



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) 7%-12%



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)

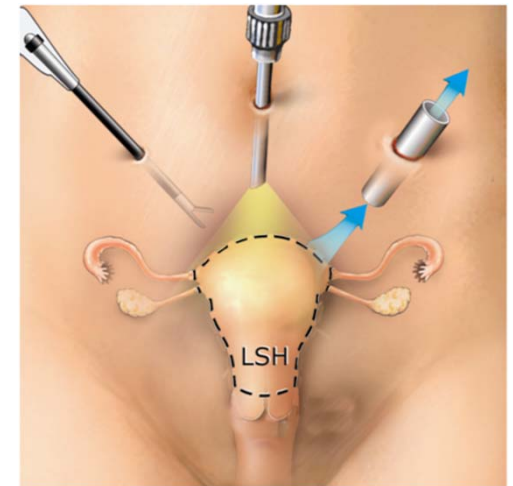
- Uterus/cervix removed through vaginal incision
- Least invasive, but not always technically feasible
- Inability to concurrently treat many coexisting extra-uterine conditions





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*



American Association of Gynecologic Laparoscopists Position Statement -- Published online Nov. 9, 2010

- 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%).

* J.I. Einarsson, N.R. Chavan, H. Sangi-Haghpeykar; The Journal of Minimally Invasive Gynecology; November 2009 (Volume 16, Issue 6, Supplement, Page S44)



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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