Results for Laparoscopic Hysterectomy Similar

Complication rates are about the same whether procedure is for benign or cancerous conditions.

BY SHERRY BOSCHERT
San Francisco Bureau

San Diego — The rate of surgical complications with laparoscopic hysterectomy is similar whether the procedure is performed for benign or cancerous conditions, Ali Mahdavi, M.D., said at an international congress of the Society of Laparoendoscopic Surgeons.

Laparoscopic hysterectomy in 74 women with gynecologic cancers required more surgical time and longer hospitalization, compared with laparoscopic hysterectomy in 85 women with benign gynecologic conditions, a retrospective review of consecutive cases found.

A higher rate of postoperative fever in the cancer group was not associated with major morbidity.

DR. MAHDAVI

There were no significant differences between groups, however, in estimated blood loss, rate of procedures converted to laparotomy, and intraoperative bowel or bladder injuries, said Dr. Mahdavi, a gynecologic oncologist at the University of California, Irvine.

"Laparoscopic procedures for gynecologic cancers are complicated and technically demanding procedures," but appear to be safe when done by experienced surgeons, Dr. Mahdavi said. "Operators who decide to proceed with laparoscopic hysterectomy for gynecologic cancers should not only be trained gynecologic oncologists, but should [also] have extensive operative laparoscopy skills."

The study won first prize among scientific papers on gynecology presented at the meeting.

All hysterectomies were performed by the same group of surgeons, assisted by residents and fellows, using standard techniques and the same preoperative care for all patients. The study analyzed data from patient admission up to 30 days following discharge after surgery.

Women in the cancer group were older than the women with benign conditions (a mean age of 57 and 51 years, respectively) and had a larger mean body mass index (28 vs. 24 kg/m^2).

Mean operating times were 253 minutes in the cancer group and 188 minutes in the benign conditions group. Patients remained hospitalized for 3.5 days in the cancer group, significantly longer than the 2.5 days in the benign conditions group.

Although the mean estimated blood loss did not differ significantly (201 and 184 mL, respectively), the rate of transfusion was significantly lower in the cancer group. Two women in the cancer group and four in the benign conditions group required transfusion.

A significantly higher rate of postoperative fever in the cancer group (four cases, compared with two in the benign conditions group) was not associated with major morbidity, however, Dr. Mahdavi noted.

Two surgeries in each group were converted to laparotomy. One patient in the cancer group suffered an intraoperative bladder injury. There were no bowel injuries or wound infections.

Laparoscopic hysterectomy is a relatively new approach to managing gynecologic cancers, and questions have been raised about perioperative complications and long-term outcomes, compared with abdominal or vaginal hysterectomies.

The results support retrospective studies suggesting the feasibility and safety of laparoscopic hysterectomy for gynecologic cancers, he said. Randomized, controlled trials comparing different hysterectomy routes may never be performed for some gynecologic cancers because the number of patients needed for such trials could not be attained, Dr. Mahdavi said.

In the current study, women in the cancer group had malignancies of the endometrium (49 patients), cervix (15), ovary (7), vagina (1), or other areas (2).

Women in the control group underwent laparoscopic hysterectomy for symptomatic uterine myomas (18 patients), benign adnexal masses (33), pelvic endometriosis (10), and other benign conditions (24), including genital prolapse, cervical dysplasia, and endometrial hyperplasia.

Most patients in the cancer group underwent cancer staging procedures such as lymphadenectomy in addition to hysterectomy, which contributed to operating time, he said.

Other additional procedures in the cancer group included salpingo-oophorectomy, sigmoidoscopy, and cystoscopy. Additional procedures in the control group included salpingo-oophorectomy, colpopexy, urethropexy, cystoscopy, appendectomy, and anterior or posterior colporrhaphy.

In the cancer group, 46 underwent laparoscopic-assisted vaginal hysterectomy, 24 had a total laparoscopic radical hysterectomy, and 2 each underwent total laparoscopic hysterectomy or laparoscopic supracervical hysterectomy.

In the control group, 59 patients had a laparoscopic vaginal hysterectomy, 15 underwent total laparoscopic hysterectomy, and 11 had a laparoscopic supracervical hysterectomy. ■

Outpatient Laparoscopic Subtotal Hysterectomies Considered Safe

BY SHERRY BOSCHERT
San Francisco Bureau

San Diego — Laparoscopic supracervical hysterectomies can be done safely on an outpatient basis, a review of 190 cases suggests, Stefanos Chandakas, M.D., reported.

The surgeries were performed over a 14-month period by a two-surgeon team at Princess Royal University Hospital, London, where subtotal hysterectomies have been the norm since 2001. Patients underwent the hysterectomies to treat endometriosis (22%), menorrhagia (66%), and endometrial pathology (12%). All had failed medical therapy.

Operating times decreased when the surgeons switched to disposable morcellators.

DR. CHANDAKAS

Patients lost an estimated 200 mL of blood on average, ranging from 50 to 2,000 mL. Less than 100 mL of blood was lost in 74% of cases, estimated Dr. Chandakas of the hospital, and his associates.

There were no significant intraoperative complications, vascular injuries, or nerve or ureter injuries. The average length of stay was 8 hours, and 94% of patients were discharged in less than 24 hours.

Postoperative complications included bladder infection or dysfunction in 2%, deep vein thrombosis in less than 1%, and paralytic ileus in one patient. Minimal cyclic bleeding occurred in 1% of patients. That's better than complication rates of 1%-10% reported in the literature, perhaps "because we spend 3-5 minutes coagulating the cervical canal" during the surgery, he said. One patient required reoperation for an intraabdominal abscess.

Compared with total abdominal hysterectomy or total vaginal hysterectomy, laparoscopic supracervical hysterectomy is "a much safer and easier operation to do," Dr. Chandakas said.

Patients ranged in age from 33 to 53 years, with uterine sizes of 8-41 weeks and uterine weights of 36-325 g. The procedure took 125 minutes when first adopted by Dr. Chandakas' institution, but in recent years 80% of laparoscopic supracervical hysterectomies have averaged 40-45 minutes. The main reason for the longer surgical times was difficulty with the morcellator. Operating times decreased when the surgeons switched to disposable morcellators, he noted.

The team performed laparoscopic supracervical hysterectomy using PlasmaKinetic energy for tissue dissection and coagulation and a 12-mm morcellator to remove dissected organs. U.S. physicians in the audience said that surgeons in this country are just starting to use this approach.

"In the last 3-4 years, we can see a trend of supracervical hysterectomies coming back and becoming more and more widespread both in the U.K. and in the U.S.," Dr. Chandakas said. The laparoscopic approach to supracervical hysterectomies is newer and easier, he added.

Concerns have been expressed in the literature that subtotal hysterectomies to treat malignancies may leave patients with higher risk compared with total hysterectomies, because the cervix remains intact. There is no evidence, however, that total hysterectomies decrease mortality from cervical cancer. It's the Pap screening that reduces mortality, he noted. ■

Outcomes Data Show Durability of Uterosacral Ligament Vault Suspension

Atlanta — Uterosacral ligament vault suspension for the repair of enterocele and vaginal vault prolapse is a durable procedure, 5-year outcomes data suggest.

Of 110 patients who underwent the procedure for advanced pelvic organ prolapse, 72 returned for follow-up assessment at a mean of 5.1 years. Vaginal hysterectomy was performed in 37% of the patients, anterior colporrhaphy was performed in 58%, posterior colporrhaphy was performed in 87%, and a urethral sling was performed in 34%.

Surgical failure, defined as recurrent symptomatic prolapse of stage II or greater in at least one segment, occurred in 15%, and only two patients had further surgery for prolapse, William A.Z. Silva, M.D., reported at the annual meeting of the American Urogynecologic Society.

Furthermore, most patients had improvement or maintenance of pelvic floor function. Overall, postoperative Incontinence Impact Questionnaire (IIQ) and Urogenital Distress Inventory (UDI) scores were significantly improved, compared with preoperative scores, as were scores in the irritative, obstructive, and stress domains of these instruments.

The rate of bowel dysfunction did not differ significantly in the pre- and postoperative periods, with 33% reporting preoperative dysfunction, and 27% reporting postoperative dysfunction, said Dr. Silva, formerly of Good Samaritan Hospital, Cincinnati, and currently with St. Francis Hospital, Federal Way, Wash.

Mean postoperative Female Sexual Function Index (FSFI) scores for arousal, lubrication, orgasm, satisfaction, and pain were all in the normal range. About 54% were sexually active postoperatively, compared with 66% in the preoperative period, but 94% at follow-up reportedly were satisfied with their sex lives.

—Sharon Worcester