

# E<sup>ESGE</sup> VISION

Newsletter of the European Society for Gynaecological Endoscopy

## ESGE 30<sup>th</sup> Annual Congress

*Per Aspera ad astra.  
through hardship  
reaching the stars*

**ISSUE 5 – JUNE 2021**

### **INSIDE**

**All the details of the ESGE 30th  
Annual Congress in Rome**

**And much more...**



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## Message from the Editor



This issue of ESGEVISION comes out at a time we are still living through the coronavirus pandemic. We have lived and worked under exceptional circumstances for more than a year now. Vaccination programmes are making a significant impact on the suffering, but some parts of the world are still experiencing the burden of the disease. Meanwhile, educational and training activities have taken a different shape and an increased number of virtual programmes have demonstrated our resilience.

ESGEVISION is again full of news and interesting information related to our field. Firstly, we are preparing for our next ESGE Congress which is due to take place in Rome on 3-5 October 2021. The Congress is planned as a 'hybrid' meeting so that both 'virtual' and 'on site' attendance will be possible. As usual, a very rich programme has been put together and you can find further details of the programme by using the link in the article prepared by the Congress Team.

You will also find two interviews in this issue. The first one is an interview with one of the pioneers of gynaecological endoscopic and microsurgery, Professor Victor Gomel. Victor Gomel talked to ESGEVISION about the years when foundations of our field were being laid down. The second interview is with Professor Frank Willem Jansen who was one of the keynote lecturers at the ESGE Live 2020 event. He gave an interesting lecture on 'sustainability of minimally invasive surgery operating theatre'. The interview covers important aspects of his lecture and touches upon a subject many of us have never thought about.

Global Community of Hysteroscopy (GCH) is a rapidly expanding entity which has followers from all parts of the world. The expansion is probably the result of a combination of factors including increased availability of the range of equipment which allow outpatient hysteroscopic therapies without general anaesthesia and replacement of major abdominal procedures with less invasive hysteroscopic alternatives. The leaders of the GCH have written an article in this issue highlighting the changes we are seeing in this part of gynaecological endoscopic surgery.

The new President of ESGE, Professor Giovanni Scambia, has written his first article for ESGEVISION. In his article he highlights the significance of training in gynaecological endoscopic surgery.

I thank all contributors and hope that you enjoy reading ESGEVISION. I look forward to seeing many of you in Rome, in person!

**Ertan Saridoğan**  
Editor, ESGE-VISION



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## Message from the ESGE President

### Endotrain project: we never stop learning

The endless evolution of medical-scientific research and technological innovations mean that doctors must constantly keep up to date; therefore continuous and adequate training are fundamental steps in order to guarantee the right competence and correct patient care.

During the past decades, endoscopic gynaecological surgery, both laparoscopic and hysteroscopic, has made great strides, improving its qualitative offer and expanding the possibilities of minimally invasive surgery being more acceptable by patients and with significantly reduced hospitalization times.

However, the complexity and peculiarity of endoscopic surgery requires specific skills, and it is well known in the literature, and evident in daily clinical practice, that if the endoscopic surgeon has not had adequate training, a dramatic increase in accidents and complications is observed.

For this reason in Europe the GESEA Programme (Gynaecological Endoscopic Surgical Education and Assessment Programme) was developed by ESGE in collaboration with the European Academy of Gynaecological Surgery, directed by Dr. Rudi Campo, following the joint declaration by the most important international scientific societies on the requirements of training in gynaecological endoscopy, in order to guarantee a safe and highly qualified surgery for the patients

The development of such a programme was recognised as an important step towards the standardisation of surgical training for young endoscopists in Europe.

The Rome Gemelli GESEA Diploma Centre, together with the GESEA Diploma centres of Turin and Naples are integrated into an international network and, after having obtained the recognition of adequacy for the European standards, they are the only three Italian Centres, certified by the European Academy of Gynecological Surgery for the GESEA programme.

In order to guarantee a permanent training programme in Gynaecological Endoscopy during the 5 years of training of the Residency Programme in Obstetrics and Gynaecology of the Catholic University in the A. Gemelli University Hospital Foundation - IRCCS directed by Prof. Giovanni Scambia the ENDOTRAIN PROJECT has been developed, an Italian project in collaboration with the GESEA programme and the ESGE.

The goal is to ensure a continuous training programme for trainees who can be followed during their 5 years of residency school. In fact, from the first year of residency, trainees will be involved in this programme and the training and testing phases will have varying degrees of difficulty.



The course includes lectures on the basics of laparoscopy and hysteroscopy, practical sessions on the pelvic trainer and wet lab and testing sessions based on the GESEA programme. During the testing sessions, LASTT, SUTT and HYSTT data is recorded on the Online Scoring Platform and everyone has the opportunity to monitor the learning curve and performance improvement.

A fundamental requirement at the end of the residency school will be to obtain the Bachelor in Endoscopy within the 3rd year and the Minimally Invasive Gynaecological Surgeon Diploma by the end of the 5th year. To do this, trainees will have to go through various steps in the different years of residency school.

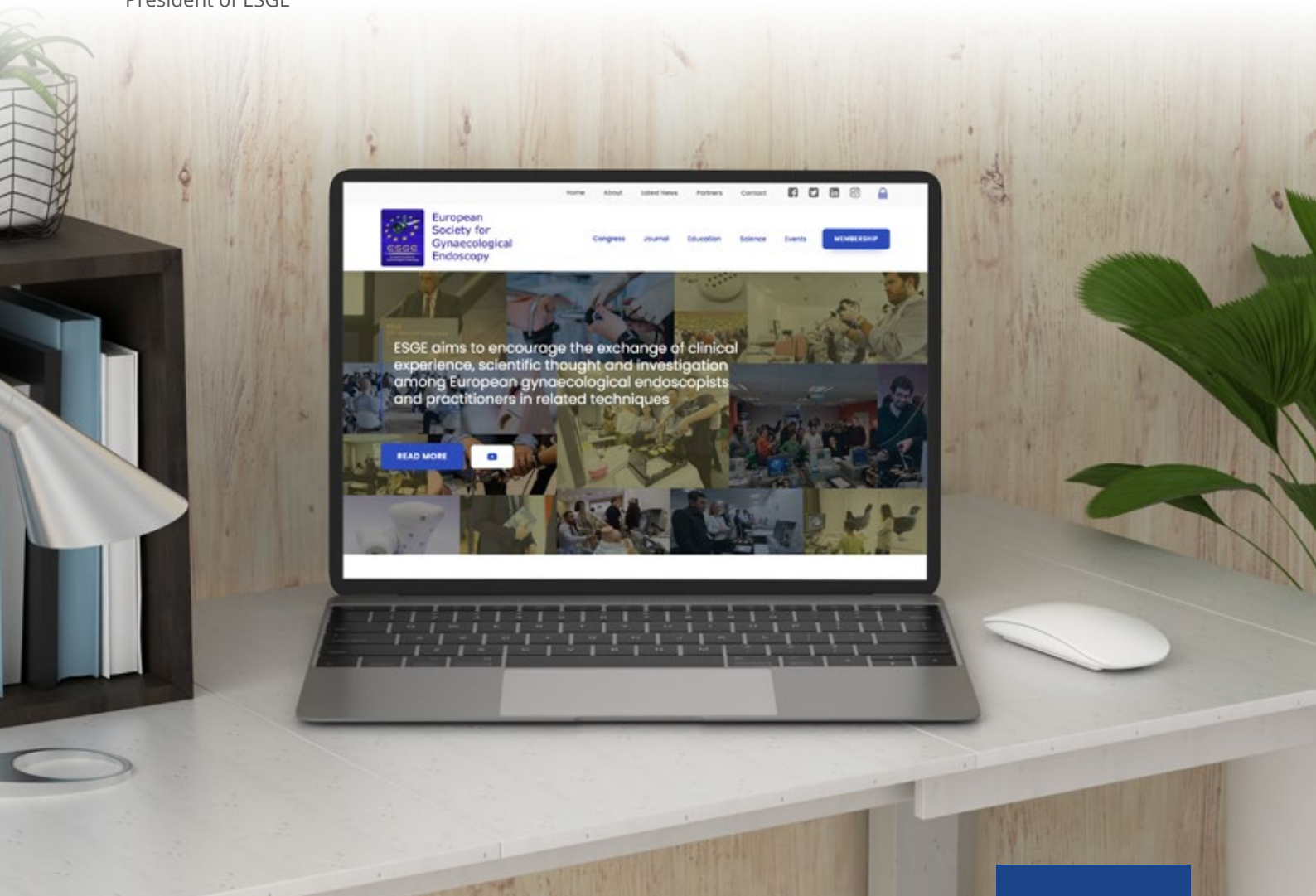
The Italian Association of University Gynaecologists (AGUI) supports the ENDOTRAIN programme throughout Italy thanks to the collaboration of all the full professors of the various OBGYN residency schools which can refer their trainees to the 3 national GESEA Diploma centres.

The project started in March 2020 and despite the difficulties experienced with the COVID-19 pandemic, it has continued in compliance with current rules. 350 trainees per year are expected to take their Bachelor Level 1 certification in their third year of specialty and their Minimal Invasive Gynaecological Surgeon certificate and diploma within the 5th year.

We hope that this project can continue successfully and will also be shared by other European countries.

**Prof. Giovanni Scambia**

President of ESGE





# ESGE 30th Annual Congress is taking place as a hybrid meeting this year in Rome, Italy on 3-5 October 2021

**This year, we are honoured and proud to host the ESGE 30th Annual Congress in the beautiful and timeless city of Rome.**

The theme of the Congress, *Per Aspera ad astra*: through hardship reaching the stars is especially appropriate in these current times. Believing in something, defining ambitious projects and working hard to realise them, are 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.

The Scientific Committee has developed a programme to offer participants high-quality, evidence-based topics from the contemporary developments in various parts of gynaecological endoscopy.

Furthermore, live surgical sessions, innovative pre-congress courses and GESEA certification exams will be among the ingredients of the scientific programme, which aim to improve the necessary skills to ensure better outcomes for our patients.

## Why in Rome?

Rome, or Roma in Italian, is a historic city and capital of the country of Italy. Once the capital of an ancient republic and empire whose politics defined the Western world in antiquity and left seemingly indelible imprints thereafter and the site of major pinnacles of religious, artistic and intellectual achievement, Roma is the Eternal City and is also called *Caput Mundi* (Capital of the World), remaining today a political capital, a religious centre, and a memorial to the creative imagination of the past.

We are looking forward to welcoming you and sharing great learning experiences together, “E poi uscimmo a riveder le stelle” (Then we went out to see the stars again) cit. Dante Alighieri, *L'Inferno*.

The full scientific programme and registration details are now available online and can be accessed here





# ESGE Journal

## FACTS, VIEWS & VISION IN OBGYN

**Vol. 13, Issue 2**

**OUT IN JUNE 2021**

Lots of interesting topics in this issue such as recurrent ectopic pregnancy, hysterectomy, Pelvic Congestion Syndrome and the ESGE-ISUOG-IOTA-ESGE Consensus Statement



## Webinars

The ESGE, in collaboration with Facts, Views and Vision in ObGyn has organised topical webinars in Gynaecological Endoscopy. Learn more from the experts via our platform [academy.esge.org](https://academy.esge.org)!

**All information on upcoming publications, events and more to be found on:**

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## Interview with Professor Victor Gomel



**Professor Victor Gomel**  
Professor Emeritus in the  
Department of Obstetrics  
and Gynecology, University  
of British Columbia

Victor Gomel is Professor Emeritus in the Department of Obstetrics and Gynecology, University of British Columbia, Canada. He served as Chairperson of his Department for fifteen years, during which the Department was greatly expanded and attained international recognition. He is internationally known for his pioneering work in both gynaecological microsurgery and operative laparoscopy. With his team, their IVF programme was the first to achieve success, resulting in the birth (on December 25, 1983) of the first IVF baby in Canada.

ESGEVISION Editor Ertan Saridogan interviewed Victor Gomel to highlight historical landmarks of gynaecological microsurgery and operative laparoscopy.

***ES: Thank you very much for allowing some time to have this interview with us for ESGEVISION, the newsletter of the European Society for Gynaecological Endoscopy.***

***You are one of the pioneers of reproductive surgery still active in the field and you know the history of the last 50 or so years. What we would like to do in this interview is to just start from the beginning of your career to see what the landscape was like then and perhaps give a brief history of how we have come to what we are today.***

VG: I am very pleased to do this interview, especially with you because you are a dear friend I love and admire.

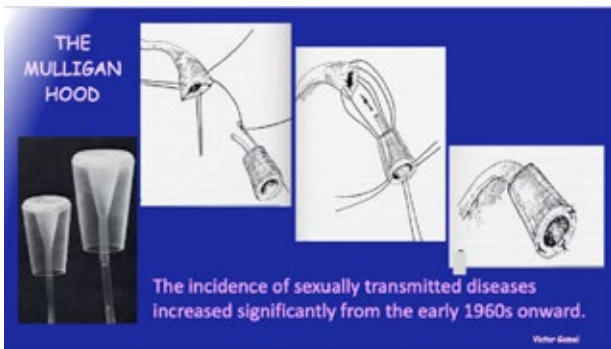
What created the interest in reproductive medicine in me was the following: When I was a chief resident, I operated on a lot of patients who had no insurance; I also assisted at the surgeries of several gynaecological surgeons on staff. At the time there was an epidemic of sexually transmitted diseases; Chlamydia was in vogue with a proportional increase in salpingitis and its subsequent consequences on fertility. Hence there were many operations performed to treat pelvic adhesions and perform salpingostomies on hydrosalpinges. Then all the abdominal and pelvic operations were performed through a laparotomy. Large sponges were used to retract the bowel; the peritoneal cavity was exposed to the room atmosphere and to the heat of the lights illuminating the operative site. Intraoperative irrigation was rarely used.

When opened, the abdomen was usually free of adhesions as opposed to the pelvis. Pelvic adhesions were dissected but not removed; they were just cut. The hydrosalpinx was opened, and usually a Mulligan





hood (a device) was inserted into the tube and kept in place with three sutures to prevent occlusion. Two or three months later it was necessary to perform a second laparotomy to remove the devices. What surprised me was the presence of adhesions when we opened the abdomen, where there were none previously. We had to dissect these abdominal adhesions to reach the pelvis, which also was full of adhesions. This made it obvious that recurrence of adhesions was responsible for the modest outcomes of these procedures. We had to find a system to reduce adhesions.



I spent a year as a fellow, teaching, doing research, and due to the paucity of residents in the department, also clinical work. I was successful with my specialist exams and was offered to stay in the department to teach and practice. At the end of that year, I took a further, more difficult exam to become a fellow of the Royal College of Surgeons of Canada.

***ES: If you don't mind me asking, what year did you become a specialist?***

VG: I really started this work in 1968 and 1969. In the summer of 1968, I spent a month in Paris with Dr. Raoul Palmer, to learn laparoscopy. In February and March of 1969 I was in Gothenburg, Sahlgrenska Hospital, largely to see the work of Kurt Swolin.

After my return from Gothenburg to Vancouver I started to work on what we had to do to reduce adhesions. I started to search the literature starting with the late 1800's, and to my great surprise there was a wealth of research that had been done in Germany and elsewhere. I wrote all of this in my recent article in *Fertility and Sterility* 'From laparotomy to laparoscopy to in vitro fertilization.'

I found out that in 1905 K. Baisch, a German surgeon demonstrated if the peritoneal surface is damaged and if there is blood in the peritoneal cavity, the blood adheres to the damaged site and causes adhesions. He stated: "These experiments show the dire consequences of leaving blood in the peritoneal cavity, whenever the serosa is also damaged. Blood

may find the smallest area denuded of epithelium, whereon it may begin to clot and build up fibrin"

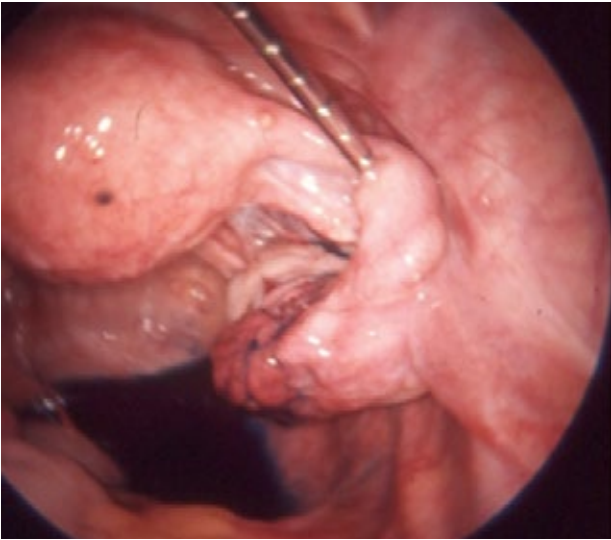
There were many more such articles starting from the 1880's on: The coalescence of two injured and closely apposed serosal surfaces; the importance of fibrin and fibrinolytic mechanisms, clotted blood becoming firmly adherent to desiccated serosal surfaces, the importance of bowel peristalsis. Somewhat later: heparinised or defibrinated blood does not adhere and does not cause adhesions; the deleterious effects of ischemia, of talcum powder, which usually covered surgical gloves, of gauze sponges, and of saline solution's toxicity to the peritoneal cells, the inhibition of bowel peristalsis because of drugs. The saline solution's toxicity to the peritoneal cells was also told to me by Prof. Richard Blandau of Seattle, who also advised me to use Ringer's Lactate instead of saline solution.

This was a rich trove of knowledge upon which to develop a reproductive microsurgery programme in Vancouver. So I decided, first of all, to go and take a microsurgery course, where we ended up doing anastomosis on a 1 mm vessel on rats using 10/0 suture.

The microsurgical tenets (see the box) were developed over time with the use of animal experiments and clinical observations, which included systematic second-look laparoscopies, performed 8 to 12 weeks after the initial surgery. These postoperative observations drove changes and improvements in practice and techniques. Thanks to the OR nurses we were able to use the operative microscope of the Ophthalmology department on the days they were not using it. All we needed to do was to change the optic lens.

With experience and observation at second look laparoscopy we changed certain things. Early on, we abandoned the use of prosthetic devices such as stents. We had used peritoneal grafts to cover the denuded areas of peritoneum, as recommended by Palmer, but we realised that not infrequently the grafts undergo necrosis and cause adhesions, so we abandoned the practice altogether. The same applied to postoperative hydroperturbation, which was very much in vogue at the time. Initially the irrigation fluid used during surgery was close to body temperature, this was changed to OR room temperature. We improved the techniques of various procedures, more importantly initiating the technique of tubo-cornual anastomosis to replace tubo-cornual implantation, which was a very traumatic procedure.





*Second look laparoscopy after tubal surgery*

The magnification and the ease of operation afforded by the operating microscope allowed us to assess the tissues and perform a more precise and atraumatic surgery that yielded significantly better outcomes.

## Microsurgery: Principles

- Delicate handling of tissues (Atraumatic technique.)
- Judicious use of electrical & laser energy
- Irrigation with heparinized Ringers' lactate
- Meticulous pinpoint hemostasis
- Identification and use of cleavage planes
- Complete excision of abnormal tissues
- Excision and removal of broad adhesions
- Precise alignment & approximation of tissues
- Thorough lavage with Ringers', at the end of the procedure
- Instil 500 ml of Ringers' sol. with 500mg hydrocortisone succinate before closure
- Use of magnification as necessary
- Give 1 or 2 doses of Dexamethasone postop.

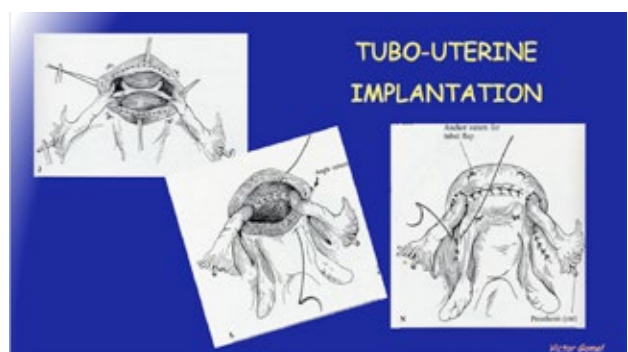
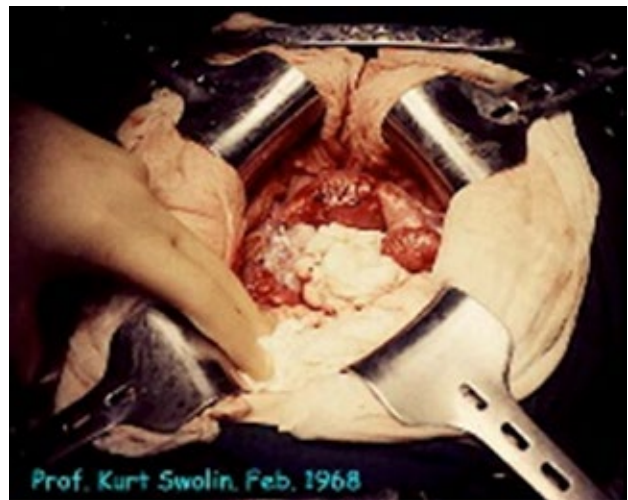
### **ES: How did you arrange to see the leading gynaecologists of that time?**

VG: I met Kurt Swolin in an IFFS congress in 1968. In 1966 he had reported on 50 "various fertility operations using, what he called, a type of microsurgery as atraumatic and bloodless as possible" together with the application of 2,000 mg of hydrocortisone acetate into the peritoneal cavity before closure.

I spent two winter months at Sahlgrenska Hospital's building named "Koko Et" where the Department of Obstetrics and Gynaecology still resides. We spent a lot of time together with Kurt and became great friends despite our age difference. During my presence there, he did only three cases; two salpingostomies and one tubo-cornual implantation using Shirodkar's technique. He operated with magnifying glasses. His operations took a very long time, as much as 6 hours with breaks in between.

Kurt Swolin was a very nice man, and we became very close friends to the extent that when he was separated from his wife, he came to Vancouver on September 1, 1971, the day I myself had just moved to my new house; and he stayed the whole month of September.

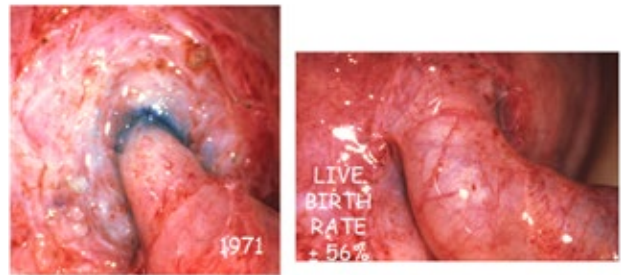
In those days you could have a Professor, even from a foreign country, to scrub and operate with a local without any problems. A few days after his arrival, I booked two cases of tubo-cornual anastomosis and invited him to assist. We were operating with an operative microscope enabling the two of us to view the operative field. I can still vividly recall his surprise and enthusiasm when he saw this procedure.



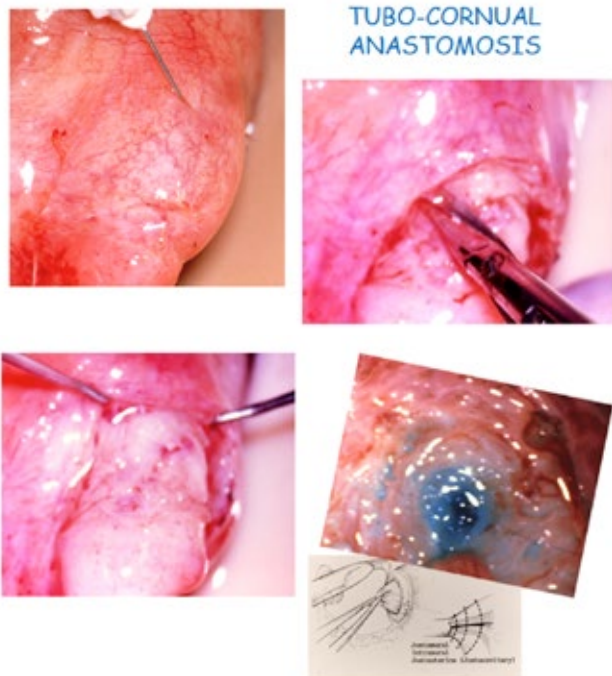
His presence in Vancouver also gave me the opportunity to do a two-days, hands-on course on operative laparoscopy with the Department of Anaesthesia at the Vancouver General Hospital.



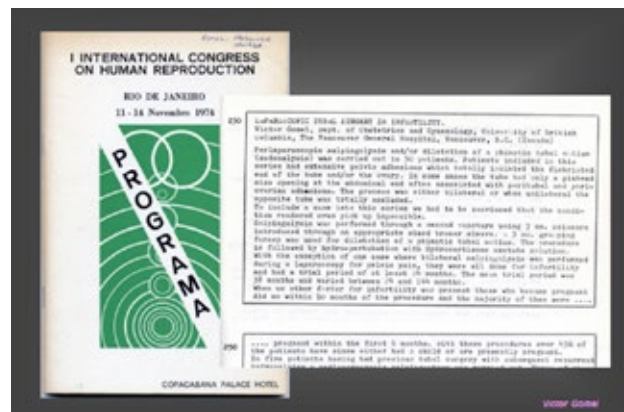
I started performing microsurgery and laparoscopy at the same time, and started to publish from 1974 onwards. The first presentation of my laparoscopic data was on June 13, 1973 at the Canadian Fertility Society Annual Meeting held in Vancouver, where I was given 35 minutes to talk on "Experience with Operative Laparoscopy". I also presented the same data at Laval University in Quebec City later in the same month.



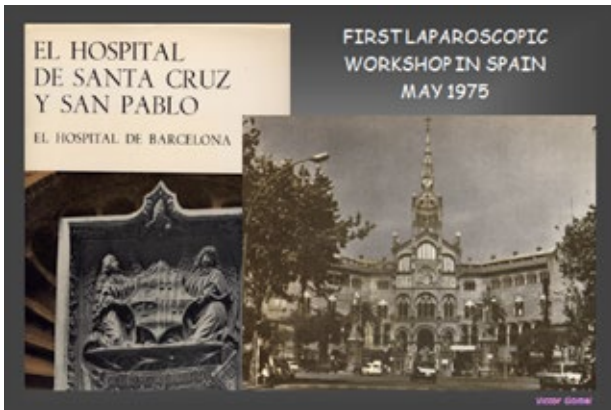
I presented 50 cases of microsurgical salpingostomy, tubo-tubal and tubo-cornual anastomosis in November 1974 at the IFFS World Congress in Buenos- Aires in Argentina.



Professor A. Campo da Paz from Rio de Janeiro formed a new Society "Human Reproduction" and invited several people from the IFFS, to his Congress in Rio, taking place a couple of days later. I was one of the invitees and was asked to give two keynote lectures (One on Microsurgery and another on Operative Laparoscopy). After my talk, a young assistant professor from the University of Barcelona in Spain approached me asking if he could come to Vancouver to see my techniques. He arrived a few weeks later and got to see all that we were doing. Soon after his return home I was invited to direct a large didactic and hand-on course with operative demonstrations in their University in May 1975. This was the first such endeavour in Spain.



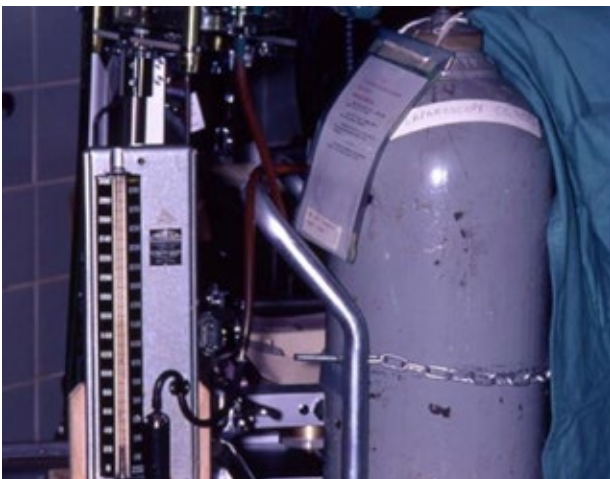




**ES: Victor, the practice of laparoscopy, was it actually routine when you were a resident?**

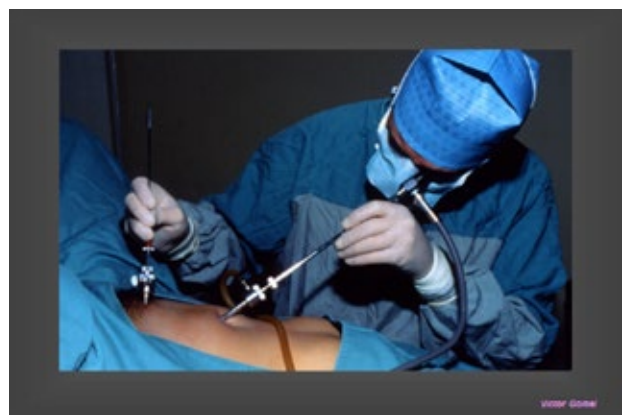
VG: There was nobody who knew or did laparoscopy. I was the first in Canada. As I indicated earlier, I performed the first laparoscopy in Vancouver towards the end of 1969. When I started laparoscopy my confreres, including my chairman, did not believe in it. Many would open the OR door where I was operating, make a mocking remark and shut the door.

There was only \$600 in the gynaecology department's budget for instruments, and I had to add the rest. I bought a Wolf laparoscope with the necessary accessories. The price of the CO<sub>2</sub> insufflator was quite expensive for me at the time and I decided to build one in place. We had huge CO<sub>2</sub> tanks and volumeters on the Cyclopropane anaesthetic machines, no longer in use that would serve our purpose. The OR nurses were always very helpful and the Head Nurse put me in contact with the technician of the Department of Anaesthesia. He agreed to help but I had to get permission from the Head of the Department. I went to see him, Prof HB Graves. After I explained the project to him, he started quizzing me wanting to know all of the minute details of laparoscopy. Then, he said "fine, I will tell the technician to help you". We built the insufflator on a huge CO<sub>2</sub> tank, with a mercury manometer, a Y shaped tube and the volumeter of the Cyclopropane anaesthetic machine.



When I booked the first case around November 1969 and arrived in the OR I was very surprised to see Prof. Graves preparing to give anaesthesia to my patient. He very rarely gave anaesthesia in gynaecology. It was a diagnostic laparoscopy and all went well. These were the times when we had only monocular vision through the scope. It was easy for me to show Dr. Graves and the scrub nurse what we were able to see through the laparoscope; their eye was as sterile as mine! In my second case when I saw once more Dr. Graves giving anaesthesia, I wondered if he was there to supervise me. I asked the head nurse; no, she said, did you not see that he is taking blood samples from the patient frequently. He started a research project. He is studying the blood pCO<sub>2</sub> levels, at various abdominal pressures, different positions and especially in the Trendelenburg position. I realised how lucky I was to have such an important and influential person with me, when many did not believe in what I was doing.

It did not take long to recognise that laparoscopy provided a surgical access route. I purchased a pair of forceps and scissors, both insulated and inserted through 3mm trocar-cannulas. I started with adhesiolysis, tubal sterilisation, and commenced to apply the microsurgical principles to treat patients with infertility caused by distal tubal disease, starting with salpingo-ovariolysis, and soon after fimbrioplasty and salpingostomy. Having Dr. Graves, showing him the pathology and having his consent permitted me to attempt more and more difficult procedures. I was also asked to do laparoscopies by general surgeons, mostly on men and more rarely by pediatricians; I had then a thin Storz laparoscope. And in 1971 we acquired a real insufflator and more instruments.



In September 1972 the wife of a family practitioner I knew well was admitted with the possibility of an ectopic pregnancy. At the time the only way to make a proper early diagnosis was laparoscopy.



The patient was booked sometime in the evening. Fortunately, Dr. Graves was there. She had a tubal ectopic in the ampullary region close to the isthmic-ampullary junction. Dr. Graves agreed to my trying to do it by laparoscopy, we had the option of a laparotomy, as was done at the time, if I failed. I had the necessary tools including a special camera that attached to the objective of the laparoscope and permitted me to take good half frame pictures without a flash, holding the camera without moving for 15th of a second. I performed a segmental excision on the part of the tube that contained the pregnancy. We took pictures as well.



Such procedures were performed by monocular vision, viewing the operative field directly through the ocular of the laparoscope. It was still possible to operate with two hands while the scope was held steadily in place by an assistant, and to treat the patient during the initial diagnostic laparoscopy.

The next day, late in the morning my chairman saw me in the OR and came towards me. I thought he would congratulate me. He told me: "You are going to kill a woman in this department; if you do another one, I will fire you." For a kind, gentle person to tell me this; I was truly surprised. He had never come to see a laparoscopy. I asked him if he saw the patient and told him that she wanted to go home when I saw her and had to force her to stay. I continued to operate; fortunately, I was never fired. Six years later they insisted for me to take the chair of the Department!

Laparoscopy also made us realise that it was not necessary to make the large abdominal incisions we used to do. Many procedures could be effectively performed with smaller ones. We started to perform all microsurgical tubal anastomosis procedures with a 5 to 6 cm suprapubic incision from 1984 onwards. Distal tubal pathologies were all treated by laparoscopy. It was also possible to simplify more complex laparoscopic procedures with a small suprapubic incision or by opening the posterior vaginal cul de sac.

Technical progress, especially the development of small, lightweight, high-definition cameras and high-definition television monitors, made it possible to view the operative field through one or more television monitors. This allowed surgical teams to work harmoniously, enabling the expansion of operative laparoscopy and its use for increasingly more complex procedures from the early 1980's onward.

***ES: So Victor, one thing I wanted to ask, you obviously started doing microsurgery – do you know who actually started microsurgery – gynaecologists or vascular surgeons?***

VG: Micro-surgery was started before, with vascular surgeons initially using magnifying glasses, hand surgeons and ophthalmologists, whose operating microscope we used, until Carl-Zeiss Germany gave us one as a gift.

***ES: Around the time that you bought your laparoscope yourself with your own money, how much laparoscopy was happening around the world at that time?***

VG: Obviously in France and Europe. Gynaecological laparoscopy started with Raoul Palmer in the early 1950's. Steptoe from England went to Palmer to learn and published a book in 1962. The book contains only all that he saw when he was with Palmer. The same with Ettore Cittadini from Palermo Italy; Frangenheim from Germany went to Palmer as well, as did Melvin Cohen from Chicago USA. Palmer was the source; many more went to learn from him.

***ES: Good, so we've come to the mid-1980's and I suppose things started expanding much faster after that, is that right?***

VG: Yes, by then I was already the head of our department, trying to improve it as fast as I could. When I took over, the Department was unable to fill all the residency positions and did not have residents from our own medical school. We first had to deal with urgent, long neglected issues and improve the morale in the department. I asked to start an



IVF clinic in 1973, but could not get the approval of my Chairman. We started in 1982 and had the good fortune to obtain the first Canadian IVF baby, born on December 25, 1983. We also started a very successful Science programme; "Developmental and Reproductive Sciences" which provided Master and PhD degrees.

By then we had published results with our microsurgical techniques; live births for: salpingostomy: 31.5% despite 6 of the cases being operated for a second time, due to their initial surgery's failure performed elsewhere. Live births after post tubo-tubal anastomosis for reversal of sterilisation were 78.8%; and tubo-cornual anastomosis for pathologic tubal occlusion 56.2%. Among 9 patients who had one or more previous tubal pregnancies, microsurgical anastomosis of a single oviduct resulted in live births for 5 of them. We have to be reminded that at the time reconstructive surgery was the only realistic option for the treatment of infertility caused by tubal and peritoneal factors.



We had already started to offer hands-on microsurgery courses since 1976. I was invited by several universities in the USA, Latin America, Europe, Asia and Africa; and started to receive Fellows in Vancouver. In the beginning of 1980, I received a Fellow from Lyon, France (Alain Bremond) who had obtained a bursary from Canada. He wished to be helped with his thesis and also learn our new surgical techniques. While he was with us for 3 months, I was invited to organize a course in June in his school "Université Claude Bernard - Faculté Alexis Carrel, Clinique Gynécologique," in Lyon, France. Subsequently I was asked to give 2 to 3 courses a year, for many years in France.



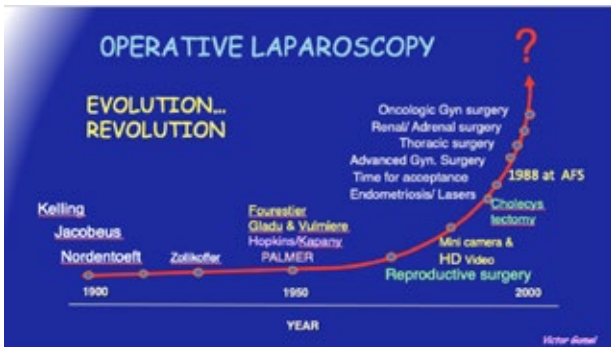
A few months after my first visit to Lyon, I received a letter from a certain Maurice Bruhat, whom I did not know, stating that he wanted to come to Vancouver as Bremond and would apply for the same bursary. I replied he was welcome to come, but unfortunately he could not obtain the bursary. Thereafter, he became famous in France by establishing a superb division of reproductive surgery in Clermont-Ferrand. Later he was elected Dean of the faculty of Medicine and was also admitted as a member at the French National Academy of Medicine.





**ES: And how long did you stay as the head of department**

VG: 15 years. They wanted me to serve another 5 years, but I thought it was enough. Later I was asked to be a candidate for Deanship, I refused; a candidate for the presidency. I also refused. I had worked 16 hours a day and many weekends to bring up the department at the level it was.



**ES: And despite being in Canada, you had close links with Europe as well. I remember you had Legion d'Honneur, when was it?**

VG: The links were truly international. You would be surprised if you see my traveling schedule during those years. With France it was special; I also spent a sabbatical year there (October 1998- 1999) in Antoine Beckler Hospital, University of Paris XI.

Yes I was awarded the Legion d'Honneur in 2003.

**ES: Which French president was it?**

VG: Jacques Chirac

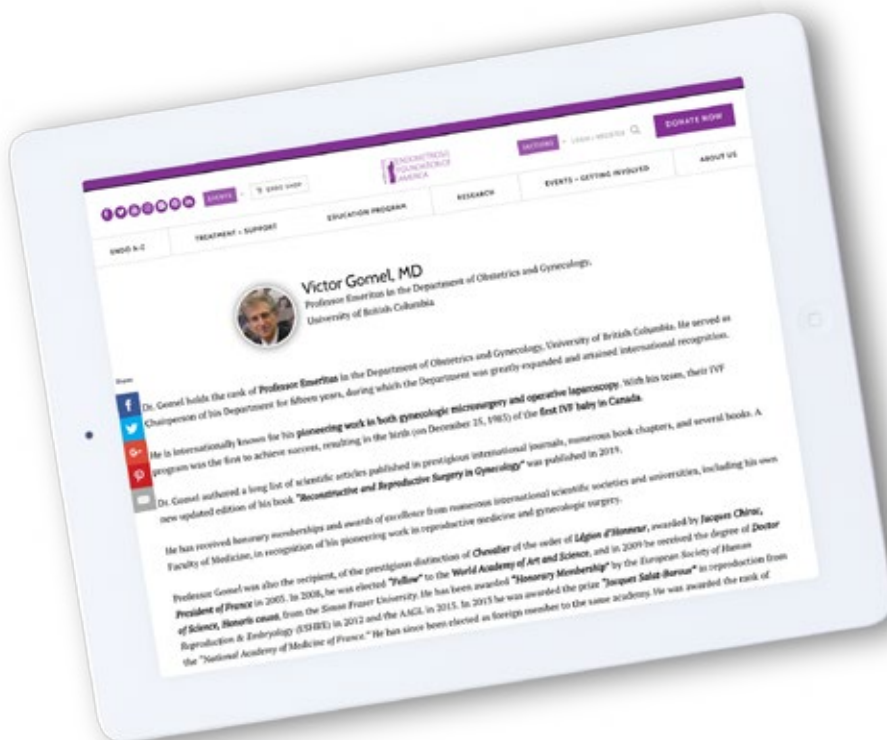
**ES: And that link was it for any contribution that you did in France or was it for your overall international, global work?**

VG: In the letter I received from President Chirac the "link" was the second paragraph: "This prestigious distinction that I wanted to bestow on you recompenses an eminent specialist who participated for more than twenty years in the formation of French gynaecologists. It recompenses the quality of services that you have rendered to Medicine and our Country".

**ES: You must have been very pleased to receive that.**

VG: Certainly. I was truly surprised and could not believe what I was reading in his letter. France has been very generous with me. The National Academy of Medicine honoured me with their major award in reproduction (Jacques Salat-Baroux award), in January 2013, and a few months later elected me as foreign member to the Academy.

**ES: Victor, thank you again for talking to me this evening for ESGEVISION and I look forward to seeing you soon.**





## Interview with Professor Frank Willem Jansen



**Professor Frank Willem Jansen**  
Leiden Academic Medical Centre

Professor Frank Willem Jansen from the Leiden Academic Medical Centre gave one of the keynote lectures at the ESGELive2020 Event entitled 'The sustainable MIS-OR of the future: facts and vision'. The Editor of ESGEVISION Ertan Saridogan spoke to him about his lecture.

***ES: Can I start by asking you why you chose the subject of sustainable MIS OR for the ESGE Live 2020 Event?***

My professional appointment at the Leiden Academic Medical Centre and at the Technical University Delft is 'Implementation of new techniques and technologies in Minimally Invasive Surgery'. In this context I guard the patient safe implementation of new instruments, but also new surgical techniques. In this line I observed a tremendous increase of the use of disposable instruments. We, as surgeons, do not take the managerial consequences of the implementation of MIS techniques. For the latter I mean that we overlooked that the work content of the OR nurse changed tremendously. Their assistance during the operation is reduced and their knowledge about technology has to be improved. I found that during my MIS surgery (compared to conventional open procedures), OR nurses were talking about holidays, or other social things, and were not involved in the surgery itself. These factors, summarised in the 3P's (People, Planet, Profit), made me aware that there are lots of challenges if you consider sustainability. The international warning in general, on this subject made me curious what we, as health professionals can do. The subject fits perfectly in my appointment at the Technical University to challenge the engineers to help us.

***ES: When you look at the overall changes in environment and pollution, is what we produce with minimally invasive surgery a drop in the ocean or a significant contribution?***

FWJ: The OR produces 30% of the total hospital waste and inherently contributes to the CO2 footprint. When you look at the MIS itself they have a big part of this contribution. A good example is the use of disposables. In the last decades, the industry convinced us that disposables work better and are more sustainable compared to reusables, as you do not need to wash or re-sterilise them. I think they made a miscalculation. I am not against the use of disposables and I actually love working with them because they always work, are safe etc, etc. But I think we have to develop a new concept of instruments. The engineers, together with the industry have to develop half reusable instruments, in other words how can we reuse the parts which are still working? As gynaecologists we know that when we use coagulation



instruments, we are not only coagulating, but also use the instrument for preparation and dissection of tissue. A good example is the Harmonic or Ligasure; after three (coagulation) steps at an ectopic pregnancy operation, we throw them away. This has to change, so that we combine the advantages of disposables with the reusable concept.



*Rubbish generated after just one laparoscopic hysterectomy*

**ES: Going back to my previous question about overall contribution of MIS to pollution; you mentioned OR produces the 30% of the hospital pollution. How does this compare to the airline industry, for example?**

Approximately 6-8% of our global CO<sub>2</sub> footprint is produced by the health sector. The airline industry counts for approximately 3%. But in that latter calculation the Nitrogen part is not included.

**ES: 6-8% is not insignificant at all.**

FWJ: In the Dutch way we say: every bit helps. And don't forget, producing that much waste is probably not necessary. We are producing now in the name of patient safety a huge amount of plastic and other hospital waste. We measured that approximately 1400kg of waste per hospital bed per year is produced. That is significant!

My goal in this field is 'to measure is to know'. Where can we reduce our CO<sub>2</sub> footprint significantly without compromising patient's outcome and safety. And don't forget that in this context cynicism is another word for laziness. We have also the responsibility for the generation after us.

**ES: Do the figures for disposable/reusable instruments take the manufacturing phase into account when you calculate the footprint or only their use in hospital environment?**

FWJ: That's a very good question. You can analyse that with a LCA, or Life Cycle Analysis. When I am analysing the footprint of a disposable or a reusable instrument, where do I start? I think the industry sells with an incomplete LCA. Let's say the plastic comes from the US, metal comes from China, it is transported to the UK by aeroplane, used in Holland and the waste goes to Nigeria; all these things need to be considered. But I am not sure that there is an LCA available for all instruments. My dream is that besides the Euro/Dollar/Pound costs an Eco cost is available. What is the LCA footprint of each instrument? In that way surgeons/doctors can decide whether to use that instrument or not. For example, let's say I have a case of ectopic pregnancy. There may be a cheap instrument with a high LCA footprint but we may choose a more expensive one with a better footprint. We have to develop a mindset that we take LCA footprint into account if we want to use an instrument. In my presentation I gave the example of the robot, I am not against the robot but the industry has to think about all the plastic covers, disposable instruments etc and their LCA. If I have a difficult endometriosis or cancer case, I may be allowed to have a bigger LCA footprint, but not for a simple hysterectomy for example. We have to change the way we think, together with the industry to make the instruments more sustainable.

**ES: I suppose it will also depend on what technology is being used. That brings me to the next question. Do you think if the bigger component of the LCA is packaging, or is it the actual device? For example, if you are looking at a pair of single use scissors, how do they compare with harmonic scalpel?**

FWJ: I don't know yet. That's part of the research we have to do. Because we do not have the data. On the other hand, European legislation can manage centrally to control the introduction and use of different materials (e.g plastics).

**ES: Did you say that the European law now requires that LCA needs to be on the label?**

FWJ: That will be a good one. I'm afraid that when each country adapts its own rules for this issue, we do not reach our goal to diminish our CO<sub>2</sub> footprint by 30%, to the level of 1990. Currently we are still in the phase of awareness. So please doctors be aware that we are producing a CO<sub>2</sub> footprint. The next step and I have started with that, is measuring, and knowing what we are talking about, actually. We have to measure quite a lot of things, but we have to





work together with the engineers and the industry, because the packages with plastics are also different, you have hard plastic, soft plastics etc. One is reusable, the other one has to be destroyed, etc. We are in daily practice not aware of this phenomenon. However, at home we are separating our waste. In my opinion, at the hospital we, as a doctor can be in the lead on this subject.

It is a broader issue than health care sector alone, but I think that 'centrally formulated' rules can make us and the industry to adapt to these obligations.

**ES: Definitely, I agree. I think that's an important issue to highlight. The amount of garbage we produce, mostly because of packaging, is huge. It probably requires some kind of, first of all, awareness – you know quite often we leave things behind and we don't think about what happens to them. Are there differences between different countries? Do you know if it has been looked into? Are there countries that do better compared to the others in this field?**

FWJ: I am not so sure about that. What I see is that the pushiness of the industry in the developing countries to work with all these disposable instruments is big, but I do not know the comparison between countries. I know that there is research done in the United States and in the UK. In the Lancet, recently, they highlighted this issue and I know that in the UK at the NHS level concern and more awareness about this polluting issue is created. In the Netherlands we established 'the Green OR team' where all scientific societies of surgeons (eye surgeons, gynaecologists, general surgeons, plastic surgeons, anaesthesiologists etc) are represented. In this way we get a broader level to all OR's in the Netherlands to introduce similar rules to diminish the CO2 footprint. With other researchers I am constructing a 'CO2 – barometer' for the OR. In that barometer we measure per OR with a benchmark the number of disposables, the amount of energy you are using etc. so that we can compare different hospitals and take action if necessary. Additionally we can, after the pilot in the Netherlands launch it internationally.

**ES: Yes, it would be interesting to see if there are ways of firstly, increasing awareness, and secondly minimising this because it doesn't look insignificant. When I saw the proposal of your presentation title, I jumped on it because there isn't much awareness amongst those in the medical profession or amongst the hospital managers and administrators. So, we perhaps need to promote this subject more and more and increase its visibility within conferences and annual meetings of this type.**

FWJ: Yes, it should be highlighted all the time, because there are things to be done and I think it is possible to do it. For example, the blue wraps is a good example – you are using the blue wraps as well or do you have these boxes?

**ES: We do use blue wraps, and then it's not just one layer, usually it is two or three layers.**

FWJ: But you know, for the hospital management it is cheaper, it is handy, etc. But the box is costly – we figured out that the box can be used very often – after 20 times, it is overall even cheaper, but it is an investment up front because you have to buy them etc. But in the end, they will find that the blue wrap is more expensive and produces more pollution and wastage. But we are customised to the blue wrap already. It's difficult to change. However, in the sustainable discussion it might be better to change the winning team.



**ES: I think that the overall policies, government policies, healthcare policies, probably influenced it. If you provide subsidies for these kind of longer-term investments, then it will be easier for the hospitals to utilise it, whereas if the hospital is supposed to live on its own annual budget so that they can't make big capital investments for the next five years or ten years, then they'll just use the blue wrap.**

FWL: Yes, but you know Ertan, that's why I think we as doctors need to be the lead. I think the management will listen to the doctors as well, if you are talking about patient safety, etc, because we are saying "I need my disposables because I am working patient safe" – no manager will say "you're not allowed to" because of the air pollution or the polluting factor in it. But if we say as doctors "I can make a change" they will change. We have to be in the lead. That's an important message for me – doctors please be in the lead about this subject. Because we know what patient safe working is and we know that we can diminish a little bit in one way or the other, and we have to make it more precise in another way.

**ES: Yes, I agree and for that we first of all need to make sure that people know the impact on the environment. So, to perhaps contribute to that, the other thing that we should probably do, is to get you to write an article for our journal.**

FWJ: Yes, deal.

**ES: I don't know whether you want to write it in an editorial format or perspective opinion for comment, or also a review is also possible. So, I leave it to you, but I think in the next one or two issues, if you can prepare something with some of your colleagues, that would be interesting to actually publish in the journal, because it will be visible.**

FWJ: Yes, ok, I will make something about what we do here at this moment and what we are working on.

I just wrote an article in Dutch about it as well to create awareness and where we are busy with the engineers and I can translate that. No worries.

**ES: So, just to finish with, Frank Willem, so for those people who haven't actually seen your keynote lecture, but will be seeing the ESGEVISION newsletter, what would be your take home messages of your keynote lecture?**

FWJ: Well, I think the important things are; firstly awareness, doctor be aware, and awareness means also be in the lead as a doctor, because we know the process. The second point is patient safety, we have to work in a patient safe way with sustainability in mind. And the other thing is measuring is knowing – that's an important one because we are all talking about awareness but, on the other hand, I want to know what makes sense to reduce things. I mean, I know from the airplanes now that they pollute quite a lot so we, and our generation after us, have to think about how to travel around. After the COVID pandemic, sustainability has to be high on the agenda. Don't forget, we inherently have the (sustainable) responsibility for the next generation. Third thing is, that we have to work together with the engineer and the industry to develop a new approach to manufacturing new instruments, and that means reusable things or make them modular. Summary challenges for the engineer: a new approach to instrument development. My message for MIS - Be sustainable aware, work patient safe, challenge the industry and the engineer to develop patient safe new instruments which are sustainable. The goal is: sustainable technology for sustainable health care.

**ES: Thank you very much for talking to me.**

# Hysteroscopy: A rapidly growing independent branch of gynaecological endoscopy

**Sergio Haimovich<sup>1</sup>, Antonio Simone Laganà<sup>2</sup>, Luis Alonso Pacheco<sup>3</sup>, Attilio Di Spiezio Sardo<sup>4</sup>, Jose Carugno<sup>5</sup>; from the Global Community of Hysteroscopy Scientific Committee.**

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Hysteroscopy is rapidly changing. Despite the fact that the "see & treat" philosophy for the treatment of intrauterine pathology initiated over 2 decades ago, it has not been widely adopted in clinical practice. In many hospitals, physicians continue to perform diagnostic hysteroscopy in the operating room with the patient under general anesthesia. However, lately, many more gynecologists are performing the diagnostic hysteroscopies and treating some intrauterine conditions in an office setting without anesthesia, which represents a first step in the direction of "see & treat" of the intrauterine pathology in office settings.

Over the last few years, we have witnessed an increased use of hysteroscopy, which now represents the most common gynecologic procedure performed in an office setting. Of note, most of the new devices that are being created for hysteroscopic surgery are geared towards in-office procedures. This tendency was first evident in Europe and starting in 2016 has also been the tendency in the USA. Currently, more than 500,000 hysteroscopic endometrial polypectomies are performed in an office setting every year in the USA [1].

Being able to perform in office procedures, with the patient awake and without anesthesia, requires a set of unique skills leading to the need for additional training. Three years ago, the Global Community of Hysteroscopy (GCH) adopted a phrase from Dr. Linda Bradley "My hysteroscope is my stethoscope", with the goal of promoting the role of hysteroscopy in modern gynecology. At GCH we believe that the same way that urologists are comfortable performing cystoscopies, gynecologists should also be comfortable performing hysteroscopies. In recent years, GCH has organized 2 world congresses, one regional Asia-Pacific and has been present in 18 countries in multiple events with the aim of promoting this vision. Hysteroscopy should be considered a diagnostic and therapeutic tool which should be widely available to every gynecologist.

This ambitious idea requires many steps, the most important being adequate training. This little "revolution" has already started. In our center, the gynecologists of the reproduction unit perform the exploration of the uterine cavity by hysteroscope in the office, with the patient awake, without using anesthesia, as part of the routine diagnostic work-up of the patient with infertility [2], immediately after the ultrasound.

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In our opinion, the change in hysteroscopy is being much more profound and parallels the change within endoscopy in general. In almost every country there is a scientific society dedicated to “gynecologic endoscopy” where they coordinate both hysteroscopy and laparoscopy educational activities. Laparoscopy as a surgical technique began in 1944, it was adopted by gynecologists in the late 70s and 80s, and it was not until 1988 that the first laparoscopic hysterectomy was performed [3]. Over the last 30 years the change within gynecologic laparoscopy has been impressive with a great qualitative leap in 2005 with the FDA approval of the robotic assisted technology for gynecologic surgery.

In the last 15 years, the definitions within laparoscopy with subspecialties have also changed. Uro-gynecologic laparoscopy, laparoscopy for endometriosis, oncologic gynecologic laparoscopic surgery and general laparoscopy of benign pathology other than endometriosis. This leads us to the following question, “Can a gynecologist be a skilled laparoscopist in all fields?”; The answer is “No” and represents the first step of the end of the era of “Gynecologic Endoscopy” as a broad unique field in which the surgical gynecologist was considered an endoscopist expected to be proficient at all different endoscopic procedures.

What happened to hysteroscopy? The first hysteroscopic resectoscopic procedure was performed in 1976, in which, using a device inherited from the urologists, the FDA later approved its use in gynecology in 1989; In 1990 the VersaPoint® system became available, opening the era of “See & Treat” [4] and in 2015 the first hysteroscopic morcellator (Truclear™ Smith and Nephew) or was approved by the FDA [5].

The appearance of new surgical devices and new sources of energy such as laser have led hysteroscopy to a great qualitative leap, especially for in office procedures [6]. The pathology that can be treated in an office setting with hysteroscopy is increasingly complex and diverse, but requires surgical skills and experience, which have led to many gynecologists to dedicate their surgical practice exclusively to hysteroscopy, something similar to what happens with the sub-specialties of laparoscopy.

We analyzed the evolution of the publications related to hysteroscopy searching on PubMed/MEDLINE, which has dramatically increased during the last 2 decades for both general hysteroscopy (Fig. 1) and in office hysteroscopic procedures (Fig. 2).

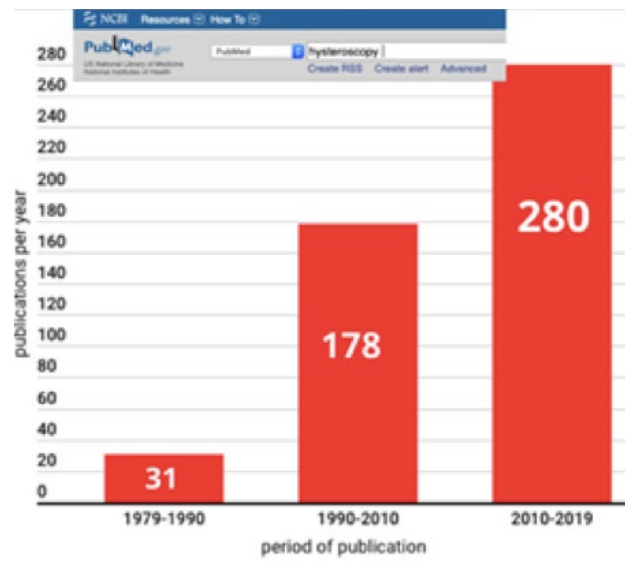


Figure 1. PubMed search for the term “hysteroscopy” (November 29, 2020).

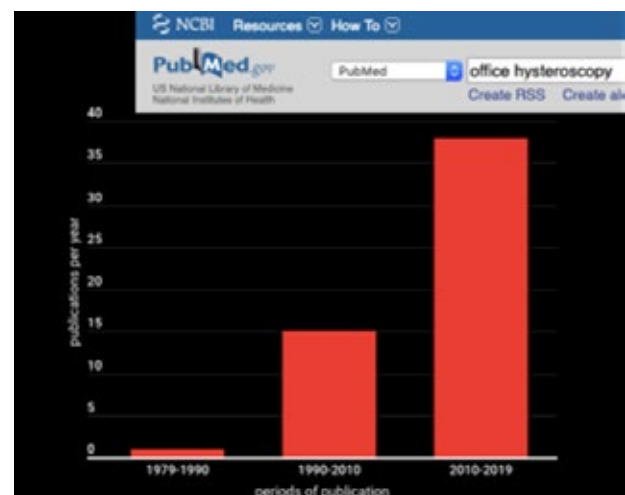


Figure 2. PubMed search for the term “office hysteroscopy” (November 29, 2020).

Until the creation of the GCH, hysteroscopy was considered the “little sister” of laparoscopy: in most gynecology endoscopy meetings it was given very little value, laparoscopy always being the big star. After only 2 world hysteroscopy dedicated congresses with such success, the change was inevitable. In October 2019, during the congress of the European Society of Gynecology Endoscopy (ESGE) that took place in Thessaloniki, Greece, a plenary session of GCH was held, where hysteroscopy was the star, ranking second in terms of number of attendees, and this is just the beginning.



The level of complexity of hysteroscopic surgery associated with the development of sub-specialties in laparoscopy makes it increasingly difficult for the gynecologist to focus on both areas simultaneously, and gynecologists in the future will likely be subdivided into endoscopists of the abdominal cavity and those of the uterine cavity.

All these changes lead us to the need to clarify the terminology. It is not the same to enter a uterine cavity with a small diameter hysteroscope in the office, carrying out a purely diagnostic procedure than performing a metroplasty or a hysteroscopic myomectomy of a large submucosal fibroid with intramural component, and this should be reflected also in the training models of the residency programs [7].

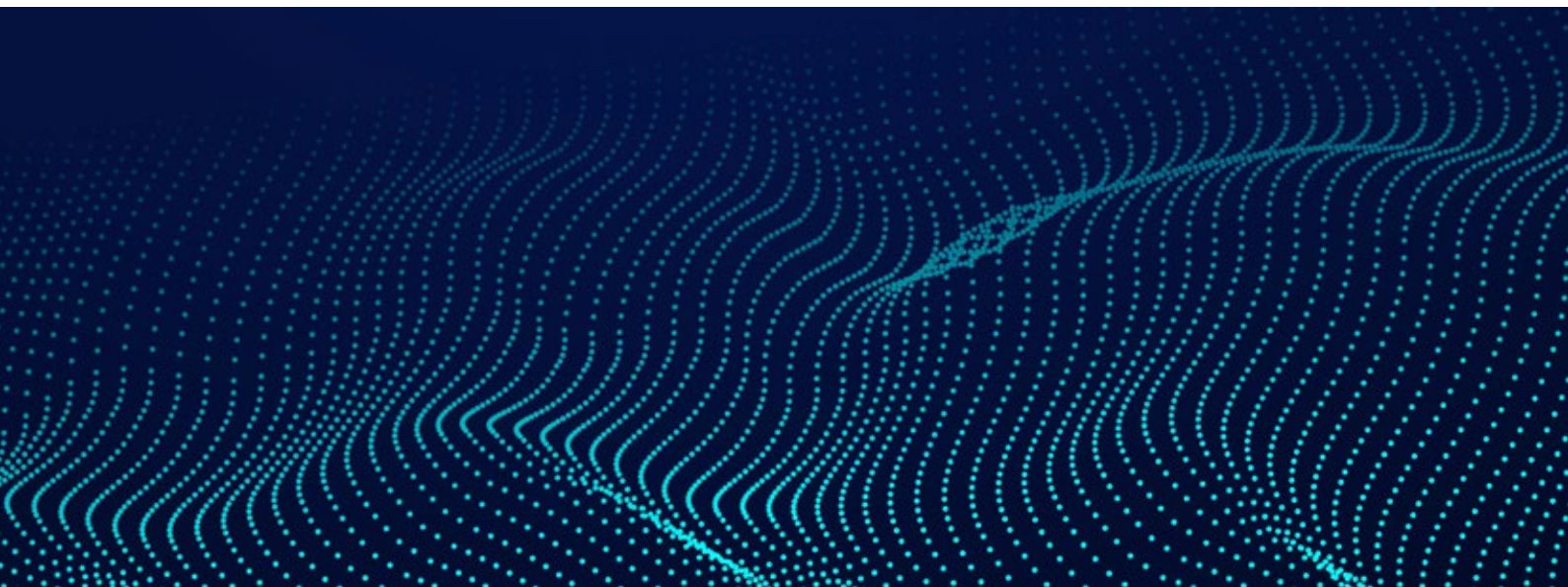
On the one hand, we have the hysteroscopy that represents the action of entering the uterine cavity and “look”, as the term itself explains; on the other hand, we have the “surgery of the uterine cavity”, which can be carried out with different techniques, different surgical devices and even different energy sources.

Those of us who perform complex hysteroscopic procedures are surgeons of the uterine cavity and we should stop identifying ourselves as hysteroscopists, the same way that urologists do not identify themselves as cystoscopists.

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## GESEA Diploma Centres

ESGE in collaboration with the European Academy of Gynaecological Surgery, elaborated a well-balanced diploma curriculum, called Gynaecological Endoscopic Surgical Education and Assessment (GESEA) programme, based on the current best scientific knowledge. The GESEA curriculum is a unique diploma programme developed to provide a structured, educative path to achieving a Minimal Invasive Gynaecological Surgeon Diploma. The programme is founded on the evidence that an endoscopic surgeon requires two different skills sets. On one hand, the instrument handling skills required to deal with the challenge of working in the endoscopic environment and on the other hand, the surgical competences.

The GESEA programme improves the proficiency of the endoscopic surgery skills of the physician, decreases the excessive long learning curves in the conventional apprentice-tutor model and the amount of endoscopic interventions required for teaching the fundamentals in MIS; provides the solutions of teaching MIGS psychomotor skills using dry labs, with the preservation of the tactile sensation an advantage over the simulators.

Assessment of knowledge and practical skills happens through an official GESEA Certification performed by an accredited GESEA Diploma Centre. During our ESGELive 2020 virtual meeting a special session was devoted to 10 GESEA Diploma centers, from 7 countries Belgium (2x), France, Italy (3x), Portugal (2x), United Kingdom, South Africa and United Arab Emirates to promote their centres to doctors interested in MIGS. They demonstrated their achievements in training and certification, number of sessions and participants and academic activities related to Gynaecological endoscopic surgery. GESEA promotion is reported to be mainly accomplished by hospital announcements, through social media, shared online groups, during events such as webinars, conferences and workshops. A Train-the-Trainer course during the ESGE Annual Congress seems to be of great interest for all centres. The decrease in GESEA programme activities has been noted by all GESEA Diploma centers during Covid-19 pandemic. New virtual approaches like e-laparoscopic suturing and knotting, remote exercising in HYSTT and Tele-GESEA certification have been explored as alternative solutions to face-to face practice.

Becoming a training centre using the GESEA Tools is easy. Acquire the tools, follow the tutorials and start your training activity. However, not every training centre can and should become a GESEA diploma centre. The application to become an accredited GESEA Diploma Centre is done through the ESGE Central Office. The ESGE evaluates the legitimacy of the application and informs the applicant centre on the potential acceptance. In case of acceptance, the ESGE will arrange an audit of the centre. During this audit, the venue, infrastructure, equipment and staff will be fully evaluated. Upon a positive outcome, the contract between ESGE and the applicant centre can be formalised.



**Vasilios Tanos MD PhD**  
*GESEA Chair*





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

## GESEA in South-East Asia

After our appointment as Ambassadors of GESEA to WHO South-East Asia region, we have focussed every effort to develop the GESEA programme in the region.

With the support of ESGE Directors and EAGS, we were able to complete successfully flagship ESGE regional Meetings and Live Surgeries by prominent ESGE faculties in the past years as below

1. Mumbai India - 2017
2. Delhi India - 2018
3. Manila Philippines - 2019



During these congresses we focussed to drive aspirants to the GESEA programme and tried to identify young talents to take up the lead for starting GESEA Diploma centres in the region in order to spread the ESGE standards in minimal-access surgery worldwide. We have identified two countries to start GESEA Diploma centres currently with certified MIGS members.

1. Jakarta, Indonesia
2. Varanasi, India

Our GESEA partners here have shown motivation and unwavering interest to invest in the space and efforts to develop regional GESEA centres from their base.

These centres are located in cities with international air travel connectivity and local hospitality interests for aspirants.

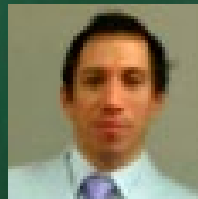
Unfortunately, this process has been delayed due to the unprecedented pandemic and the difficulties involved with the varied lockdown periods between Asia and Europe. However we do find that once travel is easier, or the least we have a virtual platform to carry the measures forward, we will have the implementation of GESEA in India & Indonesia.

(SERGS). J Gynecol Oncol, 2020.

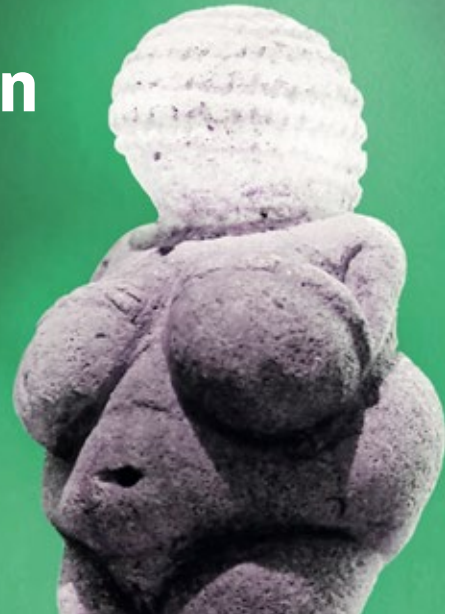
# Facts, Views and Vision Best Article Award 2020 goes to....



**Helder Ferreira**



**Andres Vigueras Smith**



As head of Minimally Invasive Gynaecological Surgery Unit at Centro Hospitalar Universitario do Porto (Portugal), I and Dr Andres Vigueras Smith were very honoured and proud to receive from European Society of Gynaecological Endoscopy (ESGE) the prize of the best article published in FVV (Facts, Views & Vision in ObGyn) during the ESGELive2020 Event on 8 December 2020.. The selected paper entitled "Bowel anastomosis leakage following endometriosis surgery: an evidence-based analysis of risk factors and prevention techniques" was written by five authors being two of them MIGS fellows in our Unit (Andres Vigueras Smith and Rok Sumak) in Porto.

The young and promising surgeon Andres Vigueras Smith, the first author, has done a one-year fellowship in our university where we aim to combine intense surgical practice with acknowledging academic research.

The award-winning scientific article, taking into account the relevance of the topic and the value of the evidence-based analysis performed, has been very well accepted by the readers. Hopefully, it will be cited by future research and publications on the subject.

Following endometriosis surgery, bowel anastomosis leakage is a significant complication that can cause severe morbidity and even the patient's death. Endometriosis affects young women of reproductive age that, apart from endometriosis, are usually healthy. Deep endometriosis most commonly involves the rectosigmoid junction, and its management often requires a colorectal resection. Anastomotic leakage is a severe complication after resection and affects 1-6% of the cases. Bowel anastomosis leakage, or a consequent rectovaginal fistula, are severe complications feared by the surgeons and challenging to accept by the patients.

Our goal was to evaluate the risk factors related to anastomotic leakage following endometriosis surgery, its prevention techniques and the role of protective stomas.

A comprehensive literature review was carried out for English-language publications in Pubmed and Google Scholar. We included all studies including the following MeSH terms and keywords: Anastomotic leakage AND bowel surgery OR Endometriosis OR Colorectal surgery OR Bowel endometriosis. Two authors independently made a selection and analysed more than 135 relevant abstracts according to this review's aim.

Risk factors and preventive measures were categorised considering the patient condition, the intra-operative setting and the surgical procedure itself. Level I and II recommendations include modifiable risk factors such as the use of stapled or handsewn anastomosis; intra-operative air leak test to check the integrity of the anastomosis; systematic use of pelvic and trans-anal drainage; application of protective or ghost ileostomy in low rectal resections; vaginal closure before the bowel resection; use of oral antibiotics the day before surgery and performing partial mesorectal resection near the bowel wall. Diverting stomas may decrease the morbidity and the clinical consequences of leakage over 65% of low rectal resections but may cause significant adverse effects.

We concluded that evidence-based protective actions are crucial to reduce clinical consequences of anastomotic leakage and minimise the use of protective stomas in endometriosis surgery.

We are looking forward to continuing and ameliorate such clinical and scientific activity towards the final goal of improving women healthcare following the ESGE philosophy.

# ESGE Special Interest Groups News

## ESGE Special Interest Group Urogynaecology



The special interest group of Urogynaecology is currently working on the practice of laparoscopic prolapse surgery among the ESGE community.

Indeed, laparoscopic sacrocolpopexy is considered the reference surgical treatment for pelvic organ prolapse in women. However, numerous technical variants are being practiced and various laparoscopic alternatives are emerging, using mesh augmentation or by native tissue repair.

The Urogynaecology SIG group invited all ESGE members to participate in the following survey: 'Practice of Laparoscopic Prolapse Surgery in Europe'.

The aim of this survey is to determine the habits of practice of laparoscopic sacrocolpopexy in Europe and whether surgeons who performed laparoscopic pelvic floor reconstruction are familiar with the practice of alternative techniques such as pectopexy, lateral suspension or native tissue repair.

This survey will be the subject of an article which will be submitted to the journal Facts, Views and Vision in ObGyn so that ESGE members can have access to the results.

Our group also organised a webinar held in April 2021 entitled 'Alternatives to laparoscopic sacrocolpopexy' which brought together experts on subjects such as pectopexy, lateral suspension, meshless laparoscopic POP treatments. This webinar also addressed the alternatives to currently available meshes and the training of surgeons in these new techniques. The webinar is now available on demand at <https://academy.esge.org>

To conclude, the management of pelvic organ prolapse is constantly evolving, especially since the recent events on mesh bashing in Europe and one of the objectives of this group is to provide elements that can help us improve our clinical practice in the field of urogynaecology.

**Laurent de Landsheere**

*Chair, ESGE SIG Urogynaecology/Uro-Gynecology*

## ESGE Special Interest Group Reproductive Surgery



The SIG on 'Reproductive Surgery' chaired by Professor George Pados and composed of 10 active members was committed to promote minimal invasive diagnostic tools for infertility, confirm the role of operative laparoscopy and hysteroscopy in the surgical management of mechanical factor infertility and cooperate with other scientific societies in order to establish a network for elaborating guidelines and recommendations for best clinical practice, under the motto "primum non nocere".

The SIG was very active during the last year and the prolific cooperation between its members resulted in two publications in the journal of our Society "Facts, Views & Vision in Vis ObGyn". The first was a survey on the conservative surgical management of endometriotic cysts, which was initiated by the coordinator of the SIG Prof. George Pados and Prof. Joerg Keckstein. The conclusions confirmed the fundamental role of laparoscopic approach in the management of endometriosis, showed that cystectomy was the preferred surgical method and stressed the importance of well-designed, good-quality studies on the issue.

The second publication, on the treatment of hydrosalpinges in infertile women, confirmed the role of laparoscopy as a first-line treatment in the management of this disease.

Also, the coordinator of this SIG is elaborating an article entitled "classification and staging of adenomyosis" for a new book on "endometriosis and adenomyosis"

ESGE has an important role in defining recommendations and providing guidelines on the role of endoscopic surgery in cases of tubal factor infertility. For this reason a working group of our SIG has initiated a collaboration with the corresponding SIG of the European Society for Human Reproduction and Embryology (ESHRE) towards the elaboration of a manuscript on the "Recommendations for surgical treatment of tubal factor infertility".

**George Pados**

*Chair, ESGE SIG Reproductive Surgery*





# ESGE Special Interest Groups News

## ESGE Special Interest Group Adhesion

The SIG Adhesions has planned various activities for the upcoming year: The Adhesion Research Grant for the Annual ESGE Meeting providing sponsorship and an independent awarding committee in collaboration with ESGE is renewed for 2021.

The follow up EU Adhesion Practice Survey is currently to be finalized before peer review. Translational Trial Projects include stem cell differentiation in adhesion response and modifying stem cell response in adhesiogenesis in an animal study. Furthermore, there are comparative studies to evaluate the effectiveness of already approved adhesion prophylactic agents.

**Rudy Leon De Wilde and Markus Wallwiener**  
Chairs, ESGE SIG Adhesion

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## ESGE Special Interest Group Robotics

The main goal of the SIG was to create a collaboration with the Society of European Robotic Gynaecological Surgery (SERGS), with the aim to integrate the robotic curriculum into the GESEA programme.

To date, after a formal agreement, we are working on the introduction of specific robotic exercises and simulators into the GESEA platform. Due to the fact that there are different robotic platforms, our objectives are to obtain from the Companies different simulators from the robotic companies with the same exercises pathways.

**Francesco Fanfani**  
Chair, ESGE SIG Robotic Surgery

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## Introducing ESGE Advisory Board Members



*Susana Maia*

I am an Obstetrician and Gynaecologist passionate about Gynaecological Endoscopy and Education. Currently, I am working as Obstetrics/ Gynecology specialist at the Department of Gynecology of Centro Materno-Infantil Norte, in Porto, Portugal. I am doing a PhD in Medicine entitled "Innovation in teaching and training in laparoscopic surgery entry techniques", which won the prize "Best PhD project" during the ESGE Annual Congress in 2018.

In 2019, I was officially elected as a member of the ESGE Advisory Board for the period of 2019 – 2023. I promote the ESGE Annual Congress, ESGE Journal and the GESEA Programme in my professional and educational activities, and also on social media. As a Chief-instructor accredited by the European Academy of Gynecological Surgery, I coordinated several GESEA Training & Testing workshops performed nationally and internationally.

During the first half of 2020, as a Local Scientific Chair, I collaborated on the proposals for the scientific programme of the ESGE 29th Annual Congress that was planned to take place in Lisbon, Unfortunately, due to the COVID-19 pandemic, this congress has been postponed to 2022.

As a member of the ESGE Working Group of Education and Training, I am working on the promotion of GESEA Programme worldwide. Together with Professor Lilo Mettler, and other colleagues, we have contributed to the ESGE Vision Newsletter Issue 4 with the article entitled "Women surgeons and women artists: History, power, challenges and opportunities". This was a report of the ESGE Women Surgeon's luncheon symposium at ESGE Thessaloniki, 2019: Art and female surgeons: Can female artists and surgeons be leaders?

For the last annual meeting, the ESGELive2020 that took place in December 2020 as a virtual event, I reviewed the abstracts and participated as a Chair of the Session Best Selected Videos 2.

This new year started with very interesting plans. I was invited to collaborate with the VirtualEndo24 scheduled for March 2021, a meeting organized by the International Society for Gynecologic Endoscopy, where ESGE was one of the participating organizations. I am working on a paper about the education of laparoscopy to be submitted to the ESGE Journal. I have some new suggestions, such as the development of an ESGE Working Group of Entry and the organization of a Virtual Masterclass about Entry techniques in laparoscopy. I am also organizing a Course of Gynecological Endoscopy in my hospital, scheduled for February 2021.

I am very grateful for being a member of the ESGE Advisory Board because it allows me to connect with all Gynecological Endoscopy community people and ideas, this has broadened my perceptions and given me the opportunity to grow as a surgeon and person.



# Introducing ESGE Advisory Board Members



*Mercedes Andeyro  
Garcia, MD PhD*

As one of the representatives of Spain in the ESGE, my role during these years has been mainly to participate actively in the meetings, congresses, courses and activities developed by the European Society of Endoscopic Gynecology and to create a link between the European Society and the Spanish Society of Endoscopic Gynecology (SEGO). In my opinion, having the opportunity to participate in this project is a mutual benefit for both Societies. I believe that Spain should work alongside with other European countries to promote, improve and lead endoscopic and hysteroscopic surgery.

In this sense, my role at ESGE has been dedicated to procedures related to training in endoscopic surgery. Years ago, I was lucky enough to participate in the development of the GESEA training programme from its inception and to lead, together with Dr Rovira, the development and expansion of the programme in Spain. Since then, we have included part of the GESEA programme in the basic and advanced gynecological surgery training courses for residents organized annually by the SEGO Endoscopy Section throughout Spain. All residents in Spain participate in these courses during their training period, thus unifying training in laparoscopic surgery in our country. The next step will probably be to obtain the ESGE certification in a Spanish centre in order to continue the expansion of the GESEA programme

Another of my functions has been to bring the work carried out at ESGE to Spanish gynecologists by, on the one hand, promoting their participation as speakers at the congresses organized by ESGE and, on the other hand, by advertising the activities of the Society, its projects and publications, among different interest groups in gynecological laparoscopic surgery and hysteroscopy.

I have also participated in the projects of different ESGE Special Interest Groups such as Innovation and New Technologies, Hysteroscopy and Training and Education in Gynaecological Surgery.

In short, I believe in the broad benefit of teamwork and I believe that ESGE is a clear example where this type of project is promoted. It is an honor for me to have known, in this time that I have been a member of the Advisory Board, the Society and its members. It is a continuous challenge of improvement that stimulates me and encourages me to continue advancing and growing in our daily clinical practice in the field of endoscopic and hysteroscopic surgery.





## Introducing ESGE Advisory Board Members



*Brice Rodriguez*

I was elected to the Advisory Board of ESGE in March 2020; unfortunately, that coincided with the beginning of the Covid-19 pandemic, and ESGE, like other organisations, was not immune from disruption.

So probably not the best time to start in my new role for the organisation, however, this global pandemic has opened new avenues and ways of working for the ESGE community.

I was able to attend the virtual Advisory Board meeting in October 2020. Appraisals on the year just gone by other members were very informative, and debate about future plans and orientations of the organisation were equally extremely interesting.

As an Advisory Board Member, I participated in the peer-reviewing and selection process of abstracts for the annual congress in December, which was virtual this year. I was given the opportunity to co-chair a session during the ESGE congress. This virtual congress was a success; it has allowed ESGE to develop new ways of working and innovating. It has brought members of the Gynaecology surgical endoscopic community together, and despite the pandemic, has reassured us that the future of Gynaecology endoscopy and of ESGE looks exciting.

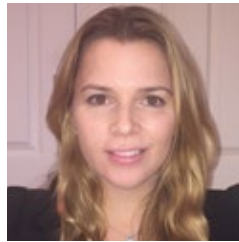
So, is the future going to be a subtle mixture of virtual and face to face meetings? Maybe yes from an environmental, practical, financial point of view. The technology is there, and our last congress has showed us that it can be reliably used. Live surgery for example, can be aired from our own hospital, offering a friendly environment to the surgical team, allowing post-op continuity of care. On the other hand, sessions like GESEA certification for example will still require physical gathering. It is may be time now for ESGE to shape and adopt new formats for future congresses and meetings, but ensuring financial viability of ESGE at the same time.

My mandate will last three years on the Advisory Board, and while continuing to participate to the activities mentioned above, I also wish to represent ESGE at other national and international organisation meetings, join the Special Interest Group on endometriosis, encourage and facilitate young trainees from my area to present their work at ESGE meetings, and finally, involve ESGE to set up partnership programs for the development of Gynaecology endoscopic surgery in emerging countries.

# ESGE-Vision Editorial Team



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## ESGE-VISION wants to represent the interests of Society members

Anyone who would like to share ideas for articles, interesting images or other items should submit them to the central office at [centraloffice@esge.org](mailto:centraloffice@esge.org)



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