Gynecol Surg (2013) 10:163
DOI 10.1007/s10397-013-0801-9

EDITORIAL

The ESHRE-ESGE consensus on the classification of female genital tract congenital anomalies

Stephan Gordts

Received: 13 March 2013 / Accepted: 8 April 2013 / Published online: 13 June 2013

We are very pleased to include an altered classification for congenital uterine anomalies in this issue. With an estimated incidence between 4 and 8 % in the general population, everyone dealing with reproduction is faced, on a regular basis, with one or another form of congenital uterine anomaly.

The impact of congenital uterine anomalies on conception and obstetric outcome is still controversial and a matter of debate. A lot of women in whom a so-called hazardous diagnosis of congenital uterine anomalies was made indeed have a normal reproductive function.

In the absence of proper controlled randomized studies, most meta-analyses have to rely on observational studies. A major problem in the analysis of these studies and the evaluation of the results is the heterogeneity of the published data. This can already start with the inclusion criteria where some studies are concentrating only on women with repeated implantation failure while others are referring to implantation failure after IVF or describing patients with long-lasting infertility without any occurrence of pregnancy.

Another reason for the Babylonian confusion of tongues is the difference in description and diagnosis of the congenital uterine anomaly involved.

At the end of an ESHRE campus 2-day meeting in Manchester, the final conclusion was that there was a lack of a user-friendly classification and standardization of the diagnostic methods. As such, treatment outcomes are hard to interpret.

This herein published new classification for congenital uterine anomalies is a final result of an ESGE-ESHRE task force (CONUTA group). For the development of this new classification, consensus between the scientists interested in the field of reproduction was assessed using the Delphi procedure. The different steps of this procedure are clearly explained in the text. This allows the reader to follow the development and how the consensus was reached.

The classification is primarily based upon anatomy, and as in the vast majority *uterine* malformations are the most common, an independent classification for cervix and vagina is used. Being aware that classification systems must be easy to use, utmost attention was given to the user-friendliness of the system. Another important issue was the possibility to have a comprehensive classification system, i.e., allowing to classify almost all the congenital malformations.

We are very pleased that this paper, simultaneously published in *Gynecological Surgery and Human Reproduction*, is highlighting the interest of this document.

I hope this will be a first step in a process of standardization. An initial agreement on a simple to use classification will allow to standardize diagnosis and compare treatment outcomes. Only when everybody is speaking the same language, the impact of the presence of these anomalies and eventual surgical correction on reproduction and obstetric outcome can be properly evaluated.

S. Gordts (✉)
Leuven Institute for Fertility and Embryology, Leuven, Belgium
e-mail: stephan.gordts@lifeleuven.be