GLOBAL CONGRESS ON MIGS

AGL 2021

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SYLLABUS

Surgical Tutorial 4 - Taking on the Hysteroscopies Your Colleagues Fear

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Mauricio S. Abrão, MD

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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.
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Surgical Tutorial 4-Taking on the Hysteroscopies Your Colleagues Fear

Co-Chairs: Keith B. Isaacson and Alka Kumar

Faculty: Stefano Bettocchi, Eleonora Castellacci

The goal of this tutorial is to demonstrate advanced hysteroscopic skills to those interested in the technique.

Learning Objectives: At the conclusion of this activity, the participant will be able to: 1) Discuss the safe techniques needed to take your hysteroscopic skills to the advanced level; 2) discuss the advantages of office based hysteroscopic techniques; 3) discuss the skill needed to hysteroscopically treat an isthmocele without injuring the bladder; and 4) discuss how to completely resect the endometrium and completely remove intramural myomas leaving no unwanted tissue behind.

COURSE OUTLINE

3:15 pm  Welcome, Introduction and Course Overview
3:20 pm  Hysteroscopic Myomectomy in the Office with No Anesthesia  S. Bettocchi
3:30 pm  Hysteroscopic Repair of the Isthmocele  E. Castellacci
3:40 pm  Performing the Challenging Tcre  A. Kumar
3:50 pm  Complete Hysteroscopic Removal of Intramural Myomas  K.B. Isaacson
4:00 pm  Questions & Answers
4:15 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*
Keith B. Isaacson, MD
Consultant: Karl Storz, Medtronic
Alka Kumar, MBBS, MS
Consultant: Arthrex, Inc

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).

Stefano Bettocchi, MD, PhD*
Keith B. Isaacson, MD
Consultant: Karl Storz, Medtronic
Alka Kumar, MBBS, MS
Consultant: Arthrex, Inc

Content Reviewers have nothing to disclose.

Asterisk (*) denotes no financial relationships to disclose.

All relevant financial relationships noted have been mitigated.

SCIENTIFIC PROGRAM COMMITTEE
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Consultant: Medtronic
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Jim Tsaltas, MBBS, FRANZCOG
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Speakers Bureau: Medtronic, CooperSurgical, Merck & Co., AstraZeneca, Roche
Linda Michels, Executive Director, AAGL*

Content Reviewers have nothing to disclose.

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OBJECTIVES

To be able to perform a challenging TCRE and understand and overcome the associated difficulties.

ENDOMETRIAL RESECTION

Endometrial resection (TCRE) is an established technique for treating menorrhagia. The fundamental principle in 'Endometrial Resection' is to resect the entire endometrium with an adequate thickness of the underlying myometrium up to a depth where no endometrial gland openings are seen.

Advantage:
Pathologies like large fibroids, large polyps, septum, adhesions can be treated simultaneously.

Disadvantage:
- Fluid Intravasation
- Continuous distension – overcoming physiological contractions of uterine musculature
- Substantial operator skill is required

CHALLENGES - TCRE

1. Apprehensive patients
2. Less informed patients
3. Suspicious lesions of the endometrium/uterine cavities that require more time.
4. Very fat patients
5. Cultural variations
6. Large uterine cavities
7. Compromised patients – CVD, Renal dysfunction, etc.

CHALLENGES AT HYSTEROSCOPY / TCRE

<table>
<thead>
<tr>
<th>Visualization</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distension</td>
<td>Myoma</td>
</tr>
<tr>
<td>Flow rates</td>
<td>Adenomyosis</td>
</tr>
<tr>
<td>Intruterine Pressure</td>
<td>Myometrial Cyst</td>
</tr>
<tr>
<td>Fluid Intravasation</td>
<td>Isthmocele / Prev LSCS</td>
</tr>
<tr>
<td>ML/min</td>
<td>Endometrial Pathologies</td>
</tr>
<tr>
<td>Fluid Deficit</td>
<td>Chronic Endometritis, GTB, CA</td>
</tr>
<tr>
<td>Bubbles</td>
<td>Deep Cornue, Septum, Tubal Ostia</td>
</tr>
</tbody>
</table>
Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding (Review)

Fergusson R.I, Bofill Rodriguez M, Lethaby A, Farquhar C

Authors’ conclusions
Endometrial resection and ablation offers an alternative to hysterectomy as a surgical treatment for heavy menstrual bleeding. Both procedures are effective, and satisfaction rates are high. Although hysterectomy offers permanent and immediate relief from heavy menstrual bleeding, it is associated with a longer operating time and recovery period. Hysterectomy also has higher rates of postoperative complications such as sepsis, blood transfusion and haematoma (vault and wound). The initial cost of endometrial destruction is lower than that of hysterectomy but, because retreatment is often necessary, the cost difference narrows over time.

ONE BIG ADVANTAGE OF ‘RESECTION’ IS THAT IT ALLOWS THE
SURGEON TO INTENTIONALLY UNDER-RESECT THE FUNDUS

THE INTERNAL OS

CORNUAE ABLATED AND INTERCORNUAL STRIP RESECTED

TCRE IN A NORMAL UTERINE CAVITY

- Constant distension required
- Constant visualization
- Constant fluid management required during the entire procedure
- Repeated suction cuts blood vessels and thereby causing fluid absorptions (1.5% glycine, 3% sorbitol, and 5% mannitol fluid) associated with electrolyte dysfunction. Even with bipolar instrumentation fluid absorptions in resectoscopy remain a challenge
- Cumbersome technology – Tubings, Energy sources, etc.
- Diameter of operative hysteroscopes
- Tissue fragment retrieval is difficult
- Production of intrauterine “bubbles” that distort visualization
- Perforation risk and increased bleeding with resection of myometrial bed
- Limited faculty trained to teach
- Limited resident education

THE INTERNAL OS

STEPS OF ROLLER BALL ABLATON

CORNUAE ABLATED AND INTERCORNUAL STRIP RESECTED

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**“DOUGHNUT TECHNIQUE” OF CORNUAL RESECTION**

Kumar Alka

TCRE

- Available in monopolar and bipolar technology
- Wide variety of diameters and loop sizes: 13, 15, 17, 21, 24, 26, 28, 31 French
- Angle of view can range between 12 or 30 degrees
- The variety of loop sizes and configuration permits management of a variety of lesions and intrauterine locations
- Loop configurations between 90 and 180 degrees and well suited to remove lesions anywhere within the uterine cavity
- Excellent cutting of dense, calcified tissues
- On-demand coagulation
- Electrode loops do not dull—loops can be shaped to fit location of lesion
- Can perform multiple concomitant procedures in same patient (polypectomy, myomectomy, targeted biopsy, lysis of adhesions)
- May be able to remove Type 0, 1, and 2 leiomyomas
- Easy to remove fundal and cornual lesions
- Amenable to variable and large lesions

**MYOMETRIAL CYSTS ENCOUNTERED DURING RESECTION**

Case 1

Case 2

- Such Myometrial Cysts Should Be Completely Resected
- It Helps In Curing Any Associated Dysmenorrhoea

**CAESAREAN SCAR**
SURGICAL MANAGEMENT OF CESAREAN SCAR DEFECT

- Improve menstrual drainage
- Reduce blood accumulation
- Eliminate congested and fibrotic tissue
- Reduce in situ blood production

TCRE WITH SUBMUCOSAL FIBROIDS – PEARLS

1. Do complete survey of endometrial cavity first
2. Resect intracavitary portion first
3. Don't resect yourself into a hole
4. Only remove chips when you need to
5. Move whole resectoscope, not just the loop to maintain visualization
6. Don't leave pieces hanging
7. When getting deeper into myometrium
   a. Expect fluid deficit to rise more quickly
   b. Identify the pseudo-capsule
   c. Desiccate bleeders as needed
   d. Reduce pressure to help more fibroid protrude into cavity

SEEDLING FIBROIDS

BASIC PRINCIPLES OF RESECTING SAFELY AND EFFECTIVELY

Learning Points
1. Do not regard women as sterile following endometrial resection
2. Counseled patients with respect to future contraception
3. Offer simultaneous sterilization

Learning Points
1. Avoid air entering the uterine cavity during surgery
2. Never use an air pressure pump without a safety gas valve
3. Use antibiotic prophylaxis (not proven)
4. Confirm uterine infection by bacteriology culture.
**Learning Points**

1. Be familiar with forces which influence fluid balance
2. Monitor intra-op fluid balance closely
3. Adhere to fluid management guidelines strictly
4. Suspect uterine perforation when sudden excessive fluid absorption occurs
5. Do not cut / reset too deep
6. Danger areas include the cornue and isthmic regions

**Learning Points**

1. Haematometra needs to be excluded in case of postoperative pain by ultrasound
2. Incidence is not increased by total as opposed to partial resection
3. Treat by repeating the resection to remove remaining endometrium.

**Learning Points**

1. Symptoms may recur in the long term
2. Persisting or recurring symptoms can be treated by repeat resection
3. Not every patient is satisfied with endometrial resection

**Learning Points**

1. Cyclic pain is part of Asherman’s syndrome
2. It can occur in the absence of haematometra
3. Exclude other causes by laparoscopy
4. Hysterectomy may be the only solution

**Potential Complications of Endometrial Resection**

<table>
<thead>
<tr>
<th>INTRAOPERATIVE</th>
<th>POSTOPERATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine perforation</td>
<td>Infection</td>
</tr>
<tr>
<td>Fluid overload</td>
<td>Haematometra</td>
</tr>
<tr>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Haemorrhage</td>
<td>Haemorrhage</td>
</tr>
<tr>
<td>Gas embolism</td>
<td>Cervical pain</td>
</tr>
</tbody>
</table>

**Short term**

- Haematometra
- Pregnancy
- Uterine malignancy

**Long term**

- Recurrence of symptoms
- Treatment failure

**False Passage**
## Excess Fluid Intravasation

- Hyponatremia
- Fluid Overload
- Pulmonary Edema
- Cerebral Edema

1. Do Not Use High Pressures Unnecessarily
2. Do Not Resect Deeper Than Required
3. Keep Surgical Time As Short As Possible
4. Keep a close watch on the fluid intravasation (preferably have a dedicated fluid management system and nursing staff)

## Fluid Loss

- Tubal
- Intravasal pressure >70mmHg
- Intravasation
- Intra Uterine Pressure vs Mean Arterial Pressure
- Deep Resection
- Intramural extension - Fibroids
- Time
- Cervical
- Do not over dilate (will not allow complete distension)
- Perforation
  - Excess fluid loss over a short time
  - Collapse cavity

---

**NEW HYSTEROSCOPY PUMP TO MONITOR REAL-TIME RATE OF FLUID INTRAVASATION**

**INTRAVASATION RATE AND FLUID DEFICIT**

<table>
<thead>
<tr>
<th>INTRAVASATION RATE</th>
<th>FLUID DEFICIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured in mL/min</td>
<td>Measured in mL</td>
</tr>
<tr>
<td>Related to fluid flow rate</td>
<td>Related to fluid volume</td>
</tr>
<tr>
<td>It reflects the rate at which fluid is still entering into the patient</td>
<td>It reflects the total volume of fluid that had entered into the patient in an initial phase of surgery</td>
</tr>
<tr>
<td>It is a real time event</td>
<td>It does not establish active intravasation</td>
</tr>
</tbody>
</table>

**PRACTICAL PROBLEMS AND THEIR SOLUTIONS DURING ENDOMETRIAL RESECTION**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Cause</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor uterine distension</td>
<td>Low distension pressure</td>
<td>Increase distension pressure</td>
</tr>
<tr>
<td>Uterine perforation</td>
<td>Cervical incompetence</td>
<td>Cervical sutures or tenacula around cervix, increase suction pressure</td>
</tr>
<tr>
<td>Insufficient suction pressure</td>
<td>Blocked outflow hole in sheath</td>
<td>Clean sheath</td>
</tr>
<tr>
<td>Blocked outflow hole in sheath</td>
<td>Cutting loop not in sheath at rest</td>
<td>Cutting loop broken</td>
</tr>
<tr>
<td>Insufficient cutting</td>
<td>Cutting power too low</td>
<td>Increase cutting power or reduce blend</td>
</tr>
<tr>
<td>Cutting loop not in sheath at rest</td>
<td>Cutting loop broken</td>
<td>Replace cutting loop</td>
</tr>
<tr>
<td>Slow clearance of debris/blood</td>
<td>Blocked outflow hole in sheath</td>
<td>Clean sheath</td>
</tr>
<tr>
<td>Blocked outflow hole in sheath</td>
<td>Cutting loop not in sheath at rest</td>
<td>Cutting loop broken</td>
</tr>
<tr>
<td>Inefficient cutting</td>
<td>Cutting power too low</td>
<td>Increase cutting power or reduce blend</td>
</tr>
<tr>
<td>Cutting loop broken</td>
<td>Cutting loop broken</td>
<td>Replace cutting loop</td>
</tr>
<tr>
<td>Poor view of endometrium</td>
<td>See Poor pressure distension</td>
<td>Remove chips before continuing with resection</td>
</tr>
<tr>
<td>And uterine cavity</td>
<td>Resected chips infra view</td>
<td>Hysectoscopic total or partial myomectomy</td>
</tr>
<tr>
<td>Bubbles on the anterior wall</td>
<td>Fibroids</td>
<td>Increase suction pressure</td>
</tr>
</tbody>
</table>

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### PRACTICAL PROBLEMS AND THEIR SOLUTIONS DURING ENDOMETRIAL RESECTION

<table>
<thead>
<tr>
<th>Problem</th>
<th>Cause</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid fluid absorption</td>
<td>Distension pressure too high</td>
<td>Reduce distension pressure</td>
</tr>
<tr>
<td></td>
<td>Uterine perforation</td>
<td>Stop and check cavity</td>
</tr>
<tr>
<td>Bleeding during surgery</td>
<td>Low distension pressure</td>
<td>Increase distension pressure</td>
</tr>
<tr>
<td></td>
<td>Inefficient coagulation during cutting</td>
<td>Increase coagulation blend</td>
</tr>
<tr>
<td></td>
<td>Resection too deep</td>
<td>Coagulate vessel(s) and resect more shallowly</td>
</tr>
<tr>
<td></td>
<td>Fibroids</td>
<td>Coagulate vessels round pseudocapsule</td>
</tr>
<tr>
<td></td>
<td>Haemorrhage after surgery</td>
<td>Uterine tamponade with balloon catheter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antibiotics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evacuate and give antibiotics</td>
</tr>
</tbody>
</table>

### POOR DISTENSION WILL RESULT IN POOR VISUALISATION

<table>
<thead>
<tr>
<th>Possible Reasons For Poor Distension</th>
<th>How To Correct?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low inflow of distention media</td>
<td>Raise height of bag Pressure cuff / Squeeze Fluid Management System</td>
</tr>
<tr>
<td>Low Intraterine Pressure</td>
<td>Increase Pressure</td>
</tr>
<tr>
<td>Excess suction</td>
<td>Turn down suction (but NOT OFF)</td>
</tr>
<tr>
<td>Over dilated cervix</td>
<td>Extra tenaculum on cervix</td>
</tr>
<tr>
<td>Perforation</td>
<td>Consider Stopping</td>
</tr>
</tbody>
</table>

### CONCLUSION

- Patient Counselling and selection
- History and physical exam
- Prior intrauterine or cervical procedures
- Risk of adhesions, stress
- Preoperative imaging and testing
- Anticipations
- Multi-step procedure
- Patient positioning
- Equipment availability
- Fluid management in operative hysteroscopy reduces technical difficulties
- Cardiovascular, pulmonary, renal compromise may limit procedure and allowable fluid deficit

### REFERENCES


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REFERENCES

Hysteroscopic resection of the Type III myoma

Keith Isaacson, MD
Director of MIG and Infertility
Associate Professor Ob/Gyn
Harvard Medical School

A Different Perspective: Evidence to Support Complete Resection as the Goal for the Treatment of Submucosal Myomas

Follow-up after incomplete hysteroscopic removal of uterine fibroids

• 528 Hysteroscopic myomectomies
• 91 Incomplete resections (17%)
• 37 repeated immediately for fertility
• 41 observed for menorrhagia

Acta Obstetrica et Gynecologica. 2006; 85: 1463–1467
Resection of Type III

Polyps
- Morcellators are superior to the Versapoint.
- No data on resectoscopic loop vs the morcellator.

Myomata
- Morcellators have side opening blades.
- Morcellator and bipolar loops are equal for Type O and some Type I.
- Bipolar loop is superior for Type II and Type III.
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.