

Performance of Endoscopic Simulation Skills among Ob/Gyn Residents

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hysterectomies increased while the number of open hysterectomies decreased in the third quarter.

Conclusions: Introduction of a robotic surgical system resulted in consistent utilization and steady case volume, while increasing the proportion of minimally invasive hysterectomies. The robot contributed to surgical education without detracting from case volume or diversity.



74 Open Communications 3 - Surgical Education (12:10 PM – 1:10 PM)

12:17 PM – GROUP A

ERAS in Minimally Invasive Gynecology: A Meta-Analysis of the Literature

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Objective: To determine the role of “enhanced recovery after surgery” or ERAS in minimally invasive gynecology.

Design: Meta-analysis of the literature.

Settings: The studies evaluated included academic and private practices, tertiary hospitals and smaller community hospitals, and US-based sites and international sites.

Patients: Women receiving laparoscopic or vaginal surgery that utilized an ERAS protocol.

Interventions: The bibliographic databases PUBMED, Embase, Medline, CINAHL, and the Cochrane Library (CENTRAL, DARE, CDSR, HTAD, and NHS EED) were searched. The search terms “enhanced recovery,” “ERAS,” “gynecology,” “gynecologic surgery,” “fast track” were utilized in the search. There were no restrictions regarding the type of study design. English language requirement was placed. In addition, reference lists of the review articles and included studies were reviewed and additional studies of interest were included. Results of all the searches were combined and duplicates removed. Review articles were excluded from analysis.

Measurements/Results: The most consistent items included in an ERAS protocol included preoperative patient education and counseling, avoidance of drains/packing, limiting IV fluids intraoperatively, local anesthetic/blocks, multimodal pain management that minimizes narcotic use, and early mobility and feeding. There was a cost savings in the ERAS group for laparoscopic and vaginal surgery but the margin appeared to be dependent on the length of stay of the pre-ERAS groups. There was up to a 80% less narcotic used in the ERAS group but not necessarily a lower pain score. Patient satisfaction scores are high in the ERAS group.

Conclusions: The value of ERAS has yet to fully be determined, especially with laparoscopic and vaginal surgery. This is a meta-analysis that is focused on the role of ERAS in minimally invasive gynecology.

75 Open Communications 3 - Surgical Education (12:10 PM – 1:10 PM)

12:24 PM – GROUP A

Performance of Endoscopic Simulation Skills among Ob/Gyn Residents

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Objective: To assess surgical simulation skills over the course of one year for PGY matched cohorts and to determine patterns of improvement in endoscopic skills during the course of an OB/GYN residency.

Design: Prospective, cohort study.

Settings: Academic affiliated community hospital.

Patients: Participants: 24 residents, ranging from PGY 1 - 4 from 2016 to 2017.

Interventions: Endoscopic skills in hysteroscopy, traditional laparoscopy, and robotics were assessed in 2016 and 2017 after an additional year of training. Assessments included time, accuracy, and economy of motion.

Measurements/Results: Individual cohort improvements were assessed via paired two-sample t-tests. The year to year differences in performance for each cohort were calculated and compared to each other using a one-way anova with a Bartlett’s test for equal variances. Each cohort improved relative to their prior performance in timed hysteroscopy and robotics skills ($p < .05$). The PGY 1 class demonstrated a statistically significant improvement in timed hysteroscopic, laparoscopic, and robotic skills, as well as in robotic economy of motion when compared to the year to year difference of all other levels ($p < .05$). In all other assessed skills, no classes demonstrated a statistically different mean improvement when compared with each other.

Conclusions: In most skills, each class’ mean performance improved; however, the largest improvement often came from the PGY 1 class. Our results suggest that the largest improvement in simulation skills coincides with the initial exposure to endoscopic procedures. This confirms the presence of a steep surgical learning curve regarding to endoscopic skills. However, this may not imply improvement in OR surgical case performance. Future investigation will include comparison of surgical simulation performance with Mytipreport.

76 Open Communications 3 - Surgical Education (12:10 PM – 1:10 PM)

12:31 PM – GROUP A

Training and Performance: Informed Consent for Hysterectomy

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Objective: To determine how surgeons learned to perform informed consent for hysterectomy, and how they currently perform it.

Design: Survey.

Settings: Society of Gynecologic Surgeons (SGS) 2018 scientific meeting.

Patients: 189 surgeon responders.

Interventions: We surveyed surgeons about how they learned informed consent for hysterectomy, the important risks, and alternative treatment options.

Measurements/Results: Of 189 responders, 51% were attendings for 5+ years. 66% were Female Pelvic Medicine and Reconstructive Surgeons, and 14% were minimally Invasive Gynecologic Surgeons. 99% were high volume surgeons, with 55% performing 5+ hysterectomies monthly. Most learned informed consent by observing senior residents (74%) and attendings (86%). 20% endorsed training including lectures (25%), role playing (16%), or simulations (15%). 80% felt competent by graduation (41% as