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Structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders: an ESGE–ESHRE–IFFS international consensus[†,‡]

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ABSTRACT

STUDY QUESTION: **How should the findings of diagnostic hysteroscopy in women with reproductive disorders be reported?**

SUMMARY ANSWER: **This collaborative document by the European Society for Gynaecological Endoscopy (ESGE), the ESHRE, and the International Federation of Fertility Societies (IFFS) provides the first detailed structured reporting template for diagnostic hysteroscopy findings in women with reproductive disorders.**

WHAT IS KNOWN ALREADY: **Despite its widespread use in women with reproductive disorders, no standardized 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 centers. 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.**

STUDY DESIGN, SIZE, DURATION: **A dedicated working group from ESGE, ESHRE, and IFFS collaborated to develop a consensus for comprehensive structured reporting of diagnostic hysteroscopy findings in women with reproductive problems.**

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PARTICIPANTS/MATERIALS, SETTING, METHODS: This consensus paper focuses on grouping diagnostic hysteroscopic findings, structuring their reporting, and adopting standardized 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 RESULTS AND THE ROLE OF CHANCE: 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's characteristics, and findings from the vagina, cervix, uterine cavity, endometrium, and tubal ostia.

LIMITATIONS, REASONS FOR CAUTION: The inclusion of a finding in this structured report is not a proof of its clinical significance, but it could be used as a validation tool for further research.

WIDER IMPLICATIONS OF THE FINDINGS: The standardized reporting of hysteroscopic findings promotes consistent data collection across centers and could help inform research and exchange of clinical experience, enhancing the value of hysteroscopy in fertility evaluation.

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Introduction

Hysteroscopy is widely recognized as the gold standard for the diagnosis and treatment of intrauterine pathologies (Gkrozou *et al.*, 2015, 2020; Di Spiezio Sardo *et al.*, 2016). 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 (Campo *et al.*, 2005, 2018; Carugno *et al.*, 2021).

As with other specialized 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 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), specially in patients experiencing recurrent implantation failure (ESHRE Working Group on Recurrent Implantation Failure *et al.*, 2023). 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 (IUAs). Hysteroscopy also permits a limited evaluation of tubal patency through indirect visualization 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 standardized 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 centers. 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 harmonizing hysteroscopic terminology at the global level, based on expert consensus (Carugno *et al.*, 2021). However, no comparable scientific efforts have been directed toward standardizing 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 ESHRE, and the International Federation of Fertility Societies (IFFS). The objective of the established working group was to develop a structured reporting of diagnostic hysteroscopy findings in women with reproductive disorders. The overarching objective was to standardize 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.

Material and methods

Organizational framework and participants

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

A total of 17 experts were nominated by the three societies based on recognized 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., A.Vit., A.A.) and critically revised by one (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 finalizing 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 (vNGT), a structured consensus-building method designed to ensure equal contribution from all participants (Khurshid *et al.*, 2023).

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 video conference, 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 synthesized 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 (Brouwers *et al.*, 2010).

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 organized into five sections, each systematically capturing patient characteristics, procedural findings, and pathological observations.

A total of 35 items were reviewed (Supplementary Data File S1). Among these, 17 (48.6%) were approved unanimously, and 18 (51.4%) required modification following group discussion before final approval (Supplementary Data File S2).

Hysteroscopic report

The structured reporting template for hysteroscopic procedures in women with reproductive disorders (Fig. 1) includes the following.

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. cesarean section, myomectomy, conization, uterine artery embolization) and possible previous infections (e.g. pelvic inflammatory disease—PID). Reproductive anamnesis, including infertility, previous implantation failures, gravidity, parity, miscarriages/abortions (with or without dilation and curettage), and preterm deliveries, are also reported. Indications for hysteroscopy (baseline assessment, failed ART attempts, and pregnancy losses) are specified, together with relevant imaging findings from ultrasound or 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 as: longitudinal non-obstructive or obstructive vaginal septum, transverse septum, others (Grimbizis *et al.*, 2013).

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) (Grimbizis *et al.*, 2013; Catena *et al.*, 2025a), intracervical synechiae, or stenosis of the internal or external uterine orifice. Cervical lesions, if present also should also be described.

Congenital anomalies of the vagina and the cervix follow the ESGE/ESHRE classification system (Grimbizis *et al.*, 2013, 2016).

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, explanation of the reason why 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 or fluid in the uterine cavity is also documented.

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 _____

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

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) (Grimbizis *et al.*, 2013, 2016; Pacheco *et al.*, 2019, 2025). Further differential diagnoses (e.g. between septate uterus and bicorporeal uterus) cannot be made based solely on intrauterine hysteroscopic visualization (Grimbizis

et al., 2016). 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 (Grimbizis *et al.*, 2016; Campo *et al.*, 2018).

Endometrial features

A dedicated section focuses on findings from endometrium.

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

The following abnormal findings, if present, should be described (Di Spiezio Sardo and Campo, 2021): hypotrophic endometrium; diffuse polypoid thickening; focal polypoid thickening; highly vascularized endometrium; 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; and/or 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 to Type 2) (Munro *et al.*, 2011), with systematic documentation on wall involvement, (anterior, posterior, lateral right, lateral left), location (fundus, corpus, isthmus), and size. Suspicion of Type 3 lesions might also be reported.

Suspected malignant findings are categorized as focal or diffuse lesions, with quantification of cavity involvement (<50% vs >50%) and potential extension toward the myometrium or cervix (Di Spiezio Sardo and Campo, 2021).

IUAs are classified by site (central, lateral, cornua), extent (less than one third, more than one third, or more than two thirds, >1/3, >2/3 of the cavity), and consistency (filmy vs dense) (AAGL-ESGE, 2017).

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), and size (small, medium, large, extreme) (Min *et al.*, 2024). Additional characteristics are fluid/blood retention and vascularization.

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 (De Wilde *et al.*, 2024).

Tubal ostia

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

Discussion

The development of a structured template for reporting diagnostic hysteroscopy findings in women with reproductive disorders represents an important step toward standardization in the standardization of reproductive diagnostics. This initiative provides a consensus-based tool designed to improve consistency across centers, 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 stratifying patients and evaluation of hysteroscopic findings. Age, BMI, hormonal profile (AMH, FSH), and reproductive history have all been shown to impact endometrial receptivity and treatment outcomes (ESHRE Guideline Group on Ovarian Stimulation *et al.*, 2026). Previous uterine surgery (e.g. myomectomy, cesarean section) or infections (e.g. PID) are relevant as they may predispose to IUAs or niche formation (Hooker *et al.*, 2022). Although that 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 IVF procedures. Cervical anomalies such as stenosis or synechiae can interfere with embryo transfer or sperm migration (Di Spiezio Sardo *et al.*, 2016). Cervical duplications and septa may also indicate Müllerian anomalies (Grimbizis *et al.*, 2013; Parodi *et al.*, 2022).

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 (Acién and Acién, 2016).

Differentiating between a single cervix with a cervical septum and true cervical duplication is crucial for accurate diagnosis and management planning (Smith *et al.*, 2014). This distinction cannot be made solely by hysteroscopy but requires integration with clinical and imaging data (Miller *et al.*, 2021). The combined use of hysteroscopy, transvaginal ultrasound, and 3-dimensional imaging enhances the diagnostic accuracy in distinguishing these conditions (Grimbizis *et al.*, 2016; Pozzati *et al.*, 2023; Catena *et al.*, 2025a). 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 uterine cavity is important for procedures like embryo transfer (D'Angelo *et al.*, 2022). Uterine cavity shape anomalies, such as T-shaped or Y-shaped uterus, were reported as potential factors impairing fertility and pregnancy outcomes; the need for more solid data makes their reporting useful for further research (Di Spiezio Sardo *et al.*, 2020). 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 (Pacheco *et al.*, 2019, 2025; Ludwin *et al.*, 2020). Furthermore, hysteroscopy alone cannot differentiate between septate bicorporeal uterus and/or bicorporeal septate uterus underlining the need of applying 3D ultrasound to improve diagnostic precision (Grimbizis *et al.*, 2016; Ludwin *et al.*, 2018). This combined approach is supported by the concept of the digital hysteroscopic clinic, where real-time hysteroscopy and 3-dimensional ultrasound are employed synergistically to enhance diagnostic accuracy (Campo *et al.*, 2018).

Congenital uterine anomalies are well-documented factors impairing reproductive outcome despite an existing debate for the need of their treatment (Venetis *et al.*, 2014; Grimbizis *et al.*, 2020; ESHRE Guideline Group on RPL *et al.*, 2023; World Health Organisation Guideline Development Group for Infertility *et al.*, 2026). Thus, the documentation of fundal indentation characteristics by hysteroscopy is extremely important in cases of women with infertility and/or impaired pregnancy outcomes (Grimbizis, 2019).

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 edema, or increased vascularity has been correlated with chronic endometritis (Bouet *et al.*, 2016; Li *et al.*, 2024). 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 (Gkrozou *et al.*, 2020).

Endometrial polyps are associated with abnormal uterine bleeding and infertility, with evidence suggesting improved implantation and pregnancy rates following hysteroscopic polypectomy in selected patients (Spiewankiewicz *et al.*, 2003; Pérez-Medina *et al.*, 2005). 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 to Type 2 for submucosal types) allows reproducibility and better surgical planning (Munro *et al.*, 2011). Studies have demonstrated improved reproductive outcomes following hysteroscopic myomectomy in women with symptomatic submucosal fibroids (Pritts *et al.*, 2009, 2024; Roy *et al.*, 2010). FIGO type 3 fibroids, which are entirely intramural but overlying the endometrium, are increasingly recognized as potentially relevant in the context of infertility (Favilli *et al.*, 2023). 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 (Etrusco *et al.*, 2023; Favilli *et al.*, 2023). 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 oncological evaluation. Descriptors such as friability, ulceration, and abnormal vascularity are established warning signs of atypical hyperplasia or malignancy (De Angelis *et al.*, 2013). Additional hysteroscopic features associated with endometrial neoplasia include irregular endometrial thickening, papillary excrescences, necrotic or hemorrhagic 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 (Di Spiezio Sardo and Campo, 2021), and when observed in the context of abnormal uterine bleeding, they have been correlated with an increased risk of endometrial cancer (Clark *et al.*, 2002). Early recognition of these findings during hysteroscopy, followed by targeted biopsy, significantly improves the diagnostic accuracy and enables early oncological referral. Moreover, in selected cases of early-stage endometrial cancer, particularly in young women with reproductive desires, accurate hysteroscopic assessment, and standardized 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 (Rodolakis *et al.*, 2023; Catena *et al.*, 2025b).

IUAs, commonly resulting from infection or trauma (e.g. post-curettage), are a well-recognized cause of infertility, amenorrhea, and miscarriage, due to distortion of the uterine cavity and impairment of endometrial function (Grimbizis *et al.*, 2021; Hanstede *et al.*, 2021). 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 of Reproductive Medicine (March, 2011), and further supported by international guidelines (AAGL-ESGE, 2017).

Hysteroscopic adhesiolysis remains the gold standard for both diagnosis and treatment of IUA, allowing direct visualization 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 (Yu *et al.*, 2008; Hanstede *et al.*, 2021; Munro *et al.*, 2025).

Recent retrospective analyses also report encouraging pregnancy and live birth rates following adhesiolysis in women with recurrent pregnancy loss and IUA (Hanstede *et al.*, 2021; Qiao *et al.*, 2025). The severity of adhesions significantly influences success, with mild disease having the most favorable reproductive prognosis (Grimbizis *et al.*, 2021; Hanstede *et al.*, 2021; Munro *et al.*, 2025).

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 (Grimbizis *et al.*, 2021; Vitale *et al.*, 2022).

The growing recognition of isthmocele (uterine niche at the site of cesarean section scar) and its impact on implantation failure, abnormal bleeding, and miscarriage risk justifies its detailed inclusion in hysteroscopic reports. Recent evidence has emphasized its role in reproductive failure and outlined classification systems based on size, residual myometrial thickness, and anatomical complexity (Gubbini *et al.*, 2011; Tower and Frishman, 2013; Klein Meuleman *et al.*, 2023; Min *et al.*, 2024). Hysteroscopic evaluation allows visualization of the defect, associated fluid retention, and vascular abnormalities, which may interfere with embryo implantation or favor endometritis (Dokras *et al.*, 2025).

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 (Pérez-Milán *et al.*, 2025).

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 standardized data collection, the structured report enhances not only diagnostic reproducibility but also facilitates the creation of multicenter 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 (Carugno *et al.*, 2021).

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.

Conclusions

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 standardized approach promotes consistent data collection across centers 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 programs.

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.

Supplementary data

Supplementary data are available at *Human Reproduction* online.

Data availability

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

Authors' roles

U.C. and G.G. conceived and designed the project. U.C., A.Vit., and A.A. developed the initial draft of the structured reporting template. All 17 expert members of the working group participated in the consensus process, including structured discussion, voting, and revision of the template. U.C. prepared the first draft of the manuscript, which was critically revised by G.G. All authors critically revised the manuscript for intellectual content, approved the final version for publication, and agree to be accountable for all aspects of the work. 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.

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