

“BENEFITS AND PITFALLS OF OPEN POWER MORCELLATION OF UTERINE FIBROIDS”

ROBERT L. BARBIERI, MD
(EDITORIAL; FEBRUARY 2014)

How I avoid open power morcellation

Several gynecologic surgeons at my hospital (I am one of them) have developed approaches to hysterectomy and myomectomy that avoid open power morcellation.

For laparoscopic hysterectomy, we place two or three 5-mm ports and use a retroperitoneal approach. We identify the ureters in the retroperitoneal space and trace them into the pelvis. They often need to be lateralized in cases involving endometriosis or large fibroids. We then coagulate the uterine artery where it crosses over the ureter, as the vessel is smaller and straighter in this location. This strategy reduces blood loss and lessens the need to fulgurate the vessels at the cervix, where the ureter is vulnerable to injury.

When the uterus is large, we morcellate it transvaginally or through a 3-cm transverse suprapubic incision after placing a retractor. Be aware that 60% of women with fibroids can have coexisting adenomyosis. As Dr. Barbieri noted in his editorial, use of an internal morcellator can disperse small tissue fragments throughout the peritoneal cavity, where they may “re-implant” and undergo malignant transformation.

For laparoscopic myomectomy, I place 600 µg of misoprostol—a very potent drug used to contract the uterus, with a large safety margin—in the rectum before starting the surgery, to help reduce blood loss. I also place atraumatic vascular clips on the uterine vessels in the retroperitoneum and on the utero-ovarian ligaments. Along with the use of vasopressin, these techniques markedly



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reduce blood loss. A 3-cm transverse suprapubic incision then is used, with fibroids removed through a retractor and the uterus then repaired.

Traditional laparoscopy enables the surgeon to change the degree of Trendelenburg, which is very helpful.

Our patients almost always go home within several hours. On postoperative day 2, most of them report needing only nonsteroidal anti-inflammatory drugs for pain and say they are eating and ambulating well. In my experience, these patients appear to have much less postoperative pain than those who undergo vaginal hysterectomy.

In 2012, 97% of major gynecologic surgical cases at my hospital were minimally invasive, with a very low complication rate. The procedures included resection of severe endometriosis, removal of very large uteri, myomectomy, and treatment of endometrial cancer, including node dissection.

Ray Wertheim, MD

Director of the AAGL Center of Excellence
Minimally Invasive Gynecology Program
Inova Fair Oaks Hospital
Fairfax, Virginia

Morcellated leiomyosarcoma is a very real risk

As a gynecologic oncologist at the University of Miami, I saw at least three cases (referred to us) of morcellated leiomyosarcomas. Within 1 or 2 months of the original surgery, each patient had to be returned to the operating room (OR) for an exploration, and disseminated tumor was found. No patient survived beyond 1 year. Therefore, I was surprised at the 5-year survival rate of 46% presented in Dr. Barbieri’s editorial.

Karen Nishida, MD
Miramar, Florida

>> Dr. Barbieri responds

I appreciate Dr. Wertheim’s excellent surgical pearls. Clinicians at the Inova hospitals are national leaders in advancing women’s health.

I agree with Dr. Nishida that open power morcellation of an occult leiomyosarcoma likely worsens the prognosis of the patient. Even with intensive treatment some of these patients will die within 2 years from sarcomatosis.

“OVARIAN TERATOMA (DERMOID CYST) AND ENCEPHALITIS: A LINK TO KEEP ON YOUR RADAR”

ROBERT L. BARBIERI, MD, AND RACHEL M. CLARK, MD (EDITORIAL; JANUARY 2014)

A likely case of encephalitis linked to teratoma

I enjoyed the interesting case presented by Dr. Barbieri and Dr. Clark in their editorial on ovarian teratoma and encephalitis. A few months ago a neurologist called me about a similar case. The patient was experiencing seizures and had a 17-cm mass beneath the umbilicus. I agreed to resect the mass, which was suspicious for an immature teratoma, and the patient recovered slowly.

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I am glad to see this reference in the literature now. I am sure the editorial by Dr. Barbieri and Dr. Clark will prove handy to our colleagues.

Courtney Ridley, MD
Sacramento, California

» Dr. Barbieri responds

I appreciate Dr. Ridley taking time from her busy practice to write about her experience with an ovarian tumor and encephalitis. The practice of obstetrics and gynecology is very rewarding because we are always encountering new ideas and constantly evolving our approaches to patient care. The link between encephalitis and ovarian teratoma was discovered only in 2007. It is regrettable that many women likely died before 2007 because they did not undergo timely removal of an ovarian teratoma, a simple operation.

“21ST CENTURY NORMS FOR ASSESSING THE PROGRESS OF LABOR”

ROBERT L. BARBIERI, MD
(EDITORIAL; DECEMBER 2013)

Trend toward longer labors is not progress

I would like to mention several points not raised in Dr. Barbieri’s editorial on 21st Century labor “norms.” First, the question is not how long the labor is but whether it involves continuous descent. If the fetus does not come down, it won’t come out. Guidelines are useful only for those obstetric care providers who lack the experience to make that judgment.

When cesarean delivery follows a long second stage, the surgery is difficult and dangerous because the anatomy is distorted, and tissues are friable and often infected.

Further, a long second stage is associated with increased rates of

stress urinary incontinence, uterine and vaginal prolapse, and even postpartum fistula.

Long labors also are associated with an increased risk of postpartum hemorrhage. All of the postpartum hysterectomies I have seen performed in the past few years have followed long labors.

Long labors—especially a long second stage—are associated with increased rates of fetal infection and birth trauma and, therefore, an increased risk of cerebral palsy and NICU admission.

I strongly suspect that if one calculated the costs correctly, a very long labor (>24 hr) would be much more expensive than a scheduled cesarean delivery.

In my opinion, this trend toward longer labors is not progress.

Approaching it as such is, in many ways, misguided.

Robert D. Dyson, MD, PhD
Portland, Oregon

» Dr. Barbieri responds

I appreciate Dr. Dyson’s wise warnings. In my editorial, I did not focus adequately on the potential pitfalls of permitting long labors. I agree that the longer the second stage, the more likely that fetal and maternal complications will ensue. More information is needed to assess the safety of permitting a prolonged second stage.

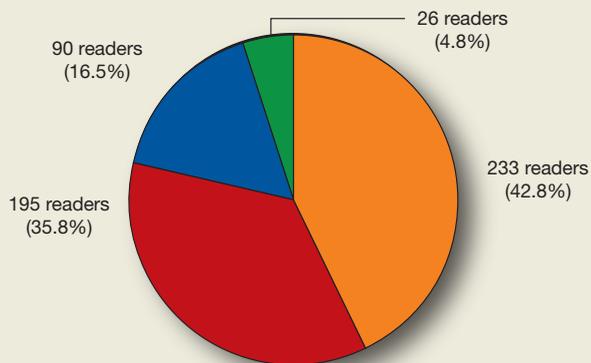
In the past, I felt very uncomfortable permitting a second stage lasting longer than 3 hours. However, based on recent reports, my current practice is to be patient and permit the second stage to continue for up to 4 hours or longer.

Quick Poll results suggest that many obstetricians prefer to nudge labor along

The OBG MANAGEMENT Quick Poll for December 2013 took as its subject Dr. Robert L. Barbieri’s editorial on “21st Century norms for assessing the progress of labor.”

Our poll asked: **Do you favor the use of amniotomy and early oxytocin administration in the management of normal labor?** More than 500 readers responded:

- **233 readers (42.8%)** reported that they actively manage labor using both amniotomy and oxytocin
- **195 readers (35.8%)** reported that they do not favor amniotomy and early oxytocin but prefer to be patient and wait
- **90 readers (16.5%)** said they actively manage labor using amniotomy
- **26 readers (4.8%)** said they actively manage labor using oxytocin.



To participate in the latest Quick Poll, go to obgmanagement.com