



THE SOCIETY
OF REPRODUCTIVE
SURGEONS

Winter 2024

Note from the Editor

Dear SRS Members, I am pleased to bring you the Winter 2024 SRS newsletter.

As usual the newsletter starts with our newly elected president's message from Dr. Mindy Christianson. This year, the ASRM annual meeting was held in New Orleans, Louisiana between October 14-18, 2023. More than 4000 professionals attended from all over the world. In addition to the superb scientific program, the meeting was remarkable for the President's Gala that raised 550,000\$ for the Research Institute. Our society's Postgraduate course, symposia and interactive sessions were another great success. Most of the SRS sessions had packed rooms and the exciting discussion continued in the hallways past the allocated time. This was especially true for the debate between Dr. Paul Lin and Dr. Sina Abhari regarding the management of the IVF patient with endometrioma.

In our Gynecologic section, we have three reports submitted by our ASRM Traveling Scholars, Dr. Leigh Ann Humphries, Dr. Katie Coyne, and Dr. Diego Manavella.

Our international urology corner includes an exciting article regarding varicolectomy for high sperm DNA index from our colleague Dr. Karthikeyan at the Apollo Fertility Clinic in Chennai, India.

In collaboration with SREI, the 2024 surgical bootcamp will be held in Cleveland Clinic between May 30 and June 1, 2024. This will be our 9th annual boot camp.

Finally, more programs continue to join the SRS Surgical Scholar Track. Three new programs joined in 2023! I continue to encourage any interested programs to contact the fellowship co-chairs, Dr. John Petrozza and Dr. Mindy Christianson.

Sincerely, Rony Elias

Message from the SRS President Dr. Mindy Christianson, MD, MBA

Dear Colleagues!

I am so excited to share with all of you recent SRS activities over the past year – all thanks to our wonderful members who share all of our enthusiasm for reproductive surgery. The Society of Reproductive Surgeons was a very active in programs at the 2023 ASRM Congress and Expo in New Orleans this year. SRS conducted a sold-out hands on post grad course on office hysteroscopy, three symposia, five interactive sessions and multiple roundtable talks. Our SRS keynote speaker Dr. Luis Alonso enthralled us with his talk "Understanding the uterus: a journey through uterine mysteries." SRS was also honored to host a hands on suturing course for the ASRM KEEPR (knowledge through engagement & education program for residents) program. Finally, we were excited to sponsor three traveling scholars at ASRM this year, with the reports from these scholars highlighted throughout this newsletter.

We see residents, fellows and recent graduates as the future of SRS. We are excited to hold the 9th annual SRS/SREI Surgical Bootcamp at the Cleveland Clinic May 30-June 1, 2024. In addition, the SRS Surgical Scholars track continues to grow. Not only is the SRS-SST enrollment now up to 10 programs, but this past year our first three SRS-SST scholars graduated. Congratulations to Drs. Victoria Fitz, Rebecca Chung and Michael Neblett for graduating from the SRS-SST program this year!

Dr. Rony Elias worked hard to bring you this edition of the newsletter. We thank all of our contributors for this newsletter. This year one important goal for SRS is to actively engage all of our members and to increase membership. I invite all of you to actively participate in the SRS activities and request you to please share with us with any ideas you may have to further our common interest in promoting reproductive surgery.

Thank you! Mindy

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The Society of Reproductive Surgeons was founded in 1984 to serve as a forum for members of the American Society for Reproductive Medicine with special interest and competency in reproductive surgery. The Society of Reproductive Surgeons strives to promote excellence in gynecologic and urologic reproductive surgery by providing and encouraging professional education, lay education, and by fostering research. By achieving these goals, it is the belief that this Society will assure the highest quality of patient care.

ASRM Scientific Congress & Expo 2023

New Orleans, Louisiana



Photos from the ASRM Scientific Congress & Expo in New Orleans, LA – SRS Awards Ceremony & Reception, October 17, 2023.

Traveling Scholars Review

During the ASRM 2023 Scientific Congress, the Traveling Scholar winners summarize sessions they attend and highlight key take-home messages and learning points. Here are their reviews.

SYM08: Management of Adenomyosis for Infertility and Recurrent Pregnancy Loss: Surgical and Medical Treatment Options

By: Leigh Ann Humphries, MD

Drs. Camran, Farr, and Ceane Nezhat Traveling Scholar Award for Endometriosis

Introduction:

Adenomyosis is a benign condition characterized by the presence of endometrial glands and stroma within the myometrium. The disease may be focal, which is localized, or diffuse, which infiltrates the entire uterus. Prevalence of adenomyosis is difficult to estimate, as it varies across studies: between 5-70% in women undergoing hysterectomy, about 21% of women presenting to a general gynecology clinic, and about 24% of infertile patients undergoing ART. The pathogenesis of adenomyosis remains uncertain, with various theories similar to those of endometriosis, such as direct invasion, misplaced Mullerian remnants, and abnormal stem cell migration. The hallmark symptom is cyclic cramping uterine pain, especially prominent in the 3rd and 4th decades of life, with the uterus often having a boggy texture on bimanual exam.

Diagnostic Approach:

Diagnosis is often achieved via imaging or hysteroscopy, yet this can be highly subjective. Only one of several criteria must be present to suggest adenomyosis. Sonography reveals adenomyosis through features like globular uterine configuration, irregular junctional zones, and myometrial cysts. MRI and ultrasound, while sensitive, show relatively poor specificity of about 70% even among trained radiologists. Definitive diagnosis is via histopathology after hysterectomy, though this is not an option in the patient population desiring future fertility.

Impact on Fertility:

Adenomyosis poses a detrimental effect on fertility. There are several theories for this phenomenon, including abnormal uterine contractility, impaired endometrial receptivity leading to reduced implantation rates, inflammatory response, effects on egg quality, and interference with tubal function. The appropriate intervention to improve fertility outcomes for patients undergoing ART is not well established. A 2019 Cochrane review showed no significant difference in clinical pregnancy rates following pretreatment with GnRH agonist therapy before IVF in patients with adenomyosis.

Surgical Interventions:

Surgery is recommended for severe symptoms unresponsive to medical treatment. The definitive treatment is hysterectomy, but fertility-sparing options like adenomyomectomy and MRI-guided focused ultrasound surgery (MRgFUS) may be employed for patients desiring future pregnancy. MRgFUS, also known as high intensity focused ultrasound (HIFU), induces cell death in targeted tissues. Most data on this method come from small case series, which have reported reductions in uterine volume, menstrual bleeding, and pain. Adenomyomectomy is a uterine debulking procedure, which is effective for symptomatic relief in patients with focal or diffuse disease. Criteria for a good candidate for adenomyomectomy are (1) presence of severe symptoms such as abnormal uterine bleeding, pelvic pain, and/or bulk symptoms, (2) failure of medical management with persistent infertility or recurrent pregnancy loss, and (3) future fertility plans. Laparoscopic and robotic methods are effective for focal adenomyosis, while larger or diffuse lesions necessitate laparotomy. The classic V-shaped resection technique, though initially effective, has a high recurrence rate. The Osada Procedure, which involves a laparoscopic-assisted laparotomy, involves an aggressive excision of diffuse adenomyotic tissue, followed by uterine wall reconstruction using the triple flap method. This method has been associated with very favorable post-surgery pregnancy and live birth rates for diffuse adenomyosis.

Postoperative Considerations:

Following surgery, most literature advises a waiting period of 6-12 months and confirmation of normal uterine blood flow before attempting conception. There is a notable risk of uterine rupture after surgery, with some reports suggesting rates exceeding 1%, though more research is needed to understand risks of uterine rupture and other perinatal outcomes, particularly after adenomyomectomy for diffuse disease.

INT-01 Cesarean Scar Isthmoceles: When and How to Diagnose and Treat Surgically

By: Katie Coyne, MD
DeCherney-Nezhat Traveling Scholar

This interactive session was led by Drs. Charles E. Miller (Rosalind Franklin), Bala Bhagavath (University of Wisconsin), and Zaraq Khan (Mayo Clinic). In terms of diagnosis, it was discussed that there is not accepted diagnostic criteria for a uterine isthmocoele; however, there is ultrasound criteria that may guide management choices. Most importantly, not all isthmoceles need to be resected, but surgical intervention should be considered for patients with symptoms or infertility, especially in the setting of failed transfers. For surgical treatment of an isthmocoele, the approach may be hysteroscopic, laparoscopic (with robotic assistance), or vaginal.

The key surgical steps for a laparoscopic resection of a uterine isthmocoele include: (1) Make initial incision over hysteroscopic light, (2) When saline emits from incision site, replace cannula, only into cervix, and excise isthmocoele, (3) Layer one: “0” Polydioxanone mattress sutures x4, (4) Repeat hysteroscopy to verify that there is no stenosis and repair is adequate, (5) Layer two: run each “0” Polydioxanone deep to midline and tie together, (6) Close peritoneum if possible utilizing 3-0 V-Loc running suture versus 3-0 Polydioxanone, and (7) Perform uterine uplift if uterus retroflexed or retroverted.

In the setting of cesarean scar pregnancy, there are additional diagnostic and treatment considerations. Ultrasound criteria for a CSP include: (1) Empty uterine cavity, (2) Hourglass uterine shape with ballooned cervical canal, (3) Presence of a gestational sac or placental tissue within the cervical canal, and (4) Closed internal os. Dr. Bhagavath presented his algorithm for management of CSP:

1. Hemodynamically stable?
 - a. Yes – go to Step 2
 - b. No
 - i. Bleeding intra abdominally – Laparoscopy/laparotomy (96-97% success)
 - ii. Bleeding vaginally – UAE + D&C + MTX (98% success)
2. Type of CSP
 - a. Type 2
 - i. Laparoscopic excision (97% success)
 - vs.
 - ii. Initial management with intrasac MTX or D50 followed by laparoscopic excision
 - b. Type 1
 - i. Future fertility is desired?
 1. Yes – MTX + D&C (80%) or Hysteroscopic resection (83-88% success)
 2. No – UAE + D&C (98% success)

In conclusion, cesarean delivery scars are common. Symptomatic patients and asymptomatic patients with infertility should be counseled for surgical correction. Surgical correction can be hysteroscopic (if myometrial thickness is > 3 mm), open/laparoscopic/robotic (if myometrial thickness is < 3 mm; high risk of bladder injury), and vaginal (at any myometrial thickness). Management of ectopic pregnancy in the cesarean scar depends on hemodynamic stability, type of CSP, and patient desire for future fertility.

Diagnosis

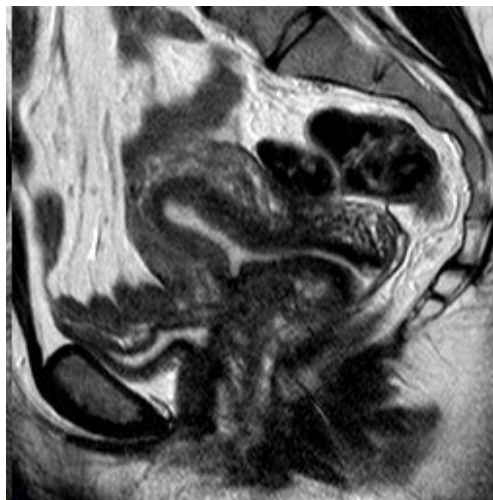
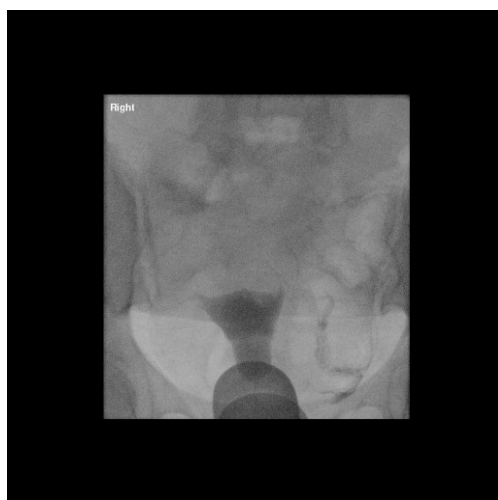


ASRM 2023 Scientific Congress & Expo



New Orleans, LA | October 14-18, 2023

Isthmocecele Seen on MRI and not HSG

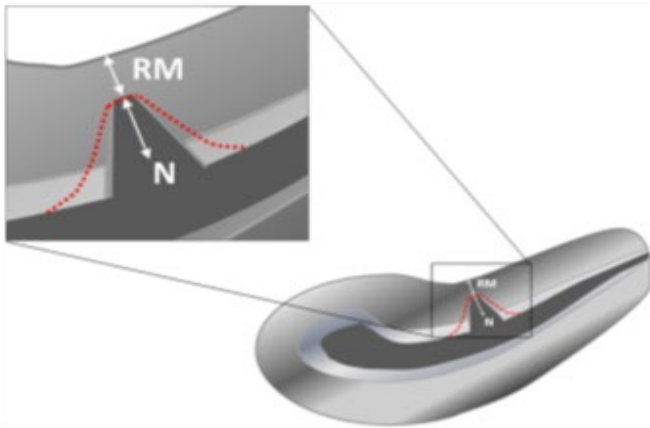


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Isthmocele - Concept of Residual Myometrium



- RM – Residual Myometrium
- N – (Niche) CSD - $\geq 2\text{mm}$
- No accepted criteria for diagnosis yet
- Repair Options
 - Hysteroscopic
 - Laparoscopic
 - Vaginal

ASRM 2023 Scientific Congress & Expo



New Orleans, LA | October 14/18, 2023

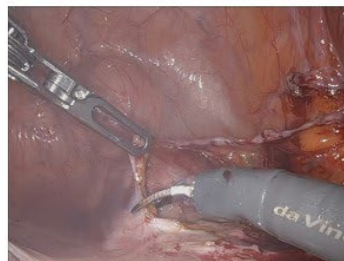
Surgical Treatment of Symptomatic Isthmocele Technique



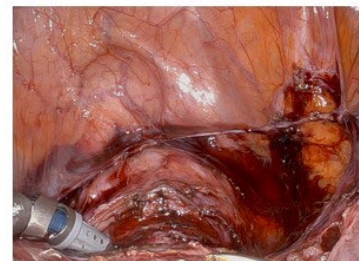
Perform hysteroscopy to verify isthmocele



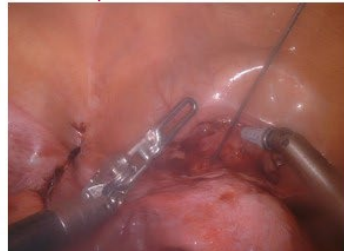
Mobilize bladder off lower uterine segment and cervix



Dissect laterally to just above uterine vessels



Inject dilute vasopressin into uterus to aid in hemostasis



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Surgical Treatment of Symptomatic Isthmoceles Technique



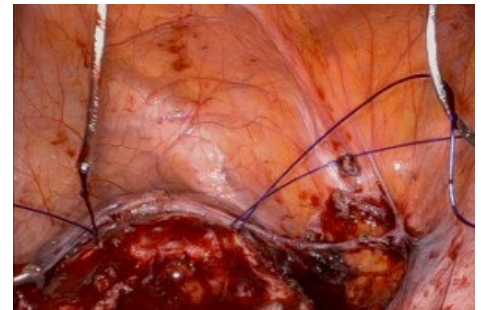
Make initial incision over hysteroscopic light



When saline emits from incision site, replace cannula, only into cervix, and excise isthmocoele



Layer one: "0" Polydioxanone mattress sutures x4



Repeat hysteroscopy to verify that there is no stenosis and repair is adequate



Layer two: run each "0" Polydioxanone deep to midline and tie together



Close peritoneum if possible, utilizing 3-0 V-Loc running suture versus 3-0 Polydioxanone



Perform uterine uplift if uterus retroflexed or retroverted.



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Conclusions

- Cesarean delivery scars are common
- Symptomatic patients and asymptomatic patients with Infertility should be counselled for surgical correction
- Surgical correction can be
Hysteroscopic: If myometrial thickness is >3 mm
Open/Laparoscopic/Robotic: If myometrial thickness is <3 mm (high risk of bladder injury)
Vaginal Repair: At any myometrial thickness
- Ectopic pregnancy in scar – management depends on hemodynamic stability, type of ectopic and desire for future fertility
- Lateral wall isthmocoeles are a common variant of anterior wall defects and are surgically much harder to manage

HOC-02: Office Hysteroscopy: Essentials for Success from Start-up to Optimizing Efficiency and Patient Satisfaction

Diego D. Manavella, MD, PhD

SRS Traveling Scholar

Introduction

Office hysteroscopy presents several advantages over other uterine cavity assessment methods and OR hysteroscopy in terms of reduced pain, quicker procedures, and cost-effectiveness. Sonography can anticipate some issues, but there are limitations. This session highlighted who should and shouldn't undergo office diagnostic hysteroscopy (Dx HSC) based on its accuracy, speed, affordability, and ease of use in identifying various pathologies.

Advantages of office HSC

The course emphasized that hysteroscopy is beneficial for a range of conditions, including endometritis, tubal potency assessment, and identifying pathologies. It's easier for non-medical professionals to identify and second-check pathology, making it a valuable diagnostic tool, especially in assessing cornua/lower areas for IUI and embryo transfer.

Limitations and Contraindications

There are limitations to who should undergo office hysteroscopy, primarily revolving around equipment availability, costs, and reimbursement preferences. Individuals with specific concerns like adenomyosis might not find Dx HSC as suitable.

Procedure Setting and Patient Care

The importance of a comprehensive pre-procedure counseling and a well-equipped, appropriately staffed setting for office hysteroscopy was emphasized. Course speakers advocated for individualized pain management strategies, optimal patient selection, and ideal timing during the patient's cycle for better outcomes.

Tubal Patency Assessment

Throughout the session the utility of hysteroscopy in assessing tubal patency was mentioned and discussed evolving techniques and considerations in ensuring accuracy, safety, and affordability.

Complications

An entire presentation outlined potential complications and techniques to manage issues like vasovagal syndrome and false passage/perforation, which was extremely useful for those considering implementation of office hysteroscopy in their practices.

Details of coding and billing, as well as business plan development was a very interesting aspect of office hysteroscopy that was covered thoroughly, which will potentially result in broad implementation of this technique by US-based physicians present in the session

Future Perspectives

One of the most interesting talks delved into the evolving landscape of hysteroscopy, considering economic factors, technological advancements, and the potential integration of AI and augmented reality in gynecological procedures, which could revolutionize the field.

Conclusion

This report highlights the essential aspects of office hysteroscopy, emphasizing its advantages, limitations, best practices, and future considerations, aiming to provide a comprehensive understanding of this diagnostic procedure and its potential evolution.

VARICOCELECTOMY FOR HIGH SPERM DNA FRAGMENTATION INDEX

Vilvapathy S Karthikeyan, MD, MBBS, MS. MCh, FAIS
Apollo Fertility, Chennai, India

Introduction:

Varicocele is associated with reversal of blood flow in the pampiniform plexus of veins within the scrotum (Fig. 1) ¹. Varicocele is associated with male infertility; however, exact mechanism behind its impact on fertility is not entirely understood. **Varicocele is graded clinically by the modified Dublin-Amelar system (Table 1)**. The most common explanation suggests that the obstruction of small blood vessels leads to hypoxia and venous stasis, leading to dysfunction of germinal cells ². The backflow of metabolic products from the adrenal and renal veins through the left internal spermatic vein may also contribute to infertility. Additionally, an increase in the scrotal temperature and certain endocrinological changes are other proposed factors contributing to infertility in varicocele patients ³⁻⁵.

Sperm DNA fragmentation index and varicoceles

An increased oxidative stress and a decrease in antioxidant capacity has been proposed as one of the additional mechanisms for infertility due to varicocele (Fig 2). It is a result of damage to sperm DNA, leading to DNA fragmentation, which can cause subfertility or lower success rates with assisted reproductive techniques ^{6,7}. It has also been observed that DNA damage associated with varicocele reduces the ability of spermatozoa to fertilize the oocytes. The percentage of sperm with denatured nuclei, known as the sperm DNA fragmentation index (SDF), is a potential parameter for investigating fertility ^{8,9}. The extent of SDF can predict outcomes for in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI). SDF greater than 20% is associated with reduced success rates following ICSI ¹⁰. Infertile men with normal sperm morphology often have high rates of SDF ^{8,9}. SDF provides additional information about fertility potential ¹¹. The link between sperm DNA integrity and reproductive outcomes after assisted reproduction treatment is inconsistent. Some studies have reported reduced fertilization rates, lower embryo quality and lower pregnancy rates in men with elevated SDF.

Does SDF index really matter?

There is no conclusive evidence on the link between sperm DNA integrity and outcomes in assisted reproduction treatment ¹². SDF measurement has become increasingly important for assessing male subfertility. Moreover, sperm chromatin abnormalities, which cannot be evaluated by routine semen analysis, can be assessed using SDF testing, especially in cases of unexplained infertility. However, it is important to note that the cut-off value for SDF varies across studies, and infertility may occur when SDF levels exceed 20-25% ¹³.

SDF in normozoospermia with varicocele and infertility

There is no clear consensus regarding the role of SDF in men with normozoospermia. The AUA and ASRM recently published a guideline on male infertility which advises against using routine SDF testing in initial fertility evaluation, but highlights its importance in cases of recurrent pregnancy loss (RPL) ¹⁴. This is becoming more useful in men with varicocele, especially large ones clinically palpable and when it is doubtful if varicocele repair (VR) will be useful. VR has been shown to increase the likelihood of future pregnancies by 40 to 50%¹⁵

Role of SDF in normozoospermia with recurrent pregnancy loss/ implantation failure

The European Society of Human Reproduction and Embryology (ESHRE) has investigated the potential of SDF testing to explain RPL¹⁶. The European Association of Urology (EAU) suggests that SDF testing should only be conducted in men with unexplained infertility or after RPL ¹⁷. Esteves et al conducted a comprehensive analysis of the impact of SDF on ART. They recommended that SDF testing can be performed before starting ART (such as IUI, IVF, or ICSI) and after failed ART attempts. Studies have consistently found a link between varicocele and increased SDF levels, and VR has been shown to reduce SDF and improve fertility. High SDF has been associated with decreased fertilization rates and increased risk of total fertilization failure or low fertilization rate in men with mild-to-moderate asthenozoospermia ¹⁸. However, the guidelines do not address the role of varicocele repair in normozoospermic men with subclinical varicoceles, which requires further research.

Substantial SDF levels were detected in clinical and subclinical varicocele patients. However, only in men with clinical varicocele, statistically significant reductions in SDF measures were detected ¹⁹. The role of SDF in subclinical varicocele is still unclear and requires further exploration given the multiple variables and inconsistent reports in this area.

Various studies are available on the value and effect of medical management of varicocele and they have showed improvement in sperm parameters. Ubiquinol and L-carnitine have been shown to be equally effective in improving semen parameters in men with varicocele. This has been proposed as an alternative to surgery for higher grade varicocele^{20,21}. The impact of VR in reducing SDF was more apparent in patients who achieved normal pregnancy²²⁻²⁶. VR appears to be a viable treatment option for subfertile men with palpable varicoceles and can improve their chances of natural and assisted pregnancy (Fig. 3).

Conclusions:

Sperm DNA fragmentation testing is relatively new and its utility in varicocele is being understood. Role of VR in men with elevated SDF with clinical or large varicoceles and sperm abnormalities appears to be justifiable. VR can improve chances of natural conception or improve outcomes of ART in these couples. Evidence for success after VR in men where SDF is elevated in situations such as clinical varicocele with normozoospermia, subclinical varicocele with sperm abnormalities or unexplained infertility and in cases of recurrent pregnancy loss is still primitive and needs research.

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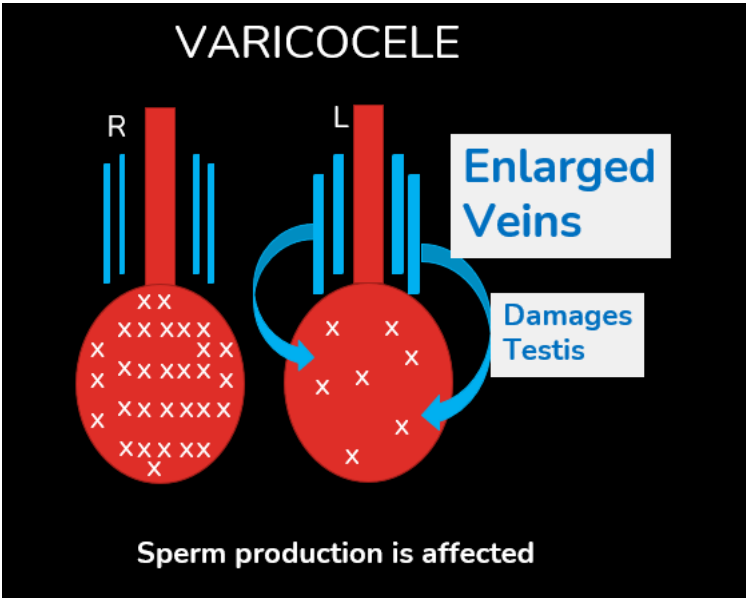
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Table 1: Clinical grading of varicocele (Dublin- Amelar)

Grade	Description
1	Dilation of pampiniform plexus, palpable with Valsalva manoeuvre
2	Palpable in standing patient, without Valsalva manoeuvre
3	Visible veins through the scrotal skin and palpable without Valsalva manoeuvre

Fig. 1: Varicocele and testis damage



x – denotes spermatogenesis; Long standing severe varicocele can cause impaired spermatogenesis

Fig. 2: Effect of varicocele on sperms

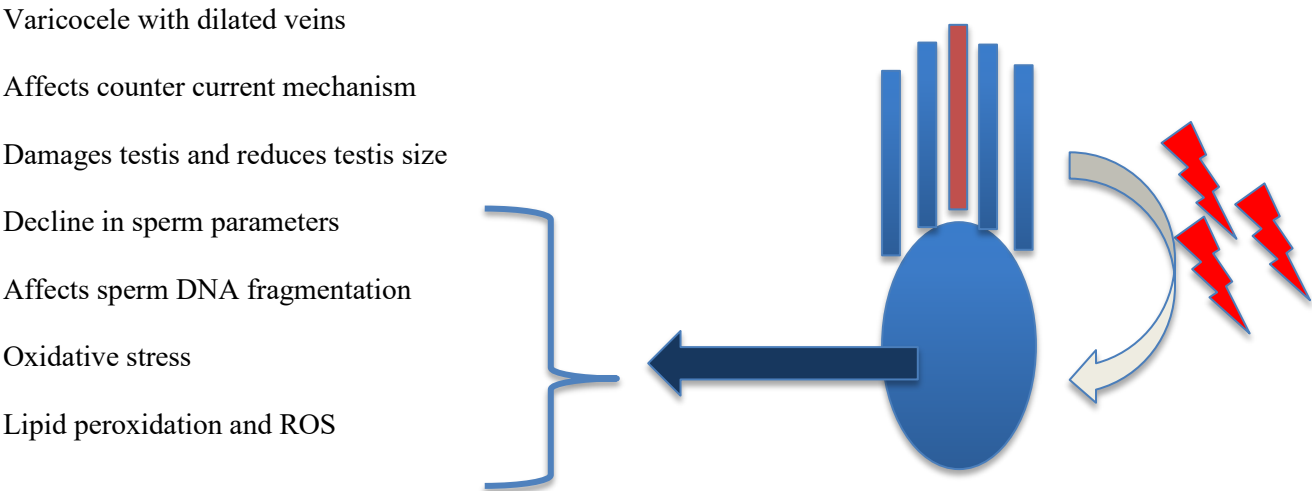
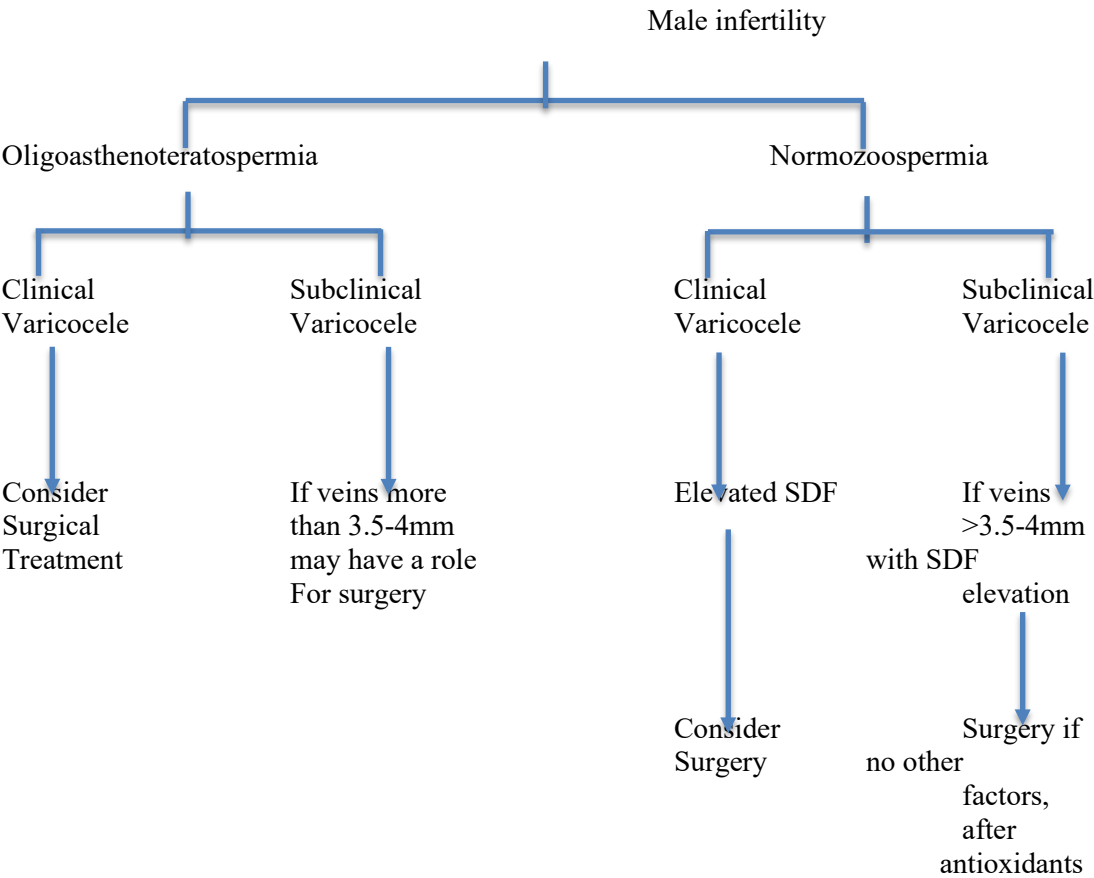


Fig. 3: Proposed Algorithm for treatment planning in varicocele with male infertility



Electronic Communications Chair Update

Joseph Findley, M.D

The SRS website has continued to deliver literature reviews and generate conversation regarding unique cases on the discussion boards.

We are continuing our partnership with the SART Electronic Communications Committee (ECC) to form a more robust group that can have representation in both SART and SRS. 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, Joseph Findley (joseph.findley@uhhospitals.org) or Megan Miller (mmiller@asrm.org).

Joseph Findley, M.D.
SRS Website Committee Chair



The screenshot displays the SRS (The Society of Reproductive Surgeons) website. At the top, the SRS logo and name are visible. Below the header is a navigation bar with links: About, Discussion, Literature Reviews, Directory, Publications, and Newsletters. A search bar is located on the right. The main content area features a large image of a surgical procedure with the text "Whether you are an REI, urologist, MIS, or have other strengths, SRS wants to help you live up to your potential." and a "Learn how to join" button. To the right, there is a section titled "Looking for Literature Reviews?" with a search prompt. Below this, a "Recent Shared Files" section lists two items: "Outcomes of Hysterectomy Performed by Very Low-Volume ..." and "Predictors of Laparoscopic Simulation Performance Among ...". A "Latest Discussions" section is also present, featuring a discussion titled "RE: Office hysteroscopy system recommendations" by John Preston Parry, M.D., M.P.H., dated 2 months ago. The discussion text mentions the Karl Storz Image1 S system and the user's decision to switch from 4 & 5 mm Bellochi's to 6 mm for better results.

Minimally Invasive Reproductive Surgery Fellowship Update

John Petrozza, 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 two 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 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.

SRS Surgical Scholars Track Fellowship

John Petrozza, MD & Mindy Christianson, MD, MBA

The Society of Reproductive Surgeons is excited to announce the acceptance of three new sites for the Surgical Scholars' Track (SST)

Program: University of Pennsylvania, Cleveland Clinic, and University of Iowa. These programs join the current seven programs that encompass the SST Program.

The SST Program was founded in 2021 after discussions with ABOG, ACGME, ASRM and SREI. The goal is to provide additional surgical and research experience for interested REI fellows in select programs that already have high reproductive surgical volume. The program must have support from the current REI faculty, the program's fellowship director, the division chief, and the departmental chair. The SST fellow is expected to complete a required number of reproductive surgical cases, mostly with an REI surgeon, but also cases with their MIGS, gyn oncology, and benign gynecology colleagues. Additionally, monthly didactics and quarterly research meetings are offered, along with statistician support for research projects and quarterly mentorship meetings.

The current SST Program sites are the following:

1. Massachusetts General Hospital
2. Mayo Clinic
3. University Hospitals - Cleveland
4. Johns Hopkins
5. Washington University
6. Brigham and Womens Hospital
7. University of South Florida
8. University of Pennsylvania
9. Cleveland Clinic
10. University of Iowa

Of course, the success of this program is based on the need, and desire, of REI practices to hire these surgical fellows to complement their practice and provide not only ART, but surgical care for pelvic pathologies. At the 2023 ASRM Meeting in New Orleans, our first 3 fellows were awarded their certificates of completion,

and we were happy to announce that each SST fellow has been hired in a reproductive surgery role.

1. Victoria Fitz, MD - Massachusetts General Hospital. Victoria will be staying at MGH.
2. Rebecca Chung, MD - University Hospitals Cleveland. Rebecca has joined the staff at the University of Washington.
3. Michael Neblett, MD - Mayo Clinic. Michael has joined the staff at Emory University.

New for this year, the SST Program has created 5 sub-committees to help foster the mission of the program and to include involvement from SRS members who wish to be involved. These committees will be chaired by SST Program board members and include program site directors, SST fellows, SST graduates, and 2-3 members from the general SRS membership.

Research

Mission:

Coordinate quarterly research meeting

Monitor research projects

Direct consortium databases

Assist with IRB questions and applications

Ensure research progress from each site

Report to SRS Research Coordinator on a quarterly basis

Authorship questions and concerns

Review and audit data as needed

Review applications for new projects

Review and assist with grant proposals

Education

Mission:

Revise SST curriculum every 2 years

Develop proposed reproductive surgery standards for REI programs

Develop programs for OB/GYN residents

Develop cross-pollination of skills (SST fellows rotating to other programs); SST site directors lecturing to REI Fellowship

programs
Develop standard surgical evaluations
Develop global education endeavors with international programs
Propose and develop programs for ASRM, AAGL, SGS, ACOG and SREI Retreat
Propose and develop programs for regional REI Conferences

about complex surgical cases, and learn from some of our experienced SRS members.

Respectfully submitted,
John C. Petrozza, MD - Chair, SST Program
Mindy Christiansen, MD - Co-Chair, SST Program

Mentorship

Mission:

Provide guidance and mentorship to SST scholars applying for jobs
Support graduating fellows during their first 2-3 years in practice

Marketing and Social Media

Mission:

Connect SST scholars and sites via social media
Market “reproductive surgery” to current fellows and OB/GYN residencies
Create awareness within our and residency programs
Work with SRS Electronic Media Director
Branding of SST program – surgical caps, awards, other swag

Finance

Mission:

To develop opportunities for economic sustainability for the SRS SST and its activities.
Examine the financial needs for the SRS SST as it grows and identify sources of funding.
Explore philanthropic opportunities to support the SRS SST program.
Develop relationships with industry to potentially support SRS SST activities and surgical training.
Develop revenue streams for the SRS SST including surgical training hands on sessions with specialized lectures.

The excitement about the SST Program has been phenomenal, and it is gratifying to see OB/GYN residents and REI fellows asking how they can participate. A recent article in Fertility and Sterility highlighted the benefits and unique approach that a reproductive surgeon brings to an infertility practice, specifically a unique approach to preserving ovarian and uterine function, and more importantly, continuity of care for patients in the practice. In the next few weeks, SRS will be sending out emails to society members asking them to get involved, if interested, with one of the SST Program sub-committees. We can all learn from each other, and our SST fellows are eager to see new faces, hear



2023-2024 SRS Board of Directors

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Surgical Scholars Track Fellowship
Chair

Mindy Christianson, M.D.
John Petrozza, M.D

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

Dr. Joe Sanfilippo In Training Surgical Research Fund

To help understand the need for an in training surgical research fund, consider the story of the physician JR. JR was applying for MIGS fellowship in 1990 and there were no pelvic trainers as we know them today. During his interview for fellowship, he described his trip to Home Depot to build a box with openings (ports) that had rubber bushings to serve as ports to accommodate instruments and a laparoscope. JR went on to leadership positions in MIGS, including serving as chair of the MIGS Fellowship Board of Directors. It is this innovative surgical research that we want to nurture, foster with the ASRM-SRS "In Training Surgical Research Fund-The Sanfilippo Fund".

When Dr. Joe Sanfilippo had the idea to create an endowment to fund research for medical students, residents, and fellows, we knew it would be something the entire SRS community would rally around. The new fund will provide grants for student research and pilot studies! Call for proposals will be offered through the ASRM Research Institute and a representative from SRS will serve on the Grant Review Committee. The fund will fill a gap in the educational opportunities for in-training reproductive surgeons.

We need your help to reach our fundraising goal of \$100,000. Please make a donation of \$100, \$500 \$1000 or more if possible to the In-Training Surgical Research Fund. Here's the link to give today!

Providing young reproductive surgeons with research opportunities will help us build the future of reproductive medicine.

We can't do this without your support. Please consider a gift to the Joseph Sanfilippo, MD, MBA, In-Training Surgical Research Fund.