THE SCOPE

Newsletter of the British Society for Gynaecological Endoscopy

All the latest news including

Details of ASM 2022
"Standing Tall after the Fall"

The Scope meets… Professor Bettocchi & Professor Sony Singh
Mez Aref-Adib reports

Morcellation of uterine fibroids the new NICE guidelines

And all the latest news

Issue 18 | Autumn 2021

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Welcome

Welcome to the Autumn edition of The SCOPE

Message from the Editor

Welcome to this edition of the SCOPE. The main theme of this issue relates to aspects of fibroid management and leads us into what will be an exciting 2022 full of BSGE activities.

The COVID-19 recovery is in full swing and the BSGE continues to grow from strength to strength. We are now officially the largest specialist society in the UK. I hope you have enjoyed the activities, particular the webinars and podcasts, which I have found very educational and interactive.

Thank you to those members who took the time to fill in the memberships survey. The results are included in this edition of the SCOPE. I also plan for a PowerPoint presentation to be made available on the website for those who are interested in more detail.

In this edition, 0. Prof Bettocchi discusses his thought provoking article the 'The destiny of Myomas' and his experiences developing instrumentation and techniques for the management of fibroids. Prof Singh talks about the importance of imaging and the need for thought and individualisation of fibroid management. He sheds light on the CAPTURE database in Canada and talks about the exciting new developments in 3D- imaging.

In this Scope, Justin's writes about NICE interventional procedures guidance on hysteroscopic removal of submucous fibroids (IPG704), published in August this year. I have also summarised the most recent guidelines for laparoscopic morcellation of fibroids (IPG703), with in-bag morcellation now advised and the governance issues that should underpin usage.

Hopefully, the breakthroughs we have made in endometriosis and other areas of minimal access surgery as a Society will soon translate into advancements in fibroid management with improved outcomes.

Oral GnRH antagonists are on the horizon for the medical management of fibroids. Though Ulipristal acetate (a SPRM) has come back in a limited capacity, GnRH antagonists like Relugolix may be a promising option for the conservative long-term management of fibroids. Hopefully, this time, robust follow-up and monitoring will be put in place from the product launch. Rebecca Mallick's article review includes a paper which features prominent experts on medical fibroid management before surgery or infertility treatment. https://www.fertstert.org/article/S0015-0282(21)01939-7/fulltext.

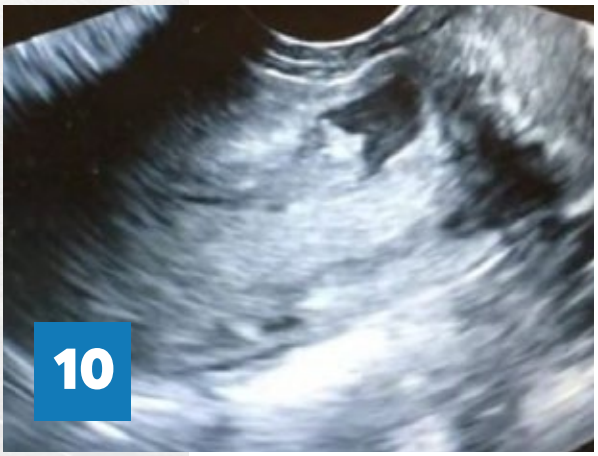
Donna Ghosh updates us on what to expect in Birmingham and, like all of you, I can't wait for the goodies promised at our next ASM 'Standing tall after the fall' in Birmingham in early 2022.

Funlayo Odejinmi (Jimi)

Scope Editor and Membership Relations Portfolio Chair
email: bsge@rcog.org.uk

Contents

IN THIS ISSUE



President's Message

I write to you after enjoying an extra hour in bed; no, not malingering courtesy of the "new normal" of working from home but simply a benefit of "the clocks going back". Sympathies to those of you on call this Halloween weekend having to toil for an extra unpaid hour.

I hope that you are all back to a more normal work schedule and getting to do plenty of gynaecological endoscopy. I am finding the challenge of trying to clear the backlog and deal with the mounting number of referrals somewhat daunting. However, actually getting to operate at full capacity and see plenty of patients provides some reassurance and comfort.

So what do I need to tell you BSGE news wise? Well, since my last missive in the late spring, I can inform you that we have exceeded 1700 members now and we are the largest UK specialist society in O&G. You will be pleased to know that we have continued to meet regularly as a Council virtually. However, all being well, I am looking forward to chairing my first face to face Council meeting at the new RCOG this month. As a society, we continue to priortise education and training initiatives for all our members in conjunction with the RCOG and industry. I hope many have, and will, take advantage of some of these offerings. I am very pleased with the continued interest in our monthly webinars with over 200 logging on to the recent 'niche' webinar. The programme is being led superbly by Rebecca Mallick. Martin Hirsch and Rebecca have also developed the new "BSGE Uncut" podcasts and I very much look forward to seeing how these develop and how they are received by you. I am sure the BSGE Information Resources team would love to hear any feedback and ideas for subject matter.

We have developed a BSGE Corporate membership package for our industry partners to subscribe to. This will enable us to develop closer links with industry as well as generating income for the society. I am keen that our revenue is invested to continue to support all things benign gynaecology and gynaecological endoscopy. We are also keen to expand our awards and bursaries. Karolina and I were delighted to see how popular the new clinical research grant has been, as gauged by the number of applications, and Council has agreed to increase these, including also an educational research award to help develop valid and deliverable methods of training.

In other news, Martin Hirsch has led the drafting of a BSGE position statement co-badged with the RCOG and Endometriosis UK on Thoracic Endometriosis, an increasingly recognised condition requiring co-ordinated, multidisciplinary and specialised care. The BSGE will be integral to developing national care pathways.

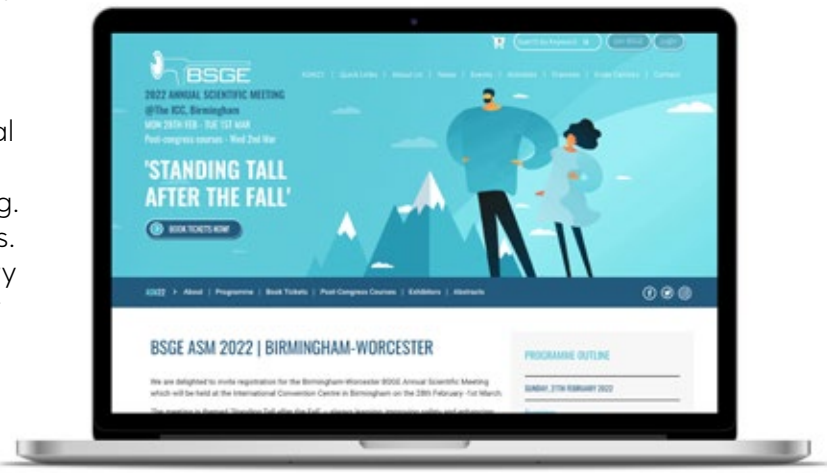
There are two specific topical developments I would also like to draw your attention to, which are detailed later in this issue of the Scope. Firstly, the need to audit nationally hysteroscopic myomectomy procedures in response to the recent *NICE interventional procedural guidance mechanical hysteroscopic tissue removal* (formerly hysteroscopic 'morcellation') *for uterine fibroids*. The BSGE SICS is perfect for this; collection of data in an easy and non-time consuming way. Zahid Khan and I would love to have 6 months' worth of procedural data to analyse and this will help inform the nature, feasibility and safety of our practice which can be fed back to NICE for further revisions of guidance. Secondly, the *GIRFT national report on maternity and gynaecology* has been released and contains some interesting stuff, particularly the direction of developing and utilising more ambulatory gynaecological care such as day-case hysterectomy and outpatient hysteroscopic interventions.

Also don't forget to sign up to join some important large, UK wide laparoscopy trials in our area. Our participation is crucial to support the BSGE goals and continue to enhance the reputation of our society. *The LAVA trial*, comparing lap and open hysterectomy, has opened and will provide important data about complications and personalised recovery to inform our practice and patients (contact: LAVA@trials.bham.ac.uk). *ESPRIT* is a trial comparing lap excision / ablation of superficial endometriosis with no surgical treatment (laparoscopy alone) and is also up and running. DIAMOND (lap excision deep endometriosis vs. medical treatment) and REGAL (repeat surgery for endometriosis vs. GnRHa) will open shortly (early 2022) and your involvement will be very much appreciated.

Finally, I must mention the Birmingham-Worcester ASM Feb 27th- March 2nd. I actually saw Atia in real life this week for the first time in almost 2 years looking as dynamic and organised as ever!! Donna Ghosh, Atia and I met at the impressive International Convention Centre in Brum. You are all in for a real treat – the programme is top notch with many great speakers, UK and international, the venue is amazing and the city is looking superb with loads of restaurants, bars and hotels right next door to the venue. Due to the pandemic, we have had to schedule our meeting a little earlier in the calendar year than has been our usual *modus operandi*. The ASM programme will run over 2 days, Monday and Tuesday, with post-congress workshops on Wednesday. We hope that as many of you as possible can travel down on the Sunday (27th Feb) for our welcome drinks at 6pm in the impressive exhibition hall at the ICC with some surprise entertainment. You can then join one of our social functions at 7.30pm – a choice between the RIGS or BSGE dinner, both at lovely restaurants. For those of you wanting to 'chill' as my kids would say, and do your own thing, you will be spoilt for choice with all amenities within walking distance.

With all best wishes, Justin

Professor Justin Clark MD (Hons) FRCOG
BSGE President



ASM22

2022 ANNUAL SCIENTIFIC MEETING

MONDAY 28TH FEBRUARY - TUESDAY 1ST MARCH
THE ICC, BIRMINGHAM

'STANDING TALL AFTER THE FALL'

www.bsge.org.uk/asm22

Illustration by vectorjuice / Freepik

CO-CHAIR DONNA GHOSH UPDATES THE SCOPE ON PLANS FOR ASM 2022

The local organising committee are delighted to invite you to register for the Birmingham-Worcester ASM 2022.

This will be held as a traditional face to face meeting at the International Convention Centre in Birmingham on the 28th February - 1st March. The meeting is themed 'Standing Tall after the Fall' – always learning, improving safety and enhancing outcomes. We acknowledge the challenges faced over the last few years and this provides an opportunity for us to come together again to learn, share experiences and of course socialise! There is the added option for delegates to attend virtually where they can access streaming of the live conference if they are unable to attend in person.

We bring you an exciting scientific programme with leading speakers, clinical experts and academics from around the world. Content will be delivered across three parallel streams and popular sessions such as Meet the Expert, Pecha Kucha and the debate are included as well as sessions dedicated for nurses and trainees across gynaecological endoscopy disciplines.

The ICC is set in the heart of Birmingham, providing the perfect backdrop for our meeting. The ICC incorporates the iconic Symphony Hall, directly facing Centenary Square, and opens out onto Birmingham canals with an abundance of bars and restaurants within a stone's throw away. There will be plenty of opportunity to explore the nearby art, culture and entertainment on offer.

There are plenty of social events organised including Welcome Drinks, the RIGs Annual Dinner and the Conference Gala dinner.

Post-congress workshops will be held on the 2nd March 2022 at Birmingham Women's Hospital and Worcester Royal Hospital. We look forward to welcoming you to Birmingham!

Local Organising Committee

- **Donna Ghosh** (Co-Chair)
- **Justin Clark** (Co-Chair)
- **Angus Thomson**
- **Jon Hughes**
- **Paul Smith**
- **Zahid Khan**
- **Yousri Afifi**
- **Preth de Silva**
- **Lina Antoun**
- **Sabrina Butt**
- **Siobhan O'Connor**
- **Corinne Shore**

POST-CONGRESS COURSES

There's a range of Post-congress courses taking place immediately after ASM 2022 on Wednesday 2nd March. The courses offer an opportunity to extend your stay in the Midlands and improve your skills and knowledge. Choose between:

RIGS Intermediate Laparoscopic course:

Designed for trainees at ST3+ level. This practical workshop will cover the theory and practice of intermediate level gynaecological procedures including salpingectomy, cystectomy and an introduction to laparoscopic suturing. This course was first established in 2018 and has been an extremely popular course for O&G trainees intending to improve their laparoscopic skills in gynaecology.

Click here to find out more

Surgical Management of Deep Endometriosis:

Available in person in the state-of-the-art Postgraduate Education Centre at the Royal Stoke University Hospital or by online stream. The morning session will cover advanced laparoscopic surgical techniques required for the excision of deeply infiltrating endometriosis with interactive discussions and consensus building exercises. The afternoon will deliver as live surgery with complex joint cases for Stage IV disease.

Click here to find out more

BSGE GESEA examination:

The BSGE in collaboration with the ESGE runs the Gynaecological Endoscopy Education and Assessment (GESEA) Programme in the UK. This is a structured training programme set up by the ESGE and the European Academy of Gynaecological Surgery. As part of the GESEA Programme, BSGE will run Level 1 and Level 2 Certification Examinations. All e-learning modules must be completed before the examination to qualify to sit the examination. The examination itself consists of both theoretical and practical assessment.

Click here to find out more

Endometriosis Nurse workshop:

This very popular workshop will include presentations and discussions around fertility, medical treatment of endometriosis, setting up a new nurse led clinic, nutrition and endometriosis and the bowel.

Click here to find out more

Hysteroscopy workshop:

The workshop will combine lectures, case study discussion and practical stations. It will help delegates recognise when and how diagnostic hysteroscopy should be performed, understand how to perform procedures in the outpatient setting and become familiar with operative hysteroscopic equipment.

Click here to find out more

Laparoscopic Hysterectomy workshop:

This is a 2 day workshop, with day 1 being in person at Birmingham Women's Hospital and day 2 being a virtual live stream. Day 1 will include talks on theory and techniques followed by a hands-on simulation session. The second day will include live-streamed surgery including laparoscopic hysterectomy for benign condition and laparoscopic hysterectomy for cancer. There will be plenty of time for questions and answers after the surgical session.

Click here to find out more

ACN meeting 2021

The third annual BSGE Ambulatory Care Network meeting took place in June 2021. Approximately 200 delegates and industry sponsors took part in the meeting, which was virtual because of the COVID-19 pandemic.

BSGE President Justin Clark launched the event saying:

"The meeting this year was virtual, however, we still endeavoured to maintain the discursive format that has made this meeting incredibly popular since its inception three years ago. 'This year's theme revolved around "Redefining Standards in Outpatient Hysteroscopy". We unveiled draft versions of the Joint BSGE/RCOG Consent, Expected Standards and Green-top Guideline (GTG 59) in Outpatient Hysteroscopy. Delegates were invited to share their opinions and adapt and shape this important guidance, which will be disseminated nationally."

During the first part of the meeting Professor Clark summarised the draft RCOG Consent and the Draft RCOG Expected Standards in Outpatient Hysteroscopy. There were presentations of the evidence base and highlights of systematic reviews and lots of debate from delegates. Preth de Silva told The Scope:

"In the past, there have been grievances that guidelines are dissociated from contemporary practice. At the ACN meeting, delegates were encouraged to share their own experiences, provide feedback on the draft guidance and take part in polls to ensure the finalised green top guidelines bridged up-to-date evidence with current practice."

Discussions took place around the evidence base and personal experiences regarding pre-procedural analgesia, local anaesthesia, conscious sedation, vaginoscopy, the optimal type, pressure and temperature of the distension media used, the role of cervical preparation, and the instruments used for operative procedures in the ambulatory setting. Where there was little evidence base, polls were used to engage delegates and achieve an understanding of issues including how to obtain consent, how we should be effectively communicating pre-procedural information, documentation, training and the optimal number of staff required for the safe delivery of outpatient hysteroscopy.

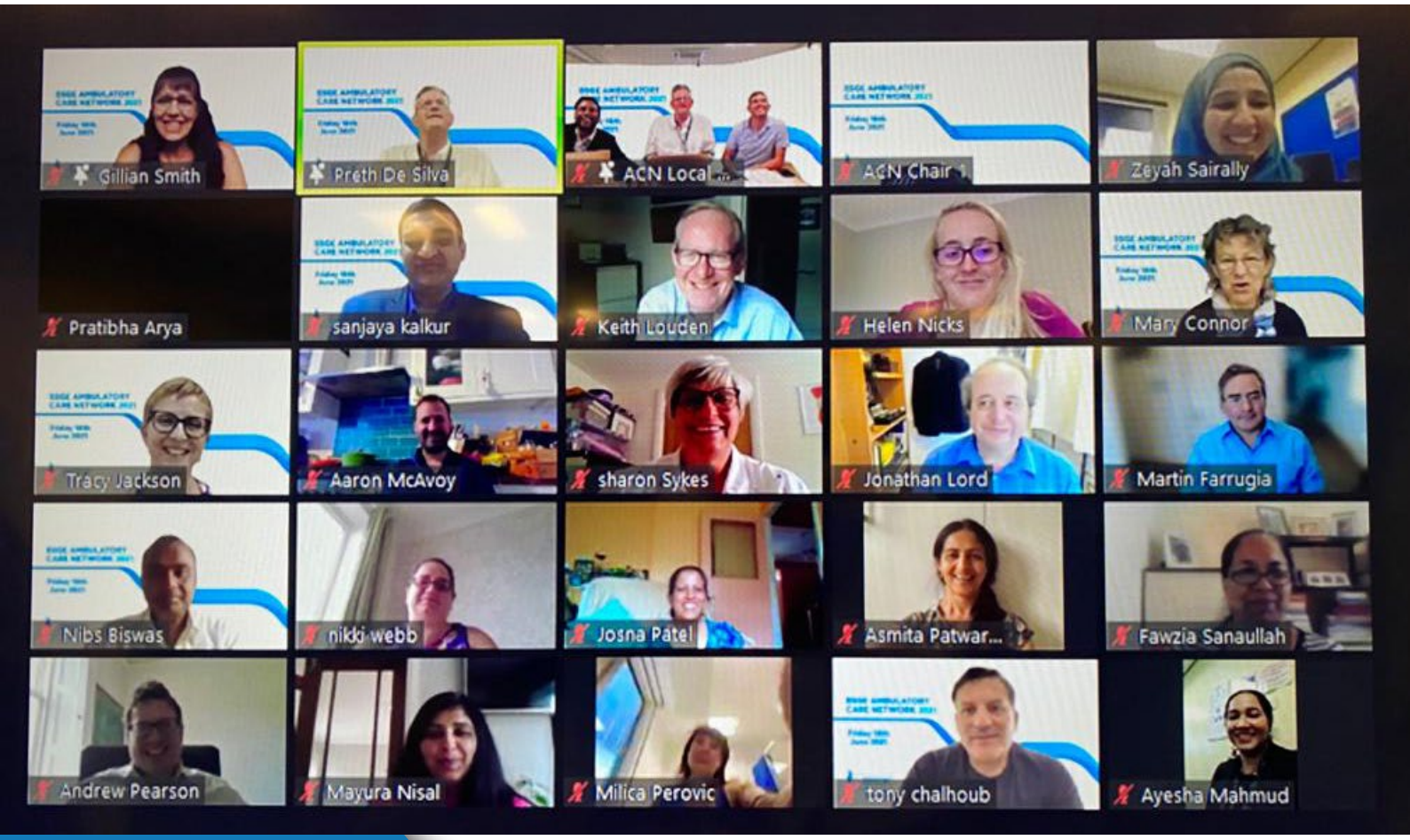
The second half of the meeting covered the management of difficult cases, tips and tricks and the presentation of algorithms for the management of pain and bleeding following endometrial ablation, before finishing on research and future directions. The algorithms are being reviewed and will be released in due course.

The keynote lecturer was delivered by Professor Attilio di Spiezio Sardo. He discussed the Naples Ambulatory Approach- summarising his clinic's practice with regards to its set up, training of junior colleagues, use of 5Fr bipolar electrode and hysteroscopic tissue retrieval systems for endometrial polypectomy. He has found that 99% of the clinic's patients do not require analgesia or anaesthesia and rarely requires intravenous sedation, but when he does, it is with the aid of an anaesthetist.

The green top guidelines are currently under review before being submitted to RCOG for publication.

The next ACN meeting is planned for June 2022, Preth de Silva said:

"Despite the success of the virtual event we are all looking forward to getting together in person next year and sharing our knowledge and experiences."



BSGE Virtual Workshop: Imaging for Endometriosis

Susanne Johnson, Associate specialist in Gynaecology at Princess Anne Hospital, Southampton reports for The Scope on the BSGE's virtual workshop on endometriosis imaging.

On Friday 9th July 2021, BSGE held a virtual workshop in 'Imaging for Endometriosis'. This was done in collaboration with BSGI (British Society for Gynaecological Imaging) and BMUS (British Medical Ultrasound Society).

The meeting had 687 registered delegates, indicating the importance attached to improving the use of imaging in the management of endometriosis and demonstrating the value of collaboration between the three societies.

In normal times it would have taken a year to organise such a program with so many international experts, but the Covid pandemic-induced general move from conferences to online webinars suddenly generated this educational opportunity. The meeting had a remarkable international faculty from UK, Italy, Canada, USA, Brazil and Australia.

The webinar heard from Shaheen Khazali, who painted an overview of delayed diagnoses; a patient voice from Lone Hummelshoj (Endometriosis.org) in conversation with Emma Cox (Endometriosis UK); George Condous on the IDEA ultrasound classification of endometriosis; Susanne Johnson on how to perform an ultrasound scan (USS) for endometriosis; Mathew Leonardi on how to diagnose superficial endometriosis; Priyanka Jha on MRI; Wendaline VanBuren on the various benefits of USS vs MRI; Ali Deslandes on the transition to sonographer expert; Martin Hirsh on laparoscopy and Katie Candy on the role of the Endometriosis Nurse Specialist.

We continued with Scott W Young on how to write a structured endometriosis USS report and then had specialists' perspectives on what they needed to glean from reports. Firstly Sameer Umranikar as a gynaecologist; Ertan Saridogan as a fertility specialist and Mauricio Abrao as a bowel surgeon.

The final session was on the practicalities of imaging with 'as live' scan demonstrations from Susanne Johnson, Natalia Rosello, Richard Dunham (MRI), Sofie Piessens and Alessandra Di Giovanni. This was followed by a virtual MDT with cases from Adam Moors, Dimitrios Miligkos, Tony Griffiths and Shaheen Khazali, all moderated by Justin Clark, Angus Thomson, Wendaline VanBuren, Priyanka Jha, Scott W Young and Mathew Leonardi.

The hosting web platform, which had performed so well during the day, was overwhelmed by so many experts and not all cases could be discussed.

Overall this virtual meeting was a huge success due to the efforts of the presenters, chairs (including some of the speakers and also Leena Gokhale, Moji Balogun, Arvind Vashisht and Hazel Edwards), technical teams and organisers. I would like to give a particular vote of thanks to Borsha Sarker and Joy Whyte (BMUS), who with Atia Khan (BSGE) organised this complex programme so well, and Alan Treharne and Gary Evans (BSGI) who designed a beautiful interactive PDF program. And thank you to our sponsors, and especially Judy Cuthbert, who all worked so hard to make this day a reality.

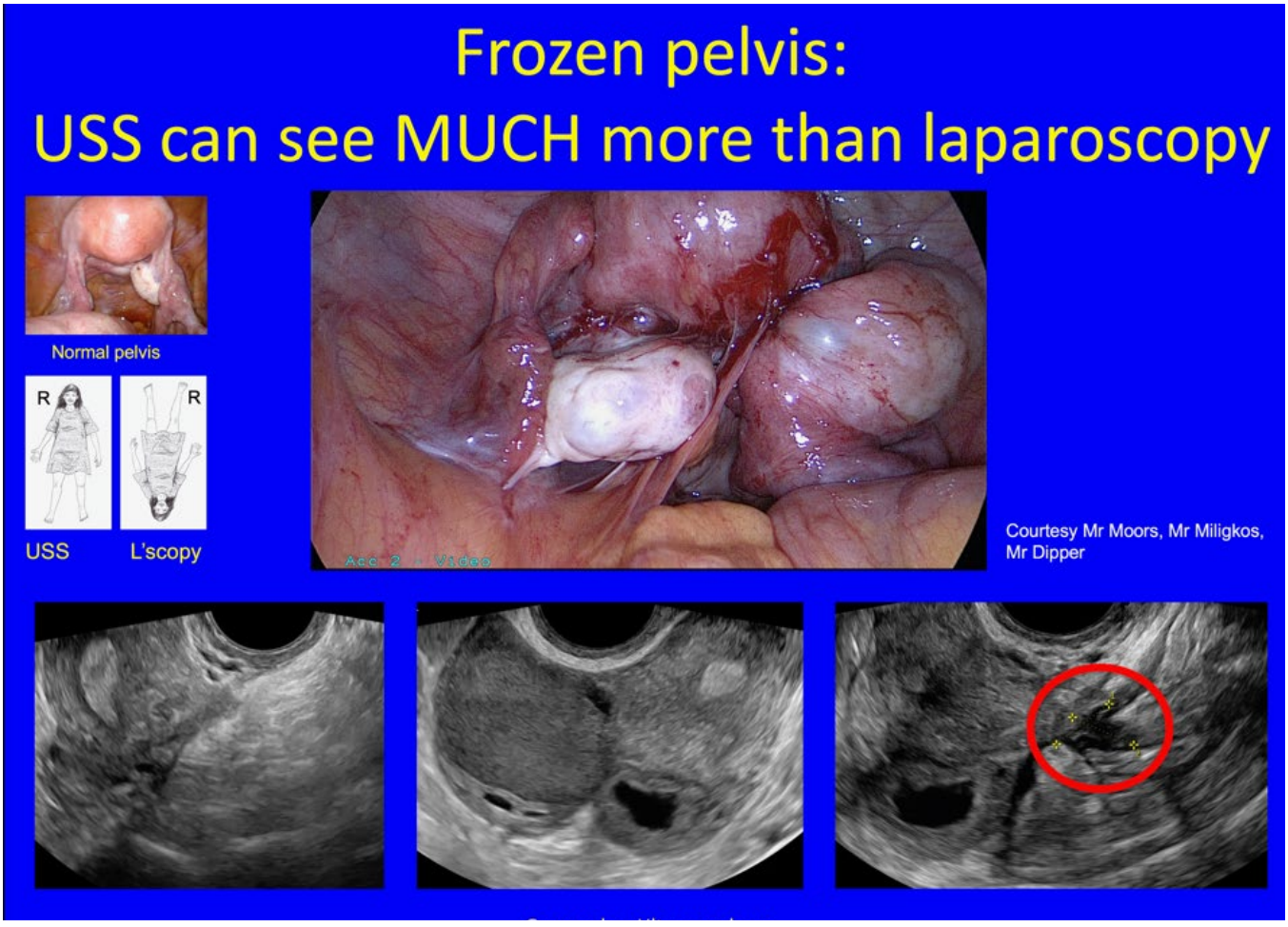
We must now continue the collaboration and harness enthusiasm to drive forward improvements in endometriosis care, which will include improvements in and better utilisation of imaging modalities.

The entire webinar will soon be available on the BSGE website for on demand viewing, as well as freely on the educational website GynaecologyUltrasound.com.

There is a great opportunity for us to work collaboratively to deliver further teaching on how to diagnose endometriosis on ultrasound, both in general units and maybe especially in the BSGE-accredited Endometriosis Centres. The target audience could consist of a large range of practitioners to include sonographers, nurses, sonologists, radiologists, gynaecologists as well as patients themselves.

I think that this will significantly reduce the 8-year delay from symptoms to diagnosis, as well as offering patients more focussed initial surgery. Ultimately the model of surgeon-sonologists will complete the diagnostic-treatment paradigm!

Please do contact me with your suggestions. I very much look forward to working with you in the future susannejohnson@gynaecologyultrasound.com



RCOG/BSGE Diagnostic and Operative Hysteroscopy course

BSGE Hysteroscopy workshop

Nadine DiDonato, BSGE Hysteroscopy Portfolio Chair, updates The Scope on the RCOG/BSGE diagnostic and operative hysteroscopy course.

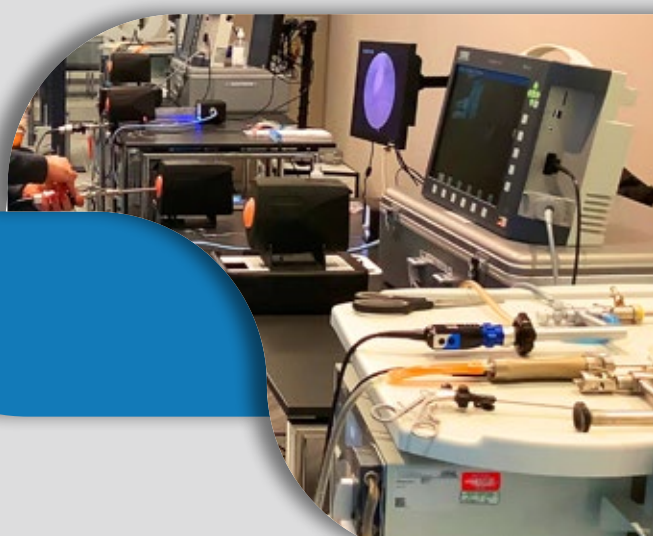
The RCOG/BSGE diagnostic and operative hysteroscopy course has been running under the lead of Miss Mary Connor, Consultant Gynaecologist, Sheffield Teaching Hospitals and Mr Stephen Burrell, Consultant Obstetrician and Gynaecologist, Luton and Dunstable Hospital NHS Foundation Trust for several years.

The course has always been very successful as it offers the theoretical and practical aspect of hysteroscopy and it gives the opportunity to learn and try with "hands on" all the new generation hysteroscopes from all the endoscopy companies

The participants are trainees in Obstetrics and Gynaecology who are registered or who plan to register for either the ATSM in Benign Gynaecological Surgery: Hysteroscopy or Benign Abdominal Surgery: open and laparoscopic, consultants, staff grade, staff doctors, trust doctors or associate specialists, wishing to enhance their hysteroscopy skills, nurse hysteroscopists who are developing their operative hysteroscopy skills and GPs with a special interest in gynaecology who wish to develop their hysteroscopy skills.

Mary and Stephen are looking to expand their faculty helping on those courses and they are happy to accept new applicants.

Please send an email to Atia if you are interested in becoming part of the team.



BSGE Diagnostic and Operative Hysteroscopy Workshops

The BSGE is running diagnostic and operative hysteroscopy workshops on November 23rd and 24th. The one-day courses will take place at the Training and Technology Centre, KARL STORZ Endoscopy in Slough.

The course aims to enable delegates to develop their hysteroscopy skills, both diagnostic and operative and to become familiar with operative hysteroscopic equipment.

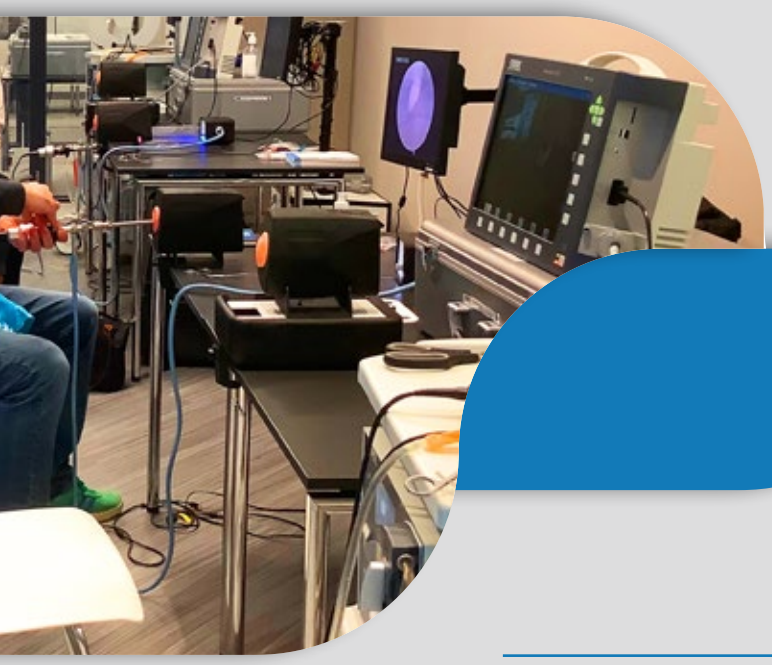
It is suitable for trainees in Obstetrics and Gynaecology who are registered or who plan to register for either the ATSM in Benign Gynaecological Surgery: Hysteroscopy or Benign Abdominal Surgery: open and laparoscopic.

It is also designed for consultants, staff grade, staff doctors, trust doctors, associate Specialists, nurse hysteroscopists and GPs wishing to enhance their hysteroscopy skills.

The course organisers Mary Connor and Stephen Burrell said:

"The workshop will be in two parts including a rotation around a series of stations using models and computer-simulated procedures. The topics to be covered include diagnostic hysteroscopy for developing camera skills and hand-eye co-ordination; endometrial polypectomy using mechanical instruments with fine scissors, graspers and hysteroscopic tissue shavers; global endometrial ablation using non- hysteroscopic devices.

The other part of the workshop will consist of a review of case studies and endometrial/fibroid resection skills."



Find out more about the course and register click here

Venue

Training & Technology Centre,
KARL STORZ Endoscopy (UK) Ltd
415 Perth Avenue, Slough,
Berkshire, SL1 4TQ

Cost

Member - £225 Non Member - £305

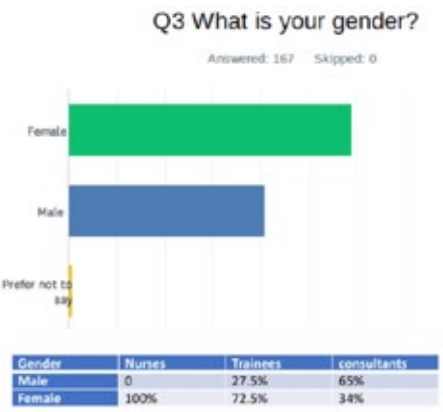
Membership Survey 2021

Thank you to all the members who took valuable time out to respond to the membership questionnaire. It was a little different from the last surveys in that it was during Covid, and most BSGE activities changed with no face to face activities.

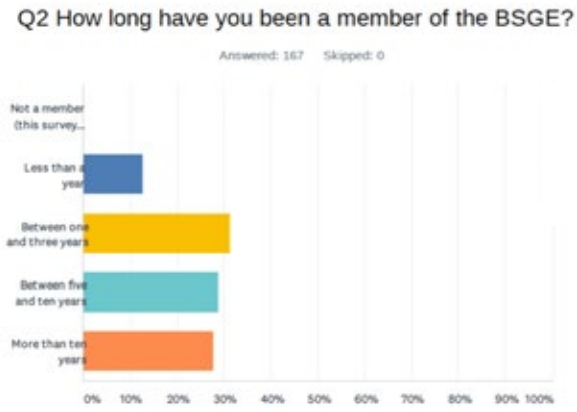
Also, different from previous years, we tried to capture the opinions of our trainee members and our nurse practitioner and consultant members with different questions for each representative group.

Below is a summary, but a full PowerPoint version will be available on the BSGE website.

In all 167 members responded to the questionnaire (nurses=19.6%, Trainees 30.7%, consultants 49.7%). The majority of respondents worked in the southeast and London, and 60% of respondents were female, but this differed by member groups.



Gender	Nurses	Trainees	consultants
Male	0	27.5%	65%
Female	100%	72.5%	34%



BSGE COVID-19 Pandemic guidelines

Most members were aware of the guidelines produced by the BSGE in collaboration with the RCOG for COVID and minimal access surgery.

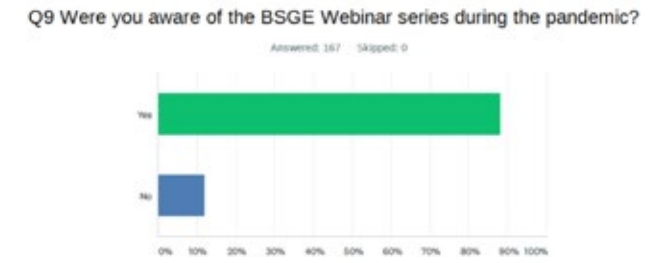
Guidelines can be found here

As well as the link for abnormal uterine bleeding

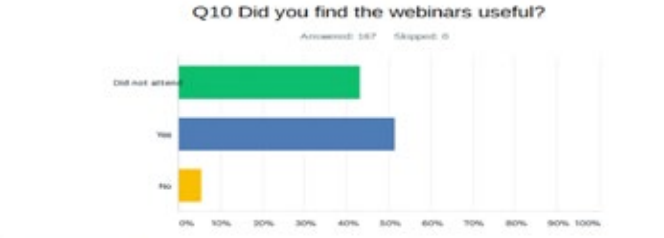
Guidelines can be found here

And almost all respondents found these guidelines helpful.

88% of respondents were aware of our recently introduced Webinars during the peak of the pandemic, 50% of respondents were able to attend, and an overwhelming majority of those who attended found the webinars useful.



ANSWER CHOICES	RESPONSES	
Yes	88.02%	147
No	11.98%	20
TOTAL		167



ANSWER CHOICES	RESPONSES
Did not attend	43.11%
Yes	51.50%
No	5.39%
TOTAL	

BSGE journal services and the SCOPE newsletter

Most members continued to use the journals from the AAGL and ESGE.

More than 70% of responders received the SCOPE newsletter, with our trainee members least likely to receive the SCOPE (57%). Most members who received the SCOPE used it as a source of information to keep up with BSGE activities.

This is my view means we need to increase the awareness of this source of information amongst trainee members.

The next group of responses is related to how members fared during the peak of the covid pandemic and responses were analysed by professional groupings

BSGE nurse practitioner responses

50% of nurse practitioners were redeployed during the pandemic; this was more common amongst endometriosis nurse practitioners (45%) than hysteroscopic nurse practitioners (5.6%). Most of those redeployed, 60% felt clinically competent to do so.

Rather than be deployed, most hysteroscopy nurses continued to perform outpatient hysteroscopy and were involved in the prioritisation process (60%) of patients during the pandemic. Most had adequate PPE to use during the pandemic.

An important aspect that emerged during the pandemic is wellbeing support, which was available in some form for most of our nurse practitioner members. Only 15% didn't have wellbeing support during the pandemic.

As expected and reported in the wider literature, most endometriosis practitioner members experienced a drop-in surgery for endometriosis in their centres. This is exemplified in this recent preprint BSGE database publication https://www.authorea.com/doi/full/10.22541/au.163256909.93155355. Most, however, were able to continue virtual appointments for patients. Over 70% continued to send out patient information leaflets and administer GnRH analogue therapy when necessary.

Although most respondents in this category of membership were aware of the prioritisation system for surgery; most were not involved in the process (84.6%)

BSGE Trainee member responses

Most of our trainee responders were ST5-7 (65%). Less than 10% of trainees were redeployed during the pandemic, but most (88%) experienced changes in their rota patterns, of which 20% experienced rota changes all the time. 30% of trainee members needed to act down often (5%) sometimes (25%). Wellbeing activities were available to more than 90% of trainee members who responded 30% all the time, 30% sometimes, and 30% often.

Training during the pandemic was affected by nearly all of our trainee members (94%). Outpatient gynaecology clinics were affected for 89% of trainees; surgical training was negatively affected for 85% of responders. Ultrasound training was adversely affected for 75% of trainees. 91.5% of trainees were concerned about the impact of the pandemic on completing their surgical training and completing gynaecological surgical competencies (92%). 70% of trainees felt that the pandemic might negatively impact their ARCP outcomes.

In 12% of trainees, a career change was considered as a result of the pandemic. Nearly 62% of trainees felt that training should be extended whilst 32% thought that training might need to be extended. 82% of responders were optimistic that they would recover from the negative impact of the pandemic.

Counsultant responses

Most of the respondents were consultants, and consultants had been members of the BSGE for the longest.

Most of the consultant respondents were male compared to trainees where the respondents were predominantly female.

Consultant respondents were least likely to be redeployed during the pandemic (12%), but rotas changed for most consultants (86%), with 48% of consultants needing to act down (sometimes 39.5%, often 6.2% and always 2.5%).

Well being facilities were available for 91.5% of consultants during the pandemic.

88% of consultants were able to continue using laparoscopy for emergency cases during the pandemic's peak. Only a minority needed to use laparotomy for the management of gynaecological emergencies. In 20% of cases at the beginning of the pandemic, laparotomy was used, but as the pandemic progressed, they could revert to laparoscopy..

During the peak of the pandemic, 42% of consultants were no longer able to offer teaching opportunities.

Overall during the pandemic, there was no increase in pooled lists for the recovery period.

During the recovery, there was not an increase in the use of laparotomy due to covid concerns.

14% of consultants responded that during the recovery, surgical networks were formed to help with the backlog.

54% of consultants felt that their organisations were prepared for subsequent waves of the pandemic.

92% of consultant respondents felt that during the recovery, it would be helpful if the BSGE organised buddying systems to support colleagues for major endoscopic surgery.

BSGE News

Proposal for a national audit of hysteroscopic myomectomy by BSGE members

NICE released "Interventional procedures guidance [IPG704]" on hysteroscopic mechanical tissue removal for submucosal fibroids in August. The BSGE collated responses from members and fedback to NICE during the draft stages and many of our recommendations were included.

In light of the limits in quantity and quality of efficacy evidence and infrequent but potentially serious side-effects, NICE recommended that the procedure should only be used with "special arrangements for clinical governance, consent, and audit or research." Part of such arrangements necessitates that clinicians "audit and review clinical outcomes of all patients having the procedure" and that they "discuss the outcomes of the procedure during their annual appraisal to reflect, learn and improve."

There are some, albeit limited data, showing comparable outcomes between conventional hysteroscopic resection and mechanical hysteroscopic tissue removal (mHTR). In light of the NICE guidance, and the relative scarcity of data, we at the BSGE believe that our BSGE SICS (Surgical Information Collection System) is the ideal audit tool to collect data not only on mHTR but also all other electrical methods of removing submucosal fibroids. The BSGE SICS can be accessed on smart phones, tablets and computers via the website (https://www.bsgesics.com) where you can register if you have not already done so. In addition, the BSGE SICS app can be accessed via the app store (search under "BSGE").

A range of common laparoscopic and hysteroscopic procedures can be accessed and relevant data about your endoscopic procedures can be simply and securely entered into pre-formed fields, mostly with drop down menus. It's rapid, simple and accessible. Importantly, at any point you can export your data as a complete excel database for you to analyse to inform your practice and annual appraisal.

In the case of hysteroscopic myomectomy, if we can all enter our cases as from now into the BSGE SICS, then we can rapidly accumulate real life, standardised and valid 'big' data over the next 6 to 12 months. Zahid Khan and I can then access the whole anonymised dataset to analyse and report back to our membership, the wider gynaecological global community and of course NICE who can revise recommendations appropriately. We will be able to understand the types of technologies being used, the range of complexity, the types of patients undergoing procedures, and the rates and types of complications and even potentially some patient outcomes (there is an option to collect follow up data if you so wish on the BSGE SICS).

So, please register for the BSGE SICS (available to BSGE members only) if you have not already done so and lets all start inputting all our hysteroscopic fibroid procedures over the next year and we will feedback to you all regarding the findings in due course.

T Justin Clark and Zahid Khan

BSGE News

Official BSGE Podcast "Uncut" launched

The BSGE has launched a new podcast 'BSGE Uncut'. The official podcast of the British Society for Gynaecological Endoscopy will be hosted by Rebecca Mallick and Martin Hirsch. Rebecca updated The Scope on this new innovation:

'The podcast is an exciting new venture which we are hoping to expand over the next few months. We want it to be a resource that is easy accessible – short and snappy and perfect for listening to on the commute to work.

'It is the perfect medium for interviews, discussions, debates and many more. Two episodes have been released so far. The latest is an in-depth chat with special guest Dr Pietro Bortoletto, senior clinical fellow in reproductive endocrinology and infertility at the Weill Cornell Center for Reproductive Medicine in New York City, and is well worth a listen.

'Upcoming discussions will include the challenges of gynaecology surgical training, women in surgery as well as an extra special Christmas edition.'

Tune in to the free podcast to hear Rebecca and Martin talk to some of the biggest names in the field of gynaecology. They will explore their guests' lives, careers, and what keeps them motivated to push the speciality forward.

Access the podcast HERE

BSGE News

Getting it right first time national report on Maternity and Gynaecology

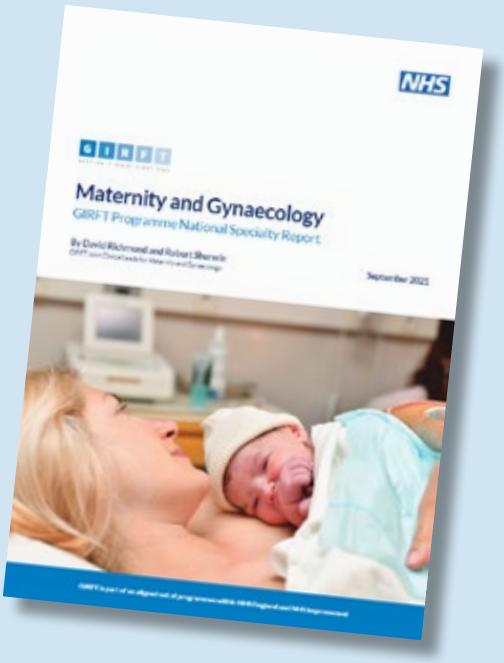
T Justin Clark reports for The Scope on the Department for Health report:

The Department of Health "Getting it right first time" or "GIRFT" national report on maternity and gynaecology was released in September. There are some areas particularly relevant to gynaecological endoscopy. Some of the areas of interest to me – essentially areas I could affect, included:

- Optimisation of outpatient pathways and in particular reducing unnecessary follow ups, aiming for a new: FU ratio near to one. This requires an emphasis on 'one stop' visits where decision making is possible. Imaging and the availability of immediate or pre-appointment testing is key. To achieve this requires good links with primary care and an investment in outpatient services such as hysteroscopy clinics amongst other things.
- More effective use of the gynaecology team, including expansion of the nursing role, greater use of virtual care and introducing more patient-initiated follow-up. From a surgical standpoint, we need to avoid unnecessary procedures and look at reducing the length of stay post-operatively where possible.
- An increased use of day surgery was emphasised, requiring pre-operative preparation of patients, especially setting expectations when counselling, and use of enhanced recovery interventions including the use of multi-modal, pre-emptive analgesia, and in particular the use of endoscopic surgery. A target of 50% of laparoscopic hysterectomies being performed as day-cases was proposed.

The variation in practice across providers and regions is always illuminating. Of interest to me was the national data on outpatient endometrial ablation. 14% of all ablative procedures are currently done in an outpatient setting but there was huge variation across the country. Similarly, the rates of day-case hysterectomy varied but reassuringly, there was no strong correlation between providers with shorter average length of stays following hysterectomy – associated with laparoscopic or day surgery – and rates of readmissions.

Arvind Vashist and I have been involved, on behalf of the BSGE, in informing data collection on surgeon performance and practice as part of the National Consultant Information Programme (NCIP). This required deciding what data and outcome metrics should be collected at surgeon level about gynaecology procedures. The idea is to use DoH HES (Hospital Episode Statistics) data, information from theatre operating systems and eventually 'PROMs' (Patient Reported Outcome Measures) to provide a summary of surgeon-specific data reported as part of every surgeon's appraisal. The aim is to allow individual clinicians to reflect on surgical data, including outcomes, as part of their annual appraisal. Department heads and clinical directors can monitor the reported NCIP procedure-level data to inform recruitment strategies, resourcing, staffing, skill-sets and to address local anomalies. This is an exciting proposal and I hope to have someone speak about this at the forthcoming Birmingham-Worcester ASM in Feb/March 2022.



The report is available in full here

BSGE News

Unit data available for BSGE Hysteroscopy Satisfaction Study

Individual unit data is now available for the BSGE Hysteroscopy Satisfaction Study. President Justin Clark announced the development saying:

"Did you or your unit contribute data to the national BSGE standardised outpatient hysteroscopy satisfaction survey (OPH-PSS) in Oct/Nov 2019? If so then please email Atia Khan at bsge@rcog.org.uk. Please state your name, job description, base hospital and email address and Atia will send you the data analysed from your hysteroscopy unit. The overall data to benchmark against is presented in the published EJOG paper (doi: 10.1016/j.ejogrb.2021.01.028) and the descriptive data has the comparative national data enclosed with it."

Justin emphasised that the team have only analysed individual data for units submitting more than ten cases. He added:

"Thank you for taking the time to participate in this important project. In light of feedback received through the Ambulatory Care Network (ACN) meetings (2020 and 2021) we have updated the BSGE patient satisfaction survey. The changes are not major.

Going forward I would encourage you to use this standardised tool (survey) to continue to monitor, quality assure and improve your services. I envisage this would be done periodically by individuals or better still units as a whole. Some may choose to collect data routinely.

Many thanks once again for your help. Within two months we generated more than 5000 hysteroscopic procedures, which shows the power of our ACN."

The updated survey is available to download from the BSGE website for members planning to give paper copies. The survey is also available electronically though BSGESICS. Once you have completed the hysteroscopic procedure information and submitted, you will get the opportunity to open electronically the patient satisfaction survey and can ask the patient to complete electronically. The advantage of this approach is that the data is automatically inputted and subsequently available on an excel spreadsheet for you to analyse later.

There is a specific page on the BSGE website for the ACN which includes all this information, including downloads.

BSGE News

BSGE Surgical Video Competition 2021

The results of the BSGE Video Competition 2021 are in. The competition was open to consultants, SAS doctors, General Practitioners, Nurse Hysteroscopists, paramedic members and overseas members of the Society.

The consultant winner was Nadine di Donato for her video 'Incidental finding of terminal ileum endometriosis during surgery for severe pelvic endometriosis.'

See Nadine di Donato's video here

There were two prizes awarded for doctors in training:

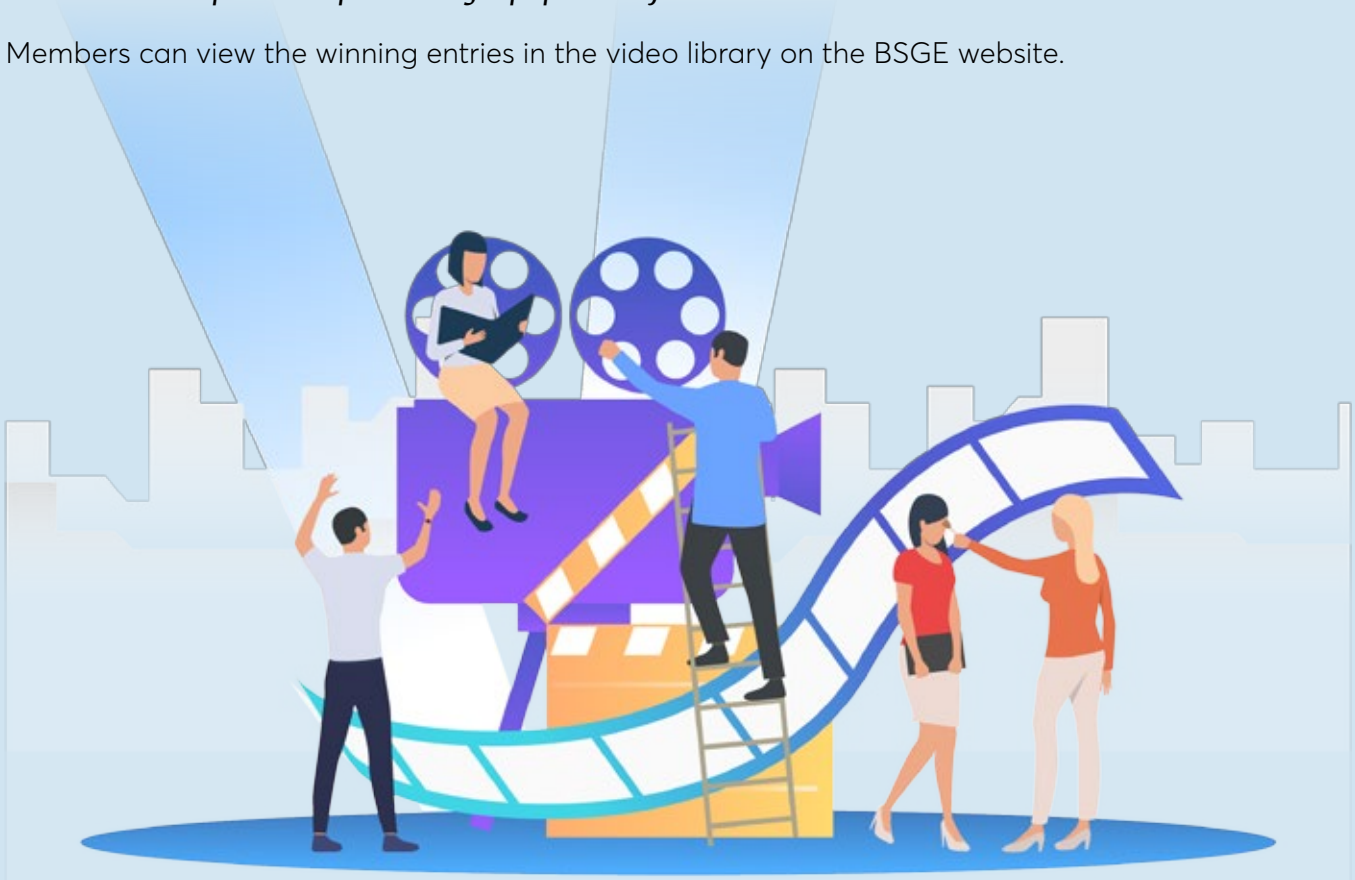
Sarah Wali won for her video 'Collaborative laparoscopic education in the midst of a pandemic' and Sarah Neary won for 'IP Ligament ligation using a modified Roeder Knot'. There were no entries from nurse or paramedic members this year.

See Sarah Wali's video here **See Sarah Neary's video here**

The three winners each claim a prize of £300 and, of course, the glory of winning this prestigious competition. Karolina Afors, portfolio chair for awards and bursaries said:

"Winning the video competition will enhance your CV and will provide the same CPD points as publishing a paper in a journal."

Members can view the winning entries in the video library on the BSGE website.



BSGE News

BSGE Webinars

The BSGE Webinar series has gone from strength to strength under the leadership of Information Resources Portfolio Chair Rebecca Mallick. The virtual nature of the sessions means that members can listen to presentations from national and international experts. The sessions take place on the last Wednesday of the month at 18.00. We have had a fantastic range of topics so far ranging from thoracic endometriosis to pelvic pain pathways to uterine niches.

Look out for our hysteroscopy session this month and our fun Christmas special in December! Please get in touch if you have any ideas or want to contribute.

Webinars have included:

Laparoscopic Transabdominal Cerclage – experiences from opposite ends of the world : Associate Professor Alex Ades from the Royal Women's Hospital Melbourne presented on laparoscopic transabdominal cerclage and Ertan Saridogan from UCL discussed interval laparoscopic cerclage; technique and obstetric outcome.

Thoracic Endometriosis Webinar: A session which focused on learning from others, with international experts including Sony S. Singh from Ottawa, Catherine Johnson, from Oxford and Ken Sinervo from Atlanta. The webinar was moderated by Martin Hirsch from the Oxford Endometriosis CaRe Centre who wrote an update on thoracic endometriosis in The Scope Issue 17.

Uterine Niche: Fantastic Niches and where to Find them: This webinar presented a comprehensive overview on the aetiology, prevalence, symptoms, and management of uterine niche and, of course, where, and how, to find them. With Shaun McGowan, Charlotte Goumalatsu, Andrew Kent and moderated by Fevzi Shakir.

The next session is VIPs- vaginoscopy, investigations, treat and service. It's on Wednesday, 24th November at 6pm and will discuss vaginoscopy, hysteroscopic investigation and the role of PGD's service needs. The webinar will be moderated by Rae Nesbitt and Caroline Bell. Speakers include Nadine Di Donato, Liz Bruen, Suzanne Taylor and Nikki Webb.

The Scope meets... Professor Bettocchi

Mez Aref-Adib reports on her interview with Italian gynaecologist Professor Stefano Bettocchi

I had the honour of a zoom interview with Professor Bettocchi, an expert in Gynaecology and Obstetrics based in Bari, Italy. He specialised in Obstetrics and Gynaecology in 1989 at the Aldo Moro University of Bari and is currently Professor there and at the Jan Palfijn General Hospital in Antwerp, Belgium. Over the next few months, he will be moving to Foggia University.

A member of numerous associations, Prof Bettocchi is an internationally renowned surgeon. He is head of the Mini-Invasive Gynaecological Surgery Unit in Bari, has over 200 publications in international journals and has published four scientific books. Professor Bettocchi is an expert in hysteroscopy, laparoscopic surgery, myoma, endometrial polyps and endometriosis. Most notably, he has designed and created five gynaecological instruments, which we use daily.

Where did you train?

I trained and did my residency in Bari, then gained experience in the United States. In 1990 I went to Antwerp, where I was taught by my master- Bruno van Herendael. I started endoscopy and was there for two years.

On my return to Bari, I started applying what I had learnt in Antwerp. I had the idea to transform hysteroscopy into something different and more practical, something that could be performed out of the operative area. I liked computers, Meccano and Lego as a kid- I had a mental background for technology. At the time, hysteroscopy was being performed with C02, a speculum and a tenaculum. I was lucky to meet an incredible person- Sybil Storz (daughter of Karl). I told her my idea of how hysteroscopy could be. In 1995, we started to design and produce the office hysteroscope. The big mission was to transform the mentality of colleagues. We were proposing using liquid distension without the use of a speculum and tenaculum.

It was like David vs Goliath. They said I was a crazy Italian guy! At the first international meeting, I didn't even have the scope available- but I was already proposing the vaginoscopic approach. I went around the world, talking about the technique. We also slowly changed the technique, so that now we use liquid and a vaginoscopic technique and the young generation don't know anything else.

Life is a combination of things happening at the right or wrong moment. When I went back to my university hospital, many nuns required hysteroscopy. They were virgins, and when I asked my boss what I should do, he said, 'you're an endoscopic surgeon, the vagina is a cavity, bye-bye', so I started thinking about it. I read a great deal about it and experimented to improve their care.

Can you tell us of the work you have done on fibroid management?

Fibroids are a big issue. I wrote the 'Destiny of myoma' paper in one day. It was not a statistical analysis – it's a psychological paper, introspective. I wrote this as we often receive patients who have had the wrong management of myoma. They come to us, and we can't solve the problem because of it.

This is still happening. The biggest problem is that it all starts from ultrasound. A patient is scanned, and the fibroid is measured as 1 cm or 2 cm- but what does this mean? If you have 10 Euros in your pocket- you know it's the cost of a pizza, 100 Euros is different, a meal. With fibroids, it's about the dimensions- but we don't understand this. Even when I 3D printed different sized fibroids from 0.5 to 5 cm in size and showed people, they still couldn't understand the volumes.

The transvaginal ultrasound is mono-dimensional. Even with 3D-ultrasound, we can only see the myoma compared to the uterus- even that is a flat image. 3D is something I can see and feel in 3D.

So, when I say a 2.5 cm fibroid is nothing and I might not care-then ultrasound tells me it is intramural, and I still don't care. However, if my anatomy master were still alive, he would not pass my anatomy if I told him that the thickness of the uterine wall was 2.5cm and an additional 2.5cm was intramural. It can't be. It can be intramural with either a submucosal or subserosal component.

Patients are often told to come back when the fibroid is bigger. But by the time it gets bigger than 12 cm, surgery is risky. The woman may need a laparotomy. If it's 4 cm into the cavity and the patient is bleeding all day and only then that we want to solve the problem, it's not easy. We need to change the mentality. If you see a 2cm fibroid- I suggest a hysteroscopy- then by exclusion, we can see if it's not in the cavity but growing outside. If I see it inside, then I can treat it. It seems easy, but it's not. It's 2021, and we still have patients coming back, and they trust as problem solvers. But if the previous management has been incorrect, it's difficult.

Can you tell us your experience of office myomectomy?

Office myomectomy was first described in 2000. A true 1.5 cm pedunculated fibroid occupies more than half the uterine cavity. We found that using bipolar energy; we could remove the fibroid-but this requires the operator to be an expert with the scope. We designed the first mini-resectoscope of 5mm. 5.5 -5.6mm is too big for a daily procedure in all women. We would like a smaller one, but it becomes technically challenging. Now, there are tissue removal devices- these are efficient with polyps, not so much with fibroids. A mini resectoscope can remove a 2.5 cm fibroid, but it also depends on the woman. I only use mini resectoscopes in the ambulatory setting. In the operating theatre, I use a standard resectoscope.

Do you have any tips for making office myomectomy easier for the patient?

People use misoprostol etc., but we don't use any drugs prior, during or after the procedure. We do exactly the same as when performing a transvaginal scan. We are not magicians, so we have to approach the patient correctly- we welcome the patient in a different way. It's all about psychology. If the nurse greets the patient and the doctor is on the phone, the patient will be anxious. I have told my team to be psychologists- welcome the patient in a nice way, show them they are taking care of them, be nice on the bed. We have a dedicated nurse who asks about family and kids. I have jokes prepared- 'do you know where my nurse comes- it's a small village- they just received the latest disc of the Beatles- they don't have CDs even'. These jokes make the patient feel comfortable – vocal anaesthesia or vocal local. It's our way. If you touch the vulva with one finger and the patient jumps on the bed, then that's not right. I have seen people do hysteroscopy in a cold way. It's not the way. The patient feels alone; she has been on the internet and is anxious.

Once I have performed an outpatient myomectomy, I repeat the ultrasound in 6 months to check.

You should also always count the number of myomas- don't say 'there are multiple fibroids and the winner is 5cm'. You always need to be retrospective and analyse mistakes of the past. I have learned from my own mistakes. I didn't know how many small fibroids there were. If you are expecting to remove only one, then you might perform the perfect procedure. They may find another myoma in the same place later- and the patient will think you left something inside, but one of the other myomas has moved and taken the place of the one you removed. Therefore I always count numbers, positions, even if the fibroid is only 0.7cm. I will explain that there is a possibility, like a waiting line, like paying something to the bank, another one comes in, that a replacement fibroid may appear.

The drugs we use should be tailor-made. If a lady is close to menopause and the fibroid is subserosal, I will play with drugs. But if the fibroid is inside the uterine cavity, then it needs to be removed. I use GNRH analogues or ulipristal to reduce the size of the fibroid.

If a submucous fibroid is bigger than 3.5 cm, there is a risk of extravasation. The possibility of a second operation needs to be clear to the patient. Performing resections is best on days 4-7; otherwise, the endometrium is thick.

I don't have a cut-off size for a fibroid in the cavity. I won't do a laparoscopic myomectomy for a fibroid that is entirely within the cavity. If I broke my AC unit, I wouldn't go through the wall on the other side to fix it! I also won't do a 5cm submucous fibroid without six months of GNRH Analogues first.

Another consideration is the thickness of the uterus before the serosa. As soon as the myoma is removed, the myometrial thickness increases because the uterus collapses. So the risk of perforation is not as high as people think.

How do you see minimal access surgery changing in the next ten years?

It will change. Hysteroscopy is always hysteroscopy, but the instruments will change. I might have my name associated with an instrument and think that's it. I have done my job. But other people will have new ideas. The development will be when robotic surgery is available for everyone. Now I only use robotics in selected cases. I also think that single port laparoscopy with a robot will change things.

How do you encourage trainee development and involvement in MIS?

Training is a big problem. In hysteroscopy, you are alone; in laparoscopy, you need to have someone near you, so it may be easier to learn. In addition, using the 30-degree scope in hysteroscopy has to be learned. Thank God with the laprotrainer, trainees can get used to stereotaxis and perform exercises for knot tying etc.

The exciting thing is all the new projects. I am moving from Bari to Forgia. It's a young university with great expectations for development; we have many ideas for remote training.

As a trainer, I prefer to run solo courses. They are one or two days, and I spend time with the trainees from the beginning. For example, I spend 4-5 hours explaining instrumentation. Often, people don't know to assemble or clean the instruments- and these things are essential. People need to understand that all starts from the beginning.

Mez Aref-Adib
Interviewer

The Scope meets... Professor Sony Singh

Mez Aref-Adib reports on her virtual road trip with Professor Sony Singh

I had the pleasure of talking to Prof Singh while he was on the road back to his home town of Ottowa. Prof Singh is a Professor and Associate Scientist at The Ottawa Hospital and University of Ottawa. He has completed fellowships in minimally invasive gynaecological surgery at the Universities of Toronto and Sydney. He developed a nationally recognised tertiary level clinical practice in complex surgical gynaecology.

His leadership roles include Fellowship Director of the AAGL, Fellowship in Minimally Invasive Gynecology and Surgical Director of The Ottawa Hospital's Shirley E. Greenberg Women's Health Centre. He is also Executive Director of the Canadian Society for the Advancement of Gynecologic Excellence (CanSAGE).

Prof Singh is a passionate doctor and teacher and has helped disseminate gynaecological surgical and educational principles worldwide. He has over 250 invited and 200 research presentations worldwide, 50 formal courses and over 150 publications. He was a steering committee member of the fibroid CAPTURE registry.

Where did you grow up?

I grew up in Toronto as the son of east Indian immigrant parents. I had strong female role models growing up. I watched my mother work two jobs in a factory setting. My grandmother, who raised me, was unable to read or write. The women in my life made me appreciate that there was unbalanced treatment of men and women in this culture.

I went to Queens University in Kingston, Ontario and did a fellowship under Nicholas Leyland. He was the first teacher who made me feel that I could be better. He wanted me to make a successful career on his shoulders. He taught me to lift others and help them succeed. He gave me so many opportunities, not just in operating but also to get involved in societies and research. Nicholas gave me the ultimate goal of being the best I could be and has been a person who made a significant impression. He treated me treated like a son.

I then went to Australia and had a mentorship under Professor Alan Lam. This was a different experience and had its advantages. The Canadian take on MIS, at that time, was new and self-taught. Prof Lam had a European approach to his techniques. On returning to Canada, I used the passion I had developed and became the head of Minimally Invasive Surgery.

What do you most enjoy about your work?

I have no regrets at all, and I would not want to do anything different. I love every moment. Sometimes there have been challenges, such as COVID, waiting lists and problems with access. We can forget why we are here.

However, despite the challenges, I remind myself that I am the luckiest person. I get to do a job I love with a real variety. Currently, I only do gynaecology as I retired from obstetrics in 2012. But I continue to have a little hand in obstetrics with the placenta accreta programme that we created, and we help when women have significant fibroids in pregnancy.

Can you tell us of the work you have done on fibroid management?

Of all the work I have done on fibroids, fibroid imaging is the most recent and most significant change. I strongly believe that fibroids need to be treated as any other complex disease system, such as cardiac or neurological disease. The management needs a thoughtful approach, especially in preservation treatment. Women are done a great disservice by just doing what we have always done. There is a better way.

In Canada, there was poor quality ultrasound for fibroids. Imaging would barely report the size, number and location of fibroids. The poor quality ultrasound data was demonstrated by our CAPTURE registry, our Pan Canadian multi-centre real-world prospective evaluation that helped us get a sense of the real world of fibroids. I introduced a specialised gynae ultrasound Unit and introduced improved imaging. We now have a full unit five days a week. Our centre has four sonographers and one gynaecologist who reviews and live scans more complex cases. We have created a sustainable service with a large volume of patients and expert sonographers. We perform 30-40 scans per day. This is all a public service, as is all health care in Canada. We are developing a research programme, and our next plan is to disseminate the importance of ultrasound to help increase understanding and standardisation of reporting.

Another exciting piece of work I am doing in fibroids is that of 3D imaging. With grants from our college, I have collaborated with a 3D printing group. With MRI, we use 3D rendering and print 3D models of the uterus with fibroids. The model is made of synthetic polymer. The patients like it, and I believe surgeons will find it very useful down the road. The next step will be to combine MRI with virtual reality and tailor treatment specific to each patient.

The biggest grant I've obtained for fibroid research is into Shear wave elastography. The technique currently uses ultrasound in patients with liver cirrhosis. Fibroid ultrasound can estimate the stiffness of the fibroids and predict the response to treatment. It can assess eligibility for radiofrequency treatments, uterine artery embolisation and plan a surgical approach. For example, manual morcellation may be too difficult if the fibroid is stiff, and a different approach may be necessary. If the fibroid is very soft, it may indicate features of concern. The biggest aim of this technique is to predict response to treatment. Currently, we are validating the data to see if it works. The next step would be to see if it could be applied clinically.

There is so much to say about fibroids. As well as the above, I've looked at race and ethnicity and the impact this has on fibroids and management and access to care.

What is the CAPTURE fibroid registry?

The CAPTURE registry was a non-interventional study with two years of data from 19 centres looking at the current clinical practice of fibroid care in Canada. It was the original national fibroid database. Now, there is the COMPARE-UF, set up by Dr William Catherino, who was on our CAPTURE advisory board.

How did it come about?

I was one of the founding members of the CAPTURE study. Originally, I applied for a registry out of my centre without funding. Then Allergan offered funding and gave us a PhD student to help. We wanted to capture data on ethnicity and race (data that hadn't been captured previously). A great deal of ethics and security has been done on this multi-centre trial- we have 19 centres and regular quality assurance and site visits. Corrections were made to the data when sites made mistakes. We selected the sites selected based on geography and their ability to recruit data. We were lucky as in Canada; everyone was open to putting data together. Each site had a research assistant or coordinator paid to complete the data correctly; then, it was double-checked. The data was warehoused and centrally extracted by a specialist group.

The study is closed, and we have over two years of data in the database that is being extracted and analysed. We have an excellent team who make sure it is done properly.

How do you think it will help in the management of patients?

Thus far, we have published articles on imaging techniques and what people want as fibroid management. These will be a good reference for advocating for change, but people need to act on our findings. Lack of momentum can be a challenge, but fibroids are a huge problem. I believe we aren't acting more aggressively because of the patient population affected. Often gynaecologists are keeping it back. Race is a huge issue, and sometimes gynaecologists are not part of the solution.

What advice would you give if we wanted to set up a similar database in the UK?

I would advise something small to get started that you can apply to the NHS. Data warehouses like REDCAP can help. I would recommend a prospective registry to extract data. A steering committee with members who are database experts is essential. Look at other registries. It is easier to look at quality assurance.

Do you think we need to develop core outcome sets for women with fibroids?

Absolutely. We know there have been several projects on this with heavy menstrual bleeding and endometriosis. Core outcome sets are essential for standardising care.

You are involved with the fibroid foundation in the USA- can you tell us about that?

The Fibroid Foundation is an incredible patient advocacy group that has taken the issue to the US government level and even got Kamala Harris involved in the fibroid bill to increase funding for research. They are heroes. The founder of the Fibroid Foundation, Sateria Venable, saw me speaking and asked me to be included in the foundation. Fibroid management of fibroids needs medical leadership and the patient's voice. We run educational symposiums together.

We need to teach doctors the patient voice, and to teach patients effectively; we need a physician expert. We need to align with each other.

How do you think we can involve patients in shaping the future for the management of fibroids?

Heavy patient involvement is vital. Undertaking patient-orientated research is necessary. Often big grants require having patients as part of the research programme.

CAPTURE included feedback and presentations from patients. To include patients more, physicians should volunteer their time. Doctors should speak to patient organisations in an unbiased way. They should educate the public, teach the next generation, and work with local advocacy groups. To achieve this, I've given many lectures in different settings, including banks and other workplaces.

Patients can make a difference at policy level; we need them to speak up.

Why has gynaecology dealt with issues like endometriosis and hysterectomy but not so much with fibroids?

To answer this, I break it down into percentages. About 75% is about race and gender: women vs man, black vs white. Often being a woman of colour can result in being ignored (this includes the Asian population). There is a lack of access to care. I think another 20% of the cause is a lack of knowledge. The last 5 % would be a lack of remuneration.

Do you think all countries should have national audits and registries?

Definitely, all audits or registries are important. For example, we have excellent registries and rates for cancer, and we need the same thing for fibroids.

How do you see minimal access surgery changing in the next ten years?

The people performing MIS will change: we will have more experts who can do finer surgery through better training, like fellowships. I believe there will be more recognition of having high volume surgeons who can provide the surgery.

Additional technology will provide another layer with better imaging and pre-operative planning. Like airline pilots, further data will make us more precise in our flight plan. In the future, we will be able to use artificial intelligence to ensure we do the right procedure for the right person.

How do you encourage trainee development and involvement in MIS?

We need excellent training in general obs and gynae to get a good knowledge base on the diagnosis and treatment of women. I encourage trainees to undertake high-quality fellowships and seek the appropriate job post-training to use the skills they develop.

I hope to open doors for others to be the best they can be.

Useful links

A Patient Registry for the Management of Uterine Fibroids in Canada: Protocol for a Multicenter, Prospective, Noninterventional Study

Read study here

Link to 3D printing- Flaxman et al

A review and guide to creating patient specific 3D printed anatomical models from MRI for benign gynecologic surgery

Read guide here

Mez Aref-Adib
Interviewer

Morcellation of uterine fibroids the new NICE guidelines

Scope Editor Funlayo Odejinmi updates The Scope on the new NICE morcellation of uterine fibroids guidelines

Power morcellation is one of the important advancements in minimal access surgery as it allows large specimens to be removed from the abdomen through small incisions.

In 2014, following a most unfortunate death after the inadvertent power morcellation of a fibroid that was assumed to be benign, the FDA in the USA blacklisted the use of power morcellation. The rest of the world continued to use power morcellation for the laparoscopic management of fibroids and hysterectomy specimens – but with caution.

The BSGE in collaboration with the RCOG produced a leaflet incorporating the risks of the procedure, patient information and consent in 2019.

Read leaflet here

In August 2021 NICE, with contributions from BSGE members, produced guidelines for the use of power morcellation and the expected governance requirements for gynaecological surgeons who practice power morcellation and organisational responsibilities.

Read guidelines here

NICE National Institute for Health and Care Excellence

Recommendations

Based on a rapid review of the medical literature and professional opinion.

It should not be regarded as a definitive assessment of the procedure.

Information sources

12 studies

2 case series

4 randomized controlled trials

2 systematic reviews

4 non randomized controlled trials

Recommendations

For women over the age of 50 or menopausal procedure should not be used.

For premenopausal women under the age of 50 should be used with:

- Governance arrangements
- Adequate consent
- Audit
- Research

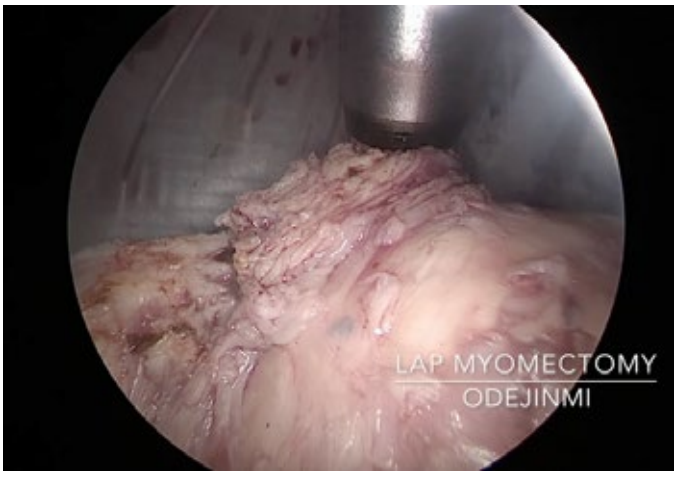
For Clinicians

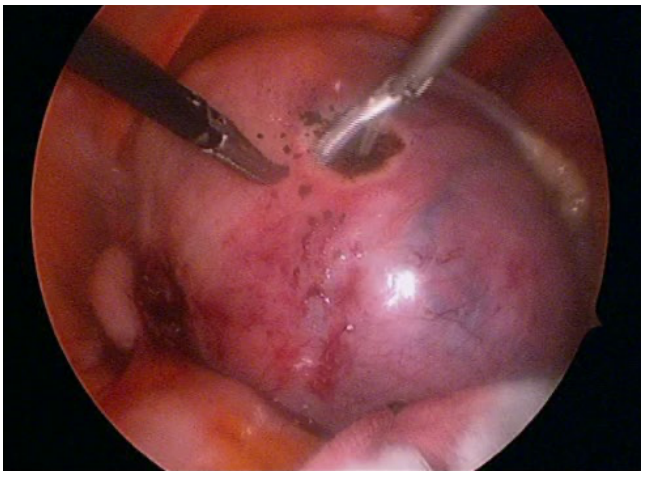
To do power morcellation for fibroids:

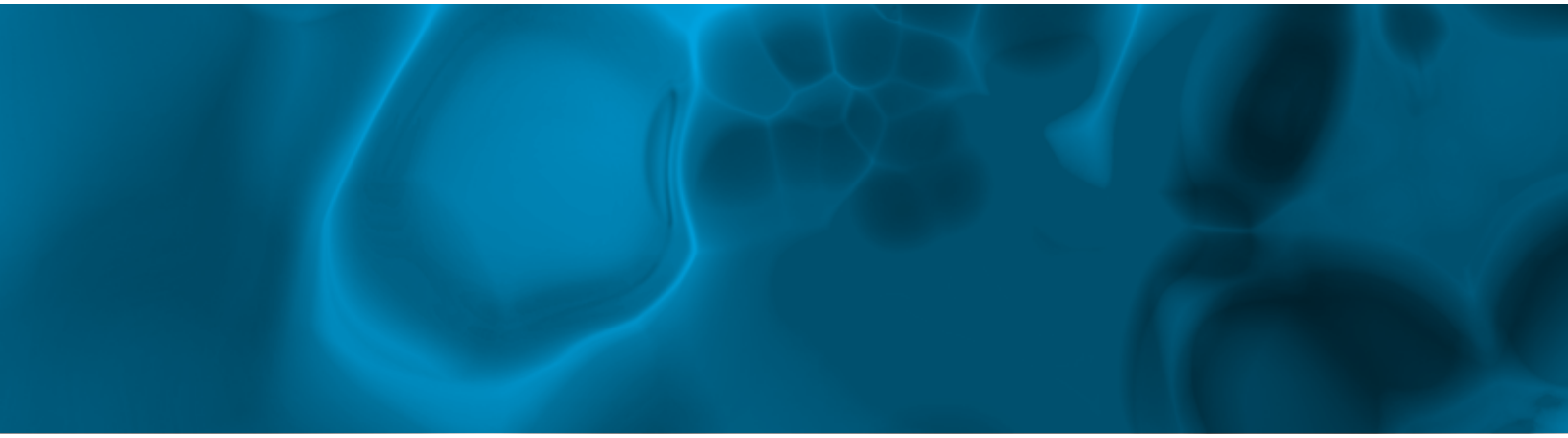
- Inform clinical governance leads
- Patient information leaflets:
  - NICERCOG/BSGE
- Audit and review clinical outcomes
- Review audit as part of clinical appraisal

For Health Care Organisations

- Ensure systems in place to support clinicians to collect data
- Review the data collected:
  - Outcomes
  - Safety
- Procedure should only be done by surgeons with specific training in using containment systems







RIGS
Registrars In Gynaecological Surgery
Training and Support in Endoscopy

Hello and welcome all RIGS members

Here's a short update on what's been happening in the trainee portfolio.

There were loads of BSGE members at the 30th annual ESGE conference in Rome. It was so amazing to see everyone in person again. Made us all excited for what's to come with our ASM in 2022!!

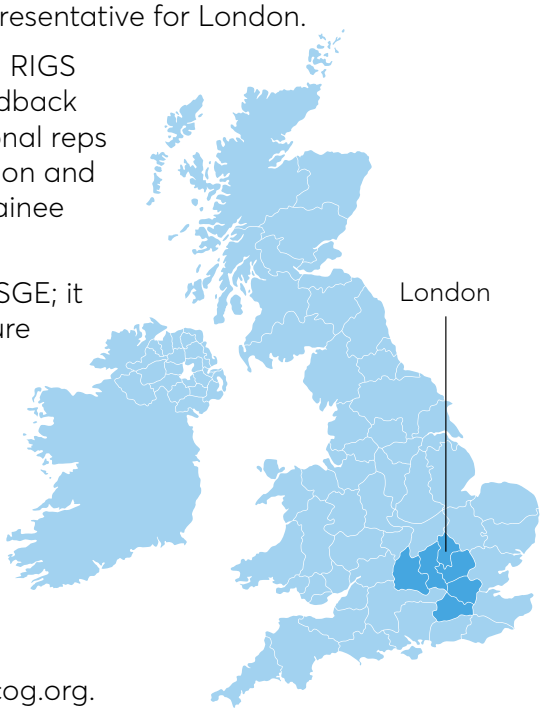
I was approached by members of the ESGE board to say how impressed they are with our commitment to trainees at the BSGE with our RIGs subcommittee, trainee dedicated sections of the ASM and also the courses like the RIGs hubs. They have requested we have input into their trainee network, to create a Europe wide committee to strengthen training in minimal access gynae surgery across the continent.

It's good to know that despite Brexit the Brits are still encouraged to be honorary Europeans and are leading by setting an example in such an important area.

RIGS recruiting for a regional rep for London

RIGS has invited applications for a second trainee regional representative for London.

Trainee regional reps play an integral role within the BSGE and RIGS (Registrars in Gynaecological Surgery). They provide useful feedback and opinions, which can be incorporated into training. All regional reps feature on the website and actively participate with the evolution and development of RIGS, providing a support network to BSGE trainee members in the deaneries.



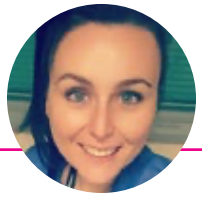
The RIGS regional rep is a key link between trainees and the BSGE; it is important in your role to be proactive and accessible to ensure trainees have the best experience.

Reps will be required to provide quarterly written updates on training opportunities within their denary and volunteer to help with BSGE trainee activities such as courses or webinars.

If a RIGS regional rep fails to engage with the responsibilities of their role, they will forfeit their position. A RIGS regional trainee rep can be of any level (ST1-ST7 or SAS doctor) but must be a fully paid member of the BSGE.

If you are interested in this role, please email BSGE at bsge@rcog.org.uk with a brief biography, a summary of why you wish to represent your deanery (max 250 words) and a photo of yourself.

The deadline for applications is 5pm on Monday 22nd November 2021



Angharad Jones and Mikey Adamczyk
BSGE Trainee Representatives

Nurses and Paramedics

Endometriosis CNS Portfolio Report

Gilly Macdonald
Endometriosis CNS Portfolio Chair

Welcome to the Autumn update of the Endometriosis CNS Portfolio.

The BSGE continues to support our work on delivering education and support to our nurse colleagues.

In October, we held the BSGE Autumn CNS Education Day. It was an excellent day and very well attended. We were very fortunate in the fact that high quality speakers gave their time to support the day and share their experience and expertise with us. Johnson and Johnson kindly moderated the day and once again, provided us with a very professional and well organised day.

Thank you to everyone who made the day such a success.

The mentoring support system is up and running and providing a much-valued network of sharing experience and knowledge. Thank you to everyone involved.

We have introduced our bitesize support sessions. These are informal opportunities where colleagues can join us virtually over a morning coffee or afternoon cup of tea to share experiences, current themes and topics of interest.

Looking ahead, we are very much focused on the 2022 ASM in Birmingham. We are working with our colleagues in Birmingham and the Local Organising Committee to develop a high quality meeting and a endometriosis CNS post congress day. We look forward to seeing you all!

The BSGE Nurse subcommittee of Claudia, Liz and Jenny join me in welcoming ideas for further growth and development. Our focus remains on creating a professional and supportive environment for all our nurse colleagues.

We look forward to an exciting year ahead!

Hysteroscopy and vaginoscopy webinar

The BSGE is holding a hysteroscopy and vaginoscopy webinar on Wednesday, 24th November at 6pm.

The free session is called V.I.Ps- vaginoscopy, investigations, treat and service. The BSGE hysteroscopy team will discuss vaginoscopy, hysteroscopic investigation and the role of PGD's service needs.

The webinar will be moderated by Rae Nesbitt, Assistant Professor, University of Bradford, and Caroline Bell, BSGE Nurse Hysteroscopists representative. Speakers include Nadine Di Donato, Liz Bruen, Suzanne Taylor and Nikki Webb.

Find out more and register
(Registration Required)

Nurses and Paramedics

Nurse Hysteroscopists Portfolio Report

Caroline Bell
Nurse Hysteroscopists
Portfolio Chair

It has been an active time for the portfolio with webinars, courses and virtual drop-in sessions. I would like to thank the subcommittee for all their continued help with the portfolio.

Bradford University Nurse Hysteroscopy training programme

I would like to congratulate the Bradford University team Rae Nesbitt and Suzanne Taylor on their successful takeover of the training programme. Because of the effects of the pandemic on waiting lists and the need for more outpatient hysteroscopy, they are training larger groups of nurse hysteroscopists. They have also improved the training content by adding new units to the curriculum including:

- Breaking bad news
- Pelvic pain
- Management of ovarian cysts

To date around 135 nurse hysteroscopists have trained through Bradford University. The success of the programme has been recognised internationally. Waikato District Health Board has emulated the Bradford programme and is training nurse hysteroscopists in New Zealand.

Vaginoscopy webinar

We're holding a Zoom webinar on November 24th at 18.00. All are welcome to join the free session. We will discuss vaginoscopy, hysteroscopic investigation and the role of PGD's service needs. Rae Nesbitt is moderating the session and the speakers include Nadine Di Donato, Liz Bruen, Suzanne Taylor and Nikki Webb. We look forward to some interesting discussions and lively debate.

Operative hysteroscopy handbook

We are currently working with the council and RCOG to develop a new operative hysteroscopy training logbook for nurse hysteroscopists to support training. Currently operative hysteroscopy training for nurses is only available through industry equipment providers, which is not standardised. The new logbook will be used in conjunction with the very successful BSGE and RCOG hysteroscopy workshops, which is an exciting development.

I look forward to catching up with you virtually at the webinar, and seeing many of you in person at the ASM in Birmingham in 2022.

BSGE Survey Section

Survey into anti-Mullerian Hormone testing in women undergoing endometrioma surgery

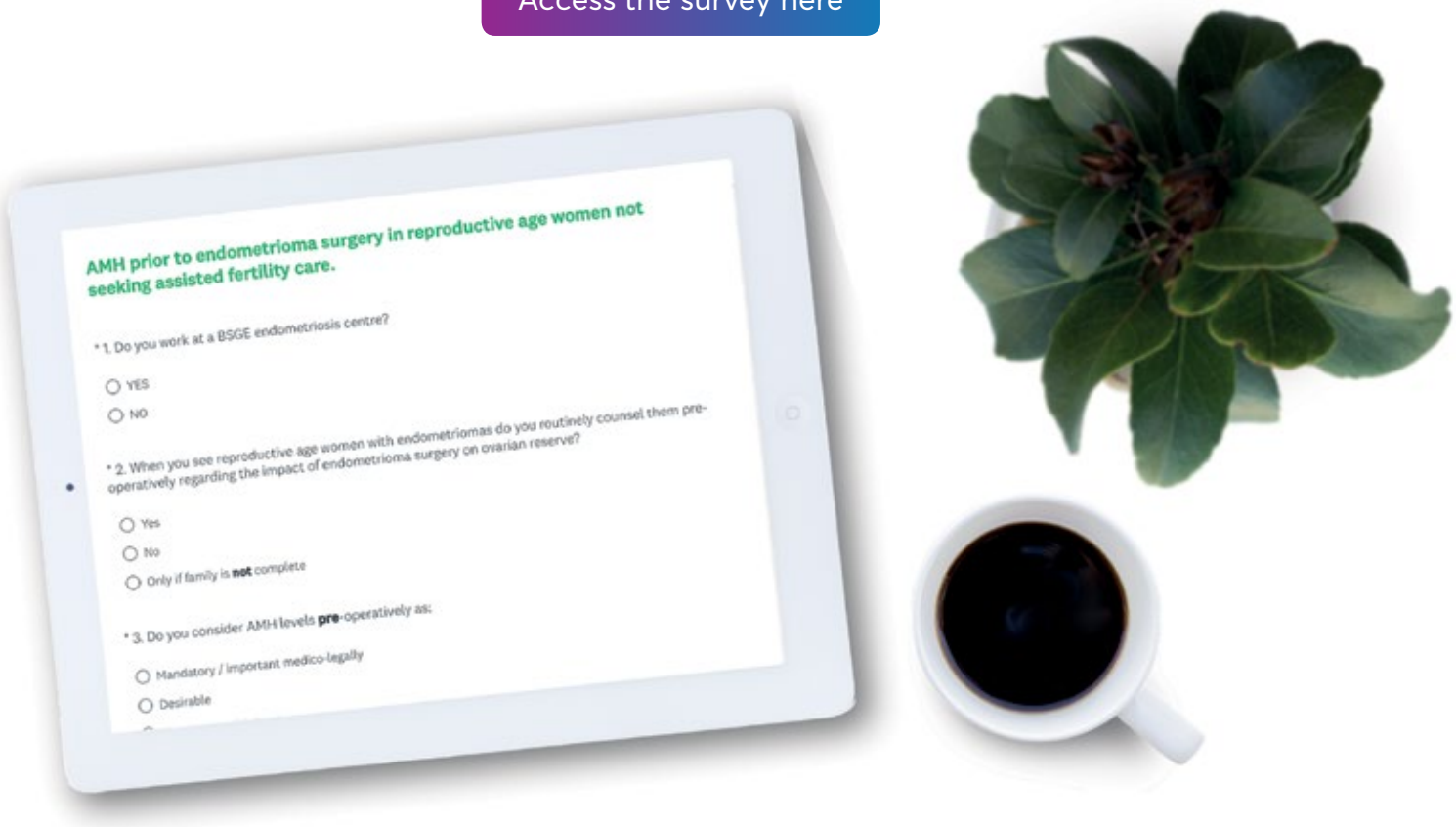
Sarah Wali, ST6 Minimal Access Surgery fellow, Chelsea and Westminster Hospital, reports on a survey into Anti-Mullerian Hormone testing. We are conducting a survey of UK based gynaecologists to assess current practice of pre-operative Anti-Mullerian Hormone testing in women undergoing endometrioma surgery who are not seeking IVF.

The survey has 10 short questions which take less than 2 minutes to complete and is anonymous. We are very grateful for your responses.

The survey is organised by:

- Miss Sarah Wali ST6 Minimal Access Surgery fellow, Chelsea and Westminster Hospital. Correspondence: sarah.wali@nhs.net
- Mr Robert Richardson Consultant Gynaecologist BSGE Accredited Endometriosis Surgeon, Chelsea and Westminster Hospital
- Miss Kate Maclaran Consultant Gynaecologist subspecialist in Reproductive Medicine and Surgery, Chelsea and Westminster Hospital

Access the survey here



Masters in Research Training for Clinicians

Dr Euan Carter, Clinical Development Fellow at NHS Grampian/University of Aberdeen reports on their survey. I represent a group at the University of Aberdeen, working on a project scoping the needs and design of a new Masters programme - Research Methods Training for Clinicians.

Strong partnerships between clinicians and researchers can result in better service and better outcomes for patients. Historically, it has been the view that engaging clinicians with research can be challenging. One of the reasons for this may be that the current research training clinicians receive does not adequately provide them with the skills and/or confidence to engage further.

Our aim is to offer an attractive training programme to local, national and international audiences that will provide clinicians with skills and confidence to develop their research portfolios and strengthen academic medicine.

As an organisation with an interest in medical training and research we value the opinion of BSGE members. This would help us to identify current skills gaps, and how best to tailor and deliver the training provision.

The short survey takes around 5mins to complete.

Fill | Scoping the needs of a new programme of research methods training for clinicians

Our aim is to offer an attractive training programme to local, national and international audiences that will provide clinicians with skills and confidence to develop their research portfolios and strengthen academic medicine forms.office.com

You can find the survey here

Upcoming Events

Nadine di Donato suggests some dates for your diary

Pre-Intermediate Course in Robotic Gynaecological Oncology Surgery (ESGO)
8-9 November 2021
Ghent, Belgium
Click here for more info >>

14 Congress of the European Society of Gynaecology (ESG)
10-13 November 2021,
Venice Italy
Click here for more info >>

50th AAGL Virtual Global Congress on MIGS
Hybrid event
November 14-17, 2021
Click here for more info >>

7th Society of Endometriosis and Uterine Disorders (SEUD)
09-11 December 2021
Stockholm, Sweden
Click here for more info >>

6th European Endometriosis Congress
16-17 December 2021
Bordeaux, France
Click here for more info >>

BSGE The British Society for Gynaecological Endoscopy 2022
February 28th-1st March 2022
Birmingham-Worcester
Click here for more info >>

The 38th Annual Meeting of ESHRE 2022
03-06 July 2022 Milan Italy
Click here for more info >>

RCOG World Congress 2022
13 – 15 June 2022, London
Click here for more info >>

ESGE - European Society for Gynaecological Endoscopy
2-5 October 2022
Lisbon, Portugal
Click here for more info >>

ISGE 2022 (The International Society for Gynaecologic Endoscopy)
Dates to be confirmed
Click here for more info >>

Update in obstetrics, gynaecology, and reproductive medicine (45th DEXEUS forum) 2022
Dates to be confirmed
Barcelona, Spain
Click here for more info >>

Noteworthy Articles

Behind on your reading? Information Resources Portfolio Chair and Webcomms Committee member Rebecca Mallick has checked out the journals, so that you can catch up on the papers that matter

Fleicher et al. Excision of endometriosis – optimising surgical techniques. The Obstetrician & Gynaecologist 2021; 23: 310– 317

A great paper by Mr Shaheen Khazali and team; a detailed summary article on the SOSURE approach to the surgical treatment of endometriosis. A must read for all surgeons undertaking endometriosis surgery.

Read more

He et al. The effect of a hysteroscopic niche resection compared with Levonorgestrel-releasing intrauterine device on postmenstrual spotting in patients with a symptomatic niche in the uterine cesarean scar: A prospective cohort study. European Journal of Obstetrics and Gynecology and Reproductive Biology 2021;265: 66 – 73

A nice prospective cohort study highlighting the benefits of the levonorgestrel intra-uterine device in the management of symptomatic uterine niches. The intra-uterine device was more cost effective and had a higher symptom resolution profile (post menstrual spotting) when compared to hysteroscopic resection. A useful non-surgical treatment option.

Read more

Dolmans et al. Intramural myomas more than 3–4 centimeters should be surgically removed before in vitro fertilization. Fertility and Sterility 2021;116; 945 – 958

Interesting debate discussing the pros and cons of surgically removing fibroids prior to IVF. A well-balanced article with strong arguments and evidence on both sides. A good read!

Read more

Franchini et al. Mechanical hysteroscopic tissue removal or hysteroscopic morcellator: understanding the past to predict the future. A narrative review. Facts Views Vis Obgyn, 2021; 13 (3): 193-201

A detailed and interesting narrative review detailing the benefits, risks and controversies surrounding hysteroscopic "morcellation". Worth reading in conjunction with the editorial on the next page.

Read more

Saridogan E. We should stop calling hysteroscopic tissue removal systems 'morcellators'. Facts Views Vis Obgyn, 2021; 13 (3): 191-192

A thought-provoking editorial that is particularly pertinent with the recently published NICE guidance on laparoscopic and hysteroscopic morcellation. Has hysteroscopic "morcellation" been given a raw deal….

Read more

Bentham et al. Review of advanced energy devices for the minimal access gynaecologist. The Obstetrician & Gynaecologist. 2021; 23: 301-309.

Nice summary paper detailing advanced energy devices, specifically their advantages, limitations as well as useful tips and tricks. Particularly helpful paper if preparing for MRCOG.

Read more

Ptacek et al. Each Uterus Counts: A narrative review of health disparities in benign gynaecology and minimal access surgery. European Journal of Obstetrics and Gynecology and Reproductive Biology. 2021; 265:130 – 136

Thought-provoking paper evaluating the prevalence of racial, ethnic and socioeconomic disparities in benign gynaecology and minimal access surgery.

Read more

International working group of AAGL, ESGE, ESHRE and WES. Endometriosis Classification, Staging and Reporting Systems: A Review on the Road to a Universally Accepted Endometriosis Classification.

JMIG epub ahead of print.

The challenges of classifying and staging endometriosis are well known. This interesting review paper assesses the 22 described systems worldwide and highlights the distinct lack of any international agreement on how to describe or classify endometriosis and re-iterates the need for a universally accepted endometriosis classification to improve patient care. Worth a read!

Read more

International working group of AAGL, ESGE, ESHRE and WES. An International Terminology for Endometriosis. 2021. JMIG epub ahead of print.

Much needed work to standardise terms and definitions in the field of endometriosis including definitions and anatomical descriptors. Definitely a step forward in standardising patient care and improving outcomes. Again, well worth a read!

Read more

De Silva et al. Conscious sedation for office hysteroscopy: A systematic review and meta-analysis. European Journal of Obstetrics and Gynecology and Reproductive Biology. 2021; 266: 89 - 98

Useful systematic review and meta-analysis in what can be a controversial topic. This review highlighted no clear reduction in pain and a higher risk of side effects suggesting routine conscious sedation should be avoided.

Read more

BSGE Scope Team

Meet our dedicated team...

Funlayo Odejinmi (Jimi)
Editor

Jane Gilbert
Assistant Editor

Atia Khan
BSGE Manager

Barbara Sanders
BSGE Administrator

Lesley Hill
BSGE Membership and Accounts

Rebecca Mallick
Noteworthy Articles

Mez Aref-Adib
Facebook

Nadine Di Donato
Events

Angharad Jones
Trainees

Mikey Adamczyk
Trainees

BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Contact Information

Correspondence address:

BSGE, 10-18 Union Street, London, SE1 1SZ

Tel: 0207 7726474 Email: bsge@rcog.org.uk

The BSGE

www.bsge.org.uk