Dr. Hugo Verhoeven: “My name is Hugo Verhoeven, I’m on the Editorial Board of OBGYN.net, and I’m reporting from the 9th Annual meeting of the International Society for Gynecologic Endoscopy at the Gold Coast in Queensland. It is a great honor for me to now interview Harry Reich, who is certainly one of the gurus or leaders in the field of endoscopic surgery. What we’d like to talk about today is hysterectomy - are there any indications left for performing this procedure by laparotomy? Harry, thank you for giving me the pleasure to do this interview with you. What is your opinion if you compare ten years ago with now - what changed in the field of hysterectomy?”

Dr. Harry Reich: “Thank you for that very interesting question, Hugo. The problem is that in the United States and in many other parts of the world, 70% of hysterectomies are still done with mutilating abdominal incisions. The only places where you have more hysterectomies done without these incisions or laparoscopically or vaginally are places like in Taiwan where the doctors are reimbursed more if they do a hysterectomy without a major incision. Unfortunately in the United States, as we all know, most of our gynecologists are trained to do abdominal hysterectomy. They then go into a busy practice, usually as a junior partner where they deliver babies for the next twenty years, and then as their patients get older they want to do some hysterectomies. Unfortunately, they don’t go to school again and find out the most efficacious way to do the hysterectomy but they resort to the technique that they learned twenty years ago when they were residents which means a large mutilating abdominal incision or in some cases of Pfannenstiel or a bikini cut. Both incisions cause more adhesions, more pain, and discomfort than if the operation were done with a laparoscope. Now we know that in almost every indication these operations can be done with a laparoscope, that includes the major indications for hysterectomy. Number one, of course, would be a fibroid uterus causing bleeding, sometimes causing pelvic pressure, and rarely causing pain. Almost all of those cases could be done laparoscopically as an outpatient or a one or two day hospital stay. The other most common indication would be endometriosis. Endometriosis can involve the uterus and it can involve the areas around the uterus. Very commonly the endometriosis will grow into the posterior cervix and cause very painful periods or in some people pain all the time, seven days a week - in all those cases, the endometriosis should be removed. In these women who have endometriosis who want further childbearing, the endometriosis could be removed and the uterus and one or both ovaries preserved. In these women who do not desire further childbearing, the endometriosis is probably best treated by first excision of the endometriosis where one finds it and then also a hysterectomy to remove possible deep endometriosis which is called adenomyosis - inside the uterus. It’s very interesting, in my opinion, in most of these cases the ovaries do not have to be removed, if the patient has extensive endometriosis, I believe you should remove the areas where the disease is and not normal ovaries, and the patient will do very well.”

Dr. Hugo Verhoeven: “So castration is not necessary.”

Dr. Harry Reich: “I believe that’s a great advance in our thinking and our publication coming out at Columbia should be to the presses very soon where we’ve shown that castration is not necessary if the surgeon has the skill and ability to remove the disease.”

Dr. Hugo Verhoeven: “That’s one of the ways of treating endometriosis in a non-surgical way to bring the patient in and a low estrogenic phase by giving medicaments to suppress the function of the ovaries so that is something very interesting.”
Dr. Harry Reich: “We know endometriosis can grow even after removal of both ovaries. Present evidence shows that there’s estrogen made by skin and also by endometriosis itself that could keep the disease going. So to just remove normal ovaries and bring the patient into surgical menopause with attendant problems that one has with that like hot flashes, bone loss, and possibly increased the risk of heart disease which again is equivocal after some recent reviews that just came out this year. I don’t think it’s fair to remove the normal ovary with endometriosis.”

Dr. Hugo Verhoeven: “Another indication for hysterectomy is of course irregular bleeding or heavy bleeding and for that we now have the technique of ablation of the endometrium. So that was the last indication for hysterectomy that is replaced by an endoscopic technique. Let us now maybe go to more complicated surgical cases like cancer. Could you give your opinion on the feasibility of laparoscopic treatment for ovarian cancer?”

Dr. Harry Reich: “Let’s go back a step to hypermenorrhea with heavy bleeding. Most of the time it’s a small uterus, and as you said, there’s so many different techniques where the surgeon could go up through the cervix and try to destroy the lining inside the uterus in hopes of preventing bleeding. Now we all know that there’s a new indication in town for hysterectomy, and that is endometrial ablation failure. Many women who have ablations once, twice, or whatever still have a bleeding problem and many of them come to hysterectomy. Now I believe that most women who have an ablation technique to destroy the lining of the uterus should be given the option from the beginning of the possibility of a vaginal hysterectomy because when the uterus is small, no matter if the patient has had children or not, in almost all cases a good vaginal surgeon could do a hysterectomy on that patient which would of course preserve both ovaries and give that patient a chance of one operation to stop this heavy bleeding problem.”

Dr. Hugo Verhoeven: “Shall we now go back to my previous question - what about cancer treatment laparoscopically?”

Dr. Harry Reich: “Cancer treatment laparoscopically is best done in women with cancer of the inside of the uterus - endometrial cancer. In most cases, endometrial cancer of the uterus is relatively small so the laparoscopic surgeon can take out the uterus and then examine the inside of it. If the depth of myometrial penetration is nil or very superficial, the patient is probably cured just by the simple hysterectomy. If there’s invasion of the muscle greater than one-half through the muscle and uterus, then the surgeon should sample the lymph nodes, usually doing a pelvic lymphoidectomy.”

Dr. Hugo Verhoeven: “But you can also do that laparoscopically.”

Dr. Harry Reich: “That’s a very acceptable laparoscopic procedure, today many doctors are doing it.”

Dr. Hugo Verhoeven: “What about ovarian cancer?”

Dr. Harry Reich: “Ovarian cancer is a little bit more difficult. Again, it depends on where it is, if the woman has one single ovarian tumor or mass that could be taken out with no spill and examined with frozen section. If it is malignant, the cancer treatment that would be done with an open incision can be done laparoscopically. That would include taking out the other ovary, taking out the uterus, and taking out a portion of omentum which is fatty tissue coming down from the stomach and transverse intestine, and finally, sampling the lymph nodes usually in the deep pelvis and also around the aorta.”

Dr. Hugo Verhoeven: “The final step would be in case of invasive cancer, for instance, if a cervical cancer is invading the bladder or the bowel is that also possible doing the laparoscopic way?”

Dr. Harry Reich: “I think that’s too time prohibitive today. Even with a simple cervical cancer the operation of radical hysterectomy done by laparoscope takes a long time, probably twice as long as with an open incision because there are few people that are doing it. Although, there are some centers where they do it with a combined laparoscopic and vaginal technique, most commonly in, of
Dr. Hugo Verhoeven: “Let’s go back now to the field of endometriosis. I heard during your presentation today that in many cases rectovaginal endometriosis requires a very radical resection of the endometriotic tissue and this requires a resection partly of the bowel. The question for me is how many gynecologists are really trained for bowel or bladder surgery or to ask my question differently, is this the field of a gynecologist to really do bowel and bladder surgery laparoscopically? We are not trained for that.”

Dr. Harry Reich: “Yes, to consider taking a portion of bowel with endometriosis means that the endometriosis has invaded the bowel wall and usually caused a stricture which is an area where the bowel is obstructed so feces would have trouble getting through that small little area. In most cases, bowel resection should be considered and if it’s not done during the primary surgery, there’s a good chance it will have to be done in the future. Now how to do it - that’s a big question. The best way would be a gynecologist because a gynecologist understands the disease of endometriosis better than a general surgeon or colon and rectal surgeon. Most of us, even myself, I try to have a general surgeon come in along and give me some technical advice and work together. There are a few of us who can and have the ability to do it on our own but I think that’s the exception rather than the rule. I think in the future, we’ll see more and more teams of gynecologists with general surgeons operating on extensive rectal endometriosis.”

Dr. Hugo Verhoeven: “So the cooperation between the gastroenterologist surgeon, the urological surgeon, the general surgeon, and the gynecologist in the field of endoscopy especially in the field of endometriosis and cancer is a reality.”

Dr. Harry Reich: “I hope so, in my case it’s reality and many other surgeons it’s reality but it must be emphasized more so that people will do the same thing we’re doing.”

Dr. Hugo Verhoeven: “So tell me, Harry, what are the final indications for laparotomy in gynecology? It is my understanding and am I correct when I say only a C-section will never be possible through the laparoscope or do you see some other indications where maybe later we’ll revise our opinion and say - we did it laparoscopically, it’s technically possible but we shouldn’t do it anymore?”

Dr. Harry Reich: “Most endometriosis operations and most hysterectomies can be done laparoscopically, the critical factor in whether something can be done laparoscopically or not, in my estimation, is the number of previous surgeries that the patients had. We all know that previous surgeries cause adhesions, and adhesions can make the next operation much more difficult. For instance, if the patient has endometriosis deep in the pelvis on the rectum and she’s had five other operations, it could take me four hours to get down to the point where the deep endometriosis is because of all the adhesions that have formed because the other surgeons have not taken out that lesion. Endometriosis involves a chronic inflammatory response, and if you don’t take it out, you sort of aggravate it to the point where you get more adhesions, I feel around it. So those cases could be so long and then you come to the time situation where the surgeon feels he’s not making progress or he’s lost - he should do an open operation with any operation. So there will always be a place to convert a laparoscopy to a laparotomy procedure, just during a normal course of surgery. Of course with complications, many surgeons feel it’s best if they were to have a large bleeding episode or have a problem with intestine, they would feel it would be best to do an open incision.”

Dr. Hugo Verhoeven: “But that will only be a matter of time until those major complications can also be treated perfectly laparoscopically I guess.”

Dr. Harry Reich: “Yes, I think as we involve general surgeons and we cross fertilize more with the general surgeons that will happen more. I don’t think that will happen with the gyn-oncologist or the uro-gynecologist, I think they have their own agendas and are not really anxious to work with gynecological laparoscopic pelvic surgeons to help them become real surgeons.”

Dr. Hugo Verhoeven: “So, Harry, I always like to finish my interviews with the future. What are your visions for the future in the field of endoscopic surgery?”
Dr. Harry Reich: “My sincere hope is that there will be a new specialty of laparoscopic pelvic surgeon.”

Dr. Hugo Verhoeven: “What are the chances to achieve that goal?”

Dr. Harry Reich: “I think we have to get a sizable group of people who are influential and approach some of our governing bodies like FIGO and try to have them look at this in more detail because if we don’t, I feel that many of the surgical operations that I do and many of the good endometriosis doctors at this meeting do will go the way of the general surgeon.”

Dr. Hugo Verhoeven: “So that will take another ten to twenty years before those official organizations will...”

Dr. Harry Reich: “I hope it will take like less than five years because if it takes twenty years the general surgeons will already be doing all of our work.”

Dr. Hugo Verhoeven: “Exactly.”

Dr. Harry Reich: “And, of course, the invasive radiologists will be doing all of our fibroid work.”

Dr. Hugo Verhoeven: “So we lose our jobs.”

Dr. Harry Reich: “You got it.”

Dr. Hugo Verhoeven: “Thank you.”

Dr. Harry Reich: “You’re very welcome.”

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