55TH GLOBAL CONGRESS ON MIGS

BOSTON, MASSACHUSETTS
NOVEMBER 13-16, 2026

Syllabus

Surgical Tutorial 412

Adenomyosis: Surgical Judgment, Technique, and Functional Outcomes in Conservative Management

HONORARY CHAIR
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Nash S. Moawad, MD

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Table of Contents

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

Financial Disclosures 4

Diagnosis to Decision: When and How to Operate on Adenomyosis
M. Truong 5

Outcomes and Pitfalls: Functional Recovery and Long-Term Results
M. Oliveira 9

Conservative Surgery for Adenomyosis: Step-by-Step Techniques and Uterine Reconstruction
T. Soares Raymundo 14

Cultural and Linguistic Competency & Implicit Bias 18

Surgical Tutorial 412 - Adenomyosis: Surgical Judgment, Technique, and Functional Outcomes in Conservative Management

Chair: Thiers Soares Raymundo
Faculty: Marco Aurelio P. Oliveira, Thiers Soares Raymundo, Mireille Truong

Course Description

This surgical tutorial is designed for advanced surgeons who wish to enhance their decision-making and technical strategies for conservative management of adenomyosis while preserving uterine function and improving quality of life. The session integrates live video analysis, case-based discussion, and technical breakdowns of excision, partial adenomyomectomy, and combined minimally Invasive approaches.

Learning Objectives: *At the end of this course, the participant will be able to:* 1) Identify patient and disease factors that guide surgical indication for adenomyosis; 2) Apply advanced conservative surgical techniques to treat focal and diffuse adenomyosis; and 3) Evaluate outcomes in terms of pain relief, fertility, and uterine function preservation.

Course Outline

11:00 am	Welcome, Introduction and Course Overview	T. Soares Raymundo
11:05 am	Diagnosis to Decision: When and How to Operate on Adenomyosis	M. Truong
11:20 am	Outcomes and Pitfalls: Functional Recovery and Long-Term Results	M. Oliveira
11:35 am	Conservative Surgery for Adenomyosis: Step-by-Step Techniques and Uterine Reconstruction	T. Soares Raymundo
11:50 am	Discussion Questions & Answers	All faculty
12:00 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.

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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

Thiers Soares Raymundo, Dr h, c., MD – Speakers Bureau: Johnson & Johnson, Intuitive Surgical

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).

Marco Aurelio P Oliveira, PhD*
Thiers Soares Raymundo, Dr h, c., MD – Speakers Bureau: Johnson & Johnson, Intuitive Surgical
Mireille Truong, MD – Consultant: Johnson & Johnson, CooperSurgical, Medtronic, Virta Med

MITIGATION OF RELEVANT FINANCIAL RELATIONSHIPS

All relevant financial relationships have been mitigated.

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

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

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

Diagnosis to Decision:
When and How to Operate on Adenomyosis

Mireille Truong, MD · Medstar Health- Georgetown University

@DrMTruong

Division Director, Minimally Invasive Gynecologic Surgery
National Center for Advanced Pelvic Surgery
MedStar Washington Hospital Center- Women's and Infants' Services

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1

Disclosures

- Ethicon/J&J (consultant)
- Cooper Surgical (consultant)
- Medtronic (consultant)
- Virta Med (consultant)

- This presentation includes AI-assisted visuals

2

Objectives

After attending this presentation, participants will be able to:

1. Identify clinical, imaging, and patient-specific factors to guide surgical decision-making in patients with adenomyosis.
2. Determine appropriate candidates for surgical management based on symptoms, disease characteristics, and reproductive goals.
3. Select an individualized surgical approach for focal and diffuse adenomyosis while considering uterine preservation and functional outcomes.

AKA: **1. WHO** should undergo surgery 2. **WHEN** to operate 3. **HOW** to select an approach

3

Clinical Scenario

38-year-old, G1P1

- Severe dysmenorrhea and heavy menstrual bleeding
- Persistent symptoms despite hormonal therapy
- Focal adenomyosis; possible coexisting endometriosis
- Wants to keep her uterus
- Unsure about future fertility



https://radiopaedia.org/articles/adenomyoma

4

What do you recommend?

A. Hysterectomy
B. Adenomyomectomy
C. Exploration with possible excision of endometriosis only
D. Continue or modify medical therapy
E. Expectant management



https://radiopaedia.org/articles/adenomyoma

5

What the patient really wants to know?

Is it really there?
Is it the problem?
Will surgery help?

6

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Diagnostic Accuracy of Imaging for Adenomyosis

Imaging modality	Sensitivity (95% CI)	Specificity (95% CI)
MRI	78% (70–84%)	88% (83–92%)
2D TVUS	74% (68–79%)	76% (71–79%)
3D TVUS	84% (77–89%)	84% (77–89%)
TVUS (overall)	78% (73–82%)	78% (74–81%)

7

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Adenomyosis ≠ Surgery

Extent of disease
- Focal / diffuse
- Intrinsic/Extrinsic

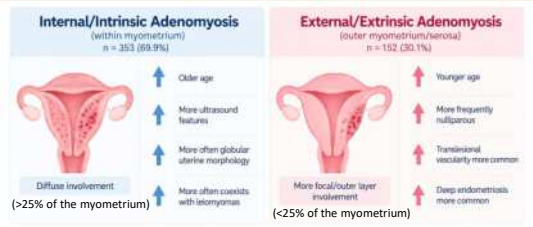
Clinical burden
- Pain
- Heavy menstrual bleeding
- Functional Impairment
- Quality of life

Patient priorities
- Symptom relief
- Uterine preservation
- Fertility status
- Understanding risks/benefits

8

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What is the extent of disease? Adenomyosis Phenotypes



Different phenotypes but no difference in symptoms

9

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Radiology images of adenomyosis phenotypes

10

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Is adenomyosis the main problem?



Competing or coexisting causes
- Endometriosis
- Fibroids
- Other causes of pelvic pain
- Other causes of AUB

11

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What are the patient's goals?

- **Symptom relief**
- **Uterine preservation**
- **Fertility status**
- **Willingness to accept risks vs benefits of intervention**

12

Symptom relief

- Data on symptom relief

13

Uterus vs no uterus

- Data on recurrence

14

Pregnancy outcomes

- Data on pregnancy outcomes/risks
- Uterine rupture
- Placenta
- Complete vs Partial excision

15

What are the alternatives?

- Medical treatment
  - LNG-IUD
- Non-excisional procedures
  - UAE, endometrial ablation, HIFU, MRgFUS
    - No comparative studies
    - Affects hormonal production and ovarian reserve
    - Decrease endometrial receptivity
  - RFA
    - Observational data only
    - Improved symptoms (dysmenorrhea, bleeding)
    - Decreased uterine volume
    - Not FDA approved
    - Re-intervention rate (28.7%)
    - Unclear fertility and recurrence data

16

When does surgery make sense?

17

Focal vs diffuse disease

Focal / adenomyoma

Discrete operative target
Potential for targeted excision
Assess defect size and cavity entry
Balance completeness vs myometrial integrity

Diffuse adenomyosis

Indistinct disease margins
Greater myometrial sacrifice
Higher reconstructive complexity
Cytoreductive approaches require careful counseling

18

Who may benefit and when to pause

More favorable

- Strong symptom–lesion concordance
- Clearly defined surgical target
- Meaningful unmet patient goal
- Feasible myometrial preservation
- Realistic expectations

Pause / reconsider

- Diffuse extensive involvement
- Unclear pain generator
- Limited residual myometrium
- Extensive uterine reconstructive (w/ planned pregnancy)
- Expectations of guaranteed cure

19

Choose a strategy—not just a procedure

Focal, resectable target

Consider targeted adenomyomectomy with reconstruction

Diffuse, high disease burden

Consider selective partial excision only if realistic benefit and safe reconstruction

Uncertain attribution or high risk

Reassess pain/bleeding drivers; optimize nonsurgical management

No fertility goal; definitive relief sought

Discuss hysterectomy as an alternative, not a failure of conservative care

20

Clinical Scenario

38-year-old, G1P1

- Severe dysmenorrhea and heavy menstrual bleeding
- Persistent symptoms despite hormonal therapy
- Focal adenomyosis; possible coexisting endometriosis
- Wants to keep her uterus
- Unsure about future fertility



https://radiopaedia.org/articles/adenomyoma

21

Would you proceed with surgery?

Clarify

Pregnancy plans, pain phenotype, bleeding workup, uterine preservation desires

Map

Determine extent of disease and coexisting diseases (endometriosis, fibroids)

Counsel

Alternatives, incomplete relief, recurrence, surgical risks and pregnancy risks

22

Three take-home messages

01 Treat the patient, not the image — Adenomyosis alone is not an indication for surgery.

02 Define the goal before the operation — Symptom relief, uterine preservation or fertility

03 Resectable ≠ appropriate — Balance benefit with uterine integrity and risks.

23

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6. Harada T, Taniguchi F, Guo SW, Choi YM, Biberoglu KO, Tsai SS, Alborzi S, Al-Jefout M, Chalermchokcharoenkit A, Sison-Aguilar AG, Fong YF, Senanayake H, Popov A, Hestiantoro A, Kaufman Y. The Asian Society of Endometriosis and Adenomyosis guidelines for managing adenomyosis. Reprod Med Biol. 2023 Sep 10;22(1):e12535. doi: 10.1002/rmb2.12535. PMID: 37701076; PMCID: PMC10493363.

24

Outcomes and Pitfalls

Functional Recovery and Long-Term Results

Marco Aurelio Pinho Oliveira, MD, PhD

Full professor of Gynecology – State University of Rio de Janeiro
AAGL Board Member (2011-2013)
Chief of Robotic Gynecologic Surgery of the Pedro Ernesto Hospital

1

Disclosure

"I have no financial relationships to disclose."

2

HETEROGENEITY

The field has no shared definition of a "success"

38 studies (6 randomized, 32 cohort) total of 5,175 patients

203	133	18%
different outcomes (in 29 domains)	measurement instruments (dysmenorrhea = 14, heavy menstrual bleeding = 17)	studies with a clear primary outcome (53% no primary outcome at all)

Tellum et al., A systematic review of outcome reporting and outcome measures in studies investigating uterine-sparing treatment for adenomyosis. Hum Reprod Open 2021

3

COSAR Initiative: *Core Outcome Set* in Adenomyosis Research

01 · THE PROBLEM

Severe Heterogeneity

38 Studies, 203 Outcomes
Measured via 133 different instruments

Only 18% Set a Primary Outcome
53% used vague terms like 'clinical efficiency'

71% Measured Uterine Volume
QoL (24%) and satisfaction (3%) largely neglected

02 · THE SOLUTION

The COSAR Framework

International Consensus
Core Outcome Measures in Effectiveness Trials (COMET) initiative

Mandatory Core Set
A minimum standardized dataset for all future trials

Minimize Reporting Bias
Prevents cherry-picking and enables meta-analyses

03 · PATIENT IMPACT

Patient-Centered Research

Direct Engagement
Patients help select trial endpoints

Standardised Tools
VAS for dysmenorrhea, PBAC for bleeding

Patient Centered Outcomes
Shifts focus from organ size to quality of life

Tellum T et al. Development of a core outcome set and outcome definitions for studies on uterus-sparing treatments of adenomyosis (COSAR): an international multistakeholder-modified Delphi consensus study. Hum Reprod. 2022

4

DEFINING THE OUTCOMES

"Success" may be defined by two outcomes

Functional recovery
The uterus completes a full reproductive cycle:
conception through delivery without rupture, once or repeatedly.

Long-term results
The disease course afterward:
symptomatic or radiologic recurrence, over years.

5

Primary Surgical Series: *Dysmenorrhea and Menorrhagia*

Author & Year	Surgical Technique (N)	Dysmenorrhea / Pain Relief	Menorrhagia / Bleeding Relief	Follow-up and Recurrence
Osada et al. (2011)	Open Triple Flap Adenomyomectomy **(N=104 diffuse)**	VAS reduced from 10.0 to 1.67 **(–83.3% pain reduction)**	VAS reduced from 10.0 to 2.87 **(–71.3% bleeding reduction)**	24–120 months; **3.8% symptom recurrence**

6

Pregnancy after surgery for *focal* adenomyosis

Study	Total N / fertility N	Design and approach	Follow-up mo (range)	Adjuvant (postoperative)	Pregnancy rate
Wang 2009	165 / 71	Prospective, nonrandomized Laparotomy, mini-lap, laparoscopy	24	None vs. GnRH-a (6 mo)	77.5% (55/71) Alone 74.1% (20/27) + GnRH-a 79.5% (35/44)

7

Pregnancy after surgery for *diffuse* adenomyosis

Study	Total N / fertility N	Design and approach	Follow-up mo (range)	Adjuvant treatment	Pregnancy rate (conception)
Osada 2011	104 / 26	Prospective case-control · **Minilaparotomy**, triple-flap cytoreductive	120	None	**61.5% (16/26)** NC 4, ART 12

8

Perinatal outcomes after adenomyosis surgery

Study	Total N / fertility N	Type · design · approach	Adjuvant treatment	Pregnancy rate	Delivery and perinatal outcomes
Zhou 2022	137 / 137	**Diffuse** · Retrospective · **Laparotomy**, double-flap	GnRH-a (3–6 courses)	**45.2% (62/137)** **Natural 56.5%** **IVF 43.5%**	**32.8% successful deliveries (45/137)** 14 miscarriages 6 preterm deliveries

9

Primary Surgical Cohorts: *Rupture Rates*

Author and Year	Surgical Technique and N	Cases and Rupture Rate (%)	Timing of Rupture (Gestational Age)	Main Observations and Obstetric Outcomes
Nishida / Otsubo (2016)	Asymmetrical Dissection **(N=1,349)**	5 cases (2.8% per patient / **2.3% per pregnancy**)	**12 to 31 weeks**	**100% of ruptures involved opening of the endometrial cavity**; RMT ≤ 7mm on TVUS/MRI.

10

SURGICAL PLATFORM

Laparoscopy and robotics performed alike in a small series

Robotic (n=22 ; 4 diffuse) vs. laparoscopic (n=21 ; 4 diffuse)

Surgical Metric	Robotic-Assisted (n=22)	Laparoscopic (n=21)	p-value
Operation Time (min)	212.5 (120.0–420.0)	160.0 (40.0–420.0)	0.106
Estimated Blood Loss (mL)	300.0 (100.0–3200.0)	500.0 (50.0–1500.0)	0.309
Resected Nodule Weight (g)	70.0 (5.0–250.0)	60.0 (5.0–185.0)	0.932
Preoperative Uterine Volume (cm³)	285.3 (94.4–564.8)	250.5 (86.5–885.3)	0.923
Hospital Stay (days)	6.0 (5.0–10.0)	5.0 (4.0–18.0)	0.277
Blood Transfusion Rate (%)	27.3% (6/22)	23.8% (5/21)	0.795

Shim et al. 2019, CHA Gangnam

11

A CASE

Anatomic and Long-term Success

A stepwise approach to robotic diffuse adenomyosis resection with double flap and concomitant abdominal cerclage

[redacted]

Fertility and Sterility® Vol. 118, No. 5, November 2022

- Robotic double-flap adenomyomectomy with concomitant abdominal cerclage
- Excellent MRI result, dysmenorrhea resolved
- No subsequent pregnancy



Marco Pinho Oliveira

12

Robot-Assisted Adenomyomectomy reduces pain

Retrospective study · N = 34 analyzed (40 recruited)

Outcome	Preoperative	Postoperative	Δ	p
Wall thickness, cm	4.02 ± 1.11	2.37 ± 0.84	−41%	< 0.0001
Pain score, 0–10	8.68 ± 1.12	0.06 ± 0.34	—	n.r.
CA-125, U/mL	121.73 ± 117.29	6.95 ± 2.60	↓	0.0156
Pregnancy rate	7 w/ infertility	Pregnancy (3/7)	42,8%	—

Hijazi et al. A novel technique for myometrial defect closure after robotic-assisted laparoscopic adenomyomectomy: A retrospective adenomyomectomy: A retrospective cohort study, Taw J Obstet Gynecol, 2022.

13

Robotic surgery: less blood loss, shorter stay, fewer endometrial exposures

Outcome	Open (n= 21)	Robotic (n= 55)	Effect
Adenomyotic lesion size	7.1 ± 2.7 cm	5.4 ± 1.7 cm	p = 0.001
Estimated blood loss	400 mL (200–700)	300 mL (200–400)	p = 0.05
Hospital stay (adjusted)	Reference	Shorter	β (−2.1) ; p < 0.001
Attempted conception	9/21 (42.9%)	10/55 (18.2%)	p = 0.026
Endometrial exposure	5/9 (55.6%)	1/10 (10.0%)	p = 0.032
Delivery	4/9 (44.4%)	6/10 (60.0%)	p = 0.497
Preterm / full-term delivery	4 / 0	2 / 4	p = 0.08 (Fisher)

Park et al. Robot-Assisted Laparoscopic Versus Open Adenomyomectomy: Comparative Surgical and Reproductive Outcomes. J Clin Outcomes. J Clin Med, 2026

14

ICG

Intraoperative indocyanine green: an emerging tool





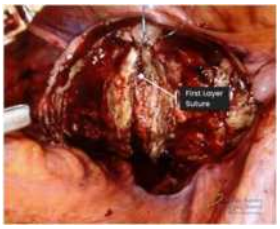
Pre-Operative MRI

15

ICG

Intraoperative indocyanine green: an emerging tool



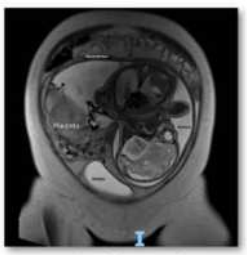


16

ICG

Intraoperative indocyanine green: an emerging tool





MRI (during pregnancy)
to evaluate myometrial thickness

17

Conservative Surgery in Adenomyosis: *Points of "Consensus"*

1. Pain & Bleeding Relief

54.6–84.6% [5]
Dysmenorrhea reduction

50.0–73.7% [5]
Heavy menstrual bleeding reduction reduction

>85–90% [1,3]
Normal flow after advanced excisional excisional techniques (Osada, double-double-flap, PUSH)

2. Obstetric Risk After Reconstruction

No Clear Margins [6]
Excision disrupts myometrial architecture

Increased Risk [9]
Uterine rupture, PAS, placenta previa, preterm labor, PPHem

Management [7]
High-risk surveillance and planned cesarean section

3. Phenotype & Age Drive Fertility

49.1–77.5% [4]
Pregnancy rate — focal adenomyosis

17.6–39.3% [4]
Pregnancy rate — diffuse adenomyosis

Age ≤39 vs ≥40 [2,9]
Clinical pregnancy 41.3–48.0% vs 3.7–22.2%; miscarriage risk rises after 40

1 Osada 2011, Reprod Biomed Online · 2 Kishi 2014, Fertil Steril · 3 Huang 2015, BMC Women's Health · 4 Tan 2018, J Minim Invasive Gynecol · 5 Younes & Tulandi 2018, J Minim Invasive Gynecol · 6 Mikos 2020, J Minim Invasive Gynecol · 7 Moawad 2024, J Clin Med · 8 Liu 2025, BMC Pregnancy Childbirth · 9 Shin 2026, Obstet Gynecol Sci

18

Contradictions Pitfalls

1. Adjuvant GnRH-a Therapy

Pro-Adjuvant
67.1% vs 49.1% [2,3]
Postoperative GnRH-a (3–6 mo) + surgery raises pregnancy rates over surgery alone in focal disease; 15% to 40.7% NC)

No Added Benefit
Rocha [3]
No significant difference (for IVF) in pregnancy, birth or miscarriage rates vs. surgery alone

2. Open vs. Minimally Invasive

Open Laparotomy
Tactile Feedback
Digital palpation to distinguish diseased tissue; laparoscopy risks incomplete excision

Laparoscopic/Robotic
Shim et al. [4]
No significant difference vs. open in operative time, blood loss, tissue weight or symptom relief

3. Route to Conception

Spontaneous Superior
Up to 100% [2]
Several focal series show natural conception matching or exceeding ART after surgery alone

ART/IVF Superior
41.0% vs 18.2% [1,3]
Higher pregnancy rates via ART than natural conception

1 Tsui 2015, Taiwanese J Obstet Gynecol · 2 Tan 2018, J Minim Invasive Gynecol · 3 Rocha 2018 · 4 Shim 2019, Medicine · 5 Youssef 2024, Facts Views Vis Obgyn · 6 Liu 2025, BMC Pregnancy Childbirth

19

Pitfalls: *Critical Unanswered Questions*

1. Optimal Interval Before Conception

The Gap
No RCT Data [3]
No prospective, evidence-based consensus on the mandatory waiting period before attempting conception

Current Status
3–24 Months [3,4]
Extrapolated from myomectomy protocols and endometrial-healing studies; no trial links interval to rupture risk

2. Superior Reconstruction Technique

The Gap
No Head-to-Head RCTs [5,6]
No trials directly compare competing uterine reconstruction techniques

Current Status
Many Techniques, No Winner [1,3,5]
Triple-flap, H-incision, PUSH and double-flap all report good outcomes, but heterogeneous reporting blocks comparison

3. Minimum Safe Myometrial Thickness

The Gap
No Validated Cutoff [2,7]
No standardized TVUS/MRI threshold for residual myometrial thickness prospectively validated for pregnancy safety

Current Status
<7 mm Flagged [2,7]
Small studies suggest a 9–15 mm buffer zone and more complications below 7 mm, but no guideline sets a cutoff

1 Osada 2011, Reprod Biomed Online · 2 Otsubo 2016 · 3 Younes & Tulandi 2018, J Minim Invasive Gynecol · 4 Tan 2018, J Minim Invasive Gynecol · 5 Youssef 2024, Facts Views Vis Obgyn · 6 Liu 2025, BMC Pregnancy Childbirth · 7 Shin 2026, Obstet Gynecol Sci

20

WHAT SEEMS PREDICTS OUTCOME

Four factors seems to offer better outcomes on any platform

1
Avoid endometrial cavity entry
Strongest single predictor

2
Multilayer reconstruction
Target residual myometrial thickness above 10 mm

3
12 months of healing
Before conception is allowed

4
Preoperative GnRH-a
Reduces vascularity and volume

21

IS THERE A LIMIT TO CONSERVATIVE SURGERY?

The limit is not uterine size or platform!

It is whether you avoid the cavity, how many layers you reconstruct, and the three questions your numbers must answer:

Pregnancy rate, delivery without rupture and recurrence of symptoms

22

Thank You!

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23

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24

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25

Conservative Surgery for Adenomyosis: Step-by-Step Technique and Uterine Reconstruction

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Cardoso Fontes Hospital

NOVEMBER 13-16, 2026 · BOSTON · #AAGL26

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Disclosure

J&J Med Tech

Intuitive

DR. THIERS SOARES
CIRURGIA GINECOLÓGICA AVANÇADA

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Current Obstetrics and Gynecology Reports (2022) 11:180–185
https://doi.org/10.1007/s13669-022-00335-6

UTERINE FIBROIDS AND ENDOMETRIAL LESIONS (T. TULANDI, SECTION EDITOR)

Surgical Treatment of Adenomyosis

Marco Aurelio Pinho Oliveira[1] · Leila Cristina Brollo[1] · Thiers Soares[1] · Thiago Dantas Pereira[1] · Ricardo Jose de Souza[1]

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Surgical Treatment of Adenomyosis

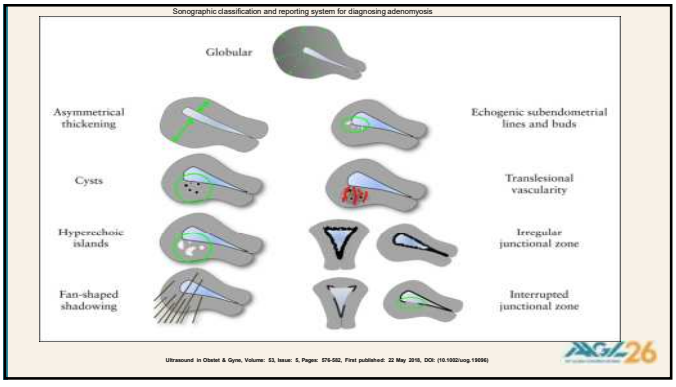
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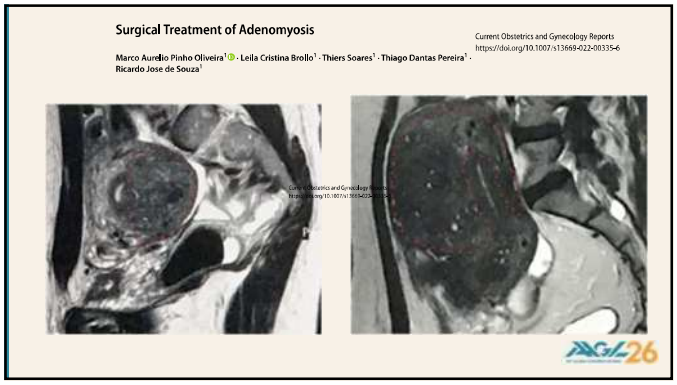
Table 1 Pregnancy outcomes after conservative surgery for adenomyosis

Adenomyosis type	Treatment	Pregnancy rate (%)	Successful delivery rate (%)	Miscarriage rate (%)
Diffuse	Surgery Alone	38.5	31.3	16.2
	Surgery & Medical	17.6	9.8	33.3
Focal	Surgery Alone	49.1	38.6	27.6
	Surgery & Medical	67.1	61.3	11.6

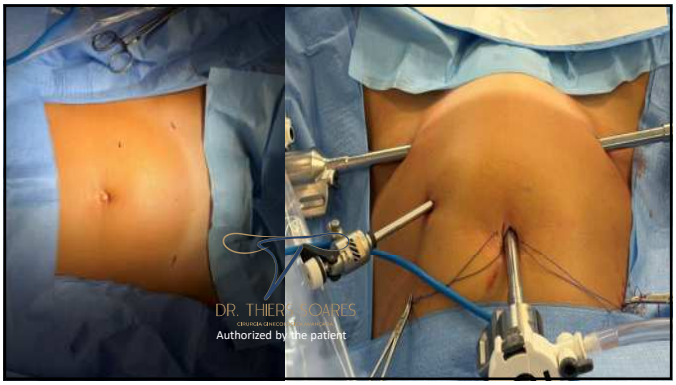
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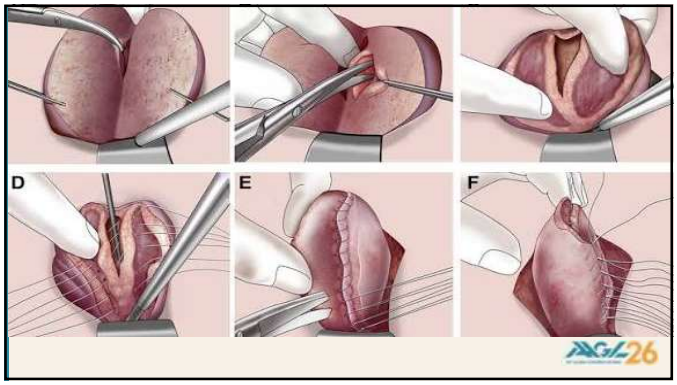
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Surgical Treatment of Adenomyosis
Current Obstetrics and Gynecology Reports
https://doi.org/10.1007/s13669-022-00335-6
Marco Aurelio Pinho Oliveira[1] · Leila Cristina Brollo[1] · Thiers Soares[1] · Thiago Dantas Pereira[1] · Ricardo Jose de Souza[1]

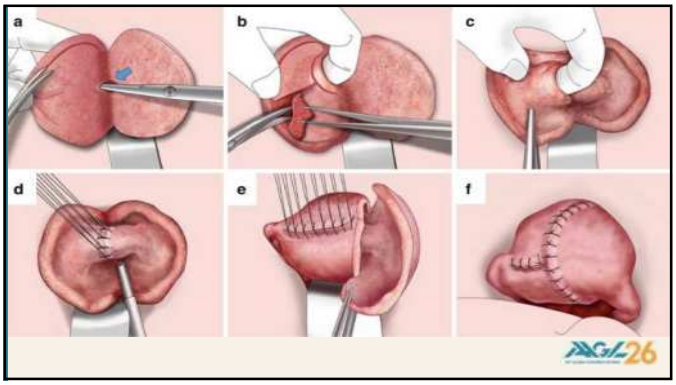
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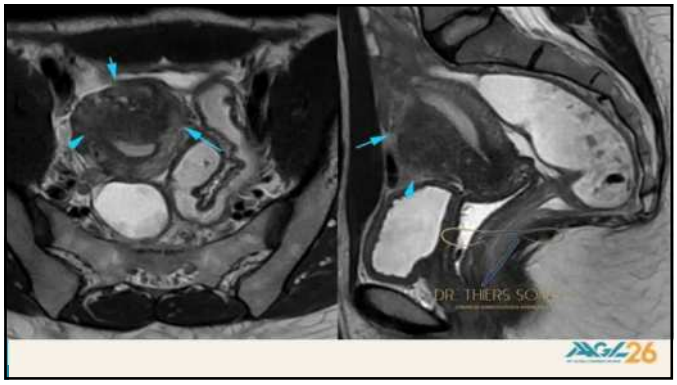
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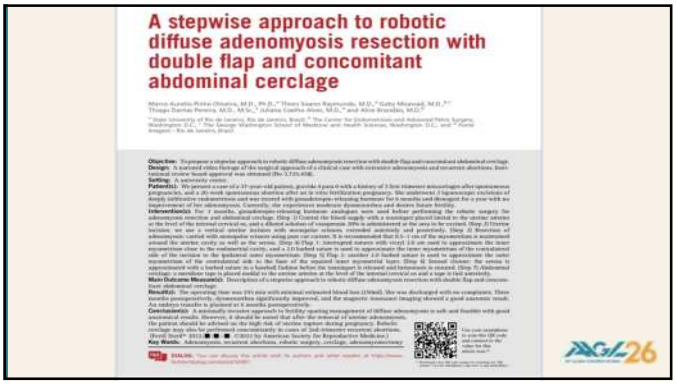
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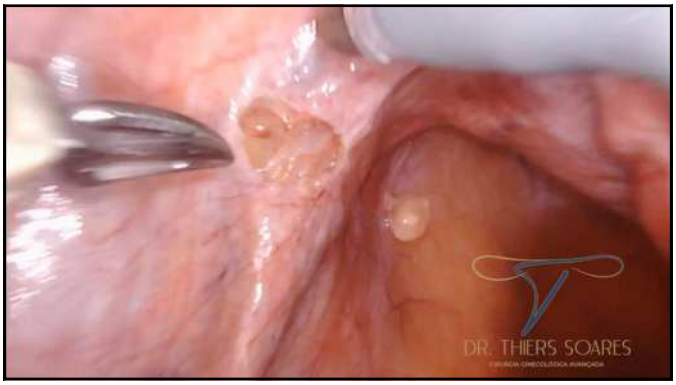
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Robotic extensive adenomyosis resection with double flap technique and concomitant cerclage in 8 steps

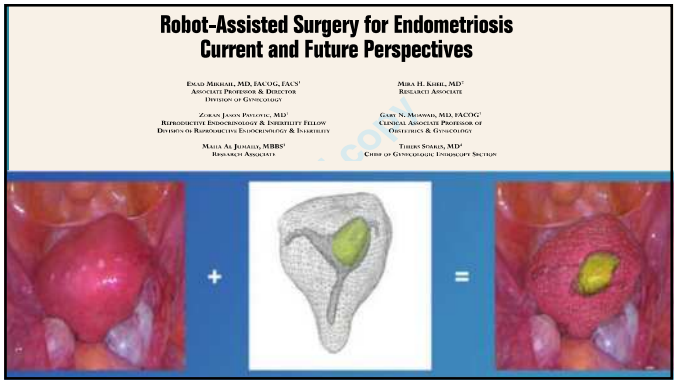
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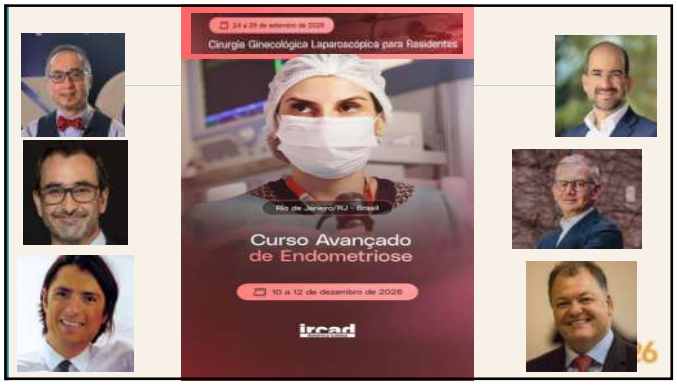


17

Take Home Message

- **Patient selection is the first surgical step:** consider symptoms, disease extent, fertility goals, and available alternatives.
- **Tailor the excision to the disease:** focal and diffuse adenomyosis require different surgical strategies.
- **Balance disease removal with myometrial preservation:** extensive excision should not compromise uterine integrity.
- **Uterine preservation does not guarantee fertility:** counsel patients about recurrence and pregnancy risks, including uterine rupture.
- **"The goal is not simply to remove adenomyosis, it is to reconstruct a uterus with the best possible structural and functional integrity."**

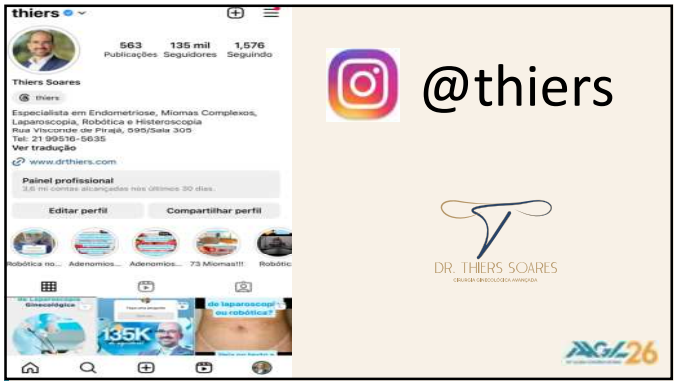
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21

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
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