Gynecol Surg (2004) 1:49–59
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SOCIETY NEWS

Dear members of the European Society for Gynaecological Endoscopy,
Dear colleagues,

Over the past quarter century, we have seen the establishment of endoscopy as the third pillar of gynaecological surgery. Abdominal surgery, vaginal surgery and endoscopic surgery offer us the wide range of therapeutic options needed to optimally deal with the individual problems of our patients. The spectacular success of endoscopy has been driven by the forces of innovation, the philosophy of minimal trauma and the willingness to look at old problems in the new light of multimodality. We have today at our disposal an armamentarium of technology and techniques ready to deal with every conceivable diagnosis and surgical problem.

What initially started as a selective society for highly experienced laparoscopic gynaecological surgeons, has opened its doors for all gynecologists with interest in endoscopic procedures and allied techniques. In 2001 at the 10th annual meeting of the European Society for Gynecological Endoscopy (ESGE) in Lisbon 21 national endoscopic societies did join the ESGE as a member society.

The success of the ESGE strongly depends on the existence of its own scientific journal.

This first issue of *Gynecological Surgery, Endoscopy, Imaging, and Allied Techniques*, the official organ of the ESGE, represents this journal and is a step into this new era for the community of gynecologic surgeons and allied scientists in Europe. For the ESGE, this scientific journal will be the platform for publication of original scientific work of the members of the ESGE and allied scientists as well as a platform to communicate new and innovative techniques that are essential for the progress the ESGE stands for.

Information of the members, communication of new guidelines, recommendation of forthcoming congresses as well as reviews of congresses and discussion of actual topics are only some aspects of this journal that outline the high impact which could be achieved for the society.

To guarantee this high impact everyone of the society is recommended to support this journal by contribution of scientific work of high standard. The Editorial Board representing the leading scientists in gynecological surgery in all European countries will take care for short review times and a peer review process to guarantee this high scientific standard.

Gynecological Surgery, Endoscopy, Imaging, and Allied Techniques will be the leading journal in its field and I am sure that the society as well as each one of the society will have a large amount of benefits from this journal that should be the scientific platform from now on.

Prof. Dr. D. Wallwiener, President of the ESGE

Structure of the society

Executive Board

D. Wallwiener, Germany (President)
M. Bruhat, France (Past President)
J. Dequesne, Switzerland (Vice President)
R. Campo, Belgium (Secretary)
K. Neis, Germany (Treasurer)
G.B. Melis, Italy (Ass. Secretary)

General Board

G. Bigatti, Italy
H. Brölmann, The Netherlands
M. Candiani, Italy
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J. Cortes Prieto, Spain
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C. Rasmussen, Sweden
B. Rudelstorfer, Austria
A. Wattiez, France

R. Lachat, Switzerland
Co-opted member to the board to establish a professional Treasury

E. Zullo, Italy
The 13th Congress Secretary

F. van den Brûle, Belgium
The 12th Congress Secretary

Special Interest Groups "SIG's"

Are meant as topic related working groups:

- Hysteroscopy (Elected Chairman: Y. Van Belle, Belgium)
- Sterility/Infertility
- Pelvic floor disorders
- Foetoscopy
- Colposcopy
- Oncology
- Teaching
- Office Endoscopy

Internal Commissions "IC's"

Are aimed to improve the functioning of the society:

Congress organisation

J. Dequesne, Switzerland

Newsletter

K. Neis, Germany

Education, training and accreditation

M. Bruhat, France	Coordinator
J. Keckstein, Austria	Laparoscopy
Y. Van Belle, Belgium	Hysteroscopy

Prizes and grants

P. O'Donovan, UK
Y. Van Belle, Belgium

Relation with national and international societies

Website R. Campo, Belgium

Journal

P. O'Donovan, UK
D. Wallwiener, Germany

Medico-legal aspects

M. Bruhat, France

Honorary Members

I. Brosens, Belgium
E. Cittadini, Italy
M. Gordji, Iran
A. Gordon, UK
H. J. Lindeman, Germany
H. Manhes, France
M. Mintz, France
H. Reich, USA
K. Semm, USA
H. Van der Pas, Belgium

ESGE Educational Project

Introduction

The ESGE considers teaching as well as encouragement of research as one of its major tasks.

Besides the efforts on the field of establishing a high quality journal and the organisation of a scientific validated annual congress, the ESGE has accepted the challenge to work out a concept, which will grant the quality of educational programs in the field of endoscopy. Until now there is no quality assurance system available and all training centres work according to their own established standards. We aim in collaboration with the major European educational centres and the national member societies to establish a European recognised validation system.

In the ESGE Internal Commission for Education, training and accreditation, Y. Van Belle has taken responsibility to elaborate a proposal for hysteroscopic techniques and J. Keckstein for laparoscopic techniques.

ESGE Training Programme on Modern Diagnostic and Operative Hysteroscopy

The concept was presented and accepted by the general assembly ESGE Annual congress in Luxembourg.

Although we have nowadays very many performing instruments and outstanding technique at our disposal, hysteroscopy still is very poorly spread in daily practice. Careful analysis of this problem has shown that the main cause for this is the lack of teaching in hysteroscopy during conventional medical training and the absence of standardized postgraduate teaching. This is the reason why the ESGE has developed a standard training programme on modern diagnostic and operative hysteroscopy. It consists of *a two days workshop with theoretical teaching, hands-on exercises and live operations, following definite guidelines.*

Furthermore, in order to support the organization of accredited workshops, the ESGE is able to provide organizers with a textbook and logbook for each participant, as well as guidelines for the preparation of models for the hands-on.

The *textbook* is comprehensive and covers all main subjects, from basics to major surgery.

(Sample pages from the *textbook*)

for therapeutic purposes. At the same time it is also worth distinguishing polyps from a (pseudo-) polypoid endometrium because of the more pronounced hyperplastic potential of the latter.

The exact aetiology is not know, but cytogenetic changes could play an important role. Polyps are more often found in the perimenopause or postmenopause (40-50 years). The prevalence of endometrial polyps is about 25% in a general population, thus being amongst the most common lesions of the uterine corpus.

Polyps can cause intermenstrual bleeding (mostly pre- or postmenstrual spotting) but most of them are asymptomatic, especially in the postmenopausal patient without hormone replacement therapy.

If polyps are coincidentally found during ultrasound, where an enlarged endometrium can be seen, it is essential to perform a diagnostic hysteroscopy in these cases. First of all the exact nature of the lesion should be assessed and secondly the hysteroscopy can decide on the correct therapeutic approach.

Hysteroscopic classification of polyps

Functional polyp (image 20)

This type shows glandular changes resembling those of the surrounding endometrium, often with proliferative activity. The surface is smooth, glistening and shows glandular dots. No special vascularisation is seen.

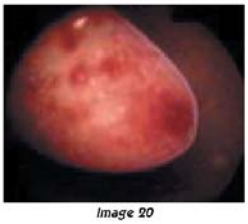


Image 20

Senile or atrophic polyp (image 21)

Typical atrophic glandular epithelium that is low columnar to cuboidal. The glands tend to be enlarged and show cystic dilatation. These polyps are frequent in the postmenopause and under Tamoxifen treatment.

Image 21

Hyperplastic or myoma-like polyp (image 22)

The glands resemble an endometrial hyperplasia, showing active growth and irregular shape and size. The surface of the polyp is smooth, almost without covering endometrium. Very little vascularisation is seen. In this group one should be on the look-out for so-called cancer-polyps, where a cancer is hidden under the smooth surface of the polyp.

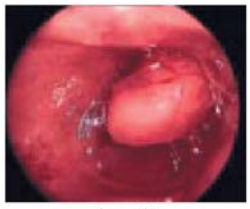


Image 22

Diffused polyposis (image 23)

This condition is characterized by the presence of multiple micropolyps. The exact pathophysiology and clinical significance have still to be determined.

Image 23

Myomas

A fibroid or myoma (image 24) consists of an excessive focal growth of muscular and fibrous myometrial tissue. They are more frequently found in the premenopausal or perimenopausal patient.

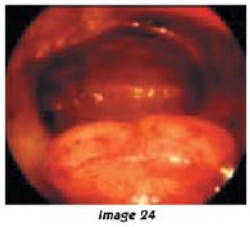


Image 24

Their prevalence is about 25–30 % in women of fertile age. Altough fibroids can be asymptomatic, they very often cause clinical symptoms in the form of menorrhagia and secondary dysmenorrhea.

In some patients the menorrhagia is very severe and leads to (severe) anaemia. This menorraghia is very typical for the submucosal location of uterine myomas and is not related to their size or number. Hypervascularisation

of the surrounding endometrium seems to be the main cause for excessive menstrual bleeding.

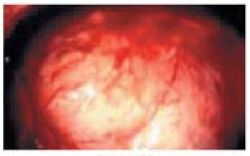


Image 25

The hysteroscopic appearance of fibroids is that of a round, pink-white, mid-consistence structure with a surface that is covered with many wide, long vessels and a thin layer of endometrial mucosa (image 25).

The former European Society for Hysteroscopy, now merged with the ESGE, proposed the following classification for submucous myomas (table VIII).

Submucous myomas - classificaton
Type 0
Complete circumference inside the uterine cavity
Type I
More than 50% of diameter within uterine cavity
Type II
Less than 50% of diameter within uterine cavity

Table VIII


Image 26

The **type 0 myoma** (image 26) represents a myoma which lies with its complete circumference inside the uterine cavity. These myomas usually are the easiest ones to treat by operative hysteroscopy. Problems with the resection of this type of myoma can be expected when their diameter is bigger than 4cm which causes difficulties with visualisation at the beginning of the procedure and later with prolonged operation time and increased risk of fluid overload.

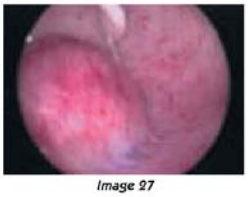


Image 27

The **type I myoma** (image 27) is a submucous myoma where more than 50% of its diameter protrudes into the uterine cavity. This myoma can also usually be treated by endoscopy. Nevertheless, one has to be very careful with the resection of the intramural part of the myoma.


Image 28

The **type II myoma** (image 28) is a mixed submucous / intramural myoma which has less than 50% of its diameter within the uterine cavity. This type of myoma should only be treated hysteroscopically by the experienced hysteroscopic surgeon since the risk of uterine perforation and fluid overload is very high during resection.

Pathology of the endometrium

This condition of the uterine mucosa can be due to hormonal deficiency in the post-menopause and to oral contraception or continuous treatment with progestogens in the pre- or perimenopausal period.


Image 29

Atrophy (image 29)

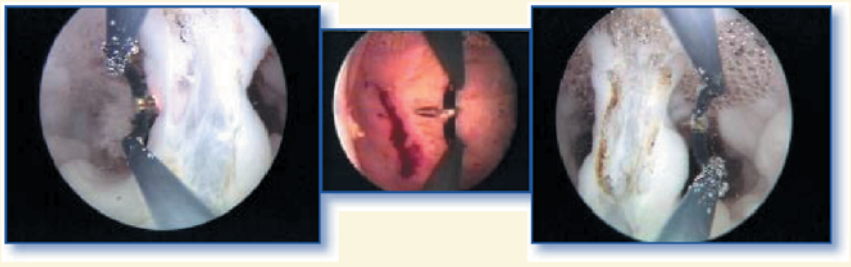
Atrophy of the uterine mucosa can be asymptomatic or lead to postmenopausal bleeding on the one hand or metrorrhagia in the case of hormone-induced atrophy on the other hand.

If this situation is due to hormone deficiency, hysteroscopy shows a very thin, white endometrium with the typical petechiae due to the distension of the cavity causing rupture of very small vessels. Histology shows a very thin layer of epithelium overlying few abortive glands. In the case of hormone-induced atrophy (oral

Participant's logbook: this 'script book' for the hands-on training includes a detailed description of every exercise, an evaluation module for the instructors and a questionnaire.

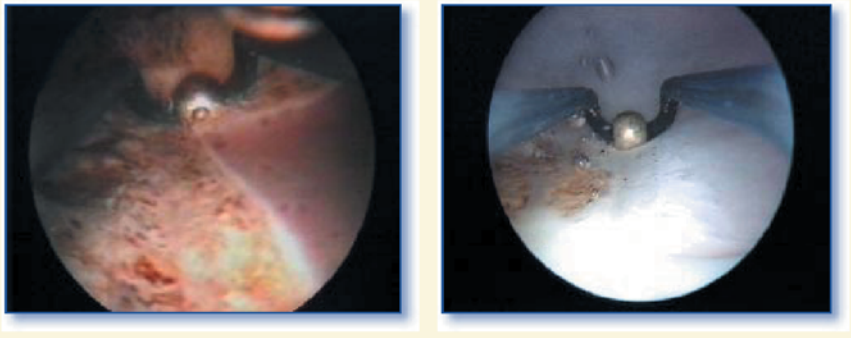
Uterine septum dissection

The uterine septum can be dissected using monopolar cutting current and a needle electrode or vaporized with laser or bipolar energy. The operation technique used by the participant has to follow the same rules as in clinical procedures. It is of utmost importance to keep at any moment both tubal ostia as landmarks. The septum must be dissected starting at the proximal part and moving in the direction of the uterine fundus. The same plane of cleavage must be maintained during the entire procedure, without any deviation to the anterior or posterior wall.



Endometrial ablation with different energy sources

A calf uterus has a modestly developed endometrium and myometrial conditions similar to the human uterus. This makes this organ a perfect model for the exercises on endometrial ablation. If the endometrium is resected with the cutting loop, special attention has to be paid to the risk of perforation. In case of coagulation with monopolar current, the rollerball should be moved slowly over the endometrium because the depth of penetration of the coagulation is not related to the power of the current but to the time of contact of the electrode with the tissue.
If destructive methods are used (coagulation, vaporization) it is advisable to take endometrial biopsies before the procedure is started.



POINTS OF INTEREST

Frequent cardinal errors:

1. Power of one or more systems not switched on.
2. Wrong flow direction of fluid or pump not on.
3. Wrong positioning of the camera.
4. Moving the instruments too fast and hectic.
5. Neglect fluid balance.
6. Working without instrument in direct sight.
7. Insufficient or too short contact of the electrode with the wall.

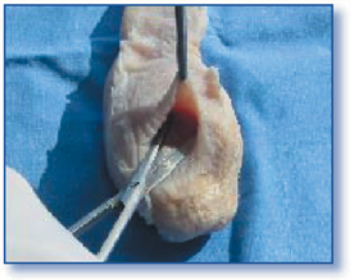
DOCUMENTATION

The procedures have to be documented as follows:

Cardinal errors:	No ❒ Yes ❒ .....
Assembling of instruments:	correct ❒ difficulties.....
Connecting in – and outflow, light cable and camera:	correct ❒ difficulties.....
White balance setting of the Camera:	correct ❒ difficulties.....
Setting and testing of the pumpsystem:	correct ❒ difficulties.....
Test run to remove air bubbles from the tubing system:	correct ❒ difficulties.....
Visual conditions:	correct ❒ difficulties.....
Polyp/Myoma resection:	correct ❒ difficulties.....
Polyp/Myoma destruction:	correct ❒ difficulties.....
Endometrial resection:	correct ❒ difficulties.....

Guidelines for models: the exercises are performed on animal models since experience with hysteroscopy workshops for more than ten years has shown that they can imitate the complete scale of findings and tactile sensations that will be encountered in real life situations and thus are, if properly prepared, by far superior to any other existing model.

3. Creation of a space under the serosal layer by blunt dissection

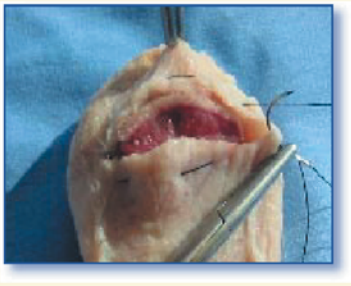


With the scissors, by blunt dissection, a space is created under the serosal layer allowing to insert a 3 to 5 cm^2 piece of cow tongue.

4. Insertion of a 3 to 5 cm^2 piece of cow tongue into the previously prepared space

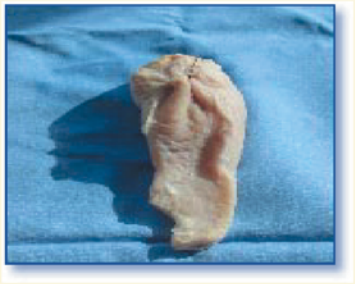
The piece of cow tongue that simulates the myoma is positioned.
This tissue offers the same consistency as human fibroids.

5. Suture of the serosal incision

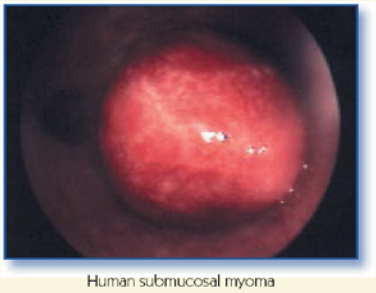


The serosal layer is sutured watertight.

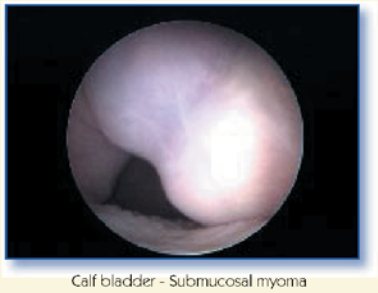
6. Extra stitch for fixation of the "myoma" to the bladder wall



An extra stitch to fix the "myoma" to the bladder wall is placed. With this model the visual appearance of the myoma is highly realistic.
Myomas can be placed on any of the bladder walls and the difficulty of the exercise changes according to the size of the myoma and to distance from the bladder neck.
The closer the myoma is to the bladder neck the more difficult the exercise becomes.



Human submucosal myoma



Calf bladder - Submucosal myoma

Guidelines for training models ESGE 10

Planning 2004: Now that this training programme is fully operational, max. 4 workshops will be organized *by the ESGE* during this year.

A first one will be held in Larnaca, Cyprus, March 4th – 7th. The fact that numerous applications had to be postponed (after registration had to be stopped at 75 participants!), clearly shows the need for this kind of events.

Individuals, National endoscopic Societies or companies who are interested in organizing *ESGE accredited workshops,* can obtain the guidelines and an application form from the ESGE Central Office or on www.esge.org.

Education in Laparoscopy

Presented by J. Keckstein (Villach, Austria) at the National society meeting in Barcelona and the annual ESGE congress Luxembourg.

The goals of an ESGE-educational project concerning laparoscopy should be:

1. Development of a standardized training course programme for gynecologists in the field of gynecological laparoscopy
2. Establish specialized training centres all over Europe, which offer such training courses according to ESGE-guidelines
3. Achieve a standardized quality-control-system for laparoscopy

In a first phase we aim to establish a standardized training course programme for gynaecologists in the field of gynaecological laparoscopy, this in collaboration with the current major training centres.

The basic idea for such a programme is to validate a "step by step" – course system, which combines theoretical and practical education.

The first step or "BASIC course" should only make use of pelvitrainers (using artificial or animal models) and/or virtual reality for practical training. Basic surgical skills (sterotaxis, dissection, suturing) should be practised.

The second level or "INTERMEDIATE course" should combine training on pelvitrainers, virtual reality and/or cadavers with assisting experienced surgeons directly in the OR on standard laparoscopic procedures like cystectomy, ectopic, myomectomy, etc...

The third level or "ADVANCED courses" would deal with specific advanced training programs where the trainee stays at the training centre for at least one week, actively involved in specific topic related endoscopic surgical procedures for example pelvic floor disorders, laparoscopic oncologic surgery etc.

For more information please contact Prof. Keckstein at the ESGE central office (orgamed@pandora.be).

Congress Organisation

Mission statement

About two years ago the ESGE decided to change its congress organisation policy. Until then congresses were managed by the hosting organiser who –without any doubt- was capable of delivering a well organised event. However, as a growing society, we felt that there was a strong need to take the ESGE annual congress organisation into our own hands. The complexity of dealing with the many involved parties and suppliers, the high expectations from the scientific floor, the quality organisational standards imposed by the supporting industry and the logical idea to centralise experience were only a few arguments to move towards professional and centralised management of the annual congress. The Society therefore decided to appoint a Congress Coordinator with a mandate to develop and maintain a workable concept leaving enough flexibility and input from local organisers on the one hand but with firm guidance and quality control from the ESGE on the other. The initial experience of this new policy was successfully implemented for the Expert Meeting on pelvic floor disorders in Barcelona (November 2002) and extended more recently to the 12th Annual Congress in Luxemburg (November 2003).

It is our belief that we are on the way to successfully running the annual scientific event of our society. Besides the volume of work, this concept has implications in new financial and organisational responsibilities and challenges. We must remain conservative and be prepared for the future. The expectations from participants as well as from the supporting industry are the driving forces to do better. Participants are critical in formulating their congress agenda selection based upon the scientific programme value and sponsors select the correct, efficient and well attended organisations. Our goal and challenge is to meet with these quality criteria. One can write it in one sentence but the work will never be finished.

J. Dequesne, ESGE Vice-President
and Congress Coordinator
Lausanne, Switzerland

Report on the 12th ESGE Congress (Luxemburg, 26 to 29 November 2003)

The 12th edition of the Congress was a success! On behalf of the Congress Presidents, J.M. Foidart and U. Gaspard, we would like to thank the 700 participants, the speakers, the sponsors and the organisers for all their efforts and work.

The scientific program focused on the best validated and emerging uses of endoscopic surgery in various disciplines of gynaecology. It also encompassed possible subsidiary and alternative techniques of diagnosis and treatment, such as in-development medical strategies and interventional radiology.

The audience was very satisfied about the technical quality and the content of the live surgery from Saarbrücken and Liège.

The specially designed ESGE educational sessions on laparoscopy (basic, intermediate and advanced level) and infertlity were added value for the attending trainees. The course on uterine diagnosis was attended by 83 young gynaecologists and 71% of them evaluated the course as 'fullfilling expectations'. More evaluation results are available on the ESGE website (www.ESGE.org).

The scientific committee received 171 abstracts for free oral and poster presentation. The R. Palmer Prize (best oral presentation) was awarded to W. Ombelet (Belgium) and the Best Poster Prize went to E. Kucera (Czech Republic).

Invitation to attend the 13th ESGE Congress

Cagliari, Sardinia, 14 to 17 October 2004
Evolution of surgical techniques to improve woman's health and reproductive function.

Organised in co-operation with the Società Italiana di Endoscopia Ginecologica (SEGi)

We are very pleased to invite you to attend the 13th Annual Meeting of the European Society of Gynaecological Endoscopy in Sardinia (Italy). The quality of the scientific programme granted by the scientific committee of ESGE seems to be very promising and innovative. In line with the previous annual meetings the programme will cover topics of contemporary development of gynaecological endoscopy and in particular will focus on the uterus.

The venue of the congress has been chosen among the beautiful area of the whole isle of Sardinia, near Cagliari, well known all over the world for the lovely natural countryside, the colours of the sea, wonderful beaches but even reach of history, traditions and folklore.

We are looking forward to welcoming you in Cagliari!

Preliminary programme:

- Life surgery (from the University of Catanzaro)
- Expert Meeting: The uterus, the modern approach
  - Classification and description of functional and anatomical anomalies of the uterus
  - New imaging techniques compared with new endoscopic procedures for the study of the uterus
  - The approach to uterine benign pathologies
  - The best hysterectomy: technical and economic aspects with particular emphasis on evidence based medicine
  - Psychological, social and legal problems in the conservative or radical surgery of the uterus
  - Controversion in conservative or radical surgery: discussion and conclusive remarks coming from the assembly
- Pelvic Floor
  - Pelvic floor defects and urinary incontinence: endoscopic or vaginal or other techniques
- Role of sentinel nodes in gynaecological oncology
  - The role of endoscopic surgery in endometrial cancer
  - The role of endoscopic surgery in cervical cancer
  - The role of endoscopic surgery in ovarian cancer

For more information:

www.ESGE.org
ESGE Central Office
Opalfeneweg 3
B-1740 Ternat, Belgium
orgamed@pandora.be

National Society Membership Project

Introduction

R. Campo (Leuven, Belgium)
ESGE Secretary

One of the aims of the European Society for Gynaecological Endoscopy is to strengthen communication with the national societies for Gynaecological Endoscopy (or the national societies of Obstetrics and Gynaecology if no specific endoscopy society exists). Both the ESGE and the National Societies do have the same area of interest and the same target group of colleagues. Having a common interest, respectively on European and on a National level, we are convinced that a network might offer positive opportunities.

An ESGE Member Society is defined as a formal engagement of collaboration both on administrative and scientific levels between the ESGE and a National Society, without any financial obligation or consequences. The agreement does not change anything to the normal procedure of individual memberships.

The Member Society receives the following benefits:

Publication of the profile of the national society on the ESGE website and in the Newsletter.

Link from the ESGE website to the website of the National Society.

Invitation to the annual ESGE – Member Society meeting at the occasion of the annual ESGE Congress.

Member societies will receive the minutes of these meetings.

The option is to have the ESGE journal as the official journal of the National Society. One of the imperative elements is the inclusion of a representative of the Member Society in the Associated Editorial Board.

A representation of the Member Society in the Advisory Board or other organ of the Annual ESGE Congress with the aim to advise on the scientific programme and speakers.

The license and authorisation to use the term 'ESGE Member Society' on official Society documents such as letter heads, not including the ESGE logo.

The ESGE receives the following benefits:

ESGE information will be enclosed in the annual meeting packages of the national society.

The ESGE receives a list of members with complete address, in electronic format.

Link from the National Society website to the website of the ESGE.

The right to publish the name of the Member Society.

At the 12th Annual Congress (Nov 2003), the scientific programme integrated for the first time symposia,

organised by different national societies. The ESGE offered the accommodation and the member societies had full autonomy on the scientific programme. The symposia were held either in English or in the language of the organising society. It was felt by all delegates to be a very successful pilot project because it gives the different national societies the opportunity to offer their experts and promising trainees a European platform for scientific exchange. For this reason it was appreciated that most of the societies performed their communication in the official congres language.

List of ESGE member societies

Czech Society for Gynaecological Endoscopy and Pelvic Surgery
Swiss Society for Gynaecological Endoscopy
Slovene Society of Reproductive Medicine
Turkish Society for Gynecological Endoscopy
Hungarian Society of Gynaecological Endoscopists
Dutch Society of Gynaecological Endoscopy and Minimal Invasive Surgery
The Society of Gynecological Surgery in Finland
German Society of Gynaecologicl Endoscopy – AGE (Germany)
Polish Society of Gynecological Endoscopy (PSGE), part of the Polish Association of Gynecology
Hellenic Society of Operative Hysteroscopy and Laparoscopy in Gynaecology
Hellenic Society of Gynaecological Endoscopy
Sociedad Ibero-Americana de Endoscopia e Imagenologia Ginecologicas
Workgroup for Gynaecologic Surgery of the Austrian Society for Gynaecology and Obstetrics
Russian Association of Gynaecologists – Endoscopists
British Society of Gynaecological Endoscopy
Portuguese Section for Gynaecological Endoscopy
Spanish Society of Gynaecological Endoscopy SENSEGO-SEGE
Società Italiana di Endoscopia Ginecologica (SEGi)
Flemish Society of Obstetrics and Gynaecology (VVOG, Belgium)
Croatian Society for Gynaecological Endoscopy
Société Française d'Endoscopy en Gynécologie (SFEG)
Groupement des Gynécologues Obstétriciens de langue Française de Belgique (GGOLFB)
Icelandic Society of Obstetrics and Gynecology