile

Tony Chalhoub

Newcastle upon Tyne Hospitals NHS Foundation Trust

Proposer: Graham Phillips

Seconder: Pinky Khatri

Read profile

Martin Hirsch

Oxford University Hospitals

Proposer: Arvind Vashisht

Seconder: Rebecca Mallick

Read profile

Haider Jan

Epsom and St Helier University Hospitals NHS Trust

Proposer: Fevzi Shakir

Seconder: Andrew Kent

Read profile

Andrew Pickersgill

Manchester University NHS Foundation Trust

Proposer: Hani Shuheibar

Seconder: Hagir Mohamed

Read profile

Trainee Representative

Lina Antoun

Birmingham Women's Hospital

Proposer: Justin Clark

Seconder: Donna Ghosh

Read profile

Babu Karavadra

Ipswich Hospital, East Anglia

Proposer: Edward Morris

Seconder: Jane Snasdell

Read profile

Endometriosis Action Month

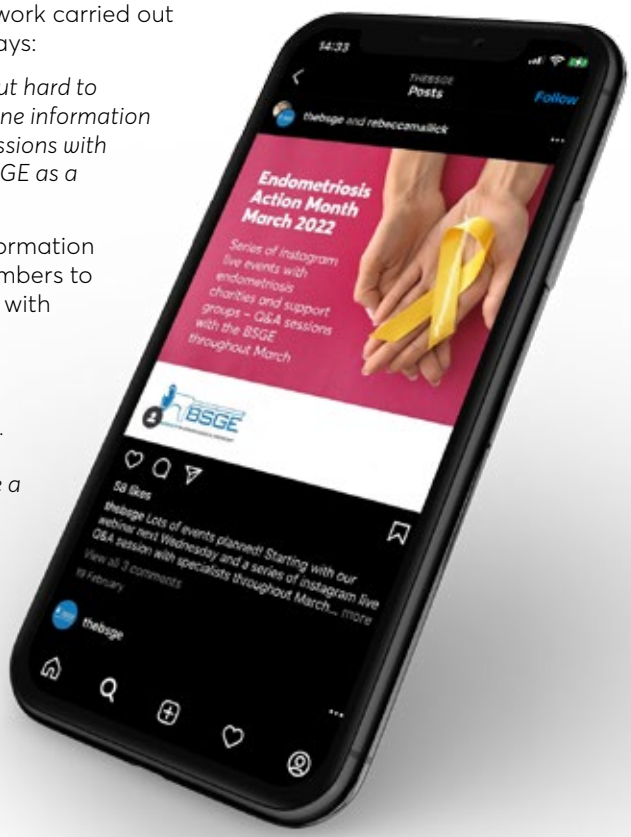
The BSGE is running a series of endometriosis events delivering high quality, accurate, and trustworthy information directly to patients this March. Previously known as 'Endometriosis Awareness Month' the name has been changed to reflect the importance of making changes as well as increasing awareness. Endometriosis UK said:

"What those with endometriosis need and deserve is tangible action and positive changes which improve their wellbeing. That's why we've decided that March 2022 will be Endometriosis Action Month."

Rebecca Mallick has taken over the new @theBSGE Instagram account and aims to raise awareness of the disease along with highlighting the amazing work carried out by the BSGE to support people living with endometriosis. Rebecca says:

"I'm really excited the BSGE are able to bridge that gap between reliable but hard to access conventional hospital based information and the unregulated online information which many patients are accessing. Through a series of Instagram live sessions with endometriosis charities and support groups we hope to establish @theBSGE as a reliable source of information online for patients."

Rebecca and Martin Hirsch have been busy posting pictures and information for women living with endometriosis.Rebecca encouraged BSGE members to follow TheBSGE on Insta and to share details of the Instagram page with their patients.



Rebecca told The Scope:

"For the Instagram Lives we are planning events that are up to 60 minutes. Questions will be submitted the week leading up to the live event and participators will have access to the planned questions. There will then be a live Q&A session with the endometriosis charity and support group.

We have pencilled in weekly themed sessions throughout March. This will be our first real venture as the BSGE into patient facing events so really looking forward to this new aspect of patient engagement! @TheBSGE Instagram account will be our main patient facing platform."

Martin Hirsch reached out to patients saying:

"Endometriosis Action Month aims to help people access the care they need. Perhaps they didn't know their symptoms could be endometriosis or perhaps they did but have been struggling to get referrals for treatment. I so often hear about the frustration people have felt when talking about their symptoms with healthcare professionals (HCP).

I know it can sometimes feel as though HCPs don't always listen or appreciate the impact these symptoms can have. This really saddens me and I hope this short "how to" series will hopefully help you to have more productive conversations with your HCP or GP."

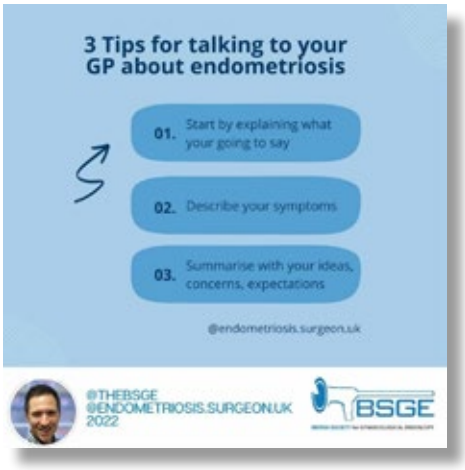
Click here to see thebsge instagram

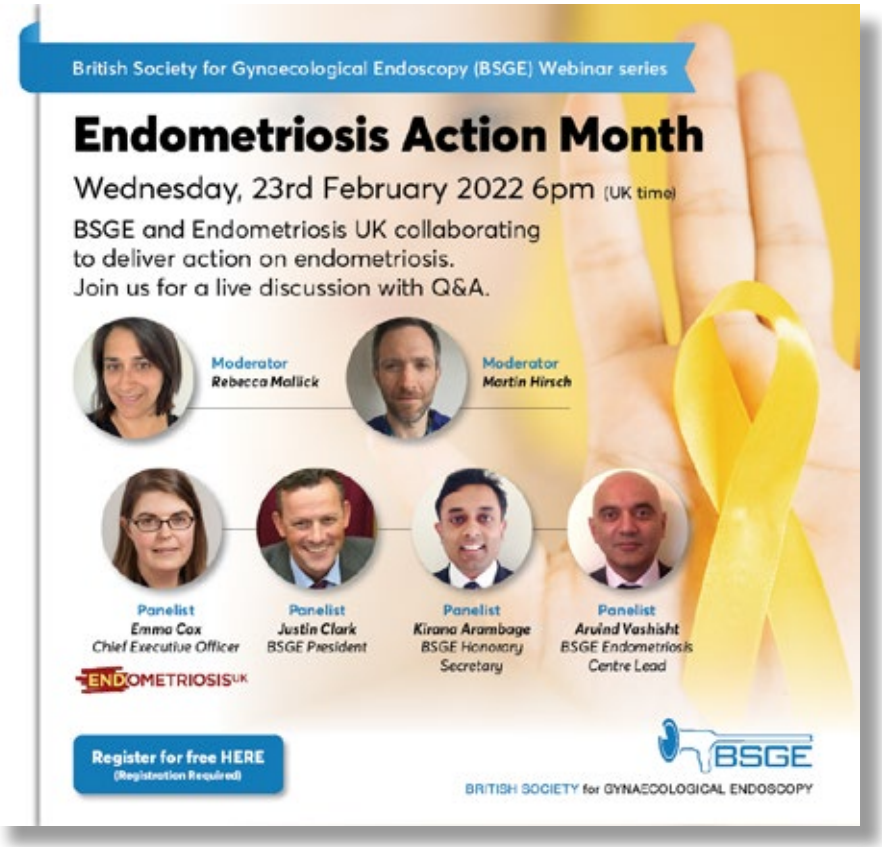
Planned Instagram Live events include:

- What is endometriosis-symptoms and signs I should be looking out for?
- How is endometriosis diagnosed?
- Management options for endometriosis
- Adenomyosis - diagnosis and management
- Endometriosis and adenomyosis Q&A

The first Instagram Live was held on Friday March 4th with @theBSGE and @pietrobortolettomd hosted by Anna an endometriosis campaigner and patient. You can watch this event on replay though Anna's account, @battlewithendo_ox. Further events are scheduled and please follow @ theBSGE for updates!

As well as Instagram, the team are using Zoom to communicate with people with endometriosis. The first Endometriosis Action event was a live patient webinar on Wednesday, 23rd February at 6pm. The BSGE and Endometriosis UK collaborated in a live question and answer session. Rebecca and Martin Hirsch moderated the event joined by Emma Cox,





CEO of Endometriosis UK, with the BSGE's Justin Clark, Kirana Arambage and Arvind Vashisht on the panel.

There is also a planned episode of the BSGE podcast BSGE Uncut 'Through the eyes of the patient-the endometriosis journey.'

Endometriosis Action Month runs for the whole of March.

Emma Cox CEO of Endometriosis UK said:

"March is a really important month for the endometriosis community. We're really grateful to everyone who has helped make noise and spread awareness of endometriosis in previous years, and we can't wait to get going with Endometriosis Action Month this year."

2022 ESHRE Endometriosis Guidelines available

In February, a fully updated version of the ESHRE Guidelines on the diagnosis and treatment of patients with endometriosis was published. BSGE veterans Christian Becker and Ertan Saridogan, who were chair/member of the core Guideline Development Group report on the exciting new developments and changes in endometriosis management.

In 2005, under the umbrella of the European Society of Human Reproduction and Embryology (ESHRE), clinical experts published the first comprehensive review of the available evidence on how to best manage patients with endometriosis. The original guidelines and the updated version published in 2014 were adopted by the RCOG and other national and international societies. On February 2nd, 2022, the third edition of the fully revised ESHRE Endometriosis Guidelines was published.

Over the last two years, international clinical and scientific experts in endometriosis management and research together with patient representatives from different European countries systematically gathered, assessed and evaluated all new and previously existing data to develop a comprehensive compendium that will help guide both clinicians and patients to find the best, evidence-based diagnostic and treatment options for endometriosis.

The work was divided into eleven subgroups consisting of experts in surgery, medical management, and fertility, as well as patient representatives. In addition to Christian Becker and Ertan Saridogan, Andrew Horne and Katrine Peterson were the other two British members of the Core Guideline Development Group. BSGE members and other subgroup members from the United Kingdom, with ten participants, formed the largest party within the subgroups. These subgroups each met multiple times. The proposed results were then presented by the subgroup leads to the core group, which was further supported by patient representatives. The resulting guidelines were then presented to the ESHRE members other stakeholders with an interest in endometriosis, and the public was addressed for review and comments for the final version.

The Endometriosis Guidelines 2022 are also published as a patient-friendly version to emphasise ESHRE's commitment to patient involvement and public outreach.

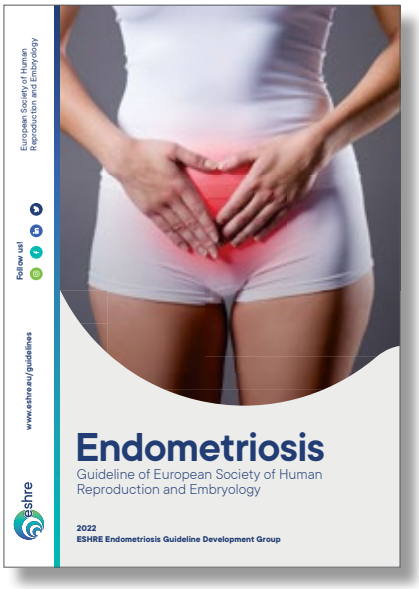
New PICO (patient, intervention, comparison and outcome) questions were addressed in the new format, further expanding the scope of the guidelines. Particularly, sections on prevention and a focus on endometriosis in adolescents and menopause are highlights of the 2022 update.

Of note, the guideline development group decided to step back from the dogma of laparoscopy generally being the gold standard to diagnose the disease, first formulated in the original guidelines in 2005. Rather, increasing evidence suggests that ovarian and deep endometriosis can be identified/ruled out with sufficient specificity/sensitivity using transvaginal ultrasound scans or MRI and should be used as a first-line diagnostic tool. For superficial peritoneal disease, empirical treatment with hormones should be the first line of treatment in women not trying to conceive.

Other changes include recommendations towards postoperative hormone treatment to improve pain management and reduce recurrence rates in women who are not trying to conceive.

With regard to fertility patients, the 2022 guidelines recommend the endometriosis fertility index (EFI) to be used to support decision making for the most appropriate option to achieve pregnancy after surgery.

Finally, the ESHRE guidelines contain excellent updated information on the association between endometriosis and certain forms of cancer, including endometrial and clear cell ovarian cancer and thyroid cancer.



The full and patient-friendly versions of the 2022 ESHRE Endometriosis Guidelines are freely available to professionals and the general public

Click here to download

See page 39 for, Endometriosis Centre Portfolio Chair updates

BSGE and RCOG Joint Statement on Thoracic Endometriosis Care

The BSGE and RCOG have released a joint statement on Thoracic Endometriosis care in the United Kingdom.

BSGE President Justin Clark and Martin Hirsch, Consultant Gynaecologist Oxford University Hospitals, said:

"The BSGE and RCOG aim to standardise care for people with thoracic endometriosis and are committing to centralise thoracic endometriosis care. We are pleased to be taking positive steps towards improved endometriosis care in the UK."

In the 2021 Scope Martin Hirsch and Islam Gamaleldin wrote:

"The true prevalence and age incidence of Thoracic Endometriosis remains unknown and while it is thought to be rare this may represent a largely under-diagnosed disease with little research existing beyond case reports.

The diagnosis and management of patients with TE is challenging with delays in diagnosis commonly experienced. This is due to the lack of awareness of the condition among clinicians (gynaecologists, thoracic and general surgeons, radiologists, and accident and emergency doctors) and the absence of national / international recommendations or guidelines to support clinicians in the diagnosis and management of this group of patients."

The joint statement aims to increase awareness of Thoracic Endometriosis and sets out RCOG and BSGE aims for Thoracic Endometriosis care. The full statement on Thoracic Endometriosis Care and an infographic to raise awareness of this challenging condition are included in this Scope.

The statement is also available to download click here

The Society encouraged members to use this infographic and share on social media to increase awareness of Thoracic Endometriosis.

Official statement

The thorax is the commonest location for extra pelvic endometriosis affecting up to 12% of those with pelvic disease. Thoracic endometriosis (TE) represents a spectrum of disease with endometriotic lesions being found on the diaphragm, pleural surfaces and / or lung parenchyma. The condition rarely occurs without pelvic disease. The main clinical manifestations include:

There is limited evidence to guide accurate diagnostic tests and efficacious therapeutic interventions internationally (1).

The BSGE was approached by Endometriosis UK and patient representatives asking for a review of TE care in the United Kingdom (UK). The concerns raised included a lack of standardised treatments, geographical inequity in accessing care, and a lack of coordinated care nationally.

In response to these concerns, the BSGE conducted a survey of its members to establish their current practice and views on managing patients with TE. The survey results revealed low rates of screening questions being asked in clinic and low numbers of clinicians routinely looking for TE at the time of surgery (2). The majority of respondents surveyed felt that the care of patients with TE should involve a multidisciplinary team within centralised centres of excellence.

We believe that centralising the care of women with TE can improve clinical outcomes by allowing higher caseloads within a few specific units leading to greater experience and acquisition of expertise. Women with TE will benefit from better co-ordination of multidisciplinary care within specialist centres across the UK. Such an approach is in keeping with the aims of the Department of Health UK Strategy for Rare Diseases (3), enabling more accurate and timely diagnosis, and the potential for improved treatment outcomes. Concentrating care in this way can also facilitate research into the disease prevalence alongside the safety, effectiveness, and long-term prognosis of treatments.

In line with the recent All Party Parliamentary Group Report into Endometriosis Care (4) the BSGE supports:

- Working closely with BSGE members and patient representatives to understand the disease burden of TE.
- Working closely with patient representatives and funders in the development of a centralised pathway of care for TE.

References

1. Nezhat C, Lindheim SR, Backhus L, Vu M, Vang N, Nezhat A, et al. Thoracic Endometriosis Syndrome: A Review of Diagnosis and Management. JSLS : Journal of the Society of Laparoendoscopic Surgeons [Internet]. 2019;23(3):e2019.00029.
2. Hirsch M, Berg L, Gamaledin I, Vyas S, Vashisht A. The management of women with thoracic endometriosis: a national survey of British gynaecological endoscopists. Facts Views Vis Obgyn. 2020;12(4):291–8.
3. Department of Health & Social Care. The UK Strategy for Rare Diseases: 2019 update to the Implementation Plan for England. Department of Health and Social Care. 2019;(February).
4. Endometriosis UK. (2020) All Party Parliamentary Group on Endometriosis. Available at:

https://www.endometriosis-uk.org/sites/endometriosis.uk.org/files/files/Endometriosis%20APPG%20Report%20Oct%202020.pdf. Accessed 06/07/2021

Affiliations and the BSGE

BSGE Vice President Andrew Kent reports on the Society's international affiliations.

Whilst we are looking forward to our ASM in Birmingham, it is timely to recognise our international links with similar Societies around the world.

For those who are not aware your Society has generous affiliations with two associate Societies namely the American Association of Gynecologic Laparoscopists (AAGL) and the European Society for Gynaecological Endoscopy (ESGE).

Both provide significant benefits at no extra cost to individual members.

We have decided to apply an opt out policy for our affiliations so unless you have chosen to opt out, which you will be able do on your dashboard going forward, you will receive appropriate communications from both the AAGL and the ESGE. In the future new members will be prompted to decide this when they join the Society .

With the ESGE we have a Corporate Membership of a 3 year duration. On offer we have the following.

ESGE affiliation benefits

- The Journal 'Facts Views and Vision in ObGyn'
  - o electronic version of FVV for all members
  - o an Associate Editor and 2 Editorial Board Members
  - o special conditions for BSGE Corporate Publications
  - o an option for members to have the printed version of FVV for €50 per year ex VAT.
- Access to the GESEA diploma programme.
- Submission of articles to the journal "Facts, Views & Vision in OgGyn."
- Publication in the journal Facts, Views & Vision in ObGyn free of charge for peer reviewed articles (Normal fee = € 1,995 per article).
- Significant reduction in registration to the ESGE Annual Congress.
- Significant reduction in registration to training courses promoted by the ESGE.
- Personalized ESGE member email communications with information on scientific meetings, training possibilities, and interesting scientific news and activities.
- Access to the initiatives of Special Interest Groups and Working Groups projects.
- Access to the decision making process of the ESGE with the possibility of applying for Special Interest Groups, Working Groups, Advisory Board member, hosting a congress.
- ESGE awards and fellowships.

I am also delighted to announce that the BSGE has recently concluded a new 3 year agreement with the AAGL.

From the 1st February 2022 the BSGE has an Affiliated Society Membership within the AAGL which applies to all our members, Consultants, Trainees and Allied Professions. Whilst we appreciate that not everyone will use everything I am sure that there is something in there for most.

AAGL affiliation benefits

- SurgeryU Video On-Demand Library.
- Monthly Electronic JMIG Subscription (Impact Factor is now 4.1).
- Bi-monthly Webinars Led by Experts on MIGS related topics.
- Access to eight active special interest groups in: Urogynaecology, Robotics, Oncology, Endometriosis, Pelvic Pain, Hysteroscopy, Fibroids, Paediatric & Adolescent Gynaecologic Surgery.
- Deep discounts on valuable CME educational meetings and member only scientific programming including the Annual Global Congress.
- EndoExchange™ (Community Forum to interact with your peers).
- Physician Finder Listing.
- Member Certificate.
- NewsScope – quarterly newsletter with clinical articles, research updates and other timely information.

The highlights, for me, are the respective journals and the conferences at discounted member rates. I am sure that those of us who have had the opportunity to attend the ESGE Annual Congress and the AAGL Global Congress in the past, will agree that they are good value and it is always a pleasure to meet up with colleagues abroad and experience the different styles and content of conference, particularly without the stress of having to organise it!

So we look forward to seeing you all in Birmingham after Easter. Then, if the wanderlust consumes you, consider dusting off your travelling clothes and pack those bags. The ESGE is in Lisbon in October and the AAGL in the Rockies in December.

The Scope meets...Ray Garry

Mez Aref-Adib interviewed Professor Ray Garry, past BSGE President, about his life and work

Prof Garry worked for more than 20 years as a Consultant Obstetrician and Gynaecologist in the North East of England before moving in his "twilight years" to a full-time Professor at the University of Western Australia, Perth.

His main interests have been developing and long-term assessment of minimal access surgical procedures. He has accumulated 189 peer review papers, including nine formal RCTs and four Cochrane Reviews. One of his most rewarding jobs was as the editor of Gynaecological Endoscopy for ten years. He was Chairman of the RCOG MAS training committee and wrote the first RCOG Basic Surgical Skills Course and a Green-Top Guideline on Management of Ectopic Pregnancy. He was a founding member, secretary and eventually President of the BSGE. He was a board member of the ESGE, who awarded him a certificate of excellence and a Board member of the iSGE with a commendation for excellence, a board member of the ISGE with a commendation for excellence, a board and life member of AGES. His awards include the Harry Reich Award for Pioneering Work in the Science and Treatment of Endometriosis and an award by the World Endometriosis Society for being one of the most influential workers in the field of endometriosis during the first decade of the 21st century. In 1993 he was also chosen as the PPP national hospital Doctor of the Year for Innovation.

From your early medical school days, can you tell us about your career path?

I graduated from Newcastle University with a first in 1967. I planned to become an Obstetrician, but in the 1960s, training opportunities were less fixed, and we had more opportunities to explore options before settling down. Accordingly, in my post-registration years, I spent time doing general medicine, endocrinology, working in a mission hospital in South Africa and a tear in general practice before setting down to regular O/G training. My first ever paper was published in the Lancet. Easy stuff, this medical publication, I thought. In fact, try as he might, none of the following 188 papers was considered acceptable for such a prestigious journal.

The paper on growing rat thyroids in organ culture was, to my knowledge, never cited, highly speculative and failed to advance medicine one single jot but still got published in our country's most prestigious medical journal—food for thought for all you young researchers!

An important moment in my career development was when I returned from Africa to work for Alex Turnbull. My experience with the great man was limited because he moved to Oxford shortly after I arrived in Wales, but an unanticipated spin-off was working with a fellow junior whose views influenced me for the rest of my professional life. Iain, now Sir Iain, Chalmers, was a fellow junior who subsequently became the founder of the Cochrane Reviews. During ward rounds and over coffee, he continually pointed out that medicine can sometimes do more harm than good. He stressed the importance of always proving efficacy and lack of harm from any new procedure. I took this advice and spent much of my subsequent career trying to fulfil this goal. I became a consultant in Middlesbrough in 1979 and subsequently also in Leeds. It was quite a tough area, but I enjoyed working there. Being away from the centre gave me the freedom to develop new approaches and services that might not have been possible in more centralised units.

In my special interests, you could say I progressively worked up the genital tract.

First, I became a colposcopist and set up a colposcopy clinic which soon became very large. We had over 1000 new patients a year, and as it was in the early phases of the national screening campaign, many of the patients had invasive disease while most of the others had well-established CIN3. I took thousands and thousands of colposcopic photographs during these sessions and subsequently submitted my MD based on these studies.

I then moved on to hysteroscopy, and I became friends with Jacques Hamou, one of the true original minds and pioneers of hysteroscopy. The transition of imaging techniques came about because Hamou had described the technique of micro-colpo-hysteroscopy whereby you were able to visualise the squamous-columnar junction deep in the canal to help define the surgical limits of an excisional cone biopsy. Once in possession of a hysteroscope, I was fascinated to be among the first gynaecologists to see inside the previously unexplored uterine cavity. The view that is now routine for younger gynaecologists was awesome to me at the time. Later I wrote up a study with Hamou that demonstrated the importance of accurately controlling the pressure of the distension fluid to avoid fluid overload during prolonged hysteroscopic examinations. I also met a most charming American Gynaecologist, Milton Goldrath, who was the first to use the hysteroscope in a therapeutic way using the Nd-YAG laser. After much fund-raising, I became a laser man and performed over 1000 cases of endometrial laser ablations to treat menorrhagia. The next step was to try and use the benefits of these rather 'sexy' tools down the laparoscope.

This effort was inspired by the brilliant American Harry Reich. Harry remains one of my best friends and an amazing innovator. He is best known for being the first to complete a total laparoscopic hysterectomy, but his work included studying many fundamental basics of successful laparoscopy. He made important contributions to virtually every area of gynaecological surgery but particularly in developing concepts about radical excision of endometriosis. During any excisional surgery, the priority is to secure haemostasis, and in the early days, we did not have adequate tools to do this. We had Kleppinger forceps that delivered electrosurgical energy to effect tubal sterilisation. When used to stop bleeding, these either were used for too short a time and did not effectively occlude the vessel or were left on for too long, thereby charring the tissue that stuck to the blades of the forceps and removing the clot as the forceps were withdrawn. Harry worked out that it was about ensuring the correct amount of tissue desiccation. He connected his generator to a meter that clicked like a Geiger counter busily beeping before desiccation and with beeps that became less frequent as the tissue dried out. When silence ensued, the vessel was safely occluded. This and many other observations provided the building blocks for safe laparoscopic surgery that are now included in all modern laparoscopic devices. I learned so much from working with him.

By the time I started laparoscopy, I'd been a consultant for years. At this time, endometriosis was considered to be only little spots. Much time was devoted to determining the difference between clear, red and black spots. I thought myself an expert at removing these lesions with my laser until I visited Harry's to watch him operate over two weeks. This was my Damascus moment of conversion. I observed one of his 'foreveroscopies'. I stood semi bored, watching him chop out hard fibrotic material that I considered 'burnt out' and of no significance. Harry patiently removed all of this, as I considered, clinically irrelevant material. He filled 19 separate specimen bottles, and by the time he'd finished, I brashly said, 'what a waste of time'. In reply, he said, 'go to the path lab and look'.

To my amazement, every single sample contained endometrial glands and stroma indicative of active endometriosis. This brought self-realisation that everything I had considered good science and good practice was absolutely wrong! This, of course, opened a can of worms because the response required the diligent removal of all this difficult material which was technically very challenging. Painfully mastering this approach gradually but seriously improved patient outcomes, which we subsequently proved in a randomised clinical trial.

Tell us about your research.

I have done four series of Cochrane reviews based in part on some of the nine randomised clinical trials I set up. The largest of these was the EVALUATE trial. This was two parallel trials of laparoscopic vs open and laparoscopic vs vaginal surgery for hysterectomy. I was proud of the study that was the combined work of many excellent professional research workers and demonstrated unequivocally that LH was associated with less operative pain, quicker post-operative recovery, quicker return to sexual activity and better long term body image score. It, however, attracted considerable criticism s from fellow laparoscopists. We reported a higher incidence of ureteric injuries and higher costs in the LH arm than in the AH arm. Hey, the observed injuries and the higher costs were not the trial's fault. Some said very experienced laparoscopists should have only undertaken the trial, but our goal had been to determine the results obtained in over 1300 cases from across the whole country to get an accurate idea of the procedure's potential. We also hoped that demonstrating the potential hazards would lead to specific steps to improve the safety and generalisability of the approach.

How did you come to do the EVALUATE study?

The HTA was concerned about the piecemeal introduction of this procedure that had some obvious potential advantages and some possible risks. We won a competitive competition to undertake the study. We were guided in the professional organisation of the trial by the excellent Yorkshire Clinical Trials Unit and had the assistance of distinguished academics in various aspects of the study.

We recruited 1380 patients from 43 surgeons working in 28 hospitals. At the time, there was a particular concern about injuries, including some high profile litigation cases. In the early stages, we had not appreciated the subtle differences in technique required for LH. In standard AH, clamps are routinely applied very close to the uterus, keeping them well away from the ureter. In LH, it was too easy to drift away from the uterus and come closer to the pelvic sidewall structures with an increased risk of damage. Poor haemostatic techniques and equipment also contributed to early problems.

Were you expecting that reaction from the results?

No, no- I thought I was heading for glory! I was proud of the study. I was proud of the people who advised us and the work, but it is what it is.

What important lessons did the trial teach us?

I think it's simple. First of all, have good equipment. Secondly, know what you're doing. Learn anatomy and learn the potential hazards. There are brilliant laparoscopic surgeons around eager to teach. But even for the less brilliant, there are now well established and verified ways of safely undertaking LH to minimise risk and increase benefits.

What's the best trial you have been part of?

Technically, the best trial I have done is a randomised trial on endometriosis. We looked at

laparoscopic excision against placebo. This was truly randomised and blinded. The patients consented to two operations three months apart. They would either have a diagnostic laparoscopy followed by operative removal later (placebo arm) or have the definitive surgery followed by a second look laparoscopy.

My excellent research fellow Jason Abbott went to extraordinary lengths to ensure that no carers or patients knew their trial arm. Happily, the trial showed that excision was significantly better than no excision, but it also showed a high placebo effect. Everybody reported improvement, but those in the placebo arm reported further improvement after excision.

Were you a proponent of subtotal hysterectomy?

No, I wasn't at the time. No, to be honest, I am still not. I don't quite see the point. Many people favoured that approach because it is quicker and technically easier. When abdominal hysterectomy was first introduced, sub-total was the main technique-but once there were better ways of also removing the cervix, sub-total fell into disuse.

I think the argument is pretty much the same for the laparoscopic approach. When you are unsure of technique, sub-total is quicker and probably safer in the short term, but it still leaves a potentially cancer-bearing structure behind. Claims there were symptomatic benefits from retaining the cervix were not confirmed in the 2012 Cochrane Review.

After your EVALUATE paper, you wrote a review of current practice in the BJOG- are you happy with how things are evolving with laparoscopic surgery?

Yes, almost everything is steadily improving, with skill, training, and equipment developing nicely. But remember, laparoscopy is just a mode of access into the abdominal cavity. Indications have to be correct and the approach correctly performed. We now know for sure that in most (but not all) cases, it is better to avoid an abdominal incision. However, the laparoscopic approach has no demonstrable advantages over the vaginal approach when the latter can safely be performed because it is cheaper and quicker.

As laparoscopic surgery is to abdominal surgery, I think vaginal surgery is to laparoscopic surgery, but only in selected cases. Harry used to think there was no indication for the abdominal route-but I disagree. I saw people spend hours and hours morcellating and removing large uteri- filling the abdomen only to finish in ITU because of the complications of, maybe unnecessarily, long surgery.

In short, it's important to choose which model of access for which patient. Ideally, every gynaecological surgeon should be equally competent in each of the three access modes.

Do you think the robot has a place in laparoscopic hysterectomy?

I have no practical experience of using the robot, and as far as I know (and I'm not up to date with this), I suspect there's no evidence that the robot improves any outcome except that it costs more to achieve the same ends. I certainly wouldn't like to do an EVALUATE mark 2 comparing robotic with laparoscopic methods.

What are the issues with training?

My concern is how much training time in O&G is spent with surgery compared with how much is spent learning obstetrics? It seems to me that the time demands of obstetric training are ever-increasing, leaving trainees less time to become competent in an ever-increasing range of technically demanding surgical skills. Has the time come to require trainees to choose between being primarily an obstetrician or gynaecologist?

Why did you go to Australia?

I went when I was 59. It was very late in my professional career. There was both some carrot and some stick involved. The carrot part was fairly easy. To take my increasingly creaky bones from the brisk weather of the north of England to the warmth and luxury of Perth was clearly appealing. Despite this, I would not have gone had my work in advanced endometriosis not been sacrificed by various managers to the God of reducing waiting times. It was, however, an opportunity to do some proper laboratory-based research.

How would you encourage trainees to get involved in research?

Most doctors are intelligent and curious and would welcome the opportunity to undertake meaningful research at a time in their careers when they are mature enough to know what questions really need answering.

The problem is how to make sufficient time and research monies available at the stage of their professional life when clinical, family and financial pressures are also at their greatest. It is, however, very satisfying to validate your ideas, and I would encourage anyone who can get involved to make the sacrifice if you can. Most importantly- try and find and follow the example of experienced leaders in the field you know and respect.

How do you think minimal access surgery will change in the next 10 to 20 years?

I think it's probably already - it is now accepted as a truly validated entry approach. The technique no longer has to be proven; it's self-evident in that it is less painful and results in more rapid recovery. So, everything else being equal, it's preferred to the abdominal approach.

In the future, every practitioner must become competent in the approach. When I was Chairman of the RCOG MAS Training Committee, I repeatedly wrote to the college suggesting that the laparoscopic management of ectopic pregnancy should become a core competency. It is extraordinary that, more than 20 years later, this evidence-validated procedure is still not a required skill for gynaecologists.

How do you think trainees can get better at minimal access surgery?

Time really. I also worked in Perth doing simulator work. It helps, but there's a world of difference between a controlled simulator environment where mistakes are not punished with bleeding etc. We need to think of ways to ensure every trainee gets access to high-quality training.

Do you have any tips or tricks for us?

Yes, my wife says I did well because I like to party - which I do! But I think meeting leaders over coffee, a drink or dinner allows you to find out about what really works. It's more important than attending any number of formal lectures or reading profound papers.

Do you have any final words for us?

In my last editorial for Gynaecology Endoscopy, we discussed how Lindsay Mcmillan (a gynaecologist at Whipps Cross Hospital) had done the first laparoscopic cholecystectomy in the UK. This was when the general surgeons had virtually no experience in operative laparoscopy. Within 15 years, some 80% of all cholecystectomies were being done laparoscopically, while only 7% of hysterectomies in the UK were done laparoscopically. So why are we, as a discipline, so slow in adopting better surgical techniques? Laparoscopic surgery, if done properly, is beneficial to our patients and great fun to do. There is lots of hassle and frustration along the way, but I think you all know you're doing something great.

Mez Aref-Adib
Interviewer

University of Western Australia, Perth

The Scope meets... Professor Fabio Ghezzi

Mez Aref-Adib spent an hour with Professor Ghezzi over Zoom to learn about his life and work.

Fabio Ghezzi is professor of Obstetrics and Gynaecology at the University of Insubria Varese, Italy. He is the Director of the Obstetrics and Gynaecology Department at the Women's and Children Hospital, Varese, Italy. He is the Director of the Obstetrics and Gynaecology Residency Program at the University of Insubria. Professor Ghezzi has performed more than 15000 gynaecological operations for both benign and malignant gynaecological diseases. He has authored more than 500 peer-reviewed scientific papers and chapters. He is a worldwide recognised leader in mini- and micro-laparoscopy in gynaecology and gynaecological oncology. He has participated at several scientific meetings in different countries as an invited speaker or surgeon during live surgeries. He is an Honorary Member of the BSGE.

Can you tell us about your journey in medicine?

When I began the residency programme in obstetrics and gynaecology, I was really interested in obstetrics. That's why I spent a couple of years in the USA working on preterm labour with Prof Roberto Romero. I went there to research ultrasound, and at the beginning, I was very disappointed because I was not allowed to see many patients in clinics. Prof Romero told me that I had to start learning biomedical statistics and focus on research. This was the most important advice in my career since it gave me the chance to understand how to design and conduct a study. I truly believe that this aspect is mandatory to become a good clinician.

Once back from America, I spent three months in Israel at Ben-Gurion University doing obstetrics. It was an extremely particular clinical experience; I worked in the middle of the desert, where they had 16,000 deliveries per year. I had the chance to do more research there, but I also practised in the delivery room and surgery. After that, I moved to Basel for one year to work on foetal cells in maternal blood. In Lugano, south Switzerland, I met the most brilliant surgeon that I have ever met in my life: Thomas Gyr. In 1997 he was performing laparoscopic radical hysterectomies with pelvic and para-aortic lymphadenectomy. I was so impressed by Dr Gyr that I started practising surgery under his supervision. This was when I realised that endoscopy was what I really wanted to do with my life.

An outstanding Finnish female doctor, Minna Kauko, came to do a laparoscopic hysterectomy for a quite big uterus using a single suprapubic 5-mm trocar, using an ultrasonic device. At that time, most surgeons were doing abdominal or vaginal hysterectomies. She demonstrated that it was possible to do a hysterectomy as an almost scarless procedure. The only problem was that this patient was bleeding everywhere, or, let's say, this was my impression! The surgeon kept saying, 'this is back bleeding, back bleeding, back bleeding'!! Finally, she concluded the operation and the patient was discharged home after only 24 hours. At this point, I realised that it is possible to perform very challenging and technically difficult operations with endoscopy, using few and very small instruments.

That was in 1997. In 25 years in our department, we have performed more than 5000 laparoscopic hysterectomies. My main idea is to be able to perform a hysterectomy (and in general any surgery) in a simple, reproducible way and at the lowest cost. This is when you have reached the future. When everyone can do this. I see today that the operating rooms are full of instruments, a hysterectomy lasts 2 hours, and they are spending a lot of money. If you come to my operating room, you will see we use reusable instruments; we only use 3 or 5 mm trocars, graspers, bipolar and scissors. Many doctors come to learn from us in the OR to see and learn how that it can be done.

When you operate and you are about to decide which approach to use, I would suggest you do the 'family test'. You should ask yourself if you would do this surgery to your mother, daughter, sister, grandmother. If you say yes, you pass the family test!

I also believe that there are many similarities between surgery and climbing.

I really like climbing. When you climb or when you trek, there are rules that you have to follow, which are very similar to those you have to follow during surgery.

1. You do not walk alone in the mountains.
2. You start very early in the morning.
3. The weakest among you determines the speed of walking.
4. Always walk along a marked trail.
5. Know exactly where you are going.
6. Avoid walking through dense fog.
7. Get good shoes.
8. Do not underestimate the power of the sun.
9. Leave everything as you found it.
10. Do not overexert yourself- walk back; there is no shame in that.

These rules apply exactly to surgery; these are the rules for safe surgery.

1. Do not work alone during surgery.
2. Start early in the morning.
3. The youngest doctor determines the speed of work.
4. Work always in spaces that you know.

5, 6 and 7.
Avoid working through dense fog - when you don't see anything get good instruments 8. Do not underestimate the power of your energy.

9. Leave everything as you found it.
10. If you feel that you will not succeed in your surgery, go back and open the patient.

Another thing you should always keep in mind is cosmesis, which is extremely important, especially in young women. When you see other kinds of minimally invasive surgery, such as robotic, at the end of the surgery, women have four or five 10mm incisions above the interiliac line or above the umbilicus. Of course, they can't be happy about that. There are no 10-mm trocars in my operating room, and we can accomplish more than 95% of the procedures laparoscopically. If we do this, it is possible for everyone.

You have to keep in mind that we often believe that the patients' pain and cosmesis are always more acceptable than ours. I don't think you need to be a so-called 'expert' to perform a hysterectomy. When I see expert surgeons say how difficult it is – I counter that doing a hysterectomy is simple; you just have to know how to do it in a simpler way. Young doctors need to understand that hysterectomy is a simple procedure.

When you see surgeons opening all these spaces, I wonder why? When you open a space, that space remains open. Do not open spaces when it is not necessary.

If a young doctor sees a complicated operation with plenty of instruments, they won't believe they can do it. In Europe, the rate of laparoscopic hysterectomy is incredibly low, and the highest rate is around 50% in Finland and Belgium. This means that most hysterectomies are done by open surgery, which is not acceptable. It won't be implementing robotic surgery that will solve this issue. It will be through the willingness to do clinical research, deep knowledge of anatomy and an attitude to make surgery simple, fast, and affordable. Costs are crucial for our health care system.

What do you think you enjoy most about your work?

Teaching young doctors is what I love most about my job at present. Many young doctors work in my department, and they're so enthusiastic about their work. This gives you the power to continue and understand that you are still useful to someone. In my hospital, we have three dedicated operating rooms working in parallel. Every day, I see our young doctors operating. Watching them operating exactly in the way I would like them to do is what makes me extremely happy.

What's your routine day?

I usually get up early in the morning, around 6 am. I don't live far from the hospital, which gives me the chance to be there at the very beginning of the working day. We usually start surgery at eight o'clock. You have to insert the first trocar at 8.00 am if you want to perform four hysterectomies or myomectomies per day. If you start at 10 am, maybe after a couple of coffees with your colleagues, you will only perform two hysterectomies.

We have three dedicated OR every day: one for benign uterine disease, one for oncology and endometriosis and the third one for urogynecology and other minor surgeries. This schedule gives us the chance of performing more than 2000 procedures per year, including 600 hysterectomies.

In what order do you do the steps for hysterectomy?

I only use 3 or 5 mm trocars, one umbilical and two or three suprapubic. I always use a 5-mm camera in the umbilicus. I use a RUMI manipulator as I think it is the best one in my hands. I start with the round ligament-coagulation and section. I then open the anterior part of the broad ligament and find the vaginal cup of the manipulator. Then coagulation of the IP or utero-ovarian ligament. We always remove the salpinx. We coagulate the uterine artery and the level of the vaginal cup. We never open the retroperitoneum for benign indications. With this manipulator, you are sure that the ureter is far from where you are working. Do not open unnecessary spaces. Then we cut above the uterosacral. Leave everything as you found it. We close the vagina vaginally.

That's it! It's half an hour surgery. The instruments are bipolar, scissors, one grasper, suction and irrigation and a monopolar hook, all reusable instruments. It makes me laugh that people use these devices (harmonic, radiofrequency, etc.) and then ask for a bipolar 'just in case' for bleeding.

How do you do vaginal cuff closure?

We did an RCT on cuff closure and found it was better to close it laparoscopically- there was a lower dehiscence rate. Then we continued to do it vaginally and wrote a paper for the European Journal of Obstetrics and Gynaecology and Reproductive Biology. The dehiscence rate was very low, much lower than reported in the RCT. The problem with the RCT study was that it included many centres.

The main reason we close the cuff laparoscopically is because it is simple. Everybody can do it. To close laparoscopically, you need to be a skilful surgeon to do intra or extracorporeal sutures. It is of fundamental importance to learn laparoscopic suturing, but the inability to do that is should not be a limitation of the laparoscopic approach nor a reason to open the abdomen for a hysterectomy.

What drives you to keep doing more and more?

It's the enthusiasm. We have very good feedback from patients- we have patients coming from all over the country. I work in a very small city- Varese, we are the department which has performed the largest number of hysterectomies in our country. This gives you energy.

What are the difficulties with a large uterus?

I never use a 30-degree scope; I think it is unnecessary. If you have a 30-degree scope- you introduce more difficulty. If your assistant is not good, then you won't see well. If you use a 5mm, zero degree scope, you can put it in any trocar and rotate it without changing your view. If you have adhesions or a big uterus, you can move your camera around it. You can change your position (to the other side of the patient when needed), and you can work under different angulation. If the uterus is big, you can cut it into pieces or morcellate in a bag through the vagina.

I never use a power morcellator. We remove all myomas through a colpotomy. We are publishing a study of 700 myomectomies followed by in-bag contained specimen retrieval through the posterior colpotomy. It is very simple- insert the bag through a colpotomy, pull the bag through the vagina to morcellate the myoma, and put two stitches in the posterior fornix, and that's it finished. It's very easy. It's different if you need to do a para-aortic lymphadenectomy; that's not easy. But if I can do it, anyone can.

What's the biggest uterus you have removed laparoscopically?

This is a funny story. I had five UK doctors visiting from the UK, and I asked one of my residents to prepare a list of patients to show them how to do it but to select the correct patients. So he decided to put a patient with a 3.3kg uterus and two previous open surgeries (including a midline)! These doctors told me I would never be able to do it, and then I did it. Obviously, it didn't take an hour. But I have the video-which is fantastic!

I bet that patient was very happy.

No- it's not true! Patients do not realise the big effort we make during surgery. When we visit them post-operatively, they tell us that they have pain in their shoulder when we are completely destroyed and cannot even move! She wanted to know when she could eat. But she was able to have the catheter removed quickly, eat, and go home the next day.

What do you think the role of the national hysterectomy database is?

There is a national database available- you can just go on the website. It is called PNE- Programma Nazionale Esiti- it means national programme of outcomes. This data set includes surgeries in different fields, and our field data on ovarian cancer, endometrial cancer, hysterectomy for benign indications and caesarean are collected.

The problem is that hysterectomies are not divided by surgical approach. In the European community, there is a statistical centre that collects data about health outcomes, and you can see the rate of laparoscopic hysterectomy in every country. In our unit- 99% of hysterectomies are performed by non-open surgery, but the mean in Europe is approximately 35-40%.

When do you do vaginal instead of laparoscopic surgery?

Most of our cases are laparoscopic. But the two main indications for vaginal are prolapse and severe obesity.

What is the place for robots?

In my opinion, currently, the role of robotic surgery for hysterectomy, myomectomy or ovarian cyst enucleation is very, very limited. Of course, robotics is less fatiguing than laparoscopy due to reduced ergonomic problems. In obese women, it could be helpful. The point is that morbidly obese women, in the US and probably in the UK, may represent 10% of the population, but I am lucky; in Italy, the rate is 0.2%.

Does mini laparoscopy have an advantage?

Obviously, there is the cosmesis. The patients are happy, but to be honest, there is no real difference. We have noted that to do a mini laparoscopy, you use one-third of the CO2. I don't know if this will create less inflammation, and I am thinking about how I can study this.

The pain level is low in laparoscopy. If you have a pain score of 3 on a scale of 10, to demonstrate it is 2 with mini-laparoscopy, you need a very large sample size in a clinical trial.

The non-reusable trocars are even bigger, and the scar is not as nice. I know this because, for myomectomy, I use one non-reusable trocar for the needle holder. The bipolar works well in mini laparoscopy, but the instruments are more flexible, so when you have to move the uterus around, it can be more difficult, but we have removed large uteruses using this technique.

What is the most important study you have done?

This is a difficult question because all the studies we have done add something important. Probably the way to remove myomas- published in BJOG is very important. Doing a colpotomy is so simple. People are concerned about tearing the colpotomy incision, but you have uterosacrals that avoid this. We have over 2000 cases where we removed the specimen transvaginally. The issues about dyspareunia are inconsistent. Why should a woman have dyspareunia where there are no nerves? The small incision we make, will that create a problem?

How do you encourage trainees to get involved in research?

I do not encourage them; I hope to give them an example. If they want, they do it; if they don't- they won't. If doctors do not realise that it is important to study and do research, it's a challenging task to change their minds.

How do you think minimal access will change in the next 10 to 20 years?

I don't think that it is going to change. Most likely, the doctors will change. I believe we have reached a point where the instruments are very high-performing, and it will be very difficult to reduce the invasiveness of this approach further.

What must change is the surgeon's approach. They have to understand that the fundamental tools are not those they have in their hands but those they have in their minds. They need to know anatomy, physiology, the natural history of disease. They must have the mental attitude to reduce invasiveness. They must realise that we're doing a job that is so important for society and that we have to make what we're doing available to every patient and to make it simple.

Robotics is not accessible worldwide due to high purchase costs and equipment maintenance, and net benefit to patients has not been demonstrated. Therefore, the implementation of robotics is not the strategy to reduce surgical trauma at a global level. It is the surgeons who must change the way of approaching this kind of surgery. It was Leonardo Da Vinci, not just anybody, who said, 'Simplicity is the ultimate sophistication.'

Mez Aref-Adib
Interviewer

University of Insubria Varese, Italy

LAVA Trial

Justin Clark reports on the LAVA trial investigating the results of laparoscopic and abdominal hysterectomies.

Professor Justin Clark
MD (Hons) FRCOG
BSGE President

LAparoscopic Versus open Abdominal hysterectomy

The LAVA trial is recruiting as we speak. We are comparing laparoscopic against open 'abdominal' hysterectomy.

I read with interest Ray Garry's reflections in his interview with the Scope on the original EVALUATE trial which compared lap hyst with both abdominal and vaginal hysts. I have always looked up to Ray as he was one of the only pioneers of endoscopic surgery who was prepared to conduct 'proper' research to demonstrate the value of this new surgical approach which we take for granted now. I hoped to emulate him.

As Ray points out in his interview, his trial was unable to demonstrate clear superiority of lap hyst over these other approaches and indeed lap hyst seemed to cause more urological injuries and be more costly. However he did demonstrate its potential. Since EVALUATE, surgical technologies have improved 10-fold as has training and familiarity with the technique. It is for these reasons that the LAVA trial is important so we can know for sure if contemporary lap hyst practice is as safe or even safer than open approaches and is more cost-effective. Furthermore, all previous trials summarised in Cochrane have not been able to clearly show recovery benefits. The LAVA trial is designed to minimise bias from surgeon expertise, and is assessing recovery in never before levels of detail and validity using mobile technology. In addition the LAVA trial is larger than all previous trials (summarised in Cochrane) altogether (n=3250!!).

In the BSGE we undoubtedly have the best lap surgeons in the land and we want everyone to become 'maestros' of the calibre of Prof Fabio Ghezzi who is also interviewed by the Scope. In reality, these superstars will never reflect the majority of us mere mortals but we can strive to improve overall operative proficiencies and in turn outcomes for all women. Evaluating surgery needs to be in 'the real world' and show what is really achievable.

I know some of you committed laparoscopists may feel that there is no need to evaluate lap and open hysterectomy as lap is clearly better. This may be true in your hands but the available data by no means show that it is; we need to know what the safety and recovery outcomes are for the average woman undergoing a hysterectomy for a benign reason in the UK in 2022 according to the operative route.

The beauty of the LAVA trial is that you can randomise where you and the patient have equipoise – for some of you this may be everyone, for others it may be where the uterus is enlarged to a certain size or where adhesions are expected. You decide where your equipoise is. I don't believe there is any hospital in the UK where zero open, abdominal hysterectomies are performed!

So please contact the Birmingham Clinical Trials Unit (LAVA@trials.bham.ac.uk) or me (t.j.clark@doctors.org.uk) or my research fellow Lina (lina.antoun1@nhs.net) to register your interest so we can get you on board. There will be CLRN support to fund your research nurses such that the extra work for you is minimal – essentially you spend 3 mins identifying the patients, introduce the concept of the trial (I've made an embarrassing short video to show how I do it in 3 mins!) and then get your CLRN funded research nurses to speak to the patients at the time or later over the phone. You or your colleagues simply then do what we like doing the best…..the surgery!! I know what a hassle recruiting to trials can be in a busy clinic, but believe me this is really easy – I promise only an extra 3 mins of your time.

We are recruiting well in Birmingham (currently 5/month) and to date have found that 50% of all women needing a hysterectomy who are considered suitable for the LAVA trial have agreed to take part. Interestingly those women with a preference do not always have a preference for 'key-hole' hysterectomy (approx. 70% lap vs 30% abdo).

Please help us understand better the benefits of lap hysterectomy and realise the potential Ray first showed and that Fabio has exemplified. Evidence is key to change and armed with high, quality valid data supporting laparoscopic surgery will allow the BSGE to embed evidence based practice within the NHS, promoting its wider use and allowing surgeons to excel by having appropriate, gynaecology only job plans and time in theatre.

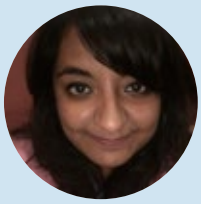
For further information please contact

LAVA trials office: LAVA@trials.bham.ac.uk

Justin Clark: t.j.clark@doctors.org.uk

LAVA Trial: http://www.isrctn.com/ISRCTN14566195

BSGE News



Krupa Madhvani

Personalising the risk of conversion from laparoscopic to open hysterectomy

Krupa Madhvani, consultant at University Hospitals, Dorset, reports on her paper in BJOG on personalising the risk of conversion from laparoscopic to open hysterectomy in benign conditions: development and external validation of risk prediction.

Using data from NHS Digital funded by the BSGE, we produced online novel calculators to personalise the risk of conversion from laparoscopic to open hysterectomy in benign disease. We have previously shown using this dataset that the proportion of laparoscopic hysterectomy is rising, and we know from other research that more surgeons are now performing laparoscopic hysterectomy. Certainly, in my practice, women ask for laparoscopic hysterectomy and whether their procedure can be performed laparoscopically or not informs their decision making about whether to proceed with surgical treatment.

There are many prediction models in obstetrics; however, benign gynaecology is one area in which this is lacking. We are also scrutinised as surgeons to provide thorough pre-operative discussions and informed consent. Our models can enhance this process. Several published papers describe factors associated with conversion, and arguably, the risk factors for conversion are known. However, our research is the first to synthesise these factors into a personalised risk for an individual patient. It is the largest study to date looking at conversion and uses data from 68,752 women undergoing laparoscopic hysterectomy in the NHS from 2011-2018 to develop and externally validate prediction models.

Our findings were an overall conversion rate of 6.0% in the dataset with a declining rate over time (7.5% in 2011 and 5.1% in 2011) in the context of a rising number of laparoscopic hysterectomies, and this is reassuring. The risk factor most predictive of conversion was adhesions which increased the odds of conversion by 2.5. Other risk factors included age, Asian ethnicity, obesity, fibroids, adenomyosis, endometriosis and adhesions.

The models are available online here

They are user-friendly calculators in which you can enter readily available clinical information and get a personalised risk of conversion.

The full paper can be found here

K Madhvani, BM Felix-Fernandez, J Zamora, T Carpenter, K Khan

Personalising the risk conversion from laparoscopic to open hysterectomy in benign conditions: development and external validation of risk prediction models

BJOG Accepted 6th October 2021

DOI: 10.1111/1471-0528.17043

BSGE News

Kirana Arambage
BSGE Honorary Secretary

BSGE International Affairs Subcommittee

The BSGE is proposing a new BSGE International Affairs Subcommittee to improve links and share knowledge and training with colleagues from across the globe. BSGE Honorary Secretary Kirana Arambage updates The Scope on the new development.

BSGE's International Affairs Subcommittee will promote and facilitate the international exchange of professional and educational values in gynaecological endoscopic surgery.

The International Affairs Subcommittee will act to promote BSGE's standing internationally and nurture international relations. Additionally it will help develop scholarships, observerships and organise joint international scientific meetings.

Benefits:

- Joint international courses and scientific meetings where BSGE faculty take part – Increase overseas members and funds (via membership fees - corporate members etc, course and meetings).
- Facilitate exchange programmes where our members can travel to centre of excellence vice versa.
- Learn from international community – eg: Laparoscopic fistula surgery and neuropelviology.
- Share our experience on Endometriosis Centre programme to improve global health.

Next steps:

1) Kirana Arambage will present it at the next AGM in Birmingham.
2) Learn from the experiences of other international gynaecological societies AAGL, AGES, ESGE.
3) Appoint liaison subcommittee members for regions following RCOG model.
4) Develop overseas liaison groups jointly with countries or regions.
5) Organise a joint international scientific meeting – this could potentially be with the Jordanian Gynaecological Endoscopic Society in 2023/24.

If you have any suggestions or are interested in getting involved in the BSGE International Affairs Subcommittee please contact Kirana at kiranasl@doctors.org.uk

BSGE News

National Clinical Impact Awards

The Clinical Excellence Awards are becoming the National Clinical Impact Awards to reflect the change in emphasis in their reforms.

The ACCEA called on BSGE members to help to recognise, retain and reward the highest performing consultant doctors, dentists and academic GPs working in the NHS.

The ACCEA are looking for assessors to join their sub-committee scoring panels to assess applications between June and July 2022 and are recruiting from across disciplines. The assessors play a critical role in making sure that scoring is fair and impartial for all applicants.

The ACCEA welcome assessors who are:

- **Professional members** (practising consultants), who can consider applications from a peer's point of view. This might include consultant doctors, dentists and academic GPs who are eligible to apply for an award.
- **Employer members** (Managers from Trusts and Arm's Length Bodies or other organisations such as ICOs employing eligible clinicians), who can consider applications from an employer's perspective and whether the applicant brings benefits back to their organisation and the wider NHS. Examples include HR Directors, Medical Directors and Chief Executives.
- **Lay / Non medical professional members** (objective individuals), who will be knowledgeable about the workings of the NHS and may have lay involvement in healthcare and experience of the patients' perspective. This could include people with healthcare system experience, other professions that are not medical or retired medical professionals. Lay / non medical professional members are remunerated for their time in meetings and in assessing awards

ACCEA's commitment to creating inclusive awards

The new NCIAs seek to encourage more applications from previously under-represented groups, such as female consultants and consultants from ethnic minority backgrounds. This is to ensure fair and un-biased scoring. Omarah Adam, ACCEA Secretariat said:

"We recognise the importance of having wider representation on our scoring panels, too – so we particularly welcome assessors from these under-represented groups."

She added:

"We hope you will volunteer to join our scoring panels. We appreciate that supporting us in this way will mean you giving your time and commitment, but we hope you'll want to be involved in recognising the outstanding contributions of your colleagues."

Click here For background information about the role, the training and support ACCEA offers and how becoming an ACCEA sub-committee member could bring benefits for you.

To join ACCEA

Click here to download application form

Or send a query FAO Omarah Adam at ACCEA@dhsc.gov.uk along with a short CV that summarises your experience.

The closing date for applications is 25th March, 2022.

ACCEA
ADVISORY COMMITTEE on CLINICAL EXCELLENCE AWARDS

BSGE Resection Workshop

The BSGE held a hysteroscopy resection workshop on 25-26 January 2022. Hysteroscopy Portfolio Chair Nadine di Donato reports on the course.

We are very pleased with the outcome of the hysteroscopy resection course, organised with the support of BSGE. The hysteroscopy workshop was focused on hands-on bipolar resection training with models, using equipment provided by Olympus. Feedback from delegates was very positive on the location and faculty members. One delegate said:

"It has been a great opportunity for hands-on and actual performing hysteroscopy procedures using bipolar resectoscope."

From a faculty point of view, the preparation of the material for resection was fun and a demonstration of team work.

From buying the right size of potatoes (large but not too large) to the creation of the 'uterine cavity' using apple cores and then painting and taping them to maintain the colour and the shape.

Each of the faculty had a role within a very structured production line and it was a really fun! We prepared more than 60 potatoes in less than a few hours.

Our work was extremely rewarded when we observed how those potatoes became the perfect uterus for resection. Delegates had a great opportunity to perform resection of the endometrium, resection of the septum, ablation of the uterine cavity and removal of intra uterine adhesions.

We need to thank all the faculty involved over the two days in Birmingham. Thanks also to Professor Justin Clark and his team for their presence and for the space provided for the event. Staff working in the Education Resource Centre in Birmingham Women's & Children's NHS Foundation Trust and the Olympus representatives were wonderful, professional and it was a pleasure working with them

This workshop happened thanks to Mary Connor, Consultant Gynaecologist Sheffield Teaching Hospital. Mary has an extreme dedication to training and educational opportunity, she has worked very hard to ensure the workshop ran smoothly and successfully. Mary dedicated this course to the participants of previous BSGE Diagnostic and Operative Hysteroscopy Workshops in May and June 2021 who did not have the resection station.

As faculty, I learnt more about different type of scopes from flexible, semi-flexible and rigid (Mr Kent was fantastic giving tips and tricks on flexible hysteroscope use!), different scope diameters and much more on camera stack and optimisation of the hysteroscopy view.

We had few dinners out and Birmingham was amazing! It is such a lively city perfect for a good balance between work and fun. I look forward to being there again for the ASM in April 2022.

One final mention - Atia was amazing and efficient as always with her extra mile speed in resolving problems.

Portfolio Reports

Information resources portfolio report

One of the main aims of the Information resources committee was to expand our patient facing events and we felt the best time to launch this would be March 2022 to coincide with Endometriosis Awareness Month.

We have created an Instagram account @thebsge that is for patients where we can share trusted resources and information. We encourage all members to follow this account and to also share the details of the Instagram account with their patients.

We ran a patient webinar hosted by myself and Martin Hirsch and Endometriosis UK last week. This was the first of many exciting events planned for Endometriosis Action Month including:

- Weekly Instagram live events for patients co-hosted by the BSGE Instagram account and other accounts involving patient support groups and specialists.
- Video shorts to be released weekly for patients covering a range of topics including thoracic endometriosis, the holistic approach to endometriosis, medical and surgical treatment options.
- Meet your local endometriosis centre Monday

And many many more!

This will not just be for endometriosis. We will share a variety of resources and will continue to grow the account and hope that it will become a useful source of information for patients.

The podcast BSGE Uncut continues. In the latest episode I shared highlights of our successful webinar on Endoscopic Treatment for Stress Incontinence with talks from Mr Dudley Robinson and Miss Rhona Kearney. Catch up on any episodes you missed on Spotify or on the BSGE website at www.bsge.org.uk/bsge-uncut-podcast/

The next podcast will be a discussion with Mr Joel Naftalin around improving the diagnosis of endometriosis and will be released 23rd March.

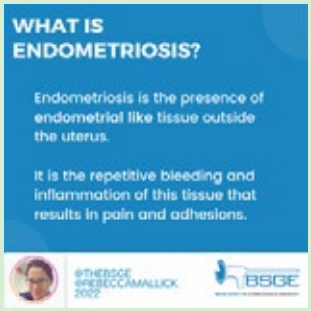
Rebecca Mallick MBChB MRCOG
Chair – Information Resources

Endometriosis Centre Update

It's been exciting times for the Endometriosis Centres portfolio.

Of course we have the annual accreditation and we are in the throes of publishing the list of successful centres following review of the case submissions as well as the videos. This is all looked at by a scientific advisory group and as ever we are impressed by the efforts and enthusiasm. This is happening nationally to provide the highest possible care for women with endometriosis. I am grateful to the Advisory Group for their input -and always, always, to Atia for her coordination, reminders, hard work and patience!

As part of Endometriosis Action Month we were able to engage in a patient facing webinar with colleagues from Endometriosis UK as well as senior Council members to discuss Endometriosis Centres amongst other things. Thank you to Martin and Rebecca for organising the event.



We are currently looking to revamp the database and include additional questions, as well as tease out the best parts of the previous questionnaires and make it as contemporary and fit for purpose. I am indebted to the help of our subcommittee members Dominic, Lucky, Neelam, Jon, Justin and Oli, who are helping with this process and helping with some of the IT parts of the service. We are working to make it more user friendly and once again trying to bring things up to the very modern day. We also continue to look at ways of improving follow up for women to assess their outcomes and help shape future practice.

Finally, we have been looking at some recent exciting work on thoracic and extrapelvic endometriosis. This is driven by a degree of lack of awareness, coupled with many requests from patients about the need for some form of national recognition and treatment of this. We are very much in the exploration phase of looking at what ideal services could look like, as well as linking it in with a wider ranging project looking at how endometriosis services are delivered nationally.

Many exciting things, much activity going on and lots of work still to do!

Arvind Vashisht
Endometriosis Centre Portfolio Chair

>>>

Portfolio Reports

Laparoscopic Training

Over 300 trainees across the UK have now completed a stream of the inaugural RIGS Hubs National Training Programme. Trainees attended three practical sessions at their locally facilitated 'Hub' with the course content being delivered by a central, virtual BSGE faculty.

Feedback has so far been outstanding; however, we are using this feedback to effectively improve the delivery of the course in 2022. We plan to open registrations for this in May following an introductory summary at the BSGE ASM RIGs session.

We will be running the three-day BSGE/RCOG Benign Abdominal Surgery course in May this year. Due to COVID, the course last ran virtually in 2020 and was suspended in 2021. The two days of virtual lectures will take place on the 11th and 12th May, and the one-day hands on practical workshop on the 17th and 18th May entitled 'Essential Skills for Laparoscopic Hysterectomy', and will be held at the RCOG.

The lap training subcommittee are very pleased to welcome on board Helene Hoyte who is a ST7 trainee at Stoke hospital in West Midlands. I am confident with her knowledge and enthusiasm she will be an asset to our team.

Donna Ghosh
Laparoscopy Training sub-committee Portfolio Chair

RIGS
Registrars In Gynaecological Surgery
Training and Support in Endoscopy

RIGS has been busy planning for ASM 2022 and completing the first RIGS Hubs programme.

Soon we will advertise the next round of applications, so keep an eye out for more information on the website and social media. We're looking forward to meeting up with you all at ASM 2022. RIGS will host our annual dinner on the night before the conference, April 20th at 19.30. The ever popular event will take place at the Malmaison, Birmingham. The RIGS dinner provides an ideal opportunity to mingle with minimal access gynaecology trainees from across the country. This year, Marc Possover will speak after dinner, so the evening promises to be interesting, educational and fun!

Tickets are limited so please book with your registration to avoid disappointment.
Dinner tickets are only available to delegates who register for the ASM.

In Birmingham also keep an eye out for RIGS sessions including:

- RIGS Intermediate Laparoscopic pre-congress course on April 20th
- The popular Pecha Kucha – this year on the theme 'Innovations in Training' on the morning of the second day of the conference.
- Trainee video sessions on the afternoon of day two.

Elections are under way for a new trainee representative, we wish the candidates all the best for the vote.

See you all in Birmingham.

RIGS recruiting for seven regional reps

RIGS has invited applications for six regional representatives. They will include reps to cover:

- Yorkshire
- Mersey and the North-West
- Wessex
- The North-East
- West of Scotland
- And two reps to cover Kent, Surrey and Sussex

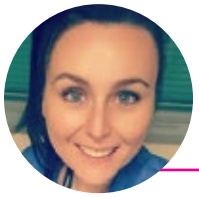
Trainee regional reps play an integral role within the BSGE and RIGS (Registrars in Gynaecological Surgery). They provide useful feedback and opinions, which can be incorporated into training. All regional reps feature on the website and actively participate in the evolution and development of RIGS, providing a support network to BSGE trainee members in the deaneries.

The RIGS regional rep is a key link between trainees and the BSGE; it is important in your role to be proactive and accessible to ensure trainees have the best experience. Reps will be required to provide quarterly written updates on training opportunities within their deanery and volunteer to help with BSGE trainee activities such as courses or webinars.

If a RIGS regional rep fails to engage with the responsibilities of their role, they will forfeit their position. A RIGS regional trainee rep can be of any level (ST1-ST7 or SAS doctor) but must be a fully paid member of the BSGE.

If you are interested in this role, please email BSGE at bsge@rcog.org.uk with a brief biography, a summary of why you wish to represent your deanery (max 250 words) and a photo of yourself.

The deadline for applications is 5pm on Monday 21st March 2022.




Angharad Jones and Mikey Adamczyk
BSGE Trainee Representatives

Nurses and Paramedics

Endometriosis CNS Portfolio Report

Gilly Macdonald
Endometriosis CNS
Portfolio Chair

Welcome to the Spring update of the Endometriosis CNS portfolio.

The BSGE Endometriosis Nurse Subcommittee of Claudia, Liz and Jenny join me in continuing our focus on creating a professional and supportive environment for all our nurse colleagues. The informal bitesize sessions continue and are providing much needed support and conversation and our mentor programme is now well embedded.

We are very much looking forward to the 2022 BSGE ASM and the pre-congress endometriosis CNS Education Day. Once again, we are very fortunate that high quality speakers are supporting both events.

The programme for the CNS Education Day will include sessions on fertility, medical management of endometriosis, challenges of setting up a new nurse led clinic, the menstrual cycle, nutrition, and endometriosis and the bowel. This is a long-awaited live face to face event! We hope to facilitate some lively discussion by having planned workshops in the afternoon to share and discuss complex case studies.

We have all missed the benefit of networking at big events such as this, we look forward to seeing you all!

Nurse Hysteroscopists Portfolio Report

Caroline Bell
Nurse Hysteroscopists
Portfolio Chair

I would like to thank my wonderful sub-committee and fellow hysteroscopists for your continued support.

We have made progress on the operative logbook- it is now awaiting approval at the next Council meeting in April 2022.

We have continued to look at ways to provide updates and support. We held our first bite size session on 15th March at 7pm. We had an open discussion on a range of subjects brought to the table by fellow hysteroscopists. More than 30 people registered to take part in the successful session and we look forward to continuing these bitesize events quarterly.

We are now focused on the ASM and pre Congress Hysteroscopy workshop.

BSGE Survey Section

Laparoscopic skills Acquisition in obstetrics/ Gynaecology and General Surgical trainees (LAGGS)

Zaibun Khan updates The Scope on her study into laparoscopic training:

I am an ST4 in O+G and the Chief Investigator of the LAGGS study.

LAGGS study is divided into two parts; one evaluates the laparoscopic proficiency of trainees through simulated laparoscopic tasks and the other part involves surveys to both consultants and trainees from gynaecology and general surgery.

The paucity of laparoscopic training in O&G has been an ongoing source of concern. There is an overwhelming focus on achieving labour ward competencies throughout the training and trainees are expected to focus on gynaecology operating in the final two years of the training program. Is that period long enough to equip trainees with fundamental laparoscopic skills and prepare them for a job as a consultant laparoscopic surgeon?

We are, therefore, interested in exploring consultants' perception of what they regard as important laparoscopic skills at CCT and comparing it with trainees' perceptions. This information will provide insight into training standards, which are currently largely unknown.

We would therefore be extremely grateful if you would spare three minutes of your time to participate in our survey and support this important educational project.

If you are a consultant please follow this link to complete the survey.

Access the consultant survey here

If you are a trainee, please follow this link to complete the survey.

Access the trainee survey here

The study authors are: Zaibun Khan, Donna Shrestha, Abdulwarith Shugaba, Dr Chris Gaffney, Prof Justin Clark, Dr Karolina Afors, Dr Elizabeth Haslett and Mr Daren Subar.

If you would like more information on the LAGGS study please visit out website: **www.surgicalbridges.co.uk/laggs** or contact: **zaibunkhan@gmail.com**

BSGE Survey Section

Research into Telemedicine

Liza Ball tells The Scope about her survey into telemedicine:

The pandemic has changed the way we consult. NHS-E is encouraging the use of telemedicine, both phone and video, going forward. However, currently there is little evidence about the pros and cons of each modality.

A group of London-based researchers from BartsHealth and UCL are obtaining funding to record and compare face to face, phone and video appointments in gynaecology.

We are currently trying to identify units where significant numbers of video appointments are carried out as a part of gynaecology outpatient clinic provision.

If this applies to you and you are interested in participating as an investigator or you know of such a unit please contact eball69@gmail.com

Upcoming Events

Nadine di Donato suggests some dates for your diary

BSGE The British Society for Gynaecological Endoscopy 2022
21-22 April 2022
Birmingham-Worcester
Click here for more info >>

BSGE/Olympus Module 1– Essentials of Anatomy Seminar
26 April 2022
Via video conference
Click here for more info >>

BSGE/Olympus Module 2- Relative Risks & Patient...
3 May 2022
Via video conference
Click here for more info >>

BSGE/RCOG Benign Abdominal Surgery course Theory course: 'The challenges of benign gynaecological surgery'
11-12 May 2022
RCOG
Click here for more info >>

BSGE/RCOG Benign Abdominal Surgery course Hands-on practical workshop: 'Essential skills in Laparoscopic Hysterectomy'
17-18 May 2022
RCOG
Click here for more info >>

The 38th Annual Meeting of ESHRE 2022
3-06 July 2022
Milan Italy
Click here for more info >>

RCOG World Congress 2022
13-15 June 2022
London
Click here for more info >>

ESGE - European Society for Gynaecological Endoscopy
2-5 October 2022
Lisbon, Portugal
Click here for more info >>

ISGE 2022 (The International Society for Gynaecologic Endoscopy)
18-21 May 2022
Agadir
Click here for more info >>

Update in obstetrics, gynaecology, and reproductive medicine (45th DEXEUS forum) 2022
Dates to be confirmed
Barcelona, Spain
Click here for more info >>

AAGL Annual Global Congress 2022
1-4 December 2022
Aurora, Colorado
Click here for more info >>

BSGE Diagnostic and Operative Hysteroscopy WORKSHOPS

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

9 & 10th June 2022

Click here to register

STORZ
KARL STORZ—ENDOSKOPE

Venue

Training & Technology Centre,
KARL STORZ Endoscopy (UK) Ltd
415 Perth Avenue, Slough,
Berkshire, SL1 4TQ

Cost

Member: £220 / Non Member: £325

Objectives

The aim of the workshop is to enable delegates to develop their hysteroscopy skills, both diagnostic and operative and to become familiar with operative hysteroscopic equipment.

Overview

The workshop will be in two parts including rotation around a series of five stations each of 40 minutes' duration using models and computer-simulated procedures. The topics to be covered are endometrial polypectomy using mechanical instruments with fine scissors, graspers and hysteroscopic tissue shavers; local anaesthetic simulation for cervical and fundal blocks; global endometrial ablation using non-hysteroscopic devices.

The other part of the workshop will consist of training in diagnostic hysteroscopy for the development of camera and hand-eye co-ordination skills; a session for case-based discussion following a video-quiz of various case studies and finally hands-on training for endometrial/fibroid resection skills.

There will be 2 groups with staggered start times: 0800 and 0830 am to allow for logistic arrangements, so please arrive on time to avoid delay.

Who Should Attend?

Trainees in Obstetrics and Gynaecology who are registered or who plan to register for either the ATSM in Benign Gynaecological Surgery: Hysteroscopy or Benign Abdominal Surgery: open and laparoscopic. This workshop is suitable for those people who attended just the theoretical component but not a workshop in November 2021. Theoretical course will be offered again in November 2022.

Consultants, Staff Grade, Staff Doctors, Trust Doctors or Associate Specialists, wishing to enhance their hysteroscopy skills

Nurse Hysteroscopists who are developing their operative hysteroscopy skills

GPs with a special interest in gynaecology who wish to develop their hysteroscopy skills.

- Delegates may claim a maximum of 7 CPD credits for attendance

Course Organisers:

Miss Mary Connor FRCOG, Sheffield
Mr Stephen Burrell MRCOG, Luton
Ms Amelia Davison, MRCOG, London
Miss Shilpa Kolhe, FRCOG, Derby
Miss Nadine di Donato, MRCOG, Portsmouth

BSGE UNCUT

THE OFFICIAL PODCAST

The official podcast of the British Society for Gynaecological Endoscopy (BSGE) hosted by Martin Hirsch and Rebecca Mallick.

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Tune in to hear talks with the biggest names in the field of gynaecology. The hosts explore their guest's lives, careers, and what keeps them motivated to push the speciality forward.

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BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Contact Information

Correspondence address:

BSGE, 10-18 Union Street, London, SE1 1SZ

Tel: 0207 7726474 Email: bsge@rcog.org.uk

The BSGE

www.bsge.org.uk