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Why a special issue on diagnostic hysteroscopy?

Letter to the editor

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Endoscopy is the branch of medicine where the inside (endo) of an organ's cavity is viewed (scopy) and eventually treated. Depending on the targeted organ, different terms have been defined: colonoscopy; arthroscopy; laryngoscopy to name just a few. Hysteroscopy is the branch of endoscopy dedicated to the uterine cavity. Etymologically, it derives from "scopy", which means "viewing", and "hystero" which means "uterus". It literally means visualization and examination of the uterus and by extension, the surrounding cavities (vagina, cervix and part of the tubes).

Visual examination of a part of the organism is a very important discipline in medicine. As opposed to "endo", the visual examination of the external covering of the human body, the integument, is a whole specialty in medicine termed dermatology. It has tremendously evolved throughout the centuries and possesses large references about visual diagnosis of skin disorders, as well as their treatment. When

taking a closer look at this specialty, it is a fact that all dermatologists know by heart the composition of the integument, the fundamental lesions to target and biopsy in order to the diagnosis-making process. Dermatology is an independent specialty that cannot be replaced by maxillofacial surgery for instance. The latter is led by surgeons who do not have the expertise of a dermatologist in terms of skin examination, but do better know the rules of how to properly remove pathology. Although the two specialties have different scopes and skills, they complete one another.

Hysteroscopy however, is like dermatology being led by surgeons. In fact, today's opinion-leaders in hysteroscopy seem to have a typical "surgeon mindset", with a particular interest in advanced uterine surgery, but with limited interest in diagnosis. This makes sense as surgery and diagnosis consist of two different approaches requiring different backgrounds and skills. This

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separation has already been made, not only in dermatology/maxillofacial, but also in nephrology/ urology and in gastroenterology/general surgery. Colonoscopy for instance is the visual examination of the colon-rectum, with identification of the lesions to be biopsied and/or removed. It is performed by gastroenterologists trained in endoscopy, not by surgeons. If cancer is documented however, surgeons take over and remove the colon-rectum under oncological requirements. A surgeon will not be interested in the colonoscopic criteria of medical conditions colonoscopy can diagnose, such as rectocolitis, tuberculosis, Biermer disease etc. Likewise, a gastroenterologist is not supposed to acquire the surgical skills surgeons have. This is why separating the two disciplines has allowed expansion and progress in both.

Unfortunately, this separation has not yet been officially acknowledged in “hysteroscopy/ intrauterine surgery”, at the detriment of hysteroscopy as a diagnostic tool. Any gynecologist who would dive in the depths of endometrial physiology, histology and histopathology could clearly confirm that our practice of hysteroscopy is not based on a deep knowledge of these basics. It becomes factual that we are not doing hysteroscopy, but rather under vision intrauterine procedures. Hysteroscopists worldwide are dealing with the endometrium like a dermatologist, who has a poor idea of what the skin is made of, would deal with his specialty. Not to mention that unlike the skin, the endometrium undergoes cyclical changes, which make it even more complex to comprehend. Despite that, there is to date a lack of proper training for hysteroscopists in this area.

Today, hysteroscopy being led by expert uterine surgeons is limiting the development of the diagnostic aspect of medical conditions, such as dysfunctional and inflammatory disorders. To date, the term “diagnostic hysteroscopy” has become almost exclusively linked with the instrumental and technical issues, including indications and pain management (1-7). Although targeted biopsy has received attention and been improved in the last years, still mostly in terms of technique and comfort (8;9). However, in the absence of evident intrauterine anomalies such as overgrowths, adhesions or malformations, there are to date no specific guidelines for the assessment of the mucosa itself to define the optimal sites for targeted biopsy in diagnostic hysteroscopy. In “an empty cavity”, hysteroscopy is usually conducted in a “come in – come out” fashion and blind sampling with Pipelle continues to be performed at the end of the procedure. The technical aspect of the procedure has been much more invested than the analytic aspect of its diagnostic possibilities. This is quite problematic and is limiting the potential of the procedure, especially in medical conditions, such as dysfunctional disorders in symptomatic patients suffering from abnormal uterine bleeding (AUB) or unexplained infertility. Analogically, it looks more like a dermatologist who views inflammatory lesions to which a histological etiquette is requested, yet instead of performing a targeted sampling within the observed lesions, the skin would be blindly and randomly scratched anywhere else.

It is a regrettable fact that there is to date no standardized methodology to examine the endometrium in respect to its basics of physiology and histopathology (10). Uterine surgery continues to shade diagnostic hysteroscopy and the latter continues to receive limited attention and to be performed by

practitioners who have a modest knowledge on the different facets of the endometrium. Additionally, many colleagues are persuaded there is no point in putting efforts into developing diagnostic hysteroscopy because the final diagnosis belongs to histopathology. The lack of education in the areas of endometrial physiology and histopathology has turned hysteroscopists into passive actors, completely relying on the pathologist's conclusions. This is why diagnostic hysteroscopy has not much progressed as opposed to the other branches of endoscopy, such as colonoscopy and fibroscopy.

As a thoughtful practice of diagnostic hysteroscopy by a warned hysteroscopist can considerably transform the diagnostic and decision-making process for the patient's benefit (11), this special issue will exclusively be dedicated to the diagnostic opportunities hysteroscopy provides. It aims at providing an educational content for a more standardized practice of diagnostic hysteroscopy in a way which is founded on the available evidence, including basic sciences. We advocate separation of diagnostic hysteroscopy from uterine surgery, as well as the importance of a proper training of colleagues with a special interest in diagnostic hysteroscopy. Hopefully, this will allow the latter to evolve like all the other branches of diagnostic endoscopy.

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Guest editor of The Trocar's special issue on diagnostic hysteroscopy.

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