Debate 2 -
Vaginal Surgery/vNotes vs. Laparoscopic Hysterectomy for the 1 Kilo Club– What’s Your Way?
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

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

The AAGL designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure of Relevant Financial Relationships
As a provider accredited by the Accreditation Council for Continuing Medical Education, AAGL must ensure balance, independence, and objectivity in all CME activities to promote improvements in health care and not proprietary interests of a commercial interest. The provider controls all decisions related to identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the activity. Course chairs, planning committee members, presenters, authors, moderators, panel members, and others in a position to control the content of this activity are required to disclose relevant financial relationships with commercial interests related to the subject matter of this educational activity. Learners are able to assess the potential for commercial bias in information when complete disclosure, resolution of conflicts of interest, and acknowledgment of commercial support are provided prior to the activity. Informed learners are the final safeguards in assuring that a CME activity is independent from commercial support. We believe this mechanism contributes to the transparency and accountability of CME.
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Debate 2-Vaginal Surgery/vNotes vs. Laparoscopic Hysterectomy for the 1 Kilo Club—What’s Your Way?

Chairs: Harry Reich and Anastasia Ussia

Faculty: Xiaoming Guan, Resad P. Pasic

This debate will discuss and compare vaginal hysterectomy/V notes and laparoscopic hysterectomy for the especially large uterus. Vaginal hysterectomy with reusable instruments will also be considered.

The reason for the 1 kg club will be explained.

Learning Objectives: At the conclusion of this course, the participants will be able to: 1) Demonstrate advantages and disadvantage including complications of each procedure; 2) demonstrate control of the uterine artery; and 3) discuss costs of these procedures.
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
Linda J. Bell, Admin Support, AAGL*
Linda D. Bradley, MD, Medical Director, AAGL*
Erin T. Carey, MD, MSCR
Honorarium: Teleflex Medical, MedIQ
Mark W. Dassel, MD
Contracted Research: Myovant Sciences
Linda Michels, Executive Director, AAGL*
Vadim Morozov, MD
Speaker: AbbVie
Consultant: Medtronic, Lumenis
Erinn M. Myers, MD
Speakers Bureau: Laborie Medical Technologies, Teleflex Medical
Other: Unrestricted educational grant to support NC FPMRS Fellow Cadaver Lab: Boston Scientific Corp. Inc.
Amy Park, MD
Speaker: Allergan
Nancy Williams, COO, CME Consultants*
Harold Y. Wu, MD*
Harry Reich, MD, FRCOG*
Anastasia Ussia, MD*

AUDREY T. TSUNODA
Speaker Bureau: Medtronic, CooperSurgical, Merck & Co., AstraZeneca, Roche
Linda Michels, Executive Director, AAGL*

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Xiaoming Guan, MD, PhD*
Resad P. Pasic, MD, PhD
Speakers Bureau: Olympus, Medtronic, CooperSurgical

Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.

SCIENTIFIC PROGRAM COMMITTEE
Linda D. Bradley, MD, Medical Director, AAGL*
Francisco Carmona Herrera, MD, PhD
Contracted Research: ADAMED
Speakers Bureau: ADAMED, Gedeon Richter Pharmaceuticals
Consultant: Medtronic
Marcello Ceccaroni, MD, PhD*
Sarah L. Cohen Rassier, MD, MPH*
Julian A. Gingold, MD, PhD*
Charles E. Miller, MD
Consultant: AbbVie, Boston Scientific, Espiner Medical Inc
Contracted Research: Allergan Pharmaceutical, Blue Seas Medical Spa – Investor, Eximis Surgical, Inc.
Speakers Bureau: Allergan Pharmaceutical
Jim Tsaltas, MBBS, FRANZCOG
Education Partner and Fellowship Funding: Covidien
Speakers Bureau: Covidien
Transvaginal NOTES Hysterectomy: the 1 Kilo club—what is your way

Xiaoming Guan, M.D, Ph.D,
Professor
Baylor College of Medicine, Houston, Texas

Objectives
• Ascertain the concept of vNOTES surgery
• Identify the key steps of vNOTES hysterectomy
• Determine when to converted to another route for patient safety
• Review the videos of laparoscopic and robotic vNOTES hysterectomy for large uterus, endometriosis, sacrocolpopexy

Nature Orifice Trans-vaginal Endoscopic Surgery
The next generation of “least invasive surgery”

Types of vNOTES Hysterectomy
• Laparoscopic Transvaginal NOTES hysterectomy
  First report total hysterectomy: 2012 Dr. Su
  First report Supracervical hysterectomy: 2018 Dr. Su

• Robotic Transvaginal NOTES hysterectomy
  First report total hysterectomy: 2015 Dr. Lee

Six Steps of Transvaginal NOTES hysterectomy
1. Transvaginal Hysterectomy
   Circumcision of cervix
   Anterior colpotomy
   Transect as much as you can

2. Transvaginal NOTES port placement
   Successful anterior and posterior colpotomy
   Only anterior colpotomy

3. Transvaginal laparoscopic or robotic hysterectomy

4. Specimen removal
   In-bag tissue extraction

5. High uterosacral ligament suspension

6. Vaginal cuff closure
**Posterior Colpotomy**

- Most vNOTES hysterectomy can be performed if posterior colpotomy done
- Anterior colpotomy can be delay if have long cervix
- Anterior adhesion can be done after port placement

**vNOTES port placement**

- Can be very challenging
- Two babcock clamps
- Airseal trocar
- Easy when complete anterior and posterior colpotomy

**Instruments for laparoscopic vNOTES hysterectomy**

- 30 degree 5 mm or 10 mm scope
- TVH instrumentation
- Laparoscopic Grasper
- Ligasure or Harmonic energy devices
- Airseal
- Single site port-Gelpoint Mini

**Robotic vNOTES hysterectomy**

- Regular multiple port instruments
Advantages of vNOTES hysterectomy

- Large uterus: secure uterine artery first and reduce blood lost
- No abdominal incision and pain
- Previous multiple surgeries with extensive pelvic adhesion

Compared to transabdominal laparoscopic or robotic hysterectomy
- See better: salpingectomy
- Additional surgery: sacrocolpopexy, endometriosis
- Large uterus
- In-bag morcellation

Compared to TVH

See better: salpingectomy
- Additional surgery: sacrocolpopexy, endometriosis
- Large uterus
- In-bag morcellation

Specimen removal

- For large uteri or specimens with need for morcellation, a 15mm Endo Catch™ bag
- Contained bag morcellation with "big C" technique.

vNOTES Hysterectomy - most common

- A total of 33 cases of patients, with pathology confirmed endometriosis, who underwent vNOTES total hysterectomy with resection of endometriosis
- 29 cases were completed successfully by RvNOTES, and one case was converted to robotic para-umbilical single incision laparoscopic surgery (RALS) plus one additional port due an obliterated posterior cul-de-sac and upper abdominal wall endometriosis.
- The average operative time was 141.93±40.22 (85-264) minutes, and the mean estimated blood loss was 52.25±33.82 (25-150) milliliters.
- The mean preoperative pain score using the visual analogue score (VAS) was 6.73±2.62 (0-10), which was significantly lower when compared to scores preoperatively (P=0.059). The mean VAS pain score in the second and third week after surgery was 6.63±2.63 and 6.57±2.58 respectively, which were both significantly lower than those before surgery (P<0.001).
- There were four postoperative complications: urinary tract infection, pneumonia, headache requiring admission, and conversion disorder.
When to convert and when to try vNOTE hysterectomy?

Encouragement
• Large uterus
• Anterior adhesion
• Previous surgery
• Broad ligament fibroid

Conversion
• Stage IV endometriosis with obliterated cul del sac
• Difficulty to enter posterior and anterior cul dec sac?

vNOTES Hysterectomy converted to SILS

References

LAPAROSCOPIC HYSTERECTOMY VS VAGINAL SURGERY/V-NOTES FOR THE 1 KILO CLUB

Rosal Pala, MD, PhD
DEPARTMENT OF OB/GYN
UNIVERSITY OF LOUISVILLE
LOUISVILLE, KY

V-NOTES

INTERESTING GIMMICK WITH LIMITED POTENTIAL
INDUSTRY DRIVEN APPROACH
LIMITED ADVANTAGE COMPARED TO CONVENTIONAL LAPAROSCOPY
COMPATABLE COST COMPARED TO LAPAROSCOPY

DISCLOSURES

SPEAKER
COOPER SURGICAL
MEDTRONIC
OLYMPUS

V-NOTES

INCREASING NUMBER OF STUDIES
REQUIRES GOOD VAGINAL SURGICAL SKILLS
STILL REQUIRES GOOD LAPAROSCOPIC SKILLS
GREAT NUMBER OF SURGICAL CONDITIONS THAT IS UNABLE TO DEAL WITH!

NOT FOR ME!
I ONLY DO THINGS WITH PROVEN TRACK RECORD

COST

GEL PORT = $565
TROCAR S 24 x 4 = $99

V-NOTES
FOR LAPAROSCOPY
No Patient is too Big!

Choose the right Insufflation technique

UTERUS ADHESIONS

BLADDER ADHESIONS

RECTOVAGINAL NODULE
CULTURAL AND LINGUISTIC COMPETENCY

Assembly Bill 1195 was signed into law on July 1, 2006 requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP). It is the intent of the Legislature to encourage physicians and surgeons, continuing medical education providers located in California, and the Accreditation Council for Continuing Medical Education to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development.

Linguistic Competence: Providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Cultural Competence: A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.1 Cultural and Linguistic Competence: The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Cultural competence requires organizations and their personnel to:
• Value diversity.
• Assess themselves.
• Manage the dynamics of difference.
• Acquire and institutionalize cultural knowledge.
• Adapt to diversity and the cultural contexts of individuals and communities served.

California Business & Professions Code §2190.1(c)(3) states that associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the cultural competency requirements. The associations may update these standards, as needed, in conjunction with an advisory group that has expertise in cultural and linguistic competency issues. Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following: (A) Applying linguistic skills to communicate effectively with the target population. (B) Utilizing cultural information to establish therapeutic relationships. (C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment. (D) Understanding and applying cultural and ethnic data to the process of clinical care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 [http://www.usdoj.gov/crt/cor/pubs.htm].

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 [http://www.usdoj.gov/crt/cor/13166.htm] was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (Assembly Bill 305) requires that state agencies that serve a substantial number of non-English-speaking people employ a sufficient amount of bilingual persons in order to provide certain information and render certain services in a language other than English.