

“APPLYING SINGLE-INCISION LAPAROSCOPIC SURGERY TO GYN PRACTICE: WHAT’S INVOLVED”

RUSSELL P. ATKIN, MD; MICHAEL L. NIMAROFF, MD; AND VRUNDA BHAVSAR, MD (SURGICAL TECHNIQUES, APRIL 2011)

A few tools and techniques can simplify single-incision laparoscopic surgery

I commend Drs. Atkin, Nimaroff and Bhavsar for their excellent article! I’d like to raise several additional important matters about single-incision laparoscopic surgery.

A good uterine manipulator is critical to get good exposure.

I have had great success with the VCare (ConMed Endosurgery) uterine manipulator. While an assistant holds the camera, I usually have a LigaSure (Covidien) in my right hand and my left hand on the manipulator. This positioning allows me to push either side of the uterus up into the vessel-sealing device. It also limits the number of instruments that need to be placed through the umbilical port, reducing the problem of having too many instruments crowded together.

In the absence of a flexible laparoscope, consider using a 5-mm 30° or 45° bariatric laparoscope.

This moves the camera head back out of the area where the surgeon’s hands must operate. A little judicious practice with this scope allows one to easily see around corners and up the posterior aspect of the uterus. This maneuver is similar to using a 30° hysteroscope to easily visualize the tubal ostia.

For supracervical hysterectomy, consider placing a 5-mm port in the midline at the pubic hairline.

Although some surgeons claim that this technique is “cheating,” the cosmetic impact is minimal. Moreover, as with most midline incisions, there is less innervation here and,



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therefore, minimal discomfort. This access allows for easy placement of a LiNA Loop (LiNA Medical) or similar device to excise the fundus from the cervix.

Other observations from my experience:

- After the 12-mm morcellator is placed through the umbilical port, I can observe the morcellation process using a 5-mm scope in the suprapubic port. This affords a considerable safety margin.
- Almost all single-incision procedures are performed using standard, straight laparoscopic instruments. Articulating graspers, scissors, and cautery devices are an expensive and usually unnecessary complication.
- In total laparoscopic hysterectomy cases, we close the vagina from below, using standard surgical techniques.

Most of my single-incision hysterectomy patients go home within 4 hours after surgery. The gyn nurses maintain telephone contact with them for several days. Patients are reassured that, even though they are leaving the hospital, the hospital does not leave them! This arrangement

also saves the surgeons from having to handle many routine late-night calls.

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Dr. Schulman reports no financial relationships relevant to his letter.

“UPDATE ON CERVICAL DISEASE”

J. THOMAS COX, MD (MARCH 2011)

How should we manage pregnant teenagers who have abnormal Pap tests?

Cervical cytology screening guidelines from ACOG recommend that Pap screening be initiated at 21 years of age. It also is widespread practice to obtain a Pap test at the first prenatal visit. I’ve had several pregnant teenagers who have had abnormal Pap test results. The group practice to which I belong reached consensus that we would perform colposcopy in a pregnant teenage patient only if Pap test results are designated as high-grade squamous intraepithelial lesions (HGSIL); we also defer most biopsies until the postpartum period. Nevertheless, it is difficult to counsel a teenage patient who has an abnormal Pap test during pregnancy about her options.

Do you have any recommendations on how to advise this type of patient?

Deni Malave-Huertas, MD
Vero Beach, Florida

>> Dr. Cox responds
Don’t screen adolescents—pregnant or not

The ACOG guidelines call for screening to begin at 21 years. There is no exception for pregnant adolescents, nor was there any exception given for pregnant women under the age of screening in either the American

Cancer Society guidelines of 2002 or the US Preventive Services Task Force guidelines of 2003. Although it may be accepted practice to screen pregnant adolescents in Dr. Malave-Huertas's locale, it is more appropriate to stop screening patients under the age of 21, whether they are pregnant or not.

"WHERE HAVE ALL THE YOUNG MEN GONE? NOT TO OBSTETRICS AND GYNECOLOGY"

LOUIS WEINSTEIN, MD
(COMMENTARY, JANUARY 2011)

Complete reversal of discrimination is not a problem for some

I'm not surprised that Dr. Weinstein's commentary on the dwindling number of young men entering the specialty of obstetrics and gynecology generated a number of letters [see the April 2011 issue of OBG MANAGEMENT]. Both the commentary and the letters were more balanced than the conversation I was recently a party to, which involved a young female resident in our program. This resident argued that any patient who specifically requests a male provider is "sick, twisted, obviously damaged, seeking secondary gain" or "sexually motivated." When the logical argument was then made that any patient specifically requesting a female provider could have the same motivations, I was met with incredulity at my gall. Quite obviously, to the resident in question, a patient requesting a female provider has made the sane and natural choice.

It sickens me that an attitude such as this can be accepted as fact due to the complete reversal of discrimination that has come about in the specialty. I will continue doing my best to combat such an attitude, although it does become a self-fulfilling prophecy, as Dr. Weinstein

pointed out. I have seen our residency program shift from having 50% male residents to now having less than 9% for the upcoming academic year.

Name withheld upon request

Complaints about reverse discrimination are nothing more than sour grapes

Do you want a glass of wine with that whine? The letter to the editor from William Phillips, MD ("Comment & Controversy"; April 2011), in response to Dr. Weinstein's commentary, is sour grapes! The world is dominated by men. Women in most other walks of life have to work harder for less. On the April 2011 homepage at obgmanagement.com, there was even an article attesting to that fact: "Low pay for new female doctors tied to gender, not job."

Stats can swing both ways, so don't get drowned in the dregs but pick yourself up by the bootstraps and vow that you'll work harder to earn a reputation that will keep you busy with the kind of patients you're seeking.

If you don't like it, start your own club. The Boy Scouts of America don't take girls, so "women-only" ObGyn practices don't have to take men!

Ian Taras, MD
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"ALERT! THE 2011 ICD-9 CODE SET IS ALREADY IN FORCE"

MELANIE WITT, RN, CPC, COBGC, MA (RE-IMBURSEMENT ADVISER, NOVEMBER 2010)

Definition of maternal death should include gestational trophoblastic disease

The 9th revision of the International Classification of Diseases, and the proposed 10th revision, coming into force in 2013 (ICD-9/10), define

"maternal death" as "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."

My concern here is that one of the ICD revisions should include gestational trophoblastic disease (GTD; also known as molar pregnancy and gestational trophoblastic tumor) in the definition of maternal death. First, some background on the classification of maternal death.

ICD-9/10 subdivides "maternal death" after the initial definition. Specifically, **direct maternal deaths** result from conditions or complications (or their management) unique to pregnancy, occurring during the antenatal, intrapartum, or postpartum period. **Indirect maternal deaths** arise from previous disease or disease that develops during pregnancy—not from direct obstetric causes but aggravated by the physiologic effects of pregnancy.

ICD-10 also introduces two terms related to maternal death: **pregnancy-related death and late maternal death**. Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of the end of her pregnancy, regardless of cause. This category includes deaths with accidental and incidental causes, even though these deaths would have occurred even if the woman had not been pregnant. ICD coding classifies these cases as "fortuitous" maternal deaths.

Late maternal death is defined as the death of a woman from direct or indirect causes more than 42 days but less than 1 completed year after the end of the pregnancy.¹

To repeat: The ICD revisions do not include GTD in the definition of maternal death.

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Because GTD is related to conception and gestation, I believe that it should be included in maternal mortality studies and statistics. Inclusion of GTD would certainly permit us to learn more about these deaths and, as a result, help save women's lives.

Abortion and miscarriage are included in the ICD definition of maternal death. However, because the natural history and pathophysiology of GTD pregnancies are very different than abortion and miscarriage,

they should not be coded or listed under the abortion and miscarriage category.

GTD pregnancy is common enough globally—particularly in low-resource countries—to justify inclusion of GTD-related deaths in the ICD definition of maternal mortality. Perhaps it's time for the World Health Organization, the International Federation for Gynecology and Obstetrics, and other global women's health organizations to reconsider GTD

pregnancies as worthy of inclusion in the definition of maternal mortality.

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Reference

1. Lewis G, ed. Saving Mothers' Lives. The Confidential Enquiry into Maternal and Child Health (CEMACH). Reviewing maternal deaths to make motherhood safer—2003–2005. The seventh report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH; December 2007.