# Visual dilation and curettage for the fertility-sparing treatment of atypical endometrial hyperplasia/endometrial intra-epithelial neoplasia: an easy to perform in-office technique

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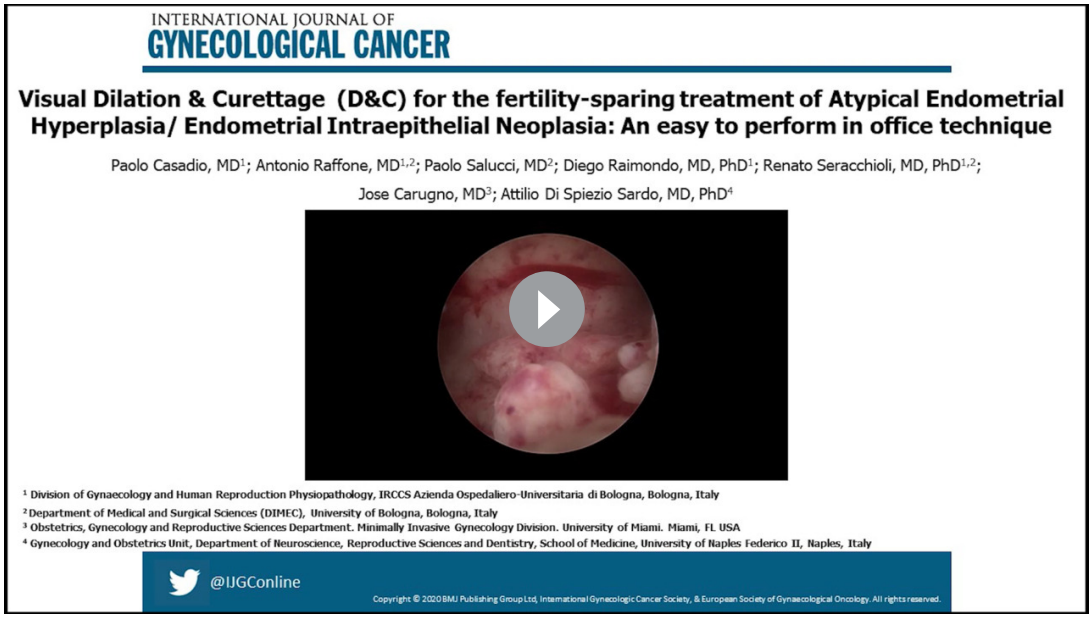
Hysteroscopic endometrial resection when added to progestin therapy has been shown to improve the outcomes of fertility-sparing treatment in patients diagnosed with atypical endometrial hyperplasia/endometrial intra-epithelial neoplasia .[1 2] Unfortunately, with such a technique, the extension and depth of endometrium removal appears poorly reproducible. Moreover, the procedure must be performed in the operating room, and potential thermal damage of the specimen may affect its quality for histological examination.[3] Hysteroscopic tissue removal systems have shown greater safety and better outcomes for the length of the procedure, the learning curve, and successful complete removal of benign intrauterine pathology compared with resectoscopes.[4] However, further studies are needed to investigate the role of hysteroscopic tissue removal systems in patients with malignant pathology. Hysteroscopic procedures, when performed in the office/outpatient setting, are cost-effective, with a low complication rate and high patient satisfaction.[5] However, their use in the fertility-sparing treatment of atypical endometrial hyperplasia/endometrial intra-epithelial neoplasia has never been described. The aim of this video article was to demonstrate the use of hysteroscopic tissue removal systems for the fertility-sparing treatment of patients with endometrial hyperplasia/endometrial intra-epithelial neoplasia.

We report the management of two women diagnosed with atypical endometrial hyperplasia/endometrial intra-epithelial neoplasia who expressed the desire to preserve fertility. After counseling, women opted for fertility-sparing treatment of the disease.




**Video 1** Hysteroscopic endometrial resection using a hysteroscopic tissue removal system

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Fertility-sparing treatment was performed in the office setting and consisted of hysteroscopic endometrial resection using a hysteroscopic tissue removal system, followed by immediate insertion of a 52 mg levonorgestrel-releasing intrauterine device. The total procedure time (endometrial resection and intrauterine device insertion) ranged from 10 to 13 min. The women were closely followed up every 3 months with endometrial biopsy to assess the response to treatment.

A hysteroscopic tissue removal system allowed us to perform hysteroscopic endometrial resection in an-office setting. Its use is a safe and feasible in-office/outpatient alternative for the fertility-sparing treatment of women diagnosed with atypical endometrial hyperplasia/endometrial intra-epithelial neoplasia. However, further studies are needed to investigate the safety of using hysteroscopic tissue removal systems for the treatment of uterine pre-malignant or malignant pathology.

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