AGL 2022

51st GLOBAL CONGRESS ON MIGS

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

SYLLABUS

HSC-602: Hysteroscopy – Taking Your First Steps in Intrauterine Surgery

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Christina A. Salazar, MD*

HSC-602: Taking Your First Steps in Intrauterine Surgery

Co-Chairs: *Jude E. Okohue, MD, Christina A. Salazar, MD*

Faculty: *Alka Kumar, MBBS, MS, Bolarinde Ola, MBBS, MD, Erica F. Robinson, MD*

Course Description

This course provides a comprehensive beginner's tutorial on the basics of intrauterine surgery. You will learn how to identify the optimal candidates as well as how to preoperatively plan for success. We will review the principles for performing intrauterine surgery using vaginoscopy and use videos to demonstrate techniques for tips and tricks to overcome commonly encountered challenges, as well as review both normal and abnormal findings in the uterus. Through hands-on simulation, we will demonstrate the way to safely explore the intrauterine cavity to identify abnormalities and treat pathology using the basic hysteroscopic tools.

Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Demonstrate an understanding of the indications for intrauterine surgery and how to plan for success; 2) Become comfortable performing vaginoscopy and exploring the uterine cavity; and 3) Acquire basic skills with hysteroscopic scissors and graspers.

Course Outline

7:00 am	Welcome, Introduction and Course Overview	C.A. Salazar/J.E. Okohue
7:05 am	When & Why: Preoperative Screening and Planning	C.A. Salazar
7:30 am	Ergonomics and Vaginoscopy, How to Overcome the Cervix	B. Ola
7:55 am	Staying Safe: Exploring the Uterine Cavity	J.E. Okohue
8:20 am	Using Your Tools	E.F. Robinson
8:45 am	Seeing the Endometrium: Normal & Abnormal	A. Kumar
9:10 am	Questions & Answers	All Faculty
9:30 am	Adjourn	

Taking First Steps in Intrauterine Surgery

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When and Why: Preoperative Planning & Screening

Christina A Salazar, MD FACOG

Minimally Invasive Gynecologic Surgery Division
Assistant Professor, Department of Women's Health
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Disclosures

- None.

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Aims

1. Identify optimal candidates for hysteroscopy
2. Review evidence-based pre-procedure planning
3. Increase awareness of complications

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Aim 1

Identify optimal candidates for hysteroscopy

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Common Indications for Hysteroscopy

- Evaluation and treatment of submucous fibroids and polyps.
- Diagnosis and treatment of intrauterine adhesions.
- Correction of septate and dysmorphic muteri.
- Detection and diagnosis of malignancy.
- Management of rPOC or focal accreta.
- Foreign body removal (IUD with non-visualized strings or malpositioned IUD).
- Detection and treatment of isthmocele.
- Management of cesarean scar pregnancy.

Aim 2

Review evidence-based pre-procedure planning

Where to Operate

- RCTs have shown that patients prefer office-based hysteroscopy over same-day surgery center.
  - ✓ Patient and physician convenience.
  - ✓ Avoidance of general anesthesia.
  - ✓ Less patient anxiety related to familiarity with the office setting.
  - ✓ Cost effectiveness.
  - ✓ System-wide efficiency that increases use of the OR for complex cases.

Kremer C, Duffy S, Moroney M. Patient satisfaction with outpatient hysteroscopy versus day case hysteroscopy: randomised controlled trial. BMJ. 2000 Jan 29;320(7230):279-82.

Marsh FA, Rogerson LJ, Duffy SR. A randomised controlled trial comparing outpatient versus daycase endometrial polypectomy. BJOG. 2006 Aug;113(8):896-901.

ELSEVIER

JMIG The Journal of Minimally Invasive Gynecology

Original Article

Office versus Institutional Operative Hysteroscopy: An Economic Model

Malcolm G. Munro, MD, Jamie L. Kasiewicz, BS, and Vrunda B. Desai, MD

From the Department of Obstetrics and Gynecology, Kaiser Permanente, Los Angeles Medical Center and Department of Obstetrics and Gynecology, David Geffen School of Medicine at UCLA (Dr. Munro), Los Angeles, California, and CooperSurgical, Inc. (Ms. Kasiewicz and Dr. Desai), Trumbull, Connecticut

ABSTRACT **Study Objective:** Model and compare estimated health system costs and gynecologic practice revenues when hysteroscopic surgery is performed in the office or institutional setting, either an ambulatory surgical center (ASC) or a traditional operating room (OR).
Design: Economic modeling exercise.

Munro MG, Kasiewicz JL, Desai VB. Office versus Institutional Operative Hysteroscopy: An Economic Model. J Minim Invasive Gynecol. 2022 Apr;29(4):535-548.

European Journal of Obstetrics & Gynecology and Reproductive Biology 260 (2021) 70–77

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Endometrial polyps. An evidence-based diagnosis and management guide

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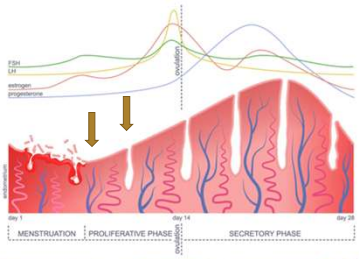
Vitale SG, Haimovich S, Laganà AS, Alonso L, Di Spiezio Sardo A, Carugno J; From the Global Community of Hysteroscopy Guidelines Committee. Endometrial polyps. An evidence-based diagnosis and management guide. Eur J Obstet Gynecol Reprod Biol. 2021 May;260:70-77.

When to Operate



Which Meds to Consider Pre-Op

Cicinelli E, Pinto V, Quattromini P, Fucci MR, Lepera A, Mitola PC, et al. Endometrial preparation with estradiol plus dienogest (Qlaira) for office hysteroscopic polypectomy: randomized pilot study. J Minim Invasive Gynecol 2012;19:356–9.

Lagana AS, Vitale SG, Muscia V, Rossetti P, Buscema M, Triolo O, et al. Endometrial preparation with Dienogest before hysteroscopic surgery: a systematic review. Arch Gynecol Obstet 2017;295:661–7.

Which Meds to Consider Pre-Op

Kamath MS, Kalampokas EE, Kalampokas TE. Use of GnRH analogues pre-operatively for hysteroscopic resection of submucous fibroids: a systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol 2014;177:11–8.

Which Meds to Consider Pre-Op

Al-Fozan H, et al. Preoperative ripening of the cervix before operative hysteroscopy. Cochrane Database of Systematic Reviews 2015, Issue 4.

Casadei L, et al. Role of vaginal estradiol pretreatment combined with vaginal misoprostol for cervical ripening before operative hysteroscopy in postmenopausal women. Obstet Gynecol Sci 2016;59:220–6.

Which Meds to Consider Intra-Op

Phillips DR, Nathanson HG, Milim SJ, Haselkorn JS, Khapra A, Ross PL. The effect of dilute vasopressin solution on blood loss during operative hysteroscopy: a randomized controlled trial. Obstet Gynecol 1996;88:761–6.

European Journal of Obstetrics & Gynecology and Reproductive Biology 252 (2020) 70–81

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Local anaesthesia for office hysteroscopy: A systematic review & meta-analysis

Prathiba M. De Silva[a,*], Alasdair Carnegy[b], Paul P. Smith[a], T. Justin Clark[c]

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De Silva, Prathiba M. et al. "Local Anaesthesia for Office Hysteroscopy: A Systematic Review & Meta-Analysis." *European journal of obstetrics & gynecology and reproductive biology* 252 (2020): 70–81.

Aim 3

Increase awareness of complications

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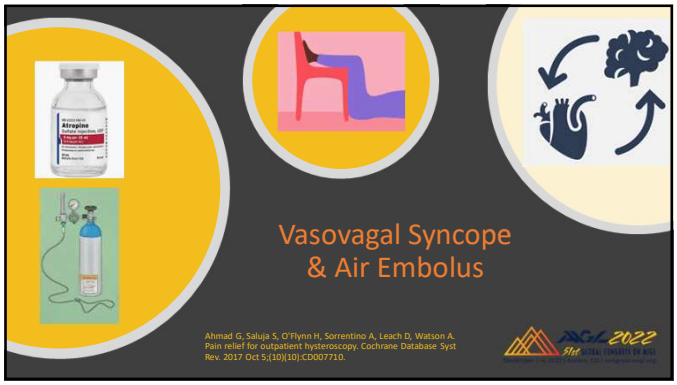
Table 2. Potential Complications, Incidence, and Risk Factors of Hysteroscopy

Potential Complication	Incidence	Risk Factors
Perforation	0.12% to 1.61%*†‡	Blind insertion of instruments, cervical stenosis, anatomic distortion (eg, leiomyomas and congenital anomalies, intrauterine adhesions, myometrial thinning, and uterine malposition [extreme anteversion or retroversion])
Air and gas embolism (clinically significant)	0.03% to 0.09%§‖	Repetitive instrumentation through cervix, inadequate purging of air from tubing and instruments, excessive intrauterine pressure
Fluid overload	0.20%†	Excessive absorption of any distending fluid, resection of large or deep lesions and high intrauterine pressure; increased risk of hyponatremia with use of electrolyte-free distending media, and cerebral edema with hypotonic distending media.
Hemorrhage	0.03% to 0.61%*¶	Cervical laceration, uterine perforation, adhesiolysis, resection of cavitary lesions
Vasovagal reaction	0.21% to 1.85%#	Triggering of parasympathetic nervous system during manipulation of the cervix and instrumentation of the cervical canal or uterine cavity

The Use of Hysteroscopy for the Diagnosis and Treatment of Intrauterine Pathology: ACOG Committee Opinion Summary, Number 800. Obstet Gynecol. 2020 Mar;135(3):754-756.



Ahmad G, Saluja S, O'Flynn H, Sorrentino A, Leach D, Watson A. Pain relief for outpatient hysteroscopy. Cochrane Database Syst Rev. 2017 Oct 5;(10)(10):CD007710.

Ergonomics and Vaginoscopy; How to Overcome the Cervix

Mr Bolarinde Ola FRCOG
Consultant Gynaecologist
Subspecialist in Reproductive Medicine & Surgery

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My Professional Affiliations


Ancient City of Sheffield, UK


Much Newer City of Abuja, Nigeria

Aims

- Present theoretical knowledge as foundation to safe vaginoscopic hysteroscopy
- Emphasise principles of ergonomics as it relates to:
  - Team, task, equipment and set-up
  - Navigating the vagina and finding the cervix
  - Safely navigating through the cervical canal
  - Dealing with the difficult cervix

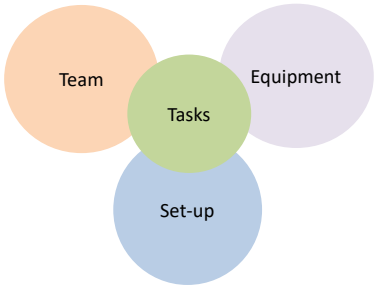
Ergonomics: Definition

Ensuring that……

- theatre set-up
- environment
- tasks
- equipment
- Information
- team functioning

….. all fit EACH key worker

Ergonomics

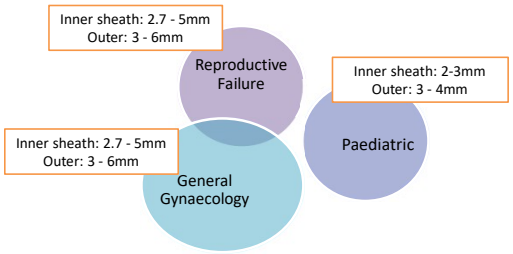


Patient Selection

Always take good gynae history – (standard questionnaire)

- Age
- Past medical and surgical histories
  - Concurrent medical conditions
  - Previous surgery (retrieve old records)
  - Previous surgical complications
  - Is prior cervical preparation required?
- Examine and review available images
  - acute anteversion
  - acute retroversion
  - Axial uterus
- Provide adequate analgesia/anaesthesia
- Prepare for the planned and unplanned

Type of Hysteroscope
The smaller the better

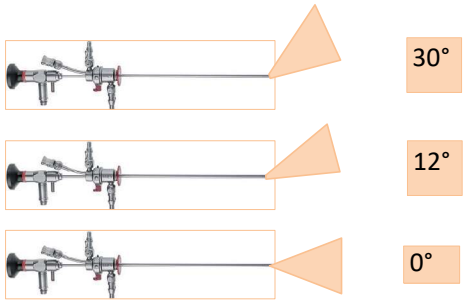


Equipment

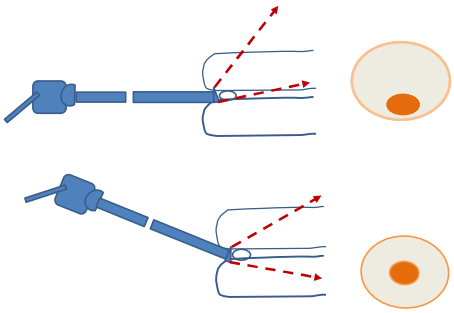
Know Your Equipment

- Rigid Office Hysteroscope
- Flexible
- Resectoscope

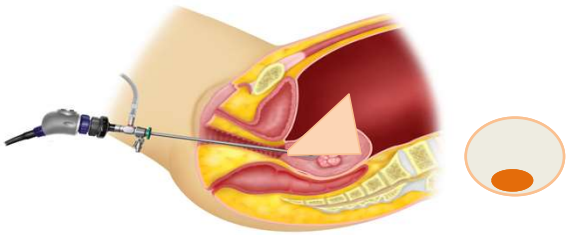
Know Your Equipment
Angle of Objective Lens



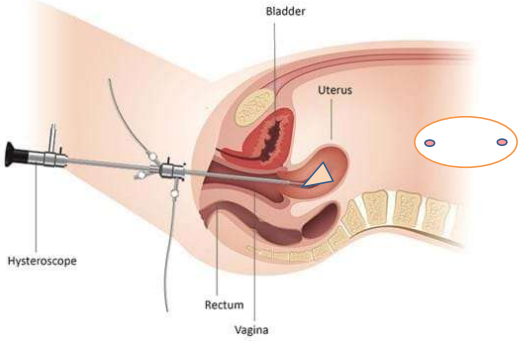
Internal Cervical Os with Off-Set (30° 25° or 12°) Objective Lens



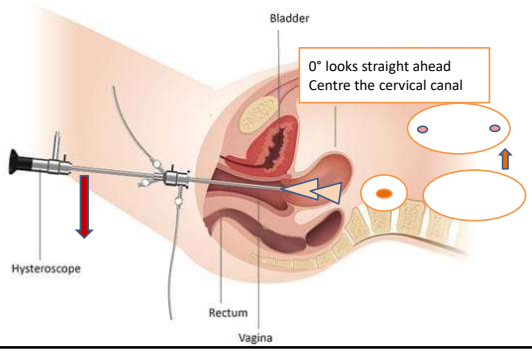
Internal Cervical Os with Off-Set (30° 25° or 12°) Objective Lens



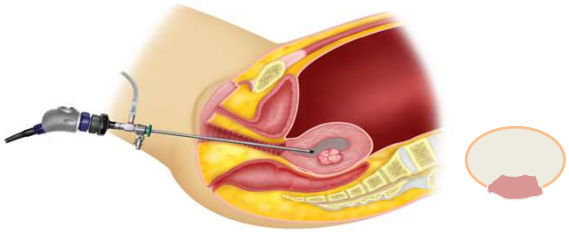
Fundal view with Off-Set (30° 25° or 12°) Objective Lens



Looks also Matter: Diagnostic 0° Objective Lens



Operative Hysteroscope or Resectoscope with 0° or 12° Lens



Team

Set-up

Team and Set-Up

- Experienced Nurse
- Trained Auxiliary Staff
- Ask patient to empty bladder just before start
- Adjustable theatre bed and monitor
- Adjustable surgeon's stool / position assistant
- Diagnostic hysteroscopic set up
- Operative hysteroscopic set up
- Analgesia / Local Anaesthesia
- Entonox (50% Nitrous oxide & 50% Oxygen)

Step-by-Step of Vaginoscopic Hysteroscopy

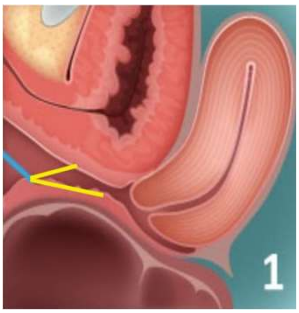
- Select patients carefully / look at available images
  - Adequate analgesia
- Room Set-up: Check your equipment
- Insert hysteroscope into lower vagina & start Saline
- Advance hysteroscope up posterior vaginal wall
- Identify cervix
- Insert tip of hysteroscope into cervical canal
- Keep cervical canal view at 6º Clock for off-set objectives
  - Minimises risk of posterior wall perforation
- Centre the canal view for 0º objectives

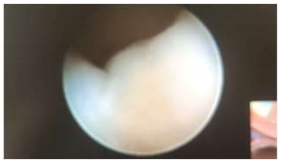
How I Do It

Preamble

- I review all available gynae images
- I don't usually rely on reports alone
  - Acute anteversion may be reported simply as anteverted
  - Same for acute retroversion

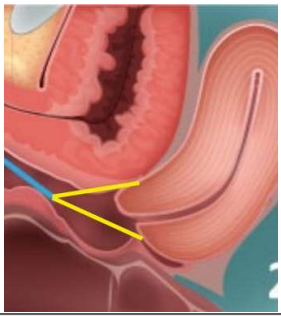
Navigating Lower Vagina: with 30° Objective Lens





Courtesy https://elearning.rcog.org.uk//uterine-cavity-surgery/outpatient-hysteroscopy/no-touch-technique-diagnostic,

Navigating Mid-Vagina: with 30° Objective Lens



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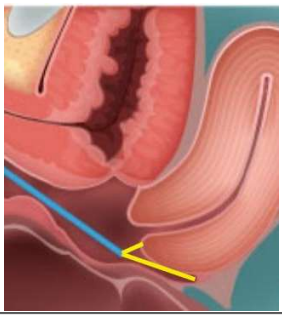
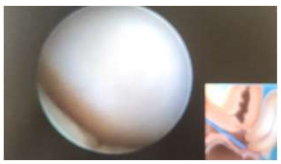
Navigating Upper Vagina: Finding the Cervix with 30° Lens





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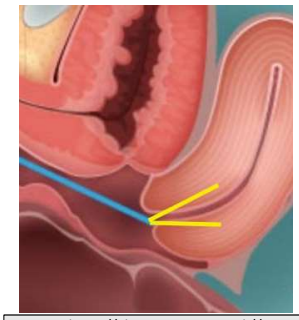
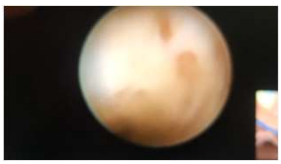
Navigating the Cervix: with 30° Objective Lens





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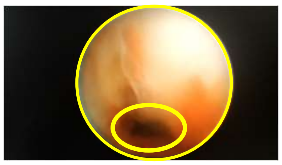
Navigating the Cervix with 30° Objective Lens

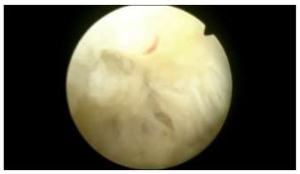


The Difficult Cervix: Causes

- External Cervical stenosis
- Lower canal stenosis
- Internal os stenosis
- Complete stenosis
- Deficient cervix - surgery
- Absent cervix
- The gaping patulous cervix

The Difficult Cervix: Management

- Review images
- Analgesia
- Avoid blind dilatation
- Use 0° miniaturised hysteroscope (2/3mm)
- Blunt dissection: gently rotating tip of scope
- Sharp dissection with hysteroscopic scissors
- Consider using tenaculum



Video courtesy of Dr Jude Okohue FWACS

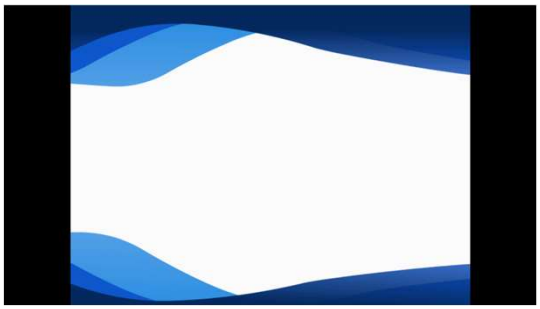
The Difficult Cervix – Rescheduled Further Attempt

- Review history
- Review images again
- Consider pre-treatment with misoprostol
- Analgesia
- Consider day case under RA or GA
- Consider ultrasound guided attempt
- Use miniaturised hysteroscope (2/3mm)

Summary

- Select patients carefully
  - Look at available images
  - Adequate analgesia
- Room set-up: check your equipment
- Insert hysteroscope into lower vagina & start Saline
- Advance hysteroscope up posterior vaginal wall
- Identify cervix
- Insert tip of hysteroscope into cervical canal
  - Keep cervical canal view at 6^0 Clock for off-set objectives
  - Keep view at centre for 0° Objective Lens
- In difficult cases; review strategy or re-schedule

In Summary



References

- https://elearning.rcog.org.uk/tutorials/core-knowledge/surgical-procedures-and-postoperative-care/uterine-cavity-surgery
- https://elearning.rcog.org.uk//uterine-cavity-surgery/outpatient-hysteroscopy/no-touch-technique-diagnostic

Staying Safe: Exploring the Uterine Cavity

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Declaration

I have no financial interest to declare

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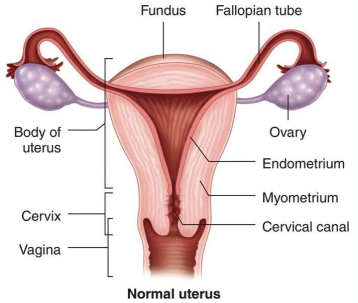
Objectives

At the conclusion of this presentation, participants should be able to:

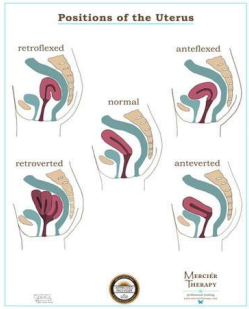
- Apply tricks learned on how to navigate a difficult cavity in cases of moderate/severe Asherman's syndrome
- Recognize uterine perforation and employ steps in preventing a perforation.

Summary: Remain in the "cavity"



Normal uterus

Introduction



Uterine Positions

- Anteverted
- Retroverted
- Anteflexed
- Retroflexed

Uterine Dimensions

- Uterus weighs an average 50 – 60g[1]
- Length, 6 – 8.5cm and 8 – 10cm in nullipara and multipara, respectively.
- Endometrial cavity volume 5 – 10ml[2]
- Transfundal endometrial cavity width 22 – 34mm[3]

Landmarks

- External os
- Endocervical canal
- Internal os
- Endometrial cavity
- Tubal ostia

Most difficulties occur in cases of Asherman syndrome

- IUA with symptoms
- Mild/Moderate/Severe

Systematic Review and Meta-Analysis

Medicine

OPEN

Cold scissors versus electrosurgery for hysteroscopic adhesiolysis

A meta-analysis

Liuqing Yang, MD, PhD[a], Ling Wang, BM[a,b], Yun Chen, MD, PhD[a], Xiaoshi Guo, MD, PhD[a], Chenyun Miao, MD, PhD[a], Ying Zhao, MD, PhD[a], Lu Li, PhD[c], Qin Zhang, BM[a,*]

2022

Abstract

Background: Intrauterine adhesion seriously affects reproductive health in women. Hysteroscopic adhesiolysis using cold scissors or electrosurgery is the main treatment, although there is no consensus on the preferable method. This review aimed to compare the efficacy and safety of these methods for treating moderate to severe intrauterine adhesion.

Methods: PubMed, EMBASE, MEDLINE, Cochrane Database of Systematic Reviews, Web of Science, Chinese Biomedical Literature Database, and China National Knowledge Infrastructure were searched on April 30, 2020. Randomized controlled trials and observational studies that were published in all languages (must contain English abstracts) and compared hysteroscopic cold scissors with electrosurgery for the treatment of intrauterine adhesion were included. Mean differences, odds ratios, and 95% confidence intervals (CIs) were reported. Bias was evaluated using the Cochrane Risk of Bias assessment tool for randomized controlled trials and the Newcastle-Ottawa Scale for observational studies. Data were analyzed using RevMan software (Review Manager version 5.3, The Cochrane Collaboration, 2014). Two researchers independently extracted data and assessed the quality of the included studies. If a consensus was not reached, a third researcher was consulted.

Results: Nine studies (n = 761; 6 randomized controlled trials and 3 retrospective studies) were included. The intrauterine adhesion recurrence rate with second look hysteroscopy was significantly lower (odds ratio = 0.30, 95% CI = 0.16–0.56; $P = .0002$) with hysteroscopic cold scissors than with electrosurgery. The total operation time was significantly shorter (mean difference = −7.78, 95% confidence interval = −8.50 to −7.07; $P < .00001$), intraoperative blood loss was significantly lower (mean difference = −9.88, 95% CI = −11.25 to −8.51; $P < .00001$), and the menstrual flow rate was significantly higher (odds ratio = 4.36, 95% confidence interval = 2.56–7.43; $P < .00001$) with hysteroscopic cold scissors than with electrosurgery. There were no significant differences in the pregnancy rate. One complication (1 perforation case, hysteroscopic cold scissors group) was reported.

Conclusions: Hysteroscopic cold scissors is more efficient in preventing intrauterine adhesion recurrence, increasing the menstrual flow, reducing intraoperative blood loss, and shortening the operation time.

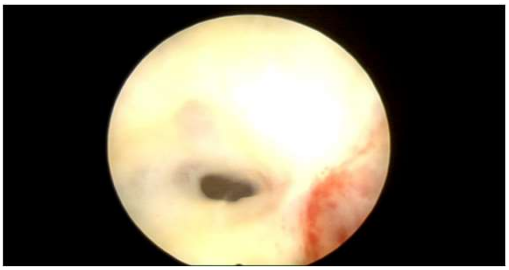
Abbreviations: CI = confidence interval, CS = cold scissors, ES = electrosurgery, HA = hysteroscopic adhesiolysis, IUA = intrauterine adhesions, MD = mean difference, NOS = Newcastle-Ottawa Scale, OR = odds ratio, RCTs = randomized controlled trials.

Keywords: Asherman syndrome, electrosurgery, gynatresia, hysteroscopy, recurrence

Central before Lateral Adhesions[4,5]

Exploring the hole

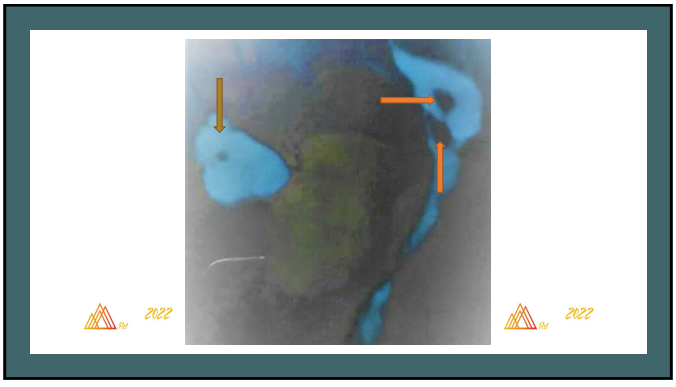
Exploring the hole 2



Exploring Dark Areas(6)

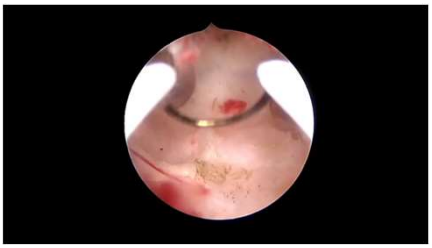
The Hole, Columnar Epithelium, and Dark areas

Deciding which Hole to explore



Perforation with Scissors

Perforation with Energy



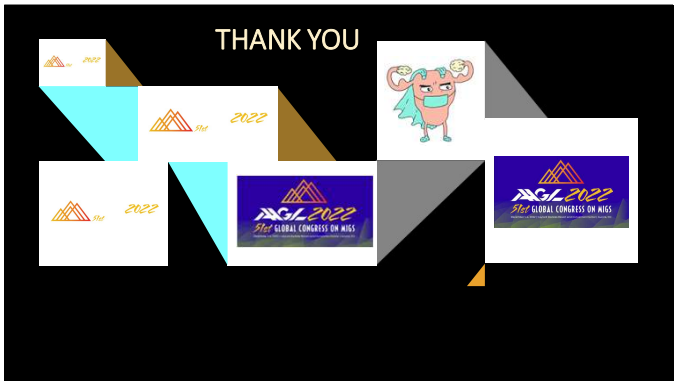
- Concomitant use of USS, laparoscopy or fluoroscopy
- Might be used in very severe cases
- Limited data that they prevent perforation or ↑ outcome
- Fluoroscopy can delineate free areas above/behind adhesions
- Laparoscopy might reduce damage to intestines
- Incidence of perforation: 5% reported by Zikopoulos et al.[7]

Conclusion

- The endometrial cavity is a small space
- Safer to explore moderate/severe adhesions with scissors
- Bowel and bladder can be injured following a perforation
- Extreme care and relevant expertise is key

References

- [1]Qingsong S, Ma N, Huang H, et al. Significance of preoperative calculation of weight as an indicator for preserving the uterus in pelvic reconstructive surgery. Int J Clin Exp Pathl. 2015; 8(1): 900-5
- [2]Shild RL, Indefree D, Eschweiler S, et al. Three-dimensional endometrial volume calculation and pregnancy rate in an in-vitro fertilization programme. Hum Reprod 1999; 14(5): 1255-8
- [3]Goldstuck ND. Dimensional analysis of the endometrial cavity: how many dimensions should the ideal intrauterine device or system have? Int J Womens Health 2018; 10: 165-8.
- [4]Okohue JE. Role of Assisted operative hysteroscopy in Asherman's management. In: Manchanda R (ed). Intra uterine adhesions. Springer, Singapore. 2021; 123-35.
- [5]Deans A, Abbott . Review of intrauterine adhesions. J Minim Invasive Gynecol. 2010; 17: 555-69.
- [6]Emanuel HH, Hanstede M. Hysteroscopic treatment of Asherman syndrome. In: Hysteroscopy. Tinelli A, Alonso LP, Haimovich S (eds). Springer, Switzerland. 2018; 709-18.
- [7]Zikopoulos KA. Live delivery rates in subfertile women with Asherman's syndrome after hysteroscopic adhesiolysis using the resectoscope or the versapoint system. Reprod Biomed Online. 2004; 8, 720-5



Hysteroscopy: Knowing & Using Your Tools

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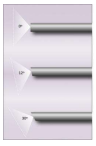
AAGL 2022 51st GLOBAL CONGRESS ON MIGS
December 1-4, 2022 | Aurora, CO | congress.aagl.org

Disclosure

- Consultant: CooperSurgical™

Objectives

- IDENTIFY THE CURRENT TOOLS AVAILABLE FOR OPERATIVE HYSTEROSCOPY
- CLARIFY INDICATIONS FOR USE OF EACH TOOL
- APPRECIATE THEIR LIMITATIONS



Operative Scope

- Rigid scope with a Rod Lens (0°, 12°, 25°, 30°)
  - Light post opposite to direction of view
- Single sheath
- OD 5.5mm
- Instrument channel 5-7Fr
  - Rigid, semirigid, flexible instruments
  - Semirigid tend to give most stability for guidance and cutting
    - Biopsy forceps, scissors, alligator forceps
  - Can use bipolar electrodes for vaporization, desiccation, or cutting
    - Normal Saline for distension
- Continuous flow

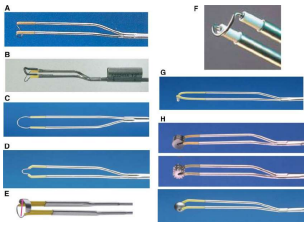
Resectoscopes: Continuous flow

Monopolar

- Requires hypotonic, nonconductive and electrylyte free distension media
  - **Glycine, sorbitol, mannitol**
  - **Max deficit <1000mL**
- Pros: **GREAT** visualization
- Cons: Due to risk of hypOnatremic hypERvolemia, smaller deficits are tolerated and therefore increased risk of incomplete procedures.

Bipolar

- Isotonic, electrolyte containing distension media
  - **Saline, lactate ringers**
  - **Max deficit <2500mL**
- Pros: Safer than monopolar
- Cons: visualization can be murkier than the hypotonic solutions



Resectoscope & Electrodes

Mechanical Morcellators

- The Pros
  - Continuous flow
  - Maintain intrauterine pressure
  - Use Saline
  - Short learning curve
  - Decreased perforation risk
  - Cutting device with suction (no chips)
- The Cons
  - Mechanical blades- can dull
  - Limited to endometrial pathology (Type 0 and 1 myomata)
  - Cost?
  - Variable amounts of waste

Mechanical Morcellators

Truclear™ (Medtronic)	Myosure™ (Hologic)	Aveta™ (Meditrina)

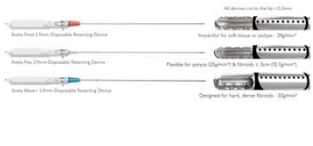
• Scope 5.6mm and 9.0mm
• Truclear system includes Control Unit, Handpiece, Footswitch
• Truclear Devices are pathology-specific with 4 blades: soft tissue mini, soft tissue plus, dense tissue mini, dense tissue plus
	• Omniscope 5.5mm and 6mm Sheath
	• 0- and 30-degree options with interchangeable sheaths
	• 200mm working length
	• 4 Blades: XL, Reach, LITE, Manual
		• Scope 4.6mm and 5.7mm
		• Only disposable option
		  • Disposable scope
		  • Disposable instruments
		• Handpiece controls irrigation, flush, image capture
		• 3 Disposable blades: Smol, Flex, Wave+

Truclear™ (Medtronic)

- Continuous inflow and outflow with suction
- Angled tip
- Rod lens optical system with HD images
- 4 Blades
  - Soft Tissue Shaver Mini: Open window, rotary style
  - Dense Tissue Shaver Mini: 10mm cutting window, reciprocating
  - Soft Tissue Shaver Plus: Open window, rotary style (large scope)
  - Dense Tissue Shaver Plus: 10mm cutting window, reciprocating (large scope)
- Reuseable handpiece
- Disposable blades

Hysteroscopy Systems | Medtronic

Myosure™ (Hologic)

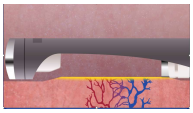


Aveta™ (Meditrina)

- Relatively new system– launched at AAGL in 2019
- Single-use hysteroscopy system with an expandable working channel
  - "Smallest insertion diameter with largest operative channel"
- Integrated fluid management system

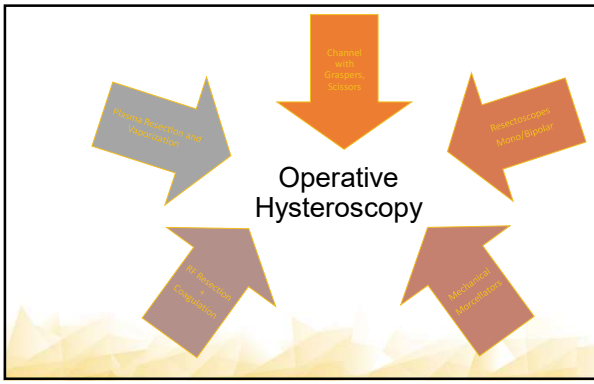
Aveta® System — Aveta® System (avetasystem.com)

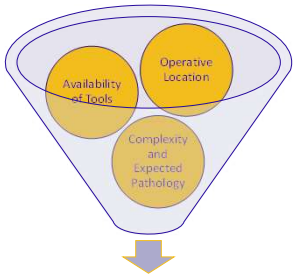
RF Resection and Coagulation



- Closed loop saline fluid management with recirculation of filtered distension fluid
- Allows for resection and coagulation of leiomyomas and polyps
- Bladeless radiofrequency-based resection with simultaneous aspiration of debris. No blade dulling on tough tissue
  - Simultaneous sealing of microvascular bed while tissue is cut to decrease bleeding and fluid intravasation
- Bipolar cut current for resection
- 6.3mm OD scope, resection device disposable

https://minervasurgical.com/wp-content/uploads/2020/10/Symphion-device@1.5x.png





What Tool Will You Choose?

SEEING THE ENDOMETRIUM: NORMAL & ABNORMAL

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DISCLOSURE

CONSULTANT – ARTHREX, INC.

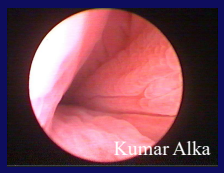
LEARNING OBJECTIVE

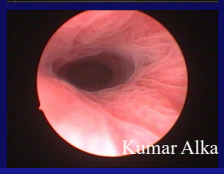
To be able to differentiate and recognize the normal and the abnormal endometrium on hysteroscopy.

CERVICAL CANAL

HYSTEROSCOPY ASPECTS

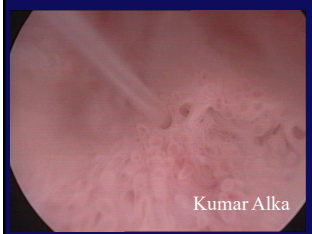
- Papillary structures are most noticeable in the first 2 cm above the external os
- *Glandular crypts are situated between the papillea*
- *Arbor vitea form the lateral columns*
- *Cervical polyps, adhesions, cervical atresia, cervical cysts are pathologies clearly diagnosed with hysteroscopy*



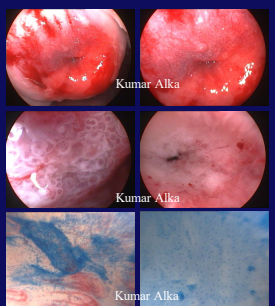


Hamou et al, Hysteroscopy and Microcolpohysteroscopy text and atlas, 1991, 5:55-79

ENDO CERVICAL MUCOUS STRANDS



MICROCOLPOHYSTEROSCOPY - Hamou Microhysteroscope II



Kumar et al , J Am Assoc Gynecol Laparosc 2004, 11(2):131-2

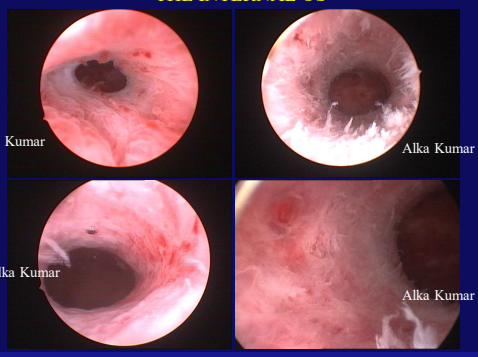

JMIG

Images in Gynecologic Surgery

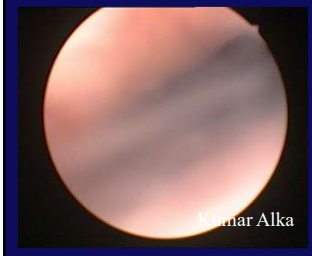
Microcolpohysteroscopy of the Transformation Zone

Alka Kumar, MS, and Atul Kumar, MS

THE INTERNAL OS



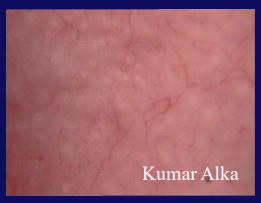
EVALUATION OF ENDOMETRIUM



It can be done mainly on three modes:

- Imaging the patterns of endometrium by transvaginal ultrasound (TVUS 2D, 3D, Doppler), hysterosonography also called as saline infusion sonohysterography (SIS) and to some extent a magnetic resonance imaging (MRI).
- Visual assessment by hysteroscopy.
- Cellular assessment by microscopic evaluation of endometrial samples.

EARLY PROLIFERATIVE

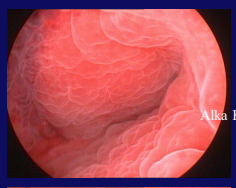


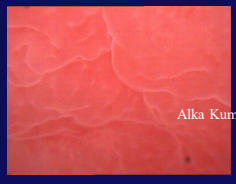
Post Menstrual Endometrium / Proliferative Endometrium

- Endometrium pale and smooth
- Glands are visible
- Capillary vascularisation is barely visible
- The crease it will make with the telescope will be 3-4mm

SECRETORY PHASE ENDOMETRIUM

- Endometrium is more pink
- Lightly folded
- Glands stand out
- Capillary vessels visible





Hamou et al, Hysteroscopy and Microcolpohysteroscopy text and atlas, 1991, 5:55-79


ELSEVIER

THE JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

Images in Endoscopy

Atrophic Endometrium

Atul Kumar, MS*, and Alka Kumar, MS

From the Hysteroscopy Surgery Division, Women's Health Center, Jaipur, Rajasthan, India (both authors).

DISCUSS You can discuss this article with its authors and with other AAGL members at https://www.AAGL.org/jmig-19-6-11-00279

THE JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

Fig. 1

Fig. 2

Kumar Alka

ATROPHIC ENDOMETRIUM

- Crisscross interlacing myometrial fibers, with overlying endometrium barely visible in the form of ill-defined island patches
- No endometrial gland openings visible
- Abundant capillary vascularization observed

Kumar A, Kumar A. J Minim Invasive Gynecol. 2012 Mar-Apr;19(2):148-9

DECREASED ENDOMETRIAL RECEPTIVITY

1. Leiomyomata – Submucous
2. Septum
3. Polyps
4. Endometritis
5. Thin Endometrium
6. Hyperplasia
7. Adhesions / Synechiae

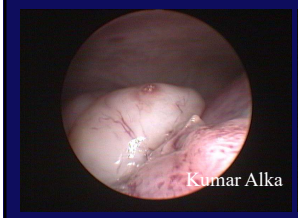
DECREASED ENDOMETRIAL RECEPTIVITY

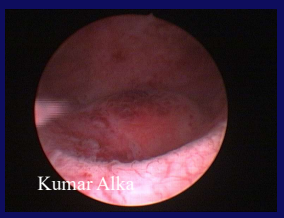
FIBROID

- Obtsacles to sperm migration
- Impariment of embyro implantation
- Obstacles to oocyte transport
- Altered contour of the uterine cavity
- Anmolaies of uterine contractility
- Alterations in focal endometrial perfusion
- Endometrial inflammation, secretion of vasoactive substances or androgen local increase

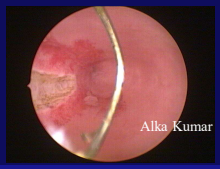
Somigliana E et al. Reprod Update, 2007; Bettochi S et al. Hum Reprod 2002; Buttra VC et al. Fertil Steril 1981; Cicinelli Et al. Obstet Gynecol 1998; uttra VC et al. Fertil Steril 1981

SUBMUCOUS FIBROID





SEPTOPLASTY

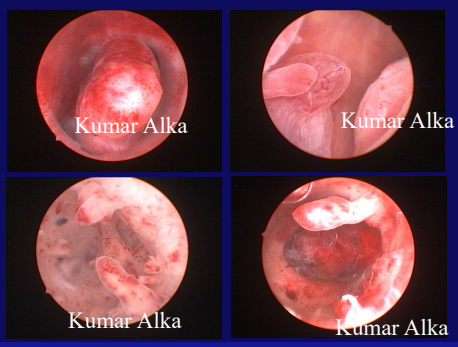


POLYPS

- Endometrial polyps are exophytic mucous lesions that differ greatly in shape, size, number and appearance.
- The surface epithelium of the single or multiple sessile forms is similar to that of the surrounding endometrium and soft in consistency upon contact with the tip of the hysteroscope
- Polyps can be associated with glandular hyperplasia and can remain latent for rather long periods
- Once diagnosed, endometrial polyps should be treated by hysteroscopy because curettage has been shown to be ineffective.

Luca Mencaglia, Luiz Cavalcanti de Albuquerque Neto and R. Alfonso Arias Alvarez, Manual of hysteroscopy- Diagnostic, Operative and Office Hysteroscopy 2015, 29-30

PEDUNCULATED POLYPS



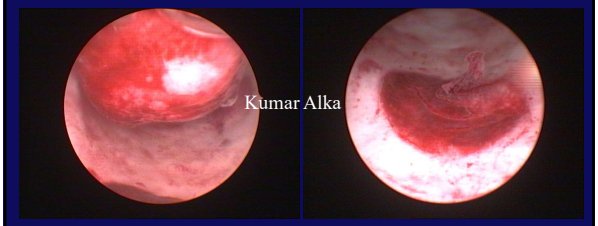
POLYPS AND INFERTILITY

SESSILE POLYP

- Interference with the sperm migration
- Interference with implantation and embryo growth
- Increased production of factors that inhibit implantation (ie. Glycodelin)
- Anomalous endometrial vascularization

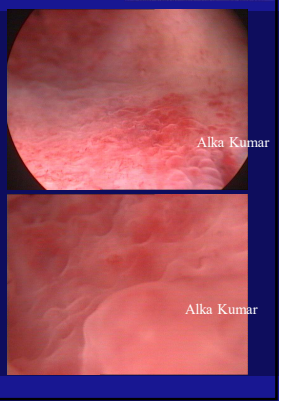
Brown, 2000, Richlin, 2002, Stewart, 2005

KISS HYPEREMIA



ENDOMETRIAL HYPERPLASIA

- Increased endometrial thickness
- Non-homogenous endometrial regeneration
- Increased vascularization
- Presence of ciliated epithelium
- Presence of cystic dilatation
- Polypoid formations
- Necrotic areas
- Irregular arrangement of the glandular orifices



ENDOMETRIAL HYPERPLASIA

EIN (Endometrial Intraepithelial Neoplasia) Classification

The EIN simplified the histological classification into two groups: a combined category for simple hyperplasia and complex hyperplasia, referred to as "hyperplasia" and a combined category for atypical hyperplasia and well differentiated adenocarcinoma, called "endometrial intraepithelial neoplasia".

Hysteroscopy has the sensitivity of 78% in diagnosing endometrial hyperplasia

ENDOMETRIAL HYPERPLASIA

Diagnosis

More than 90% of patients present with abnormal uterine and bleeding

Transvaginal Ultrasonography
In post menopausal women Endometrial thickness >4mm
Endometrial Stripe abnormalities – Heterogenicity or cystic changes
Junction between endometrium and myometrium
Endometrial volume
Endometrial vascularization index and flow index – increased in CA

Hysteroscopy

ENDOMETRIAL HYPERPLASIA

Hysteroscopy

The morpho logical criteria derived on hysteroscopic inspection are subjective, operator related, and poorly reproducible. In the diagnosis of endometrial hyperplasia, hysteroscopy sensitivity is no more than 78%

Clark TJ, Voit D, Gupta JK, Hyde C, Song F, Khan KS. Accuracy of hysteroscopy in the diagnosis of endometrial cancer and hyperplasia: a systematic quantitative review, JAMA 2002:2889:1610

ENDOMETRIAL HYPERPLASIA

Endometrial hyperplasia always results from chronic oestrogen stimulation unopposed by the counterbalancing effects of progesterone leading to a wide range of manifestation creating various clinical conditions.

- Women at extremes of age groups, i.e. puberty and perimenopause due to anovulatory cycles.
- Women of the reproductive age group due to anovulatory cycles, e.g. polycystic ovary syndrome (PCOS).
- Postmenopausal women on oestrogen therapy.
- Obese women with a high rate of peripheral conversion of androgens to oestrogens.
- Women on tamoxifen, a nonsteroidal antiestrogenic compound used for treatment of breast cancer.

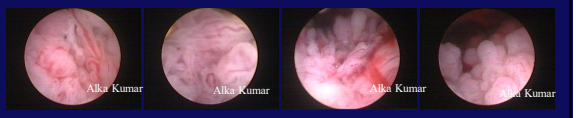
All These conditions giving to conditions like:

- Endometrial hyperplasia.
- Endometrial polyp.
- Endometrial carcinoma.

HYSTEROSCOPIC MORPHOLOGICAL CRITERIA FOR ENDOMETRIAL HYPERPLASIA

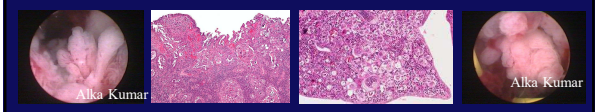
1. Nonhomogeneous endometrial thickness
   - Less than 4mm in post menopausal women
   - No compression on the endometrium (high intra uterine pressure to avoided)
   - Micro polypoid mucosal thickening
   - Focal Endometrial thickness
   - Sessile polyp
2. Surface
   - Notice glandular openings, vascular projections, cystic or necrotic areas, etc.
3. Vascular abnormalities
   - Increased Capillary density
   - Venulocapillari dilatation
4. Glandular cystic dilatation
   - Multi focal or group pseudopolypoid areas
5. Architectural distortion of glandular outlets
   - Revealed only with close range hysteroscopic view
   - Abnormal spacing of glands
   - Dilation of glands yellowish white color of gland openings

ENDOMETRIAL CARCINOMA



- Endometrial carcinoma: Fourth most common malignancy in females.
- Most common malignancy of the female reproductive tract
- The prevalence of endometrial cancer is increasing with rising levels of obesity.
- App. 75% cases occur in postmenopausal women, median age at diagnosis is 70 years.
  - Postmenopausal bleeding—most common symptom.
  - Adenocarcinomas account for 90% of endometrial neoplasms,
  - Uterine sarcomas-- only 2%–6%;
  - remaining include adenocarcinoma with squamous cell differentiation and adenosquamous carcinoma.

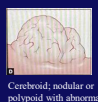
ENDOMETRIAL CARCINOMA



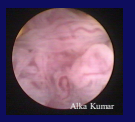
- Depth of myometrial invasion is the most important morphologic prognostic factor, correlating with tumor grade, presence of lymph node metastases, and overall patient survival.

ENDOMETRIAL CARCINOMA


Polypoid; thin pedicles


Cerebroid; nodular or polypoid with abnormal surface vessels


Papillary; numerous dendritic projections




Glomerular; polypoid with a papillary-like feature containing intertwined neovascular vessels covered by a thin layer of endometrial tissue


Nodular; bulging

ADENOMYOSIS

MYOMETRIAL CYSTS

ENDOMETRIAL TUBERCULOSIS

Endometrial tuberculosis tends to manifest as infertility, menstrual irregularities and/or lower abdominal pain. Endometrial tuberculosis may have severe reproductive consequences on fertility in spontaneous as well in vitro fertilization (IVF) cycles.

Cicinelli et al. Journal of Minimally Invasive Gynecology 2008;15(6):752

Kumar Alka

Hysteroscopic Markers for Endometrial Tuberculosis

- Bizarre endometrial architecture
- Tubercular deposits (Microscopic to large macroscopic structures)
- ILL defined endometrial gland openings
- Adhesions / Synechiae

(Hysteroscopic imaging under magnification is helpful)

Kumar Alka

Endometrial Tuberculosis Kumar and Kumar

Images in Endoscopy

Endometrial Tuberculosis

Atul Kumar, M.S., and Alka Kumar, M.S.

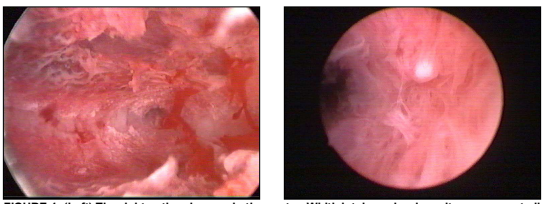


FIGURE 1. (Left) The right ostium is seen in the center. Whitish tubercular deposits are present all around the ostium and involve the intramural part of the right tube. The endometrium is thin, dirty-looking, pale, and irregular, with no endometrial gland openings visible. (Right) A whitish tubercle is present over the scarred left lateral wall of the endocervical canal.

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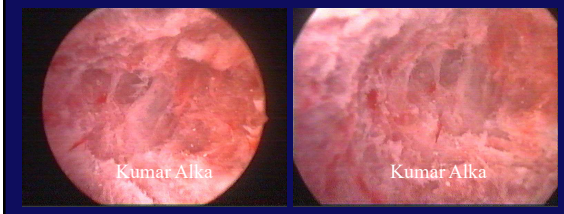
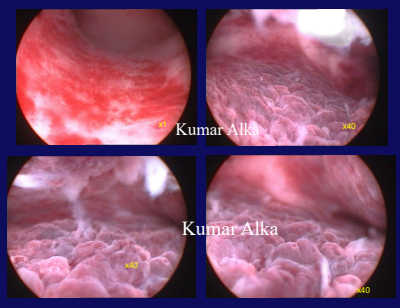
(J Am Assoc Gynecol Laparosc 2004, 11(1):2)

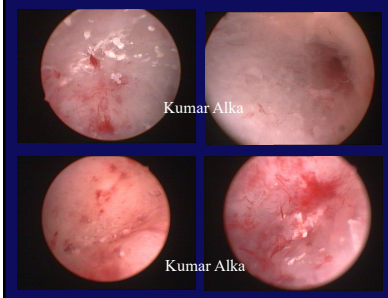
BIZARRE ENDOMETRIAL ARCHITECTURE

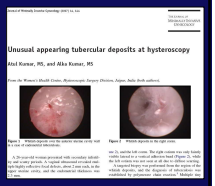


SURFACE ARCHITECTURE



DEPOSITS IN ENDOMETRIAL TUBERCULOSIS



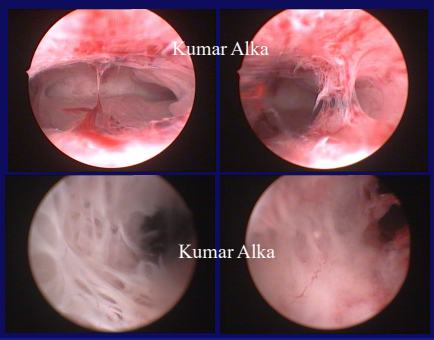


Unusual appearing tubercular deposits at hysteroscopy

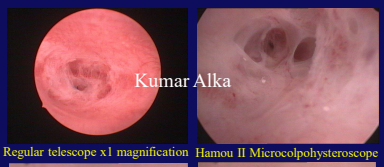
Atul Kumar, MS, and Alka Kumar, MS

A Tubercular deposit resting over posterior uterine cavity wall

ADHESIONS - ENDOCERVICAL CANAL



DEPOSITS ARE SEEN AFTER INCREASING THE MAGNIFICATION



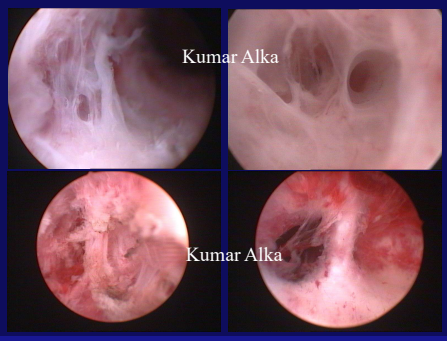
Regular telescope x1 magnification

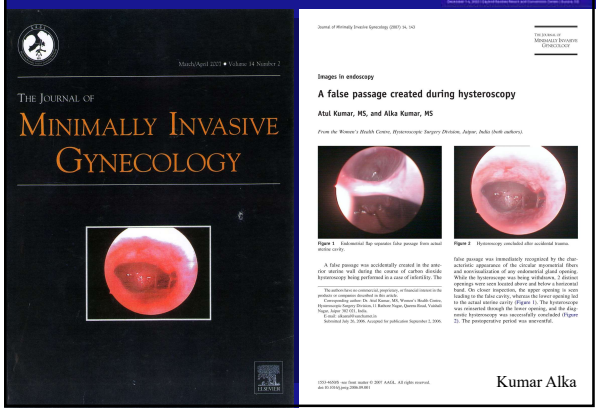
Hamou II Microcolpohysteroscope

x20 at source magnification

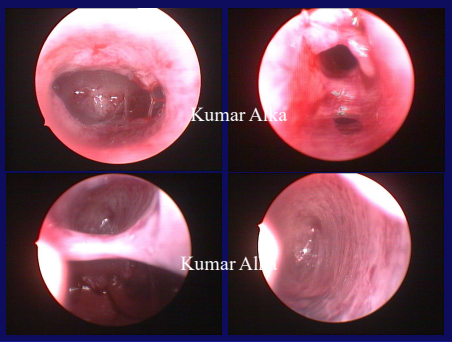
x40 at source magnification

ADHESIONS IN ENDOMETRIAL TUBERCULOSIS

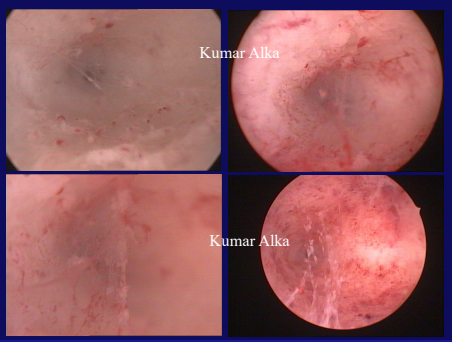


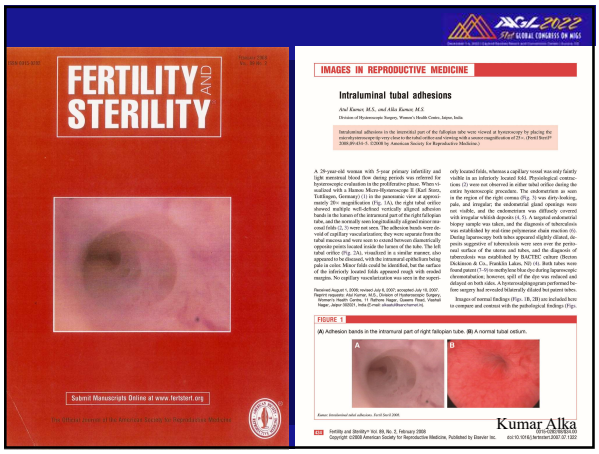


FALSE PASSAGE



DEPOSITS IMPREGNATED OVER FLIMSY ADHESIONS




FERTILITY AND STERILITY
IMAGES IN REPRODUCTIVE MEDICINE
Intraluminal tubal adhesions
Submit Manuscripts Online at www.fertstert.org
Kumar Alka


IMAGES IN REPRODUCTIVE MEDICINE
Relook hysteroscopy after antitubercular therapy
REFERENCES
FIGURE 1
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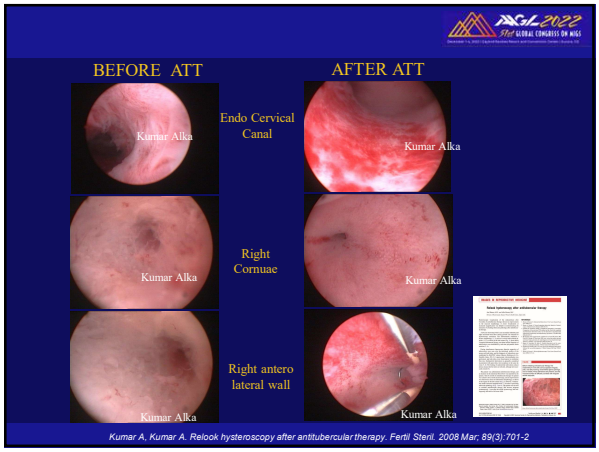
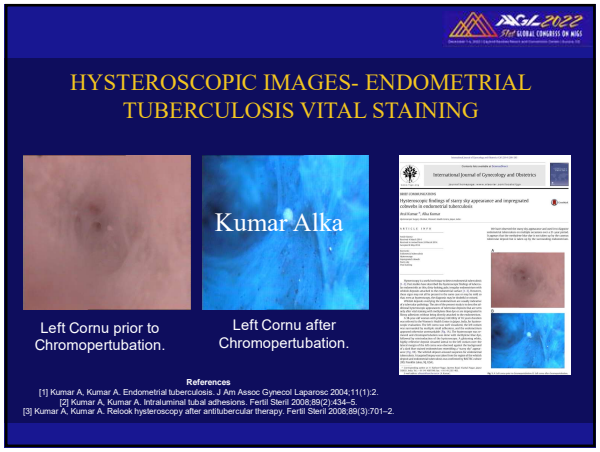
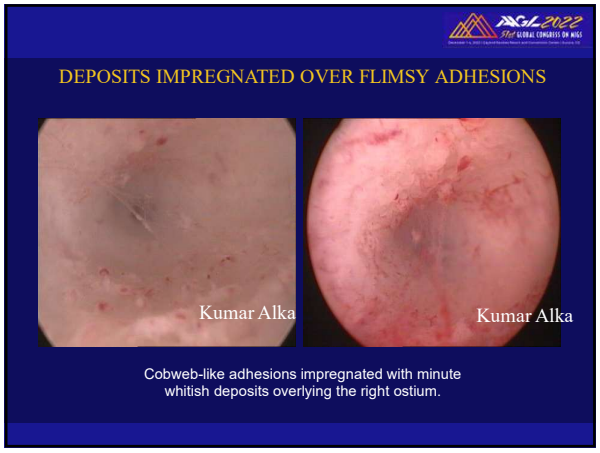
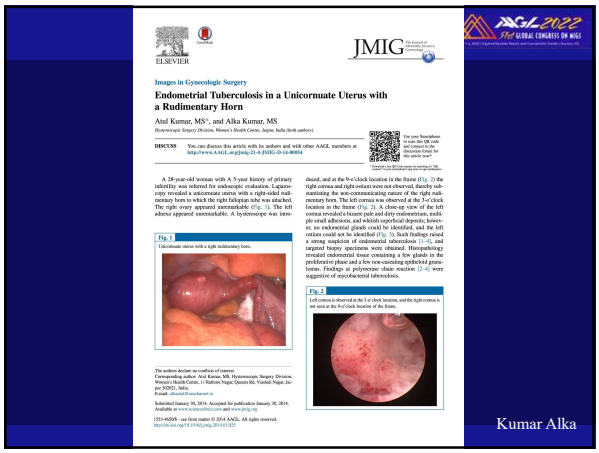
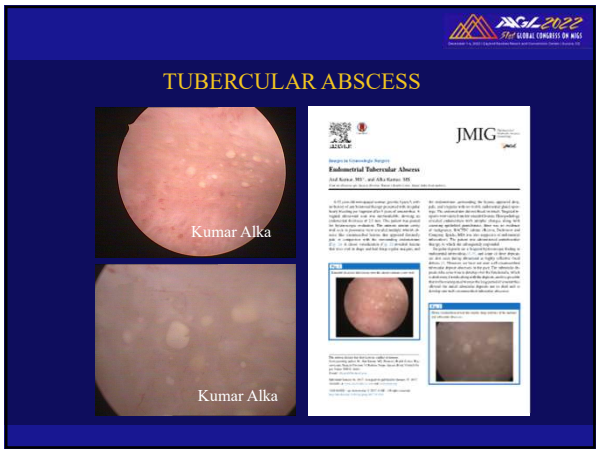

BEFORE ATT
AFTER ATT
Endo Cervical Canal
Right Cornuae
Right antero lateral wall
Kumar Alka
Kumar A, Kumar A. Relook hysteroscopy after antitubercular therapy. Fertil Steril. 2008 Mar; 89(3):701-2

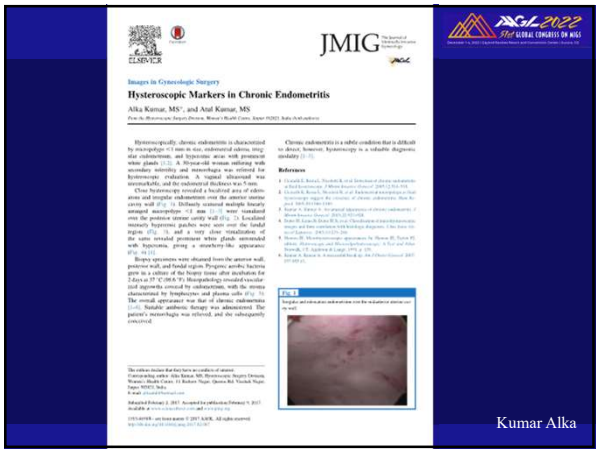

HYSTEROSCOPIC IMAGES- ENDOMETRIAL TUBERCULOSIS VITAL STAINING
Kumar Alka
Left Cornu prior to Chromopertubation.
Left Cornu after Chromopertubation.
References
[1] Kumar A, Kumar A. Endometrial tuberculosis. J Am Assoc Gynecol Laparosc 2004;11(1):2.
[2] Kumar A, Kumar A. Intraluminal tubal adhesions. Fertil Steril 2008;89(2):434–5.
[3] Kumar A, Kumar A. Relook hysteroscopy after antitubercular therapy. Fertil Steril 2008;89(3):701–2.

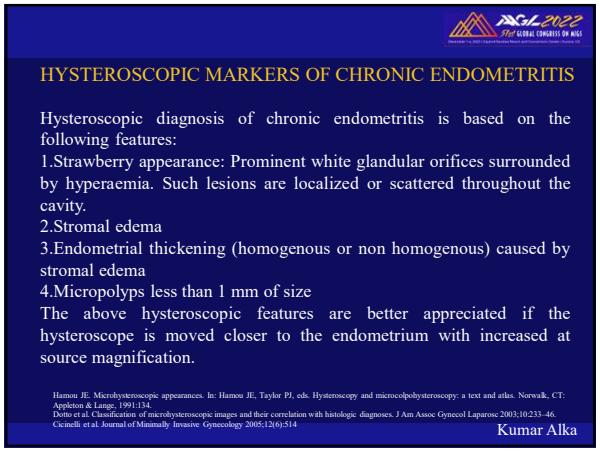

HYSTEROSCOPIC IMAGES- ENDOMETRIAL TUBERCULOSIS VITAL STAINING
Kumar Alka
Kumar Alka
Kumar Alka
Kumar Alka

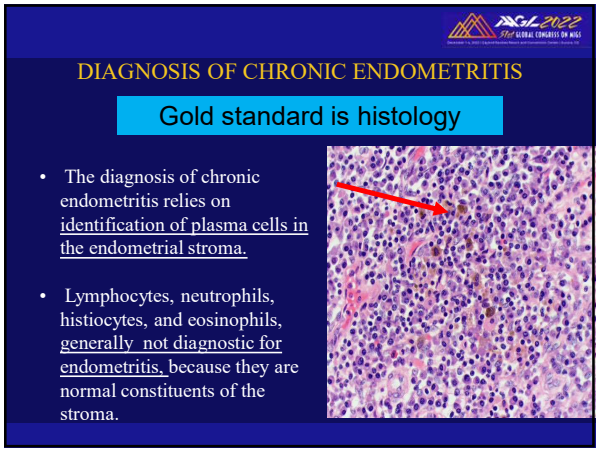

DEPOSITS IMPREGNATED OVER FLIMSY ADHESIONS
Kumar Alka
Kumar Alka
Cobweb-like adhesions impregnated with minute whitish deposits overlying the right ostium.

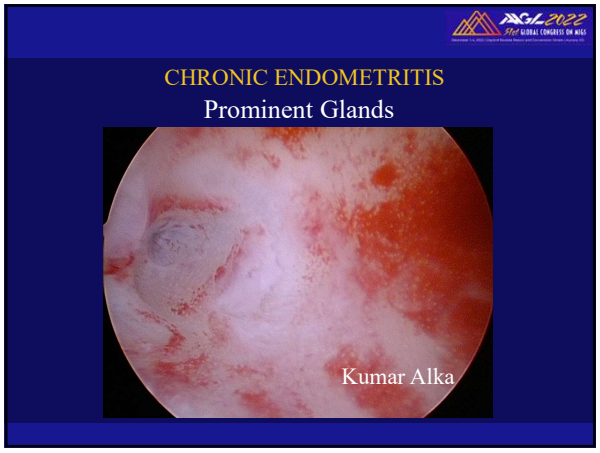

JMIG
Images in Gynecologic Surgery
Endometrial Tuberculosis in a Unicornuate Uterus with a Rudimentary Horn
Atul Kumar, MS*, and Alka Kumar, MS
Kumar Alka


TUBERCULAR ABSCESS
Kumar Alka
Kumar Alka
JMIG
Endometrial Tubercular Abscess


JMIG
Images in Gynecologic Surgery
Hysteroscopic Markers in Chronic Endometritis
Alka Kumar, MS*, and Atul Kumar, MS
Kumar Alka


HYSTEROSCOPIC MARKERS OF CHRONIC ENDOMETRITIS
Hysteroscopic diagnosis of chronic endometritis is based on the following features:
1.Strawberry appearance: Prominent white glandular orifices surrounded by hyperaemia. Such lesions are localized or scattered throughout the cavity.
2.Stromal edema
3.Endometrial thickening (homogenous or non homogenous) caused by stromal edema
4.Micropolyps less than 1 mm of size
The above hysteroscopic features are better appreciated if the hysteroscope is moved closer to the endometrium with increased at source magnification.
Hamou JE. Microhysteroscopic appearances. In: Hamou JE, Taylor PJ, eds. Hysteroscopy and microcolpohysteroscopy: a text and atlas. Norwalk, CT: Appleton & Lange, 1991:134.
Dotto et al. Classification of microhysteroscopic images and their correlation with histologic diagnoses. J Am Assoc Gynecol Laparosc 2003;10:233–46
Cicinelli et al. Journal of Minimally Invasive Gynecology 2005;12(6):514
Kumar Alka

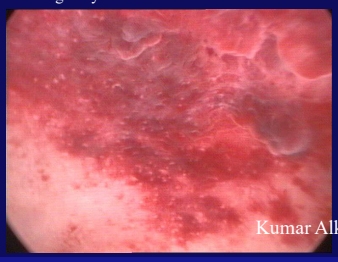

DIAGNOSIS OF CHRONIC ENDOMETRITIS
Gold standard is histology
• The diagnosis of chronic endometritis relies on identification of plasma cells in the endometrial stroma.
• Lymphocytes, neutrophils, histiocytes, and eosinophils, generally not diagnostic for endometritis, because they are normal constituents of the stroma.


CHRONIC ENDOMETRITIS
Prominent Glands
Kumar Alka

CHRONIC ENDOMETRITIS

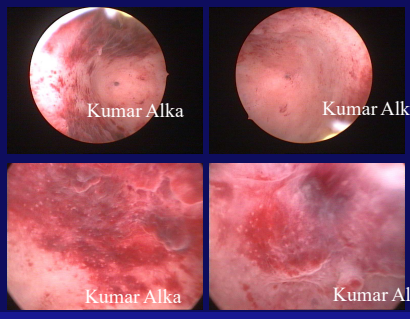
Prominent Glands

These hysteroscopic images have been taken only from histologically confirmed cases chronic endometritis.



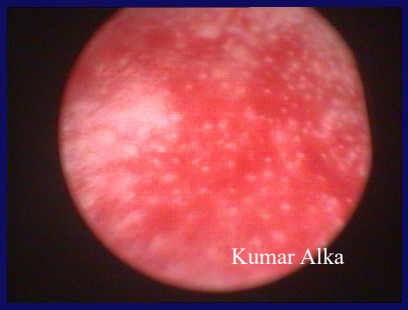
CHRONIC ENDOMETRITIS

Prominent Glands Different Case



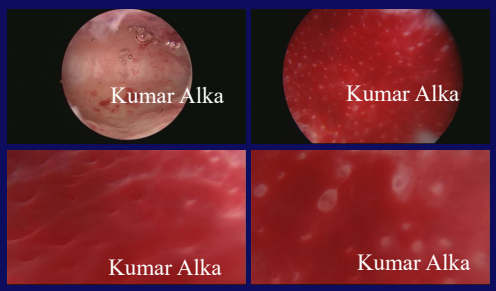
CHRONIC ENDOMETRITIS

Prominent Glands



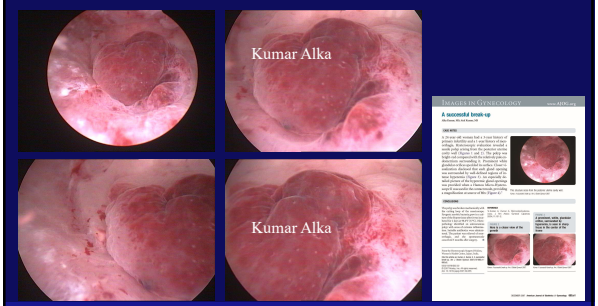
CHRONIC ENDOMETRITIS

Prominent Glands



CHRONIC ENDOMETRITIS

Prominent Glands



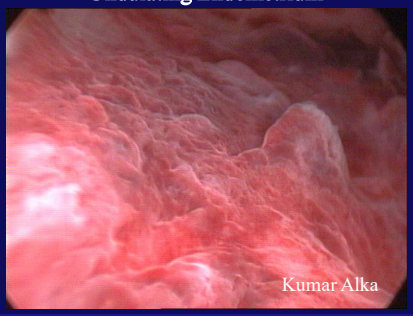
Kumar A, Kumar A. Am J Obstet Gynecol Dec 2007

CHRONIC ENDOMETRITIS

Stromal Oedema

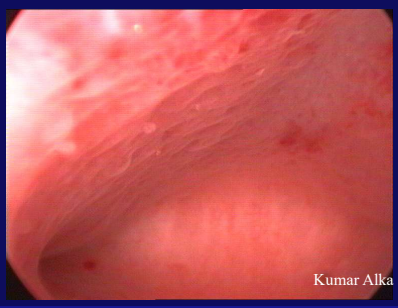
CHRONIC ENDOMETRITIS

Undulating Endometrium



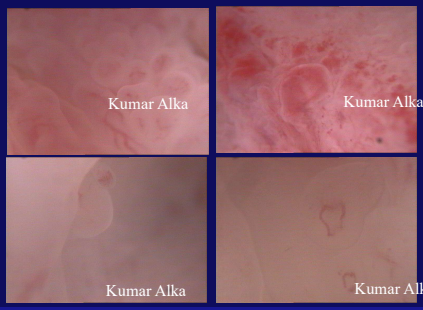
CHRONIC ENDOMETRITIS

Undulating Endometrium



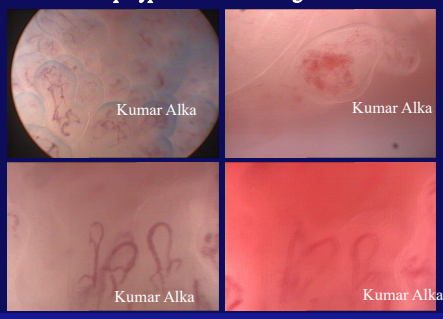
CHRONIC ENDOMETRITIS

Micropolyps - At Source Magnification



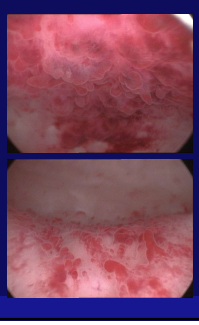
CHRONIC ENDOMETRITIS

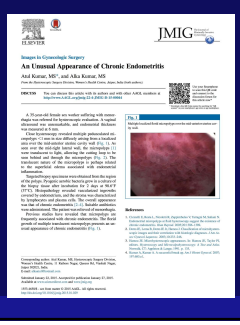
Micropolyps - At Source Magnification



CHRONIC ENDOMETRITIS

Micropolyps





ELSEVIER JMIG

Images in Gynecologic Surgery

An Unusual Appearance of Chronic Endometritis

And Kumar, MS*, and Alka Kumar, MS

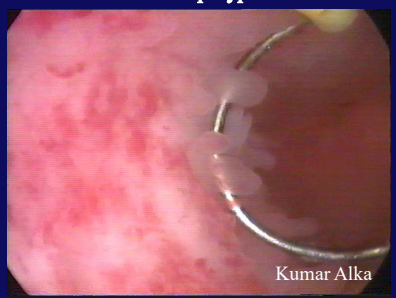
DOI/URL: You can choose this article with its authors and with other AAGL members at http://www.AAGL.org/jmig.

Fig. 1

References

CHRONIC ENDOMETRITIS

Micropolyps



CHRONIC ENDOMETRITIS

Micropolyps

NORMAL OSTIUM

1. Intramural epithelium is pink
2. Mino folds have smooth surface
3. Normal vascularization of minor folds (along the longs axis of the folds)
4. Collateral vessels seen
5. Physiological contractions seen during hysteroscopy

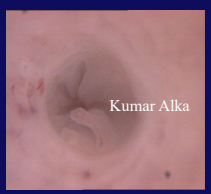
Dotto JE, et al. J Am Assoc Gynecol Laparosc. 2003; 10(2):233-246

TUBAL ORIFICES

PERITUBAL DIAPHRAGM – looks like a translucent membrane. It is the junction of the tubal epithelium with the endometrium.

The contractions occur every 10-13 seconds rhythmically and are best seen in the ovulatory phase

DISEASED OSTIUM



1. Intramural epithelium is dirty white
2. Minor folds have rough surface with eroded margins
3. No vascularization seen
4. No collateral vessels seen
5. No physiological contractions seen

Dotto JE, et al. J Am Assoc Gynecol Laparosc. 2003; 10(2):233-246

Journal of Minimally Invasive Gynecology (2007) 14, 269

THE JOURNAL OF MINIMALLY INVASIVE GYNECOLOGY

Images in endoscopy

An uncommon presentation of a tubal polyp

Atul Kumar, MS, and Alka Kumar, MS

From the Women's Health Centre, Hysteroscopic Surgery Division, Jaipur, India (both authors).

A 25-year-old woman presented with a 5-year history of primary infertility. The patient did not have any other complaints such as menorrhagia or breakthrough bleeding. Initially, the right tube was found not patent to methylene blue dye during laparoscopic chromotubation. Subsequent hysteroscopy revealed a round, flattened, and button-like polyp snugly lodged exactly in the center of the right cornual cup (Figure 1), and obviously the right ostium could not be visualized. The external surface of this polyp was covered with a small, well-demarcated, circumscribed area of degeneration. While the polyp was being removed by a flexible grasping forceps, it was observed that this polyp was arising from the intramural part of the right fallopian tube via a long pedicle. Immediately after the polyp was re-

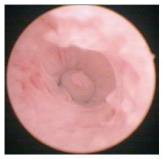
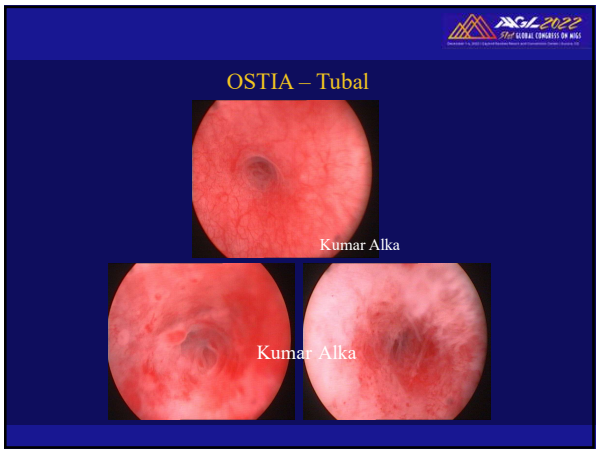


Figure 1 Tubal polyp impacted in right cornuae.

Kumar Alka


OSTIA – Tubal
Kumar Alka
Kumar Alka


ABNORMAL OSTIA
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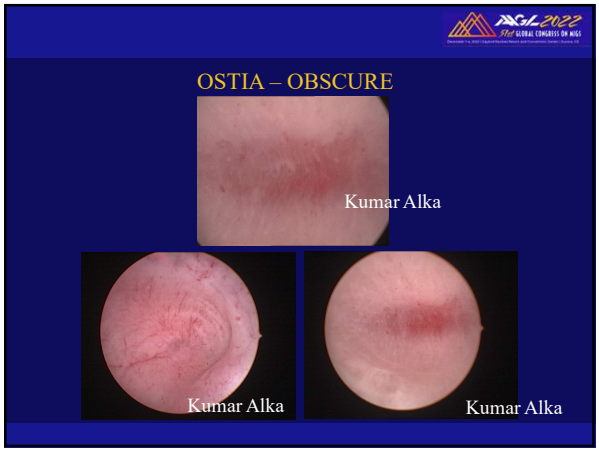
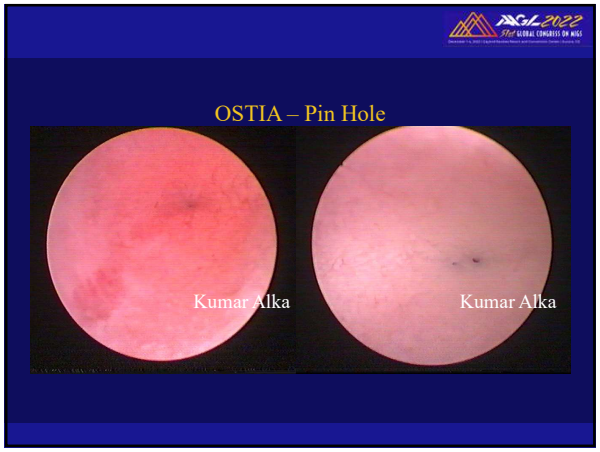
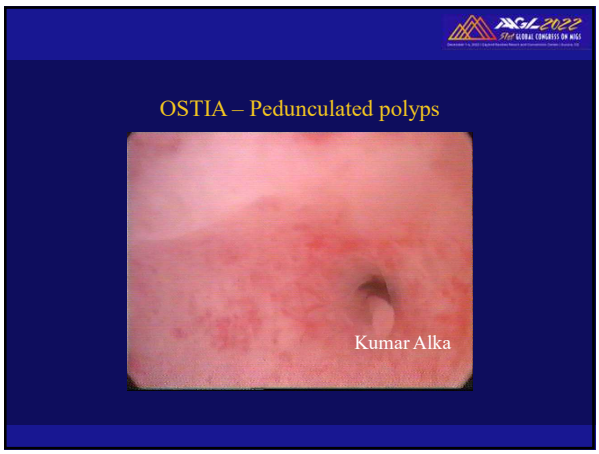
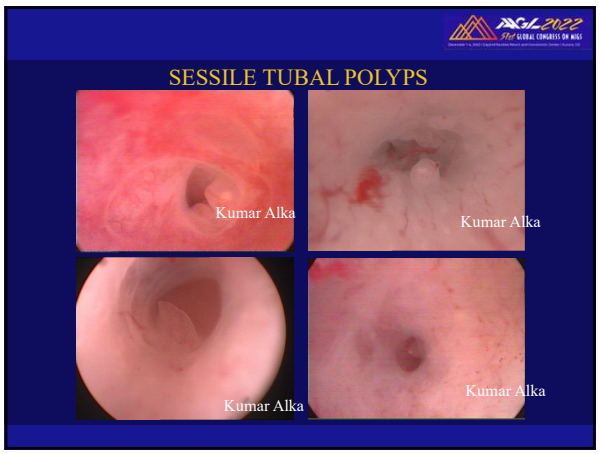
Kumar Alka
Kumar Alka
Kumar Alka


OSTIA – OBSCURE
Kumar Alka
Kumar Alka
Kumar Alka


OSTIA – Pin Hole
Kumar Alka
Kumar Alka

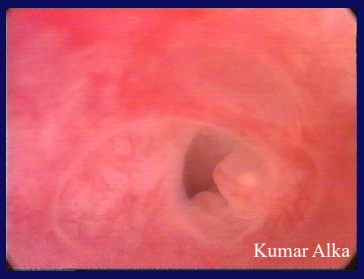

OSTIA – Pedunculated polyps
Kumar Alka


SESSILE TUBAL POLYPS
Kumar Alka
Kumar Alka
Kumar Alka
Kumar Alka

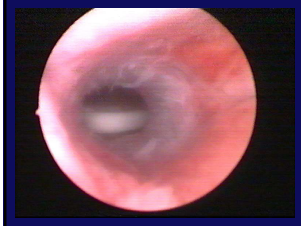
OSTIA – Pedunculated polyps

OSTIA – Sessile polyps

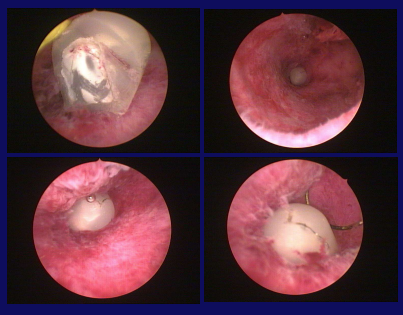
OSTIA – Sessile polyps



LIPPES LOOP



BROKEN TIP OF KARMAN CANNULA



REFERENCES

1. Hamou et al, Hysteroscopy and Microcolpohysteroscopy text and atlas, 1991, 5:55-79
2. Kumar A, Kumar A. Benign müllerian papilloma of the cervix. J Minim Invasive Gynecol. 2012 Sep-Oct; 19(5):541-2.
3. *Kumar et al , J Am Assoc Gynecol Laparosc 2004, 11(2):131-132*
4. *Luca Mencaglia, Luiz Cavalcanti de Albuquerque Neto and R. Alfonso Arias Alvarez, Manual of hysteroscopy- Diagnostic, Operative and Office Hysteroscopy 2015, 29-30*
5. Kumar A, Kumar A. Chronic Cervicitis, J Minim Invasive Gynecol. 2018 Feb 21; 25(1):4-5
6. Luca Mencaglia, Luiz Cavalcanti de Albuquerque Neto and R. Alfonso Arias Alvarez, Manual of hysteroscopy- Diagnostic, Operative and Office Hysteroscopy 2015, 29-30
7. Kumar A, Kumar A. J Minim Invasive Gynecol. 2012 Mar-Apr;19(2):148-9.
8. Kumar A, Kumar A. Atrophic endometrium. J Minim Invasive Gynecol. 2012 Mar-Apr.
9. Cicinelli et al. Journal of Minimally Invasive Gynecology 2008;15(6):752
10. Kumar A. Kumar A. Surface Architecture in Endometrial Tuberculosis, J Minim Invasive Gynecol. 2014 Jan 28; 21(5):727-8
11. Kumar A, Kumar A. Unusual appearing tubercular deposits at hysteroscopy. J Minim Invasive Gynecol. 2007 Mar-Apr; 14(2):144
12. Kumar A, Kumar A. Relook hysteroscopy after antitubercular therapy. Fertil Steril. 2008 Mar; 89(3):701-2

REFERENCES

13. Kumar A, Kumar A. Endometrial tuberculosis. J Am Assoc Gynecol Laparosc 2004;11(1):2.
14. Kumar A, Kumar A. Intraluminal tubal adhesions. Fertil Steril 2008;89(2):434–5.
15. Kumar A. Kumar A. Hysteroscopic finding of starry sky appearance and impregnated cobwebs in endometrial tunignrculosis, Int. J Gynaecol Obstet 2014 Sep; 126(3):280-1
16. Kumar A, Kumar A. Endometrial Tubercular Abscess, J Minim Invasive Gynecol. 2017 Feb 3; 24(7):1067-1068
17. Cicinelli E et al, Fertil Steril. Chronic endometritis: correlation among hysteroscopic, histologic, and bacteriologic findings in a prospective trial with 2190 consecutive office hysteroscopies. 2008 Mar;89(3):677-84.
18. Cicinelli E et al, J Minim Invasive Gynecol. Detection of chronic endometritis at fluid hysteroscopy. 2005 Nov-Dec;12(6):514-8.
19. Cicinelli E, et al, Hum Reprod. Endometrial micropolyps at fluid hysteroscopy suggest the existence of chronic endometritis. 2005 May;20(5):1386-9.
20. Cravello et al. Identification and treatment of endometritis. Contracept Fertil Sex. 1997;25:585-586
21. Greenwood et al. Chronic endometritis: morphological and clinical observations. Obstet Gynecol. 1981;58:176-184
22. Cicinelli et al. Journal of Minimally Invasive Gynecology 2005;12(6):514
23. Hamou JE. Microhysteroscopic appearances. In: Hamou JE, Taylor PJ, eds. Hysteroscopy and microcolpohysteroscopy: a text and atlas. Norwalk, CT: Appleton & Lange, 1991:134.

REFERENCES

24. Dotto et al. Classification of microhysteroscopic images and their correlation with histologic diagnoses. J Am Assoc Gynecol Laparosc 2003;10:233–46.
25. Hamou JE. Microhysteroscopic appearances. In: Hamou JE, Taylor PJ, eds. Hysteroscopy and microcolpohysteroscopy: a text and atlas. Norwalk, CT: Appleton & Lange, 1991:134.
26. Kumar A, Kumar A. Hysteroscopic Markers in Chronic Endometritis, J Minim Invasive Gynecol. 2017 Feb 16; 25(1):4-5
27. Kumar A, Kumar A. A successful break-up. Am J Obstet Gynecol. 2007 Dec; 197(6):685
28. Kumar A, Kumar A. An Unusual Appearance of Chronic Endometritis, J Minim Invasive Gynecol. 2015 Sep-Oct; 22(6):927-8
29. Kumar A, Kumar A. Mirror lesion at hysteroscopy. J Minim Invasive Gynecol. 2008 Nov-Dec; 15(6):662
30. Kumar A, Kumar A. A false passage created during hysteroscopy. J Minim Invasive Gynecol. 2007 Mar-Apr; 14(2):143
31. Kumar A, Kumar A. Intraluminal tubal adhesions. Fertil Steril. 2008 Feb; 89(2):434-5
32. Kumar A, Kumar A. An uncommon presentation of a tubal polyp. J Minim Invasive Gynecol. 2007 May-Jun; 14(3):269
33. Kumar A, Kumar A. Broken tip of Karman cannula removed at hysteroscopy J Minim Invasive Gynecol. 2015 May-Jun; 22(4):700-1

REFERENCES

34. Kumar A, Kumar A. Deep Adenomyosis, J Minim Invasive Gynecol. 2017 Nov - Dec; 24(7):1060-1061
35. *J Am Assoc Gynecol Laparosc 2004, 11(1):2*
36. Kumar A, Kumar A. Localized subendometrial leiomyomatosis at hysteroscopy. J Minim Invasive Gynecol. 2012 May-Jun; 19(3):284-5
37. Kumar A. Kumar A. Endometrial tuberculosis in a unicornuate uterus with a rudimentary horn. J Minim Invasive Gynecol. 2014 Feb 1; 21(6):974-5.
38. *Somigliana E et al. Reprod Update, 2007*
39. *Bettochi S et al. Hum Reprod 2002;*
40. *Buttra VC et al. Fertil Steril 1981;*
41. *Cicinelli Et al. Obstet Gynecol 1998;*
42. *Utra VC et al. Fertil Steril 1981*

CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

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

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

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

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

Important Definitions:

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

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

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

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

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

CLC & IB Online Resources:

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