INDIAN ASSOCIATION OF GYNAECOLOGICAL ENDOSCOPISTS

MASSK

BULLETIN

MARCHING AHEAD IN SAFETY, SKILL & KNOWLEDGE

(FROM FEAR, IMAGINATION TO INNOVATION & EDUCATION)

"SAFETY FIRST- PATIENT & SURGICAL TEAM"

DR S KRISHNAKUMAR
PRESIDENT IAGE (2020-21)

DR P PALASKAR
GEN SECRETARY IAGE (2020-21)

IAGE FLAG

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STARTING SOON: IAGE APP

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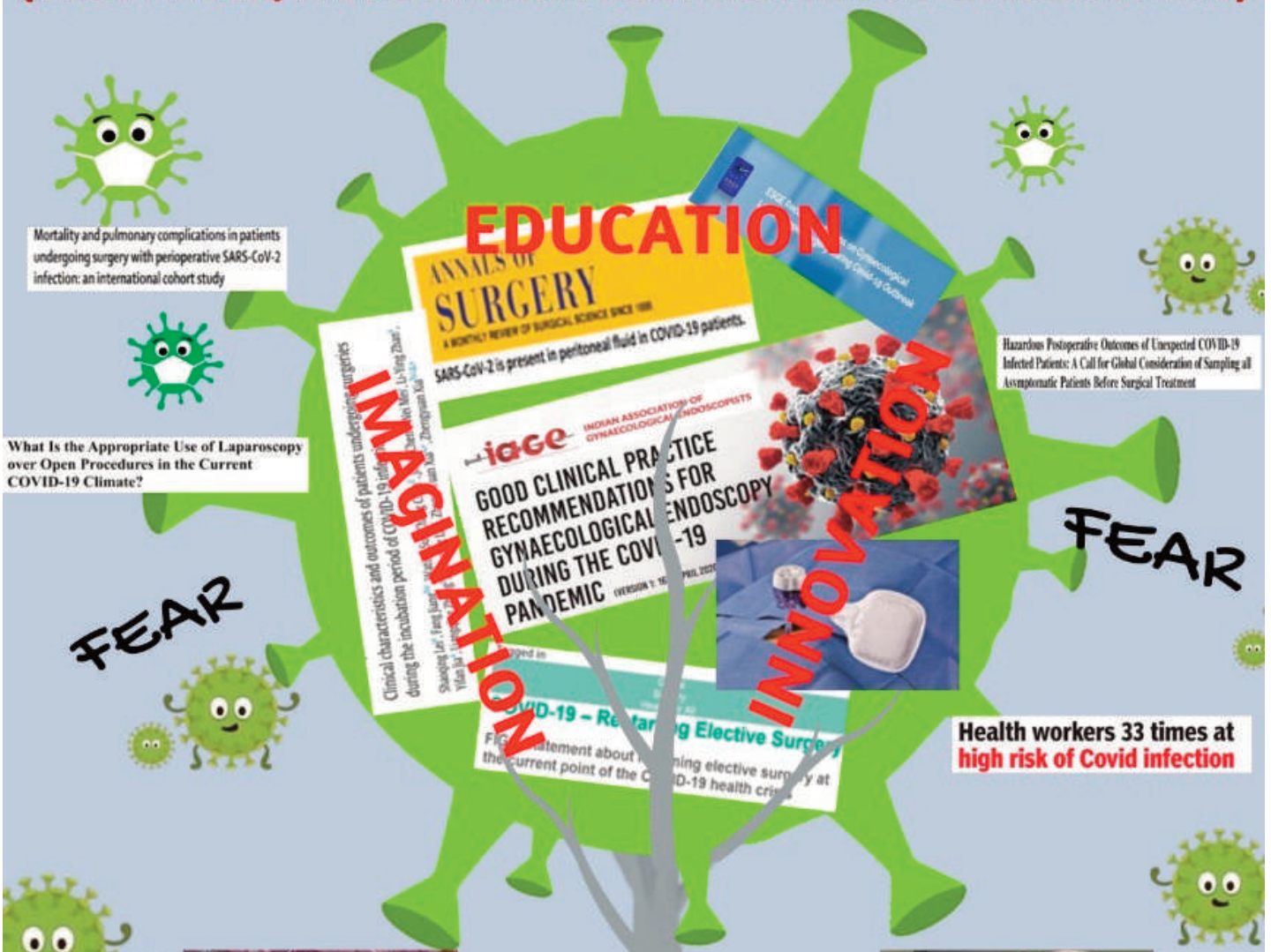

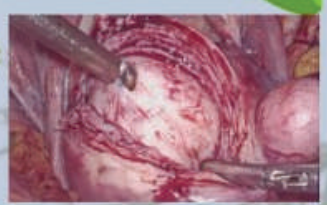

iage

EDITORS

DR ROHAN KRISHNAKUMAR

DR ANURAG BHATE

DR ABHISHEK CHANDAVARKAR

DR SUBHASH MALLYA

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TEAM IAGE 2020 - 21

Dr S. Krishnakumar
President
2020-2021

Dr. Pandit Palaskar
Hon. General Secretary
2020-2021

Dr Bhaskar Pal
Vice-president Secretary

Dr. Atul Ganatra
Joint Secretary

Dr Kalyan Bhamade
Honorary Treasurer

Dr Sunita Tandulwadkar
Immediate Past President

Dr. Ashish Kale

Dr. Kawita Bapat

Dr. Sujata Kar

Dr. Sujal Munshi

Dr. Anurag Bhate

Dr. Sejal Naik

Dr. Ganpat Sawant

Dr. Abhishek Chandavarkar

Dr. Aswath Kumar

Dr. Mala Raj

Dr. Nitin Shah

Dr. Sanket Pisat

Dr. Soumil Trivedi

Dr. Sushila Saini

Dr. Vidya Bhat

Dr. Kiran Coelho

CO-OPTED MEMBERS

Dr. A.K. Boruah

Dr. Dinesh Kansal

Dr. Rajesh Darade

PRESIDENT'S MESSAGE

Dear Colleagues,

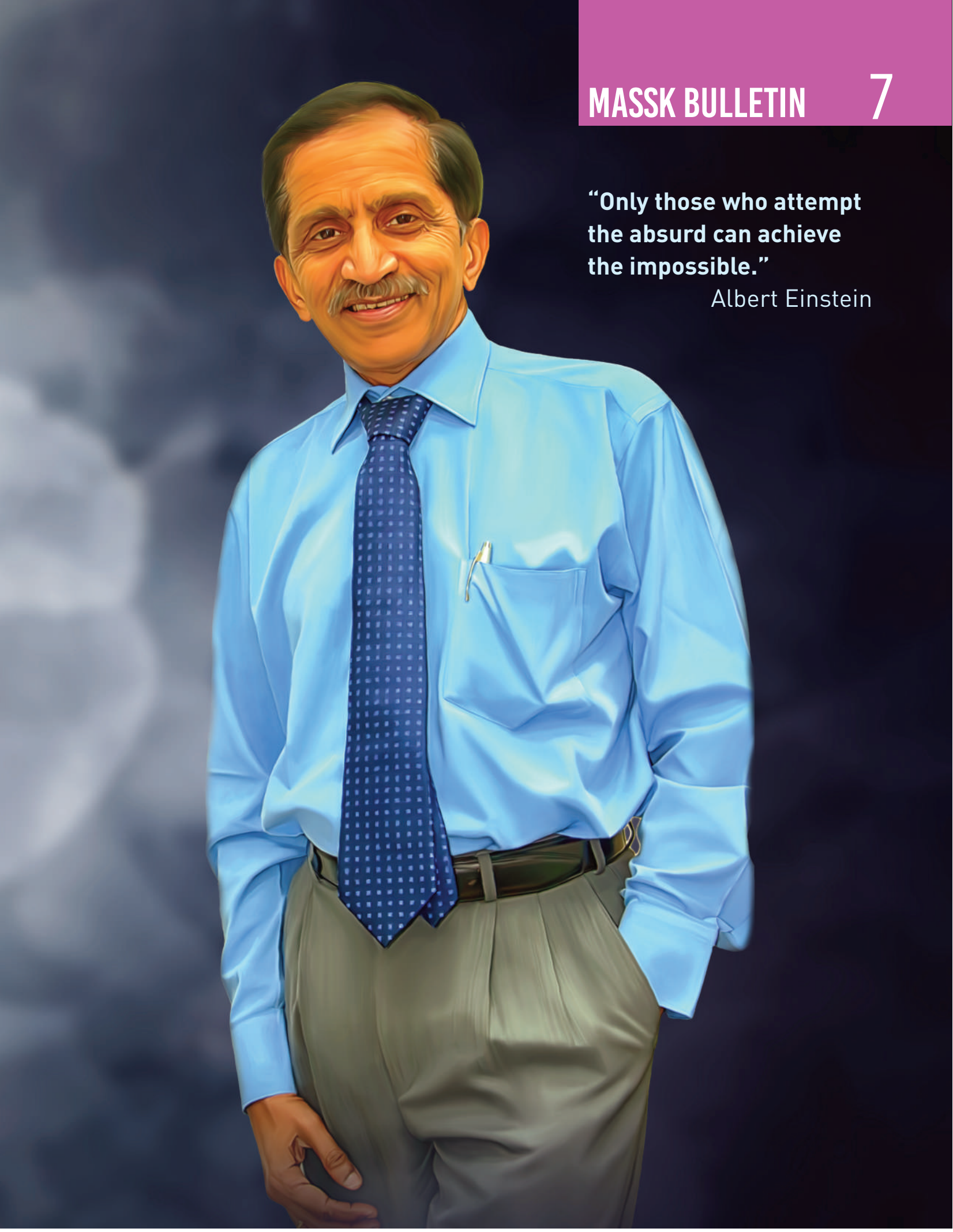
The extraordinary challenge, the whole of mankind is going through, aptly reinforces the belief of the old proverb "Man proposes God disposes". As we entered Twenty-Twenty, which is synonymous with exuberance energy and thumping success, for a cricket crazy nation like ours, I had energetic and great plans for my term as the incoming President of our association. All those plans were disposed off, by the invisible virus. Never did I imagine that the initial theme set by me for my term as IAGE President – "Eyeing new challenges, elevating to the next level, will bring this extraordinary new challenge and we were all thrown out of gear. As the very survival of mankind was being threatened by this unforeseen circumstance, you will agree that it has brought extreme hardships in every walk of life, universally.

Endoscopic surgery is synonymous with women care today and we cannot dissociate it from offering the same to women the world over. Risk of transmission inherent to the intubation process being well established, combined with the fear and imagination of the early reports of the presence and risk of the virus in the surgical plumes generated with Laparoscopic surgery and in the body fluids, the very survival of modern Gynaecological care was threatened to be banished. Being the most intelligent of creatures in the universe not only we have all risen above the challenge, we all have learnt the new way to connect, stay engaged, innovate, learn and share. Resilient as we are, all of us have reimagined, reshaped ourselves to restart.

I am honoured, but feel extremely blessed to be taking over as the president of IAGE, which is scaling new heights, with strong foundation and great work by all past presidents and members of their team. They all have been my motivators to reach to this position and I am indebted to all of them, with the role Dr Prakash Trivedi being the greatest factor. He has always been my motivator, right from my early days in medicine as he was the immediate senior at Medical college and apart from my wife has been responsible to shape my career in Gynaecology. Things have to continually evolve and am proud to say that every newer crop of gynaecologists is more focussed and have progressed to the next level very early. Early days in endoscopic surgery I remember most of us were a little conservative but a new era started in the field of Gynaecological endoscopic surgery when every new aspiring surgeon was pushed after hearing this now very popular voice of push, push and push, and in the post Puntambekar era every new Gynaecological endoscopic surgeon has been pushed retroperitoneal. I cannot forget many of the stalwarts of our field who have been instrumental in elevating the level of Gynaecological endoscopic surgery, and I call them the "ENDOWALL" of India, few of them you can see them in this bulletin. My predecessor Dr Sunita Tandulwadkar has done exemplary work for the association with true innovative plans, the EAGLE and the GVES being a cut above all. My heartfelt compliments to her and the General secretary of IAGE during her term Dr Bhaskar Pal. We must not forget the role played by every member of the team with the energy and commitment displayed. I am sure they all will be there for the association in future too.

I cannot forget the founders of our association and as a tribute to them I have decided to start a "IAGE Foundation day" to be celebrated on the 10th of June every year, with lot of social, educational and charity work planned for the public in general. Needless to emphasize no association can grow without a premise of its own and the proposed office of the association at Mumbai should take shape in my term provided the pandemic eases out. Another aspect which needs immediate attention for the growth of our association is updating database of existing members which is far from satisfactory. Many attempts in the past to rectify the same have not be fruitful. My earnest request to each one of you will be to help us on the same and all are requested to inform the office the changes in their address, e mail and mobile numbers. Also requesting your cooperation for the attempts on the same in future.

After a spate of excellent webinars, initiated by Dr Sunita Tandulwadkar, we are slowly limping back to the best way of learning endoscopic surgery, which as you all will agree is by live surgery demonstration. I am extremely blessed to be able to start my year though with a virtual conference, but a live surgical demonstration during the same. My immediate plans for the year will be in tune with current restrictions imposed on all of us, and the focus will be on safety, education, and skill developments of all our members. Starting with Pre- Entry safety I have laid out plans for focussing on the Medico-Legal aspects to the benefit of the members and highlighting importance of Role of Imaging modalities before embarking upon surgery with focussed "Pre Entry Safety" webinars on the same. Other aspects which is of great importance in safety in our field is definitely knowledge pertaining to allied field in our speciality- General Surgery, Urology and Onco surgery. We will be having focussed "Cross-Roads" webinars along with societies of these specialities. I am planning to have focussed themed workshops on main subjects in our field- Hysterectomy, Fibroid, Endometriosis, Uro-Gynaecology and Hysteroscopy, with whole day expert talks on the subject and live surgeries relayed on the same subject. Ambulatory hysteroscopy will be a



"Only those who attempt the absurd can achieve the impossible."

Albert Einstein

special focus for the year. These will comprise the Knowledge part of my theme. Developing and elevating skill will be through many skill development programs. I had always believed every Gynaecologist should be knowing the retroperitoneal spaces and preserving the integrity of vital structures there and to achieve the same goal have designed specific programs for the same in the form of experts talks by masters in the field and for the first time in our field hands on "Cadaver" training will be started, the plans of which were finalized before the pandemic derailed it. But I am sure I will be able bring them back on track once the pandemic recedes and we unmask ourselves and IAGE. This I am sure will go a long way in advancing skills of our members. Of course, basic skill development will be always there for the beginners, with either short hands on courses at the training centres of Ethicon institute and Olympus, the plan and dates will be announced once the situation allows us. The most popular project initiated last year for the Post graduate students- EAGLE will continue once situation settles and also on the cards is "Endoscopy training on Wheels" with the help of J & J. But you will appreciate that a doubt of uncertainty will prevail for some more time and as we recover from the pandemic, we will definitely, rethink and re strategize our plans. Once we unmask the conference with physical presence of you all is being planned, notable of which is Endogyn 20+1 to be held between 19-21 at Kolkatta, 20th International conference of AAGL, between 22-26 september2021, and the YUVA IAGE being planned at Varanasi from 26-28 November 2021.

Finally, my message to all is pursue your dreams and provide leadership, in whatever you do. Persistence is more important that talent. To many endoscopic surgery skills may look a difficult to learn but believe me these great surgeons you see were not born with those skills, but their persistence and self-belief took them where they are today. Hence do not give up. If you have a goal, keep working at it, without letting failures put you down. Believe you are second to none. In fact, I had failed not once but twice to enter in to the IAGE committee. IAGE is democratic and collaborative society. Not long ago there were only 10-15 great surgeons whom everybody knew and were considered the leaders. Today I can see so many young talented youngsters amongst you all and all have the potential to be successful leaders and am sure you all can lead IAGE to greater heights. IAGE is also getting recognition globally with many international societies recognising our work, and we cherish recognition given by the AAGL to IAGE. But I am sure like me, we all are negligent in maintaining record of our work and publishing them.

Finally, I am here as the President because of all the motivation and sacrifice from my wife Jayashree and the popular proverb "Behind every successful Man there is a woman" gets restructured as "Behind very successful Man is a Woman in front" as J is always in front of K and I am truly blessed to have her by my side. I cannot the neglect the sacrifice by my family in my growth and am truly blessed to have my son Rohan also a Gynaecologist, who is also making rapid strides in our field and he is married to Niveditha also a Gynaecologist, and my daughter Krithika who is pursuing her final in M. D. Pediatrics.

I am lucky to have the sincere, silent but dynamic Dr Pandit Palskar as the secretary of the association during my term and sure will there helping in all the goals for the year. The other office bearers during this year, Dr Bhaskar Pal, Dr Atul Ganatra, and Dr Kalyan Barmade come with tremendous experience having worked for FOGSI in high positions and no doubt will be walking with me always. And needless to mention, the immediate past president Dr Sunita Tandulwadkar I can bank upon always for advice and direction. The goals can only be achieved with a supportive dedicated team and I am extremely satisfied with the members of my managing committee, which has the perfect blend of youth and experience. We all owe a lot to our industry partners, who have not only brought so many innovative technologies and also are ready in many ways to be associated with us as the educational partners. I acknowledge the contribution of our Academic partners listed in the bulletin pages and I sincerely thank all of them for being with us despite the extreme hardships each one of them is going through. Kudos to them.

Before I conclude, it has been an honour and privilege to serve the IAGE committee with all those wonderful people. I have learned a lot being closely associated with some great leaders and friends and am sure they will be always there by my side as I begin my journey as the President and help me achieve whatever I have dreamt to do for IAGE during my extended term this year.

Me and my team will be always available for any help and guidance and would welcome any suggestion for the benefit of the association.

Dream big. Don't be scared.
Do it once, Do it again.
Turn work into play. Struggle into fun
The journey though exhausting will be exciting
Let your quest be endless.

Yours,

Dr S Krishnakumar
President IAGE
2020-2021

GENERAL SECRETARY'S MESSAGE

Dear Friends and Colleagues,
It gives us immense pleasure to welcome you all to this IAGE 3D Virtual Annual Conference MASSK 2020. We are working hard with our organizing team under the leadership of our dynamic president Dr. S Krishnakumar to present you the feast of virtual live workshop and conference.
Covid-19 pandemic has affected almost every area of our life and brought many drastic changes in our professional life with many challenges. Many of us have fear, anxiety and unresolved doubts about endoscopic surgery in today's Covid-19 era. To overcome these challenges and clear our doubts, special focus is put on safety measures that must be undertaken while performing endoscopic surgery in today's time. The theme of conference is Marching Ahead in Safety, Skill & Knowledge – safety first- patient and surgical team.
The medical science is progressing by leaps and bounds and endoscopic surgery is not an exception. To meet the needs of recent advances in endoscopic surgery and safety aspects in today's era of Covid-19 pandemic, we have organized three days conference on October 30, 31 and November 1, 2020. Day one is dedicated exclusively for free paper presentation. On day two, we are having virtual live operative workshop by stalwarts in the gynecological endoscopy from three different centers in India. On day three, we are having very well-orchestrated scientific program covering different aspects of endoscopic surgery.
We take this opportunity to extend warm welcome to AAGL team for associating with IAGE and enriching our knowledge in the field of endoscopic surgery.
In future we will be organizing virtual workshops, conferences and webinars for our IAGE members till the pandemic subsides.
The virtual conference is free for all IAGE members. We appeal all gynecologists to become the life member of this esteemed and vibrant organization and get lifetime benefits.
On behalf of organizing committee, we welcome you all for this virtual annual conference and reserve your dates for this scientific extravaganza.
Long live IAGE!

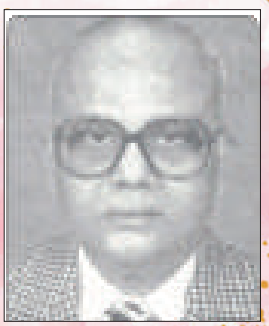
Dr Pandit Palaskar
General Secretary IAGE
2020-2021

"Challenge yourself everyday to do better and be better. Remember, growth starts with a decision to move beyond your present circumstances."

Robert Tew

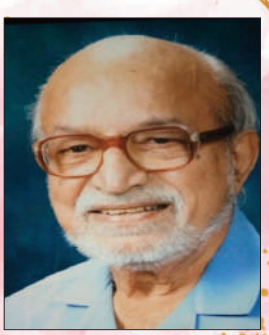
PAST PRESIDENT MESSAGES

DR N MOTASHAW



DR SIDHARTHA KHANDWALA

DR M N PARIKH



Dr S S THAKUR

DR ADI DASTUR

Looking forward to an excellent and educational conference, MASSK 2020, and am sure IAGE will achieve more in your tenure. My best wishes for the same.

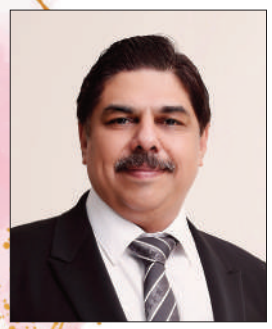
The Indian Association of Gynaecological Endoscopists has evolved from its humble beginnings' way back in the 1970s. The reasons for the rapid growth in the speciality are more than the evolution of technology and instrumentation it was the need for a minimally invasive approach to a gynaec problem and the demand from our patients for the latest in medical care
The COVID 19 pandemic has deterred the continued demand but looking forward it seems a temporary slowdown and in the near future we should be back on track.

DR SHYAM DESAI

All the best for TEAM IAGE

DR PRASHANT MANGESHIKAR

IAGE has been blessed with a great team over the years with dedicated past Presidents and hence today has become a great organization. It has been instrumental in training many Gynaecologist in various aspect of endoscopy and today we have excellent crop of young Gynaecological Endoscopic surgeons. I am sure the present team at IAGE led by a very dedicated President Dr S Krishnakumar, and secretary Dr Palaskar will take IAGE to a position of strength. I wish them all success.



DR H D PAI

DR RAKESH SINHA

All the very best for the new team under Dr S Krishnakumar and IAGE will reach greater heights

DR P K SHAH

DR PRAKASH TRIVEDI

IAGE has always been close to my heart, and I have always cherished my presidency at IAGE. IAGE has progressed enormously in the last few years with some outstanding work by the past presidents and their team. Last year we had Dr Sunita Tandulwadkar, President, Dr Bhaskar Pal, Secretary and their team undertaking some path breaking steps. The incoming President Dr S Krishnakumar, whom I know for several decades, is a dependable and dedicated worker for IAGE. He has excelled himself in various aspects of Endoscopic surgery and am sure he along with his sincere Secretary Dr Pandit Palaskar and brilliant team will outshine all other previous team at IAGE. I wish Dr Krishnakumar all success in his journey as the President of IAGE.

I wish to congratulate you for your brilliant achievement and becoming President of IAGE 'one of the world's oldest endoscopy organisations'. I am very much sure that you will take the organisation to further heights, even in this difficult scenario.

DR RAJENDRA SANKPAL

PAST PRESIDENT MESSAGES

DR NANDITA PALSHETKAR

Gynaecological endoscopy as we know it is nowadays is possible, thanks to important technical advances, along with the sophistication and the miniaturization of the equipment used. Gynaecological endoscopy is one of the latest, most effective and minimally invasive surgical procedures used both for diagnostic purposes and for the treatment of gynaecological disorders. My personal journey was from medical student to gynaecologist and now as an IVF specialist and Endoscopist. Endoscopic skill today is a must if you are a practising obgy. Keeping this in mind I felt upgrading endoscopic skills is very important. Therefore during my tenure as President of IAGE my theme was - Advanced Endoscopy : Investing in the future.
I also would like to Congratulate Dr S Krishnakumar on being installed as President IAGE in this pandemic and I am sure he will take IAGE to greater heights, even in these tough times.

DR RISHMA PAI

I am very happy to hear the news of your installation as the President of IAGE on 31st October 2020.
It has been an extremely difficult and unpredictable year -yet despite all obstacles life and work has to go on.
You, with your years of experience in the field of endoscopy -not only practising it but training hundreds of other gynaecologists to become competent endoscopic surgeons, really deserve to be in this position.
Having worked with you closely when I was president of ISAR and IAGE-and you were the secretary general, I have seen your sincerity and commitment to the organization.
I wish you the very best and I am sure that you will succeed despite the challenges ahead.

INDIAN ASSOCIATION OF GYNAECOLOGICAL ENDOSCOPISTS

PRESENT MEMBERS STRENGTH- 3360 (till 25 Oct 2020)

FOUNDER MEMBERS

SL.NO	NAME	DESIGNATION
1.	Dr. N.D. Motashaw	President
2.	Dr. D.N. Patel	Vice-President
3.	Dr. S.D. Khandwala	General Secretary
4.	Dr. Mahendra N. Parik	Joint Secretary
5	Dr. P.V. Mehta	Treasurer
6.	Dr. Rohit V. Bhatt	Member
7.	Dr. Sadhana K. Desai	Member
8.	Dr. C.L. Javeri	Member
9.	Dr. Shirin P. Mehtaji	Member
10.	Dr. V. N. Purandare	Member
11.	Dr. A. Padama Rao	Member
12.	Dr. R.P. Soonawala	Member
13.	Dr. S.S. Thakur	Member
14.	Dr. B.C. Lahiri	Member
15.	Dr. M. Kochar	Member
16.	Dr. P.R. Vaidya	Member

PATRON MEMBERS

SL.NO	NAME
1	DR.HRISHIKESH PAI
2	DR.RISHMA DHILLON PAI
3	DR.S.KRISHNAKUMAR
4	DR.SUNITA TANDULWADKAR
5	DR.MALVIKA SABHARWAL
6	DR.PANDIT PALASKAR
7	DR.KALYAN BARMADE
8	DR.NUTAN JAIN
9	DR.VIVEK SALUNKE
10	DR.AMEYA PADMAWAR
11	DR.NAGENDRA SARDESHPANDE

HON MEMBER - DR SHAILESH PUNTAMBEKAR

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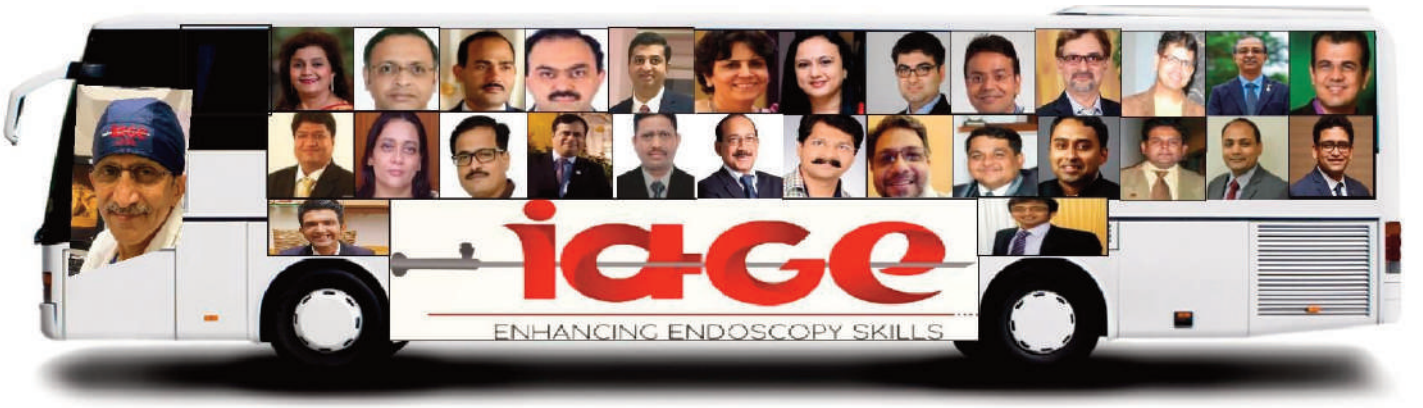
	E-mail Id:	arunmadhob@gmail.com	yashodhandeka@gmail.com

MEMBERSHIP DRIVE

JOIN THE IAGE BANDWAGON, BECOME LIFE MEMBER OF IAGE



Become IAGE LIFE MEMBER
Join the IAGE BANDWAGON

Champion of IAGE AWARD Who gets Maximum -Member

Each Member Makes One More Life Member

State Chapter Who Make Maximum member will be Felicitated

ADVANTAGE OF BECOMING A NATIONAL IAGE

1. You will be member of the second largest country-based Gynaec Endoscopy organizations in the world with life membership strength above 3000.
2. You will get a life membership certificate, which you can put up on the wall.
3. You will get concessional access to Annual, YUVA IAGE Regional conferences workshops and other training programmers.
4. You will be able to become member of an IAGE local chapter, specific to your state or union territory at a nominal life membership fee.
5. You will have access on IAGE website: www.iageonline.com

ADVANTAGE OF BECOMING A NATIONAL IAGE MEMBER

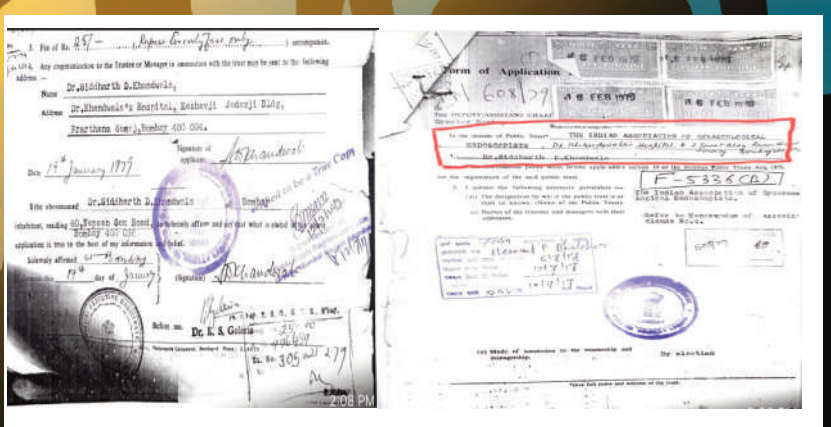
6. You will receive 3-4 issues of the newsletter IAGE Express.
7. You will be able to apply for IAGE Accreditation of your centre for training gynaecologists in Endoscopic Surgery
8. Get E-membership of AAGL the largest Gynaec Endoscopic Society in the world at the rate of 75 $ per year, with E- Journal subscription and free access to Surgery U. Best paper presented selected at the IAGE annual conference gets a direct free entry for presentation in annual AAGL conference USA.
9. You will Elevate your skills and empower yourself, in Gynaecological Endoscopy
10. Become a member by visiting www.iageonline.com

BE SECOND TO NONE!

FOUNDATION DAY

10/06/1978

IAGE was founded by an enthusiastic group of 16, led by Dr N D Motashaw on the 10th of June 1978. Truly they were all visionary who imagined the infinite future of Endoscopic surgery. True to their pioneering efforts and further inputs of all past presidents and their team, IAGE has become a powerful organization, and is making further strides. To commemorate the efforts of the early masters, 10th of June every year will be celebrated as IAGE Foundation day with participation from all its members in the following way:



Activities Planned on Foundation Day

EVERY MEMBER – PLEDGE –
1. MAKE AN ADDITIONAL MEMBER –IAGE
2. ONE ENDOSCOPIC SURGERY- FREE A SIMPLE HYSTEROSCOPY- MENORRHAGIA, BIOPSY FOR AUB, TCRE ETC, TLH. SEND THE LIST OF THE PATIENT DONE FREE /ACTIVITY TO IAGE SECETARIAT- CHARITY WORK
3. PUBLIC AWARENESS- PROGRAM- SAVE THE UTERUS (Can be combined with a FOGSI Society)
- SPREADINGTHE BENEFITS OF ENDOSCPIC SURGERY
- WOMAN'S HEALTH- FAMILY'S WEALTH - Every Women deserves the best & the Safest, SKITS, WALKATHON, LECTURES, VIDEOS

STATE CHAPTERS TO CARRY THE ACTIVITIES- WITH HELP FROM – PHARMA COMPANIES- LOCAL SOCIAL ORGANISATION
IAGE SHORT FILMS- FOR PUBLIC
1. SAVE THE UTERUS- HYSTEROSCOPIC PROEDURES/AUB/FIBROIDS/ENDOEMTRIOSIS- SAVING THE UTERUS
2. Womens Health- Family's Wealth – focus on women well being & Modern simplified treatment on womens disease

.... and many more


D Limbachiva


M Borse


V Salunke


S Kade


P Shah


D Shukla


M Sabharwal

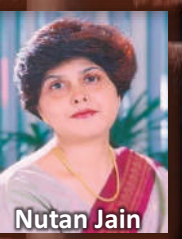

U Jha


V Marwah


R Modi


P Palaskar


S Puntambekar


Nutan Jain


P Patel


N Warty


P Kotdawala


R Sankpal


S Krishnakumar


S Tandulwadkar

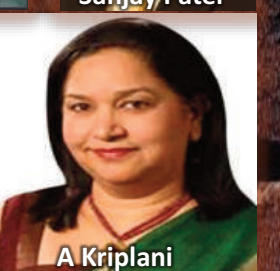

B Ramesh

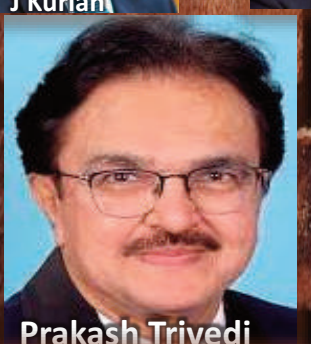

Sanjay Patel


J Kurian


P G Paul


H Rehman


A Kriplani


Prakash Trivedi


Prashant Mangeshikar


Rakesh Sinha


Nargis Motashaw


S Khandwala


Shyam Desai

ENDOWALL

Remembering some of our Endoscopy Stalwarts

YUVA BRIGADE


ROHAN KRISHNAKUMAR


CYRIAC PAPPACHAN


JAY MEHTA


GAURAV DESAI, MUMBAI


DHAVAL BAXI


KAILASH GADHVI


ADITI TANDON, MUMBAI


ADITYA KHURD, PUNE


AKHILA B, KOCHI


AKSHAY PRABHU, KOCHI


AMIT VARIA, GUJRAT


AMITI AGRAWAL, MUMBAI


AMOGH CHIMOTE, NAGPUR


AMRUTHA JAIDEEP, HYDERABAD


ANKIT CHAUDHARY, GUJRAT


APOORVA REDDY, BANGLORE


DAMODAR RAO, COIMBATORE


DEEPA RAJAN, KERALA


DINESH TADHA, SURAT


ADITI JOSHI, KALYAN


AMOL RAKHADE, NAGPUR


ASHWINI KALYANKAR, MUMBAI


PANKAJ MATE, AHMEDNAGAR


NILESH BALKAWADE, PUNE


NEHA MADURWAR, NAGPUR


LATIKA CHAWLA, MUMBAI


KRISHNA MANDADE, LATUR


KIRAN PARADHI, AKOLE


H PANDIT, BHINGAR


GAUTAM UNAGAR, SURAT


GARIMA SRIVASTAV


DIVYESH PANCHAL, AHEMDABAD


DIVYA TEKANI, BHUJ GUJARAT


D NARASIMHAN, CHENNAI


PRAVINA BIRBAL JAIN, WARDHA


PRIYANKUR ROY, SILIGURI


PRITI RAJPUROHIT, BIKANER


R M GUNDRA, SANIYA, GUJARAT


LOVELY JETHWANI, JODHPUR


KUNAL DOSHI, MUMBAI

KESHAV PAI, MUMBAI

KAJAL PARIKH, MUMBAI

JANHVI TALLURI

JAGRUT JOSHI, GUJRAT

HEMASHREE PATEL, MUMBAI

HEENA CHAWLA, CHANDIGARH

GRISHMA AGARWAL, GUJRAT

GEORGE PAUL, COCHIN

MINAKSHI GOYAL, HARYANA

FIZZA REHMAN, ASSAM

VIME BINDRA, HYDERABAD

VARUN NABHOYA, SURAT-GUJURAT

UDAY BHANU RANE, HIMACHAL

SUYASH NAVAL, JALGOAN

SHRIDHAR DAYAMA, NASHIK

SAUMYA BULUSU, NAVI MUMBAI

MANGESH MANCHKE

MADHAV HIRANI, GUJRAT

MADHUMITA ARUNKARTHIK, TN

YUVA BRIGADE


M VENKATARAMAN, MUMBAI


MANORHITA GAIKWAD, MUMBAI


YASHODHAN DEKA, ASSAM


VIKRAM KUDUMBALE, LATUR


VIKAS DEVKARE, MAHARASHTRA


VARUN SHAH, MUMBAI


ULHAS MAHAJAN


TARUN JOSEPH, CHENNAI


SWAR SHAH, GUJRAT


SUVARNA DAHITANKAR


SURAKSHIT BATTINA, CHENNAI


SUNITA BIJARNIA, RAJASTHAN


SOUMIL TRIVEDI, MUMBAI


SONAL RIVASTAVA, PUNJAB


SMEET PATEL, AHMEDABAD


SIDDHARTH SHAH, GUJRAT


SHWETA SHAH, AHMEDABAD


SHRUTI ASHWIN, CHENNAI


SHRIRAAM AYYAR, MUMBAI


SHREYA MANOHAR, CHENNAI


SHAILESH JAIN, JAIPUR


SARIKA SOLANKE, MAHARASHTRA


ASMITA KATTI, BELGAUM


NAYANIKA GAUR, JODHPUR


SANTWAN MEHTA, AHMEDABAD


SANJAY VAGHSIYA, GUJRAT


SANJANA SAINANI, NAGPUR


SANDIP SONARA, GUJRAT


SANDIP DATTA ROY


SALONI MANWANI, PUNE


S. GAYATRI, TAMIL NADU


RAKSHA SHARMA, KOTA


RAKHI SADRA, LATUR


R TAYSHETE, MUMBAI


RAHUL MAHALE, MUMBAI


MUMUKSHA CHAUDHARY, GUJRAT


RAGUL JADHAO


PRIYA S, BANGLORE


PRANITA BANKER, MUMBAI


PRANAY DESAI

PRADNYA CHANGEDE

PANKHURI GAUTAM, JAIPUR

NIYATI SRIVASTAVA, ROORKEE

NIRANJAN M.S, KANCHIPURAM

NIKET PATEL, GUJRAT

M DHARMADHIKARI, MUMBAI

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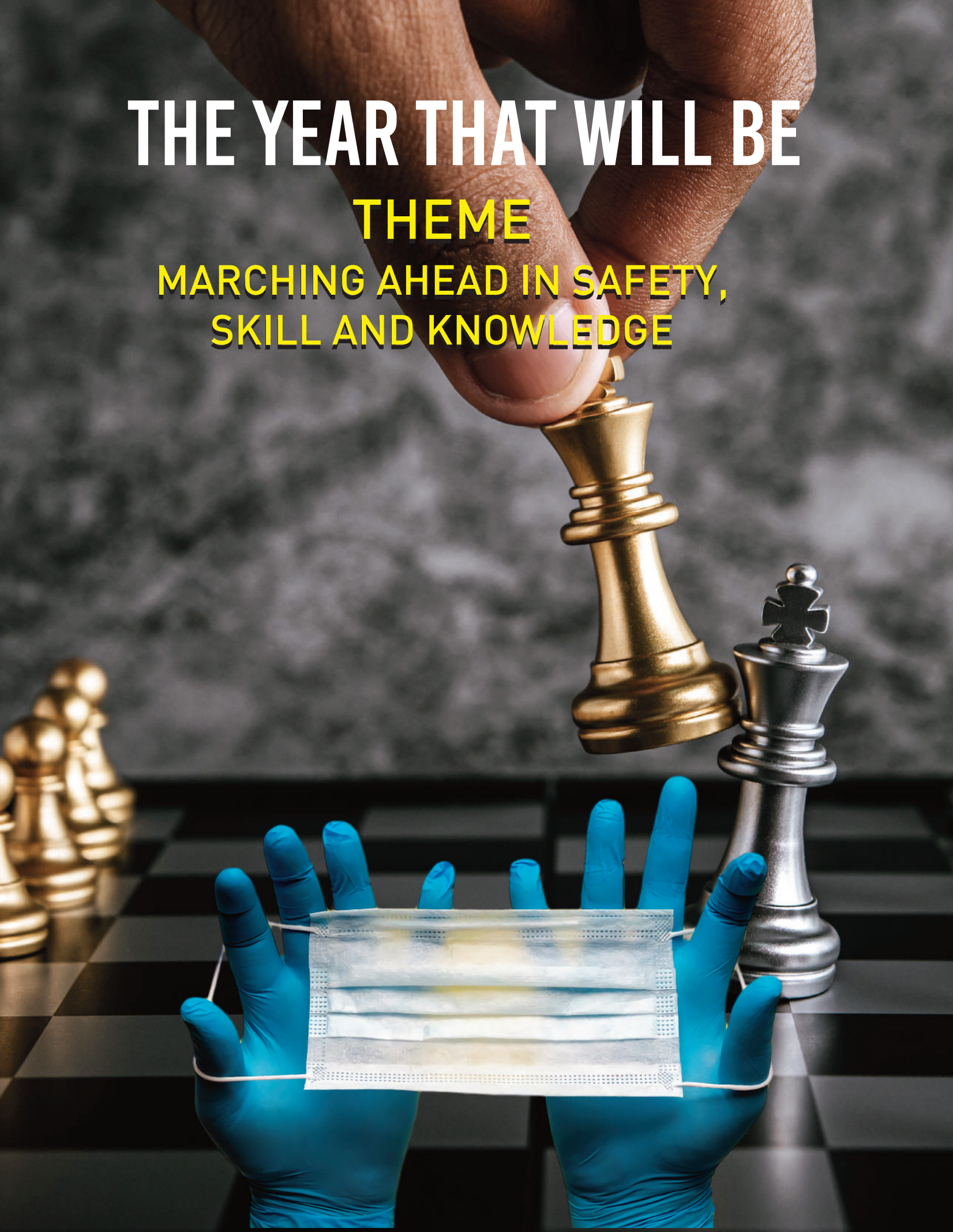


THE YEAR THAT WILL BE

THEME

MARCHING AHEAD IN SAFETY, SKILL AND KNOWLEDGE

GEM (Gaining Endoscopy Mastery–PROJECT)
FOCUSSED MASTER COURSES–

2 DAY FOCUSSED ON FOLLOWING SUBJECTS – EXPERT TALKS WITH INTERACTION & LIVE SURGERY.

DAY 1- TALK BY LEADERS WITH INTERACTIVE DISCUSSION 30+15 MINS ON EACH ASPECT- 5-6 HOURS

DAY-2- LIVE RELAY OF SURGERIES

A. HYSTERECTOMY
B. ENDOMETRIOSIS
C. MYOMECTOMY
D. HYSTEROSCOPY
E. UROGYNAECOLOGY & PELVIC FLOOR
F. ROBOTICS

IAGE MEMBERS
FREE
NON-IAGE MEMBERS
RS 2000/COURSE

GEM- HYSTERECTOMY

- Office bearer in charge- Dr S Tandulwadkar, Dr Atul Ganatra

MC Member in charge : Dr Ganpat Sawant, Dr Sujal Munshi, Dr Sejal Naik, Dr Ashwath Kumar.






Dr Sunita Tandulwadkar Dr Atul Ganatra Dr Ganpat Sawant Dr Sujal Munshi Dr Sejal Naik Dr Ashwath Kumar

GEM- ENDOMETRIOSIS

Office bearer in charge: Dr Bhaskar Pal

MC Member in charge: Dr Sujata Kar, Dr Ashish Kale, Dr Abhishek Chandavarkar




Dr Bhaskar Pal Dr Sujata Kar Dr Ashish Kale Dr Abhishek Chandavarkar

GEM- MYOMECTOMY

- Office bearer in charge : Dr P Palaskar

MC Member in charge : Dr Vidya Bhat, Dr Mala Raj , Dr Sanket Pisat
Dr Soumil Trivedi


Dr Pandit Palaskar


Dr Vidya Bhat


Dr Mala Raj


Dr Sanket Pisat


Dr Soumil Trivedi

GEM- HYSTEROSCOPY

Office bearer in charge : Dr Kalyan Barmade
Dr A Bhate, Dr Nitin Shah, Dr R Dharade


Dr Kalyan Barmade


Dr A Bhate


Dr Nitin Shah


Dr Rajesh Darade

GEM- PELVIC FLOOR & UROGYNAECOLOGY

Office bearer in charge : Dr P Palaskar,

- MC Member in charge : Dr Kavita Bapat, Dr Sushila Saini, Dr A K Barooah


Dr Pandit Palaskar


Dr Kavita Bapat


Dr Sushila Saini


Dr Arunmadhab Borsah

GEM – ROBOTICS

Office Bearer in charge - Dr Atul Ganatra,
MC Member in charge – Dr Kiran Coelho, Dr Dinesh Kansal



PRIDE- PROJECT-
Projecting Rising Indian Dynamic Endoscopists

Project Guru - Dr P C Mahapatra,
Project Director- Dr S Krishnakumar
Project Groomers- Dr P Palaskar, Dr Kalyan Barmade

1. Seminars/Webinars
2. Surgical workshops- 4 proposed in different zones
3. National PRIDE (YUVA) Conference – Varanasi

SCHEDULED PROGRAM (VIRTUAL FORMAT WITH LIVE SURGICAL RELAY)

1. PRIDE PROJECT I- DECEMBER 26, 27, 2020
CONVENOR- DR KALYAN BARMADE, DR SANKET PISAT

2. GEM-ROBOTIC SURGERY IN GYNAECOLOGY – JANUARY 16,17 2021
CONVENOR- DR ATUL GANATRA WITH ACCLAIMED INTERNATIONAL FACULTY

3. GEM- ENDOMETRIOISIS- FEBRUARY 19,20 2021
INTERNATIONAL FACULTY- PROF HORACE ROMAN (FRANCE)-
DAY 1- LIVE REALY OF ADVANCED ENDOMETRIOSIS SURGERY FROM FRANCE.
DAY 2- LIVE SURGICAL RELAY- INDIA

4. ENDOGYN 2020+1 – KOLKATTA (PHYSICAL/VIRTUAL) MARCH 12-14, 2021
ORG CHAIRPERSON- DR BHASKAR PAL

5. PRIDE II- APRIL 10,11, 2021
CONVENOR- DR KALYAN BARMADE, DR SOUMIL TRIVEDI

6. GEM- HYSTEROSCOPY -24, 25 APRIL , 2021
INTERNATIONAL FACULTY- DR ATTILLIO DI SPIEZOSARDO (ITALY)
DAY 1- LIVE RELAY FROM ITALY
DAY 2- LIVE RELAY FROM INDIA

7. GEM- PELVIC FLOOR & UROGYNAECOLOGY- MAY 8, 9 2021
CONVENOR- DR PANDIT PALASKAR

8. MOGS-IAGE ENDO CONCLAVE – JUNE 12, 13, 2021
ORG CHAIRPERSONS- DR SARITA BHALERAO, DR S KRISHNAKUMAR

9. IAGE-AAGL: 23-26 SEPTEMBER 2021. MUMBAI
ORG CHAIR: DR TED LEE, DR PRAKASH TRIVEDI,
CO–CHAIRS- DR S KRISHNAKUMAR, DR S PUNTAMBEKAR, DR ARNAUD WATTEIZ.

10. NATIONAL PRIDE (YUVA IAGE) CONFERENCE:
(CO-HOSTED BY UP CHAPTER IAGE) VARANASI. 26-28 NOVEMBER 2021.
ORG CHAIRPERSONS- DR N. MALHOTRA, DR NEELAM OHRI. ORG SECRETARY- DR ANURAG BHATE, DR SHRIKANT OHRI.

& MANY MORE AS THE PANDEMIC IMPROVES

MAS- SAFETY SERIES – MARCHING AHEAD IN SAFETY OPEN FOR ALL (WEBINARS)

1. PRE ENTRY SAFETY- ALL ASPECTS OF IMAGING MODALITIES BEFORE ENDOSCOPIC SURGERIES
2. BETTER BE SAFE THAN SORRY- MEDICOLEGAL ASPETS IN ENDOSCOPIC SURGERY
3. SAFETY AT ENTRY- ALL ENTRY TECHNIQUES DISSECTED INSIDE OUT

MAKE SERIES- MARCHING AHEAD IN KNOWLEDGE IN ENDOSCOPY – OPEN FOR ALL

I WEBINARS-

1. CROSSROADS IN ENDOSCOPY I- IN ASSOCIATION WITH SURGICAL ENDOSCOPY SOCIETY
2. CROSSROADS IN GYNAECOLOGY- CLARITY ON ENDOSCOPIC SURGERY IN GYNAECOLOGICAL ONCOLOGY (ASSOCIATION WITH ONCOLOGICAL SOCIETY)

UNMASKING IAGE (POST COVID)

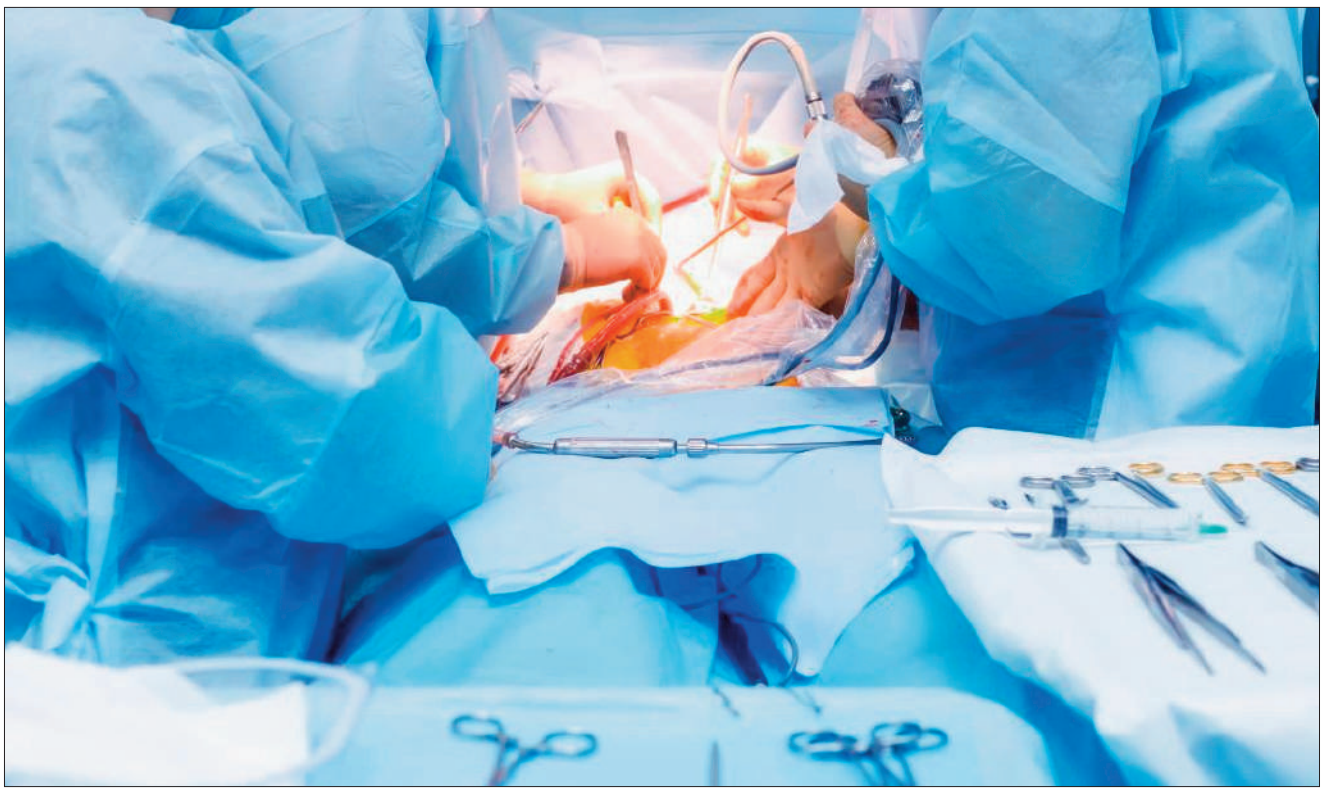
MAS- 2- MARCHING AHEAD IN SKILL
(SKILL TRAINING AND ADVANCEMENT)
BASIC (HANDS ON INSTITUTIONAL) (FREE FOR IAGE MEMBERS)

A. EAGLE PROJECT- AS INITIATED BY THE PAST PRESIDENT WITH MINOR MODIFICATIONS
B. BEST PROJECT (BASIC ENDOSCOPIC SKILL TRAINING)- (IN ASSOCIATION WITH EISE- (CHENNAI & MUMBAI)
2 DAY COURSE ON BASICS IN ENDOSCOPY
HANDS ON TRAINING- PELVITRANER/HYSTEROSCOPY TRAINER/TISSUES
BEST (IN ASSOCIATION WITH OLYUMPUS- GURUGRAM)
SAME AS ABOVE
C. ENDOSCOPY ON WHEELS – TRAINING ON THE MOVE- WITH J&J
DEDICATED MOBILE ENDOSCOPY VAN – TRAVELLING TO DESIGNATED MEDICAL COLLEGES WITH PRE INFORMED DATES
D. FEES SERIES – IN ASSOCIATION WITH ISAR ON FERTILITY ENHANCING ASPECTS IN ENDOSCOPIC SURGERY-
EISE CENTRE- CHENNAI & MUMBAI

ADVANCED

INSTITUTIONAL

A. TALI PROJECT- ADVANCED TRAINING IN RETROPERITONEUM AND SPACES 6 HOUR SESSION- EXPERTS-45+15 MINUTES INTERACTION, 6 TOPICS
CADAVER COURSES – 3 DAY COURSE - 3 PLANNED FOR THE FULL YEAR – 15 CANDIDATES
(IAGE MEMBERS- SUBSIDISED RATES)



DAY 1 – LECTURE - TALI
DAY 2 – HANDS ON CADAVERS
DAY 3 – HANDS ON CADAVERS+1 LIVE DEMONSTRATION OF SURGERY
B. KNOWLEDGE & SKILL **(IAGE MEMBERS ONLY)**
SMALL GROUP TRAINING WITH MASTERS- 2 DAY LIVE SURGICAL WITH HANDS ON TRAINING WITH SELECTION CRITERIA

COMING SOON

AGL ELEVATING GYNECOLOGIC SURGERY iage

Fellowship in Minimally Invasive Gynecologic Surgery – International (FMIGS-I)

ACADEMICS

DR. KALA ESWARAN
M.D (Anaesthesia)

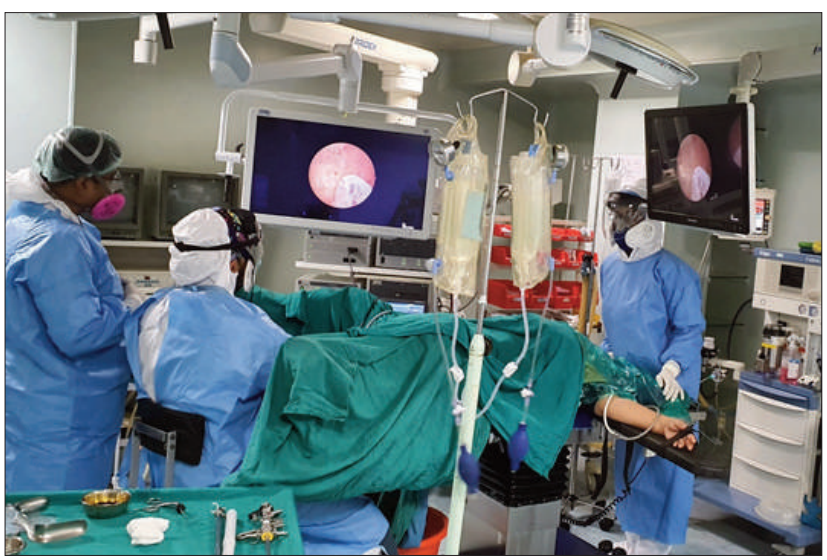
LESSONS LEARNT IN COVID PANDEMIC

ANAESTHESIA CONSIDERATIONS IN ENDOSCOPY & LAPAROSCOPY PROCEDURES

UNLEARNING IS THE NEW LEARNING
"The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn and relearn" - Alvin Toffler

Covid 19 has indeed has proved the above sentence.
Anesthesiologists as operation theatre physicians had to take over the role of the captain of the ship, taking care of infection control protocols and protection of the patient, doctors, staff and healthcare workers in the operation theatre. Since, Covid 19 is there to stay we need to follow protocols in anesthesia management for elective / semi emergency surgeries like endoscopic and laparoscopic surgeries.

Picture showing hysteroscopic procedure (Fig 1)
Pre-Anaesthesia Consultation (PAC):



1. All patients in addition to surgical and anaesthesia evaluation are tested for Covid 19 RT-PCR and /or HRCT chest
2. In elective surgeries, prefer a video consultation and digital preemptive assessment of reports
3. In emergencies, a Rapid Antigen test (RAT) with HRCT chest is recommended
4. History of Covid 19 in patient and relatives
5. Covid 19 testing of relatives / attendant
6. Covid 19 consent form.

Covid 19 positive patients are to be postponed for a minimum of 14 days, preferably 28 days if possible, till infectivity period is almost over or two consecutive negative reports in a gap of 4 days. If, this is not possible then patient can be referred to a dedicated Covid center designated by the authorities.

Personal Protective Equipment (PPE):
According to ICMR/MOHFW guidelines: LEVEL 3 protection is needed for all surgical procedures.
PPE includes protective water proof clothing, hoods, gloves, goggles, face shields, facemasks &/ respirators
- Donning of PPE shall be done in procedure/operation theatre area.
- Doffing in the designated wash area

We doff and soak the used PPE in sodium hypochlorite solution, before disposing them off, to avoid any further contamination.

Preparation:
1. Patient wears a surgical 3 ply mask and a cap
2. In case, patient is within 28 days of post-Covid period then replace surgical 3 ply mask with N95 mask.
3. Disposable gown

Anaesthesia Management:
Goal is infection control during anaesthesia which includes prevention of transmission of infection to care providers and prevention of contamination of anaesthesia machines and all other equipment's. This can be achieved by having minimum number of people in the operation theatre as much as possible.
The choice of anaesthesia technique, general anesthesia [GA], regional anesthesia [RA], total intravenous anaesthesia with spontaneous respiration [TIVA] or monitored anesthesia care [MAC]
Regional anaesthesia: Regional anaesthesia is preferred choice as far as possible as it avoids airway manipulation and aerosol generation
Many Covid patients are anticoagulated which may affect decision of RA
Distance from the patient is to be maintained to avoid infection
Patient should wear a surgical mask at all times throughout the procedure.
If supplemental oxygen is required oxygen facemask can be placed over the surgical mask or nasal prongs under the surgical mask with lowest possible oxygen flow.
Most hysteroscopic procedures can be done under spinal anaesthesia. Patient should be explained the need for 24 hours admission or complete bed rest to prevent post dural puncture headaches. Drugs like chloroprocaine or levo-bupivacaine can be used for faster recovery.
TIVA {Total intravenous anaesthesia}: If patient is RTPCR and HRCT negative hysteroscopy can be done under TIVA on spontaneous respiration with oxygen under mask with cover of surgical mask and transparent plastic drapes. General anaesthesia [to be readied for all patients irrespective of technique]

Hysteroscopy under TIVA with supplemental oxygen given over mask under plastic drapes (Fig 3)

Intubation with full PPE using videolarynygoscope under aerosol box (Fig 4)

Intubation (Fig 4)
- Minimum necessary equipment only. Back-up / emergency equipment's kept ready immediately outside OR
- Minimum personnel in the OT. Back up waiting outside for help
- Surface contamination- cover with plastic all monitors and machines particularly for high touch surfaces and cleaning immediately after AGP
- Use disposable breathing circuits
- Closed circuit with scavenging system preferred
- Avoid Bains circuit and Magill's open circuit
- Breathing circuit should contain two filters rated for virus filtration efficacy (VFF) – one at airway at ETT (Fig 6) sampling line connected on the side of the filter away from patient and the second filter at the expiratory limits of breathing circuit (Fig 5)
- Video laryngoscope – Made as mandatory equipment as per AIDAA guidelines 2020. Avoids anesthesiologist to be in line with aerosol during intubation. (Fig 6)
- Endotracheal tube preferred over supraglottic airway devices
- Low flow anaesthesia technique allows safety margin by giving less expelled gases
- Use of clear acrylic aerosol box with or without arm sleeves, plastic tent or plastic drapes, suction incorporated in vent for intubation and extubating
- A small bucket filled with sodium hypochlorite is mandatory so as to directly soak used equipment like laryngoscope immediately after use.
- Laminar flow in air conditioning duct system should be set at 20 cycles or more air exchanges per hour.
- Intubating bougie especially the flexible ones are very handy,

HMEV filters at the expiratory limb (Fig 5)

Video laryngoscope with disposable blade and HMEV filter attached to ETT (Fig 6)

when intubating through aerosol box.
- Minimum time for intubation, preferably a senior anesthesiologist
- Change in steps to be explained to the assistant
- Rapid sequence induction and intubation
- Preferably avoid mask ventilation, if needed use low pressure small volume breaths maintaining a tight mask seal to minimize air leak around mask.
- Inflate endotracheal cuff before attaching the breathing circuit
- Cover patients mouth with 3 ply masks to avoid aerosols from peri cuff leaks
- Intra-operative
- Avoidance of bucking, coughing on tube
- For circuit disconnection leave filter with ETT
- Extubation
- Preferably done deep and under drapes to avoid aerosol generation. (Fig 7)
- Consider medications like lidocaine, dexmedetomidine should be considered
- All personnel should leave the OT prior to extubating, except only one assistant
- Suction should be done and kept under the drapes. (Fig 7)
- Keep a surgical mask over patient while ETT is still in place and extubated under transparent drapes
- After extubating keep the surgical mask over patient's airway over which oxygen mask can be placed for supplemental oxygen
- Minimum of 15 to 20 minutes allotted for cleaning and decontamination before the next patient taken in.

Points to keep in mind for endoscopy and laparoscopy

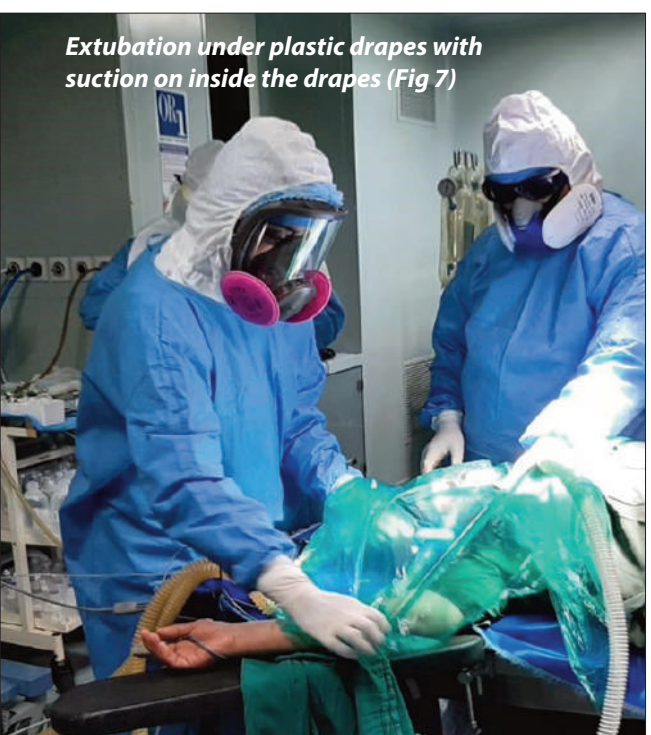
Patients to be tried to managed medically as far as possible

Route open / laparotomy or laparoscopy in view of safety of patient and HCWs

Minimal use of electrocautery

Though role of CO_2in aerosol formation is unclear, use of laparo hepafilters or smoke evacuators to filter CO_2 from pneumoperitoneum and cautery smoke to be considered

Extubation under plastic drapes with suction on inside the drapes (Fig 7)



Viral shedding in feces is documented, hence surgeon should take care of aerosol from anus since their faces are in line of the site while operating especially during vaginal manipulations

Conclusion: In this COVID 19 Corona virus pandemic, the health sector is at the epicentre of this unprecedented global pandemic challenge. With each passing day a greater numbers of healthcare workers are being affected

We should remember,

"THE UNKNOWN IS NOT WHAT TO BE AFRAID OF, IT'S ONLY WHEN THE UNKNOWN BECOMES KNOWN THAT ONE CAN DECIDE WHETHER TO BE AFRAID OR NOT " —Markus Peterson.

Until then it's wise to use all adequate precautions and design protocols suited to each centre using the guidelines so that there is minimum hazard involved for both patients and healthcare workers.

Be compassionate, communicate well with the staff and patients for this virus is there to stay for some time and we will have to learn to be in harmony with it.

ANAESTHESIA IS ETERNAL VIGILANCE MORE SO IN COVID ERA - STAY SAFE.

DR. AMEYA PADMAWAR
MD DGO DNB FCPS

DR. ROHAN KRISHNAKUMAR
MS(OBGY), DNB, FCPS, DFP

SURGICAL SMOKE EVACUATION

Novel coronavirus has raised concerns about the risk of virus transmission to staff in the operating room. This relates not just to intubation and extubation of the airway during anesthesia, but also to the release of potential infectious particles in laparoscopic smoke or plume

Surgical smoke is the airborne by product of aerosol produced by the use of energy-based instruments on tissues in the operation theatres. Energy sources form an integral part of modern minimally invasive surgery. With their usage, surgical smoke liberated as a consequence of their application may have wide reaching implications.

WHAT DOES THE SURGICAL SMOKE CONTAIN?

Surgical smoke contains 95% water vapor and 5% of cellular debris in the form of particulate matter- containing blood, chemicals, tissue particles, viruses and bacteria.

Chemicals present in surgical smoke:		
Acetonitrile	Ethylbenzene	Pyridine
acetylene	Formaldehyde	toluene
benzene	Indole	xylene
butene	Methane	styrene
Carbon monoxide	2-methyl propanol	
ethane	Phenol	

Garden *et al* documented concerns about surgical smoke and determined that surgical smoke transmits disease. The researchers found that the pathogens capable of transmitting were present in surgical smoke and demonstrated the presence of different viruses in surgical smoke, including Corynebacterium, human papillomavirus (HPV), poliovirus, human immunodeficiency virus (HIV) and hepatitis B. The aerosol produced by laparoscopic or robotic surgery, particularly when using low-temperature ultrasonic devices, may not effectively deactivate the cellular components of a virus

The possibility of disease transmission through surgical smoke does exist in humans, but documented cases are rare. HPV transmission during anogenital surgery is the most widely reported in the literature

The evidence is lacking to support that biologically replicable corona virus is present in peritoneal fluid of affected patients undergoing surgery.

Also, as the COVID 19 pandemic builds up the necessity of resuming normal functioning and starting surgery in necessary cases has emerged as an eventuality. Social distancing, triaging of patients, potential safety issues surrounding aerosol generating procedures have necessitated the use of smoke evacuation, aerosol handling of prime importance. If the Exposure of HCP [Health Care Professionals] is minimized the restoration of smooth and safe functioning in the New Normal will become possible.

SMOKE PRODUCTION IN THE OR:

Primary mechanism of smoke generation in the OR is by the heat produced by use of energy sources such as ESU, lasers and ultrasonic devices, high speed bone saws, burrs and drills on the patient's tissue. The focus is drawn to these modalities in the event of COVID19 pandemic.

The concentration of particles in surgical plume after 10 minutes of using electrosurgical devices is higher in laparoscopic vs open surgery. Electrocautery use for 15 minutes generates plume equivalent to the smoke generated by six non-filtered cigarettes. The size of particles found in surgical plume varies from 0.05 µm to more than 25 µm and they can travel up to 1 meter from their source. Particles ranging from 2.5 µm to 10 µm can enter the respiratory tract and can be found as far distal as the alveoli. Ultra-small particles (0.1–0.8 µm) had been found in surgical plume from laparoscopic ports after using laparoscopic monopolar cautery. In laparoscopic surgery, the generation of 0.3 µm particles was higher after 10 minutes of electrocautery use.

Because of the similarities in the tissue effects of ESUs and lasers, the manner of smoke evacuation and policies governing these remain similar.

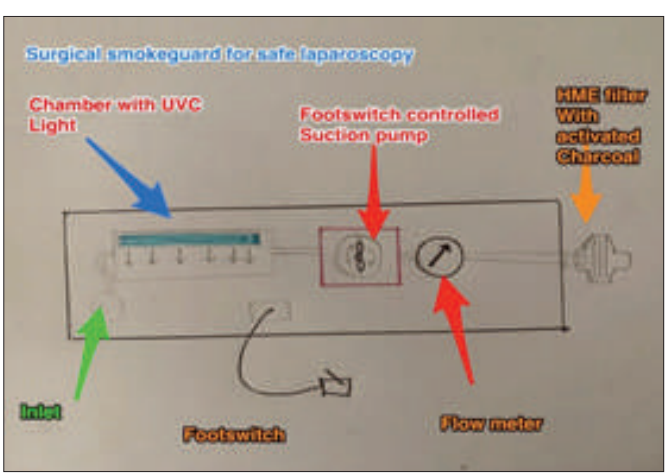
In the current COVID19 pandemic it is significant to know that Aerosol Generating Procedures must be restricted to

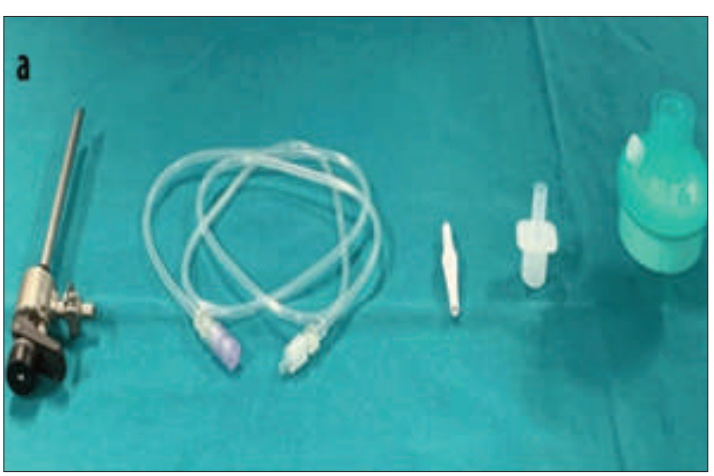
prevent spread of this respiratory illness to all HCP's. Alternate safety protocols have to be established to curtail spread of this aerosol based respiratory illness.
The use of appropriate filters for surgical plume evacuation has been recommended by the Centers for Disease Control and Prevention (CDC) even before the pandemic. Filters for surgical smoke evacuation can reduce its inhalation by healthcare workers by about 66%. These evacuation systems were designed as ultralow particulate air (ULPA) filters that can include activated carbon in their composition to neutralize toxic gases and odor
In view of the harm posed by the surgical smoke, means to mitigate this threat were imposed by the following measures:

GENERAL OR VENTILATION:
PARTICLE SIZE AND DISSEMINATION:
Smaller particles – less than 2 microns can travel farther and impact people circulating during the procedure as well as the scrubbed team members. These smaller particles can reach the respiratory bronchioles and alveoli- the gaseous exchange segment of the lungs. Reported results in absence of smoke evacuation systems, particle concentration can increase from 60,000 particle in a cubic foot to about one million particle per cubic foot within 5 mins of activation of the ESU. The risk prevails to every member present in the OR. The recommendation of 20 minutes for the OR ventilation to return to baseline levels, necessitates 20 minutes to elapse before bringing the next patient for surgery in the OR.
Air exchanges in the OR using positive pressure airflow with at least 15 cycles per hour is recommended to reduce exposure of the OR team to the same column of air with the accompanying aerosol. This is useful but runs the risk of contaminating Adjacent OTs and the hallways.
What would be beneficial, would actually mean a Negative pressure airflow system which rapidly evacuates any air column and suspended aerosols but requires very frequent changes of the filters, making this option not feasible. Of course, the safety in the OR in managing aerosols is magnified.
In the current scenario, a non-recirculatory type of air conditioning system. The HVAC system should have a dedicated return duct, but only a ceiling return system. The exhaust air quantity should be greater than the supply air quantity so that a negative pressure of 2.5 pa is achieved in the room. The position of the extract duct should be above the head of the patient. [Recommendations from the ISA]. The exhaust of air from the AHU should be preferably filtered through a HEPA filter or UV C radiation for 15 minutes or heating – 45 mins at a temperature of 750C.
SURGICAL MASKS: Surgical masks were made with the intention to protect the patients from pathogens harbored by the members of the OR. There is an imminent need to provide Health care professionals from aerosols released into the atmosphere from surgical smoke. Masks also protect the surgical team and filter particles of 5-micrometer size efficiently. Quality compliant with N95 respirators (NIOSH n95, EN 149FF2 or equivalent) with high filtration efficiency of 95% against particulate aerosols of <0.3 microns should be worn by each member in the OR.

WALL SUCTION:
Wall suction units pull over 5 cu ft of air and may be effective for procedures which produce a small amount of smoke. This mechanism requires a frequent change of inline filters and incur a significant recurrent cost.

PORTABLE SMOKE EVACUATION SYSTEMS:
This is the most versatile choice for ORs and especially for ORs performing laparoscopic procedures. These are miniaturized systems which evacuate the surgical smoke from the surgical field and significantly reduces the exposure of the surgical team to the surgical plume.

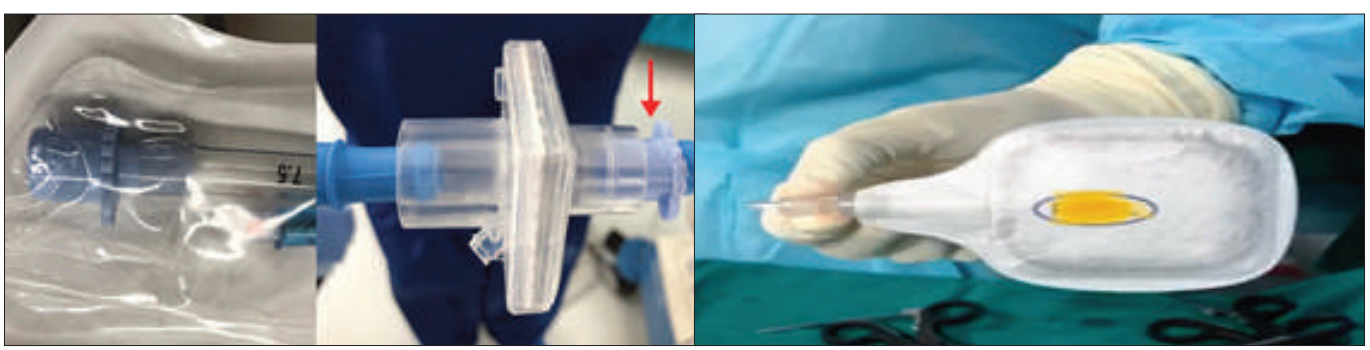




(L) Design of Smoke evacuator.
(R) Basic equipment

These devices include the following:
1. An array of adaptable channels for drawing away the surgical smoke
2. A four-level filter system which includes
a. A prefilter which arrests all particulate matter- larger particles.
b. ULPA: ultra-low particulate Air filter: these filters have a depth media material capable of capturing 0.12 microns of particulate matter at an efficiency of 99.999%. At this rate only one in one million particles will escape capture.
3. The next layer is composed of activated charcoal which by its unique ability to adsorb VOC [volatile organic chemicals]
4. The fourth layer is a compressed sponge which arrests the contained moisture in the aerosol.

Different Smoke evacuation systems



Adaptation of filter to suction system

An effective, portable smoke evacuator system has an efficient suction mechanism with three modes of suction – low, medium and high, which can be activated by a switch or a footswitch. the suction mechanism is able to pull 30-50 cubic feet per minute to be able to capture smoke. These units have a graded suction pump to draw more air from the surgical zone according to its generation while using energy systems. Some smoke evacuators are equipped with an RF sensor which enables suction of fumes when electrosurgery is activated.
A variety of capture devices are used with these units. A small carriage unit or an attachment to the ESU pencil allows for smoke capture almost at the site of its generation. Larger sized tubing may be used to evacuate the smoke when it is not possible to use pencil – carriage systems. When used, larger tubing-based suction generates significant sound from the system.
The composite filters are in the form of encased cartridges and standard precautions should be used while discarding these. These cartridges can pose a biological hazard to the handling personnel.

LAPAROSCOPIC SMOKE EVACUATION:
The fumes in laparoscopy are trapped in the closed compartment of the abdomen. This smoke built up can hinder the

surgeons view.
The use of energy sources which produce less smoke such as bipolar ESUs or tissue function systems can be beneficial.
There exists a constant leakage of gases from the trocar sleeves and is significantly reduced when a constant suction is applied to one of the side ports. This can be used to initiate the suction mechanism actively when the energy source is activated- imparted by RF sensors attached.
In addition to allowing better visibility during surgery, evacuating the smoke reduces the amount of methemoglobin and carboxy hemoglobin in the patients' blood stream
Even at the end of the procedure or while retrieving a specimen from the abdomen, the intraabdominal CO2 has to be evacuated and filtered through the smoke evacuator system, to prevent spewing of the abdominal contents in the faces of the surgical team. Evidence is lacking for infectivity of the surgical smoke and of other energy based instruments such as ESUs and ultrasonic devices. Given the fact that Ultrasonic devices reach a lower temperature to have a tissue response, the possibility exists that this cellular debris generated may carry organisms and still remains infectious. Also, the average particle size after use of ultrasonic devices is 5-6 microns and can possibly carry organisms- like viruses.
Future research is required to compare the smoke generated in similar operations in infectious and noninfectious patients. A small body of evidence suggests that surgical smoke carries a mutagenic risk with no linkage to disease. Both infective and malignant cells have been found in the surgical smoke but their viability and infectivity has not been ascertained.
Review of all available literature concludes that the surgical smoke has the potential for harm, but the risk posed to the OR staff remains unproven.

RISK TO PERIOERATIVE PERSONELL:
The chemical composition of the surgical smoke is well documented. Many nurses have complained of bronchial symptomatology such as cough, wheezing, increased congestion, throat irritation, headache, fatigue, and eye irritation. Additionally, they correlate with lessening of symptomatology when not exposed to surgical smoke on a daily basis. Hence it is fair to conclude that steps taken to eliminate a controllable hazard such as surgical smoke can minimize health costs and improve health of perioperative personnel and patients.

NEWER INNOVATIONS:
The currently available Smoke evacuation systems are expensive devices with a Disposable filtration cartridge which is a potential health hazard when it comes to disposal. The threat of the biological hazard prevails.
This led to developing a device which incorporates the currently available HMEF filters and UV C radiation chambers with a frequency of 250-280 nm along with an inbuilt suction apparatus to evacuate intraabdominal plume at the time of advanced laparoscopic procedures.
This unit – SURGICAL SMOKE GUARD readily utilizes the germicidal, veridical qualities of the UVC light and the ULPA / HEPA filter to eliminate the biological and particulate threat of AGP such as operative laparoscopy in this SARS COV-2 virus induced COVID 19 pandemic.

Criteria to be fulfilled while selecting a portable smoke evacuation system in a laparoscopy OR
1. Cost and operating expenses
2. Effectiveness
3. Size
4. Filter and canister designing
5. Filter monitoring
6. Fluid removal ability
7. Footswitch activation vs automatic activation
8. Reusable/single use
9. Potential threat to handling and service personnel
10. Noise production
11. Consumables used and ease of availability
12. Ability to maintain pneumoperitoneum during surgery

RECOMMENDATIONS

General:

Every patient should be considered COVID-19 positive.

Indications for emergency surgery and urgent oncological procedures during COVID-19 pandemic should be similar as surgical indications used before the pandemic

In patients with confirmed or suspected COVID-19 diagnosis, the use of a disposable surgical equipment is recommended to avoid the contamination risk during cleaning and sterilization processes.

At the institution, an exclusive operative room should be assigned for the procedures in patients with confirmed or suspected COVID-19 diagnosis.

Keep the doors of the operating room closed during surgery.

Patients with suspected or confirmed COVID-19 diagnosis require closer surveillance during the postoperative period considering that they are at higher risk of developing a condition requiring ICU management and they also have a higher mortality rate compared with surgical patients without COVID-19.

Healthcare Workers:

Management guidelines regarding COVID-19 patients undergoing surgery should be individualized according to the reality of the country and the specific healthcare institution.

The route for transport of COVID-19 patients between the areas of the hospital should be standardized, known by healthcare workers and respected in every case.

Healthcare workers should receive training in donning and doffing the personal protective equipment.

Surgical team should wear the personal protective equipment according to CDC guidelines.

The number of healthcare workers (including surgeons, anesthesiologists, nurses, and technicians) should be limited to the minimum required to safely perform the procedure.

During Laparoscopic Surgery:

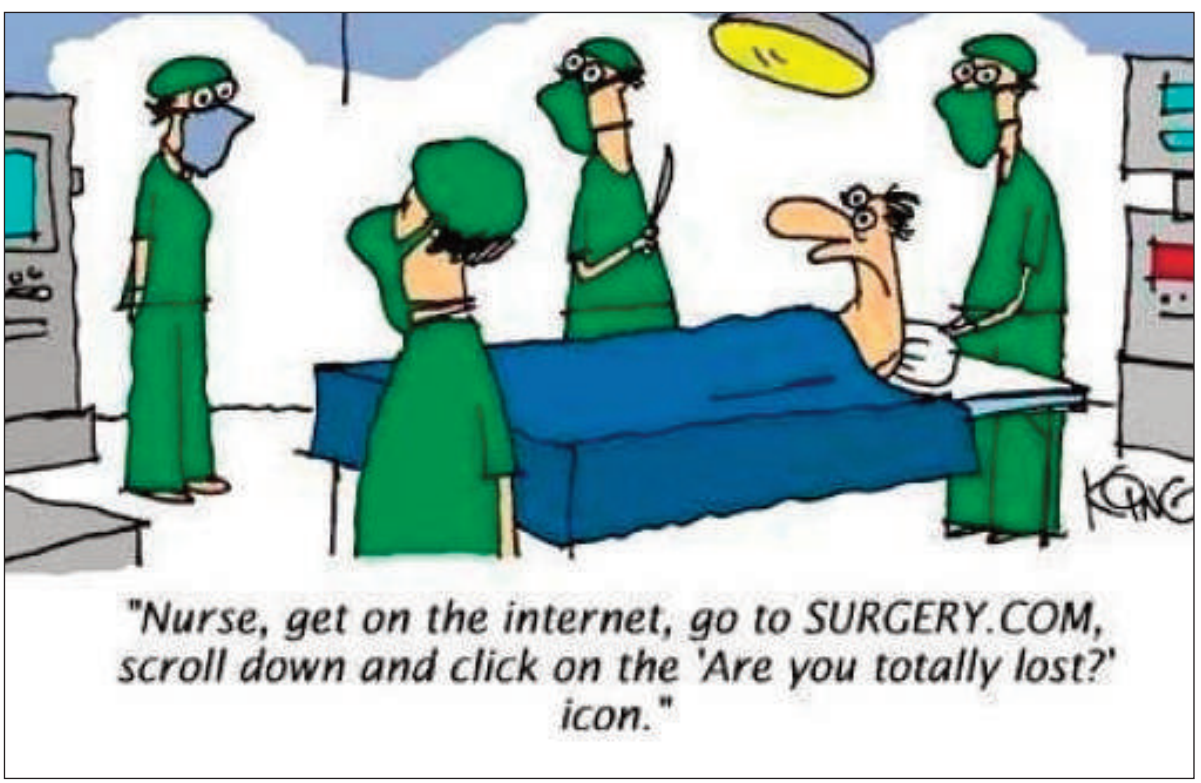
The number and diameter of trocars should be the minimum required to safely perform the procedure.

The intra-abdominal pressure during laparoscopic surgery should be between 8 and 12 mm Hg

Minimize the use of electrosurgical devices, especially ultrasonic scalpel. In case of using monopolar, the energy should be used at the lower intensity to achieve desired effects.

Surgical plume and pneumoperitoneum should be evacuated in a controlled manner and it is recommended to use an appropriate filter to guarantee safety of healthcare workers.

HUMOUR UNDER A SCALPEL



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JALGAON, MAHARASHTRA

VNOTES... VAGINAL SURGERY 2.0

Vaginal surgery is the oldest form of gynaecological surgery. It is essentially a no abdominal scar surgery. The evolution of gynaecological surgery has come full circle (Fig. 1). The big scars of open surgery were reduced to few small scars with the advent of laparoscopy at the beginning of 20th century. Several versions of minimally invasive surgery were developed over the period like mini laparoscopy, robotic surgery and single incision laparoscopic surgery whilst vaginal surgery was still being performed and recommended. Minimally invasive transabdominal surgery did lead to abdominal scars while it had the advantage of magnified endoscopic vision over the traditional vaginal surgery.

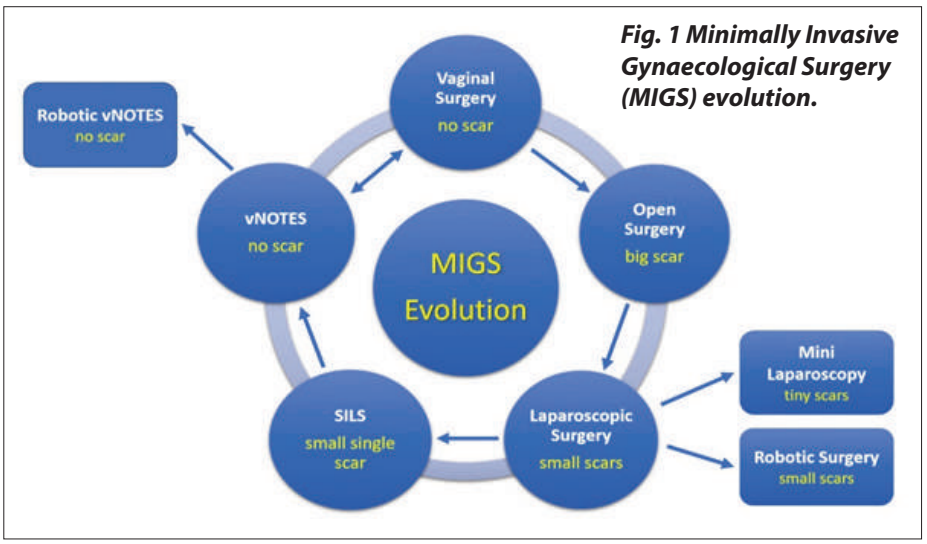

Fig. 1 Minimally Invasive Gynaecological Surgery (MIGS) evolution.

In the decade of 2010s, Transvaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) has emerged as a successful new technique in gynaecology. It utilises the principles of single incision/ single port laparoscopic surgery which are applied transvaginally. The single incision laparoscopic surgery is performed through a transumbilical single incision to improve the cosmesis. On the contrary, in pure vNOTES procedure, no abdominal incision is made. Therefore, there is no visible scar after the procedure.

The first Natural Orifice Transluminal Endoscopic Surgery (NOTES) in humans was described by Rao and Reddy from India in 2004 [1]. They described transoral appendectomy in their study. The first description of transvaginal endoscopic cholecystectomy was published by Zorron *et al* from Brazil [2]. Later, similar procedure was reported from USA & France [3,4]. Transvaginal NOTES has been utilized to perform appendectomy, cholecystectomy, nephrectomy and several gynaecological surgeries [5-10].

Lee *et al* reported the first case series of pure transvaginal NOTES for adnexal diseases in 2012 [8]. Su *et al* reported the first case series of transvaginal NOTES for performing hysterectomy in 2012 [9]. Baekelandt, reported his technique of total vaginal NOTES hysterectomy (TVNH), in which the entire procedure was performed using transvaginal NOTES under the pneumovagina [10].

In gynaecology, transvaginal route is the oldest route of surgery. The initial concept of transvaginal endoscopy was called 'culdoscopy' when it was mainly described for a diagnostic purpose. Recently, the applications of vNOTES has become wider to do several therapeutic surgical procedures. The advancement of technology for the endoscopic instrumentation and the optics has facilitated the progress of vNOTES. Application of robotic surgery will further facilitate and widen the scope of vNOTES procedures. Application of robotic surgery in vNOTES has been described [11,12].

This article will focus on the basics of the technique of vNOTES and its application to do several gynaecological surgeries.

Advantages of vNOTES:

Several authors have compared vNOTES with standard laparoscopic procedures [13,14]. Certain benefits of vNOTES observed over laparoscopy were:

• Shorter operative time • Less pain • Faster recovery • More discharges within 12 hours • No scars

vNOTES has an advantage of better visualisation and more operative space over traditional vaginal surgery especially in cases with narrow vagina, high apex, obesity, large size of pelvic pathology and indicated adnexectomy.

Patient selection and contraindications:
vNOTES surgery is suitable choice for most procedures except:
1. Malignancy **2.** Severe endometriosis
3. Obliterated cul de sac **4.** Pelvic abscess/ active infection
vNOTES hysterectomy for cancer endometrium with sentinel lymph node biopsy has been demonstrated in a clinical trial setting.

Instrumentation:
All standard laparoscopy instruments and vaginal surgery instruments are required for vNOTES.
For vNOTES hysterectomy, it is preferred to use an advanced bipolar system with vessel sealing technology. The instrument described here is 5mm LigaSure (Medtronic).
10 mm 0 degree or 30 degree telescope can be used for all procedures.
Other essential instrumentation includes wound protector (fig. 2), a latex surgical glove or premade vNOTES port (fig. 3).

Anaesthesia and patient position:
Patient is given general anaesthesia followed by dorsal lithotomy position. During the surgery, 15 degree Trendelenburg position is given to facilitate retraction of bowel (Fig. 4).
Assembly of vNOTES port:
There are essentially two parts of vNOTES port-
1. Wound protector (Medtronic /Applied Medical)
2. Glove port/ premade vNOTES port like GelPOINT (Applied Medical)

For making a glove port, we use a size 7 orthopedic grade latex glove (Ansell). The tip of the fingers of glove are cut with scissors. The size of the cut is about 4 mm and 8 mm for a 5 mm port and 10 mm port to be inserted through it respectively. For most procedures, 3 ports are inserted through the incised fingers, one 10 mm port for telescope and two 5 mm ports. CO_2 insufflation tube is connected to one of the 5 mm ports or can be inserted into one of the remaining fingers of the glove. All ports are secured by tying a thread to avoid any leakage. After the wound protector is inserted transvaginally, the wrist of the glove is applied to the outer ring of wound protector which is then rolled over the perineum till it snugly fits (Fig. 5).
While using a glove port is a cost-effective technique, the floppy fingers of glove do not provide a stable support for the ports and instruments. Therefore, with added cost, premade vNOTES port may be used to overcome this disadvantage. In our experience, with a short learning curve, surgical team can adapt to use glove port for all vNOTES procedures. While doing vNOTES procedures through a glove port, surgeon consciously lifts the instruments rather than completely resting it on the port.

Fig. 2 – Wound protector (Applied Medical, Rancho Santa Margarita, CA)

Fig. 3 – V path, Gelpoint (Applied Medical, Rancho Santa Margarita, CA)

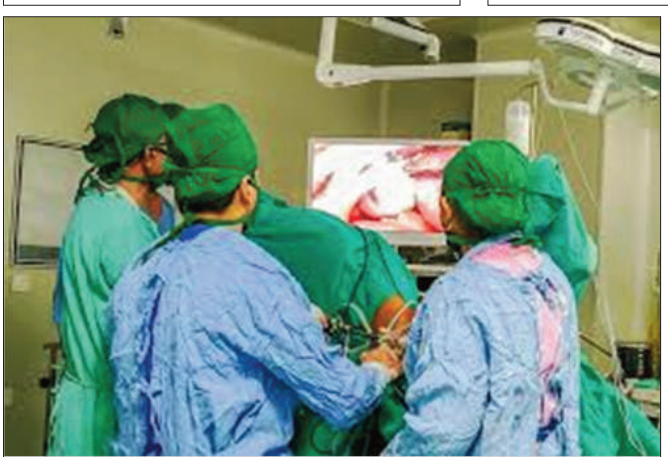

Fig. 4- Lithotomy with Trendelenburg position of patient. Surgical team position between the legs of patient.

vNOTES vision and anatomical orientation:
The vision obtained by vNOTES is reverse to that of laparoscopic vision and therefore the anatomical orientation is also reverse. As a result, under vNOTES view, all the right sided anatomical structures appear on the left side of the screen and vice versa (Fig. 6). Surgical team can gain this orientation quickly with dry lab practice.

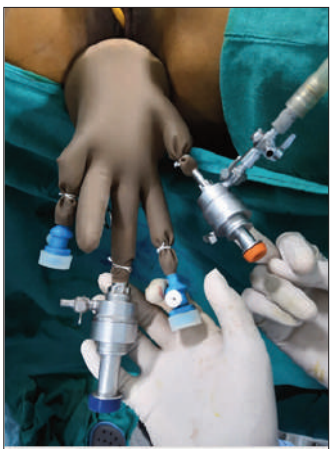

Fig. 5- vNOTES glove port

vNOTES hysterectomy:
vNOTES hysterectomy is divided in two types:
I. Vaginally Assisted NOTES Hysterectomy (VANH)- Initial steps of surgery from colpotomy to division of uterosacral ligaments are performed like in traditional vaginal hysterectomy. The rest of the steps are performed by vNOTES.
II. Total Vaginal NOTES Hysterectomy (TVNH)- All the steps of hysterectomy from colpotomy to completion of hysterectomy are performed by vNOTES.

The technique described here is VANH by ATRIUM (Aided by TRanscervical Instrumental Uterine Manipulation) technique [15]:
Step 1- Colpotomy: Circumcising incision over cervicovaginal junction
Step 2- Opening P pouch and A pouch: Posterior pouch is opened to enter the peritoneal cavity. Anterior pouch is opened after bladder dissection and retraction to enter the peritoneal cavity.
Step 3- Division of uterosacral ligaments: Bilateral uterosacrals are ligated and divided as in traditional vaginal hysterectomy. The sutures are used later to suspend uterosacrals to vaginal cuff.
Step 4- Insertion of wound protector and assembly of glove port: The flexible ring of wound protector is inserted transvaginally beyond the edge of vagina. The wrist of the glove is applied to the outer ring of wound protector which is then rolled over till it snugly fits the perineum. The wound protector retracts bladder, rectum and lateral pelvic wall. It also creates space in the vagina for easy passage of instruments. The glove port after insufflation provides a reservoir in which specimen/ sutures can be temporarily stored.

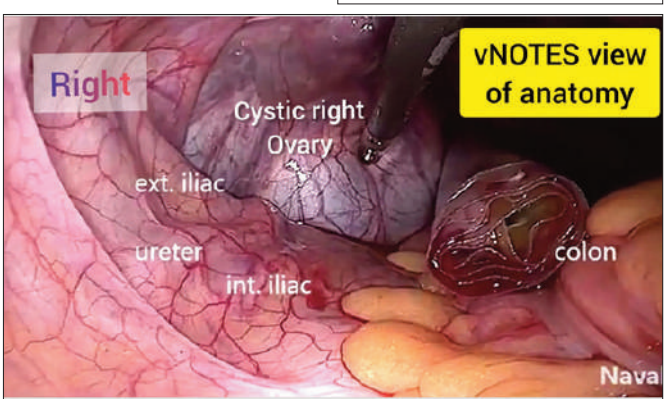

Fig. 6- vNOTES view of pelvic anatomy with reverse orientation.

Step 5- Hysterectomy on left side aided by instrumental uterine manipulation: The cervix is deflected to right side by a toothed needle holder/ grasper, left uterine pedicle is isolated by dissection. The uterine pedicle is sealed by LigaSure and divided. Then the needle holder/ grasper is passed transcervically into the uterus. It is pushed inside and deflected to right side. This manipulation of uterus exposes the pedicles on left side (Fig. 7). All the pedicles are sequentially sealed and divided to complete the hysterectomy on left side. Salpingectomy is also done during these steps in similar fashion.
Step 6- Hysterectomy on right side aided by instrumental uterine manipulation: The same steps of surgery are repeated as on left side to complete the hysterectomy. Subsequently, bilateral salpingectomy is performed. Opportunistic salpingectomy is easier to perform by vNOTES compared to traditional vaginal surgery.
Step 7- Specimen retrieval and removal of vNOTES port: The specimen is grasped and removed transvaginally through the wound protector. Large specimen can be put in an endobag and brought out transvaginally by debulking with a surgical knife. Following this the wound protector and vNOTES port is removed. Using endobag or not for transvaginal morcellation depends on the surgeon's discretion of the case.
Step 8- Closure of vaginal cuff: The vaginal cuff is closed as in traditional vaginal surgery by 1-0 polygalactin or equivalent barbed suture. It is advisable to suspend the vaginal cuff with uterosacral ligaments.

vNOTES adnexal surgery:
The principles of vNOTES remain same for doing adnexal surgery except a few differences.
Only posterior colpotomy of about 3-4 cm is made. Extra-small size wound protector is inserted through it. The technique of insertion and the assembly of glove port is same.
Generally, the pathological adnexa will fall automatically in the cul de sac. The required adnexal surgery is done following standard steps. Specimen is put in an endobag and retrieved transvaginally. Vaginal incision is closed with 1-0 polygalactin after removal of vNOTES port.
Following adnexal surgeries can be performed safely by vNOTES:

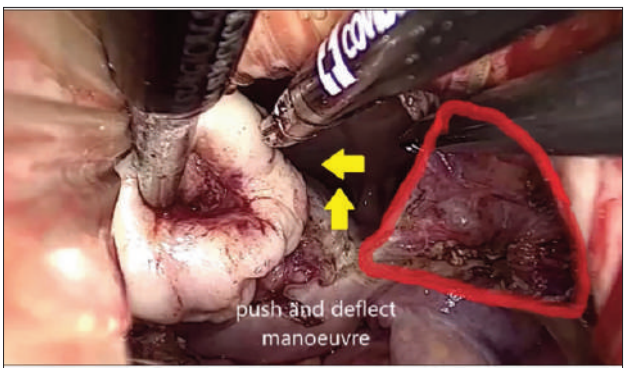

Fig. 7- Transcervical instrumental uterine manipulation. Uterus is deflected to right side to expose left side pedicles.

• Ovarian cystectomy • Para-ovarian cystectomy
• Adnexectomy • Salpingectomy/ salpingotomy for ectopic pregnancy
• Tuboplasty/ tubal recannalisation.

Other vNOTES procedures:
Several other procedures have been reported-
• vNOTES Myomectomy • vNOTES Supracervical Hysterectomy • vNOTES High Uterosacral Ligament Suspension • vNOTES Sacrocolpopexy • vNOTES Sentinel Lymphadenectomy

Postoperative management:
Patient is mobilised 3 hours after the surgery. Oral intake is allowed 6 hours after surgery. Discharge is given on Day 2 in our protocol. However, vNOTES can be done in a day care setting.

Limitations:
• Learning curve- Although short for a trained and proficient laparoscopic surgeon, there is definitely a learning curve [16,17]. Therefore, structured and systematic training in vNOTES is recommended.
• Triangulation and space- Although the triangulation in vNOTES is enough to perform most procedures comfortably, the limitation of space compared to laparoscopy can be challenging in difficult cases. Therefore, importance of case selection needs no emphasis.
Future development of instrumentation will allow vNOTES to overcome these limitations.

vNOTES is a new and latest advancement in minimally invasive gynaecological surgery. It has the potential to widen the scope of vaginal surgery, which is the most preferred route in gynaecological surgery [18]. Most gynaecological procedures can be performed by vNOTES. In clinical practice, vNOTES can result in better surgical and cosmetic outcome. However, experienced vaginal and laparoscopic surgeons should adopt it after efficient training.
Currently, more focus is needed on the standardised training of gynaecologists in this new procedure. International NOTES Society (www.notesurgery.org) and vNOTES Academy of India *(www.vnotesacademy.in)* have designed a well structured and systematic training program that can help gynaecologists to develop essential skills in the transvaginal natural orifice transluminal endoscopic surgery (vNOTES). Subsequently, trained vNOTES surgeons should enter the data of their vNOTES procedures in the International complication database. This will help in documentation, research and further standardisation of vNOTES.
Today, vNOTES should be utilised by a trained surgeon whenever traditional vaginal surgery is not possible or is challenging within the available setting. Laparoscopy and transabdominal open surgery may be reserved for contraindications of transvaginal route.

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I hereby apply to be a Life Member of **INDIAN ASSOCIATION OF GYNAECOLOGICAL ENDOSCOPISTS (IAGE).** I am herewith sending the entrance and membership fees by D.D./ Cheque No:_____ Dated_____ for ₹. _____ on _____(bank) in favour of IAGE

Life membership fee *(Including Entrance Fee & GST)* **₹ 7500/-*** with effect from 1st November 2018

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7. Date of Application: _____

Recommended by:

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2. Dr. _____ Signature of applicant: _____

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INDIAN ASSOCIATION OF GYNAECOLOGICAL ENDOSCOPISTS

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