AGL 2022

51st GLOBAL CONGRESS ON MIGS

December 1–4, 2022 | Gaylord Rockies Resort and Convention Center | Aurora, Colorado

SYLLABUS

Surgical Tutorial 6: Laparoscopic Hysterectomy

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Sangeeta Senapati, MD, MS – Consultant: Myovant, PEC< Emmi; Ownership Interest: KLAAS
Kelly N. Wright, MD – Consulting: Aqua Therapeutics, Ethicon, Hologic, Karl Storz

Surgical Tutorial 6: Laparoscopic Hysterectomy

Chair: *Hye-Chun Hur, MD, MPH*

Faculty: *Sangeeta Senapati, MD, MS, Kelly N. Wright, MD*

Course Description

At the conclusion of this course, the participant will be able to: 1) Identify complex cases to allow for appropriate preoperative counseling and surgical planning; 2) Employ intraoperative strategies to minimize blood loss during complex laparoscopic hysterectomies for large mass size or anatomically challenging fibroids; and 3) Integrate tips and tricks to minimize complications like visceral organ injury or cuff dehiscence during complex laparoscopic hysterectomies presenting with extensive adhesions or advanced endometriosis.

Learning Objectives

At the conclusion of this course, the participant will be able to: 1) Identify complex cases to allow for appropriate preoperative counseling and surgical planning; 2) Employ intraoperative strategies to minimize blood loss during complex laparoscopic hysterectomies for large mass size or anatomically challenging fibroids; and 3) Integrate tips and tricks to minimize complications like visceral organ injury or cuff dehiscence during complex laparoscopic hysterectomies presenting with extensive adhesions or advanced endometriosis.

Course Outline

3:15 pm	Welcome, Introduction and Course Overview	H.C. Hur
3:20 pm	Tackling the Complex Laparoscopic Hysterectomy (Adhesions, Endometriosis): Breaking it Down to “Doable” Steps	K.N. Wright
3:35 pm	Tackling the Complex Hysterectomy (Large Mass Size, Challenging Fibroids, and Hypervascular Uterus): Optimizing Success and Avoiding Common Pitfalls	S. Senapati
3:55 pm	Specimen Extraction, Cuff Closure, and Management of Cuff Complications	H.C. Hur
4:05 pm	Questions & Answers	All Faculty
4:15 pm	Adjourn	

Tackling the Complex Laparoscopic Hysterectomy: breaking it down to doable steps (a focus on endometriosis and adhesions)

Kelly Wright, MD, FACOG, FACS
Director, Division of Minimally Invasive Gynecologic Surgery
Associate Professor, Obstetrics and Gynecology
Associate Program Director, FMIGS
Cedars-Sinai Medical Center

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Disclosures

Consulting:
- Aqua Therapeutics
- Ethicon
- Hologic
- Karl Storz

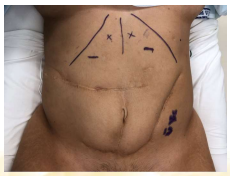
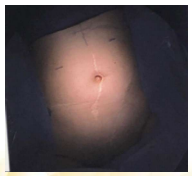
Objectives

1. Articulate keys to laparoscopic success
2. Approach the difficult anterior culdesac
3. Approach the difficult posterior culdesac
4. Prevent and identify injuries

Back to basics: The keys to laparoscopic success

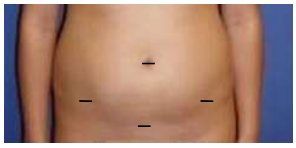
Back to basics

- Reproducible set-up
- Consistent comfortable entry
- Know the steps that set up the next steps

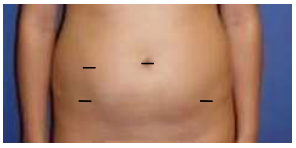




Abdominal entry

Port positioning



Port positioning



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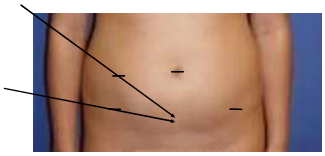

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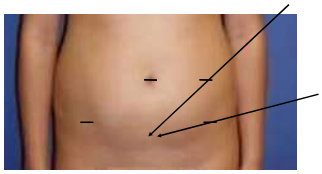
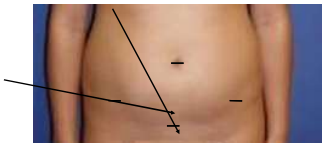
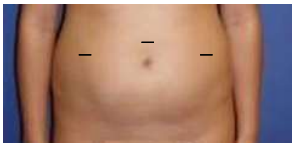


Port positioning

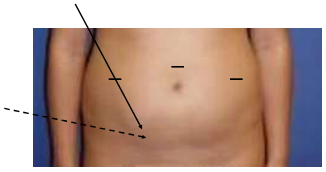


Port positioning

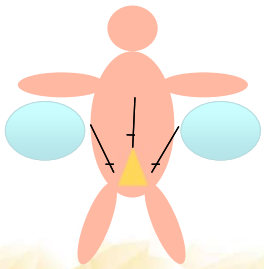


Port positioning

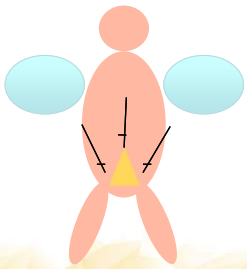
Port positioning



Laparoscopic set-up



Laparoscopic set-up

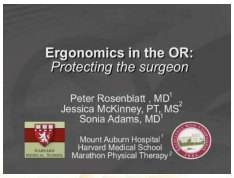


Ergonomics

- Work-related musculoskeletal disorders (WMSDs) are common among gynecologic surgeons
  - 66-95% open surgery
  - 73-100% laparoscopy
  - 54-87% vaginal surgery
  - 23-80% robotic surgery

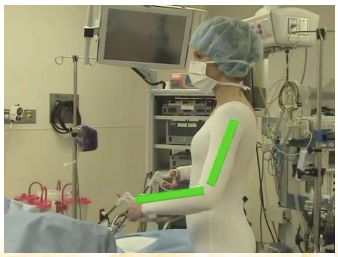
Ergonomics in gynecologic surgery

Tatiana Catanzarite[a,b], Jasmine Tan-Kim[a], and Shawn Adam Menefee[a]



Laparoscopic set-up

Laparoscopic set-up



Laparoscopic set-up

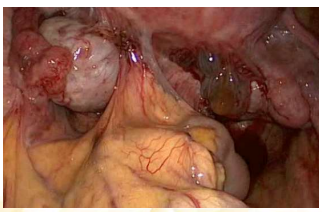
Reproducible laparoscopic set-up

- Stand at the shoulders
  - Tuck arms, no toboggans
- Arms at a 90 – 120 degree angle
- Monitor across from you
- Right handed = stand on the right
- RLQ port as low as possible for suturing

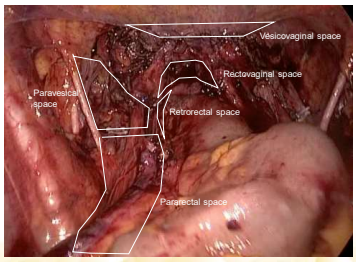
If it feels awkward, something is wrong

Circle the dragon

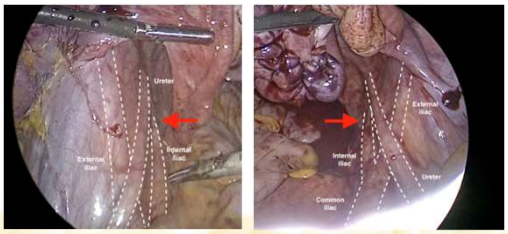
Approaching adhesive disease



Using your spaces



Using our sidewalls



Anterior culdesac video

Posterior culdesac video

Putting it all together (endo+fibroids video)

Recognizing injury

GU injury

79 studies of over 100,000 patients

- 0.3% ureteric injury
- 0.8% bladder injury

However up to 4.3% for hysterectomy

- 1.8% ureteric injury – junction of ureter and uterine artery
- 2.9% bladder injury

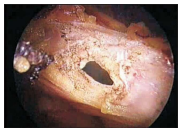
Review

Urinary Tract Injury at Benign Gynecologic Surgery and the Role of Cystoscopy

A Systematic Review and Meta-analysis

Brahmananda Teelucksingh, MD, LMCC, Donna Gilmour, MD, FRCSC, and Gordon Flowerdew, DSc

Bladder injury



Management
- Dome:
  - Less than 1cm: repair or catheterization
  - Less than 2cm: 1-layer
  - Greater than 2cm: 2-layer
  - *Test for water-tightness*
  - Catheterization 5-14 days
  - Antibiotics not needed
  - Retrograde cystogram before removing catheter for larger injuries
  - Injuries near the trigone: consult, stent

Bowel injury is rare

- 90 studies including 474,000 patients
- Incidence of 1 in 769 (0.13%)
- Increased by complexity of procedure:
  - 0.39% for hysterectomy
- ~50% was small bowel
- ~50% occurred during first entry
- *No deaths associated with recognized injury*
- *3.2% mortality rate for unrecognized entry*

References

- Ahmad G, Baker J, Finnerty J, Phillips K, Watson A. Laparoscopic entry techniques. *Cochrane Database Syst Rev.* 2019;1(1):CD006583.
- Rahn DD, Phelan JN, Roshanravan SM, White AB, Corton MM. Anterior abdominal wall nerve and vessel anatomy: clinical implications for gynecologic surgery. Am J Obstet Gynecol. 2010 Mar;202(3):234.e1-5.
- Sandadi S, Johannigman JA, Wong VL, Blebea J, Altose MD, Hurd WW. Recognition and management of major vessel injury during laparoscopy. J Minim Invasive Gynecol. 2010 Nov-Dec;17(6):692-702.
- Teeluckdharry B, Gilmour D, Flowerdew G. Urinary Tract Injury at Benign Gynecologic Surgery and the Role of Cystoscopy: A Systematic Review and Meta-analysis. Obstet Gynecol 2015; 126:1161.
- Ibeanu OA, Chesson RR, Echols KT, Nieves M, Busangu F, Nolan TE. Urinary tract injury during hysterectomy based on universal cystoscopy. Obstet Gynecol 2009;113:6–10.
- Misal M, Dizon AM, Louie M, et al. Risk of Urinary Tract Infection Symptoms after Posthysterectomy Cystoscopy with 50% Dextrose as Compared with Saline Cystoscopy with Indigo Carmine. *J Minim Invasive Gynecol.* 2021;28(2):282-287.
- Llarena NC, Shah AB, Milad MP. Bowel injury in gynecologic laparoscopy: a systematic review [published correction appears in Obstet Gynecol. 2015 Oct;126(4):903]. *Obstet Gynecol.* 2015;125(6):1407-1417.
- Glaser LM, Milad MP. Bowel and Bladder Injury Repair and Follow-up After Gynecologic Surgery. *Obstet Gynecol.* 2019;133(2):313-322.
- Saiid MS, Siddiqui MR, Baig MK. Single layer versus double layer suture anastomosis of the gastrointestinal tract. The Cochrane Database of Systematic Reviews 2012, Issue 1. Art. No.: CD005477.
- Rosenblatt PL, McKinney J, Adams SR. Ergonomics in the operating room: protecting the surgeon. *J Minim Invasive Gynecol.* 2013;20(6):744.

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Thank you!
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@Migsrunner

Tackling the Complex Laparoscopic Hysterectomy: Optimizing Success and Avoiding Common Pitfalls

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Clinical Associate Professor
Pritzker School of Medicine, University of Chicago

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Disclosure

- Consultant: Myovant, PEC, Emmi
- Ownership Interest: KLAAS

Objectives

- Discuss appropriate preoperative counseling and surgical planning
- Optimize intraoperative strategies to tackle a challenging/enlarged uterus
- Demonstrate techniques to safely address vascular supply to the uterus/fibroids

Can this be done laparoscopically?

- A non-vaginal hysterectomy candidate who by traditional methods would have undergone hysterectomy abdominally

There are no absolute contraindications, just relative: **surgeon experience, anatomical considerations, operating field**, anesthesia, abdominal entry issues…

Aarts et al JWM 2015

Pretreatment

- Luprolide
- Relugolix/estradiol/norethindrone
- Elagolix +/- norethindrone/estradiol
- Letrazole

Lethaby A et al Cochrane Rev 2017
Schaff W et al NEJM 2020
Al-Hendy A et al NEJM 2021

Patient Positioning

- Dorsal lithotomy
- Arms padded and tucked at sides
- Steep Trendelenburg
- Decompress stomach & bladder

Positioning

- Obese patients AND long cases are at a greater risk of pressure sores and neural injuries!
  - Ultrafins: Yellowfins for the obese
  - Shoulder braces or other antiskid measures
  - Vacuum beanbag
  - Toboggans or arm supports
  - Neck support

Work with anesthesia! +/- T-berg

Don't forget surgeon positioning!

Technical Steps

- Survey of operative field: Create a game plan
- Adnexal management
- Round ligament & entry into broad ligament
- Vesico-uterine reflection
- Skeletonization & ligation of uterine vasculature
- Management of vaginal cuff
  - Colpotomy
  - Closure
- Specimen extraction

Laparoscopic Access

- Direct vs. open (Hasson technique) vs. Veress needle (standard, long)
- Left upper quadrant (Palmer's Point)
- Transforniceal

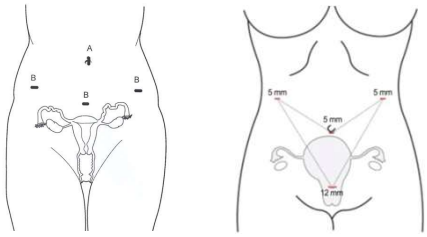
Ports and Port Placement

- Balloon tipped ports

- Increase pneumoperitoneum to 18-20mm Hg
- Consider more lateral +/- superior port placement
  - More exposure
  - Decreased the torque on the ports

Youn et al J Kor Med Sci 2007

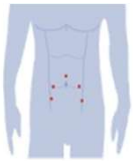
Trocar Placement - cephalad



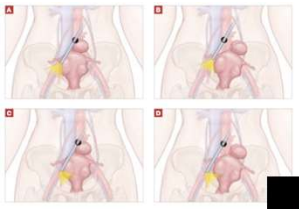
Youn et al J Kor Med Sci 2007

Tailored Port Placement

- Complex cases - consider using > 3 ports
  - 2 ipsilaterally to allow bimanual engagement
- Placement of ports should allow most operating to occur using 1/2 - 2/3 instrument length



Angled Scope



Electrosurgical Vessel Sealing Technology

Halo PK
LigaSure
EnSeal
Harmonic Ace
Thunderbeat

Instruments

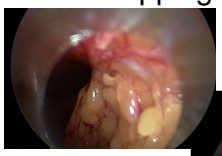
Uterine Manipulator

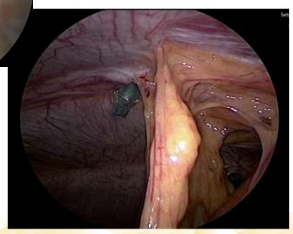
- VCARE
- RUMI + Koh colpotomy rings
- Advincula Arch/Delineator

TLH configuration

(Koh colpotomy ring, ZUMI uterine manipulator, vaginal balloon pneumo-occluder)

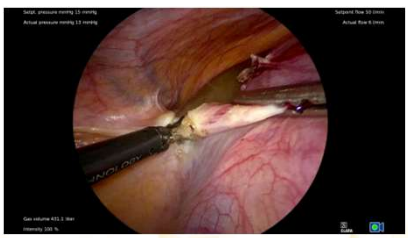
Port Hopping



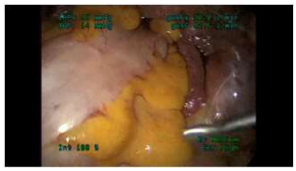


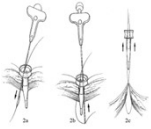
Adnexa

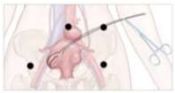
Round Ligament



Retraction Techniques

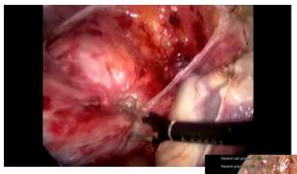


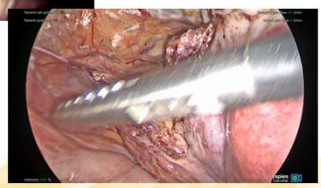




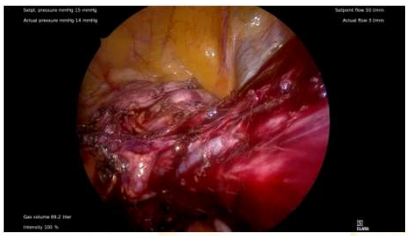
Retraction Techniques

Uterine Vasculature

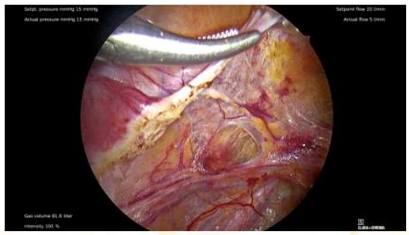




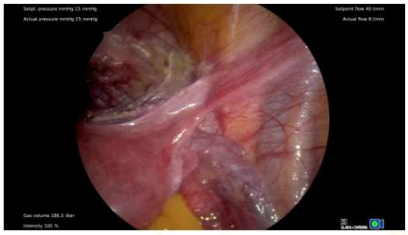
Large Uterine Vasculature



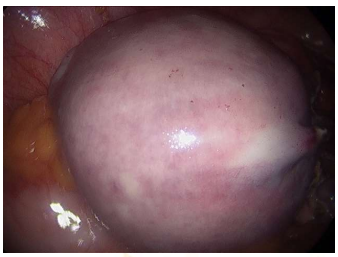
Uterine Artery – Alternate Approach



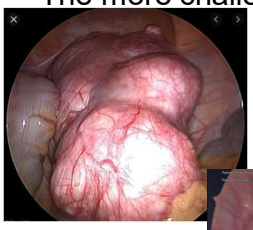
Vascular Clips

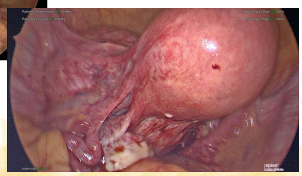


Blanched Uterus



The more challenging cases…





Retroperitoneal Fibroids

Ureteral Stents?

- Ureter will be more prominent and rigid
  - Lighted?
- 3141 patients underwent gynecologic surgery ureteral injury occurred in 1.2% of patients with stents and 1.09% without stents
- NO difference in ureteral injury with or without stents

Chou MT Int Urogyn J Pelvic Floor Dysfunct 2009

Cystoscopy – Safety Check!

- Overall urinary tract injury rate 0.73%[1]
  - Risk is greater than with abdominal hysterectomy[2]
  - May have delayed injury from thermal damage
- Procedure: 70 degree or 30 degree scope
  - Water, saline, or 10% dextrose as the distention media
  - Can use IV indigo carmine, IV methylene blue, IV flourescein, or preoperative oral phenazo-pyridine for visualization of ureteral jets of urine

Adelman et al JMIG 2014[1]
Aarts et al Cochrane Database Syst Rev. 2015[2]

References

- Al-Hendy A, Lukes AS, Poindexter AN 3rd, Venturella R, Villarroel C, Critchley HOD, Li Y, McKain L, Arjona Ferreira JC, Langenberg AGM, Wagman RB, Stewart EA. Treatment of Uterine Fibroid Symptoms with Relugolix Combination Therapy. N Engl J Med. 2021 Feb 18;384(7):630-642.
- Adelman MR, Bardsley TR, Sharp HT. Urinary tract injuries in laparoscopic hysterectomy: a systematic review. J Minim Invasive Gynecol. 2014 Jul-Aug;21(4):558-66
- Arts JW, Nieboer TE, Johnson N, Tavender E, Garry R, Mol BW, Kluivers KB. Surgical approach to hysterectomy for benign gynaecological disease. Cochrane Database Syst Rev. 2015 Aug 12;8:CD003677
- Chou MT Int Urogyn J Pelvic Floor Dysfunct 2009
- Lethaby A, Puscasiu L, Vollenhoven B. Preoperative medical therapy before surgery for uterine fibroids. Cochrane Database Syst Rev. 2017 Nov 15;11(11):CD000547.
- Schaff WD, et al. Elagolix for heavy menstrual bleeding in women with uterine fibroids. The New England Journal of Medicine. 2020;382:328.
- Yoon, Hyo & Kyung, Min & Jung, Un & Choi, Joong Sub. (2007). Laparoscopic Myomectomy for Large Myomas. Journal of Korean medical science. 22. 706-12. 10.3346/jkms.2007.22.4.706.

The Magic of MIGS:

Specimen extraction, Cuff Closure, and Cuff Dehiscence Complications

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Minimally Invasive Gynecologic Surgery

Disclosure

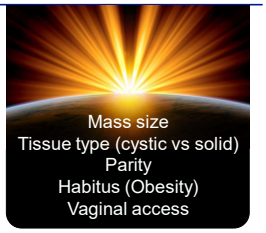
- Author: Up To Date (Vaginal dehiscence)

Objectives

- Discuss how to optimize removal of large specimens during laparoscopy
  - Assess different specimen extraction techniques
  - Review different types of specimen retrieval bags available in U.S.
  - Consider best bag selection & extraction technique for different clinical scenarios
- Review ideal cuff closure techniques
- Address how to minimize cuff complications
  - Cuff dehiscence

Different Specimen Extraction Techniques

- Vaginal Extraction
  - colpotomy (TLH)
  - posterior cul de sac (MMY)
- Laparoscopic Extraction
  - open power morcellation (extinct)
  - contained power morcellation
- Mini-laparotomy
  - contained cold-cut extraction
- Laparotomy
  - intact removal



Mass size
Tissue type (cystic vs solid)
Parity
Habitus (Obesity)
Vaginal access

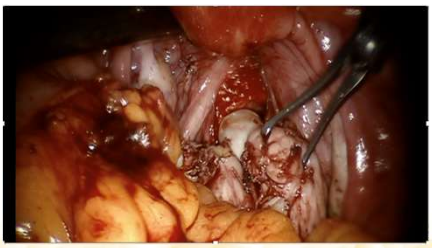
➡ Match Extraction Strategy to Pathology & Patient

Video: Mini-lap Extraction (LSC MMY)

Tips and Tricks for Minilap Extraction

- Skin should be the rate limiting step (fascia slightly more extended than skin)
- Use self-retracting wound retractor (optimize exposure, retract specimen bag)– even with Alexis CES bag
- Use penetrating instrument to grasp specimen (Lahey clamp)
- Non-dominant hand grabs specimen, dominant hand holds scalpel (10 or 11-blade) for cold cut extraction

Video: Cul de sac Extraction (ROB MMY)



Video: Vaginal Extraction (ROB TLH)

Video: Intact Vaginal Extraction (TLH)

Video: Vaginal Extraction (Bagged)

Predictors for Vaginal Extraction

- Selection Factors
  - Parity (mode of delivery)
  - Vaginal access (narrow introitus, android pubic symphysis; h/o radiation)
  - Colpotomizer cup size
  - Mass size (total uterine dimensions vs dominant mass)
  - Habitus

Tool Kit: "Cold-cut" Extraction

Vaginal Extraction
- Bag selection (Alexis CES)
- Vaginal retractors (breisky, sims)
- Perforating clamp (eg tenaculum, towel clips)
- 10 or 11-blade scalpel
- Long knife handle

Minilap Extraction
- Bag selection (mass size)
- Alexis wound retractor (mini)
- Perforating clamp (eg lahey)
- 11 blade scalpel
- regular length knife handle

Bag Selection

Know Pathology:
- Mass Size
- Tissue type (solid vs cystic)
- Shape

→ Select Bag → Select Trocar

Specimen Bags

Bag characteristics
- Trocar size (insertion)
- Bag dimensions (open)
  - Mouth diameter (bag entry)
  - Bag length
- Bag shape, taper (ball fit)
- Bag strength (material)

FIGURE 1 Laparoscopic retrieval device components and terminology

Tiffany Sia, HC Hur

Ball fit

Bag taper and bag shape determine the "ball fit" of a bag.

Mass diameter, 10.0 cm

Mouth diameter can fit 10 cm mass, but bag shape and taper hinders bag closure (poor "ball fit")

15 mm Anchor bag (1550 mL)

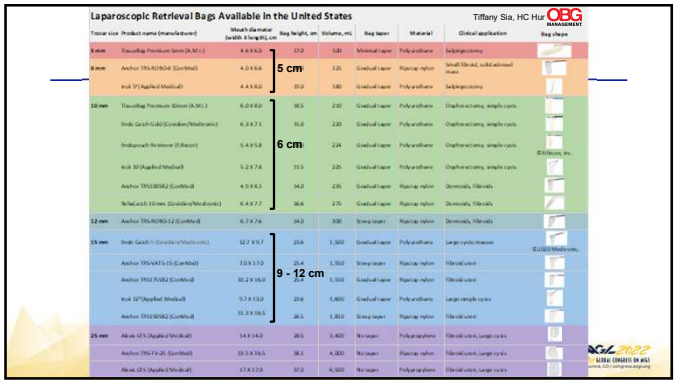
Mass diameter, 9.0 cm

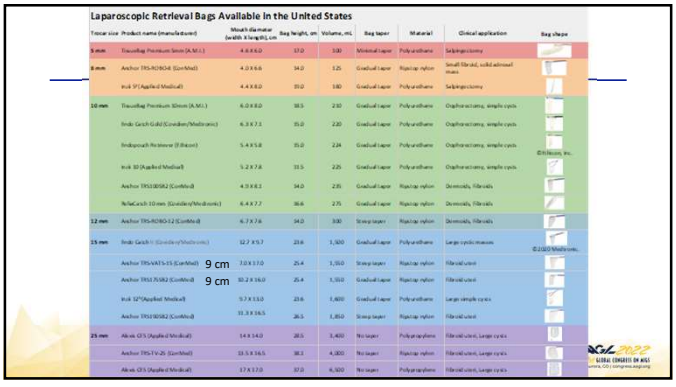
Entire 9 cm mass fits, so bag can close (complete "ball fit")

A Bag taper. Two examples of masses with different mass diameters within the same Anchor TRS175SB2 bag (ConMed). **Left:** The mass diameter of the specimen is just able to be accommodated by the mouth diameter of the bag, but the degree of bag taper hinders closure. The ball fit for the bag is smaller than the mouth diameters. **Right:** Although the specimen's mass diameter is smaller

Bag Shape (15 mm Bags)

Steep taper	Gradual Taper	Gradual Taper
Anchor 15mm Bag (1550 mL)	Inzii 15mm Bag (1600 mL)	Anchor 15 mm Bag (1850 mL)



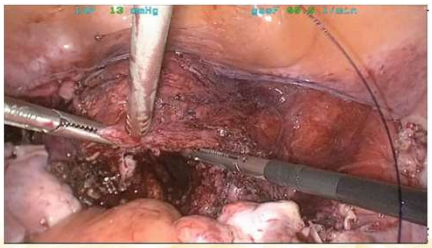


Recommendations (Specimen Extraction)

- Best route of delivery depends on “fit.”
- Nulliparous patients with tight introitus, narrow vagina, and android pubic arch → mini-laparotomy
- Multiparous patients with favorable pelvic exam → consider colpotomy delivery (up to 16 wks)
- Obesity (best to avoid minilap, but vaginal access may be a challenge) → vaginal extraction when possible (parity & mode of del)
- Limited or no vaginal access (G0, narrow introitus, radiation patients, android pelvis) → mini-laparotomy extraction

Cuff Closure Techniques

Video: Cuff Closure (IC Knots)

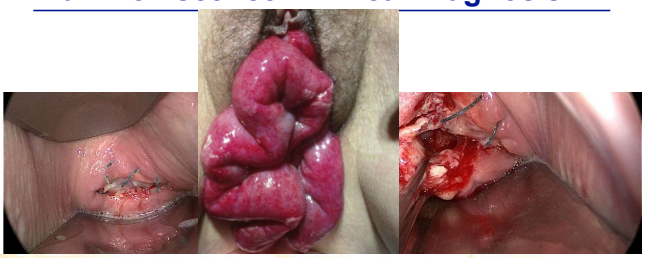


Cuff Closure: Key Points

- Full thickness bites (include vaginal mucosa & pubocervical fascia)
- Place suture ≥1 cm deep
- Travel 1 cm for each suture placement
- Reapproximate, don’t strangulate
- Some cuff bleeding is healthy

Minimizing Cuff Complications

Cuff Dehiscence: Clinical Diagnosis



Dehiscence Risk

MOI	TLH Risk Ratio	Incidence	(Range)
TVH	17.2	0.12%	(0.05 - 0.32%)
TAH	9.1	0.3%	(0.02 - 0.60%)
TLH		0.7%	(0.64 - 1.35%)
RA-TLH		2.3%	(0.4 - 4.1%)

?

Risk Factors

Patient Characteristics

• Obese	x	Thin
• Postmenopausal	x	Younger, premenopausal
• African American	x	Caucasian
• Smoker	✓	Smoker

Risk Factors for Cuff Dehiscence

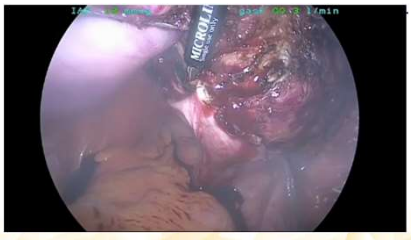
Non-modifiable Risk Factors
- Demographics: Thin, smoker, Caucasian, young age
- Infection (diabetic, immunocompromised)
- Pathology (extensive LOA, eg endometriosis, adhesions)
- Poor tissue quality (connective tissue disease)

Modifiable RF's:
- BV, cuff infection
- Avoid premature coitus
- Excessive valsalva (heavy lifting, constipation, coughing)

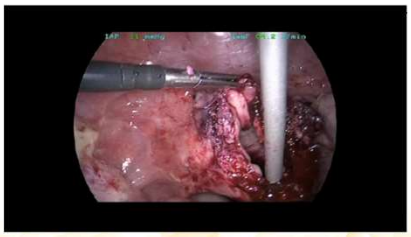
Surgical Factors: Dehiscence Risk

- Mode of incision for closure (LSC vs vag)
- Colpotomy (cut vs coagulation waveform)
- Suture selection
  - polyfilament vs monofilament
  - faster vs delayed absorbable
  - absorbable vs permanent
  - traditional vs barbed suture
- Closure method
  - Vaginal closure vs LSC closure
  - interrupted vs figure of eight vs continuous running
  - 1 vs 2-layer closure

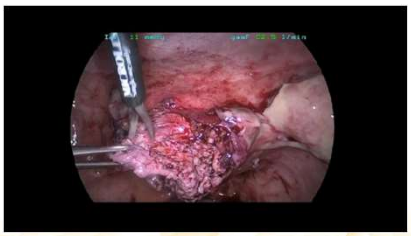
Video: Colpotomy



Cuff Dehiscence Repair



Excise Old Cuff (healthy edges)



Vaginal Dehiscence Repair

1. Identify & normalize anatomy (expose cuff)
2. Find defect, open & mobilize cuff (dissect bladder off)
3. Excise cuff edges (healthy tissue)
4. Close new cuff incision (full thickness, >1 cm deep)
5. Antibiotics (pre-op, intra-op)

Mitigating Risks

- Treat BV (preop and postop)
- Intra-op
  - Antbiotic prophylaxis
  - Good surgical technique (colpotomy, cuff closure)
  - Vag exam
- Postop
  - Stool softeners
  - Cuff exam 2wk POV (suture check, BV check)
  - Timely eval if pt calls with cuff complaints (pain with sitting, back pain, pain with urination)

Take Home Points (Cuff Dehiscence)

An ounce of prevention is worth a pound of cure.

- Ben Franklin

Questions?

References (Deh)

1. Hur HC, Donnellan N, Mansuria S, Barber RE, Guido R, Lee T. Vaginal cuff dehiscence after different modes of hysterectomy. Obstet Gynecol. 2011 Oct;118(4):794-801. doi: 10.1097/AOG.0b013e31822f1c92. PMID: 21934442.

2. Uccella S, Ceccaroni M, Cromi A, Malzoni M, Berretta R, De Iaco P, Roviglione G, Bogani G, Minelli L, Ghezzi F. Vaginal cuff dehiscence in a series of 12,398 hysterectomies: effect of different types of colpotomy and vaginal closure. Obstet Gynecol. 2012 Sep;120(3):516-23. doi: 10.1097/AOG.0b013e318264f848. PMID: 22914459.

3. Ala-Nissila S, Laurikainen E, Mäkinen J, Jokimaa V. Vaginal cuff dehiscence is observed in a higher rate after total laparoscopic hysterectomy compared with other types of hysterectomy. Acta Obstet Gynecol Scand. 2019 Jan;98(1):44-50. doi: 10.1111/aogs.13459. Epub 2018 Oct 29. PMID: 30199573.

4. Kho RM, Akl MN, Cornella JL, Magtibay PM, Wechter ME, Magrina JF. Incidence and characteristics of patients with vaginal cuff dehiscence after robotic procedures. Obstet Gynecol. 2009 Aug;114(2 Pt 1):231-235. doi: 10.1097/AOG.0b013e3181af36e3. PMID: 19622982

5. Morgan DM, Kamdar NS, Swenson CW, Kobernik EK, Sammarco AG, Nallamothu B. Nationwide trends in the utilization of and payments for hysterectomy in the United States among commercially insured women. Am J Obstet Gynecol. 2018 Apr;218(4):425.e1-425.e18. doi: 10.1016/j.ajog.2017.12.218. Epub 2017 Dec 26. PMID: 29288067; PMCID: PMC5931386.

6. Wright JD, Herzog TJ, Tsui J, Ananth CV, Lewin SN, Lu YS, Neugut AI, Hershman DL. Nationwide trends in the performance of inpatient hysterectomy in the United States. Obstet Gynecol. 2013 Aug;122(2 Pt 1):233-241. doi: 10.1097/AOG.0b013e318299a6cf. PMID: 23969789; PMCID: PMC3913114.

CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) announced new standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations beginning January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Cultural Competence In Health and Human Services | NPIN (cdc.gov)
Cultural Competency – The Office of Minority Health (hhs.gov)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Unconscious Bias Resources | diversity.ucsf.edu
Act, Communicating, Implicit Bias (racialequitytools.org)
https://kirwaninstitute.osu.edu/implicit-bias-training
https://www.uptodate.com/contents/racial-and-ethnic-disparities-in-obstetric-and-gynecologic-care-and-role-of-implicitbiases
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/