AAGL 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

Debate 641

Bowel Resection Versus IVF in the Infertile Patient With Rectosigmoid Nodule

HONORARY CHAIR
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Debate-641: Bowel Resection Versus IVF in the Infertile Patient With Rectosigmoid Nodule

Chair: John Preston Parry
Faculty: Sarah Choi, Tommaso Falcone

Course Description

Surgical intervention in patients with meaningful endometriosis is often logical and appropriate. Yet procreative balances sometimes push patient management in directions we might not choose for ourselves or that can be counter intuitive. This debate will pit surgical REI's against CBG's for balancing IVF and surgical balances in maximizing fertility. Moreover, the side taken by speakers will be randomized so that they must be prepared to speak on either side (and will be allowed a brief self-rebuttal at the end). Evidence based medicine fused with nuance will be the emphasis, seasoned with friendly rivalry and humor in this debate on bowel resection versus IVF in the infertile patient with a rectosigmoid nodule.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Evaluate the mechanisms by which bowel resection for rectosigmoid endometriosis may improve fertility outcomes beyond those achievable with in vitro fertilization (IVF), including restoration of pelvic anatomy, reduction of inflammatory burden, and alleviation of pain-related factors affecting conception; 2) Assess the advantages of IVF in infertile patients with rectosigmoid nodules, including avoidance of surgical morbidity, reduced time to conception in selected patients, and the ability to overcome fertility barriers that may persist despite surgical intervention; and 3) Apply patient-centered and evidence-based principles to balance surgical and assisted reproductive approaches when counseling infertile patients with rectosigmoid endometriosis, incorporating disease characteristics, reproductive goals, symptom burden, ovarian reserve, and treatment-related risks and benefits.

Course Outline

3:30 pm	Welcome, Introduction and Course Overview	J. Parry
3:35 pm	Bowel Resection	S. Choi
3:45 pm	IVF in the Infertile Patient With Rectosigmoid Nodule	T. Falcone
3:55 pm	Self Rebuttal for Pro-Bowel Resection Speaker	S. Choi
4:00 pm	Self Rebuttal for Pro-IVF Speaker	T. Falcone
4:05 pm	Discussion Questions & Answers	All faculty
4:15 pm	Adjourn	

ADA Statement: In accordance with the Americans with Disabilities Act (ADA), please contact CMEsupport@aagl.org should you require any special assistance.

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Disclosure information and acknowledgment of any commercial support are provided to learners before the activity to promote transparency and maintain the independence and integrity of the education.

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The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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COURSE CHAIR DISCLOSURE

John Preston Parry, MD – Expert Witness: CooperSurgical, Teva Pharmaceuticals; Owner/IP Rights for Devices: Parryscope Fertility

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).

Sarah Choi, MD*
Tommaso Falcone, MD*

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.

Dr. Parry's role was limited primarily to course oversight and moderation, rather than development of educational content. Any planning decisions or content under his influence were subject to independent peer review by individuals without relevant financial relationships. Additionally, Parryscope Fertility has not initiated the FDA premarket approval process and is not currently classified as an ACCME-defined ineligible company. These measures addressed potential commercial bias and mitigated relevant financial relationships.

The Case for Bowel Resection

Sarah Choi, MD

MIGS Fellowship Supervisor, Sydney Women's Endosurgery Centre
St. George Hospital | Macquarie University Hospital, NSW, Australia
International Faculty, International School of Surgical Anatomy, Italy

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1

Disclosure

- I have no financial relationships to disclose.

2

Objectives

- **Appraise** the evidence on spontaneous and IVF pregnancy rates after surgery for rectosigmoid endometriosis
- **Compare** surgery-first and IVF-first strategies for the infertile woman with a rectosigmoid nodule
- **Identify** the patients most likely to benefit from bowel resection before, or instead of, IVF

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The Harder Side of the Debate

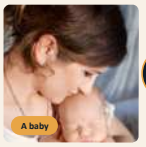


Tommaso Falcone, MD
Case for IVF

Sarah Choi, MD
Case for bowel resection







VS





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Is Infertility the Only Problem?



- **Does not** remove a rectosigmoid nodule
- **Does not** directly treat the pain
- **Does not** treat bowel dysfunction

5

My Position

I am NOT advocating

Surgery for **every** nodule

Segmental resection for **every** woman

I AM advocating

An **appropriate** operation

when the **disease itself** warrants treatment

and the **reproductive plan** makes surgery first a defensible choice

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My Case

Three parts of my case

1. **WHY** surgery
2. **WHO** benefits
3. At what **COST**

One principle

- The right **patient**
- The right **operation**
- The right **expertise**

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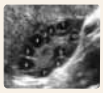
Meet Emma

Emma, 35
Illustrative patient · a real dilemma


2 years trying to conceive


3 cm rectosigmoid nodule


Dyschezia & deep dyspareunia


Reasonably preserved ovarian reserve

Your initial decision?

- A IVF first
- B Surgery first
- C Coordinated sequence

8

Are We Asking the Wrong Question?

IVF
- Addresses fertility
- Leaves the disease behind

+

Surgery
- Addresses endometriosis
- Restores anatomy
- May allow natural conception
- Surgical risks

The right treatment strategy
Reproductive opportunity · Symptom relief · Function · Acceptable risk

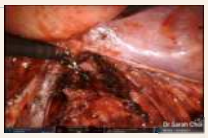
Is avoiding surgery always in the patient's best interest?

9

What Do I Mean by Bowel Surgery?


1 Shaving
Removes the lesion from the bowel wall without opening the lumen


2 Discoid excision
Removes a full-thickness portion of the bowel wall


3 Segmental resection
Removes a length of bowel and creates an anastomosis

Sometimes: leave a small, non-stenosing nodule in place → *More extensive*

The least extensive procedure that achieves the agreed objective

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The Case for Bowel Resection

Meaningful Benefits
WHY?
does surgery offer advantages beyond immediate IVF

The Right Patient
WHO?
is likely to benefit

Justifiable Risks
AT WHAT COST?
in complications, recovery and reproductive time

For the right patient, bowel surgery is a **deliberate, evidence-informed** treatment choice, whose **benefits can justify its risks**

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Beyond IVF: What Can Surgery Offer?

IVF may be effective at **overcoming certain barriers** to conception



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Beyond IVF: What Can Surgery Offer?

But

BYPASSING
a problem

≠

TREATING
it

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First, Anatomy







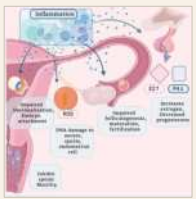
Excision and adhesiolysis can **restore anatomy**

Adamson GD, Pasta DJ. Endometriosis fertility index: the new, validated endometriosis staging system. Fertil Steril 2010;94:1609–15.

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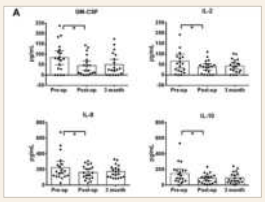
Second, Inflammatory Environment

Inflammation impairs reproduction



Excision

Plasma cytokines fall 2 weeks after excision



Mohammed Rasheed HA, Hamid P. Cureus 2020;12(11):e11516. · Monsanto SP, et al. Fertil Steril 2016;105:968–77.

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Third, Symptom Relief

- IVF does **not excise** bowel disease
- **Pain & bowel symptoms** improve in selected women
- **837 women:** marked ↓ dyschezia & dyspareunia across techniques
- **ENDORE:** benefits **persist for years**

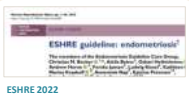
ENDORE randomized trial · long-term follow-up



Roman H, et al. Hum Reprod 2019;34:2362–71. · Roman H, et al. J Minim Invasive Gynecol 2022;29:767–75. · Roman H, et al. Am J Obstet Gynecol 2026 (epub ahead of print).

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What Do the Current Guidelines Say?



ESHRE 2022

- Excision of deep disease before ART: guided by **pain & patient preference**
- Fertility effect: **uncertain**



Australian 2025 · Rec 63

- Deep disease incl. bowel, trying to conceive: **discuss benefits & risks** of surgery
- Improved fertility: **not demonstrated**



German-speaking S2k 2025

- Symptomatic intestinal disease: **resection** after failed, intolerated or declined medical therapy
- **Interdisciplinary** expert care in a certified centre

NONE mandates IVF first

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What Do the Guidelines Leave Unanswered?

Uncertain ≠ Surgery is ineffective

Uncertain ≠ IVF first is better

2.22× **Live birth**
Surgery for deep endometriosis before IVF vs IVF directly

Casals et al. · cited in German-speaking guideline

Observational · selection bias

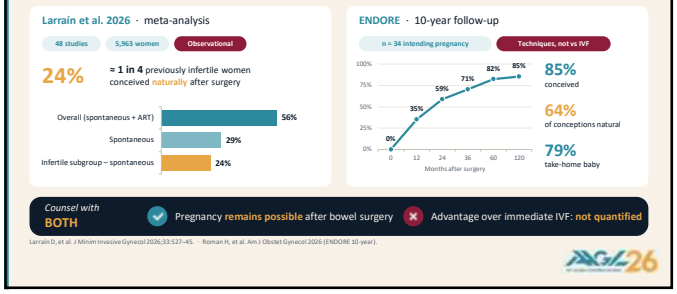
The guidelines **predate** the newest randomised evidence

ESHRE 2022 · **Australian** 2025 · **German-speaking** 2025 · **EFFORT RCT** Aug 2026

Casals G, et al. J Minim Invasive Gynecol 2021;28:1303–12. · Burghaus S, et al. Geburtshilfe Frauenheilkd 2026;86:133–88.

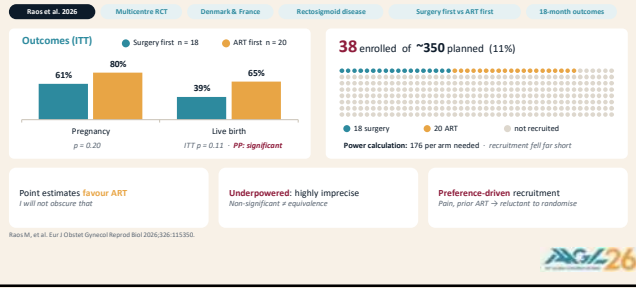
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Pregnancy After Bowel Surgery



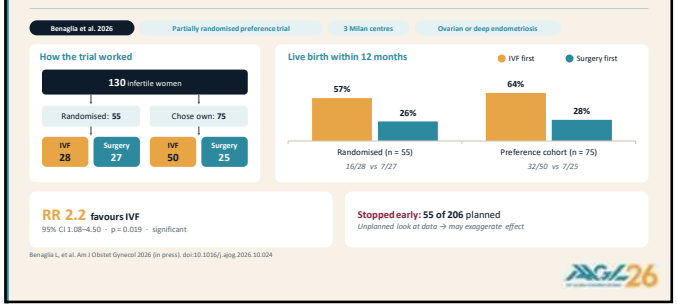
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EFFORT: The Trial We Must Confront



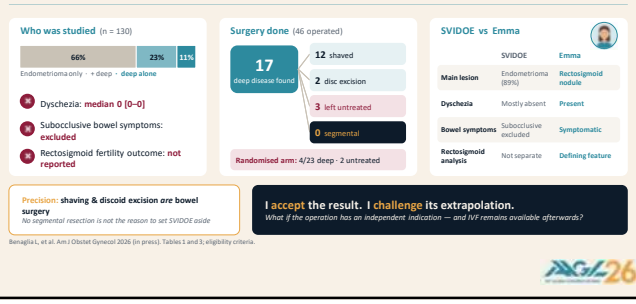
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SVIDOE: A Significant Result for IVF



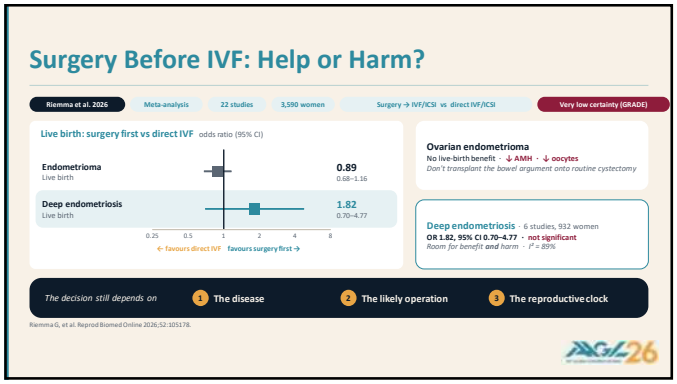
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SVIDOE: Applicability Is the Question



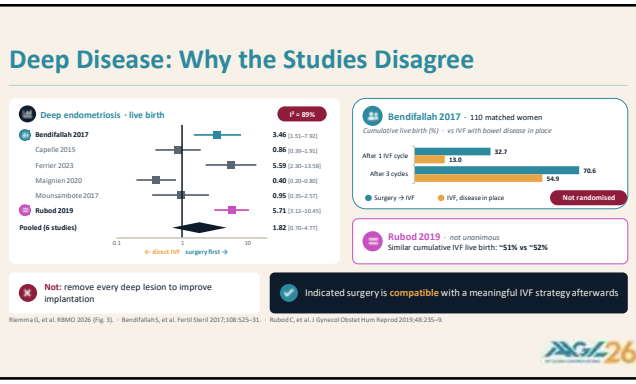
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Surgery Before IVF: Help or Harm?



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Deep Disease: Why the Studies Disagree



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WHY: The Evidence in One Sentence

Infertility-dominant
little bowel morbidity
→ IVF first: strong short-term case

Significant rectosigmoid disease
symptoms, bowel morbidity
→ + treat the disease itself

For the selected patient, one plan:

Surgery — treats the disease → Natural conception — possible after surgery → IVF — without indefinite delay

Benefit signals mixed · no high-certainty evidence that surgery beats IVF first for live birth

Not a universal recommendation — a reason to ask: **who is that patient?**

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Part 2 · WHO

WHY ✓ | 2 WHO | 3 AT WHAT COST



Who is that patient?

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WHO: Start With the Woman, Not the Nodule

Not decorative details
In a fertility referral

- Severe dyschezia
- Persistent pain
- Disturbed bowel function
- Significant stenosis

Painful bowel disease + wish to conceive: three routes

Hormonal suppression	Keep trying / IVF	Surgery: a third route
✓ symptoms ✗ natural conception	✓ pregnancy attempt ✗ disease untreated	✓ treats the disease ✓ natural conception possible

Q1 How strongly does her bowel disease warrant an operation? *Disease burden* + Q2 How realistic is spontaneous conception after treatment? *Age · other infertility factors* = **Both favourable** Strongest case for surgery first

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Two Factors, Four Practical Pathways

Bowel disease calls for surgery (low → high) \ Reproductive time & natural-conception prospects (limited → good)	
Coordinated sequence Consider fertility preservation · weigh symptoms, obstruction risk, surgical delay	**Surgery first** Treat the disease · open a window for natural pregnancy
IVF first Unless a separate urgent organ indication	**Discuss & plan** Expectant management · fertility work-up · priorities. A nodule alone does not compel surgery

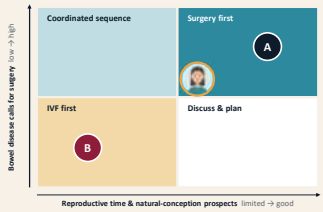
Separate urgent organ indication
e.g. obstruction, hydronephrosis → surgery regardless of quadrant

Not a validated prediction model
A counselling framework

Expert centre · MDT
Least extensive operation that meets the goal

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Same Nodule, Different Decision



A Woman A, 32
Severe dyschezia · rectal stenosis · patent tubes · normal semen
→ Surgery first

B Woman B, 39
Minimal symptoms · no stenosis · ↓ ovarian reserve
→ Prompt fertility treatment

Emma, 35
2 years infertile · dyschezia · dyspareunia · 3 cm nodule
→ Lean to surgical assessment; not yet an operation

A surgeon being consulted ≠ an indication for surgery *Next: which operation, at what cost?*

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Part 3 · AT WHAT COST

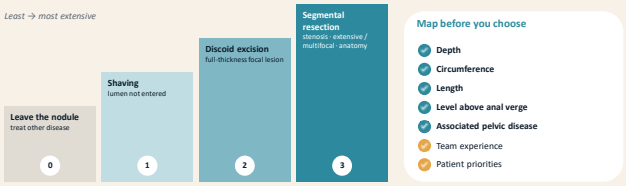
WHY ✓ | WHO ✓ | 3 AT WHAT COST



At what cost?

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HOW: The Operation Must Fit the Disease



Map before you choose

- Depth
- Circumference
- Length
- Level above anal verge
- Associated pelvic disease
- Team experience
- Patient priorities

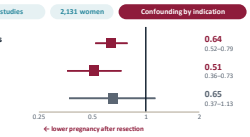
Proportionality: sufficient surgery for the objective · no unnecessary bowel sacrifice

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Does Segmental Resection Cost Fertility?

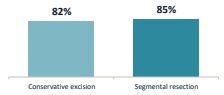
Vallée et al. 2025 · pregnancy after segmental resection vs...

13 observational studies · 2,131 women · Confounding by indication



ENDORE · randomised, 7 years

Small - not powered for equivalence



Avoid resection when a less extensive effective procedure will do

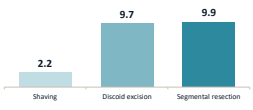
Don't exclude it when the lesion genuinely requires it

Vallée A, et al. Sci Rep 2025;15. doi:10.1038/s41598-025-93705-y · Roman H, et al. J Minim Invasive Gynecol 2022;29:767–75.

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AT WHAT COST: Complications Are Real

Mean complication rate (%) · Bendifallah 2021



Serious harms

- Anastomotic leakage
- Rectovaginal fistula
- Stenosis
- Urinary dysfunction
- Stoma

Averages ≠ Emma's risk

Procedure & severity confounded · reporting and expertise vary

*"For the woman who develops a fistula, it is **not small**."*

Managing risk responsibly

Careful indication → Preoperative mapping → MDT colorectal team → Informed consent → Least extensive technique

The right expertise does not abolish risk — it is how we manage it responsibly.

Bendifallah S, et al. J Minim Invasive Gynecol 2021;28:453–66.

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ENDORE: The Long View

ENDORE RCT · 55 women · substantial rectal disease · Conservative excision vs segmental resection · Small, selected · not vs IVF

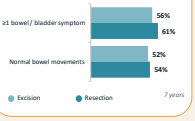
Durable benefit

85.3%
conceived (intending pregnancy, 10 y)

7.4% · 3.6%
rectal recurrence at 10 y (excision · resection)

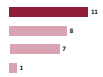
No clear difference
between techniques in function, recurrence, fertility

Residual symptoms common



Reoperations

37% · 35.7%
by 7 years (excision · resection)



A serious operation may bring **durable benefit** — and needs **serious, transparent counselling**

Roman H, et al. J Minim Invasive Gynecol 2022;29:767–75 (7 y; reoperation reasons = 27 procedures). · Roman H, et al. Am J Obstet Gynecol 2026 (10 y).

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Must Every Bowel Nodule Be Removed?

Hudelist et al. 2026
the challenge

- Nodule size ≠ symptom severity
- Limited evidence that adding bowel excision improves pain or fertility

Anatomical completeness ≠ clinical necessity

Leaving it may be sensible

- Small
- Non-stenosing
- Minimally symptomatic
- Including when going to IVF

These shift the balance

- Severe stenosis
- Obstruction
- Persistent disabling bowel symptoms

Deliberate non-treatment also has consequences

Don't operate because a lesion exists

Don't refuse an indicated operation because IVF exists

An indication beyond an IVF statistic. **Not anti-surgery — good surgery.**

Hudelist G, et al. Acta Obstet Gynecol Scand 2026. doi:10.1111/aogs.70212

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A Decision You Can Defend to Your Patient

1 · WHY
What meaningful benefit?

- Symptom relief
- Bowel function
- Treatment of disease
- Possible natural conception

2 · WHO
What reproductive opportunity?

- Age · ovarian reserve
- Tubal function · semen
- Adenomyosis
- Infertility duration · goals

3 · COST
Can we justify this operation?

- Detailed imaging
- Risks of each option
- *incl. leaving the nodule*
- When to reassess for IVF

A reproductive plan before the first incision — *not an open-ended wait after surgery*

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Back to Emma: Make the Decision



Emma, 35

2 years infertile

Dyschezia · deep dyspareunia

3 cm rectosigmoid nodule

IF *all three are met*

- Specialist mapping: lesion warrants treatment
- Wider fertility assessment favourable
- She accepts the risks

Bowel surgery first
Smallest effective operation · experienced MDT

Agreed in advance

- Surgery
- Time-limited natural conception
- Reassess fertility
- IVF if needed

A baby matter. So does the LIFE she will live while trying for one.
Treat the woman, not just her infertility.

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The right patient.
The right operation.
The right expertise.

Bowel surgery first — with IVF ready if she needs it
Thank you

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3. Monsanto SP, Edwards AK, Zhou J, Nagarkatti P, Nagarkatti M, Young SL, Lessey BA, Tayade C. Surgical removal of endometriotic lesions alters local and systemic proinflammatory cytokines in endometriosis patients. Fertil Steril 2016;105:968–77.e5.
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5. Roman H, Huet E, Bridoux V, Khalil H, Hennetier C, Bubenheim M, Braund S, Tuech JJ. Long-term outcomes following surgical management of rectal endometriosis: seven-year follow-up of patients enrolled in a randomized trial. J Minim Invasive Gynecol 2022;29:767–75.
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Bowel Resection Versus IVF in the Infertile Patient With Rectosigmoid Nodule

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- I have no financial relationships with industry
- Receive honoraria
  - Section Editor- Up-To-Date

2

Case Presentation

- 29 year old woman referred for evaluation of her infertility associated with endometriosis. Her husband is a 32-year-old male has never fathered a child and has a normal semen analysis. The patient's anti-müllerian hormone is 3.89. Her investigation which included a hysterosalpingogram is normal. She is ovulatory.
- Her most recent ultrasound revealed the left ovary has a complex cyst measuring 2 cm, 5 cm is bladder cyst (unilocular simple cyst adherent to the back of the uterus and has a cystic and solid area) the right ovary has a 9 cm endometrioma.
- Her menstrual cycles are regular between 28 and 31 days-dysmenorrhea. Associated dyschezia and dyspareunia.

3

Impression

IMPRESSION:

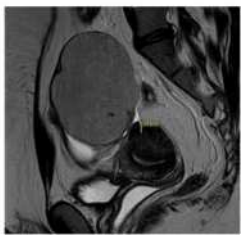
Endometriotic plaque along the uterine fundus tethering bilateral ovaries and rectosigmoid as described.

Bilateral round ligament thickening likely reflecting endometriosis.

Focal adenomyosis involving uterine fundus.

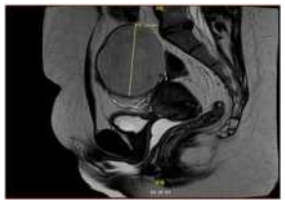
Bilateral ovarian endometriomas up to 9.1 cm on the right and 2.5 cm on the left.

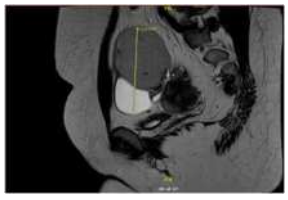




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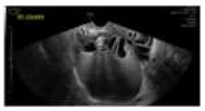
MRI result





5

IVF ultrasound







6

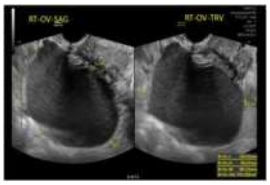
Summary of her IVF cycle



7

Embryo transfer







8

What parameters should we consider

- Pregnancy rate : surgery or IVF?
- Will surgery impact subsequent IVF outcome if required?
- Immediate intraoperative and postoperative complications?
- What are the specific patient concerns and priorities?

9

Treatment decisions for management of deep endometriosis

- Pain is almost always the most important decisive factor
- Wish to conceive and strong fear of complications can change this choice
- Fertility is important for most (but not all) women
- Shared decision making requires
  - → exploration of treatment goals
  - → training of healthcare providers
  - → better patient information provision



Recommendations for deep endometriosis care

Improvement of information provision
- Information about disease, treatment options, complications, and side effects of medication
- Preferably digital information (e.g., web site, patient journey apps)
- Importance of patient support groups

Shared decision-making training for doctors
- Improving communication skills
- Creating and providing tools (e.g. decision aid, videos)

Aiming for personalized medicine
- Every woman is different and has different wishes/needs
- These wishes should be respected, even if this is against guideline advice or the opinion of the doctor

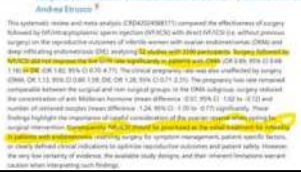
10

Pregnancy Rate : Surgery versus IVF

IVF/ICSI or surgery as first approach for the treatment of infertility associated with ovarian and deep infiltrating endometriosis? A systematic review and meta-analysis

Gaetano Riemma [1], Juan Antonio García-Velasco [2], Mauricio S Abrão [3], Umberto Leone Roberti Maggiore [4], Michele Vignali [5], Eugenio Solima [6], Marcello Ceccaroni [4], Vito Chiantera [7], Gaby N Mowaad [8], Antonio Simone Laganà [9], Vittorio Agrifoglio [9], Pasquale De Franciscis [1], Mariano Cafello Di Donna [10], Antonio D'Amato [11], Alessandro Favilli [12], Andrea Etrusco [13]

Reprod Biomed Online. 2026 Feb;52(2):105176.



11

Do not operate to improve IVF outcome

Cochrane Library



Meta-analysis: Tsoumpou et al. Fertil Steril 2009
- -5 studies: No treatment versus surgery before IVF:No difference in clinical pregnancy rate
  - No significant difference in outcome (PR/oocytes retrieved/ embryos/gonadotropins/estradiol)

Cochrane database Syst Rev 2010: Benschop et al
- -4 trials- Ovarian cystectomy or aspiration does not yield improved clinical PR

12

Reproductive Biology and Endocrinology

REVIEW Open Access

Endometriosis and IVF treatment outcomes: unpacking the process

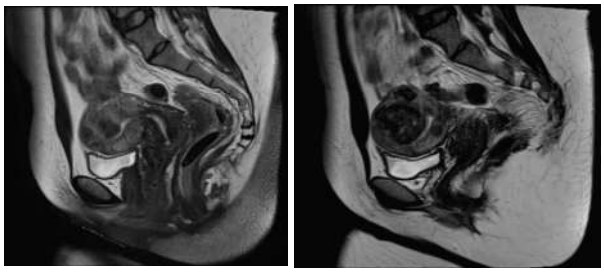
Insights from a rigorous matching design

To provide an unbiased evaluation of ovarian responsiveness in women with endometriosis, we have designed a study where $n=248$ women with endometriosis and an adequate ovarian reserve (AMH > 1.1 ng/ml) were meticulously matched to $n=248$ controls, according to age, pharmacological regimen (same drug, same initial

1. Endometriosis is unremarkable to ovarian response. A reduction in the response to ovarian stimulation can be detected only for endometriomas larger than 4 cm. The follicular steroidogenesis is unaffected.
2. Oocyte quality is preserved. Fertilization rate is similar, making ICSI unjustifiable. Embryological development does not differ from other forms of infertility, with no surge in aneuploidy rate.
3. Endometrial receptivity is not or minimally reduced. To note, the most informative studies supporting this perspective did not exclude women with adenomyosis, a main confounder that was expected to lower the success of the procedure. This further strengthens the idea that women with endometriosis should not be considered at increased risk of implantation failure. However, our selected evidence does not allow us to draw any conclusion on women with most advanced and disrupting forms of adenomyosis. These cases are rare, and the selected studies cannot be used to conclude that adenomyosis is unremarkable.

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Case 2: MRI- rectosigmoid nodule- otherwise normal



14

Cleveland Clinic Controversies in Endometriosis, Adenomyosis and Fibroids

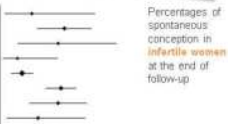
Rectosigmoid nodule –normal tubes and ovaries-

- Normal pelvis except the recto-sigmoid
- Normal infertility investigation



15

Studies on the effect of radical surgery for rectovaginal and rectosigmoid endometriosis on reproductive performance



Source, year	Pregnancies/ total	Length of follow-up[a]
Dana et al. 2005	3/12	24 (6–42)
Vercellini et al. 2006	15/44	27
Ghezzi et al. 2006	4/13	13 (3–27)
Ferrero et al. 2009	2/21	50 ± 24
Mirelli et al. 2009	13/113	20 (6–48)
Stepniewska et al. 2009	43/133	27
Dana et al. 2010[b]	12/59	34 (6–68)
Dana et al. 2010[b]	3/15	19 (5–36)
Dousy-Hauzer et al. 2011	14/75	44[a], 49[b]
Kavallaris et al. 2011	7/17	94 (32–119)
Meuleman et al. 2011[b]	8/26	27 (18–40)
		Overall weighted mean:

Percentages of spontaneous conception in infertile women at the end of follow-up

Pregnancy rate (%)

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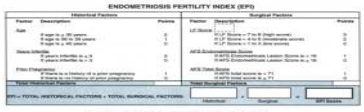


ENDOMETRIOSIS FERTILITY INDEX (EFI) SURGERY FORM

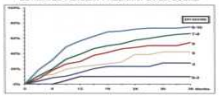
LEAST FUNCTION (LF) SCORE AT CONCLUSION OF SURGERY



ENDOMETRIOSIS FERTILITY INDEX (EFI)



ESTIMATED PERCENT PREGNANT BY EFI SCORE

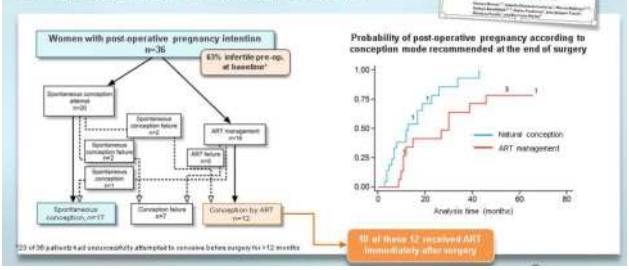


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Confounding variables:

Fertility status; length of follow up; use of ART





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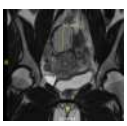
Does endometriosis affect IVF outcomes via oocyte quality or the endometrium?

- Retrospective cohort
  - 459 euploid frozen embryo transfer cycles in 328 women (i.e. controlling for embryo quality using FET)
  - Deferred blastocyst transfers using E2 and progesterone preparation cycles
- There were no differences in clinical pregnancy, pregnancy loss or LBR in patients with endometriosis compared with control groups without suspected endometrial factors[3]
- Endometriosis patients had aneuploidy rates similar to those of the male factor infertility patients
- Endometriosis alters natural conception rates

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Case presentation

- Case presentation
- 24-year-old G0 woman presents for evaluation of **severe chronic pelvic pain and stage IV endometriosis diagnosed at previous diagnostic (only)** laparoscopy for pain. **She has a history of an STI with both chlamydia and gonorrhea**. The MRI **shows bilateral endometriomas with the right ovary measuring 5 x 5 cm and the left ovary measuring approximately 3 x 3 cm**. Furthermore she has diffuse wall thickening between the anterior lower uterus and adjacent margin of the bladder she has a subperitoneal fluid in the anterior pelvis she has bilateral thickening of the uterosacral ligaments. The anterior rectal wall has thickening continuous with the thickening of the sigmoid colon which **apparently is a full-thickness circumferential wall thickening of the distal colon**. Her anti mullerian hormone level is 0.02 (range 1.22-11.70 ng/ml). She is interested in immediate fertility. Her partner investigation is normal. Regular ovulatory but painful periods. Both tubes are obstructed.
- .
- Your recommendation for management.





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Cleveland Clinic Controversies in Endometriosis, Adenomyosis and Fibroids

Crossroad decisions in deep endometriosis treatment options: a qualitative study among patients

Conclusion(s): In the treatment decision process for patients with DE, pain is almost always the most important decisive factor. The wish to conceive and strong fear of complications can change this choice. Doctors should understand the importance of fertility for the majority of women, but, also, if this is not considered paramount, respect that view. To improve shared decision making, exploration

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Informed Consent

- Modern informed consent extends beyond knowledge acquisition to encompass shared decision-making, preference-sensitive care, values clarification, and decision quality; while improving patient knowledge is an important outcome, it alone is insufficient to determine the quality of the informed consent process

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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/