ESHRE 2021 Virtual (26 June – 1 July 2021)

Questions for the speakers

PCC12: Step by step reproductive surgery

Surgical approach of Müllerian anomalies - María Isabel Acien (Spain)

Q: Is there any difference in the reproductive performance by performing laparoscopic cerclage compared with the conventional vaginal one?

A: There are two different reviews on the topic with similar conclusions

Although transabdominal cerclage (TAC) is reserved as a **second-line treatment** option over transvaginal cerclage (TVC), it has some advantages. TAC is a **more effective procedure** to TVC **in reducing preterm birth and maximizing neonatal survival**. Although TAC is a slightly more complex procedure compared with TVC, advances in minimally invasive surgery now allow gynecologists to perform this procedure laparoscopically and therefore without the added morbidity of open surgery but with the same if not better outcomes. Senarath S, Ades A, Nanayakkara P. Cervical Cerclage: A Review and Rethinking of Current Practice. Obstet Gynecol Surv. 2020 Dec;75(12):757-765. doi: 10.1097/OGX.0000000000000847. PMID: 33369686.

Laparoscopic abdominal cerclage is emerging as the preferred treatment option **for patients with refractory cervical insufficiency**. Laparoscopic abdominal cerclage **reduces second-trimester loss and preterm birth** with success rates similar to open abdominal cerclage. Increasing evidence also suggests **improved neonatal survival rates** with abdominal cerclage compared with repeat vaginal cerclage **in patients who delivered prematurely despite a vaginal cerclage**. The option to perform a highly effective treatment using minimally invasive techniques suggests laparoscopic abdominal cerclage will become the standard of care for refractory cervical insufficiency. Clark NV, Einarsson JI. Laparoscopic abdominal cerclage: a highly effective option for refractory cervical insufficiency. Fertil Steril. 2020 Apr;113(4):717-722. doi: 10.1016/j.fertnstert.2020.02.007. Epub 2020 Mar 5. PMID: 32147177.

Surgical approach of ectopic pregnancy - Antoine Watrelot (France)

Q: After MTX treatment for ectopic pregnancy, is it possible for congenital anomalies in further pregnancy? How long time we need to wait for further pregnancy?

A: It has not be described and 2-3 months' time are sufficient for a complete wash-out of Mtx and therefore a pregnancy may be planned rather soon after ectopic

Q: Provided that we have all the prerequisites for salpingotomy, do we have to take into account the condition of the contralateral tube, to avoid future ectopic?

A: Yes indeed if the contralateral tube seems perfect salpingectomy may be considered as the best option whereas if the tube is not normal we have to do the best to avoid salpingectomy. Now if the question is : does the aspect of the contralateral tube may be predictive to a recurrence of ectopic and help to practice a salpingotomy instead of salpingectomy ,answer is No it impossible to predict a further ectopic.

Transvaginal laparoscopy - Stephan Gordts (Belgium)

Q: How to reduce the risk of reformation of hydrosalpinx after opening it?

A: It is important to make the correct evaluation before deciding to perform a salpingostomy. Thick walled hydrosalpinges are a contra indication for an operative correction. By performing a salpingostomy the tubal mucosa is easily everted in cases of thin walled hydrosalpinges and has to be fixed by suturing with thin suture material (6/0 or 7/0). Fixung the everted mucosa by heating with CO2 laser or bipolar coagulation is not advisable as there the risk of closure and adhesion formation is very high

Q: Do you use local anaesthesia?

A: you can easily perform the THL under local anaesthesia if you have experience with it. For performing the local anesthesia you can use the syringes as the ones used by the dentist (very fine needle)

Q: If you discover ultrasound mild endometriosis without pain symptoms but only infertility do you suggest a TVL or a LPS for treatment?

A: THL can be performed up to a cyst diameter of 2 cm, if greater a standard lapsc has to be performed.

Q: What was the management of bowel perforations?

A: Conservative: slow withdrawal of the instruments and 6-7 days of antibiotics. None of the patient developed fever afterwards, but you have to inform the patient in case fever occurs she has to contact you. A standard laparoscopy can eventually be performed after 6-8 weeks after discussion with the patient

Q: Could we use ultrasound guidance to avoid bowel perforation?

A: there are some publications claiming a lower incidence of bowel perforation with the concomitant use of ultrasound.

Q: Do you perform pudendal anesthesia also?

A: no never

Q: Could we use ultrasound guidance to avoid bowel perforation? as in egg retrieval??

A: see previous

Q: Have we an idea about the evolution of the very subtle endometriotic lesions seen during TVL, should we advise to the patient a long term hormonal therapy?

A: the patients we treated are consulting for fertility. So we never advised the use of hormonal therapy. In case of only pain this can be advised.

Ovarian cyst surgery - Michelle Nisolle (Belgium)

Q: Regarding fertility issue, if she has recurrent endo which one is less damage for ovarian reserve aspiration or cystectomy?

A: Aspiration and ablative technique

Q: A 31-year-old nulliparous asymptomatic with recurrent 10 cm endometrioma post lap aspiration. Not trying for a baby, low AMH 8.4, What to do?

A: AMH: 8.4 is not low, I would propose a surgical approach (ablative technique) as it is very large.

Q: How much should we wait before performing AMH after such operation ?

A: 3 months

Q: Are you performing surgery in bilateral endometrioma?

A: yes

Q: After the cystectomy, suture or energy which one is less damage?

A: To close the ovary is rarely needed except in very large cyst. Suture is preferable.

Q: What is the rate of endometrioma recurrency after CO2 laser ablation?

A: < 10%. (4,9% in the manuscript of Candiani JMIG, 2019)

Q: Do you recommend dienogest (visanne) before surgery?

A: Yes

Q: What is your view on the three step approach?

A: Indicated in very large ovarian cyst, more than 8 cm if the ablative technique in one step is not possible.

Q: Is there a risk of alcohol dissemination inside the peritoneum (peritonitis) with sclerotherapy?

A: Yes, specially if the procedure is performed by transvaginal route.

Q: Is the assessment of ovary vascularisation important after laparoscopic treatment of ovarian endometrioma in assessment of ovarian reserve?

A: No but it is crucial to avoid deep bipolar coagulation at the hilus part of the ovary.

Q: Alcohol 70% ?

A: /