Bangladesh J Obstet Gynaecol, 2012; Vol. 27(1) : 36-37

Abstracts

Hysterectomy surgical trends: a more accurate depiction of the last decade?

Lindsay C. Turner, MD, Jonathan P. Shepherd, MD, MS, Li Wang, MS, Clareann H. Bunker, PhD, Jerry L. Lowder, MD, MSc

AJOG, 32nd Annual Scientific Meeting of the American Urogynecologic Society, Providence, RI, Sept. 14-17, 2011

All hysterectomies performed at Magee-Womens Hospital from 2000 to 2010 were reviewed to describe trends in hysterectomy route at a large tertiary center. This database was chosen over larger national surveys because it has been tracking laparoscopic procedures since 2000, well before laparoscopic hysterectomy *International Classification of Diseases*, ninth revision (ICD-9) procedure codes were developed. There were 13,973 patients included who underwent hysterectomy during the period. In 2000, 3.3% were laparoscopic (LH), 74.5% abdominal (AH), and 22.2% vaginal hysterectomy (VH). By 2010, LH represented 43.5%, AH 36.3%, VH 17.2%, and 3.0% laparoscopic converted to open (LH'!AH). Hysterectomies performed for gynecological malignancy represented 24.4% of cases. The average length of stay for benign LH and VH, 1.0 ± 1.0 and 1.6 ± 1.0 days respectively, was significantly shorter than the average 3.1 ± 2.3 day stay associated with AH ($P < .001$). It was concluded that the percentage of LH increased over the last decade and by 2010 had surpassed AH. The 43.4% LH rate in 2010 is much higher than previously reported in national surveys. This likely is due to an increase in the number of laparoscopic procedures being performed over the last few years.

Staging laparoscopy for the management of early-stage ovarian cancer: A meta-analysis

Hyun Jong Park,MD , Ga Won Yim,MD, Eun Ji Nam,MD, PhD, Sung oon Kim, MD, PhD

AJOG, 12 April 2013

Electronic searches for studies of Laparoscopic Staging Surgery (LSS) in patients with ovarian cancer were performed within three electronic databases (MEDLINE, EMBASE and the cochrane library) to perform a quantitative analysis on operative outcomes of (LSS) in patients with presumed early-stage ovarian cancer (EOC) using a meta-analysis. Eleven observational studies we identified. The combined results of three retrospective studies showed that the estimated blood loss in laparoscopy was significantly lower than that for laparotomy ($p<0.001$). The overall upstaging rate after laparoscopic surgery was 22.6% The overall incidence of conversion from laparoscopy to laparotomy was 3.7% =95% CI: 2.0-6.9%). The overall rate of recurrence in studies with a median follow-up period of 19 months was 9.9%. It was concluded through the quantitative analysis, that the operative outcomes of a laparoscopic approach in patients with EOC could be compatible with those of laparotomy. In the future, further randomized controlled trials may be needed.

Outcomes following hysterectomy or endometrial ablation for heavy menstrual bleeding: retrospective analysis of hospital episode statistics in Scotland

K Cooper[1], AJ Lee[2], P Chien[3], EA Raja[2], V Timmaraju[2], S Bhattacharya

BJOG, 31 MAY 2011

This Population-based retrospective cohort study was done in Scottish hospitals between 1989 and 2006. Anonymised data collected by the Scottish Information Services Division were analysed using appropriate methods across the hysterectomy and endometrial ablation groups. A total of 37 120 women had a hysterectomy, 11 299 women underwent endometrial ablation without a subsequent hysterectomy and 2779 women underwent endometrial ablation followed by a subsequent hysterectomy. Compared with women who underwent hysterectomy, those who underwent ablation were less likely to need pelvic floor repair or tension free vaginal tape surgery for stress urinary incontinence. Abdominal hysterectomy was associated with a lower chance than vaginal hysterectomy of pelvic floor repair surgery.

It was concluded that hysterectomy is associated with a higher risk than endometrial ablation of surgery for pelvic floor repair and stress urinary incontinence. Surgery for pelvic floor prolapse is more common after vaginal than abdominal hysterectomy.

Does cervical preparation before outpatient hysteroscopy reduce women's pain experience? A systematic review

NAM Cooper[1], P Smith[2], KS Khan[3], TJ Clark[4]

BJOG, 29 JUL 2011

To compare the effect on pain and need for cervical dilatation of various methods of cervical preparation before outpatient hysteroscopy. MEDLINE, EMBASE and CINAHL were searched. The Cochrane Library was searched using the keywords 'hysteroscopy' and 'cervical'. There were no limits or filters placed on the searches. Randomised controlled trials that examined women undergoing outpatient hysteroscopy, where the intervention was the use of cervical preparation versus a control or placebo and the outcome was pain assessment. Meta-analysis was performed for adverse effect and feasibility. Data were extracted on pain, the effect on dilatation, adverse effects, trauma and feasibility. From 585 abstracts, six studies were selected for inclusion in the systematic review. The results suggest that there may be a benefit of using prostaglandins for postmenopausal women; however, there is no high-quality evidences that giving misoprostol before outpatient hysteroscopy reduces the pain experienced by women of reproductive age. There is some evidence that prostaglandins reduce the force and requirement for dilatation of the cervix beyond 5 mm. It was concluded that there is no evidence to recommend the routine administration of mifepristone or misoprostol to women before outpatient hysteroscopy. Cervical priming with vaginal prostaglandins may be considered in postmenopausal women if using hysteroscopic systems >5 mm in diameter.

Five-year follow up of women randomised to medical management or transcervical resection of the endometrium for heavy menstrual loss: clinical and quality of life outcomes

Kevin G Cooper, Stuart A JackDavid E Parkin, Adrian M Grant Department of Obstetrics and Gynaecology, Aberdeen Royal Infirmary, UK

Health Services Research Unit, Aberdeen, UK

BJOG 2001

A Five year follow up using postal questionnaires and operative databank review in Gynaecology department of a large UK teaching hospital was done to assess clinical status, changes in health related quality of life, and subsequent management five years after medical management or transcervical resection of the endometrium for treatment of heavy menstrual loss. The study was done in women referred to the gynaecologist for treatment of heavy menstrual loss. Eligible women, without a treatment preference, were randomised equally to either medical treatment or transcervical resection of the endometrium.Women's satisfaction with treatment, menstrual status, changes in health related quality of life, and additional treatments received at five years.One hundred and forty-four patients completed questionnaires, achieving 77% follow up. At five-year follow up, 7/71 (10%) of those randomised to the medical arm still used medical treatment, while 72/94 (77%) had undergone surgical treatment and 17/94 (18%) a hysterectomy. Twenty-five (27%) women allocated to transcervical resection of the endometrium had undergone further surgery, 18/93 (19%) a hysterectomy. At five years women initially randomised to medical treatment were significantly less likely to be totally satisfied. It was concluded that a policy of immediate transcervical resection of the endometrium for women referred to a gynaecologist for treatment of heavy menstrual loss achieves higher levels of satisfaction, better menstrual status, and greater improvements in health related quality of life than medical treatment. An effective endometrial ablative technique should be offered to all eligible women seeking treatment of their heavy menses from a gynaecologist.