Dear SRS Members:

I am excited to bring you the 2021 Spring edition of the SRS newsletter. While we wish we can delete the last year from our memory, the last 12 months brought some exciting and positive news. Our newly elected president, Dr. John Petrozza, continues to be actively involved in the ASRM COVID Taskforce, which released much needed guidelines and recommendations.

Despite the unprecedented challenges, the ASRM annual meeting was held virtually; SRS members had many exciting presentations and plenary sessions.

More importantly, we were able to successfully do our first virtual Boot camp; the feedback from the different fellows was amazing.

As promised in my first newsletter, we continue to bring you an international perspective to reproductive surgery. I hope you enjoy reading the article titled “The hymen conservation: what seems obvious to some, can become complicated to others.”

In our urology corner, our newly elected board member and recent graduate course, as we typically do, our other sessions were well-attended. In fact, our session on transgender surgery and fertility counseling, moderated by Dr. Linnea Goodman was selected as the REI fellow’s teaching session. With a program that continued to focus on the standard themes of endometriosis, fibroids, and adenomyosis, this past meeting also delved into updates with uterine transplantation, uterine transposition for women prior to pelvic radiation therapy, and the need for reproductive surgical training in resources-poor areas. Our plenary speaker, Dr. Alfred Murage, a reproductive endocrinologist, and surgeon from Kenya, wonderfully highlighted the need for a more global presence of not only assisted reproductive technologies, but also reproductive surgery.

To this end, SRS is in the process of establishing an International/Global Health Committee to engage REIs and reproductive surgeons from across the globe to engage membership, collaborate on educational endeavors and research, increase diversity, and to foster discussion and areas of need, not only in the United States, but across the globe. It is an ambitious project, which...
The 6th annual SRS/SREI Surgical Boot Camp rose to the challenges of the COVID-19 pandemic by transitioning to a completely virtual format in 2021. The event, which took place on 23-24 January 2021, received resoundingly positive reviews from instructors and fellows alike. Unlike many conferences, which center around a classic didactic tradition, the boot camp has historically been a “hands-on” event. Despite this, REI fellows and dedicated staff were able to engage in a dynamic and energetic weekend, where key principles in reproductive surgery were relayed through the use of innovative surgical videos and interactive lectures. The boot camp was able to retain the energy and educational value of a “live” event through this change in format. More than 40 fellows from REI programs around the country attended the first day of lectures and discussion; 12 fellows registered for the second day of virtual surgical simulations and training.

The Co-chairs for the course were Dr. Kathleen Hwang (University of Pittsburgh School of Medicine) and Dr. Pres Parry (Parryscale Fertility). The course was supported by SRS President Dr. John Petrozza, SREI President Dr. Ruben Alvero, ASRM President Dr. Hugh Taylor, and ASRM CEO Dr. Ricardo Azziz. Dr. Azziz gave an energetic and inspiring talk regarding “Pathways to Executive Leadership in Healthcare.” The course sponsor, Inception Fertility, shared a presentation illustrating valuable industry insights and perspectives within the field of reproductive medicine.

To be successful in surgical education within a virtual format, significant emphasis was placed on surgical videos detailing techniques that in prior years were taught through PowerPoint slides and hands-on demonstrations. The high-quality videos and pictures sharing step-by-step techniques reinforced the notion that “a picture (or in this case, a video) is worth a thousand words” in the sphere of surgical education. This included not only the “how” of performing procedures; tips and tricks are also given to ensure better, safer, and faster performance in the operating room.

The topics of the boot camp were wide-ranging, including surgical basics such as port placement, patient positioning, choosing a surgical approach, and pre- and post-operative considerations. In addition to the co-chairs and leaders listed above, the all-star faculty included Drs. Bala Bhagavath, Stephanie Estes, Steven Lindheim, Rebecca Flyckt, Linnea Goodman, Samantha Pfeifer, Mindy Christianson, Divya Shah, and Ceana Nezhat. Advanced sessions included presentations on hysteroscopy and the challenging cervix, management of Mullerian anomalies, the performance of complex uterine, pelvic, and ovarian surgeries, the retroperitoneal approach, avoiding complications, and beyond.

A conscious effort was made this year to help fellows both navigate entry into a surgical practice in contract negotiations and engage in networking and interactions with teaching faculty in smaller and more intimate sessions. Leveraging the bells and whistles of our new format of zoom meetings, we had both larger group experiences with asynchronously recorded lectures coupled with interactive synchronous Q&A within the chat boxes as well as smaller group experiences involving breakout rooms with individual faculty. Each of these features received highly favorable reviews from attendees.

The second day of the boot camp was a completely novel offering of a

CONTINUED ON PAGE 3
Also, this year, SRS has joined forces with SREI and SART to collaborate more on education, marketing, and other endeavors. Joe Findley, MD, is our delegate to SART while Ranjith Ramasamy, MD, is our delegate to SREI. Since SRS strove to have a urologist on their executive board, the relationship between SRS and SMRU has always been strong; now with our other delegates, the crosstalk between our Affiliate Societies will be vastly improved.

Our SRS/SREI REI Fellow’s Boot Camp was a resounding success, thanks to the direction of Kat Hwang, MD and Pres Parry, MD, co-directors for this year’s program. Imagine taking a two-day course, usually held in Houston, Texas, at the Houston Methodist Institute for Technology, Innovation & Education, where fellows work tirelessly on cadavers, simulators, and listen to lectures from some of the top reproductive surgeons in the country.

remote “hands-on” course. Despite the challenge of remote learning, the course was met with unequivocally favorable reviews and offered highly engaging skills-based training with an emphasis on being hands-on all the time. Gynesim, a non-profit surgical education and training company, partnered with ASRM to provide the curriculum and the training models for this intensive advanced laparoscopic training. Twelve REI fellows attended this pilot hands-on session, which was led by Malcolm “Kip” Mackenzie from Gynesim and Drs. John Petrozza and Mindy Christianson. The first half of the day focused on key laparoscopic suturing skills that included needle loading, knot tying, and various suturing techniques. The second half of the day focused on fellows performing laparoscopic procedures on Gynesim tissue models.

Each fellow and instructor had a uterine tissue model that they were able to work with remotely; fellows received real-time feedback and tips as they operated. Procedures taught and performed by fellows during the hands-on course included laparoscopic myomectomy, C-section isthmocele repair, ovarian transposition, and ovarian cystectomy. One benefit of the hands-on course, performed via Zoom, was that fellows needing additional instruction could go into a breakout room to work one-on-one with an instructor. Fellows reported being impressed with how the realistic models provided an opportunity to practice their laparoscopic surgery skills with specific skill training.

Overall, the 2021 boot camp was a tremendous success in the context of completely new organizational and technical formats. This year’s bootcamp was made possible by the generous support of the ASRM and the SREI. We are thankful to our administrative team, led by the incomparable Susanna Scarbrough, Dani Mosley, and Keith Ray, as well as generous support from our industry sponsors including Inception Fertility, Hologic, Karl Storz Endoscopy, and LINA Medical. We appreciate our supporters and look forward to planning next year’s event. We hope that the next bootcamp will resume in person in January of 2022 at the MITIE Center in Houston.

Despite an unusual year, the legacy of advanced reproductive surgery lives on through the commitment of the SRS and SREI teams and the exciting platform of the yearly fellow bootcamp.

Finally, the SRS Fellowship Committee, led by Drs. Mindy Christianson, Rebecca Flyckt, Ranjith Ramasamy, and Steve Lindheim has completed months of work in creating the new “Surgical Scholar’s Tract.” This program will enable REI fellows interested in developing a surgical niche, access to surgical lectures, surgical mentoring, research collaboration, and career guidance... all within a fellow’s designated REI fellowship program that has adequate surgical volume, a designated point of completely new organizational and converting this learning experience to a completely virtual format. As this newsletter shows, a virtual hands-on course with actual tissue models was elegantly done that was innovative, inspiring, and a look into how SRS can continue to provide surgical education to our fellows, mid-career providers, and our international colleagues. Also, this year we presented the inaugural Nezhat Lectureship, a tribute to Dr. Ceana Nezhat, former SRS President and instrumental in creating the surgical boot camp.

I hope you enjoy this newsletter, with special thanks to Dr. Rony Elias and SRS Coordinator, Dani Mosley, for their work on putting this together. As you can see, SRS continues to be a thriving, active, innovative, and more importantly, relevant society.

Sincerely,
John C. Petrozza, M.D.
SRS President
International Corner: The hymen conservation: “what seems obvious to some, can become complicated to others”

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Introduction

Vaginal surgery is one of the safest and easiest approaches to treat many gynecological pathologies including intrauterine, cervical, and vaginal lesions. It is also a common way to evaluate many congenital anomalies associated with vaginal malformations. One of the most common situations is the excision of cervico-vaginal pedunculated fibroids that account for 5% of total myomas. It is also helpful to treat less common scenarios such as transverse vaginal septum with hematocolpos, associated or not, with other malformations such as Obstructed Hemitrigon in and Ipsilateral Renal Agenesis OHVIRA Syndrome.

Nevertheless, what seems obvious and easy in most of the countries can become complicated in many others. In some societies in the Middle East, virginity is still considered a sign of integrity and honor, thus preserving the integrity of the hymen during any surgical procedure is of utmost importance.

The vaginal fibroids are common, and because of the high incidence of congenital anomalies in the Middle Eastern countries, we are more often facing this barrier to our classic vaginal route. Hence, we have to improvise alternative techniques to shortcut the problem of hymen preservation and still be able to offer the patient the best surgical solutions.

The case series

In 2016, we published our first alternative technique to treat a prolapsed pedunculated submucous leiomyoma, which was associated with symptomatic anemia in a 20-year-old virgin patient. On gynecologic examination, inspection showed normal vulvar area with annular intact hymen. Abdominal examination was unremarkable. Rectal examination revealed significant vaginal fullness. Laboratory tests showed anemia, as hemoglobin was 8 g/dl. Pelvic ultrasound revealed a 5×5 cm solid hypo-echoic mass in the cervico-vaginal zone, well-delineated, filling the vaginal margins, clearly out of endometrial cavity. Uterus and adnexa were normal. Pelvic MRI confirmed the ultrasound findings and suggested that this mass was most likely to be a prolapsed pedunculated submucous leiomyoma.

Surgical removal of the myoma via vaginal approach was offered to the patient as a first-line surgical option. The patient was informed that her hymen integrity can be lost during the procedure, and a hymenal repair can be done directly after the termination of the intervention. The patient and her family refused the vaginal approach. Due to the patient’s desire for preserving hymenal integrity, a laparoscopic abdominal approach was performed.

Inspection showed a normal uterus, adnexa, and pelvic surfaces. A bulky appearance located under the posterior vaginal wall was noticed. The uterus was sutured to the anterior pelvic wall in order to have better exposure and enough access to the Douglas pouch, because the introduction of uterine manipulator was not possible in this virgin patient. A vertical posterior colpotomy was performed. A firm regular pedunculated mass (Figure 1) was identified and delivered through the incision after coagulation using...
bipolar electrocautery and section of its peduncle. A 5×5 cm mass was removed and extracted by an electrical morcellator. Vaginal defect was repaired with absorbable Vicryl 0 laparoscopic simple sutures (figure 2). Histopathologic evaluation showed a benign leiomyoma with degeneration changes. The postoperative course was smooth; the patient was discharged without any complications 48 hours after the surgery.

Two years later, another young patient consulted for a similar situation with a symptomatic vaginal fibroid of 4x4 cm. During the imaging investigation, the patient also had small bilateral endometriomas. The same technique was proposed and accepted by the patient and her family. Upon our laparoscopic entry, we were surprised to have a frozen pelvis due to her endometriosis. The cul de sac of Douglas was totally filled with adhesions, preventing us to proceed with our predescribed posterior colpotomy (Figure 3). Once again, we improvised and decided to dissect the bladder anteriorly, until we identified the vaginal bulging due to the mass effect. We performed then an anterior vertical colpotomy instead and extracted the fibroid through the peritoneal cavity (Figure 4). The colpotomy was repaired with interrupted Vicryl 0 sutures.

In 2019, we published another alternative technique, this time, to treat a more complicated situation of a symptomatic hematocolpos associated with OHVIRA syndrome in a young 16-year-old virgin patient (5).

The patient was referred to our clinic for primary amenorrhea, chronic pelvic pain, and cyclic painful distension of the lower abdomen. Physical examination showed a normal stature lady with normal breast, axillary, and pubic hair development. Inspection of genital area showed normal external genitalia. The patient and her family insisted on respecting her virginity; they refused the speculum examination and the bimanual pelvic examination as they would disrupt the hymen integrity. A digital rectal examination revealed a palpable soft mass occupying the vagina. The transabdominal ultrasound showed two uterine cavities, with fluid collection seen in the right one, a vaginal collection of 6 · 4 · 4 cm, and the absence of the right kidney. A pelvic magnetic resonance imaging showed anatomical features compatible with OHVIRA syndrome: a didelphic uterus along with a dilated right endometrial cavity contiguous with a right obstructed hemivagina. An exploratory laparoscopy and hysteroscopic resection of the septum through vaginal approach were offered to the patient. She was informed that her hymen integrity can be harmed during the procedure, and a hymenal repair can be done directly after the termination of the intervention. She and her family absolutely refused the vaginal approach. We proposed thereafter a laparoscopy-assisted vaginal resection
of the septum. The surgical inspection confirmed the presence of a didelphys uterus with a dilated right cavity, along with normal adnexa and pelvic surfaces. A small posterior colpotomy was performed through which the obstructed hematocolpos was drained and washed. A fenestrated grasping atraumatic forceps was introduced to gently push the high vaginal septum downward, reaching the hymenal ring from inside and making it accessible for a classical resection/marsupialization without harming the hymen (Figures 5 and 6). The vaginal defect was repaired with absorbable laparoscopic simple sutures. The postoperative course was uneventful, and the patient was discharged without any complications 48 hours after the surgery.

Discussion

The conservation of an intact hymen has an undeniable social value in the conservative societies. The inability to confirm virginity on the wedding night may have serious social impact on women (7). Consequently, surgical techniques requiring the use of medical instrument through the hymen in virgin women are unacceptable; although, the risk of harming the hymenal integrity is low. It is a limiting and challenging factor for gynecologists in diagnosing and treating several illnesses. Other safe surgical alternatives, taking into consideration the patient’s desire and informed consent, should be considered.

Vaginal myomectomy is the treatment of choice for prolapsed pedunculated submucous myoma with a minimal associated morbidity (8). Hysteroscopy with the vaginoscopic approach is also feasible, quick, and a well-tolerated intervention. Few reports discussed the protection of hymenal integrity during operative vagino-hysteroscopy (9). The hysteroscopic approach is usually successful for resection of small pedunculated submucous myomas. However, this technique is limited while operating on large masses. In our case, the size of the myomas was too big to consider a vaginoscopic hysteroscopic conservative approach.

Mini-laparotomic anterior colpotomy has been described as a hymenal integrity sparing technique for the excision of a cervico-vaginal pedunculated submucous myoma in a virgin lady (10). Nevertheless, in the presence of a skilled laparoscopic surgeon, a minimal invasive approach is a safer alternative to laparotomy with shorter stay and better outcomes.

In the first case, we proceeded by posterior colpotomy due to the easier access to the vaginal fibroid and the unnecessary dissection of the bladder with the anterior approach. Suturing the uterus to the abdominal wall is a key step to facilitate the exposure. In the second case, the posterior access was impossible because of the endometriosis. We decided then to reproduce the pre-described laparotomic anterior access, this time with the advantage of the laparoscopic approach. The bladder was dissected to have enough access to the colpotomy, the extraction, and the vaginal suturing.

Both patients were discharged without complications 24 hours after the surgery.

Vaginal septum can be isolated or associated with other malformations such as OHVIRA syndrome. The vaginal access remains the “gold standard” route in the management of vaginal septum. However, different factors such as septum position, anatomic obstacles, or patient’s consideration regarding their hymenal integrity limit this approach.

That is why we thought of “bringing” the high vaginal septum to behind the hymenal ring with a laparoscopic assistance. We also suggest that this step can be useful even in non-virgin women. When the septum is highly situated and the hematocolpos is not bulging enough, it is difficult for the surgeon to start the vaginal incision, risking an injury to the bladder anteriorly or to the rectum posteriorly. With the laparoscopic grasper introduced through a small posterior colpotomy by pushing downwards the septum, it is easy to identify our landmarks and make the first cut to the septum, avoiding injuries to the nearby structures.

In conclusion, we as health care professionals are providing not only the physical, but also the psychological support for our patients. Respecting some important social considerations may limit our classical approaches. With the advance of instrumentations and the continuous improvement of our skills, we can overcome such problems. “Even when it seems complicated to some, it is still obvious and easy to others.”
References


NOTE FROM THE EDITOR, CONT.

ASRM New Investigator Award recipient, Dr. Ranjith Ramasamy, and his group published an exciting article about "crossed vasoepididymostomy."

Finally, as vaccination rollout is progressing, soon our young, healthy, and reproductive patients will become eligible. Therefore, I encourage you to stay up to date with the ASRM Task force recommendations (last updated February 22), especially as they relate to scheduling non-urgent procedures around the vaccination.

Best regards,

Rony T. Elias, M.D.
The use of vasoepididymostomy is typically reserved for vasectomy reversal. About 6-10% or 30,000 vasectomies are reversed annually; as a result, vasoepididymostomies are relatively common [1]. The majority of these well-documented and common cases are corrected by traditional ipsilateral anastomosis. This is where a patent abdominal vas deferens and a dilated epididymal tubules are found ipsilaterally; these are able to be conjoined without much worry of anatomic differences risking proper anastomosis. In cases where a vas deferens is not patent or dilated epididymal tubules are not seen, reconstruction on the same side is not possible, and a crossed vasoepididymostomies can be considered. (Figure 1)

We describe a case of crossed VE and believe that this is an uncommon operation that allows couples the opportunity for natural conception. We document the steps for a practical approach to the operation.

Case

A 37-year-old male with a history of infertility of three years presented with his wife, who is 32 years old, with a desire to conceive naturally after his vasectomy that was 7 years prior. His wife had regular menstrual periods with an otherwise normal work-up. The couple has a two-year-old child with previous IVF and percutaneous epididymal sperm retrieval but had ovarian hyperstimulation syndrome; they did not want to pursue IVF again.

The patient has no pertinent medical or social history. There was no history of cryptorchidism, testosterone usage, infection, trauma, and toxin/chemical exposure in the man. Physical exam demonstrated bilateral testis size of 24 mL, and mild induration of the epididymal head. Vasectomy sites were palpable.

Semen analyses showed (1) a volume of 2mL, pH 8.0, azoospermia and (2) volume of 2 mL, pH 9.0, and azoospermia. Hormonal evaluation showed FSH of 2.2 mIU/mL, LH of 3.9 mIU/mL, and a testosterone of 562 ng/dL. Genetic evaluation showed 46, XY with no Y chromosomal micro deletion.

During the procedure, following sequential vas deferens patency assessment and epididymal tubule evaluation, a diagnosis of obstructive azoospermia via epididymal obstruction was made. One of the vasa was not patent, despite serial examinations likely due to extensive use of cautery at the time of vasectomy. The epididymal tubules were flat and scarred on the contralateral side likely due to multiple attempts at needle passage during percutaneous epididymal sperm retrieval.

Surgical plan of crossed vasoepididymostomy was made with specific prioritization and requirements of crossover vas deferens length, contralateral dilated epididymis, and sperm presence in epididymis. We successfully performed a crossed anastomosis between the right vas deferens to the left dilated epididymal tubules. We are waiting semen analysis results from the man after 6 weeks of prednisone (anti-inflammatory) medications.

### Urology Corner, cont.

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<tr>
<th>FINDINGS</th>
<th>RIGHT SIDE</th>
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<td><strong>ABDOMINAL END OF VAS DEFERENS</strong></td>
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<td><strong>EDPIDIDYMIS</strong></td>
<td>![Image of flat tubules]</td>
<td>![Image of dilated tubules]</td>
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**Figure 1**

**Figure 2a**

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*Images depict surgical findings. The table compares findings on the right and left sides for the abdominal end of vas deferens and epididymis.*
**Urology Corner, cont.**

*Figure 2c*

*Fig. 2 (Sequential images showing Crossover of R. Abdominal Vas to Contralateral Left Side)*
Urology Corner, cont.

Fig. 3 Invagination formation indicating successful crossover vas + dilated epididymal tubule anastomosis

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
The SRS website has continued to deliver literature reviews and generate conversation regarding unique cases on the discussion boards. This summer/fall, we are focusing on seminal contributions made in the field of endometriosis.

We are continuing to evolve and are in the process of partnering with the SART Electronic Communications Committee (ECC) to form a more robust group that can have representation in both SART and SRS. We are planning to re-vamp the SRS electronic presence by adding monthly case reviews and commentaries on the latest reproductive surgery related articles. We will be seeking volunteers to join the SRS Electronic Communications Committee as well. The hope will be to generate academic debate on surgical technique and share pearls of excellence. If you are interested in contributing surgical videos or literature reviews, email me at khan.zaraq@mayo.edu or dmosley@asrm.org (Dani Mosley).

Zaraq Khan, M.D.
SRS Electronic Communications Committee Chair

**Reproductive Surgery: The Society of Reproductive Surgeons’ Manual available now! Order your copy today!**

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, at www.cambridge.org. SRS members will receive a 35% discount on the purchase price of the manual by entering the code “SRS19” at checkout.
Minimally Invasive Reproductive Surgery Fellowship Update
Steven R. Lindheim, M.D.

SRS established a 1-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 1-year preceptorship with a high volume, master reproductive surgeon.

The following are the programs currently accepting applications for 2020-2021:
- Nezhat Medical Center, Atlanta, GA, Program Director: Ceana Nezhat, MD
- Camran Nezhat Institute, Palo Alto, CA, Program Director: Camran Nezhat, MD
- The Advanced Gynecologic Surgery Institute, Park Ridge, IL, Program Director: Charles Miller, MD

Since most REI fellows are not receiving adequate training in reproductive surgery, SRS has created this fellowship to provide them with the 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.