

Swift recovery after supracervical hysterectomy

In his February editorial, "Minimally invasive hysterectomy: We are at the tipping point," Dr. Barbieri asked for feedback from readers on their experiences with hysterectomy. I am a general ObGyn practicing in a predominantly blue-collar city of about 70,000 people. I have been performing laparoscopic supracervical hysterectomies (LSH) since 1999. During that period, operative time has decreased from about 75 minutes to approximately 35 minutes, with the major variant being uterine volume. The largest uterus I have removed via LSH exceeded 1,200 g.

I have been amazed by the speed of recovery, with the vast majority of patients returning to full duties within 2 weeks, some as early as 5 days. A handful of women have asked to be discharged home the same day as the operation, and have done quite well. I believe total laparoscopic hysterectomies are an exercise in futility because the expense equals or exceeds that of LSH procedures and the recovery is essentially the same as total vaginal hysterectomy (4 to 8 weeks).

LSH has become my technique of choice. In 2005, roughly 80% (40) of my hysterectomies were laparoscopic supracervical procedures (total vaginal hysterectomy = 15%; total abdominal hysterectomy = 5%). I exclude patients who may have malignant conditions, abnormal Pap smears within the previous 3 years, symptomatic pelvic relaxation, or pain of unknown cause.

Although the learning curve for this technique is moderately steep and the initial cost is no doubt higher than for total vaginal or total abdominal hysterectomy, I believe the speed of recovery and minimal morbidity make it superior in most cases.

Rick L. Evans, MD
Burlington, NC

Vaginal route is practical choice in small hospitals

I trained in laparoscopic hysterectomy but prefer the minimally invasive vaginal approach. My abdominal hysterectomy rate is less than 5%, while the vaginal rate is 95%. Because I work in a small hospital, there are not enough cases requiring laparoscopy for me to remain proficient in it. Vaginal hysterectomy takes about 15 minutes, can be done as an outpatient procedure, and involves little postoperative pain (the endostapler does not bunch the tissue). I rely on the vaginal approach unless the uterus is 5 months' size or larger.

R. Brandon, MD
St. Mary's, Ga

You need an excellent assistant

At least 50% of all hysterectomies can be accomplished vaginally. The 2 main requirements: knowing the technique and having an excellent assistant.

Robert S. Ellison, MD
West Covina, Calif

"Total laparoscopic hysterectomies are an exercise in futility"



“Bread-and-butter” vaginal approach is best

The least invasive approach to hysterectomy—and the route burdened with the least complications—is still the plain old bread-and-butter vaginal hysterectomy, with or without oophorectomy. This is what needs to be emphasized—not the smoke and mirrors of laparoscopic supracervical hysterectomy or total laparoscopic hysterectomy. Laparoscopic skills are nice, but we do not do enough simple vaginal hysterectomies.

Contraindications to the vaginal approach are really quite few. In contrast to Dr. Barbieri, who advocated ensuring that every major gynecologic service has at least 1 gynecologic surgeon competent in total laparoscopic hysterectomy, I believe it is more important to have a surgeon adept at vaginal approaches and a medical staff willing to use those skills. This is how we bring our abdominal rate down and our vaginal approach up. This is how we decrease known morbidities of surgery and bring about true improvement in women’s health.

There is no reason that a skilled surgeon should not perform 70% or more of hysterectomies using the vaginal approach.

Gerrit J. Schipper, MD
Frederick, Md

The insanity of “meddlesome” surgery

Thanks for the roundtable discussion of hysterectomy (“Hysterectomy: Which route for which patient?” moderated by Dr. Mickey Karram [February]). I believe the art of vaginal hysterectomy is dying, despite the fact that it allows me to finish the procedure in 30 to 45 minutes, remove ovarian cysts, and do an appendectomy, salpingo-oophorectomy, or other necessary procedures.

A uterus as big as a fetal head can be removed vaginally, although, occasionally, excision of fibroids and/or morcellation is

necessary before the operation can be completed, as Dr. Karram and the panelists point out. Meddlesome surgery, like meddlesome midwifery, should be discouraged.

To convert a simple vaginal hysterectomy to a laparoscopic procedure costing several hours of OR time and wasting more than \$2,000 of disposable instruments and supplies is insane. By the same token, with the modern technology available, it would be wrong to resort to vaginal hysterectomy in overly difficult cases.

As for training the next generation of surgeons, I believe residents need to learn vaginal hysterectomy before they are allowed to do the laparoscopic procedure.

Hamid H. Sheikh, MD
Lexington, Ky

Why are we obsessed with hysterectomy?

My colleagues, we are fixated on hysterectomy.

I’m tired of hearing, year after year, that the hysterectomy rate is stuck at 600,000 in the United States. We can justify this any way we prefer, but why do we have one of the highest rates in the developed world? Is it because we accept only amenorrhea as a sign of success, necessitating extirpation of the “diseased” organ? After all, we can do a vaginal hysterectomy in a snap, and the recovery is easy. Or is it our love of the many innovative “toys” used in laparoscopic hysterectomy?

Even when women come to us asking for hysterectomy, it is usually out of ignorance. They don’t know they have other options. Endometrial ablation, for example, is a low-risk procedure that offers excellent compensation when performed in an office setting. More importantly, it has high patient-satisfaction rates (>95% with microwave endometrial ablation). I believe it merits serious consideration.

Scott Kramer, MD
Fremont, Calif

Dr. Kramer is a consultant to Gynecare and Microsulis.

“Emphasize vaginal hysterectomy—not the smoke and mirrors of total laparoscopic or laparoscopic supracervical hysterectomy”

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Progesterone gel for preterm prevention

I read Dr. Robert L. Barbieri's editorial, "The pipeline runneth over" (January), with great interest. It's nice to see some attention paid to drugs likely to be of use to gynecologists. I share Dr. Barbieri's enthusiasm for this area of research.

Like Dr. Barbieri, I am concerned about the lack of development in the obstetric arena, with one glaring exception: Columbia Labs' (Livingston, NJ) ongoing study of the vaginal progesterone gel, Prochieve, for the new indication of preventing preterm delivery. If the gel proves to be effective in the trial, it will be an important advance.

Ken Muse, MD

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Dr. Muse has received grant/research support from and is a speaker for Columbia Labs.

Collaboration preferred over competition

In his December editorial ("Massive obstetric hemorrhage: High- and low-tech tools"), Dr. Robert L. Barbieri pointed out that high- and low-tech approaches are often complementary.

I would expect any woman known to have an invasive placenta, as mentioned in the editorial, to be delivered at a facility equipped for high-risk situations, and that such a facility would have fully equipped interventional radiology services.

One method Dr. Barbieri described, prophylactic placement of internal iliac artery occlusion balloons, has proven safe and effective. It is important to inflate the balloons as early as possible (as soon as the baby is delivered) to forestall hemorrhage, rather than wait until hemorrhage begins.

As for the tamponading intrauterine

balloon, I think it is a wonderful idea. We have learned from managing esophageal and gastric varices that balloon tamponade can be excellent for acute control of bleeding, but usually not for definitive control.

Embolization is more effective than surgical ligation of the internal iliac or uterine arteries at controlling postpartum and postsurgical hemorrhage. And because ligation without control of bleeding precludes effective embolotherapy, I encourage balloon tamponade followed by embolotherapy at the earliest opportunity.

Dr. Barbieri also posed the question, "Should all obstetric services have access to the high-technology interventional radiology procedures?" The Letters page subsequently reflected some views that filled me with sadness for the patient population for whom we all care: the assertion that newly introduced technologies are unproven and overly expensive, and the concern that IR in every hospital might mean that "our hysterectomies disappear into their intervention rooms."

An IR suite costs about as much as an OR to install, but is almost always a source of profit to a hospital. OR services are often a source of operating loss.

It is unreasonable to fear that gynecologists will no longer perform hysterectomies in the presence of an IR service. Depending on who you read, 30% to 70% of hysterectomies are done for causes other than fibroids; these patients are not candidates for embolization. Even with fibroid disease, there are more than enough patients for both gynecologists and interventional radiologists. Current published data show that 20% to 25% of women having uterine artery embolization will go on to have another procedure (hysterectomy, myomectomy, or repeat uterine artery embolization) within 5 years. Most have hysterectomies. This rate is no higher than the rate of subsequent procedures for fibroids after



"It is unreasonable to fear that gynecologists will no longer perform hysterectomies in the presence of an interventional radiology service"

myomectomy, and far below the rate of recurrent procedures after endometrial ablation.

I want to emphasize the importance of ObGyns and interventional radiologists viewing one another as colleagues rather than competitors. If I decide that a patient would be better served by surgery, I refer her—even set up an appointment with the surgeon. If I thought uterine artery embolization were an obsolete procedure, I would stop doing it and direct patients to a better procedure—if it existed. That is part of my oath as a physician: to place patients' health and safety interests above my own professional or economic interest.

Robert L. Worthington-Kirsch, MD
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Dr. Worthington-Kirsch receives grant/research support from Terumo Interventional Systems, is a consultant to BioSphere Medical, and is a speaker for both companies.



went a modified radical mastectomy. Six months later, I received a summons for failing to diagnose her breast cancer in a timely fashion. The patient's record revealed that she had been advised to undergo mammography 4 times over the 2.5 years preceding her diagnosis, yet had never done so until the day the mass was palpated.

Her counsel admitted failing to review the case prior to filing suit and volunteered to withdraw the suit if I agreed not to counter sue or file a bar complaint. I agreed, provided my legal expenses were paid in full, plus a reasonable hourly rate for time spent reviewing the case, and a personal letter of apology. Both the plaintiff and her counsel agreed to these terms and voluntarily withdrew the suit.

Brad Youkilis, MD
Lexington, Ky

“The plaintiff was advised to have mammography 4 times over 2.5 years; she never did until a mass was palpated”

A true story: Doing the right thing paid off

After reading the article, “Cutting the legal risk of breast cancer screening,” by Dr. Samuel Zylstra and colleagues (September 2005), I decided to let you know about a recent lawsuit I was involved in. Perhaps it will remind those of us in the trenches that doing the right thing occasionally pays off.

When a 41-year-old patient complained of breast pain around the left nipple, and observed that it felt similar to the puerperal mastitis she had experienced 3 years earlier, I told her to have a mammogram, placed her on antibiotics, and reexamined her 2 weeks later, at which time I palpated a mass.

Since she had not yet made an appointment for the mammogram, we set her up to see the radiologist the same day. A biopsy of the mass confirmed infiltrating ductal breast cancer, and she under-

Diversity of your letters is gratifying

I appreciate the wealth of perspectives offered by our readers this month. We hope we can continue to keep you up-to-date and advance your clinical practice, and we appreciate your taking the time to communicate with the OBG MANAGEMENT community of readers.

Robert L. Barbieri, MD
Editor-in-Chief

Care to comment on an article in this issue?

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