ESGE PAGES

DOI: 10.52054/FVVO.2026.547
Facts Views Vis Obgyn 2026;18(3):250-260

Structured Reporting of Diagnostic Hysteroscopy Findings in Women with Reproductive Disorders: An ESGE–ESHRE–IFFS International Consensus

International Hysteroscopy Working Group of ESGE, ESHRE and IFFS; Ursula Catena[1], Grigoris Grimbizis[2], Alessandro Arena[3], Rudi Campo[4], Carlo De Angelis[5], Attilio Di Spiezio Sardo[6], Anis Feki[7], Hervé Fernandez[8], Marcos Horton[9], Edgar Mocanu[10], Luis Alonso Pacheco[11], G. Pados[2], Attila Vereczkey[12], Sotirios Saravelos[13], Amerigo Vitagliano[14], Maribel Acién[15], Luca Gianaroli[16,17]

[1]Gynaecology Oncology Unit, Fondazione Policlinico Universitario A. Gemelli IRCCS, Rome, Italy
[2]1st Department of Obstetrics and Gynecology, Medical Faculty, Aristotle University of Thessaloniki, Greece
[3]Division of Gynecology and Human Reproduction Physiopathology, IRCCS S.Orsola Azienda Ospedaliero-Universitaria di Bologna, Bologna, Italy
[4]Life Expert Centre, Leuven, Belgium
[5]Department of Maternal and Child Health and Urological Sciences, "Sapienza" University of Rome, Rome, Italy
[6]Department of Public Health, School of Medicine, University of Naples Federico II, Naples, Italy
[7]Department of Obstetrics and Gynecology, HFR Fribourg - Hôpital cantonal, Fribourg, Switzerland
[8]University Paris-Saclay, Paris, France
[9]Pregna Medicina Reproductiva, Buenos Aires, Argentina
[10]Department of Reproductive Medicine, Rotunda Hospital and RCSI, Dublin, Ireland
[11]Obstetrics and Gynecology Department, Reproductive Surgery Unit, Hospital Quirón, Malaga, Spain
[12]Versys Clinics-Human Reproduction Institute, Budapest, Hungary
[13]Hammersmith Hospital, Imperial College, London, United Kingdom
[14]Unit of Obstetrics and Gynaecology, Department of Interdisciplinary Medicine (DIM), University of Bari "Aldo Moro", Policlinico of Bari, Bari, Italy
[15]Obstetrics and Gynecology Service, San Juan University Hospital. Division of Gynecology, Miguel Hernández University, Alicante, Spain
[16]International Institute of Reproductive Medicine - IIRM - Lugano, Lugano, Switzerland
[17]Interdisciplinary Institute of Reproductive Medicine - IIRM - Bologna, Bologna, Italy

Corresponding Author: Ursula Catena, MD, Department of Women's and Children's Health and Public Health, Agostino Gemelli University Hospital IRCCS, Rome, Italy
E-mail: ursula.catena@gmail.com **ORCID ID:** orcid.org/0000-0002-7813-7993
Received: 13.07.2026 **Accepted:** 30.07.2026 **Publication Date:** 15.09.2026

Cite this article as: International Hysteroscopy Working Group of ESGE, ESHRE and IFFS; Catena U, Grimbizis G, Arena A, Campo R, De Angelis C, et al. Structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders: an ESGE–ESHRE–IFFS International Consensus. Facts Views Vis Obgyn. 2026;18(3):250-260

ABSTRACT

Background: Despite its widespread use in women with reproductive disorders, no standardised framework currently exists for reporting of hysteroscopic findings. This lack of uniformity may limit the utility of the procedure and contribute to substantial heterogeneity among operators and centres. As a result, the reproducibility of hysteroscopy is limited, making it difficult to conduct robust studies that define its prognostic value in specific patient subgroups.

Objectives: To develop an international consensus on the structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders.

Methods: A dedicated working group from the European Society for Gynaecological Endoscopy (ESGE), European Society of Human Reproduction and Embryology (ESHRE), and International Federation of Fertility Societies (IFFS) collaborated to develop a consensus for comprehensive structured reporting of diagnostic hysteroscopy findings in women with reproductive problems. This consensus paper focuses on grouping diagnostic hysteroscopic findings, structuring their reporting, and adopting standardised terminology for women with reproductive disorders. The virtual Nominal Group Technique, a structured consensus-building method, was adopted to ensure equal contribution from all members in the development of the final consensus.

Main Outcome Measures: A consensus for comprehensive structured reporting of diagnostic hysteroscopy findings in women with reproductive problems.

Results: This collaborative document by ESGE, ESHRE and IFFS provides the first detailed framework for structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders. The document provides a structured reporting of hysteroscopic findings into five sections, each systematically capturing patient characteristics, procedural findings, and pathological observations as follows: patient characteristics, findings from the vagina, cervix, uterine cavity, endometrium and tubal ostia.

Conclusions: The standardised reporting of hysteroscopic findings promotes consistent data collection across centres and could help inform research and exchange of clinical experience, enhancing the value of hysteroscopy in fertility evaluation. This report could be used as a validation tool for further research.

What is New? This collaborative document by ESGE, ESHRE and IFFS provides the first detailed structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders.

Keywords: Consensus, hysteroscopy, infertility, reproduction, reproductive disorders, International consensus

Introduction

Hysteroscopy is widely recognised as the gold standard for the diagnosis and treatment of intrauterine pathologies.[1-3] Technological advancements, including smaller-diameter scopes with operative channels and the use of saline distension media, have greatly simplified hysteroscopy, making it more patient-friendly and enabling outpatient procedures without the need for cervical dilation or analgesia.[4-6]

As with other specialised diagnostic procedures, the use of hysteroscopy should be guided by specific clinical indications and diagnostic objectives. Reproductive disorders such as infertility, recurrent pregnancy loss, late miscarriage, and repeated Assisted Reproductive Technologies (ART) failures represent common indications, requiring evaluation by operators with expertise in reproductive medicine. In patients with reproductive disorders, hysteroscopy provides valuable information on the vagina, cervix, cervical canal, uterine cavity, endometrium, and tubal ostia. It should be regarded not merely as an anatomical inspection, but as a comprehensive functional assessment of factors relevant to reproduction, as well as a tool that may improve the performance of ARTs (e.g., resolution of cervical canal stenosis, anatomical assessment for embryo transfer), especially in patients experiencing recurrent implantation failure.[7] Among its key advantages, the procedure enables detailed assessment of endometrial morphology and its concordance with the menstrual phase, while allowing the identification of common congenital and acquired uterine abnormalities, including uterine malformations, niches, fibroids, and intrauterine adhesions (IUA). Hysteroscopy also permits a limited evaluation of tubal patency through indirect visualisation of the morphological and dynamic characteristics of the tubal ostia, potentially revealing infertility-related factors that may escape detection by ultrasound. Overall, hysteroscopy represents a technically refined procedure with substantial diagnostic value.

Despite its widespread use in women with reproductive disorders, no standardised framework currently exists for reporting of hysteroscopic findings. This lack of uniformity may limit the utility of the procedure and contribute to substantial heterogeneity among operators and centres.

As a result, the reproducibility of hysteroscopy is limited, making it difficult to conduct robust studies that define its prognostic value in specific patient subgroups.

In recent years, progress has been made toward harmonising hysteroscopic terminology at the global level, based on expert consensus.[6] However, no comparable scientific efforts have been directed toward standardising the execution and reporting of diagnostic hysteroscopy in women with reproductive disorders. Given its potential global value, there is an urgent need for a scientifically validated and universally accepted framework.

To address this gap, a joint working group was established, composed of representatives from the European Society for Gynaecological Endoscopy (ESGE), the European Society of Human Reproduction and Embryology (ESHRE), and the International Federation of Fertility Societies (IFFS). The objective of the established working group was to develop a structured reporting framework for diagnostic hysteroscopy findings in women with reproductive disorders. The overarching objective was to standardise terminology and facilitate global adoption of this framework in both clinical practice and research settings. The present document represents the outcome of this collaborative effort.

Methods

Organisational Framework and Participants

This project was implemented as an international, multidisciplinary consensus initiative jointly endorsed by three leading organisations in the field of reproductive medicine and gynaecological endoscopy: the ESGE, the ESHRE, and the IFFS.

A total of 17 experts were nominated by the three societies based on recognised expertise in hysteroscopy and reproductive medicine, as well as significant academic contributions to the field. To strengthen the global relevance of the consensus, experts were selected to ensure representation from diverse geographic regions.

Draft Development and Consensus Methodology

A preliminary draft of a structured hysteroscopy recording template was prepared by a steering committee composed of three members (U.C., Am.V., A.A.) and critically revised by one member (G.G.). This draft was developed following a critical review of the current literature and existing recording systems in gynecology and served as the basis for the consensus process. The consensus process was completed in two virtual meetings and one final round of written feedback. The entire process was conducted between July 2025 and February 2026. After finalising the reporting template, the manuscript was prepared by U.C. and G.G. and sent for comments and final approval by the members of the working group.

To refine and validate the draft template, we adopted the virtual Nominal Group Technique, a structured consensus-building method designed to ensure equal contribution from all participants.[8]

Step 1-Silent Generation of Comments

Each expert independently reviewed the draft template and documented its strengths, limitations, and potential modifications.

Step 2-Round-Robin Sharing

During a moderated videoconference, each participant in turn presented a proposed modification. All suggestions were recorded without immediate discussion until the full set of comments was collected.

Step 3-Structured Discussion

Each proposed modification was then discussed by the group to ensure clarity, avoid redundancy, and consolidate overlapping proposals. The discussion was moderated to maintain focus and equitable participation.

Step 4 -Voting and Ranking

All participants subsequently rated each proposed modification anonymously using an electronic survey tool (five-point Likert scale: strongly disagree to strongly agree). A predefined threshold of ≥75% agreement (scores 4-5) was required for inclusion. Items with <50% agreement were excluded, whereas those with 50-74% agreement were revised and re-discussed before re-voting in the same session.

Step 5-Consolidation

The steering committee synthesised the voting outcomes, integrated approved modifications, and produced a revised version of the recording template. This version was circulated electronically among all 17 experts for final written comments. At this stage, only minor editorial

adjustments were accepted, and no new items were introduced.

The final text was reviewed and approved by the ESGE Academic Faculty, ESHRE and IFFS Executive Committees.

Ethical Considerations

As this initiative did not involve patient recruitment or the collection of clinical data, formal ethical approval was not required. Nonetheless, the process was conducted in full compliance with the principles of transparency, inclusivity, and respect for intellectual contributions, following Good Consensus Practice recommendations for scientific societies.[9]

Results

Development of the Structured Reporting Template

To ensure a comprehensive and reproducible evaluation of uterine anatomy and pathology in women with reproductive disorders, a structured hysteroscopic reporting template was developed. The report is organised into five sections, each systematically capturing patient characteristics, procedural findings, and pathological observations.

A total of 35 items were reviewed (Supplementary File 1). Of these: 17 (48.6%) were approved unanimously; 18 (51.4%) required modification following group discussion before final approval (Supplementary File 2).

Hysteroscopic Report

The structured reporting template for hysteroscopic procedures in women with reproductive disorders (Figure 1) includes:

Patient Characteristics

The initial section records baseline demographic and reproductive data, including age, anthropometric parameters (height, weight), hormonal profile [anti-Müllerian hormone (AMH), follicle-stimulating hormone (FSH)], and menstrual history. It further includes previous hysteroscopic or uterine interventions (e.g., caesarean section, myomectomy, conisation, uterine artery embolisation) and possible previous infections [e.g. pelvic inflammatory disease (PID)]. Reproductive history, including infertility, previous implantation failures, gravidity, parity, miscarriages/abortions (with or without dilation and curettage), preterm deliveries, is also reported. Indications for hysteroscopy (baseline assessment, failed ART attempts and pregnancy losses) are specified, together with relevant imaging findings from ultrasound or magnetic resonance imaging (MRI).

Hysteroscopic Findings

Vagina, Cervix and Cervical Canal

The second section addresses the anatomical and pathological findings in the vagina, cervix, and cervical canal.

Potential vaginal anomalies are listed: longitudinal non-obstructive or obstructive vaginal septum, transverse septum, others.[10]

Cervical morphology and orientation/course of the endocervical canal (anteverted, axial, retroverted) are documented, along with potential abnormalities such as congenital malformation (single cervix with cervical septum or double cervix),[11,12] intracervical synechiae, or stenosis of the internal or external uterine orifice. Cervical lesions, if present, should also be described.

Congenital anomalies of the vagina and the cervix follow the ESGE/ESHRE classification system.[10,12]

Uterine Cavity

As a first step, the difficulty in accessing the uterine cavity should be reported; if the access to the uterine cavity is not possible, an explanation is required. Evaluation of the uterine cavity includes distension quality (optimal/non-optimal), wall irregularities, uterine orientation (anteverted, axial, retroverted), and overall uterine morphology. The presence of foreign bodies is also documented.

Regarding uterine morphology, the report may include a diagnostic suspicion of a dysmorphic uterus (T-shaped or Y-shaped), unicorporeal uterus or other (e.g., I-shaped, infantilis).[10,12-14] Further differential diagnoses (e.g., between septate uterus and bicorporeal uterus) cannot be made based solely on intrauterine hysteroscopic visualisation.[12] In the hysteroscopic report, the description of the fundal indentation is also required following the ESHRE/ESGE classification system: partial (including also the indentation length) or complete. In case of fundal indentation, a 3D ultrasound examination is recommended, as only the combination of hysteroscopy and 3D ultrasonography ensures the highest diagnostic accuracy.[5,12]

PATIENTS CHARACTERISTICS

Name _____ Age ____ H ____ W ____ Last menstrual period _____ AMH____ FSH ____ Other _____
Current medical therapy: _____ Previous hysteroscopies: _____
Previous uterine procedures (i.e. caesarean sections, abdominal or hysteroscopic myomectomy, conization, uterine artery embolization):
_____ Previous infections (type)_____
Reproductive anamnesis: Infertility (duration in months: _____) ◊ Primary ◊ Secondary
Previous implantation failures (number): _____ Gravidity _____ Parity_____
Miscarriages/Abortion _____ D&C: ◊ YES. ◊ NO Preterm delivery _____
Indication: ◊ baseline examination ◊ failed ART ◊ Recurrent pregnancy loss
◊ Ultrasound findings: _____ ◊ MRI findings: _____
◊ Other: _____

HYSTEROSCOPIC FINDINGS

VAGINA
◊ **Normal**
◊ **Abnormal:** ◊ Longitudinal obstructive septum
◊ Longitudinal non-obstructive septum
◊ Transverse septum
◊ Other: _____

CERVIX AND CERVICAL CANAL
◊ **Normal** ◊ **Septate** ◊ **Double**
Stenosis: ◊ External uterine os
◊ Internal uterine os
Intracervical adhesions ◊ obstructive ◊ non obstructive
Orientation: ◊ Anteverted
◊ Axial
◊ Retroverted
Cervical lesions: _____

UTERINE CAVITY **Access to the uterine cavity** ◊ Easy ◊ Difficult ◊ Not possible (*reason*) _____
Distention: ◊ Optimal ◊ Non-optimal (reason)_____ **Wall irregularities**_____
Orientation: ◊ Anteverted ◊ Axial ◊ Retroverted
Other (i.e. foreign bodies): _____ **Presence of fluid in the uterine cavity** ◊ YES ◊ NO
Morphology: ◊ Normal
◊ Dysmorphic ◊ T-shaped ◊ Y-shaped ◊ Unicorporeal ◊ Others (i.e. I-shaped, infantilis) _____
◊ Fundal indentation ◊ Partial (specify according to the cavity length) _____ ◊ Complete

ENDOMETRIAL FEATURES
Synchronous ◊ YES ◊ NO
Abnormal findings
◊ Hypotrophic endometrium ◊ Diffuse polypoid thickening ◊ Focal polypoid thickening
◊ Highly vascularized ◊ Easily bleeding areas ◊ Strawberry pattern
◊ Cystic dilations of the uterine glands ◊ Micropolyps ◊ Stromal edema
◊ Microcalcifications ◊ Ulcerated areas ◊ Crumbly consistency
◊ Haemorrhagic cysts ◊ Small opening on the surface ◊ Endometrial vascular dystrophia
◊ Endometrial compaction ◊ Other: _____

Polyps (*number*)_____ ◊ Pedunculated ◊ Sessile
Wall (anterior, posterior, lateral right, lateral left): _____
Location (fundus, corpus, isthmus): _____**Size (mm):** _____

Fibroids (*number*)_____ ◊ Type 0 ◊ Type 1 ◊ Type 2 ◊ Suspicion of Type 3
Wall (anterior, posterior, lateral right, lateral left): _____
Location (fundus, corpus, isthmus): _____**Size (mm):** _____

Suspicion of malignancy ◊ Focal lesion ◊ Diffuse lesion ◊ <50% of the cavity ◊ >50% of the cavity
◊ Suspicion of myometrial infiltration ◊ Suspicion of cervical infiltration

Adhesions ◊ Central ◊ Lateral right ◊ Lateral left ◊ Right cornua ◊ Left cornua
◊ Extension <1/3 ◊ Extension >1/3 ◊ Extension >2/3
Consistency: ◊ Dense ◊ Filmy

Isthmocele **Location** ◊ Isthmus ◊ Cervix
Classification ◊ Simple niche ◊ Simple niche with one branch ◊ Complex niche
Size ◊ Small ◊ Medium ◊ Large ◊ Extreme
◊ Fluid/blood retention ◊ Vascularization: _____

Other pathologies (e.g. RPOC, foreign bodies) _____

Tubal ostia right
◊ Normal ◊ Abnormal
Adhesions ◊ YES ◊ NO
Polyps ◊ YES ◊ NO
Vascularization ◊ YES ◊ NO
Others _____

Tubal ostia left
◊ Normal ◊ Abnormal
Adhesions ◊ YES ◊ NO
Polyps ◊ YES ◊ NO
Vascularization ◊ YES ◊ NO
Others _____

Structured Reporting of Diagnostic Hysteroscopy Findings in Women with Reproductive Disorders: an ESGE–ESHRE–IFFS International Consensus

Figure 1. Final structured reporting template for diagnostic hysteroscopy in women with reproductive disorders.

Endometrial Features

A dedicated section focuses on findings from the endometrium.

It is recommended to describe whether the endometrium appears synchronous with the phase of the menstrual cycle or consistent with ongoing hormonal therapy, if any.

The following abnormal findings, if present, should be described:[15]

- Hypotrophic endometrium
- Diffuse polypoid thickening
- Focal polypoid thickening
- Highly vascularised endometrium
- Easily bleeding areas
- Strawberry pattern
- Cystic dilations of the uterine glands
- Micropolyps
- Stromal oedema
- Microcalcifications
- Ulcerated areas
- Crumbly consistency
- Haemorrhagic cysts
- Small opening on the surface
- Endometrial vascular dystrophia
- Endometrial compaction
- Other

This section additionally records intrauterine lesions. Polyps are described according to morphology (pedunculated, sessile), position on the uterine walls (anterior, posterior, lateral right, lateral left), location (fundus, corpus, isthmus), and dimensions.

Fibroids are classified following the FIGO system (Type 0-Type 2),[16] with systematic documentation on wall involvement (anterior, posterior, lateral right, lateral left), location (fundus, corpus, isthmus) and size. Suspected Type 3 fibroids may also be reported.

Suspected malignant findings are categorised as focal or diffuse lesions, with quantification of cavity involvement (<50% vs. >50%) and potential extension toward the myometrium or cervix.[15]

IUAs are classified by site (central, lateral, cornua), extent (<1/3, >1/3, >2/3 of the cavity), and consistency (filmy vs. dense).[17]

Isthmocele is described according to its location from the internal uterine os (isthmus or cervix), classification (simple niche, simple niche with one branch, complex niche), size (small, medium, large, extreme).[18] Additional characteristics are fluid/blood retention and vascularisation.

Other intrauterine pathologies, such as retained products of conception (RPOC) or foreign bodies, are also documented when present. The size and the location of RPOCs may be specified in the report.[19]

Tubal Ostia

The characteristics of right and left tubal ostia are reported, together with the presence of adhesions, polyps, or abnormal vascularisation.

Discussion

The development of a structured template for reporting diagnostic hysteroscopy findings in women with reproductive disorders represents an important step toward standardisation of reproductive diagnostics. This initiative provides a consensus-based tool designed to improve consistency across centres, enhance communication among clinicians, and facilitate the design of robust scientific studies. In this section, we discuss the rationale and evidence supporting the inclusion of each section and item within the final report.

Patient Characteristics

Accurate documentation of baseline characteristics is essential for patient stratification and the evaluation of hysteroscopic findings. Age, body mass index, hormonal profile (AMH, FSH), and reproductive history have all been shown to impact endometrial receptivity and treatment outcomes.[20] Previous uterine surgery (e.g., myomectomy, caesarean section) or infections (e.g., PID) are relevant as they may predispose to IUAs or niche formation.[21] Although this information is usually included in the patient's main records and inclusion in the hysteroscopy report might be a duplication, the working group considers that it is important to be included in the record due to their clinical significance and as a way to avoid ignoring them.

Hysteroscopic Findings

Vagina, Cervix and Cervical Canal

The evaluation of vaginal and cervical anomalies is necessary to identify congenital malformations or structural barriers that may hinder conception or *in vitro* fertilisation (IVF) procedures. Cervical anomalies such as

stenosis or synechiae can interfere with embryo transfer or sperm migration.[1] Cervical duplications and septa may also indicate Müllerian anomalies.[10,22]

Vaginal anomalies, although rare, may include longitudinal non-obstructive or obstructive septa and transverse vaginal septa. These anomalies can have significant implications for reproductive outcomes and may be associated with obstructive symptoms, hematocolpos, or dyspareunia. Importantly, their identification can suggest the presence of more complex Müllerian anomalies.[23]

Differentiating between a single cervix with a cervical septum and true cervical duplication is crucial for accurate diagnosis and management planning.[24] This distinction cannot be made solely by hysteroscopy but requires integration with clinical and imaging data.[25] The combined use of hysteroscopy, transvaginal ultrasound, and three-dimensional imaging enhances the diagnostic accuracy in distinguishing these conditions.[11,12,26] In cases of a single cervix with a septum, hysteroscopy may reveal a central longitudinal ridge without duplication of cervical canals, whereas true duplication will typically present as two distinct cervical orifices, often associated with complete uterine septum or bicorporeal uterus.

Uterine Cavity

Documenting any difficulties in accessing the uterine cavity is important for procedures like embryo transfer.[27] Uterine cavity shape anomalies, such as T-shaped or Y-shaped uterus, have been reported as potential factors impairing fertility and pregnancy outcomes; the need for more robust data makes their report useful for further research.[28] Further subclassification of dysmorphic uteri, including T-shaped, Y-shaped, I-shaped, and uterus infantilis, has been proposed in recent years, with an increasing need for simultaneous hysteroscopic and ultrasound evaluation of the cavity.[13,14,29] Furthermore, hysteroscopy alone cannot differentiate between septate bicorporeal uterus and/or bicorporeal septate uterus underlining the need to use 3D ultrasound to improve diagnostic precision.[12,30] This combined approach is supported by the concept of the digital hysteroscopic clinic, where real-time hysteroscopy and three-dimensional ultrasound are employed synergistically to enhance diagnostic accuracy.[5]

Congenital uterine anomalies are well-documented factors impairing reproductive outcome despite an existing debate for the need of their treatment.[31-34] Thus, the documentation of fundal indentation characteristics by hysteroscopy is extremely important in cases of women with infertility and impaired pregnancy outcome.[35]

Endometrial Features

A comprehensive description of endometrial appearance is a key feature in this consensus. Several hysteroscopic patterns have been associated with endometrial dysfunction, endometritis, or implantation failure. For example, the presence of micropolyps, stromal oedema, or increased vascularity has been correlated with chronic endometritis.[36,37] Glandular-cystic changes and irregular vascular patterns may indicate hormonal imbalance or underlying endometrial pathology. The recognition of endometrial post-ovulatory compaction has recently been proposed as a marker of receptivity.[3]

Endometrial polyps are associated with abnormal uterine bleeding and infertility, with evidence suggesting improved implantation and pregnancy rates following hysteroscopic polypectomy in selected patients.[38,39] Their systematic documentation by size, morphology (sessile or pedunculated), and location is fundamental for evaluation of their clinical impact and management.

Submucosal fibroids are linked to impaired implantation and increased miscarriage rates. Their classification using the FIGO system (Type 0-Type 2 for submucosal types) allows reproducibility and better surgical planning.[16] Studies have demonstrated improved reproductive outcomes following hysteroscopic myomectomy in women with symptomatic submucosal fibroids.[40-42] FIGO type 3 fibroids, which are entirely intramural but overlying the endometrium, are increasingly recognised as potentially relevant in the context of infertility.[43] Although they do not distort the endometrial cavity per se, some studies have suggested a possible detrimental effect on implantation due to their proximity to the endometrial–myometrial interface.[43,44] The management of Type 3 fibroids remains controversial, with ongoing debate regarding the indication for surgical removal in asymptomatic women seeking fertility treatment. Their potential documentation in hysteroscopic reports, as they are only partially visible by alterations in the overlying endometrium, is important for their management.

Although rare, the systematic recording of suspicious endometrial lesions is necessary to guide timely histological sampling and further oncologic evaluation. Descriptors such as friability, ulceration, and abnormal vascularity are established warning signs of atypical hyperplasia or malignancy.[45] Additional hysteroscopic

features associated with endometrial neoplasia include irregular endometrial thickening, papillary excrescences, necrotic or haemorrhagic areas, and spontaneous bleeding upon touch. The presence of atypical vascular patterns—such as densely packed, irregular, or chaotic vessels—may further raise the index of suspicion,[15] and when observed in the context of abnormal uterine bleeding, have been correlated with an increased risk of endometrial cancer.[46] Early recognition of these findings during hysteroscopy, followed by targeted biopsy, significantly improves diagnostic accuracy and enables early oncologic referral. Moreover, in selected cases of early-stage endometrial cancer, particularly in young women with reproductive desire, accurate hysteroscopic assessment and standardised documentation of lesion characteristics may support timely decision-making for fertility-sparing treatment. Recent evidence underscores the importance of detailed endometrial evaluation to guide conservative management strategies.[47,48]

UAs, commonly resulting from infection or trauma (e.g., post-curettage), are a well-recognised cause of infertility, amenorrhea, and miscarriage due to distortion of the uterine cavity and impairment of endometrial function.[49,50] Accurate description of IUA location, extent (<1/3, 1/3–2/3, >2/3 of the cavity), and consistency (filmy vs. dense) is essential and reflects the parameters used in established classification systems such as those originally proposed by March and adopted by the American Society for Reproductive Medicine (ASRM),[51] and further supported by international guidelines.[17]

Hysteroscopic adhesiolysis remains the gold standard for both diagnosis and treatment of IUA, allowing direct visualisation and targeted lysis of adhesions under vision with restoration of cavity anatomy. Evidence consistently shows that hysteroscopic adhesiolysis can restore normal menstrual function and improve fertility outcomes, with conception rates reported to exceed 40% following effective treatment in infertility cohorts.[49,52,53]

Recent retrospective analyses also report encouraging pregnancy and live birth rates following adhesiolysis in women with recurrent pregnancy loss and IUA.[49,54] The severity of adhesions significantly influences success, with mild disease having the most favourable reproductive prognosis.[49,50,52]

In addition to surgical technique, the use of mechanical barriers and anti-adhesion gels, as well as second-look hysteroscopy, has been advocated to reduce recurrence rates and improve reproductive outcomes.[50,55]

The growing recognition of isthmocele (uterine niche at the site of caesarean section scar) and its impact on implantation failure, abnormal bleeding, and miscarriage risk justifies its detailed inclusion in hysteroscopic reports. Recent evidence has emphasised its role in reproductive failure and outlined classification systems based on size, residual myometrial thickness, and anatomical complexity.[18,56-58] Hysteroscopic evaluation allows visualisation of the defect, associated fluid retention, and vascular abnormalities that may interfere with embryo implantation or favour endometritis.[59]

Tubal Ostia

Though hysteroscopy does not directly assess tubal patency, the evaluation of the ostia and surrounding areas can reveal signs of prior salpingitis, occlusion, or peritubal adhesions. Recent studies have proposed that tubal ostial abnormalities may correlate with tubal infertility and reduced IVF success.[60]

Strengths and Limitations

A major strength of this consensus-based template is its ability to bridge the gap between clinical practice and research. By promoting standardised data collection, the structured report enhances not only diagnostic reproducibility but also facilitates the creation of multicentre registries and prospective studies exploring correlations between hysteroscopic findings and reproductive outcomes.

The proposed record may also play a pivotal role in training and certification of hysteroscopists, enabling objective evaluation of procedural completeness and reporting accuracy. Furthermore, its adoption may help reduce inter-operator variability, a known limitation in the interpretation of hysteroscopic images and terminology.[6]

However, several limitations should be acknowledged. First, although the template is grounded in available literature and expert consensus, the clinical significance and prognostic impact of all recorded hysteroscopic findings have not been conclusively established. Some abnormalities included in the structured report—particularly subtle endometrial patterns or minor morphological variations—may not yet have robust evidence demonstrating a direct causal relationship with infertility or adverse reproductive outcomes. Therefore, the inclusion of these items should be interpreted as a comprehensive documentation strategy rather than as confirmation of proven clinical relevance.

Second, the consensus reflects expert opinion and structured discussion rather than prospective validation studies. The ultimate value of the reporting system will depend on its application in real-world settings and on future research assessing interobserver agreement, feasibility, and correlation between specific hysteroscopic findings and reproductive prognosis, particularly in IVF cycles.

Future research should focus on validating the predictive value of individual items, determining which findings carry independent prognostic significance, and refining the template accordingly based on outcome-driven evidence.

Conclusion

This international consensus developed by ESGE, ESHRE, and IFFS provides the first structured framework for reporting diagnostic hysteroscopy in women with reproductive disorders. The final template includes comprehensive clinical, anatomical, and pathological parameters based on literature and expert validation.

The standardised approach promotes consistent data collection across centres to enhance the value of hysteroscopy in fertility evaluation. It represents a pragmatic tool for clinical care, research, and educational purposes, with the potential to inform predictive models and digital health integration. Its adoption is recommended in both routine clinical settings and IVF programmes.

Future work will focus on the implementation of the structured report across diverse healthcare systems, translation into additional languages, and validation through prospective outcome studies.

Acknowledgements: None.

Contributors: Surgical and Medical Practices: C.D.A., E.V.M., A.V., Concept: U.C., C.D.A., E.V.M., A.V., C.R., L.G., G.G., M.H., G.P., A.Vi., Design: U.C., C.D.A., E.V.M., A.V., C.R., A.D.S.S., L.G., A.Vi., Data Collection or Processing: U.C., E.V.M., M.A., A.A., C.R., A.F., L.A.P., Analysis or Interpretation: U.C., C.D.A., E.V.M., S.S., A.V., M.A., A.D.S.S., A.F., F.H., L.G., G.G., M.H., L.A.P., G.P., A.Vi., Literature Search: U.C., E.V.M., A.A., F.H., L.G., G.G., M.H., G.P., Writing: U.C., E.V.M., A.V., A.A., G.G., M.H., G.P., A.Vi.

Funding: No external funding was received for the development of the consensus process or manuscript preparation.

Competing interests: Ursula Catena, Grigoris Grimbizis, Attilio Di Spiezio Sardo, George A. Pados, Maribel Acien, serve as Associate Editors for Facts, Views and Vision in ObGyn. Rudi Campo, Carlo De Angelis, Luis Alonso Pacheco, are members of the Editorial Board of the Facts, Views and Vision in ObGyn. They had no involvement in the peer review of this article and had no access to information regarding its peer review. The other authors declare that they have no competing interests.

Ethical approval: Not required.

Informed consent: Not required.

Data sharing: All materials relevant to the structured reporting template are included within the manuscript and its supplementary files.

Transparency: The lead author affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the work have been omitted; and that any discrepancies from the study as originally planned have been explained.

Supplementary Files 1-2: https://d2v96fxpocvxx.cloudfront.net/7a593d95-86ec-4d2b-8dd3-26b0d0b79ea4/content-images/76d75108-3cc3-49e3-aafc-14a32e4615b0.pdf

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