

67th Annual Meeting
of the
Society of Pelvic Surgeons



October 11-14, 2017
Fairhope/Point Clear, Alabama

Thank you for Attending!

67th Annual Meeting of the Society of Pelvic Surgeons October 11-14, 2017

Target Audience

Members and Guests of the Society of Pelvic Surgeons.

Accreditation: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of Alabama College of Medicine and the Society of Pelvic Surgeons. The University of Alabama College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Credit: The University of South Alabama College of Medicine designates this live activity for a maximum of **11 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of South Alabama College of Medicine and the Society for Pelvic Surgeons. The University of South Alabama College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

Participants requiring special accommodations or with dietary restrictions should contact registration in person two weeks prior to the date of activity. USA is in compliance with the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

Learning Objectives

- Identify different quality improvement initiatives in pelvic surgery
- Recognize that laparoscopic approaches may result in fewer adhesions
- Utilize newer methods of staging pelvic cancers including techniques utilizing genomes and proteomics as well as new techniques in staging using minimally invasive surgery and sentinel lymph node biopsy
- Identify the role of tertiary cytoreductive surgery in recurrent ovarian cancer
- Identify adverse functional results that may follow radical surgery for pelvic surgery for pelvic cancer, ways to assess these and improve quality of life.

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Officers and Committees

Officers

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President Elect: William Cliby
Immediate Past President: Steven Campbell
Vice-President: Tracy Hull
Secretary/Treasurer: William Cliby
Secretary/Treasurer Elect: Stephen Strup
Members: Michael Finan
Gheorghe Peltecu
Stephen Strup
Historian: Gheorghe Peltecu
Wassail Toastmaster: John H. Shepherd, "The Bard"

Executive Committee

President: Wolfram Trudo Knoefel
Vice-President: Tracy Hull
President Elect: William Cliby
Immediate Past President: Steven Campbell
Secretary/Treasurer: William Cliby
Secretary/Treasurer Elect: Stephen Strup
Members: Michael Finan
Gheorghe Peltecu
Stephen Strup

Membership Committee

President: Wolfram Trudo Knoefel
Vice-President: Tracy Hull
Secretary/Treasurer: William Cliby
Secretary/Treasurer Elect: Stephen Strup
Chair: William Cliby
Members: Michael Finan
Thomas Ind
Marcus Quek
Scott Strong
Larissa Temple

Nominating Committee

President: Wolfram Trudo Knoefel
Immediate Past President: Steven Campbell
(Chair):
Secretary/Treasurer: William Cliby
Secretary/Treasurer Elect: Stephen Strup
Members: At Large (2)

By-Laws Committee

Chair: Margit Fisch
Members: Bernard Bochner
Roberto Biffi

Education/Research Committee

President: Wolfram Trudo Knoefel
Immediate Past President: Steven Campbell
Chair: Luca Stocchi
Committee Members: Thomas Jobling
Karl Tamussino

Program Committee

President: Wolfram Trudo Knoefel
Secretary/Treasurer: William Cliby
Secretary/Treasurer Elect: Stephen Strup
Chair: Sean Dowdy
Members: Marcus Quek
O. Lenaine Westney

Meeting Sites/Hosts and Past Presidents

Year	Location	Host(s)	President
2017	Point Clear	Michael Finan	Wolfram Trudo Knoefel
2016	St. Louis	David Mutch	Steven Campbell
2015	San Francisco	Jonathan Berek	William Creasman
2014	Tampa	Mitchel Hoffman and Jorge Marcet	Joachim Thüroff
2013	Düsseldorf and Leiden	Wolfram Trudo Knoefel and Baptist Trimbos	Mitchel Hoffman
2012	Louisville	Susan Galandiuk	Neville Hacker
2011	Toronto	Amodio DePetrillo	Susan Galandiuk
2010	Durham	David Albala Daniel Clarke-Pearson John Soper	S. Bruce Malkowicz
2009	Nashville	Howard Jones, III	Kenneth Hatch
2008	Sydney and Cairns	Neville Hacker	John H. Shepherd
2007	Cleveland	Tracy Hull	Frederick Moffat, Jr.
2006	Philadelphia	S. Bruce Malkowicz	Robert C. Flanigan
2005	Lyon and Avignon	Daniel Dargent	Maurice J. Webb
2004	Key Biscayne	Hervy Averette	Barrie Anderson
2003	Pittsburgh	Gregorio Delgado	Victor W. Fazio
2002	Tucson	Kenneth Hatch	Raymond Lee
2001	Oslo and Bergen	Claes Tropé	Randall G. Rowland
2000	Bermuda	Amodio DePetrillo	Walley Temple
1999	Calgary and Banff	Walley Temple	John J. Mikuta
1998	Sarasota	Byron Masterson Denis Cavanagh	James H. Nelson, Jr.
1997	Indianapolis	Randall Rowland	John P. Donohue
1996	London and Dublin	John Shepherd John Bonnar	Carmel J. Cohen
1995	Lexington	James Glenn	Julian P. Smith
1994	Chicago	Gregorio Delgado Robert Flanigan Arthur Herbst	Donald C. McIlrath
1993	Birmingham	Hugh Shingleton	Douglas J. Marchant
1992	Munich and Innsbruck	Gunther Kindermann Otto Dapunt	Rudolf Hohenfellner
1991	Scottsdale	William Crisp	David L. Barclay
1990	Charleston	William Creasman	Richard C. Boronow
1989	Tampa	Denis Cavanagh	Alfred S. Ketcham
1988	Toronto	Amodio DePetrillo William K. Kerr	Vincent J. O'Conor, Jr.
1987	Milan, Florence and Rome	Giovanni Candiani Luigi Carenza	George W. Mitchell, Jr.
1986	Newport Beach	Philip DiSaia Lagasse, Leo J. George Moore	Otto Käser

Year	Location	Host(s)	President
1985	Miami	Hervy Averette Alfred S. Ketcham	William J. Staubitz
1984	New Orleans	Philip J. Krupp, Jr.	George W. Morley
1983	Philadelphia	John J. Mikuta	Hugh R.K. Barber
1982	Ann Arbor	Julian Smith George W. Morley Harry Nelson	Oliver H. Beahrs
1981	Chicago	Arthur Herbst Vincent J. O'Connor, Jr. John Isaacs George D. Wilbanks, Jr.	Richard F. Mattingly
1980	Durham	James F. Glenn Roy Parker William Creasman David Paulson	James F. Glenn
1979	Rochester	Richard Symmonds Joseph H. Pratt Oliver H. Bears David C. Utz	Felix N. Rutledge
1978	New York	Saul B. Gusberg Henry Frick, II	Howard H. Jones, Jr.
1977	Charlottesville	W. Norman Thornton, Jr.	W. Norman Thornton, Jr.
1976	Munich and Basel	Josef Zander Otto Käser	Saul B. Gusberg
1975	Boston	Howard Ulfelder	John McLean Morris
1974	Atlanta	John Ridley	Thomas H. Green, Jr.
1973	New Haven	John McLean Morris Bernard Lytton	Eugene M. Bricker
1972	Louisville	Laman A. Gray, Sr.	Gray H. Twombly
1971	Oxford and Newcastle-Upon-Tyne	Sir John Stallworthy Stanley Way	James S. Krieger
1970	Houston	Felix N. Rutledge John Wall Julian Smith	William K. Kerr
1969	Augusta	George McInnes	Somers H. Sturgis
1968	Cleveland	James S. Krieger	Joseph H. Pratt
1967	Toronto	William Kerr	Clyde L. Randall
1966	Richmond	Randolph H. Hoge	Laman A. Gray, Sr.
1965	Boston	Langdon W. Parsons	Victor F. Marshall
1964	Rochester	Oliver H. Beahrs Joseph H. Pratt	Randolph H. Hoge
1963	Durham	F. Bayard Carter	F. Bayard Carter
1962	New York		Langdon W. Parsons
1961	Baltimore		Richard W. TeLinde
1960	Washington DC	Charles Brack	Waring G. Cosbie
1959	Richmond	Randolph H. Hoge	Howard Ulfelder
1958	Toronto and Buffalo	Waring G. Cosbie	John C. Burch

Year	Location	Host(s)	President
		Clyde L. Randall	
1957	Louisville	Laman A. Gray, Sr.	Alexander Brunschwig
1956	New York	Alexander Brunschwig Howard Taylor	Karl H. Martzloff
1955	New Orleans	Conrad Collins	Karl H. Martzloff
1954	Baltimore	Richard W. DeLinde	Joe V. Meigs
1953	St. Louis	Eugene Bricker	Joe V. Meigs
(Dec)			
1953	Boston	Joe V. Meigs	Joe V. Meigs
(May)			
1952	New York	Alexander Brunschwig	Joe V. Meigs

Alabama Host Information

Host

Michael Finan, MD

Abraham A. Mitchell Chair
Cancer Center Director
Director, USA Mitchell Cancer Institute

Local Organizer/Information

Cristin Waite

Senior Special Events Coordinator
Phone: 251-341-4085
Email: cristinwaite@southalabama.edu

Guest Faculty

Sydney Brevard, MD

Director, Division of Acute Care Surgery and Burns
Program Director for Surgical Critical Care Fellowship
Professor, Surgery
Mitchell Cancer Institute

Edward Partridge, MD

Director, Comprehensive Cancer Center
Professor of Gynecologic Oncology
Evalina B. Spencer Chair in Oncology
University of Alabama at Birmingham

Rodney Rocconi, MD

Chief, Gynecologic Oncology Service
Associate Director for Clinical Research
Abraham A. Mitchell Clinical Cancer Research Scholar
Professor, Interdisciplinary Clinical Oncology
Mitchell Cancer Institute

C.M.A. (Max) Rogers, IV, MD

Obstetrician Gynecologist
Springhill Hospital: Mobile, Alabama
Former Captain and Navy Pilot, United States Marines

Future Meetings

- 2018 September 23-29, 2018
Romania
Host: Gheorghe Peltecu
- 2019 TBD
Chicago, Illinois
Hosts: Scott Strong, Marcus Quek, Robert Flanigan
- 2020: TBD

*If you have interest in hosting a future meeting,
please let us know at sps@ccf.org.*

Delegate Program

Wednesday, October 11, 2017

8:00 am – 1:00 pm	Executive and Committee Meetings <i>Grand Hotel, Magnolia 2</i> (Breakfast and Lunch available before and after)
6:00 pm – 7:30 pm	Registration and Welcome Reception <i>Grand Hotel, Julep Point</i>

Thursday, October 12, 2017

7:00 am – 7:45 am	Continental Breakfast <i>Grand Hotel, South Ballroom Foyer</i>
7:50 am – 8:00 am	Welcome/Opening Remarks – <i>Michael Finan</i> <i>Grand Hotel, South Ballroom</i>
8:00 am – 8:45 am	New Paradigms of Ovarian Cancer Screening – <i>Rodney Rocconi</i>
8:45 am – 9:30 am	Advances in the Management of Hemorrhage and Traumatic Shock – <i>Sydney Brevard</i>
9:30 am – 10:00 am	Break – Exhibitors in <i>Beachside Room</i>
10:00 am – 10:45 am	Slavery, The Civil War, Segregation, Civil Rights, and the Future of Cancer Care Delivery – <i>Edward</i> <i>Partridge</i>
10:45 am – 11 :30 am	Safety in the Operating Room: Lessons Learned from the Flight Deck of an Aircraft Carrier – <i>Charles “Max”</i> <i>Rogers</i>
11:30 am – 11:50 am	Questions and Answers
11:50 am – 12:00 pm	Closing Remarks – <i>Michael Finan</i>
12:00 pm – 1:45 pm	Buses depart from Grand Hotel to Naval Air Museum – Includes Box Lunch <i>Grand Hotel, Porte Cochere</i>
1:45 pm – 4:00 pm	Naval Air Museum Tour
4:00 pm – 5:00 pm	Reception at Cubi Bar at the Naval Air Museum
5:00 pm – 5:45 pm	Transport from Naval Air Museum to Cobalt Restaurant
5:45 pm – 6:45 pm	Cocktail Hour at Cobalt Restaurant
6:45 pm – 8:15 pm	Dinner at Cobalt Restaurant
8:15 pm – 9:00 pm	Transport from Cobalt Restaurant to Grand Hotel

Delegate Program Continued**Friday, October 13, 2017**

7:00 am – 7:45 am	Continental Breakfast <i>Grand Hotel, South Ballroom Foyer</i>
7:45 am – 9:45 am	PRESIDENTIAL PANEL – Back to Our Roots? Using Our Surgical Skills to Maximize Outcomes in Multivisceral Cancer Operations <i>Grand Hotel, South Ballroom</i>
7:45 am – 7:55 am	Panel Introduction – <i>Wolfram Trudo Knoefel</i>
7:55 am – 8:15 am	Perspectives from Urology – <i>Bernie Bochner</i>
8:15 am – 8:35 am	Perspectives from Gynecology – <i>Baptist Trimbos</i>
8:35 am – 8:55 am	Perspectives from Colorectal Surgery – <i>Luca Stocchi</i>
8:55 am – 9:15 am	Perspectives from Orthopedic Surgery – <i>Francis Hornicek</i>
9:15 am – 9:45 am	Panel Discussion and Questions and Answers
9:45 am – 10:00 am	Break – Exhibitors in <i>Beachside Room</i>
10:00 am – 12:00 pm	Abstract Presentations – See Scientific Program
12:00 pm – 1:00 pm	Lunch at <i>Grand Hotel, South Ballroom</i>
1:00 pm – 1:15 pm	Eulogies
1:15 pm – 1:45 pm	Presidential Address – <i>Wolfram Trudo Knoefel</i>
1:45 pm – 2:00 pm	Break – Exhibitors in <i>Beachside Room</i>
2:00 pm – 3:30 pm	Society Business Meeting
3:30 pm – 7:00 pm	Leisure Time
7:00 pm – 11:00 pm	Wassail Banquet – <i>Grand Hotel, Grand Ballroom Patio</i>

Saturday, October 14, 2017

7:00 am – 8:00 am	Continental Breakfast <i>Grand Hotel, South Ballroom Foyer</i>
8:00 am – 12:00 pm	Abstract Presentations – See Scientific Program – <i>Grand Hotel, South Ballroom</i>
12:00 pm – 12:30 pm	Closing Discussion – <i>Howard Jones, III</i>
12:30 pm	Meeting Adjournment
12:30 pm – 5:00 pm	Leisure Time
5:00 pm – 5:30 pm	Bus departs to USA Mitchell Cancer Institute
5:30 pm – 6:30 pm	Cocktails
6:30 pm – 7:30 pm	Dinner
7:30 pm – 8:00 pm	Tours of USA Mitchell Cancer Institute for those interested
8:00 pm	Bus departs for Grand Hotel

Companion Program

Wednesday, October 11, 2017

6:00 pm – 7:30 pm	Registration and Welcome Reception – <i>Julep Point</i>
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Thursday, October 12, 2017

8:00 am – 9:00 am	Continental Breakfast, <i>Salon DEF Foyer</i>
9:00 am – 12:00 pm	Painting with B’Beth Weldon, <i>Salon DEF</i>
12:00 pm – 1:45 pm	Buses depart from Grand Hotel to Naval Air Museum – Includes Box Lunch, <i>Porte Cochere</i>
1:45 pm – 4:00 pm	Naval Air Museum Tour
4:00 pm – 5:00 pm	Reception at Cubi Bar at the Naval Air Museum
5:00 pm – 5:45 pm	Transport from Naval Air Museum to Cobalt
5:45 pm – 6:45 pm	Cocktail Hour at Cobalt Restaurant
6:45 pm – 8:15 pm	Dinner at Cobalt Restaurant
8:15 pm – 9:00 pm	Transport from Cobalt Restaurant to Grand Hotel

Friday, October 13, 2017

8:00 am – 8:45 am	Continental Breakfast, <i>Salon DEF</i>
8:45 am – 9:30 am	Transport to Gulf Coast Ducks, <i>Porte Cochere</i>
9:30 am – 11:00 am	Gulf Coast Duck Boat Tour
11:00 am – 11:45 am	Transport to Grand Hotel
12:00 pm – 1:00 pm	Lunch at <i>Grand Hotel, South Ballroom</i>
1:00 pm – 1:15 pm	Eulogies
1:15 pm – 1:45 pm	Presidential Address – <i>Wolfram Trudo Knoefel</i>
2:00 pm – 2:15 pm	Transport to Downtown Fairhope
2:15 pm – 5:00 pm	Downtown Fairhope Shopping Option
5:00 pm – 5:15 pm	Transport to Grand Hotel
5:15 pm – 7:00 pm	Leisure Time
7:00 pm – 11:00 pm	Wassail Banquet – <i>Grand Ballroom Patio</i>

Saturday, October 14, 2017

8:45 am – 9:45 am	Continental Breakfast, <i>Magnolia 1</i>
9:45 am – 10:00 am	Transport to Downtown Fairhope
10:00 am – 1:00* pm	Shopping in Downtown Fairhope
1:00* pm	Transport to Grand Hotel
1:00* pm – 5:00 pm	Leisure Time
5:00 pm – 5:30 pm	Bus departs to USA Mitchell Cancer Institute
5:30 pm – 6:30 pm	Cocktails
6:30 pm – 7:30 pm	Dinner
7:30 pm – 8:00 pm	Tours of USA Mitchell Cancer Institute if interested
8:00 pm	Bus departs for Grand Hotel

**choice of 1:00 pm or 3:00 pm*

Scientific Program

Friday, October 13, 2017, – Moderator – *Sean Dowdy*

10:00 am – 10:07 am	Adjuvant pelvic radiation is associated with improved survival and decreased disease recurrence in pelvic node-positive penile cancer after lymph node dissection: a multi-institutional study – <i>Philippe Spiess</i>
10:07 am – 10:10 am	Discussant – <i>Marcus Quek</i>
10:10 am – 10:15 am	Floor Discussion and Closure
10:15 am – 10:22 am	A single institution contemporary experience with hemipelvectomy for sarcoma – <i>David Joyce</i>
10:22 am – 10:25 am	Discussant – <i>Francis Hornicek</i>
10:25 am – 10:30 am	Floor Discussion and Closure
10:30 am – 10:37 am	Predictors of postoperative complications associated with loop ileostomy reversal – <i>Joel Bauer</i>
10:37 am – 10:40 am	Discussant – <i>Scott Strong</i>
10:40 am – 10:45 am	Floor Discussion and Closure
10:45 am – 10:52 am	ERCC1-expressing circulating tumor cells as a potential diagnostic tool for monitoring response to platinum-based chemotherapy and for predicting outcome of ovarian cancer – <i>Pauline Wimberger</i>
10:52 am – 10:55 am	Discussant – <i>Jonathan Zager</i>
10:55 am – 11:00 am	Floor Discussion and Closure
11:00 am – 11:07 am	Robotic urinary diversion using an anti-peristaltic loop and stent-free uretero-intestinal anastomosis reduced uretero-intestinal anastomotic leakage – <i>Nadim Bou Zgheib</i>
11:07 am – 11:10 am	Discussant – <i>Bernard Bochner</i>
11:10 am – 11:15 am	Floor Discussion and Closure
11:15 am – 11:22 am	What do women scheduled for laparoscopic cholecystectomy think about potential concomitant salpingectomy – <i>Karl Tamussino</i>
11:22 am – 11:25 am	Discussant – <i>Howard Jones, III</i>
11:25 am – 11:30 am	Floor Discussion and Closure
11:30 am – 11:37 am	Small cell neuroendocrine tumors of the cervix (SNEC). Do tumor characteristics and order of multimodality therapy influence outcome in early stage disease? – <i>Ane Gerda Zahl Eriksson</i>
11:37 am – 11:40 am	Discussant – <i>Baptist Trimpos</i>
11:40 am – 11:45 am	Floor Discussion and Closure

Scientific Program Continued

Friday, October 13, 2017, – Moderator – *Sean Dowdy*

11:45 am – 11:52 am	A matter of margins: surgical and pathologic risk factors for recurrence in extramammary Paget's disease – <i>Beverly Long</i>
11:52 am – 11:55 am	Discussant – <i>David Mutch</i>
11:55 am – 12:00 pm	Floor Discussion and Closure

Saturday, October 14, 2017 – Moderator – *Marcus Quek*

8:00 am – 8:07 am	Ovarian tissue banking for cancer patients: non-invasive detection of cancer cells in tissues for safe cryopreservation – <i>Peter Oppelt</i>
8:07 am – 8:10 am	Discussant – <i>Christian Marth</i>
8:10 am – 8:15 am	Floor Discussion and Closure

8:15 am – 8:22 am	Emergency peripartum hysterectomy: a single-center analysis of 42 cases of cesarean and postpartum hysterectomy – <i>Nikolaus deGregorio</i>
8:22 am – 8:25 am	Discussant – <i>John Soper</i>
8:25 am – 8:30 am	Floor Discussion and Closure

8:30 am – 8:37 am	Dermal allograft for pelvic prolapse repair – <i>Susan Tarry</i>
8:37 am – 8:40 am	Discussant – <i>Karl Tamussino</i>
8:40 am – 8:45 am	Floor Discussion and Closure

8:45 am – 8:52 am	Simulation of evaluation and management of thermal bowel injury during robotic surgery utilizing the porcine model – <i>Mitchel Hoffman</i>
8:52 am – 8:55 am	Discussant – <i>Richard Boothby</i>
8:55 am – 9:00 am	Floor Discussion and Closure

9:00 am – 9:07 am	Factors associated with hospital readmission following diverting ileostomy creation – <i>Luca Stocchi</i>
9:07 am – 9:10 am	Discussant – <i>Susan Galandiuk</i>
9:10 am – 9:15 am	Floor Discussion and Closure

9:15 am – 9:22 am	Rectus abdominis myoperitoneal flap for vaginal reconstruction: review of the literature and report of four cases – <i>Genevieve Lennox</i>
9:22 am – 9:25 am	Discussant – <i>Kenneth Hatch</i>
9:25 am – 9:30 am	Floor Discussion and Closure

Scientific Program Continued

Saturday, October 14, 2017– Moderator – *Marcus Quek*

9:30 am – 9:37 am	Vaginal hysterectomy is an effective surgical option for the treatment of endometrial cancer in a diverse, obese and medically-challenged patient population – <i>Matthew Kohler</i>
9:37 am – 9:40 am	Discussant – <i>Marta Crispens</i>
9:40 am – 9:45 am	Floor Discussion and Closure
9:45 am – 9:52 am	Immune clusters in omentum provide a niche for ovarian cancer early metastasis – <i>Oliver Dorigo</i>
9:52 am – 9:55 am	Discussant – <i>Gottfried Konecny</i>
9:55 am – 10:00 am	Floor Discussion and Closure

Saturday, October 14, 2017– Moderator – *TRACY HULL*

10:00 am – 10:15 am	Break
10:15 am – 10:22 am	Enhanced recovery after surgery (ERAS) program in gynecologic/oncology—audit of compliance and practice associated with improvement in health system and clinical outcomes – <i>Gregg Nelson</i>
10:22 am – 10:25 am	Discussant – <i>David Larson</i>
10:25 am – 10:30 am	Floor Discussion and Closure
10:30 am – 10:37 am	Differences in survival between symptomatic vs asymptomatic recurrence following cystectomy for bladder cancer – <i>S. Bruce Malkowicz</i>
10:37 am – 10:40 am	Discussant – <i>Steven Campbell</i>
10:40 am – 10:45 am	Floor Discussion and Closure
10:45 am – 10:52 am	Pelvic intraoperative neuromonitoring to identify and preserve autonomous nerves during surgery for deep infiltrating endometriosis – <i>Markus Fleisch</i>
10:52 am – 10:55 am	Discussant – <i>Matthew Robertson</i>
10:55 am – 11:00 am	Floor Discussion and Closure
11:00 am – 11:07 am	Genomic comparisons between histologic and molecular subtypes of endometrial cancer reveal opportunities for therapeutic crossover – <i>Gottfried Konecny</i>
11:07 am – 11:10 am	Discussant – <i>Rodney Rocconi</i>
11:10 am – 11:15 am	Floor Discussion and Closure

ABSTRACTS

Adjuvant Pelvic Radiation is Associated with Improved Survival and Decreased Disease Recurrence in Pelvic Node-Positive Penile Cancer After Lymph Node Dissection: a Multi-Institutional Study

Spiess PE*

Purpose

There is a paucity of data pertaining to the role of adjuvant radiation therapy (AXRT) in advanced penile squamous cell carcinoma. The aim of the present study was to evaluate the association of pelvic AXRT with survival and recurrence for patients with penile cancer and positive pelvic lymph nodes (PLN) following pelvic lymph node dissection.

Methods

Data were collected retrospectively across 4 international centers of patients with penile squamous cell carcinoma (PeCa) undergoing lymph node dissections from 1980 to 2013. 92 patients with positive PLN were analyzed. Variables recorded included age, stage, histological grade, PLN status, pelvic extranodal extension (ENE), chemotherapy status, disease-specific survival, overall survival, and recurrence.

Results

43% (N=40) patients received AXRT after a positive PLN dissection. Median follow up was 9.3 months (IQR 5.2-19.8). The median number of positive PLN was 2 (IQR 1-3). Patients receiving AXRT had an improved median overall survival (OS) of 12.2 months vs 8 months in those who did not receive radiation ($P=0.0447$). Median disease-specific survival (DSS) was 14.4 months vs 8 months in the AXRT and non-AXRT group respectively ($P=0.0232$). Patients not receiving AXRT was associated with worse OS (HR: 1.9; 95% CI: 1.11-3.26; $P=0.0195$) and DSS (HR: 2.08; 95% CI: 1.18-3.66; $P=0.0112$) on multivariable analysis. Median time to recurrence was 7.7 months vs 5.3 months in the radiation and non-radiation arm respectively ($P=0.0425$). Patients not receiving AXRT was also independently associated with higher overall recurrence on multivariable analysis (HR: 1.98; 95% CI: 1.15-3.42; $P=0.0131$).

Conclusions

AXRT is associated with improved OS and DSS, and decreased recurrence in this population of PeCa patients with positive PLN.

*Presenter

A Single Institution Contemporary Experience with Hemipelvectomy for Sarcoma

Joyce DM,* Horowitz E, Mullinax JE, Naghavi AO, Binitie O, Letson GD,
Gonzalez RJ

Introduction

The purpose of this report is to describe the outcome following hemipelvectomy at a single institution.

Methods

After IRB approval, the clinical information was obtained from all patients that underwent hemipelvectomy from 2008-2016. Data included demographic and perioperative variables. Survival and recurrence was also recorded.

Results

Thirty-four patients were included (18 male, 16 female) with median age 59 (19-85). Resection included classic (type I or III) hemipelvectomy in 12 (35%) patients and modified (combined subtype) in 22 (65%) procedures. Median tumor size was 9.5 cm (4.5-17) and an extensive soft tissue component was present in 20 (59%). The intent was curative in 25 (74%) and palliative in 9 (26%). Median blood loss was 2400 mL (100-6400) with median operative time of 6.4 (2.5-14.2) hours. Most tumors were high grade (22, 65%) and 19 (56%) originated from bone, with the remaining from soft tissue. Sixteen (47%) patients had no complications and the two most common complications were infection (6, 17%) and VTE (4, 11.8%). Resection with curative intent was less likely to have a postoperative complication ($P=0.052$). With median follow up of 18 months, the median overall survival (MOS) for all patients was 76 months and median disease free survival (DFS) was 14 months. Those with curative intent had higher overall (84% vs 38%, $P=0.009$) and disease-free (60% vs 0%, $P<0.001$) survival at 2 years compared to those with palliative intent.

Conclusions

Hemipelvectomy is safe and excellent two-year survival can be expected when performed for curative intent.

**Presenter*

Predictors of Postoperative Complications Associated with Loop Ileostomy Reversal

Bauer J*

Purpose

Diversion with loop ileostomy is often used to protect distal anastomoses. Ileostomy reversal is considered a relatively simple procedure; however, it is associated with significant morbidity. There is limited literature on the influence of nutritional status on complication rates associated with loop ileostomy reversal. To identify factors associated with complications after ileostomy reversal, with specific focus on the impact of nutritional factors.

Methods

A retrospective review of patients who underwent loop ileostomy reversal at a single surgical practice at the Mount Sinai Medical Center was conducted. Clinical and demographic data were collected including 30-day post-operative major complications defined as SBO/ileus, anastomotic dehiscence, any condition requiring emergent reoperation, or death.

Results

Four hundred eighteen patients underwent loop ileostomy reversal between 1981-2015. The most common indication for ileostomy was diversion proximal to an ileal-pouch-anal anastomosis in patients with chronic ulcerative colitis. Median time to ostomy reversal was 13.6 weeks. Major complications occurred in 62/418 (14.8%), and 18 (4.3%) required reoperation. The most common complication was SBO/ileus (56/418, 13.3%). Older age ($P<0.05$), lower hemoglobin preoperatively ($P<0.005$), lower BMI at reversal ($P<0.05$), and greater interval decrease in BMI between stoma creation and reversal ($P<0.05$) were associated with major complications. Albumin at reversal, the change in albumin between formation and reversal, and the duration of time between formation and reversal were not found to be risk factors for major complications.

Conclusion

Poor nutritional status, as defined by BMI and hemoglobin preoperatively, is associated with major complications after loop ileostomy reversal. This suggests that some stomas are being closed before patients have returned to optimal nutritional status.

*Presenter

ERCC1-Expressing Circulating Tumor Cells as a Potential Diagnostic Tool for Monitoring Response to Platinum-Based Chemotherapy and for Predicting Outcome of Ovarian Cancer

Wimberger P*, Chebouti I, Kuhlmann JD, Buderath P, Weber S, Bokelch Y, Hauch S, Kasimir-Bauer S, Kimmig R

Objectives

We recently showed that the presence of ERCC1+CTCs (defined as positive for at least one of the AdnaTest markers and ERCC1-positivity), is an independent predictive biomarker for primary platinum-resistance and poor prognosis of ovarian cancer. The aim of our study was to determine, whether the additional assessment of ERCC1-transcripts increases the overall CTC-detection rate. Moreover, we analyzed clinical relevance of ERCC1+CTCs after adjuvant chemotherapy.

Methods

65 paired blood samples of primary ovarian cancer patients at primary diagnosis and after adjuvant chemotherapy were studied for CTCs with the AdnaTest *OvarianCancer* (QIAGEN, Germany). We analyzed the tumor-associated transcripts EpCAM, Muc-1 and cA-125. ERCC1-transcripts were investigated in a separate approach by singleplex RT-PCR.

Results

Besides AdnaTest+CTCs, the additional assessment of ERCC1 allows the detection of CTCs, which are negative for AdnaTest ERCC1+CTCs). This results in an increased overall CTC-detection rate from 23% to 40% before surgery and from 20% to 38% after adjuvant chemotherapy. However, CTCs with combined positivity for at least one AdnaTest marker and ERCC1-positivity (ERCC1+CTCs) showed the most relevant prognostic information and correlated with platinum-resistance ($P=0.01$) and reduced PFS ($P=0.029$) and OS ($P=0.0008$). Moreover, the persistence of ERCC1+CTCs after adjuvant chemotherapy indicated poor prognosis (PFS: $P=0.005$; OS: $P=0.006$).

Conclusion

The combined detection of AdnaTest ERCC1+CTCs and AdnaTest+ERCC1+CTCs increases the overall detection rate of CTCs in ovarian cancer patients. Specifically, we suggest that ERCC1+CTCs could be used as blood-based biomarker for monitoring platinum-based chemotherapy and for identifying ovarian cancer patients with poor prognosis.

*Presenter

Robotic Urinary Diversion Using an Anti-Peristaltic Loop and Stent-Free Uretero-Intestinal Anastomosis Reduced Uretero-Intestinal Anastomotic Leakage

Zgheib NB*

Introduction

Urinary diversion is traditionally performed in an iso-peristaltic manner, requiring a pirouette maneuver to bring the proximal end of the conduit into proximity with the distal ureters prior to the uretero-intestinal anastomosis, and usually requires stents to protect the anastomosis.

Objective

To report our experience with urinary diversion using an Anti-Peristaltic Loop (APL) compared to Iso-Peristaltic Loop (IPL) with or without stents during robotic urinary diversion \pm radical cystectomy (UD \pm RC).

Methods

We reviewed our IRB approved administrative database for patients having UD \pm RC stratified by technique and outcome. Anastomotic Leak Rate (ALR) was determined by detectable drain creatinine postoperatively. Chi Squared Fisher's Exact Test and Student's t-tests were used as applicable.

Results

54 patients have undergone robotic UD \pm RC since 2003, and of these ALR was evaluable in 46. Of these, 28 underwent IPL and 18 underwent APL.

Of patients with IPL, ALR was 9/28 (32%), while the ALR among those having APL was 3/18 (17%) ($P<0.05$).

Stents were used in 27/46 cases, and the ALR among those in whom stents were used was 10/27 (32%) while the ALR among patients in whom stents were not used was 2/13 (15%) ($P<0.05$).

The ALR was 7/21 (33%) when IPL was combined with stents, while the ALR was 2/12 (17%) when an APL was performed without stents ($P<0.05$).

Conclusions

An anti-peristaltic loop in robotic urinary diversion avoids the pirouette maneuver, and can be performed without stents with a lower anastomotic leak rate. Stents may worsen the ALR in urinary diversion.

**Presenter*

What Do Women Scheduled for Laparoscopic Cholecystectomy (LCHE) Think About Potential Concomitant Salpingectomy?

Tomasch G, Bliem B, Uranüs S, Tamussino K*

Background

The role of the fallopian tubes in the genesis of serous pelvic cancers has led to recommendations for salpingectomy at the time of gynecologic surgery. Laparoscopic cholecystectomy (LCHE) is a common procedure in women and may afford a possibility for salpingectomy. We explored attitudes, reactions and concerns regarding concomitant salpingectomy in women scheduled for LCHE.

Methods

A clinical psychologist conducted semistructured interviews with 20 women >45 years scheduled for elective LCHE. The interviews explored the domains fertility, femininity, sexuality and body awareness and assessed the potential acceptance of salpingectomy.

Results

17 women (85%) had a positive reaction toward concomitant salpingectomy (12 would agree immediately, 5 said they needed more time to think about it but would likely accept), 2 women were equivocal and would need more information, and 1 said she would decline.

Conclusion

These results suggest that a sizable percentage of women >45 scheduled for LCHE would be open to the possibility of concomitant salpingectomy.

**Presenter*

**Small Cell Neuroendocrine Tumors of the Cervix (SCNEC).
Do tumor Characteristics and Order of Multimodality Therapy
Influence Outcome in Early Stage Disease?**

Eriksson AGZ*, Turtzer M, Smaastuen MC, Nesbakken AJ, Hetland TE,
Kristensen GB

Objectives

To report our experience in the management of women with SCNEC. To explore favorable tumor and treatment characteristics related to survival.

Methods

All cases with SCNEC treated at our institution from 01/1978-12/2015 were identified. Demographic, pathologic, treatment and survival-data were collected. Appropriate statistical methods were applied.

Results

64 women met inclusion criteria. 22 (34%) presented as early stage (ES) (I-IIA), 41% (9/22) had lymph node metastasis (LNM). 20/22 (91%) ES cases underwent initial radical surgery accompanied by platinum-based neoadjuvant chemotherapy (NACT) in 10/20 (50%), adjuvant chemotherapy (AdCT) in 6 (30%) and adjuvant radiotherapy in 4 (20%). NACT versus surgery as initial therapy did not influence overall survival (OS) ($P=0.72$). There was no association between ≤ 3 NACT < 3 cycles and recurrence free survival (RFS) ($P=0.61$) or OS ($P=0.55$).

Tumor size ≤ 4 cm < did not influence RFS ($P=0.31$) or OS ($P=0.08$). Early versus advanced stage (AS) was not associated with RFS ($P=0.073$), it was however associated with OS ($P=0.002$). Presence of LNM negatively influenced RFS ($P=0.015$) and OS ($P=0.008$). With a median follow up of 23.3 months (range 0.4-315.7) 1 patient is currently without evidence of disease. Median time to recurrence was 28.1 months in ES and 13.5 months in AS. The 5-year OS was 49.4% for ES and 18.1% for AS.

Conclusions

SCNEC is an aggressive disease. LNM and AS were negatively associated with survival. NACT versus AdCT did not influence survival. Targeted therapies being investigated for small cell lung cancer should also be tested for patients with SCNEC.

**Presenter*

A Matter of Margins: Surgical and Pathologic Risk Factors for Recurrence in Extramammary Paget's Disease

Long B*, Schmitt AR, Weaver AL, McGree M, Bakkum-Gamez JN, Brewer J, Cliby WA

Methods

Medical records of patients seeking care for EMPD at our institution from 1/1992-9/2015 were reviewed. Both males and females were included to allow comparison between Mohs micrographic surgery (MMS) and other excisional methods. Follow-up was restricted to 5 years following primary surgery. Recurrence-free survival (RFS) was estimated using the Kaplan-Meier method. Risk factors for recurrence and positive margins were evaluated using Cox proportional hazards regression and logistic regression, respectively.

Results

Of 167 patients, 97 (58.1%) were female and 70 (41.9%) were male. Treatment consisted of wide local excision (WLE, includes WLE or radical vulvectomy, 72.5%), MMS (18.0%), abdominoperineal resection (6.0%), and other (3.6%). RFS at 1, 3, and 5 years was 85.2% (95% CI, 79.3-91.6%), 64.9% (95% CI, 56.5-74.5%), and 55.3% (95% CI, 46.3-66.0%), respectively. Presence of positive margins was univariately associated with higher risk of recurrence (HR 3.46, 95% CI 1.71, 7.00). Margin status significantly correlated with procedure type (HR for positive margins, WLE vs. MMS 14.00, 95% CI 1.83, 107.31). Among patients with negative margins, recurrence was 4.5 times higher following WLE compared to MMS.

Conclusion

In contrast to prior studies including solely female patients, we observed strong association between margin status and recurrence risk in EMPD. Risk of positive margins was significantly higher after WLE compared to MMS. These data highlight an opportunity to explore the use of MMS in gynecologic patients to improve outcomes for women with EMPD.

**Presenter*

Ovarian Tissue Banking for Cancer Patients: Non-Invasive Detection of Cancer Cells in Tissues for Safe Cryopreservation

Oppelt P*, Shebl O, LeRenard PE, Ebner T

Introduction

Women have a given store of oocytes at birth. This pool is slowly used up until menopause. In malignant diseases the indicated chemo- or radiotherapy does not only damage cancer cells, but depending on the medication and necessary dosage, also damages the oocytes. In order to preserve fertility in these women one feasible option is to cryopreserve small pieces of ovarian tissue for retransplantation after cure. One associated risk, however, is the presence of malignant cells in the stored ovarian tissue which in the worst case would cause recrudescence of the tumor after transplantation. This feasibility study was set up to non-invasively prove the absence of malignant cells in the ovarian tissue samples.

Methods

Therefore, ovarian tissue was removed from 42 cancer patients (mainly breast tumors and Hodgkin lymphomas) by laparoscopy. Cortex of the ovarian samples was cut into small pieces and cryopreserved by means of a slow-freezing technique. Cryoprotective solutions containing test tissues of the respected patients were then ultra-centrifuged and screened for exosomes and free floating micro RNAs (miRs). In order to distinguish between miRNA profile of normal and tumor cells onco-miR cluster (17-92, 106) and normalizer miRs (16, 93, 103, 191) were tested on tissue and cryoprotective solution.

Results

It could be shown that tissue of breast cancer patients showed significantly higher expression of miRs 16a and 19b compared to lymphoma patients but no difference was found to tumor-free tissue. Here level of significance was not reached due to the fact that healthy tissue also has a basal expression of onco-miRs. Using freezing solutions as a potential source of miRs no differences could be observed.

Conclusions

Using ultrasensitive methods we could show different miR-profiles of healthy and malignant ovarian tissue. Once exclusive miR candidates in tumors are identified this approach seems to be a safe method in order to avoid retransplantation of ovarian tissue contaminated with malignant cells.

**Presenter*

Emergency Peripartum Hysterectomy—a Single-Center Analysis of 42 Cases of Cesarean and Postpartum Hysterectomy

DeGregorio N*, Schramm A, Friedl TWP, Ebner F, Janni W

Background

Peripartal hysterectomy (PH) is a much dreaded procedure and often the last resort in managing postpartum hemorrhage.

Materials & Methods

During 2003 and 2016, 32,047 deliveries with 42 subsequent emergency PHs were performed at the tertiary care center of the Department of Gynecology and Obstetrics at the University of Ulm. Retrospectively, we analyzed all cases for patient's characteristics, surgical and anesthesiological management, morbidity and outcome.

Results

The incidence of PH in our hospital was 13.1 per 10,000 deliveries with a maternal mortality of 0.024% (one patient died postoperatively). PH followed in 81% (N=34) after C-section, 19% after vaginal deliveries (N=7), and once after ventouse. Underlying causes for PH were abnormal placentation (54.8%; N=23), uterine atony (26.2%; N=11), uterine lacerations (14.3%, N=6), and in rare cases uterine infection (4.8%; N=2). Clinically relevant intra- and postoperative complications occurred in 52% of patients. The median number of transfused blood products was 28.5 with 14.3 packed red blood cells (0-55 products), 11.8 FFPs (1-43), and 2.5 platelet concentrates (0-16). Loss of blood, estimated by surgeons, was clinically relevant often discordant to actual transfused blood volume.

Conclusion

PH is even in a maximum resource setting a high risk procedure. Although the mortality rate was low, more than 50% of patients experienced severe complications.

Future efforts must focus on prepartal risk assessment as well as intrapartal awareness in order to reduce maternal morbidity.

**Presenter*

Dermal Allograft for Pelvic Organ Prolapse Repair

Tarry SE*, Secret CL

Introduction

Both autologous and non-autologous materials have been used for the transvaginal repair of pelvic organ prolapse. Of those materials that are non-autologous, the FDA has issued a warning for the use of transvaginal mesh. We report 2 years of experience using an alternative to mesh, using dermal allograft to support the pelvic organ prolapse repair.

Methods

A retrospective review of patient charts in which dermal allograft was utilized during repair of pelvic organ prolapse from August 2013 to October 2015 was performed. The repair was performed by a single surgeon using a standardized technique including sharp dissection of the compartment of prolapse off of the vaginal mucosa, plication of the tissue using vicryl suture, and then placement of the dermal allograft to bilateral non-absorbable sutures affixed into the sacrospinous ligaments. The grafts were trimmed to fit the patient's anatomy.

Results

Forty-six female pelvic floor repairs were performed in 42 patients using allograft dermis. Mean age was 66 yrs with 30/46 (65%) exhibiting Baden-Walker Grade III prolapse and 15.46 (33%) Baden-Walker Grade IV prolapse. Simultaneous pubovaginal sling placement with allograft fascia lata was performed in 29/42 patients (67%). Complications included wound dehiscence in 1/46 (2.2%) and hematoma requiring evacuation in 1/46 (2.2%). No patient had recurrent prolapse more severe than Baden-Walker I on exam at 6 months after surgery.

Conclusions

Allograft dermis is an effective and safe alternative for pelvic organ prolapse repair.

**Presenter*

Simulation of Evaluation and Management of Thermal Bowel Injury During Robotic Surgery Utilizing the Porcine Model

Hoffman M*, Wenham R, Apte S, Chon, HS, Shazad M

Background

Thermal bowel injury is an infrequent but serious complication of surgery. Training in the assessment and management of this injury might be enhanced through animate simulation.

Objective

This paper describes and assesses simulation of evaluation and management of thermal bowel injury during robotic surgery.

Study Design

Utilizing the domestic pig, three degrees of thermal bowel injury were created and managed during robotically-assisted surgery. An edited video-clip of the model was assessed by 11 senior learners and 14 attending faculty. The assessments included four key competencies and four domains of fidelity. A scale of poor, fair or good was utilized.

Results

The excision, defect and repairs simulated that in the human both anatomically and surgically. Related to fidelity, the key competency of recognition of thermal injury was rated as fair by approximately 16% of the participants.

Conclusion

Reported here is a porcine model for simulation of thermal bowel injury during robotically-assisted surgery that may be useful for training purposes.

**Presenter*

Factors Associated with Hospital Readmission Following Diverting Ileostomy Creation

Li W, Stocchi L*, Cherla D, Liu G, Agostinelli A, Delaney C, Steel S, Gorgun E

Introduction

The creation of a diverting loop ileostomy is associated with the risk of readmission due to stoma-related complications. We hypothesized that the assessment of our institution-specific readmissions following ileostomy creation would help identifying at-risk groups which should be the focus of future preventative strategies.

Methods

Patients who underwent loop ileostomy formation from 2009 to 2013 were reviewed. We evaluated readmissions within 30 days after discharge following loop ileostomy construction. Possible associations between readmission and demographic, disease-related and treatment-related factors were assessed using univariable and multivariable analyses.

Results

Out of 1267 patients undergoing loop ileostomy construction, 163 patients (12.9%) were readmitted to our institution. The main causes of readmissions were organ/space infections (43, 3.4%), small bowel obstruction/ileus (42, 3.3%), dehydration (38, 3%). Independent factors associated with overall readmission were cardiovascular (OR=2.0) and renal comorbidity (OR=2.9), preoperative chemo/radiotherapy (OR=4.0), laparoscopic approach (OR=1.7) and longer operative time (OR=1.2). Cancer diagnosis was associated with reduced readmission rates (OR=0.2). Independent factors associated with readmission due to dehydration were chemo/radiotherapy (OR=4.7) and laparoscopic approach (OR=2.6).

Conclusions

Dehydration associated with diverting ileostomy creation was relevant as an individual cause of readmission, but its overall incidence was relatively rare. Dedicated strategies to prevent dehydration should be directed to patients who received chemoradiotherapy and/or laparoscopic surgery.

**Presenter*

Rectus Abdominis Myoperitoneal Flap for Vaginal Reconstruction: Review of the Literature and Report of Four Cases

Lennox GK*, Covens A

Objective

The Rectus Abdominis Myoperitoneal (RAMP) flap has distinct advantages over myocutaneous flaps. To review the literature and our experience with RAMP flaps for vaginal reconstruction.

Methods

A literature search was conducted of vaginal reconstruction. In addition, all cases of vaginal reconstruction at Sunnybrook Health Sciences Center (SHSC) from 2007-2015 were reviewed to identify cases with RAMP flaps.

Results

Nineteen published cases of vaginal reconstruction with RAMP flaps were identified in the literature. Among 11 cases of partial vaginal reconstruction for longitudinal defects, none developed vaginal stenosis; 8 resumed sexual activity. Eight patients with circumferential (N=3) or unspecified (N=5) defects developed vaginal stenosis. There were 2 reported cases of donor site hernia and 4 donor site infections, but no flap loss. At SHSC, 4 cases of RAMP flap vaginal reconstruction were identified. Cases 1-3 had circumferential vaginal reconstruction and Case 4 had anterior reconstruction. There were no cases of flap necrosis or donor site hernia. Case 1 died 18 days after pelvic exenteration from bowel ischemia. Case 2 developed a rectovaginal fistula after an anastomotic leak from a low anterior resection. Case 3 had a wound infection and vaginal shortening to 3-4 cm. Case 4 had no complications and the vagina appeared normal on exam four months post-operatively.

Conclusion

The literature and our experience support the use of RAMP flaps for reconstruction of partial longitudinal vaginal defects but not for circumferential defects where the risk of vaginal stenosis and shortening is higher.

**Presenter*

Vaginal Hysterectomy is an Effective Surgical Option for the Treatment of Endometrial Cancer in a Diverse, Obese and Medically-Challenged Patient Population

Kohler MF*, Buchanan T, Underwood PB, Muller B, Creasman WT

Introduction

The rising prevalence of both endometrial cancer (EC) and obesity is inter-related and clinically challenging. One in four Americans will also have a chronic medical condition which increases risk of general anesthesia during an extensive surgical procedure. The role of vaginal hysterectomy (VH) in the management of EC has been shown to be both safe and effective in a variety of populations who are not ideal candidates for either abdominal or laparoscopic hysterectomy. However, these studies have been limited by patient selection, sample size, and histology. To better apply data to a realistic population of patients, our objective is to compare demographics, diagnostic accuracy, safety, and recurrence rates of patients who have undergone VH versus total abdominal hysterectomy (TAH).

Methods

A retrospective review of a single institution's experience in a large academic medical center of patients who underwent surgery for endometrial cancer between 1987 and 2012 was performed. Patients were included only if they underwent VH or TAH without lymph node dissection. Patients were compared with respect to age, BMI, comorbidities, final pathology, diagnostic accuracy of procedure, surgical complications, readmission rate, and recurrence. Prevalence of various comorbidities were examined including hypertension, diabetes, myocardial infarction, and stroke. Histologic concordance between pre-operative endometrial biopsy (EMB) and/or D&C was compared to final surgical pathology. Surgical complications and readmissions within 30 days were analyzed. Recurrence was determined at a minimum follow up of 3 years after hysterectomy.

Results

Sixty-nine VH patients and 209 TAH patients were identified who had complete data for analysis. The patients were similar with respect to age and proportion of type 2 histology. VH patients had a mean BMI of 46.1 compared to 34.7 for the TAH patients and a higher rate of comorbidities (88.4% vs 76.5%, $P=0.035$). Histologic accuracy was similar between the two groups. Approximately 75% of VH patients and 62% of TAH patients ($P=0.30$) had final pathology that was consistent from EMB. Readmission rate was the same for both groups and the TAH group had a higher rate of any postoperative complication (16% vs 3%, $P=0.003$). Thirty-four patients who underwent TAH had stage 1a disease. Even

in this select subgroup, there were 5 recurrences (14.7%) in the TAH group compared to 4 total recurrences (5.8%) in the VH group ($P=0.13$).

Conclusion

When compared to TAH, VH is equivalent with respect to diagnostic accuracy and efficacy for patients with any type of endometrial cancer at presentation. In addition, VH is superior to TAH with respect to safety, even when patients are more obese and have a higher rate of medical comorbidities. This holds true within a complex and diverse population of patients not previously observed. As the rates of obesity and medical comorbidities have continued to increase, our utilization of vaginal hysterectomy in the surgical treatment of endometrial cancer at our institution not only remains robust, but may be accelerating, even as the use of robotic hysterectomy largely replaces abdominal hysterectomy. As such, we are in the process of updating the current database to include the last three years (2012-2015) of our clinical experience, with the expectation that the data we hope to present at the October, 2017 Society of Pelvic Surgeons Meeting will include substantially more patients.

**Presenter*

Immune Clusters in Omentum Provides a Niche for Ovarian Cancer Early Metastasis

Krishnani V, Taliapragadal S, Schaarl B, Rinker-Schaefer C, Dorigo O*

Purpose

The homing and invasion of ovarian cancer cells to the omentum is poorly understood. Interestingly, omental adipose harbors immune aggregates which contain macrophages, B, T, and natural killer cells. The purpose of our study was to investigate if these immune clusters play a role in the metastatic colonization of ovarian cancer cells to the omentum.

Methods

Mice were injected intraperitoneally with murine ovarian cancer cells (IDS). The omentum was harvested 7 days after injection and examined by histology for the presence of cancer cells. Several different immune mouse strains with varying immune-competency were used to determine the requirement of specific immune cell types. Depletion of macrophages in mice was accomplished with clodronate liposome treatment. Human omentum from ovarian cancer patients was used to characterize immune clusters.

Results

We found that IDS murine ovarian cancer cells colonize preferentially to immune clusters within the omentum. This early metastatic colonization process was crucially dependent on the presence of macrophages, but independent of B, T, and NK cells as demonstrated in transgenic mice. Cytokine arrays of omentum derived conditioned medium revealed high concentrations of macrophage secreted cytokines (e.g., MCSF-1, IL10). Clinical samples from patients with high-grade serous cancer confirmed that microscopic metastasis are found mainly in areas of immune clusters.

Conclusion

Our study showed that omental immune clusters are the preferential site for early ovarian cancer metastasis to the omentum. We identified omental macrophages as the key mediators of this process.

**Presenter*

Enhanced Recovery After Surgery (ERAS) Program In Gynecologic/Oncology—Audit of Compliance and Practice Associated with Improvement in Health System and Clinical Outcomes

Nelson G*, Glaze S, Chu P, National J, Ghatage P, Gilmour L,
Trudeau P, Gramlich L

Objectives

Following the publication of Enhanced Recovery After Surgery (ERAS) guidelines in gynecologic/oncology, many centers are looking to obtain benefits with protocol implementation. Necessary components required to achieve improvements in health system and clinical outcomes include both an ERAS team and an audit system. Auditing compliance to ERAS care elements is essential to successful implementation of an ERAS program. The ERAS Interactive Audit System (EIAS) has been developed to measure compliance to the guidelines. The objective of this study was to evaluate an ERAS gynecologic/oncology program using EIAS at a tertiary level cancer center.

Methods

Data from 194 patients undergoing laparotomy (85 debulking [Db], 109 staging [Stg]) for gynecologic cancer were entered into EIAS (100 pre-ERAS; 94 ERAS). Data fields were captured spanning the pre-, intra-, and postoperative phases of surgical care. Length of stay (LOS), complications, and compliance to the guidelines were reported. A cost-impact analysis was also performed.

Results

Median LOS for the Db and Stg groups pre-ERAS was 7.5 and 4 days, respectively, compared to 6 days (Db) and 3 days (Stg) in the ERAS group. Overall compliance increased from 47% (pre-ERAS) to 71% (ERAS). Overall complications decreased following ERAS implementation in both Db and Stg groups. Conservative estimation of the health system savings in this small cohort ranged between \$105,590 - \$199,558 USD.

Conclusions

Formal implementation of an ERAS program in gynecologic/oncology using EIAS to iterate towards improved compliance translated to benefits for both the health system and the patient.

**Presenter*

Differences in Survival Between Symptomatic vs Asymptomatic Recurrence Following Cystectomy for Bladder Cancer

Osterman CK, Alanzi J, Kaufman EL, Narayan V, Boursi B, Cambareri C, Malkowicz SB*, Mamtani R

Background

The benefit of surveillance after curative treatment in bladder cancer is controversial, but might be justified if early detection of asymptomatic recurrence improves survival. Prior studies demonstrating a benefit of surveillance may have been impacted by lead-time bias, which is the overestimation of survival duration due to earlier detections of disease. To avoid this bias, we examined time-dependent differences in survival with symptomatic vs. asymptomatic diagnosis of recurrence after cystectomy.

Methods

We conducted a retrospective cohort study among 463 cystectomy patients between 1987 and 2011 at the University of Pennsylvania. Patients were followed by standardized protocol and classified by mode of recurrence detection (asymptomatic or symptomatic). Primary outcome was all-cause mortality. To reduce lead-time bias, we used cox regression models with varying cohort-entry times to assess the impact of mode of recurrence on survival from both time of cystectomy (Model 1) and time of recurrence (Model 2), adjusted for time to recurrence.

Results

197 patients (42.5%) recurred; 71 were asymptomatic (36.0%), 107 were symptomatic (54.3%), and 19 (9.6%) were unknown. In all models, relative to asymptomatic patients, patients with symptomatic recurrence had significantly increased risk of death (Model 1 HR 1.74, 95% CI 1.13-2.68, Model 2 HR 1.98, 95% CI 1.27-3.10) and had lower 1 year overall survival (30.43% vs 55.66%). Group differences in median survival (246 days) were greater than the estimated lead-time (10 days).

Conclusions

Symptomatic recurrence is associated with worse outcomes than asymptomatic recurrence, even after lead-time bias adjustment. These data support consensus guidelines for intensive surveillance post-cystectomy. Similar methods to account for lead-time bias should be considered in future studies evaluating the benefit of surveillance following curative cancer resection.

**Presenter*

Pelvic Intraoperative Neuromonitoring (pIONM) to Identify and Preserve Autonomous Nerves During Surgery for Deep Infiltrating Endometriosis (DIE)

Fleisch MC*, Hartog M, Hepp P

Objectives

Radical surgery in the small pelvis can lead to significant injuries of autonomous pelvic nerves leading to impaired postoperative urinary, sexual or anorectal function. With this pilot study we evaluated application and potential benefits of pelvic intraoperative neuromonitoring (pIONM) during resection of DIE in the small pelvis.

Methods

27 consecutive patients (n=15 simultaneous infiltration of cul de sac/anterior rectal wall and sacrouterine ligament, 10 of the sacrouterine ligaments only, and two of the rectovaginal septum) undergoing laparoscopic pelvic surgery for symptomatic DIE were included. Pre- and postoperative workup included questionnaires for urinary (IPSS), sexual function (FSFI) and measurement of post voiding residual bladder volume prior to surgery and 6 months after. Intraoperatively, bladder pressure and internal anal sphincter EMG were continuously monitored. During retroperitoneal preparation pelvic nerve fibers were verified by direct stimulation using an endoscopic bipolar microfork probe and effects were registered. Whenever reasonable, dissection was adapted to preserve nerve function.

Results

All patients were treated by laparoscopy. 15% (N=4) had measurable urinary dysfunction already prior to surgery. Five patients had laparoscopic rectal segment resection, six full thickness excision of the rectal wall and 10 rectal mucosal shaving all in combination with resection of additional infiltrated organs. Lateral retroperitoneum was opened in all cases and pIONM allowed reliable identification of autonomous nerves by bladder muscles or anal sphincter stimulation in all cases. Deep infiltration of the uterosacral ligament was associated with pre- and/or postoperative impaired urinary function.

Conclusion

pIONM is applicable and has potential to improve nerve preservation during surgery for DIE.

**Presenter*

Genomic Comparisons Between Histologic and Molecular Subtypes of Endometrial Cancer Reveal Opportunities for Therapeutic Crossover

Konecny GE*, Prendergast EN, Liu AY, Cohen JG, Elvin A

Objectives

In endometrial cancer, comprehensive genomic profiling (CGP) evaluates genomic alterations (GA), microsatellite instability-high (MSI-H) status and tumor mutation burden (TMB) to identify potential biomarkers capable of predicting response to therapy. This study will report genomic patterns for endometrial cancer specimens based on histologic and molecular sub-classifications.

Methods

CGP was analyzed for 65 clinical cancer specimens by hybridization-capture of up to 315 cancer-related genes (FoundationOne®). Reports provided Gas, TMB, and MSI status. TMB was calculated by counting mutations across a 1.25Mb region spanning 315 genes. Patients were classified as TMB high (TMB-H) or low using a computational algorithm developed by Foundation Medicine.

Results

The cohort was comprised of endometrioid (41/63%), serous (15/23%), clear cell (4/6%), and mixed (5/8%) tumors. Molecular subtypes were as follows: POLE (1/2%), MSI-H (11/17%), and copy number high (CN-h) (27/42%), and copy number low (CN-L) (25/38%). Major GA for MSI-H categorization were *PTEN* (91%), *ARID1A* (82%) and *PIK3CA* (55%). Histologies for the MSI-H group included 9 (23%) endometrioid, 1 (25%) clear cell, and 1 (20%) mixed tumor. Major GA for CN-H categorization were *TP53* (97%) and *PIK3CA* (47%). CN-H included 11 (27%) endometrioid, 12 (80%) serous, 1 (25%) clear cell, and 1 (20%) mixed tumor. There was also no correlation with Cn-L and histologic subtype. Prognostic relevance of each subgroup and tailored treatment approaches will be presented.

Conclusions

Molecular categorization of endometrial cancer demonstrates crossover between histologic subtypes, which may have therapeutic implications. Additionally, CGP may reveal opportunities for biomarker-matched therapy.

*Presenter

Geographical Directory of Membership

ALABAMA

Finan, Michael
Long, Robert

ARIZONA

Hatch, Kenneth
Parker, Susan

CALIFORNIA

Berek, Jonathan
DiSaia, Philip
Dorigo, Oliver
Konecny, Gottfried
Lagasse, Leo
Lieskovsky, Gary
Mirhashemi, Ramin
Morrow, Charles P.
Ordorica, Raul
Skinner, Donald G.
Skinner, Eila

CONNECTICUT

Kohorn, Ernest
Lytton, Bernard
Schwartz, Peter

FLORIDA

Delgado, Gregorio
Fiorica, James
Gonzalez, Ricardo
Hoffman, Mitchel
Ketcham, Alfred S.
Lockhart, Jorge L.
Marcet, Jorge A.
Masterson, Byron
Moffat, Frederick, Jr.
Paulson, David
Peñalver, Manuel
Runowicz, Carolyn D.
Spiess, Philippe

ILLINOIS

Flanigan, Robert C.
Herbst, Arthur
Mueller, Elizabeth
Quek, Marcus
Strong, Scott

INDIANA

Rowland, Randall G.

IOWA

Anderson, Barrie

KANSAS

Kraybill, William

KENTUCKY

Galandiuk, Susan
Hilgers, Robert
Strup, Stephen E.

LOUISIANA

Braly, Patricia

MARYLAND

Efron, Jonathan
McLeod, David G.
Park, Robert

MASSACHUSETTS

Barrett, David
Hornicek, Francis
Marchant, Douglas J.

MICHIGAN

McGuire, Edward J.

MINNESOTA

Cliby, William
Dowdy, Sean
Lawson, Russell K.

MINNESOTA

McIlrath, Donald C.
Podratz, Karl
Stanhope, C. Robert
Utz, David C.

MISSISSIPPI

Weems, W. Lamar

MISSOURI

Mutch, David G.

NEW JERSEY

Abu-Rustum, Nadeem R.
Morgan, Mark A.

NEW YORK

Albala, David
Bauer, Joel
Bochner, Bernard
Cohen, Carmel J.
Hoskins, William
Remzi, Feza
Olsson, Carl A.
Sufirin, Gerald
Temple, Larissa

NORTH CAROLINA

Clarke-Pearson, Daniel
Homesley, Howard
Pruthi, Raj
Soper, John T.
Zervos, Emmanuel

OHIO

Belinson, Jerome
Campbell, Steven
Hopkins, Michael
Hull, Tracy
Klein, Eric A.
Stocchi, Luca

OKLAHOMA

Cookson, Michael

PENNSYLVANIA

Daly, John
Malkowicz, S. Bruce
Noumoff, Joel
Wein, Alan Jr.

RHODE ISLAND

Wanebo, Harold

SOUTH CAROLINA

Creasman, William
Rovner, Eric S.
Underwood Jr., Paul

TENNESSEE

Dmochowski, Roger
Jones, Howard, III

TEXAS

Secrest, Charles L.
Smith, Julian P.
Westney, O. Lenaine

VIRGINIA

Dunn, Leo
Jordan, Gerald H.

AUSTRALIA

Allan, John
Hacker, Neville
Heriot, Alexander
Jobling, Thomas
Webb, Maurice J.

AUSTRIA

Koelbl, Heinz
Marth, Christian
Tamussino, Karl
Winter, Raimund

BELGIUM

Vergote, Ignace

CANADACovens, Allan
DePetrillo, Amodio
Gotlieb, Walter
Mack, Lloyd
Temple, Walley**FRANCE**

Querleu, Denis

GERMANYBaltzer, Jörg
Beck, Lutwin
Bender, Hans
Diedrich, Klaus
Fehm, Tanja
Fisch, Margit
Fleisch, Markus
Friedrich, Michael
Hepp, Herman
Hohenfellner, Rudolf
Janni, Wolfgang
Kaufmann, Manfred
Kimmig, Rainer
Kindermann, Gunther
Knoefel, Wolfram Trudo
Köhler, Christhardt
Lampe, Bjoern
Lichtenegger, Werner
Pfleiderer, Albrecht
Schneider, Achim
Sehoul, Jalid
Thüroff, J.W.
Tulusan, Augustinus
Vestweber, Karl-Heinz
Wimberger, Pauline**HUNGARY**

Ungar, Laszlo

IRELANDBonnar, John
Gleeson, Noreen
O'Connell, P. Ronan**ITALY**Angioli, Roberto
Biffi, Roberto
Maggioni, Angelo**JAPAN**

Ochiai, Kazunori

NETHERLANDSHeintz, Peter
Trimbos, Baptist**NORWAY**

Tropé, Claes

PHILIPPINES

Sotto, Luciano

ROMANIA

Peltecu, Gheorghe C.

SWITZERLANDHohl, Michael
Mueller, Michael**UNITED KINGDOM**Barton, Desmond
Ind, Thomas
Monaghan, John
Shepherd, John H.
Tekkis, Paris A.
Turner-Warwick, Richard
Woodhouse, Christopher

Deceased Members

Antoine, Tassilo (1980)
Vienna, Austria

Averette, Hervy (2005)
Miami, FL

Barber, Hugh R.K. (2006)
New York, NY

Barclay, David L. (2011)
Amarillo, TX

Bastiaanse, Marius Adolphus
Van Bouwdijk (1964)
The Hague, Holland

Bazan, Narciso Diaz (2011)
San Salvador, El Salvador

Behrs, Oliver H. (2006)
Rochester, MN

Beecham, Clayton (1990)
Sunbury, PA

Bickenbach, Werner (1974)
Munich, Germany

Blandy, John (2011)
London, UK

Block, George (1994)
Chicago, IL

Borja, Manuel (2011)
Quezon City, Philippines

Boronow, Richard C. (2015)
Brandon, MS

Brack, Charles (1963)
Baltimore, MD

Bravo, Alfonso Alvarez (1996)
Hidalgo, Mexico

Brewer, John (1997)
Boise, ID

Bricker, Eugene M. (2000)
St. Louis, MO

Brunschwig, Alexander (1969)
New York, NY

Buchsbaum, Herbert (1989)
Milwaukee, WI

Burch, John C. (1977)
Nashville, TN

Burghardt, Erich (2006)
Graz, Austria

Butcher Jr., Harvey (1989)
St. Louis, MO

Candiani, Giovanni (2004)
Milano, Italy

Carenza, Luigi (1992)
Rome, Italy

Carter, F. Bayard (1976)
Durham, NC

Cavanagh, Denis (2012)
Sarasota, FL

Clark, Donald (2005)
Valhalla, NY

Colby, Fletcher (1966)
Brookline, MA

Collins, Conrad (1971)
New Orleans, LA

Coppelson, Malcolm (2017)
Sydney, Australia

Cosbie, Waring G. (1987)
Vancouver, BC

Counsellor, Virgil (1977)
Scottsdale, AZ

Crisp, William (2012)
Tempe, AZ

Daniel, William W. (2011)
Free Union, VA

Dapunt, Otto (2016)
Bogenweg, Austria

Dargent, Daniel (2005)
Lyon, France

Deddish, Michael (1980)
Cambridge, OH

Dewhurst, Sir John (2006)
London, UK

Donohue, John P. (2008)
Sault Ste. Marie, Ontario

Fazio, Victor (2015)
Shaker Heights, OH

Fitzpatrick, John (2014)
 Dublin, Ireland
Frick, Henry, II (2007)
 Alpine, NJ
Gallup, Donald G. (2011)
 Savannah, GA
Glenn, James (2009)
 Lexington, KY
Graham, John (1971)
 Buffalo, NY
Gray Sr., Laman A. (1992)
 Louisville, KY
Green Jr., Thomas H. (1980)
 Boston, MA
Gusberg, Saul B. (2005)
 North Branford, CT
Hoge, Randolph H. (2004)
 Charlottesville, VA
Ingersoll, Francis (1991)
 Newton, MA
Ingiulla, Wladimiro (1972)
 Florence, Italy
Isaacs, John (2007)
 Wilmette, IL
Jones Jr., Howard (2015)
 Norfolk, VA
Julian, Conrad (1979)
 Nashville, TN
Käser, Otto (1995)
 Basel, Switzerland
Kerr, William K. (1999)
 Toronto, Canada
Kerr Jr., William S. (2013)
 Milton, MA
Kimbrough, Robert (1967)
 Tucson, AZ
Kolstad, Per (1991)
 Oslo, Norway
Kottmeier, Hans (1982)
 Stockholm, Sweden
Krauer, Felix (2004)
 Geneva, Switzerland
Krieger, James S. (1998)
 Cleveland, OH
Krupp Jr., Philip J. (2012)
 New Orleans, LA
Leadbetter, Wyland (1974)
 Boston, MA
Lee, Raymond (2012)
 Rochester, MN
Lewis Jr., John (2012)
 Birmingham, AL
Louros, Nicholas (1986)
 Athens, Greece
Marchetti, Andrew (1970)
 Chevy Chase, MD
Marshall, Victor F. (2001)
 Charlottesville, VA
Martzloff, Karl H. (1978)
 Portland, OR
Mattingly, Richard F. (1986)
 Milwaukee, WI
McCall, Milton (1963)
 Pittsburgh, PA
McDuff Jr., Henry (1998)
 Providence, RI
McInnes, George (1987)
 Augusta, GA
McKelvey, John (1985)
 Golden Valley, MN
Meares Jr., Edwin (2000)
 Kennebunk, ME
Meigs, Joe V. (1963)
 Boston, MA
Mikuta, John J. (2013)
 Lambertton, NJ
Mitchell Jr., George W. (2012)
 San Antonio, TX
Moore, J. George (2003)
 Malibu, CA
Morley, George W. (2005)
 Ann Arbor, MI
Morris, John McLean (1993)
 New Haven, CT

Morton, Daniel (1980)
 Los Angeles, CA
Navratil, Ernst (1979)
 Graz, Austria
Nelson, Harry (1983)
 Bloomfield Hills, MI
Nelson Jr., James H. (2010)
 Isle of Palms, SC
Nichols, David (1998)
 Providence, RI
Novak, Franc (1999)
 Ljubljana, Slovenia
O'Conor Jr., Vincent J. (1992)
 Chicago, IL
Papanicolaou, George (1962)
 Miami, FL
Paquin Jr., Albert (1967)
 Charlottesville, VA
Parker, Roy (2003)
 Durham, NC
Parsons, Langdon W. (1980)
 Brookline, MA
Peters Sr., Paul (2002)
 Dallas, TX
Pettersson, B. Folke (2013)
 Uppsala, Sweden
Pratt, Joseph H. (2003)
 Rochester, MN
Prem, Konald (2015)
 Plymouth, MN
Prout Jr., George R. (2013)
 Duck Key, FL
Pyrah, Leslie (1995)
 Leeds, UK
Randall, Clyde L. (1990)
 Sykesville, MD
Read, Sir Charles (1957)
 London, UK
Richardson, George (2011)
 Nahant, MA
Riches, Sir Eric (1987)
 London, UK
Ridley, John (2005)
 Atlanta, GA
Riva, Humbert (2003)
 Short Hills, NJ
Roddick Jr., John (1997)
 Ormand Beach, FL
Rutledge, Felix N. (1997)
 Geneva, TX
Schmitz, Herbert (1960)
 Chicago, IL
Schubert, Gerhard (1964)
 Hamburg, Germany
Shingleton, Hugh (2014)
 Decatur, GA
Skinner, David (2003)
 New York, NY
Spratt Jr., John (2005)
 Charleston, SC
Stallworthy, Sir John (1993)
 Gloucester, UK
Staubitz, William J. (2003)
 Buffalo, NY
Stein, John (2008)
 Los Angeles, CA
Stening, Malcolm (2014)
 Narrabeen, Australia
Straffon, Ralph (2004)
 Shaker Heights, OH
Sturgis, Somers H. (1991)
 Cambridge, MA
Symmonds, Richard (2016)
 Salt Lake City, UT
Taylor Jr., Howard (1985)
 Southport, CT
TeLinde, Richard W. (1989)
 Baltimore, MD
Ternberg, Jessie (2016)
 St. Louis, MO
Thomsen, Klaus (1992)
 Hamburg, Germany
Thornton Jr., W. Norman (1999)
 Charlottesville, VA

Twombly, Gray H. (1992)
Bloomfield, CT
Ulfelder, Howard (1990)
Boston, MA
Uyttenbroeck, Franz (1994)
Antwerp, Belgium
Valle, Giuseppe (1994)
Rome, Italy
Vernon, C. Peter (1987)
Toronto, Canada
Wall, John (1982)
Houston, TX
Walton, Kenneth (2005)
Atlanta, GA
Way, Stanley (1988)
Newcastle, UK
Wilbanks Jr., George D. (2012)
Durham, NC
Zacharin, Robert (2012)
Victoria, Australia
Zander, Josef (2007)
Grunwald, Germany
Zincke, Horst (2011)
Rochester, MN

Deceased Members Since 2016 Meeting

2016

Jessie Ternberg

2017

Malcolm Coppelson

Guests of Members

Richard Boothby
Guest of James Fiorica

David Larson
Guest of Scott Strong

Nadim Bou Zgheib
Guest of Mitchel Hoffman

Genevieve Lennox
Guest of Al Covens

Marta Crispens
Guest of Howard Jones, III

Beverly Long
Guest of William Cliby

Nikolaus deGregorio
Guest of Wolfgang Janni

Gregg Nelson
Guest of Sean Dowdy

Ane Gerda Zahl Erickson
Guest of Claes Tropé

Peter Oppelt
Guest of Christhardt Köhler

Viola Heinzelmänn-Schwarz
Guest of Neville Hacker

Edward Partridge
Guest of Michael Finan

James Jensen
Guest of Mitchel Hoffman

Matthew Robertson
Guest of Sean Dowdy

Nathaniel "Nate" Jones
Guest of Michael Finan

Rodney Rocconi
Guest of Michael Finan

David Joyce
Guest of Ricardo Gonzalez

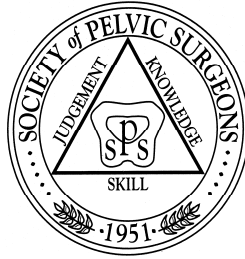
Susan Tarry
Guest of Charles Secret

Matthew Kohler
Guest of William Creasman

Jonathan Zager
Guest of Philippe Spiess

The Society of Pelvic Surgeons

**68th Annual Meeting
2018**



**September 23-29, 2018
Romania**

Host:
Gheorghe Peltecu

ABSTRACTS DUE:
APRIL 15, 2018 (TENTATIVE)

MORE INFORMATION:
Email: SOCPELVICSURG@att.net

Notes

Notes

