

“Medicare actually penalizes us for choosing the laparoscopic route”

Is vaginal hysterectomy a dying art?

“Vaginal hysterectomy: Is skill the limiting factor?” by Dr. Carl W. Zimmerman (March), was not only a great paper, it was especially timely in light of our specialty’s reduced resident work hours, diminishing number of surgical procedures, and increasing time restraints. Vaginal hysterectomies are commonly performed by gynecologists and no other specialties. They are often referred to as “bread and butter” procedures because of their common use.

Most ObGyn training programs are in tertiary referral centers. Women go to these centers for cancer surgery and major pelvic reconstruction, not vaginal hysterectomies for uterovaginal prolapse, abnormal uterine bleeding, and other benign reasons. Thus, residents in training get less and less exposure to pelvic surgery, including vaginal hysterectomy. Less work time and fewer procedures confound this issue.

I recently attended a clinical meeting of the American College of Obstetricians and Gynecologists in which removing vaginal surgery—including vaginal hysterectomies—from training programs was proposed. The rationale behind this proposal: If one were interested in pelvic surgery, he or she would consider a pelvic surgery fellowship.

Dr. Zimmerman’s paper is well put. Skill is truly the limiting factor. If residents are not exposed to sufficient numbers of vaginal hysterectomies in training, how can they be proficient at more adept vaginal surgery such as Dr. Zimmerman describes? Many of

us older gynecologists are concerned that vaginal surgery may be a dying art!

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Fair reimbursement would increase laparoscopic procedures

In his February editorial, “Minimally invasive hysterectomy: We are at the tipping point,” Dr. Robert L. Barbieri asked for suggestions of ways to increase the percentage of laparoscopic and vaginal procedures and decrease the percentage of abdominal hysterectomies. I think laparoscopic hysterectomy rates would more than double if we were adequately compensated for our skill and time.

At present, Medicare compensation is about \$900 to \$1,400 for laparoscopic hysterectomy and about \$1,000 for abdominal hysterectomy. Yet the laparoscopic approach takes about 38 minutes longer.¹ Thus, Medicare actually penalizes us for choosing the laparoscopic route.

Despite the satisfaction of doing the right thing for the patient by performing laparoscopic hysterectomy, the lower reimbursement rate certainly remains a deterrent.

Daniel N. Sacks, MD
West Palm Beach, Fla



REFERENCE

1. Wattiez A, Cohen SB, Selvaggi L. Laparoscopic hysterectomy. *Curr Opin Obstet Gynecol.* 2002;14: 417–422.

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Hysterectomy approach isn't the only key to rapid recovery

I appreciated Dr. Barbieri's February editorial on minimally invasive hysterectomy. I'd like to tell you about steps taken at my institution.

Dr. Henrick Kehlet, a colorectal surgeon from Denmark, has developed a technique for colon resection using regional (epidural) anesthesia and early ambulation and nutrition.¹ At his hospital in Copenhagen, patients begin consuming liquids the day of surgery and begin a regular diet the next day. They leave the hospital 2 to 3 days after the colectomy.

I became interested in his principles while visiting the Cleveland Clinic in 2001, and subsequently had him visit us in Minneapolis.

Since his visit, our department of 20 gynecologists has begun utilizing regional anesthesia/analgesia (spinal anesthesia with bupivacaine and morphine sulfate) with enforced ambulation and intake of liquids the day of surgery, and a regular diet and strict restriction of any narcotic analgesia on postoperative day 1 and subsequent days.

Using this regimen, 65% of our patients are discharged home on postoperative day 1, and 87% by postoperative day 2. The total number of patients seen last year was 256. All were encouraged to be as active after surgery as they were prior to surgery; many returned to work 2 weeks after surgery.

The use of a regional anesthetic and restriction of all intravenous or oral narcotics (using only scheduled nonsteroidal anti-inflammatory drugs and acetaminophen), as well as encouragement to be active immediately after surgery, are instrumental factors in the success of this

program. Except for the cosmetic effect, we question whether there is any appreciable benefit to laparoscopically assisted vaginal hysterectomy.

John A. Reichert, MD
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REFERENCE

1. Smedh K, Strand E, Jansson P, et al. [Rapid recovery after colonic resection. Multimodal rehabilitation by means of Kehlet's method practiced in Vasteras.] *Lakartidningen*. 2001;98:2568-2574.

Dr. Barbieri responds:

Readers' ideas thoughtful, innovative

I appreciate the insight of Dr. Sacks and Dr. Reichert. The readers of OBG MANAGEMENT consistently send us wonderfully thoughtful and innovative ideas.

Dr. Sacks' letter has prompted me to contact our Blue Cross carrier to see if it would be willing to increase physician reimbursement for laparoscopic hysterectomy, provided we could ensure reduced costs related to fewer days of hospitalization.

Dr. Reichert points out the critical importance of anesthesia and intraoperative and postoperative care on the rate of recovery from hysterectomy. I agree with him that regional anesthesia and early feeding reduce the length of stay for a number of different abdominal or

pelvic surgeries. However, laparoscopic hysterectomy may be associated with shorter convalescent time than abdominal hysterectomy. In 1 randomized trial, the median convalescent times for laparoscopic and abdominal hysterectomy were 16 and 35 days, respectively ($P<.001$).¹

REFERENCE

1. Olsson JH, Ellstron M, Hahlin M. A randomized prospective trial comparing laparoscopic and abdominal hysterectomy. *Br J Obstet Gynaecol*. 1996;103:345-350.



"65% of our patients are discharged home on postop day 1, and 87% by postop day 2"

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For interstitial cystitis, which test is the real “gold standard”?

In her February article on interstitial cystitis (“The generalist’s guide to interstitial cystitis”), Dr. Christine LaSala called cystoscopy with hydrodistention the “gold standard” for diagnosis, but also observed that “the need for this procedure is under debate.” She does mention the potassium sensitivity test, but her remarks about it are slightly negative, despite the fact that it had only a 4% false-positive rate among controls in the study she cited.¹

Many sources now consider cystoscopy with hydrodistention the previous gold standard and point out that it is of limited benefit or uncommonly used. How do you explain this discrepancy?

Mark Tomsho, MD
Summersville, WV

REFERENCE

1. Parsons CL, Dell J, Stanford EJ, Bullen M, Kahn BS, Willems JJ. The prevalence of interstitial cystitis in gynecologic patients with pelvic pain, as detected by intravesical potassium sensitivity. *Am J Obstet Gynecol.* 2002;187:1395–1400.

Dr. LaSala responds:

Potassium sensitivity test hurts—a lot!

Cystoscopy with hydrodistention under anesthesia remains a viable option in diagnosing interstitial cystitis. It rules out an intravesical source for irritative bladder symptoms (eg, neoplasms, foreign bodies). If a generalist’s office is unable to perform the potassium sensitivity test (due to staffing or reimbursement problems), cystoscopy under hydrodistention is reasonable.

Frankly, the potassium sensitivity test can be quite uncomfortable for the woman and can make for a very angry and upset patient. I’ve experienced an angry reaction a couple of times, which is why I choose not to do the test in my office. It isn’t fair to warn a patient that it may hurt a lot, and then hurt her!

I also feel that a picture “paints a thousand words,” and I find it very helpful for the patient and her family or partner to actually see what an affected bladder looks like. It may help her justify the painful or aggravating symptoms she has experienced.

My point: Although cystoscopy under anesthesia may be controversial in some quarters, it is acceptable and valuable. I choose to perform it on almost all my patients.

“Frankly, the potassium sensitivity test can make for a very angry and upset patient”

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