Plenary 3: Hysteroscopy

MODERATOR
Richard J. Gimpelson, MD

CO-MODERATOR
Jorge E. Dotto, MD

DISCUSSANTS
Radu Apostol, DO
Scott G. Chudnoff, MD, MS
Malcolm G. Munro, MD, FRCS(c), FACOG

Aarathi Cholkeri-Singh, MD
Mark D. Levie, MD
Kirsten J. Sasaki, MD

Hervé Fernandez, MD, PhD
Megan C. Lutz, MD, MPH
Sebastiaan Veersema, MD, PhD

Miriam Hanstede, MD
Julia Kefalas Troncon, MD
Dabao Xu, MD
Professional Education Information

Target Audience
This educational activity is developed to meet the needs of surgical gynecologists in practice and in training, as well as other healthcare professionals in the field of gynecology.

Accreditation
AAGL is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The AAGL designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS
As a provider accredited by the Accreditation Council for Continuing Medical Education, AAGL must ensure balance, independence, and objectivity in all CME activities to promote improvements in health care and not proprietary interests of a commercial interest. The provider controls all decisions related to identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the activity. Course chairs, planning committee members, presenters, authors, moderators, panel members, and others in a position to control the content of this activity are required to disclose relevant financial relationships with commercial interests related to the subject matter of this educational activity. Learners are able to assess the potential for commercial bias in information when complete disclosure, resolution of conflicts of interest, and acknowledgment of commercial support are provided prior to the activity. Informed learners are the final safeguards in assuring that a CME activity is independent from commercial support. We believe this mechanism contributes to the transparency and accountability of CME.
# Table of Contents

Course Description ................................................................................................................................. 1

Disclosure .................................................................................................................................................. 2

Hysteroscopic Proximal Tubal Occlusion versus Laparoscopic Salpingectomy as Treatment for Hydrosalpinges Prior to IVF or ICSI: A RCT
S. Veersema ................................................................................................................................................. 4

Tertiary Prevention of Morbus Asherman: A Randomized Controlled Trial Title
M. Hanstede .................................................................................................................................................. 7

Uterine Synechiae after Hysteroscopic Myomectomy: Should We Use Bipolar or Monopolar Energy?
H. Fernandez ............................................................................................................................................... 10

Analysis of the Differential Genetic Expression between Symptomatic and Asymptomatic Endometrial Polyps
J.K. Troncon ............................................................................................................................................... 13

Video: Myomectomy of Type II Submucous Uterine Myoma Using Hysteroscopy Endo-Operative System (HEOS)
D. Xu ....................................................................................................................................................... 16

Video: Effective Management of Essure Complications
M. Lutz ....................................................................................................................................................... 17

Cultural and Linguistics Competency ..................................................................................................... 18
**Plenary 3: Hysteroscopy**

Moderator: Richard J. Gimpelson  
Co-Moderator: Jorge E. Dotto

Discussants: Radu Apostol, Aarathi Cholkeri-Singh, Scott G. Chudnoff, Mark D. Levy, Malcolm G. Munro, Kirsten Sasaki

Faculty: Hervé Fernandez, Miriam Hanstede, Megan Lutz, Julia Kefalas Troncon, Sebastiaan Veersema, Dabao Xu

This session will discuss advanced analysis and hysteroscopic surgical techniques, as well as effective management of complications.

**Learning Objectives:** At the conclusion of this course, the participant will be able to: 1) Describe advanced indications; and 2) discuss additional surgical techniques to improve outcomes of Hysteroscopic surgery.

**Course Outline**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Discussant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:15</td>
<td>Hysteroscopic Proximal Tubal Occlusion versus Laparoscopic Salpingectomy as Treatment for Hydrosalpinges Prior to IVF or ICSI: A RCT</td>
<td>S. Veersema</td>
</tr>
<tr>
<td>2:21</td>
<td>Discussant</td>
<td>A. Cholkeri-Singh</td>
</tr>
<tr>
<td>2:25</td>
<td>Tertiary Prevention of Morbus Asherman: A Randomized Controlled Trial</td>
<td>M. Hanstede</td>
</tr>
<tr>
<td>2:31</td>
<td>Discussant</td>
<td>S.G. Chudnoff</td>
</tr>
<tr>
<td>2:35</td>
<td>Uterine Synechiae after Hysteroscopic Myomectomy: Should We Use Bipolar or Monopolar Energy?</td>
<td>H. Fernandez</td>
</tr>
<tr>
<td>2:41</td>
<td>Discussant</td>
<td>M.G. Munro</td>
</tr>
<tr>
<td>2:45</td>
<td>Analysis of the Differential Genetic Expression between Symptomatic and Asymptomatic Endometrial Polyps</td>
<td>J.K. Troncon</td>
</tr>
<tr>
<td>2:51</td>
<td>Discussant</td>
<td>K.J. Sasaki</td>
</tr>
<tr>
<td>2:55</td>
<td>Video: Myomectomy of Type II Submucous Uterine Myoma Using Hysteroscopy Endo-Operative System (HEOS)</td>
<td>D. Xu</td>
</tr>
<tr>
<td>3:01</td>
<td>Discussant</td>
<td>R. Apostol</td>
</tr>
<tr>
<td>3:05</td>
<td>Video: Effective Management of Essure Complications</td>
<td>M. Lutz</td>
</tr>
<tr>
<td>3:11</td>
<td>Discussant</td>
<td>M.D. Levy</td>
</tr>
<tr>
<td>3:15</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
Art Arellano, Professional Education Manager, AAGL*
R. Edward Betcher*
Amber Bradshaw
Speakers Bureau: Myriad Genetics Lab
Other: Proctor: Intuitive Surgical
Sarah L. Cohen
Consultant: Olympus
Erica Dun*
Joseph (Jay) L. Hudgens
Contracted Research: Gynesonics
Frank D. Loffer, Medical Director, AAGL*
Suketu Mansuria
Speakers Bureau: Covidien
Linda Michels, Executive Director, AAGL*
Karen C. Wang*
Johnny Yi*

SCIENTIFIC PROGRAM COMMITTEE
Sawsan As-Sanie
Consultant: Myriad Genetics Lab
Jubilee Brown*
Aarathi Cholkeri-Singh
Consultant: Smith & Nephew Endoscopy
Speakers Bureau: Bayer Healthcare Corp., DySIS Medical, Hologic
Other: Advisory Board: Bayer Healthcare Corp., Hologic
Jon I. Einarsson*
Suketu Mansuria
Speakers Bureau: Covidien
Andrew I. Sokol*
Kevin J.E. Stepp
Consultant: CONMED Corporation, Teleflex
Stock Ownership: Titan Medical
Karen C. Wang*

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).
Radu Apostol*
Aarathi Cholkeri-Singh
Consultant: Smith & Nephew Endoscopy
Speakers Bureau: Bayer Healthcare Corp., DySIS Medical, Hologic
Other: Advisory Board: Bayer Healthcare Corp., Hologic
Scott G. Chudnoff*
Jorge E. Dotto*
Hervé Fernandez*
Richard J. Gimpelson
Contracted Research: Minerva Surgical
Other: Advisory Board: Mirabilis Medical
Other: Clinical Events Committee: Halt Medical
Royalty: CooperSurgical
Miriam Hanstede*
Mark D. Levie
Consultant: Bayer Healthcare Corp.
Megan C. Lutz*
Malcolm G. Munro
Consultant: Aegea Medical, Boston Scientific Corp., Inc., Gynesonics, Hologic
Stock Ownership: Channel Medical
Kirsten J. Sasaki*
Julia Kefalas Troncon*
Sebastiaan Veersema
Consultant: Bayer Healthcare Corp.
Royalty: Olympus
Dabao Xu*
Content Reviewer has no relationships.

Asterisk (*) denotes no financial relationships to disclose.
Objective

Discuss whether hysteroscopic proximal tubal occlusion by Essure devices as treatment for hydrosalpinges results in comparable ongoing pregnancy rates following IVF/ICSI as compared to laparoscopic salpingectomy.

In- en exclusion criteria

- Hydrosalpinx visible on ultrasound uni- or bilateral.
- Hydrosalpinx confirmed by HSG or laparoscopy
- 18-41 years
- Indication for IVF/ICSI
  - < 18 years
  - > 41 years
  - Pregnancy
  - PID recently (< 6 months)
  - Declining Essure
  - Submucous myomas type 0 and 1

Patient characteristics

<table>
<thead>
<tr>
<th></th>
<th>Essure® Salpingectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) (mean ± SD)</td>
<td>32.6 ± 4.5</td>
</tr>
<tr>
<td>Duration of subfertility (months) (median with 25th to 75th percentile)</td>
<td>32.4 (18.4-50.9)</td>
</tr>
<tr>
<td>Subfertility Primary/Secondary</td>
<td>64.3% / 35.7%</td>
</tr>
<tr>
<td>Hydrosalpinx Unilateral/Bilateral</td>
<td>42.9% / 57.1%</td>
</tr>
<tr>
<td>BMI (kg/m2) (mean ± SD)</td>
<td>24.5 (22.0-27.2)</td>
</tr>
<tr>
<td>Cycle duration (days)</td>
<td>28.0 (28.0-29.0)</td>
</tr>
<tr>
<td>Semen (TMSC) (x106 /ml)</td>
<td>29.0 (10.5-59.3)</td>
</tr>
<tr>
<td>Prior IVF/ICSI</td>
<td>Yes (27.1%)</td>
</tr>
</tbody>
</table>

Presenters: Sebastiaan Veersema
UMC Utrecht
The Netherlands
Clinical pregnancy rate
Ongoing pregnancy
Primary outcome
Ectopic pregnancy rate
Miscarriage rate

Per included patient 11/27 (40.7%) 20/32 (62.5%) 21.8 (-6.0 – 46.4) 0.121 0.65 0.38 – 1.11
Per embryo transferred 11/61 (18.0%) 20/48 (41.7%) 23.7% (5.3 – 41.1) 0.01 0.43 0.23 – 0.81

Pregnancy outcomes; per protocol

Embryo quality

<table>
<thead>
<tr>
<th>Embryo quality</th>
<th>Fresh</th>
<th>Frozen</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embryo transferred</td>
<td>9/27 (33.3%)</td>
<td>0/27 (0.0%)</td>
<td>2/27 (7.4%)</td>
</tr>
<tr>
<td>Embryo transferred</td>
<td>9/61 (14.8%)</td>
<td>0/61 (0.0%)</td>
<td>2/61 (3.3%)</td>
</tr>
<tr>
<td>Embryo transferred</td>
<td>18/48 (37.5%)</td>
<td>8/48 (16.7%)</td>
<td>1/48 (2.1%)</td>
</tr>
<tr>
<td>Embryo transferred</td>
<td>13/32 (40.6%)</td>
<td>8/32 (25.0%)</td>
<td>0/32 (0.0%)</td>
</tr>
</tbody>
</table>

References


Take to work message

- In the treatment of hydrosalpinges prior to IVF/ICSI is Essure inferior to laparoscopic salpingectomy.
Acknowledgements

Mark Hans Emanuel
Kim Dreyer
Peter Hompes
Valja Mijatovic

Free University Amsterdam, Spaarnestraat Hoofddorp
UMC Utrecht
The Netherlands
Tertiary Prevention of Morbus Asherman, a Randomized Controlled Trial

Miriam Hanstede M.D.
Spaarne Gasthuis Haarlem/Hoofddorp
The Netherlands

Plenary Session 3: Hysteroscopy on November 16, 2016

Objective

Discuss the best way to treat an Asherman patient after successful adhesiolysis to prevent spontaneous recurrence of adhesions

Intra Uterine Adhesions

Presence of symptoms

RCT, prevention of recurrence of adhesions

- Single center, single blind RCT
- IRB approval
- Power calculation
- 110 women were included in the study
- 60 were included in the hormone group of endogenous 60 were included in the control group

- Schedule
  - Day 1 to 10: 4 mg oestradiol
  - Day 11 to 15: 4 mg oestradiol en 10 mg norethisteron
  - Day 16 to 20: geen medicatie
  - Day 21 to 35: 4 mg oestradiol
  - Day 36 to 40: 4 mg oestradiol 10 mg norethisteron

Recurrence and grade of adhesions

<table>
<thead>
<tr>
<th>Grade ESGE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20.8</td>
</tr>
<tr>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>2a</td>
<td>22.7</td>
</tr>
<tr>
<td>3</td>
<td>29.1</td>
</tr>
<tr>
<td>4</td>
<td>38.5</td>
</tr>
<tr>
<td>5</td>
<td>41.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade AFS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>22.9</td>
</tr>
<tr>
<td>Moderate</td>
<td>22.7</td>
</tr>
<tr>
<td>Severe</td>
<td>36.5</td>
</tr>
</tbody>
</table>

Protocol Asherman Treatment

Methods

• Inclusion
  Women with M. Asherman whom underwent successful
  hysteroscopic adhesiolysis

• Exclusion
  - Women with anovulation
  - Oligomenorrhea or amenorrhea
  - Prior to the development of
  - Uterine congenital anomalies
  - Women who do not master the
  - Women younger than 18 years of
  - Women with contraindications of
  - Women who use hormonal

Baseline Caracteristics

<table>
<thead>
<tr>
<th></th>
<th>Hormones</th>
<th>No-Hormones</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>60</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>32.5 (22-41)</td>
<td>33.2 (23-43)</td>
<td>0.471</td>
</tr>
<tr>
<td>BMI</td>
<td>23.9 (18-40)</td>
<td>24.4 (18-36)</td>
<td></td>
</tr>
<tr>
<td>Causal procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First trimester</td>
<td>71%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Post partum</td>
<td>30%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Grade Adhesions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>7%</td>
<td>8%</td>
<td>0.80</td>
</tr>
<tr>
<td>Moderate</td>
<td>65%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>48%</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>

Primary outcome

Secondary outcome
Secondary outcome

- Endometrial thickness
  - Hormone group 5.1±1.2mm
  - Control group 5.5±2.1mm
  (Mann-Whitney test, p=0.894).

Secondary outcome

- Good outcome/Bad outcome combined
  - 8 to10 weeks
    - Hormone group 80.0%
    - Control group 83.3%
  - 6 months
    - Hormone group 57.6%
    - Control group 68.6%
  - 9 months
    - Hormone group 90.5%
    - Control group 82.4%
  - 12 months
    - Hormone group 95.5%
    - Control group 91.7%

Take to work message

Weather or not women are treated with a hormone schedule in Asherman patients after a successful adhesiolysis, does:

- Influence the chance of getting pregnant after adhesiolysis
- Influences the endometrial thickness
- Not influence the chance of recurrence of adhesions

Take to work message 2

If your causal procedure is a post partum curettage

- The grade of adhesions tends to be higher
- They are more difficult to restore uterine anatomy
- They have more risk of spontaneous recurrence of adhesions
- They have a significant smaller chance of getting pregnant

Acknowledgments

- Mark Hans Emanuel
- Els Hijmans
- Jolies van de Berg

References

Uterine Synechiae after Hysteroscopic Myomectomy: Should We Use Bipolar or Monopolar Energy?

Presenter: Hervé FERNANDEZ

Disclosures

I have no financial relationships to disclose.

Objective

The main objective was to compare the rate of synechiae after resection of myomas FIGO type 0, 1 and 2 using bipolar or monopolar energy.

Design

Randomized controlled trial, Single-blind, two-centre, Superiority trial

WOMEN

Under 42 years,
With either symptomatic menometrorrhagia and/or primary/secondary infertility,
One or more myoma type 0-2 by 3D US,
Amenable to hysteroscopic surgery

Material & Methods

Pre operative visit: consent form and randomization
2D and 3D ultrasound by abdominal & vaginal way
Office hysteroscopy by vaginoscopy
Day surgery
Systematic control by office hysteroscopy at 6 weeks
HYSTEROSCOPIC SURGERY

- Hysteroscopic myomectomy was performed using a rigid (Karl Storz®) 26 Fr resectoscope with either monopolar or bipolar energy through an electrode with a cutting loop of 4mm
- All procedures were planned to occur during the follicular phase of the menstrual cycle
- No anti-adhesion devices or hyaluronic acid were inserted into the uterine cavity after the resection

Main Results

- 58 patients randomized and analysed into two arms depending on the type of energy: monopolar (n = 27) vs. bipolar (n = 31).
- No statistically significant differences existed between the two treatment arms regarding women characteristics
  - monopolar 25 ± 10.4 mm vs bipolar 29.2 ± 12.2 mm

Measurements and Main Results

The synechiae rate observed during the postoperative follow-up visit at 6 weeks

- in bipolar energy = 1/31 (3.2%)
- versus
- monopolar energy = 7/27 (26.9%)

(p = 0.012)

Conclusion

Due to significative difference, the study stopped for ethical reason to avoid a loss of opportunity for the women

First randomized comparative clinical study that shows a significant superiority in reducing the synechiae rate using bipolar energy in the resection type fibroids 0-2 compared to the monopolar energy
Conclusion

• Office hysteroscopic control, 6 weeks after resection of myoma in order to treat iatrogenic, uncomplicated synechiae, using simple fluid distension techniques must become the gold standard

• Place of routine use of anti-adhesional treatments or device on debate

Acknowledgements

André Nazac, M.Comtet, AG.Pourcelot, X. Deffieux, M. Vassilieff, C.Lalanne, M. Duracinsky
Analysis of the Differential Genetic Expression between Symptomatic and Asymptomatic Endometrial Polyps

Júlia Kefalás Troncon, M.D.
MSc Student in Obstetrics and Gynecology,
Assistant Physician - Department of Obstetrics and Gynecology, Faculty of Medicine of Ribeirão Preto, University of São Paulo - USP, Ribeirão Preto (SP), Brazil

I have no financial relationships to disclose.

OBJECTIVES

• Discuss the association between endometrial polyps and endometrial cancer

• Evaluate if there is benefit in performing hysteroscopic polypectomy in asymptomatic postmenopausal patients

BACKGROUND

• PATHOGENESIS OF ENDOMETRIAL POLYPS

- Differential hormonal receptor expression favouring hyperestrogenism

- Unbalance between cellular proliferation and apoptosis favouring tissue growth

Association with type I endometrial cancer?

• RISK FACTORS FOR MALIGNANCY

- Age (> 60 years)
- Menopausal status
- Polyp size (> 15mm)
- Postmenopausal bleeding

Around 3.5% prevalence of endometrial hyperplasia and cancer

BACKGROUND

• CROSS-SECTIONAL STUDY

- Tertiary referral hospital
- Postmenopausal patients undergoing hysteroscopic polypectomy

39 symptomatic
21 asymptomatic

• Exclusion: use of hormonal therapy or tamoxifen
• Signed informed consent

METHODS
METHODS

- Sample of tissue from the extracted polyp
- DNA extraction and PCR (Polimerase Chain Reaction)
- Analysis of the differential genic expression: genes involved in endometrial carcinogenesis

GENES EVALUATED

- **PTEN**  
  Tumor-suppressor gene (favors apoptosis)
- **MLH-1**  
  Mismatch repair system (Microsatellite instability)
- **CTNNB1**  
  Beta-catenin protein (WNT pathway of cellular differentiation)
- **BCL-2**  
  Inhibits apoptosis

RESULTS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>N. Obs.</th>
<th>Average</th>
<th>Minimum</th>
<th>Maximum</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>0</td>
<td>21</td>
<td>60.26</td>
<td>48</td>
<td>70</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>63.15</td>
<td>51</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>SPERMATOPHAGIS</td>
<td>0</td>
<td>21</td>
<td>11.48</td>
<td>2</td>
<td>24</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>38</td>
<td>14.79</td>
<td>2</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>BCL2 _RQ</td>
<td>0</td>
<td>21</td>
<td>2.84</td>
<td>0.23</td>
<td>17.88</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>2.14</td>
<td>0.02</td>
<td>26.95</td>
<td></td>
</tr>
<tr>
<td>PTEN _RQ</td>
<td>0</td>
<td>21</td>
<td>2.93</td>
<td>0.1</td>
<td>31.28</td>
<td>0.13</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>4.37</td>
<td>0.06</td>
<td>11.68</td>
<td></td>
</tr>
<tr>
<td>MLH1 _RQ</td>
<td>0</td>
<td>21</td>
<td>4.74</td>
<td>0.38</td>
<td>64.31</td>
<td>0.16</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>3.74</td>
<td>0.17</td>
<td>66.98</td>
<td></td>
</tr>
<tr>
<td>CTNNB1 _RQ</td>
<td>0</td>
<td>21</td>
<td>2.01</td>
<td>0.52</td>
<td>18.7</td>
<td>0.17</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>1.65</td>
<td>0.15</td>
<td>11.17</td>
<td></td>
</tr>
<tr>
<td>POLYP SIZE</td>
<td>0</td>
<td>21</td>
<td>2.55</td>
<td>1.5</td>
<td>4.8</td>
<td>0.18</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>39</td>
<td>2.51</td>
<td>0.8</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

DISCUSSION

- Lack of evidence establishing if endometrial polyps are in fact cancer precursors – **DETECTION BIAS**
- It can not be determined if the bleeding was truly originated from the polyp – **LESS THAN 1% OF CANCERS CONFINED TO THE POLYP**
- **EPIDEMIOLOGICAL ASSOCIATION?**

CONCLUSIONS

- Evaluate the uterine cavity in its entirety
- Offer polypectomy in symptomatic patients whenever possible
- Individualize the conduct in asymptomatic polyps / Patient’s desire
- Further studies needed – are polyps only markers of endometrial disease and not cancer precursors?

REFERENCES

ACKNOWLEDGEMENTS

Julio C. Rosa-e-Silva, MD, PhD
Juliana Meola, PhD
Francisco J. Candido-dos-Reis, MD, PhD
Omero B. Poli-Neto, MD, PhD
Antonio A. Nogueira, MD, PhD

Department of Obstetrics and Gynecology, Faculty of Medicine of Ribeirão Preto, University of São Paulo - USP, Ribeirão Preto (SP), Brazil
Myomectomy of Type II Submucous Uterine Myoma Using Hysteroscopy Endo-Operative System (HEOS)

Presenter: Dabao Xu, MD
Third Xiangya Hospital of Central South University, Changsha, Hunan Province, China

Objective: This video demonstrates the advantages of using HEOS, a specially designed operative hysteroscope with a 13 Fr working channel and 3mm cold instruments, to remove a type II myoma while protecting the endometrium overlying the surface of the myoma in a single procedure.

Design: Step-by-step explanation of the technique using videos and pictures (educative video) (Canadian Task Force Classification III).

Setting: Third Xiangya Hospital

Patient(s): A 37 yo, G2P0 underwent routine ultrasound revealed a 33mm*32mm*34mm myoma located in the left uterine wall, and 1/5 of the myoma protruded into the uterine cavity.

Intervention: Myomectomy of type II submucous uterine myoma using HEOS (Sopro-comeg Company, Bordeaux, France).

Measurement and Main Results: The type II submucous myoma was removed completely using HEOS cold scissors and graspers in a single procedure. The operation time totaled 28 minutes. No complications. Postoperative pathology: uterine myoma. The myoma bed appeared well-healed at the follow up visit 2 months postoperatively.

Conclusion: When indicated, myomectomy of a submucous myoma using HEOS is safer than using traditional resectoscopy.
Effective Management of Essure Complications

Presenter: Megan Lutz, MD, MPH
Women's Health Institute, Cleveland Clinic, Cleveland, Ohio

Objective: To demonstrate management of complications with Essure tubal sterilization.

Design: Narrated video of three case studies demonstrating surgical management of Essure complications. Setting: After the introduction of Essure hysteroscopic tubal sterilization to the market in 2002, the first formal post-market FDA study on safety and effectiveness was published in September 2015. Because the conclusions from the study do not seem congruent with patient concerns for safety and adverse events, the FDA is evaluating the need for further studies. Gynecologists currently seek such substantiated studies to properly guide clinical counseling and patient consent for management of under-documented Essure complications, as well as evidence based techniques for Essure complication management. While techniques for removal have been described, this video aims to address common factors encountered with management of Essure complications.

Interventions: Laparoscopic and hysteroscopic approach to adverse events from Essure with several key points for successful removal.

1. Diagnostic laparoscopy revealing the malpositioned Essure insert when imaging modalities are otherwise equivocal
2. Informed consent establishing the goal of the patient, addressing risk of retained fragments, discussing desire to retain or remove uterus, and discussing exposure to fluoroscopy and radiation
3. Visual inspection and routine intra-operative imaging evaluating for retained fragments with fluoroscopy and KUB

Conclusion: Until larger studies are available, we demonstrate several safe and effective strategies to navigate complications with Essure tubal sterilization.

CULTURAL AND LINGUISTIC COMPETENCY

Governor Arnold Schwarzenegger signed into law AB 1195 (eff. 7/1/06) requiring local CME providers, such as the AAGL, to assist in enhancing the cultural and linguistic competency of California’s physicians (researchers and doctors without patient contact are exempt). This mandate follows the federal Civil Rights Act of 1964, Executive Order 13166 (2000) and the Dymally-Alatorre Bilingual Services Act (1973), all of which recognize, as confirmed by the US Census Bureau, that substantial numbers of patients possess limited English proficiency (LEP).

California Business & Professions Code §2190.1(c)(3) requires a review and explanation of the laws identified above so as to fulfill AAGL’s obligations pursuant to California law. Additional guidance is provided by the Institute for Medical Quality at http://www.imq.org.

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any of their activities. In 1974, the US Supreme Court recognized LEP individuals as potential victims of national origin discrimination. In all situations, federal agencies are required to assess the number or proportion of LEP individuals in the eligible service population, the frequency with which they come into contact with the program, the importance of the services, and the resources available to the recipient, including the mix of oral and written language services. Additional details may be found in the Department of Justice Policy Guidance Document: Enforcement of Title VI of the Civil Rights Act of 1964 http://www.usdoj.gov/crt/cor/pubs.htm.

Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency”, signed by the President on August 11, 2000 http://www.usdoj.gov/crt/cor/13166.htm was the genesis of the Guidance Document mentioned above. The Executive Order requires all federal agencies, including those which provide federal financial assistance, to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access.

Dymally-Alatorre Bilingual Services Act (California Government Code §7290 et seq.) requires every California state agency which either provides information to, or has contact with, the public to provide bilingual interpreters as well as translated materials explaining those services whenever the local agency serves LEP members of a group whose numbers exceed 5% of the general population.

If you add staff to assist with LEP patients, confirm their translation skills, not just their language skills. A 2007 Northern California study from Sutter Health confirmed that being bilingual does not guarantee competence as a medical interpreter. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2078538.