The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

Guidelines for performing gynaecological endoscopic procedures

This statement has been developed by the Women's Health Committee. It has been reviewed by the Endoscopic Surgery Advisory Committee (RANZCOG/AGES) and Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee and Endoscopic Surgery Advisory Committee (RANZCOG/AGES) Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: July 1993
Current: July 2017, Amended November 2018
Review due: July 2020

Consensus statement of the Royal Australian and New Zealand College of Obstetricians & Gynaecologists (RANZCOG) and the Australasian Gynaecological Endoscopy & Surgery Society (AGES).

Objectives:
To describe the guidelines for performing gynaecological endoscopic procedures.

Target audience: All Australasian registered health practitioners who perform gynaecological endoscopic procedures.

Values: The evidence was reviewed by the Endoscopic Surgery Advisory Committee (RANZCOG/AGES) and Women's Health Committee, and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by the RANZCOG Women's Health Committee in July 1993. It was recently updated by the Endoscopic Surgery Advisory Committee (RANZCOG/AGES) and Women's Health Committee in November 2018.

Funding: The development and review of this statement was funded by RANZCOG.

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1. Introduction

Endoscopic surgery, encompassing laparoscopic, robot-assisted laparoscopic (see Robotic statement) and hysteroscopic approaches, is an appropriate diagnostic and therapeutic intervention for a range of gynaecological conditions.

Like any surgery, practitioners wishing to perform endoscopic procedures are subject to standards in relation to training and practice. Competency in the performance of endoscopic procedures necessitates not only an understanding of the surgical pathology, surgical technique and complications that may arise from such interventions but also specific visuospatial skills. As such, no minimum performance or training numbers can be specified.

As for any surgical procedure, gynaecologists should not perform unsupervised endoscopic procedures until they have reached the appropriate scope of clinical practice. Credentialing of gynaecologists should be undertaken by appropriate hospital or regional credentialing committees, with reference to the guidelines in this document. However, credentialing bodies need to understand that some endoscopic surgical competencies do not fall within the framework described in this document.

Most importantly, credentialing in endoscopic surgery must always proceed on an individual basis, and as such, may proceed outside of this framework, based on individual proof of training, skills and currency.

2. RANZCOG/AGES Levels of Scope Clinical Practice

RANZCOG and AGES have classified procedures that require similar endoscopic scope of practice.

2.1 Level 1 Scope of Clinical Practice

Description
Level 1 procedures encompass diagnostic endoscopic procedures.

RANZCOG Training Pathway
Level 1 competency should be achieved by all those awarded FRANZCOG.

Inclusions
Level 1 procedures include, but are not limited to, diagnostic hysteroscopy and laparoscopy, including alternative entry techniques and port site placements.

2.2 Level 2 Scope of Clinical Practice

Description
Level 2 procedures encompass simple operative endoscopic procedures.

RANZCOG Training Pathway
Level 2 competency should be achieved by all those awarded FRANZCOG.

Inclusions

Level 2-A: procedures include, but are not limited to, simple operative procedures such as hysteroscopic retrieval of an intrauterine device, laparoscopic tubal ligation, simple cyst aspiration, simple adhesiolysis and ablation of ASRM stage 1 endometriosis.

Level 2-B: procedures at this level include salpingotomy/salpingectomy for treatment of ectopic pregnancy.

2.3 Level 3 Scope of Clinical Practice

Description

Level 3 procedures encompass operative endoscopic procedures.

RANZCOG Training Pathway

Level 3 competency should be achieved by those awarded FRANZCOG who have completed the Generalist Pathway.

Inclusions

Level 3-A: procedures include, but are not limited to, operative procedures such as hysteroscopic polyp resection including the base, laparoscopic ovarian cystectomy without complexity, excision of ASRM stage 2 endometriosis and oophorectomy (without complexity).

Level 3-B: procedures include laparoscopically-assisted vaginal hysterectomy (LAVH).

2.4 Level 4 Scope of Clinical Practice

Description

Level 4 procedures encompass advanced operative endoscopic procedures.

RANZCOG Training Pathway

Level 4 competency should be achieved by those awarded FRANZCOG who have completed the Hysteroscopic & Laparoscopic Surgery ATM.

Inclusions

Level 4 procedures include, but are not limited to, operative procedures such as salpingo-oophorectomy, adhesiolysis, hysteroscopic submucosal fibroid (type 0-1), hysteroscopic endometrial ablation; excision of ASRM stage 3 endometriosis, laparoscopically assisted vaginal hysterectomy with complexity (as described in this scope of clinical practice) and laparoscopic hysterectomy without complexity (other than described in this scope of clinical practice).

2.5 Level 5 Scope of Clinical Practice

Description

Level 5 procedures encompass endoscopic procedures of advanced complexity.

RANZCOG Training Pathway

Level 5 competency should be achieved by the completion of an accredited advanced training program, such as the AGES Fellowship Accredited Training Program or a similar formalised training program of no less than 24 months' duration. This stage incorporates a capacity for endoscopic suturing.

Inclusions

Level 5 procedures include, but are not limited to, laparoscopic hysterectomy with complexity (such as endometriosis and fibroids), Burch colposuspension, myomectomy, management of ASRM stage 4 endometriosis, hysteroscopic myomectomy (type 2) and hysteroscopic septoplasty. This level also includes all single site and robotic approaches.

2.6 Level 6 Scope of Clinical Practice

Description

Level 6 procedures encompass the highest level of complexity and are domain specific. Practitioners may be credentialed in more than one domain.

RANZCOG Training Pathway

Level 6 competency may be achieved by the completion of the RANZCOG Subspecialist Training Program or another accredited advanced training program, such as the AGES Fellowship Accredited Training Program.

Inclusions

Level 6-B (benign gynaecological surgery): Procedures at this level include laparoscopic excisional surgery for ASRM stage 4 endometriosis necessitating bowel or urological resection, ureterolysis, removal of residual cervix, removal of residual ovaries with significant distortion of the anatomy and extensive adhesiolysis. This level includes coordination of a multidisciplinary team, including colorectal and urological colleagues.

Level 6-U (urogynaecological surgery): Procedures at this level include urogynaecological procedures (laparoscopic pelvic floor repair and sacrocolpopexy).

Level 6-R (reproductive gynaecological surgery): Procedures at this level include laparoscopic tubal reanastomosis and management of congenital disorders.

Level 6-O (gynaecological oncology surgery): Procedures at this level include laparoscopic oncological procedures such as laparoscopic pelvic/para-aortic lymph node dissection and radical hysterectomy).

3. Credentialing

Although this statement will help guide institutional credentialing for a new Fellow, it should not be used to restrict scope of practice of any Fellow who is able to demonstrate training in a specific area of practice or procedure. Credentialing in endoscopic surgery must always proceed on an individual basis, and as such, may proceed outside of this framework, based on individual proof of training, skills and currency. Refer to College statement *Credentialing in Obstetrics and Gynaecology (WPI 23).*

Appendices

Appendix A Women's Health Committee

Name	Position on Committee
Professor Yee Leung	Chair
Dr Joseph Sgroi	Deputy Chair, Gynaecology
Associate Professor Janet Vaughan	Deputy Chair, Obstetrics
Associate Professor Lisa Hui	Member
Associate Professor Ian Pettigrew	EAC Representative
Dr Tal Jacobson	Member
Dr Ian Page	Member
Dr John Regan	Member
Dr Craig Skidmore	Member
Professor Susan Walker	Member
Dr Bernadette White	Member
Dr Scott White	Member
Associate Professor Kirsten Black	Member
Dr Greg Fox	College Medical Officer
Dr Marilyn Clarke	Chair of the ATSI WHC
Dr Martin Byrne	GPOAC Representative
Ms Catherine Whitby	Community Representative
Ms Sherryn Elworthy	Midwifery Representative
Dr Amelia Ryan	Trainee Representative

Endoscopic Surgery Advisory Committee (RANZCOG/AGES) Membership

Name	Position on Committee
Dr Stephen Lyons	Chair, Representative AGES
Professor Michael Permezel	Deputy Chair, Representative RANZCOG
Dr Stuart Salfinger	Representative AGES
Professor Ian Symonds	Representative RANZCOG
Dr John Tait	Representative RANZCOG
Associate Professor Anusch Yazdani	Representative AGES
Associate Professor Jason Abbott	President AGES
Professor Steve Robson	President RANZCOG

Appendix B Overview of the development and review process for this statement

i. *Steps in developing and updating this statement*

This statement was originally developed in 1994 and was most recently reviewed in November 2018. The Endoscopic Surgery Advisory Committee (RANZCOG/AGES) carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.

- At the March 2018 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii).

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Endoscopic Surgery Advisory Committee (RANZCOG/AGES).

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Endoscopic Surgery Advisory Committee (RANZCOG/AGES) members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines.[17] Where no robust evidence was available but there was sufficient consensus within the Endoscopic Surgery Advisory Committee (RANZCOG/AGES), consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution

Consensus-based	Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note	Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.