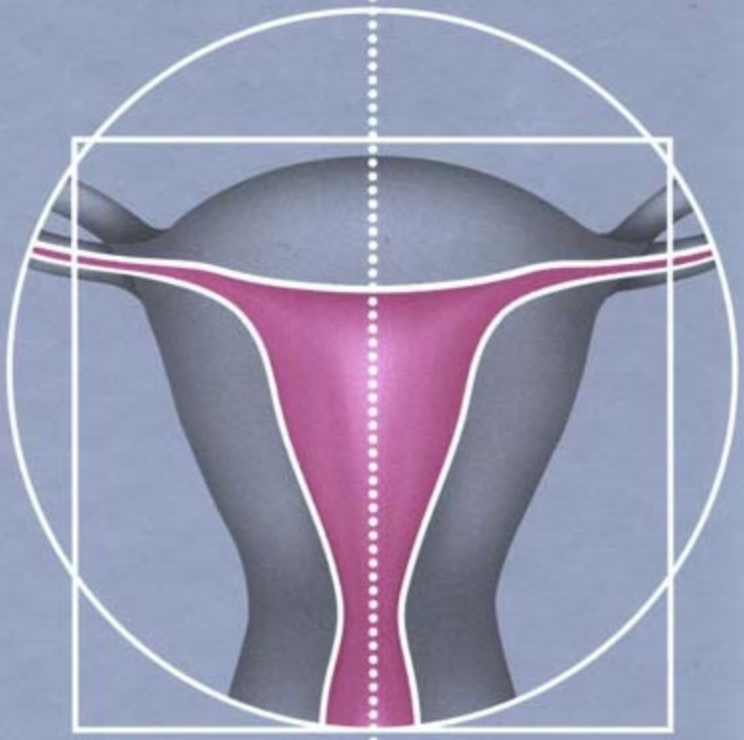
A PRACTICAL MANUAL OF

HYSTEROSCOPY AND ENDOMETRIAL ABLATION TECHNIQUES

A Clinical Cookbook



Resad P. Pasic M.D., Ph.D.
Ronald L. Levine M.D.

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We dedicate this book to the memory of Dr. Jay Cooper and other modern day pioneers of hysteroscopy, several of whom have contributed chapters to this publication.

It is because of their persistence, vision, expertise and the application of scientific principles in their research, that our patients benefit from the advantages of hysteroscopy.

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FOREWORD

Not so many years ago hysteroscopy was known as a procedure in search of an indication. Much has changed since then, and now hysteroscopy has a broad range of diagnostic and therapeutic indications, which is only fitting, considering that early attempts to peer into the uterus predated early laparoscopy. It has always seemed strange, at least to me, that gynecologists persist in performing grasping procedures, curettage, biopsy, and deliver energy into the organ of our chief interest without the aid of visualization. Would you allow an orthopedic surgeon to do the same in your knee without an arthroscope? Ardent hysteroscopists will tell you that the ability to make an instant diagnosis in an office, often with direct treatment has changed management of abnormal uterine bleeding. Office-based hysteroscopic uterine canalization as a tool to open corneal blockage in cases of infertility spawned the technology to accomplish the opposite; office transuterine sterilization is no longer a horizon topic, but an approved, effective method to permanently occlude the Fallopian tubes. Hysteroscopic uterine septum incision, described herein by one of the world's masters, Dr Valle, has rendered the hysterotomy route obsolete.

Flush on the heels of their widely acclaimed book on laparoscopy, Drs Pasic and Levine have applied the same logic and template to produce a similar work on hysteroscopy, which happily includes a chapter on saline infusion sonography as a related diagnostic technique. Described as a "cook-book" approach, the text serves as an excellent primer for the neophyte as well as for those with experience who are interested in expanding their repertory of operative interventions. Cook books come in various formats. Some are lavishly

illustrated, but quickly become beautiful coffee table ornaments, never to be put to actual use in the kitchen. Others furnish the ingredients, quantities, time in the oven, but are devoid of helpful hints. The best practical cook book tells you what to use and in what amount, sequentially how to do it, pitfalls to avoid, and has illustrations that make the point. As such, a hysteroscopic Julia Child would laud this work. The chapters are informative and concise. The illustrations, actual photos or line drawings, deliver the message. The reader quickly grasps what to do, and just as importantly, what not to do. New methods of endometrial ablation are clearly detailed, with appropriate pros and cons.

Over 2.5 million visits are made annually to gynecologists in the United States because of menorrhagia. Instructive texts such as this open diagnostic and therapeutic doors outside traditional hospital settings with great savings of time, money and a tremendous reduction of patient anxiety. Combined endometrial ablation and sterilization, which can be accomplished simultaneously in a matter of minutes, allow us to vastly improve the quality of life for our patients.

STEPHEN L. CORSON, M.D.

PREFACE

In 2002, we published a book on laparoscopy entitled *A Practical Manual of Laparoscopy: A Clinical Cookbook*. At first, the name of the book was criticized greatly; however, its merits became apparent and subsequently it was widely accepted as an easy to read and understandable text – the title became a mark of edification.

We were then encouraged to edit a book on hysteroscopy along the same vein that could be used by physicians in training, but would also serve as a handy reference for practicing physicians. This book continues in the style of the laparoscopy text, using the outstanding digital images created by Branko Modrakovic based on photos and drawings of the individual chapter authors. Each chapter has been written by experts in hysteroscopy who are renowned for not only their knowledge, but also their ability to teach.

Hysteroscopy, although known since 1869 and used since 1925, has gained general acceptance by gynecologists relatively slowly. It wasn't until 1970 when 32% Dextran was used to distend the uterine cavity, that gynecologists slowly began to utilize hysteroscopy, not only for diagnosis, but also for operative procedures.

Many other techniques have subsequently been developed since 1981, when Goldrath and colleagues published data on the use of hysteroscopy to ablate the endometrium with a laser. This opened the gates for the everyday gynecologist to offer alternatives to hysterectomy in the treatment of severe meno-metrorrhagia.

The hysteroscope also permits the outpatient treatment of many other pathologies including sub-mucosal leiomyomas, endometrial polyps, uterine synechia and uterine septa. Recently, hysteroscopic sterilization techniques have been developed and widely accepted as office based procedures.

This book has chapters that address all of the present hysteroscopic therapies and will provide an in depth discussion of the current knowledge of hysteroscopy and global ablation techniques.

The reader will note that many topics may appear to be repetitious as the individual chapter authors were allowed to express their views of procedures. There are also some differences in opinion as to techniques. We believe that allowing the freedom to disagree, even in the same book, is in itself, an educational benefit and will expose the reader to a more balanced view of current knowledge. We, the editors, also may not be in complete agreement with some of the views expressed by the chapter authors; however our role is to educate not censor.

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RONALD L. LEVINE, M.D.

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A CLINICAL COOKBOOK

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We also must thank the Department of Obstetrics, Gynecology and Women's Health for their continuing encouragement and support.

This book, as well as our other contributions to the medical literature, would not be possible with out the hard work and long hours spent by our executive secretary Ms. Laura Lukat-Coffman and our editorial assistant Ms. Leta Weedman. We cannot thank them enough.

CONTENTS

SALINE INFUSION SONOGRAPHY

Linda D. Bradley, M.D.

The introduction of intracervical fluid during TVUS (Transvaginal Uterine Sonography) constitutes one of the most significant advances in ultrasonography during this past decade. Instillation of saline during ultrasound (SIS) enhances and augments the image of the endometrial cavity, as well as provides valuable information about the uterus and adnexa in patients with abnormal bleeding. Given the disparity between endometrial biopsy results and TVUS evaluation, pathologic reports including: "insufficient tissue," "atrophic endometrium," or "scant tissue" on biopsies are no longer sufficient to rule out pathology. SIS provides an exquisite view of the endomyometrial complex that cannot be obtained with TVUS alone. SIS differentiates between focal and global processes and improves the overall sensitivity for detecting abnormalities of the endometrium.

Saline infusion sonography overcomes the limitations of traditional TVUS for evaluating menstrual and postmenopausal bleeding disorders. It offers the advantages of distending the uterine walls to create a three-dimensional view of the uterus, and provides a more concentrated

HYSTEROSCOPIC INSTRUMENTS

Ronald L. Levine, M.D.

Many instruments are available for the hysteroscopist. Instruments which may be used for a particular procedure, such as global therapy instruments, will be described in each chapter (See chapters 14–18). In this chapter we will only describe instruments for general use:

Hysteroscopes and Sheaths;

Fluid Management Systems;

Accessory Instruments;

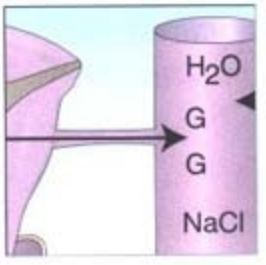
Resectoscopic Instruments;

Ancillary Equipment;

Light source;

Energy source.

DISTENSION MEDIA IN HYSTEROSCOPY



Philip G. Brooks, M.D.

Hysteroscopy provided precious little information concerning the causes of abnormal bleeding or reproductive problems until safe, effective distension was developed. What became evident was that, ideally, the distension medium had to allow the endometrial cavity to be opened, the view to be clarified (even in the face of blood), and little, if any, toxicity to the patient should the medium be absorbed into the vascular tree. In addition, the medium should be readily available at a minimal cost and be very compatible with the instruments used. Along with the dramatic advances in optics, light sources and documentation technologies, the advances in the development and utilization of different media have made hysteroscopy a standard tool for the evaluation and treatment of intrauterine pathologies.

CHOICE OF ANESTHESIA

Laura Clark, M.D.

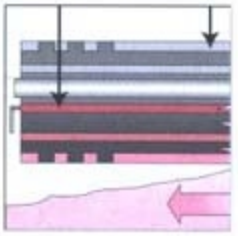
INTRODUCTION

Hysteroscopy presents unique anesthetic implications that have been learned through experience and with correlations from transurethral prostate procedures. Both the anesthesiologist and the gynecologist can initiate interventions that increase the safety and further the applications of this technique. This chapter will briefly address the anesthetic implications of hysteroscopy in general, but will focus on the unique aspects of hysteroscopy as different from other endoscopic procedures.

COOPERATIVE PLANNING BETWEEN ANESTHESIOLOGIST AND SURGEON

Cooperation between the anesthesiologist and surgeon is vital, including their careful planning based on awareness of the physiologic and mechanical forces that lead to complications. Good

ELECTROSURGERY IN THE UTERUS



Malcolm G. Munro, M.D.

INTRODUCTION

Operative hysteroscopy is used to dissect, resect, or ablate tissue within or adjacent to the endometrial cavity. Cup forceps are effective for targeted biopsy and mechanical scissors can be used for adhesions and removal of a septum occasionally. However, most therapeutic procedures require the use of an energy source transmitted to the endometrial cavity. Although lasers were the first energy sources used, electrosurgery provided the best combination of effectiveness, efficiency, and acceptable cost. Electrosurgery refers to the application of radiofrequency (RF) alternating current to elevate intracellular temperature resulting in tissue vaporization or coagulation. The uterine environment and the incumbent requirement to operate in a fluid environment present a number of challenges both to surgeons and to the manufacturers of hysteroscopic surgical equipment. The surgeon should be familiar with electrical principles as they apply to the equipment, thus ensuring that the desired tissue effect is achieved and risks of complications are minimized.

TECHNIQUES FOR DIAGNOSTIC HYSTEROSCOPY, HYSTEROSCOPIC RESECTION AND CYSTOSCOPY

Sari Kives, M.D.
Resad P. Pasic, M.D., Ph.D.

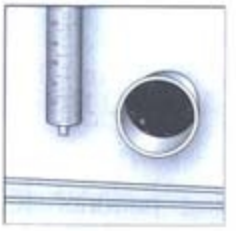
Diagnostic hysteroscopy is ideal for assessing the uterine cavity in women with a history of abnormal bleeding, a misplaced intrauterine device, infertility, or an abnormal ultrasound. It enables direct visualization of the uterine cavity so that pathology can be identified, biopsies can be performed and small lesions can be removed.

To perform a diagnostic hysteroscopy successfully several requirements must be fulfilled.

PATIENT PREPARATION

Patients can be scheduled for diagnostic hysteroscopy after obtaining a comprehensive patient history, performing a physical examination, discussing choice of anesthesia, and obtaining informed consent. The patient is placed in dorsolithotomy position. A pelvic examination is performed to determine the size and position of the uterus. A weighted speculum in addition to a single toothed tenaculum is used

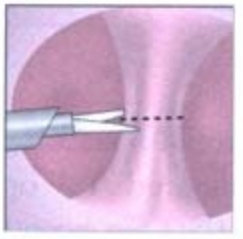
OFFICE HYSTEROSCOPY



Beverly R. Love, M.D.
Roosevelt McCorvey, M.D.

Office hysteroscopy is defined as an office-based procedure performed under local anesthesia (OHULA). This pneumonic stands for OFFICE HYSTERSCOPY UNDER LOCAL ANESTHESIA. Most gynecologists perform hysteroscopy in outpatient surgery centers and hospitals. In fact only 20% of gynecologists perform hysteroscopy at all. More importantly, only 5% of gynecologists participate in office hysteroscopy. Factors that explain the low utilization of office hysteroscopy by gynecologists include lack of knowledge about this technique which is probably a reflection of lack of training in hysteroscopy in the residency program. Therefore, there is a lack of awareness about the diagnostic and therapeutic capability of hysteroscopy. The lack of training in local anesthesia for office hysteroscopy suggests a large reason for the minority of gyn participation in this technique. The fact that there is a significant money outlay for office hysteroscopy is probably the second most significant factor preventing gynecologists from involvement in this endeavor. The corollary is that reimbursement for office hysteroscopy is sorely lacking. The combination of all of these factors adds up to the lack of interest in office hysteroscopy. It

HYSTEROSCOPY FOR INFERTILITY



Andrew L. de Fazio, M.D.
Ceana Nezhat, M.D.

INTRODUCTION

Infertility is a common problem in today's society affecting about 15% of couples. There are multiple etiologies, with the most common being male factor (35%) and female tubal/pelvic factor (35%). Anovulation is the cause in 15% of cases and approximately 10–15% of infertility is unexplained. Congenital uterine anomalies are present in about 0.1% to 0.5% of the population and 20% of females with these anomalies experience reproductive failures, usually in the form of recurrent spontaneous abortions and preterm delivery. These anomalies result from abnormalities in lateral fusion of the mullerian ducts and include defects such as uterus didelphys, unicornuate and bicornuate uterus, and septate uterus (Figure 1). The septate uterus is the most common of these anomalies and is associated with the highest risk of pregnancy loss. It is also unique among these anomalies in that operative hysteroscopic correction is possible and very successful. Arcuate uterus is a variant of normal and is not associated with increased rates of infertility or pregnancy wastage. Other intrauterine

ENDOSCOPIC TREATMENT OF UTERINE ANOMALIES

Rafael F. Valle, M.D.

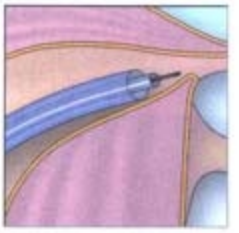
The septate uterus is a uterine anomaly that frequently interferes with normal reproduction. The bicornuate uterus does not occur as frequently but may also cause pregnancy wastage and fetal malpresentations resulting in premature deliveries. The traditional methods for treatment were by classic abdominal metroplasty requiring a laparotomy and a hysterotomy. Presently, when surgical treatment of these anomalies is required, it can be provided transcervically via the hysteroscope using a variety of methods. These include hysteroscopic scissors, thermal energies via the resectoscope or hysteroscope, and laser energy via fiber optic lasers.

HYSTEROSCOPIC TECHNIQUES FOR TREATING THE SEPTATE UTERUS

PREOPERATIVE PREPARATION:

While medical preparation to thin the endometrium prior to hysteroscopic treatment of the uterine septum may be used, it is not nec-

CANNULATION OF THE FALLOPIAN TUBE



Joseph S. Sanfilippo, M.D., M.B.A.
Jonathon Solnik, M.D.

INTRODUCTION

Selective salpingography using specialized catheters under fluoroscopy has become increasingly popular for both tubal sterilization and the evaluation of tubal patency and pathophysiology. Transcervical tubal cannulation by hysteroscopic, fluoroscopic, and ultrasonographic methods are presently the most minimally invasive options for patients with infertility and proximal tubal occlusion. Approximately 20–50% of female infertility is associated with tubal obstruction, of which 20% is due to proximal disease. In the past, these patients were treated with extensive reconstructive surgery involving uterotubal implantation. Subsequent tubal patency rates ranged from 30–50% utilizing macrosurgical technique; however, the term delivery rate was unacceptably low. In 1977, microsurgical anastomosis was described. Prior to Assisted Reproductive Technologies (ART), it had been considered the gold standard for the surgical treatment of proximal tubal occlusion, yielding significantly higher, yet unreliable, term pregnancy rates. Consequently, the wide range of suc-

HYSTEROSCOPIC TUBAL STERILIZATION

Jay M. Cooper, M.D.

INTRODUCTION

A transcervical approach to tubal sterilization offers a non-incisional alternative to laparoscopic surgery that eliminates the need for general anesthesia and that can be readily adapted to an outpatient or office setting. Benefits of this less invasive approach include reduced postprocedure pain, allowing a patient to resume normal activities more quickly.

A transcervical approach could be especially valuable when laparoscopic surgery is contraindicated, e.g., in women who are obese, have severe cardiopulmonary dysfunction or diaphragmatic hernia, or have previously undergone abdominal/pelvic surgery.

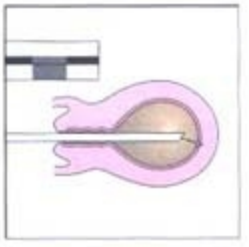
A system that employs a hysteroscopic approach for non-incisional tubal sterilization has recently been developed and shown in clinical trials to be safe and effective. The Essure® (Conceptus, Inc.) permanent birth control system consists of a micro-insert, a disposable delivery system, and a disposable split introducer (Figure 1). A standard hysteroscope employing continuous flow technology with a 5 Fr work-

HYSTEROSCOPIC MYOMECTOMY

Keith B. Isaacson, M.D.
Ginger N. Cathey, M.D.

Approximately 620,000 hysterectomies were performed in the United States in 2001 with uterine leiomyomas being the most common indication. While many women have benefited from a hysterectomy that was appropriately indicated and correctly performed, it is widely believed that numerous unnecessary hysterectomies are performed each year. With greater scrutiny of hysterectomy for myomas and with various surgical and technological advancements arising, many alternatives to hysterectomy are now present. It must be recognized however that all surgical alternatives to hysterectomy allow for the possibility of new leiomyomas to form, and preexisting leiomyomas that were too small to be detected or were intentionally not removed may exhibit significant growth. For women who desire more children or want to retain their uterus and for patients who are not surgical candidates for more invasive procedures, hysterectomy alternatives should be considered. Myomectomy is one of the more common alternatives to hysterectomy. While gynecologists in this country often perform abdominal myomectomy, endoscopic myomectomy is infrequently utilized for treatment of symptomatic uterine fibroids.

ENDOMETRIAL RESECTION



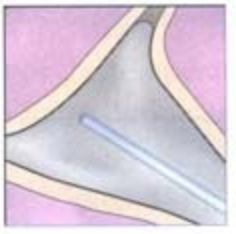
Hervé Fernandez, M.D.

INTRODUCTION

Operative hysteroscopy has modified the surgical management of benign uterine neoplasms. The first endo-uterine procedures using a resectoscope were performed for uterine malformations and submucosal myomas. Endometrial pathologies subsequently became indications for use of the resectoscope (endometrial ablation).

In endometrial resection, all or most of the endometrium is removed. The procedure is combined with the destruction of the superficial layer of the myometrium and is performed under visual guidance. Six to eight millimeters of thickness of the endometrium is resected or destroyed. This resection includes the base of the glands and the internal longitudinal layer of the myometrium, and preserves the external circular layer and its venous plexus.

THERMACHOICE BALLOON ABLATION



Marlies Y. Bongers, M.D., Ph.D.

The first report on the thermal ablation balloon appeared in 1994. Dr. Robert Neuwirth developed this device, initially referred to as the "endometrial ablator." GYNECARE THERMACHOICE Uterine Balloon Therapy System (Gynecare, Johnson & Johnson, NJ, USA) was the first second-generation ablation technique commercially available and has since been thoroughly evaluated.

PATIENT SELECTION

Women suffering from menorrhagia have several treatment options, including balloon endometrial ablation. Patients must have completed childbearing and be committed to using contraception consistently and correctly until menopause. In the last decade, the introduction of transvaginal sonography, saline infusion sonography, and hysteroscopy has enhanced our ability to diagnose intracavitary abnormalities. The Instructions for use (IFU) approved by the FDA, states that the "safety and effectiveness of GYNECARE THERMACHOICE UBT System has not been fully evaluated in patients with submucosal myomas . . ."One

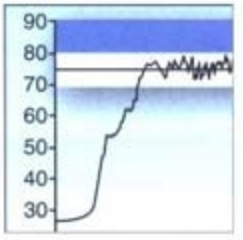
HYDROTHERMAL ABLATION (HTA®)

Milton H. Goldrath, M.D.

Hydro thermablation is a technique to ablate the endometrial layer of the uterus utilizing heated saline (80–90°C) introduced into the uterine cavity by a hysteroscopic system. This system is called the Hydro Thermablator® (HTA®).

Hydro thermablation is safe, simple, very effective and exceptionally easy to perform as a minor operative procedure for the treatment of menorrhagia. Since the HTA® system offers the opportunity for office-based, or ambulatory interventions, it is an attractive choice compared with traditional rollerball or resectoscopic surgery. It eliminates electrosurgical hazards and serious fluid management problems. In contrast to other "global" ablation techniques, the HTA® system offers the safety and confidence of hysteroscopic visualization throughout the procedure. It is essentially insensitive to variations from the norm regarding cavity size and shape that limit treatment devices with set sizes or shapes.

MICROWAVE ENDOMETRIAL ABLATION



Kevin G. Cooper, M.Sc, M.D., M.R.C.O.G.

Microwave endometrial ablation (MEA™) is a second generation, blind endometrial ablative technique developed and pioneered in the UK in the mid 1990's. It causes no bleeding and does not require fluid distension of the uterine cavity, negating two of the problems associated with first generation hysteroscopic methods. To date, more than 15,000 treatments have been performed worldwide, principally in the UK, Canada, and Australia. The microwave endometrial ablation (or MEA™ system), having completed the necessary evaluation, received U.S. FDA approval in September 2003.

MICROWAVE ENERGY

Microwave ablation should not to be confused with radio frequency endometrial ablation (RaFEA), which was misnamed "microwave" by some sources. Microwaves are electromagnetic waves with a wavelength of 0.3 cm to 30 cm and frequency, 300 to 300,000 Mhz (between radiowaves and infrared radiation) (Figure 1). At a frequency of 9.2 GHz, and at a low power of 30 W, microwave energy predictably and effec-

ENDOMETRIAL CRYOABLATION

Errico Zupi, M.D.
Alessio Piredda, M.D.
Daniela Marconi, M.D., Ph.D.

Cryoablation of the endometrium is a second generation endometrial ablation technique. Recently Cryogen™, Inc. (San Diego, CA, USA) developed a new effective device called Her Option™ System.

First generation techniques include:

Transcervical resection of the endometrium;

Rollerball ablation;

Endometrial laser ablation.

These techniques required surgical expertise and experience, were potentially dangerous because of use and absorption of distension media, required general anesthesia and had a high number of recurrences because of the difficulty to obtain a complete resection of the endometrium considering the depth of tissue destruction.

Compared to the first generation ablation techniques, second generation have common features. In fact second generation techniques were developed mostly to reduce the level of operator skill without compromising effectiveness. These methods are easy to learn and don't require extensive training.

NOVASURE™ GLOBAL ENDOMETRIAL ABLATION

Jay M. Cooper, M.D.
Eugene V. Skalnyi, M.D.

Radio Frequency (RF) energy has been successfully employed with the use of "First Generation" (i.e., hysteroscopic) endometrial ablation systems (rollerball, loop, and rollerbar). With the development of "Second Generation" products, this time tested energy found an application as well.

NOVASURE™ TECHNOLOGY OVERVIEW

The NovaSure™ System consists of a disposable ablation device, portable RF controller, desiccant, foot switch, and power cord (Figure 1). The disposable device consists of a single-patient use, conformable bipolar electrode array mounted on an expandable frame (Figure 2). The 7.2 mm diameter device is inserted trans-cervically into the uterine cavity. The protective sheath is then retracted to allow the bipolar electrode array to be deployed and conform to the uterine cavity. The electrode array consists of a gold-plated, porous fabric mesh through which steam and moisture are continuously suctioned as tissue is desiccated.

REPEAT ENDOMETRIAL ABLATION

Richard J. Gimpelson, M.D., P.C.

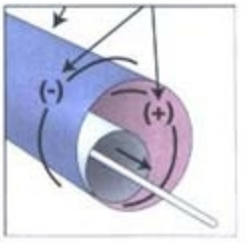
Endometrial ablation is an excellent alternative to hysterectomy for women with prolonged or heavy uterine bleeding and in whom hormonal therapy is unsuccessful, undesired, or contraindicated. Endometrial ablation by many methods will be successful up to 90% of the time. Women in whom the procedure is not successful have the choice of hysterectomy, observation, or repeat ablation.

INDICATIONS

The indications for repeat endometrial ablation will be one of five categories:

1. Uterine bleeding improved, but still heavy or prolonged and adversely affecting the patient's quality of life;
2. Physical or mental disability in which amenorrhea is desired;
3. Initial procedure not completed because of excess fluid absorption, leiomyomas, instrument malfunction, or uterine perforation;
4. Amenorrhea desired by patient despite achieving reduced or normal flow;

HYSTEROSCOPIC SURGERY: INDICATIONS, CONTRAINDICATIONS AND COMPLICATIONS



George A. Vilos, M.D.

INDICATIONS FOR HYSTEROSCOPY/SURGERY

There are several indications for hysteroscopy:

Direct visualization of the endometrial cavity for assessment and sampling, when indicated, in women with menstrual or fertility disorders.

Diagnostic hysteroscopy and biopsy in women with abnormal uterine bleeding is indicated when one is unable to perform an office biopsy or the sample is inadequate or inconclusive.

Direct surgical access for intrauterine surgery versus trans-abdominal and/or trans-uterine surgery for removal of foreign body (misplaced intrauterine contraceptive devices) and for therapy of endometrial polyps, intracavitary, submucosal and some intramural fibroids, division of intrauterine adhesions and septa, tubal cannulation for proximal tubal disease, tubal occlusion for family planning and finally treatment of abnormal uterine bleeding by ablating or resecting the endometrium.

ENDOMETRIAL ABLATION TECHNIQUES

Ginger N. Cathey, M.D.

Approximately 600,000 hysterectomies are performed each year in the United States. Abnormal or dysfunctional uterine bleeding is reported as the primary indication for surgery in 20% of these patients. With the advent of endometrial ablation, this subset of patients, about 120,000 women annually, now has a less invasive alternative to hysterectomy. Endometrial ablation is not intended to replace hysterectomy. But it does provide treatment options for both the physician and the patient. If the patient desires permanent cessation of menses, she should likely be treated with hysterectomy. But if the patient would be satisfied with lighter or normal cycles and desires to preserve her uterus or prefers a procedure with less morbidity, then endometrial ablation is an excellent alternative. Regardless of the treatment option that is chosen, women who are given a choice are more satisfied patients.

Endometrial ablation is primarily designed for the treatment of abnormal or dysfunctional uterine bleeding (AUB/DUB). This is defined as excessive uterine bleeding with no demonstrable organic

A Practical Manual of Hysteroscopy and Endometrial Ablation Techniques

A Clinical Cookbook

Edited by Resad P. Pasic M.D., Ph.D. and Ronald L. Levine M.D.

The past decade has seen an explosive growth in both knowledge and techniques used in hysteroscopy and endometrial ablation. This clearly written and beautifully illustrated practical manual describes in detail the technical aspects of both diagnostic and operative hysteroscopy and the most useful endometrial ablation procedures.

The editors, Resad P. Pasic and Ronald L. Levine, have brought together an internationally renowned group of authors to contribute their knowledge and expertise in the field of hysteroscopy. This manual is essential reading for all gynecologists and ObGyn residents – particularly those unfamiliar with the indications and technical aspects of more recent techniques.

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