ESGE VISION

Newsletter of the European Society for Gynaecological Endoscopy

ISSUE 4 – OCTOBER 2020

INSIDE

All the latest news and updates from the ESGE in the era of COVID-19 Pandemic

Women surgeons and women artists "History, power, challenges and opportunities"

ESGE
European Society for Gynaecological Endoscopy

Message from the Editor

We have decided to release this issue of ESGEVISION with some delay this year due to the significant changes we all had to make in our lives in the era of coronavirus pandemic. ESGE responded promptly to the COVID-19 pandemic shortly after it hit Europe and released its guidance to clinicians on gynaecological endoscopic surgery in March. These recommendations have since been published in our official journal Facts, Views and Vision and can be found using the link https://fvvo.be/assets/821/FVVinObGyn-12-5.pdf. Our Editorial I co-wrote with Professor Grimbizis can also be found in the same issue (https://fvvo.be/assets/820/FVVinObGyn-12-1.pdf). These resources are likely to be useful to colleagues during a possible second wave of the pandemic.

As with many congresses and annual meetings, our 29th Congress which was due to take place in Lisbon has been converted to an online meeting under the title of 'ESGE Live 2020' and will take place on 6-8 December 2020. Further information on this event and registration details can be found in this issue and also on the ESGE website. The registration is now open and free for ESGE members.

In this issue of ESGEVISION we have an interview with one of the pioneers of hysteroscopic surgery, Professor Stefano Bettochi. Professor Attilio Di Spiezo Sardo interviewed him on behalf of ESGEVISION on the evolution of hysteroscopy. We also have an interview with Dr. Bernd Holthaus and Prof. Uwe Ulrich from AGE, one of the corporate societies of ESGE. You will find regular contributions from our corporate societies in future issues of ESGEVISION.

Professor Lilo Mettler, one of the living legends of gynaecological endoscopic surgery and her colleagues have contributed with a very interesting article to this issue entitled 'Women surgeons and women artists: History, power, challenges and opportunities'. I recommend everyone to read this article in its entirety as it provides detailed insight to the history of women in art and surgery.

Lastly, you will find the message of our outgoing President Professor Grigoris Grimbizis who worked tirelessly and has led many significant advances we have seen in our field. I thank Grigoris for his contributions to our society and journal and for his support during his reign. Grigoris will remain an important figure in our society in his role within the Board of Directors.

We hope to prepare and release our next issue after the ESGE Live 2020 Event and I wish you remain healthy and safe during the course of the pandemic.

Ertan Sarıdoğan
Editor, ESGE-VISION

Contents

Message from the ESGE President

ESGE in the era of COVID-19 Pandemic

In 2020, COVID-19 pandemic changed our lives dramatically and had a major impact on the healthcare services and professionals, necessitating the need to adapt all our activities to the urgent demands for protection from coronavirus infection.

ESGE quickly responded to this new situation and adapted its activities to the new situation.

In March, the Society published the first version of "ESGE Recommendations for Gynaecological Endoscopic Surgery for COVID-19 Outbreak" on our website, to guide our colleagues with their activities in the new era. The updated version was released in April and published in the first issue of our official journal FVVO*.

As the planned face-to-face scientific activities were not feasible, the Society re-arranged its scientific programme for the year:

1. A new concept in Webinars was introduced. In July we organized the highly attended Webinar entitled "No need for Septum Incision: is it true?". The contents of the webinar are summarized in an Editorial in the 2020 Issue 3 of Facts, Views and Vision and the recording of the webinar is available on our website. This successful way of scientific activity will be continued in the future with educational events by our SIGs.
2. The planned Annual Congress in Lisbon, Portugal in October 2020 was postponed to October 2022 due to the current venue and travel restrictions. Thus, our next Annual Congress in October 2021 will take place in Rome as originally planned and will be followed by the Annual Congress in Lisbon in October 2022, underlying the ESGE commitment to hold its annual congress in Portugal.
3. We decided to organize the "ESGE live 2020" in December 2020 and this will be our main scientific activity for 2020 substituting our Annual Congress. For the organization of this event, we took into consideration the experience from other virtual congresses trying to provide a unique experience to our members. The event will focus on surgical activities with live transmission and surgical tutorials and face-to-face GESEA training and certification activities will be provided throughout our European centres and in ESGE Academy. Free communications submitted for the ESGE Congress will be presented in best selected abstracts and videos sessions, and in collaboration with our official journal, all the accepted research work will be published in a supplement of FVVO.

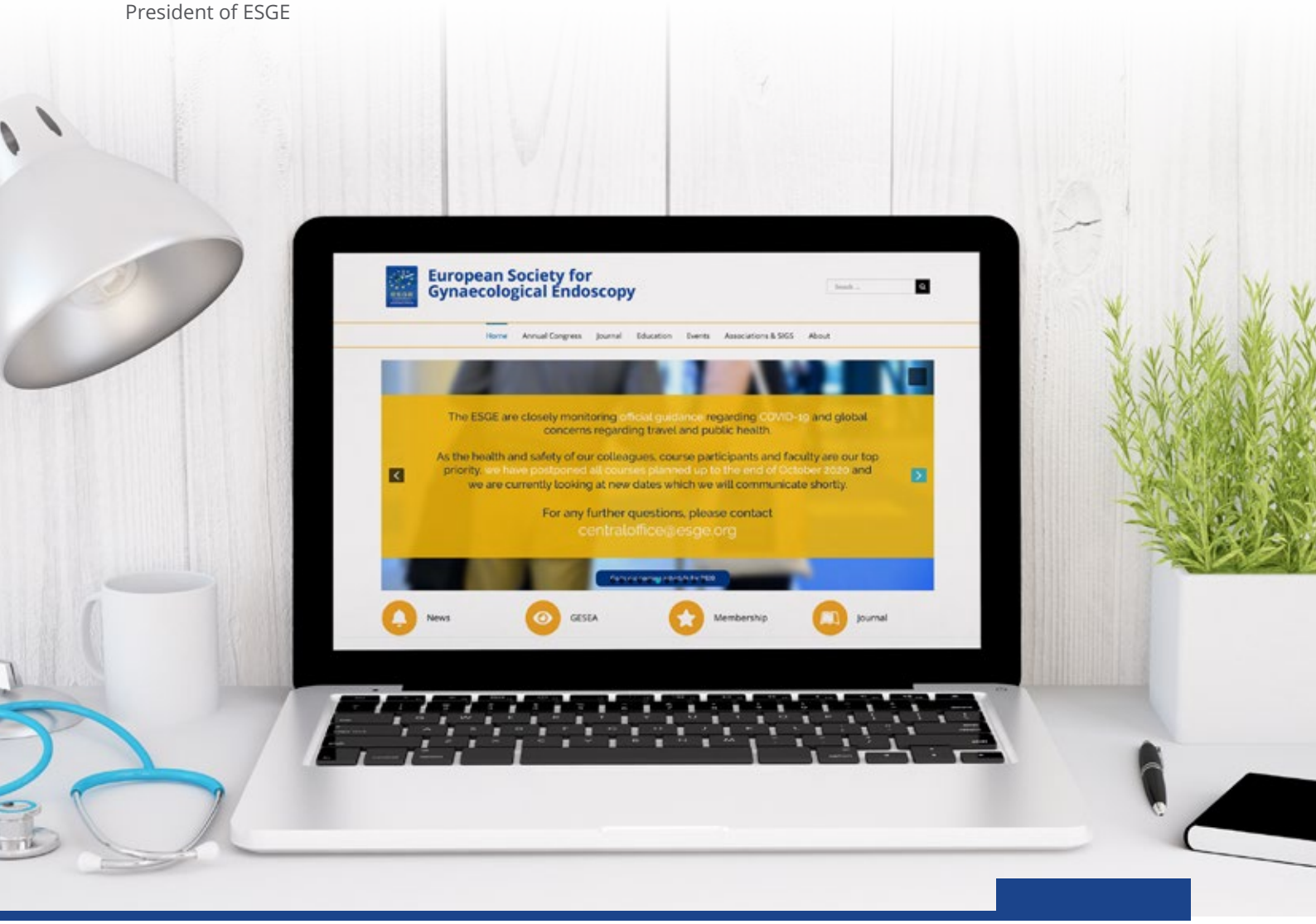
E-vision is published in December and June. As it is obvious, it was a necessity to postpone the regular release of the June issue in order to provide the ESGE community with all the updated information for our activities.

Following the rules of governance of our Society, after 2 years in office as the President, I will step down in October 2020 and the leadership of ESGE will pass to the hands of Professor Giovanni Scambia for the next two years. I am also pleased to announce that Professor Benoit Rabischong was elected to be next ESGE President, supported by the Professors Ertan Saridogan, Michelle Nisolle, Sven Becker and Vasilis Tanos as Executive Board members and from Professors Attilio Di Spiezio Sardo and Helder Ferreira as co-opted members. It is noteworthy to mention that the presidents of our corporate Societies actively participate also to the works of our Executive Board as co-opted members.

Taken the opportunity, I would like to cordially thank all the members of the ESGE Executive Board for their fruitful collaboration; central office and especially Rhona O'Flaherty for her dedication all these years; and the ESGE Board of Directors, particularly Dr Rudi Campo for their guidance. I also feel that it is most important to thank our enthusiastic members and especially the young colleagues. Being the ESGE President was a unique experience for me and a delightful "journey" with friends.

The Society continued to grow all these years, with firm relationships with our corporate Societies, a worldwide recognised training and certification programme, its own official journal in Pubmed, regular release of guidelines and recommendations, relationships with other scientific societies and a global reputation. ESGE represents the European leader in minimally invasive surgery.

Prof Grigoris F. Grimbizis
President of ESGE



ESGE LIVE 2020 will replace the ESGE Annual Congress for this year as a virtual event.

High quality scientific content will be broadcasted:

- Live Surgery Marathon
- Keynote Lectures on HOT Topics
- Live Surgical Tutorials
- ESGE 2020 Best Selected Abstracts
- Virtual Exhibition
- and much more!

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OLYMPUS

Editorial by Grimbizis et al – No need for septum incision, really?

A recent alert from a well-known scientific journal based on a published retrospective study informed the scientific community that septum incision does not improve reproductive outcome and this operation should therefore not be offered anymore as a treatment, even in symptomatic women unless as part of a clinical trial (Rikken et al., 2020) . Indeed, such a recommendation from a high-ranked journal, officially representing a Society based on only one retrospective study was, at least, unexpected and scientifically unjustified, particularly considering that the authors of this publication are strong supporters of evidence-based medicine.

Read more in Facts, Views & Vision

Highlighted Articles

Bowel anastomosis leakage following endometriosis surgery: an evidence based analysis of risk factors and prevention techniques by Vigueras Smith et al

This study evaluates the risk factors related to anastomotic leakage following endometriosis surgery, its prevention techniques and the role of protective stomas. A comprehensive literature review was carried out for English publications in Pubmed and Google Scholar. We included all studies including the following MeSH terms and key words: Anastomotic leakage AND bowel surgery OR Endometriosis OR Colorectal surgery OR Bowel endometriosis. Two authors independently made a selection and analysed relevant abstracts according to the aim of this review.

A double-blinded randomised controlled study to investigate the effect of intraperitoneal levobupivacaine on post laparoscopic pain by Cunningham et al

Laparoscopic surgery is the cornerstone of modern gynaecological surgery, with shorter hospital stays and a quicker return to normal activities. However postoperative pain remains problematic. No strategy to reduce phrenic nerve irritation, including heating or humidifying the insufflating gas, alternatives to CO^2, and intraperitoneal analgesics, has shown superiority.

Read more in Facts, Views & Vision

Evolution of hysteroscopic surgery: where next?

Prof Stefano Bettocchi

Attilio Di Spiezio Sardo interviewed Prof Stefano Bettocchi, one of the pioneers of hysteroscopy, on behalf of ESGEVISION

ADSS: ***Prof. Bettocchi, you are considered one of the experts that revolutionised the field of hysteroscopy. In your lecture at the last ESGE Annual Congress you showed the evolution of hysteroscopic surgery. Do you think that hysteroscopy has finally reached its limits?***

SB: I don't think so. There are many aspects of the uterine cavity which still need to be completely elucidated. I am thinking about endometrial receptivity, embryo implantation, uterine congenital anomalies, the progression from hyperplasia to carcinoma, the endocervical canal…. All the technological improvements which could help us to investigate and treat these and other unknown aspects/conditions of the uterine cavity will represent the "future" of hysteroscopy!

Prof. Bettocchi, you have contributed significantly to the development and spread of office hysteroscopy, mostly introducing the atraumatic vaginoscopic approach (no-touch technique). How did you develop the vaginoscopy approach?

The vaginoscopic approach was developed in '92 as an answer to my experience abroad and for the need to overcome the shortage of anesthesiologists we used to have compared to the increasing number of patients; so we decided to find a way to avoid the operating theatres for anaesthesia, performing a hysteroscopy based on a non-invasive access to the cervical canal.

Prof. Bettocchi, how important is the "hands-on" training in hysteroscopy for you?

I think anyone who practices obstetrics and gynaecology is expected to achieve a level of independent competence in diagnostic hysteroscopy, at least. This is why I think it is necessary to create a specialized group taking care of a specific professional teaching programme. However, being a minimally invasive surgery, the great fault, is to consider the hysteroscopic surgery as a procedure extremely easy to accomplish and therefore to believe that it requests a "minimal" training commitment. So, I invite all colleagues to train before going straight to the operating room.

In your opinion, what could be the role of virtual reality in training doctors at hysteroscopy?

I think it could be very useful to speed up the learning curve during a training programme. It could offer an incredible opportunity to teach and practice advanced skills outside of the operating theatres/surgical ambulatory before using them on real patients.

The great attendance of your lecture and of all hysteroscopic sessions during the ESGE Annual Congress in Thessaloniki has confirmed there is a growing interest in hysteroscopy, what can we do to further promote hysteroscopy?

Well, non-enthusiasts commonly consider hysteroscopy just a secondary and minor procedure. So we shall first of all "convert" them and make them understand that they are in front of a very important and valuable procedure. Furthermore, hysteroscopy is in the hands of the youngest gynaecologists who consider this technique suitable for them compared to laparoscopy; then we shall try to have an effect on the young blood!

ESGE and AGE partnership and joint projects interview

Prof. Dr. Uwe Andreas
Ulrich, AGE Executive Board

Dr. Bernd Holthaus,
AGE Executive Board and ESGE Executive Board

Interviewer: Prof. Dr. Markus Wallwiener, ESGE Advisory Board

How do you judge the current collaboration between AGE and ESGE?

The cooperation between our two societies at the level of the boards – as far as exchange of opinions and committees are concerned – works quite well in our view. However, regarding the number of AGE members participating in the Annual ESGE Congresses, there is room for improvement.

Dr. Holthaus has greatly promoted and shaped the collaboration between AGE and ESGE during his term of office and fortunately will remain a member of the ESGE executive board, thus being committed to further cooperation between our societies. This will ensure continuity and provide opportunities for synergy.

Why is the upcoming ESGE Congress relevant for members?

Hopefully, every – not just the upcoming – ESGE congress will also be relevant for AGE members. Also, joint meetings – some of which have already been arranged in the past – are options. Joint meetings of the AGE and ESGE with AGE speakers would – ideally – also reflect, and perhaps increase, the number of German participants. So, the next congress offers an opportunity to expand the cooperation.

Training and further education - what is important?

This question has kept us brainstorming and busy during AGE Board meetings, as we have put quite some passion, work and time into the qualification in minimally invasive surgery. Each specialist society - ESGE and AGE - has been working long and hard on the respective degrees. A common goal, for instance, could be a certified qualification in minimally invasive surgery that is mutually recognized by both the AGE and ESGE.

Also, the journal “Facts, Views & Vision in ObGyn” may be of particular interest to our young colleagues. Articles that are placed there are listed in Medline and PubMed. So, we look forward to working with the editors of the journal.

More Info on AGE activities can be found here

Women surgeons and women artists "History, power, challenges and opportunities"

Report of our ESGE Women Surgeon's luncheon symposium at ESGE Thessaloniki, 2019: Art and female surgeons: Can female artists and surgeons be leaders?

Lilo Mettler, Pascale George, Meenu Agarwal, Anastasia Ussia, Susana Maia, Bhavini Gupta

Fig.1 Venus of Milo

History and introduction:

From a time, where women were worshipped as goddesses, to being burnt on stakes for possessing the art of healing, to the modern world, the heritage of women as healers goes back to ancient history. Over this period, their journey has not been smooth. Rather it has weathered several fluctuations influenced by different religious, social and scientific influences. How was it in the ancient era?

In ancient Egypt, Goddess Isis was worshipped for her great healing prowess. The school of medicine in the city of Isis, admitted **only women as teachers and students**, for training **in childbearing** issues. Illustrations of women as surgeons and healers in the tombs and temples of Egypt, underlined the fact that women as practitioners and healers were widely accepted, revered and praised by the society.

Ancient Greeks worshipped Goddess Athena, a woman who was believed to cure blindness. A renowned Greek physician, Galen, recorded the journey of women who not only provided obstetrical care, but also performed surgeries, took care of patients and taught medicine. The "medicae" were female physicians in Rome, and they managed busy practices and were on equal footing with their male counterparts.

Greek goddesses were good archetypal figures because of their exaggerated personalities (figure 1: Venus of Milo)

Despite their immortality and similarities to modern day superheroes, they were still plagued with personal flaws and negative emotions which caused destruction in their lives and the lives of other gods and mortals.

This position of women in the field of medicine saw a significant declension when the **Roman Empire** disintegrated under the pressure of invading barbarians. The rise of the Church, stressed the inferiority of women in society, subjecting them to their houses. Art, literature and pan medical sciences suffered during the dark ages. Italy, during this time, still encouraged women to pursue academic and literary careers, opening their doors to women from a vast multitude of European and Asian countries. But, contrary to what many think it was in the time of the **Renaissance** that the witch hunts were more intense in the European subcontinent. **Women were forbidden from studying medicine** and any **skill in healing** was assumed to have been obtained from the **devil**. Such female healers and midwives were frequent targets of witch hunt and **burnt on stakes (fig.2)** in public squares. As a result, women edged out of the medical practice and lost access to formal education.

Fig 2. Execution of Anne Henricks Amsterdam 1571

However, it was only after the feminist movement that the witch hunt came out of the dungeons where it had been relegated (1) … Feminists understood that hundreds of thousands of women could not have been massacred and subjected to the most cruel tortures **without having threatened the power structure**. They also realized that such a war against women waged over more than two centuries, was a turning point in the history of women in Europe. Men tortured the "Bitch Witch of the Devil" and burned them when they had not died before, … sometimes it was their own annoying ex-wives or lovers. The infamous drowning test (the women tied up were thrown into the water, … if they did't drown it was proof that they were witches …). **This phenomenon had to be revisited if we wanted to understand the misogyny that still permeates institutional practices and male-female relationships.**

In Egypt and France, the passage of licensure laws and formation of guilds pushed women further away from the practice of medicine. Midwifery, a woman's arena was taken over by men by the **17th century**. As an example, in **India**, women have been worshipped as Goddesses and healers, but the **first lady doctor** graduated only in **1886**, from the university of Pennsylvania, to return to India and practice medicine. Even in the world of art, women were pushed to the status of being objectified for the art of men. While women posed for masterpieces, most men created artworks. They were often portrayed as vain subjects, concerned with the matters of the house, vanity and beauty, without knowledge of the worldly matters. In 1984 a group of anonymous American female artists, known as Guerrilla Girls, create a range of activist poster. (fig.3)

Fig 3. Guerrilla Girls- Met Museum 1984

"Are all recognized artist coincidentally male? Are women just not capable of being great artist, or were women disadvantaged in the world of art history?"

The Victorian debate helped pave the way for women back into the academic world. The drive to reclaim their place back in medicine began in the **19th century**, thanks to several enterprising women.

At the same time, through the same difficulties, women artist needed faith to exist… (fig.4)

Fig 4. Virtuoso Clara Wieck-Schuman 1819-1896: "There was a time when I thought I had a creative talent, but I came back from this idea. A woman should not pretend to compose. None yet has been able to do this, why would I be an exception? It would be arrogant to believe that, it is an impression that only my father once gave me. "(2)

Fig 5. The Painter Frida Kahlo 1907-1954: "I don't follow the same path as all the other Mexican women, submissive, silent. No, I want to travel, study, I want freedom and pleasure. All pleasures."

As a good precursor of feminism, initially predestined for a medical career, Fri-da was one of the few girls admitted to medical school, only 35 out of 2000 students, a finding that deeply alarmed her. Forced to abandon her studies af-ter her terrible accident, Frida devotes herself to painting (fig. 5.) partly be-cause painting her suffering helps her to overcome her trauma, but also because she wants to work and earn a living independently. Frida systematically rejects the traditional role of women, especially in Catholic and conservative Mexico (3)

Still now, we have to face not only objective obstacles (family building and the care of them), but we have to erase our secular subordinate role of servant, of support and of asserting that finally became registered epigenetically, deep into the collective unconsciously by Soraya Chemaly (4).

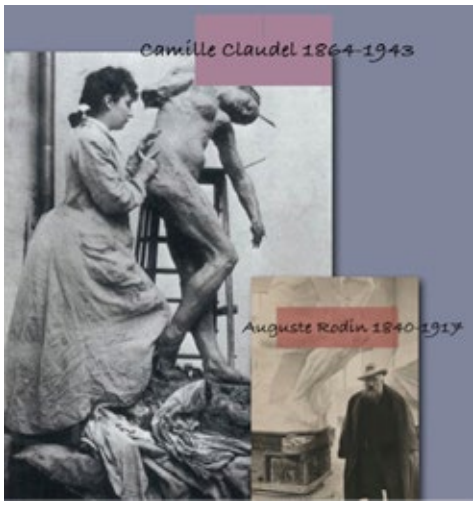

Fig 6. Camille Claudel Sculptor

Fig 7. The Implorer Camille Claudel

Reviewing the life story of the French sculptor Camille Claudel (1864-1943) in the light of Soraya Chemaly makes us comprehend her so-called "madness" in another way. What is the part of the rage, of the frustration, of the feeling of injustice of this "illness"? (fig. 6 and 7)

How to accept to disappear from the scene under the sole pretext that your mentor is no longer your lover? How to endure 30 years of psychiatric internment when one has been considered as the best pupils of the master, when one has done a number of works allotted to him?

The anger of the women was certainly at the time even more than nowadays read as synonymous with madness... unlike the wrath of man that enhanced their power and inspired respect. (4 and 5)

The advent of modern surgical training brought to North America by Halstead, posed to be an arduous journey for women, who were often referred to as the "beardless" lads. The prevailing view still believed that women were unsuitable for the profession of medicine.

When Robert Virchow in 1898 in Berlin addressed an audience of medical students and doctors to present his innovations he said. "Gentlemen , through this lens you see the world", He was right as in his time there was not a single woman in his audience at the Charite in Berlin. This. has changed in the 20th century.

In 2019 I, Liselotte Mettler, received the honorable membership of the Berlin Society of Obstetricians and Gynecologists in the same lecture hall and many females were present.

In the beginning, Medical colleges around the world open to women, saw a steep decline in attendance. Slowly women exclusive medical colleges merged with male colleges, anticipating equality. But co-educational schools tended to have less prestige and these colleges reduced the number of women enrolling into medical courses. (fig.8)

Fig 8. Newspaper "Die Woche" January 1930, 3 pages of report about the wom-en of Bauhaus school (6)

Most male and female surgeons want to build a successful professional life and a family. At the time that male surgeons work hard to master their art, their feminine colleagues have to be one step behind because it's time for them to find the right partner and to be pregnant. Women pay the price of such very long formation in having less children that their male colleagues That mean that most of the time they have to make a choice between ultra-specialization and family. Leader position in the OR is for sure an ultra-specialization....

So, surgery was believed to be male dominated throughout the whole world and it can be quite daunting and discouraging for a woman to make her place.

Fig 9. Sex Harasment Survey (7)

More than the working hours, the "macho" attitude (8 and 9) including the yelling and humiliation, could be off-putting for female surgeons and residents. Monica Morrow as Storyteller (in the last ASCO meeting said "Surgery is Never Elegant When Women are in the OR" and the National Survey of Sexual Harassment Among Surgeons by A. Nayyar & coll. (10) relates to similar issues (Fig. 9).

Above all, skepticism from patients and incompatibility with family life, are fueling the destiny of women in surgery. There are also publications mentioning male surgeons attitudes to be associated with reoperation and readmission rates of patients (9)

In the 1970s, the rise of the feminist movement and affirmative action, lead to empowerment of women and created environments more conducive to women becoming physicians and surgeons. Yet, still female physicians lag in income and are under-represented in research and leadership positions.

Fig. 10 Feminists

Women still don't receive similar performance ratings, mentorships and encouragement in surgery as in other specialties. A lot of surgical instruments were not designed with smaller operators in mind. Being physically "less strong" than men, poses a physical barrier for women looking to practice surgery. Women working in the male dominated world, for almost 18-20 hours a day, feel "masculinized", like their male peers. This highlights the fact that women are considered incapable of working long hours and facing the challenges posed by a surgical residency and career.

As we notice in the artistic world, men want to keep the pole-position on stage (fig.10) as well and they can be very aggressive when they feel that women are better.

In 2019, I (Pascale George) had a very bad experience; we had a new WhatsApp-group in our unit and I posted a short video where I was dissecting the internal iliac artery, the video was very nice showing how it is possible to clamp the uterine artery safely just next to a very big myoma (fig 11) ... you know what happened? My dear oldest male colleagues threw me out of the group after having copiously abused me ... This was 2019, ... in 2000 in another place, in Belgium, after being insulted in many ways, I was fired from the service ... for equivalent reasons. In both situations nobody says a word against such injustice... "scapegoat syndrome" well known with the witch ...

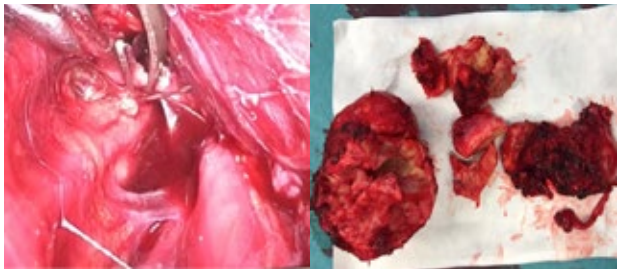

Fig. 11 Clamping of the uterine artery in an open case of cervical cancer surgery

While men begin their careers unencumbered by family pressures, women often hide the fact that they have children and family issues. Program directors may try to avoid females planning on having children in the near future, for the fear of long "maternity" leaves. From early on, they are often burdened with familyobligations. There is a "culture" that discourages women from pursuing careers in surgical branches. The structure of medical training has changed little since the 1960's, when almost all surgical residents were males, with little to no household duties. Support for those trying to balance home and work life hasn't kept pace with changing demographics, nor has the division of domestic labour shifted to reflect the rise of women in the medical workforce. Female surgeons and physicians are more likely to cut back professionally if they have families and children. This makes them a little bit less desirable to the residency program directors in the first place. In addition to these practical considerations, I(Pascale George) can share what our Professor said to me when I came to him in 1983 in order to let him know my desire to be involved in the gynecologic-residency: "I do prefer to take male residents... women are good keepers but not sowers. I need sowers."

Now the mentality is changing. Women are trying to be more dedicated and trained in the field of surgery. They are more sought after than their male counterparts, both by residency programs and patients, especially those with breast diseases and obstetrical complaints. Research reveals that women are equally good or bad surgeons Generally, the best women in the craft become surgeons, in a typically male-dominated field.

A lot of women find it a heady and powerful experience to be a surgeon. Being in charge in the operating theatre can be exhilarating for them.

Of course, surgical immediate results and the technical aspects may be challenging, but carry their own allure for surgeons, males and females alike. The decision to enter such a demanding field should, however, be open for males and females alike.

Medicine styles itself as both art and science.

In the times of Leonardo da Vinci and Rubens the man represented the anatomy, the female the object in art. Today the surgical robot company "Intuitive" explains why a Robotic surgical system replaces "chopsticks" used in conventional laparoscopic surgery (fig.12)

We know that **art advances healing**, cheers up minds. Art is used by all of us in medicine more or less and accepted as helping to understand situations and conditions . Pictures and paintings are used in hospitals to give joy and happiness.

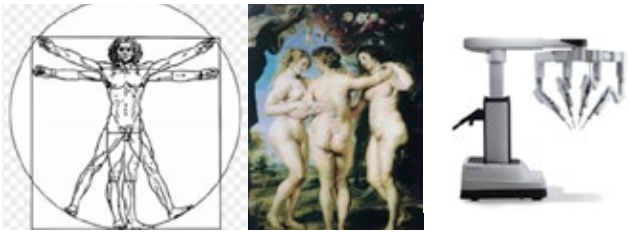

Figure 12 Art and science: from the da Vinci Code, a painting of Rubens to 20th century surgery

Gender hierachy

We authors are spanning the ESGE net from the Baltic Sea to the Mediterranean Sea and to the Indian Ocean. While science creates new knowledge and treatments, art helps to recognize another's humanity. Women are known to have an innate artistic capacity- a definite asset to a surgery. It allows them to look at things, the way other people have not or cannot, over the horizon. They can connect the dots that aren't always next to each other. However we do not at all want to fight for equality, just recognition, and we need to get rid of the archetype of gender hierarchy (fig. 13)

Fig: 13. left: shapes the fight for equality. right: Archetype of the gender hierarchy

Conclusion

Women have always been an integral part of the art, whether as creators and innovators of new surgical techniques and procedures or as contributors to pre-existing ones, they have faced challenges due to gender biases and had to overcome difficulties in training and gaining recognition. They have now come forward as such strong voices in today's world, that they are not just making their own place but also highlighting the stories of those forgotten in the pages of history.

From being respected as healers with special powers from deities, to alleged witches and intruders into the male medical establishments, to respected peers once again, the journey has not been very accessible and undemanding. Despite being hindered by lack of educational opportunities, women have persisted throughout the span of history and shifting social, religious and scientific ideologies to make great strides in the field of medicine. As we enter the 20th millennium, we see women making spectacular advances. It is a tough journey, and women have had to be tougher to survive the weathering and challenges thrown in their paths. We will need more women in leadership and mentorship roles to help with the larger cultural shift that seems an indispensable part of integrating women within the surgical field. The disparities in gender pay, promotion, mental health and the shift from a boy's club to one with more women, will have to be closed as more women step into the world of surgery and medicine (11)The times of fights for feminism have gone (Fig. 13)

And like they say: "some women feared the fire, while some became the fire." Women rose out of the flames to take everything that was thrown in their paths in a stride. We love to live in peace, equal rights and love with men to be happy.

Together we have to change our world, to create the conditions that will allow a young generation of women to succeed in both professional and private life.

ESGE, the **European Society for Gynaecological Endoscopy**, today gives us an equal platform and we are an integral part of it and promote it with all our possibilities, vigor and hopes.

Contributors

Art and Female surgeons: Can female surgeons be leaders

LILO Mettler (Germany)

Similarities between the acceptance of art and gynecological surgery

Pascale George (Belgium)

Prominent women leaders in surgery

Anastasia Ussia (Italy)

Women as Surgeons: Challenges and Opportunities

Meenu Agarwal (India)

Women as artists and surgeons

Susana Maia (Portugal) and Bhavini Gupta (India)

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Coronavirus induced severe acute respiratory syndrome and obstetrics activities

Michelle Nisolle

Even though we are endoscopic surgeons, many questions are arising, related to pregnant women and the risk for themselves and the neonate as we do not have any previous experience on this new viral infection. In general, because of the physiologic adaptative state and the relative immunosuppressive state during pregnancy (increased oxygen consumption, elevated diaphragm, ...) pregnant women are more susceptible to respiratory germs. (1). Nevertheless, it seems that pregnant women are not more susceptible to COVID-19 infection than the general population and their symptoms are similar. Principles for management of pregnant women with confirmed or suspected coronavirus disease 2019 (COVID-19) are detailed in the literature (2).

Once a maternal infection of COVID-19 is suspected or confirmed, not only adapted procedures are to be followed in order to protect the hospital staff, but also obstetrical procedures are required to provide adequate medical care to the pregnant woman.

There is limited evidence on COVID-19 in pregnancy but we could summarize (3,4) that:

- There are no cases of maternal death or neonatal deaths
- There is no evidence that the virus crosses the placenta from mother to baby (5)
- There is no elective indication for cesarean section in women with COVID-19 infection
- There is a risk of fetal distress in labor, continuous fetal heart monitoring is recommended
- There is no evidence that the virus is present in breast milk.

Each maternity hospital should prepare a care pathway for the management of suspected or confirmed cases that provides appropriate obstetric assistance at delivery.

A nasopharyngeal swab of the pregnant woman should be performed in accordance with regional protocols. The possible detection of all pregnant women admitted for spontaneous or induced deliveries should be discussed. The nasopharyngeal swab used for the detection by real time RT-PCR associated with the evaluation of the symptoms possibly due to COVID-19, will permit to organize deliveries in two different wards, either a normal delivery room or in a COVID room where specific precautions have to be taken.

In a very recent publication the rate of asymptomatic SARS-CoV-2-positive pregnant women presenting for delivery was evaluated at 13.5% compared to 1.9% in symptomatic SARS-Co-2-positive patients (6). A universal testing approach seems to be essential in order to determine hospital isolation practices

Even if the COVID-19 infection is associated with SARS and death, occurring more frequently in men older than 50 years old, we could hope that young pregnant women will not be severely affected by this new virus and that the newborn will not be secondarily contaminated. In the recent publication of Chen et al, mild disease was observed in 92% and severe in 8% in a series of 118 pregnant women with COVID-19(7).

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Pr Hervé Fernandez,
President SCGP, Hôpital Bicêtre, University Paris-Saclay

Gynaecological surgery in the era of Covid-19 – Recommendations for deconfinement by SCGP

The SCGP, French society of gynecology, has written specific recommendations for surgery in the Covid-19 era and recommendations for deconfinement.

The end of the epidemic is currently not predictable and requires defining recommendations that can be kept until the end of 2020. This fear is related to Chinese data on excess mortality during an epidemic and this regardless of Covid status (1)

We could summarize the problem with a short sentence: “everyone is Covid + until proven otherwise”.

In the short term, in the discussion of deconfinement, it is necessary to adapt to the regional health environment, the availability of medical and non-medical personnel, and the resources of equipment, which implies that the recommendations made should be adapted. This is the role of the SCGP to define a policy for ending the crisis. A national strategy for screening patients against COVID 19 must be recommended before taking charge of their gynecological pathology, benign or malignant, to both protect them from a severe form of COVID-19 and protect healthcare teams.

In addition, caution must be exercised, because the truth of today will not necessarily be that of the coming weeks.

The operating room

The hygienists and the French Society of Anesthesiologist (2) follow the recommendations of the high council of public health which advises to keep the ventilation of the operating room in overpressure. The risk of spreading the virus in the corridors is very low because the air in the rooms is changed 15 times per hour. If you wait 5 minutes before opening the doors after intubation or extubation, the risk seems acceptable. Limit entry and exit to the operating room. On the other hand, it is necessary to extubate in the operating room more than in the recovery room which is not ventilated.

Laparoscopy or laparotomy

The ESGE recommendations (3) apply for laparotomy when there is a risk of digestive injury or complex surgery.

Laparoscopy has the advantage of better postoperative ventilation conditions in fragile patients. Laparoscopy should remain the first line of reference whenever possible as opposed to laparotomy. Possible but unconfirmed risks can be prevented by an appropriate technique.

To contraindicate laparoscopy, the good reason would be to contraindicate general anesthesia. The question asked is that of the risk associated with intubation, which seems to worsen respiratory disease and which it seems desirable to avoid in some of these patients. This discussion is done on a case-by-case basis with the anesthesia and resuscitation team. In an absolute surgical emergency (rupture of EP with blood pressure instability) a laparotomy can be discussed. In situations of relative emergency, such as anemia due to AUB, the intervention can often be postponed for a few days until the recovery from Covid disease. However, a large number of vaginal hysterectomies or hysterectomy procedures can be performed with loco-regional anesthesia. The consultation with the anesthesia team remains the key to this question as the discussion in the surgical team so that the surgeon becomesaccustomed to an approach route.

This may be the time when return to the vaginal way should be discussed.

Prospectives for emerging from the crisis and reprogramming methods

Risk prevention is determined by a questionnaire (score to be validated in the future), a PCR test, possibly coupled with a thoracic scan, then in the days or weeks to come, to serology tests, depending on the logistical availability of each center and can also be pulmonary ultrasound.

Informing patients about the pathological context, the risk / benefit balance, the existence of a waiting list linked to the prioritization of certain diseases are essential prerequisites.

For surgeons, especially freelance surgeons, contact with their insurer to confirm that they are effectively covered seems essential.

A “crisis unit” validating the operating programs in order to avoid overloading of operations that can be deferred is to be set up at the level of each operating room.

Two situations, depending on the Covid-19 status.

A circuit should be set up in operating theaters for positive patients whose surgical management cannot be deferred:

- The patient is Covid +

The indication relates only to the non-differentiable emergency:

- D&C for miscarriage.
- Legal abortion even if we must favor medical methods by avoiding being late.
- Ectopic pregnancy to be treated by laparoscopy or Methotrexate depending on the indications which do not change.
- Twisting of annexes.
- Genital infections treated by puncture-evacuation under ultrasound control or laparoscopy depending on the clinical situation.

The indication relates to the differable emergency

- Uterine bleeding with anemia (Hb <10g / l) requiring operative hysteroscopy, hysterectomy or even embolization in the absence of a subsequent desire for procreation or medical treatment with agonists and iron supplementation.

In all these situations, favor epidural when possible.

The other operating indications will depend on the pathology and the acceptable time to defer the treatment (maximum 4 weeks in most cases).

Resumption of surgical activity will depend on material constraints, anesthetic drugs, ventilation and dressing materials for surgeons, etc.

For the patient Covid negative or supposed negative

- Cancers (if possible to delay intervention by initiating or extending chemotherapy only when this is indicated), if the prognosis is good and / or if surgery is the best treatment and / or if postponing the procedure is a loss of opportunity. We must decide on the indication for surgery after multidisciplinary consultation and link the recommendations of the cancer societies and those of the National Cancer Institute (4). It is only in the event of difficulties of access to the operating theater due to a saturated structure by COVID-19 patients that an adaptation of the management can be proposed (5). The absence of care for a cancer patient is more harmful than care adapted to existing medical resources.

The creation of a patient follow-up register is in progress (5).

For robotic surgery, the framework for monitoring recommendations is identical and must above all be linked to the other specialties using the robot (6).

- Oncological breast surgery without reconstruction.
- Anemic pathologies with ineffectiveness of medical treatment.
- Pathologies suspected of neoplasia requiring conization, hysteroscopy, laparoscopy (adnexal surgery).
- Painful pathologies that are resistant to medical treatment (as endometriosis).
- The issue of infertility surgery for women> 38 years of age (hysteroscopy, laparoscopy) should be compared with the possibility of resuming IVF/ICSI
- Urogynecology is probably to be shifted apart from the case of disabling prolapse (Stage IV).

In all situations, Covid + or Covid-, if the patient refuses the therapeutic proposal, it appears necessary, failing to have a letter of refusal signed, to record the desire not to receive care when it has been proposed.

These recommendations to end the crisis or deconfinement are intended to relaunch surgical activity to limit loss of therapeutic opportunity and avoid observing a negative impact on public health due to the absence of the treatments deemed necessary.

These recommendations have been sent to regional and national authorities and made available to all surgeons.

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Evaluation of GESEA Instructors

Vasilios Tanos MD PhD
GESEA Chair

The instructors of the GESEA curriculum are the backbone of this structured educational programme.

A prerequisite to become a GESEA instructor is GESEA Level 2 certification accreditation. Instructors are evaluated on their knowledge regarding the GESEA pathway and exercises, certification rules and theoretical knowledge. Emphasis is placed on their understanding of the GESEA theoretical content, hands on training, skills performance and transmission, personal and communication skills.

Special attention is paid to their ability to keep their training station in good order, maintain the good condition of the models and function of the devices and instruments prior to initiation of any workshop. Correct use and operation of the LASTT, HYSTT and SUTT exercises is important together with their ability for effective demonstration, communication and teaching of the vital aspects as well as tips and tricks for optimal surgical moves for both hysteroscopic and laparoscopic surgery. Psychomotor skills and stereotactic orientation demand guidance and escalating learning process by acquiring skills that function complementary to each other. For instance, good performance of LASTT exercises is essential for a trainee to start performing intracorporeal suturing.

Hence, an instructor has to make this parallelism of LASTT exercise 1, camera navigation focus in / out and exercise 2, hand – eye coordination with grasping and loading the needle during suturing and exercise 3, bi-dexterity by transferring and adjusting the needle from one needle holder to another one. Clear and adequate explanation of theoretical and practical skills to trainee are considered a prerequisite for the selection of an instructor.

Personal and communication skills are also evaluated, by observation of the instructor interaction with the trainee, degree of focus on the trainee, dedication to the course and ability to communicate the learning objectives in a clear and concise manner, in an encouraging and approachable way, being pro-active and problem-solving. A good instructor is expected to be punctual, conduct the training in a professional manner and have good command of the English language.

Additionally, he or she must be able to respect and perform the instructions of the educational programme and chief instructor during a workshop and have good interaction with other instructors. The evaluation process of a candidate instructor is performed during workshops by the chief instructor. In addition, the trainees' performance scores and answers to questionnaire are also used as a feedback of the candidate instructor abilities in teaching and mentoring.

From the reproductive surgery special interest group:

Surgery in all cases of minimal-mild endometriosis to improve reproductive outcomes prior to ART? Wrong answers for right questions

Daniilidis Angelos[1], Pados George[2]

[1]2nd Dept. OB-GYN, [2]1st Dept. OB-GYN, Aristotle University, Thessaloniki, Greece

What is the current recommendation for treating minimal and mild endometriosis infertility?

IVF preempts most of the deleterious effects of endometriosis as it removes the oocyte–sperm interaction from the peritoneal cavity and is not dependent on fallopian tube function. However, controversy exists as to whether surgical treatment of endometriosis stage I & II prior to IVF improves the chance of success. According to ESHRE recommendations (Dunselman et al. 2014) for women with stage I/II we should always perform operative laparoscopy rather than only diagnostic, in order to increase ongoing pregnancy rates. Also, for infertile women with stage I/II endometriosis physicians may consider the complete surgical removal of endometriosis to improve live birth rate prior to ART. This last recommendation is not well established.

Is there evidence that laparoscopic treatment will enhance fertility?

Evidence is quite robust that laparoscopic destruction of minimal to mild endometriosis and associated adhesions enhances fecundity. In women with endometriosis Stage I/II, the evidence summarized in a Cochrane review (Duffy et al 2014), showed that operative laparoscopy was more effective than diagnostic laparoscopy in improving ongoing pregnancy rate. Compared with diagnostic laparoscopy, laparoscopic surgery was associated with an increased live birth or ongoing pregnancy rate.

Does the outcome of IVF/ICSI depend on the presence of minimal or mild endometriosis?

It is more than obvious that the outcome of IVF/ICSI is totally irrelevant to the presence or not of minimal endometriosis. Therefore, surgical treatment prior to ART in order to improve fertility in these specific cases cannot be safely recommended. In 2013 Harb et al published a meta-analysis with 27 observational studies (n=8984 women) on the effect of endometriosis on in vitro fertilization outcome (Harb et al. 2013). Pooling of results from eight studies reported no difference in implantation rate compared with controls. 14 studies that reported clinical pregnancy as an outcome for stage I/II endometriosis did not show any difference at all. As for live births, results from six studies did not show a difference in live birth rates compared with controls. A more recent meta-analysis by Hamdan (Hamdan et al. 2015) concluded after subgroup analysis that, in women with less severe disease, all of the outcomes of IVF were comparable to women with no endometriosis.

What is the key message of all these?

In a disease as diverse as endometriosis, treating individual components of the disease may have different impacts on each patient. Further studies are needed to assess the mechanisms of endometriosis-associated infertility and how it may be overcome in cases of minimal and mild endometriosis. Thus, surgical treatment prior to assisted reproductive treatment in order to improve fertility cannot be safely recommended for all patients.

Shaheen Khazali
United Kingdom

Endometriosis Centres – does size matter?

There is very little disagreement around the merits of centralisation of severe endometriosis surgery. It makes a lot of sense, patients want it, surgeons believe in it and policy makers support it. Most European countries already have Endometriosis centres in one form or another. The question is no longer "if" endometriosis centres are needed. The main challenge is to figure out what a successful service should look like and how to measure its success.

I have been involved in setting up or further developing three endometriosis centres in three very different settings: in the UK's National Health Service; in the independent sector in the UK and in Iran. The Tehran experience was by far the most challenging, yet incredibly rewarding. I travelled to Tehran four times a year between 2014 and 2018 and operated in two adjoining operating rooms 10 hours a day for 9 days each time. I had 4 excellent fellows, who are now very skilled endometriosis surgeons, and together we would perform between 35-45 cases of severe (and I mean severe!) endometriosis during those 9 days. I have learnt a lot from all these three experiences and continue to learn every day.

One thing I learnt is that the components of a successful endometriosis centre are the same, wherever you go. In this opinion piece, I will argue why surgical volume is the most essential of these components.

Why does surgical volume matter?

Quality and Safety

An excellent article published in New England Journal of Medicine in 2002 (1) beautifully demonstrates the importance of surgical volume. They looked at 2.5 million procedures across the US and found a striking difference in mortality rates for all procedures between low volume hospitals and high volume ones. For example, if you were having a pancreatic resection in a "very high volume" hospital, your risk of dying was 3.8% but if you were unfortunate enough (and needing a pancreatic resection is very unfortunate anyway, to say the least) to be in a "very low volume" hospital, your risk of death was a massive 16.3%.

Another study on around 2000 radical prostatectomies (2) showed (surprise, surprise) significantly better preservation of erectile and continence function in the high volume surgeons (47% function preservation in high volume surgeons vs 21% for low volume ones).

This has been shown again and again, including in gynaecology but I would argue that we don't need more research to demonstrate this point. It is simple. If you do the same thing again and again, you will get better at it. The more you do, the better you get (well, usually).

I suspect if a similar study is done in endometriosis, looking at completeness of excision and outcome of surgery, we may find an even bigger difference between the two groups. It is much easier to measure mortality rates and erectile dysfunction that happens shortly after the procedure. In contrast, pain persistence or recurrence or presence of endometriosis in subsequent surgeries are often attributed to the "nature of the disease" and the notion that "there is no cure for endometriosis".

Infrastructure and resources

A successful endometriosis centre needs to have access to the right equipment and personnel and infrastructure. This can only be justified if there is a significant volume.

It is rare to have all the right people with the right expertise and interest in the same place from the beginning. Recruiting, for example, a pain specialist with an interest in endometriosis will only make sense if there is enough work for them.

Multidisciplinary team

It's not just the endometriosis surgeon that needs to gain and maintain the skills required for advanced surgery. This is as important, perhaps even more important for the rest of the team. The colorectal surgeons and the urologists will only be able to gain a better understanding of endometriosis and the complexities that goes with it, if they are called upon regularly to join forces with the endometriosis surgeon.

Training the next generation

Low-volume units won't have enough cases to maintain or develop the skills of the lead surgeon, let alone training others.

So, what is the appropriate surgical volume?

I don't know and not sure if anyone does.

In the NEJM paper (1), they saw a meaningful and sharp drop in complications in colectomy (the closest procedure to our field in the list) in hospitals that were doing more than 124 procedures per year. In the urology paper (2), the authors considered surgeons doing more than 100 cases a year as high volume and those doing less than 25 were put in the lowest volume group. Maybe these numbers (100 cases/year per surgeon) are the kind of figures we should be looking at as a minimum.

Whatever the correct minimum number is, I strongly believe that if one is serious about becoming an advanced endometriosis surgeon, one needs to dedicate the majority of their weekly schedule to this field so that they can keep up to date with the recent developments, develop their skills, learn new skills, do research and train others.

In the UK, complex gynaecological cancers are treated only in cancer centres and in those centres surgery is done by subspecialty trained gynaecological oncologists who spend most of their time, if not all of it, looking after women with gynaecological cancer. Quite rightly so. I believe that a similar system should be introduced for severe endometriosis surgery.

Disclaimer: I am the Honorary secretary of BSGE and ISON. I am also a member of ESGE and EEL advisory board. This article reflects my personal opinion and not those of the above organisations.

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Dr Yves Van Belle
21.08.1953 – 18.07.2020

In memoriam of Dr Yves Van Belle

It is with great sadness we mourn the passing of our dear friend and colleague, Dr. Yves Van Belle.

Yves was a pioneer in ambulatory hysteroscopy, one of the founders of the European Academy and played an integral role in the development of the GESEA Programme.

He brought GESEA and hysteroscopic training throughout Europe, Africa and Asia through teaching, whilst also sharing his warmth, culture and sense of humour with all those who met him. Very strict in the quality of work but very humble and tolerant out of its task, Yves loved to work with all his medical colleagues and his enduring friendships with many of them saw him through life's challenges. His dedication and attention to detail set an example to those who have followed in his footsteps.

It is better to teach than to curse ignorance, he always said.

He started his career as Obstetrician and Gynaecologist at the St Jans Kliniek in Brussels, Belgium in the eighties and already in 1989 he has documented 4240 consecutive ambulatory office hysteroscopies. In 1990 he joined the Rollerball team, a group of young dedicated hysteroscopists who traveled all over Europe to teach the modern hysteroscopic approach. He was one of the best instructors ever and he loved to share experience. Later on, he was the heart of the ESGE-Academy workshops! No matter where in the world they were, he would be there preparing everything in advance and ensuring their success. The workshops had to be immaculate in every respect. He was a perfectionist, blessed with a rare ability to teach and explain things in the simplest way that could be understood by all.

Yves was also a very sensitive person and present in our families as a member and as a dear friend. He would write poems for our birthdays and for the difficult times of our lives to encourage us and give us strength as well as hope.

Yves was a genuine man with true feelings and a big heart. Big enough to include us all and love us all. We are all privileged to have been around such a wonderful unselfish man always giving his love, knowledge, and experience. Unfortunately, we will no longer listen to music together, or dance after a hard days work to relax. We will miss the spiritual conversations on medical subjects as well as those beyond medicine.

We extend our sincere and deepest sympathy to his family – his wife Carine, his daughter Lise, his son Koen and his beloved grandchildren who brought such joy to his life and whose photos always held pride of place on his desk.

ESGE has lost a valuable member and a special friend. A sensitive man whose delicate heart betrayed him at an early age. Yves was such a strong personality, fighting every day with lots of courage and determination against his disease.

May he rest peacefully.

Dr Luca Minelli

Memoriam Luca Minelli

Our friend Luca has sadly passed away. He passed away silently and humbly as he lived his life.

Luca was a great professional, a humanist and an extraordinary friend.

Both of us could tell thousands of stories to explain how Luca changed the face of surgery in Italy, in Europe and in the world. Luca did that with humility and with an open heart to his colleagues, his patients and to the entire world. We have done countless courses together in Negrar, many people we have convinced and so many of those have become close friends.

Luca first created a kind of fraternity of minimally invasive surgeons that is rarely found in our profession. We were proud to be part of this incredible story of women's health revolution with him and he was the most revolutionary of us.

Luca could have pretended to have a higher position, be more academic; or more honourable, but he was not interested in status. His interest can be summarized as 'Curing, Caring and Teaching'. He invented new and better techniques to treat and cure patients with endometriosis, he cared so much for them, but also for all his colleagues, especially the younger ones who he taught tirelessly.

No one can pretend to have been the best or the preferred fellow of Luca, that was not in his character... Luca loved them all equally.

Sharing knowledge was a duty for Luca and he has been successful! But for him it wasn't enough and improving the human condition was also his duty. Very few of us knew that all profits of the school that Luca founded were donated to humanitarian causes.

This is certainly because of his humble character that he left us silently during this terrible period of pandemic. The deep sadness of his loss is added by our inability to accompany him one last time. But we will come to you Luca, to salute you and certainly we will not be the only ones.

Rest in Peace, Brother...

Arnaud Wattiez

Armando Romeo

Important recent publications

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Diestsevest 43/0001 3000 Leuven, Belgium
+32 (0)16 629.629
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