MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

PG-26173

The Endometriosis Playbook: Case-Based Medical and Surgical Management Across the Lifespan

HONORARY CHAIR
Charles H. Koh, MD

SCIENTIFIC PROGRAM CHAIR
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PG-26173: The Endometriosis Playbook:
Case-Based Medical and Surgical Management Across the Lifespan

Chair: Olga Bougie
Co-Chair: Jade Desilets
Faculty: Olga Bougie, Jade Desilets, Chandrew Rajakumar, Jonathon Solnik

Course Description

Endometriosis impacts patients across their lifespan and effective management requires individualized, evidence-based approaches that may change throughout the patient's journey. This postgraduate course will use case-based learning to walk participants through medical and surgical decision-making for endometriosis management across adolescence, reproductive years and perimenopause. Each vignette will be structured to mirror day-to-day clinical practice and highlight the unique challenges/controversies patients encounter throughout different life stages. Participants will be encouraged to participate through interactive discussions and polling options. The course will address common real-world dilemmas such as: Optimal patient selection for surgery and ideal timing of surgery, how to select hormonal suppression while considering tolerability and adverse effects, review of chronic pain management, consideration for fertility optimization/preservation. The session will emphasize shared decision-making, aligning treatment choice with symptom burden, and fertility goal. We will review surgical planning and operative strategies for superficial and deep disease with surgical videos and technique pearls that can be used to reinforce best practices while minimizing complications and protecting ovarian reserve. Target Audience • MIGS surgeons and advanced laparoscopy/robotics gynecologic surgeons • Reproductive endocrinology/infertility-focused gynecologists • Fellows and senior residents • Clinicians managing chronic pelvic pain and endometriosis across age groups.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Apply a lifecycle-based framework to select initial endometriosis management (medical vs surgical), aligned with patient goals, symptom severity, and long-term fertility plan; 2) Choose and counsel on evidence-based hormonal suppression options (including risk–benefit considerations such as bone health and tolerability) and to individualize therapy selection based on age, health history, symptoms, and treatment goals; and 3) Plan the timing and scope of surgery based on symptoms, disease complexity and reproductive goals.

Course Outline

10:30 am	Welcome, Introduction and Course Overview	O. Bougie
10:35 am	Medical and Surgical Management of Endometriosis for Patients of Reproductive Age	O. Bougie
11:00 am	Medical and Surgical Management of Endometriosis in the Perimenopause Patient Population	J. Desilets
11:25 am	Medical Management of Endometriosis in the Adolescent Patient Population	J. Solnik
11:50 am	Medical Management of Endometriosis and Chronic Pelvic Pain	C. Rajakumar
12:15 pm	Discussion Questions & Answers	All faculty
12:30 pm	Adjourn	

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

Disclosure of Relevant Financial Relationships

As an ACCME-accredited provider, AAGL is responsible for ensuring that accredited education is fair, balanced, free of commercial bias, and supports safe, effective patient care. AAGL maintains control over all aspects of educational planning, content, faculty selection, delivery, and evaluation.

All individuals in a position to control educational content are required to disclose financial relationships with ACCME-defined ineligible companies within the past 24 months. AAGL identifies and mitigates all relevant financial relationships before individuals assume their respective roles. Educational content is also subject to independent peer review by individuals without relevant financial relationships.

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.

Asterisk (*) denotes no financial relationships with ACCME-defined ineligible companies to disclose.

PLANNER DISCLOSURES

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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SCIENTIFIC PROGRAM COMMITTEE

Nash Moawad, MD, MS, Chairman – Consultant (ended 12/2024): Medtronic, Womed, Integra Life Sciences
Amani Harris, MD*
Ted Lee, MD – Advisory/Consultant: Johnson & Johnson, Regeneron Pharmaceuticals
Nucelio Lemos, MD, PhD – Speakers Bureau: Pfizer, Inc., Medtronic; Advisory Board: Knight Therapeutics, Vecfer Pharma
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Linda D. Bradley, MD, Medical Director*
Linda Michels, Executive Director, AAGL*

COURSE CHAIR DISCLOSURE

Olga Bougie, MD, MPH, FRCSC – Consultant: AbbVie, Knights Pharmaceutics; Speakers Bureau: AbbVie, Knights Pharmaceutics

COURSE CO-CHAIR DISCLOSURE

Jade Desilets, MD, MScHQ, FRCSC – Travel Grant: AbbVie

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).

Olga Bougie, MD, MPH, FRCSC – Consultant: AbbVie, Knights Pharmaceutics; Speakers Bureau: AbbVie, Knights Pharmaceutics
Jade Desilets, MD, MScHQ, FRCSC – Travel Grant: AbbVie
Chandrew Rajakumar, MD – Consultant: Ethicon Endo-Surgery, Hologic, Olympus, Pfizer; Speakers Bureau: Hologic, Knight Pharmaceutical, Pfizer
Jonathon Solnik, MD – Medical Advisor: Felix Health, Inc.; Consultant and Speaker: Terumo Medical

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.

Drs. Bougie and Desilet's roles as Course Chair and Co-Chair were limited primarily to course oversight and moderation, rather than development of educational content. Any planning decisions or content under their influence were subject to independent peer review by individuals without relevant financial relationships.

The presentation content for course faculty, Drs. Bougie, Desilets, Rajakumar, and Solnik, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

The Reproductive Years

Endometriosis Across the Lifespan

Olga Bougie, MD · University of Toronto/Mount Sinai Health System

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosure

- I have the following relationships to disclose:
  Consultant: Abbvie, Knight Pharmaceuticals
  Speakers Bureau: Abbvie, Knight Pharmaceuticals

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Objectives

- Understand the factors influencing fecundity in a patient with endometriosis
- Analyze the evidence supporting the role of surgical intervention vs. artificial reproductive technologies in optimizing endometriosis related infertility
- Create a framework to optimize fertility in a patient with endometriosis while considering treatment of other symptoms

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Case

- Emily is 33F G0 referred as has been trying to conceive x3 years
- Experiencing debilitating pain, unable to work
- 2 failed IVF transfers, good quality embryos
- No frozen embryos

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Case 2: *Emily is 33F G0 referred as has been trying to conceive x3 years*

- Endometriosis Related Symptoms
  - severe dysmenorrhea (previously managed with dienogest)
  - Deep dyspareunia
  - Rectal spasm, denies hematochezia
  - Daily moderate to severe pain, impacting ability to work

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Preoperative Imaging

FINDINGS:
RT KIDNEY: 11.4 cm. Unremarkable.
LT KIDNEY: 10.3 cm. Unremarkable.
UTERUS: 7.2 x 3.3 x 2.5 cm. Heterogeneous echotexture.
Endometrial Thickness: 3 mm. IUD in appropriate position.
RIGHT OVARY:
Size: 3.7 x 2.7 x 2.4 cm. Unremarkable.
Large right endometrioma measuring 8.3 x 7.3 x 6.4 cm.
LEFT OVARY:
Size: 1.9 x 1.8 x 0.8 cm. Unremarkable.
BLADDER: Unremarkable.
Free Intra-peritoneal Fluid: No.
GROIN: Unremarkable.
Endometriosis Mapping:
-Ovary: No significant adhesions to the pelvic sidewall. Adhesions between the right ovarian endometrioma and the uterus medially. No significant adhesions around the left ovary.
-Pouch of Douglas: Not involved
-Rectal wall: There is a suspected plaque in the rectosigmoid measuring 2.3 cm in length and 0.7 cm in thickness.
-Uterosacral Ligament: Likely involved.
-Rectovaginal Septum: Unremarkable.
-Uterus surface: No significant involvement
-Bladder wall: Unremarkable.
IMPRESSION:
Right ovarian endometrioma and findings of deep pelvic endometriosis.
Patient notes neuropathic symptoms on the right side possibly related to the obturator nerve. MRI can be considered for better assessment .

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Imaging

- Uterus 7.2x3.3x2.5cm
Heterogenous echotexture



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Imaging

- Right ovarian endometrioma 8.3x7.3x6.4cm



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Imaging

- Rectosigmoid plaque 2.3x0.7cm



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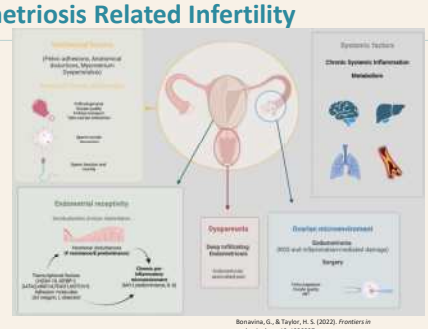
Other Investigations

- Tubal patency – N
- AMH 7.3pmol/L
- Normal TSH, CBC
- Ferritin 27ng/mL

- Sperm count - N

10

Endometriosis Related Infertility



Bonavina, G., & Taylor, H. S. (2022). *Frontiers in endocrinology*, *13*, 1020627

11

Considerations

Comprehensive Evaluation

Role of surgery vs. ART

Optimizing Surgical Approach

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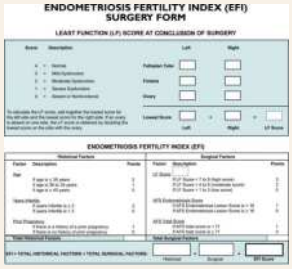
Preoperative Evaluation

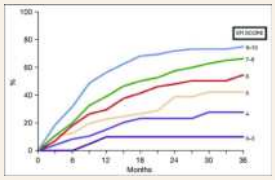
- Define patient goals
- Assess fertility potential – AMH, AFC, EFI
- Fertility counseling
- Role of egg freezing

- Accurate imaging:
  - Adenomyosis
  - Endometrioma
  - Deep disease
  - Fallopian tubes

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Endometriosis Fertility Index

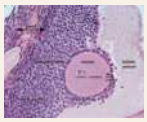




Adamson G, Pasta D. **Endometriosis fertility index: the new, validated endometriosis staging system.** Fertility and Sterility, 2009; 94, 1609-1615

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anti-Müllerian hormone (AMH)



Strengths

- Strongly correlated with AFC
- Reproducible
- Little variation within/between cycles
- Predicts response to supraovulation

Limitations

- Does not assess oocyte or embryo quality
- May be influenced by co-diagnoses (ie. PMOS)

Seifer, D. B., et al 2002). Early follicular serum müllerian-inhibiting substance levels are associated with ovarian response during assisted reproductive technology cycles. *F&S*, *77*(3); 468-471.

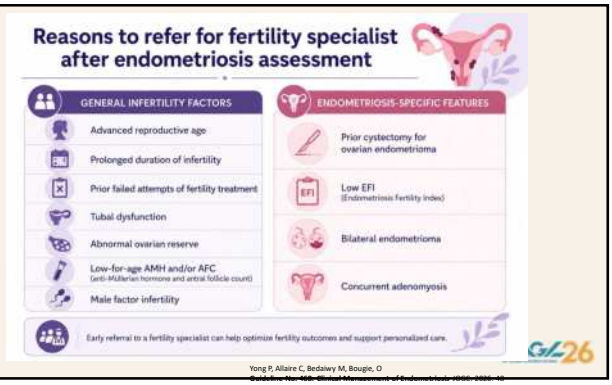
15

AMH, AFC, other tests

- AMH and AFC lower in patients with endometriomas than controls
- Patients with endometrioma have a significantly lower number of oocytes retrieved than the controls, despite the same AMH levels in both groups

Inal, Z. O., et al (2019). Does the anti-Müllerian hormone truly reflect ovarian response in women with endometrioma? *JOGC*, *39*(4), 516-521.
Ersahin, A. A., et al (2017). AFC vs. AMH: prediction of ovarian response in women with endometrioma undergoing controlled ovarian stimulation. *European Review for Medical & Pharmacological Sciences*, *21*(10).

16



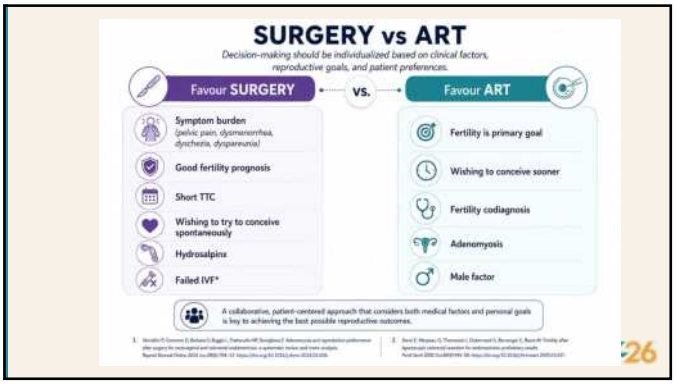
Yong P, Allaire C, Bedaiwy M, Bougie, O
Guideline No. 468: Clinical Management of Endometriosis. JOGC. 2025; 47

17



The Fertility Crossroads: To Operate or Ovulate?

18



19

Surgery

- Surgery should be offered in symptomatic patients aiming to conceive
- Spontaneous conceptions in excess of 60 % may be achieved*
  - Negatively impacted by **concurrent** adenomyosis and **endometriomas**

*** Not defined as infertility preop**

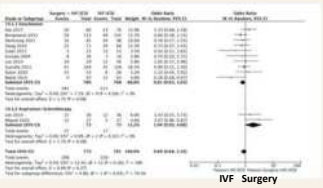
Vercellini P, et al Reprod Biomed Online 2014 Jun;28(6):704-13.
Daral E, et al Fertil Steril 2005 Oct;84(4):945-50.

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Surgery vs ART: Live Birth Rate

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

ENDOMETRIOMA



DEEP ENDOMETRIOSIS



Riemma, G., et al(2026). 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. *Reproductive BioMedicine Online*, 52(2), 105178.

21

IVF in patients with Endometriosis

- **Overall IVF success is generally preserved:** Women with *stage I/II endometriosis* and those with *endometriomas* have similar live birth and clinical pregnancy rates compared with women without endometriosis, although ovarian response may be modestly reduced.
- **Advanced disease has a greater impact:** *Stage III/IV endometriosis* is associated with fewer oocytes retrieved and significantly lower clinical pregnancy and live birth rates compared with women without endometriosis.

Supramaniam, P.R., Mittal, M., Becker, C., Jayaprakasan, K. and the Royal College of Obstetricians and Gynaecologists (2025). The Effect of Surgery on Endometriomas on Fertility (2025 Second Edition). BJOG, 132: e175-e184. https://doi.org/10.1111/1471-0528.18221

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Endometriomas

- **Endometriomas mainly affect ovarian response, not pregnancy outcomes:** associated with fewer oocytes retrieved, higher cycle cancellation rates, and likely reduced ovarian reserve, but do *not consistently reduce implantation, clinical pregnancy, or live birth rates.*
- **Routine IVF management is generally unchanged:** Ovarian stimulation protocols have not consistently altered outcomes, oocyte retrieval appears safe with appropriate antibiotic prophylaxis, and current evidence does *not support a clinically meaningful adverse effect of endometriosis on oocyte quality* or justify different ART strategies solely because an endometrioma is present.

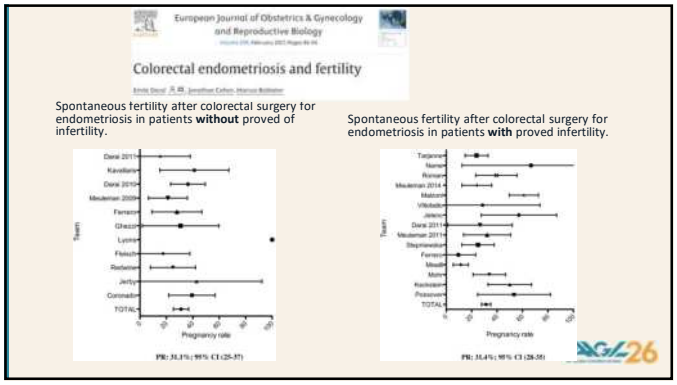
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Surgery vs. ART

- Even in cases of advanced colorectal DE, livebirth rates of up to 64.4 % after 1 to 4 IVF attempts may be achieved
- The role of surgery in patients with repeated ART failures appears favorable
- Considerations:
  - Surgical risk
  - Risk of disease progression with ART
  - Obstetrical complications

Maignien, Chloé, et al. "Infertility in women with bowel endometriosis: first-line assisted reproductive technology results in satisfactory cumulative live-birth

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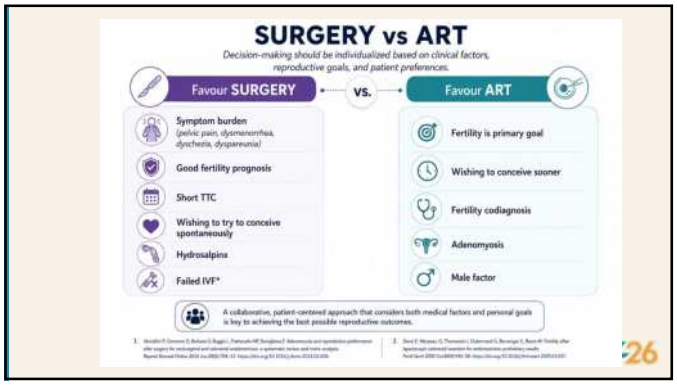
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Uncertain Role of Surgery in Asymptomatic Patient

- Offering routine surgery in cases of deep endometriosis for the sole purpose of restoring fertility in otherwise asymptomatic patients is not well established
- Potentially some reproductive advantage in treatment of mild/mod. endometriosis

Hodgson R, et al
Fertility and Sterility, 113, 374-382.e2
Befort C, et al . Cochrane Database of Systematic Reviews 2020, Issue 10 Art. No.: CD011031. Accessed 24 August 2026.

26



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Surgical Considerations

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Endometrioma

- Present in 1/5 patients with infertility undergoing IVF
- Affects ovarian reserve, anatomical distortion and embryo implantation
- Risk of damage to the primordial follicle pool during surgery

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Summary of the evidence on the risks of conservative management of ovarian endometriomas prior to IVF.

Item	Theoretical relevance	Demonstrated clinical relevance	Effect of prophylactic surgery
Ovarian responsiveness	++	–	Detrimental
Oocytes competence	++	–	Ineffective
Technical difficulties	+	–	Doubtful
Endometrioma rupture	+	–	Effective
Injury to adjacent organs	++	–	Doubtful
Infection of the endometrioma	++	+	Effective
Follicular fluid contamination with the endometrioma content	+	+/–	Effective
Progression of endometriosis	++	–	Effective
Pregnancy complications	++	+/–	Doubtful
Occult malignancy missed	+++	–	Effective
Cancer development after IVF	+++	+	Effective

Somigliana E., et al *Human Reproduction Update*, Volume 21, Issue 4, July/August 2015, 486–499, https://doi.org/10.1093/humupd/dmv012

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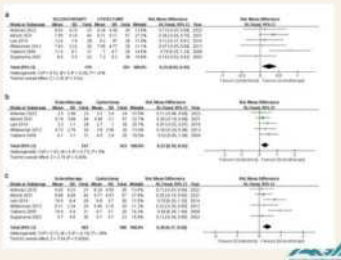
Surgical Principles

- Conscientious hemostasis
- Dissect in correct planes
- Minimize adnexal manipulation

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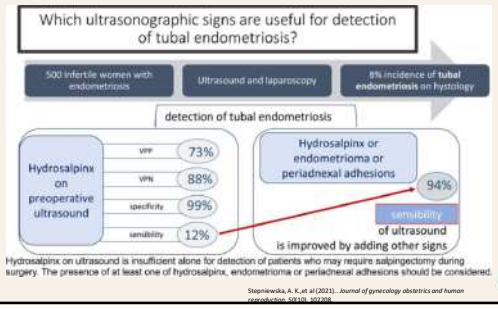
Ovarian cystectomy vs. sclerotherapy





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Fallopian Tube



Stepniewska, A. K., et al (2021). . *Journal of gynecology obstetrics and human reproduction*, 50(10), 102208.

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Deep endometriosis

- **Surgery for colorectal deep endometriosis can restore fertility**
  - Surgical options include *rectal shaving, disc excision, and segmental bowel resection*
  - Overall postoperative pregnancy rates often *>60%*
  - >50% pregnancies occurred spontaneously
- **No clear fertility advantage of one surgical technique over another:**
  - Long Term Data from EndoRE randomized trial
  - Excellent fertility outcomes regardless of surgical approach
    - 84% conception
    - 76% live birth
    - 57% spontaneous conception

Roman H, et al J Minim Invasive Gynecol. 2022 Jun;29(6):767-775.
Larrain D, et al Facts Views Vis Obgyn. 2025 Dec 22;17(4):369-380. doi:

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Deep Endometriosis

- **Complete treatment of colorectal DE may improve reproductive outcomes**
  - Leaving colorectal DE untreated is associated with *lower spontaneous pregnancy rates*, while excision of colorectal lesions appears to improve fertility without compromising outcomes
  - Combining surgery with *assisted reproductive technology (ART)* may further increase overall pregnancy rates in selected patients.

Roman H, et al J Minim Invasive Gynecol. 2022 Jun;29(6):767-775.
Larrain D, et al Facts Views Vis Obgyn. 2025 Dec 22;17(4):369-380. doi:

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Discoid vs. segmental resection

	Segmental resection (n = 81), n (%)	Disk resection (n = 31), n (%)	P-value
Presurgical infertility	50/81 (61.7)	11/31 (35.4)	0.01
Pregnancy rate (spontaneous and IVF—subfertile women)	32/50 (64.0)	7/11 (63.6)	0.98
Spontaneous pregnancy rate	20/50 (40)	6/11 (54.5)	0.41
IVF pregnancy rate	12/50 (24)	1/11 (9)	0.018
Time to pregnancy (months), median (min-max)	7 (2-51)	5 (1-48)	0.83
Miscarriage	5/32 (15.6)	1/7 (14)	0.94
Extrauterine pregnancy	0/32 (0)	0/7 (0)	1
Preterm birth	4/32 (12.5)	1/7 (14)	0.91
Term delivery	21/32 (65.6)	4/7 (57.1)	0.70
Ongoing pregnancy	2/32 (6.3)	5/7 (71.4)	0.011

Hudelist, Gernot, et al. et al." *Acta Obstetricia et Gynecologica Scandinavica* 97.12 (2018): 1438-1446.

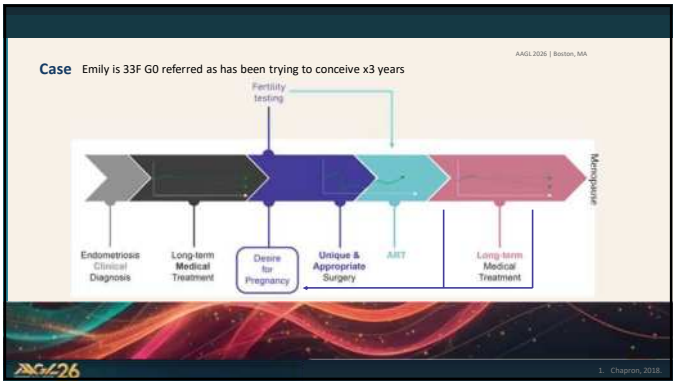
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Case 2: *Emily is 33F G0 referred as has been trying to conceive x3 years*

- Restarted on dienogest daily while waiting for egg freezing and subsequent endometriosis resection and ovarian cystectomy

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Summary

- Ascertain the impact of endometriosis associated pelvic pain and symptoms in patients wishing to conceive
- Complete fertility investigations to determine ovarian reserve, as well as other factors predicting fecundity rate
- Discuss the pros/cons of surgery vs. ART for endometriosis related infertility
- When surgery is indicated, optimize preoperative preparation and surgical technique to maximize subsequent fertility outcomes

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Thank you

- Questions?
- Olga Bougie, MD, FRCSC – University of Toronto, Mount Sinai Health Systems



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Endometriosis in perimenopause: The last chapter ?

Jade Desilets, MD, MSc, FRCSC · McGill University Health Centre

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Case 3: Endometriosis in perimenopause; the last chapter ?

AAGL 2026
Endometriosis Across the Lifespan:
Case-Based Medical & Surgical Decision-Making

2

Speaker profile & Disclosure

I have no financial relationships to disclose



Jade Desilets, MD, MScHQ, FRCSC
Assistant Professor in the department of obstetrics & Gynecology
McGill University Health Centre, Qc, Canada

3

Objectives

1. Highlight the essential differences in the management of endometriosis in perimenopausal patient population
2. Review the relationship between ovarian cancer risk and endometriosis
3. Compare the medical and surgical management for perimenopausal patient

4

Endometriosis in perimenopause

- May become less hormonally active after menopause, but the **anatomical consequences do not necessarily disappear**
- The challenge:
  - Bridge the patient to menopause medically, vs
  - Perform conservative surgery, vs
  - Perform definitive surgery

How much surgery is much is too much surgery?

5

Clinical case

Perry is a 48 yo woman, G2P1

History of severe dysmenorrhea, improved since childbearing
Irregular cycles x 1 yr, experiencing vasomotor symptoms
Recently worsening dysmenorrhea, dyschezia

PMHx: Nil
Sgx: Cesarean Section

FamHx:
- Mother had clear cell endometrial carcinoma

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Clinical case

Perry is a 48 yo woman, G2P1

Healthy
History of severe dysmenorrhea, improved since childbearing
Irregular cycles x 1 yr, experiencing vasomotor symptoms
Recently worsening dysmenorrhea, and occasional dyschezia

Surgical Hx: Cesarean Section

Family Hx:
- Mother had clear cell endometrial carcinoma

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Clinical Case

- Ultrasound image

Ultrasound :
- Bilateral thickened USL
- RO endometrioma 8cm
- Rectosigmoid tethering, small bowel nodule 1.5 cm, involving muscularis, but mucosa not involved

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Clinical case

48-year-old, G2P1

HISTORY

Severe dysmenorrhea since adolescence
Improved after childbearing; now worsening again

New dyschezia
Irregular cycles × 1 year
Mild vasomotor symptoms

Confirmed DEI on imaging

PMHx: none | Prior CS

THE PATIENT'S QUESTIONS

"Do I need surgery now?"

"Should my ovaries come out?"

"Could this become cancer?"

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What would you recommend at this point?

A. Medical hormonal suppression and interval imaging

B. Endometrioma surgery only

C. Endometrioma surgery plus conservative bowel surgery

D. Hysterectomy, BSO and excision of all visible disease

E. Additional investigation before deciding

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The challenge in these cases



- 4 questions to answer, with imperfect evidence for each

Endometriosis & malignancy risk	Symptoms mechanism	Uterus & Ovaries	Surgical burden
Does the adnexal mass needs surgery ?	**Are the symptoms hormonal, mechanical, or both ?**	**Should we preserve ovarian function ?** **Should we offer hysterectomy?**	**What surgical morbidity is acceptable ?** (how aggressive should we be ?)

11

The challenge in these cases

- 4 questions to answer, each with imperfect evidences

Ovarian mass & malignancy risk	Symptoms mechanism	Uterus & Ovaries	Surgical burden
Does the adnexal mass need surgery ?	**Are the symptoms hormonal, mechanical, or both ?**	**Should we preserve ovarian function ?** **Should we offer hysterectomy?**	**What surgical morbidity is acceptable ?** (how aggressive should we be ?)

Does she need surgery ?

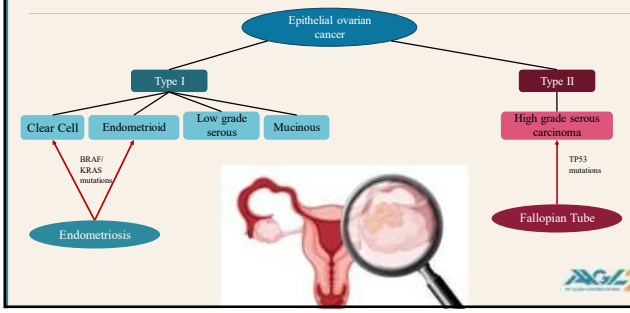
If so, what type of surgery?

12

Endometriosis & ovarian cancer risk

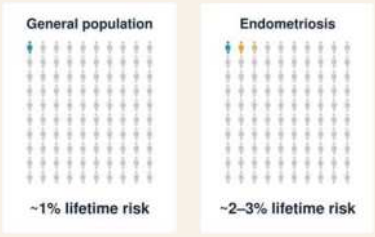
13

Dual model of ovarian carcinogenesis & endometriosis



14

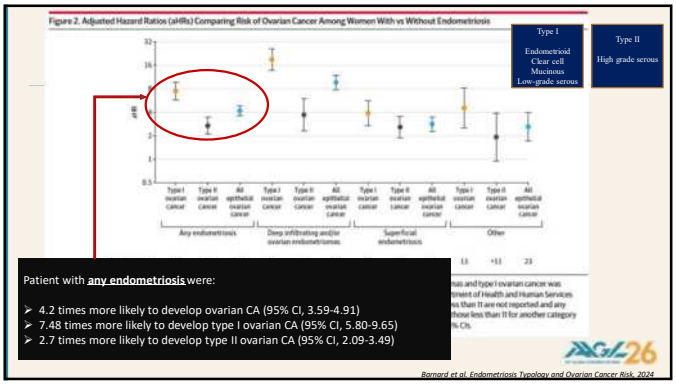
Current practice for patients with endometriosis



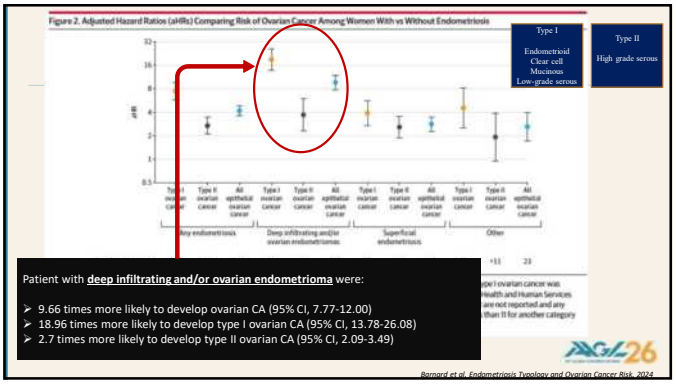
- Relative risk of ovarian cancer is 2-4x increased
- Absolute risk remains relatively low

Uptodate – September 2024

15



16



17

Gynecologic Oncology: *Original Research*

Risk of Gynecologic Cancer According to the Type of Endometriosis

Liisu Saavalainen, MD, Heini Lassus, MD, PhD, Anna But, MSc, Aila Tiitinen, MD, PhD, Päivi Härkki, MD, PhD, Mika Gissler, PhD, Eero Pukkala, PhD, and Oskari Heikinheimo, MD, PhD

- Overall increased risk of ovarian cancer (SIR 1.76, 95% CI 1.47-2.08)
- Highest risk among women with **ovarian endometriosis** and especially for **clear cell** and **endometrioid**
- Risk of ovarian cancer was not increased among women with peritoneal and deep infiltrating endometriosis

18

Can we mitigate the risk ?

- Decreased risk of developing ovarian cancer in women who had prior unilateral oophorectomy or radical excision of endometriosis

  Melin, Anna-Sofia, et al. "Hormonal and surgical treatments for endometriosis and risk of epithelial ovarian cancer." *Acta obstetricia et gynecologica Scandinavica* 92.5 (2013)

- Ovarian cancer is more likely to develop after recurrence of endometrioma

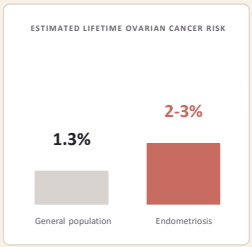
  Haraguchi, Hirofumi, et al. "Development of ovarian cancer after excision of endometrioma." Fertility and Sterility 106.6 (2016)

- Use of oral contraceptives for >10 years was associated with a substantial reduction in risk among women with endometriosis

  Modugno, Francesmary, et al. "Oral contraceptive use, reproductive history, and risk of epithelial ovarian cancer in women with and without endometriosis." *American journal of obstetrics and gynecology* 191.3 (2004)

19

Endometriosis & Ovarian cancer risk



- Ovarian endometrioma (+/- DEI) is associated with higher risk of developing epithelial ovarian cancer
  - Stronger association with clear cell and endometrioid histotype
- Some evidence that radical excision of endometriosis, oophorectomy, and prolonged use of COC decrease the risk

20

The challenge in these cases

- 4 questions to answer, each with imperfect evidences

Ovarian mass & malignancy risk	Symptoms mechanism	Uterus & Ovaries	Surgical burden
Does the adnexal mass needs surgery ?	**Are the symptoms hormonal, mechanical, or both ?**	**Should we preserve ovarian function ?**	**What surgical morbidity is acceptable ?** (how aggressive should we be ?)
	Does she need surgery ?	**Should we offer hysterectomy?**	**If so, what type of surgery?**

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Mechanism of the symptoms

22

Mechanism of the symptoms

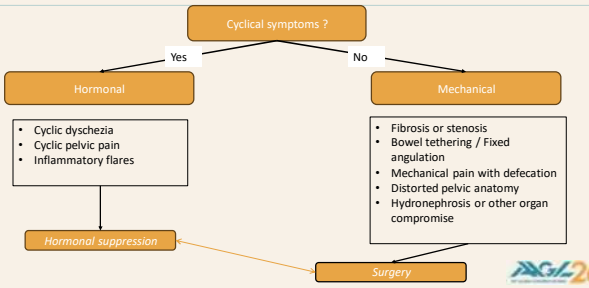
Hormonally driven	Mechanically driven
	
Activity decrease after menopause	Fibrosis and tethering persist

Menopause may quiet disease activity, but it does not release fixed anatomy

Images generated with openAI

23

Will the symptoms disappear after menopause ?



24

1. Does she need surgery ?

Favoring medical management:

- Mild or manageable symptoms
- Reassuring imaging
- Mild or stable disease
- Strong preference to avoid surgery
- High operative risk

Favoring Surgical management:

- Large endometrioma / Worsening symptoms
- Mechanical obstruction (ureters, bowel, etc)
- Possibility of increasing surgical complexity if disease progress
- Patient preference

25

The challenge in these cases

- 4 questions to answer, with imperfect evidence for each

Ovarian mass & malignancy risk

Does the adnexal mass needs surgery ?

Symptoms mechanism

Are the symptoms hormonal, mechanical, or both ?

Does she need surgery ?

YES

Uterus & Ovaries

Should we preserve ovarian function ?

Should we offer hysterectomy?

Surgical burden

What surgical morbidity is acceptable ? (how aggressive should we be ?)

If so, what type of surgery?

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What surgery would you offer ?

Uterus & Ovaries

A. Right cystectomy

B. Right salpingo-oophorectomy

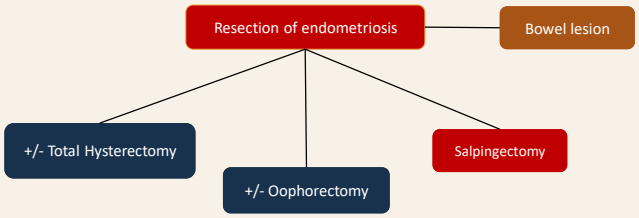
C. Bilateral salpingo-oophorectomy

D. TLH, USO

E. TLH, BSO

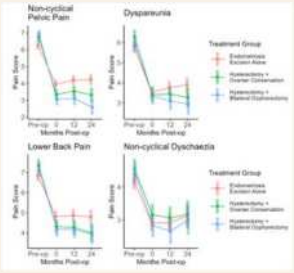
27

Surgical plan



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Hysterectomy




BJOG An International Journal of Obstetrics and Gynaecology

Comparing the treatment of endometriosis-related pain by excision of endometriosis or hysterectomy: A multicentre prospective cohort study

- Hysterectomy had greater improvement in non-cyclical pain, dyspareunia and QoL
- Hysterectomy with bilateral oophorectomy had even greater improvement non-cyclical pain, dyspareunia, back pain and QoL

29

Hysterectomy – Additional benefits

- Amenorrhea
- May provide better surgical access for complete excision
- Reduce risk of recurrence
- Removal of co-existing adenomyosis (13-89%)*
- *Possibility of avoiding progestin in HRT*

Higher complication rate:

- Ureteric injury
- Conversion to laparotomy
- Pelvic hematoma)

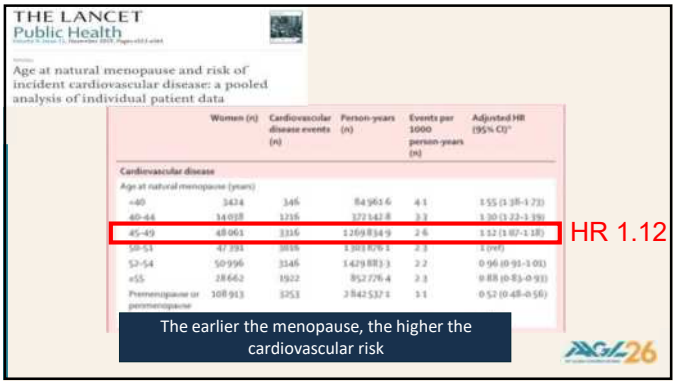
30

Bilateral oophorectomy


THE LANCET
Public Health
Age at natural menopause and risk of incident cardiovascular disease: a pooled analysis of individual patient data

Data from 15 cohorts in 5 countries (Australia, Scandinavia, United States, Japan, United Kingdom)= **301 438 women**

31


THE LANCET
Public Health
Age at natural menopause and risk of incident cardiovascular disease: a pooled analysis of individual patient data

HR 1.12

The earlier the menopause, the higher the cardiovascular risk

32

Re-operation risk


GYNECOLOGY
Long-term follow-up of endometriosis surgery in Ontario: a population-based cohort study

Category	Group	Adjusted HR (BSO as Reference)
Repeat Surgery (Within 1 Year)	Major with BSO	1.0
	Major without BSO	**2.27**
Hysterectomy Subgroup	Hysterectomy with BSO	1.0
	Hysterectomy without BSO	**3.57**

14.15% reoperation rate.

33

Re-operation risk

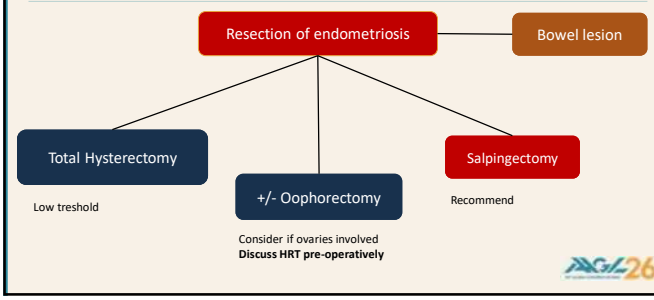

GYNECOLOGY
Reoperation and pain-related outcomes after hysterectomy for endometriosis by oophorectomy status

Hyst only	**13%**
Hyst + BSO/BO	5.3%

* Median follow-up = 10 years
* p=0.0001
* N=4489

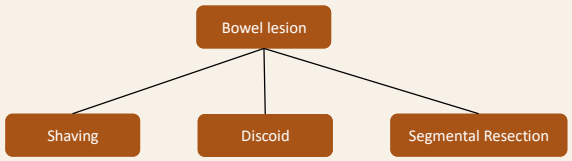
34

Surgical plan



35

Approach to then bowel lesion in perimenopause



36

What surgery would you offer ?

A. Restore anatomy, but do not address bowel lesion
B. Rectal shaving
C. Discoid resection
D. Segmental bowel resection

- Rectosigmoid tethering
- Nodule 1.5 cm, involving muscularis,
- Mucosa not involved
- 12cm from anal verge

37

Approach to the bowel lesion

	Shaving	Discoid	Lower Anterior Resection (LAR)
Infiltration Dept	Serosa / outer muscularis	Submucosa / mucosa	Deep transmural
Nodule size	<2-3 cm	< 3 cm	> 3 cm
Circumference	30%	30-40%	40-50%
Number of lesions	Single / (multiple)	Single	Single / multiple
Bowel stenosis	None	Mild / none	Severe

Recommendations for the surgical treatment of endometriosis. Part 2: deep endometriosis , *Human Reproduction Open*

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Complications

Shaving	Discoid	Lower Anterior Resection (LAR)
Lowest rate of complications	Lower risk of severe complications than LAR (leak, fistula)	Major short / long term complications - Anastomotic leak (5.2% - Rectovaginal fistula (5.2%) - Fecal incontinence (1.3%)

European Journal of Obstetrics & Gynecology and Reproductive Biology: X

Post-operative complications and recurrence rate after treatment of bowel endometriosis: Comparison of three techniques

Alicia Hernández Gutiérrez[a,*], Emanuela Spagnolo[b], Ignacio Zapardiel[b], Rubén García-Abadilla Seivane[a], Ana López Carrasco[a], Patricia Salas Bolívar[a], Isabel Pascual Miguelañez[a]

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Complications

GYNECOLOGY

Long-term functional outcomes following colorectal resection versus shaving for rectal endometriosis

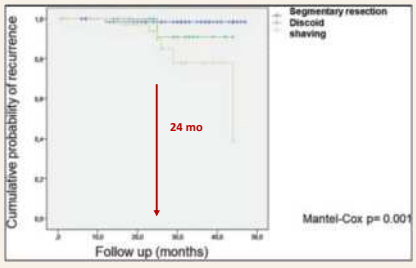
Horace Roman, MD, PhD; Mathilde Milles, MD; Maud Vassilieff, MD; Benoit Resch, MD; Jean-Jacques Tuech, MD, PhD; Emmanuel Huet, MD; Basma Darwish, MD; Carole Abo, MD

Rectal shaving vs LAR:

- Better Gastrointestinal Quality of Life Index values
- lower KESS scores for postoperative constipation
- better anal continence

40

Recurrence

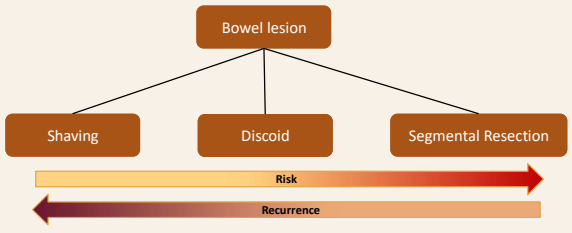


Higher recurrence rate : Shaving

Median recurrence time: 44 months (3.6 yr)

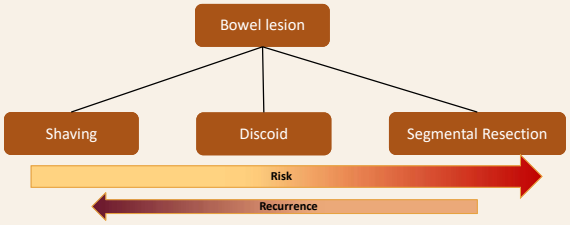
41

Approach to then bowel lesion in perimenopause



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Approach to then bowel lesion in perimenopause



Aim for the most conservative approach

But escalate if needed

43

Take home

1. Perimenopausal patient with endometriosis should be offered same therapeutic options, with specific surgical consideration
2. Endometriosis is associated with an increased risk of ovarian cancer
   - Risk factors: Increasing age, endometrioma > 9cm, DEI
3. Distinguishing cyclical pain vs mechanical pain might help in guiding surgical management
4. Consider unilateral oophorectomy with hormonal suppression vs BSO with HRT
5. Favor conservative bowel surgery, but escalate when needed

44

Acknowledgments

- Dr Carlos Tripia

45

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1. Nezhat, F. R., Pejovic, T., Reis, F. M., & Guo, S. W. (2014). The link between endometriosis and ovarian cancer: Clinical implications. *International Journal of Gynecologic Cancer, 24*(4), 623–628.
2. Barnard, M. E., Farland, L. V., Yan, B., Wang, J., Trabert, B., Doherty, J. A., et al. (2024). Endometriosis typology and ovarian cancer risk. *JAMA, 332*(6), 482–489.
3. Kvaskoff, M., Mahamat-Saleh, Y., Farland, L. V., Shigesi, N., Terry, K. L., Harris, H. R., et al. (2021). Endometriosis and cancer: A systematic review and meta-analysis. *Human Reproduction Update, 27*(2), 393–420.
4. Melin, A. S., Lundholm, C., Malki, N., Swahn, M. L., Sparén, P., & Bergqvist, A. (2013). Hormonal and surgical treatments for endometriosis and risk of epithelial ovarian cancer. *Acta Obstetricia et Gynecologica Scandinavica, 92*(5), 546–554.
5. *Coexisting adenomyosis in endometriosis: Similar pain and quality of life, with longer bleeding and bowel symptoms—A comparative cross-sectional study*. *Int J Gynecol Obstet*. 2026; 00: 1-10. doi:10.1002/ijgo.70988

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The Endometriosis Playbook: Case-Based Medical & Surgical Management Across the Lifespan

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

1

Speaker profile & disclosures



M Jonathon Solnik, MD, MBA, FACOG, FACS
Professor of OB/GYN & Medical Imaging (cross appointed)
Deputy Chief of Gynecology
Sinai Health & Women's College Hospital

Disclosures
Consultant: Temuro Medical
Medical Advisor: Felix Health Inc

Official headshot source: Sinai Health

2

Why this course?

Management changes as symptoms, fertility goals and ovarian function change.



- A chronic disease
- A changing question
- An individualized plan

3

Course Objectives

Apply a lifecycle-based framework to choose initial medical versus surgical management aligned with patient goals and symptom burden

Individualize hormonal suppression based on age, health history, symptoms, tolerability, bone health and fertility goals.

Plan the timing and scope of surgery based on symptoms, disease complexity, ovarian reserve and reproductive goals.

Integrate fertility preservation and ART into surgical decision-making when relevant.

4

Guiding questions

These are the questions we will revisit throughout the course:

- What is driving the symptoms?
- Is surgery needed — and if so, how much?



- What matters most to the patient now?
- What does today's choice mean over time?

5

Today's journey

Three cases. One framework. Three decision points across the lifespan.



Case 1 — Young adult

Chandrew Rajakumar

symptoms • diagnosis • initial suppression • timing of surgery



Case 2 — Reproductive years

Olga Bougie

fertility • ART • pain • role of surgery



Case 3 — Perimenopause

Jade Desilets

symptom mechanism • malignancy considerations • surgical extent

6

Concluding remarks: The playbook

Treat the patient in front of you and not the life-stage label.

Reassess the dominant clinical problem as symptoms, ovarian function and reproductive priorities change.

Medical therapy, surgery and ART are complementary tools; the right sequence is patient-specific.

Timing and scope of surgery matter as much as technical execution.

Shared decision-making is the constant: symptom burden, fertility priorities, ovarian function and tolerance for recurrence or re-intervention should drive the plan.

7

Thank You

Panel Q&A

Jonathon Solnik
Olga Bougie
Chandrew Rajakumar
Jade Desilets

8

Case 1: The young adult

AAGL 2026

Endometriosis Across the Lifespan:
Case-Based Medical & Surgical Decision-Making

1

Speaker Profile



Dr. Chandrew Rajakumar
Chief of Surgery, South Health Campus, AB, CAN
Disclosures / Funding

Advisory boards, speakers' bureaus, consulting:

- Hologic
- Ethicon
- Olympus
- Pfizer
- Knight Pharmaceutical

2

Agenda

1. Consider the presentations of endometriosis and associated pathologies in the young adult stage of life
2. Determine the role for and timing of surgery in this population
3. Determine the role for pharmacologic disease suppression
4. Consider fertility planning

3

Case

Algea is a 20 yo G0 who is a heterosexual, sexually-active woman

Referring physician: Primary Care Provider
Reason for referral: Pelvic pain

Has low pelvic pain that worsens with her period. Physical examination, hemoglobin, vaginal swabs, and sonography normal. Is not interested in birth-control. Uses condoms for contraception. Please rule out endometriosis.

4

Case *Algea* is a 20 yo G0 who has pelvic pain

Menstrual History

Cycles q28 days with heavy flow for 2 of 4 days

Future fertility:	Possibly
Dysmenorrhea:	Severe
Dyspareunia:	None however, moderate - following intercourse for approximately 24 hours
Dyschezia:	None however, mild following BM if constipated usually on menses
Dysuria:	Mild, if bladder full and worse on menses
Contraception:	Condoms PRN; on/off *"boyfriend"*

5

Case *Algea* is a 20 yo G0 who has pelvic pain and severe dysmenorrhea

Pain History

- Constant vs intermittent
- Baseline intensity vs intensity
- Character
- Location
- Radiation
- Aggravating and alleviating factors

6

Standardization

How would you describe *that pain*?

I will give you some adjectives you tell me which ones describe *that pain*.

- none
- aching
- burning
- colicky
- cramping
- dull
- hot
- pressure-like
- sharp
- shooting
- stabbing
- tingling
- ***

baseline

Abdominal Pain: Patient complains of abdominal pain. The pain is described as [quality] and is [0-10] /10 in intensity. Pain is located in the [anatomy; location abdomen] [abdomen pain radiation]. Onset was [numbers; 0-10] [unit] ago. Symptoms have been [course: unchanged] since. Aggravating factors: [aggrav factors]. Alleviating factors: [alev factors].

7

Case

Algea is a 20 yo G0 who has pelvic pain and severe dysmenorrhea

AAGL 2026 | Boston, MA

Has daily constant 4/10 pain in the RLQ and LLQ in a band across the low abdomen ("belt line"). It started on the RLQ and became bilateral but the R > L. She is not sure she can remember if this started with her period and thinks maybe. But, not as intense and so has been gradually worsening over time. Her periods have always been severe and the intensity of the pain flares with her periods.

8

Case

Algea is a 20 yo G0 who has noncyclic low abdominal pain with cyclic flares and severe dysmenorrhea

AAGL 2026 | Boston, MA

Physical Examination – Carnett's Sign



Imaging – US/MRI



1. Speer LM, Muchlbar S, Erbele T. Am Fam Physician. 2016 Mar 1;93(5):380-7.
2. Ortiz DD. Am Fam Physician. 2008;77(11):1585–1592.
3. US image is CC BY Creative Commons License. Credit/Roboflow Universe - midhoc, Creator: midhoc https://universe.roboflow.com/midhoc-eytbl/detectionuterus

9

Case

Algea is a 20 yo G0 who has noncyclic somatic low abdominal wall pain with cyclic flares and severe dysmenorrhea and may have early-stage endometriosis

AAGL 2026 | Boston, MA

The presumption of endometriosis is based on imaging data that she does not have rASRM stage 3 or 4 disease but has severe dysmenorrhea.

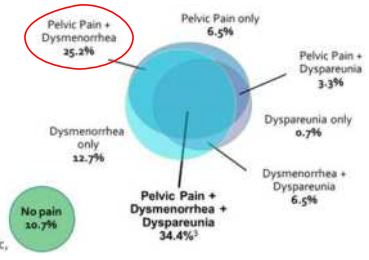
Is this endometriosis?

Does it matter to know for sure?

10

- Pain is the main symptom of endometriosis[1]
- Most women diagnosed with endometriosis experience[2]:
  - Dysmenorrhea
  - Nonmenstrual pelvic pain
  - Dyspareunia

Because clinical features are nonspecific, this leads to delays in diagnosis.[1]



Barbieri R. OBGM. 2017;29(3).
De Graaff AA, et al. *Hum Reprod.* 2013;28(10):2677-85.
Smaki N, et al. *Fertil Steril.* 2008; 89:538-545.

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Case

Algea is a 20 yo G0 who has noncyclic somatic low abdominal wall pain with cyclic flares and severe dysmenorrhea and may have early-stage endometriosis

AAGL 2026 | Boston, MA

The presumption of endometriosis is based on imaging data that she does not have rASRM stage 3 or 4 disease but has severe dysmenorrhea.

Is this endometriosis? 25-30% chance

Does it matter to know for sure?

12

Case *Algea* is a 20 yo G0 who has noncyclic somatic low abdominal wall pain with cyclic flares and severe dysmenorrhea and 25-30% chance of early-stage endometriosis

Menstrual History

Cycles q28 days with heavy flow for 2 of 4 days	
Future fertility:	Possibly — Other
Dysmenorrhea:	Severe — Primary Dysmenorrhea vs Secondary: AUB vs endometriosis
Dyspareunia:	None however, moderate - following intercourse for approximately 24 hours
Dyschezia:	None however, mild following BM if constipated usually on menses
Dysuria:	Mild, if bladder full and worse on menses
Contraception:	Condoms PRN; on/off *"boyfriend"* — Somatic Abdominal Wall Pain

13

OPTIONS

- No intervention → No change in QoL; Possible worsening of QoL over time; Possible reduction in fertility over time
- Pharmacologic Cycle Suppression → Improved QoL; Possible prevention of disease progression; Possible preservation of fertility potential over time
- Surgical Excision of Possible Endometriosis
  - ODBP → No change in QoL; Possible complications of surgery
  - ODBP → Improved QoL; Possible complications of surgery; Possible 12-mon improvement in fertility

14

OPTIONS

Diagnostic laparoscopy is not required before treatment in all patients presenting with pelvic pain. Clinicians can initiate medical management based on patient **history**, pelvic **exam** and **imaging** (SOGC).[1]

Up to **40%** of women with chronic pain will have no findings on laparoscopic assessment.[2]

Overall risk of any complication with laparoscopy is 8.9% [3]

Therefore, a **see and treat** approach should **ALWAYS** be taken which requires **pre-operative planning, counseling, and the appropriate skill set**.[3]

- Surgical Excision of Possible Endometriosis
  - ODBP → No change in QoL; Possible complications of surgery

1. SOGC Guidelines. Endometriosis: Diagnosis and Management. JOGC. 2010;32(7 Suppl 2):S1-32.
2. Tirlapur SA, et al. Curr Opin Obstet Gynecol. 2015 Dec;27(6):445-8.
3. Chapron C, et al. Hum Reprod. 2002;17:1334-42.

15

OPTIONS

- Surgical Excision of Possible Endometriosis
  - ODBP → Improved QoL; Possible complications of surgery; Possible 12-mon improvement in fertility

2020 Systematic Review of Surgical Excision of Endometriosis[1]
- 11.8% - no improvement in pain
- 34.3% - postoperative pain
- 28.7% - recurrent pain
- 14.8% - adverse events
- 22.6% - additional surgery

Chronic pain may persist despite complete excision - Central sensitization.

Pain severity correlates imperfectly with lesion burden. [3]

2025 Prospective Cohort study on Long-term Effect if Radical Excision of Endometriosis[2]
- 37.0% - no improvement global health score
- 79.2% - improvement in menstrual pain
- 64.4% - improvement in noncyclic pain
- 36.0% - additional surgery

With rASRM stage 1-2 endometriosis surgery can improve fertility[4,5]:
- Increase >20 wk pregnancy = 13%
- NNT = 8

1. Singh S., et al. JOGC. 2019; 42, 881-888.e11
2. McDonnell R., et al. Gynecol Minim Invasive Ther. 2025 Jan 8;14(1):57–65.
3. Becker C., et al. ESHRE guideline: Endometriosis. Human Reproduction Open, Volume 2022, Issue 2, 2022, hoac009
4. Marcoux S, Maheux R, Bérubé S. NEJM 1997;337(4):217-222.
5. Carvalho L, et al. Rev Assoc Med Bras (1992). 2012 Sep-Oct;58(5):607-14

16

COUNSELING POINT

CYCLIC		NON-CYCLIC	
AUB	DYSMENORRHEA	ENDOMETRIOSIS	SOMATIC PAIN
		HORMONE-MEDIATED	STRUCTURAL

- Menstrual suppression (LNG-IUS, EA, Hysterectomy)
- Cycle suppression (P, E+P, GnRH, Oophorectomy)
- Fibrosis
- Anatomic changes
- Physically reproducible
- Excisional Surgery
- May be hormonally mediated (not cause-effect relationship)
- + Carnett's sign
- Will often improve following surgery, but will return
- Myofascial injections or trunk blocks can help with patient understanding

17

CYCLIC		NON-CYCLIC	
AUB	DYSMENORRHEA	ENDOMETRIOSIS	SOMATIC PAIN
		HORMONE-MEDIATED	

- Cycle suppression (P, E+P, GnRH, [illegible])

PHARMACOLOGIC MANAGEMENT

18

PHARMACOLOGIC MANAGEMENT



Luteal Phase simulation : Progestin +/- Estrogen

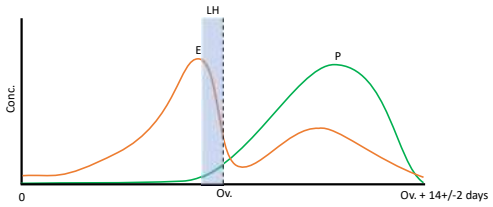


Premenarche simulation : GnRH Analogs

1. Pill image is Creative Commons License: Credit: Roboflow Universe - wow, Creator: wow https://universe.roboflow.com/wow-69251/circular-objects-t2htm

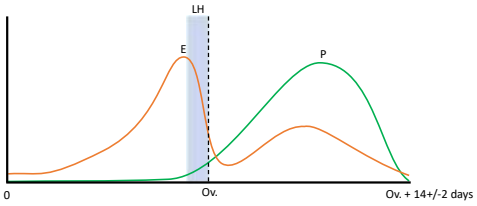
19

OVULATORY-MENSTRUAL CYCLE



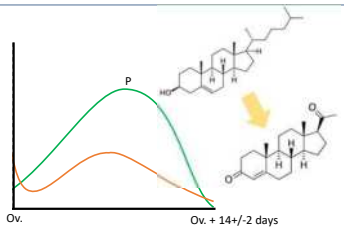
20

PROGESTERONE



21

PROGESTERONE



- Prevents menstruation
- Prevents ovulation
- Endometrial growth reg.
- Thickens mucus
- Smooth muscle relaxation
- Very short half-life[1]

1. Aufrère MB, Benson H (June 1976). "Progesterone: an overview and recent advances". Journal of Pharmaceutical Sciences. 65 (6): 783–800. doi:10.1002/jps.2600650602. PMID 945144

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Luteal Phase Simulation

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PROGESTINS

- Receptor Specific
  - Customizable
- Longer half-life
  - Customizable
- Shelf stability
- Multiple routes of administration
- Cheap (relatively)

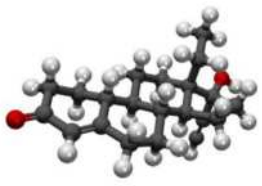
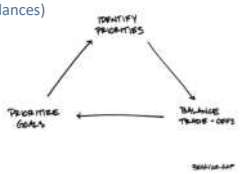


Image: Wikimedia Commons "Levonorgestrel3D" Creative Commons License

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How to choose?

Therapeutic goals
Therapeutic secondary goals (bonuses and avoidances)
Past experiences
Route of administration
Half-life
Dose of added estrogen
Metabolites



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How to choose?

Primary goals
Secondary goals
Past experiences
Route
Half-life
Estrogen
Metabolites

25

How to choose?

- Cycle suppression
  - Endometriosis – inflammation
  - Endometriosis – proliferation
  - AUB
  - Dysmenorrhea
- Contraception
- Acne, coarse hair growth, PMDD ?
- Break-through bleeding prevention

Primary goals
Secondary goals
Past experiences
Route
Half-life
Estrogen
Metabolites

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How to choose?

- Drug history
  - What did they try?
  - How long until they stopped?
  - What were the side effects?
- Progestin families/classes

Primary goals
Secondary goals
Past experiences
Route
Half-life
Estrogen
Metabolites

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Progestin Families





Gonanes	Estranes	Pregnanes	Atypicals
• Levonorgestrel	• Norethindrone	• MPA	• Drospirenone
• Norgestrel	• NETA	• Megestrol	
• Desogestrel	• Ethynodiol	• Cyproterone Ac	
• Etonogestrel	• Lynestrenol	• Progesterone!	
• Gestodene			
• Norgestimate			

Image: Wikimedia Commons "Steroid Common" Creative Commons License - https://en.wikipedia.org/wiki/Steroid#/media/File:Steroid_Common.svg
Image: Wikimedia Commons "Progesterone" Creative Commons License

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How to choose?

- Drug history
  - What did they try?
  - How long until they stopped?
  - What were the side effects?
- Progestin families/classes
  - Gonanes
  - Estranes
  - Pregnanes
  - Atypical

Primary goals
Secondary goals
Past experiences
Route
Half-life
Estrogen
Metabolites

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How to choose?

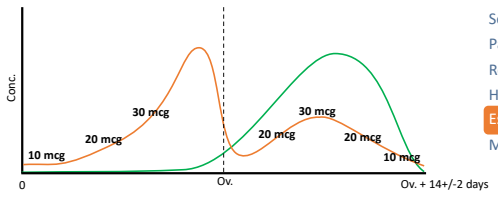


Primary goals
Secondary goals
Past experiences
Route
Half-life
Estrogen
Metabolites

Image: Wellness OBGYN Creative Commons License

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How to choose?



- Primary goals
- Secondary goals
- Past experiences
- Route
- Half-life
- **Estrogen**
- Metabolites

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How to choose?



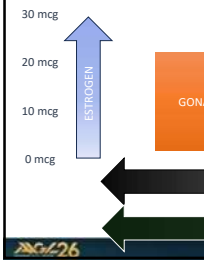
Some medications may cause the same side effects because of their metabolites:

- Desogestrel → Etonogestrel
- Norgestimate → Levonorgestrel (LNG)

- Primary goals
- Secondary goals
- Past experiences
- Route
- Half-life
- Estrogen
- **Metabolites**

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Deciding 101



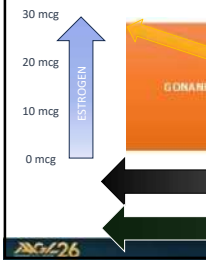




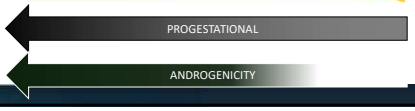
- Primary goals
- Secondary goals
- Past experiences
- Route
- Half-life
- Estrogen
- Metabolites

33

Deciding 101



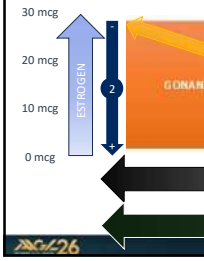


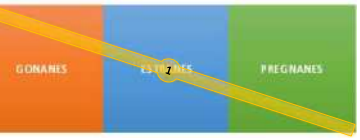


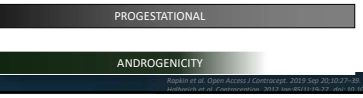
1. Primary goals
- Secondary goals
- Past experiences
- Route
- Half-life
- Estrogen
- Metabolites

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Deciding 101



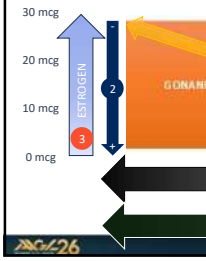




1. Primary goals
2. Secondary goals
- Past experiences
- Route
- Half-life
- Estrogen
- Metabolites

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Deciding 101





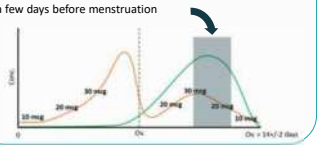


1. Primary goals
2. Secondary goals
3. Past experiences
- Route
- Half-life
- Estrogen
- Metabolites

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Case *Algea* is a 20 yo G0 who has noncyclic low abdominal pain with cyclic flares and severe dysmenorrhea

- Best QoL is a week after ovulation to a few days before menstruation
- Needs reliable contraception
- Fertility preservation



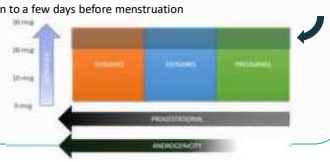
37

Case *Algea* is a 20 yo G0 who has noncyclic low abdominal pain with cyclic flares and severe dysmenorrhea

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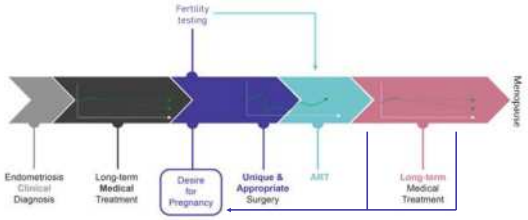
Bone Health

- Encourage Ca, Vit D, exercise
- Long term P is associated with a decline in BMD, but there is no clinical evidence of increased fracture rate



38

Case *Algea* is a 20 yo G0 who has noncyclic low abdominal pain with cyclic flares and severe dysmenorrhea



1. Chapron, 2018.

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Conclusions

1. Differentiate between what are cyclic-dependent symptoms and cycle-associated symptoms
   a. History
   b. Physical Exam
   c. Imaging

2. For noncyclic pain, determine if it is somatic versus visceral
   a. Physical Exam – Canrnett's sign

3. Discuss endometriosis
   a. Fertility
   b. Microscopic vs Macroscopic disease
   c. Hormone-mediated vs structural disease

4. Chronic progressive diseases' life-long treatment is through induction and maintenance of remission with acute interventions (chemical or surgical), but the timing must be right and based on pt's values

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Thank You

Questions?

Dr. Chandrew Rajakumar
Calgary, AB, Canada

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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/