Go Minimally Invasive for Most Hysterectomies

Taking a vaginal or laparoscopic approach is best, except in a few specific, defined circumstances.

BY MIRIAM E. TUCKER

Minimally invasive approaches should be the "procedures of choice" for nearly all women undergoing hysterectomy to treat benign uterine disease, according to a new position statement from AAGL.

Currently, more than two-thirds of the 600,000 hysterectomies performed annually in the United States are done through an abdominal incision, despite the availability of less-invasive vaginal and laparoscopic approaches, which are associated with reduced morbidity, faster recovery, and lower cost.

The AAGL Advancing Minimally Invasive Gynecology Worldwide (formerly known as the American Association of Gynecologic Laparoscopists) has now issued a strongly worded statement advising that abdominal hysterectomies be limited to only a few specific, defined circumstances.

"When hysterectomy is necessary, the

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DR. LOFFER

demonstrated safety, efficacy, and cost-effectiveness of vaginal hysterectomy (VH) and laparoscopic hysterectomy (LH) mandate that they be the procedures of choice.

"When hysterectomy is performed without laparotomy, early institutional discharge is feasible and safe, in many cases within the first 24 hours," the AAGL said in the statement, posted online in November and due to be published in the January issue of the Journal of Minimally Invasive Gynecology.

The statement went on to advise that, "Surgeons without the requisite training and skills required for the safe performance of VH or LH should enlist the aid of colleagues who do or should refer patients requiring hysterectomy to such individuals for their surgical care."

The short list of contraindications given for LH include medical conditions in which the risk of either general anesthesia or increased peritoneal pressure are deemed unacceptable, or where morcellation may be required or uterine malignancy is known or suspected. For both VH and LH, the only contraindications are when there is no access to an experienced surgeon or the necessary facilities, or where the anatomy is so distorted that neither a laparoscopic nor vaginal approach is deemed safe.

Other clinical situations such as obesity or previous cesarean section should not be considered contraindications to minimally invasive procedures, AAGL said. Obesity may be associated with longer operative times but otherwise does not impair safety or efficacy of minimally invasive procedures, and the risks of inadvertent cystotomy and other complications with LH in women with previous Cesarean section is low (J. Minim. Invasive Gynecol. 2010;17:186-91).

The statement is aimed at several constituencies, AAGL executive vice president and medical director Dr. Franklin Loffer said in an interview. "We want patients to know, insurance companies to pay attention, and we want doctors to either learn how to do the procedures, get someone to help them, or just refer. I don't think it's justified doing an abdominal hysterectomy simply because you can't do anything else. That's not in the patient's benefit."

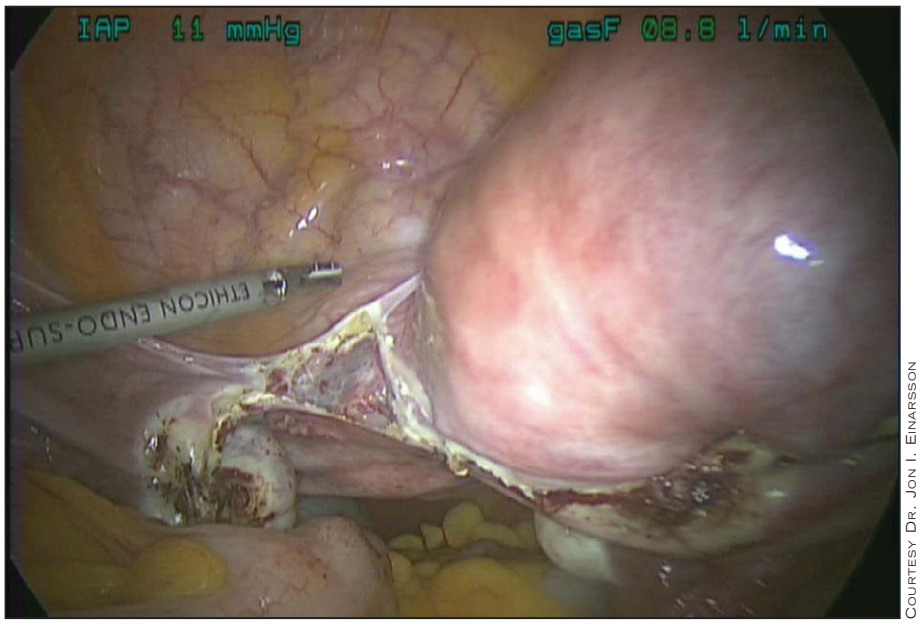
He added, "We wish to point out that our specialty needs to do a better job of educating people to do these procedures."

In calling for a dramatic reduction in the number of abdominal hysterectomies, the AAGL position is in line with that of the American College of Obstetricians and Gynecologists, issued in a committee opinion paper "Choosing the Route of Hysterectomy for Benign Disease" in November 2009 (#444). But ACOG differed from AAGL in that it deemed the vaginal approach as the procedure of choice, with the laparoscopic approach second and abdominal approach as a last resort. Also, ACOG did not recommend referring patients to specialists as AAGL did.

According to Dr. Cheryl B. Iglesia, chair of the ACOG Committee on Gynecologic Practice, which wrote the opinion paper, "We do agree that for the most part hysterectomy should be done minimally invasively, and the least invasive [approach] is vaginal over laparoscopic. It's associated with less operator time, less pain, less cost, and less potential injury. But, there are some technical skills to be developed," she said in an interview.

As for the referral issue, "We have lots of constituents, and we have to look at what's practical. If you're the only doctor in a big rural setting for 300 miles, you're going to do whatever is safest in your hands. We try to be very practical at ACOG," said Dr. Iglesia, who is section director for female pelvic medicine and reconstructive surgery at Washington Hospital Center and is in the ob.gyn. department at Georgetown University, Washington.

Dr. Loffer noted that the ACOG evidence base included a Cochrane review (Cochrane Database Syst. Rev. 2009 [doi: 10.1002/14651858.CD003677.pub4]) containing data from the earliest laparoscopic procedures when there were more complications as surgeons acquired the skills and that now the complication rates are approximately equal to that of vaginal hysterectomy. But, he said with regard to the two organizations' positions in general, "I don't think we're that far apart."



COURTESY DR. JON I. EINARSSON

Physicians should learn to either do minimally invasive hysterectomies, get someone to help them, or just refer, according to Dr. Franklin Loffer.

Indeed, both AAGL and ACOG – as well as the American Board of Obstetrics and Gynecology – are exploring ways to improve training at the residency level, where currently the amount of exposure to minimally invasive hysterectomy procedures varies considerably from one program to the next, and is often quite low. This contrasts with general surgery,

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DR. IGLESIA

where completion of a didactic and clinical program "Fundamentals of Laparoscopic Surgery" is now a requirement of residency training.

"Developing something similar for gynecology is one of the AAGL's current initiatives," Dr. Loffer said.

Movement also could come from the payer side. AAGL has had discussions with private insurers expressing interest in such approaches as "incentivizing" patients via lower co-pay to choose surgeons who do minimally invasive procedures. The AAGL provides a registry of qualified surgeons, the Council of Gynecologic Endoscopy (www.aagl.org/CGE), but it is relatively recent.

Dr. Iglesia noted that on the Medicare side, a recent change in the hysterectomy CPT codes giving a greater relative value unit for removal of uteri greater than 250 grams either vaginally or laparoscopically means higher payment. "That should incentivize a bit. … They are trying."

According to the AAGL statement, the 66% abdominal hysterectomy rate in the United States contrasts dramatically with some European countries in which the proportion is less than 25%. Some insight to the attitudes of American practitioners can be found in the results of an online/paper survey conducted by Dr. Jon I. Einarsson of Brigham and Women's Hospital, Boston, and his associates (J. Minim. Invasive Gynecol. 2010;17:167-75).

Of the 1,500 randomly sampled practicing obstetrician-gynecologists surveyed, 376 responded. Among those, the most commonly performed hysterectomy procedure in the previous year was AH (84%), followed by VH (76%). But when asked to rank which hysterectomy approach they would prefer for themselves or their partner, 56% ranked VH as their first choice and 41% ranked LH as their first choice, with only 8% opting for AH.

When asked about barriers to performing minimally invasive procedures, the most common ones reported for VH included technical difficulty, potential for complications, and personal caseload. For LH, respondents cited lack of training, technical difficulty, personal surgical experience, and operating time as barriers.

Nonetheless, when asked about their ideal goal for mode of access, the respondents felt on average that minimally invasive techniques should comprise 79% of all hysterectomy procedures.

Not surprisingly, the survey also revealed that gynecologic surgeons who had a high surgical volume were more likely to feel comfortable offering a minimally invasive hysterectomy to their patients.

"This suggests that more emphasis needs to be placed on training opportunities … given the desire among practicing gynecologists to change their surgical mode of access," Dr. Einarsson and his associates concluded.

Dr. Loffer declared that he owns stock in Johnson & Johnson and Interlace Medical. Dr. Iglesia, and Dr. Einarsson and his coauthors all stated that they had no disclosures. ■