GLOBAL CONGRESS ON MIGS

SYLLABUS

613-HSC: Becoming a Hysteroscopy Guru
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.

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613-HSC: Becoming a Hysteroscopy Guru

Co-Chairs: Luis Alonso Pacheco and Christina A. Salazar

Faculty: Attilio Di Spiezio Sardo, Martin Farrugia, Amy L. Garcia, Mariam Hanstede

From the AAGL Hysteroscopy SIG we are confident that this will be the most interesting and educational course that you have attended. This session will offer a fresh vision from the daily use in common situations to the recently proposed hysteroscopic treatment. We want to provide you a deep understanding of the surgical technique in three different situations (Retained products of conception, Polyps and Cesarean scar defects) and highlight the benefits of the new miniresectoscopes. We will also discuss about the role of the hysteroscopy in PALM-COEIN. Our goal is to provide you a new vision of the hysteroscopy to become a Hysteroscopy Guru.

Learning Objectives: At the conclusion of this course, the participant will be able to: 1) Demonstrate the role of hysteroscopy in PALM-COEIN; 2) discuss the best surgical approach for the different intracavitary pathology; and 3) describe more about mini and maxi resectoscopes.

COURSE OUTLINE

9:45 am  Welcome, Introduction and Course Overview
9:50 am  Hysteroscopy and PALM-COEIN  L. Alonso Pacheco
10:10 am  Mastering the Resectoscope Mini- and Maxi  M. Farrugia
10:30 am  Practical Experience for Hysteroscopic Polypectomy  A.L. Garcia
10:50 am  How to Deal with Congenital Mullerian Anomalies  A. Di Spiezie Sardo
11:10 am  Hysteroscopic Niche Resection  M. Hanstede
11:30 am  Hysteroscopic Management of Retained Products of Conception  C. Salazar
11:50 am  Questions & Answers  All Faculty
12:15 pm  Adjourn
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The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).
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Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.
Hysteroscopy And PALM-COEIN

Luis Alonso Pacheco

Objectives

- Evaluate the abnormal uterine bleeding in nongravid women from a "hysteroscopic" point of view
- Analyze the role of the hysteroscopy in the PALM-COEIN classification system
- Learn different hysteroscopic patterns related to AUB

POLYPS

- Polyps
- Adenomyosis
- Leiomyoma
- Malignancy
- Coagulopathy
- Ovulatory
- Endometrial
- Iatrogenic
- Not otherwise classified
Endometrial polyps are areas of growth of endometrial tissue inside the uterine cavity

Uterine polyps have a vascular Axis

ADENOMYOSIS
References

**Objectives**

- Illustrate the use of the resectoscope in modern practice
- Define the use of mini-resectoscopes
- Employ the resectoscope correctly
- Apply in the hands-on session

**Choice of Equipment**

- **Availability**
  - Diagnostic
    - Office procedure
    - Under general / regional anaesthesia
  - Operative
    - Expected pathology
    - Expected difficulty

Fig. 1. Schema of treatment indications for office operative hysteroscopy after introduction of bipolar instrumentation, proposed by Bertiocchi et al [9].
Blind procedural steps add risk

- Cervical dilatation
- Use of a curette
- Use of a suction curette
- Use of a polyp forceps, sponge holder, Rampley’s, etc
- Use of an obturator
- Use of an Elk evacuator (do not use!!)

The Obturator – entry under direct vision preferred

Instruments to avoid and not use

- Outflow perforations need to be beyond cervix to function
- Caution in miniature hysteroscopes: either channel may be used as the operating channel reducing their effectiveness.

Hysteroscopic Sheath: Multichannel

- Diagnostic
  - 30° is the traditional choice

- Operative
  - 12° or 0° a better choice
  - 30° make visualization of resecting loop or tip of 5Fr difficult to visualise
Choice of Offset Angle

Gynaecological Resectoscope
- Has a passive (Iglesias Type) handpiece
- Outer diameters 6.5-10 mm
- Inflow/outflow channels
- Rotating tubing connections

Passive vs Active
Gynaecological vs Urological
SHORT REPORT

The mini-resectoscope: A new instrument for office hysteroscopic surgery

PASCHI P, PALAMARA P, PIETRO GAGLIARDI M, NIKOLAIS PHINOPULOS, DESMOND POULTON, LIENE CIPRIANS I, ASAR MACOS

University Department of Obstetrics and Gynaecology, The Royal Free Hospital, London, UK

Abstract

Reproductive laparoscopy has become reimbursable for the investigation of chronic pelvic pain. Although the so-called "short" uterine dedicated mini-resectoscope has been safely introduced, few data are available regarding its use in hysteroscopic surgery. The objective of this study was to introduce, for the first time, a mini-resectoscope for hysteroscopic surgery, which is easy to handle and portable and allows the performance of hysteroscopic surgery without the need for general anesthesia. The mini-resectoscope is designed to be simple and safe to handle. The surgical technique was successfully performed in 15 patients and 10 were discharged on the same day. The mini-resectoscope is a new instrument for hysteroscopic surgery and can be used without general anesthesia for minor procedures such as polypectomy and the removal of small submucous fibroids.

Operating Room Set-up

Patient Positioning
Cervical Dilatation

- Difficult dilation leads to tears, bleeding, false passages and perforation
- Consider misoprostol preparation, particularly if GnRH analogues have been used
- Half size dilators helpful in difficult cases
- Carry out diagnostic hysteroscopy with smaller diameter hysteroscope prior to dilation to 8 – 10 mm
Cervical Dilatation

- Difficult dilation leads to tears, bleeding, false passages and perforation
- Consider misoprostol preparation, particularly if GnRH analogues have been used
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- Carry out diagnostic hysteroscopy with smaller diameter hysteroscope prior to dilation to 8 – 10 mm

Control of the Resectoscope

Method 1: Loop Release

- Limited versatility compared to resectoscope
- No electrosurgery for hemostasis
- Loss of resectoscopic skill
- What can I do if the equipment fails?
- Cost
Closing Remarks

- Know your equipment inside out
- Hysteroscopy is a single operator procedure – you're in charge!
- Gather as much information about the pathology you are about to deal with – choose your kit wisely!

References (Last Slide)

- Please list EVERY reference cited in the presentation without exception.
- Compile using the following citation format (authors, article titles, journal/book, year, volume, inclusive pages).

Thank You
Practical Experience for Hysteroscopic Polypectomy

Amy Garcia, MD
Fellowship Trained in MIGS
Director, Center for Women's Surgery – Garcia Sloan Centers
Clinical Assistant Professor, University of NM Health Sciences, Department of OB/GYN
Albuquerque, New Mexico

Disclosure

• ARK Surgical Consultant
• Medtrina Consultant
• Minerva Surgical Consultant
• UVision360 Consultant
• Karl Storz Endoscopy Speaker’s Bureau

Objectives

• Apply physics of the hysteroscope to polyp removal
• Maximize utility of a hysteroscope with a forward oblique angle
• Optimize polyp removal with surgical removal techniques

Mastering The Hysteroscopic Field of View

• Lens position
• Lens angle—forward oblique
• Asymmetric visual field
• Camera head position
• Operative instrument—lens relationship

Field of View – Lens Angle

Field of View – Lens Position
Visual Guidance for Cervical Access

Understanding the 30° Lens

Understanding the 30° Lens

Where am I looking?

Field of View – Operative Instrument

Field of View – Lens and Instrument Position

The instrument is parallel to the uterine wall and perpendicular to the base at the cutting edge.

The instrument and hysteroscope are moved together as one tool.
Field of View – Lens and Instrument Position

The instrument is parallel to the uterine wall and perpendicular to the base at the cutting edge.

The instrument and hysteroscope are moved together as one tool.

Field of View -- Camera Orientation

Light post up

Uterine view

Camera Head

Camera Head

Reusable Operative Instrument

- Semi-rigid
- Double or single action
- 3Fr, 5Fr and 7Fr diameter
- 34 and 40 cm length

Considerations for Hysteroscopic Polypectomy

- Type of attachment
  - Pedunculated, sessile
- Position of attachment
  - Anterior, posterior, lateral or fundal
- Size
- Tissue density
- Number

Hysteroscopic Polypectomy

Grasper

Location of Polyp Attachment -- Fundal

The instrument is perpendicular to the fundus and attachment.
References


How To Deal With Congenital Mullerian Anomalies

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MULLERIAN ANOMALY

OVERTREATMENT

MULLERIAN ANOMALY

UNDERTREATMENT

Congenital anomalies of the female genital tract
Mullerian anomalies
Uterine anomalies

Congenital anomalies of the female genital tract
Mullerian anomalies
Congenital anomalies of the female genital tract

Müllerian anomalies

Uterine anomalies

Mullerian anomalies

HYSTEROSCOPY

HYSTEROSCOPY AND FEMALE GENITAL TRACT ANOMALIES

HYSTEROSCOPY AND FEMALE GENITAL TRACT ANOMALIES

HYSTEROSCOPY

HYSTEROSCOPY AND FEMALE GENITAL TRACT ANOMALIES

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HYSTEROSCOPY AND FEMALE GENITAL TRACT ANOMALIES

HYSTEROSCOPY
**UTERINE CAVITY**

- **Volume**
  - **Tubular**
  - **Normal**

- **Duplicity**

- **Number of tubal ostia**
  - 1/3
  - 2/3
  - 3/3

**SEPTATE UTERUS (U2a-U2b)**

- Most frequent Mullerian anomaly: incidence 2-3%
- Highest rate of pregnancy complications

- Miscarriages in the I and II trimesters *
  
  (Rapa, 1981)

- Preterm labor and intrauterine growth retardation
  
  (Raga, 1997)

- Infertility (?) **
  
  (Fedele, 1993; Pabuccu, 2004)

- Miscarriages in the I and II trimesters *

  * increase in intrauterine pressure and a decrease in the volume of the uterine cavity

  ** structural and ultrastructural endometrial changes and changes in the vascularization at the site of implantation

**Hysteroscopic metroplasty**

- Objectives
  - Section of the fibrotic part of the septum
  - Leave a fundal notch of 1.0-1.5cm

**Mistakes**

- Section along a paramedian plane of the septum (damage to healthy myometrium)
- "Aggressive" section (lesion of fundal myometrium/uterine perforation)

**Metroplasty with miniaturized instruments**

- Preserves the cervical canal
- Precise surgical maneuvers
- Latero-lateral approach
- Outpatient (with or without sedation)
METROPLASTY WITH 15Fr RESECTOSCOPE

- PRESERVES THE CERVICAL CANAL
- PRECISE AND EASY SURGICAL MANEUVERS
- OUTPATIENT (WITH OR WITHOUT SEDATION)

LIMIT OF HYSTEROSCOPY
UTERINE FUNDUS

3D ULTRASOUND
LAPAROSCOPY

ACCURACY OF METROPLASTY

POSSIBILITY TO MEASURE THE DEPTH OF SECTION

5 Fr INTRAUTERINE PROBE

ORIGINAL ARTICLE

Accuracy of Hysteroscopic Metroplasty With the Combination of Presurgical 3-Dimensional Ultrasoundography and a Novel Graduated Intrauterine Tether: A Randomized Controlled Trial

Antonio Di Spizzirro Sanda, MD, PhD, Bruna Zinzolle, MD, Stefano Bettocchi, MD, Caterina Emanuele, MD, Caterina Nazzaro, MD, Giovanni Nazzaro, MD, Mariana da Costa Vieira, MD, and Carmen Nappo, MD
**ANATOMICAL ISSUES**

"NOT all the septa are the SAME"

The pathophysiology of septate uterus

**B.JOG**

- **A "PURE" re-absorption defect with normal fusion**
  - Fibrous and less vascularized
  - **SUBFERTILITY** changes in the overlying endometrium

- **A "MIXED" re-absorption and obscure fusion defect**
  - More muscular and vascularized
  - **RECURRENT MISCARRIAGES** pre-term birth
  - Abnormal pattern of muscular architecture and uterine mobility

**RESECTOSCOPIC METROPLASTY WITH UTERINE SEPTUM EXCISION: AN HISTOLOGICAL ANALYSIS OF THE UTERINE SEPTUM**


- Collagen tissue with muscle fibers arranged in a "fusiform" manner, in a "myoma-like" aspect
- Myometrial tissue with linear muscle fiber arrangement
- Normal Myometrium
- Collagen tissue with muscle fibers arranged in a "fusiform" manner, in a "myoma-like" aspect
- Normal Myometrium

**The update technique**

"The removal of the septum"

*gentle courtesy of Prof Betocchi*

**TO TREAT OR NOT TO TREAT CERVICAL SEPTUM?**

**HOW TO APPROACH A COMPLETE UTERINE SEPTUM WITH DOUBLE CERVIX?**

**Hysteroscopic metroplasty of the complete uterine septum, duplicate cervix, and vaginal septum**

**Group A: metroplasty including section of the cervical septum**

**Group B: same procedure with preservation of the cervical septum**

Resection of the cervical septum during hysteroscopic metroplasty of complete uterine septum makes the procedure safer, easier, and less complicated than the procedure with preservation of the cervical septum. This procedure is recommended for all cases of complete uterine septum.
**Measurements**

1. Fundal cavity width (W1) (the distance between the two internal tubal ostia)
2. Width of uterine cavity at corpus-isthmic level (W2)
3. Uterine fundal wall thickness (M) (the distance from interostial line and the external uterine sersosa)
4. The lateral angle between the corpus-isthmic cavity and the two fundal endometrial layers (A right; A left)
5. In case of cavity fundal indentation the indentation length (L1) (the distance from the tip of the fundal indentation to the interostial line) and fundal indentation angle (α2) (the angle between the two endometrial layers)

A lateral angle ≤ 140° and a fundal corpus-isthmic cavity ratio (W1/W2) ≥4.5:1 are suggestive for T-shaped uterus.

**Hysteroscopic outpatient metroplasty to expand dysmorphic uteri (HOME-DU technique): a pilot study**

A Di Spiezo Sardo,*, P Florio,*, G Nazzaro,*, M Spinelli,*, D Paladini,*, C Di Carlo,*, E Napoli,*. 

**HOME-DU TECHNIQUE**

**T-SHAPED UTERUS**
Mean follow-up time of 35.7 months

<table>
<thead>
<tr>
<th>Procedure</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary infertility</td>
<td>116 (72.6)</td>
</tr>
<tr>
<td>Repeated early spontaneous miscarriage</td>
<td>37/68 (54.4)</td>
</tr>
<tr>
<td>Total, N (%)</td>
<td>153 (78.4)</td>
</tr>
</tbody>
</table>

- Clinical pregnancy rate: 22/114 (19.2) vs 8/14 (57.1) (P < 0.001)
- Miscarriage rate: 16/114 (14.0) vs 1/14 (7.1) (P = 0.25)
- Term delivery rate: 83/91 (91.7) vs 9/14 (64.3) (P = 0.001)
- Labor induction by procedure: 26/87 (30.1) vs 6/9 (66.7) (P = 0.001)
- Labor induction by pregnancy: 20/26 (77.0) vs 3/6 (50.0) (P = 0.05)
- Mode of delivery: 47/81 (57.9) vs 15/26 (57.7) (P = 0.13)
- Vaginal delivery: 44/81 (54.4) vs 13/26 (50.0) (P = 0.5)
- Mode of conception: Spontaneous: 53/119 (44.5) vs 21/37 (56.7) (P = 0.15)
- ART: 6/119 (5.1) vs 6/37 (16.2) (P = 0.026)

OBSTETRIC COMPLICATIONS

- Potential remnants 5.1%
- Hysteroscopic removal 0.5%
- Manual removal of the placenta 0.4%
- Hysterectomy 0.0%
- Thrombosis of umbilical cord 0.0%
- Urinary retention 0.0%
- Exeural incompetence 0.0%

HYSTEROSCOPIC SURGERY

IT IS NOT A COSMETIC SURGERY……

P. Casadio & G. Gubbini

HYSTEROSCOPIC SURGERY

IT IS A FUNCTIONAL SURGERY…

P. Casadio & G. Gubbini
**Hysteroscopic Niche Resection**

Miriam Hanstede, M.D. Hysteroscopic Training Center, Haarlem, The Netherlands

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**Disclosure**

- I have no financial relationships to disclose

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**Objectives**

- Isthmocele, cesarean scar defect, niche, or diverticulum
  - Explain the pathogenesis of niche related post menstrual spotting
  - Formulate the best diagnostic modalities to measure an isthmocele
  - Demonstrate the hysteroscopic steps of resecting a niche

---

**Definition post-cesarean niche**

- Indentation in the myometrium at the site of the uterine scar
- Most authors and experts agree that the depth of the defect should be at least 2 mm Jordans 2019

---

**Cesarean Section Rate**

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Incidence

Depends on population, definition and imaging modalities
- 60% of women have a niche after a cesarean section (c.s.)
- 30% experience postmenstrual spotting
- 100% after 3rd c.s.

Risk factors
- Surgical, closure techniques, single layer
- Labouring, prolonged labour, >5cm dilation
- Wound healing, age, obesity

Symptoms
- Abnormal uterine bleeding,
  - post menstrual spotting
  - prolonged and/or heavy bleeding
  - intermenstrual bleeding
  - postcoital bleeding
- Dysmenorrhea
- Dyspareunia
- Chronic pelvic pain
- Impaired fertility
- Ectopic (isthmocele) pregnancy
- Abnormal placental implantation
- Uterine rupture.

Pathogenesis: post menstrual spotting
- Mechanical outflow problem, with the retention of menstrual blood in a niche
- Accumulation of blood because of impaired uterine contractions at the site of the niche
- Newly formed fragile vessels in the niche may play a role in the formation of blood or fluid in the niche and uterine cavity.
Diagnostic modalities

- Ultrasound
- Sonohysterographic methods: saline or gel infusion
- MRI
- Hysterosalpingography
- Hysteroscopy

Ultrasound

- Length
- Depth
- Residual myometrium thickness
- Width
- Adjacent myometrial thickness
- Distance CSD-vesicovaginal fold,
- Distance CSD-external os

Residual myometrium thickness (RMT)

- No consensus regarding the optimal RMT for hysteroscopic resection.
  - >2 mm Cheng 2009
  - >2.5 mm Li 2014
  - >3 mm most widely accepted
Therapeutic options

- Hormonal options
  - OAC
  - LNS-IUS
  - GnRH agonist

Surgical options

- Intrauterine
  - Hysteroscopic Niche Resection
  - Endometrial ablation

- Extrauterine
  - Vaginal surgery
  - Laparoscopy
  - Laparotomy

Surgical approach

- Hysteroscopy
- Vaginal surgery
- Laparoscopy
- Laparotomy

Remodel or repair the isthmocele

Work-up flowchart: symptomatic isthmocele

- Ultrasound
- Transvaginal ultrasound
- MRI
- Hysteroscopic management
- Laparoscopic management

Hysteroscopic Niche resection

- Proximal and Distal Correction vs Distal Correction Alone

Figure 3. Schematic diagram of two approaches of hysteroscopic niche resection: (A) proximal isthmocele; (B) proximal isthmocele and generalised uterine fibroid.
Hysteroscopic modalities

- A hysteroscopic niche resection can be performed in different ways:
  - The lower rim (closest to the external cervical os) can be resected to facilitate menstrual outflow
  - Both the lower and the upper part of the niche can be resected
  - Above techniques combined with coagulation of the vessels in the niche
  - Above techniques combined with coagulation of the entire niche surface

Resectoscope with loop and ball electrode

Resectoscope vs Rollerball Ablation

Effect of hysteroscopic niche resection

- abnormal uterine bleeding: 59.6% to 100% of patients usually become asymptomatic after hysteroscopic surgery.
- fertility results after hysteroscopy vary from a 46% pregnancy rate to a 100% pregnancy rate and a 90% delivery rate.
- pain/dysmenorrhea: 78% improvement and 80% improvement; extensive studies showed 100% improvement.

Questions

#donothesitatetoask

References

References

Disclosure

- I have no financial relationships to disclose.

Objectives

- Review common clinical presentations of RPOC.
- Understand diagnostic pitfalls of RPOC.
- Employ surgical techniques in the hysteroscopic management of RPOC.

Definition of RPOC

- Persistence of intrauterine tissue of placental trophoblastic origin.
- Pathological diagnosis is based on the presence of chorionic villi.

Clinical Presentation of RPOC

- Abnormal uterine bleeding
- Pelvic pain
- Fever
- Commonly occurs after 2nd trimester delivery or termination of pregnancy. 1

Important Risk Factor

- Placenta accreta. 2, 3

Figure 1: Placenta accreta
Diagnosing RPOC

- Distinguish between RPOC and normal postpartum blood clots.
- Echogenic endometrial mass in setting of abnormal bleeding or infection – sensitive indicators of RPOC.4,5

Diagnostic Pitfalls

Differential Diagnosis

- Blood clots
- Sub involution of placental implantation site
- Invasive moles
- Arteriovenous malformations (AVM)5
- Hematomata/Pyometra
- Gestational trophoblastic disease
- Endometrial polyp or submucosal fibroid

Surgical Treatment for RPOC

Directed hysteroscopic removal
In office or under sedation

- Resectoscope – “cold looping” technique (no energy current)
- Hysteroscopic scissors, graspers, etc.
- Hysteroscopic morcellators.

Surgical Technique

**RESECTOSCOPE**

Cold looping techniques can be used to dissect off the placental remnants from the uterine wall.

Surgical Technique

**RESECTOSCOPE**

Recommend sparing application of energy only when needed to dissect off the uterine wall.
Surgical Technique

Place traction on the tissue by using the hysteroscopic grasper to grasp the tissue and gently rotate.

Perioperative Management

- Prophylactic antibiotics.
- Uterine perforation – higher risk in infected uterus.
- Development of uterine synechiae (Asherman’s syndrome).

References

Assembly Bill 1195 was signed into law on July 1, 2006 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). It is the intent of the Legislature to encourage physicians and surgeons, continuing medical education providers located in California, and the Accreditation Council for Continuing Medical Education to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development.

Linguistic Competence: Providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Cultural Competence: A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.1

Cultural and Linguistic Competence: The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Cultural competence requires organizations and their personnel to:
• Value diversity.
• Assess themselves.
• Manage the dynamics of difference.
• Acquire and institutionalize cultural knowledge.
• Adapt to diversity and the cultural contexts of individuals and communities served.

California Business & Professions Code §2190.1(c)(3) states that associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the cultural competency requirements. The associations may update these standards, as needed, in conjunction with an advisory group that has expertise in cultural and linguistic competency issues. Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following: (A) Applying linguistic skills to communicate effectively with the target population. (B) Utilizing cultural information to establish therapeutic relationships. (C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment. (D) Understanding and applying cultural and ethnic data to the process of clinical care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

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 (Assembly Bill 305) requires that state agencies that serve a substantial number of non-English-speaking people employ a sufficient amount of bilingual persons in order to provide certain information and render certain services in a language other than English.