THE SCOPE

Newsletter of the British Society for Gynaecological Endoscopy

BSGE news...

ASM25 Leeds President's Address

Full round-up of ASM25

Full details of ASM26 London - everything you need to know

BSGE at the RCOG World Congress

NEW Feature Image of the Edition

Plus all the usual Portfolios and much more

Issue 27 | Summer 2025

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

Welcome

Welcome fellow BSGE members to our Summer 2025 edition of The Scope

Message from the Editor

Dear BSGE members,

Awaiting copy

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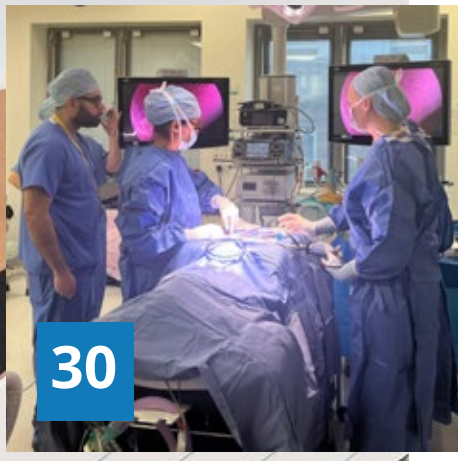


In this issue

President's Address

It's a pleasure to give my address, which I've entitled 'Knowing the Unknown'. I think that originally stems from the Rumsfeld quote that I've lost in terms of what are knowns and unknowns. But I'll try and explain what I really mean by that through the course of this address.

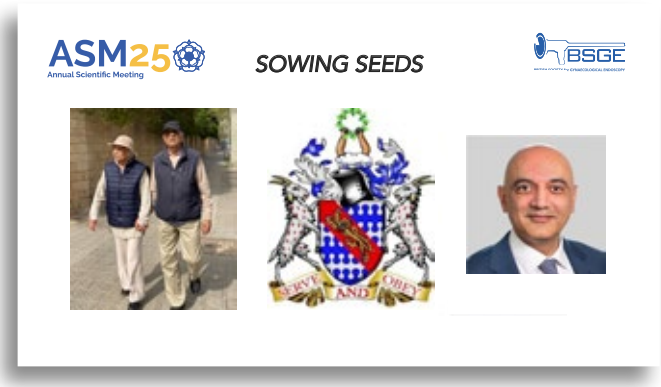
I'd like to thank Dorota, James and their Local Organising Committee for a terrific show in Leeds, it has been a really enjoyable conference. The ASM was entitled 'Bringing new skills to your armoury'- I think that's really important for all of us.

There are challenging situations for all of us as healthcare practitioners, but above and beyond healthcare we are all tested in any line of work. We're often placed in difficult situations where we may feel a little lost, short of skills, exposed even. The problem is, we're all too busy to ask anyone for help. Everyone's busy. We've got a lot of noise in the course of our work. So, it's always good to have a suit of armour- and if you haven't got the armour, it's great to have friends who have the armour to help you get through.

How do we, as the BSGE, do that? We lay on lots of tools to help us all to study and learn. We have the fantastic Scope magazine put together, most recently with Angharad Jones and previously with Jimi with Jane Gilbert who tirelessly pulls everything together. There's some excellent information and interviews with some of the legends of minimally invasive surgery, recently there was an interesting article about Ray Garry. We also provide podcasts and webinars, we run workshops, we share videos, and we also organise some great conferences, ambulatory network meetings and, of course, we welcome you all to our Annual Scientific Meeting, where we can acquire those skills to strengthen our armoury and progress.

This has been my philosophy. You've got to have your innate skill, you've got to acquire knowledge, and you've got to train. If you put all of the key parts of the triad together, you should progress. You should perform well. You should succeed.

Please allow me to indulge you with my own story of, let's call it, progression.



This is a picture of my parents in Barcelona, they are the unsung heroes of my life. England in the 1960s was not quite as cosmopolitan and multicultural as it is now. Through, I'm sure, lots of adversity, they managed to ensure I was well-educated. These photos show me at school, sowing the seeds of my education. I used to see the school motto 'Serve and Obey' every day, and it stuck in my brain. Serve and obey- that stood me in pretty good stead. It got me through university, through medical school and then through my first house job at St Andrews Hospital. St Andrew's was an old poor house with Victorian wards. On my first day at my first job, I met the outgoing house officer, who looked rather like he'd been dragged through a bush! He had a white coat and all the trappings of the house officer- stethoscope dangling, the invaluable Oxford book of medicine, some pathology forms, some old ECGs, a packet of silk cut- t that was the uniform! He said:

"This is your ward – now you've got to listen. You've got to know a couple of things. Firstly you've got to know Bob."

Bob was the charge nurse on the ward from Newcastle and Bob knew everything about everything! No matter what you had been learning at medical school for six years, you knew that Bob was the person that got you through. So you had to know Bob, and you also had to know your two enemies. He went on :

"And your two enemies are your consultants and your patients. If you can navigate between these two, then you will be just fine."

Actually, it wasn't a kind of antipathy to those two. It was more about knowing that those were the people you were doing your job for. So, you had to make sure that they were happy, and then you'd get on and you'd do well.

The philosophy was serve, serve your patients and obey, obey your bosses.

I was reminded of this clip from ER. You can watch the video here:

This quote gives a flavour of how they described life as a junior doctor:

"You're on five days a week, 5am until you finish up after 7pm. You're on call every third weekend and every third night, which means that every three days you will be here from 5am the first day till at least 7pm the next breakfast with your senior surgical resident, Dr Benton.

Dr Benton is an intern's worst nightmare. He's smarter than you. He never eats, he never sleeps, and he reads every medical journal, no matter how obscure he is. The antichrist, Beelzebub, Lucifer, a devourer of wedges. You'll go to sleep at night wishing plague and pestilence on his unborn children, and you will wake up every morning praying for his approval. You won't get it. Welcome to hell, ladies and gentlemen."

Maybe it wasn't quite as bad as that. But there was a kind of mindset that doing all of the things in my triad, making sure that you had the winning combination of decent inherent skills, knowledge and training managed to get me through graduation, then all the way through surgical fellowships to a nice consultant job.

COVID- a jolt to the system

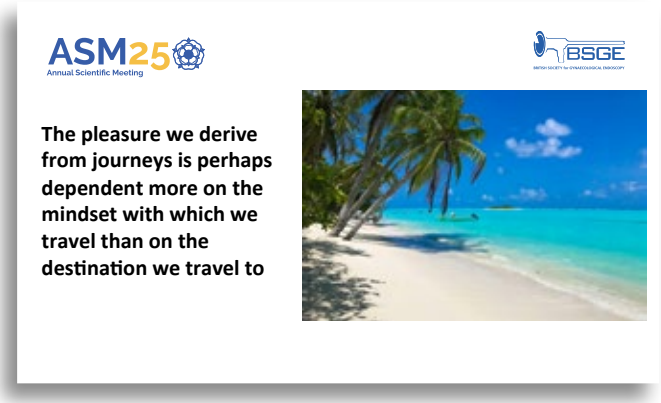
All was going seemingly smoothly but then along came COVID. And for many people COVID was a big jolt to the system. There were certainly many tragedies. This picture is of my mother-in-law, Mercedes, who sadly died during the COVID outbreak.

We started as clinicians to have our own new suits of armour – PPE- that looked pretty scary, and it was scary to be within them. Our levels of activity dropped. This graph of the BSGE Endo Centres shows dramatic reductions in the number of cases during the COVID pandemic. There were effects on staff and effects on our patients. During that time, I took up running for the first time in my life. I never ran. I did sports at school but never ran. At the time, no one was being tested for the virus. I figured that if I could run into work and make it, that meant I didn't have COVID.

While running, I initially listened to 90s music, but then I switched to podcasts. These podcasts were essentially about thinking more deeply about things- so a little bit more introspective than the key triad that I mentioned earlier. On the one hand, I realised that I was doing okay-I had my suit of armour. I wasn't fazed by much in the way of clinical matters. I was generally in a good groove, and yet some days were better than others. Why was that? Why do we have good days? Why do we have bad days? Is it just the universe? I began to realise that it was a reflection of the things going on in our heads- what was beneath the armour. These kind of feelings that all of us may experience at different times like insecurity, imposter syndrome and a whole array of different things that can determine whether we have a good day or a bad day. Maybe it wasn't just random, but there was a little bit of science behind it.

The Art of Travel

I was reminded of a book that I'd read by Alain de Botton: 'The Art of Travel.' In it, the author talks about holidays being something that helps keep us going when we're working.



We go to work to work, but if we've got the prospect of a holiday a few weeks or months in the future we can keep our heads down with the thought that when we get to that holiday we will be happy.

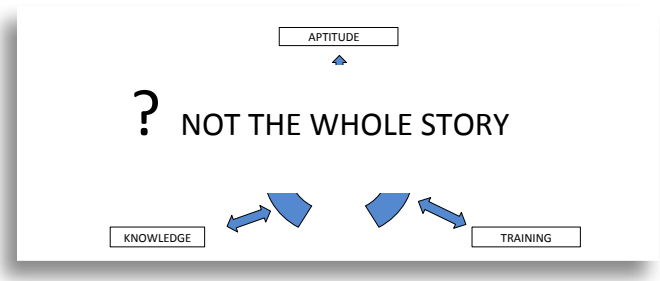
De Botton describes a dreary day in London when he looks at a magazine stand and sees a picture of a beautiful tropical beach. The image sets off a chain of thoughts in his head. Fast-forward

six months and he ends up on that island -but within five or 10 minutes, he's a little bit jet lagged, maybe there's some flies buzzing around, it's a bit too hot, or there's sand where it shouldn't be. And suddenly, rather than having that kind of nirvana moment of being on this beach, he's experiencing a lot of the same difficulties that he remembers having in London. He describes it as inadvertently bringing himself with him to the island. He'd forgotten that: *"the eyes with which he saw the brochure were intimately tied to a body and mind that would travel with me."*

In other words, the pleasure we derive from journeys is perhaps dependent more on the mindset with which we travel than on the destination we travel to.

I started to think about how we could explore the things that affect our mindsets. Was that a reflection of how my days might be going, and how I could try to optimise those days?

Some of the things I've learned (but not necessarily put into practice- because I think we remain eternal students) is that performance is related to mindset. It's about optimising you and optimising your team. So, perhaps that key triad (aptitude, knowledge and training) that I had served and obeyed wasn't the whole story.

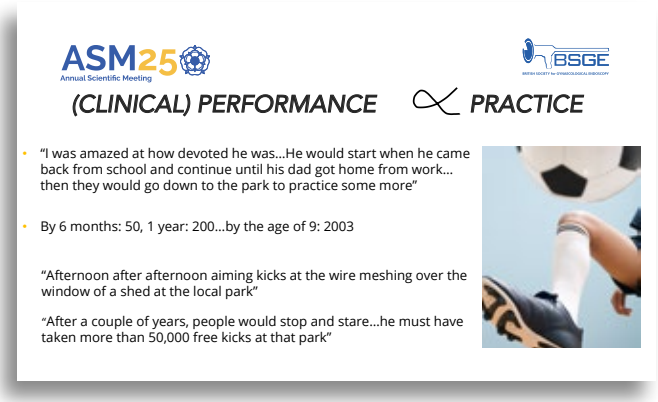


The innate expert?

So, what else is relevant for success? What else is relevant for progression? What else is relevant for performing well? Let me take you back to 2002 and England versus Greece in a qualifier for the Football World Cup. England had to draw, at the very least, in order to progress to the World Cup. Here, I think the score currently is 2-1. England are behind, and it's pretty much full-time and more.

David Beckham scored the goal to take England all the way to the World Cup finals.

But did he just turn up and do that?



As a six year-old Beckham practised keep-me-uppies, kicking the ball up in the air and not letting it hit the ground. His mum, Sandra, watched him from the kitchen and said that she was amazed at how devoted he was. He started when he came back from school and continued until his dad got home. Then he'd go down to the park and practise more. This is his progression: by six months he was up to 50, by a year up to 200 and then by the age of nine he reached a record of 2003. If you

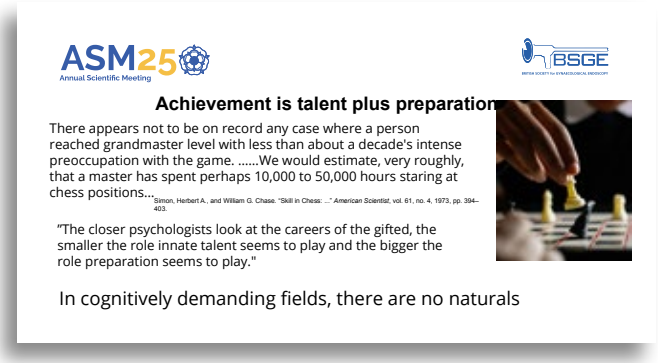
turned up and saw David Beckham as a nine year-old doing 2003 keep-me-uppies you'd think that the guy is gifted, an incredible kid. But his mother would have quite a different perspective. She would have seen all of the frustrations, the anxieties every night. She'd seen that kid trying to keep the ball up in the air, only managing to do it five times, only managing to do it seven times, tears, and then picking up the ball and trying to do it again.

Then once he'd got to what he thought was the limit, they'd go down to the park, and he'd practise trying to kick a ball onto a particular spot on a wall, and the ball was progressively moved further and further back. His dad said that:

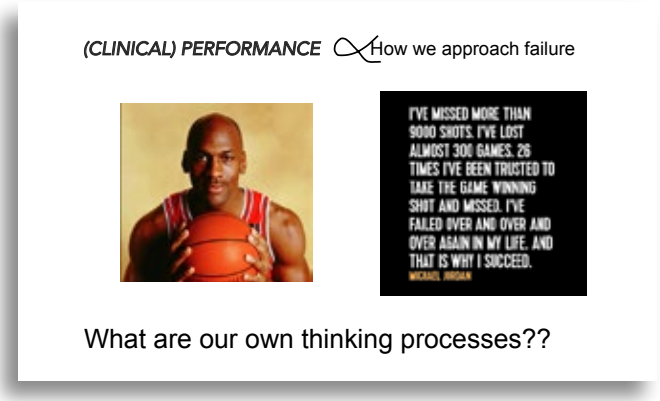
"After a few years, people would stop and stare... he must have taken 50,000 free kicks at the park."

How can we learn from that? In surgery, we can emulate that with simulation. We have the opportunity to practise. And I think successful people like Beckham have a counterintuitive response to failure, to the ball not going up in the air as many times. Rather than giving up, they continue. It's about persistence.

I want to try to dispel the myth of the instant or innate expert. Nobody walks into an operating room and is able to perform fantastic neurosurgery. That comes from years and years of practice. Achievement is talent plus preparation.

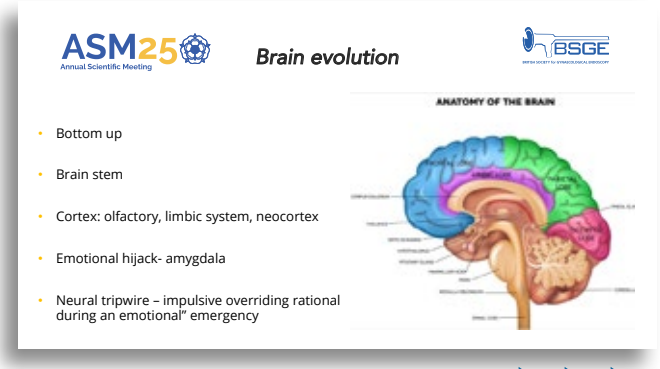


This is from chess, where the concept of the so-called 10,000 hours that we've all heard about was popularised in the book by Malcolm Gladwell. Like in sports, in cognitively demanding fields, there are no naturals. I think it's useful for us all to know that. When we see the great and the good, it's useful to realise that they didn't just wake up and were inherently like that. There's a trajectory and a journey to get there, and some of that involves how we approach failure.

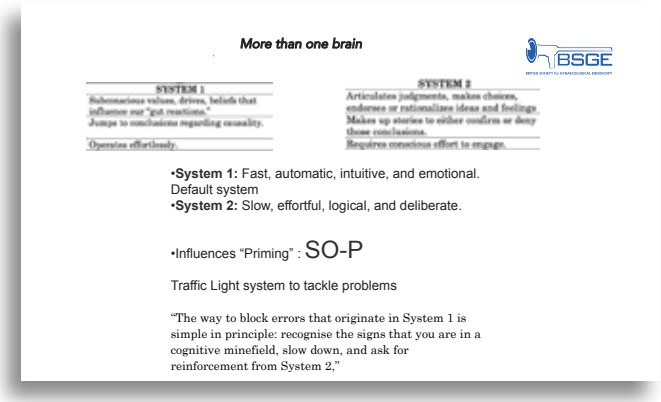


Michael Jordan is one of the most famous basketball players in history. He talks about the motivation to continue. He says that he's missed more than 9000 shots, he's lost almost 300 games and 26 times he's been trusted to take the winning shot in a game, and he's missed it. He catalogues and broadcasts his failures and describes them as the incentive and motivation to succeed. He doesn't mean we should champion failure and have an 'everyone's-a-winner' mindset. Instead, there's the cold, stark realisation that we progress fastest when we face up to failure and when we learn from it.

Think of a golfer who's blindfolded, they can't see the results of their drive. If they practise at the driving range, they improve most of the time by watching what shot they've hit and where the ball goes. It's the same in other walks of life- you need to be able to see the outcomes of your actions. If you're wearing a blindfold, you'll never improve.



What are our thinking processes? It all evolves from parts of our brain. Initially, the brain started off with the brain stem, that's all to do with existence. And then as evolution progressed, there was the development of the olfactory area (sense of smell) and the limbic system- the ring-like area that's the emotional part of the brain. And in humans, we have the cerebral cortex, the neocortex, which is very developed in human beings, giving us the ability to think. We have these different areas that represent what's happened over evolution: the brain stem, limbic system and cerebral cortex. In the limbic system, there's a key area, the amygdala, that's responsible for some of our immediate reactions. When we have a little bit of a rage, it's the limbic system and the amygdala in particular that is firing off a neural trip wire that's getting us going.



More than one brain?

It isn't that we just have a brain; there are different parts of the brain, and there are different levels of thinking within the brain. In his book 'Thinking Fast and Slow', Daniel Kahneman describes two different systems in the brain. System one is fast and automatic. If you're driving a car, you're often doing things without necessarily being consciously aware of what you're doing. The car's just going and you're driving. System two is a slower, more effortful type of thinking. That's when you actually have to invest time and give some thought process- if you were in a car but suddenly there was traffic and you needed to get to an appointment, you'd have to start employing system two to think, plan which route to take and how to make a plan and navigate being late.

In system one, the immediate thinking is subject to our own biases. In surgery, for example, if you do a laparoscopy and have a quick look inside and see a pool of fluid, you might think that you have automatically, inadvertently caused injury. Then once your logical mind kicks in, you might ultimately realise that you've performed a hysteroscopy before and that's why there's a lot of fluid in there.

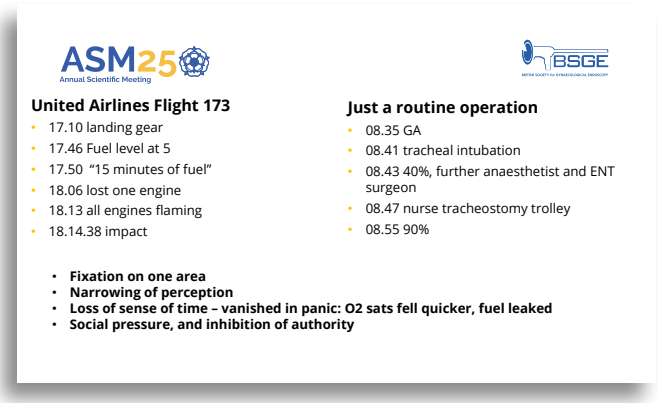
All the time we've got systems one and two working in peaceful coexistence. However, most usefully or most often we're employing system one- and that system is prone to influences.

Look at the word S O _ P and consider the missing letter. If I had been talking to you about food, you might say that missing letter is U for SOUP. If we were talking about washing machines, you might go for an A for SOAP. That's how advertising works, it preys upon priming you to get your system one thinking process working.

In Prof Steve Peters' book 'The Chimp Paradox' he talks about the chimp brain, which is the human initial response for survival. For example, if somebody cuts you up when you're driving and some people (not me, of course (!)) suddenly start shaking their fists or getting very angry. That's the chimp working- you're feeling threatened, somebody's in your patch, somebody's going to attack you in the jungle and the inner chimp is in full force. Then, five minutes later, once the human thinking process has started, you might think that was a bit silly and maybe the other driver was in a rush and only needed to get somewhere.

We've got the dynamism of these different ways of thinking through the course of any actions. I think we can translate that into how we work and always try to maintain some degree of perspective and aim to balance the system one and system two ways of thinking. If we don't and if we solely rely on system one, we can get down a channel of thinking that isn't helpful and sometimes can be detrimental.

Situational awareness and perception



As an example, I'll share a story from 1976. United Airlines flight 173 was travelling from JFK to Portland with 189 people on board. The Captain was extremely experienced with 25 years as a captain. He was one of the airline's most senior pilots with nearly 30,000 hours of flight time. Towards the end of the flight he pulled the lever to get the landing gear down, and rather than the usual click, there was a thud. It was a strange noise for the captain, the co-pilot and the engineer to hear, so everyone was a little perplexed. In the cockpit, they did some checks, and they radioed in to say that they were not going to come down yet, they were going to have to sort out whether it was safe to land and what the noise was, and whether the landing gear had properly engaged. If a plane lands without its landing gear, it is a calamity, but it is not associated with significant loss of life.

They continue flying around- this is the captain and he's keen to know what that noise is. The initial incident was at 17.10 and at 17.46, the engineer points out that the fuel levels are getting a little low. There's no response from the captain. He's needs to know. He needs to know what's happening with the landing gear. At 17.50 the engineer pipes up again, but the captain says that they've got 15 minutes left of fuel and continues to invest time wondering whether his landing gear is down, whether it is safe to land the plane.

Time continues and by 18.13 all the engines are flaming and the only thing that they can now do is look for a place to land. It's not going to be the runway and sadly, the plane landed in a suburban spot with the loss of about ten of the passengers.

Just a routine operation

Now let's talk about a problem closer to home. This is a story that's been broadcast many times and starts the book "BlackBox Thinking" by Mathew Syed, which is an inspiration. It's about a patient called Elaine Bromiley. She was the wife of a pilot and went in for a routine operation for sinus problems. At 08.35 she is going to have an operation with her consultant ENT surgeon with 25-30 years of experience. She starts being put to sleep, unfortunately, the anaesthetist, with 16 years of experience, struggles to get the laryngeal mask down. He gives more relaxant and reverts to tracheal intubation- but he's still struggling. The oxygen saturation is dropping and dropping and dropping. At this stage, the surgeon and anaesthetist comes in. Over the next few minutes, they continue to try and take a role in trying to get a tube down the throat.

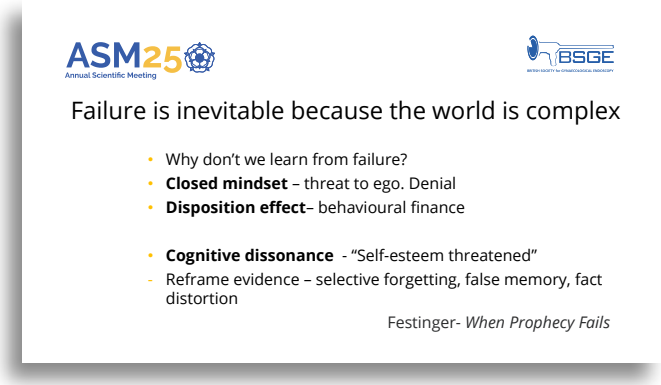
At 08.47 one of the nurses wheels in the tracheostomy trolley. Doesn't say anything but wheels in the tracheostomy trolley. It takes the surgeon and the anaesthetist another eight minutes to actually get the tube in and get the oxygen saturations up. Sadly, the patient passed away, on ITU, a few days later due to the detrimental impact of oxygen deprivation.

In many ways, these situations have similar themes. In each of them, there's lack of situational awareness and fixation on one area- a narrowing of perception. The anaesthetist thought:

"Where did that time go?"

Similarly, the pilot thought that maybe there was a leak somewhere in the fuel. He had just lost the perspective of what was going on. There are also examples of the engineer not being able to pipe up and the nurse not feeling empowered to say: 'You know what? This is the time for doing a tracheostomy'.

Learning from failure



So, why don't we learn from failure? We don't learn from failure because sometimes it's a kind of difficult concept for us to take on board. We don't like admitting when we're wrong about things and sometimes it's a threat to our self-esteem.

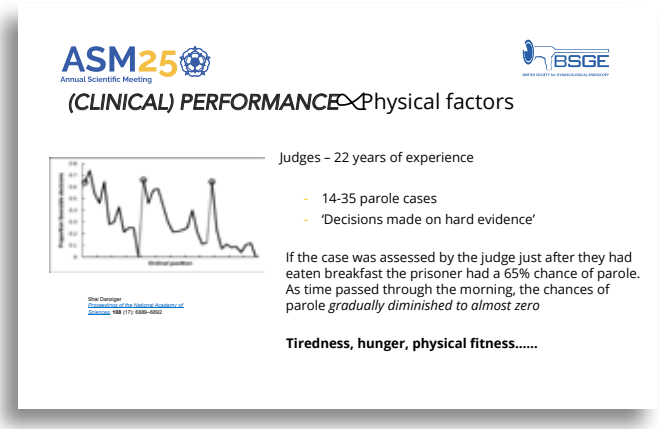
For example, we might have thought that weapons of mass destruction existed, and it would be very detrimental to have to kind of change that particular mindset. So we reframe the evidence and use different ways of describing what we actually said or what we meant.

Man know thyself

This photo is me again, when I attended an even earlier school with the motto 'Man know thyself.'

I think that it's very important that all of us, as healthcare practitioners, realise what makes up our mindsets and what makes up how we make decisions.

I hope, in this address, I've been able to show you that there are different ways of thinking, and that we need to have insight into how our minds work, what our pressures are and the things that help determine our decision making. Once we've done that, we also need to understand that we're also subject to physical factors.



To illustrate this, here's a study from Israel: These are judges who were deciding parole for their prisoners. They get presented the case, and for ten minutes they need to decide whether the prisoner is eligible for parole or not. Of course, judges being judges, they're very rational, objective people. Clearly they base their decision entirely on evidence. But actually, if you look at their acquittal rates or their giving out parole rates, the study showed that the best chance of getting parole was when the judges first sat. The closer it got to a break or meal-time, lunchtime, afternoon, tea time, the chances of receiving a favourable call diminished. So, in a field that you would imagine is entirely objective, it's clear that factors such as tiredness, hunger and physical fitness all have an impact.

These are things for all to consider. There's lots of good data now on the performance of surgeons, stress and the physical factors that help determine and can change those margins of how we perform.

Luck, rituals and managing our inner chimp

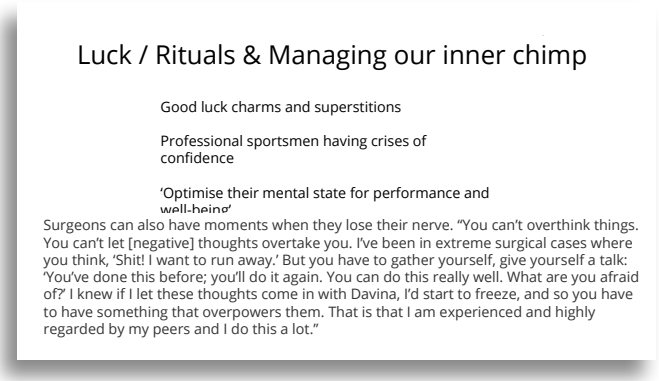
Many of us still also rely on a degree of luck. We may depend on rituals. We may have everything sussed- but even the best sportsmen still require a few rituals to give them that sprinkling of luck to succeed.

Let's talk about Davina McCall. She's probably done more for women's health than many people by changing the perceptions of HRT for a lot of women. Recently, she had a brain tumour that was treated by the neurosurgeon Kevin O'Neill. I was reading their article in the newspaper recently . Kevin must be good at his job, I'm sure she did her background research. But even he starts to worry about performing surgery on her. He said that despite his experience, he found the procedure stressful:

"Because she was high profile and her career rests on her memory'. He added that he 'prayed in the run-up. And just before, on holiday in Venice, I dropped my glasses and when I went to pick them up, I bent down and saw a card with my birthday printed on it. I saw it as a good sign."

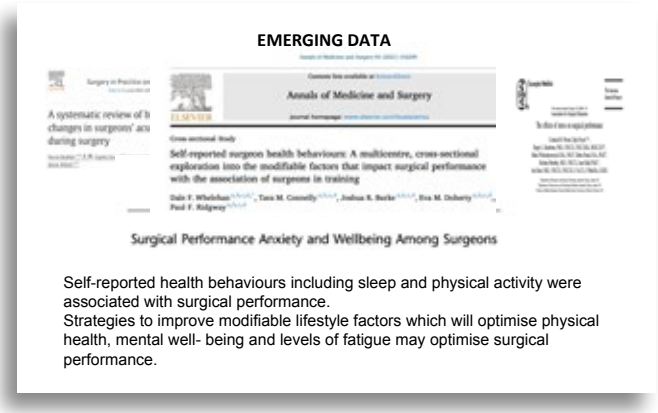
This shows that the best of the best still rely on degrees of luck. He went on to say this as well:

I thought this was telling, even the best of the best will have voices in their head saying

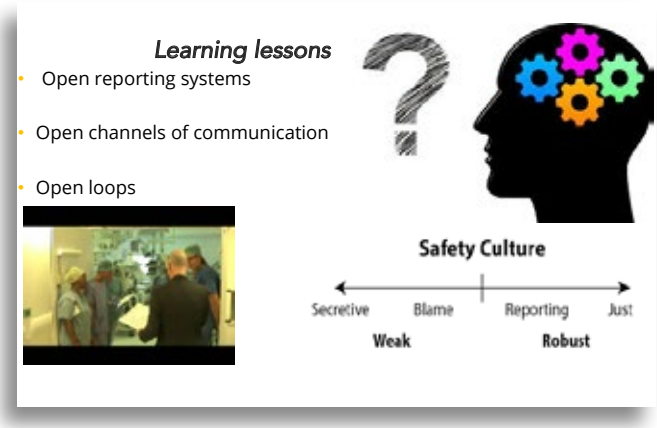


'Maybe you're going to fail here, you're not going to do a good job.' It's how you talk yourself down out of those voices that makes the difference. Everybody has voices in their heads about imposter syndrome and whether you're good enough to do the job. It's how you can tackle and manage these doubts that makes us survive and thrive.

Let me just finish by mentioning Sully Chesley Thornberger. He was one of the pilots who landed his plane in the Hudson, and was heralded as a hero. His take on the experience was not to say that he did anything good, but that all the tools that he used in order to perform the heroic act of landing the plane in the Hudson was built on failures. It was built on the lessons learned from previous disasters.



In the health service, I think we're getting better at having these open reporting systems, open channels of communication and open loops where you investigate what's gone wrong and learn from it. But it's really important that we go in with the right mindset. That is really the biggest message I want to share, that we go into these things with the right mindset, otherwise they become just a tick box exercise.

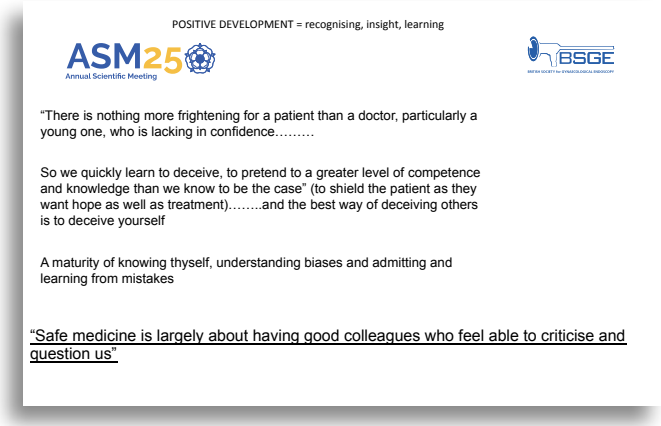


I started by saying that there was a triad of things that we need to progress. However, maybe some of the enforced maturity and self-reflection that COVID brought, made me realise that it's more sophisticated than that.

There's not a written script, rather, there's a lot of work that we need to do to optimise ourselves and become the kind of people to be the kind of doctors, nurses and humans we want to be.

Of course, we sometimes rely on luck. We mustn't forget the importance of practice, awareness, remembering situational awareness, not getting bogged down in one clinical scenario, remembering that we're attentive to our own physical needs and that we're aware of those negative voices in our heads. How we manage that background noise is so important. When we learn , we should aim to learn in an open fashion, and remain critical and don't take everything as read. In his ASM lecture, we heard from Ray Garry about having theories and dispelling theories. That's how we evolve and that's how we learn.

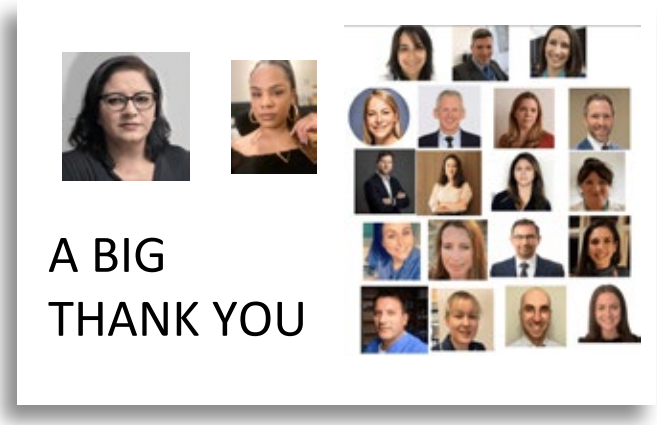
My school motto was changed from 'Serve and obey' to 'Together boundless' which I think is a lot more appropriate for now.



I'll finish with Henry Marsh. He's a renowned neurosurgeon who worked at St George's. He very openly talks about his journey as a neurosurgeon and how there's nothing more frightening for a patient than a doctor, particularly a young one, who is lacking in confidence. You don't want to come across as a healthcare professional who doesn't have self-confidence. Part of the skill that we learn very quickly is this kind of self-deception.

He says that "we learn to deceive, to pretend that we know things to a greater level of competence and knowledge than we know to be the case". We don't do that because we're egotistical, it's because we want to put patients at ease. If the patient feels that you're confident, then, almost by osmosis, you can exude some of that confidence.

Marsh describes our trajectory as healthcare professionals. Ultimately, when we go through that journey if we can reflect well, then we begin to understand our own biases, and learn from our mistakes. He says that safe medicine is ultimately about having good colleagues who feel able to criticise and question us.



I want to sign off by thanking all my officers and council members, all of you in the subcommittees that don't always get a mention here, who work through the year to help run the workshops and the conferences. And, of course, thanks to all of you as the members, we're all eternally grateful for your contributions. I always reserve particular gratitude to the managerial team, Atia and Charis who are the engine that makes it all what it is. A big thank you very much.

BSGE Annual Scientific Meeting 2025

Dorota Hardy, Co-Chair of BSGE ASM 2025 reports on her experience of running the meeting and shares a few of her conference highlights

It's no exaggeration to say that organising the BSGE ASM 2025 was an incredibly intense, at times overwhelming, but ultimately deeply rewarding experience. As my first time leading the organisation of such a major meeting, I found it both a personal and professional challenge- and one I'm genuinely proud of having undertaken.

In the months leading up to the event, we faced multiple unexpected hurdles, ranging from venue closures to programme changes and even the Royal Armouries itself being placed on the market. The original venue for our consultant and BSGE dinners went bust only a few weeks before the event, and we had to pivot and rebook everything at short notice. Add to that last-minute changes to speakers and logistical issues with live surgery sponsorships, and it felt at times like a series of mini-disasters.

Despite all this, what carried us through was the phenomenal team around me. My fantastic co-Chair James Tibbott, the excellent local organising committee, our event coordinators Naomi and Andrea and, of course, the amazing Atia and Charis who were all instrumental in helping us pull everything together. We also had invaluable support from Professor Balen and the BSGE Council, especially Arvind, who was always on hand to assist with rapid decision-making. Without them, this event simply wouldn't have been possible.

Once the meeting began, something magical happened – everything slotted into place. The atmosphere was vibrant, and the engagement from delegates was unlike anything we'd anticipated.

The final numbers speak for themselves:

888
Attendees – our highest ever

102
Sessions delivered

73
Speakers

38
Sponsors

11
Pre-congress Workshops the most ever hosted

4
Social events

Leeds life

The venue itself, the Royal Armouries Museum in Leeds, gave the conference a unique character. It wasn't a traditional conference centre, and I think people really responded to that.

We were incredibly lucky with the weather, it was warm, sunny, and bright throughout. Believe me, that's not normal for Leeds! The unexpected result was a festival-like atmosphere. Delegates sat along the canal with ice creams, took boat trips into the city, and mingled outdoors between sessions. Our 800 umbrellas, ordered to protect delegates from the rain, were mostly used as parasols. There are photos everywhere of a sea of yellow umbrellas floating through the city centre and strolling by the water.

Bringing New Skills to Your Armoury

Scientifically, I genuinely believe this was one of the strongest ASMs we've ever delivered.. Developed under the academic leadership of Professor Adam Balen and with valued input from Arvind and the BSGE Council, the programme was built around three transformative streams:

- Enhancing UK's Leadership in Endoscopic Surgery
- Fostering Multidisciplinary Collaborative Work
- Applying State-of-the-Art Technology

We poured weeks, months of effort into curating a diverse, high-calibre programme, and the feedback has been overwhelmingly positive. For me, everything was a highlight, but I'll pick out some sessions to give anyone who missed the meeting a flavour of Leeds 2025:

Pre-congress Courses

With 11 courses and hands-on workshops the pre-congress programme at Leeds was the biggest and most diverse to date. We held sold-out sessions on da Vinci Robotic Surgery, VNotes, Sontata Treatment, Advanced Urogynaecology Workshop, a Pelvic Pain Workshop led by Carolina Afros, the always popular Endometriosis CNS Education Day, and a fantastic Gynaecological Ultrasound for minimal access surgery masterclass. The Hysteroscopy workshop (see the report in this issue of the Scope) and RIGS ST5-7 Laparoscopic Workshop were also very successful.

The first Cadaveric Endometriosis Masterclass was run by Professor Mabrook, this was the first of its kind. Held in Leeds using locally donated cadavers, it received extraordinary feedback and will now form the basis of a long-term collaboration on future training events. We introduced a GRASP (Gynaecological Response to Acute Surgical Presentations) workshop, inspired the hands on training courses they run in obstetrics. The session was delivered in real clinical settings, with real-world scenarios that even moved participants to tears due to their emotional intensity. See Jay Ghosh's report and pictures in this Scope.

Championing Women and Regional Voices

We didn't set out to host such a large meeting. I'm not like Trump- bigger is better! It evolved into that, organically. But our vision was clear: I wanted the ASM 2025 to feel different- to be inclusive, empowering and diverse

It was important to me that this meeting reflected diversity, not just in science, but in speakers. The aim was not just to inform, but to represent, and I believe we achieved that. We had a significantly higher proportion of female presenters, including in sessions on technology and robotics, such as Nadine di Donato and Manchester-based colorectal surgeon Dina Harinji, who were both outstanding. There was an inspirational lecture from trailblazing surgeon Dame Averil Mansfield. In 'A woman in a man's world' Dame Mansfield shared her extraordinary career in vascular surgery and as founder of RCS Women in Surgical Training. She epitomised her message for success: ' Hard work, humility and humour.' Historically male-dominated fields need visibility and balance, and I believe this year's meeting made real progress.

As a northern meeting, it also showcased local talent, with the oncology and extra-pelvic endometriosis sessions delivered entirely by northern clinicians. The fantastic Alec Turnbull Lecture was presented by our own Professor Adam Balen. Adam gave a thought-provoking keynote lecture on the evolution of assisted conception since the first IVF birth and discussed the ethical dilemmas the new technology brings, including the potential for artificial wombs, solo genetic parenting and gene editing.' How far should we go?' Overall, the programme had a strong regional voice and flavour, and many of the talks stood out as highlights of the programme.

Global Health

Ahead of the meeting, I looked forward to our star session on global health. It was a unique, first-of-its-kind session at the BSGE ASM. My colleague John Dalton has been travelling to East Africa since 2005 and contributed to an inaugural laparoscopy camp at Mengo Hospital, Kampala, Uganda in March 2024. He has invited colleagues from Africa as well as those closer to home to share their stories.

The Global Health Session lived up to my expectations. International experts joined local specialists to share their experiences of caring for women in rural facilities and low-resource settings. Joseph Njagi gave an eye-opening talk on endometriosis care in Kenya and the myth that endometriosis is rare in African women. Joseph pointed out the inadequate reporting of endometriosis, lack of awareness of the condition, poor access to diagnostic and therapeutic facilities and the long delays. Is endometriosis rare in Africa? He said a resounding 'NO- African women present only with the most severe symptoms and tend not to seek medical attention for dysmenorrhea.'

There was also a fascinating lecture on gasless laparoscopy and rural surgery from Noel Aruparayil and Peter Culmer. They talked about developing frugal equipment and introducing sustainable, remote surgical training and proctorship to address the needs of patients in these settings.

A holistic approach to Endometriosis

We launched a Pioneering Therapies Research Meeting taking a holistic approach to endometriosis. This included respiratory physicians, plastic surgeons, urologists, gastroenterologists, thoracic specialists, radiologists and dietitians – reflecting our belief that endometriosis is not just a pelvic disease, but one that affects the entire body. It was truly multidisciplinary, and that was a point of pride.

Live surgery

The live surgery, broadcast from St James's, was another well-attended element, even though it started early in the morning after the Gala Dinner! While we originally hoped to feature female robotic surgeons, last-minute sponsor changes forced us to adapt the content. It's something to refine next year, but overall, engagement was strong and the surgery was fascinating with lots of tips and tricks.

We watched teamwork in action from St James Hospital with Lizzie Bean live-scanning and Ertan Saridogan performing abdominal cervical cerclage laparoscopically to prevent mid-term pregnancy loss. We also watched Andrew Kent, James Tibbott and the gynaecology team working with Lizzie Bean scanning and urology colleagues performing a live laparoscopic hysterectomy, excision of #endometriosis and insertion of ureteric stents to treat recurrent endometriosis.

I'd like to thank the surgeons and the St James's theatre team for what was described in the auditorium as 'slick and faultless procedures.' Thanks also to the women who very generously allowed their procedures to be filmed and shown to BSGE members so that they could learn from experts.

Science and socialising

The ASM is about science and sharing knowledge and experiences- but it's also about getting together with friends and colleagues and relaxing.

Socially, this year's meeting was electric. The Gala Ball was nothing short of spectacular – a full 1920s theme with sequins, feathers and vintage glamour. The stunning art deco surroundings of the Queens Hotel made the perfect backdrop for music, dancing and so much fun!

The RIGS Dinner and BSGE Dinner were equally successful, the latter held by the river, made even more memorable by the flawless weather. Feedback from attendees, speakers and industry alike was overwhelmingly positive.

Industry and the ASM

Industry engagement this year exceeded all expectations. All exhibition spaces sold out weeks in advance, and industry partners were unanimously happy. The layout, which encouraged attendees to pass through exhibitor areas for refreshments, created natural traffic and networking.

One new innovation, reflecting our Royal Armouries location, was our Endoscopic Knight Trials. Delegates could collect a stamp card from The ASM reception, then visit the participating stands and collect at least 10 stamps to complete their quest and enter a draw to win a free ticket to BSGE ASM 2026 in London. The feedback I received was that this was the best industry experience they'd had at any BSGE event.

Looking forward to London

Most of all, what I'll take away from this experience is what I learned – not only about events management, logistics, and the science of gynaecology – but about myself, teamwork, and perseverance. I genuinely miss the meeting now it's over. It was an unforgettable experience. I feel I've grown, professionally and personally, and I'm grateful to everyone who made BSGE ASM 2025 such a success.

Here's to BSGE 2026. I wish all the best to Fevzi and the team and we look forward to seeing you in London!

BSGE ASM25 Leeds Prize Winners

ABSTRACT PRESENTATION	PRIZE	AWARDED TO
VIDEO PRESENTATION		
GOLD	THE KARL STORZ – HAROLD HOPKINS Golden Telescope and KARL STORZ-supported BSGE bursary to attend a KARL STORZ supported course, within Europe.	**Florence Britton** ABSTRACT NO: 147 – Ten Surgical Steps for Natural Orifice Specimen Extraction (NOSE) In Segmental Bowel Resection for Endometriosis. The Ongoing Debate on its Superiority to Conventional Technique?
SILVER	£200	**Kyle Fleischer** ABSTRACT NO: 182 – More than Meets the Eye: Robotic-Assisted Laparoscopic Excision of Endometriosis Infiltrating the Sacral and Pudendal Nerves.
BRONZE	£100	**Sarah Rizeq** ABSTRACT NO: 253 – Advanced Deep Parametrial Dissection in Minimally Invasive Gynaecologic Surgery: A Step-by-Step Surgical Approach
ORAL PRESENTATION		
GOLD	£300	**Maxine Reindorf** ABSTRACT NO: 78 – Addressing Equity in Laparoscopic Myomectomy: Expanding Access and Improving Outcomes for Ethnic Minority Women with Large and High-Order Fibroids
SILVER	£200	**Roopa Nair** ABSTRACT NO: 173 – Robotics in urogynaecology: initial experience of 64 cases
BRONZE	£100	**Miski Scerif** ABSTRACT NO: 262 – Ultrasound Scanning – the Key for any Endometriosis Centre
VIDEO POSTER PRESENTATION		
GOLD	£150	**Mohamed Shahin** ABSTRACT NO: 270 – A Step-by-Step Video Demonstration of vNOTES Scarless Salpingectomy for Tubal Ectopic Pregnancy

SILVER	£100	**Mohammed Al Kharfan** ABSTRACT NO: 275 – Laparoscopic treatment of a Mullerian anomaly with rudimentary fibroid uterus and fallopian tube hernia
BRONZE	£75	**Jyoti Sharma** ABSTRACT NO: 201 – The Stubborn Ovary: Repeated Battle with Ovarian Remnant Syndrome, Ureteric Stenosis, and Reimplantation Using Robotics & ICG Fluorescence
E- POSTER PRESENTATION		
GOLD	£150	**Ghazal Datta** ABSTRACT NO: 87 – Early Diagnosis and Laparoscopic Management of a Live 8-Week Rudimentary Horn Pregnancy: A Case Report with Surgical Video
SILVER	£100	**Ria Kamboj** ABSTRACT NO: 94- Anastomotic leak and fistula rates following bowel surgery for endometriosis: Results from nearly ten thousand patients on the British Society for Gynaecological Endoscopy database
BRONZE	£75	**Zahra Azeem** ABSTRACT NO: 120 – Are we achieving our objectives without proper standardization of Investigations? Time to develop a Gold Standard Pathway for managing bowel endometriosis
RIGS VIDEO PRESENTATION	£250	**Kyle Fleischer**
RIGS SUTURING	KARL STORZ GOLDEN NEEDLE + GESEA	**Muna Ewadh**
SILVER	£100	**Mohammed Al Kharfan**
BRONZE	£50	**Hassan Zeinah**
ENDO CNS INNOVATION AWARD		
£100 GIFT CARD	**Joanne Street, Worcester Royal Hospital**	
Runner up	**Elizabeth Malone, Katie Morris, Joanne Hanley, Tanya Mitchell, Camilla Birkhead, from Manchester Foundation Trust.**	
ENDO UK RAFFLE	FREE ASM	**Liz Bruen**

Sustainable Surgery at ASM25

This year at BSGE ASM 2025 there was a focus on minimising the environmental impact of surgery and increasing the sustainability of the ASM

Professor Hugh Mongomery presented the Rhodium Lecture for Karl Storz on ' Deep Cuts: Surgery and the threat of climate change' and Chris Scott from Ethicon talked about ' Partnering with the NHS to reduce the environmental impact of surgery.'

It's a hot topic; surgical care has a significant environmental impact, contributing substantially to the carbon footprint of healthcare. In gynaecological surgery, the use of energy-intensive equipment, single-use plastics, and anaesthetic gases plays a major role in greenhouse gas emissions. According to the RCOG, surgery is one of the most resource-heavy aspects of clinical practice, with a single operating theatre generating hundreds of kilograms of CO_2 each day. Factors such as the overuse of disposable instruments, the prevalence of desflurane anaesthetic and inefficient theatre utilisation all contribute to the environmental burden. With the NHS committed to becoming the world's first net-zero health service, surgical disciplines including gynaecology will be expected to assess their practices through a sustainability lens.

The College recommends practical changes such as switching to lower-impact anaesthetic alternatives, reprocessing single-use devices where safe and permitted, and using reusable surgical gowns and drapes, enhancing energy efficiency in theatre and optimising surgical lists to reduce downtime.

The LOC made an effort to reduce the environmental impact of this year's ASM. The conference programmes were fully digital and, for the first time, the meeting was also part of a carbon offsetting programme.

The Society offset 30 tonnes of Carbon Dioxide against the carbon footprint of the meeting by allocating nine recently planted trees in the Skipbridge Wetland Reserve, North Yorkshire. Sophia Pownall from the Leeds LOC said:

"We calculated the estimated carbon footprint of the conference and researched how to best offset that carbon locally. We accounted for all the emissions, excluding travel, as this was too challenging to estimate. We found a lovely charity project (started by doctors) called 'Make it Wild' to support our initiative."

'Make it Wild' say:

"We believe that one of the best possible ways to compensate for some or all of your unavoidable carbon foot-print, is through planting trees."

Leslie Coleman, Projects Manager, added:

"The BSGE's partnership with 'Make it Wild' is supporting biodiversity in the UK, and our ongoing work in our nature reserves."

MAKE IT WILD

This is to certify that the

BRITISH SOCIETY FOR GYNAECOLOGICAL ENDOSCOPY

has offset

30 tonnes of CO_2e

against the carbon footprint of

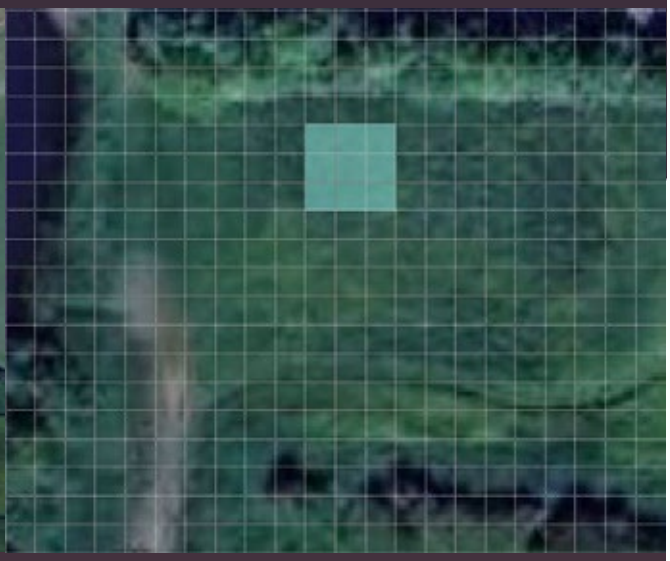
The British Society of Gynaecological
Endoscopy Conference in Leeds
on Thursday 1st May 2025

by allocating 9 recently planted trees

in our Skipbridge Reserve, North Yorkshire

25th April 2025

Skipbridge new woodland



The allocated trees are in the area highlighted in green

IT'S NOT OUR AIM TO PROTECT NATURE, IT'S OUR PURPOSE!

Make it Wild ® This name, words and logo are protected by trademark nos. UK00003425982 + UK00004006791
Make it Wild Limited is UK registered company no. 10512492 VAT no. 281 9479 58 ® Make it Wild Limited
Google Imagery 2024 Airbus, CNES/Airbus, Getmapping plc, Infoterra Ltd & Bluesky, Maxar Technologies

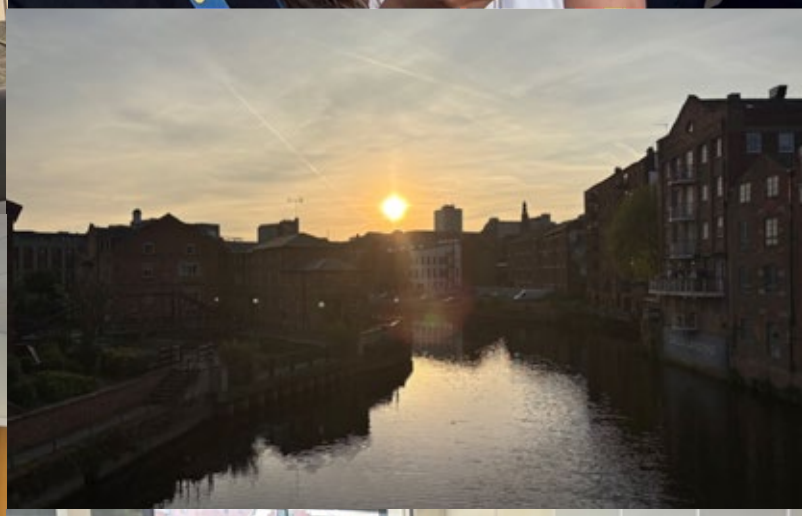
Hysteroscopy Pre-congress Workshop

Nadine Di Donato reports on the hands-on hysteroscopy workshop that ran ahead of ASM 2025 in Leeds

We had another very successful hysteroscopy pre-congress day in Leeds during our national ASM BSGE conference. There was a lot of passion and support from an amazing faculty and an equal amount of enthusiasm from the delegates.

I'd like to thanks to all the industry partners who supported the BSGE and the workshop. I am pleased that we are moving in the direction of having ultrasound skills embedded in our ambulatory service. Susanne Johnson presented a fantastic talk on the role of 3D ultrasound in the diagnosis and management of uterine anomalies. As always, we had excellent collaboration and support from our nurse hysteroscopy group and the hysteroscopy subcommittees including Mary Connor, Amelia Davison, KOLHE, Shilpa, Rowena Sharma, Oudai Ali, Caroline Bell, Ghadah Z Ahsan and Mahshid Nickkho-Amiry. Thanks also to Maria Chalmers who helped with the preparation of our models (large frozen potatoes) and assisted with the development of the programme and the organisation of the pre-congress course.


ASM25




Understanding Camera Systems
4K UHD
2160

Nadine di Donato, said...

"I'd like to thank everyone involved in ASM 2025 for an incredible ASM experience. It had to be one of the best ASMs ever!"

"I am so honoured to be senior council member and to have contributed to the scientific programme at ASM 2025 . My talk was on the advancement of robotic surgery in endometriosis frozen pelvis. This was a great opportunity to share complex surgery in endometriosis using robotic technology. A big thank you to the local organizers in particular Dorota Hardy and James Tibbott. I am really proud to be part of such a wonderful society which has the aim to support training and innovation. I am looking forward for 2026 and London edition with Fevzi Shakir.

Gala dinner was more than fun on the 1920's Great Gatsby theme. There was dancing and a true desire to have fun and be together. The live surgery was outstanding. I was so proud that finally we had incorporated advanced ultrasound as pivotal role in the diagnosis of disease in women.'"

BSGE GALA DINNER

GRASP: Ready for Theatre's Toughest Moments

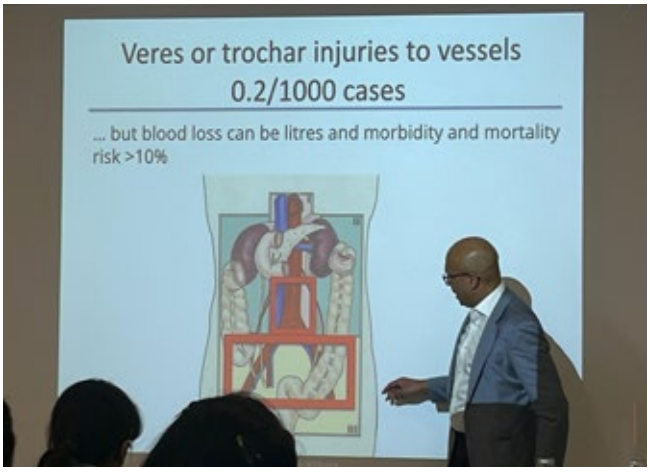
Jay Ghosh and Jessica Preshaw report for The Scope on behalf of the GRASP course faculty

Why isn't there a PROMPT style course – but for gynaecology and better?

We all recognise that moment in theatre when a routine case takes a turn. The bleeding won't stop. Observations change. The ureter isn't where you expected it. In these high-stakes scenarios, there's no time to think twice – yet structured, practical training for such emergencies has historically been lacking in gynaecology.

The GRASP course (Gynaecological Response to the Acute Surgical Presentation) set out to change that.

This pioneering, one-day, simulation-based course was developed to support senior residents and consultants in managing acute surgical emergencies. The aim was to equip participants with a structured approach to less common but critical situations, such as intraoperative haemorrhage, sepsis, and visceral injuries – all underpinned by human factors.



GRASP aimed to:

- Prepare gynaecological surgeons for the emergency scenarios they may encounter in theatre or on-call.
- Standardise responses to critical presentations such as acute haemorrhage, sepsis, urological and vascular injury, and the perioperatively deteriorating patient.
- Encourage leadership, communication, and multidisciplinary coordination under pressure.

Course Format

The course took place in a high-fidelity simulation environment in a real operating theatre at St. James's Hospital, Leeds, designed to replicate the operating theatre environment with genuine theatre staff, actual operative equipment, realistic timelines and team dynamics. Participants rotated through emergency scenarios in small groups, allowing for active engagement and reflective debriefing allowing delegates to understand their own intrinsic responses to stressful and unfamiliar situations.

Key components included live simulation scenarios, such as:

- A major vascular injury requiring haemostatic control and simultaneous team coordination and escalation
- A bradycardia station during insufflation, testing speedy recognition and prompt action
- A postoperative septic patient, incorporating complication recognition and MDT working

Each scenario was accompanied by a pre-briefing and debriefing providing a cognitively supportive and safe environment during high-stress situations.

Interactive lectures and facilitated discussions were delivered by a diverse faculty, including:

- A surgeon and performance management coach, who spoke on optimising performance under intense extrinsic and intrinsic pressure.
- A medical negligence barrister and KC, who offered medicolegal perspectives on dealing with complications
- A vascular surgeon, who discussed inter-specialty support, escalation and requirements for communication and action
- An obstetrician who has expertise surrounding hot and cold debriefing following traumatic events for healthcare professionals

Feedback and Future Directions

Participant feedback was universally positive. Attendees praised the course's realism, structure, and practical relevance, particularly the opportunity to rehearse rarely encountered emergencies in a safe, supportive environment.

One participant shared:

"I attended the first GRASP course at the BSGE ASM this year. It was a fantastic course supported by an enthusiastic and experienced faculty. A particular highlight was the multidisciplinary vascular injury scenario in theatre which really prepared me for managing the rarer and more complex complications. It felt very true to life! An essential for any senior trainee — and a really fun day. Thank you!"

Following this success, there are plans to run GRASP again at the next BSGE Annual Scientific Meeting, with active discussions underway about expanding the course into a multidisciplinary format and incorporating decision-making algorithms both their use and creation.

Conclusion

GRASP has filled a much-needed gap in gynaecological surgical training — one that acknowledges the reality that emergencies don't wait, and preparedness saves lives.

By offering a structured, collaborative, and hands-on approach to acute surgical presentations, GRASP empowers gynaecologists to lead confidently when it matters most.

Because in theatre's toughest moments, we don't rise to the occasion — we fall back on our training. And GRASP ensures that training is sharper than ever.

Faculty

- Donna Ghosh MBBS BSc (Hons) FRCOG
- Jessica Preshaw BSc (Hons) MBChB MRCOG
- Lina Antoun MRCOG
- James Tibbott MRCOG
- Jay Ghosh BSc MBBS PhD MRCOG
- Jennifer Tamblyn MBChB BmedSci PhD MRCOG
- Sabrina Butt MRCOG
- Carl Ilyas FRCA
- Robert Jackson FRCA
- Paul Panesar FRCA

Expert speakers

- Lilli Cooper FRCS (Plast) CPCC
- Jacqueline Clarke MBBS MRCOG PGCert
- John Coughlan KC, BCL, LLb (Hons)
- Jonathan Ghosh MA MD FRCS (Vasc)

BSGE at the RCOG World Congress

Lina Antoun and T Justin Clark report for The Scope from the RCOG World Congress at The ExCeL in London

The RCOG World Congress 2025 took place from June 23-25, 2025, at the ExCeL Conference Centre in London and brought together over 3,000 delegates from more than 100 countries. A comprehensive scientific program with over 200 global speakers was structured around seven parallel streams, offering a diverse range of topics and perspectives within the field of obstetrics and gynaecology.

As always, the BSGE session was one of the most highly anticipated segments of the Congress, attracting surgeons, trainees, and multidisciplinary teams with an interest in minimally invasive techniques and advanced pelvic surgery. Our session was "Delivering key pledges for improving endometriosis care" and was so popular that the rooms was packed and delegates were having to be turned away. The session was chaired by our president Mr Arvind Vashisht & Dr Jason Lim from Singapore General Hospital. Lizzie Bean kicked off and talked about standard setting in ultrasound diagnosis of endometriosis. Lina Antoun was next up and described how to navigate different pathways in laparoscopic training. Dr Suruchi Pandey addressed how to implement robotic surgery in benign gynaecology. Our own Donna Ghosh, Honorary Sec, won a fun but stimulating debate against Prof Jan Deprest on "Choosing your surgeon: does sex (gender) matter?" She was against the motion that sex (gender) did. The session was attended by many BSGE members to cheer her on!

The BSGE input was not restricted to the main congress. Professor Justin Clark (past-President) and Lina Antoun organised and chaired the pre-congress workshops. We had six; three in obstetrics and three in gynaecology. We thought (we would!) that the gynaecological workshops were the best ever!! We had an innovative workshop, packed with content on early pregnancy & gynaecology scanning, general gynaecology and endometriosis run by Tom Holland and Lizzie Beans. Hemant Vakharia and Sabrina Butt organised, as efficiently and expertly as ever, a popular laparoscopic simulation course. We were very excited to run for the first time a practical abdomino-pelvic anatomy workshop demonstrating laparoscopic techniques in basic and advanced surgery. This involved lectures and a live cadaveric dissection by the amazing Prof Mabrouk from the Arthrex Centre in Solihull beamed into the impressive Fetal Medical Research Institute through a session that was chaired by Prof Ertan Saridogan and Mr Arvind Vashisht. Thanks to all our BSGE members who gave up their Sunday for free to participate as lecturers, facilitators, operators and chairs. It made us both very proud to be BSGE members to witness this commitment to our speciality - you should know what stars you all are and how grateful we are.

It was not all science and practise. The RCOG social programme offered plenty of opportunities for catching up and 'shooting the breeze' with colleagues. There were formal events - some of us were invited to the President's dinner to recognise BSGE contribution – to great laughs at more informal gatherings.

From a BSGE perspective, our annual ASM remains front and centre. However, it was clear to us that the RCOG is there to represent us all and women's health. The RCOG packs political and strategic influence. The current Secretary of State for Health, the right hon. Wes Streeting, attended the congress. He spoke and was interviewed by the RCOG president Ranee Thakar. Many questions were posed from RCOG members and the assembled large audience about the governments record and plans for women's health care both nationally and globally. We believe that it is of key importance that the BSGE works closely with the RCOG, to push our agenda. This includes advocating for better surgical training and job plans and working conditions as well as investment to reduce surgical waiting lists in women's health and ensuring equitable service provision and patient-centred care. Together, the BSGE and the RCOG form a powerful partnership—combining the College's strategic leadership in women's health with the BSGE's deep expertise in surgical innovation. This collaboration ensures that minimally invasive and advanced gynaecological surgery remains an integral part of high-quality, future-facing healthcare.

GET UP! (Gynecology Expert Training) programme sponsored by Olympus

Amena Shelleh reports on her experience on the Olympus sponsored GET UP programme

Having recently returned from the brilliant ninth 'GET UP' (Gynecology Expert Training) programme sponsored by Olympus, I wanted to inform Scope readers on how they can attend for next year's program should it be of interest. I first heard about this course from a colleague who had attended previously and told me how great it was and even better, that it was sponsored! At the ESGE conference in Marseille 2024, I met the lovely Olympus team and signed up to their mailing list regarding course applications which came out shortly after the conference.

The GET UP programme is an advanced gynaecological endoscopy and hysteroscopy course open to trainee gynaecologists in their 'final year of residency' or in their 'first year post-specialization'. The concept of this course was derived from the need to provide young gynaecologists, who were at the beginning of their surgical career, with training in clinical and technical skills to confidently perform minimally invasive procedures. After receiving a place on the program, there was some pre-learning material in the form of online lectures to watch and beyond this, no additional preparation was necessary. The Get Up program took place this year on 9-12th April at the Olympus Campus in Hamburg, Germany; the venue was a modern and well-equipped facility perfect for such a course. One hundred participants were invited from across the world to take part, with the faculty comprised of thirty-seven experienced gynaecological surgeons from all over Europe who were keen to share their expertise in gynaecological laparoscopy and hysteroscopic skills through keynote lectures, tutorials, and interactive hands-on training sessions.

Olympus funded the four-night stay in the lovely modern Courtyard by Marriott hotel, a short walk to the Olympus Campus. The four-day course consisted of four modules: laparoscopy, hysteroscopy, complications, disorder related endoscopy. Each module was covered within 'Hands-on Training (HOT)' sessions and 'Short Interactive Communication (SIC)' sessions where small group teaching and interactive discussions could take place.

GET UP
Gynecology Expert Training
For Upcoming Professionals

Learning goals of each module:

Module 1: Laparoscopy

- Basic knowledge of laparoscopic surgery, including positioning, entry of the trocars, trocar position, optics (2D, 3D, single port, mini-laparoscopy), haemostasis with electrical and ultrasonic energy, robotics
- Adnexal surgery
- Mild to moderate endometriosis

Module 2: Hysteroscopy

- Basic knowledge on hysteroscopic surgery including analgesia, hysteroscope diameter, navigation and horizon, resectoscopy, fluid management
- Hysteroscopic fibroid surgery
- Asherman's syndrome
- Endometrial polyps
- Office hysteroscopy

Module 3: Complications

- Incidence of complications in hysteroscopy and laparoscopy and prevention
- Ureter and vascular lesion in laparoscopy
- Imaging during endoscopy for safe performance

Module 4: Disorder-Related Endoscopy

- Fibroids and adenomyosis
- Deep infilitrating endometriosis
- The role of endoscopy in gynaecological oncology
- Endoscopic applications in obstetrics (niche repair and cerclage)
- Urogynaecology

Our first day at the Olympus campus was particularly exciting as we met our tutor groups for the next four days as well as our faculty. We had brilliant keynote lectures including: 'Vascular lesions in laparoscopy' presented by Dr Vito Chiantera from Italy, 'New techniques in pelvic floor surgery' presented by Dr Bernd Holthaus from Germany and 'Anatomy in the retroperitoneal space' which was a brilliant revision of retroperitoneal anatomy delivered by our own Professor Mohamed Mabrouk from the UK. The day was rounded off with a social gathering of games and a novelty photo booth onsite.

Day two did not disappoint and keynote lectures included: 'The role of robotics in gynecological surgery' presented by Dr Salvatore Guëli Alletti from Italy and 'Artificial intelligence in gynecological surgery' presented by Professor Sven Becker from Germany. At the end of the day, a fellow attendee acted as our walking guide having become familiar with the city himself, and we were treated to a tour of Hamburg which was lovely.

On day three, keynote lectures included 'Is V-Notes and laparoscopy: complementary or replacing?' presented by Associate Professor Stefanos Chandakas from Greece and 'The role of laparoscopy in ovarian cancer' presented by Associate Professor

Giuseppe Vizzielli from Italy. We were treated to live surgery from the Gemelli Hospital in Rome, the procedure was a total laparoscopic hysterectomy with sentinel lymph node dissection for endometrial cancer and the commentary was brilliant. That evening we enjoyed a lovely social dinner at the stylish Hobenköök restaurant.

On day four, we learnt about 'Myoma surgery during pregnancy' by Dr Pere Barri from Spain and were given an update on neuropelveology by Associate Professor Robert de Leeuw from the Netherlands. At the end of this last day, the competitive laparoscopic suturing skills competition took place. It was taken extremely seriously and was won by our only Bulgarian attendee at the course, well done!

During each day we had discussions within groups and covered different topics as part of the 'SIC' sessions including: 'Laparoscopy in the very obese', 'Vessel injuries, prevention, diagnosis and management (including deep epigastric)', and 'Endoscopic treatment of the non-tubal ectopic pregnancy, treatment options?'.

'HOT' Learning Goals included a laparoscopic model of 'Dissection of peritoneal layer, removal of adhesions' and intracorporeal knot tying, as well as hysteroscopic fibroid resection using animal tissue models.

The Get Up course was a brilliant all-encompassing experience, with valuable learning made richer with the varied plenary lectures, interactive sessions, and hands-on workshops led by a well renowned European faculty chaired by Professor Hans Brölmann from the Netherlands, with hands-on training sessions coordinated by Dr. Cristiano Rossitto from Italy. Fitting tributes were made to the late Professor Giovanni Scambia from Italy who was co-founder of the GET UP course and led a career passionate in teaching the new gynaecologists of today, he will be greatly missed.

BSGE ASM 2026

Fevzi Shakir Chair of the London LOC and BSGE Honorary Treasurer shares the exciting plans for ASM 2026 in London

One World, One Vision: Breaking Surgical Ground in Endoscopy

It's really exciting and a great privilege to invite you to our BSG ASM 2026, which will be held in London. Our conference venue will be at the spectacular QE2 Conference Centre, in the heart of Westminster. The location offers easy access to the capital and stunning views across central London.

Our event will be held over three days from the 29th April to the 1st May, 2026, with pre-Congress workshops on the 28th of April.

Our event will showcase and emphasise London's global influence, its innovation and its connectivity as an international hub for professionals.

BSGE President Arvind Vashisht said:

"I'm delighted and really excited to invite you all to the 2026 British Society for Gynaecological Endoscopy Annual Scientific Meeting here in London. We're going to be running an educational and fun-packed session with plenty of parallel meetings, so there'll be something in it for everyone, from Clinical Nurse Specialists to trainees and consultants alike."

Nicola Fitzharris- Barton, Specialist Nurse for Gynaecology and Endometriosis and member of the London LOC said:

"We look forward to welcoming you all to the London ASM in 2026. There will be an exciting Pre-Congress program for all nurses and resident doctors, as well as on the main ASM event itself."

For our London ASM 2026 event, we'll have exclusive use of the QE2 Conference Centre for the entire duration. Our ASM networking events will enjoy spectacular views along the River Thames and iconic London landmarks. We entice and encourage all of our members to participate, as well as have an international audience for what is shaping up to be an engaging scientific programme and networking events, which you would not want to miss.

London 2026 will include:

- An iconic Westminster venue that can accommodate more than 1000 delegates
- Multiple networking events
- Interactive zone
- Four parallel streams
- Engaging scientific programme
- Dedicated sessions for nurses, residents and other allied healthcare professionals

This all fits in with our theme of:

One world, one vision: Breaking Surgical Ground in Endoscopy.

Arvind Vashisht added:

"Each ASM is getting busier and busier and more and more popular- so, I really hope that you take up the opportunity to join us in London. You won't be disappointed- and I really look forward to seeing all of you there."

So everyone, save the date, 29th of April to the 1st of May, 2026, with Pre-Congress workshops on the 28th of April. Book in for your study-leave early for #BSGEASM26, submit your abstracts for presentation and sign up to the networking events. It's truly going to be spectacular.

Driving Change in Menstrual Health: The Scope meets… Emma Cox, CEO of Endometriosis UK

Emma Cox, Chief Executive of Endometriosis UK, reflects on what she describes as a "pivotal moment" for menstrual and women's health. Talking to The Scope at ASM 2025 in Leeds, Emma outlined both the opportunities and challenges facing the endometriosis community as broader awareness of women's health issues gains traction in public discourse and policymaking.

"There's real momentum around menopause, which is fantastic," Cox said. "But we're keen to make sure menstrual health isn't left behind. For example, there's legislation going through Parliament—the Employment Relations (Flexible Working) Bill—and we've been advocating for companies to implement not just menopause policies, but *menstrual health* policies too." Endometriosis UK has worked with MPs to explore the possibility of an amendment to the bill, aiming to broaden its scope. "There's a real danger that if we don't keep pushing, endometriosis will be seen as 'done' just because it's mentioned in the Women's Health Strategy," she warned.

Cox highlighted the disparities in diagnosis and care for menstrual health conditions, especially among ethnic minority communities. "We've heard anecdotally, and we believe it's backed by the wider data from the RCOG on gynaecological outcomes, that there are serious inequalities in care," she said.

To address this, the charity is collaborating with Cysters, a grassroots Birmingham-based organisation that supports people from the South Asian and broader communities with gynaecological issues.

Decision-makers in healthcare and government rely on data and statistics to inform policy and resource allocation. However, the data may not accurately reflect the experiences of marginalised communities. A recent report from Endometriosis UK that gathered data on the experiences of being diagnosed with endometriosis in the UK was not illustrative of the ethnic diversity of the UK, with 15% of respondents choosing not to respond to the ethnicity question. Emma said: "We know that the current statistics are not inclusive of all communities, particularly marginalised groups. We're rerunning our diagnosis survey with them to ensure it speaks more effectively to different audiences, but it's been a challenge getting the response numbers we need."

Beyond endometriosis, Cox sees the value in expanding support across the broader spectrum of menstrual health conditions—including fibroids, PCOS, adenomyosis, and PMDD. “We’re doing a Department of Health and Social Care-funded project aimed at supporting mental health in SMEs, where there’s often no HR support,” she explained. “The learnings from endometriosis can benefit everyone living with chronic menstrual conditions.”

Cox also reflected on the importance of cultural attitudes and education in shaping how menstrual health is perceived across different populations. “We hosted leaders from Hungary, the Czech Republic, Iceland and the Netherlands and learned that in some countries, post-operative care includes spa and wellness support as standard. In contrast, here in the UK, we often struggle to get even one physio session after surgery.” She added, “It really showed us that no one country has it all figured out, there are lessons to learn from everyone.”

On the role of social media and mainstream media, Emma was optimistic: “Platforms like Instagram and TikTok give people space to tell their stories and validate their experiences. It’s different now- young people are learning about conditions like endometriosis much earlier, rather than waiting until university or adulthood when someone finally says, ‘Your period shouldn’t be like this.’”

Finally, she noted the long-term generational shift in how women experience menstruation. “If you go back to our grandmothers’ generation, they started periods later, had more pregnancies, breastfed longer and entered menopause earlier. Women today start menstruating younger, have fewer children and have them later in life. So they are experiencing many more menstrual cycles, often without any medical support to suppress or manage them. That may well contribute to rising rates or greater recognition of conditions like endometriosis.”

As Cox sees it, the path forward must be intersectional, holistic and persistent: “We’re proud to champion endometriosis, but the bigger mission is to elevate all menstrual health conditions and make sure they’re supported at every level, from education to workplace to healthcare.”

You can encourage your patients to complete the survey ‘ Delayed Diagnosis of Endometriosis Among People of Colour in the UK’ at: https://www.surveymonkey.com/r/WV5MX9J

New Accreditation Criteria for BSGE Endometriosis Centres (Effective 2026)

Finalised May 2025 | Review Date: May 2028

Angus Thomson
Chair Endometriosis Centres Sub-Committee
Consultant Gynaecologist - Worcestershire Acute Hospitals NHS Trust

Karim Abdallah
Committee Member
Consultant Gynaecologist – Sheffield

(On behalf of the BSGE Endometriosis Centres Sub-Committee)

The BSGE was founded in 1989. The concept of BSGE Endometriosis Centres was formulated following the 2003 World Congress on Endometriosis in San Diego. The current database platform was completed in 2007 and Centre accreditation began in 2008.

Since then there have been minor amendments to the database and accreditation process, including the introduction of 'Provisional Centres' in 2011. This is the first major overhaul of Centre Accreditation which will be live from January 2026.

Until that date the current accreditation process remains in place. This is a dynamic process and it is expected that further amendments will be introduced in coming years – so a review date in three years' time (May 2028) has been agreed.

Severe endometriosis should be treated by specialists with appropriate expertise working in multi-disciplinary teams within specialist centres. From 2026, the BSGE will accredit centres where gynaecologists operate as part of appropriate clinical teams, maintain audit of their outcomes, and have sufficient workload to retain their surgical skills.

2026 Accreditation Criteria for BSGE Endometriosis Centres includes 10 requirements that must all be achieved, adhered to and signed off by the centre lead each year to maintain accreditation. These are:

1. Appropriately trained gynaecologist(s) with named lead
2. Endometriosis Clinical Nurse Specialist
3. Named Colorectal Surgeon(s)
4. Other named clinicians
5. MDT (scheduled monthly / 8 per year minimum)
6. Endometriosis Clinic
7. Workload – 12 cases per gynaecologist minimum (based on ~Enzian)

8. Data Entry:
   - 100% consent, baseline questionnaires and surgical data
   - Enzian staging
   - 70% 6 months / 60% 12 months follow up data
9. Service sustainability commitment / planning
10. Quality control and audit:
    - Exemplar video only for provisional centres (each surgeon)
    - Before and after photos > 50% cases
    - Audit analysis of case mix, complications and outcomes

1. Consultant Gynaecologist(s)

To be accredited, centres must have consultant gynaecologists with specialist training and expertise in managing severe endometriosis.

- A lead consultant gynaecologist should coordinate the service, ideally supported by a team of gynaecologists, all of whom are BSGE members.
- Surgeons must have advanced minimally invasive surgery training demonstrated by one of the following:
  - RCOG-accredited ATSM or SITM in laparoscopy
  - A postgraduate degree (e.g. MSc in Advanced Gynaecological Endoscopy)
  - A two-year fellowship in advanced laparoscopic surgery. Ideally under the supervision of an experienced advanced laparoscopic surgeon working within an accredited endometriosis centre.
  - An experienced gynaecologist who is already working in an endometriosis centre with a proven track record in Endometriosis.
  - Equivalent specialist training under a senior surgeon in a specialist centre

Each gynaecologist must engage in CPD within endometriosis and laparoscopic surgery, attending a relevant course or conference at least every two years.

2. Endometriosis Clinical Nurse Specialist (CNS)

Having a dedicated CNS is mandatory and enhances patient care.

- CNSs should be at AFC Band 7 or Band 6 (with a development plan to reach Band 7).
- A minimum of 15 protected hours per week must be allocated solely to the endometriosis role.
- Larger centres (handling >24 cases/year) should aim for 1 WTE CNS.

Each CNS must also attend the BSGE Nurses' Day, Annual Scientific Meeting, or equivalent in-person CPD at least biannually.

Centres should offer a dedicated CNS clinic, either nurse-led or joint with consultants.

3. Supporting Colorectal Surgeon

Each centre must have at least one named colorectal surgeon who:

- Participates in preoperative assessments and MDT meetings
- Co-operates with gynaecologists during surgery where bowel involvement is present

The number of surgeons should reflect the centre's caseload. Participation must be logged in the surgical database.

4. Other Supporting Clinicians

Centres must have named individuals in each of the following specialities:

- Urologist
- Radiologist
- Fertility Specialist
- Pain Specialist
- Ultrasound Lead (may be a gynaecologist, radiologist, radiographer or CNS)

Additional support (e.g. from plastic, cardiothoracic, or upper GI surgeons) may be included as required.

Clinicians must have appropriate time allocated in their job plans.

5. Multidisciplinary Team (MDT) Meetings

MDTs are a key component of accreditation.

- Meetings must occur at least six times a year, ideally monthly.
- Core MDT members must include:
  - All accredited gynaecologists
  - Endometriosis CNS
  - Colorectal surgeon
  - Radiologist

Cases with suspected deep disease (bowel, bladder, ureter) or complex scenarios must be discussed. MDT outcomes should be recorded and shared with patients and GPs. Documentation of MDT discussion (or lack thereof) is mandatory in the surgical database.

6. Dedicated Endometriosis Outpatient Clinic

Centres must host a specialist endometriosis clinic, ideally labelled explicitly to facilitate referrals.

- Clinics should occur at least monthly (more frequently in busy centres).
- May be gynaecology-led or multidisciplinary.
- Should have CNS involvement.
- Designed to improve visibility and patient access to specialist services.

7. Surgical Workload

To ensure maintenance of complex surgical skills:

- Each gynaecologist must complete a minimum of 12 index cases per year, involving surgery for deep endometriosis (as per #Enzian classification must include at least one of A1–A3 and/or B3 and/or C1–C3 and/or FB, FU, FI).
- Centres must meet combined totals (e.g. 2 surgeons = 24 cases/year etc).
- Cases must be logged on the BSGE database.
- Surgery may be laparoscopic, robotic, or open (route to be recorded).

8. Data Collection

Each centre must agree to:

- Record all surgical excisions of deep endometriosis (as defined in section 7) in the BSGE database.
- Obtain patient consent and baseline symptom/quality of life questionnaires.
- Achieve follow-up data entry rates of:
  - 70% at 6 months
  - 60% at 12 months

24-month follow-up is encouraged but not mandatory.

9. Service Sustainability and Resilience

To safeguard long-term service delivery:

- Each centre must aim to have more than one named gynaecologist.
- Evidence of a sustainability plan (covering leave, retirement, etc.) must be provided at each annual re-accreditation.
- Lack of a sustainability plan may result in loss of accreditation.

10. Compliance with BSGE Quality Assessment

Provisional centres must submit video assessments before 31st December of their provisional year. Videos must:

- Be anonymised and under 3 minutes
- Show panoramic views before and after surgery
- Demonstrate pararectal dissection and complete excision of rectovaginal disease
- Exclude hysterectomy cases for assessment

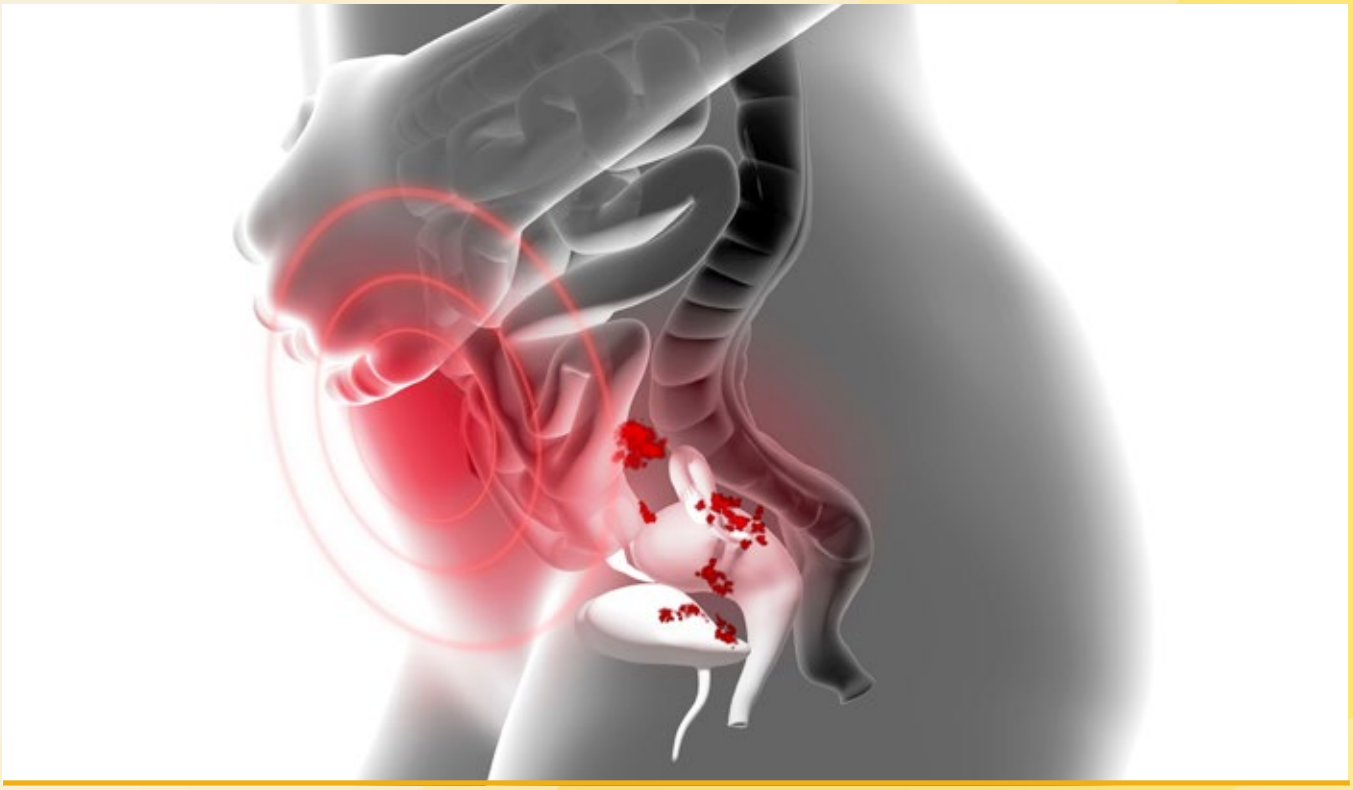
Additionally, centres must provide:

- Still images ("before" and "after") for at least 50% of cases (randomly reviewed at re-accreditation)
- Outcome and complication data, also reviewed by the Scientific Advisory Group

From 2025, annual video submission is no longer required unless prompted by specific concerns.

The BSGE Endometriosis Centres Sub-Committee have worked hard to procure a new database platform, agreed by the BSGE Officers and Council (huge thanks to Jon Hughes who has put in an immense amount of work and personal expertise on this). The platform is now being built to enable release to the Endometriosis Centres as soon as possible, so that everyone is as familiar as possible by January 2026.

Please use the end of 2025 to familiarise yourselves with the #Enzian classification system so that you are ready for the new platform data entry. Also please discuss the new Accreditation Criteria within your teams as each centre will be asked to be achieving the required standards for personnel, MDTs and Clinics for 2026.



Dipankar (Ron) Chowdhury
Locum Consultant, O&G, London North West University Healthcare NHS Trust

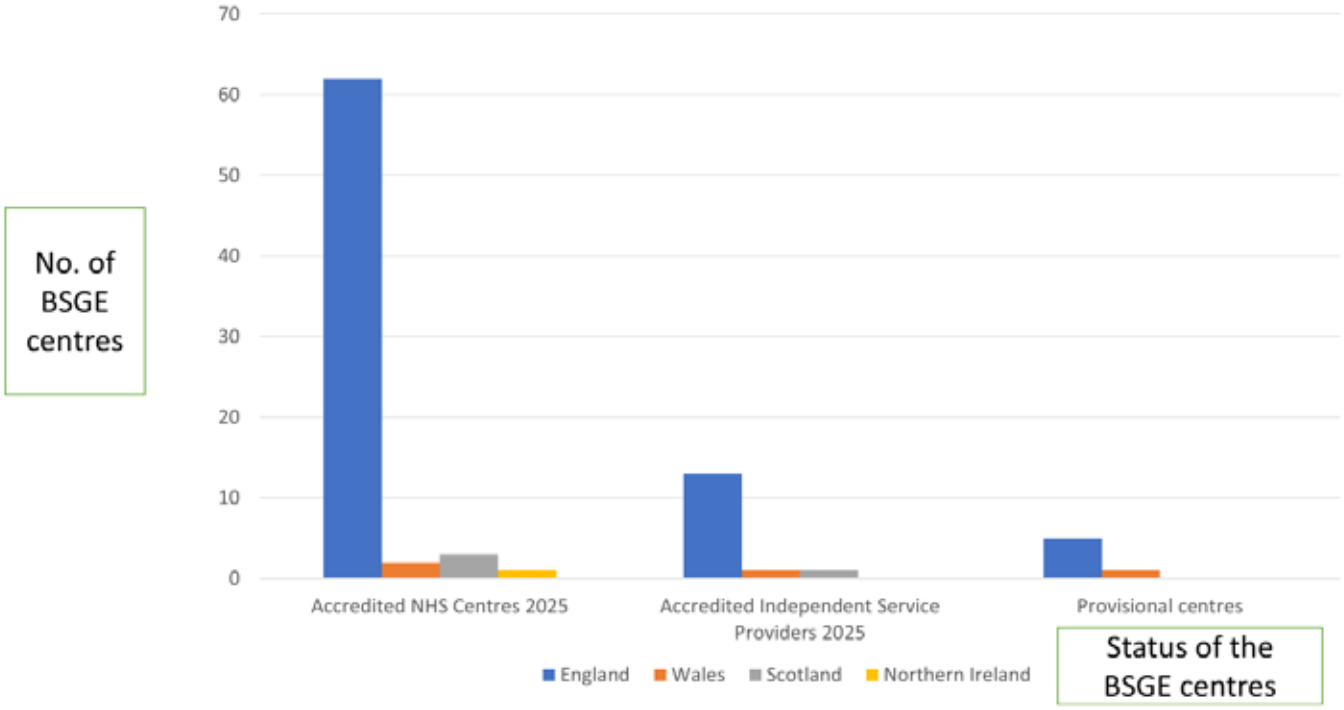
Neelam Potdar
Consultant Gynaecologist and Hon Associate Professor, University Hospitals of Leicester NHS Trust

Unpacking the Numbers: Performance of BSGE Endometriosis Centres 2024-2025

Dipankar (Ron) Chowdhury, and Neelam Potdar report for The Scope on behalf of the Endometriosis Centres Sub-Committee

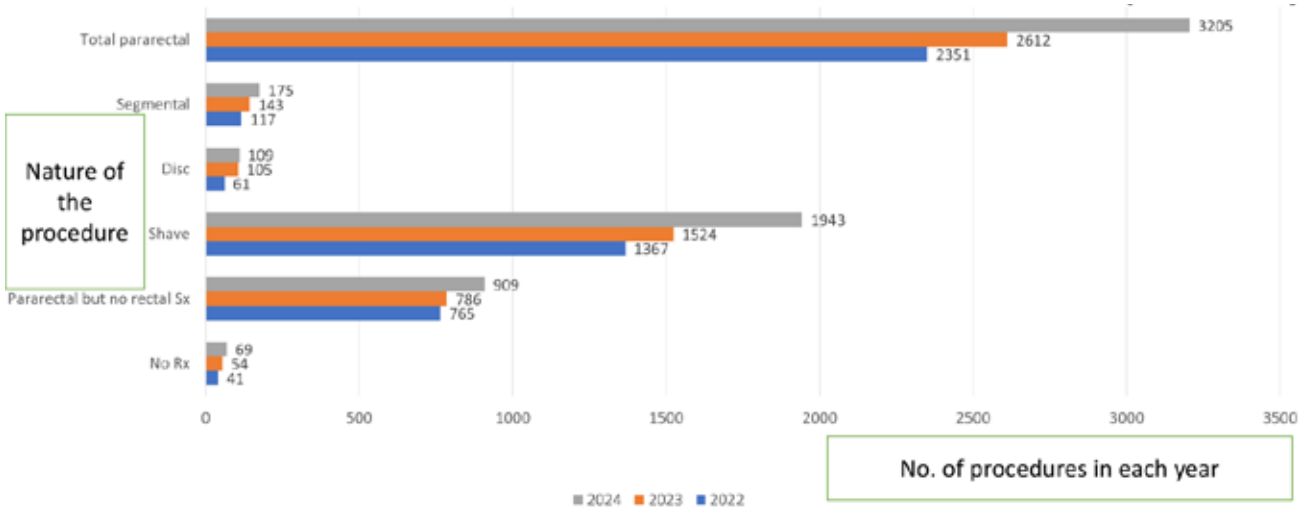
The British Society of Gynaecological Endoscopy (BSGE) Endometriosis Centre accreditation programme began in 2008. In 18 years, we have come a long way. In 2025, there are 89 centres accredited nationwide (6 provisional and 83 full). This article provides a data-driven summary of the accomplishments of BSGE centres in the year 2024-'25, set against the context of remaining objectives.

Fig 1- BSGE Centres 2025



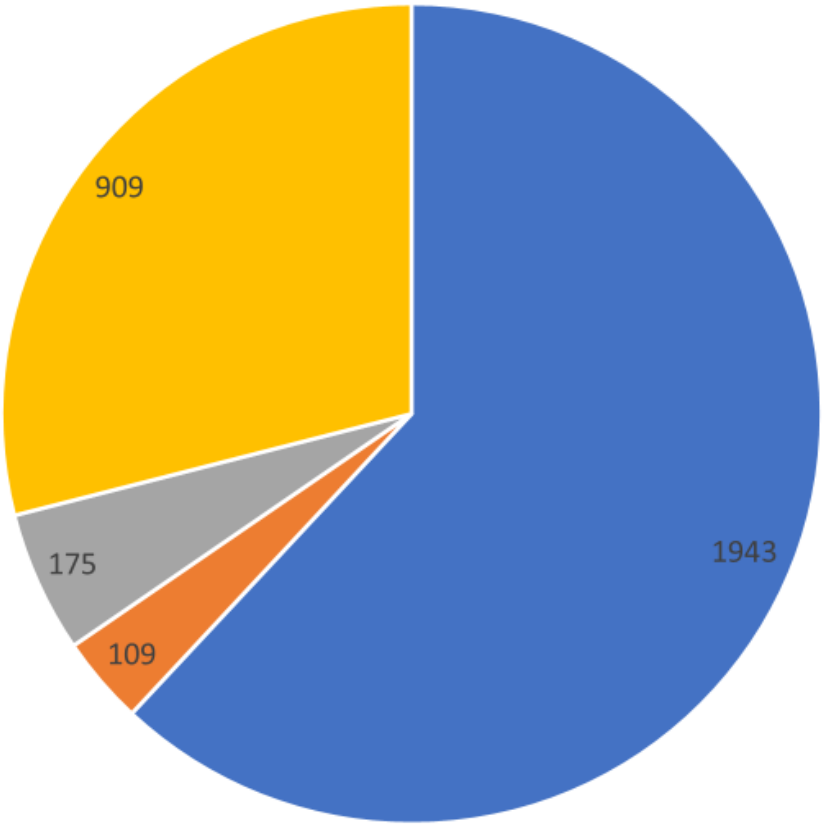
In 2024, alongside seeing an increase in the number of endometriosis centres (see Fig. 1), we also noted an increase in the number of cases of pararectal dissection (PRD) (see Fig. 2). While 2024 saw increases across all colorectal endometriosis excisions—including disc excision (up 3%) and segmental resection (up 22%)—there was a notable rise in the 'shaving' procedures (27%) (see Fig. 2).

Fig 2 - Trends in pararectal dissections and colourectal procedures (2022-24)



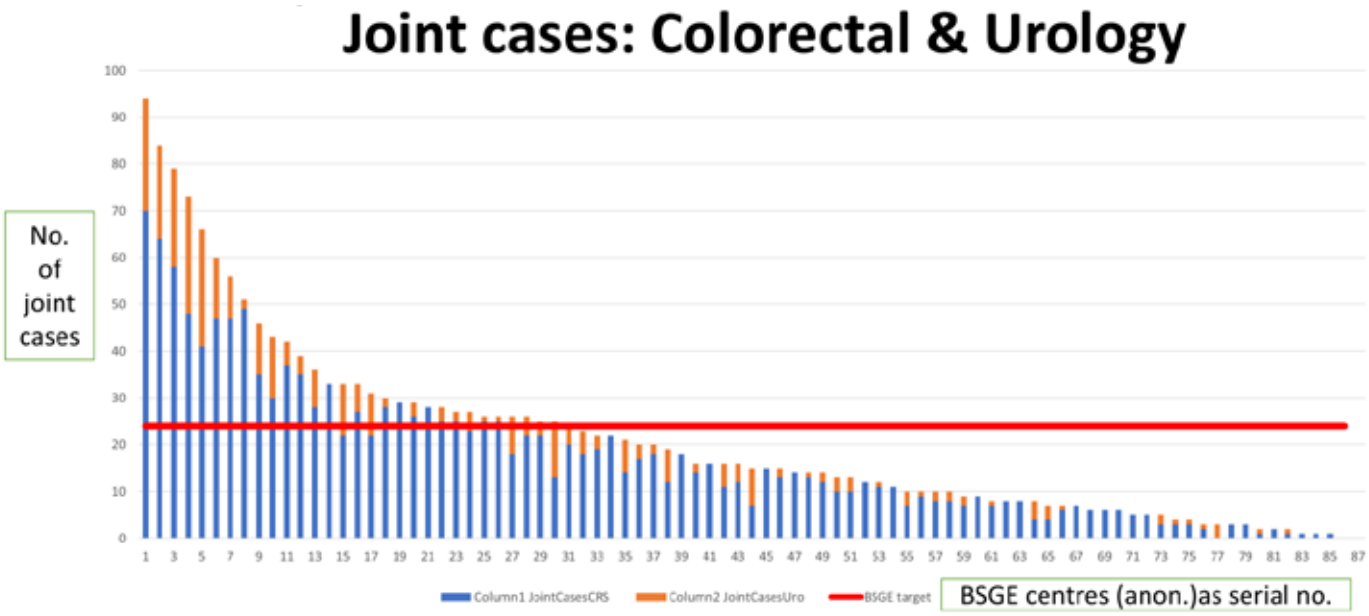
It is important to emphasise that the BSGE criteria for database entry include 'cases of rectovaginal endometriosis', necessitating dissection of the pararectal space. Consistent with previous years' trends, 28% of PRDs were entered into the database even when no colorectal excision (e.g., shaving, disc excision, or segmental resection) was required (see Fig. 3).

Fig 3- Pararectal dissection in 2024



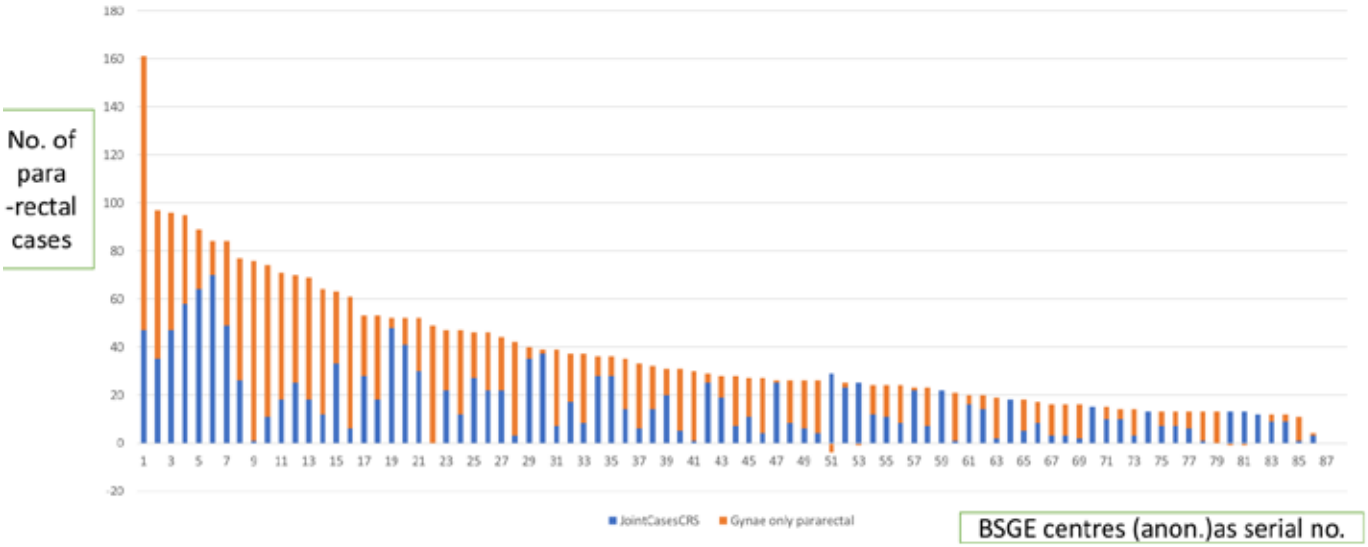
The value of multidisciplinary surgery in endometriosis is well accepted. There are ongoing discussions to move towards an 'Endometriosis Network' framework where there may be two levels of centres – those doing complex joint procedures with other specialties (with a minimum of 24 joint cases gynaecology with colorectal/ urology/ any other specialities) and also other centres doing cases not requiring joint operating (up to and including straight forward rectal shave procedures). Impressively, current data indicate that at least one-third of all BSGE centres (31 out of 89) are already meeting this benchmark of 24 joint cases (see Fig. 4).

Fig 4 - Joint cases: Colorectal & Urology



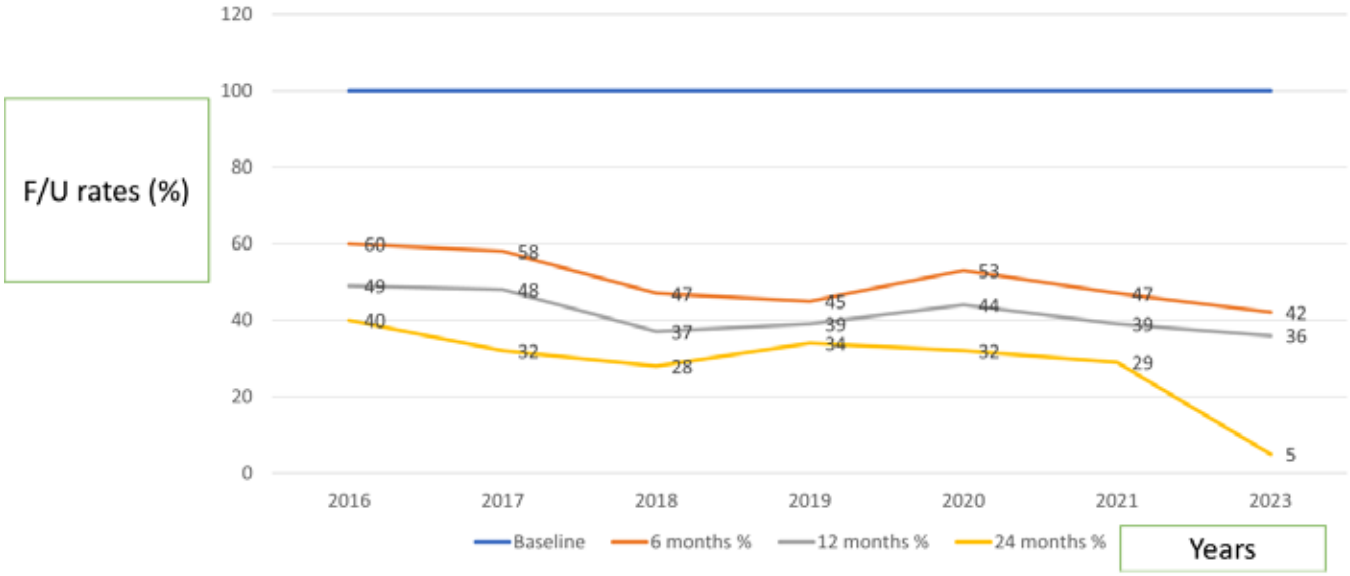
It is worth noting that a significant proportion of BSGE centres have the Gynaecologists performing the PRDs (60% or more of total PRD cases) (see Fig. 5). Conversely, in 4 centres (4.4% of centres), colorectal assistance was required even when the pararectal space was not dissected. This could be due to other complex surgical needs.

Fig 5- Pararectal dissections: joint colorectal & Gynae only



The usefulness of the BSGE database in supporting high-quality research depends on the robustness of the follow-up data. Beginning in 2026, our target follow-up rates for BSGE database cases are 70% at 6 months and 60% at 12 months. The 2023 data indicates that our progress was significantly behind, with the achievement of follow-up data of only 42% at six months and 36% at 12 months. This is a decline from the previous years (see Fig. 6). To improve the follow-up rates, from 2026, BSGE aims to implement a digitally integrated database that sends patient notifications at 6 and 12 months to complete follow-up questionnaires. Additionally, a dedicated Endometriosis Clinical Nurse Specialist (CNS) with at least 15 protected hours per week for this role will help ensure patients are regularly contacted, thereby improving follow-up rates.

Fig 6 - Trends in follow up rates



The BSGE endometriosis centres project was developed by a band of spirited gynaecologists to improve the quality of care for women with severe endometriosis. This project has led to more streamlined treatment of women with endometriosis, the evolution of well-coordinated multidisciplinary care and the creation of a unique world-class treatment outcome database. Clinicians are as integral to this project as the patients who interacted with the healthcare system, transforming their lived experiences into objective scientific data. As this database advances, incorporating more objective operational criteria, its ultimate goal remains improving the quality of life for women with endometriosis. It's the beginning of a new chapter, and we need all hands on deck!

- Before and after photos > 50% cases
- Audit analysis of case mix, complications and outcomes

Next Generation Therapies in Endometriosis: AI Driven Imaging and AR Guided Surgery

Sophie Walter, ST7 trainee in Obstetrics and Gynaecology, Advanced laparoscopy and endometriosis and Islam Gamaleldin, Consultant Gynaecologist & Endometriosis Surgeon report for The Scope

Introduction: The Urgency of Innovation

Endometriosis remains a challenging and often life-altering condition for millions of women. Diagnostic delays averaging 7–8 years are still common, and even when diagnosis is achieved, surgical treatment varies widely in complexity, access, and outcomes. As we enter a new era of digital medicine, artificial intelligence (AI) and advanced visualisation tools—like augmented reality (AR) and robotics—are beginning to transform how we diagnose and treat this disease. This article explores how these technologies are now entering clinical reality, offering practical benefits for patients and surgeons alike.

1.Artificial Intelligence in Imaging: Current Limitations in Imaging

Traditionally, endometriosis was diagnosed through laparoscopy and histological confirmation. However, recent guidance recommends imaging- primarily transvaginal ultrasound (TVUS)- as first line (ESHRE 2022.) In expert hands, transvaginal ultrasound can reliably detect both deep and ovarian endometriosis (Guerreiro et al, 2015; Guerreiro et al, 2016; Niseblat et al 2016.) Superficial peritoneal endometriosis (SPE) detection is more challenging, although developing techniques infusing saline into the Pouch of Douglas (POD) show promising results (Leonardi et al., 2019; Chen et al, 2025). MRI detects deep endometriosis (DE) with a similar accuracy to TVUS (Pereira et al, 2020; Guerreiro et al, 2018) but has similar difficulties in detecting SPE.

Despite these advances in imaging, the subjective nature of scan interpretation introduces variability and potential diagnostic delays. In cases of negative imaging or treatment, non-responsive women may still undergo laparoscopic surgery simply for diagnostic purposes.

AI-Enhanced Imaging: A New Frontier

AI models are now being developed in TVUS to improve the diagnosis, localisation and classification of endometriotic lesions (Figure 1).

Figure 1: How does AI work in ultrasound?

Task	AI Role
Lesion detection	Identifies hypoechoic nodules, adhesions, or anatomical distortions suggestive of DE.
Segmentation	Outlines the borders of lesions or affected organs (e.g., rectovaginal septum, bladder, ovaries).
Classification	Differentiates between DE, SPE, and other pathologies (e.g., cysts, fibroids).
Staging	AI may assist in mapping disease extent (e.g., using the #Enzian classification).
Triage or decision support	Flags images needing senior review or suggests when additional imaging (e.g., MRI) is warranted

Models are trained on large datasets of anonymised, labelled ultrasound images and video clips. Deep learning models, commonly, convolutional neural networks (CNNs) are used for image recognition and segmentation. Image recognition refers to, for example, the ability to differentiate between endometrioma and haemorrhagic cysts using doppler and grayscale features. Image segmentation then allows the suspected endometriotic lesion to be highlighted against other structures to allow the operator to map the extent of disease. Optimised models can then run in real time on ultrasound machines to provide instant feedback.

AI in ultrasound has been demonstrated to reliably predict endometriosis (AUC of 90% and accuracy of 80%) (Balica et al, 2023) and differentiate lesions from complex surrounding tissues, including post-operative scarring, fibrosis, tubo-ovarian abscess and malignancy (Wei et al, 2025.) In cases of POD obliteration, which may present higher surgical complexity, deep learning models demonstrated high diagnostic accuracy (AUC 96.5%, accuracy 88.8%) (Maicas et al, 2021.) In MRI, similar models improved the detection rates of POD endometriosis from an AUC of 65.0% to an AUC of 90.6% (Zhang et al) and outperformed experienced radiologists (Indirelle-Kelly et al, 2020.) 3D reconstructions of pre-operative MRIs closely correlate with intra-operative findings in rectosigmoid endometriosis therefore facilitating improved surgical planning (Borghese et al., 2022).

From a practical perspective, TVUS for diagnosing all forms of endometriosis can be time-consuming, invasive and limited to individuals or centres with specific expertise. In obstetrics, using AI during routine mid-trimester ultrasound scans reduced scan times by 7 ½ minutes per scan (iFIND) and, in endometriosis, AI-enhanced ultrasound improved all lesion detection from 70% to 94% in non-specialist sonographers (Xu et al, 2025.) Both DEFEND and IMAGENDO® are ongoing studies applying AI algorithms to non-invasive diagnostic techniques (TVUS, MRI and or biomarkers) to create a non-invasive diagnostic pathway and to predict findings at laparoscopy (Sarris I et al, 2022; Avery et al, 2024). These models have the potential to reduce diagnostic delay, prioritise referrals to BSGE-accredited Endometriosis Centres, reduce surgical burden and facilitate the earlier implementation of treatments, including pain management and fertility preservation.

2. AI in Endometriosis Research

Women's health research is disproportionately underfunded; endometriosis being no exception. Aetiology, symptomatology, comorbidities, and progression of disease are poorly defined despite its effect on 1 in 10 women. The heterogeneity of symptoms in patients with endometriosis has further complicated efforts to fully understand and address this condition. New, powerful methods of analysis have the potential to uncover previously unidentified patterns in data and facilitate the analysis of large quantities of data relating to endometriosis.

The use of AI has allowed researchers to create models for diagnostic imaging as discussed above. Moreover, an evolving area of research is the use of AI in predicting surgical success and patient outcomes following endometriosis surgery. AI has been a hopeful avenue for identifying reliable predictors for studies working on clinical prediction models for surgical success based on pain reduction and overall quality of life or health status (e.g. Creating a Clinical Prediction Model to predict Surgical Success in Endometriosis (CRESCENDO) study). Machine learning was employed to identify pelvic pain comorbidities associated with underlying central sensitisation (PHQ-9 depression scores, abdominal wall pain, and pelvic floor myalgia) as important predictors of pain-related quality of life after endometriosis surgery. The analysis considered a variety of endometriosis-related factors, including revised American Society for Reproductive Medicine (rASRM) stage and residual endometriosis after surgery. Multivariate logistic regression was used in the work by Vesale et al to predict the occurrence of voiding dysfunction after surgical removal of deep endometriosis lesions. Both clinical characteristics and imaging were used to generate risk predictions in the model. Studies using AI have provided a richer understanding of predictors of successful treatments and are part of a continual effort to change that standard and give patients autonomy in choosing their treatment path.

Additionally, biomarker discovery is one of the research priorities in endometriosis that is progressing with the help of AI. AI has been used for analysis of large datasets, genetic analyses for biomarkers present in endometrial tissue, serum, and saliva (such as: CXCL 12, PDGFRL, AGTR1, PTGER3, and S1PR1) using salivary microRNA are now emerging as possible avenues for improving diagnosis of endometriosis.

3. Augmented Visualisation and Robotic Precision in Surgery

Complex endometriosis surgery—especially when involving bowel, ureter, or pelvic nerves—demands exceptional precision. While laparoscopy remains the gold standard, traditional two-dimensional imaging has limitations in depth perception and tissue differentiation.

Robotic Platforms: Expanding Capabilities

In the UK, many BSGE-accredited Centres now routinely perform robotic surgery for cases of DE. Robotic systems like Da Vinci and Versius offer magnified 3D vision, articulating instruments, improved dexterity and range of motion. These benefits allow surgeons to comfortably perform meticulous dissection and suturing in complex cases. Preliminary data suggest robotic surgery improves nerve preservation, reduces length of hospital admission and intra-operative blood loss when compared to laparoscopic surgery in those undergoing excision of DE with or without modified radical hysterectomy, with no increase in peri- or post-operative complications (Pavone et al, 2024; Kanno et al, 2024; Prodromidou et al, 2020). Robotic platforms have the capability to apply real-time near-infrared imaging with indocyanine green contrast to improve the visualisation of structures including ureters during complex dissection, enhance detection of endometriotic lesions and assess anastomotic perfusion. Improved ergonomics means that robotic surgery is associated with the lowest rates of work-related

musculoskeletal disorders of all surgical routes (Catanzarite et al, 2018) increasing surgical career longevity and enjoyment.

Augmented Reality (AR): Real-Time Surgical Navigation

AR-enhanced laparoscopy is emerging as a cutting-edge adjunct. Endometriotic lesions may be small, deeply infiltrating or difficult to distinguish from fibrosis. AR can improve visualisation of these lesions through fusing MRI/TVUS images with real-time laparoscopic videos, highlighting lesion locations with AR-guided annotations, enhancing depth perception for DE and assisting in dissection by mapping pelvic neural, vascular or ureteric pathways.

They work through obtaining high-resolution, pre-operative images, which are segmented to identify the endometriosis. A 3D model is then generated, marking the endometriotic lesion and surrounding structures. During laparoscopy, this image is overlaid and visualised by the surgeon using specialised headsets or scopes.

A Japanese study investigated an AI navigation model in colorectal surgery, demonstrating improved recognition of pelvic nerves in all cases, which facilitated safe surgical dissection with no adverse outcomes, even for more junior surgeons (Ryu et al, 2023.) In gynae-oncological surgery, AR-based robotic assistance systems, which performed real-time, multimodal and temporal fusion of laparoscopic images with pre-operative images (CT/SPECT) improved sentinel lymph node detection significantly when compared to direct vision, as well as reliably detecting ureters and pelvic vessels (Lecointre et al., 2022). AR-enhanced laparoscopy, therefore, has the capability to improve the safety of complex surgery as well as enhance training through improved recognition of pelvic structures.

4. Challenges to Adoption Infrastructure and Training Gaps

AI and AR tools require significant investment in hardware, software, and digital integration. Moreover, surgical teams need structured training—not just in operating systems but also in interpreting AI-assisted outputs responsibly.

Ethical and Patient Perspectives

As with any AI application in healthcare, ethical considerations around data privacy, bias and equitable access need to be carefully addressed. Moreover, patients remain central to this conversation. While technology offers speed and precision, it must be applied transparently. Patients should provide informed consent for AI-assisted diagnostic techniques and robotic or AR-enhanced interventions. They must understand how their data is used by AI algorithms and robust data privacy systems in place to store data. Both patients and clinicians alike must be aware that AI remains a support tool and should not override human judgment. AI remains subject to potential error through misguiding treatment without nuanced context. Clear quality assurance processes and guidance surrounding accountability must be developed by organisations utilising AI technology.

A Role for BSGE Centres

With its accredited network and commitment to clinical excellence, the BSGE is in the exciting position to be able to co-ordinate early adopter sites for AI/AR technologies, launch multicentre outcome registries and develop consensus protocols on patient selection, safety and training. Through leading on the development and implementation of AI/AR technologies into gynaecological surgery and endometriosis care, the BSGE has the potential to significantly improve patient experience and outcomes across the UK.

Conclusion

The future of endometriosis care is not machine-led—it is machine-supported. AI and AR will not replace the skill, experience, and intuition of gynaecological surgeons, but they will increasingly enhance what we can see, measure, and achieve. By combining digital tools with compassionate, expert care, we can move closer to our goal: earlier diagnosis, safer surgery, and better quality of life for every patient.

BSGE News

BSGE Approval for Patient Hysteroscopy Information Video

Liza Ball and Una Hutton report for The Scope on their patient information video: "Awake Hysteroscopy - Is This the Right Choice for Me?"

When we discuss procedures with our patients, we typically emphasise risks and benefits. However, the crucial question—"How will I feel during and after the procedure?"—cannot be authentically answered by clinicians who lack first-hand, lived experience. Women who have undergone hysteroscopies are uniquely positioned to share genuine insights. To address this, we co-produced a unique patient information video on outpatient hysteroscopy, featuring women's authentic, lived experiences.

BSGE Hysteroscopy Portfolio Chair Nadine di Donato said: *"The awake hysteroscopy film has been approved by the BSGE hysteroscopy subcommittee and it is available on the BSGE website for members to download"*

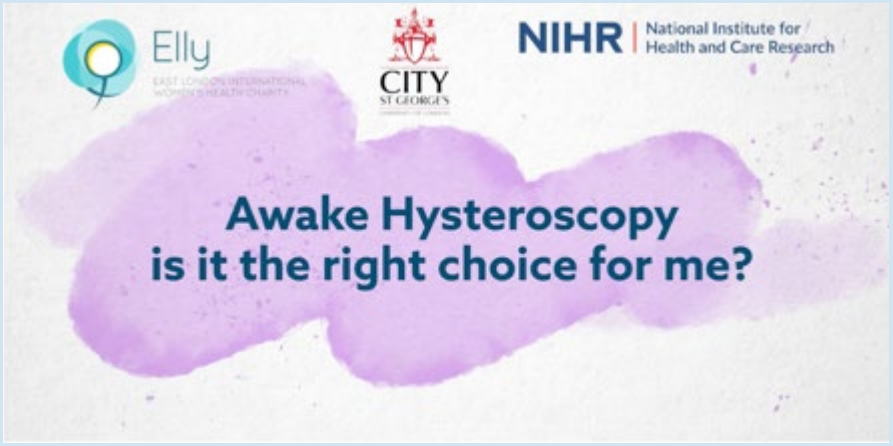
We encourage you to view and disseminate this resource within your practice and among your patients. The project brought together a diverse team of women, researchers, filmmakers, lawyers and gynaecologists. Based on official patient information from the RCOG, the film was developed through a series of workshops where women contributed to both content and presentation. It has now been translated into Hindi, Gujarati, and Bengali to reach a wider community.

Participants found the process enriching—learning the importance of honesty about pain, the need for open communication, and patients' desire for choice between awake and general anaesthesia. Women emphasised the importance of being able to halt the procedure if they wished, which has led us to advocate for the right to withdraw consent at any point, rather than enduring a procedure that does not 'feel right'.

Funded by the Elly Charity, NIHR and City St George's University, this initiative has reinforced our belief that all future patient information should be co-produced, incorporating personal testimonies but also inviting editorial decisions.

We are now preparing to publish a step-by-step guide for co-producing patient information materials.

Given women's reports of painful hysteroscopies we heard when making the film, we are now collating a training module, covering pain ethics and vaginoscopic technique—stay tuned!



>> Cink here to the film

The Legend Slot... Professor T Justin Clark

"Train the best and allow them to excel"

I caught up with local legend and BSGE stalwart Professor Justin Clark in a dingy pub in London before a Gynaecology Visiting Society dinner at the luxurious RAC Club on Pall Mall.

Hi Justin, thanks so much for taking the time to speak to the Scope today. With this edition documenting the recent successful ASM in Leeds we thought it fitting to celebrate a home-grown legend.

So, we will start at the beginning... Where did you grow up?

Funny enough the hospital I work in now, Birmingham Women's Hospital, used to be the Birmingham Maternity Hospital, but I was born there in 1969! My dad was a houseman at the time but went to Birmingham Medical School. He was the only one in the family who was medical. He had my sister as a medical student. My mum was a teacher.

I was in Birmingham for the first 6 months of my life, then we went up North to Scarborough and I was brought up in Rotherham in South Yorkshire. I was there from the age of 3. It was great as I went to a normal comprehensive school and there was a proper range- there were enough bright kids, not loads, but enough that there would always be people doing A-levels and always a kid who went to Oxford. I honestly think it made me a better doctor. I'm not patronising or important with the patients. Being brought up with a range of different people I feel like I know everyone. I was really happy there. It was a real Rufty tufty comp but I really enjoyed it.

Did you always want to do O&G?

I think the funny thing is it was the last thing I did at med school and it's what I did best in. I got my best marks in O&G. And I know this is going to sound cheesy, but I really liked the physiological maternal adaptions in pregnancy. I found it so interesting. I also liked the range within the speciality.

So, the honest answer is, I did my house jobs, did an A&E job, and when I did A&E I was really good at all the procedural things like suturing, putting the dislocations back. I really enjoyed it. I thought I should do something surgical, and I applied for O&G and general surgery. I got a job in Leicester for O&G, then in that time I did the part 1 MRCOG, which was like going back to med school as it was such a lot of work. Then when I got back to Birmingham, I did a general surgery and urology job for 6 months. In those days you had to do a year of something else. You did 3 years SHO- 2 years obs and gynae and 1 year something else.

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Because I had done 6 months A&E I only needed 6 months something else, so it was a urology job on the general surgery rota. I did hernias and appendixes and cystoscopies. You got to do loads of stuff back then- more than trainees get to do now. I really liked general surgery and urology- to be honest if I had done that first and not already done the part 1 MRCOG exam I might have done surgery. But because I had invested so much time in the O&G exam, I thought I may as well carry on.

So I was in Birmingham Uni in 1988 for med school, did the 5 years, did my house jobs in Birmingham, did 6 months A&E in Sandwell, went to Leicester for a year, then back to Birmingham. I did my 6 months general surgery and urology then did the rest of my time- another year SHO, 7 months as a "senior SHO" which was basically a registrar paid as an SHO. Then Kalman training came in, so you had to apply for numbers and run through training. I first applied to Leeds for a job from the BMJ advert, then after I had applied a Birmingham job came out and I applied for that. Leeds were really slow in getting the interviews out, because I applied for Birmingham 2 or 3 weeks later but had the interview first. I definitely would have moved to Leeds or wherever- I wasn't being parochial thinking I'll just stay in Birmingham. But the job offer came first, so I thought fine, I'm staying here!

How did you get into academia?

I do really love sitting in a coffee shop or a bar and working- sounds a bit cheesy and I do sometimes wonder if I'm on the spectrum. But I do really like it.

As a trainee I met David Luesley, a prof in oncology, big into colposcopy, and I did a case report with him which got published in BJOG, and I also did a series on lichen sclerosus with him. But I think he was impressed with me because I was keen.

I did all my projects in med school on pen and paper. The first computer I got I was about 26. I got a computer in 1996 or 1997 and had to buy a book on how to use the internet. I remember doing a search on the internet on 'gynaecology' and it was awful – basically porn. That's how naive I was. I really didn't have any research training but when I got published, I really liked having my name in print and I just took to it.

At that point I already had a training number so this wasn't for career progression I just genuinely liked it.

David Luesley was a bit tough, but bosses like that, they like you if you impress them. I wanted to impress him because I was impressed by him! So he was the initial inspiration, but then the main thing was then I got offered a research job with Janesh Gupta and Khaled Khan. Khaled had been to university in Canada and that's the home of evidence-based medicine and that was just coming in. Nobody was really doing evidence-based medicine. I remember if you went to antenatal clinic, you would ask your reg "how do I do this, that or the other" and everyone would give you a different answer. There was this little handbook of summaries of the Cochrane reviews and it was so good. I loved that it told you all the evidence and it just so happened I met Khaled through this research job, and he knew all about evidence-based medicine.

Nobody at that time was doing diagnostic systematic reviews. The methodology for RCTs was there but diagnostic reviews for accuracy wasn't there, there was no software. So me and Khaled developed it and then I published it in JAMA. It's my most highly cited paper from 2002 on the accuracy of hysteroscopy in diagnosing cancer and hyperplasia. I had 65 studies, got the forest plots and aggregated them all. Then I did my MD and ran loads of trials. I had far too much for my MD and I just found that I really took to it.

Despite all that I had never been to conferences. The first BSGE I went to- I can't actually remember where it was, it may have been Chertsey where Jeremy Wright was. But I got into the conference thing as it was a great laugh and being around like-minded people was fun.

I just put the hours in- stayed late, went to private lists on a weekend, you know then they want to train you. You do the groundwork, see the pre ops, see the post ops, review the patients. They then want to spend time training you. And this is still true today.

I got a lecturer's job and the nice thing about that was it was half clinical and half academic. I used my time to my advantage- I taught myself to scan, always went to theatre- so I was free to learn all these things in the day and then do the academic part in the evening. So out of my 5 academic sessions I always had a whole day theatre. I actually really enjoyed it. I managed to do the academia, enjoy the travelling, presenting, the conferences and got more confident at that. I was invited to speak at BSGE, got to know people across the country who I really liked. I was aware there was this reputation of gynaecologists being "boys with toys". I think people used that to stop progress. I thought there's something in this I can change, I knew a lot of them were boys with toys, so I thought if I provide the evidence base then we can work with that. Everyone was doing great stuff, but it needed evidence.

Always though my career with the BSGE I have been conscious I don't want to be a boring academic poo-pooing everything people say. But equally I am aware that we must play the game and find some evidence to form guidance to allow things to be done properly. It's not I want to hold back things at all, it's the opposite. We must allow things to progress in the right way. There is a greater recognition of that now, and the BSGE has always recognised having science behind what we're doing as surgeons is important. It has been a growing society, but I remember saying to Sanjay Vyas, there is no benign gynaecology society with as much potential as the BSGE. Anyone who does benign gynaecology- we need to get them in. Not everyone is an endo warrior. Even those who just pick up a laparoscope to do an ectopic. And I think we have been successful in achieving that and I will take some credit for it. We became more inclusive, especially now with including more hysteroscopy, the ACN, the nurse portfolio, the trainees. We have become a very big and broad society, which is diverse and a good mix of different genders, specialist interests, trainees, consultants. Not everyone is endo or a robotic surgeon- we're the most thriving and diverse society and we must not lose sight of that.

You took over the BSGE presidency during a really tough time in Covid. You didn't have all the fun perks like travelling abroad as a president. How did you deal with that?

What I did do is ensure the society continued to thrive and the numbers went up because I pulled all the team together and supported diversifying, like with the RIGS programme for example. A lot of this stuff has continued post Covid and has transformed the society.

I think a thing that was crucial during Covid is that I have always really liked the people I have worked with on the council. I was busy on RCOG council 2007 – 2013 so I didn't do much with BSGE until after then. I was always involved in guidelines but never on the council. The first joint guideline that was done between the BSGE and RCOG was a lot of work but helped to put BSGE on the map. I was doing stuff for the BSGE, but I didn't start doing anything with council until 2013 because I wanted to do well and not do half a job. So I got invited to the Brighton meeting and took over the research portfolio and Sanjay said to me after the Nottingham GVS in the bar- "you should go for president" and so he encouraged me to apply. I was very flattered. I took what he was saying and applied and got it. I think funny enough,

even though Covid came, sort of that delivery of rapid guidance played to my strengths. I think we did a really good job as we did some joint stuff too. We steadied the ship.

At that time, we needed to innovate and change the way we worked. I had never heard of Zoom, but I was the first one who used Zoom to develop the webinar programme with Rebecca's (Mallick) help. Then there was the RIGS national programme with the help of Donna (Ghosh), you and Mikey (Adamczyk)- we really promoted that. The virtual ASM – we got so lucky with the company we used. They were such great value, so with that and generous sponsorship from industry we made a healthy profit. I think the expansion in numbers, pushing the RIGS, the webinars, the rapid guidance around Covid were all great achievements.

My only regret is that I couldn't do one thing I really wanted. I had this mantra- "train the best and allow them to excel". So what I meant is have the best people, but put them into job plans where they can excel. Like if someone is an endometriosis surgeon you don't put them on labour ward. It's just like in rugby, you don't say to the players if you're a scrum half you need to play number 8 for a game just to be fair to everyone. You have to play to strengths, and everyone has different ones. We really need to get the right people in the right place. Donna did a survey of trainees to get data to see what trainees want from their jobs compared to what they're actually getting, and did the same with consultants. The RCOG are using that data to say people aren't going into the right jobs. The only people who are happy are the older ones like me who have "done their time" and found their niches. But I don't think it should be like this. People should be going straight into jobs doing what they've trained for. Because you know what, you get better, it's like driving a car. The more you do, the better you are. And because you're better, the people you train are better. It's a no brainer. I wanted to promote all of that but because of the other things going on, I couldn't get the same traction politically with the college as I would have done outside of Covid. It seemed unfair to be too moany about it when people were so worried about everything else. And it took such a long time to recover, I guess we are still recovering.

Do you enjoy training the next generation of gynaecologists?

I am proud of the people I have trained. I encourage them and get them involved as much as possible. I want them to experience the good laugh I had as well. I think the reason we are getting some burnout is because some of the joy is being lost. We should be able to sit and laugh and cry with each other. Celebrate what's gone well, show off a bit and make people laugh. You know someone is a good surgeon and you can respect them if they can admit to you their disasters. I think that's the beauty of the BSGE as a society- the friendships and the camaraderie. If you get the young ones involved and they can realise there's a support network and it's fun. And I think the really successful units have that team structure where they travel to meetings together, publish together, they support their trainees in presenting, they have dinner and drinks together.

The training now, although there are some problems, you have really good endoscopic surgeons who will train if you're lucky to get to them. When I was learning laparoscopy, I sort of taught myself. I did observe people and the BSGE is really useful for having contacts for people to get advice. But because I had been trained so well in open

surgery, I knew my way around the pelvic side wall, so I sort of picked it up easily. I am what you call a "true surgeon" in the traditional way of dissect, diathermy, cut, dissect. So I have come from that background, but I had to teach myself laparoscopically with just monopolar and scissors before moving onto bipolar and then later using advanced energy devices. I had good support, but I had to go out and do it for myself. There's more support for training now.

I think what all my colleagues will say is the reason we do it, even though we're all quite different, is it's working with good people. The common theme is we've all had great mentors who we can say "I am where I am because of them". So I want to pass that on. As you get older, your legacy is your team, there's no point retiring with a technique named after you. I have supervised a lot of PHDs and MDs and I definitely say to people- there's no issue if you're not academic. If you participate, work hard, be the best in your area you can, learn from others, always be humble, that's the best you can do.

Are you primarily a hysteroscopic surgeon?

I'm known for being a hysteroscopist and I will still now learn from eminent people like Attilio Di Spezio Sardo, Ursula Catena, but I will also learn some new things form trainees. I'm seen as a hysteroscopic surgeon, but I also do lots of laparoscopy. Don't get me wrong, I wrote a book in 2005 on outpatient hysteroscopy. Nobody was really doing it at the time. It had all about electrosurgery, ablations, polyps, fibroids, fertility. It was a groundbreaking book and really changed things. Everywhere I went people knew who I was because I had written this book. So suddenly I had got to know all these new people and that is partly why I've got the hysteroscopic label. But a lot of my trials and funding aren't hysteroscopy. I'm not saying I'm Shaheen Khazali level at laparoscopy, but I'm a pretty decent pair of hands at both open and laparoscopic surgery.

You've done loads of brilliant stuff, but what would you say is the best achievement in your career?

Ooooo that's a really tough one.

I think I have been proud of innovating for example outpatient hysteroscopy- taking it to a therapeutic, see and treat level. Not only doing it, but also collecting and disseminating data in books and guidelines. That's one thing I'm very proud of. I think I have in a small way made a difference. I'm really happy the next generation is thinking this is just standard practice now.

I think the other thing would be- it sounds cheesy, but the legacy of my trainees. If you have a lot of trainees who may look up to you as being a prof. Even if you're a bit tough on them, they want to impress you and that's because you're there supporting them and pushing them to be the best they can. I also like the idea of trainees laughing at me for being the grumpy Prof too.

Finally, a genuine thing, like when we first met each other in the Hull BSGE at the bar, we had a right laugh and have been friends since. It's meeting people from around the country, seeing great people coming into our specialty and enjoying the friendships. We are all like family. Like with burnout, if you make yourself busy, enjoy your work, see like-minded people, then your stress should be – "how do I fit all of this in? Because I enjoy it so much". Not dreading your work when you wake up every morning. You know when you go to a conference, it's so great meeting people and seeing friends while learning about stuff you love. And the majority of people in the BSGE especially are approachable and inclusive.

You've been the president of the BSGE, on RCOG council, ESGE exec team, editor of Facts, Views and Vision journal... what's next for Justin Clark?

I'm on 10.6 Pas, I can't go part time because of pensions, I'm not a massive private practice guy although that side of things is busier than ever. Being Editor of FVV takes up most of my other time and I don't want to compromise that as I'm very proud of this role. The kids have left home and now I have more time to enjoy myself, so I don't think I'm going to take on much more. But it's always a quandary as there's so much I could do!

But seriously I think the BSGE is the best society. I honestly think it's because we've got such a diverse group of people from hysteroscopy, simple laparoscopy, neuropelveologists, nurses, robotic surgeons, paramedics, students, complex laparoscopy. We're very encouraging, we're not up our own bums. We're not risk takers, but it's a type of personality where we work really hard and play really hard. Doing our jobs you have to take the opportunity to let your hair down and have a laugh. It's not we're Jekyll and Hyde, but it's about knowing when to be professional. It may be you're in fancy dress on the dancefloor at the gala dinner for the BSGE ASM, but then you're back at work comforting a woman who you've had to break bad news to in clinic.

You have to enjoy these opportunities to let it go, to then be even better when you're refreshed and inspired when you're back doing the actual job.

You're the Convener of the Gynaecology Visiting Society too? That's a big honour!

Yes, I have been in the GVS for a while now. But again, the same principles apply- you meet some amazing people. These big famous names, what you realise is they are normal like us. You get to know them at a personal level and they're just normal people who work really hard and also like to have fun. The Blair Bell thing is pretty amazing though, he founded the GVS before the RCOG existed and reading the old records of the meetings is so interesting. I like history and in a small way it's nice to be part of the history. It's not loads of work, but it's enough responsibility to take on.

You've attended and organised loads of meetings over the years. What do you think makes a great conference?

The best conferences are the ones where you look at the programme and can't decide what room to go to because there's so many interesting topics. But it's also important to have times when you toss it off and go for a coffee and a chat or wander around the exhibition hall. And a great

example I had of this was when I designed a trial I published in BJOG on Word catheters after meeting Ben Mol in Amsterdam at the ESGE. We were sat in a bar eating "bitterballen" which are little balls full of mincemeat which you dip in mustard. I dipped one in the mustard and said, "this looks like a Bartholin's abscess", so we got into a conversation about Bartholins and I said, "what the hell are these Word catheters?" We designed a trial then, got our fellows to do it, and published it in BJOG! So, I don't like the term "networking"- it sounds ingenuine, but this was the best example of it! Just sharing ideas, relaxing, getting to know people.

Do you consider yourself to be a legend in gynaecology?

I'm middle class, my dad's a GP and my mum's a teacher. I went to comprehensive school. I never had big ideas about myself. You know some people flatter me, but I hope people realise I'm self-deprecating and I don't think I'm a big deal. Sometimes people underestimate me because they might see me out at the party having a laugh, or drunk or saying a joke, or speaking to anyone and everyone. Then when they meet me on a committee meeting or see a paper I've written all of a sudden they understand and respect me. With the GVS, initially I didn't have the identi-kit to be there. But because I can be genuine and talk to anyone, plus people like those with personality, I manage to fit in. I sometimes play up to being the fool to make people like me, but I have always liked the fact I know I'm respected amongst my peers.

When I got made a professor in 2001 in Birmingham university, the letter had been on the doormat for 2 weeks before I saw it. It was after a GVS in Birmingham where everyone said "hey, why are you not a professor?". So after that I applied, and the funny thing was my daughter who was 9 then, she was eating her breakfast. She said are you a mad scientist? And I thought you know what? Lots of them are! They're very straight or serious. I'm not that, but I deserve it and I'm proud of it.

I'm aware I don't fit the mould for an academic professor. I know I don't, but I am, and I know I'm good at academia. This is actually my most proud thing, going back to the previous question. I can inspire people to be a professor when they feel they don't fit the mould. People need to realise how hard I have worked for it though. It doesn't happen by accident. Maybe that's what's unique about me. I fit my own mould and actually it's worked for me. Although saying that, I don't want everyone to look like me because it takes away my USP! The beauty is diversity.

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The last legend Keith Isaacson left you a question to answer...

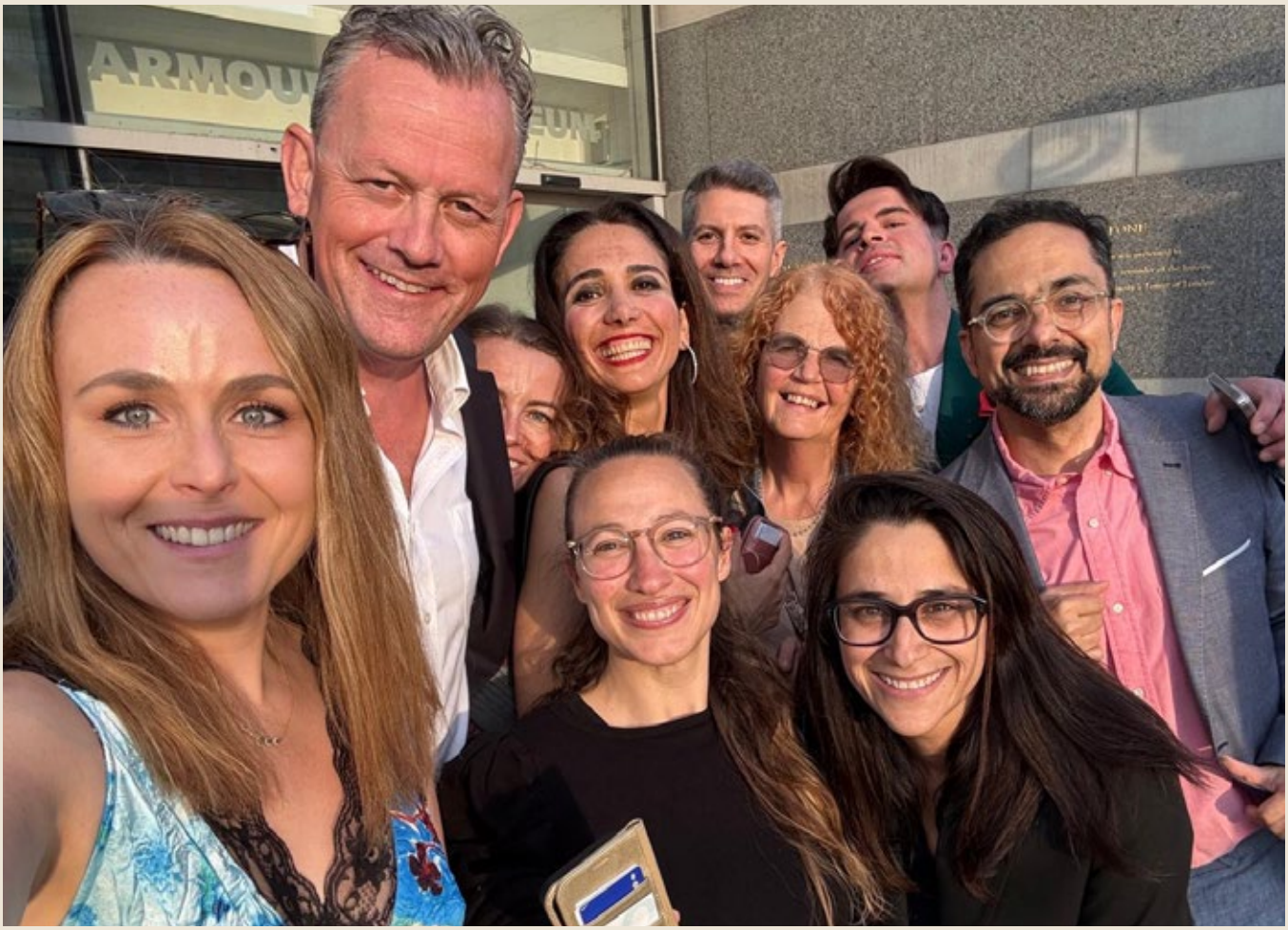
Is the quality of patient care affected by the reduction in surgical volume by the OBGYN generalist?

Okay, so I agree with Keith. To quote Gary Player, the South African golfer, "the more I practice, the luckier I get". And it's simple, if you look at the data, higher volume surgeons, have better outcomes in terms of fewer complications and better clinical outcomes. It's absolutely clear, and that's why train the best, allow them to excel, put them into job plans, where they're not messing about in obstetrics, and they've got big cases on their operating lists. I don't want my daughters being operated on by someone who has done three laparoscopic hysterectomies or three laparoscopies in a year, I want them to have someone who's done 200. When I need my hip doing it'll be the exact same!

Get to know Justin Clark

- **Star sign**: Virgo
- **Favourite colour**: Blue
- **Dogs or cats?** Definitely dogs
- **Favourite food?** Anything Italian or Spanish
- **Favourite cocktail?** Negroni
- **Karaoke song?** Touch me by The Doors
- **Favourite holiday destination?** Any Greek Island
- **Ski or Snowboard?** Neither! Too working class
- **Football team?** West Brom (c'mon you Baggies!)

Angharad Jones
Interviewer / Scope Editor



Portfolio Reports

Research and Innovations Portfolio Report

I am pleased to announce that we will be incorporating the work of clinical scientists into our committee. We aspire to create the first event that brings together endometriosis experts to collaboratively discuss clinical sciences in endometriosis. This initiative seeks to connect the outstanding research conducted in various institutions with the excellent surgical and clinical work being done. Lucy Whitaker from Edinburgh, a wonderful new addition to our committee, will be leading this effort.

Additionally, we are organising workshops on day case hysterectomy and revisiting surgical concepts such as mini-laparoscopy and single port surgery in upcoming webinars. Please keep an eye out for advertisements for these events by email, on the website and on social media. We will also be conducting future surveys to determine the best route for hysterectomy, considering different modalities, and to understand surgeons' standard practices regarding intra-abdominal pressures during laparoscopic surgery.

We are excited to begin preparations for the next ASM in London and welcome your thoughts and ideas.

Oudai Ali (Research and Innovations Portfolio Chair)
Research and Innovations Portfolio Chair

Website and Digital Governance Portfolio Report

The Website and Digital Governance Subcommittee has been working hard to revamp our video library, a project we're really excited to share with you. This has been a team effort, and we're proud of the progress made so far.

We've carefully reviewed and reorganised all the existing videos, making sure each one is placed in the right section with clear headings and relevant topic categories. All of this is aimed at making the library easier to navigate and more enjoyable for everyone to use.

This project is still ongoing, and we continue to build on what's already been done. One of our next steps is expanding the library to include a new Diagnostics section, featuring videos on ultrasound and MRI. This will include content such as ultrasound diagnostics of adnexal masses and endometriosis, as well as other gynaecological conditions. The same will apply to MRI and other imaging modalities, highlighting how they can support diagnosis in a range of gynaecological presentations. These videos will provide an excellent opportunity to enhance clinical understanding and visual learning in diagnostics.

We'd love to make this a collaborative space, so if you have any videos you think could be useful for the library, surgical or diagnostic, please don't hesitate to reach out. We're always happy to hear from members and would really welcome your contributions.

Once complete, we hope the updated video library will be a valuable resource for both junior and senior members alike. And just as a reminder, if you're an AAGL member, you also have access to the SurgeryU platform, where you can both view and submit content.

We're looking forward to sharing more updates soon and hope you enjoy exploring the new video library as it continues to grow.

Mikey Adamczyk
Website and Digital Governance Portfolio Chair

Nurse Specialists

Nurse Operative Hysteroscopy Course

Caroline Bell and Nadine di Donato report for The Scope:

We successfully ran our third nurse operative hysteroscopy course on July 1st and 2nd, 2025. There was a lot of teaching and plenty of fun as well! Once again the course received great feedback and was well supported by our industry partners.

The innovative operative hysteroscopy course covers the theory needed for operative hysteroscopy and includes hands on training with operative devices.

The training was supported by a fantastic faculty including nurses and consultants. The core of the course was to have lectures that helped increase nurses' knowledge, skills and confidence.

The workshop is designed for all nurses who have successfully completed the Bradford University diagnostic course and feel competent in their role.

The nurse hysteroscopy subcommittee generally recommends that you spend 12 months performing diagnostic procedures before progressing to operative training. The course provides a log book which the nurse can use to collect cases.

As from September, the University of Bradford will have a satellite site at the Kings in London. This will allow more nurse hysteroscopists to be trained annually. Please visit the University of Bradford web page to find out more.

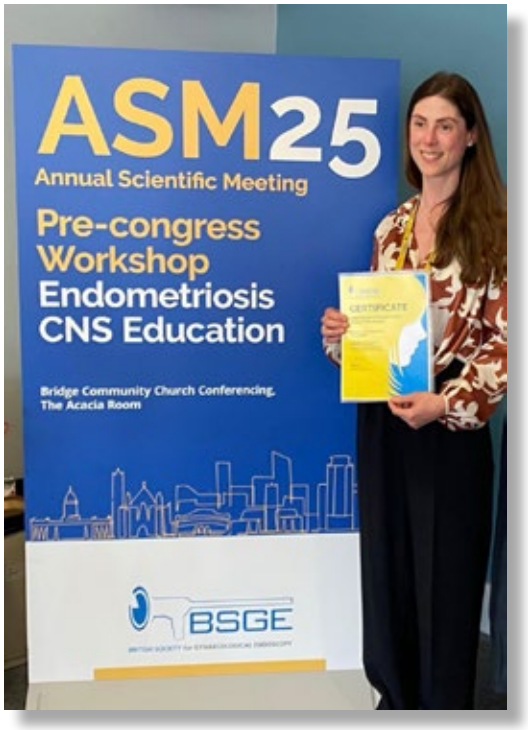
Our next nurse operative course will run on the 1st and 2nd of December.

Nurse Specialists

Endometriosis Nurse Innovation Award

The BSGE has introduced a new award to celebrate the vital role of endometriosis specialist nurses. Endometriosis clinical nurse specialists were invited to apply, citing innovations or changes – big or small –that they have made to improve patient care. Suggestions included introducing a new clinic process, pathway, or team approach.

This new award is designed to highlight the everyday improvements nurses make that often go unrecognised, allowing CNSs to learn from and celebrate each other's achievements in endometriosis care.



The inaugural award was given at the ASM in Leeds with prizes going to:

- Joanne Street from Worcester Royal Hospital for her Endometriosis Art project. Congratulations to Joanne who won £100.
- There was a very strong field, so runner-up £50 awards were given to Elizabeth Malone, Katie Morris, Joanne Hanley, Tanya Mitchell, Camilla Birkhead, from Manchester Foundation Trust.

RIGS

Registrars In Gynaecological Surgery
Training and Support in Endoscopy


Meet Your BSGE Senior Trainee Representatives

We are delighted to welcome Zahra Azeem and Oscar Barnick as the new BSGE senior trainee representatives! They will be working to represent trainees, drive educational initiatives, and enhance the overall trainee experience.

RIGS Training Programme – Kicking Off This October!

We received a huge number of applications for the upcoming RIGS Training Programme, launching this October.

Hands-On Workshop Days:

- BASIC – Thursday, 30th October 2025
- INTERMEDIATE – Thursday, 13th November 2025
- ADVANCED – Thursday, 27th November 2025

Educational Webinars (Evening Sessions):

- BASIC – Monday, 27th October at 18:30
- INTERMEDIATE – Monday, 10th November at 18:30
- ADVANCED – Monday, 24th November at 18:30

If you didn't manage to secure a place on a hands-on workshop, the Monday evening webinars are open to all. We have some fantastic speakers lined up to share their tips, tricks, and insights.

We are still welcoming faculty for the hands-on courses. If you are an ST6/7 or consultant and would like to support any of the streams, we would be hugely grateful for your involvement. Please drop us an email if you can join us!

Trainee Highlights from the ASM

This year's ASM offered a fantastic experience for trainees. We kicked things off with a pre-Congress workshop for ST5–7, focusing on hands-on laparoscopic skills. It was a brilliant day packed with industry-provided equipment, including myomectomy and pelvic side wall models, and there were loads of opportunities to practise tips and tricks under consultant guidance.

The suturing competition was a real highlight, with impressively fast suturing on display. The knockout rounds were intense, but in the end, Muna Ewad came out on top, taking home the Karl Storz Golden Needle Holder.

The trainees really rose to the occasion with a huge number of abstract submissions and excellent presentations throughout the meeting. Several awards were presented, with highlights including:

- Kyle Fleischer – Winner of the RIGS talk on tackling a frozen pelvis
- Flo Britton – Winner of the Karl Storz Golden Telescope for her presentation on natural orifice specimen extraction

A huge well done to all our trainees for their enthusiasm, hard work, and fantastic contributions to the ASM this year!

Image of the Edition

Sian Mitchell from the Diagnostics Portfolio reports for The Scope on a new innovation, shares the first 'Image of the Edition' and invites everyone to share their interesting cases with other BSGE members:

The 'image of the edition' is a new addition to The Scope. For this initial entry, the diagnostics subcommittee have selected a case of interest. For future editions, we invite the readers to submit their interesting case with an image(s) (USS/MRI) of interest and a summary of the case. Entries will be assessed by the diagnostics committee and the winning entry will be published in The Scope. The winner will receive a certificate to acknowledge their achievement. Your entry should be a maximum of 2 A4 pages and contain no patient identifiers, dates or the name of the hospital where the images were obtained. Please send entries to diagnostics@BSGE.org.uk

Case summary:

Title: Degenerating pedunculated fibroid mimicking an ectopic pregnancy

A 39 year old presented at 8 weeks' gestation with left iliac fossa pain. An ultrasound showed a multifibroid uterus and a 7.3mm gestational sac within the endometrial cavity. She then experienced heavy vaginal bleeding and at her following scan the previously seen gestational sac was absent. A complete miscarriage confirmed.

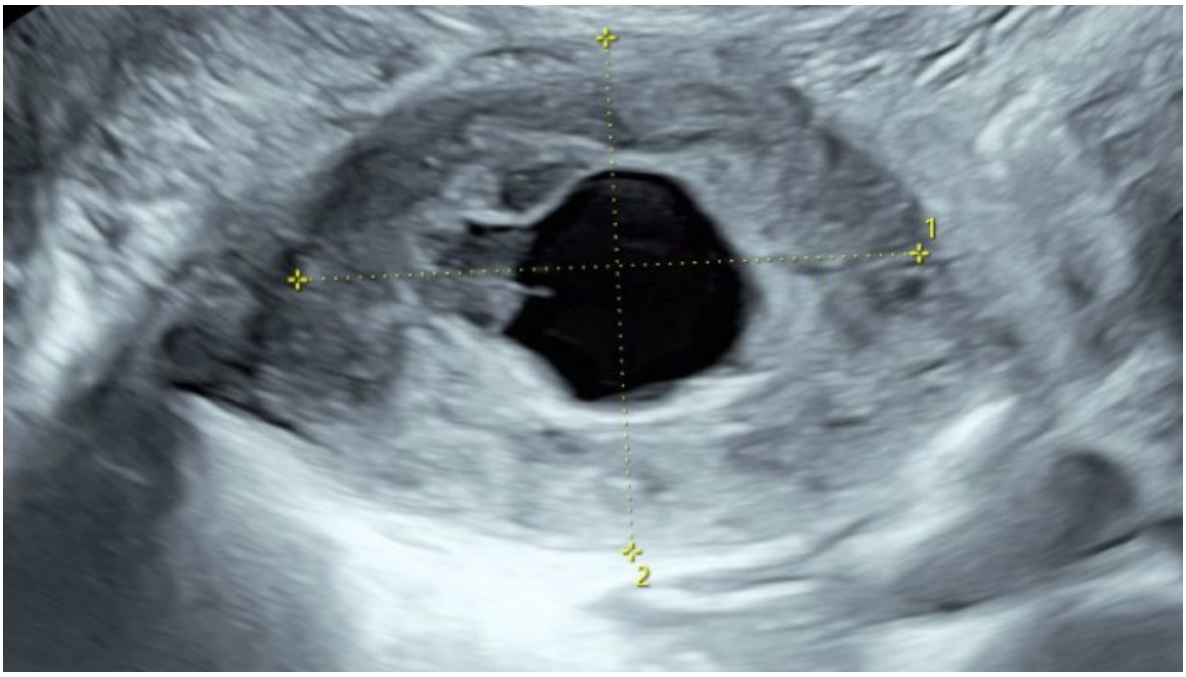


Fig 1.

A month later, she re-presented with a persistently positive UPT. On transabdominal scan, the right ovary was not visualised and in the right adnexa, there was a well-defined solid lesion, with cystic content. The lesion appeared to be separate to the uterus and measured 56x46mm (Fig 1.). This was suspected to be an ovarian ectopic pregnancy. Serum hCG was 1136 and progesterone was 9.0.

On a follow up scan, the right ovary was identified separate to the lesion. (Fig 2.).

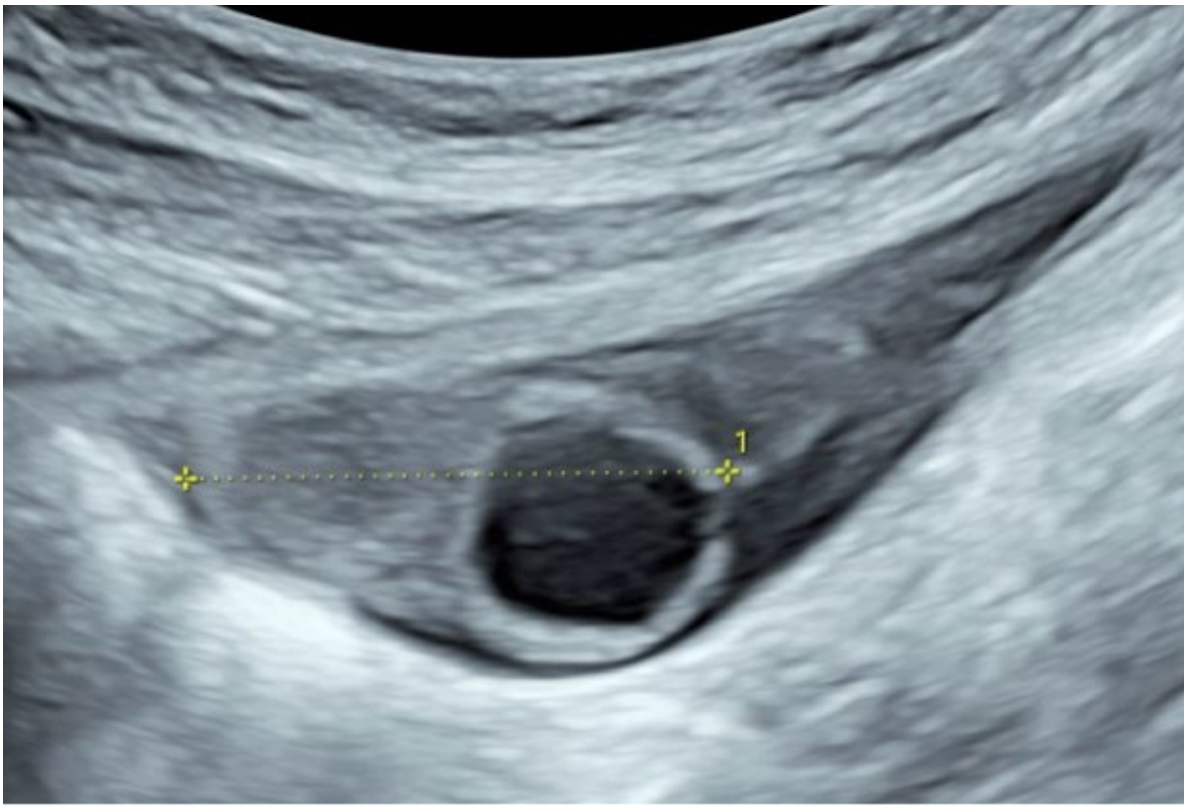


Fig 2.

The lesion had not changed significantly and there was a vascular pedicle between the lesion and the right fundal aspect of the uterus. The lesion was re-classified as a pedunculated fibroid with cystic degeneration and she was advised expectant management (Fig 3). She attended for serial hCG until complete resolution.

Ovarian ectopics are identified as a gestation sac or solid mass surrounded by healthy ovarian stroma with intact ipsilateral fallopian tube [1]. Often, it is ipsilateral to corpus luteum. The pressure from the ultrasound probe cannot separate the ovary and the pregnancy and colour doppler can identify peri-trophoblastic blood flow of the ovarian ectopic separate to the corpus luteum [2,3]. Haemoperitoneum often complicates ovarian ectopics [1,2].

Fibroid degeneration can be identified as homogenous lesions with reduced echogenicity, hyperechogenic rim and in some cases, absent internal vascularity. Fibroids may also have mixed echogenicity with anechoic cystic areas [4].

Conclusion

Concurrent gynaecological pathology can pose a challenge to the diagnosis of early pregnancy complications. Ultrasound is a valuable tool to manage patients with suspected early pregnancy complications and triage patients appropriately to conservative or surgical management.

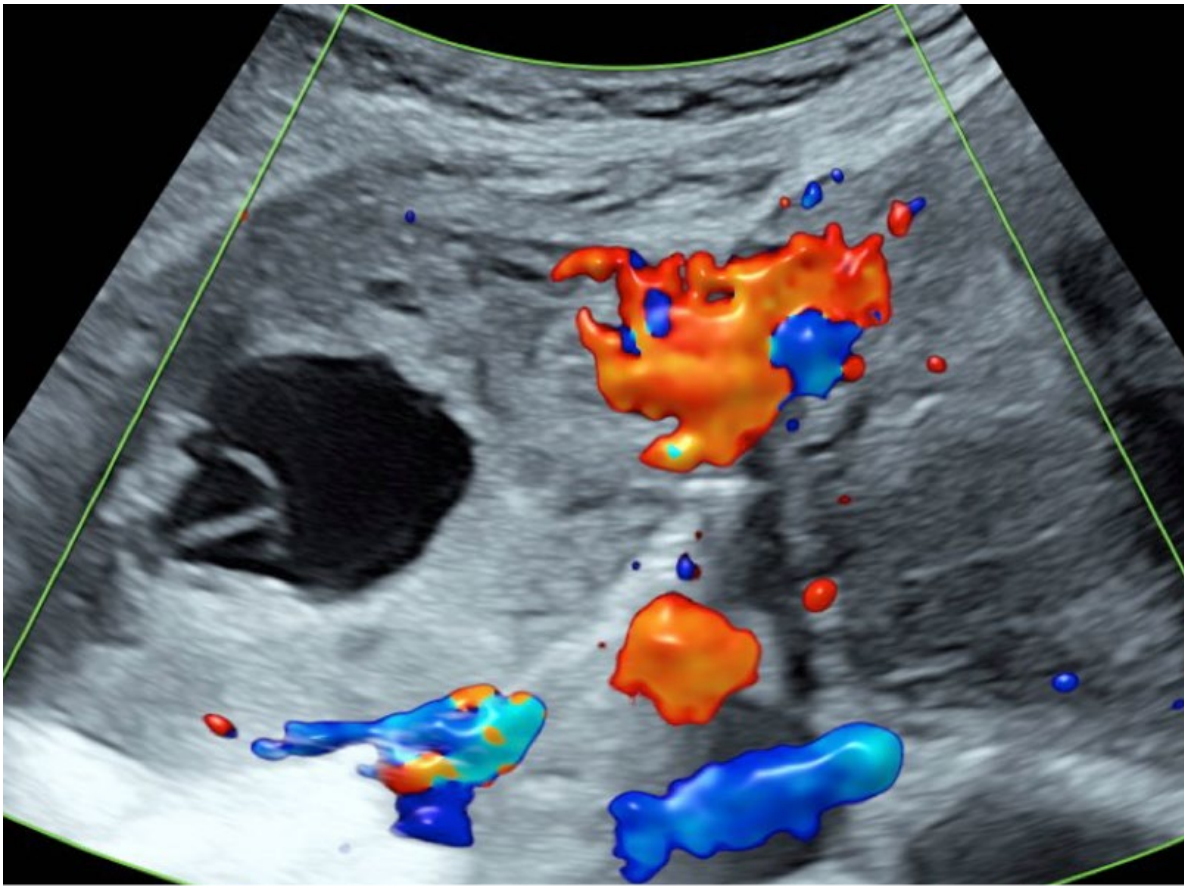


Fig 3.

References

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Upcoming Events

Here are the important meetings, conferences and courses for your diary.

Please note that the BSGE courses are highlighted in blue.

BSGE Endo CNS Drop-in Bite-size Session

Start Date: 19/08/2025
End Date: 19/08/2025
Location: Zoom
Find out more >>

*BSGE State of the Art Endoscopic Practical Skills Course

Start Date: 08/09/2025
End Date: 10/09/2025
Location: Karl Storz Training and Technology Centre, 415 Perth Ave, Slough SL1 4TQ
Find out more >>

Urogynaecology & Urology Procedures Course

Start Date: 08/09/2025 End Date: 08/09/2025
Location: ICENI centre, Colchester Hospital
Find out more >>

Intermediate and Advanced Gynaecological Laparoscopic Surgery Course

Start Date: 08/09/2025 End Date: 11/09/2025
Location: Surgical Skills Centre, Ninewells Hospital, Dundee, Scotland
Find out more >>

Endometriosis Enhanced Care Course

Start Date: 09/09/2025 End Date: 18/11/2025
Location: Online
Find out more >>

Joint RCOG/BSGE event- Gynaecological Abdominal Surgery

Start Date: 10/09/2025 End Date: 17/09/2025
Location: Lectures- Online Practical workshops- In-person at RCOG, London
Find out more >>

Hysteroscopy, Hysteroscopic Surgery and Endometrial Ablation

Start Date: 12/09/2025 End Date: 12/09/2025
Location: Surgical Skills Centre, Ninewells Hospital, Dundee, Scotland
Find out more >>

Hysteroscopy and Ambulatory Gynaecology Workshop

Start Date: 18/09/2025
End Date: 19/09/2025
Location: Manchester Surgical Skills and Simulation Centre, Stopford Building, Oxford Rd, Manchester M13 9PT
Find out more >>

LapSim Gynaecology Laparoscopic Simulation course

Start Date: 26/09/2025
End Date: 26/09/2025
Location: Lap Sim Training Lab, Level 5, Royal Gwent Hospital, Newport, Wales
Find out more >>

BSGE Endometriosis CNS 2-Day Education Event

Start Date: 07/10/2025
End Date: 08/10/2025
Location: Karl Storz Training and Technology Centre, 415 Perth Avenue, Slough, SL1 4TQ
Find out more >>

BSGE Seniors Professional Development Meeting

Start Date: 16/10/2025
End Date: 17/10/2025
Location: MATTU, The Leggett Building, Daphne Jackson Road, Guildford, Surrey, GU2 7WG
Find out more >>

ESGE 34th Annual Congress

Start Date: 19/10/2025
End Date: 22/10/2025
Location: Istanbul Congress Centre (ICC) Darulbedai Cad. No:3 34367 Şişli Maçka İstanbul/Türkiye
Find out more >>

Joint RCOG/BSGE Event - Chronic Pelvic Pain

Start Date: 23/10/2025
End Date: 23/10/2025
Location: ONLINE
Find out more >>

International Conference on Gynecology, Obstetrics and Women's Health

Start Date: 03/11/2025
End Date: 04/11/2025
Location: City Seasons Dubai Hotel
Find out more >>

Joint RCOG/BSGE Event - Diagnostic and Operative Hysteroscopy

Start Date: 04/11/2025
End Date: 14/11/2025
Location: RCOG, 10–18 Union Street London SE1 1SZ UK
Find out more >>

Meeting for those working in a cancer unit

Start Date: 28/11/2025
End Date: 28/11/2025
Location: IET Austin Court, 80 Cambridge Street, Birmingham, B1 2NP
Find out more >>

BSGE Nurse Hysteroscopy Operative Workshop 2025

Start Date: 01/12/2025
End Date: 02/12/2025
Location: Karl Storz Training and Technology Centre, 415 Perth Avenue, Slough, SL1 4TQ
Find out more >>

15th World Endoscopy and GI Conference

Start Date: 17/12/2025
End Date: 19/12/2025
Location: Dubai, UAE
Find out more >>

Joint RCOG/BSGE Event - Ultrasound for the Diagnosis of Endometriosis

Start Date: 28/01/2026
End Date: 28/01/2026
Location: ONLINE
Find out more >>

ACN26
Ambulatory Care Network

BSGE AMBULATORY CARE NETWORK 2026

Start Date: 26/2/2026
End Date: 27/2/2026
Location: The Vox Conference Venue, Birmingham, B40 1PU
Find out more >>

ASM26
Annual Scientific Meeting

BSGE ASM 2026

Start Date: 29/4/2026
End Date: 1/5/2026
Location: The Queen Elizabeth II Conference Centre, Westminster, London
Find out more >>

Gynecology and Obstetrics

Start Date: 11/05/2026
End Date: 12/05/2026
Location: AC Hotel by Marriott Kuala Lumpur, 09, Off, Jalan Lumut, Jalan Ipoh, 50400 Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur, Malaysia
Find out more >>

BSGE Seniors Professional Development Meeting

16th and 17th October 2025

The aim of this meeting is to bring together a cohort of individuals at the start of their consultant careers who are passionate about minimal access in gynaecology and who wish to enhance their professional skills and build relationships that will last a lifetime.

MATTU,
The Leggett Building,
Daphne Jackson Road,
Guildford, Surrey,
GU2 7WG

Registration fee: £350

Strictly for 24 BSGE members only

Click here to register

Who should attend?

ST7 and Junior Consultants within 1 year of appointment.

Provisional agenda

Thursday 16th October

11:30-12:30 – Arrival, Registration, Lunch

12:30-17:30 – Dr Joe Amaral

20:15 – Conference Dinner

Friday 17th October

08:30 – Arrive

09:00 – Live link to theatres and skills lab (Advanced Energy)

15:30 – Close

Registration fee includes access to two day meeting, refreshments and lunch, networking dinner plus one night accommodation at Holiday Inn, Guildford booked by the BSGE.

Faculty

Mr Andrew Kent
BSGE Immediate Past President, Director Gynaecological Surgery, MATTU

Dr Joe Amaral
Professor of Surgery(Emeritus), The Warren Alpert School of Medicine Brown University

Mrs Alison Snook
Manager, MATTU

Prof Jeremy Wright
BSGE Past President

Mr Ben Mondelli
Consultant Gynaecologist, Royal Surrey Hospital

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

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A maximum of 13 CPD credits may be claimed for learning achieved at this meeting.
The rate of claim is 1 credit per hour excluding breaks.

BSGE Scope Team

Meet our dedicated team...

Angharad Jones
Editor

Jane Gilbert
Assistant Editor

Atia Khan
BSGE Manager

Charis Ayton
BSGE Administrator

Nadine Di Donato
Events

Oscar Barnick
Trainees

Florence Britton
Trainees

Zahra Azeem
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

www.bsge.org.uk