

# The Incidence of Endometriosis in Posthysterectomy Women

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## Supracervical Laparoscopic Hysterectomy (SCLH)

C Morin, AMJ Rene, I Perez-Villa, J Rodriguez. Clinica Ginemedex, Barcelona, Spain.

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Results, including operating time, blood loss, subjective feelings of nausea, emesis, oral tolerance, and resumption of ambulation were all evaluated in the immediate postoperative period. All patients resumed their normal daily activities at 6 to 10 days postoperatively.

A preliminary report addressing sexual function and satisfaction at 3 months postoperatively as compared with the preoperative period was developed. No difference in experience was noted.

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tional total laparoscopic hysterectomy (LH). SCLH appears to offer several advantages over total LH.

## Narrow Caliber Office Hysteroscope

<sup>1</sup>MG Munro, <sup>2</sup>J Jensen, <sup>3</sup>TF Purdon. <sup>1</sup>University of California, Los Angeles, Los Angeles, CA; <sup>2</sup>University of Irvine, Irvine CA; <sup>3</sup>University of Arizona, Tucson, AZ.

Although hysteroscopy has been available for decades, only a few gynecologists perform the procedure in an office or clinic setting. Among the presumed reasons for this lack of acceptance is the requirement for local anesthesia and subsequent dilation of the cervix for the insertion of a hysteroscope sheath, usually five millimeters in diameter. Despite such anesthesia, many patients still experience pain and discomfort. In an attempt to deal with these issues an inexpensive three millimeter diameter hysteroscope with a through lumen was designed and developed for comfortable office use, with or without either a surrounding sheath or a video camera. A multicenter pilot study was performed in 34 patients, comparing image quality, ease of viewing, requirements for anesthesia, and patient discomfort associated with the use of the new and other hysteroscopes. Because the device could almost always be inserted without dilation of the cervix and pain, discomfort and requirements for anesthesia were reduced compared with standard hysteroscopes. The angled eyepiece permitted comfortable viewing without the need for a video camera. Image size was smaller and the quality was slightly reduced compared with larger diameter hysteroscopes, but in most instances, with fluid media, visualization was adequate for diagnostic evaluation.

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One hundred consecutive patients, age 24-62, status post total hysterectomy with and without bilateral oophorectomy (BSO), presented with chronic pelvic pain. All underwent laparoscopy. Of those who did not have BSO, 30 had definite endometriosis found at laparoscopy and five had questionable

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## Hysterectomy

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endometriosis. Of the 30 patients found to have definite endometriosis, 24 had a positive history of endometriosis, five had a negative history and one had a questionable history. Sixty-four underwent total hysterectomy with BSO. Of these 64, definite endometriosis was found in 22 at laparoscopy, questionable endometriosis was noted in 3, and findings for 39 were negative. Of the 22 women with positive endometriosis, 19 had a positive history of endometriosis, 2 had a negative history and 1 had a questionable history. Of these 22 patients, 13 were on estrogen replacement therapy, 2 were on estrogen and progesterone, 2 were on testosterone estradiol pellets, 2 were on GnRH analogs, 1 was on danazol and 2 received no medication. In this group, the time between hysterectomy and our laparoscopy was eight months to 15 years. Twenty-four of the 100 patients had a positive history of endometriosis with negative findings at laparoscopy. Our findings support the view that endometriosis will be found at laparoscopy in a significant number of women with chronic pelvic pain status post hysterectomy with or without BSO, especially if the woman has a positive history of endometriosis.

## Laparoscopic Management of Genitourinary Endometriosis

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<sup>1</sup>CH Nezhat. <sup>1</sup>Department of Ob/Gyn, Mercer University  
Macon, GA; <sup>2</sup>Department of Ob/Gyn, Stanford University,  
Stanford, CA; <sup>3</sup>Department of Ob/Gyn, Sheba Medical  
Center, Tel Hashomer, Israel.

We treated 17 patients with severe endometriosis involving the genitourinary tract. Eight women presented with persistent right or left flank pain, two presented with known ureteral obstruction, and five presented with urinary frequency and burning, and/or hematuria with their periods. Presented are the results of laparoscopic management in these patients. We performed segmental bladder resection in six patients and ureteral resection and reanastomosis in two. Nine additional patients underwent partial resection of the ureteral wall for complete removal of endometrial implants. The ureter was repaired with 4-0 PDS in seven patients and a stent was left in place

for 4 to 6 weeks. Two required only a stent due to the small size of the ureterotomy. The postoperative course of these patients was uneventful. Following ureteral repair/reanastomosis, all women underwent an intravenous pyelogram at follow-up, and normal bilateral excretion was demonstrated. Cystoscopy revealed no abnormal findings in five patients who had undergone partial bladder resection. All patients reported significant pain relief or complete resolution of symptoms. Operative laparoscopy can be safely used to achieve relief from severe symptomatic endometriosis of the genitourinary tract.

## Complications of 361 Laparoscopic Hysterectomies

<sup>1</sup>CH Nezhat, <sup>1,2</sup>C Nezhat, <sup>3</sup>D Admon, <sup>3</sup>D Seidman,  
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Stanford, CA; <sup>3</sup>Department of Ob/Gyn, Sheba Medical  
Center, Tel Hashomer, Israel.

We evaluated the results and complications of 361 hysterectomies performed at operative laparoscopy to treat a variety of benign gynecologic conditions. The hysterectomies were classified according to the number of steps performed endoscopically. There were no conversions to laparotomy for the hysterectomy, although one required laparotomy for rectosigmoid resection and anastomosis due to severe stricture of the rectosigmoid colon. There were no cases of mortality during the hospitalization nor during 42 postoperative days. The overall complication rate was 10.23 per 100 women. Intraoperative complications included three inferior epigastric vessel injuries, two hemorrhages requiring blood transfusion, one small bowel injury and one bladder injury. The overall complication rate in this series is lower than that reported for abdominal or vaginal hysterectomy. Laparoscopically assisted hysterectomy allows the surgeon to directly visualize uterine artery pedicles, to clearly delineate ureteral paths, to accomplish immediate and precise hemostasis, to use hydrostatic lavage and irrigation to continuously disperse microclots and tissue debris, and to operate with accuracy. While this procedure seems to offer several advantages such as reduced devitalized tissue, near elimination of the potential for suture reaction, and diminished inflammatory responses during the healing phase, complications can be encountered.

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### Is Hormonal Suppression Efficacious in Treating Functional Ovarian Cysts?

<sup>1,2</sup>F Nezhad, <sup>1</sup>CH Nezhad, S Borhan, <sup>1,2</sup>CR Nezhad. Mercer University, Macon, GA; Stanford University, Stanford, CA; Midwestern University, Chicago, IL.

We randomly assigned 95 women, age 17-55 (mean 36.5) with unilateral or bilateral ovarian cysts measuring 1.1 to 6.1 cm in greatest diameter, to four groups to determine the efficacy of hormonal suppression. Eleven did not complete the study, and 9 did not follow up, for a study population of 75. Of these 75, 29 women had a history of endometriosis and 12 were treated with ovulation induction within 6 months of inclusion. Group I (24), received no treatment and served as a control; Group II (15) took oral contraceptives (OCP) containing 35 µg ethinyl estradiol and 1 mg norethindrone; Group III (23) received OCP's with 50 µg ethinyl estradiol and 1 mg norethindrone; and Group IV (13) took danazol 800 mg/day. All medications were taken continuously for 6 weeks. Patients were then re-evaluated by pelvic examination and transvaginal ultrasound.

If the cysts persisted, the patient was scheduled for diagnostic and possible operative laparoscopy. Complete resolution of cysts was found in: Group I - 14(58%), Group II - 6(40%), Group III - 15(65%), and Group IV - 7(54%). Of the 33 women with persistent cysts, 28 underwent videolaparoscopy. The results were as follows: Group I (42%) - five functional, two endometriomas, one hydrosalpinx, and one benign paraovarian serous cyst; Group II (60%) - three functional, one endometrioma, and one benign simple cyst; Group III (35%) - two functional, five endometriomas, and one loop of bowel; and Group IV (46%) - four functional and two endometriomas. The results, analyzed using the  $\chi^2$  test, indicated that there is no significant difference between expectant management and hormonal suppression in treating functional ovarian cysts. A CA 125 was obtained on 48 women. Using the *t*-test, we compared values for cysts which persisted and those which did not. There was no correlation between CA 125 levels and persistence or resolution.

### The Fate of a Myoma When Left Intraabdominally: A Case Report

N Niroumand, NM Tabrizi, H Dabirashrafi, O Azmoudeh. Mirza Koucheh Khan Hospital, Tehran University of Medical Sciences, Tehran, Iran.

A 30 year old infertile woman was a candidate

for laparoscopic myomectomy. There were two large myomas, 6x7 cm, and 5x6 cm attached to the corpus of the uterus with a broad base. The 6x7 cm one was separated with the use of bipolar coagulation. At this point the anesthesiologist urged that the operation be finished because of cardiac arrhythmia. The separated mass (6x7 cm) was biopsied and left intraabdominally. After surgery, repeated sonographies showed gradual resolution of the mass. Four months afterwards she had another laparoscopy. There was no sign of the 6x7 cm myoma. There were no intraabdominal adhesion. However, there was an adhesion on the uterus at the place of the separation of the 6x7 cm myoma. During the second laparoscopy, the 5x6 cm myoma was separated by laparoscopy and then removed via minilaparotomy.

### Laparoscopic Burch Colposuspension — New Approaches

RT O'Shea, E Seman. Reproductive Medicine Program, Flinders Medical Centre, Adelaide, South Australia.

Endoscopic surgical developments have produced considerable benefits in reduction of postoperative morbidity and healthcare costs for the community. The Burch colposuspension via a transverse lower abdominal incision has achieved widespread acceptance in the management of stress incontinence. However, the potential benefits of laparoscopic Burch colposuspension include decreased perioperative and postoperative morbidity, shortened hospitalization, reduction of blood loss, and early return to normal activity. We present our initial 10 cases, 7 via the transperitoneal approach, and 3 using balloon distension of the retroperitoneal space via an extraperitoneal approach. In all cases, the bladder neck and iliopectineal ligaments were clearly visualized laparoscopically. Sutures were placed between the paravaginal fascia and iliopectineal ligaments bilaterally, producing good bladder neck elevation. A suprapubic catheter was subsequently inserted. This initial group (N = 10), mean age 41 years (range 35-54 years) all had preoperative urodynamic studies confirming stress incontinence. A mean operating time of 3 hours 7 minutes (range 2-5 hrs) was achieved using the transperitoneal approach. However, switching to the balloon extraperitoneal method (N = 3), mean surgical time diminished to 65 minutes. All patients were managed with postoperative suprapubic catheterization with hospital discharge after 5.5 days

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