# ESGE VISION

Newsletter of the European Society for Gynaecological Endoscopy

ISSUE 6 – MARCH 2022

## INSIDE

**Details of the ESGE 31st Annual Congress 2nd – 5th October 2022, Lisbon, Portugal**

**And much more...**

ESGE
European Society for Gynaecological Endoscopy

# Message from the Editor

We are pleased to present another issue of ESGEVISION, full of news and information related to our society and gynaecological endoscopy. The ESGE was proud to be able to hold the first and largest onsite Congress after the pandemic in Rome in October 2021. You will find a summary of activities from the Congress, prepared by the member of the Congress Team Dr Federica Campolo. Our next Congress is going to Lisbon in October this year. Lisbon was going to be our venue in 2020 but this had to be postponed due to the coronavirus pandemic. Rhona O'Flaherty, our very able General Manager, gives you a description of our plans for the ESGE 31st Annual Congress in Lisbon.

We have two very important interviews in this issue of ESGEVISION. One of these is with Professor Hans Brölmann, one of our past presidents. Hans talked to us about his personal professional journey, which gives us some insight into the history of endoscopic surgery in Europe, and the history of the European Society for Gynaecological Endoscopy.

The second interview is with Professor Ranjit Manchanda who gave one of the keynote lectures at the ESGE 30th Annual Congress on 'Risk reducing strategies for ovarian cancer'. The interview provides a very useful resume of current and future approaches to prevent ovarian cancer and the philosophy of prevention strategies.

The current issue is again full of news from ESGE Special Interest Groups, Working Groups and our Corporate Societies. I hope you enjoy reading it and look forward to seeing many of you again in Lisbon.

**Ertan Sarıdoğan**
Editor, ESGE-VISION

# Contents




# ESGE held the first large onsite Gynaecological Endoscopy Congress in Rome since the start of the covid pandemic!

## The ESGE 30th Annual Congress took place in the beautiful and timeless city of Rome, capital of Italy. The Eternal City, called "Caput Mundi" is an iconic place, symbol of resilience.

This year, the ESGE President, Professor Giovanni Scambia and the Congress President, Professor Enrico Vizza, were proud to host the congress in Italy together with the Honorary President Dr Rudi Campo, a great supporter of Italy and Italians.

This was the ESGE's first hybrid congress after the COVID pandemic that forced the world to a complete halt. Fortunately we were able to return to sharing great learning experiences together. The theme of this Congress, Per Aspera ad astra: through hardship reaching the stars was especially appropriate in these current times. Believing in something, defining ambitious projects and working hard to realise them, all legitimate and important purposes, because they build their foundations in hope. The hope that we have not lost in the difficult months we have faced and that guides us towards rebirth and innovations. This has been the driving force for ESGE scientific activities and adds new purpose for our patient-centred approach.

With extreme satisfaction, the Annual Congress, a sign of rebirth for all of us, the first chance to meet again in person, brought together delegates from over the world, the top five countries being Italy, the United Kingdom, The Netherlands, Germany, and Greece with a total of 61 countries participating onsite and virtually and more than a thousand participants. The meeting was very popular with our colleagues, we reached the maximum capacity for the venue and had to close registrations before the Congress, leaving some disappointed!

The Scientific Committee, led by the congress' Scientific Chairs Professor Ertan Saridogan and Professor Attilio Di Spiezio Sardo, in close and harmonious collaboration with the "young" local committee led by Drs Federica Campolo and Ursula Catena, expertly guided by Prof Scambia and Prof Vizza, the ESGE Central Office and its very able manager Rhona O'Flaherty and our PCO Eurokongress in collaboration with the industry offered an exciting and up to date programme with a total of 27 scientific sessions, 4 live surgeries and 17 industry symposia.

The scientific content of the congress was of a high level, with various contemporary topics of interest in gynaecological endoscopy and with sessions in collaboration with other international societies such as ESGO and SERGS.

The latest devices available in endoscopic surgery and robotics were presented with live demonstrations of their efficacy and safety for the patients.

The congress started on Sunday October 3rd with the Pre-Congress Courses. One of the highlights of these educational courses was the cadaveric dissection demonstrations from the Gemelli Anatomica Center Human Body Project on Surgical Anatomy. Both PC courses on Neuropelveology and Access to Pelvic Side Wall with a live demonstration of cadaveric dissection and lectures were very highly attended.

The on-site new Pre-Congress course "Where 3D sonography meets Hysteroscopy" with 3D ultrasound and hysteroscopic simulator where people could train on the Digital Hysteroscopic Clinic concept, was extremely successful and fully booked, as were the Pre-Congress courses on Hysterectomy, Endometriosis and the GESEA Train The Trainer course. Adding to the educational content, GESEA Certification exams also took place on the first day of congress.

It was also a great honour to have the Italian Society of Gynaecological Endoscopy (SEGI), one of the Corporate Member societies of ESGE, join Sunday's programme, with their contribution on Fertility Sparing Surgery.

The first day ended with the splendid Opening Ceremony, followed by a reception in the exhibition hall of the congress venue.

On Monday October 4th and Tuesday October 5th, delegates were able to attend both on site and virtually 27 scientific sessions, 3 Keynote Lectures, 3 Best Selected Abstracts sessions, Best Selected Poster Session, 17 industry symposia and 8 hours of live surgeries transmitted from the dedicated gynaecological operating rooms and from the new Class Hysteroscopy Center of Policlinico Agostino Gemelli – IRCCS in Rome.

The industry exhibition hosted 29 stands and 16 sponsors, in which industry partners presented their latest products and research. In addition, 9 very well-attended lunch symposia were held in the framework of the industry exhibition. This year also saw breakfast and evening symposia included in the programme.

The Congress was a great success, the organisers and the Society would like to thank all participants for attending and hope that they enjoyed the meeting. We now look forward to the ESGE 31st Annual Congress in Lisbon, Portugal in 2022.

https://esge.org/congress/rome-2021-congress/

# ESGE 31st Annual Congress, Lisbon, 2–5th October 2022


The ESGE 31st Annual Congress is planned this year from 2nd-5th October 2022, in Lisbon, Portugal. Following the postponement of the event in 2020 due to the Covid-19 pandemic, we fortunately were able to move the Congress to 2022 and maintain the same venue, the Lisbon Congress Centre.

Being a geographically small country, Portugal has learnt from the past to broaden the horizons by travelling around the world, meeting New Worlds and New People. This spirit is represented in the congress' image.

The ESGE Scientific Committee led by Professor Attilio Di Spiezio Sardo, together with the Congress President, Dr Luis Ferreira Vicente and the Local Scientific Committee have put together an innovative scientific programme this year which is guaranteed to have something for everyone. The first day will be centred around young doctors, from beginners upwards, with a full day of new pre-congress courses, Winners Day, Robotics, Train the Trainer and much more. As the congress is being hosted in Portugal, there will be a full day Ibero-American session to include Portuguese, Brazilian, American and Spanish speakers, also taking place on Sunday.

The following three days will be packed with a multitude of high-level expert lectures on current and innovative topics related to all doctors in the field of gynaecology. Four dedicated live surgery sessions will take place over Monday and Tuesday, Best Selected Abstract sessions on Monday and Wednesday, Meet the Expert sessions, surgical tutorials plus the latest research presented in Free Communication and plenary sessions will ensure a wide ranging programme for all delegates.

GESEA certification exams for both Level 1 and Level 2, will take place on Monday and Tuesday at the congress venue, to meet the increasing demand.

## Registration will open in April 2022

**Avail of the opportunity to register early at the best prices and ensure your place in Lisbon.**

## Important deadlines

**Dates and deadlines for the ESGE 31st Annual Congress are as follows:**

Abstract Submission opens ..... 24th February

Start Online Registration ..... 26th April
(Individual & Group Registration)

Abstract Submission Deadline ..... 16th May

Notifications regarding abstract ..... 27th June
acceptance/rejection

Deadline for Early Bird Registration ..... 13th July
Registration Deadline Abstract Submitters

Cancellation Deadline ..... 26th August

Pre-Registration closed ..... 16th September
(Individual & Group Registration)

## We really look forward to seeing you in person, in Lisbon, in October !

**For the latest information and updates, check out www.esgecongress.eu**

# ESGE Journal

## FACTS, VIEWS & VISION in ObGyn

Vol. 13, Issue 4

December 2021

Lots of interesting state-of-the art developments and news from the world of gynaecological endoscopy


# FVVO

International peer-reviewed open access journal. Primarily publishes original scientific articles, reviews, guidelines, new techniques and instrumentation and video articles relevant to gynaecological endoscopy and surgery, gynaecological oncology, urogynaecology and reproductive surgery.

FVVO is listed in Pubmed and is also the official journal of the ESGE Corporate member societies.

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# FACTS, VIEWS & VISION

## an overview of VOLUME 13, NUMBER 4, DECEMBER, 2021

## EDITORIAL

### Endometriosis classification/staging and terminology - Are we getting closer to finding a universally accepted language?

S. Khazali, E. Saridogan

## ESGE PAGES

### International Consensus Statement for recommended terminology describing hysteroscopic procedures

J. Carugno, G. Grimbizis, M. Franchini, L. Alonso, L. Bradley, R. Campo, U. Catena, C. De Angelis, A. Di Spiezio Sardo, M. Farrugia, S. Haimovich, K. Isaacson, N. Moawad, E. Saridogan, T.J. Clark

### An International Terminology for Endometriosis, 2021

International Working Group of AAGL, ESGE, ESHRE and WES, C. Tomassetti, N.P. Johnson, J. Petrozza, M.S. Abrao, J.I. Einarsson, A.W. Horne, T.T.M. Lee, S. Missmer, N. Vermeulen, K.T. Zondervan, G. Grimbizis, R.L. De Wilde

### Endometriosis classification, staging and reporting systems: a review on the road to a universally accepted endometriosis classification

International Working Group of AAGL, ESGE, ESHRE and WES, N. Vermeulen, M.S. Abrao, J.I. Einarsson, A.W. Horne, N.P. Johnson, T.T.M. Lee, S. Missmer, J. Petrozza, C. Tomassetti, K.T. Zondervan, G. Grimbizis, R.L. De Wilde*

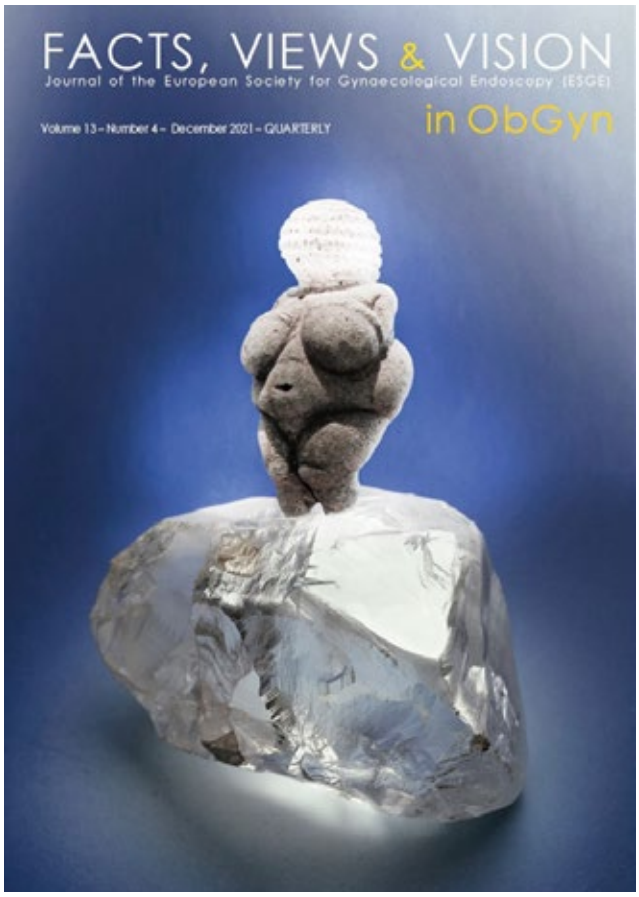
## REVIEW ARTICLES

### What to choose and why to use – a critical review on the clinical relevance of rASRM, EFI and Enzian classifications of endometriosis

G. Hudelist, L. Valentin, E. Saridogan, G. Condous, M. Malzoni, H. Roman, D. Jurkovic, J. Keckstein

### Indirect and atypical imaging signals of endometriosis: A wide range of manifestations

Vigueras Smith, R. Cabrera, C. Trippia, M.Tessman Zomer, W. Kondo, H.Ferreira, L. Carttaxo Da Silva, R. Sumak



## ORIGINAL ARTICLES



## CASE REPORTS



## VIDEO ARTICLE



# 2022 Webinars by ESGE and FACTS, VIEWS AND VISION


**3 March 2022:** 18.00-19.30 CET

## Demonstration with Cadaveric Dissection

**Pelvic anatomy for gynaecological surgery: All you need to know on retroperitoneum and pelvic nerves**

**28 April 2022:** 18.00-19.30 CET

## Controversies in the diagnosis and management of endometriosis

**30 June 2022:** 18.00-19.30 CET

## Uterine Niche: a major gynaecological challenge or 'much ado about nothing?

**22 September 2022:** 18.00-19.30 CET

## ESGE recommendations on surgical techniques for uterine fibroids

**27 October 2022:** 18.00-19.30

## Reproductive Surgery

# ESGEVISION Interviews Professor Hans Brölmann

***Professor Hans Brölmann***
*Former president of the European Society for Gynaecological Endoscopy*

Professor Hans Brölmann is a former president of the European Society for Gynaecological Endoscopy. He was a very active member of the society and received the prestigious Honorary ESGE Membership in 2020 during the ESGE Live Meeting. ESGEVISION Editor Ertan Saridogan spoke to him about his professional career, and his contributions to the ESGE and gynaecological endoscopy.

***ES: Dear Hans, thank you very much for agreeing to give this interview to ESGEVISION. You are a leading figure in the field of gynaecological endoscopy and I am sure the reader would appreciate learning about your involvement in this field. Can I start by asking when you began medical school and residency training and how you came to be interested in endoscopic surgery?***

HB: I studied medicine in Groningen in the north of the Netherlands, at that time very popular, and still is. As I was born and bred in Amsterdam, it could have been logical to study in Amsterdam, but of course you want to get as much away from your parents as possible!

***ES: Yes I know.***

HB: I did my studies there from 1969 to 1974, then I wanted to do tropical medicine, to go to a developing country, but by the time I was more or less prepared to go, I didn't have any partner in my life, and I would be stationed for four years in a rural area in Africa without many social facilities. So at the end I decided not to go, as I would probably be unhappy if I was alone for a long time. Then I had to do military service which was obligatory at that time. I worked for 2 ½ years in the military hospital where they had a maternity department – the reasons for it were quite vague but it had something to do with the fact that they could finance nurses education which was not possible if they didn't have a maternity ward, so I worked there for 2 ½ years as a military doctor, I was a lieutenant, and there I performed my first laparoscopy which must have been in 1975. It was really new at that time. And my supervisor – he was quite able and proficient in open surgery, said he would never learn laparoscopy but for me there was a chance as I was young and he instructed me to do the laparoscopy. That was quite exciting. I had never done a laparoscopy before, I never saw it and I only acted as a robot on my supervisor's commands. Now there was also a resident training of anaesthesiologists and probably one of the residents had filled up the stomach with air, but we didn't know so I put the needle directly into the stomach, and then the patient finally started to burp, a very long one, and if you closed the tap on the Veress needle, then the burping stopped, and when I opened it, it started again, so we knew the needle was in the stomach! And that was my first experience with laparoscopy.

After the start I did quite a lot of laparoscopies which at that time was only for sterilisation. And in those days, maybe you have seen them as well, there were some publications that described very serious complications, e.g in 1978 regarding a patient from Sri Lanka who had an explosion in the abdominal cavity and died as a consequence thereof, maybe a combination of bowel injury and using bipolar current. Laparoscopy had a doubtful reputation in those days and was considered really experimental.

Then in 1984 by the age of 33 years I finished my training in ObGyn and was appointed as a gynaecologist in Eindhoven. Hence, I was really in good spirits and committed myself to gynaecological oncology, at that time my field of interest. I did a lot of oncology, but then after a while, gynaecological oncology became a formal subspecialty of gynaecology and that meant that I would have to go into training again for a few years, in another hospital, and finally I chose not to because I was very happy where I was. I had a nice practice and my family lived in Eindhoven. So I stopped practising oncology. Then, in another hospital in Eindhoven, there were two gynaecologists who were very advanced in laparoscopic surgery. The older one was Dr Ad IJzerman – he did the first appendectomy laparoscopically in the Netherlands, and his younger colleague was Dr Eric Mendels. They had learned laparoscopic surgery from Professor Kurt Semm from Kiel. To prevent our practice lagging behind, we decided that I would focus on laparoscopic surgery as well. That was the reason I started with laparoscopy, because oncology was not accessible to me anymore and there was a good reason from marketing perspectives to start with laparoscopic surgery. We always stayed very good friends with the gynaecologists from the other hospital. Every year they organised a meeting on laparoscopic surgery and at that time, the French gynaecologists were far ahead regarding laparoscopic surgery. During those meetings I met Kurt Semm from Germany and Maurice Bruhat and Manhes (the person the commonly used grasper is named after!) from Clermond Ferrant in France, who I considered as giants of keyhole surgery. The videos they showed always were, apart from instructive, very entertaining with a good sense of humour, e.g. you saw a goldfish swimming around and then suddenly you were rinsing the abdominal cavity. That kind of trick in their videos made it more attractive.

***ES: This is in early 80's?***

HB: Probably a bit later at the end of the eighties, we started laparoscopic surgery as well as hysteroscopic resection of fibroids or endometrium which at that time was the predecessor of the second generation (hot balloon) ablation, a good alternative for hysterectomy. In 1990 Marlies Bongers came into our gynaecology group in the hospital and we both developed endoscopy in our hospital.

That was all Eindhoven. At that time gynaecologists all over the Netherlands were developing endoscopic surgery. Dr Andreas Thurkow was already active in Amsterdam, Dr Sjoerd de Block, practising in another hospital in Amsterdam was very proficient in hysteroscopy. At that time I was confident about the potential of endoscopic surgery in gynaecology and, together with the members of the first board, I founded, the Dutch Society of Gynaecological Endoscopy (Werkgroep Gynaecologische Endoscopie: WGE). That was 8th Oct 1992 and thanks to committed colleagues after me, it is currently still a successful and active society, comparable to he BSGE. The Society should reinvent itself sometimes and focus more on surgery in general and on benign gynaecology, therewith keeping itself attractive for gynaecologists.

***ES: Were you the founding President?***

HB: No, I started it but I was still young and thought Ad IJzerman much deserved to be the first President and I started off as the Secretary. After my role as the Secretary, I was the President between 1998-2002. We had a course in Eindhoven that was quite successful and we combined a theoretical part with live surgery which could be attended in the OR. That was new at that time. People liked to be in the OR, they could ask very practical questions to the operating surgeon for instance about suture material, instruments and approach.

***ES: Did you also have trainees at that time?***

HB: We had a ObGyn residency training in Eindhoven and therefore we could not accommodate fellows in laparoscopy who wanted to improve their skills after their residency training. There were two reasons, one it was not financed, so we had to pay for the fellow ourselves. Secondly the residents in training wanted to learn endoscopy as well, they were really competitive. We did not have so much surgical volume that we could both accommodate fellows and residents in training.

***ES: Do you have anyone from those early years of endoscopic surgery who have become household names these days?***

HB: Not from the early days. Marlies Bongers joined me however as a consultant in Eindhoven. She came from the Amsterdam region. She now has a Professorial Chair at Maastricht, in endoscopy, so she is quite well known in the endoscopy world. In later years I collaborated with Judith Huirne, Wouter Hehenkamp and Robert de Leeuw, all very active in benign gynaecology research.

***ES: Still in the late 1990s, you were President of the Dutch Society and you were still in Eindhoven. When did you move?***

HB: In 2002, to Amsterdam, but first let me make one more remark on my Presidency. We were active and wrote articles in the national gynaecology journal, you may recognise some of it. We had fierce obstruction from colleagues from other fields of interest, who really thought that laparoscopy and laparoscopic surgery especially was a hype. I can remember a comment of one of the professors at that time, who said "mark my words, in 20 years nobody will know anymore about laparoscopy" and he was really convinced. Nevertheless, those were exciting times because we felt more or less like pioneers and we enjoyed that role very much. After all, we are very satisfied with the result and how endoscopic surgery has come to play a key role in surgery.

So in 2002, I went to Amsterdam because at that time somebody thought I was suitable to be an academic gynaecologist. At first it had not been my goal in life, but I was honoured by the invitation to have a Chair in the university (we have 8 universities in the Netherlands) and I was lucky to move to the VU University in Amsterdam because that's my original hometown and some of my family lived there (my sister and my parents), therefore I enjoyed coming back to Amsterdam. My assignment in the VU University was to further develop endoscopy in the university medical centre.

***ES: Had you completed your term in office as the President when you moved to Amsterdam?***

HB: Yes, I had completed my term. In the Dutch society we didn't have the Past President position as it is known in the European Society, which makes it easier to gradually detach from your responsibilities in office.

So in Amsterdam I had to start a scientific track for endoscopy which was not easy because, I don't know how it was in England, but we really had difficulty in getting our scientific research financed, because laparoscopic surgery or endoscopy by then was not a priority in funding compared to e.g. oncology. Endoscopy was mainly seen as a surgical trick and not as a useful improvement in surgical practice.

So we had to do a lot of research activities by ourselves without the help of PhD students, but anyway we did try our best.

I had a few fields of interest in endoscopy but first I should mention my only invention: the laparoscopic Deschamps needle. You definitely have never heard of it for a good reason because it never broke through. Do you know the Deschamps needle in open surgery?

***ES: Deschamps needle?***

HB: Yes, used in vaginal hysterectomy.

***ES: Yes, we call it aneurysm needle I think***

HB: Yes it was originally used for aneurysms in the Napoleonic War, because many soldiers had syphilis and they developed aneurysms in the popliteal artery. Surgeons used the blunt needle of the Deschamps to ligate the aneurysm. Well I made a laparoscopic one, it was manufactured by Karl Storz and I think my total earnings are below €10 because it was hardly ever sold. However it was practical, a straight instrument for introduction through a 5 mm port. After insertion you turned a knob and the blunt needle came at an angle at 90 degrees. You could very bluntly use it to insert sutures around the uterine vessels and tie knots. But at that time the bipolar current energy was already available as well as this combined instrument named after Seitzinger that could seal and cut. And of course later came ultrasound and staplers.

So that was my only invention which I used for a long time in laparoscopic cerclage in cervical incompetence. The Deschamps needle could insert the suture material without harming the vessels. I was one of the first in the world to perform a laparoscopic cerclage.

***ES: Why don't we have your name in the literature on laparoscopic cerclage? Did you not publish it?***

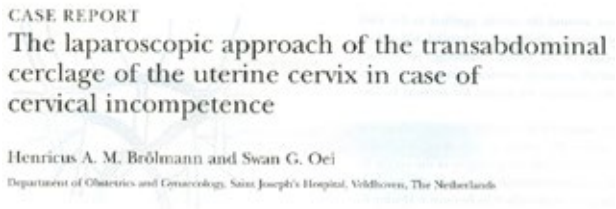
HB: I published it in Gynaecological Endoscopy, but Gynaecological Endoscopy was never in PubMed.

***ES: I know, but we need to change it.***

HB: I can send you the article.

***ES: Yes it would be a good idea. So we can actually do something with it.***

HB: Ray Garry at that time was the Editor-in-Chief, a lovely man, I just had so much fun with him. Ok I will send you the article because we were just a little bit too late, because I think when I sent it, or when it was published, I also saw a similar publication in Fertility and Sterility from another group.



CASE REPORT

The laparoscopic approach of the transabdominal cerclage of the uterine cervix in case of cervical incompetence

Henricus A. M. Brölmann and Swan G. Oei

Department of Obstetrics and Gynaecology, Saint Joseph's Hospital, Veldhoven, The Netherlands

***ES: Yes there were two around the same time, in late 1980's.***

HB: I also did a lot of pelvic floor surgery laparoscopically, such as sacrocolpopexy, I even had a research line on tissue engineering which was good for two PhD theses but never really did fly. I mean, we had the intention to implant a graft with stem cells. The stem cells differentiated into fibroblasts that could make collagen and then the graft would be replaced by native collagen – never happened. I mean that research has been a cemetery of good ideas.

Other areas of interest were ultrasound imaging pre-operatively but also intraoperatively. I tried to promote virtual reality training. We had one of the first virtual reality trainers in laparoscopy in our hospital. Everybody was enthusiastic but the implementation was problematic, because there was no curriculum that obliged residents to practice. And if you don't have a kind of obligation, or pressure to use it, the laparoscopic simulator is bound to be somewhere gathering dust, which it did finally. I contributed to research on innovations, such as the Gyneclamp. Have you ever heard of it? It was an instrument which was studied by J&J in order to commercialise it. They did the first clinical studies in Europe because the certification necessary for clinical use was easier in Europe than in the USA where the FDA was more strict. We did the phase 2 trials for safety and efficacy.

***ES: What was it again?***

HB: The Gyneclamp was an instrument which you introduced in the vagina like forceps in obstetrics, after introduction you clamped both uterine arteries guided by the Doppler sounds generated by the clamp. The clamp was supposed to stay in place for six hours.

***ES: Similar to uterine artery embolisation via the vaginal route?***

HB: Yes, but then only by compression.

***ES: Yes, I remember I saw it.***

HB: Gyneclamp was the name they wanted to conquer the world with, but then it appeared that in 7% of treated patients with fibroids, treated patients also had transient ureteral damage on one or both sides. That was a serious setback and obviously incompatible with safe practice. The whole project was cancelled.

We also researched postoperative recovery; we had a recovery app with a quality of recovery questionnaire. Judith Huirne who is my successor in the VU University continued this research very ably. The last topic of my research is the caesarean scar or niche research which I started in 2006. And we did find that if you had a visible scar indentation by ultrasound you had more complaints of intermenstrual bleeding. This is now quite a prominent scientific topic.

***ES: Yes, a very popular topic. So how did you actually become interested in the niche?***

HB: I remember I once read an article that patients after a caesarean section had more menstrual complaints of abnormal uterine bleeding and that it might be related to the scarring of the caesarean. In our department we had, between the different pillars, reproductive medicine, oncology, obstetrics and gynaecology, a lot of competition, there was always shortage of money, everybody wanted to have more personnel, so I thought, this may be a topic which is nice for the obstetrician and nice for the gynaecologist. We also found that it is related to fertility as well, so it is also a productive topic for reproductive medicine researchers. So it could be a research field which would bring us all together. That was my intention and one of the reasons to explore it.

***ES: So this is from 2006? I can't remember exactly but I think it was 2009 when I first saw you in Amsterdam?***

HB: 2008 I think it was – was it at the Annual Meeting?

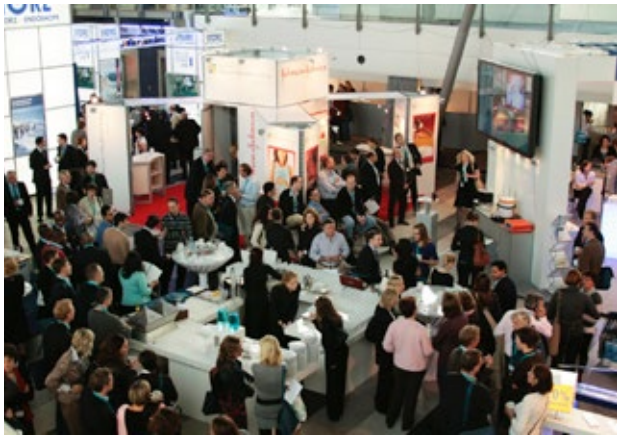
***ES: Yes, the ESGE Annual Meeting. You brought the***

***Mayor of Amsterdam to the opening of the meeting. Our fellow submitted two abstracts and then he won the best abstract and he was presented with Dutch clogs. He still has them. It was Dr Gulumser, he is from Turkey and he's back in Turkey at the moment.***

***ES: For me, that was probably the turning point for the European Society, because before that I think the European Society was relatively unknown and a small group of people. So obviously you know the story better than I do, those years, do you want to expand on a little?***

HB: I had been in the Executive Board since 2004. I became the General Secretary, after Rudi Campo. At that time I wrote a bid to have the annual congress in Amsterdam. At first it was planned in 2007 and in the end it was moved to 2008. We had annual meetings in Clermont Ferrand, Strasbourg, and in Luxembourg, and usually we had about 600-700 paying participants. I organised the congress in Amsterdam with Andreas Thurkow who is a very good friend. We were quite inexperienced in this activity, but we spent much time in having a good PR strategy which I later used with you for the ESGE Budapest meeting as well.

So we started mass mailing about topics in the programme. I mailed all residency trainers in Europe and especially in the Netherlands, to say the circus only 'lands once' in Amsterdam so please use the opportunity. Amsterdam is of course an attractive city and I think delegates from abroad liked to see Amsterdam, so I don't know what happened, but we were surprised to have 1800 delegates, which was marvellous. And after that the ESGE maintained this level of attendance during annual meetings. The only problem was, it is actually a funny story, that we were ripped off by the catering organisation and at the end we had hardly any profit for the European Society. And that was really an issue, because the Annual Meeting was the money making event for the European Society, the rest of our activities were not very profitable. Finally a bit sad that we had so many people and at the end, hardly any profit.



*Exhibition area during ESGE Annual Congress in 2008 in Amsterdam.*

***ES: Yes, I remember and I think it affected the discussions in later meetings. I wasn't involved with ESGE until London and after I saw you in Amsterdam, our first joint work started in London. I was the Local Organising Committee Chair so I remember we met in Excel Centre, you flew into the city airport***

HB: Yes, I went very often there, which now in these Corona times, is unimaginable. But I went there every six weeks and we had meetings and I also looked around, and I enjoyed it very much.

***ES: London meeting was also a successful meeting, quite well attended and you were the President in London.***

HB: I think I was President between 2011 and 2013, so the standard term was two years at that time.

***ES: Obviously for me, Amsterdam was the turning point because when endoscopic surgery opened up to wider people, more gynaecologists started becoming interested in it. Do you recognise it as the turning point when you look back and see whether there was a specific turning point or whether it was a gradual thing that changed over the years without an obvious landmark?***

HB: I hadn't noticed it as a turning point, but yes the European Society became more popular. I know that after 2008 a lot of Dutch people became members of the European Society. Moreover the ESGE started the Corporate Membership and that meant that the big societies could, by paying a lump sum yearly, have all their members automatically become individual members of the European Society. So we had skyrocketing numbers of members of the European Society.


***ES: Yes, from the British side, it was an important change, because then all of a sudden we started having access to the European Society with our ordinary membership to the British Society. I think more people then started attending the European meetings as well. It did have a big impact for us, because then we were more aware of what was happening in Europe through ESGE.***

HB: I must say we organised the Amsterdam meeting together with the British Society, Ellis Downes was the representative.

***ES: Yes, Ellis is a very good negotiator!***

HB: Absolutely, and a funny guy – I had a lot of fun with him. Going back to your question, I see it more as a gradual process, from the very beginning in the 90's of the last century, until now. The role of endoscopy has become gradually more important in surgery over the years.

***ES: After your presidency you must have become the Chair of the Scientific Programme, because again, the next point that we were together was the organisation of the Budapest Meeting.***

HB: I was Congress Chair together with you for Budapest and I have wonderful memories of that collaboration. We had a lot of fun and it was quite successful.

***ES: I learned everything I know about organising programmes from you, I have to say. So that was an extremely good experience for me to have a tutor like you.***

***And you retired from the University in 2016. I remember your year of retirement and I missed your retirement meeting.***

HB: Yes you couldn't attend because you had a heart problem at that time. Which was quite a good excuse I would say.


***ES: So since your retirement, I know that you've been interested in the medicolegal field or malpractice. Do you want to tell us a bit more?***

HB: I think in all countries you are sometimes asked by the court to give your expert opinion on a case, if there was malpractice or it was just a complication. I did it a lot of times on laparoscopic ureteral injury etc, and then you have to talk to the patient. It always struck me that when you question the patient about seeing the gynaecologist after the complication they said, 'well only once for 10 minutes in the outpatient clinic but we didn't have very good contact, they said, well these things may happen and have a good day!'. So I thought when I retire I will just have a look to see if it is possible to do some coaching work for people who are involved in complaints, catastrophies, or similar problematic things. Coaching did not respond to a need and quickly came to a dead-end, because the hospitals organised their own peer support facilities. Usually a colleague from the hospital who is selected and trained to support you. So there was not so much need for an external coach to do that. But I read a lot about it and saw a fascinating development in the US, the disclosure of medical errors, called open disclosure in Australia. The funny thing is that everyone agrees that it is important to be open to patients and family after adverse events because, it is good for the patient, increases confidence in the doctor and prevents medico-legal escalation, it is good for the caregiver because if he's traumatised he will recover more quickly from his own trauma. It's good for patient safety because you can openly discuss all errors and mistakes and everybody can learn from it. Since 2016 disclosure has been established in an article of law in the Netherlands, as in many Western countries these days. It is therefore remarkable that scientific studies report that disclosure is given in only 30-50% of the adverse events. So on the one hand nearly all patients prefer

to know the truth in case of adverse events and the doctors – if not involved in an adverse event – consider disclosure as the norm, on the other hand under real circumstances, in the heat of the moment, the caregiver refrains from being transparent about the event. This phenomenon is called the disclosure gap. So I did workshops to train colleagues on open communication after adverse events, and to teach how to de-escalate. But in corona time, it stopped, so I suddenly had all the time in the world, and I was able to write this book on disclosure communication in healthcare. And I mailed you about giving it to Marcel Levi who is now the Chief of a huge governmental research fund in the Netherlands. Did you meet Marcel yourself?


*Hans Brölmann is presenting his book to Professor Marcel Levi, Chief Medical Officer of the Netherlands.*

***ES: Yes he was the Chief Executive of our hospital for four or five years.***

HB: That's right. Well I know him from my time, when I was the head of department. He was the Chief Executive of the other university hospital, which has now merged with ours. I was involved in the merging process because I was not only the head of department, but also the head of the division which was with six specialties and therefore I went with the Board of Directors to Marcel and we talked about merging, and now the merge is completed.

So, I wrote a book and I was on the radio last week and next week I'm on the radio again. I'm so busy at the moment, my workshops are really flying, but it is probably a temporary effect. I had good critics in the medical journals of my book. Anyway, this only lasts for a few months, and then I will get back to my previous pensioner state!

***ES: You never know, it might lead to other things. I think you have built up all this experience in that field and I'm sure lots of us would benefit from it. Is the interest mainly from medical people or is there interest from outside medicine as well, lawyers or the general public?***

HB: Well because it's actually a universal problem, anyone who makes a mistake, has some resistance to admit the mistake, it's human. We're all human and I have some examples in my book, from other fields, such as law, aviation industry. We have this wonderful, but terrible near miss of a plane which was nearly hitting Heathrow on a row of hotels, but escaped at the very last moment. It's a famous case history in the aviation industry, showing that mistakes are not only caused by individuals (e.g. pilots) but also systemic factors. You have in hospitals, those quality officials and legal people, supporting patients, and for those people the book is meant as well.

***ES: Are you still in touch with the university department?***

HB: Yes, but I work as a career coach. I worked for five years doing the scientific traineeships for the medical study of students and I was their examiner. I just stepped down and then they asked if I wanted to be a career coach, because they wanted a career office in the medical faculty. I said I'd love to. It is very funny to talk to students, tomorrow I have five students, we do it all by Zoom video calling. I'm completely done in my career and they are starting their career and this gap is very exciting and very productive as well. So I help them to be aware of what they like and what they know and what they're good at. So that's what I'm still doing. And once a month I chair a promotion ceremony which is, we do it after your retirement as a professor, then you are asked to chair promotion ceremonies, but I do it only once a month, it's just fun, but not too often.

***ES: Hans, do you have any time to do things outside medicine? I know you have a big family.***

HB: I'm playing golf, handicap 17 and I love to play the piano now that I have a lot of time. Sometimes I play for my grandchildren, it's all amateurism but I love to do it. I have an apartment in the Dutch beach resort Noordwijk aan Zee where we live in the summer. When the waves are ok I do little stand up paddling to stay fit.

Our children are very dear to us, we have two, a son and a daughter. I'm happily married – 40 years this year – and I've 5 ½ grandchildren, because the 6th grandchild is on the way.

***ES: Excellent, is there anything else that you would like to add, that you wanted to include? And maybe I've led you in a different direction?***

HB: No I'm completely happy. I think I'm done. I feel very privileged to have someone interested in my history, so I hope you can use it.

***ES: It was a pleasure, and thank you for giving up your time this evening for this interview.***

# ESGEVISION spoke to Professor Ranjit Manchanda, one of the Keynote Lecturers of ESGE 30th Annual Congress

***Professor Ranjit Manchanda***
*Professor of Gynaecological Oncology at Wolfson Institute of Population Health in London*

Professor Ranjit Manchanda gave a keynote lecture in Rome during the ESGE 30th Annual Congress. He is a Professor of Gynaecological Oncology at Wolfson Institute of Population Health in London and is a leading academic and researcher in the field of ovarian cancer prevention, amongst many other lines of research.

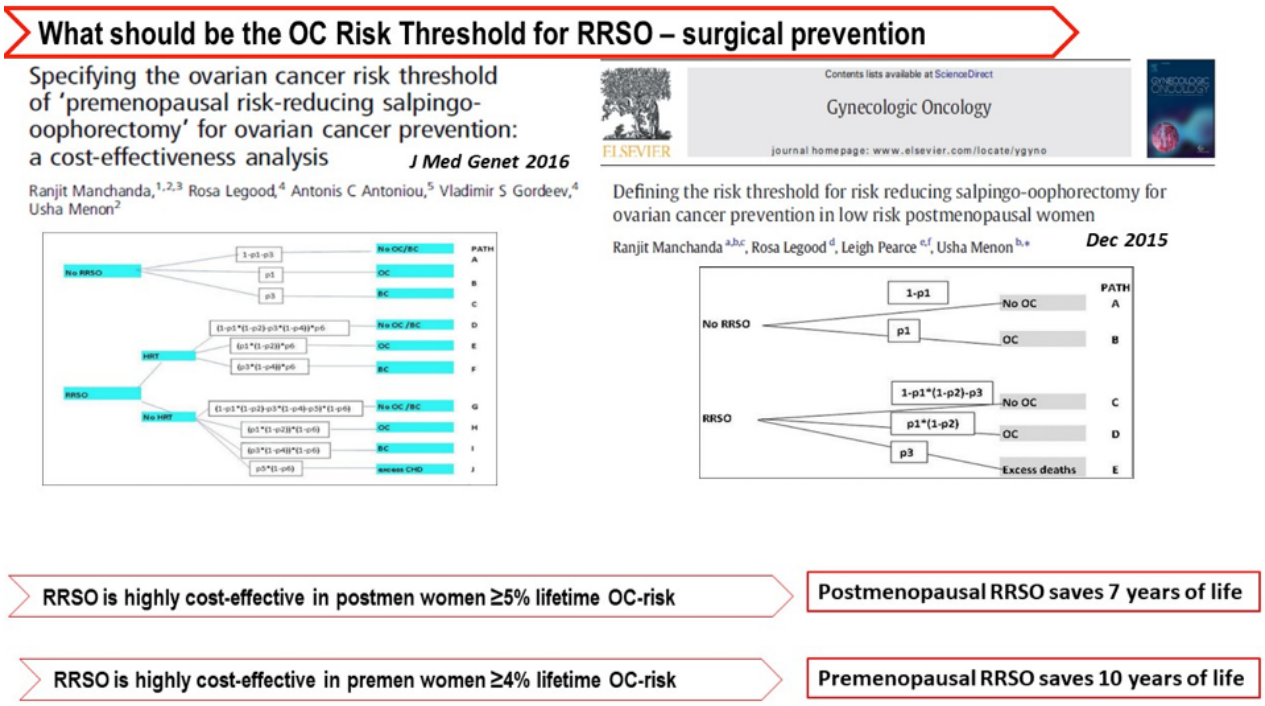
ESGEVISION Editor Professor Ertan Saridogan spoke to him about the highlights of his presentation at the Congress.

***ES: Professor Manchanda, thank you for giving one of the keynote lectures at the ESGE 30th Annual Congress in Rome and for agreeing to this interview. The first thing that I would like to start with is the main messages that you wanted to give in the keynote lecture, so if you can start off with that. Obviously, we asked you to talk about prophylactic salpingectomy, or the role of prophylactic salpingectomy in the prevention of ovarian cancer. There are a number of aspects that you covered in your lecture.***

RM: Yes, I spoke about both salpingo-oophorectomy and salpingectomy, covering both aspects. So from that point of view I'll address them one by one.

From the point of view of salpingo-oophorectomy, without doubt bilateral salpingo-oophorectomy or risk-reducing salpingo-oophorectomy is the most effective way of preventing ovarian cancer in women. This has been shown to reduce ovarian cancer incidence, ovarian cancer mortality and all cause mortality. It has been shown that it's cost effective to do risk-reducing salpingo-oophorectomy at 4-5% lifetime ovarian cancer risk level and this saves about 7-10 years of a woman's life, which is a substantial benefit. We have shown that this is acceptable to women at this threshold of risk.

Additionally, there are new ways of identifying women beyond this risk threshold which are now in clinical practice This includes some of the new moderate risk of ovarian cancer genes like PALB2, BRIP1, RAD51C, RAD51D, which are at a 5% or above lifetime ovarian cancer risk thresholdand now testing for these is part of clinical practice so women with these levels of risk are being identified. Surgical prevention is now being offered to these women as part of routine clinical practice.




**RRSO is highly cost-effective in postmen women ≥5% lifetime OC-risk**

**Postmenopausal RRSO saves 7 years of life**

**RRSO is highly cost-effective in premen women ≥4% lifetime OC-risk**

**Premenopausal RRSO saves 10 years of life**

***ES: Ranjit, can I just interrupt? So you used cut-off of 4-5% or above risk. What's the rationale here?***

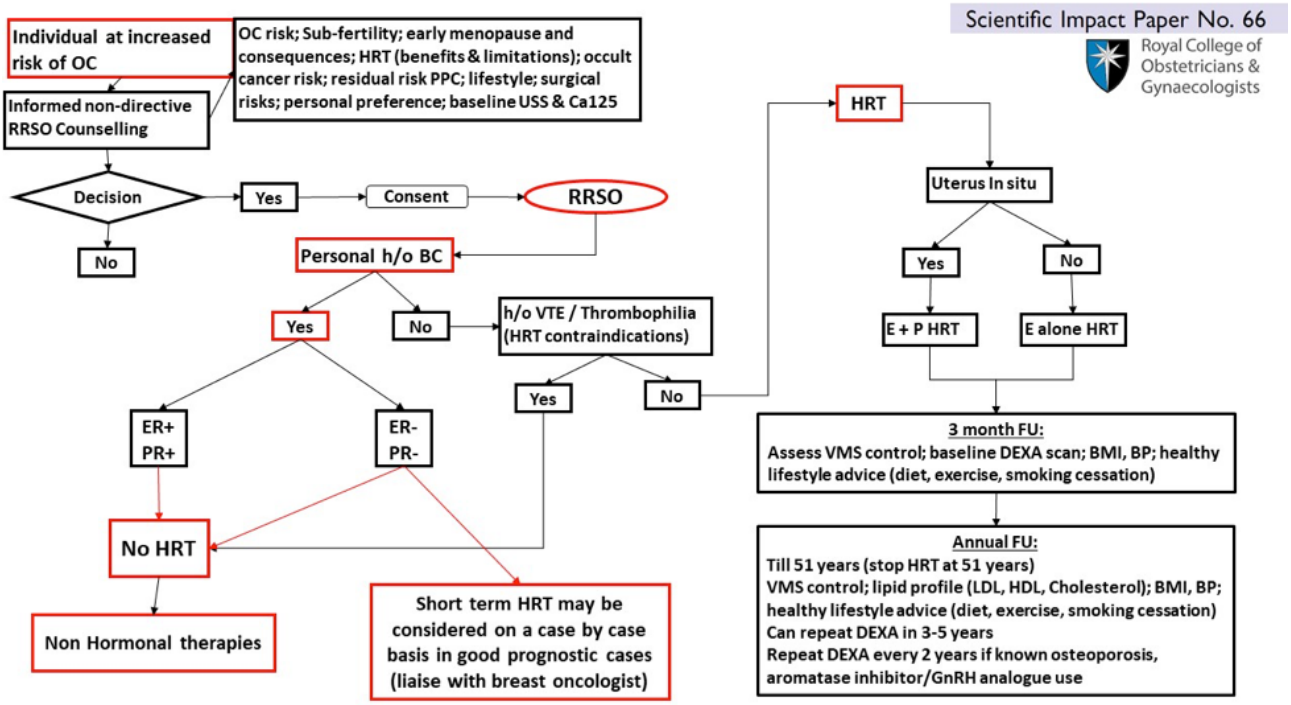
RM: The rationale there is at this level of risk you're saving lives and it is cost effective for the health system to make a policy change or offer a new intervention. So that means the investment from the point of view of weighing up the costs of doing surgery, when you compare that against the treatment costs of ovarian cancers you avoid, and take into account the life years a woman gains, on a balance of risks and benefits or costs and consequences it is beneficial for the health system. This threshold of decision making (called the willingness to pay threshold) is £20,000-£30,000 per QALY (Quality Adjusted Life Year) for the UK NHS.

***ES: Ok. Does this calculation take the complication of surgery into account as well?***

RM: This calculation is a complex calculation, which takes into account costs of all procedures and consequences. It takes into account the cost of, for example, HRT, the impact of cardiovascular disease, excessive deaths from excessive cardiovascular disease, which may occur if you don't take hormone replacement therapy. And it takes into account the disutility from the procedure (risk reducing salpingo-oophorectomy). That means how the quality of life is detrimentally impacted from the operation. We know that salpingo-oophorectomy leads to a long range of detrimental consequences so there is a disutility attached to that.

Whether to undergo surgery or not requires non directive informed counselling and consent. The consent process is separate and complications of surgery need to be dealt with or addressed routinely during the informed counselling process. There is a 3-5% potential complication rate. Whether we undertake surgery at a 5% or a 10% risk threshold, the complications do not change.

These are peer-reviewed published analyses and have been given careful thought. It's complex decision analysis modelling. Papers which have been published, coupled with the advances in our understanding of genetic risk and ability to predict risk have led to conversations and discussions around broadening access to surgical prevention. Some centres have changed practice. We had a consensus meeting led by the UK Cancer Genetics Group just a couple of months ago which covered this particular issue, and this new threshold has now been accepted. Also we recently published, on behalf of the Royal College of Obstetricians and Gynaecologists, a Scientific Impact Paper on this issue which covers the ovarian cancer risks at which surgical prevention should be offered and issues around HRT management, etc. Again this is highlighted within that Scientific Impact Paper (SIP) which has undergone international peer review. The same need to broaden access to surgical prevention at these risk thresholds has been published.

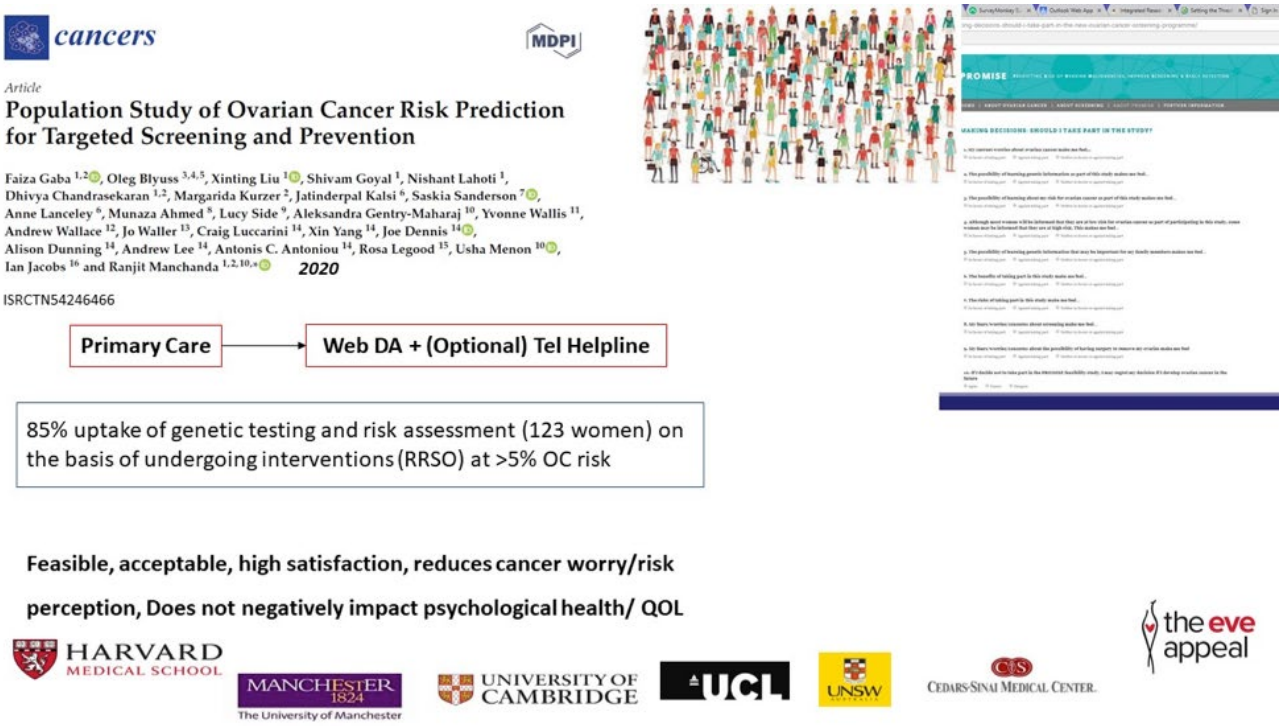



***ES: Are there people who disagree with this threshold? Is there criticism?***

RM: I think there is increasing understanding and acceptance. There will always be some people who may have a different point of view. That is the case in lots of things we do. And whenever something new in practice or new thought comes in, or when we start talking about doing things in a different way or changing practice, you will get different points of view. In any institute, a change of practice or a change in management will always have different ranges and points of view. The thing is to present the evidence and the advantages and disadvantages and show the strength of the evidence and therefore help people make their decisions.

Similarly, I don't think we should have a paternalistic approach. This is not about just undertaking surgery. Ultimately women need to make the decision and the counselling undertaken and evidence need to be presented in an unbiased manner, non-directive way. There needs to be informed counselling. So when I counsel or when anyone counsels someone that has a 5% risk of getting cancer you have to tell them that there's a 95% chance of not getting it. And you may find that the patient may decide not to have surgery. So it's not that everybody at that level of risk will undergo surgery. Surgical decision making is a complex, dynamic process, which changes with time and a lot of women find it challenging and need to be helped through this process while they make this decision. And for some women the right decision will be not to undergo surgery. But a number of them will want it and may choose to undergo surgical prevention. And ultimately it's about saving lives. And we know that we will save lives if we offer surgery at this increased level of risk. There is a recent paper out, I think probably published after the ESGE talk, I think from the USA, which argues for a 3-4% risk threshold. But that's a separate paper which came out in the last few weeks.

So the other thing about high risk cancer genes is our ability to predict risk and in the future this will improve and is improving. Personalised ovarian cancer risk modelling will come to the fore in the future as more validation data come out. There is the CANRISK model which is well validated for breast cancer and validation for ovarian cancer is improving. Initial, preliminary data on ovarian cancer validation were published I think in the last couple of weeks. This is a model built by / work led by Antonis Antoniou, the Cambridge team, undertaken within the PROMISE Programme (funded by CRUK and Eve Appeal) and we were part of the PROMISE Programme and contributed to this work. This allows you to predict a personalised ovarian cancer risk estimate for a woman, using epidemiological factors, family history, reproductive factors, SNP based polygenic risk score, and presence of moderate and high risk cancer genes. We have shown in a proof of principal pilot study that this is acceptable to women and women will come forward for gene testing and we've shown that this approach reduces anxiety, is not causing harm to women and it can be done on a population basis. Further implementation studies and validation data of these risk models are needed and will occur in the future. But that will eventually be I suspect and I hope the direction of travel. I know there are other colleagues in the USA who are also validating similar sorts of risk models to predict




personalised ovarian cancer risk and I've definitely seen data which is not published on this, and these data will be coming out in the future.

***ES: Again can I just quickly come in here? When you talk about identifying people who are at risk, obviously you need to go by some parameters to decide who should have the test, otherwise obviously we don't have a system where we gene-test the general population. So how do you decide who to test?***

RM: I think the future vision is that we want to be able to offer it to everybody in the general population. That is the big vision, the blue sky vision and thinking. We are not there yet, and we are interested in doing the population implementation studies to get there. From an academic point of view, we are going to address this. So today you have studies like the PROCAS study led by my colleague Gareth Evans running, where they are stratifying women coming for breast cancer screening using demographic characteristics, a mammogram, breast density, as well as SNP based polygenic risk score.

This demonstrates the ability to stratify populations by risk for clinical interventions of benefit. So that women who are at the appropriate higher risk level get, or are able to avail of it more frequently and those who are at a lower risk level may not necessarily need it as frequently or may not need it at all. So you are better at targeting the intervention for people that are at different levels of risk. This approach of personalised risk adapted intervention is going to improve and is improving. We see it coming into the breast and I suspect that it will come into all cancer types, and potentially all chronic diseases in the future. So for ovary specifically, yes, while we are not there offering this to everybody at present, definitely that is the direction of travel and one hopes that as these models get validated we will be able to offer them and identify more people who are at risk so that we can prevent more cancers in the future. Some modelling suggests that 60% of ovary cancers are preventable at 5% risk threshold. So that's the potential target from a risk reduction and prevention strategy perspective. We have to identify those women who are at or above that level of risk and that is a road that needs to be travelled.

***ES: And can you make a wild guess that how far away are we from this kind of universal testing? You say we are doing it for breast cancer but I assume that it's still at pilot level, as far as I'm aware it's not established practice.***

RM: You see it's still all in the research context. I wouldn't say it's pilot level but it's still in the research context. Policy is not changed and it's still on the back of a screening programme so it's stratification for a screening programme and there are more studies being designed and being implemented along these lines. I think maybe 10 years, if I'm optimistic, between 5 and 10 years.

So I think you would need a big implementation study and you will need at least 5 year outcome data from those studies to address this issue properly so we're looking at that sort of a timeline, and if you really want long term then it is 7-8 years or even longer for long term. It's going to take that amount of time to do these studies and generate those data to convince policy makers to change policy. But that's what we need to do. We need to do the research to show this can be made available in the population context. In clinical practice these models are now beginning to become available to improve risk assessment and I suspect they will become more widely available and will be used within the clinical setting in the future.

***ES: Thank you. And so going back to the salpingo-oophorectomy subject, without this testing being available, can you give a few examples of who actually reaches that 4-5% threshold based on their personal or family history at the moment?***

RM: So someone who's got a strong family history of ovarian cancer, if they're even a first degree relative with high grade serous ovarian cancer, particularly at a young age, or 2 ovarian cancers in the family, is likely to hit that sort of level of threshold. But also women with ovarian cancer now are offered gene testing and on the test directory you will now be offered testing for not just for BRCA genes, but BRCA1, BRCA2, RAD51C, RAD51D, BRIP1, PALB2, and all the Lynch genes, MMR gene, which is you have about 9-10 genes that are relevant. PALB2 is at the 5% risk threshold. BRIP1 is 6%. RAD51C and D are 11% to 13%. If you add family history to them then the risk goes even higher.

***ES: So this would be useful for other family members if you have anything that specific.***

RM: Absolutely. When you pick up someone with a familial mutation there will be cascade testing available and you can identify family members who have the gene mutations who have not had cancer. So BRIP1 is like a moderate risk of ovarian cancer gene, PALB2 is again a moderate risk 5% risk ovary cancer gene, but the RAD51C/D genes have a higher ovarian cancer risk (11-13%) but are moderate risk breast cancer genes. So there will be implications for management for these genes for breast and ovary cancer risk and these are coming into clinical practice now. We have seen patients and have undertaken surgical prevention in our centre and across our network for women with PALB2, RAD51C, RAD51D, and BRIP1 pathogenic variants (mutations) over the last few years.

***ES: Good. So this is about salpingo-oophorectomy. Is there anything else that you would like to add on salpingo-oophorectomy?***

RM: Yes, two more points I'd like to make about salpingo-oophorectomy. One, hormone replacement therapy is very important for women who have early surgical menopause. And clearly anybody who's got receptor positive breast cancer you can't give HRT. Receptor negative breast cancers are a grey area, but for women who are unaffected, HRT should not be neglected and needs to be continued to the age of 50-51 years, average age menopause in the country. Women report their GPs or clinicians don't often prescribe it for all the duration that it needs to be prescribed and there's a limited awareness and knowledge about the importance of it. I think those issues need to be addressed. And some sort of long-term follow up on management needs to come into play to manage menopause, early surgical menopause, in a better way. Some of our research suggests that women who are managed in high-risk multidisciplinary clinics or high-risk specialised clinics are more likely to receive HRT and have greater satisfaction with their care. So we need more of these types of setups/centres where you have clinicians with special interest managing these women for the long-term. I think that's an important thing to establish for the future..

***ES: When you talk about receptor positivity, we are talking about women with oestrogen receptor positive breast cancer, is that right?***

RM: Yes that's right, yes. Sorry, yes that's what I meant.

***ES: Ok. And the second point you wanted to make?***

RM: And the other thing is women need a lot of support in the form of support from psychologists, a clinical nurse specialist, HRT specialist, etc. For risk reducing mastectomy for increased risk women seeing a psychologist is mandatory, otherwise surgeons won't do a mastectomy. I personally don't think it should be mandatory here, but definitely some women like the option of having access to someone should they need it. That appears to be the case and this should be made available (as optional).

***ES: Good. So that is salpingo-oophorectomy. It's an established, proven way of prevention of ovarian cancer. What about salpingectomy?***

RM: So, I think we should look at salpingectomy in two ways. One is the opportunistic salpingectomy in the low-risk population and the other one is early salpingectomy and delayed oophorectomy in the higher risk population. Let's take them one by one.

Opportunistic salpingectomy has been shown to be safe. It has acceptable morbidity, minimal additional operating time. It does not increase your complication rate, it may be associated with increased analgesia need and we've seen that across the board, particularly in North America, there's an increasing uptake of it. There's data coming in that demonstrates that quite clearly. Salpingectomy and caesarean section; there's an increasing uptake of that rather than doing tubal ligation. During caesarean section there's a slightly increased risk of associated haemorrhage but the absolute risk still remains small. The limitations in my view around salpingectomy relate to the evidence on the effect size of what proportion of cancer this can't prevent. The original data were from the Scandinavian countries, Denmark and Sweden, and they showed that the overall hazard ratio ranged from 0.58 to

0.35, so about a 65% to a 40% reduction in ovarian cancer risk. These studies were retrospective, did not properly adjust for all confounders, had a number of biases, and systematic reviews have shown that there is indication detection bias, other types of biases, the confidence intervals are wide, the number of ovarian cancers are small, there are problems with the retrospective design. Also, these were not opportunistic salpingectomy, they were clinical salpingectomies, so clinical indications which bring in other confounders.

***ES: Again, can I clarify – when we talk about opportunistic salpingectomy, are we talking about just pure gynaecological surgery, or are we talking about other intraabdominal surgeries, like cholecystectomy?***

RM: There are studies on-going with respect to all of these, like cholecystectomy. Or there is an opportunity to use that to implement salpingectomy during cholecystectomy. I think it's a great idea but it does raise a number of issues, for systemic implementation. You either need to train the surgeons to do it or you need to expand the gynaecological input to be available when these operations happen. All things have their challenges, huge challenges. So I think from a point of view of systemic implementation, it is going to be challenging.

But definitely, I suppose for that argument any intraabdominal surgery, not just cholecystectomy, could be used as an opportunity to do this. One, to counsel the women. Two, to undertake the procedure. I think even from a systemic point of implementing it across gynaecology has its challenges across various health systems and maybe some health systems are better geared to do it than others.

There's definitely a training issue in our health system and one of the papers we published demonstrated that even a number of senior obstetricians and gynaecologists would be uncomfortable with having to do it routinely. In our general obstetrics and gynaecology training curriculum, doing a hysterectomy independently is no longer needed to get your CCT. So, regrettably people are not coming out with the same level of skills they used to. So there is a training and workforce issue to be implemented across the board.

Also, from the point of view of confounders, it is really interesting that Professor Henrik Falconer who published initial data from Sweden and clearly showed a 65% risk reduction with salpingectomy. He republished recently, adjusted for pelvic inflammatory disease in the data set. And the effect size came down from 65% to 28%. So it has a hazard ratio of 0.72 instead of 0.35. So there is an issue about needing more robust data around effect size, adjusting for confounders to make better informed decisions. I think the cost-effectiveness of the procedure is also dependent significantly on the effect size. So unless we have good data on that, uncertainty will remain. I think that does need further work in the literature. There are papers suggesting it would be cost-effective but I think they are limited predominantly by what the right effect size is.

The other issue with salpingectomy is that we don't know the long-term impact on ovarian function. There's good data that there is no detrimental short-term impact, probably. But that is not predictive of menopause. So that issue has not been addressed properly and there's no shortcut to long-term follow up data. We do need to come together to collect these data and we've spoken about it before and I think there's a need/desire for us to come together to do something in a large way, to collect these data. Ideally you need an RCT but I suspect doing that will become really challenging and there may not no longer be equipoise for that. So implementing a randomised trial will be hugely difficult. But definitely there is an opportunity to design and implement prospective cohort data collection and there is a need to do that. Even when you take the tubes out there is some fimbrial tissue left on the surface of the ovary. We demonstrated that there is another paper in the literature showing the same thing, these are hypothesis-generating rather than saying it is actually a site of carcinogenesis.

So there are a number of issues in the literature which need to be addressed. Will salpingectomy prevent ovarian cancer? Yes, it will prevent ovarian cancer. What proportion will it prevent? It's difficult to say, it depends on what data you look at and who you ask and what people believe. But there is a limitation to the quality of the data that's currently available from the point of view of ovarian cancer risk reduction. And I think from an epidemiological point of view we need more robust data collection which is long-term in perspective to address this issue properly. And also look at the menopause issue. So I think those are the sort of the limitations around opportunistic salpingectomy at the moment.

***ES: And how much do we know? You know that, obviously, there is a different group of women who are undergoing fertility treatment and when they are diagnosed with hydrosalpinges we do salpingectomy. And these women are actually quite well-assessed before and after their salpingectomy, that they either have AMH, although, AMH may not necessarily help in all, but it should if they are having bilateral salpingectomy. But also, some of them have unilateral salpingectomy, and antral follicle count actually is a good surrogate marker there. And amongst us, as fertility specialists, there is some concern that, especially if you don't do that operation well enough, you do cause a significant impact on ovarian reserve on the same side. So I wonder whether one can actually extrapolate data from fertility patients to the risk reduction group.***

RM: I think if you have long-term outcome data and if you can get the cohort, then definitely you could analyse outcome data if you have ovarian cancer incidence. What you raise is an interesting, important point. There is also data on this issue of salpingectomy in the American Journal, which shows menopause symptoms coming on a year earlier after salpingectomy. We know that if we take one side ovary out, you get early menopause. So again, I think that these questions need to be addressed. If you want to correlate it with the last menstrual period and actual menopause, then we need to follow the women up for a substantial duration of time to see that outcome and I think those analyses need to be done, ideally prospectively. But if those data sets exist as you described, then long-term data with ovarian cancer incidence would be a really helpful thing to look at.

***ES: You also mentioned early salpingectomy and delayed oophorectomy concept?***

RM: Yes, I think it is an attractive concept for women who are at increased risk of ovarian cancer. A number of women who undergo surgery for prevention who are at increased risk do so pre-menopausally and that sends them into surgical menopause. That's associated with hot flushes, sweats, irritability, mood swings, osteoporosis, neuro-cognitive problems, an increased risk of heart disease, sexual dysfunction and detrimental consequences which a number of them are quite concerned about. In our experience and our data suggest that they can be split largely into two groups – one group of women who want to maximize ovarian cancer risk reduction and therefore will opt for surgical prevention in the form of full salpingo-oophorectomy, and another group of women who are more concerned about sexual dysfunction and menopause symptoms and tend to avoid or delay salpingo-oophorectomy and they tend to prefer the early salpingectomy option. So we've found good acceptability of early salpingectomy in some of our studies and there's a higher regret rate of about 10% in women who undergo premature surgical menopause compared to those who have post-menopausal salpingo-oopherectomy, for which the regret rate is just 1%. So definitely it's an issue, although there is high satisfaction with the operation amongst all these groups of women with an increased risk.

So given the issues around salpingectomy, there's no prospective data showing what proportion of cancers we'll prevent. If I take the tubes out in these women they are still at an increased risk. The data from the BRCA population shows that 5% of these women have STICs, or occult early invasive disease, and in 7 out of 10 of those these lesions are in the tube, not the ovary. But we don't know what proportion of cancers we will prevent just from salpingectomy alone in high risk women. There's a lot of things we understand better about aetiopathogenesis of ovarian cancer but also there are things which have not yet been elucidated and things we don't know. We don't know what the precise trigger is. They may develop a STIC, there may be precursor escape and other routes of carcinogenesis. So there are things which are unaddressed. Genomically BRCA STICs may be different from general population sporadic ovarian cancer STICs. So the number of unaddressed issues about the impact on menopause, the lack of outcome data on the effect size of risk reduction, and the fact that it's taking tubes and ovaries out, which shows that ovarian cancer risk is reduced.

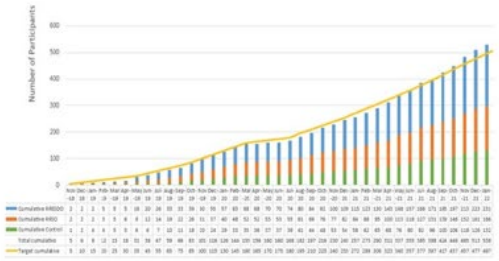
I think there's general consensus that this procedure should be offered in a research context. So we have research studies running. In the UK, we have the PROTECTOR study, we are running it across 38 sites. We have recruited about 500 women, we want to go to a thousand and then develop a long-term follow up cohort. The Dutch are running the TUBA study and in the US there are a couple of studies running, one is the WISP study. The Dutch and the WISP groups are also combining to do the TUBA-WISP-II study. So there are on-going studies. The first study was actually a fimbriectomy study, which was undertaken in a small number of women, around 120 or so, from France by Professor LeBlanc. So there are a few studies there which will produce data over a period of time. And all these data probably need to come together to answer the question of what proportion of cancers we reduce the risk by undertaking early salpingectomy.

As data emerge, we will gradually, hopefully, be able to make more informed decisions and let patients know by what level their risk reduction may be, so that they can make more informed decisions. From a quality of life point-of-view, the emerging data already suggests that salpingectomy is associated with lower menopausal symptoms and better sexual function than salpingo-oophorectomy. But that's what you would expect to see. So I think this should still be done in a research setting. There also are concerns about attrition from delayed oophorectomy so it's better offered within a controlled environment at present as these data accumulate.

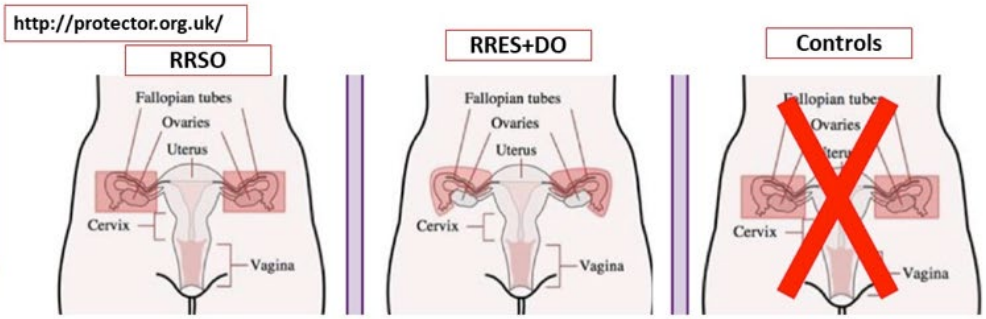
***ES: Good. Were there any other points that you highlighted in your keynote lecture in Rome that you would like to add?***

RM: I think I mentioned the issues around opportunistic salpingectomy. From an early salpingectomy perspective, it is an alternative to premature surgical menopause which has a detrimental impact on the sexual function and menopause outcomes. Early salpingectomy does have good acceptability, fewer menopause symptoms, better sexual function, but the long-term impact on hormonal function and cancer incidence is not known and should therefore be offered in a research context.


To evaluate the impact on sexual function with ES and DO, as a two-step OC prevention strategy in premenopausal women at high-risk of OC








***ES: So you're reiterating that when we're talking about an intervention we also need to talk about collateral damage, not only reduction but also quality of life.***

RM: Yes, quality of life is important and we don't know if after early salpingectomy you can get an interval cancer or not, so that's the concern. So we need careful follow-up of these women at the moment as we understand this better.

***ES: And on a general subject, did you enjoy the Congress in Rome?***

RM: Yes, thank you very much, it was fantastic. It was the first meeting after COVID started, it was wonderful to get out and attend a meeting and thank you for having me there. I really enjoyed the meeting, it was very well attended, there were a thousand people, which was amazing.

***ES: It was our pleasure to have you there, thank you. I hope that we will be able to repeat it again at some stage.***

RM: I hope so too, yes. I think within the new normal you have to live this new normal, it's not going away. It's going to continue like this for a few years and we just need to carry on and find ways of meeting together and holding these conferences which are very important and exchanging ideas.

***ES: Good. Anything else you'd like to add on this specific topic?***

RM: I think surgical prevention is really important for tackling ovarian cancer and is becoming more and more important. For ovarian cancer screening at a population level, we don't have a screening modality which works. The recent screening trials have not shown a mortality impact. Of course screening is not the same as prevention. Unlike breast cancer we don't have a valid ovarian cancer screening strategy for the larger population. So using prevention to tackle the burden of disease is going to be more and more important in the future. One in five of ovarian cancers, approximately 1 in 5 to 1 in 6, are caused by high-risk genes. And these are potentially preventable. So if we treat ovarian cancer, if we do gene testing for everybody and we pick up someone who has a high-risk gene, then arguably that patient could have been prevented from getting ovarian cancer. And potentially that's a failure of cancer prevention. So we need to address that issue.

***ES: Great, thank you very much Ranjit for talking to me.***

# News From ESGE Special Interest Groups and Working Groups

## SIG Endometriosis

*Jörg Keckstein, Ertan Saridogan (SIG Endometriosis)*

## Classification of endometriosis, a never-ending story? Or, is there a solution?

### Facts:

Endometriosis is a very 'individual' disease, which in recent years has been treated with new therapeutic concepts through much more differentiated diagnostics and individualised surgery. For many decades, attempts have been made to record the extent of the disease through descriptions, documentation and classifications. The aim is to learn more about the dynamics of the disease in terms of symptoms, therapeutic procedures and prognosis. Most of these classifications have been created from the findings diagnosed during surgical procedures. The advantages and disadvantages of the different classifications should be evaluated and compared in appropriate studies. The ESGE has been dedicated to the surgical treatment of endometriosis for many years by developing advanced surgical endoscopic procedures.

Purely diagnostic laparoscopy is usually no longer suitable for diagnosing the disease and determining its extent in its entirety. This is often only achieved by very extensive and sometimes also clearly risky interventions. Advanced endoscopic surgery usually leads to a significant improvement in the patients' quality of life, but it is essential to openly discuss the risks as well as the benefits.

In addition, non-invasive procedures such as transvaginal sonography(TVS) and MRI have become established for precise imaging of the localisation and extent of the disease. For this reason, questions have been raised in the past as to whether a comprehensive classification for the disease is meaningful and possible. The rASRM classification is used worldwide because, despite detailed calculations, it can ultimately be reduced to only four stages. This may seem more feasible and understandable for the surgeon and also the patient. However, it has clearly been shown that this simplification could result in a significant loss of information and possibly lead to wrong conclusions during the decision to treat process.

That there is a great need for a common language for different forms of endometriosis is shown by the various working groups of ESGE, which cooperate in particular with other important societies in the field of endoscopy and endometriosis.

An ESGE/ESHRE/WES working group worked very intensively on the surgical therapy of endometriosis. Two important publications with recommendations for ovarian and deep endometriosis resulted from this work (1,2).

### Views:

On the way to finding an all-satisfactory classification, another ESGE working group in collaboration with ESHRE, WES, AAGL, reviewed the classifications published to date (22 various classifications). In the resulting publication, the authors came to the conclusion that there was probably no ideal method for classifying or describing endometriosis (3). However, is it possible that there will never be a definitive system as we all continue to evolve both clinically and scientifically to better understand and treat endometriosis?

Ultrasonographers and radiologists clearly show that non-invasive methods for detecting endometriosis are also very well suited to depicting and describing the extent of the disease in detail. For this purpose, special classifications have been proposed and used by various working groups (4). This means that the significance of the surgical classification will have to be completely re-evaluated. In the future, purely diagnostic laparoscopy for the detection of endometriosis will perhaps only be useful in selected cases.

Members of the ESGE Endometriosis SIG, in collaboration with expert sonographers, have begun a search for a better classification for both non-invasive and invasive diagnosis for endometriosis over the last two years. The aim was to come up with a classification that should be comprehensive, easy to use and also well suited for clinical as well as scientific purposes. With the new #Enzian classification was prepared with this objective, eliminating the need to use several classifications in parallel or separately (4).

The #Enzian classification is based on the findings of the original Enzian classification, which was created only for deep endometriosis and is used in combination with the rASRM classification. #Enzian now completely considers all other localisations. It describes the various anatomical structures and also assesses the size of the foci of deep endometriosis. This new classification is applicable both surgically and non-invasively (in the context of TVS and MRI).

The discussion on this project was prepared by Jörg Keckstein and presented by Ertan Saridogan at the ESGE 30th Annual Congress in Rome in October 2021. Furthermore, a review paper was prepared and published in Facts, Views and Vision, describing and analysing the advantages and disadvantages of the most commonly used systems classifications (5).

The new #Enzian classification currently refrains from a simplified classification of endometriosis into a few stages. The validation of this new comprehensive classification has just been analysed in both retrospective (6) and prospective studies of 745 patients (7) . The results showed a significantly high agreement between sonographic and surgical classification in most compartments. These promising data are currently being verified by means of further studies.

The possibility of using a classification for both non-invasive and surgical treatment could facilitate the assessment of symptoms, benefits and risks of different treatment options.

## Vision:

The latest project of the ESGE Endometriosis SIG, in collaboration with ISUOG, EEL, IDEA, ESHRE, ISGE and AAGL will develop a consensus statement on the “Use of imaging techniques for the non-invasive diagnosis and classification of endometriosis” to be published jointly in Ultrasound in Obstetrics & Gynecology, Human Reproduction Open, Journal of Minimally Invasive Gynecology and Facts, Views & Vision. ESGE members contributing to this project are J. Keckstein (Austria), E. Saridogan (UK), G. Grimbizis (Greece), U. Ulrich (Germany), M. Mueller (Switzerland), M. Nisolle (France), H. Ferreira (Portugal), FW Jansen (The Netherlands), Arnaud Wattiez (UAE) and Jim English (UK).

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# SIG Urogynaecology

ESGE Urogynaecology Special Interest Group organised a webinar on the 24th of April 2021. The following text summarises the contents of this webinar. The aim was to present the technical aspects and the results of sacrocolpopexy and its alternatives, including pectopexy, lateral suspension or meshless laparoscopic management of pelvic organ prolapse (POP). The alternatives to currently available meshes, the learning aspects of these techniques and the long-term results of laparoscopic sacrocolpopexy are developed.

## Alternatives to laparoscopic sacrocolpopexy

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### Introduction (L. de Landsheere)

Since 2008 and the first FDA warning regarding the severe adverse events related to transvaginal mesh surgery, the surgical management of pelvic organ prolapse has dramatically changed. Vaginal surgery using native tissues has reemerged as well as laparoscopic management of pelvic organ prolapse (POP) has developed and gained in popularity. Sacrocolpopexy is considered as the "gold standard" for management of women with apical prolapse (Maher et al., 2013). But in some cases, access to the promontory can be challenging (such as severely obese patients, adhesions over the promontory, unusual low position of the iliac vessels). When this occurs, one can switch to alternative techniques, like pectopexy, lateral suspension, or to the vaginal route. The second concern is the use of meshes in pelvic floor repair. In April 2019, the transvaginal mesh-related complications led the FDA to ban the use of all types of transvaginal meshes. But it is possible over time restrictions may also be extended to meshes used for abdominal repair of prolapse or even incontinence. One way to avoid these graft-related complications is the development of mesh-less laparoscopic treatments of prolapse. Apart from that, there is a need for training and teaching in standard and any innovative techniques as well as the reporting of medium and long-term outcomes of both standard laparoscopic sacrocolpopexy or any of its alternatives.

### Laparoscopic pectopexy (GK. Noé)

Alternative to laparoscopic sacrocolpopexy (LSCP) for Delancey levels 1 or 2 support can be useful in case of severe obesity and can also probably reduce defecation disorders related to disturbances in the control nerves of the rectum (Coolen et al., 2013; K.-G. Noé et al., 2015). In addition to other factors such as unfavorable position of the large vessels in relation to the promontory or other problematic anatomical conditions, this has motivated our team to develop an alternative and to evaluate it scientifically. The pectineal ligament (or Cooper's ligament) runs along the inside of the pubic bone. It is therefore slightly inclined to the body axis from anterior to posterior. The section to be reached on the dorsal side lies in relation to the longitudinal body axis at the level of the sacral vertebra 1. Therefore, an attachment there allows the vaginal apex not to be lifted from its natural level. Computer analyses have shown that the bilateral suspension has a beneficial effect on the shearing forces occurring on the pelvic floor, with potentially favourable impact on the risk of mesh exposure (Bhattarai & Staat, 2020). In 2011 we published the first pilot study and a precise description of laparoscopic pectopexy (Banerjee & Noé, 2011). More than 40 publications on pectopexy by different groups have since been published in the peer reviewed literature. The operative outcomes, the short and medium-term results were evaluated in randomised studies in comparison to laparoscopic sacrocolpopexy (K. G. Noé et al., 2013; K.-G. Noé et al., 2015). In summary, no decisive new risks for the pectopexy were reported and there were no significant operational differences. A follow-up over 2 years showed a significantly better performance regarding defecation disorders for the pectopexy as well as significantly less occurring de novo lateral defects. A prospective, international multicenter study was initiated to evaluate the application of the technology outside the development centre (G. K. Noé et al.,

2020, 2021). A total of 501 performed pectopexies could since be evaluated. Only three visceral injuries (two bladder and one ureter) occurred, all of which could be managed intraoperatively. The operating times for the pectopexy together with the additional interventions for other defects were comparable to study data for sacropexy using deep mesh placement. Overall, the implications, as well as the operative data, were also convincing in the multi-center application. The anatomical success rate for apical suspension was 97%. All typical POP complaints could be positively influenced to a high degree. The reintervention rate due to complications, de novo defects or complaints was only 3.5%.

In conclusion, the laparoscopic pectopexy is a clearly defined alternative strategy with less impact on the pelvic space and nerves. In a randomised controlled trial with a mean follow up of 28 months, outcomes were equal, and complications comparable with LSCP, with an advantage in terms of defecation. In an international, prospective trial the transfer from the specialised development centre to multiple surgeons with different volumes, showed a low complication rate and a notably good outcome with high satisfaction rates. Native tissue repair combined with an effective apical fixation provides a good outcome and less mesh use of artificial material in sensitive areas.

## Lateral suspension (J. Dubuisson)

Laparoscopic sacrocolpopexy using mesh is currently considered a reference procedure for symptomatic pelvic organ prolapse repair (Maher et al., 2013). However, the dissection of the promontory area may represent a challenging surgical step, especially in patient with obesity, severe pelvic adhesions, megacolon, large varicose veins, or vascular anomalies such as low bifurcation of the vena cava with coverage of the promontory with the primary left iliac vein or artery. In addition, a recent study reported that de novo back pain occurs in up to 50% of patients after LSCP with the use of sutures or tackers on the promontory (Vieillefosse et al., 2015). Moreover, there is a risk of spondylodiscitis at the points of fixation on the promontory, although this complication is rare (Brito et al., 2015). As early as the 90s, the technique of lateral suspension (LS) by laparoscopy was developed to simplify LSCP and to avoid the potential operative complications related to it (Dubuisson & Chapron, 1998). The current indications of LS are symptomatic anterior POP and apex descent. Uterine preservation is preferred if the uterus is healthy, but LS is also efficient and proposed for post-hysterectomy vaginal vault prolapse. LS with mesh can be performed via a laparoscopic or a robotic approach. The procedure is now well standardised. Its originality is the subperitoneal tunnel of the lateral long arms of the T-shaped mesh through the lateral abdominal wall, leaving the skin above the iliac crest. The suspension axis is strictly transverse so that the preserved uterus or the vaginal vault remains in the centre of the pelvis. Concerning the anatomical and functional results, the largest series evaluated 417 patients treated between 2003 and 2011 at the University Hospitals of Geneva, Switzerland (Veit-Rubin et al., 2017). At the 1-year follow-up, 78.4% of patients were asymptomatic, and the anatomic success rates, defined by the POP Quantification grading system (POP-Q) points Ba, C and Bp of less than -1cm, were 91.6% for the anterior compartment, 93.6% for the apical compartment, and 85.3% for the posterior compartment. The rate of complications (Clavien-Dindo grade 3 or higher) was 2.2% at 1-year follow-up. After LS, only 7.3% of patients underwent reoperation for POP with a follow-up of at least 4 years.

In conclusion, lateral suspension using mesh represents a safe and efficient alternative to treat POP, especially if the surgeon prefers to avoid the dissection of the promontory and preserve the uterus. A randomised controlled trial comparing both LSCP and LS procedures should be conducted.

## Mesh-less laparoscopic POP treatments (R. Botchorishvili)

Large amount of clinical data supports laparoscopic prolapse treatments as very efficient and safe. However, recent data clearly shows that the use of meshes can be responsible for rare but serious complications, with severe morbidity and sequelae, usually difficult to treat and which often require multiple interventions to solve the problem. Complications related to the use of transvaginal meshes are more frequent compared to laparoscopy (Gornall, 2018). However, graft-related complications also occur during laparoscopic surgeries. Moreover, recent studies show that the use of synthetic meshes (like polypropylene meshes), regardless of the surgical technique, can be responsible for autoinflammatory/autoimmune phenomenons (Cohen Tervaert, 2018). Unclear future of the synthetic meshes obliges the gynaecologists to find an effective alternative way of management of patients with POP. Mesh-less techniques may present a valuable alternative to the usual laparoscopic surgeries with good results in clinical studies (Syed et al., 2021). Laparoscopic vaginal repair or “internal colporrhaphy”, by cervical and rectovaginal

fascia plication, already described in the vaginal approach can easily be adapted and performed laparoscopically (G. K. Noé, 2021; G. K. Noé et al., 2019). Deep vesico-vaginal and rectovaginal dissection is mandatory to perform efficient internal colporrhaphy and to reduce the risk of recurrences (Halpern-Elenskaia et al., 2018). The use of delayed absorbable suturing material may also be of interest (Bergman et al., 2016). The treatment of apical compartment and the restoration of the DeLancey level I support is cornerstone of the POP surgical treatment. Laparoscopic sacrocolpopexy (LSCP) is considered as a "gold standard" for this indication (Maher et al., 2013). Various techniques of utero-sacral ligaments suspension are well known; however, the long-term results of these techniques are clearly inferior to the results of laparoscopic sacrocolpopexy due to the reduced strength of these ligaments in patients with POP (Donaldson et al., 2021; Lin et al., 2005; Rondini et al., 2015). The use of fascial or aponeurotic tissues instead of meshes, also proposed by some authors, appears to be aggressive in the era of the minimally invasive surgeries (Hornemann et al., 2020; Seth et al., 2019). They require preliminary removal, often by laparotomy. Before the era of meshes, vaginal or cervical suspension to the sacrum or the promontory was achieved with threads. The technique of suspension using just suturing material can be updated laparoscopically (Seracchioli et al., 2018). After total or supracervical hysterectomy, the vaginal cuff or cervical stump can be suspended to the promontory using a nonabsorbable polypropylene suture. The continuous suture is realised along the right utero sacral ligament, assuring safe and simple suspension of the apical compartment. Suture hysteropexy without mesh is also feasible (Jan & Ghai, 2019). Mesh-less pectopexy is also conceivable using just permanent threads which are incorporated into the round ligaments bilaterally (Liang et al., 2017).

In conclusion, the use of mesh may be responsible for severe adverse events. At same time mesh-less laparoscopic prolapse surgery offers various technical possibilities to treat POP. To avoid recurrences, deep dissection of the spaces to repair is important, as well the use of delayed absorbable suturing material for the internal colporrhaphies and of non-absorbable threads for the promontory or pectineal ligament suspensions. Despite some promising data on the laparoscopic mesh-less prolapse surgery, we lack long term results. However, we must be prepared to practice these techniques if meshes were to be banned. For the success of the mesh-less laparoscopic prolapse surgery the excellence in laparoscopic suturing techniques is mandatory.

## Alternative to currently available meshes (R. Devassy)

The advantages of mesh surgery to treat pelvic organ prolapse are well known. However, the negative impacts of meshes cannot be ignored. With the recent FDA warning on placement of transvaginal meshes, it is imperative to plan a meshless era or alternative prolapse repair, while achieving the similar success rates and the lifestyle comfort of minimal access surgery (MAS), either vaginal or abdominal (Devassy et al., 2013). Laparoscopic surgery has given more perspective to prolapse surgery, but the mesh problems seem to have reemerged in this category of patients as well, for numerous reasons such as its widespread use, the absence of standardisation of meshes and application methods, the lack of systematic training in techniques and the mesh properties.

Native tissue repair and alternative fixation methods have shown initial evidence of success with less complication rates (G. K. Noé et al., 2021). Standardisation and implementation of MAS in pelvic organ prolapse surgery is necessary. The complications associated with prolapse surgery using mesh need to be kept in mind to consider future accountability (Aleksandrov et al., 2021; Paz-Levy et al., 2017). Vaginal Incision or breach of the epithelium, even by a laparoscopic approach (like in laparoscopic total hysterectomy) increases the risk of mesh exposure. However, if placed laparoscopically, this risk is reduced. The rigid and sharp texture of meshes like polypropylene or composite can cause mesh protrusions in the surrounding structures (viscera, nerves, and vagina) even without incision. Solution is to reconstruct and reinforce native tissue and types of prosthesis that do not have property by itself to cause erosion.

- Polypropylene – Good fibrosis, Cheaper, higher erosions
- Goretex – High rate of infection, rejection, costly, may require removal
- Biosynthetic – Applicability, Cost, availability,
- Dynamesh – Biocompatibility, good dynamometric properties
- Polyester (Parietex, Parietex ProGrip) – Infection comparatively lesser, Applicability

It is a fact that treatment of POP often requires surgical repair. Both abdominal and vaginal routes have been found to be anatomically appropriate. Laparoscopic methods have proven to be effective and equivalent to traditional laparotomy techniques.

The question which is pertinent would be if the future repair directing towards mesh or native tissue repair and what results can we deliver without compromising the patient safety and efficacy? In the future, evaluation of the patient by simulation to assess the feasibility of a particular repair to plan a strategy would support the cause (Wattiez et al., 2016). LSCP Sacral has been a part of standardised practice (Campagna et al., 2020). However, implementing a change of this practice without using a mesh could be difficult for most MAS surgeons. It would be now a time to practice alternative methods or change the type of prosthesis that will be suitable both clinically and legally.

## How to learn these techniques? (H. Ferreira)

The genital prolapse surgical correction is a challenging procedure that restores the quality of life of those women who suffer from pelvic floor failure complaints (Ferreira et al., 2016). Despite the adopted technique, the goal is to repair the pelvic anatomical defects responsible for the prolapse. For that, the surgeon must know the structural and functional pelvic anatomy. It is also of paramount importance to have robust suturing skills and dissection competencies. The learning process to perform the surgical repair should be well organised and efficient. Based on the current best scientific knowledge, the Gynaecological Endoscopic Surgical Education and Assessment (GESEA) programme is a unique diploma programme developed to provide a structured, educative path to achieving a minimally invasive gynaecological surgeon proficiency (Ferreira et al., 2018). The programme is founded on the evidence that an endoscopic surgeon requires two different skill sets. On the one hand, the instrument handling skills needed to deal with the challenge of working in the endoscopic environment and, on the other hand, the surgical competencies.

Therefore, to learn the alternative techniques to sacrocolpopexy, it is recommended to get the knowledge and the competencies offered by the GESEA well-balanced diploma curriculum developed by ESGE in collaboration with +he European Academy of Gynaecological Surgery.

## Outcomes of standard laparoscopic sacrocolpopexy (J. Deprest)

In 2012 *level I evidence* became first available that laparoscopic sacrocolpopexy (LSCP) yields as good anatomic (Pelvic Organ Prolapse Quantification System (POP-Q point C) and subjective (Patient Global Impression of Improvement-score) outcomes as the same operation by laparotomy. Moreover, LSCP was associated with less blood loss, less pain and a shorter hospital stay. Conversely, operation time, return to normal activities, or functional effects were similar for both modalities (Freeman et al., 2013). Since other studies have confirmed these outcomes (Coolen et al., 2013; Costantini et al., 2016; De Gouveia De Sa et al., 2016). There are numerous reports on the good outcomes of LSCP, most of them retrospective in nature, monocentric or from a single surgeon, often rather small, potentially including the learning curve (Claerhout et al., 2014). A somewhat dated review on 11 retrospective studies (n=1,197 patients at a mean follow-up of 24.6 months) reported overall objective anatomical and subjective success rates of 92% and 94.4%, respectively (Ganatra et al., 2009). Today larger single center series have confirmed the efficacy of LSCP and acceptable short term complication rates (Vandendriessche et al., 2015; Vossaert et al., 2018). We implemented LSCP already in the late 1990s, and earlier reported on the medium-term outcomes (Vandendriessche et al., 2017). At a mean follow-up of 12.5 months, we observed an anatomical cure rate approaching 95% and a functional cure rate of 92% (Vandendriessche et al., 2017). Since we have reported on the long term outcomes in a prospective cohort of 331 consecutive patients with a POP-Q stage ≥2, who had LSCP with a minimum of 1.5 years follow-up (Deprest et al., 2009). Primary outcome measures were Patient Global Impression of Change-score (PGIC) and failure at the apex (=C≥-1 cm; POP-Q stage≥2) (Claerhout et al., 2010). Secondary outcomes were anatomical failure in other compartments, duration of follow-up, occurrence and time point of complications, re-interventions, functional outcomes by response to a standardized 24-questions interview on prolapse, bladder, bowel, and sexual function. Our follow-up rate was 84.6%. Of these patients, 56% were both examined in person and interviewed and 26% were interviewed only.

The median age at interview was 72 years at an average follow-up of 85.5 months (IQR 46). Approximately 83% reported improvement, 6% were unchanged, 6% felt slightly worse and 7% reported clear deterioration (Figure 1). Anatomical failure at point-C was 9%; anterior (22%) and posterior (29%) prolapse were more common than apical prolapse (Figure 1). Of those with level-I anatomical cure, 10% felt worse; half of them because of prolapse in another compartment. The others had urinary problems, obstructive defecation, or dyspareunia. Conversely, most patients with recurrence at the vault considered themselves improved, demonstrating the discrepancy between signs and symptoms. There were 18% re-operations, including 7% for graft related complications and 3% for prolapse. In conclusion, over four out of five patients feel improved 86 months after laparoscopic sacrocolpopexy. Of those who do not feel improved, two thirds have recurrent prolapse, however typically mid-vaginal rather than at the apex. The other third report urinary, bowel problems or dyspareunia. We also looked at the safety of LSCP in the elderly. With increased activity and a healthier population, POP surgery, hence also the demand for vault suspension in the elderly will increase accordingly. Therefore, we compared perioperative outcomes in patients under and above 70 years part of a larger consecutive cohort (n=571) undergoing LSCP at a median age of 66.3 years (range: 27-91) (Vossaert et al., 2018). In our hands, septuagenarians were not more likely to have intra-operative (4% >70 years vs 3% <70 years, p=0.686) or early postoperative complications (14% vs 16% <70 years, p=0.455) than younger patients. Mesh complications were also equally uncommon (Vossaert et al., 2018). Therefore, we also offer LSCP to this age group.

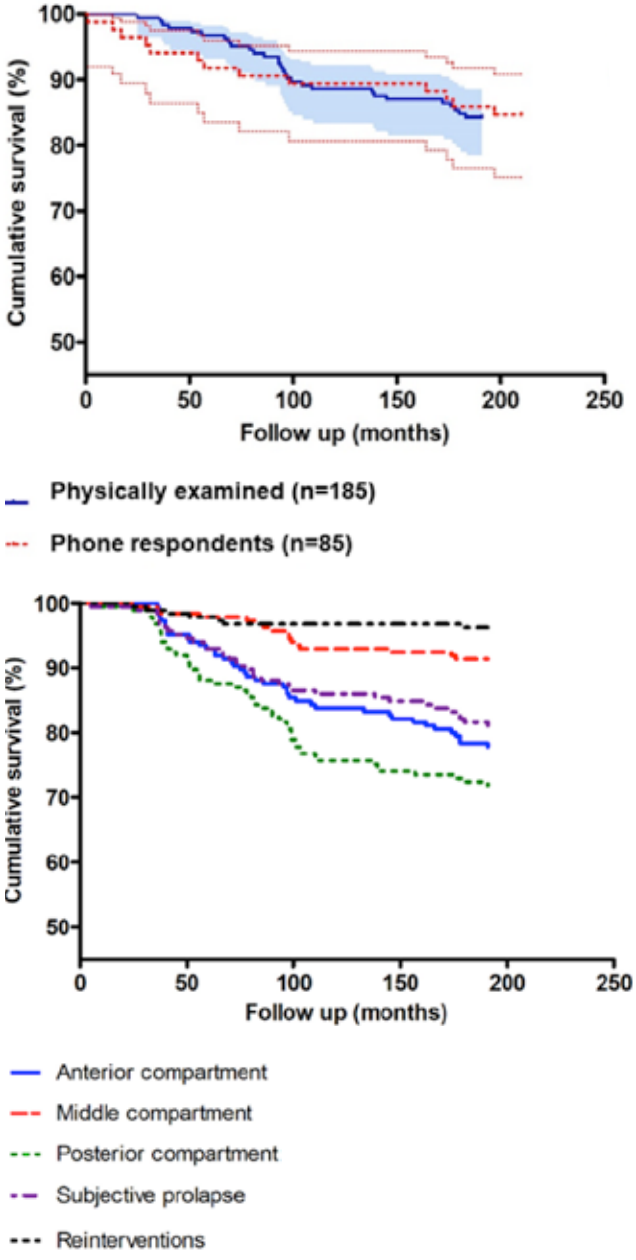


**Figure 1:** Left: Graphical display of time course of the fraction of patients with a PGIC≥4 in the 85 phone respondents and in the 185 patients who were physically examined (p=0.86). The Y-axis starts at 50%; confidence intervals are shaded or indicated by dotted lines[10]. Right: Graphical display of time course of anatomical findings, recurrence of prolapse symptoms and reintervention for prolapse. The Y-axis starts at 50%. Confidence intervals (CI) were left out for clarity.

## Conclusions

Laparoscopic sacrocolpopexy offers good long-term results but can lead to severe complications. This technique may be challenging because of difficult operating conditions (obesity, limited access to the promontory, etc.). The emergence of alternatives to the LSCP widens the panel of POP management possibilities. Functionally, LSCP may have unfavourable effects such as defecation or urinary dysfunction, or dyspareunia and these outcomes could potentially be less impacted by lateral approaches. The use of meshes is also increasingly being criticised because of their potential of graft related complications. Meshless treatments are currently not widely practised but may be a valuable alternative to LSCP. Rigorous evaluation of any of these innovative techniques is essential, and their anatomical and functional results must be compared to the gold standard LSCP in large randomised clinical trials to avoid the pitfalls that have been encountered in the past. To perform these procedures in optimal conditions, urogynaecological surgeons must acquire specific skills in anatomy, dissection, and suturing. Training and teaching in these techniques must be organised, for instance by specific endoscopic training courses such as the Gynaecological Endoscopic Surgical Education and Assessment (GESEA) program. The ESGE special interest group of urogynecology recommends and encourages young surgeons to participate in these education programs.

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***Rudy Leon De Wilde and Rajesh Devassy***
*ESGE-GESEA Ambassadors for South-East Asia*

# GESEA Asia Programme

Overall, the COVID-19 pandemic has had a devastating impact on active projects, the woes of the healthcare industry are particularly known. In countries where only onsite learning is applicable and still has not returned to normalcy, struggle continues. In Asia and especially East-Asia, unlike the rest of the world, on-site learning and teaching opportunities have had a significant impact in these 2 years of the pandemic.

During the pandemic, learning has moved significantly toward online channels, and industries have responded in pursuit. The attendance results confirm the rapid shift toward interacting with faculty through digital channels. They also show that rates of adoption are years ahead of where they were and even more in developed Asia than in other regions. Respondents are three times likelier now than before the crisis. However, the healthcare industry still lacks the element of the in-person feel. This was realised in response to the much-awaited ESGE Annual Congress Rome 2021.

GESEA in Asia would pursue beyond the boundaries of the pandemic. Asia occupies 30% of the world and over 60% of its population, Asian partners have always cooperated with the ESGE in promoting scientific excellence in the region. Therefore, our commitment remains cardinal to promote educational activities in the region.

## A. Lecture: Training and certification in GESEA Taiwan Association for Minimally Invasive Gynecologic Annual Meeting (TAMIG) 24th October 2021

## B. GESEA new Diploma / accredited centres accreditation process for Asia region Including China

1) The first step would be to begin with the accreditation process in the existing and ready MIGS certified member institutes: Indonesia, India and Philippines
2) The second step is to start identifying and establishing key centres to implement on-site GESEA -MIGS certification in China
3) Therefore, these MIGS qualifiers to be motivated to become GESEA Diploma / Accredited centres in China

## C. Fellowship Programmes at our partner GESEA centres outside Europe.

We foresee this as an attractive incentive for the GESEA centres to become accredited.

The shift to online methods could be in the advantage of having less time for travel and outstation accommodation. However, the future still needs the physical nature as in the science we deal with – The Humans. Therefore, we continue in a momentum to the future, free from the pandemic. In the future, purely diagnostic laparoscopy for the detection of endometriosis will perhaps only be useful in selected cases.

# ESGE Working Group on non-surgical ablative therapy of benign uterine disease

*Hugo Verhoeven, Rudy Leon De Wilde, Rajesh Devassy*

In spite of the difficult times of COVID-19, there was increasing scientific activity all over the world. For 2 years we have been trying to set up HIFU centres in Vienna, Dubai and Oldenburg. We couldn't make any progress due to the strict travel policy implied by the Chinese government. The WG is planning to research more studies in the future especially on side effects and contraindications of non-invasive therapies in benign uterine disease, and to publish our work in leading journals.

## A. Scientific activities In Year 2020-2021

1) Several lectures, workshops and symposia all over the world were planned, however, most of them were cancelled or postponed. The WG was active especially outside of Europe. We had lectures on minimal or non-invasive treatment of benign disease of the uterine wall in Africa, South-America and the Middle East.
2) APAGE-ISMIVS HIFU 2020 Webinar: Hifu and fibroid part 1, China Singapore, June 11, 2020
3) APAGE-ISMIVS HIFU 2020 webinar: Hifu and fibroid part 2, China-Singapore, June 23, 2020
4) APAGE-ISMIVS HIFU 2020 webinar: Hifu and fibroid part 3, China-Singapore, July 3, 2020
5) APAGE-ISMIVS HIFU 2020 webinar: Hifu – spotlight on adenomyosis and infertility, China-Singapore, July 23, 2020
6) SESGE congress, Guangzhou, China, September 23-26.2020. Virtual lecture (September 26, 2020): non-surgical ablative therapy of adenomyosis
7) ESGE live event 2020, December 6-8, 2020: ESGE working group webinar: non-surgical ablative therapy of benign uterine disease (December 8, 14-30 – 16.30)
8) Endo Dubai 2021, virtual congress, Dubai, UAE, February 23-25 ESGE working group webinar: present and future of minimal access surgery in myoma therapy: where do we go from now (February 25, 18.45 – 20.15)

## B. Publications made in 2020-2021:

1) Torres-de la Roche LA, Verhoeven HC, De Wilde RL. Regarding "Laparoscopic Radiofrequency Ablation of Uterine Leiomyomas: Clinical Outcomes during Early Adoption into Surgical Practice". J Minim Invasive Gynecol. 2021 Jan;28(1):149. doi: 10.1016/j.jmig.2020.07.027. Epub 2020 Sep 17. PMID: 32950664.
2) Cezar C, Torres de la Roche LA, Hennefründ J, Verhoeven HC, Devassy R, De Wilde RL; Working Group on Minimally Invasive Therapy in Benign Disease of the Uterine Wall (European Society of Gynecological Endoscopy, ESGE). Can uterine artery embolization be an alternative to plastic and reconstructive uterus operation by minimally invasive surgery? GMS Interdiscip Plast Reconstr Surg DGPW. 2021 Jun 9;10:Doc07. doi: 10.3205/iprs000157. PMID: 34194918; PMCID: PMC8204672.
3) Torres-de la Roche LA, Devassy R, Makhlouf G, San Juan J, Eidswick J, De Wilde RL. Retroperitoneal angioleiomyomatosis. J Obstet Gynaecol India. 2021 Jun;71(3):337-341. doi: 10.1007/s13224-020-01404-7. Epub 2020 Dec 23. PMID: 34404967; PMCID: PMC8310811.

## C. Cooperation of ESGE WG and ISMIVS (International Society of Minimally Invasive and Virtual Surgery) WG

Because of the huge experience and amount of data in China and Asia, this ESGE-WG is proud to be able to cooperate with the ISMIVS Society in future, in order to further improve gynaecological surgery for the well-being of our patients. After the COVID- pandemic, we will surely be able to join forces with common scientific meetings and publications to follow.

## D. The cooperative ESGE-MESGE working group on non-surgical ablative therapy of benign uterine disease

The goal of this cooperative MESGE-ESGE WG would be scientific work on the above topic with studies, reviews, online meetings and symposia. A yearly get-together also during the ESGE and the MESGE Annual Congress with a special session of the new WG is set, starting 2022.

## E. We plan to include other societies at a later stage, that are currently very interested, could join with the ESGE WG cooperation.

# Adhesions Working Group

*Markus Wallwiener, Rudy Leon De Wilde, Rajesh Devassy*

It was yet another good year for the WG of Adhesions to publish and hold sessions. We realise the importance of this problem on a growing scale, since minimal-access surgery has been a common practice now. Therefore, detecting and treating adhesions have become easier, and therefore the pertinence for its prevention has become invariable.

## A. Scientific sessions:

An Expert Consensus Meeting: Clinical Trial Endpoints and Design for Post-Operative Tissue Fibrosis Drug Research on July 15th 2021 with 21 experts all around the world.

## B. Publications made in 2020-2021:

1) Lier EJ, van den Beukel BAW, Gawria L, van der Wees PJ, van den Hil L, Bouvy ND, Cheong Y, de Wilde RL; CLAS Collaboration, van Goor H, Stommel MWJ, Ten Broek RPG. Clinical adhesion score (CLAS): development of a novel clinical score for adhesion-related complications in abdominal and pelvic surgery. Surg Endosc. 2021 May;35(5):2159-2168. doi: 10.1007/s00464-020-07621-5. Epub 2020 May 14. PMID: 32410083; PMCID: PMC8057995.

2) Herrmann A, Torres-de la Roche LA, Krentel H, Cezar C, de Wilde MS, Devassy R, De Wilde RL. Adhesions after Laparoscopic Myomectomy: Incidence, Risk Factors, Complications, and Prevention. Gynecol Minim Invasive Ther. 2020 Oct 15;9(4):190-197. doi: 10.4103/GMIT.GMIT_87_20. PMID: 33312861; PMCID: PMC7713662.

3) Ziegler N, Torres-de la Roche LA, Devassy R, De Wilde RL. Changed inflammatory markers after application of 4DryField PH for adhesion prevention in gynecological surgery. Arch Gynecol Obstet. 2021 Oct;304(4):951-955. doi: 10.1007/s00404-021-06095-7. Epub 2021 Aug 6. PMID: 34357446; PMCID: PMC8429371.

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***Attilio and Justin at AAGL. Attilio is the one in the cowboy hat!***

# Proposal for a European audit of hysteroscopic myomectomy by ESGE members

**T Justin Clark, President,**
**British Society for Gynaecological Endoscopy**

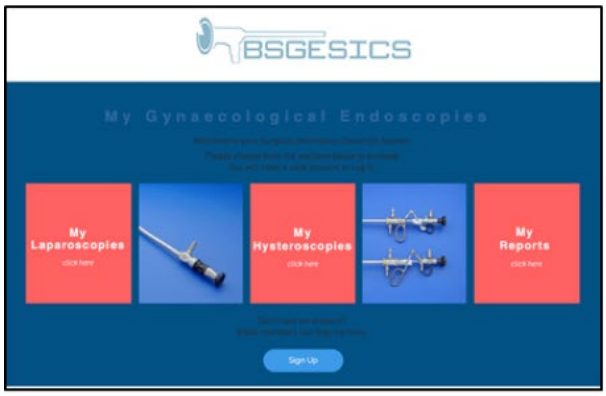
This year, the ESGE President, Professor Giovanni Scambia and the Congress I have just returned from the 50th AAGL conference in Texas where there was an interesting hysteroscopy session (moderated by Keith Isaacson from Boston, USA), demonstrated it was clear clear that there were differences of opinion and practice for the hysteroscopic removal of myomas. I was also lucky enough to be at the ESGE 30th Annual Congress in Rome in October where different approaches to hysteroscopic myomectomy were beautifully demonstrated by European surgeons during the live surgery sessions.

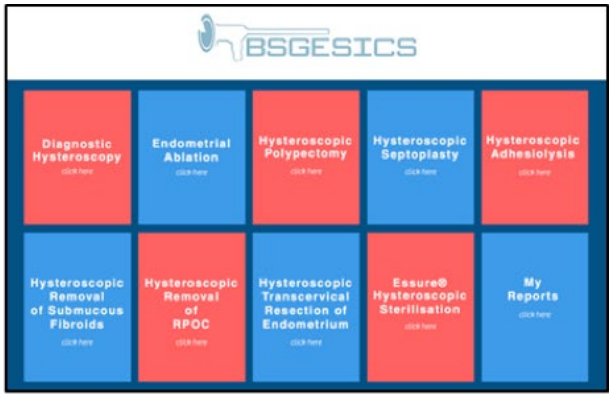
So what is the best way to remove fibroids with the hysteroscope? Ok, I think we will all agree that there is not one simple answer to this question. It depends upon ? size, ? type ? parity ? surgeon proficiency ? setting for surgery

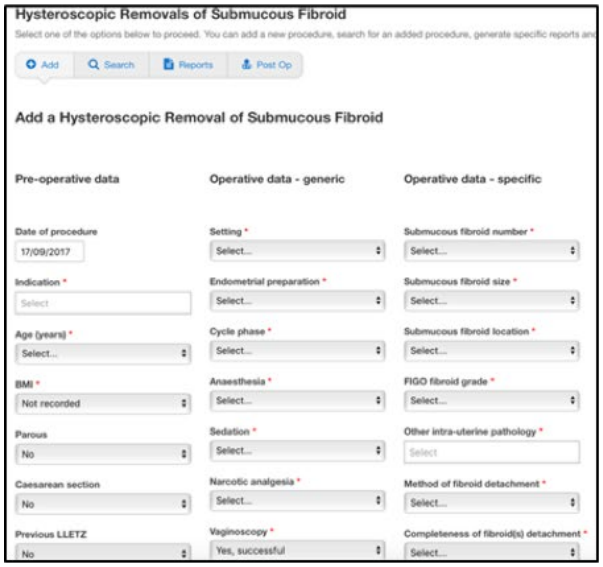
As current President of the British Society for Gynaecological Endoscopy (BSGE) I have recently called for a national audit of hysteroscopic myomectomy across the UK to run over the next year. My main motivation for this request was a report published in August from a UK health regulatory body called “NICE” – the National Institute for Health and Care Excellence . This “Interventional procedures guidance [IPG704]” report into hysteroscopic mechanical tissue removal for submucosal fibroids published in August. This report recommended that clinicians “audit and review clinical outcomes of all patients having the procedure” and that they “discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve.”

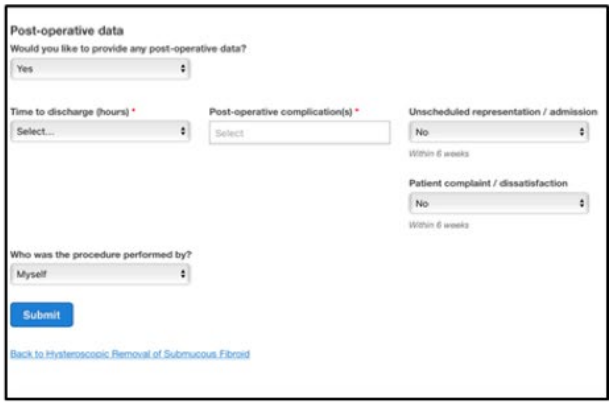
However, it is clear to me that we do not just need more information about mechanical tissue removal systems for myomas but also for other electrosurgical methods. Collecting such data will inform us about the safety and feasibility of methods of hysteroscopic myomectomy and importantly the relative benefits of one approach / technology over another in different circumstances.

At the BSGE we have developed the BSGE SICS (Surgical Information Collection System) - an audit tool to collect data on a whole range of common hysteroscopic and laparoscopic procedures. This includes all methods of hysteroscopic myomectomy The BSGE SICS can be accessed on smart phones, tablets and computers via the website (https://www.bsgesics.com) or the app that can be accessed via the app store (search under “BSGE”), where you can register. However access is limited to BSGE members. However, for this specific audit of hysteroscopic myomectomy I would like to create a specific electronic platform accessible on all media types for ESGE members to input their hysteroscopic myomectomy cases with my colleague and fellow founder of the BSGE SICS, Zahid Khan.

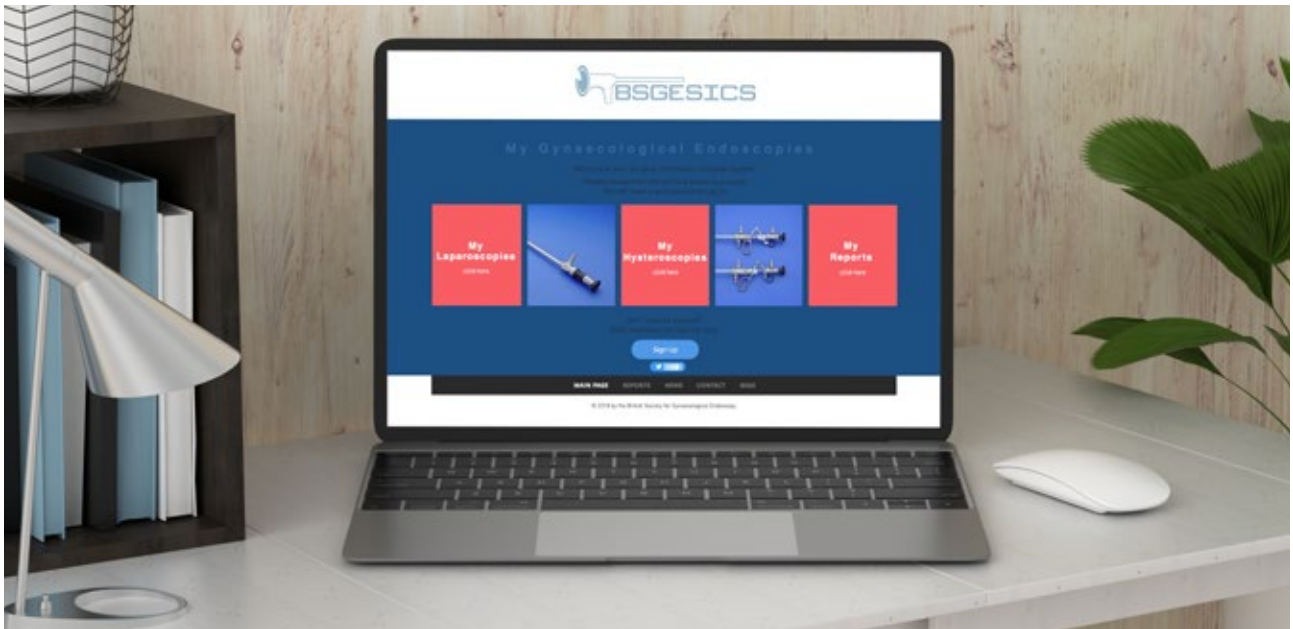



The platform is so quick and easy utilising mainly pre-formed fields, mostly with drop down menus. Your own data can be exported by you at any time of your choosing so you can analyse your own data. However, even more importantly we can rapidly collect thousands of cases to give us a really powerful data set that we can analyse and publish to direct our practice. We will be able to understand the types of technologies being used, the range of complexity, the types of patients undergoing procedures, and the rates and types of complications and even potentially some patient outcomes. All data entered is anonymous; there will be no patient identifiable data. If ESGE members join this concerted effort we can present the data hopefully at the ESGE conference in Lisbon 2022. We aim to have the platform ready to go in Spring 2022.



# Recent ESGE publications

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