

**“SHOULD CYSTOSCOPY BE ROUTINE AT THE TIME OF HYSTERECTOMY?”**

BY CHERYL IGLESIA, MD  
(EXAMINING THE EVIDENCE; MARCH 2009)

**Cystoscopy is a skill, not a requirement**

Yes, cystoscopy is valuable—not just at hysterectomy but also at oophorectomy and cases involving stress urinary incontinence and pelvic relaxation. However, the data quoted by Dr. Iglesia seem suspect. I would estimate that 90% of hysterectomies performed today are laparoscopic or vaginal and 10% are abdominal—at least in my hands and those of my colleagues. In contrast, in the study discussed by Dr. Iglesia, approximately 65% of hysterectomies were performed abdominally, 27% vaginally, and 7% vaginally with laparoscopic assistance.

Moreover, when I added up the numbers, I got a total of 832 hysterectomies—not 839 as listed. The reason the numbers do not add up is that, in the original article, seven cases were missing the primary surgery label.

These do not seem like real-world numbers to me!

It is unrealistic to conclude, on the basis of this report, that every case should include cystoscopy. I do believe that every gynecologist should have cystoscopy privileges and know how to find the ureteral orifices and identify problems—and know when



MARCH 2009

to call in a urologist. But the declaration that every case requires cystoscopy provides yet another opportunity for lawyers to sue us. Why not require intravenous pyelography before every surgery, too?

I believe medical judgment is the critical ingredient for every case.

**Robert Frischer, MD**  
Wichita Falls, Tex

» Dr. Iglesia responds:  
*In expert hands, cystoscopy may not always be necessary*

*I concur. Medical judgment is the critical factor when deciding when and how to perform hysterectomy. Dr.*

Frischer's perception about the most common route of hysterectomy performed in the United States is incorrect, however. In 2006, according to the National Center for Health Statistics ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)), 569,000 hysterectomies were performed—65% of them abdominally, and approximately 35% laparoscopically or vaginally.

Dr. Frischer's surgical experience in minimally invasive gynecologic surgery is clearly above the national average. Therefore, the recommendation for cystoscopy at the time of hysterectomy may not be applicable for him and his colleagues, especially if their rate of injury to the lower urinary tract is known to be less than 1.5%.

**“USING MESH TO REPAIR PROLAPSE CALLS FOR MORE THAN A KIT – IT TAKES SKILL”**  
(JANUARY 2009)

**“USING MESH TO REPAIR PROLAPSE: AVERTING, MANAGING COMPLICATIONS”**  
(FEBRUARY 2009)

BY MICKEY M. KARRAM, MD, VINCENT LUCENTE, MD, MBA, SHLOMO RAZ, MD, AND MARK D. WALTERS, MD

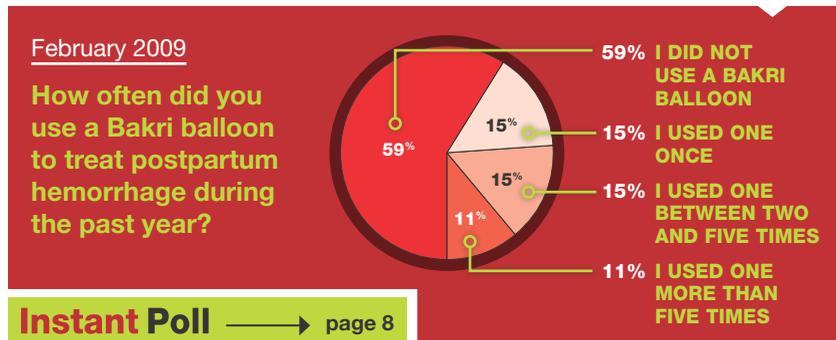
**Are the benefits of mesh really worth the risk?**

Since I began working at Loma Linda University Medical Center 7 months ago, I have spent about one quarter of my time managing complications of vaginal mesh—mainly erosion into the vagina or bladder, dyspareunia, and debilitating de novo pelvic pain. It is difficult for me to believe that Dr. Lucente and Dr. Raz do not experience these complications if they spend the majority of their time placing mesh vaginally—either custom-fitted or using a prolapse kit.

I recently saw an advertisement in a southern California newspaper that was placed by an attorney from the Midwest. The ad was soliciting patients who had experienced mesh-

CONTINUED ON PAGE 15

**Instant Poll Results**



related complications. The US Food and Drug Administration also has issued a warning about use of synthetic mesh.

Based on the evidence available so far, I would conclude that lightweight polypropylene mesh that is placed vaginally to augment prolapse repair may have a role in the correction of anterior wall prolapse—but it comes at a cost. The surgeon must communicate the risks (erosion, pelvic pain) to the patient and make sure she understands them, as well as the alternatives (suture-based repair such as high uterosacral ligament suspension) and benefits (slightly lower rate of recurrence).

I agree with Dr. Karram that the small reduction in the rate of recurrence may not be worth the potential for complications, especially pelvic pain, which can be hard to manage.

**Sam Siddighi, MD, MS**

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» Dr. Lucente responds:

**High complication rate usually signals lack of skill**

*I never stated that we experience no complications. Of course, we do, but the rate is very low. Our erosion rate is 2.2%, operative injury (mostly cystotomy) is 3%, and new-onset dyspareunia ranges from 3% to 4%. These rates compare very favorably with the complication rate associated with abdominally delivered mesh.*

*Most centers that report high complication rates are actually seeing the effects of ineffective “credentialing” for operative privileges to use transvaginal mesh. That is to say, the problem lies in the surgeon’s lack of training or experience—not the technology.*

**Some mesh-related complications can be intractable**

After publication of the series on the use of mesh augmentation in prolapse repair in the January and February 2009 issues of **OBG MANAGEMENT**, a number of readers contacted us to relate their experience with mesh-related complications. The following case may be extreme, but is an accurate representation of one patient’s experience.

**CASE** Eroded mesh proves difficult to remove

An otherwise healthy, 43-year-old mother of three underwent a transurethral sling operation, using a polypropylene sling and the transobturator approach, which restored urinary continence. One year later, she developed an intermittent yellow discharge that gradually became chronic. Three years after the original procedure, she underwent a Burch procedure and four additional surgeries to remove mesh that had eroded bilaterally through the vaginal wall. The surgeries were increasingly aggressive vaginal attempts to remove eroded mesh, which had fractured. After each procedure, the surgeons monitored stubborn granulation tissue.

Although the surgeons have tracked through the right sinus tract where the remaining mesh should be located, they have been unable to find it. For the fifth surgery, after magnetic resonance imaging (MRI), a guidewire is placed under computed tomography (CT) guidance, and the surgeons use a vaginal approach to reach the wire and remove more mesh. After the fifth surgery, the patient continues to suffer the same symptoms that were present before the first attempt to remove the mesh—chronic yellow discharge, pelvic pain, and irregular bleeding—although slight improvement has been noted: The left side of her injury has healed, but the right side remains a problem.

The patient is considering a sixth surgery. The surgeons tell her that a laparoscopic approach is not feasible because she has a Burch colposuspension in place that is working “beautifully.” One surgeon would like to approach the injury from above, via laparotomy. Another suggests cutting into the inner right thigh with orthopedic assistance.

How would you pinpoint the remaining mesh? And what surgical approach is most likely to be successful?

**Dr. Karram responds:** *If there continues to be granulation tissue and bleeding into the vagina, then the mesh that is causing the problem is most likely to lie on the vaginal side of the obturator membrane, so I do not think that a thigh or abdominal approach will allow access to the problematic mesh. I think a more aggressive vaginal exploration in skilled hands would be the best option.*

*This response could be significantly altered if the exam is inconsistent with the history.*

**Dr. Raz responds:** *I don’t think that an open abdominal approach will help this patient. She needs aggressive exposure of the obturator area on the right (vaginal area and also lateral to the pubic bone).*

*The obturator tape must be an ObTape to create this type of infection. I just operated on two patients who had complications from the ObTape—one with necrotizing fasciitis and another with abscess in the inner thigh.*

*It is not easy to image mesh. MRI is ineffective. In this case, translabial ultrasonography may be able to locate the mesh laterally. CT imaging may be of assistance if it is focused on the area.*