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Syllabus

Panel 527

Beyond the Surgeon's Eye: Solving the Pathology-Visual Disconnect in Endometriosis Surgery

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Panel-527: Beyond the Surgeon's Eye:
Solving the Pathology-Visual Disconnect in Endometriosis Surgery

Chair: Tarek Toubia
Co-Chair: Erin T. Carey
Faculty: Erin T. Carey, Lori Scanga, Tamer Seckin, Tarek Toubia

Course Description

Every endometriosis surgeon faces a diagnostic dilemma: compelling visual disease that tests negative on pathology, or conversely, uncertain-appearing tissue that proves pathologically positive. These scenarios create clinical uncertainty, delay diagnosis, and leave every surgeon grappling with a fundamental dilemma: how to avoid both unnecessary excisions of benign tissue and missed excisions of true endometriosis.

This panel brings together experienced endometriosis surgeons and a gynecologic pathologist to dissect both sides of this mismatch—why it happens, how to minimize its occurrence, and most importantly, how to navigate it clinically when it does occur.

The panel will: Present the dual diagnostic problem-Scenario A: Visually classic endometriosis that returns negative pathology and Scenario B: Uncertain or atypical lesions that could prove positive; Showcase real surgical findings through case-based presentations featuring intraoperative images and descriptions of lesion characteristics, location, and surgeon impression; Engage the audience interactively by presenting surgical findings and polling participants on their predicted pathology results—then revealing the actual pathologic outcomes; Review the pathologic evidence of key endometriosis variants—explaining why standard H&E staining misses certain presentations and what enhanced pathology protocols can detect; and Provide actionable strategies for optimizing specimen collection, requesting enhanced pathology workup, and improving surgeon-pathologist communication.

Why this matters: Negative pathology should not be interpreted as unnecessary excision. Conversely, uncertain lesions warrant thoughtful evaluation as dismissing them outright risks missing true disease. Understanding this science improves diagnostic confidence, reduces delayed diagnoses, and strengthens the collaboration of gynecologic surgeons with pathologists.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Recognize dual diagnostic scenarios, understand their incidence, and recognize clinical implications; 2) Recognize and distinguish between the two key diagnostic paradoxes in endometriosis (negative pathology on visually compelling disease AND positive pathology on uncertain lesions) and articulate the incidence and clinical implications of each using evidence from the literature; 3) Explain the pathologic mechanisms underlying false-negative diagnoses in endometriosis; 4) Explain at least three specific pathologic mechanisms that result in false-negative endometriosis diagnoses despite true disease being present—thereby understanding the molecular and cellular basis for why standard H&E staining fails to identify certain endometriosis variants; 5) Apply evidence-based strategies to optimize pathology yield and improve diagnostic accuracy; 6) Apply evidence-based strategies to maximize endometriosis diagnostic accuracy by (1) modifying intraoperative specimen collection technique, (2) requesting enhanced pathology workup, and (3) interpreting negative standard histology in clinical context, thereby enabling them to make more accurate endometriosis diagnoses, reduce false-negatives, and improve communication between gynecologic surgeons and pathologists.

Course Outline

2:00 pm	Welcome, Introduction and Course Overview	T. Toubia
2:05 pm	When What We See Doesn't Match What We Get: The Endometriosis Diagnostic Paradox in the OR	T. Toubia
2:15 pm	From Mismatch to Management: Practical Strategies to Improve Endometriosis Diagnostic Accuracy	E. Carey
2:25 pm	Why Pathology Says 'No' When It Should Say 'Yes'	L. Scanga
2:35 pm	The Disease We Don't See: Occult Endometriosis and the Limits of Visual Diagnosis	T. Seckin
2:45 pm	Discussion Questions & Answers	All faculty
3:00 pm	Adjourn	

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Tarek Toubia, MD, MSCR, FACOG*

COURSE CO-CHAIR DISCLOSURE

Erin T. Carey, MD, MSCR - Co-Founder: Violet Medical; Poppi Biotherapies, Inc (FDA regulatory process not yet initiated); External Steering Committee: Absci; Consultant: Johnson & Johnson, BoldType

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).

Erin T. Carey, MD, MSCR - Co-Founder: Violet Medical; Poppi Biotherapies, Inc (FDA regulatory process not yet initiated); External Steering Committee: Absci; Consultant: Johnson & Johnson, BoldType
Lori Scanga, MD*
Tamer Seckin, MD*
Tarek Toubia, MD, MSCR, FACOG*

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. Carey's role as Course Chair was limited primarily to course oversight and moderation, rather than development of educational content. Any planning decisions or content under her influence were subject to independent peer review by individuals without relevant financial relationships.

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

When What We See Doesn't Match What We Get

The Endometriosis Visual–Pathologic Paradox

TAREK TOUBIA, MD · Pelvic Rehabilitation Medicine · Nashville, TN

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosure

- I have no financial relationships to disclose.

2

Objectives

At the end of this presentation, participants will be able to:

- **Describe** the two directions of discordance: disease we see that pathology doesn't confirm, and disease we miss or doubt that pathology does confirm
- **Quantify** how often each pattern occurs, based on the published literature
- **Explain** why published rates vary so widely

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What Would You Predict?

Based on appearance alone — will pathology confirm endometriosis?

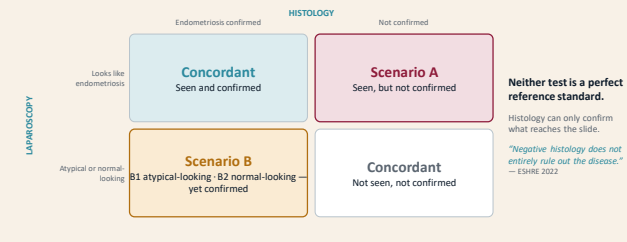




A Endometriosis B Uncertain C No Endometriosis

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Two Imperfect Tests, One Disease



Neither test is a perfect reference standard.

Histology can only confirm what reaches the slide.

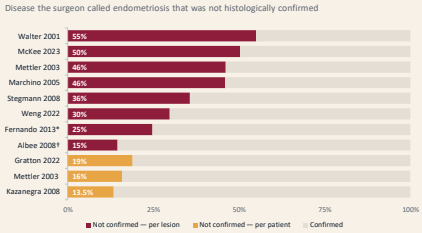
"Negative histology does not entirely rule out the disease." — ESHRE 2022

Becker CM et al. ESHRE guideline: endometriosis. Hum Reprod Open 2022 (good practice point).

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Scenario A: Seen, but Not Confirmed

Disease the surgeon called endometriosis that was not histologically confirmed



NOT CONFIRMED

15–55%

Per lesion: 15–55% of the lesions we called endometriosis were not histologically confirmed (most studies 25–55%)

Per patient: 13–19% of the patients we diagnosed with endometriosis had no lesion confirmed

*Enrolled only women with ≥1 confirmed specimen; likely underestimates non-confirmation. †All 13 sites pooled (site range 6–29%). Per lesion = the individual biopsy, lesion or site as defined by each study.

Walter AJOG 2001; McKee J Gynecol Surg 2023; Mettler JSLS 2003; Marchino Fertil Steril 2005; Stegmann Fertil Steril 2008; Weng JMIG 2022; Fernando JMIG 2013; Albee JMIG 2008; Gratton JOGC 2022; Kazanegra JMIG 2008.

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Why the Numbers Disagree

Three levers explain most of the spread

1 How you count

84% vs 54%

Mettler 2003: same 164 patients — 84% had ≥1 confirmed lesion, but only 54% of suspected sites were confirmed.

2 Whom you operate on

45% vs 85%

PPV rises with prevalence: Walter (pelvic-pain cohort) 45% vs Albee (referral excision practice; prevalence 71%) 85%.

3 What counts as positive

Strict vs broad

Albee & Stegmann required both glands and stroma; Mettler also accepted fibrosis and hemosiderin. Punch biopsy + coagulation vs complete excision; H&E alone vs deeper levels + CD10.

With 3 deeper levels + CD10 on every negative lesion, **~1 in 3 surgeon-suspected lesions stayed negative** (Stegmann, NIH).

Mettler JSLS 2003; Walter AJOG 2001; Albee JMIG 2008; Stegmann Fertil Steril 2008; Fernando JMIG 2013.

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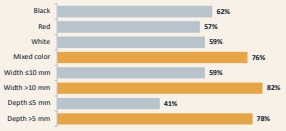
What increases probability of disease

Color rankings do not replicate

Mettler 2003	Red 100% > black 92% > white 31% *(patient-level)*
Jansen 1986	White opacification 81% = red flame 81% > glandular 67%
Stegmann 2008	Black 62% = white 59% = red 57%
Weng 2022	Puckering OR 9.8 > blue/black 3.0 > white 2.0 > red 1.7
McKee 2023	Powder-burn 66% > white 52% > clear 46% > red 39%

"No lesion characteristic was able to exclude the possibility of endometriosis."

What raises probability (Stegmann)



Fernando 2013 (1,439 specimens):
Stage I 50% not confirmed vs ~20% in stages II–IV · superficial 41% vs deep 17% not confirmed · no significant difference among 5 experienced surgeons

Best multivariable model (color + size + site): **66.5%** of lesions correctly classified.

Mettler JSLS 2003; Jansen AJOG 1986; Stegmann Fertil Steril 2008, 2009; Weng JMIG 2022 (quote); McKee J Gynecol Surg 2023; Fernando JMIG 2013.

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Scenario B: Doubted, Yet Confirmed

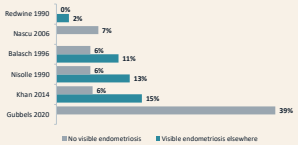
B1 · Atypical-looking, yet confirmed

52% of tissue the surgeon called atypical was endometriosis (439/852, 13 sites)
Albee 2008 · recalculated from Table 2

37% of small, subtle lesions in atypical sites were positive (20/54)
Stegmann 2008

12% of lesions the surgeon judged not endometriosis were positive (7/59)
Stegmann 2008

B2 · Normal-looking, yet confirmed



Endometriosis in biopsies of normal-looking peritoneum: ~6% without visible disease, 11–15% with visible disease elsewhere

Definition matters: with strict close-up criteria for "normal" plus serial sections, only ~2% was found (Redwine & Yocom 1990).

Albee JMIG 2008; Stegmann Fertil Steril 2008; Redwine Fertil Steril 1990; Nascu JMIG 2006; Balasch Hum Reprod 1996; Nisolle Fertil Steril 1990; Khan Hum Reprod 2014; Gubbels Int J Gynaecol Obstet 2020.

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Does a Negative Report Matter?

A negative report does not mean she was not suffering

Before surgery

Same symptoms

Histology-negative women (145 of 390, 37%) had the same symptom prevalence and pain scores as histology-positive women (dysmenorrhea VAS 5.7 vs 6.1).

Chapron 2025 · preoperative data only

Pain after surgery

83% vs 53%

Pain improved >12 months after excision: endometriosis confirmed vs no evidence of disease at surgery (n=250; OR 4.4).

Maslenko 2026 · abstract data

Fertility after surgery

53% vs 52%

Pregnancy after excision in unexplained infertility, with vs without histologic confirmation (39/74 vs 15/29).

Miller 2016

ESHRE 2022: *confirm laparoscopic findings by histology — "although negative histology does not entirely rule out the disease."*

Chapron Gynecol Obstet Invest 2025; Maslenko JMIG 2026; Miller Clin Exp Obstet Gynecol 2016; Becker Hum Reprod Open 2022.

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Why Can a Truly Suspicious Lesion Be "Negative"?

Five mechanisms

Operative field	Specimen	Processing	Microscopy	Report
Mimic	**Sampling mismatch**	**Processing limitations**	**Altered endometriosis phenotype**	**Ancillary workup**
Scar • adhesions • inflammation • prior surgical change • vascular/mesothelial lesions	Focal disease • deep disease • nonrepresentative tissue	Thermal artifact • fragmentation • limited tissue levels	Sparse glands • stromal predominance • fibrosis • smooth muscle metaplasia • decidual change	Selected cases may benefit from deeper levels or CD10 immunohistochemistry

Why technique matters. • Deeper levels: +6.7% diagnostic rate in initially negative cases • CD10: endometriosis identified in 11/70 initially H&E-negative specimens

Negative histology is not automatically a verdict on the necessity of excision. It needs to be interpreted as one component of the larger clinical picture.

Clement. Adv Anat Pathol. 2007.
Int J Gynecol Pathol. 2024. PMID: 39475364.
Patlog-Nahari et al. Fertil Steril. 2004;82:1461–1467.

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Clinical Judgment Integrates Three Evidence Streams

Surgical findings
- Appearance and lesion phenotype
- Location, depth, fibrosis, tethering
- Completeness and quality of excision/sampling

Pathology
- Glands and/or stroma
- Hemorrhage, fibrosis, chronic inflammation
- Sampling adequacy, deeper levels, ancillary studies when appropriate

Clinical picture
- Symptoms and pain phenotype
- Examination findings and imaging
- Prior surgery, hormonal treatment, and patient goals

↓ ↓ ↓

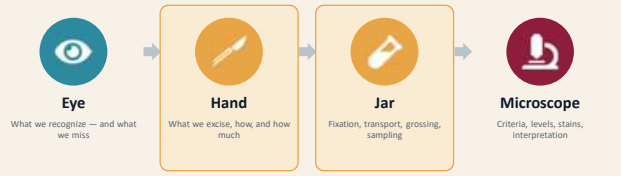
Patient-centered interpretation and management

Not "visual OR pathology"—visual findings + pathology + clinical context

Appearance informs probability. Pathology informs tissue-level confirmation. Clinical context determines meaning.

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Where Does the Disconnect Begin?



UP NEXT **The practical journey of the endometriosis specimen: from excision to the path lab**

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- Erin Carey, MD, MSCR
- Lori Renee Scanga, MD, PhD
- Tamer Seckin, MD
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- All endometriosis excision surgeons and our pathology colleagues
- The patients whose experiences drive better endometriosis care

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References

1. Becker CM, et al. ESHRE guideline: endometriosis. Hum Reprod Open 2022;2022:hoac009.
2. Walter AJ, et al. Endometriosis: correlation between histologic and visual findings at laparoscopy. Am J Obstet Gynecol 2001;184:1407–11.
3. McKee DC, Girardo ME, Wasson MN. Diagnosis of endometriosis: the surgeon's eye compared to histopathology. J Gynecol Surg 2023;39:235–9.
4. Mettler L, et al. Accuracy of laparoscopic diagnosis of endometriosis. JSLS 2003;7:15–8.
5. Marchino GL, et al. Diagnosis of pelvic endometriosis with use of macroscopic versus histologic findings. Fertil Steril 2005;84:12–5.
6. Stegmann BJ, et al. Using location, color, size, and depth to characterize and identify endometriosis lesions in a cohort of 133 women. Fertil Steril 2008;89:1632–6.
7. Weng CS, et al. Association between laparoscopic appearance of superficial endometriosis, positive histology, and systemic hormoneuse. J Minim Invasive Gynecol 2022;29:1339–43.
8. Fernando S, et al. Reliability of visual diagnosis of endometriosis. J Minim Invasive Gynecol 2013;20:783–9.
9. Albee RB Jr, Sinervo K, Fisher DT. Laparoscopic excision of lesions suggestive of endometriosis or otherwise atypical in appearance. J Minim Invasive Gynecol 2008;15:32–7.
10. Gratton SM, et al. Diagnosis of endometriosis at laparoscopy: a validation study. J Obstet Gynaecol Can 2022;44:135–41.
11. Kazanegra R, et al. Diagnosis of stage I endometriosis: comparing visual inspection to histologic biopsy specimen. J Minim Invasive Gynecol 2008;15:176–80.
12. Jansen RP, Russell P. Nonpigmented endometriosis: clinical, laparoscopic, and pathologic definition. Am J Obstet Gynecol 1986;155:1154–9.
13. Stegmann BJ, et al. A logistic model for the prediction of endometriosis. Fertil Steril 2009;91:51–5.
14. Redwine DB, Yocom LB. A serial section study of visually normal pelvic peritoneum in patients with endometriosis. Fertil Steril 1990;54:648–51.
15. Nasca PC, et al. Histopathologic findings on uterosacral ligaments in women with chronic pelvic pain and visually normal pelvis at laparoscopy. J Minim Invasive Gynecol 2006;13:201–4.
16. Balasch J, et al. Visible and non-visible endometriosis at laparoscopy in fertile and infertile women and in patients with chronic pelvic pain. Hum Reprod 1996;11:387–91.
17. Nisolle M, et al. Histologic study of peritoneal endometriosis in infertile women. Fertil Steril 1990;53:984–8.
18. Khan KN, et al. Occult microscopic endometriosis: undetectable by laparoscopy in normal peritoneum. Hum Reprod 2014;29:462–72.
19. Gubbels AL, et al. Prevalence of occult microscopic endometriosis in clinically negative peritoneum during laparoscopy for chronic pelvic pain. Int J Gynaecol Obstet 2020;151:260–6.
20. Chapron C, et al. Clinical characteristics of women with surgical signs of superficial peritoneal endometriosis but a negative histology. Gynecol Obstet Invest 2025;90:447–52.
21. Maslenko M, et al. Surgery for pain symptoms in women with isolated superficial peritoneal endometriosis. J Minim Invasive Gynecol 2026 (epub ahead of print).
22. Miller PB, et al. Laparoscopic surgery improves pregnancy outcomes in women with suspected endometriosis with or without pathological confirmation. Clin Exp Obstet Gynecol 2016;43:31–6.

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Backup: Key Studies at a Glance

Study	Design	Unit	Sample	Key finding
Walter 2001	Prospective, all suspicious areas excised + normal peritoneum	Site	44 pts	PPV 45%, sens 97%, NPV 99%, spec 77%; 36% down-staged
Mettler 2003	Retrospective, punch biopsy + coagulation	Patient / site	164 pts; 264 sites	84.1% of patients vs 53.8% of sites confirmed
Albee 2008	Prospective, single surgeon, complete excision, blinded path (glands + stroma); normal peritoneum not sampled	Specimen	512 pts; 2,005 specimens	PPV 85% overall (72–94% by site); 51.5% of atypical tissue positive
Stegmann 2008	NIH trial cohort; levels + CD10 if negative (glands + stroma)	Lesion	133 women; 544 lesions	350/544 confirmed (PPV 64%); subtle lesions 58%; 7/59 surgeon-negative positive
Fernando 2013	Prospective, 5 surgeons, 3 centers; enrolled only women with ≥1 confirmed specimen	Specimen	431 women; 1,439 specimens	1,082/1,439 (75.2%) confirmed; stage I 49.7%; deep > superficial (aOR 2.5)
Gratton 2022	Retrospective validation	Patient	96 women	Sens 90.1%, spec 40.0%, PPV 81.0%, NPV 58.8%
Weng 2022	Retrospective, video-verified	Lesion	266 women; 841 lesions	70% positive; no feature excluded disease; hormones → clear lesions
McKee 2023	Prospective, high-volume surgeons	Specimen	77 pts; 1,069 specimens	PPV 49.7%, NPV 88.7%; 11.3% of non-visible specimens positive

See reference list. PPV = positive predictive value; NPV = negative predictive value.

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From Mismatch to Management

Practical intraoperative strategies to improve endometriosis diagnostic accuracy

Erin T. Carey, MD, MSCR
Professor
Minimally Invasive Gynecologic Surgery
University of North Carolina at Chapel Hill

UNC SCHOOL OF MEDICINE

1

Disclosures

No disclosures relevant to this presentation.

Scientific Advisory Board: Absci

Consultant: BoldType, Johnson&Johnson

Co-founder: Violet Medical, PoppiBiotherapies, Inc

Expert witness testimony

Funding: North Carolina Collaboratory, National Institutes of Health, National Vulvodynia Association, North Carolina Biotech Center

2

The journey of the specimen

True disease can be lost at every point before the pathologist ever sees a slide. The surgeon controls the first four.

1	2	3	4	5	6
Recognition in situ	**Excision**	**Energy**	**Container and requisition**	**Grossing and sectioning**	**H&E read**
What you decide is a lesion	Depth, margin, whole lesion	What thermal injury leaves behind	Separation, orientation, what you wrote	Which face is cut, how many levels	Two of three criteria, or not

3

Lesion in situ to the pathologist's slide

[Insert video: excision, transfer to pathology, grossing, embedding, sectioning]

What the video shows

- Full-thickness peritoneal excision
- Retrieval and placement in formalin
- Grossing: the block is cut on one face
- Paraffin embedding and microtomy
- H&E staining and the final slide

A 5 mm lesion becomes one or two 4 micron sections. What we do upstream decides whether the glands land in them.

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1. Excise the whole lesion, not just the surface

Excise through the fibrotic rim

Lesions sit inside a reactive layer of host fibrosis and the active glands and stroma are a shallow component of it. Take the transition zone between nodule and normal tissue.

No peeling, no scrapings

Superficial removal of the colored surface returns fibrous tissue and hemosiderin-laden macrophages, and the diagnostic tissue stays in the patient.

Excision preserves the diagnosis

Ablation destroys the specimen. Excision gives the pathologist something to read and is associated with better long-term pain outcomes.

[Intraoperative image: lesion before excision]

[Intraoperative image: fibrotic component after full-thickness excision]

Healey 2014; Pundir 2017; Albee 2008; S2k guideline (Burghaus 2021)

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2. Protect the specimen edge from thermal injury

Cut, then coagulate

Cutting current or cold scissors at the specimen boundary. Coagulation for hemostasis only once the specimen is free.

Why it matters

Coagulation artifact at the margin obscures glands and stroma. A 3 mm lesion can be cauterized entirely and read as fibrosis.

Keep the energy off the sample

Grasp the specimen, not the tissue you are cutting through. Retract with traction, not with the active electrode.

On laser

No demonstrated histologic yield advantage over cold scissors or monopolar cutting current. Thermal spread is narrower but the margin is still heated, and it adds cost and setup without a diagnostic benefit. I do not use it.

Wright 2005; Law and Lyons 2013; Nisolle 1990

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3. Submit separately, and know the trade-off

The case for one lesion per container

- The pathologist sections the focus you were worried about
- Site-level results calibrate your visual recognition
- Pooled fragments dilute a positive lesion into a negative case

The tension

- Peritoneal excision is easiest and most complete as a full sheet
- One intact sheet beats several fragmented lesions in separate jars
- Cutting the sheet to separate lesions can fragment the tissue you need

The compromise

Submit the sheet intact. Consider marking the suspicious foci with ink or a suture tag. Submit deep, nodular, or atypical lesions individually. Orient deep specimens. Fix immediately.

Clement 2007; Stegmann 2008

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4. Tell the pathologist what you saw

On the requisition	What it changes
Anatomic site, per specimen	Localizes the read and the feedback
Appearance: classic, red, clear, white fibrotic, atypical	Sets expectations for subtle histology
Depth and lesion size	Guides how the block is grossed
Recent hormonal suppression: GnRH analog, progestin, continuous OC	Atrophy and decidualization change the picture; the pathologist can read it correctly
Bowel or bladder resection: ink or suture the margins	Margin status and depth of infiltration into muscularis get reported
"High clinical suspicion for endometriosis"	Prompts deeper levels and IHC before a negative is signed out

Standardize the words

Use one lesion vocabulary across your group. The AAGL 2021 classification gives a shared description of site, depth, and morphology that pathology can map to.

What the pathologist does with that request is Dr. Scenga's talk.

Clement 2007; AAGL 2021 Endometriosis Classification; S2k guideline (Burghaus 2021)

8

Ask for deeper sections before accepting a negative

73%	80%	1 in 12	6 to 10
diagnosed on initial sections	after three deeper levels	initial negatives were false negatives	slides per diagnosis

Glands can be sparse inside an extensive scar. A single level through the block frequently misses them; deeper levels are cheap relative to a missed diagnosis.

Write it on the requisition

"Highly suspicious for endometriosis. Please perform deeper sections if the initial slides are negative."

Chen 2025 (UCSF, n = 135); Improving Diagnostic Yield in Peritoneal Endometriosis, Int J Gynecol Pathol 2026

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Reading the negative report

Classic appearance, negative histology

- Ask for re-review and additional levels before accepting the negative
- Document a surgical diagnosis of endometriosis
- Treat as disease

Atypical appearance, negative histology

- Record the finding, site, and your impression
- Weigh the clinical picture, not the slide alone
- Do not close the door on the diagnosis

Charting language

"Lesions with classic laparoscopic features of endometriosis were excised from [sites]. Histology did not confirm endometriosis. Given the characteristic appearance, a surgical diagnosis of endometriosis is made and management will proceed accordingly."

ESHRE 2022: surgical visualization can support the diagnosis when histology is negative.

ESHRE 2022; AAGL 2021

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Takeaways

1. Excise, don't ablate
2. Full thickness with a margin
3. Cut at the edge, coagulate after
4. No laser required
5. Separate containers, or an intact marked sheet
6. Site, impression, and hormone history on every requisition
7. Ask for deeper sections and IHC before accepting a negative
8. Negative pathology on a classic lesion is not a negative diagnosis

11

References

1. Healey M, Cheng C, Kaur H. To excise or ablate endometriosis? A prospective randomized double-blinded trial after 5-year follow-up. J Minim Invasive Gynecol. 2014;21(6):999-1004.
2. Pundir J, Omanwa K, Kovoor E, et al. Laparoscopic excision versus ablation for endometriosis-associated pain: an updated systematic review and meta-analysis. J Minim Invasive Gynecol. 2017;24(5):747-756.
3. Albee RB Jr, Sinanno K, Fisher DT. Laparoscopic excision of lesions suggestive of endometriosis or otherwise atypical in appearance: relationship between visual findings and final histologic diagnosis. J Minim Invasive Gynecol. 2008;15(1):32-37.
4. Wright J, Lotfallah H, Jones K, Lovell D. A randomized trial of excision versus ablation for mild endometriosis. Fertil Steril. 2005;83(6):1830-1836.
5. Law KS, Lyons SD. Comparative studies of energy sources in gynecologic laparoscopy. J Minim Invasive Gynecol. 2013;20(3):308-318.
6. Nisolle M, Paindaveine B, Bourdon A, et al. Histologic study of peritoneal endometriosis in infertile women. Fertil Steril. 1990;53(6):984-988.
7. Clement PB. The pathology of endometriosis: a survey of the many faces of a common disease emphasizing diagnostic pitfalls and unusual and newly appreciated aspects. Adv Anat Pathol. 2007;14(4):241-260.
8. Stegmann BJ, Sinaii N, Liu S, et al. Using location, color, size, and depth to characterize and identify endometriosis lesions in a cohort of 133 women. Fertil Steril. 2008;89(6):1632-1636.
9. Becker CM, Bokor A, Heikinheimo O, et al. ESHRE guideline: endometriosis. Hum Reprod Open. 2022;2022(2):hoac009.
10. Abrao MS, Andres MP, Miller CE, et al. AAGL 2021 Endometriosis Classification: an anatomy-based surgical complexity score. J Minim Invasive Gynecol. 2021;28(11):1941-1950.
11. Chen CV, Orlando MS, Abel MK, Opoku-Anane J, Rabban JT. Diagnostic utility of deeper level tissue sections of negative peritoneal biopsies for clinically suspected endometriosis. Int J Gynecol Pathol. 2025;44(4):349-354.
12. Improving diagnostic yield in peritoneal endometriosis: value of additional level sections and sampling protocols. Int J Gynecol Pathol. 2026 [authors and issue to confirm; PMID 41212933].
13. Burghaus S, Schafer SD, Beckmann MW, et al. Diagnosis and treatment of endometriosis. Guideline of the DGGG, SGGG and OEGGG (S2k level, AWMF registry number 015/045, August 2020). Geburtshilfe Frauenheilkd. 2021;81(4):422-446.

12

Session Course 527: Beyond the Surgeon's Eye: Solving the Pathology-Visual Disconnect in Endometriosis Surgery
Why Pathology Says 'No' When It Should Say 'Yes'

Lori Renee Scanga, MD, PhD
Clinical Associate Professor, The University of North Carolina at Chapel Hill
Director of Gynecologic Pathology
Chapel Hill, NC

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Disclosure

- *"I have no financial relationships to disclose."*

2

Why Pathology Says "No" When It Should Say "Yes"



- **When pathology fails to detect endometriosis that is truly present (false negative)**
- **Despite visual endometriotic lesions, peritoneal biopsies are frequently nondiagnostic (47-91%).**

3

Histology is the gold standard for the definitive diagnosis of endometriosis



Classic Histologic Triad: at least 2 of 3 criteria	WHO: 2 of 2 criteria*
1. Endometrial glands	1. Endometrial glands
2. Endometrial stroma	2. Endometrial stroma
3. Hemosiderin-laden macrophages (indicates chronic hemorrhage)	*with or without recent hemorrhage or hemosiderin

4

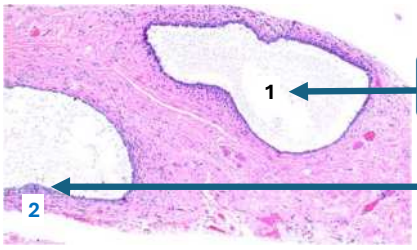
Classic Histologic Triad: 3 of 3 criteria



- **1. Endometrial glands:** columnar epithelial cells surrounding a gland lumen (white space)
- **2. Endometrial stroma:** cellular small spindled cells that surround glands
- **3. Hemosiderin-laden macrophages:** golden brown pigment

5

Classic Histologic Triad: 2 of 3 criteria

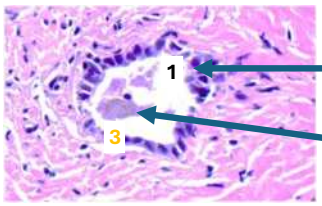


- **1. Endometrial glands:** columnar epithelial cells surrounding a gland lumen (white space)
- **2. Endometrial stroma:** cellular small spindled cells that surround glands



6

Classic Histologic Triad: 2 of 3 criteria



1. Endometrial glands: columnar epithelial cells surrounding a gland lumen (white space)

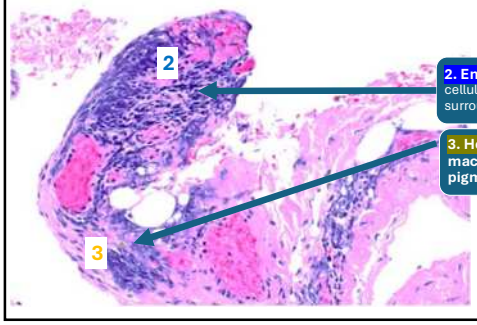
3. Hemosiderin-laden macrophages: golden brown pigment



Yes

7

Classic Histologic Triad: 2 of 3 criteria



2. Endometrial stroma: cellular small spindled cells that surround glands

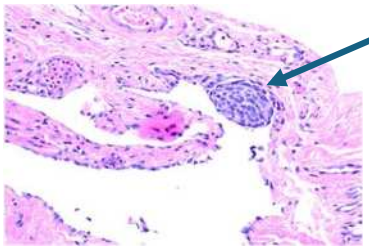
3. Hemosiderin-laden macrophages: golden brown pigment



Yes

8

1 of 3 criteria: endometrial stroma only with absence of glands and hemosiderin



Endometrial stroma: cellular small spindled cells that surround glands

?



9

Broaden and Expand Histologic Diagnostic Criteria

1. Less stringent histologic diagnostic criteria (1 of 3 features) especially in certain clinical scenarios and with associated features

2. Recognition of associated but non-specific features due to tissue damage:

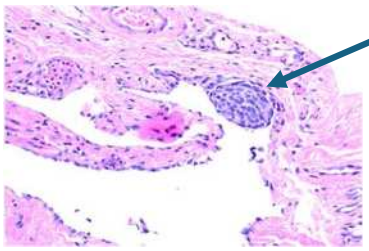
- **Chronic inflammation**
- **Calcification**
- **Vascular proliferation**
- **Adhesions**
- **Fibrosis**
- **Granulation tissue**

Histologic Feature	Clinical Scenario

Boyle DP. *J Clin Pathol* 2009
Clement PB. *Int J Surg Pathol* 2000
Clement PB. *Am J Surg Pathol* 1990

10

1 of 3 criteria: stromal endometriosis

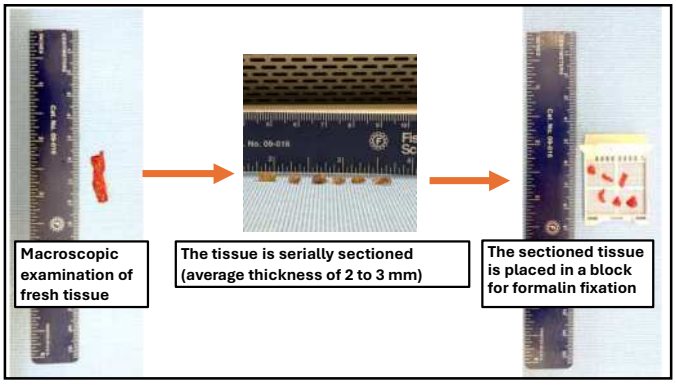


Endometrial stroma only

Yes



11



12



Formalin Fixed Paraffin Embedded (FFPE) Tissue Block

Microtomy: slices sections of block to mount on slides

13



- Microtome sections measure 5 microns (5/1000 of a millimeter) in thickness
- The majority of the tissue (2-3 mm) is not evaluated on slides
- Peritoneal specimens may contain microscopic foci of endometriosis (< 1 mm) that may be unsampled

14





If the initial H&E slide is negative for endometriosis, recut sections deeper into the block ("recut levels") evaluates more tissue and increases the detection of endometriosis

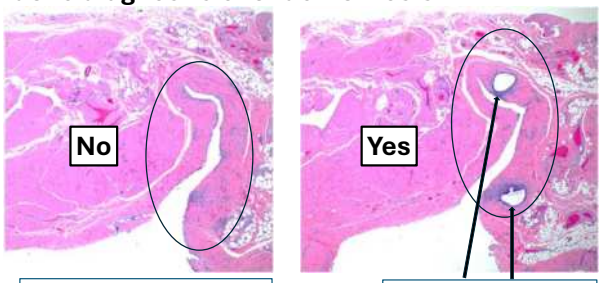
Watkins JC, *Int J Gynecol Pathol.* 2021
Chen CV, *Int J Gynecol Pathol.* 2025
Alvarez V, *Int J Gynecol Pathol.* 2026

Fresh Tissue

Initial H&E-stained slide

15

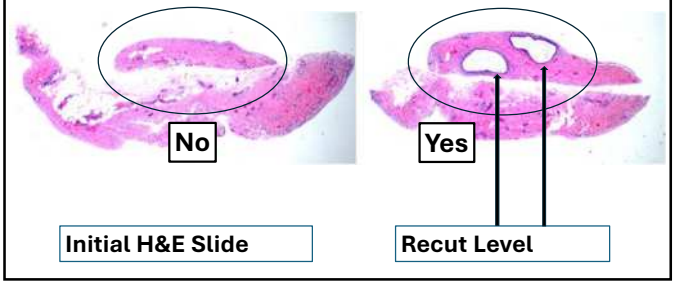
Recut levels converted an initially non-diagnostic slide to diagnostic of endometriosis



Initial H&E Slide

Recut Level

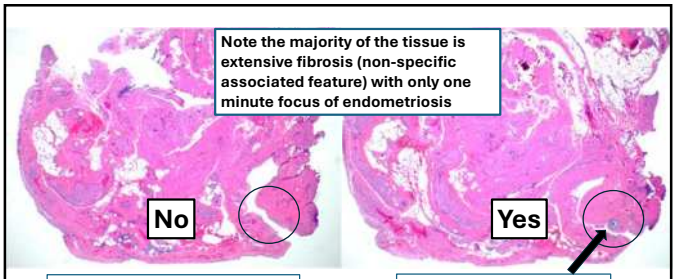
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Initial H&E Slide

Recut Level

17



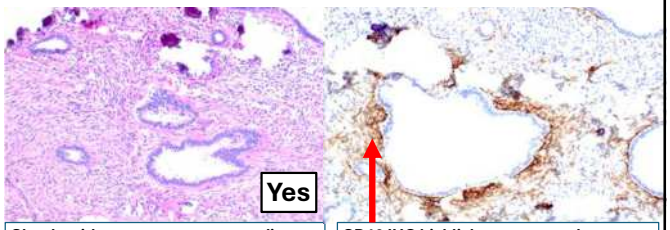
Initial H&E Slide

Recut Level

There may be a discordance between surgical impression of extent of disease and pathology findings due to the extensive tissue damage that is secondarily induced by endometriosis. Associated non-specific findings may completely replace and/or obscure identification of endometrial glands and stroma.

18

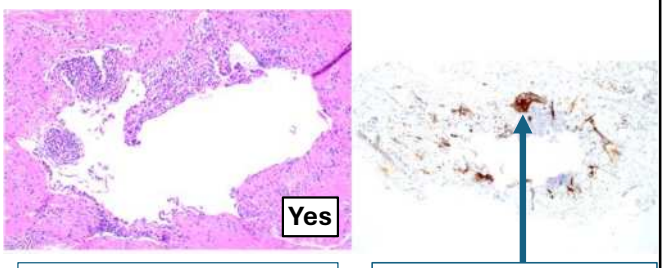
WHO: CD10 immunohistochemistry can be used to help confirm the presence of endometrial stroma when the morphological appearance is subtle or ambiguous



Glands without apparent surrounding endometrial stroma: endometriosis versus endosalpingiosis

CD10 IHC highlights attenuated endometrial stroma around glands that confirms endometriosis

19

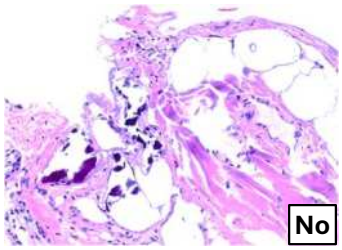


Endometrial stroma with obscuring chronic inflammation versus chronic inflammation only

CD10 IHC confirms a component of endometrial stroma among obscuring lymphocytes

20

Why Pathology Says 'No' When It Should Say 'No'



- If after recuts and/or CD10 IHC if applicable, and none of the 3 diagnostic criteria are identified
- Associated Findings only are Non-Specific*
  - Chronic inflammation
  - Fibrosis
  - Neovascularization
  - Calcifications
  - Adhesions
  - Granulation Tissue

*Visually atypical red/vascular and white/fibrotic or old burnt out calcified lesions may have associated features only due to secondary tissue damage induced by endometriosis that replaces endometrial tissue.

21

Why Pathology Should Say "Yes" Instead of "No"

- Standard practice of recut levels when initial slides are negative
- CD10 immunohistochemical staining to identify endometrial stroma
- Additional work up increases resource utilization and time
- Practical approach: if the initial slides of at least one of multiple specimens shows endometriosis, then that is sufficient for establishing a clinical diagnosis even if multiple other specimens are negative
- Lower interpretive threshold (1 of 3 criteria or 1 of 3 criteria with associated features), especially in certain clinical scenarios
- Associated features only (0 of 3 criteria) are non-specific and cannot make a definitive diagnosis; however, a negative histopathologic result does not exclude the possibility of endometriosis (GOOD PRACTICE POINT, 2026 ACOG Clinical Practice Guideline No. 11).

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- **Tamer Seckin, MD,** The Seckin Endometriosis Center, New York, NY

23

References

Clement, P.B. (1994). Diseases of the Peritoneum. In: Kurman, R.J. (eds) Blaustein's Pathology of the Female Genital Tract. Springer, New York, NY. https://doi.org/10.1007/978-1-4757-3889-6_17

Tadrous, Paul J. Diagnostic Criteria Handbook in Histopathology: A Surgical Pathology Vade Mecum (1st ed.). Wiley. pp. 239. ISBN 978-0470519035

WHO Classification of Tumours Editorial Board. Female Genital Tumours. Lyon (France): International Agency for Research on Cancer; 2020 (WHO Classification of Tumours Series, 5th ed.; vol. 4).

Chen CV, Orlando MS, Abel MK, Opoku-Anane J, Rabban JT. Diagnostic Utility of Deeper Level Tissue Sections of Negative Peritoneal Biopsies for Clinically Suspected Endometriosis. Int J Gynecol Pathol. 2025 Jul 1;44(4):349-354. doi: 10.1097/PGP.0000000000001071. Epub 2024 Oct 30. PMID: 39471364.

Singh SS, Allaire C, Al-Nourhi O, Bougie O, Bridge-Cook P, Duigenan S, Krofti J, Lemyre M, Leonardi M, Leyland N, Maheux-Lacroix S, Wessels J, Wahl K, Yong PJ. Guideline No. 449: Diagnosis and Impact of Endometriosis - A Canadian Guideline. J Obstet Gynaecol Can. 2024 May;46(5):102450. doi: 10.1016/j.jogc.2024.102450. Epub 2024 Mar 28. PMID: 38555044.

Becker CM, Bokor A, Heikinheimo O, Horne A, Jansen F, Kiesel L, King K, Kvaskoff M, Nap A, Petersen K, Saridogan E, Tomassetti C, van Hanegem N, Vulliemoz N, Vermeulen N; ESHRE Endometriosis Guideline Group. ESHRE guideline: endometriosis. Hum Reprod Open. 2022 Feb 26;2022(2):hoac009. doi: 10.1093/hropen/hoac009. PMID: 35350465; PMCID: PMC8951218.

Alvarez V, Parent E, Hecht JL. Improving Diagnostic Yield in Peritoneal Endometriosis: Value of Additional Level Sections and Sampling Protocols. Int J Gynecol Pathol. 2026 May 1;45(3):223-227. doi: 10.1097/PGP.0000000000001145. Epub 2025 Oct 23. PMID: 41212933.

Watkins JC, DiVasta AD, Vitonis AF, Crum CP, Laufer MR, Terry KL, Howitt BE, Missmer SA. A Clinical and Pathologic Exploration of Suspected Peritoneal Endometriotic Lesions. Int J Gynecol Pathol. 2021 Nov 1;40(6):602-610. doi: 10.1097/PGP.0000000000000743. PMID: 33323857; PMCID: PMC10180xx7d7b. 72. Clement PB. The pathology of endometriosis: a survey of the many faces of a common disease emphasizing diagnostic pitfalls and unusual and newly appreciated aspects. Advances in anatomic pathology. 2007;14:241e260. 173. Sumathi VP, McCluggage

(2026). ACOG Clinical Practice Guideline No. 11: Evaluation and Diagnosis of Endometriosis. Obstetrics & Gynecology, 147(3), 432-448. doi: 10.1097/AOG.0000000000006181.

Nordin N, Ab Rahim SN, Wan Omar WFA, Zulkarnain S, Sinha S, Kumar S, Haque M. Preanalytical Errors in Clinical Laboratory Testing at a Glance: Source and Control Measures. Cureus. 2024 Mar 30;16(3):e57243. doi: 10.7759/cureus.57243. PMID: 38559530; PMCID: PMC10981510.

Boyle DP, McCluggage WG. Peritoneal stromal endometriosis: a detailed morphological analysis of a large series of cases of a common and under-recognised form of endometriosis. J Clin Pathol. 2009 Jun;62(6):530-3. doi: 10.1136/jcp.2008.064261. Epub 2009 Jan 20. PMID: 19155237.

Clement PB, Young RH. Two Previously Unemphasized Features of Endometriosis: Micronodular Stromal Endometriosis and Endometriosis with Stromal Elastosis. Int J Surg Pathol. 2000 Jul;8(3):223-227. doi : 10.1177/106689690000800310. PMID: 11493995

Clement PB, Young RH, Scully RE. Stromal endometriosis of the uterine cervix. A variant of endometriosis that may simulate a sarcoma. Am J Surg Pathol. 1990 May;14(5):449-55. doi: 10.1097/00000478-199005000-00004. PMID: 2327550.

Kurman, R. J., Ellenson, L. H., & Ronnett, B. M. (Eds.). (2019). *Blaustein's pathology of the female genital tract* (7th ed.). Springer.

Jansen RP, Russell P. Nonpigmented endometriosis: clinical, laparoscopic, and pathologic definition. Am J Obstet Gynecol. 1986 Dec;155(6):1154-9. doi: 10.1016/0002-9378(86)90136-5. PMID: 2947467.

Sumathi VP, McCluggage WG. CD10 is useful in demonstrating endometrial stroma at ectopic sites and in confirming a diagnosis of endometriosis. J Clin Pathol. 2002 May;55(5):391-2. doi: 10.1136/jcp.55.5.391. PMID: 11983749; PMCID: PMC1769659.

Rimbach S, Ulrich U, Schweppe KW. Surgical Therapy of Endometriosis: Challenges and Controversies. Geburtshilfe Frauenheilkd. 2013 Sep;73(9):918-923. doi: 10.1055/s-0033-1350890. PMID: 24771943; PMCID: PMC3988469.

Images of pathologists Designed by Magnific www.magnific.com

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The Disease We Don't See: Occult Endometriosis and the Limits of Visual Diagnosis

Tamer Seckin, MD

Founder of Endometriosis Foundation of America
Seckin Endometriosis Research Center - Cold Springs Harbor Laboratories
Professor of OB/GYN Zucker SOM, New York City
Lenox Hill Hospital, New York City

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1

Disclosure

"I have no financial relationships to disclose."

2

Objectives

At the conclusion of this presentation, participants will be able to:

- **Describe** the spectrum of peritoneal endometriosis, including classic pigmented lesions, subtle non-pigmented white or colorless lesions, and occult microscopic disease.
- **Explain** the proposed contributions of retrograde menstrual debris and peritoneal surface inflammation to early lesion formation.
- **Discuss** the proposed role of peritoneal structural changes and pores in the development of new lesions.
- **Identify** challenges in recognizing subtle peritoneal lesions, including those encountered during repeat surgery.
- **Evaluate** the limitations of visual lesion recognition and the potential role of artificial intelligence in assisting detection.

BLOOM'S TAXONOMY VERB LIST - COGNITIVE DOMAIN

3

Subtle Endometriosis?

What is it?

- Typical Classic Pigmented Endometriosis
  - Non typical Subtle Non Pigmented-
  - White to colorless Endometriosis
  - Occult Invisible Microscopic Endometriosis
  - Re-operative Lesions
  - Limits, with A little help from AI

4

Subtle Endometriosis?

What is it?

- Endometriosis is a systemic disease. It often begins with subtle inflammation that is hard to see and varies from patient to patient. This helps explain the 10-year diagnostic delay, the repeat surgeries, and the incomplete, technically inadequate procedures we still see.

5

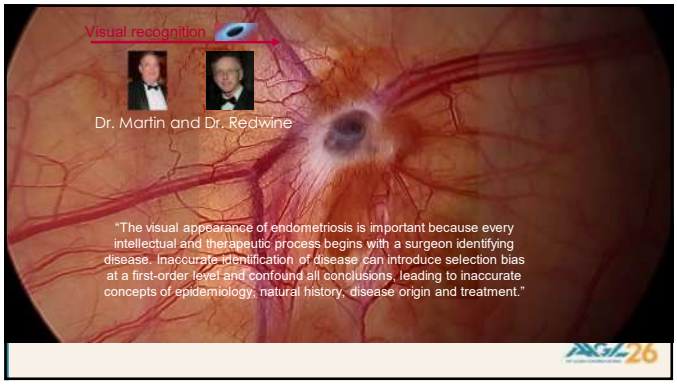
Subtle Endometriosis?

How does it really start?

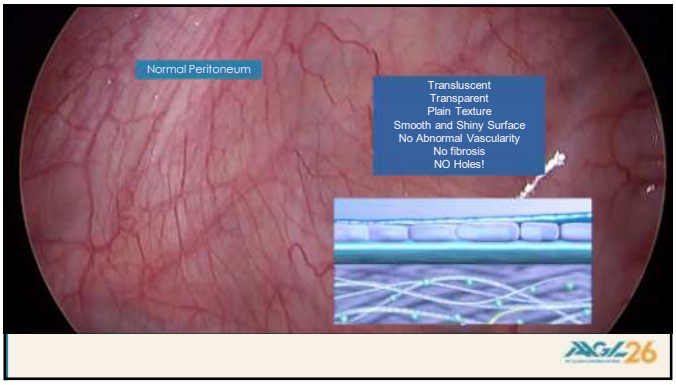
- Retrograde Menstrual Debris
- Inflammation Surface
- Peritoneal Structural Changes
- Peritoneal Pores
- Birth of new lesions



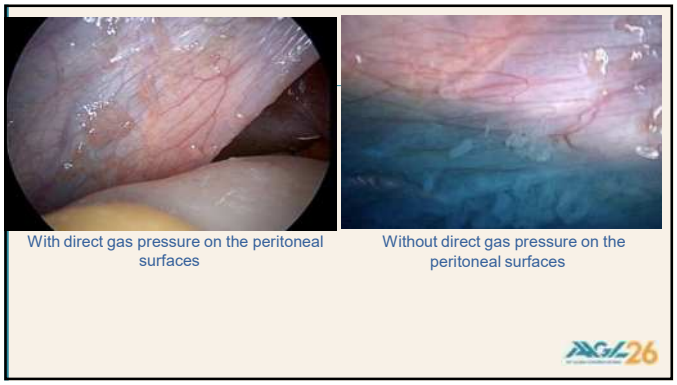
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Visual recognition
Dr. Martin and Dr. Redwine
"The visual appearance of endometriosis is important because every intellectual and therapeutic process begins with a surgeon identifying disease. Inaccurate identification of disease can introduce selection bias at a first-order level and confound all conclusions, leading to inaccurate concepts of epidemiology, natural history, disease origin and treatment."

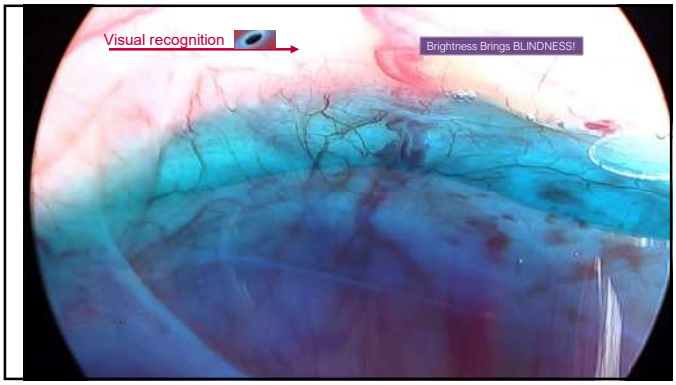
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Normal Peritoneum
Transluscent
Transparent
Plain Texture
Smooth and Shiny Surface
No Abnormal Vascularity
No fibrosis
NO Holes!

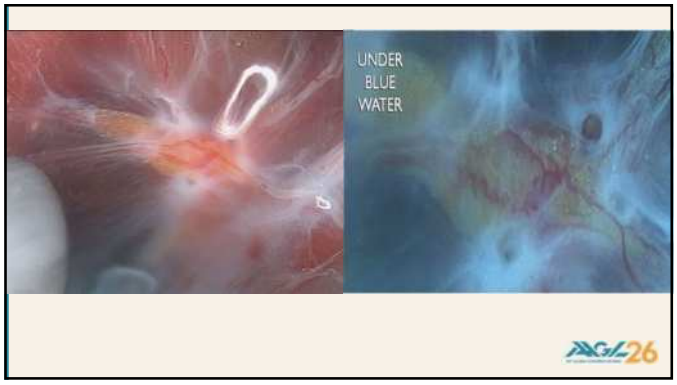
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With direct gas pressure on the peritoneal surfaces
Without direct gas pressure on the peritoneal surfaces

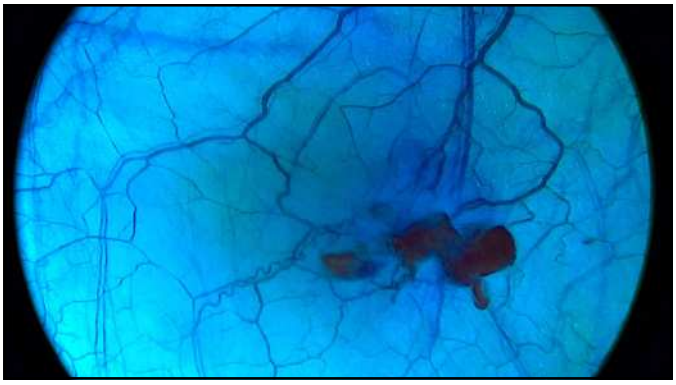
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Visual recognition
Brightness Brings BLINDNESS!

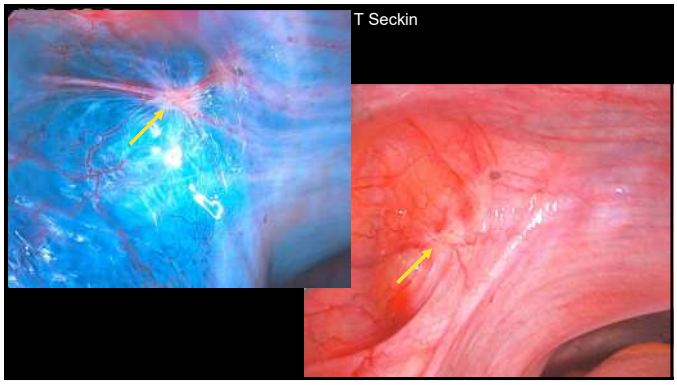
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UNDER
BLUE
WATER

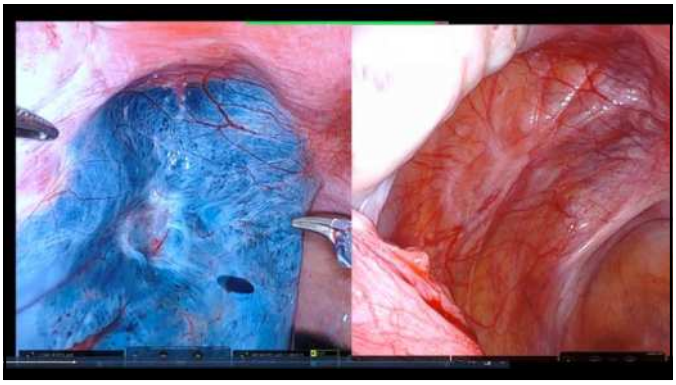
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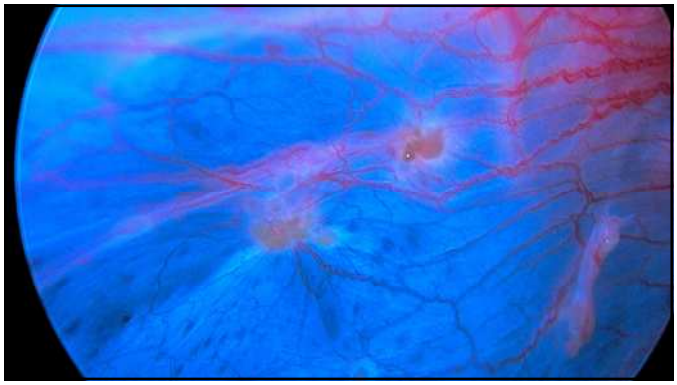
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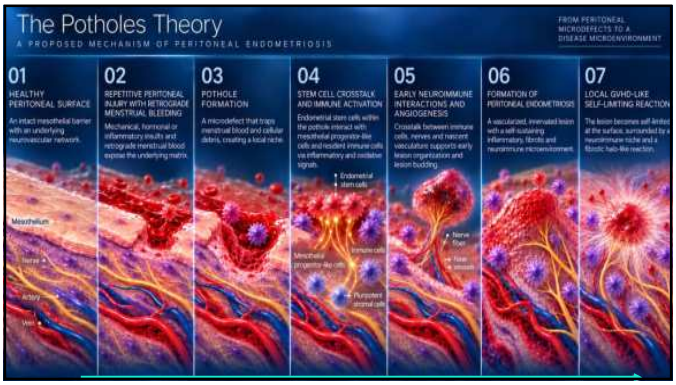
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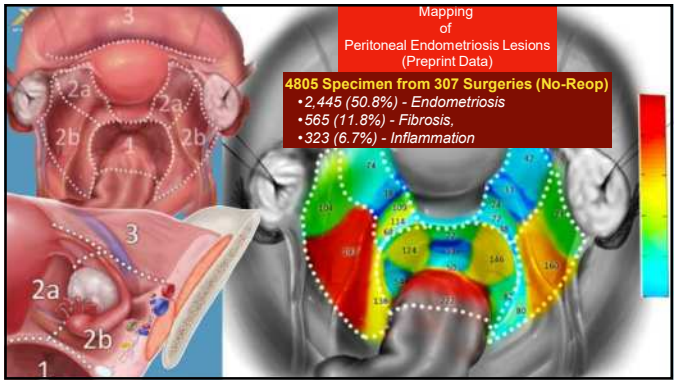
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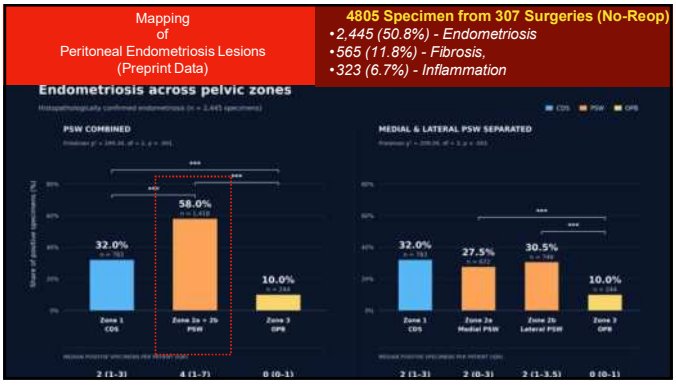
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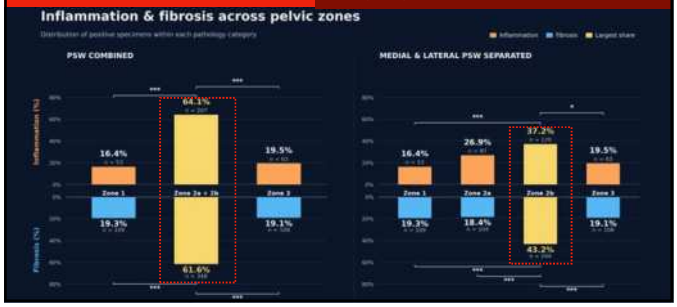
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18

Mapping
of
Peritoneal Endometriosis Lesions
(Preprint Data)

4805 Specimen from 307 Surgeries (No-Reop)
- *2,445 (50.8%) - Endometriosis*
- *565 (11.8%) - Fibrosis,*
- *323 (6.7%) - Inflammation*



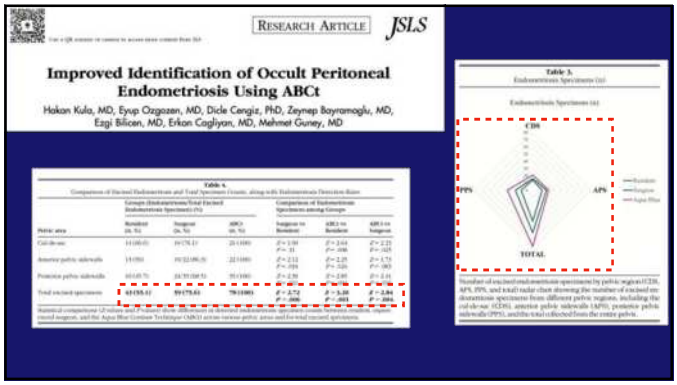
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20



21

Acknowledgments

- **None**

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References

1. Jansen RP, Russell P. Nonpigmented endometriosis: clinical, laparoscopic, and pathologic definition. Am J Obstet Gynecol. 1986;155(6):1154-9. doi:10.1016/0002-9378(86)90136-5
Pigment is not needed for diagnosis. White opacified and red flame-like lesions were endometriosis in 81% of biopsies.
2. Redwine DB. Age-related evolution in color appearance of endometriosis. Fertil Steril. 1987;48(6):1062-3. PMID: 3678506
Most lesions were nonblack and easy to miss. Color appearance may change with age.
3. Martin DC, Hubert GD, Vander Zwaag R, et al. Laparoscopic appearances of peritoneal endometriosis. Fertil Steril. 1989;51(1):63-7. doi:10.1016/s0015-0282(16)60429-6
Diagnosis at laparoscopy rose from 42% to 72% between 1982 and 1988. Subtle lesions showed the largest increase.
4. Nisolle M, Paindaveine B, Bourdon A, et al. Histologic study of peritoneal endometriosis in infertile women. Fertil Steril. 1990;53(6):984-8. doi:10.1016/s0015-0282(16)53571-7
Histology showed endometriosis in 13% of visually normal peritoneal biopsies from women with endometriosis.
5. Redwine DB. 'Invisible' microscopic endometriosis: a review. Gynecol Obstet Invest. 2003;55(2):63-7. doi:10.1159/000070176
Argues that with magnification nearly all endometriosis becomes visible. Calls "invisible" microscopic disease unproven.
6. Kula H, Ozgozen E, Cengiz D, et al. Improved identification of occult peritoneal endometriosis using ABCt. JSLS. 2025;29(4). doi:10.4293/JSLS.2025.00105 *126 specimens from 14 women. ABCt identified 24.4% more histologically confirmed lesions than the experienced surgeon and 44.9% more than the resident*

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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/