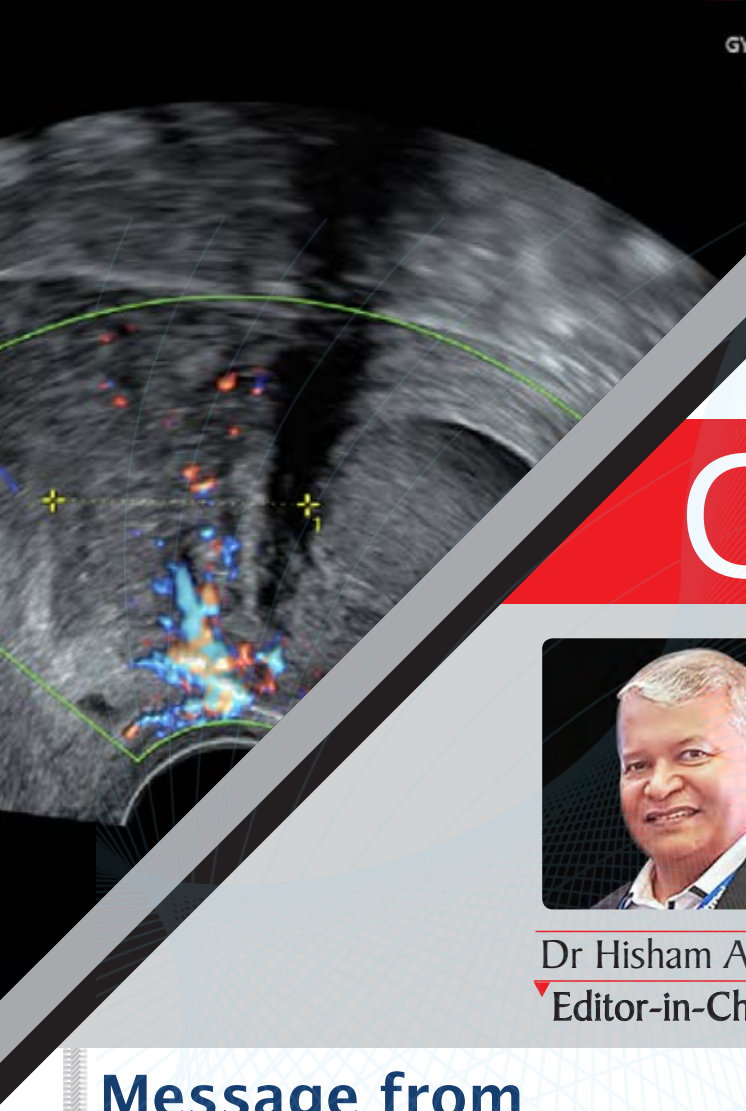
Summer Issue, July 2020



THE INTERNATIONAL SOCIETY FOR GYNECOLOGIC ENDOSCOPY

PROMOTING VAGINAL SURGERY

OPUS The ISGE Newsletter

Dr Hisham Arab
Editor-in-Chief

Dr Ellis Downes
Associate Editor

Dr Meenu Agarwal
Associate Editor

Message from the Editor

Meenu Agarwal

Dear friends,

Endoscopic surgery is back after a hiatus due to Covid scare albeit with due precautions. It has brought in a new discipline in life and in surgery. It has shown us how fragile the life is, yet we braved it out with sheer determination, thanks to the tireless efforts of our frontline warriors – doctors, nurses and the paramedical staff.

The online training has become the new normal and it is heartening to see so many postgraduates and practicing gynecologists logging into various webinars for their quest for learning.

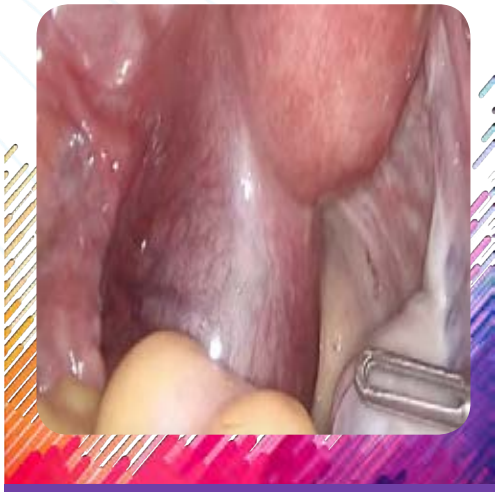
With the huge sincere efforts put in by our medical director, we do have many interactive webinars and courses by ISGE as well.

I hope you enjoy this issue which has been put up with collective efforts. Thanks to my editorial team.

Cheers!

Meenu Agarwal

Cover Quest



G2P1 with amenorrhea 11 weeks Looking at the laparoscopic image guess the diagnosis

For the answer and more details, please click on the image above

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Message from the President

Resad Paya Pasic

Dear colleagues and friends,

This is indeed very strange and unpredictable times that we live in and the whole world is affected. The global pandemic is growing and has reached over 10 million cases and over 500,000 deaths worldwide. While the pandemic is declining in China, Australia, most of Asia and in Europe, countries with a large population such as United States, Brazil, Russia and India are experiencing a sharp increase in new infections.

Scientists, researchers and medical professionals around the world are relentlessly working around the clock on many fronts such as prevention and treatment of the infections and development of the vaccine, which certainly requires huge financial resources and time. Scientific Journal publication was up to eight times faster for COVID related articles then for other topics according to the non-peer reviewed study on the preprint server medRxiv.

At this moment in time, the most important thing that will change the spread of infection is individual behavior and our respect towards recommendations of social distancing, wearing the mask, hand washing and protecting the most vulnerable. It is our task as physicians to set the example and to educate the public and our patients to respect and follow those recommendations. We all are experiencing difficult times, some more than others, and I appeal to you to show compassion toward those less fortunate.

Almost all medical meetings and educational courses around the world have been canceled or postponed placing a great burden on surgical education. With the help of our industry partners, ISGE has taken the initiative to organize 19 educational webinars and prerecorded surgeries that are free for any physician to attend. So far, we have had four webinars and the response has been outstanding with aver thousand physicians from all over the world participating in them.

I strongly encourage you to tune in and participate in those free educational events.

Sincerely,

Resad Paya Pasic

Message from the Honorary Secretary

Dear friends,

The economic catastrophe we face is intricately imbricated in the grief and loss of human lives that we have experienced. Be that as it may, we need to realize the positives of this event and make the best of these seemingly negative events. Throughout this experience, I am certain we have all realized areas of growth which were needed be it personally or professionally albeit at a grave price. Although we were forced to pay this price, it would truly be a negative experience if we fail to listen to the agonizing cries from our planet. As we immerse ourselves in trying to understand these events, we need to re-contemplate the mortality of our profession. This crisis has offered us another opportunity to embrace the reason we chose to serve and I wish to appreciate all our efforts during this time.

Stay safe

Viju Thomas

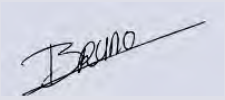
Viju Thomas

Message from the Medical Director

Bruno Van Herendael

The International Society for Gynecologic Endoscopy (ISGE) was formed as a non-for-profit Inc. in the State of Maryland in 1989 by a group of gynecologists committed to endoscopy. The founding members came from Europe and North America and were soon joined by others from all over the world. They recognized the need for a scientific group dedicated to teaching endoscopic techniques, both hysteroscopy and laparoscopy, who would meet at regular intervals to share their knowledge, expertise and techniques.

This did lead to the creation of an ISGE Accreditation system, in three steps, with the aim to form endoscopists who can practice their techniques in all safety for their patients. The aim being to reintegrate the women all over the world as soon as possible in their families, a factor of utmost importance in the emerging countries. In these times of SARS – CoV – 2 these efforts did lead to the creation of e-learning platforms with webinars for the theory but in most cases with surgeries embedded and nearly live surgeries where the techniques are illustrated by non-edited videos. Here the surgeons do point out the difficulties and the possible pitfalls. This E-learning platform will also lead to tele congresses. The first will be the VirtualEndo24 where the diagnosis, the theory and the surgery of endometriosis will be the center of attention.



Hysteroscopic and Laparoscopic Treatment of Robert's Uterus

Mamata Deenadayal,[1] Aarti Tolani,[1], Rooma Sinha,[2] Liselotte Mettler[3]
[1]Mamata Fertility Hospital, Hyderabad, India
[2]Apollo Health City, Gynecology, Hyderabad, India
University Clinics of Schleswig Holstein, Kiel Arnold Heller Str.3, Haus C, 24105, Kiel, Germany
Email Liselotte Mettler: profmettler@gmx.de

Introduction

The overall prevalence of mullerian duct system anomalies is 0.5% and the early recognition of these conditions is extremely important in order to minimize wrong diagnosis and inappropriate management.[1] A specific entity of these congenital uterine anomalies (CUA) is Robert's uterus.

This septate uterus with a non-communicating hemicavity was first described by Robert in 1969–70 as specific malformation of the uterus.[2,3] Usually a blind uterine horn with unilateral hematometra, contralateral unicornuate shaped uterine cavity and normal external shape of the uterine fundus is detected by ultrasound. Main symptoms are repeated pain attacks at regular 4 weeks distances around menarche in young girls, repeated dysmenorrhea, recurrent pregnancy loss as well as infertility. Normal pregnancies can occur in the communicating horn of the uterus.

The authors give a short review of the disease and its diagnostic as well as therapeutic methods and describe 5 cases of Robert's uterus in their analysis. In 4 cases, the 3D vaginal ultrasound imaging confirmed the diagnosis. Only in case 1, in a 13-year-old girl, where we wanted to avoid vaginal access and MRI, 3D transrectal ultrasound gave the right diagnosis and in case 2 an additional MRI was performed to support the diagnosis.

Therapeutically, the following procedures were applied: Laparoscopic endometrectomy, hysteroscopic septum resection,[4] laparoscopic uterine horn resection and total laparoscopic hysterectomy (TLH) (Table 1).

	Age	Key information	Thickness of septum	Vascularity score	Associated findings	Surgery
Case 1	13 years	Dysmenorrhea	1.35 cm	2	–	Endometrectomy of the blind cavity and closure of the cavity.
Case 2	25 years	Primary infertility, dysmenorrhea	4.1 mm	1	Adenomyosis, Endometrioma	Hysteroscopic septal resection
Case 3	36 years	2 full term LSCS, dysmenorrhea	2.7 cm	2	–	Laparoscopic excision of blind horn
Case 4	39 years	2 live children	1,00 cm	2	Adenomyosis, Recurrent Grade 4 endometriosis	Hysterectomy with unilateral Salpingo-oophorectomy (recurrent endometrioma)
Case 5	28 years	3x 16-week abortions	5 mm	1	–	Patient conceived during investigations

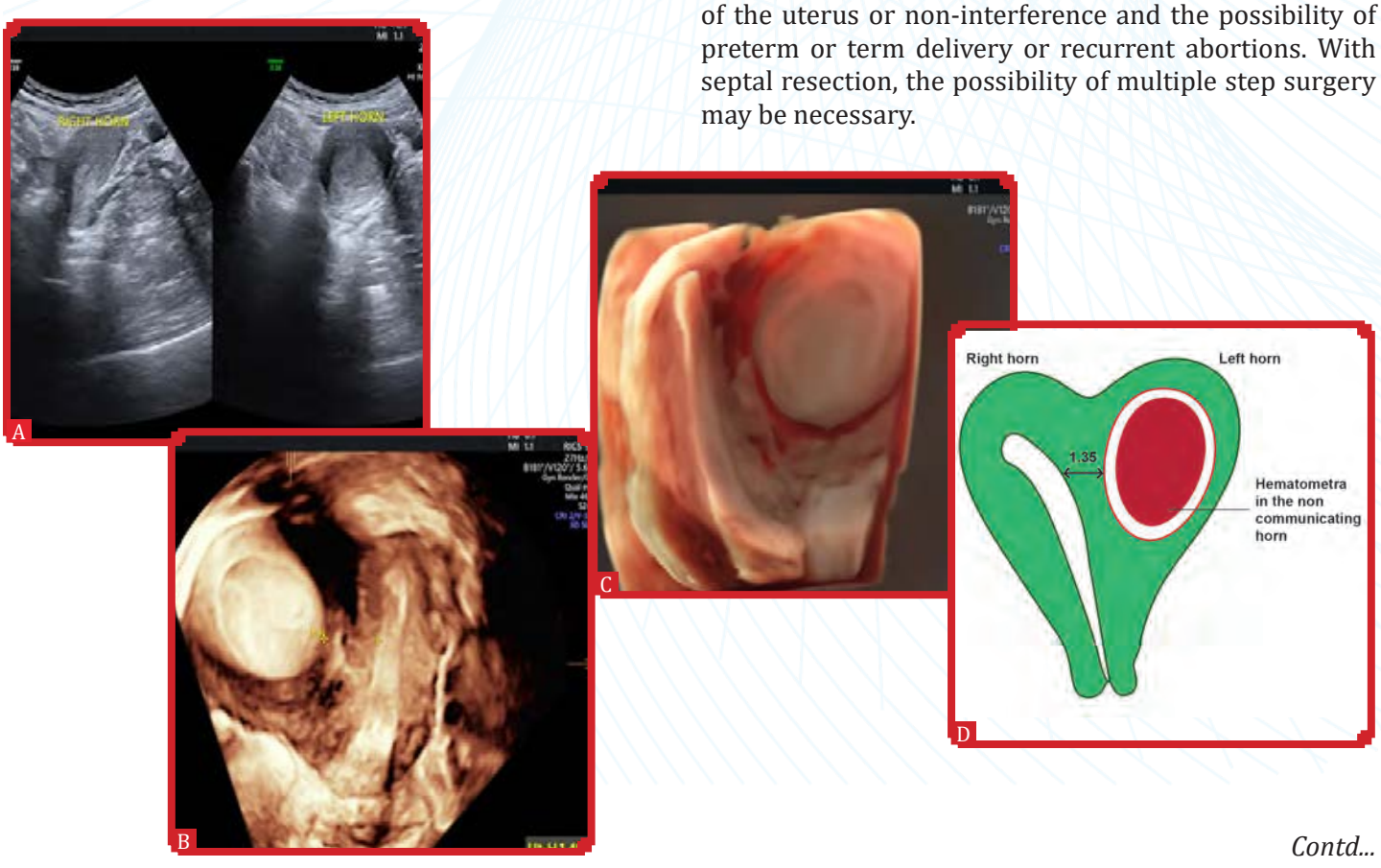
Findings that play a role in deciding the plan of treatment:

1. Age
2. Adenomyosis and endometriosis
3. Wish to retain child-bearing function
4. Ultrasound:
    a. Conformation of Robert's uterus
    b. Thickness of the septum
    c. Vascularity of the septum
    d. Thickness of the uterine walls
    e. Presence of adenomyosis
    f. Presence of endometriosis

Results and Discussion

The 5 cases compare well with International literature and published classifications of uterine anomalies.[5] The figure legends explain the 3D ultrasound diagnosis and the specific treatment of each patient.

When a patient is diagnosed with Robert's uterine anomaly, it is important to explain to the patient the possibility of pregnancy in the normal or non-communicating horn, the possibility of recurrent endometriosis, adenomyosis, the advantages and disadvantages of either complete horn removal, only endometrectomy with fortifying of the wall of the uterus, septal resection with the unification of the uterus or non-interference and the possibility of preterm or term delivery or recurrent abortions. With septal resection, the possibility of multiple step surgery may be necessary.



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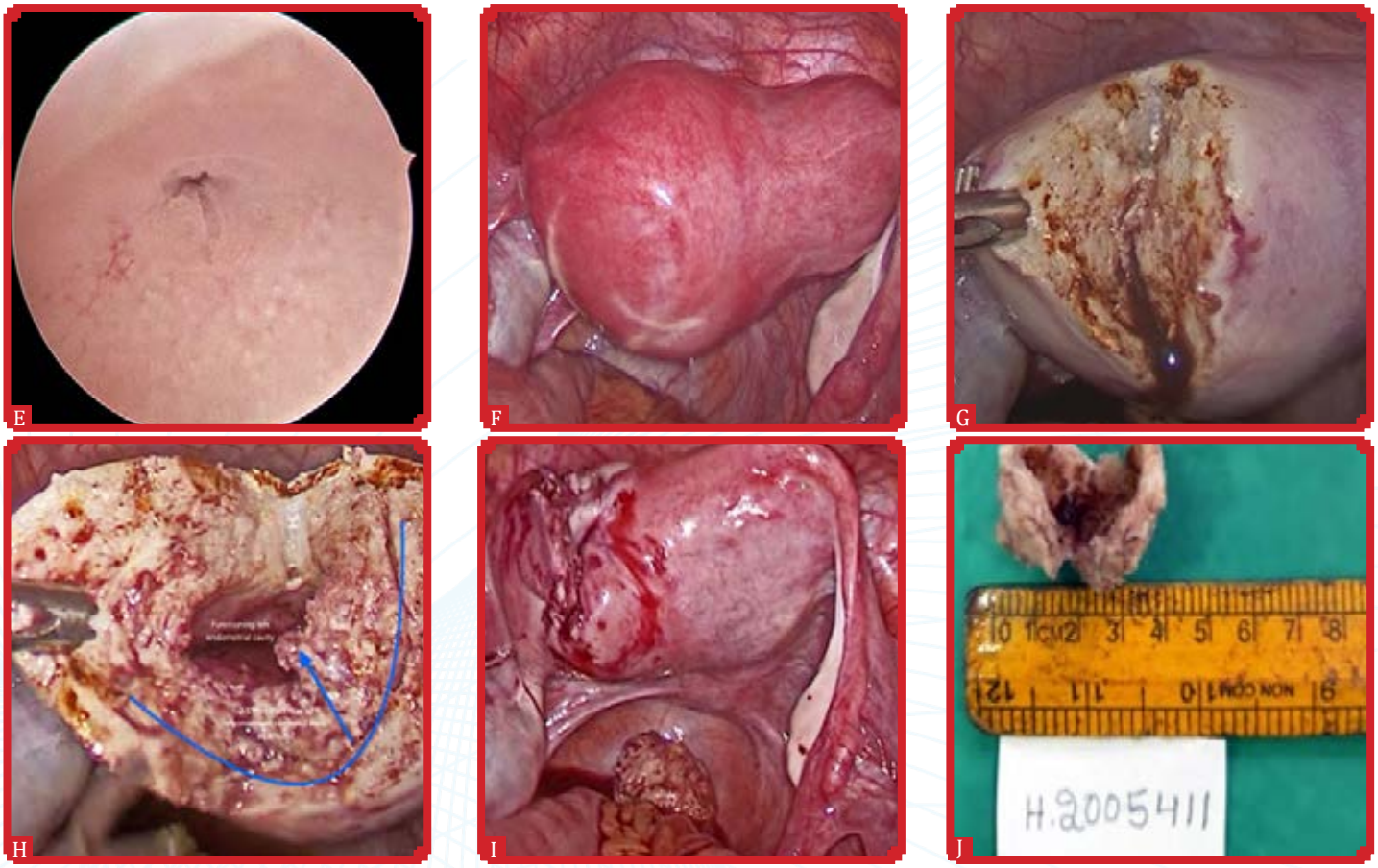
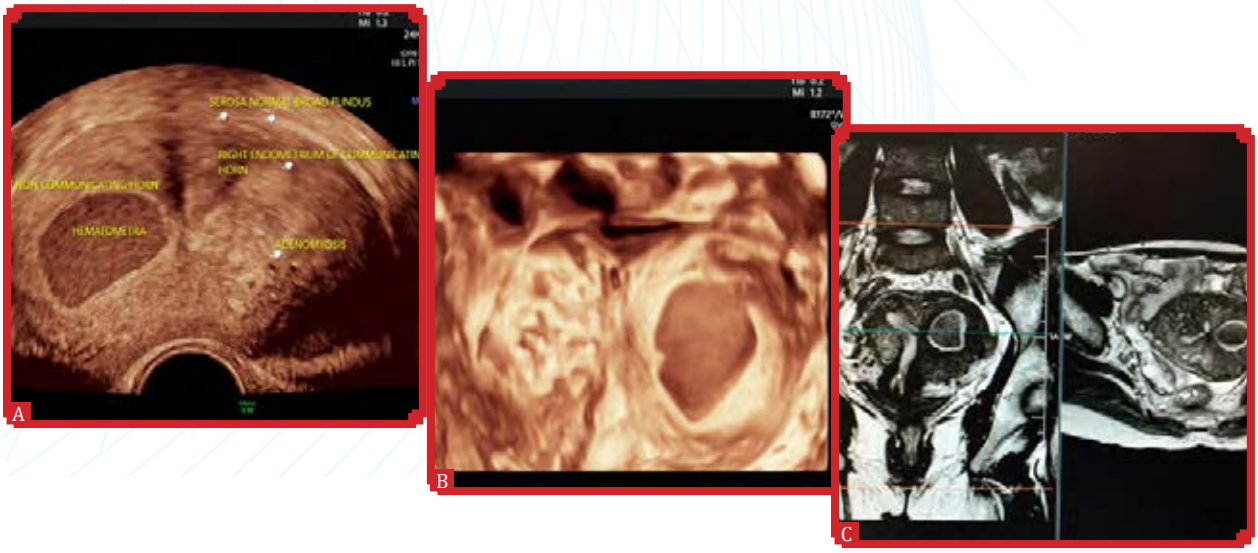


Figure 1. Patient: Teenage girl with dysmenorrhea.

(A) 2D ultrasound suggests a hematometra on the left side and a right uterine horn with an endometrium of 10 mm, (B) Transrectal ultrasound with a C1-5D probe confirmed a 5 x 5 cm hematometra on the left side and a right horn with an endometrium of 10 mm; (C) The transrectal scan with a RIC-9D probe with 3D rendered view and HD live confirmed the existence of a hematometra in the left horn and a unicornuate like right horn and the1.49 cm septum dividing the 2 cavities; (D) Explanatory line drawing of Robert's uterus; (E) Hysteroscopically only the right tubal ostium was seen; (F) Laparoscopic picture of the uterus; (G-I) Surgical endometrectomy and myometrial reconstruction of the right uterine horn; (J) Excised specimen.



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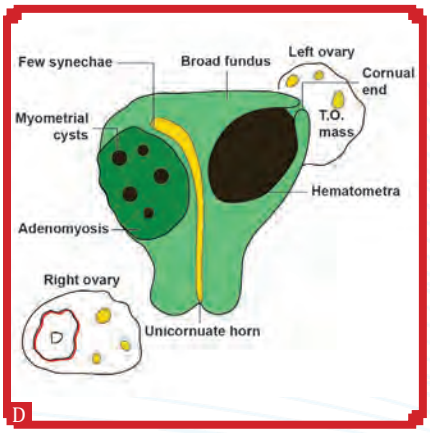
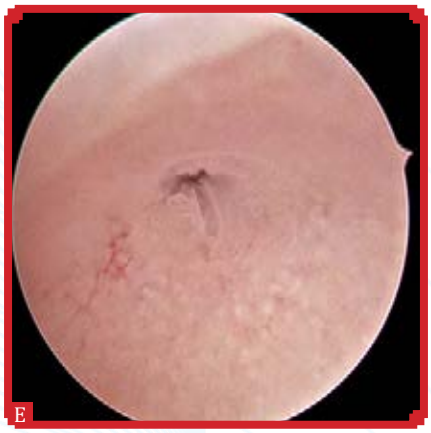
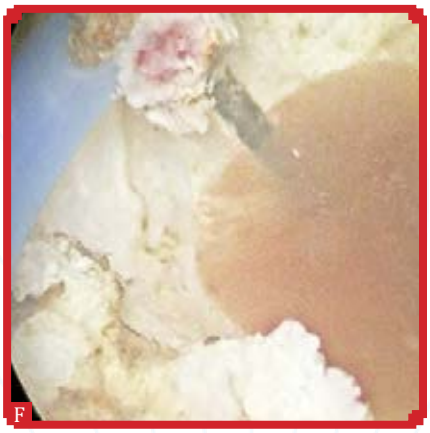






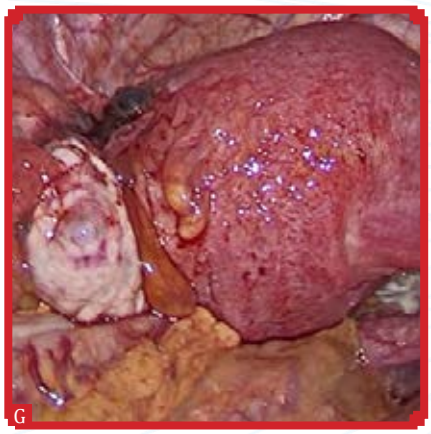
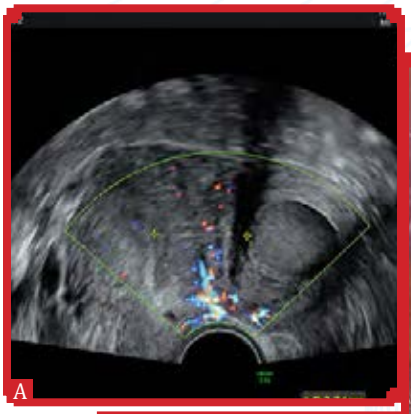
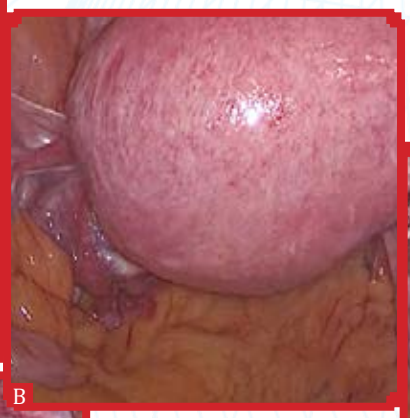
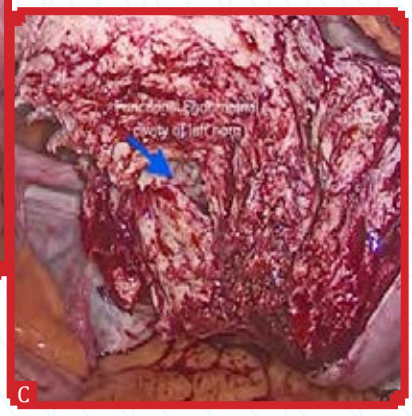


Figure 2. Patient: Primary infertility with endometriosis.

(A) 2D ultrasound image with transvaginal RIC 5-9D volume probe of left horn hematometra and right unicornuate cavity; (B) 3D rendered view with 4,1 mm thick septum, normal outer contour of uterus; (C) MRI image; (D) Explanatory drawing; (E) Hysteroscopic view with right tubal ostium only, (F) Situs after hysteroscopic septum resection; (G) Laparoscopic picture with single fundus and endometrioma of the right ovary, which was resected.







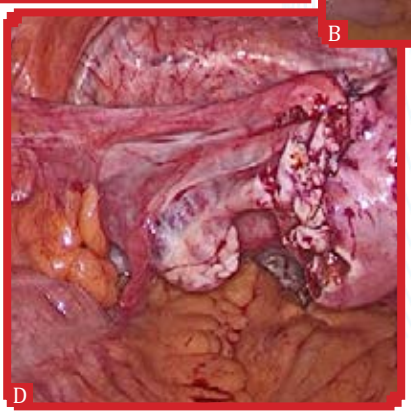


Figure 3. Patient: 2 live children with dysmenorrhea.

(A) 2D ultrasound image with left hematometra; (B) Laparoscopic view of uterus with left unconnected horn; (C and D) Laparoscopic resection of the left horn and uterine reconstruction.

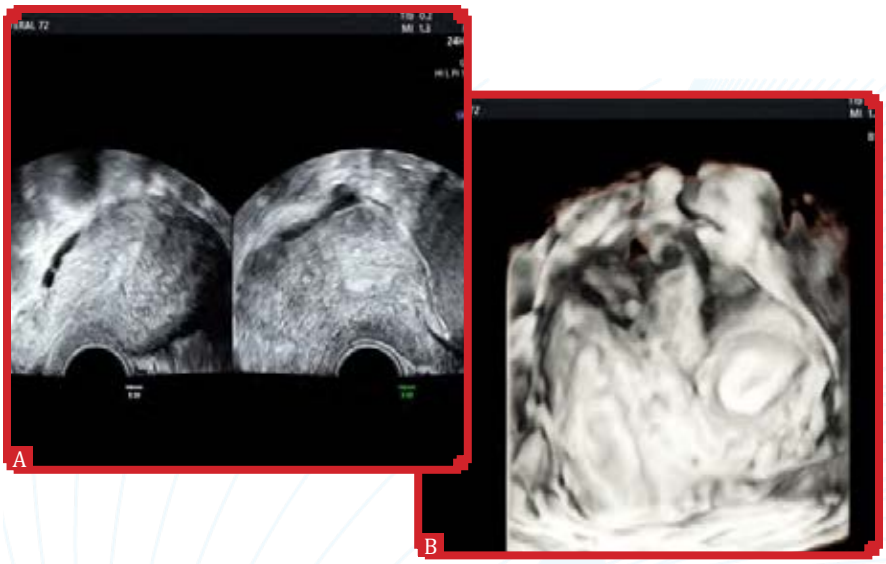


Figure 4. Patient: 2 live children with recurrent endometriosis.

(A)-Left side of the picture, the right horn of the uterus shows an anterior wall adenomyosis and a 6 mm endometrium, (A)-right side of the picture, left horn of the uterus and a 7 mm endometrium with a polyp. No communication between the left and right horns. A 6 cm endometrioma is seen in the left ovary; (B) 3D image with normal uterine contour.

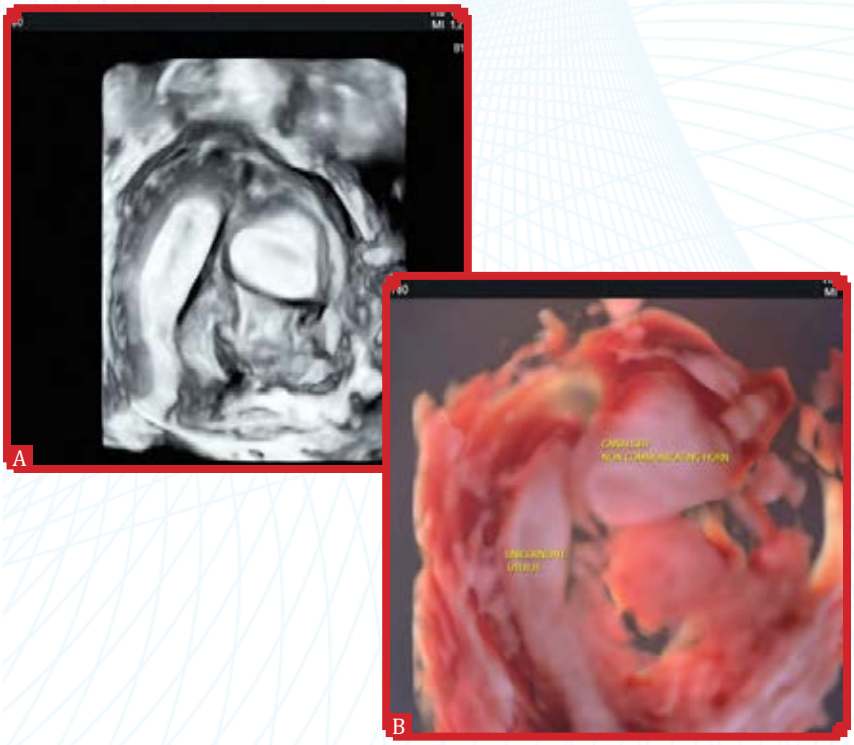


Figure 5. Patient: Recurrent (n = 3) miscarriage with dysmenorrhea.

(A) Small communicating uterine cavity on the right side and blind uterine cavity on the left side in a 3D rendered vaginal ultrasonic view; (B) 3D live reconstruction.

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Hysteroscopic Metroplasty of T-shaped Uterus and Subsequent Reproductive Outcome

Rebecca C Pierson,[1] Johanna S Archer,[2] Shan M Biscette[1]
[1]University of Louisville, Department of Obstetrics, Gynecology, and Women's Health, Louisville, Kentucky 40202
[2]Fertility First, Louisville, Kentucky 40205

Corresponding author:
Rebecca C Pierson MD
Department of Obstetrics, Gynecology, and Women's Health
Ambulatory Care Building, First Floor
550 S. Jackson Street, Louisville, Kentucky 40202
Fax (office): (502) 561-8684
Email: rebecca.c.pierson@gmail.com

Johanna S Archer VMD MS MD
Fertility First
6420 Dutchmans Pkwy, Suite 395
Louisville, Kentucky 40205
Email: archer.johanna@gmail.com

Present address: Dr Archer is now affiliated with the Indiana University Department of Obstetrics and Gynecology in Indianapolis, Indiana.

Shan M Biscette MD
Department of Obstetrics, Gynecology, and Women's Health
Ambulatory Care Building, First Floor
550 S. Jackson Street, Louisville, Kentucky 40202
Fax (office): (502) 561-8684
Email: shan.biscette@louisville.edu

The surgical technique employed in this patient's treatment was presented as a video abstract at the Global Congress on MIGS in Vancouver, BC, Canada in November 2019.

Funding/grant support: None

Declarations of interest: None

While there have been multiple papers published regarding dysmorphic uteri, the authors have found a paucity of information in the USA regarding T-shaped uteri. The authors wish to present their experience with a single patient with primary infertility. At the time of initial presentation, the patient was a 35-year-old woman with a BMI of 22. She had been attempting conception for approximately 1.5 years.

Her medical history was insignificant and she denied any history of abdominal or pelvic surgeries. She denied any history of sexually transmitted diseases and pelvic inflammatory disease. Gynecologic history included regular monthly menses lasting 2-4 days, mild dysmenorrhea treated with over-the-counter NSAIDs only, and vaginal intercourse 2 times per week on average. She was unaware of any family history of fertility or pregnancy issues or any gynecologic problems.

Her partner was 31-year-old and denied any medical problems or prior surgeries. He had fathered one previous pregnancy (11 years prior) with a different partner. A recent semen analysis was normal.

Prior to evaluation, the couple was treated by another fertility specialist with 11 cycles of superovulation using letrozole. She responded well (single or two follicles each cycle) but did not conceive. Five cycles included intrauterine insemination with normal total motile sperm count. Multiple cycles included a progesterone level indicative of ovulation. Her laboratory testing results showed normal thyroid function, negative thyroid antibodies, and normal vitamin D level.

Her initial transvaginal 3D ultrasound showed a T-shaped uterus (Fig. 1A) which was confirmed on hysterosalpingogram (Fig. 1B). Fallopian tubes were patent.

The patient was counseled and elected to undergo hysteroscopic metroplasty.

A 4 mm 30-degree hysteroscope was introduced without difficulty into the uterine cavity. The abnormal endometrial contour was appreciated and the view of both ostia was obstructed, though both ostia were easily visualized with manipulation of the hysteroscope. The abnormal tissue at the "shoulders" of the T was resected using the loop electrode bipolar resectoscope. The abnormal tissue was resected until the fundus and both ostia were seen in the global hysteroscopic view. A 6Fr Foley catheter was placed in the endometrial cavity. The hysteroscopic resection procedure was uncomplicated and the patient was discharged home. She was instructed to take 2 mg of estradiol daily for 2 weeks. The catheter was removed 7 days postoperatively and the patient had no complaints.

A follow-up transvaginal 3D ultrasound showed improved contour of the endometrial cavity (Fig. 1C). The patient had prompt return of regular cycles and conceived spontaneously approximately 6 weeks after

her metroplasty procedure. She had a single intrauterine pregnancy identified on transvaginal ultrasound at 6 weeks 1-day gestation (Fig. 1D). Her pregnancy was uncomplicated and she delivered a live infant by spontaneous vaginal delivery at term.

The T-shaped uterus morphology is classically associated with diethylstilbestrol (DES) exposure.[1] In the United States, most DES-exposed women are no longer of reproductive age, though in other countries the drug was in common use for a longer time and DES-exposed women may be younger. There are many reports in the literature of dysmorphic uteri,[2,3] but because of the lack of a commonly accepted definition for T-shaped uterus, it is difficult to estimate the current prevalence of T-shaped uterus. In this case report, the authors demonstrate a *de novo* T-shaped uterus which was corrected with conservative metroplasty. Spontaneous conception occurred very shortly thereafter and the patient had an uncomplicated pregnancy and delivery. The authors suggest that though likely rare, the true T-shaped uterus abnormality does present to the gynecology or fertility office, and gynecologists should be aware that resection of the redundant tissue may lead to spontaneous conception and improved reproductive outcome.

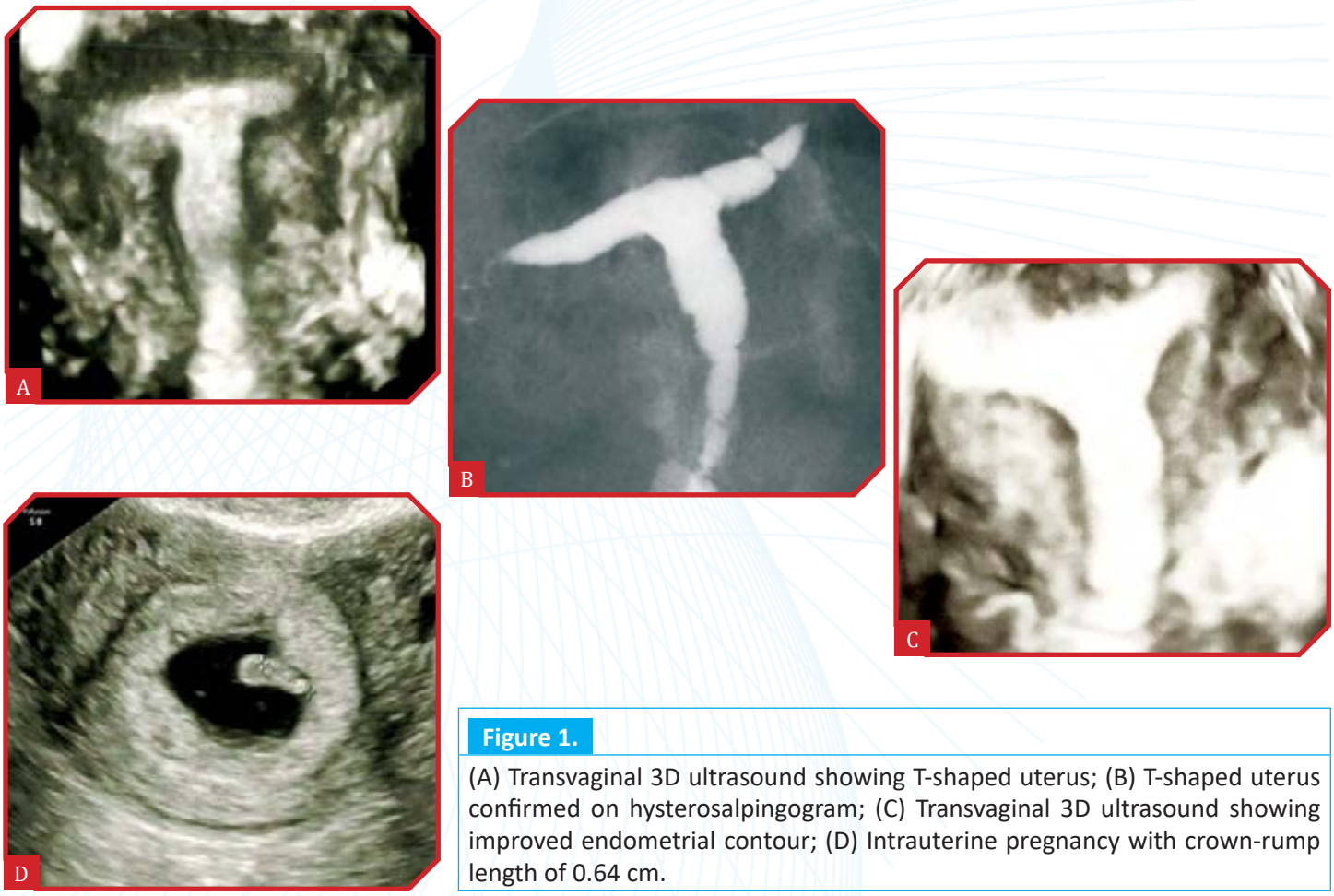

Figure 1.

(A) Transvaginal 3D ultrasound showing T-shaped uterus; (B) T-shaped uterus confirmed on hysterosalpingogram; (C) Transvaginal 3D ultrasound showing improved endometrial contour; (D) Intrauterine pregnancy with crown-rump length of 0.64 cm.

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MASK ETIQUETTE

Dr Meenu Agarwal

Surgeons! Beware!! Know your protection gear!!!

Save your own life!!!!

1. Wear a N95 mask (Standard Care) – This mask can block 95% of harmful air particles from entering your body via mouth and nose, hence the name. It protects you from the transmission of droplet-based virus or bacteria, dust, fiber particles, allergy-causing pollens, etc.
2. Always wash your hands first before wearing the mask
3. Discard the mask after each use. In case you want to reuse it, washing will make it N70, sterilization will make it N60. Its better to leave it for 72 hours before reusing it. Buying 7 N95 and rotating them every 7 days, using a new one each day. You can put them in marked bags Monday to Sunday or 1–7.
4. Multiple layers of surgical masks will not improve the filtration effectively as compared to N95, please do not use it as an alternative
5. Mask + N95 might be ok but not needed
6. Cotton surgical masks provide virtually no protection, no matter how many layers are put on
7. Face shield is the best add-on for surgeons, anesthetists, dentists and the nursing staff. In aerosols generating procedures it can protect up to 90% of the aerosol blast at face.
8. Wearing a protective goggles/spectacle has a protective compounding effect
9. The pressure drop is an indicator of breathing discomfort. N95 are bound to produce some resistance to breathing
10. If you are breathing too easy in your N95 mask, its time to discard the mask
11. The increased flow rate will not drastically change the oxygen exchange.

For the covid positive patient who is at the pinnacle of responsibilities

If we don't control the source, we can never achieve results!!

a. Patient should always wear a perfectly fitting N95 mask
b. She should never wear a mask with an exhalation valve
c. Strict no to multilayered or any other Commercial mask
d. Wearing a face shield will help
e. She should not touch mask after wearing

How to prevent fogging of the lens while operating!

1. Rinse the lens with soap and water and wipe with a soft cloth
2. Use folded tissue under your mask at the bridge of the nose
3. Seal the mask with adhesive tape
4. Rest your glasses over the mask
5. Breath downwards with an upper lip over the lower lip

Frequent hands washing is the key for both surgeon and the patient

Peter Tsai, a Taiwanese American scientist invented the synthetic fabric used to make the N95 respirators 2 years before the pandemic hit. This is considered to be the most effective barrier to prevent the spread of corona virus.

The mask's filter contains both positive and negative charges. It can attract neutral particles like bacteria from viruses, polarize these particles and trap them before they can pass through the mask

Interesting snippets on history of face masks!!

Image. Operation Theatre of Jefferson Medical College, Philadelphia 1902

There were no masks being used in the operation theatre till a publication by Dr Alice Hamilton in JAMA in 1905. She advised that surgeon and nurses should use a mask to cover their mouths so that the infection is prevented. This was concluded after a study done with culture plates kept on the table while surgeon operated and spoke and she found about 75 bacterial colonies thriving in these culture dishes, out of which about 50% were harmful. Saliva droplets from the surgeon's mouth were actually noticed by a medical student who then told his observation to his teacher Dr Alice Hamilton who then conducted this study.

ISGE's Official Facebook Group

Dr Amal Drizi
Independent Consultant in Obstetrics and Gynecology, Algiers, Algeria.
Board member of the ISGE

Endoscopy is a passionate field, however still poorly accessible in many countries. To date, many gynecologists struggle in varying degrees to gain skills in this matter. Having a respectable place where they could be in touch with their peers from different countries to share knowledge and experience, is undoubtedly one of the most stimulating and beneficial opportunities for all. One of the biggest traps for a practitioner is to end up isolated from the rest of the medical community, unaware of what is happening out there. Building bridges in a caring platform of communication, without barriers between beginners and masters, offers a warm place where endoscopy lovers can come together, speak their minds, ask questions, get answers, share their concerns about daily challenges, and thus get valuable and standardized orientation.

It is also an opportunity for us to be continuously updated about the Society's current and future activities for the benefit of all.

This is what ISGE's forum is about. It is a Facebook group exclusively dedicated to ISGE's members, allowing heartfelt exchange with the most generous and skilled masters of the world, without fear of being judged.

When I created this group a year ago, my main motivation was promoting communication between all members of ISGE, so we could learn from one another. Communication means stimulation, stimulation leads to action, and action to progress and achievements.

Today, I am very happy to be part of this forum where there is a bit of everything: questions, opinions, humor, videos, tests, discussions and even beautiful endoscopic pictures. In addition, it is always a pleasure to interact with the Society's authors who share their scientific works every now and then, thus allowing interaction and further explanations whenever needed.

The English Language

As ISGE is an international Society, gathering people from all around the globe implies many of them are not native English speakers. Depending on the difficulties every one of us is experiencing with the English language, breaking fears is the first step towards improvement. In fact, being daily stimulated through reading and making the effort of interacting in English will sooner or later lead to progress. Languages are all about practice, and ISGE's forum thankfully allows that too. Therefore, we strongly encourage all not to let the language barrier stand in their way and still express themselves despite insecurities. Let us not forget that communication is much more than language skills.

A phrase I particularly cherish from the ISGE's website:

"ISGE is a truly international society but remains to be a family for the minimal invasive surgeon in gynecology. Please ask your questions and everybody form the Board of the ISGE is here to answer and help you!" Em. Professor Bruno Van Herendael, ISGE's Medical Director.

And not to forget: you learn from us just as much as we learn from you!

Amal Drizi

THE INTERNATIONAL SOCIETY FOR GYNECOLOGIC ENDOSCOPY

PROMOTING VAGINAL SURGERY

Webinars, Nearly-Live Surgery and Virtual Conferences,

The idea to get close to our members – ISGE is a world wide society hence getting personal contact with our members is nearly impossible – was germinating since quite a while over the last years but the SARS – CoV – 2 (Corona COVID 19) pandemic has been the wake-up call to bring all the ideas we had into the real thing. The decision was made to have an own ISGE platform so that we can control all aspects of the e-learning ourselves. We did start with Webinar Jam awaiting the possibility to acquire a professional platform. It has been decided on EXCO level to offer the members free updates on the different scientific data available mainly through webinars. These webinars, the equivalent of in-depth classes, on the various subjects of endoscopy, are conceived in different languages. We did start with French and English but foresee webinars in Spanish. The registrations for these webinars vary between 800 and 600 whilst around 350 participants follow the live webinar. The webinars are all recorded and stored on www.isge.org so that these can be viewed at a later stage. During the webinars, there is a chat section allowing to ask questions that can be answered by the presenters. Also, for the recorded webinars questions can be asked that are then send to the presenters to be answered. The first webinar in English has been on fibroids with colleagues from China, Taiwan and Korea and except for some small details everything went very smoothly. Our second features are the "Nearly Live" surgeries. ISGE started opting for this form of presenting surgical procedures some years ago. The idea is to bring non-edited video recordings of surgical procedures. This procedure has the advantage mainly that the surgeon is not under stress whilst giving the explanation but also tapes can be stopped and rewinded to emphasize some details. The last feature is the e-congress or virtual congress. Here we organize a straightforward conference. The first one will be on December 5 -6 this year on Endometriosis ***"VirtualEndo 24 the global view"*** a non-stop conference starting at 08:00 am on the fifth in South Africa as our honorary secretary Viju Thomas will be the program chair. The idea is to let the different world societies make their program and to travel with the different time zones to the different continents ending in the Far East by December 6.

Medical Directors Office
Frans Reinemundlei, 14, 2900 Schoten
Belgium

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Time and Dates Schedule for ISGE Webinars and Nearly Live Surgery

Date	Time	Title	Responsible	Language	Duration
14/05/2020	Pre-recorded www.isge.org	Operations in time of SARS – CoV – 2 (Webinar)	Yamal Patel ***Sun Pharma***	English	90 min
26/05/2020	07:00 pm CEST	Basic Laparoscopy (webinar)	Adel Sedrati ***Serono - Merck***	French	90 min
06/06/2020	04:00 pm CEST	Treatment of Fibroids (webinar)	Xiaoming Gong ***Karl Storz SE & Co KG***	English	120 min
14/06/2020	02:00 pm IST 11:30 am CEST	Total Laparoscopic Hysterectomy (Webinar)	Kurian Joseph ***Olympus***	English	120 min
27/06/2020	04:00 pm CEST	Nearly live surgery Difficult Hysterectomy	Paya Pasic & Mega Cesta	English	45 – 60 min
11/07/2020	01:00 pm CEST	Treatment of Asherman (webinar)	Sanket Pisat ***Karl Storz Se & Co KG***	English	35 min
25/07/2020	04:00 pm CEST	Nearly live surgery Simple & Moderately difficult Hysterectomy	Paya Pasic & Nkiruka Chuba	English	45 – 60 min
22/08/2020	01:00 pm CEST	Nearly Live Surgery Hysteroscopic Myomectomy	Bruno van Herendael – Bart De Vree ***Karl Storz Se & Co KG***	English	60 min
05/09/2020	01:00 pm CEST	Energies in Endoscopy (webinar)	Paya Pasic – Andrew brill	English	60 min
26/09/2020	01:00 pm CEST	Nearly Live surgery Endometriosis	Adel Shervin	English	45 – 60 min
10/10/2020	01:00 pm CEST	Endometriosis a progressive disease (webinar)	Adel Shervin	English	35 – 45 min.
24/10/2020	01:00 pm CEST	Controversies in Vaginal Surgery (webinar)	Bashkar Goolab	English	45 min
14/11/2020	01:00 pm CEST	Use of Manipulator in Hysterectomy (webinar)	Prashant Mangeshikar	English	35 – 45 min
28/11/2020	01:00 pm CEST	Nearly Live Surgery Pelvic Floor Pecto Pexy	Günter Noé	English	45 – 60 min
05-06/12/2020	Start 08:00 am CEST	Tele Conference Endometriosis 24 hrs different time zones	Viju Thomas ***Karl Storz Se & Co KG***	English	24 hrs
19/12/2020	01:00 pm CEST	Nearly Live Surgery Vaginal Hysterectomy	Andreas Chrysostomou – Bashkar Goolab	English	45 min
16/01/2021	01:00 pm CEST	Uterine Malformations (webinar)	Luis Alonso Pacheco	English	50 – 60 min
30/01/2021	01:00 pm CEST	V-NOTES Single port Vaginal Surgery (webinar)	Ichnandy Arief Rachman	English	60 min

Welcome to ISGE

Members enrolled between April 2020 and June 2020

Name	Country	
Talbi Zeleikha	Algerie	
Sarah Choi	Australia	
Myriam Struyven	Belgium	
Bart De Vree	Belgium	
Charlotte Maillard	Belgium	
Ekane Halle	Cameroun	
Sandrine Mendibi	Cameroun	
Jean Media	Denmark	
Sanghamitra Satapathy	India	
Sherwan Jalal	Iraq	
Dlovan Ali	Iraq	
Edward Osewe	Kenya	
Mohamed Achour	Morocco	
Zeyar Nyein	Myanmar	
Alberto Ulises Cano Del Carpio	Peru	
Justin Mboloko	RD Congo	
Andra-Teodora Negroiu	Romania	
Eton Bvuma	South Africa	
lusandolwethu Shimange-matsose	South Africa	

ISGE Sponsors

Virtual Congress on Endometriosis

ISGE' is organizing a 24-hour virtual congress on Endometriosis, December 5 and 6 2020. Endometriosis is one of the most challenging conditions affecting 1 out of 10 women during their reproductive age which is approximately 175 million women worldwide. It causes debilitating pain and infertility.

This meeting will feature all major scientists, researchers and surgeons and will be divided into three time zones, Europe and Africa, South America and North America, Asia and Australia. Each time zone will have 8 hours of simultaneous presentations.

One channel (Room 1) with lectures of 20 minutes presentations and surgical tutorials, Channel 2 (Room 2) with live surgeries (one per time zone of 1:30 hours) and the rest nearly live surgery (1:00 hour for each presentation) and Channel 3 (Room 3) for the patients shorter exposure and conceived in a way that they cannot switch to the other channels. ISGE is partnering with all major laparoscopic societies and patient advocates around the world in organizing this meeting and we would like you to join us. Please let me know if you are interested to participate.

Resad Paya Pasic

HISHAM ARAB PRIZE 2020-2021

This prize was established in 2016 to be awarded to the best YES presenter once a year at any of the ISGE annual or regional meetings. The prize is composed of 1000 USD in cash and a plaque which should be presented at the closing ceremony of the congress.

THE WINNER FOR 2019 AT ISGE ANNUAL MEETING THAT WAS HELD IN CAPE TOWN, SOUTH AFRICA DURING 13-17 APRIL 2019 WAS DR ANNELIZE BARNARD, FROM SOUTH AFRICA.

Behind the Scenes

Paula Simons
Logistical Assistant to the Medical Director

I am a Belgian living in Malta. I have been working in the "Marketing Research" and still in Real Estate and Consultancy. After the passing away of my husband I met with Bruno van Herendael, whom me and my late husband do know for some 40 odd years. In one of our conversations he started telling me about ISGE. He told me that he was one of the founding members of ISGE and now its Medical Director after having been the president. I was intrigued to hear about the goals of ISGE. As I was looking for a new challenge in my life I did ask him if he could use some help. He eagerly accepted my offer as he is overwhelmed with work as ISGE is growing exponentially these last few years. I offered to travel with him to get to know the function better and did experience that there is quite a workload to be covered. We then did divide the tasks whilst Bruno van Herendael deals with the scientific and political aspects of the task I am concentrating on the day-to-day operation of the ISGE and management of its staff. I do attend and participate at all meetings of the Board and all committee meetings. I took the task to provide the administrative support for Board of Directors and Executive Committee activities, all committees, task forces, and other advisory bodies of the ISGE. I work in very close collaboration with the executive secretary, Patrizia Zaratti and the webmaster Hendrik Mondelaers and Dirk Schurmans in order to provide the best service to all members also in the field of e-learning, webinars and virtual conferences. All this under the supervision and in close collaboration with the medical director.

If you missed submission for this year, you still have a chance to win it next year at the Annual ISGE meeting in Split, Croatia: June 6 - 9, 2021.

ISGE Board Members

Abri De Bruin (South Africa), Annelize Barnard (South Africa), Jack Biko(South Africa), Amal Drizi (Algeria), Adel Sedrati (Algeria), Jorge Dotto(Argentina), Miguel Angel Bigozzi (Argentina), Shan Biscette (USA), Joseph Alappat Kurian (India), Eddy Hartono (Indonesia), Meenu Agarwal (India), Yang Kuang (China), Chyi-Long Lee (Taiwan), Dusan Djokovic (Portugal), Noé Guenter (Germany), Michael Anapolski (Germany), Ruben Vanspauwen (Belgium), Ameneh Haghgoo (Iran), Jim Tsaltas (Australia), Ajay Rane (Australia).

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ISGE Accreditation program
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Inclusion in ISGE Directory
Contact the secretariat for more information: secretariat@isge.org