

Tuboplasty, thank-you notes, and the revival of lost arts



For a newlywed, there are numerous daunting and foreign tasks and decisions that must be faced. There are so many questions: Where to live? How to best support one another? Will one choose to change their name or identity? Interestingly, one of the most difficult tasks that on the surface may appear so simple is sending handwritten thank you cards to family and friends. Handwritten letters have become a lost art in our modernized and technologically driven society. Text messages and e-mails, which are exceedingly more time-efficient and instantly gratifying, have driven postcards and thank-you notes to near extinction. It is not surprising then, that the responsibility of writing 100 (or more!) individualized letters following a wedding puts many at a loss.

Karen Benke, author of the book *Write Back Soon! Adventures in Letter Writing*, is a strong proponent of reviving this art. She, any many other authors, argue that handwritten letters allow for more personalization, connection, and creativity than electronic communication can provide. When taking that time to put pen to paper, it becomes easy to agree with these sentiments and with the belief that a renaissance of letter writing is in order (1).

In “Laparoscopic tuboplasty for mild distal tubal disease,” Norris et al. (2) are also proposing a renaissance of-sorts. More than a decade ago, surgical intervention for infertility was pronounced dead because assisted reproductive technologies (ART) had completely replaced surgery as the first-line treatment for infertility (3). In conjunction with this belief, the quality and volume of training in reproductive surgery has deteriorated, with many fertility centers offering primarily ART with limited access to surgical intervention (4).

Norris et al. begin their video presentation with a review of tubal disease and infertility, including risk factors and diagnosis. Tubal disease is common and accounts for ~25%–35% of female-factor infertility. Women at highest risk for tubal-factor infertility are those who have a history of ectopic pregnancy, pelvic inflammatory disease, endometriosis, or pelvic surgery, including of course, tubal ligation. Given how frequently tubal disease is encountered in infertility, and the high rate of regret following tubal ligation (20%–30%), it is important to be knowledgeable about the range of interventions available and which are best suited to our individual patients (5).

For patients with tubal disease and infertility, options for intervention include both ART in the form of in vitro fertilization (IVF) and tubal surgery. The advantages of IVF are a 47% live birth rate per cycle (patient’s own eggs, age <35 years), a faster time to pregnancy, and no need for surgical intervention. Meanwhile the disadvantages include the requirement of close monitoring, risk of obstetrical complications, such as multiple gestation, preterm delivery, fetal growth restriction, and congenital malformations, and the potential for ovarian hyperstimulation (2, 5). Surgical intervention has the advantage of being a one-time, often minimally invasive, procedure that can result in multiple future pregnancies when successful. However, surgical intervention does incur the risks

of anesthesia and intraoperative complications, including injury to reproductive organs and the result of a higher rate of ectopic pregnancy (2, 5). Surgery also has a longer time-to-pregnancy interval, with 90% of pregnancies occurring within 6–12 months. Another important factor to acknowledge when discussing these two options is cost, because for many patients, surgical intervention is still less expensive than IVF (4), although mandated IVF coverage varies by state and by country.

The question, then, is how to counsel patients on which option best fits their individual needs? The authors of the video discuss this by describing favorable candidates as those that want to avoid ART and who present “good surgical prognosis.” They further describe good surgical candidates as those with mildly dilated tubes (<3 cm), only filmy adhesions, and a lush endosalpinx (2). While having criteria to identify those who would most benefit from surgery is helpful, it is equally important to have well trained reproductive surgeons capable of offering and performing these procedures. In recent years, there have been concerns regarding a decline in the training and quality of reproductive surgery (4). One method to address this concern is by creating high-quality resources not only describing surgical techniques but also demonstrating them. Norris et al.’s publication is an example of such a valuable resource.

In the video, the authors describe three common surgical techniques used to treat tubal disease: fimbrioplasty, salpingo-ovariectomy, and salpingostomy (2). Their chosen medium allows them to then walk the viewer step by step through a case in which they skillfully execute both salpingo-ovariectomy and salpingostomy. Although the authors show only a single approach, they describe how different surgical techniques and instruments can be substituted and used based on surgeon preference or clinical scenario (2). In producing this video, the authors have created an accessible and effective platform for trainees and faculty alike to see and review techniques for surgical tuboplasty.

Although we can never expect letter writing to completely replace our electronic communication or for surgical intervention to replace the continuing advances in ART, there are still meaningful places for them in our repertoire. In the hands of a passionate author or a well-trained reproductive surgeon, these seemingly antiquated techniques can be skillfully implemented to the advantage of both the benefactor and the recipient. So the next time you find yourself sending a heartfelt e-mail, consider picking up a pen instead. And when initiating IVF consultation in a patient with tubal pathology, consider a scalpel. These lost arts are not always the answer, but in the right scenario they can be.

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