GLOBAL CONGRESS ON MIGS

NOVEMBER 14-17 • Austin, Texas

SYLLABUS

Surgical Tutorial 1 - Adenomyosis
Professional Education Information

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

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

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

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

Session Program (Description and Learning Objectives) ............................................................. 1

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

Diagnosis and Co-management of Adenomyosis
S. Singh ............................................................................................................................................... 3

Surgical Management of Diffuse Adenomyosis
G.F. Grimbizis .................................................................................................................................... 10

Surgical Management of Localised Adenomyosis (Adenomyoma)
K. Wang ............................................................................................................................................. 15

Surgical Staging Systems and Outcomes
J. Abbott ............................................................................................................................................. 18

Cultural and Linguistic Competency ............................................................................................... 21
Surgical Tutorial 1-Adenomyosis

Co-Chairs: Jason A. Abbott and Karen Wang

Faculty: Grigoris F. Grimbizis, Sukhbir Sony Singh

This course addresses the surgical issues associated with adenomyosis. The frequent occurrence of co-existing pathologies requires detailed diagnosis and consideration of modalities for diagnosis and management of both adenomyosis and other disease states. Sonography, MRI and additional diagnostic techniques will be considered. Surgical techniques for adenomyosis will vary depending on location of disease, with localised and more wide-spread pathology presenting variations that need to be approached with differing methods. Video guides, key touchpoints to reduce risk and demonstration of a variety of options and tools to assist in the surgical management of adenomyosis will be presented. Surgery with fertility preservation as a focus will be discussed and the issues and limitations around evidence and outcomes for intervention presented. How surgical staging systems can he improved into the future to aid in patient-centered outcomes will be discussed.

Learning Objectives: At the conclusion of this course, the participants will be able to: 1) Describe the options for diagnosis of adenomyosis with an emphasis on the extent of disease and co-existing pathologies; 2) choose a surgical approach that is appropriate to the pathology and aligned with the patient’s outcomes and objectives; and 3) discuss the issues and limitations in current surgical and other staging systems for adenomyosis.

COURSE OUTLINE

2:00 pm Welcome and Introduction J. Abbott / K. Wang
2:05 pm Diagnosis and Co-management of Adenomyosis S. Singh
2:15 pm Surgical Management of Diffuse Adenomyosis G.F. Grimbizis
2:25 pm Surgical Management of Localised Adenomyosis K. Wang (Adenomyoma)
2:35 pm Surgical Staging Systems and Outcomes J. Abbott
2:45 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*
Jason A. Abbott, MD
Research: Merck/MSD
Consultant: Hologic
Speakers Bureau: Bayer
Karen Wang, MD
Consultant and Surgical Education: Olympus
Consultant: AbbVie

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).
Jason A. Abbott, MD
Research: Merck/MSD
Consultant: Hologic
Speakers Bureau: Bayer
Grigoris F. Grimbizis, MD, PhD*
Sukhbir Sony Singh, MD
Consultant: Abbvie, Bayer HealthCare, Myovant
Speakers Bureau: Bayer HealthCare, Ethicon Endo-Surgery
Karen Wang, MD
Consultant and Surgical Education: Olympus
Consultant: AbbVie
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*
Diagnosis and Co-management of Adenomyosis

Surgical Tutorial
Sukhbir (Sony) Singh MD
Professor
Fellowship Director
Research Chair in Gynecologic Surgery

Thank you for attending!
It has been a crazy year and we appreciate your support!

Disclosure
- Dr Singh has been involved in research trials, advisory boards and CME events with the following industry partners:
  - Abbvie
  - Bayer
  - Myovant
  - Ethicon Endo-Surgery

Objectives
- Define adenomyosis and its subtypes
- List ultrasound imaging findings suggestive of adenomyosis
- List other conditions that are often found with adenomyosis

Definition
- Proliferation of endometrial glands and stroma leading to ill-defined lesions within the myometrium.
- May be global/diffuse or focal
- Or cystic adenomyoma
- (Focal adenomyosis is not the same as an adenomyoma)

Diffuse adenomyosis
- Adenomyosis is diffuse when numerous foci of endometrial glands and stroma are dispersed diffusely within the myometrium
Adenomyoma

- focal adenomyosis with additional compensatory hypertrophy of the surrounding myometrium

Focal adenomyosis

- Adenomyosis is focal when circumscribed nodular aggregates are observed

WHY Is it Important?

Identifying the RIGHT treatment approach

Endometriosis and Adenomyosis Go Together

- Sampson 1927: adenomyosis is "primary endometriosis"
- Bazot 2006: 27% of women with endometriosis
- Gonzales 2006: Patients with adenomyosis are more likely to have Deep Endometriosis
- Di Donato 2014: 22% in endometriosis, > in DIE
Deep Endometriosis with adenomyosis

Correlation with deep endometriosis

- 237 women with endometriosis & 55 without endometriosis
- Focal adenomyosis located in the outer myometrium (FAOM) more frequent with endometriosis, and was significantly associated with deep endometriosis
- Diffuse adenomyosis was in 35.5% of women with deep endometriosis (59 cases)
- FAOM was found in 50.2% of women with endometriosis (119 cases)
- FAOM in deep endometriosis (66.3%, 110 cases)

Another Why?

Surgery for Endo

Infertility
Success
Failure

Improve

Pain

Failure

Adenomyosis

Possible explanation of Surgical Failure At Endometriosis Surgery?
Adenomyosis impact on fertility

- 68% reduction in likelihood of pregnancy
- Radical Surgery may not be the answer when adenomyosis present
- Require ideal future cohort studies

Diagnosis

- Only confirmatory test: pathology at hysterectomy!
- Clinical evaluation
  - History
  - Physical exam
- Imaging
  - Ultrasound
  - MRI

Clinical Assessment

- Symptoms may be common in both conditions!
  - Severe Dysmenorrhea
  - Abnormal uterine bleeding
- Factors in adenomyosis versus endometriosis
  - Increasing parity
  - Increasing age
  - Dysempanthias
  - HIV

Examination

- May provide the necessary details to differentiate in OBVIOUS INVASIVE ENDOMETRIOSIS

Ultrasound Features - MUSA

- Learn Normal First!
Light blue shadowing lines at uterine corpus/fundus. Multiple shadowing lines not arising from a distinct mass.

**Pattern recognition**

**Myometrial cysts**

**Practice...**

**Image S. Singh**

**QUESTION MARK SIGN IS SEEN WITH DEEP ENDO.**

**How to Evaluate Adenomyosis in Patients Affected by Endometriosis?**

The Department of Gynecology and Obstetrics, Medical University of Innsbruck, Austria.

**CONFLICT OF INTEREST:** None.

Correspondence should be addressed to: med.de.kommend.de.komadokom@gmail.com

[Image of a question mark with a deep endo image]
3D imaging for the Junctional Zone

- Imaging findings on 2D and 3D US show an association with symptoms
- 3D JZ associated findings assoc with AUB and dyspareunia

MRI – gold standard imaging

2 Case Examples Singh

MRI – gold standard imaging

MRI

Diffuse adenomyosis

Diffuse adenomyosis S. Singh
Summary

- Adenomyosis is a heterogeneous condition
- Ultrasound evaluation is first line, MRI is useful for surgical planning and confirmation
- Endometriosis and Adenomyosis are often found together

References

Adenomyosis: forms

- Adenomyosis can be either diffuse or focal, taking the form of adenomyoma or adenomyotic cyst
  - Focal: less than 25% of the myometrium of the corpus uteri is involved (MUSA definition)
  - Adenomyomas: grossly circumscribed nodules of hypertrophic and distorted endometrium and myometrium usually embedded within the myometrium
  - Histologically, it could range from mostly solid to mostly cystic
  - Adenomyosis could be present in the form of polyps of endometrial cavity
    - It is characterized by the presence of endometrial glands between smooth muscle bundles

Description of the patient's form is necessary for the management of the patient

Diffuse adenomyosis
1. Smooth muscle hyperplasia with ectopic endometrium (junctional zone)
2. Micro-dilated ectopic endometrial glands throughout hyperplastic myometrium

Focal adenomyosis
1. Adenomyoma
2. Cystic adult adenomyosis
   - Juvenile cystic adenomyosis

Polyoid adenomyosis
1. Typical polyoid adenomyomas
2. Atypical polyoid adenomyomas

Special categories
1. Adenomyomas of endocervical type
2. Retroperitoneal adenomyosis or rectovaginal endometriosis

Surgical / Histological Classification of Adenomyosis

Uterus preserving surgery in diffuse adenomyosis

Techniques

Tips and tricks of conservative excisional surgery

Uterus sparing surgical treatment of adenomyosis

Rationale for categorization of the techniques

- Adenomyosis is an infiltrating disease
- Adenomyomectomy is always associated with concomitant removal of some amount of myometrial tissue
- Surgical techniques' categorization is based on:
  1. Radicability of adenomyotic tissue removal
  2. Preservation of the integrity (and subsequently the functionality) of the uterine wall
Complete excision of adenomyosis
- complete removal of all the clinically recognizable, non-microscopic lesions with
  maintenance of uterine wall integrity

Partial excision of adenomyosis / cytoreductive surgery
- partial removal of the clinically recognizable non-microscopic lesions, complete
  removal would lead to "functional" hysterectomy due to the concomitant excision of
  a critical amount of healthy myometrium

Non-excisional techniques
- interventions where removal of adenomyotic tissue is not included


Uterus sparing surgical treatment of adenomyosis
Categorization of the techniques

<table>
<thead>
<tr>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classical</td>
</tr>
<tr>
<td>Overlapping flaps</td>
</tr>
<tr>
<td>90° Technique</td>
</tr>
<tr>
<td>Triple flap</td>
</tr>
</tbody>
</table>

Adenomyectomy: Classical technique
- Laparoscopic "classical" adenomyectomy has the same operative steps as hysterectomy
- not clearly defined surgical borders
- excision into the neighboring healthy myometrium
- grasping and traction very difficult
- rich vascularization


Adenomyectomy: Classical technique
- Grasping of the adenomyoma
- Dissection with the use of scissors or monopolar needle
- Suturing of the myometrium


Classical technique: overlapping flaps
- Operative steps
  - Transverse incision into the adenomyotic tissue up to the endometrium
  - Surgical removal of the adenomyotic tissue with a monopolar needle
  - The normal muscle layer on the serosal side of the lesion and to
    reconstruct the uterus


Potential indication
- Diffuse adenomyosis covering one uterine wall up to 2/3 of the wall's volume

Classical technique: overlapping flaps

Excision of the adenomyotic lesion preserving myometrium below serosa

Excision on the contralateral side leaving also a healthy myometrial flap

The preserved healthy flap of one side is fixed covering the traumatic surface

Excision on the contralateral side leaving also a healthy myometrial flap

Classical technique: overlapping flaps

The preserved healthy flap of one side is fixed covering the traumatic surface

Excision on the contralateral side leaving also a healthy myometrial flap

Adenomyomectomy: “H” Technique

A vertical and two perpendicular transverse incisions over the adenomyoma form the letter “H”

Along the vertical incision myometrium is carved saving 5 mm healthy tissue below serosa

Adenomyomectomy: “H” Technique

The cutting is extended bilaterally, dividing “healthy” subserosal from the diseased central part, under the H incision; adenomyotic tissue is removed

Suturing of the myometrium; Approximation of the traumatic surface and secure hemostasis

Adenomyomectomy: “H” Technique

A vertical and two perpendicular transverse incisions over the adenomyoma form the letter “H”

Along the vertical incision myometrium is carved saving 5 mm healthy tissue below serosa

Suturing of the myometrium; Approximation of the traumatic surface and secure hemostasis

Triple flap technique

(A) Bisection of the uterus & Opening of the cavity

(B) & (C) Excision of adenomyotic tissue leaving myometrial flaps from the serosa and endometrium

(D) Closure of the endometrium

(E & (C) Closure of the uterine wall with the characteristic triple flap technique (overlapping of the two sutured flaps with the third one)

Triple flap technique

(A) Bisection of the uterus & Opening of the cavity

(B) & (C) Excision of adenomyotic tissue leaving myometrial flaps from the serosa and endometrium

(D) Closure of the endometrium

(E & (C) Closure of the uterine wall with the characteristic triple flap technique (overlapping of the two sutured flaps with the third one)
Tips and tricks: pre-operative

- Preoperative mapping of the lesion with MRI is necessary; use of the MRI images as a guide for lesion's excision in the OR
- Pretreatment with GnRH-a should be avoided; it worsens the recognition of the adenomyotic lesion’s borders
- Preparation for intraoperative use of imaging technique; consider TVS or even laparoscopic probes
- Plan for intraoperative use of necessary instruments: uterine manipulators, methylene blue or indigo-carmine

Tips and tricks: intra-operative

- Bleeding prevention and control; consider the use of vasoconstricting agents (vasopressin or epinephrine)
- Electro-surgery could be used for incision, sharp dissection of the adenomyotic lesions and bleeding control
- Meticulous technique, proper hydration of tissues and avoidance of foreign bodies in cases of laparotomy are necessary

Tips and tricks: intra-operative

- Sub-serous layer 5 to 10mm could be usually preserved during lesion excision since it is rarely affected by the disease
- The potential opening of the endometrial cavity could be checked with the injection of methylene blue or indigo-carmine
- Absorbable braided/coated polyglycolic sutures should be used, 3/0 or 2/0 for the endometrium and 0 or 1 for the myometrium
- Thorough closure of all the defect in order to minimize the risk of hematoma is necessary

Preoperative mapping with MRI as a guide for lesion's recognition in OR

- Posterior wall adenomyoma:
  1. MRI Mapping
  2. Careful inspection for recognition of the ill-defined borders

Intraoperative principles of conservative excisional surgery

- Bleeding prevention & Control
  - Injection of vasoconstricting agents (epinephrine)
  - Use of meticulous technique
  - Proper hydration of the tissues

- Sub-serous layer 5 to 10mm could be usually preserved during lesion excision since it is rarely affected by the disease
## Conclusions

| Key point 1 | Adenomyosis is an infiltrating disease to the myometrium
| Adenomyomectomy is always associated with concomitant removal of some amount of myometrial tissue |

| Key point 2 | MAPPING OF THE DISEASE IS MANDATORY FOR SURGICAL MANAGEMENT OF DIFFUSE FORMS |

| Key point 3 | Design your surgery and select the appropriate technique depending on the disease extent |
Surgical Tutorial: Adenomyosis

Surgical Management of Localized Adenomyosis

Karen C. Wang, MD
Assistant Professor
Director, Minimally Invasive Gynecologic Surgery

Disclosures

- Abbvie- consultant
- Hope Medicine- advisor
- KLAAS, LLC- cofounder
- Olympus- consultant

Adenomyomas

- Focal adenomyosis
- Circumscribed collection of hypertrophic endometrium within myometrium.

Adenomyomas

- Symptoms: dysmenorrhea, menorrhagia, CPP, infertility
- Enlarged uterus
- Diagnosis: MRI and high quality TV US

Adenomyomas

1. Hysteroscopic resection
2. Endometrial ablation/resection
3. Adenomyomectomy
4. Electrocoagulation (high frequency ultrasound, radiofrequency ablation)

Adenomyomectomy

- First described in 1952
- Similar technique (open, lsc, robotic)
- Considered investigational approach

- Difficult:
  - Ill-defined planes
  - Hard to guarantee complete resection
  - Fibrotic, woody tissue, hard to grasp or suture
Adenomyomectomy

• Techniques
  – Classic myomectomy/wedge
  – Transverse H incision
  – Osada (triple flap method)

Classic myomectomy/wedge

Transverse H incision

• Fujishita, 2004

Triple Flap

• Osada, 2011

Triple Flap Video

Optimizing surgical excision

• Vasopressin
• Temporary occlusion vasculature
  – Tourniquet
  – Bulldog clamps
• Barbed suture
Case series

- 6 consecutive cases of adenomyomectomy
  - Ages 29-38
  - No GnRH pretreatment
  - Range lesion size by US (3-8.4 cm)
  - Ave OR time 100.5 min
  - Ave EBL 163 mL
  - No complications, conversions, no inpatient stays
  - Follow up 13.7 months

Grimbizis et al. Fert Steril 2008

Complications

- Intrauterine adhesions
- Hematomas
- Intraoperative blood transfusion
- Uterine rupture (2-4%; between 12-25 weeks gestation)
- Abnormal placentation

Recurrence rate

- Less common when medical treatment started after surgery
- Estimated 9% if complete excision
- Estimated 19% if partial excision
- Estimated 32% if non-excisional

- Seen as early as 1 year after surgery

Tulandi et al. JMG 2017

Systematic review

- 27 studies (17 retrospective)
- 1398 patients
  - 890 complete excision
  - 68 partial
  - 13 adenomyoma excision
  - 9 non-excision

Tulandi et al. JMG 2017

References

Adenomyosis: Surgical staging systems and outcomes

Jason Abbott PhD FRANZCOG FRCOG B Med (Hons)
Professor Gynaecological Surgery UNSW, Sydney
AAGL 2021 - November 14-17 Austin, Texas USA

School of Women’s & Children’s Health

Disclosure

• Former Chair of the AAGL Practice Committee
• Co-chair of the CCS for ACQH in HMB
• Chair of the Gynaecology group for MBS review Australian Government
• FIGO member menstrual disorders group
• Editorial Board of IMIG and ANZOG
• Consultant: Hologic; Research: MSD/Merck; Speakers Bureau: Bayer
• Medical Director Endometriosis Australia
• Former President of AGES
• Research Grants Australian Government
• Endometriosis Advisory Group Australian government

Surgical staging systems

1. Diagnosis made pre-op
2. Intraoperative assessment (imaging, direct contact [feel])
3. Histology (limitations intra-operatively)

Histology (limitations intra-operatively)
**Adenomyectomy**

- Volume reducing disease load
- Myometrial involvement has implications for function at delivery
- Symptom outcome:
  1. Pain, bleeding
  2. Fertility

**Symptom outcomes**

- HMB reduced/absent (hyst)
- Pain and bulk symptoms reduced
- Combination with medical treatment may be beneficial
- Recurrence rates low but short follow-up time
- Complications include bleeding and infection

**Fertility outcomes**

- ? Effect on miscarriage
- Cesarean delivery
- Recurrence risk following pregnancy unknown
- With and without surgery studies inconclusive
- Uterine ruptures are reported

**Summary**

- Very early in the evidence based curve for surgical treatment of adenomyosis
- GAP: high quality clinical outcome data (hysterectomy and conservative)
- Surgically treated vs. not treated
- Techniques – minimal access vs. laparotomy

**Recommended reading**

Reproductive, Obstetric, and Perinatal Outcomes of Women with Adenomyosis and Endometriosis: A Systematic Review and Meta-Analysis

Joanne H Morton, Monica Steiner, Simon Lavoie, Akiko Nakajima, Chen Li, and Ying Cheng


ABSTRACT

Adenomyosis and endometriosis are common chronic pelvic pain disorders associated with significant impact on quality of life. The objective of this systematic review and meta-analysis was to summarize the effect of surgical and medical treatments for adenomyosis and endometriosis on reproductive, obstetric, and perinatal outcomes. Search results for randomized controlled trials (RCTs) and nonrandomized studies were used to identify studies that compared surgical and medical treatments for adenomyosis and endometriosis to no treatment, or to each other. Data on reproductive outcomes (pregnancy, miscarriage, live birth, cesarean delivery, and recurrence) were extracted. Data on obstetric and perinatal outcomes were not available for all studies. The search identified 16 RCTs and 8 nonrandomized studies. In most studies, surgery was superior to medical treatment and no treatment for reducing symptoms of pain and improving quality of life. There was insufficient evidence of benefit on reproductive outcome variables other than miscarriage. In conclusion, surgical treatments for adenomyosis and endometriosis have the potential to improve pelvic pain, quality of life, and reproductive outcome variables. Further research is needed to establish the optimal surgical techniques.
References


References

- Vannucci S, Palaghi F. Recent advances in understanding and managing adenomyosis. F1000Rev. 2018;8.
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.

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.