GLOBAL CONGRESS ON MIGS

AGL 2021

SYLLABUS

Surgical Tutorial 6 -
The Treatment of Apical Prolapse
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.

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# Table of Contents

Session Program (Description and Learning Objectives) ................................................................. 1  
Disclosure ........................................................................................................................................... 2

Tips n’ tricks for Performing Uterosacral Ligament Suspension  
O. Cardenas-Trowers ............................................................................................................................... 3

Sacrocolpopexy: Techniques and Complications  
L.G. Brito .................................................................................................................................................. 5

Vaginal Apex Prolapse Surgery: When to Mesh and Not to Mesh, Optimizing Your Tools, and Thinking Out of the Box  
M.F.R. Paraiso .......................................................................................................................................... 9

Cultural and Linguistic Competency ..................................................................................................... 16
Surgical Tutorial 6-The Treatment of Apical Prolapse

Chair: Marie Fidela R. Paraiso

Faculty: Luiz Oliviera Brito, Olivia Cardenas-Trowers

Learn from the Urogynecology experts so you can manage pelvic organ prolapse by all routes and with all tools. In this tutorial, we will present surgical techniques and review of anatomy for various procedures to treat pelvic organ prolapse. Laparoscopic procedures for apical prolapse with or without robotic assistance and vaginal route procedures will be demonstrated and discussed. Pertinent clinical outcomes will be briefly summarized. Your key takeaways from this tutorial will include when to use native tissue or mesh for apical prolapse repair and when the robotic platform is most useful.

Learning Objectives: At the conclusion of this activity, the participant will be able to: 1) Demonstrate tips and trick to minimally invasive abdominal and vaginal approaches to treatment of vaginal apex prolapse; 2) discuss various techniques utilizing native tissue or mesh-based repairs; and 3) summarize strategies to avoid and manage complications in surgical treatment of vaginal apex prolapse.

COURSE OUTLINE

3:15 pm  Welcome, Introduction and Course Overview

3:20 pm  Tips n’ tricks for Performing Uterosacral Ligament Suspension  O. Cardenas-Trowers

3:35 pm  Sacrocolpopexy: Techniques and Complications  L.G. Brito

3:50 pm  Vaginal Apex Prolapse Surgery: When to Mesh and Not to Mesh, Optimizing Your Tools, and Thinking Out of the Box  M.F.R. Paraiso

4:05 pm  Questions & Answers

4:15 pm  Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).

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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).

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Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.

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TIPS N’ TRICKS FOR PERFORMING UTEROSACRAL LIGAMENT SUSPENSION

Olivia O. Cardenas-Trowers, M.D., F.A.C.O.G.

GENERAL REMINDERS

- Address the apex!
- USLS & SSLF are equivalent
- Surgeon factors
- Patient/clinical factors

Disclosures

I have no financial relationships to disclose.

KNOW ANATOMY TO AVOID COMPLICATIONS!
CONSIDERATIONS

TIPS N' TRICKS

• Cystoscopy prior to USLS
• 3 sets of different clamps
• Protect bowel and rectum
  - Systematic bowel packing
  - Protect rectum with right angle retractor
• Tent USLs with Allis clamp

CONSIDERATIONS

TIPS N' TRICKS

• Suture needle considerations
• Systematically clamp sutures to drapes
• Close vaginal cuff prior to tying down USLs
• Perform cystoscopy after tying down each set of sutures
• Postop: consider BNO suppository if standard pain meds not helpful

TIPS N' TRICKS FOR PERFORMING UTEROSACRAL LIGAMENT SUSPENSION

Olivia O. Cardenas-Trowers, M.D., F.A.C.O.G.

AAGL 2021
November 17, 2021, Austin, TX
SACROCOLPOPEXY: TECHNIQUES AND COMPLICATIONS
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Disclosure
- Research Grant: Boston Scientific
- Speakers Bureau: Promedon, Astellas, Astra-Zeneca

Objectives
- To describe the technique of sacrocolpopexy and tips/tricks to better perform it
- To describe the most frequent complications for sacrocolpopexy and suggestions for preventing them

Sacrocolpopexy – apical prolapse
- Best option for anatomic cure
- Recommended – ACOG and several societies
- 62 studies, 50 for MA
- Less recurrence than vaginal SSF
- Lap SCP less recurrence than open SCP (OR=0.59[0.47-0.75])

Sacrocolpopexy is performed differently among urogyns...
- Operator dependent or with non-standardized techniques?
- Screened 771 studies, 22 included
- Only RCTs comparing different approaches for sacrocolpopexy or comparing SCP versus other POP surgeries

And among surgeons as well...
- 206 patients, prospective study
- Two surgical techniques
- No difference between groups regarding postop recurrence, mesh erosion and reop rate
But there is a suggestion for a standardized technique!

Step 1 – Inspect the presacral space, and if the promontory is easily exposed, continue with your plan!

- Risk in up to 10% of vascular malformations
- Plan B if sacrocolpopexy not feasible (USLS, SSF, pectopexy)

Step 1 – If plan A feasible, retract the sigmoid if necessary – left lateral and good Trendelemburg positions are needed

- High Trend angles (in the lap group) did not worsen intra-op ventilatory patterns among vaginal, lap or robot apical POP repairs

Step 2 – You have two options! Both will finish in the same destination

Step 3 – Opening of the retroperitoneum

- Identify the hypogastric plexus
- Identify the left and right anatomical landmarks
- Can tunnelize or not this space
- The champagne effect helps to reduce bleeding
Step 4 – Anterior and posterior vaginal dissection
- Use a good manipulator for the cervix/vaginal vault
- Identify the anterior and posterior limits of your dissection
- Not always you will have to dissect posteriorly till the levator ani plate (or anteriorly to the trigone) – individualize the case!
- See combined defects – large anterior or posterior and consider other procedures

Step 5 – Suturing the mesh
- Y meshes can be prepared prior to trocar insertion to facilitate anterior/posterior suturing
- Three sutures for each compartment – posterior suturing is preferred to do first as it is usually more difficult to execute
- Non-absorbable or delayed absorbable suture
- Trimming the mesh can be performed
- One or two sutures in the promontory

Step 6 – Closing the retroperitoneum (or not? – no robust data yet)
- Retrospective data not showing increase of complications for non-closure group
- Mesh scrutiny issues
- RCT - Barbed sutures – reduce OR time in 11-16 min, but similar anatomic outcomes

Learning curve for this surgery varies…
- 10-90 procedures; OR time (90-250 min); 3-16% complications

Complications
- Mesh erosion
- Infection – spondylodiscitis
- Vascular and neural injury
- Ureteral, bladder and intestinal injuries
Mesh erosion

- Abdominal apical repairs with mesh seem to have lower erosion rates than synthetic transvaginally placed mesh
- Rate 0.5-5% (3.4%)
- Explain to the patient that FDA recommendation does not apply to this procedure

Spondylodiscitis

- Fever, lumbar pain, secretion or vaginal discharge (more frequent with SCP correcting VV prolapse)
- Pelvic MRI = imaging diagnosis
- IV antibiotic treatment for 2-4 weeks
- If no improvement, discuss mesh removal

Be aware of the ALL thickness and the distance from 1st sacral nerve!

- 18 cadavers (8 unembalmed and 10 embalmed)
- Awareness of the 1st sacral nerve position – 2.5 below the midpoint of the sacral promontory, 2 cm to the right of midline
- Avoid somatic nerve injury
- ALL = 2 mm thickness
- Reduce risk of discitis

How to reduce conversion rates?

- HCUP-NIS – 2005/2014
- 2777 robot and 518 lap SCPs
- Robotic with less conversion (1.33%) vs 7.14% from lap
- Concomitant hyst more associated to robot (41.7% vs 13.9%) and not associated to conversion
- Obesity (OR=3.27[1.72-6.19]) and adhesiolysis (OR=3.32[1.89-5.85]) as risk factors to conversion, as well as to organ damage (14.9% vs 3.8%)

How to reduce complications?

- SCP presents a long learning curve
- You should have your own standardization technique
- Inspect the pre-sacral space prior to anything
- There are specific and non-specific complications to this surgery
- Identify preop risk factors for mesh erosion: tobacco users, CPP, fibromyalgia/depression patients, vaginal vault users

References

- Davis, McCauley et al. PERMIS 2020;26:175-178
- Chitale et al. J Clin Epidemiol 2020;120:1030-1039
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- Brandon et al. J Clin Epidemiol 2020;120:1030-1039
- Brandon et al. J Clin Epidemiol 2020;120:1030-1039
- White et al. Obstet Gynecol 2009;113:1098-103
Vaginal Apex Prolapse Surgery:
When to Mesh and Not Mesh, Optimizing Your Tools, & Thinking Out of the Box

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Disclosures
• Unrestricted research grants from the NIH for the Pelvic Floor Disorders Network, the Foundation for Female Health Awareness, Caldera, and Coloplast
• Uptodate royalties
• I perform surgery for pelvic organ prolapse by vaginal route, conventional and robotic-assisted laparoscopy, and sometimes use VNOTES
• I do not include pectinopexy in this lecture

Objectives
• Discuss indications and comparative data for native tissue and mesh augmented repairs
• Demonstrate surgical techniques and review of anatomy for various procedures to treat pelvic organ prolapse other than uterosacral vaginal vault colpopexy and sacrocolpopexy
• Briefly discuss options for recurrent apical prolapse after ASC and combined pelvic organ prolapse

Indications for Vaginal Route Native Tissue Surgery
• Isolated anterior or posterior vaginal wall prolapse
• Innervated pelvic floor
• Primary procedure in patient with uterus intact that requires hysterectomy or desires uterine preservation
• Older patient with multiple co morbidities who cannot tolerate longer operative times
• Obliterative procedures
• Mesh contraindicated: opposed to mesh, smoker, poorly estrogenized and contraindication to vaginal estrogen, steroid use, previous complications with synthetic mesh

Indications for Sacrocolpopexy
Vaginal apex prolapse in a patient that has
• Failed previous vaginal route surgery
• Foreshortened vagina
• Decreased pelvic floor innervation
• Condition(s) that chronically increases intra-abdominal procedure
• Heavy manual labor occupation or life situation
• Desire for uterine preservation with severe apical prolapse
• Greater risk for anatomic failure, collagen vascular disorder
• No history of multiple abdominal procedures for inflammatory bowel disease or carcinomatosis
• Ability to tolerate general anesthesia

Indications for Vaginal Route POP Synthetic Mesh Procedure
• Predominantly anterior and apical prolapse
• Vaginal mesh procedure for recurrent anterior vaginal wall prolapse with apical component
• Failed suture repair for anterior segment
• Failed anterior segment after sacral colpopexy
• Older, non-sexually active patient
• Contraindication to abdominal route surgery (inflammatory bowel disease, hx multiple abdominal surgeries)
• Willingness to accept transvaginal mesh repair
  • Adequate informed consent
  • General anesthesia is contraindicated
Vaginal Approach for Vaginal Apex Prolapse Data

Vaginal surgery is a safe, cost-effective, and efficacious for treatment of vaginal prolapse. Shorter operating time, most minimally invasive approach.

When anatomic durability is a priority, mesh ASC preferred; When minimizing adverse events or reoperation, no strong evidence supporting ASC vs vaginal repair (Siddiqui et al, 2015).

Comparable outcomes among tranvaginal mesh (TVM) surgery, native tissue repair (NTR) and laparoscopic sacrocolpopexy (LSC) (Anand et al, 2017; Kanasaki et al, 2020).

Overall perioperative safety is comparable among SSLF, USLS and minimally invasive ASC (Yadav et al, 2021).
Sacrospinous Ligament Fixation Pearls

- Avoid suture bridges with absorbable suture
- Use nonabsorbable suture in the presence of a short vagina
- Tissue must oppose tissue
- Use polyglycolic acid suture so that you do not saw through ligament
- Bury nonabsorbable suture beneath vagina
- Use of pudendal block may decrease use of NSAIDS but makes no difference with rate of buttock pain (15-40%)

Survival Analysis of Significant Vaginal Support Defects

Figure from: Paraiso MFR, Ballard LA, Walters MD et al. Pelvic support defects and visceral and sexual function in women treated with sacrospinous ligament suspension and pelvic reconstruction. Am J Obstet Gynecol 1996;175:1423.

Optimal Trial by Barber and PFDN

- 3-7 year follow up showed that uterosacral vaginal vault suspension colpopexy and sacrospinous suspension outcomes are similar
- 2020 ancillary analysis publication by Siff et al showed that a genital hiatus of 3.5 or less was associated with favorable anatomic success long-term


- Including 30 RCTs comparing surgical procedures for apical repair, evidence quality low to moderate, overall ASC associated with lower risk of awareness of prolapse, recurrent prolapse on examination, repeat surgery for prolapse, postoperative SUI and dyspareunia than a variety of vaginal interventions.; complications greater
- The limited evidence does not support use of transvaginal mesh compared to native tissue repair for apical vaginal prolapse. Most of the evaluated transvaginal meshes are no longer available and new lighter meshes currently lack evidence of safety
- The evidence was inconclusive when comparing access routes for sacral colpopexy
- No clear conclusion can be reached from the available data comparing uterine preserving surgery versus vaginal hysterectomy for uterine prolapse.
Long-Term Effectiveness of Uterosacral Colpopexy and Minimally Invasive Sacral Colpopexy for Treatment of Pelvic Organ Prolapse

Cecile A Unger, Matthew D Barber, Mark D Walters, Marie Fidela R Paraiso, Beri Ridgeway, J Eric Jelovsek
FPMRS 2017

Hysteropexy had fewer primary outcome failures (18 percentage points lower) through 5 years.

Shorter operative time for hysteropexy

No differences in Patient Reported Outcomes.

Both groups had improvement in sexual function.

Pelvic pain, dyspareunia, and de novo dyspareunia rates remained low (<10%) with no difference between groups.

Robotics and Laparoscopy

Laparoscopic compared with robotic sacrocolpopexy for vaginal prolapse: a randomized controlled trial.

Paraiso RF, Adamski J, Tschetter CC, Baltimore MD

- Robotic-assistance results in longer operating times (all parameters) and increased pain weeks 3 through 6 after sacrocolpopexy compared to the conventional laparoscopic approach
- LSC and RASC had significant improvement in anatomic and functional outcomes but no difference between groups 6 months after surgery
- We use an 8 mm ancillary port for introduction of sutures and now our patients have similar pain
- Comparative trials should include ergonomic studies

Applications for Robotic Surgery in the Hands of a Conventional Laparoscopist

- Sacral Colpopereineopexy with ventral rectopexy
- Multiple reconstructive surgeries with extensive suture labor: supracervical hysterectomy, sacrocolpopexy, Burch and paravaginal defect repair
- Dual mesh hysteropexy
- Abdominal cerclage during first trimester
- The robot is a tool, which is enabling and cost-equivalent in some studies when compared to laparotomy
- For sacrocolpopexy alone or with combined vaginal hyst, not cost-effective
- Advantages for suture labor, multiple procedures
Dual-Mesh Sacrohysteropexy

- Key steps
  - Dissect bladder, rectovaginal space, and presacral space
  - Make windows in the broad ligament and bring mesh arms through for later attachment
  - Sew mesh onto upper vagina and cervix
  - Retroperitonealize

Sacrohysteropexy Graft Placement

Sacrohysterocolpopexy Pearls

- Understand the contraindications
  - Negative uterine pathology must be confirmed
  - This particular technique is not recommended in women desiring future childbearing
  - Option is biologic graft or tunneling arms underneath cardinal ligament and ureter
  - Review the risks and benefits thoroughly with the patient
  - Future hysterectomy may be more difficult
  - The procedure leads to improved anatomical outcomes and resolution of anterior apical vaginal wall and uterine prolapse

Sacrocolpoperineopexy and Ventral Rectopexy

Sewing to Anterior Rectal Wall
Vaginal Self-Fashioned Synthetic Mesh Repair

- Measure trapezoid based on attachment points
  - Bilateral sacrospinous ligaments at apex
  - Proximal arcus tendinous fascia pelvis (ATFP) approximately 1 cm distal to ischial spine
  - Distal ATFP at the level of the bladder neck
- Do not leave mesh under tension
- Treat perioperatively with estrogen
- 2 layer closure of inverted U-incision decreases rate of mesh exposure at the site of the suture line
- Avoid in patients who use tobacco or have uncontrolled DM

Key Take Home Messages Outcomes

- Uterosacral colpopexy has similar outcomes to sacrospinous colpopexy long-term
- Bilateral sacrospinous hysteropexy with mesh outcomes at 5 years are better than native tissue colpopexy with hysterectomy
- Sacrocolpopexy is considered the gold standard repair for vaginal apex prolapse despite high level convincing comparative data
- Modified McCall culdeplasty/US colpopexy should be performed for mild uterine prolapse or prophylactically with non-prolapse hysterectomy
- Use what is best in your hands or consider consultation
- Make sure it is the best procedure for the patient
References


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. 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.