Dear SRS Members:

The ASRM annual meeting will be held in Anaheim, California, between October 22-26, 2022. Our society will host a Postgraduate Course, chaired by our Vice President, Dr. Parry, a Plenary Session, roundtables, and interactive sessions.

In our Gynecology Corner, we describe an uncommon but challenging surgical approach to hysteroscopic interstitial ectopic pregnancy resection.

Our Urology Corner includes a valuable guide to office-based sperm extraction procedure as described by Dr. Brems and Dr. Coward from the University of Carolina.

Finally, we are starting a series of interview with current fellows and program directors of the newly established SRS Surgical Scholars Track Fellowship. The first interview will be with Dr. Rebecca Flyckt, Program Director at University Hospitals, and her current fellow Dr. Kathryn Coyne. I continue to encourage any interested programs to contact the fellowship chair, Dr. Steven Lindheim.

I am happy to bring you the 2022 first edition of the SRS Newsletter. As usual, the newsletter starts with a message from our President, Dr. Kathleen Hwang.

Dear Colleagues!

I am thrilled and excited to write to you as the President of SRS. It is an honor to serve in this position and work with an incredible group of individuals, and I am so proud of what we have accomplished together.

The 2021 Annual Congress was a success in Baltimore, Maryland with SRS well represented. With a program theme of Reproduction Reimagined many innovative lectures were given on personalized medicine, in vitro gametogenesis, and applications of nuclear transplantation. SRS sessions were focused on adenomyosis, a multidisciplinary approach to endometriosis, approaching C-section scar defects, and Asherman’s. Our plenary speaker, Dr. Dan Martin, a reproductive endocrinologist, and surgeon from the University of Tennessee, gave a wonderful and inspiring talk on “A History of and Future for Endometriosis Surgery- What I Wish I had Known in 1979”.

The SRS/SREI Fellow’s Bootcamp was a resounding success under the successful direction of co-directors Mindy Christianson, MD and Ranjith Ramasamy, MD. With a full virtual program due to global landscape of living with SARS-CoV-2 in 2020, we were unsure if the program would be safely offered in person again. After multiple program drafts, the final program was an unbelievable in-person program held in Houston, Texas at the Houston Methodist Institute for Technology, Innovation & Education, where 32 fellows worked tirelessly on new tissue models, simulators, and listened to lectures from top reproductive surgeons in the country. It was an incredible time and our SRS team is busy planning the next Bootcamp already.

The SRS Fellowship Committee, led by Drs. Mindy Christianson, Rebecca Flyckt, Zaraq Khan, and Steve Lindheim developed the Surgical Scholar’s Track (SST) which enables REI fellows interested in developing a surgical niche has taken off with resounding success.

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**Introduction**

The vast majority of tubal ectopic pregnancies implant within the ampulla (70%), and a minority implant in the interstitial (2.4%), isthmic (12.0%), and fimbrial (11.1%) portion of the fallopian tube. By definition, interstitial pregnancies are located in the proximal intramural part of the fallopian tube, which is approximately 0.7 mm wide and 1-2 cm long. Due to their unique location, unruptured interstitial pregnancies are difficult to diagnose pre-operatively. Further, the myometrium surrounding interstitial pregnancies protects them from rupture as they expand, sometimes past the first trimester. As a result, these pregnancies often remain occult until later gestational ages, when ectopic rupture can be catastrophic due to their rich vascular supply. Thus, prompt diagnosis and swift management are hallmarks in caring for patients with these particularly hazardous ectopic pregnancies.

**Case**

We present the case of a 38-year-old female patient who underwent a natural frozen embryo transfer of a single blastocyst. Her beta human chorionic gonadotropin (hCG) trend was unremarkable: 77 mIU/mL (day 29) to 243 mIU/mL (day 31) to 1,790 (day 36). However, at her initial pregnancy ultrasound (day 37), she was noted to have a 2 mm area of trace nonspecific fluid in the left cornua and a 2.7 cm extraovarian structure suspicious for an ectopic pregnancy (Figure 1). She was counseled on management options and elected to undergo a laparoscopic left salpingectomy. Intra-operatively, an irregularly shaped/dilated left fallopian tube was visualized and excised (Figure 2).

After her laparoscopic salpingectomy, her beta HCG continued to rise from 3,698 on post-operative day #1 to 5,583 on post-operative day #3. A follow-up ultrasound demonstrated what was described as a “left cornual pregnancy” (Figure 3).
The patient was consented for a laparoscopic, and possibly hysteroscopic, resection of the left cornual pregnancy. After laparoscopic entry, a pelvic survey revealed a normal-appearing left cornua without any pathologic features (Figure 4). A hysteroscopic evaluation of the uterine cavity revealed a small portion of the ectopic pregnancy emanating from the left ostia and protruding into the uterine cavity. This was resected using a monopolar device (Figure 5) under laparoscopic guidance. The estimated blood loss during the resection was less than 5 mL. After complete resection of all visible gestational tissue, a transvaginal ultrasound revealed approximately 1 cm of myometrial thickness between the site of resection and uterine serosa. In addition, the laparoscope confirmed the absence of any uterine rupture or bleeding.
Three weeks after the hysteroscopy, the patient had a vaginal sonogram that showed a normal endometrial stripe and myometrium.
Three months later, she underwent a natural frozen embryo transfer cycle which resulted in a live intra-uterine pregnancy.

**Discussion**

This case highlights the challenges in diagnosing and treating interstitial pregnancies, which must first be distinguished from cornual and angular pregnancies. Much confusion surrounds these three terms, and they are often used interchangeably.

Interstitial pregnancies implant in the interstitial portion of the fallopian tube and are characterized by the following sonographic features: (1) an empty uterine cavity, (2) a chorionic sac that is separate and >1cm from the uterine cavity, (3) a thin myometrial layer surrounding the chorionic sac, and (4) an “interstitial line sign.” The term “cornual pregnancy” was traditionally reserved for gestations within a septate or bicornuate uterus; however, many sources consider implantation in the superolateral region of any uterine cavity to be “cornual.” The term “angular pregnancy” is used less frequently and refers to “implantation within the lateral angle of the uterus, medial to the uterotubal junction.” Unfortunately, this nomenclature is far from standardized. To further complicate the matter, gestational tissue may traverse the uterotubal junction and lie partly in the interstitial fallopian tube and partly within the endometrial cavity. For these reasons, the literature fails to provide precise guidance on management approaches for these eccentrically-located gestations.

Our patient ultimately was diagnosed with an interstitial pregnancy. It was not visualized laparoscopically, and the resected isthmic, ampullary, infundibular, and fimbrial segments of the fallopian tube did not contain gestational tissue on pathologic exam. This, in addition to her rising beta HCG, prompted further imaging which more convincingly revealed a pregnancy somewhere along the uterotubal junction. Although we initially planned for a laparoscopic resection, we found that the interstitial pregnancy was best approached hysteroscopically.

Treatment goals for interstitial pregnancies include resection of gestational tissue, maintenance of hemostasis, and uterine preservation. Historically, interstitial pregnancies were treated with laparotomy followed by cornual resection or hysterectomy, likely due to delayed diagnosis. The ability to diagnose interstitial ectopic pregnancies earlier has allowed for more conservative measures such as local or systemic methotrexate and laparoscopic resection. To our knowledge, the first hysteroscopic resection of an interstitial pregnancy was reported in 1989. Since then, there have been a handful of reports of successfully treating interstitial pregnancies hysteroscopically. In one case, a dilation and curettage failed to evacuate what was thought to be a missed abortion, and intra-operative ultrasound revealed an
interstitial pregnancy that could not be reached by the suction curette. The procedure was aborted, and after medical management with methotrexate, persistent gestational tissue was removed hysteroscopically. In another case involving a combined hysteroscopic-laparoscopic approach, initial hysteroscopic evaluation revealed an empty uterine cavity. The interstitial gestation was then milked into the uterine cavity using atraumatic laparoscopic graspers, then completely resected hysteroscopically.

While laparoscopy and/or laparotomy appear to be the favored surgical approach for interstitial pregnancies, hysteroscopy should also be considered. As described above, some interstitial pregnancies are more easily accessed through the uterine cavity.

References

Message from the President, Cont.

There are a total of 7 programs participating with 10 fellows from across the country. The program continues to grow and feedback from participating programs and fellows is outstanding.

SRS has sponsored a new traveling scholar program for the ASRM 2022 program. This new educational program provides an opportunity for any trainee in reproductive surgery and whose abstract submission focuses on reproductive surgery to expand their educational and networking experience in the field. Two traveling scholars, one focusing on female reproductive surgery and the second focusing on male reproductive surgery, will be awarded registration for the ASRM 2022 annual meeting in Anaheim, one roundtable luncheon, one Post graduate course, and one-year memberships to ASRM and SRS.
I’m excited to share that SRS will have a new networking event and reception at the ASRM 2022 meeting in Anaheim on Tuesday afternoon to not only highlight all of our awardees and fellows and their research, but to also allow our members to meet all of the trainees who are excited about reproductive surgery who are the future of our field.

A special thanks to Dr Rony Elias and SRS Coordinator Megan Miller, for their work on putting this together. SRS is thriving and growing.

The future is bright. I look forward to seeing all of you in Anaheim!

Kathleen Hwang, MD

Introduction

Sperm retrieval for obstructive azoospermia (OA) has evolved over the past several decades since the initial epididymal sperm aspiration used with IVF in 1985. OA may be caused by a myriad of genetic or acquired factors such as congenital bilateral absence of the vas deferens (CBAVD), cystic fibrosis, vasectomy, bilateral inguinal hernia repair, or infection. Contemporary techniques for sperm retrieval for OA include testicular sperm extraction (TESE), testicular sperm aspiration (TESA), percutaneous epididymal sperm aspiration (PESA), percutaneous vasal sperm aspiration (PVSA), microsurgical epididymal sperm aspiration (MESA) and minimally invasive epididymal sperm aspiration (MIESA).

It is important to consider the individual patient with the advantages and disadvantages of each approach. While a percutaneous technique may allow for minimal anesthesia, it can be advantageous to directly visualize the tubules from which sperm are being extracted, such as in the patient with CBAVD. Evaluating for proximal tubular aspiration yields higher quality motile sperm, and epididymal sperm is preferred by embryologists for ease of processing and handling. Consideration must also be given to the quality and quantity of sperm retrieved. Whereas testicular sperm may be advantageous in cases of elevated sperm DNA fragmentation, comparison of epididymal and testicular sperm has demonstrated a higher live birth rate with epididymal sperm in men with OA. Further, recent evidence supports equivalent live birth rates between epididymal sperm from men with OA and ejaculated sperm from unobstructed males.

The surgeon should be familiar with the unique circumstances of each patient when deciding on the approach. The optimal technique would prioritize several key features: fast patient recovery, short procedure time, high amounts of high quality sperm for cryopreservation retrieved in a single procedure, minimal/no special equipment (i.e. operating microscope), ease of transition to rescue testicular sperm with TESE if necessary, and the ability to be performed in an office-based setting without general anesthesia. We find that a minimally invasive MESA (MIESA) allows for the ideal combination of these and describe the technique here.
Technique

Anesthesia for the MIESA can be done under local or MAC. Local anesthesia allows for decreased risk, decreased cost, and flexibility of location where it can be performed. The majority of patients elect for local anesthesia to defray some expenses of fertility treatment. We provide oral Lorazepam, Cefalexin, and Meloxicam prior to the procedure. A spermatic cord block is performed using 1:1 1% lidocaine plain and 0.25% bupivacaine. Before the needle is withdrawn, the lateral and inferior edges of the scrotum are injected for a superficial pudendal block, using a total of 10 mL given from this single needle puncture. A second injection of 5 mL is given at the incision site, approximately 1 cm transverse on the upper hemi-scrotum over one testis. This injection should be between the dartos and epidermis, producing a bleb under the skin beneath the marked incision. The combination of these two injections provides substantial anesthesia that the patients may be awake and comfortable throughout.

After the incision is made, the dissection is carried down to the tunica vaginalis which is opened with electrocautery, and the edges are tagged with hemostats for ease of identification in closure. It is important to enter on the superior aspect of the testis to make delivery of the head of the epididymis easier. An eyelid retractor is placed inside the tunica vaginalis to maintain exposure. This window allows for exposure and mobility of the testis and epididymis, the latter of which can be gently grasped with toothed adson forceps and secured into the field with a 3-0 chromic stay suture for traction after a 1 mL epididymal block is given along the junction of the epididymal tunic to the testis (Fig. 1).

Loupe magnification provides enough clarity to identify and characterize the dilated tubules of the epididymis, obviating the need for a surgical microscope. The surgeon uses their non-dominant hand to grasp the epididymis between their thumb and forefinger. A 15 degree double-beveled ophthalmic blade is used to incise the dilated tubules in the upper mid-pole or head of the epididymis, and a 1.0-mL tuberculin syringe with a 24- gauge angiocatheter tip primed with 0.1 mL of sperm wash medium is used to aspirate the contents that are compressed out (Fig. 2). A slide is passed off for analysis by an andrologist to identify the quantity and quality of sperm (Fig. 3). Once a site with adequate motility is observed (we prefer roughly greater than 40%), typically 4-6 epididymotomies are made from that site and proximally toward the efferent ducts in order to adequately decompress the head of the epididymis. Multiple syringes are used for aspiration and passed to an assistant who empties them into a test tube with 3 mL of sperm wash media before priming them again and placing them on the mayo stand for reuse. A final measurement of concentration and motility of the extracted sperm in the test tube can be obtained, often approaching that of a semen analysis. Once the epididymis has been drained, spot electrocautery is used for hemostasis. If the epididymis proves inaccessible, unobstructed, or high quality sperm are not readily retrieved, we return the epididymis and then quickly pivot to a standard TESE from within the same incision.

The tunica vaginalis, dartos, and skin are closed in separate layers using a single 3-0 chromic suture (Fig. 4). Bacitracin, telfa gauze, and a scrotal support with additional Kerlix placed onto the anterior scrotum provide support and hemostasis. Patients are able to walk out of the procedure room and have minimal post-operative pain rarely requiring any opiates for pain control.
Figure 1
The eyelid retractor is placed to keep the tunica vaginalis open and expose the epididymis which has been secured with a stay suture. Hemostats can be seen on the edges of the tunica vaginalis. The testis can also be accessed for a TESE if needed with this exposure.

Figure 2
An ophthalmic blade is used to incise dilated tubules while the syringe aspirates the fluid.

Figure 3
A slide is prepared for analysis by an andrologist.

Figure 4
The small incision allows for minimal post-operative pain and quick recovery.
Discussion

With the variety of sperm extraction techniques available to providers today for OA, choosing the optimal approach may vary in order to balance cost, location, patient factors, and clinical outcomes. The ability to obtain sperm which offers the best possibility for a successful IVF in the case of a patient with OA is integral to the role of the male fertility specialist. Familiarity with different techniques is essential as is maintaining the flexibility to pivot between testicular or epididymal sperm as necessary during a retrieval. MIESA allows for the option of either sperm source, and it can be performed under local anesthesia in an office-based setting.

The ultimate goal for couples seeking fertility treatment is a live birth. Choosing testicular versus epididymal sperm, and sometimes both, offers the best opportunity to help achieve this end. Epididymal sperm in OA is may higher sperm DNA fragmentation, and previous studies have associated higher sperm DNA fragmentation with lower live birth rates in IVF/ICSI. Prior studies have found poor outcomes with epididymal sperm compared with testicular sperm; however, this may be explained by the blind percutaneously retrieved sperm obtained during a PESA. One advantage of the MIESA is that direct visualization of the tubules allows for higher quality sperm taken from the more proximal epididymal tubules. More recently, it has been found that pregnancy and delivery rates between testicular and epididymal sperm were lower for testicular sperm than epididymal sperm for IVF/ICSI. Further, a recent study found the live birth rate to be similar between cryopreserved epididymal sperm from MIESA as compared with fresh ejaculated sperm from couples with unexplained fertility undergoing IVF/ICSI. These considerations can help fertility providers and couples in their counseling and expectations before undergoing sperm retrieval for OA.

Conclusion

MIESA offers multiple advantages for sperm retrieval in men OA because of the quantity of high quality sperm extracted, the ability to be performed under local anesthesia with surgical loupes in an office-based setting, the ease to convert to standard TESE if necessary, and short recovery time of patients.

References

Introducing the SRS Traveling Scholars Award

The first SRS Traveling Scholar will be awarded at the 2022 Scientific Congress and Expo in Anaheim, CA. The objective of the SRS Traveling Scholars Award is to provide an opportunity for any trainee in reproductive medicine and whose abstract submission focuses on reproductive surgery to expand their educational and networking experience in the field by attending educational activities at the annual Scientific Congress & Expo of the American Society for Reproductive Medicine (ASRM).

Applicants are trainees in the field of reproductive health whose abstract submission to the ASRM Scientific Congress & Expo follows a reproductive medicine theme with a focus on reproductive surgery.

In addition, SRS has partnered with the Society for Male Reproduction and Urology (SMRU) to provide an opportunity for any trainee in reproductive medicine whose abstract submission focuses on male reproductive surgery.

The society has received many outstanding abstract submissions. The SRS board looks forward to recognizing the award recipients at the SRS Awards Ceremony & Reception October 25, in Anaheim. Be sure to mark your calendar!

SRS-SREI 2022 Surgical Boot Camp

The Seventh Annual SRS-SREI Surgical Boot Camp for REI fellows took place on April 28-30, 2022 at the Houston Methodist Institute for Technology, Innovation & Education (MITIE) in Houston, Texas. The course was directed by Drs. Mindy Christianson, Johns Hopkins University, and Ranjith Ramasamy, University of Miami, under the guidance of SRS President, Dr. Kathleen Hwang, University of Pittsburgh. Thirty REI fellows from across the country attended and many faculty committed time and energy to make the program successful. “It was so wonderful to have everyone back together in person this year for the surgical boot camp, especially after being virtual last year. There was a palpable excitement you could feel to be in person to learn these important surgical skills,” stated Dr. Christianson. “I was so proud of the faculty who rallied to make the changes necessary to offer the boot camp in person this year”, added Dr. Hwang.
SRS is excited to announce that in addition to the established one-year fellowship in minimally invasive reproductive surgery (MIRS) at the Nezhat Medical Center, Atlanta, GA with Ceana Nezhat, MD and the Camran Nezhat Institute, Palo Alto, CA with Camran Nezhat, MD, we are pleased to announce The new SRS Surgical Scholars Track. This specialized pathway is embedded within the traditional 3-year REI fellowship at approved sites with high surgical volume programs where fellows, during their 6-month elective, may elect to pursue at approved sites to enhance their reproductive surgical skills.

The pilot program includes sites at Johns Hopkins in Baltimore, MD with Mindy Christianson, MD, Mayo Clinic in Rochester, MN; Mass General Hospital with John Petrozza, MD, and University Hospital in Cleveland, OH with Rebecca Flyckt, MD as the Site Directors. The REI Fellows who have been selected to the SRS Surgical Scholars Program include Megan Gornet, MD at Johns Hopkins, Michael F Neblett, MD at the Mayo Clinic, Tori Fritz, MD and Karissa Hammer, MD at MGH, and Rebecca Chung, MD and Katie Coyne, MD at UH.

The SRS Surgical Scholars Track provides structured surgical training, core surgical education, and requires completion of a fellowship thesis related to reproductive surgery within the REI fellowship. Drs. Victor Gomel and Camran Nezhat launched the lecture series in August, leading a wonderful discussion on their historical perspectives on surgery and reproductive medicine. The discussions are lively, interactive, and provide enormous insights for the fellows. We are also pleased to have two outstanding statisticians, Rose Maxwell, PhD from Wright State University in Dayton, OH and Miryoung Lee, PhD from the University of Texas Health in Houston, TX who will be providing guidance into clinical and translational research initiatives for the SRS Scholar fellows.

“The SRS fellowship is an incredible addition to our current REI fellowship program. It allows our fellows with a special interest in reproductive surgery to receive additional in-depth experiences in complex laparoscopy, robotics, and hysteroscopy. Further, our SRS scholars benefit from structured didactics featuring world leaders in reproductive surgery and collaborative research projects that will address important questions in our field.” Dr. Rebecca Flyckt.

“The SRS surgical scholar program is truly an exciting opportunity for all interested REI fellows who have special interest in reproductive surgery. The didactic curriculum with talks given by well known surgical experts, research opportunities and lively journal clubs augmented with minimum surgical numbers in various techniques of reproductive surgery makes this a competitive and comprehensive fellowship. This fellowship will serve to train the reproductive surgeons of tomorrow at various approved sites nationwide. The future of reproductive surgery is indeed bright!” Dr Zaraq Kahn.

We are also delighted to announce the recently approved site at the University of South Florida with Anthony Imudia, MD as the Site Director. For REI Fellowship programs interested in applying to be a site, please contact Megan Miller, Member Group Administrator.
Fellow:

What does the SST mean to you?
It is an honor to be a part of the SST and I feel so privileged to be one of the first fellows in the program. I have the opportunity to be educated and mentored by experts and leaders in the field of Reproductive Surgery. Given the high surgical volume and skilled reproductive surgeons at my institution, I know I will be well prepared when I leave fellowship, and now being a part of the SST there is external validation to my training and skill. This will be an advantage that could set me apart when I start looking for a position after fellowship.

In addition to you obviously having interest in reproductive surgery, what was another main factor that made you join the surgical scholars track?
As a member of the SRS SST, I am able to create connections with fellows and attendings at other institutions across the country. This allows for collaboration and sharing of ideas that would not be as easily accessible without being a part of the track.

Tell us about the Program.
In addition to ensuring surgical training by having a minimum number of surgical cases required, there is a didactic component to the SST. The program includes monthly virtual sessions that include educational lectures, journal clubs, and research meetings. There are often guest lecturers in addition to site directors who may present in our lecture series, and these are individuals who are highly respected experts in the field. Each institutional site hosts a journal club where sentinel or cutting edge evidence is reviewed and evaluated.

How do you apply?
If you are at a fellowship program that is part of the SRS SST, then you can simply complete an application with a personal statement. If your fellowship program is not one of the SRS SST sites, then you may still join in virtually for the lectures without officially being part of the track.

What else does the SST have to offer other than a focus on surgery volume?
The SST offers the opportunity to collaborate on research projects and to share our ideas for future studies and receive feedback from those may have more experience. We are lucky to have statisticians and research experts as part of the program in addition to our site directors. The greatest benefit to the program, in my opinion, is the camaraderie that has been developed spending time learning and challenging ourselves to grow together.

Do you still do research?
Yes, research is still very important and built in to the program. As an REI fellow, we have a guaranteed 12 months of time dedicated to research.
What is extent of surgical pathologies you believe you are comfortable treating vs referring? How does that compare to your peers (same program or different program) who didn’t pursue the surgical track?

I feel I will be comfortable with all hysteroscopic procedures and laparoscopic and open procedures related to tubal disease, fibroids, adenomyosis, mullerian anomalies, and advanced endometriosis. I also plan to do an off site rotation as part of the track and hope to gain skills in the robotic management of advanced endometriosis specifically affecting the bowel. These are skills I would not otherwise have gained if not in the track.

What will be your ideal future practice like?

My ideal future practice will be in an academic setting with infrastructure to support a high surgical volume. I hope to become the well-respected reproductive surgeon like the site directors I look up to in this program.

Director

How did the SST come about?

It was an incredibly exciting few years getting the track up and running. We really have to thank Steve Lindheim for the original vision; he developed the concept and then he engaged Mindy Christianson at Hopkins, John Petrozza at Mass General and me at University Hospitals Cleveland in the conversations. We had a great synergy and all of us shared a passion to get this out there. Like any new, big idea, it takes a good team to push it forward and get the buy in of all the stakeholders. We were very fortunate to have support from the SREI and ASRM in getting this over the finish line. We worried that if we didn’t act now, we might lose sight of high level surgery training and committed surgical practice in REI. We have a different approach than other surgical specialists and there is nothing more satisfying to me than to be able to take a patient from the office visit, to the OR, and to the IVF suite in their pursuit of having a baby. We all felt strongly that we don’t want to see our field lose this unique focus!

Why did you get involved?

There are only so many cases you can do yourself and then you start to have a desire to do something bigger, to really influence the future of our field. Your trainees are your legacy. I couldn’t pass on the opportunity to help build up surgery an enduring part of our subspecialty and our training curriculums. I would love to see the SST available at every fellowship site around the country so that fellows that share an interest in being advanced reproductive surgeons in their careers have an opportunity to gain extra training as well as participate in surgical didactics and collaborative surgical research.

What resources do you need to become a SST site?

It’s important to know that you apply as a site first, ideally with plenty of time before the application cycle closes for the academic year. You have to send a letter of support from your chair and site director for the SST. The SST can be completed over either the first and second or second and third years of the fellowship. You also have to demonstrate that you have the depth and breadth of cases to support high quality high volume surgical training. We need to see at least 125 major cases a year. I think some people think this is just about the case logs, but site directors should know that there is also a strong research and a didactic component to the SST. In addition to attending the zoom lecture series, the fellows have to complete their research and then travel to ASRM to present their findings. The sites have to be able to support this.

As Site Director, what are your responsibilities?

In addition to the initial application, I oversee and help submit their surgical case numbers and make sure they are attending the scheduled lecture series and journal clubs. I also ensure that our SST fellows are progressing with their surgically-oriented research project.
Looking back at your fellowship, how would having a similar scholars’ track would have changed the way you practice today?

I was incredibly lucky to match at the high volume surgical fellowship of my choice. I received one-on-one dedicated training from both of my surgical mentors, Tommaso Falcone and Jeff Goldberg; honestly, they were the guiding lights to the career I have today. But the match is somewhat random and I often think about where I would be and what I would be doing if I hadn’t been at one of the few places in the country (at the time) that offered this advanced REI surgical training. As the number of sites for the SST grows, our hope is that many more fellows can access the kinds of opportunities that I did if they desire to.

As you know, the drift between REI and reproductive surgeries has been increasing over the last few decades and the SRS SST is one of the major programs aiming to change that. However, do you believe having the track as an integral part of your program will discourage high caliber REI candidates from joining your program or the other way round?

The greatest advantage of the SST is that it is optional and easily embedded within the traditional REI fellowship. Those that wish to do the SST may come to our program specifically for it or decide to do it along the way; we have fellows that do and fellows that don’t. But all of our fellows have access to the broad opportunities and full scope training that has always been available through our program. Similar to the SST, some of our fellows chose extra time in the IVF lab or doing bench research or working on reproductive education and advocacy. This is just another option available for those that have a particular passion for high level reproductive surgery.

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, please email me, Zaraq Khan, or Dani Mosley.

Zaraq Khan, MD
SRS Website Committee Chair
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 2023-2024:

- Nezhat Medical Center, Atlanta, GA, Program Director: Ceana Nezhat, MD
- Camran Nezhat Institute, Palo Alto, CA, Program Director: Camran Nezhat, 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 can be more cost-effective than IVF in multiple circumstances, may be preferred by patients, and can often restore wellness and natural anatomy when medical conditions interfere. 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. Interested preceptors also can find information on the website.
Benefits of SRS membership include:

- 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 Pre-Congress courses on a variety of topics related to the field of reproductive surgery
- Participation in collaborative research projects addressing surgical outcomes