Panel 1 -
What is the Best Treatment for Ovarian Endometrioma?
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.

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Panel 1-What is the Best Treatment for Ovarian Endometrioma?

*Chair:* Francisco Carmona Herrera

*Faculty:* Massimo Candiani, Ludovico Muzii

Ovarian endometriomas are one of most the frequently encountered forms of endometriosis as they are found in up to 40% of women with endometriosis. However, their treatment is still controversial as it may affect not only ovarian physiology and ovarian reserve, but also spontaneous or after IVF/ICSI conception rates may be decreased and pregnancy outcomes impaired. This session will provide a close overview of the available treatments for this entity, discussing which is the best treatment in case of associated infertility and describing the endometrioma’s ablative surgery, the most promising current technique of treatment.

**Learning Objectives:** At the conclusion of this course, the participants will be able to: 1) Discuss the different available treatments for ovarian endometrioma; 2) distinguish the best treatment for an infertile patient with ovarian endometrioma; and 3) explore the rationale and surgical basis of ablative treatment for endometrioma.

**COURSE OUTLINE**

2:00 pm  
Welcome, Introduction and Course Overview

2:05 pm  
Ovarian Endometrioma: Overview of the Different Available Treatments  
F. Carmona Herrera

2:20 pm  
Endometrioma’s Ablative Surgery  
M. Candiani

2:35 pm  
What is the Best Treatment in Case of Associated Infertility?  
L. Muzii

2:50 pm  
Questions & Answers

3:00 pm  
Adjourn
PLANNER DISCLOSURE
The following members of AAGL have been involved in the educational planning of this workshop (listed in alphabetical order by last name).

Linda J. Bell, Admin Support, AAGL*
Linda D. Bradley, MD, Medical Director, AAGL*
Erin T. Carey, MD, MSCR
Honorarium: Teleflex Medical, MedIQ
Mark W. Dassel, MD
Contracted Research: Myovant Sciences
Linda Michels, Executive Director, AAGL*
Vadim Morozov, MD
Speaker: AbbVie
Consultant: Medtronic, Lumenis
Erinn M. Myers, MD
Speakers Bureau: Laborie Medical Technologies, Teleflex Medical
Other: Unrestricted educational grant to support NC FPMRS Fellow Cadaver Lab: Boston Scientific Corp. Inc.
Amy Park, MD
Speaker: Allergan
Nancy Williams, COO, CME Consultants*
Harold Y. Wu, MD*
Francisco Carmona Herrera, MD, PhD
Contracted Research: ADAMED
Speakers Bureau: ADAMED, Gedeon Richter Pharmaceuticals
Consultant: Medtronic

FACULTY DISCLOSURE
The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the “best available evidence” from medical literature (in alphabetical order by last name).

Massimo Candiani, MD*
Francisco Carmona Herrera, MD, PhD
Contracted Research: ADAMED
Speakers Bureau: ADAMED, Gedeon Richter Pharmaceuticals
Consultant: Medtronic
Ludovico Muzii, MD*

Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.

Jim Tsaltas, MBBS, FRANZCOG
Education Partner and Fellowship Funding:
Covidien
Speakers Bureau: Covidien
Audrey T. Tsunoda, MD, MPH
Speakers Bureau: Medtronic, CooperSurgical, Merck & Co., AstraZeneca, Roche
Linda Michels, Executive Director, AAGL*
Ovarian Endometrioma: Overview of the Different Available Treatments

Francisco Carmona, Ph.D.
Hospital Clinic/Medicine School
Barcelona (Spain)

Disclosure
- Consultant: Medtronic.
- Speakers Bureau: Medtronic; Gedeon Richter; Adamed

Objectives
- To review the different treatments for endometrioma
- To point out their main advantages and disadvantages

Surgical treatment (stripping) is the best option

REASONS TO RECOMMEND EXCISION
- Endometrioma recurrence is lower
- Pain symptoms recurrence
- Subsequent spontaneous pregnancy is greater

THIS APPROACH SHOULD BE THE FAVOURED SURGICAL APPROACH

Cochrane Library
Cochrane Database of Systematic Reviews

Excisional surgery versus ablative surgery for ovarian endometriomata (Review)
Hart RJ, Hickey M, Mauvais P, Buckett W
THERAPEUTICAL ALTERNATIVES TO EXCISION

- Expectant management
- Medical treatment
- Modifications to excisional technique
- Ablative surgery
- Sclerotherapy
EXPECTANT MANAGEMENT

JNIG

MEDICAL MANAGEMENT

Labeled drugs
- Progestins
- GnRH agonists
- GnRH antagonists

Non Labeled drugs
- Combined contraceptives
- LNG-IUS
- Subdermal implant

Future options
- SPERMs
- Progesterone capsules and microspheres
- Histone deacetylase inhibitor
- Statins
- Vitamin D
- Others

MODIFICATIONS TO EXCISIONAL TECHNIQUE

- Excessive coagulation
MODIFICATIONS TO EXCISIONAL TECHNIQUE

- Suturing

MODIFICATIONS TO EXCISIONAL TECHNIQUE

- Tissue Sealant

MODIFICATIONS TO EXCISIONAL TECHNIQUE

ABLATIVE SURGERY

- CO2 Fiber/Free Beam Laser

MODIFICATIONS TO EXCISIONAL TECHNIQUE

ABLATIVE SURGERY

- Plasma Ablation
ABLATIVE SURGERY

Ovarian endometrioma ablation using plasma energy versus cystectomy: a step toward better preservation of the ovarian parenchyma in women wishing to conceive

<table>
<thead>
<tr>
<th>TABLE 2</th>
</tr>
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<tbody>
<tr>
<td>Table showing data on the effectiveness of ablation versus cystectomy.</td>
</tr>
</tbody>
</table>

ABLATIVE SURGERY

Evaluation of ovarian reserve after cystectomy versus 'one-step' laser vaporization in the treatment of ovarian endometriomas: a small randomized clinical trial

ABLATIVE SURGERY

Impact of endometrioma surgery on ovarian reserve: a prospective, randomized, pilot study comparing stripping with CO2 laser vaporization in patients with bilateral endometriomas

ABLATIVE SURGERY

Progressive Clinical Research Report

ABLATIVE SURGERY

Total Circulating Microparticle Levels After Laparoscopic Surgical Treatment for Endometriosis: A Pilot, Prospective, Randomized Study Comparing Stripping with CO2 Laser Vaporization

ABLATIVE SURGERY

Fig. 2

ABLATIVE SURGERY

Fig. 2
SCLEROTHERAPY

Injecting a sclerosing agent into the cyst cavity
It can be either removed ("washing") or retained within the cyst (in situ retention)
It produces a disruption of the cyst epithelial lining with subsequent inflammation and fibrosis
It will result in obliteration of the cyst

Ethanol
Methotrexate
Tetracyclines
Other:
  Progestins
  SPERMs
**CONCLUSIONS**

- No perfect method exists
- Several factors must be considered:
  - Age
  - Fertility desire
  - Previous ovarian reserve
  - Male factor
  - Size
  - Laterality
Endometrioma’s Ablative Surgery
Prof. Massimo Candiani
IRCCS San Raffaele Hospital
Milan, Italy

Disclosure

- I have no financial relationships to disclose.

ENDOMETRIOSIS AND INFERTILITY

- Responsible for approximately 10% of the indications for ART cycles in USA and 6% in United Kingdom

- The prevalence rate of endometriosis among infertile women is estimated to be 25–40%

- Ovarian endometriomas (OMAs) are found in 17–44% of women with endometriosis

PATHOGENESIS OF INFERTILITY

THE FACTS

The ovarian reserve is already depleted in patients with endometrioma BEFORE SURGERY

THE ‘BURNOUT’ EFFECT
BEFORE surgery

AFC AMH

Antimullerian hormone is reduced in the presence of ovarian endometriosis: a systematic review and meta-analysis

Muzii 2002

ENDOMETRIOMA = PSEUDOCYST

DAMAGE MECHANISM DUE TO SURGERY

Removal of healthy tissue surrounding the cyst (56% of endometrioma cystectomy specimens in comparison with 8% of dermoid cystectomy specimens)

- No cleavage plane between fibrosis and parenchyma
- The endometrial functional layer is very thin

Surgery related inflammation

Vascular compromise due to coagulation

ENDOMETRIOMA = PSEUDOCYST

STRATEGY: ABLATIVE SURGERY

Large ovarian endometriomas

Laparoscopic management of endometriomas using a combined technique of excisional (cystectomy) and ablative surgery

Jacques Devroye, M.D., Jean-Claude Guerin, M.D., Pascale Audiol, M.D., Olivier Devroye, M.D., and Jean Speiser, M.D.
WHY CO₂ LASER FOR ENDOOMETRIOMA TREATMENT?

- Significant improvement in the AFC was observed after laser vaporization.

- The rate of AMH decline after vaporization is significantly lower than after cystectomy.

- At 5 years follow-up, there were no statistically significant differences in recurrence rate.

**BENEFITS OF ‘ONE STEP’ CO₂ FIBER-LASER APPROACH**

I. Tissue Sparing
II. Better Thermal Control
III. Very Precise
IV. Simple And Easy To Use
V. Reproducible
VI. Work In Difficult To Reach Areas And Tight Spaces

Lower OV and AFC levels following excisional surgery for endometrioma versus CO₂ laser vaporization suggest a higher impact on ovarian reserve after the stripping procedure.

- The AFC of the operated ovary was significantly increased in Group 2 compared with Group 1 after surgery.
- AMH levels were significantly reduced at 3 months in Group 1 compared with no reduction in Group 2.

**Table 1:** Baseline clinical characteristics and demographics of the 2 groups of patients with ovarian endometriomas.

<table>
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<th>Group 2</th>
<th>p-value</th>
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<td>Age (years)</td>
<td>33.5</td>
<td>32.1</td>
<td>0.26</td>
</tr>
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<td>RR</td>
<td>RR</td>
<td>0.89</td>
</tr>
<tr>
<td>Previous surgeries</td>
<td>12/46</td>
<td>12/46</td>
<td>1.00</td>
</tr>
<tr>
<td>Operative time</td>
<td>11.5 min</td>
<td>11.7 min</td>
<td>0.93</td>
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- The AFC of the operated ovary was significantly increased in Group 2 compared with Group 1 after surgery.
- AMH levels were significantly reduced at 3 months in Group 1 compared with no reduction in Group 2.

**Reurrence Rate after “One-Step” CO₂ Fiber Laser Vaporization versus Cystectomy for Ovarian Endometrioma: A 3-Year Follow-up Study**

- No recurrence was observed in any of the patients.
- All patients were followed up for 3 years.
Kaplan-Meyer curves presenting the probability of pregnancy in patients submitted to cystectomy and CO2 laser vaporization.

No significant difference in postoperative spontaneous pregnancy rates between the 2 treatment groups.

CO2 laser-treated endometrioma is associated with pregnancy rates equal to those observed after cystectomy and favorable IVF outcomes.

Table V. IVF outcome in terms of total recruited follicles in the operated ovary and in the contralateral one.

<table>
<thead>
<tr>
<th>Total recruited follicles</th>
<th>Operated</th>
<th>Contralateral</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operated ovary</td>
<td>38 (45)</td>
<td>39 (42)</td>
<td>0.9</td>
</tr>
<tr>
<td>Contralateral</td>
<td>32 (39)</td>
<td>33 (36)</td>
<td>0.8</td>
</tr>
<tr>
<td>Operative follicles</td>
<td>28 (34)</td>
<td>28 (31)</td>
<td>0.7</td>
</tr>
<tr>
<td>Contralateral follicles</td>
<td>24 (29)</td>
<td>25 (28)</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Laparoscopic CO2 Fiber-Laser Vaporization

Superficial Endometriosis Ablation

Dorsal Rectal Ablation

Bladder Deep Endometriosis

Bowel and Rectovaginal Septum Deep Endometriosis
ROBOTIC SURGERY

CONCLUSIONS

- The impact of endometriosis and its surgical treatment on the ovarian reserve and infertility REMAINS controversial.
- The damage may precede surgery: endometrioma itself may cause negative effects on the surrounding tissue.
- Surgery for endometrioma must be performed carefully to limit the risk of damaging the ovary; to achieve this, we need experienced surgeons and an appropriate technique.
- CO₂ Fiber Laser ablation is a promising method to treat endometriomas and to preserve ovarian function.

References


- Other Applications

- Graphic Elements – Please use as needed

50TH GLOBAL CONGRESS ON MIGS

NOVEMBER 14-17 • Austin, Texas

References


- Other Applications

- Graphic Elements – Please use as needed
What is the Best Treatment in Case of Associated Infertility?

Ludovico Muzii
“Sapienza” University of Rome, Italy
ludovico.muzii@uniroma1.it

A Puzzling Disease

Endometriosis-Associated Infertility
• Treatment of endometriosis in the setting of infertility raises a number of complex clinical questions
• Clinical decisions are difficult because many issues have not been properly addressed in RCTs

A Causal, not Casual, Association
• 25-50% of infertile women have endometriosis
• 30-50% of women with endometriosis are infertile
• Surgical diagnosis at laparoscopy in 9-50% of patients with infertility, versus 1-7% of fertile patients undergoing tubal sterilization

Possible Causes of the Association
• Distorted pelvic anatomy
• Altered peritoneal function
• Altered uterotubal transport
• Altered immune function
• Endocrine and ovulatory abnormalities
• Compromised ovarian reserve
• Compromised oocyte and embryo quality
• Impaired implantation

Endometriosis and Infertility
Diagnosis of Endometriosis

The diagnosis of endometriosis is made by histology, with both glands and stroma present in the specimen.
Where the Evidences Are

1.3 Endometriosis symptoms and signs

1.3.1 Suspect endometriosis in women (including young women aged 37 and under) presenting with 1 or more of the following symptoms or signs:

- Chronic pelvic pain
- Period-related pain (dysmenorrhea) affecting daily activities and quality of life
- Deep pain during or after sexual intercourse
- Period-related or cyclical gastrointestinal symptoms, in particular, constipation, bloating, or diarrhea
- Period-related or cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
- Infertility in association with 1 or more of the above.

1.3.2 Consider transvaginal ultrasound:

- To investigate suspected endometriosis even if the pelvic and/or abdominal examination is normal
- To identify endometriomas and deep endometriosis involving the bowel, bladder or ureter

1.3.3 Serum CA125

- CA125 level is 30 U/mL or less.

1.3.5 If an abnormality is found:

- Evaluate the patient with further imaging or treatment
- MRI

1.3.6 Consider pelvic MRI in women with chronic pelvic pain or suspected endometriosis

1.3.7 MRI

- Assess the extent of endometriosis involving the bowel, bladder, or ureter

1.3.8 Ensure that pelvic MRI is interpreted by a radiologist or professional with special expertise in gynaecological imaging.
Endometriosis and Infertility

Diagnosis

• You will never know if the patient has endometriosis unless it is endometrioma or DIE on bimanual examination and imaging
• All other cases will be asymptomatic or nonspecific pain, for which an “unexplained infertility” diagnosis will be made

Endometriosis: a Change of Paradigm?

Diagnosis

• In case of associated pain, medical treatment can be started without surgical diagnosis
• In case of associated infertility, ART treatment can be started without surgical diagnosis
• Shared decision

Endometriosis and Infertility

Diagnosis

• If no associated pain, follow “unexplained infertility” algorithm
• Consider laparoscopy only in case of associated severe pain symptoms?
• If stage I-II is found, it should be treated

Endometriosis and Infertility

Diagnosis

• Treatment
Endometriosis: Treatment Options

• Expectant management
• Medical therapy
• Surgical therapy
• Combined Medical/Surgical
• ART

The Guidelines

What do current guidelines recommend for endometriosis treatment?

Endometriosis: Treatment Options

Treatment of endometriosis-associated infertility

The Guidelines

MARP in women with endometriosis

In infertile women with endometriomas larger than 3 cm, there is no evidence that gonadotropin-releasing hormone analogues improve pregnancy rates (Chessex et al., 2000; Martin et al., 2001). In women with endometriomas larger than 3 cm, the GOC recommend a minimum follow-up of 12 months after treatment, with repeat imaging at 6 months, to assess for recurrence or progression.

The Guidelines

Laparoscopy may be recommended in patients with severe endometriosis, including those with large endometriomas, to assess for surgical candidacy and to provide symptom relief. The procedure is performed under general anesthesia and may involve the placement of intrauterine devices (IUDs) or the use of gonadotropin-releasing hormone analogues to induce a follicular phase before surgery. The decision to proceed with surgery should be considered carefully if the woman has had previous ovarian surgery.
Endometriosis: Treatment Options

- Infertility → ART
- Pain → Medical Tx
- Both smpt → Surgery

EBM guidelines categorize patients depending on the main symptom:
- Infertility
- Pelvic pain

Endometriosis: Treatment Options

- Infertility
- Pelvic pain
- Adnexal mass
- Asymptomatic patient

However, in most cases, categories overlap, and good clinical sense is sometimes more important than guidelines or EBM...

Choice of Treatment

- Associated symptoms (infertility with or without pain and/or endometrioma)
- Age
- Ovarian reserve

Personalization

Probably we should not talk about treatment of endometriosis.
We should talk about this particular patient, with these findings and this ovarian reserve, who received those previous treatments, in that center, in that period, with these results...

Each patient with endometriosis is unique...
### Multiparametric Score for the Indication to Surgery in Case of Endometrioma (MISE score)

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size (cm)</td>
<td>&lt;3</td>
<td>3-5</td>
<td>&gt;5 (if &gt;10, score is 3)</td>
</tr>
<tr>
<td>Growth rate</td>
<td>≤1.0 cm/6 months</td>
<td>&gt;1.0 cm/6 months</td>
<td>/</td>
</tr>
<tr>
<td>Pain</td>
<td>absent/mild</td>
<td>/</td>
<td>moderate/severe*</td>
</tr>
<tr>
<td>Infertility*</td>
<td>absent</td>
<td>/</td>
<td>present**</td>
</tr>
<tr>
<td>Ultrasound features</td>
<td>typical</td>
<td>/</td>
<td>atypical, if blood flow, score is 3</td>
</tr>
<tr>
<td>History + for cancer**</td>
<td>absent</td>
<td>familiar</td>
<td>personal</td>
</tr>
<tr>
<td>Recurrent</td>
<td>no</td>
<td>yes</td>
<td>/</td>
</tr>
<tr>
<td>Age</td>
<td>≤40</td>
<td>&gt;40</td>
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Follow-up if score ≤2: surgery if ≥3.
* Additional parameters, such as age of the patient, duration of infertility, additional subfertility factors, ovarian reserve, predicted access to follicles, may be used for personalized management in endometrioma-associated infertility.
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### Multiparametric Score for the Indication to Surgery versus ART in Case of Endometrioma (MISA score)

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Follow-up if score ≤2: surgery if ≥3.
* Total score:
  0/1: Direct IVF suggested
  2: Surgery before IVF may be suggested
  3 or higher: Surgery before IVF strongly suggested

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<td>Predicted difficulty at oocyte pick-up</td>
<td>no</td>
<td>yes</td>
<td>/</td>
</tr>
<tr>
<td>Ultrasound features</td>
<td>typical</td>
<td>atypical, blood flow</td>
<td>/</td>
</tr>
<tr>
<td>History + for ovarian or breast cancer</td>
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<td>familiar</td>
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*Total score:
0/1: Direct IVF suggested
2: Surgery before IVF may be suggested
3 or higher: Surgery before IVF strongly suggested

Ovarian reserve, age of the patient, recurrent diseases are not considered.

---

Ludovico Muzii et al., Seminars Reprod Med 2017
Multiparametric score for the Indication to Surgery versus ART in case of endometrioma (MISA score)

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Ovarian reserve, age of the patient, recurrent disease are not considered (consider oocyte donation)

How can we predict an easy access to follicles?
The detrimental effect of endometrioma

- Cyst larger than 5 cm
- Difficult access to follicles
- Younger age
- Normal ovarian reserve
- Both infertility and severe pain
- Fast-growing cyst
- Non-reassuring US
- Family/personal history of Ca.

- Cyst less than 3 cm
- Easy access to follicles
- Advanced age
- Reduced ovarian reserve
- Additional male factor
- Additional tubal factor
- Reassuring US

Infertility: Surgery versus IVF

Favor Surgery
- Cyst larger than 5 cm
- Difficult access to follicles
- Younger age
- Normal ovarian reserve
- Both infertility and severe pain
- Fast-growing cyst
- Non-reassuring US
- Family/personal history of Ca.

Favor IVF
- Cyst less than 3 cm
- Easy access to follicles
- Advanced age
- Reduced ovarian reserve
- Additional male factor
- Additional tubal factor
- Reassuring US

Which COH protocol for endometriomas?

- The choice of the COH protocol in case of endometriosis is not a real clinical problem
- In case of endometriosis stage I-II, you will never know if the patient is affected; follow your “unexplained infertility” algorithm
- There is no solid evidence to prefer a long-GnRH agonist to a GnRH antagonist protocol in case of any type of endometriosis
Which COH protocol for endometriomas?

- In case of severe endometriosis, the main issue is at the time of oocyte pick-up
- In case of endometriomas, avoid puncturing the endometrioma
- If monolateral, start with healthy ovary
- If local protocols include endometrioma aspiration, do this at the end of the procedure
- In case of DIE, main issue is avoiding bowel puncture
- Antibiotic prophylaxis

Conclusions

- The difficult clinical decision on the management of a patient with endometriosis-associated infertility should be based on available evidence and solid clinical evaluation, considering many clinical parameters, as well as patient preference
- The choice of treatment is between surgery, IVF, or a combination of the two
Cultural and Linguistic Competency

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.