Limited Laparoscopic Myomectomy in Canada

ARTICLES BY DOUG BRUNK

LAS VEGAS — Only 25% of Canadian gynecologists perform laparoscopic myomectomy, and 71% cite lack of appropriate training as the main barrier to performing the procedure.

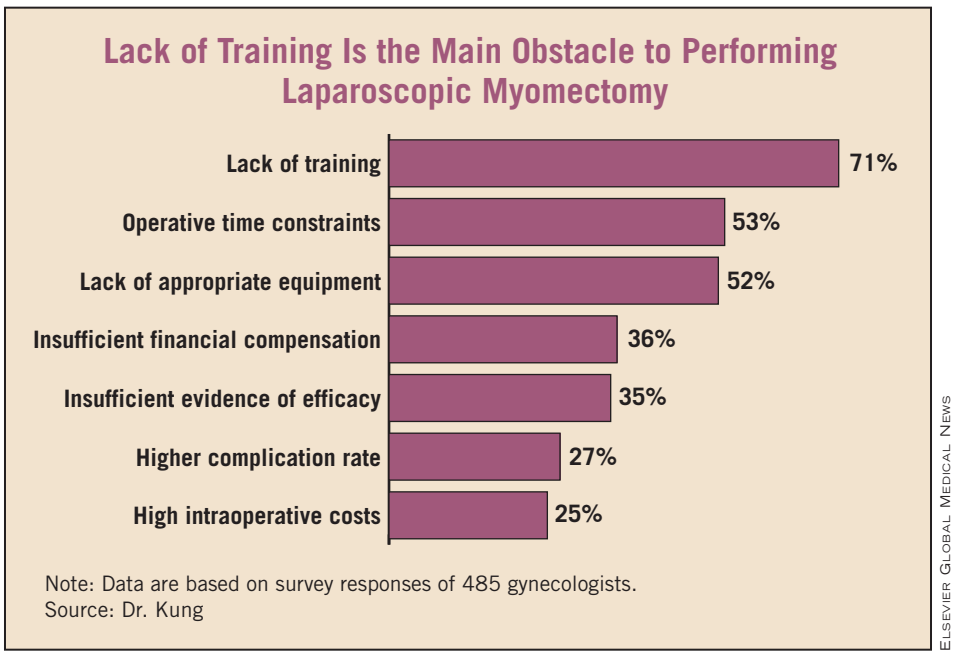
These are the key findings from the first survey to address current Canadian practice patterns regarding laparoscopic myomectomy, Dr. Rose Kung said at the annual meeting of the AAGL.

In a study led by her associate, Dr. Grace Liu of the department of obstetrics and gynecology at Sunnybrook Health Sciences Centre, Toronto, the researchers distributed surveys to 1,257 members of the Society of Obstetricians and Gynaecologists of Canada in April 2007. Of the 485 respondents who practice gynecology, 462 (95%) perform surgery, 444 (92%) perform laparoscopic surgery, and 385 (79%) perform abdominal myomectomies, yet only 119 (25%) perform laparoscopic myomectomies. Of these 119 respondents, only 15 (13%) use this approach for the majority of their cases.

The top three deterrents to performing laparoscopic myomectomy reported by the 119 respondents who use the procedure were the presence of an intramural fibroid (81%), a fibroid greater than 5 cm in size (54%), and more than three fibroids (54%), said Dr. Kung, also of the Sunnybrook Health Sciences Centre.

Among the 485 respondents overall, fewer than half of the respondents (44%) said that they have referred patients to another gynecologist for laparoscopic myomectomy. The most common reason for not referring was uncertainty as to who would be performing the procedure (33%); other reasons given by those surveyed included insufficient evidence to support the procedure (30%), a belief that the complication rate is higher with the procedure (21%), and a preference for operating on their own patients (18%).

When the respondents were asked to compare their perceptions of laparoscopic myomectomy with abdominal myomectomy, the majority indicated they believe that laparoscopic myomectomy confers a faster recovery time, less adhesion formation, and a comparable myoma recurrence rate. Most respondents were unsure about whether there were differences in outcome between the two procedures in terms of blood loss, postprocedure fertility rate, and uterine rupture risk. ■



LSH Has a Shorter Hospital Stay Than LAVH

LAS VEGAS — Laparoscopic supracervical hysterectomy for the nonprolapsed uterus was associated with significantly shorter hospital stays, compared with laparoscopic-assisted vaginal hysterectomy, but all other perioperative measures were similar between the two procedures, results from a retrospective analysis showed.

But no definitive conclusions can be made as to the preferred procedure for a patient with a nonprolapsed uterus. This is in contrast to some of the previously published reports that compared laparoscopic-assisted vaginal hysterectomy (LAVH) with laparoscopic supracervical hysterectomy (LSH), "all of which are retrospective, relatively small case series and have findings that do not seem to be consistent," Dr. Ali Ghomi cautioned at the annual meeting of the AAGL. "There are no randomized clinical trials comparing LAVH to LSH, and most studies did not account for pelvic organ prolapse as a confounding factor in LAVH. So before we make any shift to one procedure or another, we need to examine the available evidence very carefully and not jump to conclusions."

To compare the perioperative outcomes of the two procedures when performed for the nonprolapsed uterus, Dr. Ghomi and his associates from Harvard Medical School, Boston, and the State University of New York at Buffalo, where he is a member of the department of gynecology-obstetrics, evaluated 248 successive cases of LAVH and 173 successive cases of LSH between January 2001 and December 2007. The study is the largest of its kind to date.

Patient demographics were similar between the two groups, reported Dr. Ghomi, who had no conflicts to disclose. The mean age of patients was 43 years, and their mean body mass index was 28 kg/m^2.

There was no significant difference in the mean operating time between both groups (145 minutes for the LAVH vs. 143 minutes for the LSH group) or in the rate of perioperative complications (19% vs. 15%, respectively). Postoperative hemoglobin change and febrile morbidity were similar between the groups.

Hospital stay was significantly shorter for women in the LSH group, compared with their counterparts in the LAVH group (a mean of 1.2 days vs. 1.6 days, respectively). Potential confounders to this relationship such as perioperative complications, intraoperative conversion to laparotomy, postoperative fever, and hemoglobin change did not differ significantly between the two groups.

"Shorter hospital stay in LSH is an interesting observation that might suggest overall faster patient recovery," Dr. Ghomi said in a later interview. "Shorter hospital stay in LSH might also offset the cost of disposable instruments utilized in LSH, when compared to LAVH. Large randomized clinical trials are needed to further investigate the superiority of either of these two minimally invasive surgical alternatives to abdominal hysterectomy." ■

Vaginal Misoprostol Before Hysteroscopy Effective for Pain

LAS VEGAS — Using 400 mcg vaginal misoprostol 12-24 hours before hysteroscopy reduces the pain related to the procedure and the maximum peak force needed for dilatation of the cervix, results from a double-blind randomized trial demonstrated.

While the off-label use of vaginal misoprostol has been widely used to make the dilatation of the cervix easier, "most studies have measured the effects on the cervix by the largest Hegar dilator that could be inserted without resistance, which is a subjective measure," Dr. Guy Waddell said in an interview after his poster presentation at the annual meeting of the AAGL. "The quality of these studies therefore is underrated. Moreover, the pain reported by the patient was rarely assessed," said Dr. Waddell, a gynecologist at the University of Sherbrooke (Que.).

Mean pain score after dilatation to 6 mm was 42.1 in the misoprostol group, compared with 57.2 in the placebo group.

DR. WADDELL

He and his associates used a cervical tonometer to objectively measure the force needed to dilate the cervix after priming with vaginal misoprostol, compared with placebo, in 101 women undergoing diagnostic hysteroscopy. The researchers also used the Visual Analog Scale to assess pain after dilatation to 6 mm.

Of the 101 women, 50 self-administered 400 mcg vaginal misoprostol while 51 self-administered vaginal placebo 12-24 hours before hysteroscopy. Their mean age was 51 years and their mean parity was 2.2. Complete data were missing on nine patients in the misoprostol group and two in the placebo group.

Dr. Waddell and his associates reported that the mean pain score after dilatation to 6 mm was 42.1 in the misoprostol group, compared with 57.2 in the placebo group, a difference that was statistically significant. The difference between groups retained significance after the researchers adjusted for baseline pain scores measured before randomization and any intervention (43.2 vs. 55.5, respectively). The force needed to dilate the cervix at 6 mm also was significantly less in the misoprostol group than in the placebo group (5.0 newtons vs. 7.5 newtons, respectively). There were no significant differences in the force needed to dilate the cervix at 3 mm (1.7 vs. 1.8 newtons), 4 mm (2.6 vs. 3.0 newtons), or 5 mm (4.3 vs. 4.0 newtons).

The number of side effects and complications were few, but pelvic cramping was reported significantly more often in the misoprostol group than in the placebo group.

"The demonstration that the cervix is more easily dilated with misoprostol at 6 mm suggests that, for any procedure needing the insertion of a device of more than 5 mm into the endometrial cavity, priming would be facilitating and could reduce the risk of complications," the researchers wrote.

Dr. Waddell said he had no conflicts of interest to disclose. ■