# AAGL 26

## 55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

# Syllabus

## Debate 640

vNOTES Hysterectomy Versus Laparoscopic Hysterectomy


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**Debate-640: vNOTES Hysterectomy Versus Laparoscopic Hysterectomy**

**Chair:** Alan M. Lam
**Faculty**: Jan Baekelandt, Matthew Siedhoff

**Course Description**

Hysterectomy, one of the most frequently performed surgical procedures worldwide, for the treatment of pathologies of the female reproductive system, can be performed traditionally by abdominal, vaginal, or laparoscopic approach.

While laparoscopic hysterectomy has established its role as a safe and effective surgical alternative to abdominal surgery, in recent years, vNOTES (vaginal natural orifice transluminal endoscopic surgery) has emerged as a potential challenger to the status quo, with enthusiastic advocates claiming superior advantages in operative efficiency, postoperative recovery, patient satisfaction and more.

**Learning Objectives:** *At the end of this course, the participant will be able to:* 1) Describe the surgical steps involved in vNOTES versus Laparoscopic hysterectomy; 2) Compare the evidence for and against each approach; and 3) Help patients choose the approach that best delivers safety, efficacy, benefits and optimal outcomes.

**Course Outline**

| | | |
|---|---|---|
| 3:15 pm | Welcome, Introduction and Course Overview | A. Lam |
| 3:20 pm | vNOTES Hysterectomy | J. Baekelandt |
| 3:40 pm | Laparoscopic Hysterectomy | M. Siedhoff |
| 4:00 pm | Discussion Questions & Answers | All faculty |
| 4:15 pm | Adjourn | |

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Alan Lam, MD, FRACOG, FRANZCOG*

**FACULTY DISCLOSURES**

**The following faculty have agreed to support their presentations and clinical recommendations with the best available evidence from the medical literature (in alphabetical order by last name).**

Jan F. Baekelandt, MD, PhD, MBA - Consultant: Applied Medical, Momentis Surgical; Stockholder: Applied Medical, Momentis Surgical; Advisory Board: Suturion, Oasis Diagnostics
Matthew Siedhoff, MD, MSCR - Consultant: Claria Medical, Intuitive Surgical; Speakers Bureau: Intuitive Surgical

**MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS**

**All relevant financial relationships have been mitigated.**

Drs. Lee, Lemos, Mikhail, and Chaudhari's planning decisions, as part of the Scientific Program Committee (SPC), were peer reviewed by other planners on the SPC who had disclosed no financial relationships with ineligible companies, and found to be fair, balanced, and free of commercial bias. Dr. Moawad's financial relationships ended 12/2024, thus mitigating them. For most of his AAGL Professional Education Committee service, Dr. Mourad had no financial relationships to disclose. He recently disclosed a new relationship as a Proctor for Intuitive Surgical. Since then, he has not participated in activities involving control or influence over accredited educational content; therefore, no additional mitigation was necessary.

The presentation content for course faculty, Drs. Baekelandt and Siedhoff, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

# vNOTES vs TLH Debate

Jan F. Baekelandt, MD, PhD, MBA
Imelda Hospital Bonheiden, Belgium · KU Leuven, Belgium · Lund University, Sweden

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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## Disclosure

- I have the following financial relationships to disclose:

**Consulting:** Applied Medical, Momentis Surgical
**Advisory Board:** Suturion, Oasis Diagnostics
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## Objectives

- Compare the randomized evidence for vNOTES, vaginal, laparoscopic and robotic hysterectomy for benign indications
- Summarize complication and learning-curve data from the international iNOTESs registry
- Discuss how structured training and proctoring support safe implementation of vNOTES

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## Which Hysterectomy is Best for Your Patient?







EVIDENCE

4

## Patient Selection?

**Contraindications vNOTES**

- **Rectovaginal Endometriosis**
- **Rectal Surgery**
- **Severe PID**
- **Pelvic Radiotherapy**
- **Ovarian Cancer**

**Acces to Pouch of Douglas**

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## vNOTES



**2012 vNOTES**
2013 Routine Clinical Practice
>3000 Cases
Default for all gyn surgery except endometriosis

2018 Standardized Courses
>4000 Surgeons
>100000 Cases



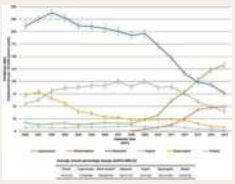
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## Guidelines Cochrane/ACOG/SFOG

- Vaginal hysterectomy is primarily recommended for benign disease. The operation time is shorter, cheaper and fewer complications.
- Laparoscopic hysterectomy is recommended when VH is not possible.
- The evidence for RH and vNOTES is too low to be able to give a recommendation.

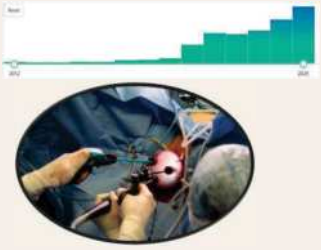
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## Vaginal Hysterectomy



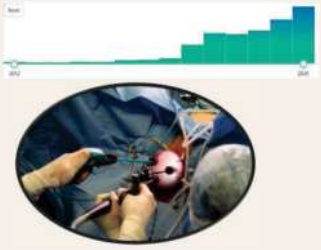
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## vNOTES: Evidence?



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## vNOTES: Randomised Controlled Trials



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## HALON Trial






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## HALON: A Randomized Controlled Trial

**H**ysterectomy by trans-**A**bdominal
**L**aparoscopy **O**r transvaginal **N**OTES

**Conclusions:**

vNOTES and TLH are equally efficacious for benign hysterectomy

vNOTES
- decreases operating time
- decreases hospitalization
- allows more women to leave the hospital on the day of surgery
- reduces postoperative complications
- reduces pain

no increased cost

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## Unpublished: Dual Center RCT Hysterectomy

**11 Surgeons – 140 Patients**

**Conclusions:**

vNOTES non inferior to TLH (Primary Outcome Complications)

vNOTES decreases operating time (MD 30 Min)

reduces postoperative pain

Data courtesy of Dr A. Mansoor with permission

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## VANH Trial

***Vaginal hysterectomy versus Vaginal Assisted NOTES Hysterectomy (VANH): A randomised controlled trial***




**VANH trial**

**Ilse Bekkers**
*The Netherlands*

Slide courtesy of Dr M. Wassen and Dr I Bekkers with permission

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## VANH Trial: Study Design

- Multi-centre, single-blinded RCT
- Randomisation 1:2 (VH:VANH)
- Inclusion: July 2021 – September 2025

- Benign indication for hysterectomy
- Exclusion:
  - History of more than one caesarean section
  - (Suspicion of) endometriosis/ rectovaginal endometriosis
  - Rectal surgery or radiotherapy in history
  - History of PID
  - Virgo
  - Pregnancy
  - Contra-indication for complete anaesthesia or same day discharge (SDD)

Slide courtesy of Dr M. Wassen and Dr I Bekkers with permission

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## VANH Trial: Results

| Outcome | VH (n=42) | VANH (n=70) | P-value | Effect size (95% CI) |
|---|---|---|---|---|
| **Same day discharge, n (%)** | 30 (71.4%) | 61 (87.1%) | 0.044 | OR 2.71 (1.029-7.141) |
| **Conversions, n (%)** | 1 (2.4%) | 1 (1.4%) | 0.715 | OR 0.594 (0.036-9.758) |
| **Uterine weight, grams (±SD)** | 110 (57) | 126 (55) | 0.066 | Not estimable |
| **Duration of surgery in minutes, mean (±SD)** | 70.38 (22.93) | 60.21 (24.63) | 0.007 | Not estimable |
| **Blood loss in milliliters, mean (±SD)** | 180 (137) | 70 (116) | <0.001 | Not estimable |
| **Succesful salphingectomy, n (%)** | 24/30 (80%) | 64/65 (98.5%) | 0.012 | OR 16.25 |

Slide courtesy of Dr M. Wassen and Dr I Bekkers with permission

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## VANH Trial: Conclusion

**SDD**

VANH significantly more SDD compared to VH

**Perioperative outcomes**

- Less bloodloss
- Shorter surgical time
- More salphingectomies
- No differences in conversions or complications

**Postoperative outcomes**

- Pain scores day 1-3 lower
- No differences in complications and post-operative recovery

Slide courtesy of Dr M. Wassen and Dr I Bekkers with permission

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## USLS Trial

> Eur J Obstet Gynecol Reprod Biol. 2024 Oct 24:303:180-185. doi: 10.1016/j.ejogrb.2024.10.032. Online ahead of print.

**Conventional vaginal approach vs. transvaginal natural orifice transluminal endoscopic surgery for treating apical prolapse, a randomized controlled study**

Lior Lowenstein [1], Omer Mor [2], Emad Matanes [2], Naftali Justman [2], Andrea Stuart [3], Jan Baekelandt [4]

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## USLS Study: A Multicenter Randomized Controlled Trial

Hysterectomy + USLS: Traditional Vaginal Approach vs vNOTES

Lowenstein Haifa
Baekelandt Bonheiden

**Conclusion:**

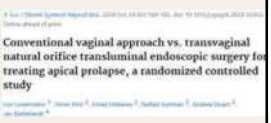
VANH+vN USLS benefits over VH+USLS

Surgical time

Bleeding

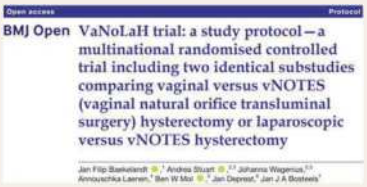
Adverse Events

Other outcomes NSD


Conventional vaginal approach vs. transvaginal natural orifice transluminal endoscopic surgery for treating apical prolapse, a randomized controlled study

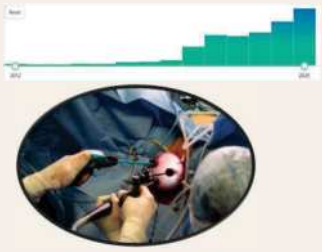
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## VANOLAH Trial


BMJ Open VaNoLaH trial: a study protocol—a multinational randomised controlled trial including two identical substudies comparing vaginal versus vNOTES (vaginal natural orifice transluminal surgery) hysterectomy or laparoscopic versus vNOTES hysterectomy

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## vNOTES: Systematic Reviews



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## Systematic Review and Meta-Analysis: vNOTES vs LH

**vNOTES EQUALLY EFFECTIVE AS TLH**

**SIGNIFICANT BENEFITS**
- Operation time
- Hospitalization time
- Pain Scores
- Postoperative Complication
- Blood Transfusion

**NO SIGNIFICANT DIFFERENCES**
- Intra-operative complications
- Conversion rate
- Analgesics Used
- Changes in Hb
- Estimated blood loss


AJOG Global Reports

Systematic review and meta-analysis of vaginal natural orifice transluminal endoscopic surgery vs laparoscopic hysterectomy

Systematic Review and Meta-Analysis on Hysterectomy by Vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES) Compared to Laparoscopic Hysterectomy for Benign Indications

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## Systematic Review and Meta-Analysis: vNOTES vs VH

**vNOTES Valid MIS Technique**

**BENEFITS**
- Estimated blood loss (non-significant)

**NO SIGNIFICANT DIFFERENCES**
- Intra- and postoperative complications
- Hospital Stay
- Pain scores at 24 hours
- Surgical Time


AJOG Global Reports

Systematic review and meta-analysis of vaginal natural orifice transluminal endoscopic surgery hysterectomy versus vaginal hysterectomy for benign indications

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## Systematic Review and Meta-Analysis: vNOTES vs LESS

**vNOTES Benefits over LESS**

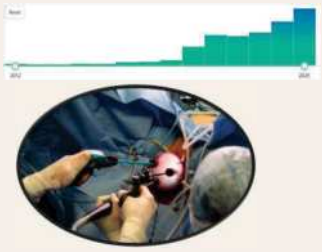
**BENEFITS**
- Lower postoperative pain


GMIT

Comparison of Outcomes following Vaginal Natural Orifice Transluminal Endoscopic Surgery and Laparoendoscopic Single-site Surgery in Benign Hysterectomy: A Systematic Review and Meta-analysis

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## vNOTES: Learning Curve



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## VANH Learning Curve

> Eur J Obstet Gynecol Reprod Biol. 2025 Apr;307:223-229. doi: 10.1016/j.ejogrb.2025.02.020. Epub 2025 Feb 10.

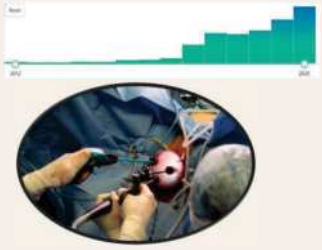
**Proctored single surgeon learning curve for vaginal natural orifice transluminal endoscopic surgery (NOTES) hysterectomy**

Susanne Housmans [1], Jan Baekelandt [2], Jan Deprest [3]

18 Cases

26

## vNOTES: Complications



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## iNOTESs Case Registry

> BJOG. 2025 Mar;132(4):464-472. doi: 10.1111/1471-0528.18000. Epub 2024 Nov 18.

**Intra- and Postoperative Complications in 4565 vNOTES Hysterectomies: International Registry Cohort Study**

Andrea Stuart [1,2], Johanna Wagenius [1,2], Levon Badiglian-Filho [3], Jens Schnabel [4], Alvaro Montealegre [5,6], Sophia Ehrström [7,8], Michael Hartmann [9], Jona Vercammen [10], Daniela Huber [11,12], Anna Lingström [1], Jan Baekelandt [13,14]

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## The Surgeons

- The vNOTES hysterectomies were performed by 201 surgeons, from multiple countries.
- The vNOTES registry mainly includes learning curve data from 90% of the included surgeons.
- The complication rate decreased with increasing surgical experience.

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## Conclusion iNOTESs Case Registry

- vNOTES is safe with low complications

The intra and post-operative complication and infection rates reported are lower or in the same range as other minimally invasive techniques, and the conversion rate to laparotomy was very low (0.2%).

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## vNOTES Complications Compared with FINHYST

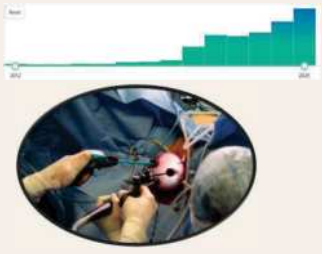
| FINHYST | AH 24% | LH 32% | VH 44% | vNOTES |
|---|---|---|---|---|
| Operative Haemorrhage >1l | 5.7 | 3 | 1.6 | 0.1 |
| Cystotomy | 0.9 | 1 | 0.6 | 1.2 |
| Ureter Injury | 0.3 | 0.3 | 0.04 | 0 |
| Bowel injury | 0.2 | 0.4 | 0.1 | 0 |
| Postop bleed./haematoma | 2.6 | 2.7 | 2.8 | 1 |
| Pulmonary Embolus | 0.1 | 0 | 0.04 | 0 |
| Urinary Retention | 0.5 | 0.5 | 1.6 | 0 |
| UTI | 2.2 | 0.7 | 1.5 | 0.6 |
| Wound infection | 2.4 | 1.5 | 0.9 | 0.1 |
| Pelvic infect/haemat/abcess | 0.8 | 3.2 | 2.2 | 1 |
| Ileus | 1.0 | 0.3 | 0.1 | 0 |
| 1 year hysterectomies in Finland | | | | |

Benign Gynaecological procedures by vaginal Natural Orifice Transluminal Endoscopic Surgery (vNOTES): Complication data from a series of 1000 patients

Conversions 0.4%
CD1-2 1.6%
CD 3 2.1%
CD 4-5 0%

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## vNOTES: Cohort Studies in Specific Subgroups



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## Cohort Studies

vNOTES LARGE UTERUS

- Operation time
- Low conversion rates
- Low complication rates
- Shorter hospitalization
- More outpatient

3361kg

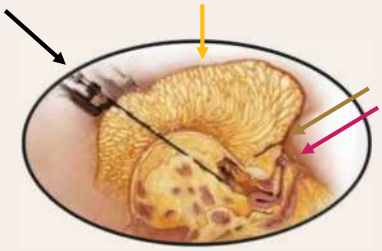
vNOTES Hysterectomy for Large Uteri: A Retrospective Cohort Study of 114 Patients

Transvaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy for uterus weighing ≥1 kg

Comparing vNOTES Hysterectomy with Laparoscopic Hysterectomy for Large Uteri

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## vNOTES



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## Cohort Studies

vNOTES vs TLH in HIGH BMI

SIGNIFICANT BENEFITS
- Operation time
- Hospitalization time
- VAS scores

vNOTES (vaginal natural orifice transluminal surgery) gynecologic procedures in morbidly and super-morbidly obese women: five year experience

The Comparison of Surgical Outcomes following Laparoscopic Hysterectomy and vNOTES Hysterectomy in Obese Patients

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## vNOTES: Implementation Effect



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## Implementation after Optimal Preparation

An example from Sweden
Helsingborg/Ängelholm Hospitals

Training Course Belgium 9/2021
2 surgeons
Good pre-course learning - planning
First case 5 days after course
Proctorships




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## Implementation after Optimal Preparation: 3 Years Later

3 Years Later

Continued Fellowship - Proctorship
650 vNOTES (600 Hyst + 50 Adnex)
7 Surgeons vNOTES
96% Hysterectomies by vNOTES (320g{26-2938g})
60% Outpatient
5 Cases per day (prior 2-3)
Stopped robotics program
Increased surgical volume 100% (125-250 Hysterectomies)



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## Data from the Yearly Gyn Op Registry Report

- The clinic from which the patients reported *quickest recovery*
- *Lowest rate of complications* among high volume centers
- One of the top clinics with *lowest rates of infections*
- One of the clinics with *quickest operating time* and *lowest bleeding*
- One of the top the clinics with *least patients seeking unplanned medical attention* after surgery
- One of the top clinics regarding *patient satisfaction* 1 year after hysterectomy



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## How Are Results Compared to Other Centers in Sweden?

- Was vNOTES the right choice?
- Dr Johanna Wagenius and Dr Andrea Stuart
  Most influential women in Sweden Award





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## Why Enter Through the Keyhole?



Why enter through the key hole if you can enter through the main door and it's less invasive?

VH and vNOTES avoid abdominal wall injury in 100% of patients




Robotic-assisted versus conventional laparoscopic surgery for endometrial cancer: long-term results of a randomized controlled trial

Trocar site hernia developed more often for the robotic-assisted group compared to the conventional laparoscopy group 18.2% vs 4.1% (odds ratio 5.42, 95% CI, 1.11-26.59, P=.028).

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## vNOTES






All benign Broaden

Contraindication: Endometriosis

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## Acknowledgments


- **Dr A. Mansoor** – unpublished dual-center RCT data, shown with permission
- **Dr M. Wassen and Dr I. Bekkers** – VANH trial slides, shown with permission
- **Dr Johanna Wagenius and Dr Andrea Stuart** – Helsingborg/Ängelholm implementation data


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# vNOTES vs TLH Debate

Matthew Siedhoff, MD, MSCR
mPathMD · Beverly Hills, CA · Cedars-Sinai

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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## Disclosure

- I have the following financial relationships to disclose:

**Consulting:** Claria Medical, Intuitive Surgical
**Presentations:** Intuitive Surgical

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## Objectives

- Declining role of hysterectomy in GYN surgery
- Practical approach to considering:
- Vaginal hysterectomy vs. vNOTES hysterectomy
- Laparoscopic/robotic hysterectomy vs. vNOTES hysterectomy
- Re-examining supracervical hysterectomy

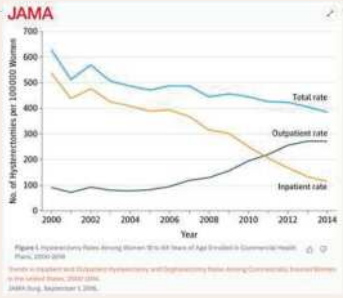
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## Opening thoughts

- Two most common benign gynecology indications:
  - Fibroids and Endometriosis
  - vNOTES not a good approach for endometriosis (including adenomyosis)
  - Fibroids
    - Increasing number of alternative treatments
    - Potential negative effects of hysterectomy
    - Requires removal of the cervix
  - Ideal practice
    - Vaginal surgery skill
    - High volume in general
    - High number of hysterectomies in particular
    - Skilled managing complications in an endoscopic environment
    - GYN Onc: Endometrial cancer

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## Hysterectomy in GYN Surgery




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## Hysterectomy in GYN Surgery

- **Hysterectomy rates rose through the mid-1970s and have fallen steadily since.**
  - US: age-standardized incidence rose from 2.4 to 10.6 per 1,000 women 1935 → 1975.
  - Projection: 3.9 per 1,000 by 2035. [1]
  - US procedures per year:
  - Commercially insured, 2000–2014: annual rate fell 39%, from 631 to 385 per 100,000. [4]
  - 2010–2013: use fell 12.4% (39.9 → 35.0 per 10,000). The largest drops were in women under 55 and in hysterectomies for fibroids, AUB and endometriosis. [5]
  - Decline reflects growing use of uterus-sparing treatments: the levonorgestrel IUD, myomectomy, uterine artery embolization and endometrial ablation. [2-3]
  - Radiofrequency ablation (abdominal, transcervical)
- **Absolute numbers:** still about 450,000–590,000 per year. Hysterectomy remains the second most common surgery in people with a uterus, after cesarean.

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## Hysterectomy in GYN Surgery

- **Hysterectomy with ovarian preservation**:
  - Earlier ovarian failure, with menopause ~ 2 years sooner [2]
  - Possibly a (very) modestly higher risk of cardiovascular disease (CVD) and stroke, mostly when surgery is done before about age 45–50 [3]
  - Slightly: more urinary incontinence in the first 10 years, and more prolapse and stress incontinence after 10 years
  - Possibly higher mortality when surgery is done at a young age [1, 5]
  - All of these data come from observational studies. Women who have hysterectomies already have more risk factors, so causation is not established.
  - These concerns are having an impact on physician counseling and patient decision making

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## Hysterectomy in GYN Surgery

| Year | Hysterectomy cases | Total surgical cases | Hysterectomy % |
|---|---|---|---|
| 2017 | 78 | 303 | 25.7% |
| 2018 | 69 | 288 | 24.0% |
| 2019 | 74 | 342 | 21.6% |
| 2020 | 78 | 336 | 23.2% |
| 2021 | 87 | 398 | 21.9% |
| 2022 | 93 | 332 | 28.0% |
| 2023 | 78 | 323 | 24.1% |
| 2024 | 80 | 302 | 26.5% |
| 2025 | 69 | 354 | 19.5% |
| 2026* | 42 | 288 | 14.6% |
| Total | 748 | 3,266 | 22.9% |

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## Vaginal hysterectomy vs. vNOTES

- Practical approach to considering:
- Vaginal hysterectomy vs. vNOTES hysterectomy

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## Guidelines Cochrane/ACOG/SFOG

- Vaginal hysterectomy is primarily recommended for benign disease. The operation time is shorter, cheaper and fewer complications.
  - → impractical recommendation based on outdated data that doesn't represent current training
  - → number of surgeons skilled in VH for non-prolapsed, diseased uterus has declined precipitously
  - Experience with VH among OB/GYN residents is limited and falling.
  - US graduates now log a median of about 20 VHs as surgeon, down from 31 in the early 2000s.
  - Fewer feel ready to do the procedure independently than for any other hysterectomy route: only 69% of graduating residents said they could perform a VH on their own in an emergency, compared with 86% for LH and 90% for AH. [Banks 2020, Gressel 2020]
- Laparoscopic hysterectomy is recommended when VH is not possible.
  - LH is much more reproducible and safer in our current training environment
- The evidence for RH and vNOTES is too low to be able to give a recommendation.

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## VANH Trial: Conclusion

**SDD**

VANH significantly more SDD compared to VH

**Perioperative outcomes**

- Less blood loss
- Shorter surgical time
- More salpingectomies
- No differences in conversions or complications

**Postoperative outcomes**

- Pain scores day 1-3 lower
- No differences in complications and post-operative recovery

vNOTES is prime target for replacing VH – easier to replicate, better for patients
Not for most generalist OBGYN — number of appropriate candidates too small, need vaginal skills
CBG – fibroid practice, not supracervical

Slide courtesy of Dr M. Wassen and Dr I Bekkers with permission

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## Randomized Controlled Trials!



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## USLS Study: A Multicenter Randomized Controlled Trial

Hysterectomy + USLS: Traditional Vaginal Approach vs vNOTES

Lowenstein Haifa
Baekelandt Bonheiden

**Conclusion:**

VANH+vN USLS benefits over VH+USLS

Surgical time

Bleeding

Adverse Events

Other outcomes NSD

**Conventional vaginal approach vs. transvaginal natural orifice transluminal endoscopic surgery for treating apical prolapse, a randomized controlled study**

vNOTES hysteropexy??

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## Laparoscopic hysterectomy vs. vNOTES

- Practical approach to considering:
- Laparoscopic hysterectomy vs. vNOTES hysterectomy

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## HALON: A Randomized Controlled Trial

**Hysterectomy by trans-Abdominal Laparoscopy Or transvaginal NOTES**

**Conclusions:**

**vNOTES and TLH are equally efficacious for benign hysterectomy**

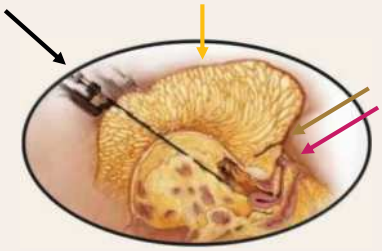
**vNOTES**

**decreases operating time**
**decreases hospitalization**
**allows more women to leave the hospital on the day of surgery**
**reduces postoperative complications**
**reduces pain**

**no increased cost**

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## vNOTES



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## Cohort Studies

**vNOTES vs TLH in HIGH BMI**

**SIGNIFICANT BENEFITS**
- Operation time
- Hospitalization time
- VAS scores

**vNOTES (vaginal natural orifice transluminal surgery) gynecologic procedures in morbidly and super-morbidly obese women: five year experience**

**The Comparison of Surgical Outcomes following Laparoscopic Hysterectomy and vNOTES Hysterectomy in Obese Patients**

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## Patient Selection?

**Contraindications vNOTES**

- Access to Pouch of Douglas
- Rectovaginal Endometriosis
- Rectal Surgery
- Severe PID
- Pelvic Radiotherapy
- Ovarian Cancer

Endometriosis is the primary indication for 20% of hysterectomies in the US [Zondervan 2020]

Leading indication for hysterectomy in women aged 30-34

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## Laparoscopic hysterectomy vs. vNOTES

| Year | With endometriosis treatment | Total hysterectomies | Proportion |
|---|---|---|---|
| 2017 | 14 | 78 | 17.9% |
| 2018 | 15 | 69 | 21.7% |
| 2019 | 20 | 74 | 27.0% |
| 2020 | 32 | 78 | 41.0% |
| 2021 | 37 | 87 | 42.5% |
| 2022 | 48 | 93 | 51.6% |
| 2023 | 40 | 78 | 51.3% |
| 2024 | 43 | 80 | 53.8% |
| 2025 | 50 | 69 | 72.5% |
| 2026* | 40 | 42 | 95.2% |
| Total | 339 | 748 | 45.3% |

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## Revisiting supracervical hysterectomy

- **Operative time:** about 13 minutes shorter (mean difference 12.88 min). [1]
- **Blood loss:** about 81 mL less, with no difference in transfusion rates. [1]
- **Hospital stay:** about 0.44 days shorter. [1]
- **Febrile morbidity:** lower after subtotal hysterectomy.

- NSQIP: lower risk of complications with LSH compared to TLH for both fibroids and endometriosis [2,3]

- Cuff dehiscence
- Vaginal length
- Reluctance to hysterectomy, bodily integrity
- Potential need for prolapse treatment in the future
- Risk of cyclic bleeding much lower than previously reported (10-15%)

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# CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) outlines standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations which began on January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

**Important Definitions:**

**Cultural and Linguistic Competency (CLC)** – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

**Implicit Bias (IB)** – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

**Diversity** – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

**Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:**

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

**CLC & IB Online Resources:**

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Act, Communicating, Implicit Bias (racialequitytools.org)
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/
https://hr.ucdavis.edu/departments/learning/certificate/implicit-bias
https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/