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Preface

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Whilst the results of in-vitro-fertilization (IVF) treatment has steadily increased over the last 20 years, there is also an increasing awareness that uterine factors contributing to infertility or pregnancy loss cannot usually be overcome by IVF. The various forms of congenital uterine anomaly and acquired uterine pathology such as fibroid, adenomyosis, endometrial polyps and intrauterine adhesions may result not only in infertility and implantation failure but also cause first trimester and second trimester miscarriage. In general, the various forms of reproductive failure associated with uterine pathology do not benefit from IVF treatment; very often surgical intervention is required to improve the outcome.

Pregnancy resulting from IVF is associated with an increase in multiple pregnancy rate which in turn leads to an increase in the risk of preterm delivery. Whilst routine cervical cerclage in women with twin pregnancy is not indicated, there are situations in which the procedure is beneficial. If cervical cerclage is considered necessary, a decision should be made regarding timing and a choice should be made regarding the transvaginal, laparotomy or laparoscopy route.

Reproductive surgery is complimentary to IVF treatment in a number of clinical scenarios. The presence of hydrosalpinx is associated with recurrent implantation failure because hydrosalpinx fluid is known to be embryo toxic and adversely affect embryo implantation. The removal of hydrosalpinx or blocking the cornual part of the tube to prevent entry of the fluid from the tube to the uterine cavity will improve implantation and pregnancy rate. The removal of peritoneal endometriotic lesions or endometrioma may not improve IVF outcome but could increase spontaneous conception rate.

The fertility potential of a woman may be impaired following a gynaecological operation involving the ovary, tube or uterus. Every step should be taken during gynaecological operation to preserve reproductive organ function in women of reproductive age and who wish to retain fertility. In this respect, the role of a general gynaecologist is crucial. Training should be implemented to increase awareness of various fertility preserving principles & techniques. Training in endoscopic surgery has traditionally been achieved by apprenticeship, the experience and skills acquired varies considerably from one individual to another. The use of structured curricula and simulation should improve training and more objectively evaluate the level of surgical skill acquired.

Whenever possible, the outcomes of a surgical procedure should be regularly monitored. The evaluation may take the form of an audit of a personal series or a systematic or meta-analysis. In this way, the efficacy and limitations of a surgical procedure may be regularly updated and rooms for further improvement identified.

Conflict of interest

The author has no conflict of interest.

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