MIGS 26

55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
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Syllabus

PGSIG-846

Advancing Excellence in Fibroid Management Through Patient Empowerment, Evidence Based Care, and Surgical Strategy

HONORARY CHAIR
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Table of Contents

Course Program: Course Description, Learning Objectives, Course Outline 3

Financial Disclosures 4

Fertility Focused Care: Optimizing Reproductive Goals in Patients with Uterine Fibroids
A. Song 5

The Failed Fibroid Operation: What Went Wrong and How to Avoid It
S. Chudnoff 9

Fibroid Surgery: Aligning Surgical Options with Patient Priorities
R. Sinha 13

Shared Decisions, Better Outcomes: Navigating the Gray Zone in Fibroid Surgery
S. Artazcoz 18

Cultural and Linguistic Competency & Implicit Bias 23

PGSIG-846: Advancing Excellence in Fibroid Management Through Patient Empowerment, Evidence Based Care, and Surgical Strategy

Chair: Arleen H. Song
Co-Chair: Scott G. Chudnoff
Faculty: Santiago Artazcoz, Scott G. Chudnoff, Rooma Sinha, Arleen H. Song

Course Description

This course endeavors to approach the management of uterine fibroids, with a focus on aligning surgical decision-making with patient priorities, fertility goals to optimize long-term outcomes. Participants will gain insight into preoperative treatment strategies and counseling of all options, intraoperative pitfalls and management, and surgical decision making. By the end of the course, participants will be prepared to make strategic surgical decisions in complex scenarios and improve both surgical and reproductive outcomes through thoughtful, collaborative, patient-centered care.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Develop a framework to counsel patients on fertility sparing options regarding fibroid treatment; 2) Discuss patient centered approach to counseling regarding fibroid management; and 3) Describe strategies to approach complex fibroid surgical situations.

Course Outline

10:15 am	Welcome, Introduction and Course Overview	A. Song
10:20 am	Fertility Focused Care: Optimizing Reproductive Goals in Patients with Uterine Fibroids	A. Song
10:45 am	The Failed Fibroid Operation: What Went Wrong and How to Avoid It	S. Chudnoff
11:10 am	Fibroid Surgery: Aligning Surgical Options with Patient Priorities	R. Sinha
11:35 am	Shared Decisions, Better Outcomes: Navigating the Gray Zone in Fibroid Surgery	S. Artazcoz
12:00 pm	Discussion Questions & Answers	All faculty
12:15 pm	Adjourn	

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Disclosure of Relevant Financial Relationships

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

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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COURSE CHAIR DISCLOSURE

Arleen H. Song, MD - Study Participant Device Design: Asensus

COURSE CO-CHAIR DISCLOSURE

Scott G. Chudnoff, MD, MS – Consultant: AbbVie, Abbott Laboratories, Hologic, Karl Storz, MicroCube, ResQ Medical

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).

Santiago Artazcoz, MD*
Scott G. Chudnoff, MD, MS – Consultant: AbbVie, Abbott Laboratories, Hologic, Karl Storz, MicroCube, ResQ Medical
Rooma Sinha, MD*
Arleen H. Song, MD - Study Participant Device Design: Asensus

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. Song and Chudnoff'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. Song and Chudnoff, has been peer reviewed and found to be fair, balanced, and free from commercial bias.

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Duke University School of Medicine
Minimally Invasive Gynecologic Surgery

Fertility-Focused Care

Optimizing Reproductive Goals in Patients with Uterine Fibroids

Arleen H. Song MD MPH
Division of Minimally Invasive Gynecology

1

LEARNING OBJECTIVES

1. Demonstrate knowledge of FIGO type fibroid and impact on fertility
2. Discuss treatment options and fertility sparing options
3. Apply a goal-concordant pathway to evaluation and treatment selection
4. Counsel on conception timing, pregnancy risk, recurrence of fibroids following fibroid intervention

2

THE CLINICAL PROBLEM

Fibroid only related fertility

>80% of Black women have fibroids by age 50, with earlier onset and more severe disease

~70% of White women have fibroids by age 50 on ultrasound screening

2.8% of women presenting for infertility evaluation have submucous fibroids

1–2% of infertile patients have fibroids as the only identifiable factor

Baird DD et al. Am J Obstet Gynecol 2003 · ASRM Practice Committee, Fertil Steril 2021 ·

3

CLASSIFICATION

FIGO type

Type	Location	Fertility relevance
0	Pedunculated, intracavitary	**Cavity-distorting**
1	Submucosal, <50% intramural	**Cavity-distorting**
2	Submucosal, ≥50% intramural	**Cavity-distorting**
3	100% intramural, contacts endometrium	Cavity intact — individualized approach
4	Intramural	Cavity intact — individualized approach
5	Subserosal, ≥50% intramural	Usually minimal; size and access matter
6–7	Subserosal <50% intramural; pedunculated	No demonstrated effect on fertility
8	Other (cervical, parasitic)	Individualize: obstruction, ET or retrieval access

Hybrid lesions are written as two numbers (e.g., **2–5**: submucosal and subserosal). Document type, size, number and distance to the serosa for every lesion.

Munro MG et al. FIGO PALM-COEIN classification, Int J Gynaecol Obstet 2011; updated 2018

4

PATHOPHYSIOLOGY

How fibroids may impair implantation

Cavity distortion
Altered implantation surface, embryo transport and endometrial contour

Endometrial receptivity
Fibroid TGF-β3 → BMP-2 resistance → ↓ HOXA10 and LIF across the whole endometrium

Uterine peristalsis
Abnormal junctional-zone contractility linked to lower pregnancy rates with intramural fibroids

Vascular change
Impaired endometrial and subendometrial blood supply

Mechanical access
Cornual or cervical obstruction; difficult oocyte retrieval or embryo transfer

Rackow BW, Taylor HS, Fertil Steril 2010 · Yoshino O et al., Hum Reprod 2010 · Sun et al., Am J Reprod Immunol 2024 · Ali M et al., 2023

5

EVIDENCE BY LOCATION

Location, location, location

Location	Clinical pregnancy vs. no fibroids	Live birth vs. no fibroids
Submucosal	RR 0.36 (0.18–0.74)	OR 0.3 (0.1–0.8)
Intramural	Modest reduction; heterogeneous	OR 0.6 (0.5–0.7)
Subserosal	No difference	OR 1.0 (0.7–1.5)

Any fibroid (23 studies): ongoing pregnancy/live birth RR 0.70 (0.59–0.83); miscarriage RR 1.68 (1.37–2.05)

Caveat: nearly all data are observational, with inconsistent definitions of cavity involvement

Pritts EA, Parker WH, Olive DL. Fertil Steril 2009;91:1215–23 · Somigliana E et al. Hum Reprod Update 2007

6

THE INTRAMURAL DEBATE

Non–cavity-distorting intramural fibroids and IVF

ASSOCIATION WITH IVF OUTCOME

RR 0.79 (0.70–0.88)

Live birth; clinical pregnancy RR 0.85 — Sunkara 2010

OR 0.56 (0.46–0.69)

Live birth; clinical pregnancy OR 0.68 — Rikhraj 2020

DOES REMOVAL HELP?

Cochrane 2020: one small RCT; very low-certainty evidence, no demonstrated benefit

Verma 2026 meta-analysis: ongoing pregnancy/live birth RR 1.64 (1.15–2.33) after myomectomy before IVF — observational

Sunkara SK et al. Hum Reprod 2010 · Rikhraj K et al. J Womens Health 2020 · Metwally M et al. Cochrane 2020 · Verma S et al. Int J Gynaecol Obstet 2026

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7

ASRM and ACOG Guidelines

Source	Position
ASRM 2017	Myomectomy may be considered for cavity-distorting myomas (submucosal, or intramural with a submucosal component) to improve pregnancy rates — fair evidence for hysteroscopic resection (Grade B)
ASRM 2017	Generally **not** advised for asymptomatic, non–cavity-distorting myomas; insufficient evidence for miscarriage or live-birth benefit
ASRM 2026 (RPL)	Remove fibroids that impact the cavity; whether surgery lowers miscarriage remains unclear
ACOG PB 228	Myomectomy for symptomatic fibroids when future pregnancy is desired; minimally invasive route when feasible; GnRH agonist as a short-term bridge

ASRM Practice Committee, Fertil Steril 2017;108:416–25 · ASRM RPL committee opinion 2026 · ACOG Practice Bulletin No. 228, 2021 · SOGC (via Turkgeldi et al. 2024)

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EVALUATION

1 Imaging

- TVUS ± 3D for mapping
- Saline sonohysterography or hysteroscopy for the cavity
- MRI for multiple or large fibroids, surgical planning, adenomyosis

2 Etiology of infertility

- Age and ovarian reserve (AMH, AFC)
- Tubal patency and ovulation
- Semen analysis
- Duration of infertility; prior IVF

3 Clinical/Patient factors

- Bleeding, anemia, bulk or pain
- Timeline to conception
- IVF plans; embryos banked
- Desired family size

ASRM Practice Committee. Fertility evaluation of infertile women: a committee opinion. Fertil Steril 2021

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9

Myomectomy

Cavity distorted Types 0–2, 2–5	Cavity intact, intramural Types 3–5	Subserosal Types 6–7
Hysteroscopic myomectomy Stage large type 2 or apposing lesions; confirm the cavity before conception or transfer	**Individualize** Weigh symptoms, size and number, failed euploid transfers, retrieval access — against age and reserve	**Leave in situ** Treat only for symptoms; no fertility benefit from removal

Any type, symptomatic or time-limited: treat symptoms with a uterine-sparing route; consider oocyte or embryo banking first when age or reserve limits time

ASRM 2017, ACOG PB 228 (2021) and cited meta-analyses; banking-first sequencing reflects expert practice, not trial evidence

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10

HYSTEROSCOPIC MYOMECTOMY · TYPES 0–2

Outcomes

OR

Clinical pregnancy after removing submucosal fibroids vs. leaving them in situ (95% CI 1.08–3.83)

Certainty is limited: the only RCT (Casini 2006) gave OR 2.04 (0.62–6.66) for pregnancy — very low certainty (Cochrane 2020)

INTRAUTERINE ADHESIONS AT SECOND LOOK

Setting	Adhesions
Single submucous fibroid	1.5%
opposing fibroids	78%
Bipolar resection, infertile cohort	7.5%
Fertility-seeking cohort (2023)	9.1%

Pritts 2009 · Metwally M et al. Cochrane 2020 · Gambadauro P et al. Obstet Gynecol Int 2012 · J Minim Invasive Gynecol 2023

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11

LAPAROSCOPIC, ROBOTIC OR ABDOMINAL MYOMECTOMY · TYPES 2–7

Optimizing Myomectomy

Indications

Symptoms (bleeding, bulk, pain); intramural lesions with a submucosal component; fibroids blocking retrieval or transfer

Route

Minimally invasive when feasible (ACOG); insufficient evidence that route changes live birth (Cochrane 2020)

Technique

Multilayer closure; limit cavity entry; minimize incisions; adhesion prevention; experienced surgeon

Counsel

Recovery delays conception; recurrence, route of delivery, timing of surgery

75.6% pregnancy rate among 1,575 women after myomectomy (Khaw 2020 meta-analysis)

ACOG Practice Bulletin No. 228, 2021 · Metwally M et al. Cochrane 2020 · Khaw SC et al. 2020, cited in Margueritte F et al. RBMO 2021

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12

Uterine Rupture

0.44%
Rupture in 54,146 myomectomies (US national data)

0.75%
Pooled, 3,685 pregnancies; laparoscopic 1.2% vs. open 0.4%, not significant

~18 mo
Mean time to pregnancy; rupture not linked to interval

Gil Y et al. 2020 · Claeys J et al. Gynecol Surg 2014 · Marguerite F et al. RBMO 2021 · ACOG Committee Opinion No. 831, 2021

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Use of GnRH agonist/antagonist

Agent	Role	Fertility caveat
GnRH agonist	Pre-operative: shrinks fibroids; raises Hb by ~0.88 g/dL	Short-term only; regrowth after stopping
Oral GnRH antagonist + add-back	Controls heavy bleeding; oral alternative pre-op	Labeling requires non-hormonal contraception during use
GnRH agonist before FET	Proposed to improve receptivity	No live-birth gain in ≥35 y with intramural fibroids (n = 769, retrospective)
Iron repletion	Correct anemia before surgery or pregnancy	Supportive; no fertility effect

Aase DA, Stewart EA. 2025 · J Clin Med 2023;12:1401

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14

Uterine-sparing alternatives and fertility

Option	Fertility data	Bottom line
Uterine artery embolization	Lower pregnancy and higher miscarriage than myomectomy (17 studies, 989 women) [22]; more reintervention in RCTs [23]	Not first-line when pregnancy is desired
Radiofrequency ablation	50 pregnancies after 923 ablations; no rupture or invasive placentation reported; number trying unknown [24]	Promising; counsel as limited data
MR-guided focused ultrasound	Heterogeneous series; early trials excluded women planning pregnancy	Limited data
Oral GnRH antagonist + add-back	Symptom control only; nonhormonal contraception advised [9]	Bridge, not fertility care

Sources: [9] ACOG PB 228; [22] Karlsen 2018; [23] Tzanis, AJOG 2024; [24] Polin & Hur, JMIG 2022

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UTERINE-SPARING ALTERNATIVES

Embolization and ablation: pregnancy data

Uterine artery embolization

RCT vs. myomectomy (Mara 2008): pregnancy 50% vs. 78%; miscarriage 64% vs. 23%

FEMME (NEJM 2020): too few pregnancies to compare; QoL favored myomectomy by 8 points; reintervention 16% vs. 7%

Not first-line when pregnancy is the goal

Radiofrequency ablation

Systematic review: 50 pregnancies among 923 patients; 88% term; no uterine rupture or abnormal placentation

AAGL 2024: most trials excluded patients desiring fertility; data remain limited

Promising; offer in shared decision-making or trials

Mara M et al. Cardiovasc Intervent Radiol 2008 · Manyonda I et al. N Engl J Med 2020 · Polin M, Hur HC. JMIG 2022 · AAGL Practice Committee, JMIG 2024

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16

Open questions and work under way

- Adequately powered RCTs of myomectomy for intramural fibroids
- Size and number thresholds that warrant surgery
- Fertility outcomes after RFA in women seeking pregnancy
- Medical therapy for prevention of recurrence

IN PROGRESS

Myomectomy before IVF — multicenter RCT
NCT07578623

PCORI systematic review to inform the ASRM guideline update
Announced 2026

SOUL: relugolix combination therapy after myomectomy vs. standard care
NCT05538689 · RCT, n = 136 · recurrence or reintervention at 24 months · no pregnancy for 12 months

ClinicalTrials.gov NCT07578623 · PCORI (2026) · Alkhrait S et al. SOUL trial protocol, PLoS One 2024

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17

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18

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AAGL GLOBAL CONGRESS · SURGICAL COMPLICATIONS

The Failed Fibroid Operation

What went wrong — and how to avoid it

Scott Chudnoff, MD, MSc, CPE, FACOG

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1

BEFORE WE BEGIN

Disclosures and objectives

Disclosures

Abbvie
Abbott
Karl Storz
Hologic
Microcube
ResQ Medical

Participants will be able to

1. Recognize the preoperative decisions that predict a failed fibroid operation
2. Apply evidence-based safeguards for fluid, blood loss and tissue extraction
3. Combine excision and ablation to treat all symptomatic pathology in one plan

All cases are composite and de-identified for teaching.

2

Most failed fibroid operations are decided before the first incision.

Mapping · Matching · Optimizing · Counseling · Documenting

3

ROADMAP

Six ways a fibroid operation fails

Case 1
Incomplete resection
The route did not fit the FIGO type

Case 2
Fluid overload
The deficit was not tracked or respected

Case 3
Hemorrhage and conversion
An unoptimized patient and no bleeding plan

Case 4
Unexpected malignancy
An occult sarcoma and a failed containment

Case 5
Residual disease
One tool for a uterus that needed two

Case 6
Persistent symptoms
The fibroid was not the whole story

4

CASE 1 · HYSTEROSCOPIC MYOMECTOMY

"A 4-cm submucous fibroid"

THE PATIENT

- 34 years old, G0, trying to conceive
- Heavy menstrual bleeding, Hgb 10.2
- Transvaginal ultrasound only: "submucous fibroid"
- Booked for OR hysteroscopic resection

WHAT HAPPENED

- At hysteroscopy: FIGO type 2, mostly intramural
- Resection stopped at the fluid limit, half remaining
- Bleeding unchanged; second procedure needed
- Second look: intrauterine adhesions

Composite, de-identified teaching case

5

CASE 1 · LESSONS

Map the fibroid before you choose the route

What went wrong

- No saline sonography, hysteroscopy or MRI to classify the myoma
- Intramural depth and free margin unknown
- Consent described one short procedure

How to avoid it

- Assign a FIGO type (0, 1, 2) and measure the free margin to serosa
- Type 2: plan and consent for a staged resection
- Fertility patients: plan an office second look

6

CASE 2 · HYSTEROSCOPIC MYOMECTOMY

“Just one more chip”

THE PATIENT

- 41 years old, 3.5-cm FIGO type 1 myoma
- Monopolar resectoscope, 1.5% glycine
- Deficit tracked by hand from gravity bags

WHAT HAPPENED

- Surgeon pushed to finish in one session
- Deficit tallied at the end: about 2,000 mL
- PACU: nausea and confusion, sodium 119
- ICU admission for hypertonic saline

Composite, de-identified teaching case

7

CASE 2 · THE EVIDENCE

Know the stop point before you start

1,000 mL
Maximum deficit, hypotonic media, healthy patient

2,500 mL
Maximum deficit, isotonic saline, healthy patient

750 / 1,500 mL
Hypotonic / isotonic, elderly or comorbid patients

500 mL
Maximum infused volume, high-viscosity media

Sources: AAGL Practice Report, hysteroscopic distending media (2013); BSGE/ESGE fluid management guideline (2016)

8

CASE 2 · LESSONS

Make the deficit everyone’s number

What went wrong

- Hypotonic medium when saline options existed
- Manual, end-of-case fluid accounting
- No stop point agreed at the timeout
- Completion valued over safety

How to avoid it

- Bipolar or mechanical removal in saline
- Automated fluid management system
- Stop point stated at the timeout; deficit called aloud
- Plan to stage; check sodium after hypotonic excess

9

CASE 3 · LAPAROSCOPIC MYOMECTOMY

“We’ll get it done robotically”

THE PATIENT

- 38 years old, desires fertility
- Six myomas, 18-week uterus, largest 9 cm
- Hgb 8.4; surgery booked in three weeks, untreated

WHAT HAPPENED

- No vasopressin; no cell salvage in the room
- Brisk bleeding from multiple open defects
- Late conversion; EBL 2,400 mL, 3 units
- Ileus and a prolonged stay

Composite, de-identified teaching case

10

CASE 3 · LESSONS

Conversion is a decision — late conversion is a failure

What went wrong

- Known anemia left untreated
- Route chosen for preference, not pathology
- No layered plan to control bleeding
- No pre-agreed trigger to convert

How to avoid it

- Correct hemoglobin: iron, hormonal suppression, delay
- Match route to myoma burden and your volume
- Vasopressin; blood and cell salvage ready
- Name the conversion trigger at the timeout

11

CASE 4 · LAPAROSCOPIC MYOMECTOMY

“Probably degeneration”

THE PATIENT

- 48 years old, perimenopausal
- Solitary 11-cm mass, grew notably over 8 months
- Intermenstrual bleeding; no endometrial sampling
- No MRI; growth attributed to degeneration

WHAT HAPPENED

- In-bag power morcellation
- Bag not inspected; small tear found later on video
- Pathology: leiomyosarcoma
- Upstaged disease; no documented sarcoma counseling

Composite, de-identified teaching case

12

CASE 4 · THE EVIDENCE

Occult sarcoma: rare, but not rare enough

1 in 225 to 1 in 580

FDA estimate of unsuspected uterine sarcoma among women having surgery for presumed fibroids

FDA final labeling guidance, 2020

- Power morcellation only with a compatible, FDA-cleared containment system
- Not for women who are postmenopausal or over 50
- Boxed warning: may spread unsuspected cancer

Sources: US FDA safety communications on laparoscopic power morcellation (2017, 2020); FDA final labeling guidance (Dec 2020)

13

CASE 4 · LESSONS

Treat every specimen as if it might be malignant

What went wrong

- Age, growth and bleeding not weighed together
- Endometrium never sampled; no MRI
- Containment bag not inspected
- No documented sarcoma counseling

How to avoid it

- Structured risk review; sample the endometrium with AUB
- MRI when features are atypical
- Contained extraction; inspect the bag before and after
- Consent states that no test excludes sarcoma

14

CASE 5 · LAPAROSCOPIC MYOMECTOMY

"We took out the big ones"

THE PATIENT

- 41 years old, done with childbearing, wants to keep her uterus
- Heavy bleeding and bulk; Hgb 9.6
- MRI: 8-cm type 5, 5-cm pedunculated type 7, three deep 3–4-cm type 3–4

WHAT HAPPENED

- Two large myomas excised laparoscopically
- Three deep myomas left: "too many incisions"
- Bulk better; bleeding unchanged
- 14 months: residual myomas larger; hysterectomy

Composite, de-identified teaching case

15

CASE 5 · THE TOOLKIT

Assign a tool to every fibroid

Fibroid	Excise	Ablate
Cavity, FIGO 0–1	Hysteroscopic myomectomy	Transcervical RFA
Deep submucous, FIGO 2	Hysteroscopic, often staged	Transcervical RFA
Deep intramural, FIGO 3–4	Laparoscopic; more incisions	Laparoscopic or transcervical RFA
Subserosal, FIGO 5–6	Laparoscopic myomectomy	Laparoscopic RFA
Pedunculated, FIGO 7	Laparoscopic excision	Not well suited

16

CASE 5 · THE EVIDENCE

Combining modalities: early but encouraging

Lap RFA + lap myomectomy

−36.4

Points on UFS-QOL symptom severity at 12 months; 49 women, mean 3.6 myomas treated; about 75% satisfied

Transcervical RFA + hysteroscopy

8% vs 11%

Complications, combined vs hysteroscopy alone (n = 100 each; not significant); 83% reported less bleeding

Lap RFA vs lap myomectomy, RCT

25 vs 82 mL

Mean blood loss; hospital stay 6.7 vs 9.9 hours (n = 45)

Caveats: registry, retrospective and small-trial data; limited follow-up; little fertility evidence for ablation

Sources: Sendukas EA, et al. JSLS 2026 (ULTRA registry) · Piriyev E, et al. Videosurgery 2025 · Rattray DD, et al. ClinicoEcon Outcomes Res 2018 (TRUST)

17

CASE 5 · LESSONS

Treat the uterus, not just the dominant fibroid

What went wrong

- Plan built around the largest myomas
- Symptomatic myomas left behind
- Only one modality available or offered
- Residual disease not counseled

How to avoid it

- Excise what cuts cleanly; ablate what doesn't
- Combine modalities under one anesthetic
- Credential the team and stock the devices
- Document what was treated and what was left

18

CASE 6 · ABDOMINAL MYOMECTOMY

“The surgery went perfectly”

THE PATIENT

- 42 years old, heavy bleeding and severe dysmenorrhea
- MRI read as “multiple fibroids”
- Four subserosal and intramural myomas removed

SIX MONTHS LATER

- Symptoms unchanged
- Re-review of the original MRI: diffuse adenomyosis
- Patient asks why she had surgery at all

Composite, de-identified teaching case

19

CASE 6 · LESSONS

Ask whether this fibroid explains this symptom

What went wrong

- Symptoms not matched to myoma location
- Imaging read only for fibroids
- Expectations never set

How to avoid it

- Link each symptom to a lesion — or keep looking
- Screen for adenomyosis and endometrial pathology
- Counsel on new growth and reintervention
- Offer the full menu, not only the operation

20

PUTTING IT TOGETHER

Eight checks before every fibroid case

1 **Mapped** FIGO type, size, number, free margin	2 **Matched** A modality assigned to every fibroid	3 **Optimized** Anemia treated, bleeding suppressed	4 **Screened** Sarcoma risk reviewed; endometrium sampled if AUB
5 **Counseled** Staging, conversion, occult cancer, pregnancy	6 **Prepared** Vasopressin, blood, salvage, ablation, containment	7 **Limits set** Fluid stop point and conversion trigger named	8 **Documented** What was treated, what was left, bag check

21

TAKE-HOME POINTS

Five habits that prevent failure

1. Map every fibroid — FIGO type, size, free margin — before choosing the route.
2. Match the operation to the pathology and to your volume; convert by plan, not by crisis.
3. Optimize hemoglobin, and set fluid and blood limits before the timeout ends.
4. Assume the specimen could be malignant: assess risk, contain extraction, document counseling.
5. Treat all the pathology: excise what cuts cleanly, ablate what doesn't, and document what remains.

22

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2. Umranikar S, et al. BSGE/ESGE guideline on management of fluid distension media in operative hysteroscopy. Gynecol Surg. 2016;13:289–303.
3. US Food and Drug Administration. Product labeling for laparoscopic power morcellators: final guidance. December 2020.
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6. Piriyev E, et al. Safety and efficacy of combining transcervical fibroid ablation with operative hysteroscopy. Videosurgery Miniinv. 2025;20(3):302–309.
7. Rattray DD, et al. Lap-RFA vs laparoscopic myomectomy: a randomized trial of uterine-sparing techniques (TRUST). ClinicoEcon Outcomes Res. 2018;10:201–212.
8. Munro MG, et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding. Int J Gynaecol Obstet. 2011;113:3–13.

23

DISCUSSION

Questions

Which of these six failures have you seen this year — and which check would have caught it?

24

Fibroid Surgery: Aligning Surgical Options with Patient Priorities

Dr Rooma Sinha
Director, Robotic Gynecological Surgery, Apollo Hospitals
Associate Professor, Macquarie University, Sydney, Australia

Founder & President, Association of Gynecological Surgeons of India (AGRS)
President, Asian Society of Gynecological Robotic Surgery (ASGRS)
(> 70 papers Publishes; >500 citations)



1

Ask this Question…

Is the best fibroid surgery the one that removes the fibroid in the best possible manner

OR

Is it the one that best fits the woman's priorities?

2

What matters to HER? ASK these 5 Questions

1. **Does she want a future pregnancy? Yes / No / Unsure**
2. **Does she want to retain her uterus? Essential / Preferred / Not important**
3. **What symptom bothers her most?-** Bleeding, Pain, Pressure, Infertility, Bulk symptoms?
4. **What matters most about surgery?-** Definitive treatment, Minimally invasive approach, Short recovery, Lowest recurrence, Fertility, Avoiding hysterectomy
5. **What risks is she willing to accept?**

3

Are we choosing surgery for the patient or for ourselves?

Why do we choose a particular operation?
HYSTECTOMY/ MYOMECTOMY; OPEN / MIS

1. Patient preference?
2. Fibroid anatomy?
3. Evidence?
4. Surgeon expertise?
5. Availability of technology?
6. Institutional resources?
7. Familiarity with a technique?
8. Financial considerations?

Patient-centered surgery requires us to separate what is technically possible from what is actually valuable to the patient.

4

Scenario 1

"She wants pregnancy, but does she need myomectomy?"

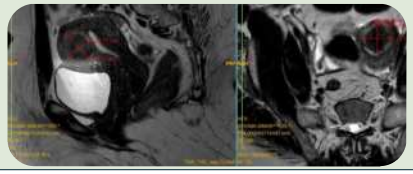
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Scenario 1

32 years- Regular Cycles, Flow for 5 days with 3-4 pads per day(Normal), Dysmenorrhoea (VAS 4/10)

HB 9.8, Rest normal

MRI-



She wants to get pregnant, but does she need a myomectomy?

6

Counselling- Five essential points to discuss

1. Acknowledge her concern
2. Explain the significance of location
3. Balance potential benefit against risk
4. Investigate both partners
5. Agree on a fertility plan

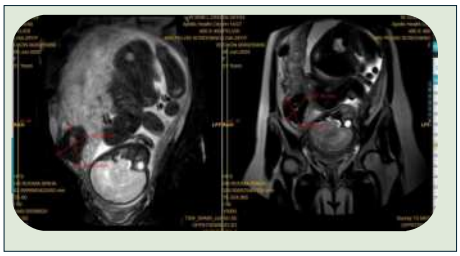
Don't make the patient choose between fertility and fibroid surgery until it is clear that surgery is likely to help her fertility
Answer her concerns!

7



8

For this patient, fertility evaluation was normal; plan to conceive without myomectomy (cavity is undistorted, and there is no other clinical indication for surgery).



9


SPECIAL ARTICLE
Obstetrics
WILEY
Fibroids and pregnancy
Diana Ramasauskaite[1] | Nikhil Purandare[2] | Ivonne Diaz[3] | Greta Kvederaite-Budre[1] | Titus K. Beyuo[4] | Jolly Beyeza-Kachesya[5] | Bo Jacobsson[6,7,8]

Situations generally suitable for expectant management

1. **No significant symptoms**
2. **Fibroids outside the uterine cavity**
3. **Small, non-distorting fibroids:** the review specifically identifies asymptomatic FIGO type 3 or hybrid 2–5 fibroids **up to 5 cm** as a situation where management is clinically challenging but can be individualised rather than automatically treated surgically.
4. **No infertility or recurrent early pregnancy loss clearly linked to the fibroid.**
5. **No high-risk location:** fibroids should not be large cervical or lower-uterine-segment masses that could deform the cavity, lie between the fetal head and cervix, or obstruct labour.

10


BMC Pregnancy and Childbirth
RESEARCH
Open Access
The influence of uterine fibroids on adverse outcomes in pregnant women: a meta-analysis

1. **Fibroids increase key adjusted risks.** Preterm birth, cesarean delivery, placenta previa, placental abruption, postpartum haemorrhage, breech presentation, preeclampsia, and intrauterine fetal death.
2. **The strongest clinically important associations include bleeding and placental complications.**
3. **Fibroid size matters more than fibroid number.** Fibroids ≥5 cm, versus smaller fibroids, were linked to greater risks of breech presentation, postpartum hemorrhage, and placenta previa
4. **Interpret the results with caution-** The findings show association, not proof that fibroids directly cause every outcome.

11

Scenario 2
Symptomatic Fibroid
does not want surgery at all

12

- 29 years, unmarried
- HMB with clots
- HB 7.8
- USG//MRI- 5 cm FGO 4 anterior wall
- Opted for UAE- some improvement in HMB
- Married soon after
- 2 years later-Recurrence of Symptoms & Planning for pregnancy- microwave ablation done under laparoscopic guidance- no improvement in symptoms
- Fertility treatment started- no pregnancy (2 years)

13

Finally- opted for Robotic Myomectomy

2 years of fertility Treatment- No Success
Advised – Underwent Robotic Myomectomy

Video

Should we always take the patient's desire into consideration and not choose the correct treatment?

14

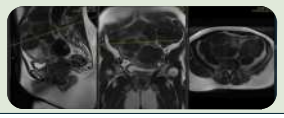
Scenario 3
One Uterus, Large Fibroid Burden

Choose Myomectomy OR Hysterectomy?

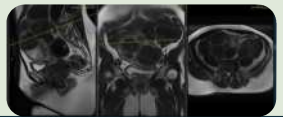
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Two cases- One Uterus; Multiple Fibroids
Want Myomectomy for fertility preservation

- Case1 – 42 year never married
- HMB with Dysm
- Right hydronephrosis
- Pressure Symptoms
- AMH 1.2
- USG Multiple Fibroids



- Case 2- 33 years Married
- Wants fertility
- 9 years ago-Open myomectomy
- HMB
- Anaemia 8.9
- AMH 0.8

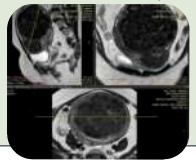


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One uterus- large uterine specimen
Wants Myomectomy for organ preservation

Case -1
42 years, one childbirth, LSCS
HMB; Severe Anaemia, Pressure symptoms
Mass per abdomen

Wants Uterus- Choice Robotic Myomectomy



Video

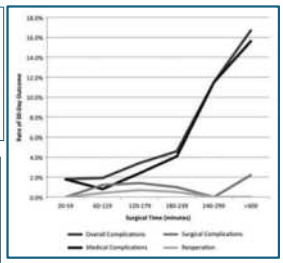
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Uterus preservation
NOT ALWAYS
Fertility preservation



18

Longer Operative Time During Laparoscopic Myomectomy Is Associated with Increased 30-Day Complications and Blood Transfusion



Longer laparoscopic myomectomy operative time >240 minutes is independently associated with substantially higher 30-day medical complications and blood-transfusion risk and re admission rates

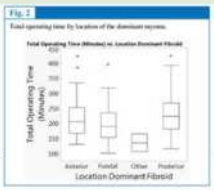
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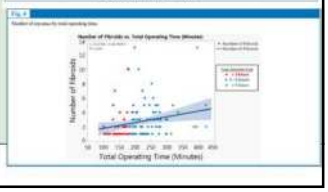
JMIG

Original Article

Predictors of Prolonged Operative Time for Robotic-Assisted Laparoscopic Myomectomy: Development of a Preoperative Calculator for Total Operative Time







20

Points to be considered- Myomectomy

- Time anticipated (3 hours)
- Multiple incisions- Healing by fibrosis- Impact on future pregnancy
- Open vs minimally invasive approach
- Risk of adhesions
- Myometrial reconstruction
- Blood loss
- Residual fibroids & Recurrence
- Possible need for cesarean delivery depending on depth/location of incisions

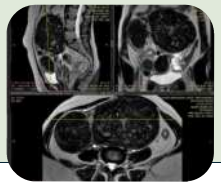
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One Uterus- Large Uterine specimen

Case -2
42 years, one childbirth, LSCS
HMB; Severe Anaemia, Pressure symptoms
Mass per abdomen

"I don't care about preserving my uterus"

Video



22

35 years, she wants…..

1. Everything preserved: uterus, Ovaries, Tubes
2. No Major Scars
3. Doesn't want a transfusion
4. Wants a normal menstrual Cycle with no pain
5. Wants to plan pregnancy next month

23

Expectation Alignment- Realistic

PATIENT EXPECTATION	SURGICAL REALITY
Preserve uterus	Possible
Preserve fertility	Often possible, but not guaranteed
No recurrence	Cannot guarantee
No scars	Depends on approach
Immediate pregnancy	Usually unrealistic
Zero complications	Impossible to promise

Key message:
Good surgical counselling is the key

24

The "Red Flags"
When should we pause before operating?

1. Asymptomatic fibroid; <5 cms
2. Fertility not adequately evaluated
3. Significant anaemia- not optimised
4. Suspicion of malignancy- age, Imaging
5. Surgical risk disproportionately high- comorbid conditions
6. Patient expectations unrealistic
7. Patient choosing surgery - Fear of Malignancy
8. Surgeon choosing approach based primarily on personal preference and skill

25

FIBROID SURGERY: 5 RULES

1. **Treat the patient's SYMPTOM, not the ultrasound/ MRI**

2. **Ask about FERTILITY DESIRE before discussing the operation**

3. **Uterine preservation and fertility preservation are not the same**

4. **Choose the route based on anatomy, expertise and patient priorities.**

5. **The "best" operation is the one that delivers the outcome but the one that the patient values most**

Don't ask: Which surgery is best for this fibroid?
Ask: Which outcome matters most to this woman?

26

Thank you
Questions ?

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27

Shared Decisions, Better Outcomes

Navigating the Gray Zone in Fibroid Surgery

Dr. Santiago Artazcoz

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

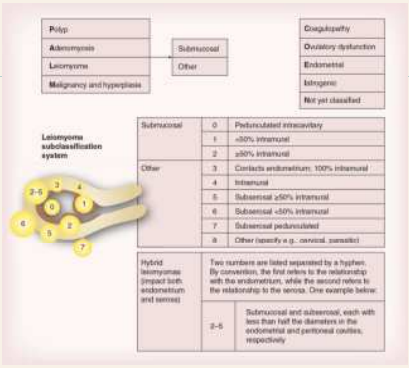
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Disclosures

No relationships to disclose.

2

FIGO



3

ESGE / FIGO



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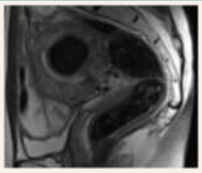
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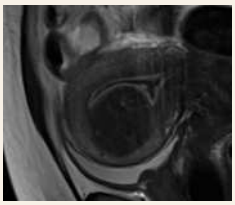
The Clinical Dilemma



6

The Clinical Dilemma - Myomectomy





Not all type 2 fibroids are alike.
Not all surgeons are alike.
And not all patients want the same thing.

7

Type 2 Fibroids — Not a Single Entity

ESGE / FIGO



Type 0
Pedunculated, fully intracavitary

Type 1
< 50% intramural

Type 2
≥ 50% intramural

STEPW

Lasmar Classification
2005 · Brazil

- **S** Size
- **T** Topography
- **E** Extension (base %)
- **P** Penetration
- **W** lateral Wall

Score ≤4 → 100% complete resection
Score >4 → 77.2%
All incomplete resections had STEPW >4

8

The Deciding Variable

HOW IT'S MEASURED
Distance between the fibroid's outer edge and the uterine serosa - assessed by 3D TVUS or MRI.

CLINICAL MEANING
A thinner margin means less safety buffer between the resectoscope and the serosal surface.

WHY IT DETERMINES APPROACH
It's the practical reason two 'type 2' fibroids can call for two completely different surgeries.

Myometrial free margin

< 5 mm

→ *complete resectoscopic resection is not advised*

9

What the Evidence Says

SIZE
Xu et al., BMC Surgery (2016)
Laparoscopy showed higher advantage for type II fibroids >4 cm; hysteroscopy for those <4 cm.

INTRAMURAL EXTENSION
Wang et al., Gynecol Minim Invasive Ther (2013)
Submucous fibroid >4 cm with >50% intramural extension: laparoscopic myomectomy proposed instead of hysteroscopy for safety.

MYOMETRIAL MARGIN & EXPERIENCE
Mazzon et al., Fertil Steril (2011)
In selected cases and experienced hands, complete hysteroscopic resection was achieved regardless of myometrial free margin.

STAGED APPROACH SAFETY
Hysteroscopic Surgery for Submucosal Fibroids, IntechOpen
For type 2 fibroids, a multi-staged hysteroscopic approach is generally safer - it avoids perforation at the base of the fibroid.

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The Two Paths — Laparoscopy



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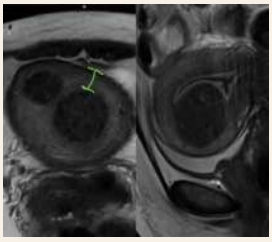
The Two Paths Hysteroscopy





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The Two Paths Hysteroscopy





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The Two Paths — Hysteroscopy



14

Myosure vs. Resectoscope

MYOSURE

MECHANISM

Mechanical morcellation — straight 0° scope, passive protrusion (pressure changes)

LEARNING CURVE

Shorter

COMPLETE RESECTION (TYPES 0–2 MIX, INCL. TYPE 2)

64% (Hamidouche et al., 2015, n=34)

RESECTOSCOPE (bipolar)

MECHANISM

Bipolar loop — cold-loop technique can enter the myometrium directly (Mazzon)

LEARNING CURVE

Longer

COMPLETE RESECTION (TYPES 0–2 MIX, INCL. TYPE 2)

69% (Hamidouche et al., 2015, n=49)

15

Options Beyond Myomectomy

TRANSCERVICAL RFA (Sonata)

- Incisionless, outpatient, no general anesthesia
- Intrauterine ultrasound-guided — can treat type 1/2 fibroids, including some not fully visible hysteroscopically
- Submucosal reintervention rate: 3.7% at 1yr (FAST-EU), 5.5% cumulative at 3yr (SONATA pivotal)
- Fertility data still limited/investigational — discuss carefully if pregnancy is desired

UTERINE ARTERY EMBOLIZATION

- Uterus-preserving, radiologic (not surgical)
- Submucosal fibroid expulsion rate ~50% — can resolve the fibroid, but is a real event to counsel on
- Severe adverse events ~3% (mainly infection) in recent submucosal-specific cohorts
- Generally not recommended if future fertility is desired

Myomectomy isn't the only option on the table — name these too, before narrowing to hysteroscopy vs. laparoscopy.

16

The Uncomfortable Question

Type 2 is genuinely challenging — hysteroscopically, laparoscopically, or robotically. No single approach makes it easy.

Am I recommending the approach that's best for this patient—
or the one I'm most comfortable performing?

The patient's fibroid, priorities, and tolerance for risk should choose the approach — not the surgeon's comfort zone.

17

What the Patient Weighs

FERTILITY

Will this affect my chances of getting pregnant? Does the approach change what happens to my uterus long-term?

TIME

One surgery or two? How long until I'm back to work, back to my life?

PAIN

What does recovery actually feel like — for each option?

FRUSTRATION

The emotional weight of an incomplete resection, a second procedure, or a plan that didn't go as expected.

18

What This Means for Her Wallet

ASC	HOSPITAL
Hysteroscopy ×1 **$2,610**	Hysteroscopy ×1 **$5,425**
Hysteroscopy ×2 **$5,220**	Hysteroscopy ×2 **$10,850**
Lap / Robotic **$6,101**	Lap / Robotic **$11,840**

19

Structuring the Conversation

1. **SHARE THE CLINICAL PICTURE**
   Classification, STEPW score, myometrial remnant — in plain language, with the imaging in front of her.
2. **LAY OUT THE REAL OPTIONS**
   Name both paths honestly, including what's uncertain — not just the one you're more comfortable performing.
3. **ASK, DON'T ASSUME**
   Fertility plans, time constraints, pain tolerance, financial reality — ask directly rather than inferring.
4. **DECIDE TOGETHER, DOCUMENT IT**
   Record the shared decision and the reasoning behind it — not just the procedure selected.

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A Framework for the Decision

Myometrial free margin < 5 mm?

- YES → Avoid single-stage complete hysteroscopic resection → staged hysteroscopic (×2) or laparoscopic/robotic
- NO → Proceed to Gate 2

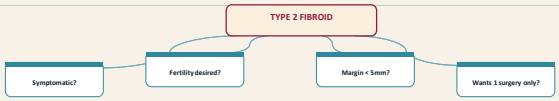
Is future fertility a priority?

- YES → Any myomectomy (hysteroscopic or laparoscopic/robotic) remains fertility-sparing; RFA fertility data still maturing — UAE generally not preferred
- NO → All options reasonable: hysteroscopic, laparoscopic/robotic, RFA, or UAE

FINAL STEP — Match the remaining options to HER priorities: time, pain, cost, comfort with the approach.

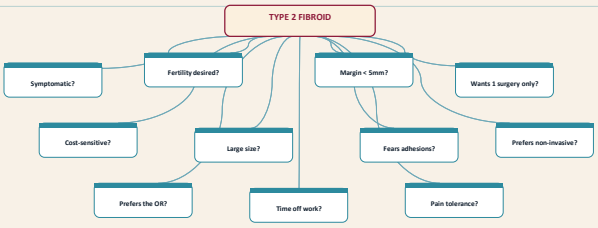
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It Starts Simple Enough...



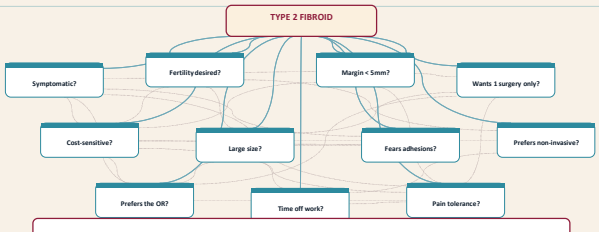
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Then Reality Adds More...



23

Why This Isn't an Algorithm



There's no flowchart that survives a real patient. That's the point of shared decision-making.

24


Takeaways
1
Type 2 isn't one entity
STEPW and the myometrial margin explain why two "type 2" fibroids can call for opposite surgeries.
2
Check the margin first
A free margin < 5mm settles part of the decision before any classification system does.
3
Comfort isn't a clinical criterion
Hysteroscopic, laparoscopic/robotic, RFA, or UAE — the surgeon's default habit shouldn't quietly decide the case.
4
There's no algorithm — there's a conversation
Fertility, time, pain, and cost are what actually decide it, together with her.
Not all type 2 fibroids are alike. Not all surgeons are alike. And not all patients want the same thing.

25


Thank You
Dr. Santiago Artazcoz, MD · Minimally Invasive Gynecologic Surgery
Questions & Discussion
NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

26

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/