Message from SRS President, Dr. Bala Bhagavath

Dear Colleagues:

I am excited to share some details of our activities in the past few months, and plenty has happened! As usual, the Society for Reproductive Surgeons was very active in the scientific programming of the ASRM 2018 Scientific Congress & Expo. The plenary lecture was given by Dr. Liselotte Mettler and was well-received. The society conducted two Pre-Congress courses, an interactive session, a surgical tutorial, an Expert Encounter, a live telesurgery and multiple roundtables. All these were well-attended.

The SRS-SREI 2019 Surgical Boot Camp for fellows was successfully conducted in Houston in January 2019. Feedback from the attendees was good. A new session, ‘Meet the Professor’ was very popular, and we plan to allot more time for this exercise next year. This year, we are conducting an IRB-approved research to study the improvement in skills after the boot camp.

The Society of Reproductive Surgeons’ manual, Reproductive Surgery was released for public consumption. The board members, as well as several other contributors, have worked hard for the past few years to achieve this. Each chapter has videos attached to it, and the initial response has been enthusiastic. Please check it out if you have not done so already!

Dr. Christianson has worked hard to bring you this edition of the newsletter with more details on the topics I have mentioned above. In addition, I thank Drs. Pfeifer and Flyckt for their contribution to uterine septum management and uterine transplantation, respectively. Once again, I invite all of you to actively participate in the society’s activities, and request that you approach us with any ideas you may have to further our common interest in promoting reproductive surgery.

Thanks!
Bala Bhagavath, M.D.
SRS President

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Fourth Annual SRS-SREI Surgical Boot Camp

The Fourth Annual SRS-SREI Surgical Boot Camp for REI fellows took place on January 25th and 26th, 2019 at the Houston Methodist Institute for Technology, Innovation & Education (MITIE) in Houston, Texas. The successful course was directed by Drs. Steven R. Lindheim, Wright State University, Boonshoft School of Medicine, and John Petrozza, Massachusetts General Hospital Fertility Center, Harvard School of Medicine. Many other faculty committed their time and energy to make this the most successful program yet. The response from attendees was tremendous, and the event was very well-attended.

The agenda of the boot camp was built upon a comprehensive mix of lectures and hands-on activities. The hands-on activities included cadaveric dissection, laparoscopic suturing in the box trainer, multiple hysteroscopic training activities, embryo transfer simulation for each attendee in the hands-on stations, and insightful lectures. This resulted in an enhanced learning experience for trainees and faculty.

Ten cadaver stations allowed for laparoscopic dissection and exercises, and two cadavers for robotic surgery exercises. At the laparoscopic cadaver stations, trainees practiced dissection in the retroperitoneal space and performed suturing tasks mimicking myometrial closure and cystotomy repairs. At the robotic surgery cadaver station, attendees practiced repair of the myometrium and tubal anastomosis.

The fellows also enthusiastically participated in suturing tasks in the dry lab. An element of competition was introduced by timing participants, which allowed for self-evaluation and feedback. Further, a computerized robotic simulation station allowed fellows to hone their skills. Lastly, the many hysteroscopic stations allowed for the practice of hysteroscopic assembly with application of scissors and graspers to remove bell pepper seed “polyps”, resectoscopes to shave potato “fibroids”, and the hysteroscopic morcellator to remove model fibroids and polyps.

The embryo transfer station was very popular, with trainees requesting that time allotted be increased in the future.

On a social level, a networking event allowed faculty and fellow trainees to interact, allowing each to learn about the other and the trainees to share their goals and aspirations. One of the favorites added this year was “Meet the Professor” where fellows could semi-privately chat and ask questions about future jobs, academics vs private sector, and what they should look for when they go job hunting. Next year, the plan is to augment this session.

All hands on deck, as Drs. Petrozza and Hwang will be running the program in 2020 to make it even better! Lastly, we thank those behind the scenes including Suzanna Scarbrough, Dani Mosley, Keith Ray, and all the vendors for their support in this most successful program!
As a first-year REI fellow, I was honored to have the opportunity to participate in the fourth annual SRS-SREI surgical bootcamp in Houston, Texas on January 25th and 26th. It was a fantastic, well-run experience, with practical learning on cadavers, state-of-the-art simulators, and with top-notch surgeons from around the country. Fellows were divided into groups for the laboratory sessions in order to have a more personalized experience with faculty members. We spent time at various hysteroscopy simulators, such as performing “polypectomies” on bell pepper seeds, “myomectomies” on potatoes, and even timed how quickly we could assemble a hysteroscope blindfolded! I can now say that I can assemble my hysteroscopy equipment with my eyes closed.

In the cadaver sessions, we were assigned multiple tasks, overseen by faculty. We laparoscopically dissected the anatomy of the pelvic sidewall, as well as practiced our laparoscopic suturing with intracorporeal and extracorporeal knot-tying. Dr. Goldberg even proctored my group as we performed a laparoscopic oophoropexy and repaired a cystotomy. We also had a station to practice laparoscopic laser ablation on chicken skin and another cadaver to practice robotic-assisted tubal reanastomosis with micro forceps. This was especially helpful for me, as I performed my first robotic-assisted tubal reanastomosis the following week. The ability to spend time at the console to practice was invaluable.

Additional stations included a robotic simulator with timed skills games, the embryo transfer simulator, and box trainers for additional laparoscopic suturing and tying practice.

Interspersed throughout the days were practical lectures, including anatomy review, proper port placement, and avoiding and managing injuries. We also learned tips for a variety of procedures, including myomectomy, hysteroscopy, tubal anastomosis, and management of Müllerian anomalies. Furthermore, there was a lecture followed by a small group session with faculty to discuss the job search and how to navigate the contract negotiation process. We also had the opportunity to network with the faculty outside of the bootcamp at a provided dinner, allowing us more time to meet with reproductive surgeons from across the country in a more informal setting.

In speaking with other fellows who were able to attend the bootcamp, it was apparent that I am not the only one who felt that the bootcamp was a great experience, regardless of skill level or fellowship surgical volume. Below are some comments from co-fellows:

“The SRS bootcamp is a well-organized, unrivaled opportunity for REI fellows to explore opportunities for surgery in our field. It utilizes lectures to introduce the material, and then allows for immediate application of the skills in the lab. So grateful for the leaders in our field who devoted their time and energies to make it happen.” – J.R.

“I think it was a great educational opportunity that does a very good job of incorporating both clinically-relevant and useful lectures with hands-on learning.” – C.B.

I believe the bootcamp will continue to inspire REI fellows to maintain their surgical skills in order to provide comprehensive reproductive care to their patients for years to come. I know the fellows from the 2019 bootcamp are very appreciative of the experience, and we would like to thank the faculty and sponsors who made this opportunity possible.
Innovations

Approach to the Septate Uterus: Tips and Tricks
Jacqueline Y. Maher, M.D., REI Fellow, Johns Hopkins University School of Medicine
Samantha M. Pfeifer, M.D., Associate Professor, Weill Cornell Medical College

Introduction
The septate uterus is the most common Mullerian anomaly, accounting for 35% of all identified uterine anomalies, affecting approximately 2-4% of patients with infertility (1-3). Hysteroscopic septum resection is performed worldwide to improve reproductive outcomes in women who desire fertility. A meta-analysis by Venetis et al. showed that septate uterus was associated with a marginal decrease in pregnancy rate, and an increased rate in miscarriage, preterm delivery, malpresentation, low birth weight, and perinatal mortality (3,4). It has been reported that hysteroscopic removal of a septum was associated with a reduced probability of spontaneous abortion (RR 0.37, 95% CI 0.25 to 0.55) compared with untreated women (4). In a 2017 Cochrane Review of nine studies, three showed a significantly higher pregnancy rate in those that were treated with surgery compared to expectant management, and six studies found no significant difference. They concluded that there is not enough evidence to support the surgical procedure because no randomized control studies have been published (5). It must be noted that the data evaluating outcomes with septate uterus and the effect of treatment are largely from small case studies, with no randomized controlled trials comparing treatment versus no treatment. Currently, the American Society for Reproductive Medicine (ASRM) and the European Society of Human Reproduction and Embryology (ESHRE) guidelines suggest surgical resection of the uterine septum for patients with recurrent miscarriage. However, for patients with infertility, it is less clear, though surgical correction is reasonable to consider after patient counseling (6). The purpose of this article is to review the evaluation and surgical management of septate uterus.

Definition
A uterine septum occurs when there is a failure of resorption of tissue after the two paramesonephric (Mullerian) ducts have fused together, typically occurring prior to the 20th embryonic week. Septate uteri have a spectrum of sizes and shapes that range from partial, complete to the internal os, complete to the external os, or complete with extension into the vagina. They vary in thickness and vascularity. To better define a septate uterus and differentiate it from an arcuate or bicornuate uterus, ASRM has released guidelines with morphometric criteria (Figure 1) (7). Arcuate, which is a normal variant, is defined as an indentation depth from the fundus of < 1cm and an angle of < 90 degrees, whereas septate uteri have an indentation depth from the fundus of > 1.5cm and an angle of < 90 degrees.

Furthermore, ESHRE and the European Society for Gynecologic Endoscopy (ESGE) working group under the name CONUTA (CONgenital Uterine Anomalies) define a septate uterus (Class U2) as one that has an internal indentation >50% of the uterine wall thickness and an external contour straight or with indentation <50%. U2 is further subdivided into U2a for partial septate, in which the septum divides the uterine cavity above the level of the internal cervical os, and a U2b is a complete septum, in which the septum fully divides the uterine cavity to the level of the internal cervical os, but may be associated with a cervical or vaginal septum as well (8). Use of the ESHRE–ESGE classification, compared with the ASRM classification, significantly increases the frequency of septate uterus diagnosis, and may potentially promote more surgeries to correct small, potentially clinically-insignificant septae (9).
Diagnosis

It is important to differentiate a septate uterus from a bicornuate uterus and a uterine didelphys. Historically, laparoscopy and hysteroscopy were used as the gold standard to differentiate these uterine anomalies. However, advancement in imaging modalities now make 3-D transvaginal ultrasound, saline infusion sonogram, and MRI appropriate diagnostic tests as well. Hysterosalpingogram also can be used to define the internal architecture, but it cannot differentiate between a uterine septum and a bicornuate uterus.

Figure 2: Partial versus Complete Uterine Septum. ESHRE/ESGE.10

Figure 3: 3D Saline ultrasound.9
Approach to the Septate Uterus: Tips and Tricks

Surgical Management for Partial Uterine Septum
Hysteroscopic metroplasty is preferred to the transabdominal approach, which historically included a Jones or Tompkins Metroplasty. Hysteroscopic approaches include septum incision with micro-scissors, unipolar cautery, bipolar cautery, or laser, or septum resection. Distending media for the uterus include saline, glycine, sorbitol, or mannitol, but is dependent on the incision technique or energy source (7). Benefits to the hysteroscopic approach include lower perioperative morbidity, decreased intra-abdominal adhesion formation, faster recovery, and decrease in pregnancy complications such as uterine rupture since the fundal serosa and superior myometrium are not incised. Thus, a vaginal delivery is not contraindicated after a hysteroscopic metroplasty.

Timing/Pretreatment:
Resection of the septum is easier when hysteroscopic visualization is optimal, and the endometrial lining is thin. This can be achieved either by timing surgery during the early follicular phase or pretreating the patient with hormonal regimens. Commonly used pre-treatment medications include continuous combined hormonal contraceptives or progestin only pills, despite lack of data in the literature evaluating these regimens. Danazol or GnRH agonist have been used with equivalent efficacy to thin the endometrium prior to metroplasty (11).

Safety:
To increase safety of the procedure and decrease uterine perforation, hysteroscopy can be performed under simultaneous abdominal ultrasound guidance or laparoscopy (12).

An important pearl is to know when to stop, and this includes stopping when:

- The tissue changes from being fibrous and avascular to pink, and capillaries are seen.
- The septum is visibly gone or the uterine ostia are seen in the same plane bilaterally.
- Ultrasound imaging shows the septum is no longer present, or you are approaching the myometrium of the fundus.

In some cases, the hysteroscopic septum resection needs to be done in two stages. As with any hysteroscopic procedure, operative time, fluid deficit, and blood loss may limit the procedure. Additionally, in one series, a residual fundal indentation of greater than 1 cm on follow-up may be an indication for repeating the septoplasty (13). Uterine rupture in subsequent pregnancy following uterine septum incision has been correlated with excessive septal excision, penetration of the myometrium, uterine wall perforation, and excessive use of cautery or laser energy during the initial procedure.

Complete Uterine Septum:
For the resection range of the complete septum, surgical management includes two options: incise cervical and uterine septum or preserve cervical septum, incise uterine septum. Resecting the cervical and uterine septum takes less time, but may increase the risk for cervical incompetence in subsequent pregnancy. Resecting the uterine septum starting at the level of the internal os while preserving the cervical septum is more time consuming but can help reduce the potential risk of cervical incompetence (14). Techniques to interrupt and traverse the uterine septum above the internal os to allow septal incision are shown here and include use of a curved hemostat or balloon.

Figure 4: Courtesy of Jeff Goldberg, CCF 2017
Post-Op Management:
Post-op complications, though rare, include uterine perforation, thermal injury, uterine infection, fluid electrolyte imbalances and intrauterine adhesions. In studies that performed a second look postoperative hysteroscopy, the uterine cavity was reported to be healed by two months (15,16). The risk of intrauterine adhesion formation or Asherman’s syndrome after hysteroscopic uterine septum incision reported a wide range from 5.3-37.5% (17,18). Intrauterine adhesions are thought to develop following endometrial denudation or injury causing the opposing uterine walls to adhere to each other. Candiani et al. showed that two weeks post op, the incised area was depressed with no endometrium, however at eight weeks the uterine cavity was normal (19). Yang et al. performed a hysteroscopic evaluation at one month and found 19% of patients had a normal cavity, but by two months, 100% of patients demonstrated a normal cavity (20).

Options for post-operative adhesion prevention are numerous as listed below, but evidence to support the use of any of these techniques is insufficient (17).

- **Estrogen**: Conjugated equine estrogen 0.625 – 1.25mg daily or twice a day for 2-4 weeks; Estradiol 1-2mg daily or twice a day; Estradiol patch 0.1mg, 1-2 patches twice weekly
- **Progestins**: Given for the last 5-7 days of estrogen therapy
- **Intrauterine balloon stent**: Pediatric foley 8-12 French or Cook uterine balloon catheter. Duration of time is undetermined.
- **Others**: e.g., antibiotics, hyaluronic acid, IUD

Though adjuvant therapies are currently being utilized, recent studies suggest that estrogen administered with a progestin, intrauterine balloon, and IUD placement had no significance in the prevention of intrauterine adhesions after septum resection, nor could it improve the postoperative pregnancy rate (21,22). There are no data evaluating the use of estrogen alone with or without the use of a balloon device to reduce adhesions, which is what many practitioners utilize. Currently, per ASRM Practice Committee guidelines, there is insufficient evidence to recommend for or against adhesion prevention treatment, and additional studies are needed.

**Timing to Pregnancy and Outcomes:**
It is recommended that following hysteroscopic septum incision, pregnancy be delayed for at least two months, based on data in the literature. One study showed that there was no difference in pregnancy and miscarriage rates at <9, 10-16, or >17 weeks post septum treatment (16). Outcomes following hysteroscopic septum incision are favorable. One study found that miscarriage rates decreased from 91.8% to 10.4% following septum incision in 361 patients who had primary infertility of >2 years’ duration, a history of 1–2 spontaneous miscarriages, or recurrent pregnancy loss. Studies have reported an overall pregnancy rate after treatment of 48% (24). After resection of the septum, fetal malpresentation frequency should return to that of the general population.
References:

Uterus Transplantation: The Next Five Years
Elliott Richards, MD; Tommaso Falcone, MD; Andreas Tzakis, MD; Rebecca Flyckt MD
Cleveland Clinic Lerner College of Medicine Obstetrics/Gynecology and Women’s Health Institute

The field of uterus transplantation has made astounding strides in a brief period of time, both in terms of technical innovation, as well as public perception. In the past five years, we have seen the first baby born in a human trial from a living donor uterus (1); the announcement of multiple uterus transplant trials worldwide (2-5); the use of alternate vessels for venous drainage (6-7); the initial use of laparoscopic and robotic approaches to organ procurement (6,8); and recently, the first baby born from a deceased donor uterus (9). Uterus transplant is no longer a theoretical surgical procedure. To our knowledge, there have been at least 14 babies born from uterus transplant to date, with more anticipated in the coming months. Furthermore, the general public appears to express overall favorable views of uterus transplant, with one recent study reporting 78% of adults in the United States supporting the procedure (10).

Uterus transplant is a burgeoning field of transplant surgery that intersects multiple domains and disciplines. It is the only treatment for absolute uterine factor infertility, which affects an estimated one in 500 women worldwide, either by congenital (e.g., Mullerian agenesis) or acquired (e.g., emergent hysterectomy) causes (11). Other than uterus transplant, absolute uterine factor infertility is an incurable condition. The diagnosis of absolute uterine factor infertility is often devastating. It is a life-framing experience that influences patients’ view of themselves and their acceptance by family, partners, and peers, with feelings of grief and social isolation commonly reported (12). For many of these patients, uterus transplant is viewed as a means to gain control of their reproductive autonomy and to play an active role in their prenatal health and well-being (12).

Like face and hand transplants, uterus transplant is not a life-saving procedure. However, uterus transplant is unique in several important ways. Uterus transplant is an ephemeral transplant, meaning that the organ is transplanted with the explicit intention to remove it at a later time, usually following 1-2 live births (13). Uterus transplant, while not life-saving, is life-propagating (14), denoting the potential of pregnancy following uterus transplant, with health implications for not only the recipient, but also future offspring. Uterus transplant involves a donated organ that may no longer be needed or wanted by a living donor, especially if the donor is post-menopausal; “success” in uterus transplant cannot be ascertained until months to years after the transplant procedure has been performed, since, while graft vascular perfusion, lack of graft rejection, onset of menstruation, and pregnancy implantation are all meaningful clinical milestones and can serve as interim markers of success, liveborn children is the ultimate endpoint determining success for all current reported protocols. Finally, while most other forms of organ transplantation involve only two surgeries (procurement and graft reimplantation), a successful uterus transplant involves a minimum of 3-4 surgeries: procurement, reimplantation, cesarean section, and graft hysterectomy.

Given the complex nature of the surgeries and the longitudinal nature of such an endeavor, it comes as no surprise that the successful creation of a uterus transplant program requires significant expertise, as well as extensive coordination between specialties, including transplant surgery, gynecologic surgery, reproductive endocrinology, psychology, bioethics, and high-risk obstetrics. This spirit of collaboration has been further extended across institutions through the establishment of international societies and inter-institutional partnerships dedicated to uterus transplant (15). Such collaborations have been critical for the development of the field of uterus transplant over the last five years.

The next five years promise to continue at a rapid pace of innovation and progress. Future areas of innovation in living donor surgery include the use of smaller incisions and refined minimally-invasive techniques, with the goal of a completely laparoscopic or robotic procurement without the need for laparotomy. Historically, procurement surgeries have been characterized by long operating times, large incisions, and occasional complications for donors. There is also concern for coercion in living directed (known) donors, who may feel that they cannot decline to provide their uterus to a loved one in need (16).
For deceased donor programs, innovation is needed in understanding and enhancing graft tissue preservation during cold ischemia. Although this approach eliminates the potential for physical harm to a living donor, there are important limitations in using a deceased donor model, including the fact that appropriate deceased donors are scarce. For 2017, the U.S. Organ Procurement and Transplantation Network reported only 4,000 female deceased organ donors that year, with only 3,400 donors between 18 and 64 years of age. Considering that many of these potential donors may have had hysterectomy or uterine anomalies, the number of potential donors with a suitable uterus would be even lower (17). Improving availability of deceased donor uteri may include increasing radius for procurement or using so-called “increased risk” donors to widen the pool of available organs.

Both living and deceased donor approaches have distinct advantages and disadvantages, and until more data becomes available, neither model is clearly superior. This represents a state of “bioethical equipoise” in the use of living versus deceased donors. It is unclear whether one or the other model will demonstrate better outcomes alongside an acceptable risk/benefit from an ethical standpoint. In addition, recent studies of women (in both uterus transplant trials and in the general public) suggest no strong preference for either model (18). It is possible that a combination of living and deceased donor models could be the future of the field if uterus transplant is ever to become a mainstream treatment.

For the recipient surgery, there is currently great variability in the approach taken by different teams throughout the world, and the optimal strategies of vascular and vaginal anastomosis need to be discussed, determined, and disseminated. For example, vaginal stricture is a common complication for recipients, and gynecologic surgeons have a role in developing improved vaginal anastomosis techniques. In addition, while current protocols restrict uterus transplant trials to healthy patients of low BMI who were biologic females at birth, the field will inevitably expand to allow patients who are not cisgender females or those who have a higher BMI or other pre-existing comorbidities.

Innovation will be needed beyond the screening clinic and operating theater. The long-term outcomes for donors, recipients, offspring, and other family members will be critical to study in transitioning uterus transplant from an experimental into an accepted medical treatment. Continued work is needed to understand the preferences and attitudes of potential and current uterus transplant patients to ensure they continue to have a voice.

It is also critical that investments are made in the basic and translational science. This is needed to allow for possibilities such as uterus tissue bioengineering and uterus xenotransplantation, future technologies which could alleviate many of the concerns for surgical risks and the limited supply of organs (19, 20). Other future surgical innovations may include the concurrent transplantation of the fallopian tubes, which are typically transected to decrease risk of ectopic pregnancy and reduce time to pregnancy using IVF (4), but if included, could allow for spontaneous conception without the need for IVF and embryo transfer.

There are still many unanswered questions in uterus transplant. Despite recent successes, the field is not without its critics, roadblocks, and challenges. Many of the ongoing concerns regarding uterus transplant revolve around access, cost, and safety. These are questions that must be addressed and answered in the coming years alongside future technical innovations. It should be noted that some of the strongest opponents of uterine transplantation are in fact reproductive endocrinologists, due to their experience with gestational carriers. In addressing these concerns, we must consider uterine factor infertility from both a national and international perspective, and recall that throughout most of the world gestational carriers are illegal, highly restricted, or banned completely. Further, research in uterine transplantation is generating insights into early pregnancy implantation, placentation, reproductive immunology, and myriad other domains that extend well beyond our own.

As more children are born through uterus transplant and the technique transitions from experimental science to standard treatment, the question of cost and coverage will become increasingly important. In addition to the surgery itself, there are the costs of immunosuppression and graft removal, which are not insignificant. For administration of uterus transplant to
be just, it should not only be available to those who can afford it. The question of insurance coverage for uterus transplant is part of a larger debate of whether and to what extent infertility treatment should be covered. Present data suggest that there is support for insurance coverage of uterus transplant among the general public, but this may change once the issue enters more public debate. Interestingly, 60% of AAGL and ASRM members responded with support towards uterus transplant as a potential treatment option with absolute uterine factor infertility, however only 35-40% felt it should be covered by health insurance (21).

The next five years of uterus transplantation promise the same spirit of progress and innovation that characterized the birth of the field. Each phase of this innovative surgical procedure has deepened our understanding of what is required for success and the challenges that lay ahead. The initial years of uterus transplant in humans demonstrated proof of concept that a surgical treatment for patients with uterine factor infertility is possible. In the next 5-10 years, uterine transplant will continue to transition from an experimental possibility to a clinical reality for women with absolute uterine factor infertility. The next phase is certain to be one of refinement, optimization, and continued momentum and innovation.

References:

Reference, cont.

After a complete revamping in 2017, the SRS website expansion and development continues. The sowing of seeds that started last year to expand video content has boosted SRS website content. The SRS textbook now has video content through the reprodsurgery.org website, and we will be developing streaming expert opinion sections for both central and favorite topics. We shortly also will be integrating *Fertility and Sterility* and other video articles into our literature review section.

Beyond continuing standard literature reviews (with particular appreciation to Dr. Stephanie Estes for spearheading a recent series on case volume and outcomes), and increasing activity on the bulletin board (led by Dr. Bala Baghavath and with gratitude to Dr. Anthony Imudia as one of the more frequent posters), we’re also reflecting on growth and engaging the next generation of reproductive surgeons.

One of the greatest opportunities for this is through the website. When reviewing for a journal, the work often performed is seen by exceptionally few people, which limits direct influence of others, as well as anonymizing the hard work these reviews often require. Participating in SRS literature reviews not only allows your colleagues to grow directly from your insights, but also builds connections and gives credit to contributors. If you are interested in participating in these reviews, please let me know (including if you have favorite topics)—we have plenty of articles that deserve greater awareness and expert perspective from SRS members!

J. Preston Parry, M.D., M.P.H.

New updates on reprodsurgery.org!

Feel free to contact the Website Chair, Dr. John Parry (drprestonparry@gmail.com) or Dani Mosley at ASRM (dmosley@asrm.org) with any comments or suggestions you may have regarding the SRS website.

The SRS website, www.reprodsurgery.org, now hosts a variety of informative features and sections ONLY available to active SRS members!

The new update includes a password protected log-in section that includes the following information:

- SRS Email Discussion List
- SRS Literature Reviews
- SRS Newsletters
- Surgical Tutorials Uploaded by SRS members

Please be sure to check the SRS website frequently to see the upcoming and ongoing changes. We value your input and suggestions.
Available now! Order your copy of *Reproductive Surgery: The Society of Reproductive Surgeons’ Manual*

The Society of Reproductive Surgeons (SRS) is excited to announce the publication of a handbook on which the Society collaborated, *Reproductive Surgery: The Society of Reproductive Surgeons’ Manual*. Authored by experts in operative gynecology and urology, the handbook serves as a key guide to understanding modern surgical procedures for female and male infertility.

Edited by SRS members, Drs. Jeffrey M. Goldberg, Ceana H. Nezhat and Jay Sandlow, the manual features step-by-step instructions illustrated with intra-operative photographs and surgical videos designed to increase physician confidence while providing readers with a comprehensive understanding of the indications, techniques, and outcomes of modern reproductive surgery in order to offer patients surgical options and avoid, or improve, IVF.

*Reproductive Surgery: The Society of Reproductive Surgeons’ Manual* is available from the publisher, Cambridge University Press. SRS members will receive a 35% discount on the purchase price of the manual by entering the code “SRS19” at checkout.

**Benefits of SRS Membership:**

- **NEW!** Secured access to SRS newsletters, literature reviews, surgical videos from SRS members, and the SRS Discussion forum! These benefits are only available to active SRS members.
- Involvement in the only society that specifically addresses the issues of pelvic reconstructive surgery in women of reproductive age
- Interaction with a national and international group of surgeons who share an interest in reproductive surgery
- The opportunity to review research abstracts with a focus on reproductive surgery
- Participation in roundtable discussions at ASRM Scientific Congresses
- The discussion of novel surgical techniques through video sessions
- Participation in surgical hands-on courses at ASRM Scientific Congresses
- Access to participate in ASRM Pre-Congress courses on a variety of topics related to the field of reproductive surgery
- Participation in collaborative research projects addressing surgical outcomes
SRS has established a one-year fellowship program in minimally-invasive reproductive surgery. The enthusiasm of REI fellows at the annual SRS Surgical Boot Camp and the favorable results of an online survey of REI fellows demonstrating their desire to obtain surgical training after REI fellowship were the impetus to develop this program. It is essentially a one-year preceptorship with a high volume, master reproductive surgeon. Our first fellow in the program is Dr. Pavan Ananth, M.D., who is currently under the training of Dr. Ceana Nezhat.

The following are programs currently accepting applications for 2019-2020:

- **Nezhat Medical Center**, Atlanta, GA, Program Director: Ceana Nezhat, M.D.
- **Camran Nezhat Institute**, Palo Alto, CA, Program Director: Camran Nezhat, M.D.
- **The Advanced Gynecologic Surgery Institute**, Park Ridge, IL, Program Director: Charles Miller, M.D.

Since most REI fellows are not receiving adequate training in reproductive surgery, SRS has created this fellowship to provide them with needed skills. It is our intention that graduates of the program will deliver excellent surgical care to their patients, and will then teach these skills to their trainees to benefit the next generation of patients. Hopefully, they also will become actively involved with SRS to assure the future of reproductive surgery.

There is good evidence-based data showing that reproductive surgery is more cost-effective than IVF in many cases, and is often preferred by patients as it is more “natural” than IVF. Reproductive surgery also is complimentary to IVF, as the surgical management of pelvic pathology can improve IVF results. It is unfortunate that many REIs have abandoned reproductive surgery or relegated it to general or minimally-invasive gynecologic surgeons. Reproductive surgeons have a different skill set and approach to surgery which could lead to improved outcomes. REIs who can operate are more “complete” physicians who can offer their patients all of the available treatment options.

Interested applicants for the Minimally-Invasive Reproductive Surgery Fellowship can find information on the SRS website at https://www.reprodsurgery.org/about/fellowship-1. Interested preceptors also can find information on the website.

Jeffrey M. Goldberg, M.D.