ESGE VISION

Newsletter of the European Society for Gynaecological Endoscopy

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INSIDE

ESGE
European Society for Gynaecological Endoscopy

Message from the Editor

We present to you a new issue of ESGEVISION prepared by a new Editorial Team. I would like to welcome the new Associate Editor, Mr Shaheen Khazali, who is a Consultant Gynaecologist in London and new Editorial Team members Benedetto Mondelli, Kyle Fleischer and Vania Ivanova. As usual ESGE Central Office Manager Rhona O'Flaherty continues to be a key member of our Editorial Team.

In this issue, you will find an introductory article from the ESGE 31st Annual Congress President Luís Ferreira Vicente and ESGE Executive Board Member Hélder Ferreira, who describe what to expect at the Congress in Lisbon. No doubt that the 31st Congress promises to be a great event, and Lisbon a wonderful venue. We are all looking forward to meeting you in person on this occasion following the restrictions of the pandemic.

We have two interviews in this issue. Professor Chris Sutton, a former President of ESGE tells ESGEVISION his account of development of British and European Societies for Gynaecological Endoscopy and the early years of gynaecological endoscopy in Europe. Professor Sutton is an excellent storyteller and I am sure the younger generations will find the text interesting.

Our Associate Editor Shaheen Khazali interviewed filmmaker Shannon Cohn on her new movie 'Below the Belt' which covers the stories of women with endometriosis and highlights their suffering. Shannon Cohn's films have increased awareness of endometriosis worldwide. If we are seeing more actions from governments, policymakers and research funders on the issue of endometriosis, we owe these at least partially to initiatives such as this movie.

Lastly, we provide a list and summary of recent noteworthy articles that we hope would be of interest to you. Benedetto Mondelli and Kyle Fleischer prepared summaries of carefully selected articles for you From our Journal Facts, Views and Vision, as well as other journals.

We hope you enjoy reading this issue of ESGEVISION and hope to see many of you in Lisbon.

Ertan Sarıdoğan
Editor, ESGE-VISION

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International Gynaecological Endoscopy Community prepares for a great Annual ESGE Congress in Lisbon

Luís Ferreira Vicente
Congress President

Hélder Ferreira
ESGE Executive Board Member

During the Covid-19 pandemics, while we continued working, still treating patients, we also managed to keep the scientific meetings going by hosting them online. In the beginning, having science from home provided us with a new normality…

Afterwards, it became a challenge to decide on how the future meetings should be organised, online, face-to-face or hybrid meetings. But thankfully all of us were quickly able to return to being together, in person, in the same room together, discussing science.

And so now, in the post Covid-19 era what are the expectations for the ESGE 31st Annual Congress in Lisbon?

In a fully onsite meeting the scientific discussions promise to be exhilarating and dynamic. We will once again be more connected with the rest of our colleagues from all over the world. We also welcome the opportunity to be directly in touch onsite with the pharma and medical devices companies present in the exhibition area.

For this year, the scientific committee has arranged a very promising programme. Every day, there is something for everyone throughout the various gynaecological fields of interest.

The exceptionally high number of abstract submissions this year have been remarked upon for their very high scientific level. So many gynaecological surgeons are contributing towards the level of science we are expecting in this meeting!

On the first day, Sunday 2nd October, the Pre-Congress courses will cover Urogynecology, two courses in v-Notes, Robotics, Hysteroscopy and Laparoscopy for beginners, a "Train the Trainer" Preparatory Course, and a Cadaveric Dissection Anatomical Demonstration by conventional laparoscopy and robotics.

Sunday will also host Winners Day, which is sure to enlighten us on 'Tomorrow's Surgeon' and will host a video competition, followed by a suturing contest.

To receive all the surgeons coming from Portuguese and Spanish-speaking countries, we have prepared the first Ibero-American meeting of Gynaecological Endoscopy. During the Congress days, you will be able to accomplish your GESEA certification and for the first time, GESEA Robotics Certification.

To welcome and include more young endoscopic surgeons, we have organised an ESGE-YEP Exchange Programme in Portugal just before the congress from 28th-30th September 2022. The selected participants will have the opportunity to experience the Exchange in numerous Portuguese cities such as Lisbon, Porto, Gaia, Coimbra, Braga, Viseu, Matosinhos and Faro. Our goal is to combine the experience of a thoroughly informative, challenging scientific programme in the welcoming hospitals and explore aspects of the Portuguese daily lifestyle, such as the local cuisine and culture. Furthermore, the ESGE-YEP Exchange hopes to bring together European trainees to improve standards, promote training and encourage research and Exchange of information in gynaecological endoscopy.The ESGE Congress in Portugal will include various live surgery didactic sessions, lectures presented by acclaimed world experts and several interactive sessions. The social programme will respect our Portuguese warm and tasty hospitality.

This year there will be awards for the following categories:

- **Best Selected Oral abstract**
- **Best Selected Video abstract**
- **Best Selected ePoster**
- **Best Selected YEP abstract**
- **Best Selected Journal Article**
- **Best Selected Abstract from Portugal**

The prizes will be presented during the Closing Ceremony on Wednesday 5th October.

We expect the contribution of all to achieve a very high scientific level, following our philosophy that 'Excellence in Gynaecology is a habit!'

Lisbon has already been prepared to welcome you in safe conditions and we look forward to meeting you in person in our host city.



ESGEVISION speaks to Professor Chris Sutton

Professor Chris Sutton is one of the pioneers of laparoscopic surgery, particularly laser surgery. He was a founding member of both British and European Societies for Gynaecological Endoscopy and became the President of both. He published the first randomised controlled trial on surgical treatment of endometriosis compared to diagnostic laparoscopy and trained many gynaecological endoscopists who are in current practice. The Editor of ESGEVISION Professor Ertan Saridogan interviewed him on behalf of ESGEVISION.

ES: First of all, thank you very much for agreeing to this interview for ESGEVISION, the newsletter of the European Society for Gynaecological Endoscopy, ESGE. I am pleased that you are recovering and are able to do this interview. The reason I wanted to interview you was to put your contribution to the field of gynaecological endoscopy on record. You have been a very prominent figure in our field for several decades. So I would like to cover the major landmark points and highlight these to the younger generations so that they know what you did and how you contributed. Can we start with your initial involvement in gynaecological endoscopy? Can you think of an obvious point when you started being involved in gynaecological endoscopy in your earlier years?

CS: Well, yes, it was really, first of all, via lasers, because I'd only just come back from Fiji and I had a job at Addenbrooke's hospital in Cambridge and I had no idea what to do because I was completely lost after three years in Fiji. I learnt how to use the laser for the cervix and then went on to St Mary's hospital in London, working for Sir George Pinker, the Queen's gynaecologist. Malcolm Anderson, who was in charge of the British Society of Colposcopy asked me to join the board. I was then appointed to Royal Surrey Hospital in Guildford in 1980 as a consultant with the idea of starting a laser colposcopy clinic. But there was no money at all, so I had to set up my own charity to get a laser. But then I realised that we see very few people in Guildford with CIN because most go up to London. And I also knew that it was safe to do laser inside the abdomen. We took out some bowel specimens, shot the laser through it, and it didn't catch fire. So we thought, well, it must be safe.

So in 1982 I did the first laser laparoscopy in the UK and I thought it was the first one in the world. But I found out later that people in Clermont-Ferrand were using it, but they'd given it up because the system they had was very clumsy, whereas ours was designed differently. And again, I thought I was the first.

And then I read a paper by James Daniell from Nashville, and he was also starting on his own to do laser laparoscopy. So we were both from non-teaching hospitals doing the same kind of thing. I went over to visit him in Nashville and I realised we were doing it slightly differently, but we were having the same results. So that's how I really got into laser surgery. And then I got into it with regards to the BSGE because Alan Gordon had realised that he'd been to work with Kurt Semm and he had met Raoul Palmer and he realised there was a lot of potential for laparoscopic surgery, but he had no idea how to start. So he approached Sir Alec Turnbull, who was the Regius Professor of Obstetrics in Oxford, and they decided to put on a meeting which I think Storz sponsored, and they brought several people over from the continent, people like Bruhat and Manhes. Manhes was the one who did the most surgery in Bruhat's department. And also they brought Hans Lindemann and Jacques Hamou to do some hysteroscopy and . And then they asked me to do the gynaecological laparoscopy, the rest were mainly doing hysteroscopy. And classically, I hit the inferior epigastric artery, which is one of the few times I've done that, but we didn't really know how to recognise it at the time. There was a great fountain of blood. Very embarrassing, because we had a big audience, I think several hundred people. Thankfully the patient was fine- if a little bruised. And so that was my first demonstration of surgery and showing what we were doing in Guildford.

In Guildford by then we had got up to something like 100 patients. But the editor of the BMJ said he'd only publish this if we followed the patients for five years. Oh, clearly by then lots of other people had published. So I published our first results in something called Lasers in Medical Science. So anyway, the next step was that there was a meeting in Clermont-Ferrand in the Auvergne in central France which was considered one of the main centres for laparoscopic surgery and they were giving out champagne because it was the foundation meeting of the French Society of Gynaecological Endoscopy. And I said to Alan Gordon, we ought to have our own Society. And he, a very surely dour Northern Irishman, said, oh, we're not going to offer free champagne, you know! Anyway, what we decided to do is to make a small list of people we knew who were involved or interested. Although it was February we had gin and tonic on the lawn in front of our farmhouse to introduce ourselves and then adjourned to have a fine lunch at The Inn on the Lake in Godalming. I had booked a private room and we had the foundation meeting of the BSGE on 10th February 1990. The first task was to elect a President and that honour went to Alan Gordon and I was elected as Honorary Secretary.

No one present was prepared to become Vice President or Treasurer and I agreed to ask Victor Lewis and Adam Magos and once they agreed we arranged a more formal meeting later in the year at the Royal College of Obstetricians and Gynaecologists to create a formal constitution. Those present at the Foundation meeting were Alan Gordon from Hull, Mike Emmens from Birmingham, Rob Beard from Brighton, Ray Garry from James Cook Memorial Hospital, Middlesborough, Pat Murphy from Teeside, Ed McKenzie from Darlington, Prof John Newton from Birmingham University, who arrived very late and was a little miffed because he thought, as the only Academic present he would automatically be appointed as President.

ES: And when did you become the President of the BSGE?

CS: Oh, God, I've forgotten. Well, I suppose after, Victor Lewis.

ES: You were the third.

CS: President, yes and then Ray Garry was my secretary and then the next President.

ES: Okay. And when this was all happening, you were also involved in the European society, ESGE at some point, is that right?

CS: Well, I didn't really quite understand what happened with the ESGE because I hadn't really put myself forward for any committee post. And I was on the board of the ESGE when we started it, but for some reason they asked me to leave the room, which I couldn't understand. And then Jacques Donnez came out and said, congratulations, you're the new President. And I hadn't actually sought that. But that was very important actually, because Ray Garry was the secretary and what was very important was that we had a very good Belgian treasurer, Rudi Campo. And the problem was that up till then, the records were not kept properly. We started looking into it and it turned out that no one was paying anything. Everyone assumed it was free.

So Ray hired a truck and went to Clermont-Ferrand and cleared everything out of Bruhat's office and put it in his truck. And then we decided that rather than have it come to Britain, it would be much more democratic to have the headquarters in Belgium. So Rudi Campo organised an office, a proper office, proper secretary, proper everything in Brussels. I think it has stayed there ever since. So that's really how we started and got involved with European society.

ES Okay, so who was the first President of the ESGE? Was it Bruhat?

CS: The first President of the ESGE, I think, was Lindemann which was then the European Hysteroscopy Society. They were very powerful and Lindemann was, you know, in charge of that. We didn't think the name was broad enough and renamed it the European Society for Gynaecological Endoscopy. So it would include both. Bruhat led the merger.

ES: Do you remember the years that you were the President of ESGE?

CS: After Bruhat Alan Gordon was next. Yes, he was the one that succeeded Bruhat. Bruhat was quite a formidable character.

ES: And Jacques Donnez. Did he come after you or before?

CS:Jacques Donnez was before me. So I followed Jacques Donnez.

ES: Right. Whilst this was all happening can you explain how the endoscopy was developing? Obviously this is the organisational development, but at the same time I think the endoscopy was progressing as well.

CS: Well, initially it was a disaster really, because what was happening was that the instrument makers would be keen to sell their equipment and so they took videos around to all sorts of people and had them have a go, which resulted in a whole series of very bad accidents. And so the whole thing really fell into disrepute, which was when the Government, through the NHS decided to set up three training centres. There was Ray Garry at Leeds and Middlesborough, we had Guildford and we were linked by optical cable with the The Royal London, and there was another one in Scotland, in Dundee. So there were three national training centres. And the NHS paid for half of the funding and the Nuffield Charity paid for the other half.

ES: Yes. And so you mentioned your frustration with the BMJ request of a five year follow up, but then you set up a randomised controlled trial to analyse later. When did it happen?

CS: What happened was that when we got to five years they published it in the, I think, British Journal. But although it was published, there was a lot of criticism that it wasn't a randomised controlled trial because there was no placebo group. So we had a placebo group and I had no idea whether they'd had laser treatment or not. The incisions were the same and the research nurse, Pat Haines, who sadly died recently- she followed them up, but none of them had any idea whether they'd had laser surgery or just a visualisation. And oddly enough, at three months they were almost identical because they had obviously a massive placebo response. But then at six months, it was obvious that 70% of the laser patients got better. Towards the end we realised that all that thick tissue was in fact endometriosis, so we would take out the whole of the uterosacral complex right down to the fatty tissue with either laser or the plasmajet. And we got much, much better results then. And that's when I retired. And everyone's forgotten me.

ES: No. We haven't forgotten you. In fact, that RCT is one of the landmark publications, because it is still quoted as part of evidence based medicine. So that's extremely important research and publication. And do you remember who the research fellow was conducting that? You mentioned the research nurse who sadly died. But did you have a fellow at that point?

CS: Well, yes, there was a whole team really. There was Naomi Whitelaw, who was senior registrar, and Simon Ewen who was from New Zealand. And Andrew Pooley as well as the research nurse, Pat Haines .

ES: And there was a follow up publication after that one I remember, was it Kevin Jones? I think he followed those patients up and published a later follow up paper. I remember.

CS: No. It was Pooley, Ewen and Haines. What was important in the follow up was that a third actually got better. In the second third, you could see it had come back. But in the last third there was no evidence of endometriosis and we thought it was irritable bowel syndrome. So it was kind of divided in three. So that was useful actually. Because, not all of them that say they've got endometriosis have endometriosis. It can be psychological.

ES: Chris, you started working at Chelsea and Westminster Hospital at some point.

CS: Oh, yes, because they hadn't got any minimally invasive surgery. So I had to take all the lasers and all the equipment and teach them laparoscopic surgery to a teaching hospital, whereas we've been doing it for about 20 years, at the Royal Surrey. The interesting thing was the way it did develop outside the teaching hospitals and I think it was because we probably had more freedom. We didn't have the establishment on our back all the time. We were free to go. Bertie Leigh* (*Editor's note – Bertie Leigh is a leading medicolegal lawyer who has been involved in many lawsuits involving gynaecological endoscopy in the United Kingdom) mentioned how it was interesting it developed from a series of non-teaching hospitals, in a pre-publication submission, but then took it out. It obviously upset people.

ES: Did you retire from the NHS at the same time from both Guildford and Chelsea and Westminster?

CS: I carried on with the NHS and what had happened was that we were having so many extra referrals, so called extra-contractual referrals - all over the country, even many from Europe.

And that was I think during the Thatcher years, we were bringing a huge amount of money into the hospital and then they changed the system and suddenly we had to pay for those people. So I went from the kind of great hero bringing loads of money into the hospital to a kind of leper. And I'd had enough by then and I just was so frustrated with the way the NHS was being run. I mean it's got worse even, and my blood pressure was soaring up and I was, I really was harming myself. So I asked the administrator if instead of carrying on doing obstetrics, I could do all gynae clinics and sessions, all gynae. He said, no way. He said, I won't let you. You'll lose half your pension and you'll regret it. And I said, you seriously think I won't get a job in one of the London teaching hospitals? He said you wouldn't have a hope. So I got offers from the Royal London, St Mary's and Chelsea and Westminster. And I chose Chelsea and Westminster because it was brand new and it was the closest to Guildford because we were always worried if there was an accident during the rush hour, it would be a nightmare. Luckily my wife taught at the French Lycee and we had a little flat up in Kensington just in case. So any time I operated there, I stayed the night up there. But actually, touch wood, we never had an accident. Not one. Not one. In fact, I've never been sued.

ES: Okay, I see. What year did you retire altogether?

CS: Well. I think it was about 15 years ago. The problem was that the BMI* (*Editor's note – BMI is a private healthcare provider in the United Kingdom) had taken over and they said, you can't operate beyond a certain age. Unless someone supervises you. But I wasn't going to have anyone I trained supervising me, it was ridiculous.

ES: That's all very interesting, Chris. And if you have to give a few most important points that you feel that you've contributed to gynaecological endoscopy, what would you include? Presumably laser laparoscopy would be the first?

CS: Yes, well, we still used it right up till the end, but we happened to introduce plasmajet as well. And the randomised controlled trial with a placebo arm was the first one ever done in surgical research. We published 190 papers and I have an absolutely enormous citation rate, about 9000 or so.

ES: Yes, that's remarkable.

CS: I think the most wonderful thing is the travel and meeting all these international people and making fantastic friends. And I count you as one.

ES: Chris, thank you very much for talking to us. I hope to see you soon.

Interview with Shannon Cohn the director of "Below the belt"

"Below the belt" , a documentary on Endometriosis, had its Europe premiere on the 8th of June in London.

Shaheen Khazali spoke with Shannon Cohn, the director

SK: Thank you very much Shannon for your time. I watched your movie and I thought it was mind blowing. Congratulations! I thought it was a great success with very powerful stories. I genuinely think it is a very well-made film and everybody who had a role in funding it or making it should be congratulated.

Would you be able to tell us a bit more about yourself and your background?

SC: Thank you. I am a filmmaker and an attorney. That was my main profession before becoming a filmmaker. I worked in an international law firm, doing mergers and acquisitions and ended up working on the Enron investigation early in my career. Ironically, after working for Enron investigation I realised I did not want to be a lawyer any longer and decided to go back to Graduate School, so I went to film school at New York University.

Most people think that going from law to film might be a bizarre and unusual transition but not for me, I had a lot of life experiences. For example, I have travelled a lot, worked with refugees in Africa and lived in the Southern United States.

I soon realised that there are a lot of really interesting stories that deserved a microphone to be heard. For these reasons I decided to go to film school and I worked on documentaries for 10 years. With the production company in New York, we were on the frontline in building social impact campaigns with our documentaries.

We were using our products not just for entertainment, but also as a tool for making a positive impact: from changing policies and public perception of an issue to generating funding for research.

I saw and experienced in real time the power of a movie that goes way beyond the cinema.

I was diagnosed with endometriosis when I was 16 years-old but, it was not until my second daughter was born when I realised that not much had changed in the last 20 years. At that time, I was reading an article that highlighted the increased incidence of endometriosis between relatives, in particular the seven times increased risk of disease among sisters and between mothers and daughters. When I was 16 years old, I sought medical advice from my paediatrician and GP but, all the endometriosis symptoms were dismissed as among these I also presented with multiple gastrointestinal problems.

In my 20s, when I went to law school and had a very demanding yet successful career despite my endometriosis and the lack of care received. I think this is unfortunately a story that I share with many women affected by this condition.

I was honestly terrified about the idea that also my daughters could go through this.

Despite medicine improving, the delay in diagnosis for endometriosis is still 6 to 10 years depending from which part of the country you come from, and is still an unacceptable long wait.

I think all of us have a role to play and thanks to my background I decided to give my contribution by making a film about endometriosis.

My aspiration is to improve people's awareness, one step at the time and everything we have done with this movie will be worth it even if just one person will see the benefits from it.

SK: This is not your first movie, Shannon. You have already made another movie on endometriosis. Can you tell us a bit more about it?

SC: Yes, you are correct, we released a film called "Endo What" in 2016 and it was screened all over the world.

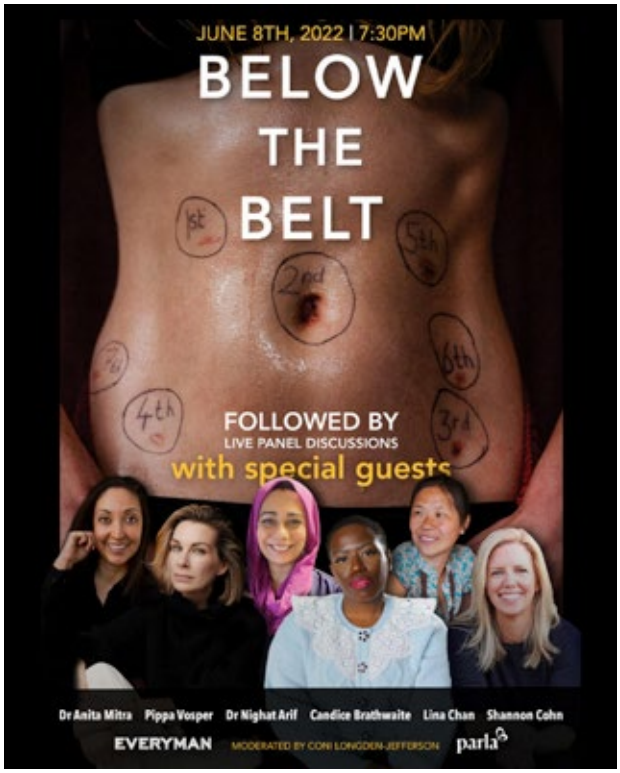
"Endo What" is quite different from "Below the belt".

"Endo what" is a film which aims to educate and inform patients, general practitioners and nurses about endometriosis. Frontline health care professionals sometimes might not be familiar with the symptoms related to this disease. The movie was designed to help patients and these frontline medical staff to recognise the symptoms therefore reducing the time for a diagnosis.

SK: How was that movie received?

SC: It was very well received.

The writer from The Guardian described the movie as very powerful and The New York Times also granted excellent feedback. Cosmopolitan and Newsweek considered the film very valuable.



All these positive feedbacks made me realise how important it was to produce a new movie, which is "Below the belt" that tells the stories of women affected by endometriosis. I really think that people need to hear those stories to understand how endometriosis can impact the life of a person.

SK: I have to confess, on my way to the premiere after a long endometriosis clinic, I was thinking, "have I not heard enough life stories of endometriosis patients?" and I wondered what I could possibly see that I haven't seen before? but I was so wrong. The stories you depicted were so touching and were told so well that I really recommend every one of my colleagues to watch this movie.

Can you tell us a bit more about the angle that you decided to take on each of those stories and how you decided what you wanted to cover.

SC: I chose the stories considering that this movie was not only directed to the general public, but also to clinicians. My intention is to remind healthcare professionals why they went into this specialty in the first place. Endometriosis is a difficult condition and it really negatively affects not only the ones suffering with it, but also the people around them, who love them. I wanted it to be nuanced so that whoever watches it walks away feeling: Yes, I can now understand the depth of the suffering but I also feel hopeful and inspired.

I would love clinicians to walk away feeling like: I actually learnt something new, I'm looking through a different lens now and this has reminded me why this field inspired me so much in the first place.

SK: Can you share with us any experiences you had or anything you learned from your movie?

SC: Something that I realised while filming and editing the documentary was how much endometriosis affects not just the person who has it but also the people around them, from their parents, to their partner or friends. The film really conveys how endometriosis is really like a pebble in a pond. I knew that but to see it in this very real, intimate, and emotional way was eye opening for me.

SK: I found the panel discussion very interesting and thought provoking. Candice Brathwaite, Pippa Vosper, Dr Anita Mitra aka Gynae Geek, Dr Nighat Arif and Lina Chan were not only speaking of endometriosis but covered a wider range of women's health issues. What were the highlights of your panel discussion after the premiere for you?

SC: The panel discussion was phenomenal!

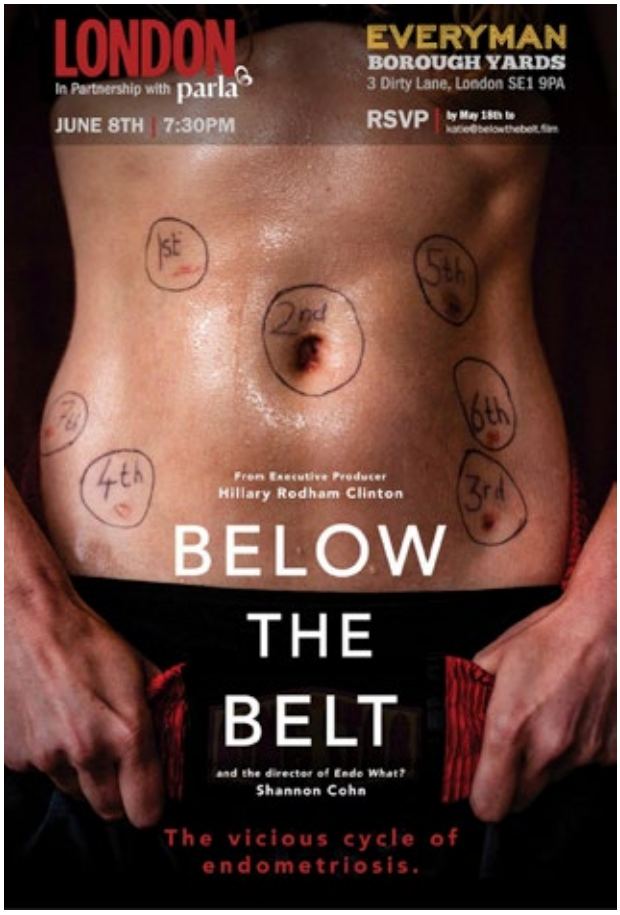
What did I learn? I thought a lot about Candice Brathwaite and what she has personally experienced, I think it was incredibly powerful. She almost died in childbirth as a young black woman in the UK and she wrote a book about her experiences. She conveyed that experience with such passion, and humour, and it was all coming from her heart. It was taking my breath away and opening my eyes.

As a white woman, I have had a different story, for this reason it's so important to listen to the experiences of others and try our best to understand. Only by understanding will we be able to improve the care around endometriosis.

I really appreciated the women who called us, who talked about pregnancy loss. Pippa Vosper is a beautiful and fashionable British vogue contributor. In the age of social media, where we see perfect images of people in their projections, she really is this. Another taboo around Women's Health is infertility and for a woman to be so honest about it in front of a room with over 100 people was very touching and powerful. She was so honest about how devastating it was losing a child.

SK: Shannon, what do you think my colleagues and members of the ESGE can take away from your movie? What message do you think your movie has for ESGE?

SC: I think it's a call to action for everyone who is involved in Endometriosis to work towards better care, better understanding and better communication. This movie will help patients sharing



the right information when they are in the clinic and doctors to ask the right questions with the idea of meeting in the middle.

This movie also has the power of improving our empathy for women affected by this condition by showing the emotions, the feelings coming from these stories.

Endometriosis is not a black and white condition; every person is different and with a different story. We are all trying to help the patients be able to live fulfilling lives. This film is a call to action for all the parties to work toward better care.

SK: I couldn't agree more with you. Endometriosis is such a complex condition and it would be wrong to reduce it to a black and white disease.

The truth is each person is different and endometriosis is only one pathology that can explain pelvic pain.

It is true that unfortunately it still takes a long time for it to be diagnosed and it is true that even when it is diagnosed sometimes it is not treated the best way it can and should be.

I think it is really important that patients collaborate with their clinicians as the answer is not always surgery and sometimes other conditions different from endometriosis can be the cause for the symptoms.

SC: Yes, you are absolutely right. If you have endometriosis your best chance at getting effective treatment is finding an endometriosis specialist or someone that understands the disease, understands the nuances that Endometriosis has and understands that a multidisciplinary approach is probably go forward. It's important to highlight that the treatment might not be the same for everyone.

In the UK in 2020 the all-party parliamentary group found that 58% of patients with endometriosis symptoms visited their GP 10 times or more before seeing a specialist. Unfortunately, there are real hurdles just getting past your GP and once you see a gynaecologist, you might not see a pelvic pain or endometriosis specialist but you might be attended by someone whose special interests are more towards obstetrics or urogynaecology for example. It is difficult sometimes to know if you are seeing the right gynaecologist.

I hope that we are all working toward a system that provides appropriate certification for endometriosis specialists so that patients will know which specialists have been trained in this field.

SK: What is next for you and for "Below the belt?

SC: For the next year I'm going to be working on the impact campaign of "Below the belt". I'm dedicated to making sure that this film can make a difference in the endometriosis care in every country.

We have in person and virtual screenings scheduled for the rest of 2022 in many countries, where we bring together different people in the same room much like we did in London.

We will have government leaders, medical experts and patient advocates. The idea is to have a constructive debate about these issues and gain a greater understanding. I really think this is how most tangible steps are made toward progress.

SK: How can people watch this movie and where?

SC: We will be doing these in person and virtual screenings for the rest of the year and we're finalising distribution deals with TV broadcasts around the world. Ultimately, it will be widely available on streaming platforms.

People can go to our website: "belowthebelt.film" and also follow us on Instagram, Facebook and Twitter for all the news and updates.

SK: Thank you again Shannon for your time and for speaking to the ESGE members and I would like to congratulate you once again on this amazing achievement

SC: Thank you

Recent Noteworthy articles

By: Benedetto Mondelli and Kyle Fleischer

Benedetto Mondelli

Kyle Fleischer

Surgical and functional impact of nerve-sparing radical hysterectomy for parametrial deep endometriosis: a single centre experience

Rosati et al

Facts, Views & Vision Volume 14, Number 2, June 2022

In this study 23 patients underwent radical hysterectomy for deep endometriosis involving the parametria. After the procedure, the post-operative outcomes analysed included gastrointestinal, urinary and sexual functions.

The study showed an overall improvement of the symptoms following hysterectomy, and the difference in sexual functions and urinary symptoms was not significant. The authors highlight that despite these findings and the nerve-sparing approach, this procedure may be associated with a non-negligible risk of post-operative bladder voiding deficit.

Satisfactory medium-long term patient reported outcomes after laparoscopic single-mesh sacrohysteropexy

Dökmeci et al

Facts, Views & Vision Volume 14, Number 2, June 2022

This is a retrospective cohort study of 71 women who underwent laparoscopic single mesh sacrohysteropexy and followed up for a median duration of 5 years between 2008 and 2020. Examining the symptomatic recurrence over time and the repeat surgery rates, this study shows how Laparoscopic single mesh sacrohysteropexy appears to be successful and safe for treating apical uterine prolapse.

Total surgical time in laparoscopic supracervical hysterectomy with laparoscopic in-bag-morcellation compared to laparoscopic supracervical hysterectomy with uncontained morcellation

Krentel et al

Facts, Views & Vision Volume 14, Number 1, March 2022

In this retrospective study involving 47 patients the authors compared the surgical time for in-bag morcellation vs uncontained morcellation following supracervical hysterectomy. Historically in-bag morcellation has been criticised because of the additional surgical time associated with this extra step but, interestingly, in this study in-bag morcellation was not related to increased time when compared to uncontained morcellation.

Reproductive performance following hysteroscopic treatment of intrauterine adhesions: single surgeon data

Direk et al

Facts, Views & Vision Volume 14, Number 1, March 2022

Pregnancy outcome following hysteroscopic treatment of intrauterine adhesion was investigated in this retrospective analysis involving 126 participants over 18 years between 2001 and 2019. Most patients achieved live birth following conception, and there was no statistical difference between subgroups based on age or severity of pathology. This study highlight how appropriate hysteroscopic treatment can lead to a successful outcome regardless of the age and level of adhesions.

Endometrial biopsy under direct hysteroscopic visualisation versus blind endometrial sampling for the diagnosis of endometrial hyperplasia and cancer: Systematic review and meta-analysis

Di Spiezio Sardo et al

Facts, Views & Vision Volume 14, Number 2, June 2022

This systematic review and meta-analysis involved four studies with a total of 1295 patients. Endometrial biopsy performed under direct hysteroscopic visualisation was compared with the biopsy taken blindly. Hysteroscopic sampling is shown to be associated with a higher rate of sample adequacy and is expected to reduce failure in detecting endometrial pathology.

The Risk of Postoperative Complications After Major Elective Surgery in Active or Resolved COVID-19 in the United States

Deng et al

Annals of Surgery February 2022 Volume 275 Issue 2

https://doi.org/10.1097/sla.0000000000005308

In a study of over 5000 patients undergoing major elective surgery, those within eight weeks of contracting COVID were more likely to have post-operative complications. There were increased risks in those within four weeks of diagnosis, symptomatic at time of surgery and symptomatic/severe infection. The evidence can help inform timing of surgery but may provide more questions than solutions when it comes to working through the waiting list backlog created by the pandemic.

This is a robust study because of the large sample size and can help inform planning of elective surgery following COVID-19 infection.

Risk of Rectovaginal Fistula in Women with Excision of Deep Endometriosis Requiring Concomitant Vaginal and Rectal Sutures, with or without Preventive Stoma: A Before-and-after Comparative Study

Roman et al

JMIG January 2022 Volume 29 Issue 1

https://doi.org/10.1016/j.jmig.2021.06.013

This retrospective comparison study of 363 patients across two centres (one of which had a liberal policy for preventative stoma and the other having a restrictive policy for preventative stoma) did not show a statistically significant difference in the risk of developing a rectovaginal fistula. The interventions included vaginal excision with either rectal disc resection or colorectal resection.

One important finding was that rectal sutures within 8cm of the anal verge increased the risk of fistula three-fold.

The authors suggest that these findings need to be confirmed by a RCT.

The risk of miscarriage following surgical treatment of heterotopic extrauterine pregnancies

Solangon et al

Human Reproduction Open January 2022 Volume 2022 Issue 1

https://doi.org/10.1093/hropen/hoab046

In contrast to previous evidence, there was not an increased risk of miscarriage in those that underwent minimally invasive management of heterotopic pregnancy. This retrospective study is limited by a small sample size, reflecting the rarity of heterotopic pregnancy.

An interesting study highlighting new information that is in contrast to previous evidence but is limited by its small sample size, reflecting the rarity of heterotopic pregnancy.

Hysteroscopic myomectomy: The guidelines of the International Society for Gynecologic Endoscopy

Loddo et al

EJOG January 2022 Volume 268

https://doi.org/10.1016/j.ejogrb.2021.11.434

This guideline outlines fourteen best practice recommendations for hysteroscopic myomectomy including preoperative assessment/classification, appropriate surgical technique and judicious fluid management to ensure safe surgery and prevent complications.

ESHRE Guideline: Endometriosis

Endometriosis Guideline Core Group Becker et al

Human Reproduction Open February 2022 Volume 2022 Issue 2

https://doi.org/10.1093/hropen/hoac009

Forming the foundation for diagnosis, investigation and management of endometriosis since 2005, this updated ESHRE guideline provides evidence-based recommendations on best practice and replaces the previous 2014 guideline. With significant updates on diagnostic laparoscopy, post-operative hormonal therapy and endometriosis in adolescence, as well as more information on menopause, pregnancy and fertility preservation in relation to the disease, the guideline is essential reading for all clinicians involved in the care of those with endometriosis.

This is a collection of the best available evidence and consensus expert opinion for the investigation and treatment of endometriosis.

Long-term Outcomes Following Surgical Management of Rectal Endometriosis: Seven-year Follow-up of Patients Enrolled in a Randomized Trial

Roman et al

JMIG February 2022 Volume 29 Issue 2

Long term follow-up of participants from a 55 patient RCT comparing segmental resection versus nodule excision either by disc resection or shave, did not show a statistically significant difference in overall quality of life, bowel symptoms, recurrence rates (radical 0 versus conservative 7.4 (p=0.24)), reoperation risk and pregnancy likelihood. Overall post procedure pregnancy rates were high.

Outcomes From Opportunistic Salpingectomy for Ovarian Cancer Prevention

Hanley et al

JAMA Network Open February 2022 Volume 5 Issue 2

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788855

This cohort study, with a very large sample size, comparing opportunistic salpingectomy against hysterectomy alone or tubal ligation showed that there was a significantly reduced risk of subsequent serous and epithelial ovarian carcinomas in the salpingectomy arm.

Risk of de novo cancer after premenopausal bilateral oophorectomy

Huo et al

AJOG April 2022 Volume 226 Issue 4

https://doi.org/10.1016/j.ajog.2021.10.040

This cohort study, recruiting over 3000 participants, confirms that bilateral oophorectomy in premenopausal women reduces the risk of subsequent gynaecological cancers but does not change the likelihood of developing other types of cancer. Oestrogen therapy did not modify the results. This evidence can be used when considering bilateral oophorectomy in premenopausal women against the non-malignant risks associated with the procedure.

Long-term outcome in endometrial cancer patients after robot-assisted laparoscopic surgery with sentinel lymph node mapping

Nordskar et al

EJOG April 2022 Volume 271

https://doi.org/10.1016/j.ejogrb.2022.02.003

& Utilization and Outcomes of Sentinel Lymph Node Biopsy for Early Endometrial Cancer

Matsuo et al

Obstetrics & Gynecology May 2022 Volume 139 Issue 5

https://Doi.org/10.1097/AOG.0000000000004733

These two studies, both with a slightly different focus, highlight the move from lymphadenectomy to sentinel lymph node mapping in the management of endometrial cancer without changes in cancer-specific survival rates. The challenge moving forward will be making these resources available in as many hospitals as possible to support the workload of tertiary cancer referral centres.

Effect of Hysteroscopic Metroplasty on Reproductive Outcomes in Women with Septate Uterus: Systematic Review and Meta-Analysis

Carrera et al

JMIG April 2022 Volume 29 Issue 4

https://doi.org/10.1016/j.jmig.2021.10.001

This comprehensive review and meta-analysis highlighted a reduction in the risk of miscarriage following hysteroscopic metroplasty. Other positive findings showed a reduction in frequency of foetal malpresentation and of subsequent preterm birth in those identified as having a resection of a partial septum (no difference in complete septum/non-specified). The authors suggest that future studies should include a robust RCT to support the findings from this review.

Relugolix Combination Therapy for Uterine Leiomyoma–Associated Pain in the LIBERTY Randomized Trials

Stewart et al

Obstetrics & Gynecology June 2022 Volume 139 Issue 6

https://doi.org/10.1097/AOG.0000000000004787

This RCT shows that Relugolix with addback HRT can be used to medically manage fibroid associated pain. It has a reasonable sample size and offers an alternative to other medical management options.

This 500 patient RCT supports the use of Relugolix combination therapy for the management of fibroids.

Redo laparoscopic sacrocolpopexy for POP recurrence: Is it the right call?

Panico et al

EJOG June 2022 Volume 276

https://doi.org/10.1016/j.ejogrb.2022.06.023

In an area where there are a limited number of studies, this case series highlights that repeat laparoscopic sacrocolpopexy can be an effective management option for recurrent POP. It has a small sample size but is strengthened by its length of follow-up.

Comparing Characteristics of and Postoperative Morbidity after Hysterectomy for Endometriosis versus other Benign Indications: A NSQIP Study

Stewart et al

JMIG July 2022 Volume 29 Issue 7

https://doi.org/10.1016/j.jmig.2022.04.009

This large (n-29742) retrospective study showed an increased risk of major morbidity and deep surgical site infection during hysterectomy compared to other benign indications. This perhaps reflects some of the surgical challenges associated with endometriosis.

Endometriosis promotes atherosclerosis in a murine model

Mamillapalli et al

AJOG August 2022 Volume 227 Issue 2

https://doi.org/10.1016/j.ajog.2022.03.040

Building on epidemiological studies showing a correlation between endometriosis and subsequent cardiovascular disease, this study showed increase severity of atherosclerosis in endometriosis induced mice compared to controls. It outlines a number of potential contributory proinflammatory mediators and hypothesises using future treatments to target inflammatory cytokines reduce the risk of CVD in those living with endometriosis.

Small but interesting animal study showing an increased severity of atherosclerosis in endometriosis induced mice compared to controls.

Future meetings

RCOG/BSGE Diagnostic and Operative Hysteroscopy
Start Date:13/10/2022
End Date: 20/10/2022
Where: Online (13 October 2022 Workshop)
Online and RCOG, London (20 October 2022 Workshop)

Click here for more info >>

The 30th World Congress on Controversies in Obstetrics, Gynecology & Infertility (COGI)
Start Date: 24/11/2022
End Date: 26/11/2022
Where: Amsterdam, The Netherlands

Click here for more info >>

Total Gynaecology Robotic Hysterectomy Surgery Conference
Start Date: 01/12/2022
End Date: 02/12/2022
Where: Newcastle Surgical Training Centre

Click here for more info >>

AAGL Annual Global Congress 2022
Start Date: 01/12/2022
End Date: 04/12/2022
Where: Aurora, Colorado

Click here for more info >>

BSGE Ambulatory Care Network 2023
Start Date16/02/2023
End Date17/02/2023
Where: Edgbaston Park Hotel, 53 Edgbaston Park Road, Birmingham B15 2RS

Click here for more info >>

16th Gynaecological Cancer Symposium
Start Date: 03/03/2023
End Date: 03/03/2023
Where: Virtual

Click here for more info >>

ESGE Regional Workshop
Start Date: 10/03/2023
End Date: 11/03/2023
Where: Istanbul Turkey

Step by step management of women with endometriosis from diagnosis to therapy: A practical approach

15th World Congress on Endometriosis
Start Date: 03/05/2023
End Date: 06/05/2023
Where: EICC, Edinburgh, UK

Click here for more info >>

BSGE Annual Scientific Meeting
Start Date: 20/04/2023
End Date: 21/04/2023
Where: Manchester, UK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