Advantages Of
Minimally Invasive Procedures (MIP)
For Hysterectomy

Presented by
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Hysterectomy – Overview

- 33% of U.S. women will have one by age 60.

- 2nd most common major surgery among U.S. women.

- Approximately 600,000 per year in U.S.
Hysterectomy – Overview

The only permanent, guaranteed cure for many gyn/pelvic conditions, including:

- Fibroids
- Uterine prolapse
- Polyps
- Abnormal uterine bleeding
- Heavy periods
- Uterine cancer
Hysterectomy – Overview

The surgical treatment of choice for many chronic gynecologic conditions in women who do NOT wish to preserve their fertility or uterus.
Hysterectomy – Breakdown by Approach

- Total Abdominal Hysterectomy (TAH) 66%-70%
- Minimally Invasive Procedures (MIP):
  - Total Vaginal Hysterectomy (TVH) 20%-22%
  - Lap.Supracervical Hysterectomy (LSH) 7%-12%
  - Total Laparoscopic Hysterectomy (TLH)
Overview of TAH

• Major surgery
• Most invasive hysterectomy
• Large, C-section sized incision
• Hospital stay of 3+ days
• Painful recovery of 6-8 weeks
• Higher risks of post-op morbidity
TAH: Post-Operative Morbidities

- Wound: infection/hernia
- Urologic injury
- Blood loss, transfusion
- Hospital-acquired infection
- Thrombotic events
- Prolonged narcotic usage
- Post-op adhesions
- Post-operative nausea/vomiting (PONV)
MIP Hysterectomy Advantages over TAH

- Outpatient procedure
- No unsightly incisions
- Far less post-op pain
- Far faster recovery
- Regular diet immediately

TAH surgery scar
LSH, TLH scar
TVH scar (none)
MIP Hysterectomy Advantages over TAH

**Far lower post-op morbidities**

- Virtually zero:
  - blood loss, transfusion rate
  - infection rate
  - risk of nerve damage
  - wound complications
  - thrombotic events

- Far lower risk of hospital readmission

- Far faster return to most ADLs

- Slightly higher equipment costs more than offset by less time out of work, quicker recovery, lower medication usage
MIP Hysterectomy:
Total Vaginal Hysterectomy (TVH)

• Uterus/cervix removed through vaginal incision

• Least invasive, but not always technically feasible

• Inability to concurrently treat many coexisting extra-uterine conditions
MIP Hysterectomy:
Lap. Supracervical Hysterectomy (LSH)

- Removes uterus only; cervix remains
- Tiny abdominal incisions
- Uterus removed in pieces via trocar
MIP Hysterectomy; Total Laparoscopic Hysterectomy (TLH)

• Removes uterus and cervix
• Tiny abdominal incisions
• Guaranteed access to ovaries
• Ability to treat all concurrent pathologies
• Highest patient satisfaction rating
• Hysterectomy of choice for gyn surgeons and their families*
MIP should be “procedures of choice” for nearly all women undergoing hysterectomy to treat uterine disease.

TAH should be limited to only a few specific, defined circumstances.

Surgeons without training/skills required for safe performance of MIP hysterectomy should enlist the aid or refer to colleagues that do.
AAGL Survey of Ob/Gyn Physicians*

- Preferred mode of hysterectomy for ob/gyns or their spouses:
  - TVH 55.5%
  - LH (LSH or TLH) 40.6%
  - TAH 8.0%

- While >96% of ob/gyns prefer MIP hysterectomy for themselves/spouse, TAH is still most common hysterectomy performed in U.S. (66-70%).

Why Is TAH Still So Common?

- Inadequate Ob/Gyn residency training in MIP.
- No MIP competency requirement for Ob/Gyn grads or practice.
- Few Ob/Gyn docs do post-residency MIP fellowships.
- Specialty demographic shift to 80-90% females who devote less time to surgery, have lower surgical volume.
- Avg. practice focus: Ob – 80%; Office Gyn – 20%.
- Lack of physician time to get MIP training.
Why Is TAH Still So Common? (Cont’d)

- Post-grad “hands-on” weekend courses are inadequate due to length of learning curve.
- Lack of mentoring by senior practice partners.
- Lack of gyn surgical volume to gain/maintain MIP proficiency.
- Lack of patient awareness/demand for MIP hysterectomy.
- Physician inertia, procrastination, lack of commitment to MIP.
- **Ethical issue**: true informed consent vs. Ob/Gyn failure to present all hysterectomy options.
Hysterectomy Quiz

True or False?
TAH provides better visualization than TLH/LSH?
False!
TLH/LSH provides unmatched visualization.

- High definition 1080p monitors/optics
- Access to anatomic areas not visible with naked eye
- Ability to see and treat endometriosis
- Ability to document surgical findings
Many patients are not MIP candidates?
False!

Less than 1% of surgical candidates are not MIP candidates.
MIP Candidates

• Prior pelvic/abdominal surgeries
• Prior pelvic infections
• Suspected adhesions
• Endometriosis
• Leiomyomata
• Adnexal pathology
• Obesity
• Nulliparity
There is a high rate of conversion from MIP to open surgery?
False!
The conversion of MIP to open surgery is highly surgeon-dependent.
Laparoscopic MIP requires longer operating time than TAH?
False!
Length of procedure is highly surgeon-dependent.

In experienced hands, there is no significant difference in O.R. time for MIP hysterectomies compared to TAH
Hysterectomy patients require inpatient observation for bladder catheterization/urine output monitoring?
False!
Even elderly patients have no problems managing Foley catheter removal at home the next day.
The costs of laparoscopic hysterectomy (TLH, LSH) are greater than TAH?
False!
TLH/LSH provides:

- Far shorter (or no) hospitalization
- Far less need for Rx pain meds
- Far lower morbidities/readmission
- Far faster return to work/ADLs
Robotic hysterectomy is superior to TLH?
Definitely False!
Robotic Hysterectomy

Disadvantages

- Far costlier
- Far longer procedure times
- No data proving better outcomes compared to “straight sticks”
- Requires more trocar incisions
- Position of robot makes reduction of large specimens awkward
- Difficult intraoperative access to vagina
- Institutional costs dramatic
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